NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

To be held on Thursday, 25 July 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 Mimnagh	GP Board Member	(AM)
Dr Ricky Sinha	GP Board Member	(RS)
Dr Paul Thomas	GP Board Member	(PT)
Dr John Wray	GP Board Member	(JW)
Roger Driver	Lay Member	(RD)
Lin Bennett	Practice Manager - 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)
Peter Morgan	Strategic Director, Sefton MBC (Co-opted Member)	(MC)

The meeting will be preceded by the following presentations:

(1) Update on Merseycare NHS Trust's application for Foundation Trust status by Fleur Blakeman

(2) Public Health Presentation by Margaret Jones.

No	Item	Lead	Verbal/ Report	Action
Introductory				
GB13/87	Apologies for Absence	Chair	Verbal	To note
GB13/88	Declarations of Interest	Chair	Verbal	To note
GB13/89	Minutes of Previous Meeting	Chair	Report	To approve
GB13/90	Action Points from Previous Meeting	Chair	Report	To discuss
GB13/91	Business Update	Chair	Verbal	To note
GB13/92	Chief Officer Report	FLC	Report	To note
GB13/93	Portfolio Leads Update	All	Verbal	To note
Performance				
GB13/94	Performance Reports			

Agenda

No	Item	Lead	Verbal/ Report	Action
	(a) Finance Update	MMcD	Report	To note
	(b) Prescribing Update	BP	Report	To note
	(c) Corporate Performance Report	MC	Report	To note
GB13/95	2012/13 Results of Prescribing Quality Scheme	BP	Report	To approve
Strategy				
GB13/96	Community Anti-Coagulation Service Procurement - Update	Billie Dodd	Report	To approve
Governance				
GB13/97	Assurance Framework	TJ	Report	To note
GB13/98	Update of Terms of Reference – Board Committees	TJ	Report	To approve
GB13/99	Multi Practice Locality Membership	SA	Report	To approve
Information				
GB13/100	Minutes of Committees	Various	Reports	To note
	a) Audit Committee *[no meeting held]*			
	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 - (1) Bootle (combined with S&L) (2) Crosby (3) Maghull (4) Seaforth and Litherland			
GB13/101	Register of Interests	FLC	Report	To note
GB13/102	Hospitality Register	FLC	Report	To note
GB13/103	Any Other Business			
GB13/104	Date, Time and Venue of Next Board Meeting Thursday, 26 September 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).

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Minutes

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

Attended		
Dr Clive Shaw	Chair, GP Governing Body Member	(CS)
Dr Craig Gillespie	Clinical Vice-Chair, GP Governing Member	(CG)
Dr Steve Fraser	GP Governing Body Member	(SF)
Dr Andrew Mimnagh	GP Governing Body Member	(AM)
Dr Ricky Sinha	GP Governing Body Member	(RS)
Roger Driver	Lay Member	(RD)
Lin Bennett	Practice Manager - Governing Body Member	(LB)
Sharon McGibbon	Practice Manager - Governing Body Member	(SMG)
Dr Dan McDowell	Secondary Care Doctor, Governing Body Member	(DMcD)
Fiona Clark	Chief Officer	(FLC)
Martin McDowell	Chief Finance Officer	(MMcD)
Debbie Fagan	Chief Nurse	(DF)
In Attendance		
Malcolm Cunningham	Head of Performance and Health Outcomes	(MC)
Brendan Prescott	Medicines Management Lead	(BP)
Stephen Astles	Head of CCG Development	(SA)
Sarah McGrath	Locality Manager	(SMG)
Lyn Cooke	Communications Manager MCSU	(LC)

The formal Governing Body meeting commenced following a brief period when members of the public were able to highlight any particular areas of concern / interest and address questions to Governing Body members.

The Chair welcomed everyone to the meeting and gave a background to the development and work of South Sefton Clinical Commissioning Group. The members of the CCG introduced themselves. The meeting noted that there have been and would continue to be opportunities for members of the public and stakeholder groups to contribute and influence the development of the CCG.

Written Question 1

Is health and wellbeing a priority within the CCG? If so is there any funding available for this. The Council has said they are closing the bowling greens. This proves a social and healthy exercise for a large number of people. To remove this socialising will deny them this exercise and socialising.

CS acknowledged the health and well-being benefits of socialising and exercise. CS further noted that the council owns the leisure facilities and currently faces enormous financial difficulties. He suggested that collaborative work should continue, with agencies, to address issues of this nature on a holistic level and potentially provide creative financial solutions where possible.

Written Question 2

a *As we have a National Health Service, why have services been divided both geographically and financially?*

b *Sefton is a small area – why do we need both a north and south CCG?*

c *Will patients have choice of provider in other regions – in particular will I be able to attend Ormskirk hospital*?

CS invited MMD to respond to this question. It was noted that due to the enormity of the NHS budget and in the interest of increased local input in the decision making process CCGs had been set up on a geographical footprint. Budgets have been allocated accordingly.
Southport and Formby and South Sefton CCGs have been set up as separate CCGs and further subdivided into eight localities. This is intended to improve connections with local people and improve productivity. Where it is considered appropriate, services will be jointly commissioned to achieve maximum value for money.
Patients can attend for treatment at any hospital that has suitable provision via the Choose and Book Service.

Question from the floor

Is there any chance of a Walk in Health Centre for the Maghull area?

CS noted that this has been an aspiration for some time. Due to complications regarding finance and land availability this has not yet come to fruition. This will continue to be an aspiration, however, cannot be guaranteed at this time.

There were no further questions.

CS completed this part of the meeting by thanking the Governing Body Members, in particular Fiona Clark Chief Officer and Craig Gillespie GP Governing Body Member Clinical vice Chair for their recent support during his short absence from the Governing Body.

The formal meeting was preceded by a presentation by Dr Pete Chamberlain on the Virtual Ward Project.

No	Item	Action
13/58	Apologies for absence were received from: Lynda Elezi, Vice Chair, Lay Member Dr Paul Thomas, GP Governing Body Member Dr John Wray, GP Governing Body Member Margaret Carney, Chief Executive, Sefton MBC (Co-opted Member)	To note
13/59	Minutes of Previous Meeting The minutes of the previous meeting were recorded as a true and accurate record pending an amendment on page 4.	To approve

No	Item	Action
13/60	**Action Points from Previous Meeting** All actions from the previous meeting were closed save for the following which remain open. 13/33 Discussions regarding the CCG Constitution are ongoing with the NHS England (Merseyside) Team. SA will bring back to a development session at a future date. 13/41 Work is continuing on summary care and an update will be brought to the next Governing Body meeting. This will incorporate IT provision. 13/44 Healthy Schools Initiative Sefton Council does not lead healthy schools initiative although it did provide a portion of the funding. This service is under review by the local authority. Janet Atherton is bringing together a group to discuss who will promote health in schools. There will be further updates in due course.	FLC PT DF
13/61	**Business Update** CG reported that he had attended the CCG Network meeting where challenges were discussed including; driving forward commissioning strategies that would benefit from a collaborative approach e.g. Out of Hours Provision, NHS 111 and emergency planning. CG further reported that he has attended the Health and Well-Being Board which had furnished an opportunity for peer review. Discussions had taken place surrounding the communication plan, public and patient involvement and CCG strategic plan. CG had also attended the CCG accountability review where he met with the Merseyside Team of NHS England to provide further assurance regarding CCG capacity for delivery going forward. This included assessment of the CCG's ability to fulfil its duties but also identified the support that may be required by the CCG. Discussion took place around current performance and it was agreed the in general terms capacity will match demand. **The Governing Body noted the business update**.	
13/62	**Chief Officer Report** FLC presented the Chief Officer report. Particular attention was drawn to the detailed safeguarding update provided by the Chief Nurse. FLC further noted that a new CCGdraft assurance framework was now in place and the discussions continue with NHS England (Merseyside) as to how this will be monitored. FLC also drew attention to the letter received from Sir David Nicholson addressing elements of whistleblowing/gagging policies of some organisations. As there is now clear direction on this issue the CCG constitution will need to be amended. **The Governing Body noted the contents of this report.**	FLC

No	Item	Action
13/63	**Portfolio Leads Update** CG reported that he had attended a Quality Review meeting with University Hospital Aintree NHSFT as a result of an action from Quality Committee meeting at Aintree NHSFT. Clinicians and Officers from all three CCGs attended the meeting, following which an action plan has been drawn up. This meeting will be followed by a further quality review later in the year. SF noted that new IT Lead – Alison Johnson is now in post. Changes regarding IT information flows Aintree into GP practices have been implemented. EMIS Practice Technology – a number of GP practices have transferred to this system during May 2013, which will provide more detailed information and improve the ability of practices to address coding issues. RS noted that the shared care protocol regarding Mental Health has been approved by LMC and will be implemented. AM updated the Governing Body that Urgent Care and NHS 111 continues to be a pressure on the system. He further reported that Local CCG's have decided on collaborative approach. NHS 111 is operational in Sefton, though it is being supported by Out of Hours providers. DMcD reported that a meeting has taken place with the Consultant Geriatrician at Aintree UHNHSFT who are ready to proceed with 2 clinics. Issues with ward 35 are now resolved. DMcD confirmed that this facility is reserved for South Sefton CCG. RD noted that the EPEG group has held a number of development sessions with local partners and has good engagement links with local community champions. FLC reiterated that the EPEG group become the critical friend of the CCG and should challenge the CCG on delivering on the NHS constitution. LB reported that efforts to improve patient engagement continue with an emphasis on making patient reference groups more interactive. SMG reported that Practice Managers feel supported and that they both she and LB are receiving messages of thanks for their support. **The Governing Body noted the verbal updates from the Portfolio Leads**	

13/64	**Performance Reports**	
	(a)**Finance Update** MMD presented this month 12 update and asked the Governing body to note the underspend of £2m at year end which represents a sound financial performance. As the CCG has operated within fixed price agreements in 12/13 there has been no overspend with hospital providers. Going forward we are at a breakeven position. **The Governing Body noted the contents of this report.**	
	(b) **Prescribing Update** BP presented this report which presented the Governing Body with an update on the prescribing budget position based upon month 11 (February 2013) prescribing data. 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. Work at practice level continues balancing practice requirements and the CCG commissioning intentions for medicines optimisation. The medicines optimisation plan for 2013-14 has been presented and approved at the Medicines Operational Group and the CCG Finance and Resource Committee. **The Governing Body noted the contents of this report.**	
	(c) **Update on Care Home Review Service** BP presented this report which provided a summary of outcomes of the South Sefton Care Home Review Service. LB commented that lessons learned from this service had been valuable and feedback from patients had been positive. **The Governing Body noted the contents of this report and recommended that a business case be submitted to the Finance and Resource Committee.**	BP
	(d) **South Sefton Sip Feed Project Report** BP presented this report which summarises the South Sefton CCG sip feed review project which ran for 12 months to promote effective use of oral nutritional supplements and promote education on nutritional screening. 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. **The Governing Body noted the contents of this report and recommended that a business case be submitted to the Finance and Resource Committee**	

	(e) **Activity and Quality Report** MC presented the Activity and Quality Report. Attention was drawn to: 1. C.Diff, March: for Aintree there were 72 cases against a tolerance of 53, therefore target has been breached in 12/13. Work is ongoing between the Trust and South Sefton CCG to reduce the number of infections in the health economy 2. Stroke - Aintree reported that 73.1% of patients spent at least 90% of their time on the stroke unit against a target of 80% for Q4. Work is ongoing to improve the patient pathway. Under performing Trusts have been asked for recovery plans. 3. Aintree A&E performance: Aintree met the year-end target of 95% of people being seen and treated within 4 hours; however performance declined during April and early May. Performance has improved towards the end of May as demand had seemingly reduced. **The Governing Body noted the contents of the report.**	
13/65	**Draft Strategic and Operational Commissioning Plan 2013-2016** MMD presented this plan which 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 — 13th July 2013 Ratification of plan by Governing Body — 25th July 2013 **The Governing Body noted the contents of the report and the table of next steps.**	
13/66	**Draft CCG Prospectus** SA presented the draft prospectus and noted that 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 provide transparency regarding spending. **The Governing Body approved the draft prospectus.**	
13/67	**Virtual Ward Update** PC presented this quarterly update report to the Governing Body. The identified the processes relating to the implementation of the Virtual Ward Model of care. The next report will be submitted August 2013. Specific comment will be included regarding risk stratification. **The Governing Body noted the contents of the Virtual Ward Update.**	

13/68	**Cancer Services** Sarah McGrath presented the Governing Body with an update on local cancer services. The report provided a summary of issues and plans around cancer. 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 Governing Body in the next quarter. **The Governing Body noted the contents of this report.**	gap
13/69	**Conflicts of Interest Policy** FLC presented this report regarding managing conflicts of interest appropriately, which is essential for ensuring sound, transparent decision-making and local accountability. The CCG aims to demonstrate the highest levels of integrity in the way that it conducts business. There were a few suggested amendments. The Register of Interests which is published in the May Governing Body 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. **The Governing Body approved the CCG Policy on Managing Conflicts of Interest pending the replacement of the statement "GP or any other individual" with "any individual" and the other amendments.**	FLC
13/70	**Board Assurance Framework** FLC presented 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 close 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. The Governing Body noted that quarterly risk registers will be added to this report. **The Governing Body noted the Board Assurance Framework.**	FLC
13/71	**Update of Terms of Reference – Governing Body Committees** As amendments are required to the Terms of Reference FLC requested that this item be deferred until the July 2013 Governing Body meeting. **The Governing Body agreed to defer this item to the meeting in July 2013**	TJ

13/72	**Register of Interests** FLC presented the register of interests and noted that the Governing Body needed to be vigilant in terms of all declarations of interest being recorded including those from the from wider membership. SMG noted that her declaration relating to her partner required amendment. DF noted that her declaration needed to be added to the register. **The Governing Body noted the contents of this report.**	SMG DF
13/73	**Hospitality Register** The Governing Body noted that there were no items of hospitality recorded on the register. **The Governing Body noted the contents of this report.**	
13/74	**Minutes of Committees** Audit Committee Nothing to further to add to the minutes. Quality Committee Nothing to further to add to the minutes. Finance & Resource Committee Nothing to further to add to the minutes. Merseyside CCG Network Nothing to further to add to the minutes. Health and Wellbeing Board Nothing to further to add to the minutes. Medicines Management Operational Group Not available at this time. Strategic Integrated Commissioning Group Nothing to further to add to the minutes Engagement and Patient Experience Group Not available at this time. Locality Meetings - Crosby Locality Maghull Locality Bootle Locality Seaforth Locality Minutes of locality meetings not available at this time. The Governing Body noted the contents of the minutes from other committees.	
13/75	**Any Other Business** There were not items of other business.	

CS read the following statement:

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).

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Action Points

Thursday, 30 May 2013 at 1.00pm to 4.00 pm

No	Item	Action
13/60	**Action Points from Previous Meeting** 13/33 Discussions regarding the CCG Constitution are ongoing with the NHS England (Merseyside) Team. SA will bring back to a development session at a future date. 13/41 Work is continuing on summary care and an update will be brought to the next Governing Body meeting. This will incorporate IT provision. 13/44 Healthy Schools Initiative Sefton Council does not lead healthy schools initiative although it did provide a portion of the funding. This service is under review by the local authority. Janet Atherton is bringing together a group to discuss who will promote health in schools. There will be further updates in due course.	FLC PT DF
13/58	**Performance Reports** (c) **Update on Care Home Review Service** The Governing Body noted the contents of this report and recommended that a business case be submitted to the Finance and Resource Committee.	BP
13/69	**Conflicts of Interest Policy** The Governing Body approved the CCG Policy on Managing Conflicts of Interest pending the replacement of the statement "GP or any other individual" with "any individual" and the other amendments.	FLC
13/70	**Board Assurance Framework** This report close 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.	FLC
13/71	**Update of Terms of Reference – Governing Body Committees** As amendments are required to the Terms of Reference FLC requested that this item be deferred until the July 2013 Governing Body meeting.	TJ
13/72	**Register of Interests** SMG noted that her declaration relating to her partner required amendment. DF noted that her declaration needed to be added to the register.	SMG DF

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2013

Agenda Item: 13/92	**Author of the Paper:**
Report date: 15 July 2013	Fiona Clark Chief Officer fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7061
Title: Chief Officer's Report	
Summary/Key Issues: This paper presents the Governing Body with the Chief Officer's monthly update.	
Recommendation The Governing Body is asked to note the contents of this report.	Note [x] Approve [ ] Ratify [ ]

Links to Corporate Objectives *(x those that apply)*	
	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 *(x those that apply)*
Patient and Public Engagement			x	

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
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 *(x those that apply)*	
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
July 2013

1. 111 Update

1.1. The 111 service went live on 21 March 2013 currently NHS Direct handle approximately 30% of the planned and contracted call volumes. Presently OOHs providers, NWAS and the 0845 national contingency arrangements are dealing with the other 70% and contingency arrangements have been made.

1.2. The South Sefton and Southport & Formby CCGs Local Clinical Assurance Group (LCAG) continue to meet to fulfil their clinical governance assurance function for the service. Proper and full reporting will ensure that the LCAG has a full picture of what has and is happening with service delivery to patients and the performance of the contract. Central Government has confirmed its commitment to the NHS 111 concept.

1.3. Clinicians from across the North West have met to consider the model of NHS 111 and have worked on this within the framework of the national model for NHS 111 to consider the options to improve and develop the services to ensure they are fit for purpose for the future.

2. Strategic Plan

2.1 The CCG Management Team are meeting with Clinical Programme Leads to develop plans which build upon the work undertaken in the last Board Development Session. These plans are due to be presented by the Head of CCG Development to the Senior Management Team in last July for further discussion.

2.2 Plans are expected to be agreed with clinical programme leads by mid-August and will then be consolidated into an overall plan for the CCG which looks at proposals within the overall affordability envelope.

2.3 This plan will then be shared with the Wider Constituent Group who will be asked to comment and approval before ratification by the Governing Body in the September meeting.

3. CQC Thematic Inspection

3.1 The CQC is undertaking a themed inspection programme focussing on transition arrangements for children with complex health needs to adult services. Information on individual cases was uploaded to the CQC system by the CSU in time for 15 July 2013 deadline.

3.2 The CCG is awaiting the outcome of this thematic inspection which could also include a site visit by the CQC to the local area. From an accountability perspective, the Chief Nurse has been identified to the CQC as the lead officer for this thematic inspection.

4. Safeguarding Children

4.1. Sefton Council are expecting a safeguarding children statutory inspection imminently (the date has yet to be confirmed).

4.2. Although the inspection will concentrate on local authority processes there may need to be involvement from the CCG and constituent practices regarding partnership working within Sefton regarding safeguarding. This has been reported to the Quality Committee who asked for communication to be commenced between the CCG and the Local Authority. The CCG has received some general information regarding the inspection process and are awaiting formal briefings to commence.

4.3. From an accountability perspective, the Chief Nurse will be the lead officer for any involvement by the CCG with support from the Safeguarding Hosted Service, Designated Doctor Safeguarding Children and Named GP for Safeguarding Children.

5. Safeguarding Adults

5.1. The CCG have been contacted by NHS England (Merseyside) following an alert from the national team about a seclusion concern in a provider unit outside of the North West. The CCG has been asked to provide assurance regarding awareness of the outcomes of CQC inspections within Learning Disability service providers, and the CCG has also been asked to cooperate by providing any necessary local intelligence.

5.2. The CCG has responded giving assurances around locally commissioned services. The Chief Nurse has asked for mutual assurance for those services commissioned by the Specialist Commissioning Team which responsibility for sits within NHS England.

5.3. The CCG is not aware of any safeguarding and patient safety issues in relation to any of the CCG residents who are placed in provider units which are commissioned by the Specialist Commissioning Team.

6. Francis (2) CCG Action Plan

6.1 This action plan has been completed and presented to the Quality Committee in June 2013. This will also be presented to the Audit Committee in September 2013. Monitoring of progress will be via the Quality Committee.

6.2 The Chief Nurse is liaising with the CCG Head of CCG Corporate Delivery and the CSU Lead for Organisational Development to further develop this plan and deliver on the actions contained within, including the internal focus on the CCGs own development needs in this area.

7. Public Health Procurement and Review Activity (Local Authority)

7.1. Public health is undergoing three large reviews which will incorporate their current commissioned activity. These are:

- Healthy Weight Services
- Integrated Well being services
- Adult and young people substance misuse services.

Following the review; the aim is to procure new services for 1st April 2014, Sefton Council have mapped all stakeholders and identified how they would like to work with them and the types of communication to enable fullest coverage and participation.

7.2. Provision for both Sexual Health and School Nursing Provision is currently being reviewed and procurement schedules defined with advertisement for expressions of interest.

8. Pioneers In Integration Care & Support Bid – West Lancashire/Southport & Formby/South Sefton Bid

8.1. At a time of wide-spread pressures on urgent care services, ageing populations and with many eyes focused on the NHS, working together in collaboration and striving for improvement has never been more important. An opportunity has arisen to participate in a national programme and therefore an expression of interest has been submitted to become a national Pioneer Site for Integration.

8.2. The joint vision for our community is simple – that they are **"Happy, well and independent"** and in essence it is about delivering better outcomes and streamlined care; and allowing for everything to be in place so that our communities can have a good and healthy life. Our ambition is to boost our integration work, while keeping a firm grasp of both the detail and the wider picture, so we can deliver the improvements our health economy, partners and local communities need. Being a pioneer site is not only a promising and natural next step, it will be a catalyst to enable us to progress our work with energy and results, allowing us to showcase the possibilities and educate our colleagues across the country. This will not only shape and enhance our own local journey, but also inspire others to do the same – in turn strengthening healthcare across the country.

8.3. There are a broad range of partners participating in this integration, including: NHS Southport & Formby CCG; NHS West Lancashire CCG, NHS South Sefton CCG; Southport & Ormskirk Hospital NHS Trust (Integrated Care Organisation); Mersey Care NHS Trust (Mental Health); Liverpool Community Health NHS Trust; Lancashire County Council; West Lancashire Borough Council; Sefton Council; Sefton Council Voluntary Services, West Lancashire Council of Voluntary Services, Independent Sector and Primary Care. An outcome is expected in Autumn 2013.

9. 2015/16 Department of Health Settlement

9.1. As part of the recent spending review announcement, the Department of Health has received details of its proposed funding settlement for 2014/15 and 2015/16. This again confirms real-terms growth funding to the NHS of 0.1%. The GDP deflator has been estimated at 1.8% leaving the overall increase to allocations at 1.9%.

9.2. As part of the settlement, CCG's are expected to provide additional new funding for a pooled arrangement with local authorities in 2014/15 and 2015/16. The impact on the CCG for the next financial year is estimated to be in the region of 0.750m rising to £7.000m in 2015/16.

9.3. This announcement and the creation of a joint fund between the NHS and local authority will mean that a large proportion of the growth funding allocated to CCG's over the timescale will need to be ring-fenced to support the initiative.

9.4. NHS England may issue allocations to CCG's for 2015/16 as part of the expected allocation process due in December of this year. This measure will be introduced to allow CCG's to plan for the impact of the significant increase in funding over a longer timescale.

10. Section 251 of the NHS Act 2006

10.1. NHS England have issued conditional approval for commissioning data flows under Section 251 to advise CCGs and CSUs regarding the steps that will need to be taken to ensure that processing of data remains lawful.

10.2. The Secretary of State has approved an application by NHS England for Section 251 support to transfer personal confidential data from the Health and Social Care Information Centre (HSCIC) to those commissioning organisations that are intending to become Accredited Safe Havens (ASHs).

10.3. This allows Commissioning Support Units access to personal confidential data until 31 October 2013 as long as they meet minimum standards set out by the HSCIC. This approval has a number conditions:

10.3.1. data flows – only covers outbound flow of personal confidential data (PCD) from HSCIC to ASH to support specific commissioning purposes, which means:

(i) PCD cannot lawfully flow from providers directly to CCGs or CSUs;

(ii) PCD cannot lawfully flow from GP practices directly to CCGs or CSUs.

10.3.2. PCDs cannot be used for finance invoice validation.

Risk stratification

10.4. The scope of Section 251 does not extend to risk stratification. NHS England has published "Information and Risk Stratification Advice and Options for CCGs and GPs" to further advise on how data can be used in line with legal requirements.

10.5. This includes a 'checklist' for CCGs, GP practise and other organisations conducting risk stratification for case finding purposes.

10.6. Members of the CCG are asked to review this document and share any views/issues with CCG officers.

11. Procurement of CSU

11.1. Work is underway to map out the timeline and necessary actions required for our duty to consider the re-procurement of the Commissioning Support services in line with the national guidance.

11.2. Dr Steve Fraser is the Governing Body lead for South Sefton CCG who will work alongside Tracy Jeffes-Head of Delivery. The Governing Body will be kept informed of progress.

12. Keogh Review

12.1. Professor Sir Bruce Keogh, National Medical Director for NHS England, was asked by the Prime Minister and Secretary of State for Health to conduct a review.

12.2. This review considered the quality of care and treatment provided by hospital trusts with persistently high mortality rates.

12.3. The Keogh review comments on the NHS being the only healthcare system in the world in which a definition of quality is enshrined in legislation. The NHS should excel in all three elements of quality:

12.3.1. effectiveness;

12.3.2. patient safety; and

12.3.3. patient experience.

12.4. The report considered 14 Trusts who were identified as outliers for the last two consecutive years of either Summary Hospital-Level Mortality Index (SHMI) or Hospital Standardised Mortality Ratio (HSMR).

12.5. The report focused on diagnosis and treatment with support and development, as opposed to identification of problems. The methodology was outlined and the Keogh report not only provides each of the 14 individual Trusts with feedback, but also identifies common themes or barriers to delivering high quality care. These include:

12.5.1. patient experience;

12.5.2. safety;

12.5.3. workforce;

12.5.4. clinical and operational effectiveness;

12.5.5. leadership and governance;

12.5.6. interpretation of data and its analysis;

12.5.7. recruitment of high quality staff and over-reliance on locums and agency staff;

12.5.8. lack of value placed on frontline clinicians as ‘patient champions’

12.5.9. the cultural ‘mind-set’ of accountability versus blame and the use of data at board level for reassurance versus a more rigorous pursuit of improvement.

12.6. The role of the Care Quality Commission (CQC) and its relationship between the CQC and Clinical Commissioning Groups and regulators via the newly formed Quality Surveillance Groups.

12.7. All of the 14 organisations have been rigorously reviewed and a summary of the findings and actions of all 14 are included – action plans are in place and are to be enacted with serious consequences for failure to do so.

12.8. The report also provides learning from the review process itself, together with stating 8 ambitions for action.

12.9. The implications for the CCG are as follows:

12.9.1. to ensure good working relationships are maintained with providers and other partners, which are robust, challenging and transparent across the healthcare system to work for the benefit of the patient;

12.9.2. to continue an active leadership role for CCG quality through the GP Clinical Quality Lead and Chief Nurse accountable to the Governing Body;

12.9.3. to actively participate in the Merseyside Quality Surveillance Group, drawing on lessons and improvements to share;

12.9.4. to actively engage and support by understanding our role with clinicians in our provider organisations;

12.9.5. to ensure the development of mechanisms for patient engagement continue to inform the Governing Body.

A copy of the report can be reviewed in full at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf.

13. Aintree Hospitals NHS Foundation Trust

13.1. The CCG was informed on in June that Monitor had issued a letter indicating their intention to investigate a possible breach of licence. As a result of this the CCG Aintree Collaborative Commissioning Forum considered the issues and this resulted in a contract query being raised in respect of the following areas;

- A&E performance
- RTT performance
- HCAI performance
- Mortality rates

13.2. A joint investigation meeting was held on the 15th July 2013 in line with contractual requirements and all concerns explored in detail with the Trust, Merseyside Deanery, NHS England (Merseyside), Public Health England, Local Authority and CQC colleagues.

13.3. A Strategic Partnership Board for Aintree is to be established, consisting of Trust Executives, CCG Leadership across the three CCGs (Knowsley, Liverpool and South Sefton CCGs) the three Local Authorities, NHSE (Merseyside), CQC, Monitor and the Deanery. This Board will oversee the many strands of work required to improve delivery in the areas. The Governing Body will receive further details of this action plan and the CCCG quality committee will have a major role in assuring the Governing Body of progress in delivering this plan.

14. The NHS belongs to the people: a call to action

An important engagement exercise on the future of NHS services with ambitions to capture a wide range of feedback has been launched by NHS England. 'The NHS belongs to the people: a call to action' sets out the current position of the NHS and describes the challenges facing it such as restricted funding, a growing older population and rising expectations of the NHS should do.

For more information: http://www.england.nhs.uk/2013/07/11/ccg-bulletin-issue-37/#action

15. Draft Governance Code for CCGs

Recognising the governance challenges facing CCGs as they become established, the Institute of Chartered Secretaries and Administrators (ICSA) has created a draft governance code to support clinicians in developing good governance arrangements, and to help build and maintain public trust in CCGs and the NHS as a whole.

ICSA has worked with an expert panel, chaired by Lord Hunt of Wirral (Chair of the Press Complaints Commission and the Lending Standard Board) who was formerly a regulatory law specialist from DAC Beachcroft, to shape the draft code. The panel represents all the specialities required within the governing body of a CCG and draws upon their experience of the NHS and effective governance.

To make sure the draft code is as practical and relevant as possible, ICSA is now seeking feedback through an expert review process from those working in the NHS and those with considerable knowledge of its governance challenges. ICSA's aim is to produce a final code that has been developed for the health service by the health service, and CCGs' input will be central to this.

View the expert review and draft code: https://www.icsaglobal.com/clinical-commissioning-groups-code.

For more information: http://www.england.nhs.uk/2013/07/11/ccg-bulletin-issue-37/#assessment

16. NHS England's 'ways of working' with CCGs launched

NHS England and NHS Clinical Commissioners (NHSCC), as the independent collective voice of CCGs and its representative body, have been working together to co-produce ways of working that support CCGs and NHS England. The ways of working flow from NHS England's vision and purpose and are integral to the way NHS England works.

For more information: http://www.england.nhs.uk/about/our-vision-and-purpose/

17. Re-assignment of Clinical Contracts to NHS England

As part of the ongoing review into legacy PCT issues, additional guidance has been issued to confirm that the accounting balances at the end of 2012/13 financial year relating to clinical contracts have been assigned to NHS England. The rationale for this is to simplify the existing arrangements which would have meant that each balance would have needed to be identified by service line in order to assign it to new commissioner body from 2013/14 onwards.

18. Recommendation

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

Fiona Clark
15 July 2013

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
JULY 2013

Agenda Item: 13/94(a)	**Author of the Paper:**
Report date: 15 July 2013	Martin McDowell Chief Finance Officer Martin.McDowell@southseftonccg.nhs.uk Tel: 0151 247 7065

Title: Financial Update

Summary/Key Issues:

This paper presents the Governing Body with an overview of the financial performance for NHS South Sefton Clinical Commissioning Group as at month 3. It details the performance against annual budget and shows the forecasted end of year 2013/14 financial position.

Recommendation

	x
Note	x
Approve	x
Ratify	

The Governing Body is asked to:

note that the CCG remains on target to deliver its financial targets for 2013/14

approve the Chief Finance Officer's recommendation in terms of virements as outlined in section 3.2

note that the CCG's likely case scenario predicts that the CCG has £1.042m to address unforeseen issues / approve investments during the year

note that CCG's worse case scenario is "amber-rated" in terms of additional actions required to deliver financial targets should the CCG financial position deteriorate.

GB13/94(a)

Links to Corporate Objectives	
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
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			Finance & Resource Committee

Links to National Outcomes Framework	
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

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
July 2013

1. Executive Summary

South Sefton CCG is reporting a year to date position of breakeven as at Month 3 (June). The forecast out-turn position for the year is £2.312m surplus and the CCG is therefore on course to deliver its financial target.

2. Introduction and Background

This is a regular monthly update of the financial position of South Sefton CCG.

3. Key Issues

3.1 Budgets

The Governing Body will be aware that operational budgets were agreed in the May Governing Body meeting. South Sefton CCG has a budget of £233.9m for the financial year 2013/14.

3.2 Virements

The finance team have reviewed values at cost centre level and have made provisional virements (a transfer of budget) from operational budgets to reserves where budgets had been initially over-stated. Under the CCG's scheme of delegation, the governing body must approve virements above £0.500m. The Chief Finance Officer is recommending that a virement of £1.380m is transferred from the reablement cost centre to the contingency reserve.

The Governing Body is asked to approve this virement.

3.3 Baseline Issues

There remains a significant degree of uncertainty regarding the baseline allocations to CCGs as a consequence of assumptions made in the exercise undertaken in 2012/13.

These risks centre upon the baseline adjustment in respect of specialised commissioning services and in terms of programme costs that were incorrectly allocated against NHS England running costs and both of these risks will be reviewed later in this paper.

3.4 Month 3 Financial Performance

Whilst the financial reporting period relates to the end of June, the CCG has only received information from Acute Trusts to the end of May.

The CCG has identified that reablement budget cost centre was over-stated by £1.380m due to a duplication in terms of social care expenditure. The governing body will be asked

to approve a transfer of this value to reserves which means that the figures presented in this paper is subject to this proviso.

South Sefton CCG is £0.612m overspent on operational budgets as at month 3 prior to the application of reserves.

Table A below which shows a summary position for the CCG, a more detailed analysis can be found in Appendix 1.

Table A: Financial Performance: Summary report to June 30th 2013

Budget Area	Annual Budget £000	YTD Variance £000	FOT Variance £000
Services Commissioned from NHS Organisations	161,953	432	1,800
Prescribing	30,000	0	0
Commissioning - Non NHS	19,008	45	0
Corporate and Support Services	4,120	53	40
Independent Sector	3,414	84	300
Primary Care	2,154	(2)	0
Sub Total Prior to Reserves	**221,088**	**612**	**2,140**
Total Reserves	**10,452**	**(612)**	**(2,140)**
Grand Total Expenditure	**231,540**	**0**	**0**
RRL Analysis	**233,852**	**0**	**0**
Planned/ Forecast (Surplus) / Deficit	**(2,312)**	**0**	**(2,312)**

Please note, figures that appear in brackets represent an under spend.

The financial position after the application of reserves is breakeven.

The over spend in operational budgets is attributable to number of pressures as outlined below.

NHS Commissioned Services

This budget is showing a year to date position of £0.432m overspend. This has been caused by an over spend on Acute Commissioning. One of the main factors is the overspend at Aintree Foundation Trust, where at month 2 the trust is under spending against non elective activity targets but over spending against elective targets. The latter is the result of improved performance against referral to treatment (RTT) wait times, The overspending specialities are gastroenterology (£0.150m), ophthalmology (£0.067m) and trauma and orthopaedics (£0.060m).

The St Helens and Knowsley NHS Trust contract is also over spending due to burns care £0.066m and plastic surgery £0.020m.

There are also a small number of contracts under spending including Liverpool Women's NHS Foundation Trust which relate to Gynaecology £0.067m and Obstetrics £0.036m.

Acute Children's Services are overspending by £0.096m due to the Alder Hey contract with paediatric surgery £0.057m, paediatric urology £0.033m being the areas with significant levels of overspending compared with contract.

The level of over spending on acute contracts at the start of the year raises concerns for the CCG and all CCG members are asked to review the information reported on the Mersey Intelligence Portal to support the data checking and validation process

Medicines Management (Including Prescribing)

The Medicines Management budget consists of High Cost Drugs, Oxygen and Prescribing. All areas of spend have a breakeven year to date position as information has yet to be analysed in detail although this will be monitored throughout the year and the next report received by the Finance and Resource Committee will have a clear view of performance. A separate paper will report the approach taken in terms of setting the prescribing budget to the Finance and Resource Committee.

Commissioning Non-NHS

Commissioning from Non NHS organisations is overspent by £0.045m due to various minor overspends against a number of cost centres. These budgets include high cost low volume areas such as continuing healthcare. These budgets had been repaired to reflect the increased number of patients into these services. The CCG is working closely with the CSU to understand the pressures in this area, with the aim for mitigating actions to be put in place to ensure the position is brought back in line with budget by the end of the financial year. Limitations in data mean that the CSU are still working to ensure the reporting system is being updated.

Corporate and Support Services

The CCG is operating within its running cost target with a breakeven year to date position. However corporate commissioning schemes are overspent by £0.053m due to an estates invoice relating to commissioned services, which is currently being investigated. Again, the budget will be closely monitored to bring the position back in line with the plan and target.

Independent Sector

The Independent Sector budget is overspent by £0.084m. This has predominantly been caused by over activity on the Spire Liverpool contract, which is currently £0.044m overspent with the main causes being increased day case and elective care activity.

3.5 Treasury and Legacy issues

The work to disaggregate the balance sheet of NHS Sefton is continuing and recent guidance has been issued from the Department of Health (DH) has advised that any prior year balances that relate to clinical contracts will be inherited by NHS England with a number of exceptions which include continuing healthcare restitution cases. The deadline for the full disaggregation of the balance sheet by successor organisation is the beginning of October.

Once this work has been approved by the DH, the final balance sheets will be shared with successor organisations and the CCG's opening balance sheet will be reported to the Finance and Resource Committee on a routine basis.

3.6 Financial Risks: Specialised commissioning

As previously reported to the Finance and Resource Committee, the CCG was subject to a proposed baseline adjustment of £6.522m in respect of specialised commissioning and this has been reflected in the CCG's baseline allocation. After reviewing this adjustment, the CCG opted to include a negative contracting reserve (£3.261m) within its expenditure budgets on the basis that this adjustment had been over-stated.

The CCG is working alongside commissioning partners to investigate the reasons behind the allocation adjustment and whilst not in a position to confirm final numbers, the CCG has been able to determine that at least £2.100m should be recovered through budget and allocation adjustments which has led to a significant improvement in the CCG's likely case scenario in Appendix 2.

3.7 Financial Risks: Other baseline issues

The baseline exercise undertaken last year was used to establish start point allocations for the successor bodies. Since the exercise it has come to light that some funding was misallocated to successor organisations. The CCG has identified the key areas where these misallocations have taken place and remains in discussion with commissioning partners to work towards correcting these issues where both sides are in agreement. These issues are listed as within Appendix 2 of the report which assesses the likely risks and scenarios.

3.8 Financial Risk and Mitigation: Other issues

Appendix 2 also highlights other risks facing the CCG that have previously been reported. Following the receipt of additional information, the CCG has revised some of its assessments, particularly regarding its worse-case scenario, notably,

- CHC restitution payments – following review of the process, the CSU have advised that not anticipated claims have reduced and the CCG has reduced its assessment in terms of impact on worse case scenario to £0.600m on this basis.

- High Cost drug costs have reduced as the bulk of this risk has now been accounted for within the CCG's operational budgets.

- The CCG plans still include £0.338m for planned investments to support the transformation of primary care.

3.9 Financial Risks and Mitigation

Appendix 2 provides a range of scenarios identifying risks and opportunities, the net of these have then been offset by mitigating actions to ensure the CCG can achieve financial balance in its worse case scenario under the assumptions identified. These mitigating actions are predominantly "amber-rated" as they will require co-operation from other bodies to enact.

The range between the CCG's best and worse-case scenario has reduced significantly during the month as some issues relating to the baseline exercise have been resolved. The range is now £5.994m, equivalent to 2.56%, which is comparatively high and reflects that there is still some work to do to complete the required review of the baseline exercise.

Appendix 2 now reports that the CCG's likely case scenario indicates that it has £1.042m available to cover all remaining risks / deferred investments for the remainder of the year.

Whilst this sum has increased since the last report, it should be noted that it remains early in the financial year and that the CCG remains open to significant levels of financial risk.

The governing body will be asked to review the CCG's current position, which is to defer all uncommitted investments until mitigation plans have been identified, taking account of this information.

Appendix 2 provides a number of mitigating actions to ensure that the CCG can achieve financial balance under the assumptions identified within the worse-case scenario. These mitigating actions are "amber-rated" as they will require co-operation from other bodies will be required to deliver them.

All members of the CCG are asked to support the review of data validation and work closely together to assess referrals into secondary care, noting that the CCG no longer holds a fixed-price agreement for elective services in the secondary care market.

4. Recommendations

The Governing Body is asked to:

4.1. note that the CCG remains on target to deliver its financial targets for 2013/14

4.2. approve the Chief Finance Officer's recommendation in terms of virements as outlined in section 3.2

4.3. note that the CCG's likely case scenario predicts that the CCG has £1.042m to address unforeseen issues / approve investments during the year

4.4. note that CCG's worse case scenario is "amber-rated" in terms of additional actions required to deliver financial targets should the CCG financial position deteriorate

Appendices

Appendix 1: Financial Position of South Sefton CCG
Appendix 2: Reserves and Risk Analysis: Month 3.

Martin McDowell
17 July 2013

Cost centre Number	Cost Centre Description	Annual Budget	YTD Variance	FOT Variance
		Total	Total	Total
COMMISSIONING - NON NHS				
598506	Child and Adolescent Mental Health	1,605	0	0
598596	Collaborative Commissioning	327	1	0
598711	Community Services	751	0	0
598682	Continuing Care	3,202	0	0
598511	Dementia	125	0	0
598691	Funded Nursing Care	3,334	20	0
598721	Hospices	1,191	3	0
598516	Improving Access to Psychological Thera	1,494	0	0
598726	Intermediate Care	222	0	0
598521	Learning Difficulties	1,884	5	0
598501	Mental Health Contracts	920	2	0
598531	Mental Health Services – Adults	875	2	0
598541	Mental Health Services - Collaborative Co	938	2	0
598551	Mental Health Services - Older People	265	1	0
598661	Out of Hours	0	4	0
598682	Personal Health Budgets	31	0	0
598796	Reablement	3,223	5	0
	Sub-Total	**20,388**	**45**	**0**
CORPORATE & SUPPORT SERVICES				
600251	Administration and Business Support (Ru	79	0	0
600271	CEO/Board Office (Running Cost)	672	0	0
600276	Chairs and Non Execs (Running Cost)	97	0	0
600286	Clinical Governance (Running Cost)	151	0	0
600296	Commissioning (Running Cost)	1,433	0	0
598646	Commissioning Schemes (Running Cost)	352	0	0
600351	Finance (Running Cost)	842	0	0
600391	Medicines Management (Running Cost O	55	0	0
	Sub-Total Running Costs	**3,680**	**0**	**0**
598656	Medicines Management (Programme Cos	440	0	0
598646	Commissioning Schemes	0	53	40
	Sub-Total Programme Costs	**440**	**53**	**40**
	Sub-Total	**4,120**	**53**	**40**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS				
598576	Acute Childrens Services	7,377	96	400
598571	Acute Commissioning	117,305	400	1,500
598586	Ambulance Services	5,807	0	0
598756	Commissioning - Non Acute (Community)	13,094	0	0
598756	Commissioning - Non Acute (Mental Heal	15,066	0	0
598756	Commissioning - Non Acute (Specialist)	1,695	0	0
598761	Commissioning Reserve	208	0	0
598616	NCAs/OATs	1,389	(61)	(100)
598786	Patient Transport	12	(3)	0
	Sub-Total	**161,953**	**432**	**1,800**
INDEPENDENT SECTOR				
598591	Independent Sector	3,414	84	300
	Sub-Total	**3,414**	**84**	**300**

PRIMARY CARE				
600356	Development Funding and GP Framewor	1,055	0	0
598651	Local Enhanced Services	1,538	(2)	0
	Sub-Total	**2,593**	**(2)**	**0**
PRESCRIBING				
598606	High Cost Drugs	1,967	0	0
598666	Oxygen	326	0	0
598671	Prescribing	27,706	0	0
	Sub-Total	**30,000**	**0**	**0**
RESERVES				
600961	Risk Share Reserve	662	0	0
600961	Contingency Reserve	2,360	(612)	(2,140)
600961	Committed Reserve	3,367	0	0
600961	General Reserve	1,300	0	0
600961	Investment Reserve	732	0	0
600961	Non Rec Reserve	4,699	0	0
600961	Contracting Reserve	(3,261)	0	0
600961	Unidentified QIPP	(787)	0	0
	Sub-Total	**9,072**	**(612)**	**(2,140)**
	Grand Total Expenditure	**231,540**	**0**	**0**
	RRL Analysis	**233,852**	**0**	**0**
	Surplus / (Deficit)	**2,312**	**0**	**0**

NHS South Sefton CCG : Reserves and Risk Analysis - Month 3 (£000's) **APPENDIX 2**

Scenario	Best	Likely	Worse
CCG Reserves			
Contingency	3,721	3,721	3,721
Committed	3,367	3,367	3,367
General	1,300	1,300	1,300
Investments	732	732	732
Non-Recurrent	4,699	4,699	4,699
Contracting	(3,261)	(3,261)	(3,261)
Unidentified QIPP	(106)	(106)	(106)
Sub-Total : Reserves	**10,452**	**10,452**	**10,452**
Available Reserves			
Contingency	3,721	3,721	3,721
Committed	0	0	0
General	0	0	0
Investments	375	375	375
Non-Recurrent	1,652	1,652	1,652
Contracting	0	0	0
Unidentified QIPP	0	0	0
Sub-Total : Available Reserves	**5,748**	**5,748**	**5,748**
Operational Pressures	**(2,140)**	**(2,140)**	**(2,140)**
Risks against reserves			
Contracting	0	(1,131)	(2,731)
NHSE (M) baseline adj	(584)	(584)	(584)
NHSE (L) Offender Health baseline adj	584	584	0
PH Baseline adj	200	0	0
Unfunded Prog Costs (baseline)	128	(834)	(834)
Primary Care IT (baseline)	50	(111)	(111)
CHC restitution	0	0	(600)
High Cost Drugs	0	(100)	(200)
QIPP not achieved	0	(53)	(106)
Transforming Primary Care	0	(338)	(450)
Implementation of 111 Services	tbc	tbc	tbc
Additional Support to Local Trusts	tbc	tbc	tbc
Sub-Total : Risks	**378**	**(2,567)**	**(5,616)**
Revised Position - Available Reserves	**3,986**	**1,042**	**(2,008)**

Mitigating actions required to deliver financial target (Worse Case only)

Reduce surplus to 0.5%	Amber	1,156
NHSE (M) baseline adj	Amber	584
55% of CHC restitution cases deferred	Amber	268
Revised Position - Financial Target		**0**

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2013

Agenda Item: 13/97(b)	**Author of the Paper:** Brendan Prescott CCG lead Medicines Management brendan.prescott@southseftonccg.nhs.uk Tel: 0151 247 7093
Report date: 11 July 2013	
Title: Prescribing Update	
Summary/Key Issues: This paper presents the Governing Body with an update on prescribing spend for April 2013 (month 1),	
Recommendation The Governing Body is asked to note the contents of this report	*x* Note: x Approve: Ratify:

Links to Corporate Objectives *(x those that apply)*	
x	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 *(x those that apply)*
Patient and Public Engagement			x	
Clinical Engagement			x	
Equality Impact Assessment			x	

GB13/94(b)

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Legal Advice Sought			x	
Resource Implications Considered			x	
Locality Engagement			x	
Presented to other Committees			x	

Links to National Outcomes Framework *(x those that apply)*	
	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
	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

Report to the Governing Body
July 2013

1. Executive Summary

South Sefton CCG practice prescribing spend for April 2013 was £ 2,184,240.

2. Introduction and Background

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

3. Key Issues

The practice prescribing spend for April 2013 cannot be used to forecast an out turn position as practice budgets were not posted to the Business Services Authority until 30 June.

The Medicines Optimisation Plan for 2013-14 was approved at South Sefton Medicines Operational Group and will direct work to support value for money prescribing from a CCG perspective.

4. Recommendations

The Governing Body is asked to note the prescribing update.

Brendan Prescott
July 2013

GB13/94(b)

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July2013

Agenda Item: 13/94(c)	**Author of the Paper:**
Report date: July 2013	Malcolm Cunningham Head of Performance & Health Outcomes malcolm.cunningham@southseftonccg.nhs.uk
Title: Corporate Performance Report	
Summary/Key Issues: The report sets out performance against the National Outcomes Framework and the NHS Constitution Pledges	
Recommendation The Governing Body is asked to note the report.	x Note x Approve Ratify

Links to Corporate Objectives *(x those that apply)*	
	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 *(x those that apply)*
Patient and Public Engagement		x		
Clinical Engagement	x			Enabling clinicians to challenge providers
Equality Impact Assessment			x	

GB13/94(c)

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Legal Advice Sought			*x*	
Resource Implications Considered			*x*	
Locality Engagement			*x*	
Presented to other Committees			*x*	

Links to National Outcomes Framework *(x those that apply)*	
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

Report to the Governing Body
July 2013

1. Executive Summary

This report sets out the CCG's 'performance' - the performance of its main acute providers and progress against the National Outcomes Framework at month 2 of the financial year.

2. Introduction and Background

CCGs have a statutory duty to improve health outcomes and ensure that the NHS Constitution pledges are being delivered.

This report sets out the CCG's performance against the National Outcomes Framework and the NHS Constitution. It also shows provider performance for the CCG's three main providers, Aintree NHS Foundation Trust, Southport & Ormskirk NHS Trust and the Walton Centre NHS Foundation Trust.

3. Key Issues

3.1. Healthcare Acquired Infections – MRSA and C Difficile

As of May 2013, both the MRSA and C Difficile indicators are above the set tolerance levels for South Sefton CCG patients. MRSA is cumulatively at one case against zero tolerance and C Difficile is at nine against a tolerance of 7.34. Aintree Hospital Trust reported 8 cases cumulatively against the tolerance of 7.16 cases of C Difficile. Each case has been thoroughly investigated by the Trust and the issues are scheduled to be discussed at the Contract and CQPG meeting. Action plans are continually reviewed and updated by the Trust and Commissioners to minimise the risk of more cases. A Health Care Acquired Infection (HCAI) group was established by the Trust in 2012/13; this group will meet as appropriate and will be chaired by the Trust Chief Executive with CCG quality leads as members.

Aintree Hospital Trust reported an incident of MRSA in May. This is being reported through the Infection Prevention Committee to the CCGs. Root Cause Analysis (RCA) has been completed.

Please note that, in the main, Business Intelligence do not have access to the level of HCAI detail which would inform CCGs if the cases highlighted above were patients from within their own CCG population. Where this information is included, this will have originated from the Trusts themselves.

3.2. Referral to Treatment (RTT) Pathways Greater than 52 Weeks for Incomplete Pathways

There is one patient on the RTT pathway greater than 52 weeks for incomplete pathways in May 2013 for this indicator. This is at Liverpool Women's Hospital. The latest information indicates that there are child welfare issues and an appointment is due with a counsellor.

GB13/94(c)

3.3. **Local Measures: % Reduction in the Number of Respiratory Disease Emergency Admissions via A&E**

This local measure is showing, in May 2013 to be adversely above plan, 237 against the plan for 214.

4. Recommendations

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

Malcolm Cunningham
July 2013

CCG CORPORATE PERFORMANCE DASHBOARD - South Sefton CCG

Baseline as at 09/07/2013 12:42:08

		Current Period			
Performance Indicators	**Data Period**	**Target**	**Actual**	**RAG**	**Fore cast**
NHS Outcomes Framework					
Treating and caring for people in a safe environment and protecting them from avoidable harm					
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative)	13/14 - April	3.67	9.00		
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative)	13/14 - April	0.00	1.00		
Enhancing quality of life for people with long term conditions					
Patient experience of primary care i) GP Services	12/13 - October - March		85.20		
Patient experience of primary care ii) GP Out of Hours services	12/13 - April - September		73.80		
Emergency Admissions Composite Indicator (Cumulative)	13/14 - May	154.69	135.72		
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (Cumulative)	13/14 - May	18.63	24.84		
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Cumulative)	13/14 - May	72.04	61.11		
Helping people to recover from episodes of ill health or following injury					
Patient reported outcomes measures for elective procedures: Groin hernia	11/12		5.50		
Patient reported outcomes measures for elective procedures: Hip replacement	11/12		35.30		
Patient reported outcomes measures for elective procedures: Knee replacement	11/12		30.30		
Emergency admissions for acute conditions that should not usually require hospital admission (Cumulative)	13/14 - May	80.4	70.75		
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI) (Cumulative)	13/14 - May	3.1	3.10		
Preventing people from dying prematurely					
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Females)	2011		1,820.50		
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Males)	2011		2,476.40		
Under 75 mortality rate from cancer	2011		130.60		
Under 75 mortality rate from cardiovascular disease	2011		76.30		
Under 75 mortality rate from liver disease	2011		32.60		
Under 75 mortality rate from respiratory disease	2011		35.30		
NHS Constitution					
Cancer waits – 31 days					
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative)	13/14 - April	98.00	96.77		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative)	13/14 - April	94.00	91.30		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)	13/14 - April	94.00	100.00		

Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative)	13/14 - April	96.00	100.00		
Cancer waits – 62 days					
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 (Cumulative)	13/14 - April		100.00		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative)	13/14 - April	90.00	100.00		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative)	13/14 - April	85.00	87.18		
Cancer waits – 2 week wait					
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative)	13/14 - April	93.00	98.42		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative)	13/14 - April	93.00	94.23		
Mixed Sex Accommodation Breaches					
Mixed Sex Accomodation (MSA) Breaches per 1000 FCE	13/14 - May	0.00	0.00		
Referral To Treatment waiting times for non-urgent consultant-led treatment					
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways.	13/14 - May	0.00	1.00		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted)	13/14 - May	0.00	0.00		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways	13/14 - May	0.00	0.00		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	13/14 - May	92.00	97.19		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	13/14 - May	90.00	93.95		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	13/14 - May	95.00	98.22		
A&E waits					
Percentage of patients who spent 4 hours or less in A&E (Cumulative)	13/14 - May	95.00	94.43		
Diagnostic test waiting times					
% of patients waiting 6 weeks or more for a Diagnostic Test (Cumulative)	13/14 - May	1.00	0.65		
Category A ambulance calls					
Ambulance clinical quality – Category A (Red 1) 8 minute response time (Cumulative)	13/14 - May	75.00	78.99		
Ambulance clinical quality – Category A (Red 2) 8 minute response time (Cumulative)	13/14 - May	75.00	77.77		
Ambulance clinical quality - Category 19 transportation time (Cumulative)	13/14 - May	95.00	96.81		
Local Measures					

5% reduction in the number of respiratory disease emergency admissions via A&E.(cumulative)	13/14 - May	214	237			
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.	Q1 data not yet available					
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. (cumulative)	13/14 - May	416	NYA			

TRUST CORPORATE PERFORMANCE DASHBOARD -

Baseline as at 09/07/2013 12:42:08

** Please note some data is provided from the quality provider submission and is subject to change

Performance Indicators		Aintree University Hospitals NHS Foundation Trust	Southport & Ormskirk Hospital NHS Trust	The Walton Centre NHS Foundation Trust
A&E waits				
A&E waits				
Percentage of patients who spent 4 hours or less in A&E (Cumulative)	13/14 - May	92.51	95.80	
Ambulance				
Ambulance				
Ambulance handover delays of over 1 hour	13/14 - May	19.00	13.00	
Ambulance handover delays of over 30 minutes	13/14 - May	55.00	63.00	
Crew clear delays of over 1 hour	13/14 - May	0.00	0.00	
Crew clear delays of over 30 minutes	13/14 - May	32.00	1.00	
Cancer waits – 2 week wait				
Cancer waits – 2 week wait				
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative)	13/14 - May	97.30		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative)	13/14 - May	95.20		
Cancer waits – 31 days				
Cancer waits – 31 days				
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative)	13/14 - May	100.00		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)	13/14 - May	100.00		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative)	13/14 - May			
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative)	13/14 - May	100.00		
Cancer waits – 62 days				
Cancer waits – 62 days				
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 (Cumulative)	13/14 - May	90.60		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative)	13/14 - May	86.70		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative)	13/14 - May	88.50		
Diagnostic test waiting times				
Diagnostic test waiting times				

GB13/94(C)

% of patients waiting 6 weeks or more for a Diagnostic Test (Cumulative)	13/14 - May	0.90		
Headline Measures				
Resources (Finance, Capacity & Activity)				
PHS05_01: Acute Bed Capacity (average number of available day only beds G&A)	12/13 - Q4 January - March	96.00	34.00	26.00
PHS05_02: Acute Bed Capacity (average number of available beds open overnight G&A)	12/13 - Q4 January - March	713.00	491.00	160.00
PHS05_03: Acute Bed Capacity (average number of ALL beds available G&A beds)	12/13 - Q4 January - March	809.00	525.00	186.00
MAR Activity				
MAR Activity				
All first outpatient attendances in general &acute (G&A) specialties (Cumulative)	13/14 - April	6,622.00	5,183.00	3,094.00
Total number of G&A elective FFCEs (Cumulative)	13/14 - April	3,509.00	2,473.00	1,020.00
Total number of non-elective FFCEs in general & acute (G&A) specialties (Cumulative)	13/14 - April	2,542.00	2,324.00	215.00
Referral To Treatment waiting times for non-urgent				
Referral To Treatment waiting times for non-urgent				
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	13/14 - May	91.70		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	13/14 - May	98.10		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	13/14 - May	97.45		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks all pathways	13/14 - May	0.00		
Supporting Measures				
Quality (Safety, Effectiveness & Patient Experience)				
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	13/14 - May		86.36	
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	13/14 - May		66.67	
Treating and caring for people in a safe environment and				
Treating and caring for people in a safe environment and				
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative)	13/14 - May	8.00		
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative)	13/14 - May	1.00		
Patient safety incidents reported (Cumulative)	13/14 - May	3.00	0.00	0.00

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2013

Agenda Item: 13/95	**Author of the Paper:** Brendan Prescott CCG lead Medicines Management brendan.prescott@southseftonccg.nhs.uk Tel: 0151 247 7093
Report date: 11 July 2013	
Title: Results of the Prescribing Quality Scheme 2012-13	
Summary/Key Issues: This paper provides the results of the South Sefton CCG Prescribing Quality Scheme (PQS)for 2012/13.	
Recommendation The Governing Body is asked to approve the PQS award highlighted in the report.	Note [x] Approve [ ] Ratify [ ]

Links to Corporate Objectives *(x those that apply)*	
x	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 *(x those that apply)*
Patient and Public Engagement			x	

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
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 *(x those that apply)*	
	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
	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

Report to the Governing Body
July 2013

1. Executive Summary

This paper presents the governing body the results of the South Sefton CCG prescribing quality scheme 2012-13.

2. Introduction and Background

Any scheme has to balance the investment against potential outcomes. Engagement with GP practices means the scheme has to be both attractive to the participants with realistic targets and reliable measurements. The scheme was developed to be as simple as possible in both execution and measurement to aid engagement but challenging enough to ensure beneficial outcomes in prescribing and for patients in South Sefton.

For 2012-13 payments to practices could not be made unless there was an overall medicines management budget under spend for South Sefton CCG.

This underspend was achieved for the financial year.

3. Content

The results in terms of points and payment out to practices are highlighted below:

Payments were made on production of invoice by practices and, as agreed by the Governing Body, the payment was direct income to the practice.

Practice	Total Points achieved	Practice list size	Total Payment £
42 Kingsway	45	6,674	£6,007
Aintree Road Med. Centre	50	2,483	£2,483
High Pastures Surgery	50	11,004	£11,004
Glovers Lane Surgery	50	7,284	£7,284
Liverpool Rd Medical Prac.	45	5,306	£4,775
Azalea Surgery	50	3,142	£3,142
Maghull Family Surgery (Phase 2)	45	2,853	£2,568
Eastview Surgery	50	6,728	£6,728
Bootle Village Surgery	50	6,154	£6,154

Practice	Total Points achieved	Practice list size	Total Payment £
Moore Street Med. Centre	50	7,422	£7,422
North Park Health Centre	50	7,496	£7,496
Blundellsands Surgery	50	10,012	£10,012
Bridge Road Med. Centre	47	7,507	£7,057
Westway Medical Centre	45	7,003	£6,303
Crosby Village Surgery Ssp	45	2,887	£2,598
Orrell Park Medical Centre Ssp	47	3,842	£3,611
The Strand Medical Centre	45	7,142	£6,428
Ford Medical Practice	50	6,063	£6,063
Park Street Surgery	47	5,787	£5,440
15 Sefton Road	50	4,750	£4,750
Concept House Surgery	50	2,622	£2,622
Kingsway Surgery	50	4,766	£4,766
Seaforth Village Practice Ssp	50	1,838	£1,838
Litherland Town Hall(Ssp.)	40	2,689	£2,151
Rawson Road Med. Centre Ssp	45	2,200	£1,980
129 Sefton Road Surgery	50	2,047	£2,047
Thornton Ssp Practice	50	2,485	£2,485
Maghull H.C. (Dr Thomas)	50	2,010	£2,010
Maghull Family Surgery (Phase 3)	50	1,990	£1,990
Hightown Village Surgery Ssp	50	2,237	£2,237
Crossways Ssp Practice	40	2,745	£2,196
Netherton Health Centre. Ssp	45	2,294	£2,065
Maghull Ssp Practice	45	3,606	£3,245
Darzi Litherland	27	398	£215

4. Recommendations

The Governing Body is asked to approve the PQS award for constituent practices of South Sefton CCG.

Brendan Prescott
July 2013

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2013

Agenda Item: 13/96	**Author of the Paper:** Billie Dodd Joint Head of CCG Development SFCCG billie.dodd@southportandformbyccg.nhs.uk.nhs.uk Tel: 01704 387034
Report date: 12 July 2013	

Title: Community Anti-Coagulation Service Procurement - Update

Summary/Key Issues:

1. Procurement going to plan
2. Provider day completed
3. Recommendation made for procurement process

Recommendation

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

Note	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
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 *(x those that apply)*
Patient and Public Engagement		x		Planned for August 2013

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Clinical Engagement	x			On-going
Equality Impact Assessment		x		Will be completed as part of specification
Legal Advice Sought		x		Not required
Resource Implications Considered	x			
Locality Engagement	x			On-going
Presented to other Committees		x		

Links to National Outcomes Framework *(x those that apply)*	
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

Report to the Governing Body
July 2013

1. Executive Summary

The Governing Body agreed in January that the existing community anti-coagulation therapy service contract be extended for the last of its optional year in order to enter into a procurement process as required by European law. This paper provides the board with an update of progress to date and offers a recommendation to take this service to procurement by tender for one provider.

2. Introduction and Background

In line with procurement best practice and in order to test the market, a provider engagement session was provided jointly with South Seton and Liverpool CCG's on the 10Th July 2013. A range of providers attended including acute trusts, community health trusts, independent sector and GPs.

The session included presentations from the GP leads and procurement team with an opportunity for questions and answers as well as an interactive session to feedback the provider opinions. Discussion took place around the options of procurement by the Any Qualified Provider (AQP) model or Full Tender. Issues around governance, safety and management of multiple contracts were the main concern in regard to AQP. In light of these conversations the procurement team would like to offer the following options with a final recommendation.

3. Options

3.1. **AQP** aims to provide extended patient choice in regard to which provider and venue the patient visits. It also stimulates competition of the market.

However, the nature of anti-coagulant services is such that consistency of provision is vital. Potentially random attendance through patient choice, misunderstanding and confusion of provision of prescriptions and referral pathways etc could be detrimental to the patient's condition.

3.2. **Full Tender** would allow one provider with the required consistency and safety of provision maintained. Governance and contract management would be with one organisation. Referral pathways would be clear, confusion limited. The most successful community anti-coagulation services are provided by one provider, as indeed is currently the case.

However, tender can impede patient choice when compared to the potential of AQP dependant on the specific model agreed. Commissioners would need to consider this as part of the service model development and would be likely to continue to specify provision out of multiple venues across Sefton.

4. Conclusions

The procurement process is going to plan. Next steps are to complete the specification and engage with service users. The market engagement and testing has gone well to such end, the procurement team are happy to make the recommendation below.

5. Recommendations

It is recommended that the community anti-coagulation service goes to procurement through **Option 2: Full Tender** in the first weeks of October 2013.

Billie Dodd
12 July 2013

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2013

Agenda Item: 13/97	**Author of the Paper:**
Report date: 17 July 2013	Tracy Jeffes Head of CCG Delivery tracy.jeffes@southseftonccg.nhs.uk Tel: 0151 247 7049

Title: Assurance Framework

Summary/Key Issues:

This paper presents the Governing Body with the Assurance Framework (AF) 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 commences the 2013/14 assurance process with a Quarter 1 update.

The Governing Body is also presented with an Assurance Rating Summary for Quarter 1, which summaries the contents of the AF.

Recommendation

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

Note	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
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 *(x those that apply)*
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 *(x those that apply)*	
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

Corporate Objective 1: To Consolidate a Robust Strategic Plan within the CCG Financial Envelope				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks ***Risk Owner*:**	**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 Delay in implementing new pathways due to non-achievement of reductions in admissions will impact on delivery of transformation within financial envelope Clinical Lead: Dr A Mimnagh	3x3	1. Virtual Ward development identified as a priority area 2. Action plan in place with Aintree UHT 3. KPIs for all non-elective admissions monitored under contract process via CSU information portals fed into contract meeting 4. Monitoring of A&E attendance conversion rates (non-elective admissions) via CSU information portals in contract meeting 5. Monthly steering groups to evaluate progress 6. Monthly agenda item on contract review meetings with Liverpool Community Health Services	Contract query process reviewed in monthly contract meetings. Minutes received by Governing Body Progress of action plan reviewed by Unplanned Care Network – exception reports produced Minutes of CCG Urgent Care Collaborative meetings	**Significant** **Reasonable** Quarterly reports/minutes of meetings received by Governing Body for oversight of delivery progress **Limited**	**(GIA)** Aintree Action plan will not achieve desired outcome	Regularly reviewed by steering group – contract query not lifted	SA – Q2
Progress Reports	**Q1**					**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 1: To Consolidate a Robust Strategic Plan within the CCG Financial Envelope				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks ***Risk Owner***	**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**
1.2 Lack of political and/or stakeholder support for changes will affect the ability to deliver effectively & impact on integration at community level	3x3	A Steering Group which involves all stakeholders meets on monthly basis (with approved & documented Terms of Reference) Schedule in place for engagement events with patients and public Agenda item for monthly Locality meetings (presented by GP lead)	Minutes/reports of Steering Group presented by GP Lead to Governing Body Feedback from stakeholder events rationalised & reviewed by Senior Management Team in collaboration with Communications & Engagement Team	**Significant** **Reasonable** Minutes/reports of Steering Group presented by GP Lead to Governing Body **Limited**			
Progress Reports	**Q1**	Stakeholder Event (Big Chat) scheduled for Quarter 2 (July 2013)				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 1: To consolidate a robust Strategic Plan within the CCG financial envelope				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks ***Risk Owner***	**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**
				Significant			

Corporate Objective 1: To consolidate a robust Strategic Plan within the CCG financial envelope				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks ***Risk Owner***	**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**
1.3 Lack of GP engagement and information sharing will affect numbers of patients making Virtual Ward project financially unviable	**2x4**	GP engagement, information sharing and risk stratification Information gathered formally via monthly Locality Meetings	Minutes of meetings for all Locality Groups received by Governing Body Attendance records retained for Organisational Development/audit purposes Implementation report submitted to Governing Body on quarterly basis	**Reasonable** Governing Body receives minutes of all Locality Meetings Implementation report submitted to Governing Body on quarterly basis **Limited**			
Progress Reports	**Q1**	Launch of Multi-Disciplinary-Team meetings in Quarter 2; launch meetings for Virtual Ward implementation				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 1: To Consolidate a Robust Strategic Plan within the CCG Financial Envelope				Governing Body Reports			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks ***Risk Owner***	**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**
Finance 1.4 Failure to maintain financial balance due to increased demand and over activity in providers or failure to manage internal budgets robustly	**3x4**	Robust financial planning identifies contingency reserves & headroom Contracts signed for 2013/14 with specified levels of activity and associated finances Internal and External Audit in place to review systems of internal control	Financial Plan for 2013/14 signed off by Finance & Resource Committee Monthly Finance performance reports to Finance & Resource Committee/exception reports to Governing Body Monthly Contract Review meetings in place to verify performance and quality (including CQUIN) Budget monitoring process in place – corrective actions identified when necessary	**Significant** **Reasonable** Governing Body in receipt of Finance & Resource Committee minutes and exception reports **Limited**			
Progress Reports	**Q1**					**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 1: To Consolidate a Robust Strategic Plan within the CCG Financial Envelope				Governing Body Reports			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks ***Risk Owner***	**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**
QIPP 1.5 Inability to deliver 2013/14 QIPP Plan which leads transformational change	**3x4**	QIPP plans in place to deliver required financial savings QIPP targets for 2013/14 identified within the Financial Plan, signed off by Governing Body	Finance & Resource Committee reviews financial performance (including QIPP targets) and associated savings – reports received by Governing Body	**Significant** **Reasonable** Finance Reports produced by/for F&R Committee received & reviewed by Governing Body **Limited**			

Progress Reports	**Q1**		**Assurance Rating**	**Reasonable**
	Q2			
	Q3			
	Q4			

Corporate Objective 2: To Enhance Systems to Ensure Quality and Safety of Patient Care				Governing Body Reports			
Lead Officer/Risk Owner: Debbie Fagan							
Principal Risks ***Risk Owner***	**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**
CQUINS 2013/14 2.1 Lack of capacity within CCG to ensure delivery of CQUINS for 2013/14 will lead to insufficient monitoring systems, impacting on quality and health outcomes	**3x3**	1. Regular reporting to Quality Committee 2. Revision of OD Plan for 2013/14 3. Formal exception reporting to Quality Committee from GP Clinical Lead for Quality and CQUIN. 4. Monthly contract meetings is in place to review and verify performance and activity on provider contracts including CQUIN	Monthly performance reports to Quality Committee received by Governing Body Clinical reviews of plans to ensure no adverse effect Chief Nurse leads on Quality to ensure that quality is maintained via established resources Quality reporting standing agenda item for Governing Body Chief Nurse member of Finance & Resource Committee. Senior Finance Team member attached to the Quality Committee to ensure risk is minimised Chief Nurse in attendance at provider quality meetings with provider since October 2012	**Significant** **Reasonable** Governing Body receipt of Quality Committee minutes/exception reports Chief Nurse has lead for Quality, is Governing Body Member and reports directly to Governing Body on Quality issues **Limited**	GIC Organisational Development Plan 2013/14 not ratified by Governing Body, but existing OD Plan still valid	On September Governing Body Agenda	Tracy Jeffes – September 2013
Progress Reports	**Q1**	Whole time equivalent resource identified to support Chief Nurse for Quality portfolio area				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 2: To Enhance Systems to Ensure Quality and Safety of Patient Care				Governing Body Reports			
Lead Officer/Risk Owner: Debbie Fagan							
Principal Risks ***Risk Owner***	**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**
HCAIs 2.2 CCG will exceed trajectories for Healthcare Acquired Infections impacting on patient safety & non-achievement of quality premium	**3x4**	1. Regular reporting to Quality Committee on HCAIs 2. Clinical Quality and Performance Group reporting 3. C Difficile Task & Finish Group established (progress reports to Quality Committee) 4. Partnership with Public Health England & NHS England to revise Children in Public Care service specification (regular meetings) ultimately introduced into contract (Chief Nurses report on progress to Quality Committee	Minutes of Quality Committee meetings Minutes of CQPG received by Quality Committee Progress/Exception reports by CDIF Task & Finish Group received by Quality Committee Chief Nurse provides monthly reports on HCAIs to Quality Committee & Governing Body	**Significant** **Reasonable** Quality Committee reports/minutes received by Governing Body (standard agenda item) Chief Nurse has lead for Quality, is Governing Body Member and reports directly to Governing Body on Quality issues **Limited**			

Progress Reports	**Q1**	Mersey Clinical Commissioning Network will meet in July 2013 (HCAI meeting)	**Assurance Rating**	**Reasonable**
	Q2			
	Q3			
	Q4			

Corporate Objective 3: To Establish the Programme Management Approach and Deliver the CCG Programmes for Whole System Transformation, Reduction in Health Inequalities and Improved CCG Performance				**Governing Body Reports**			
Lead Officer/Risk Owner: Malcolm Cunningham							
Principal Risks ***Risk Owner***	**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 Lack of capacity within CCG will restrict delivery of all programmes in 2013/14 impacting on achievement of Outcomes Framework 2013/14	**3x3**	Full capacity of Programme Management Office achieved with no gaps identified Balanced Scorecard produced for each programme PMO reporting to Finance & Resource Committee	Minutes of Finance & Resource Committee Oversight of Balanced Scorecards by PMO, exception reports to Finance & Resource Committee	**Significant** **Reasonable** Minutes of Finance & Resource Committee received by Governing Body (monthly) **Limited**			
Progress Reports	**Q1**					**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 3: To Establish the Programme Management Approach and Deliver the CCG Programmes for Whole Ssystem Transformation, Reduction in Health Inequalities and Improved CCG Performance				**Governing Body Reports**			
Lead Officer/Risk Owner: Malcolm Cunningham							
Principal Risks ***Risk Owner***	**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**
3.2 Lack of sufficient financial data for most programmes makes benefits and outcomes difficult to define	**3x3**	PMO reporting to Finance & Resource Committee	Minutes of Finance & Resource Committee	**Significant** **Reasonable** Minutes of Finance & Resource Committee received by the Governing Body (monthly) **Limited**			
Progress Reports	**Q1**	Staff recruitment to Finance Team in Quarter 2 to improve financial data/information for programmes				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 3: To establish the Programme Management approach and deliver the CCG programmes for whole system transformation, reduction in health inequalities and improved CCG performance				**Governing Body Reports**			
Lead Officer/Risk Owner: Malcolm Cunningham							
Principal Risks ***Risk Owner***	**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**
3.3 Lack of KPIs will impact on delivery of some programmes in 2013/14	**3x3**	PMO reporting to Finance & Resource Committee	Minutes of Finance & Resource Committee and exception reports	Significant **Reasonable** Minutes of Finance & Resource Committee received by the Governing Body bi-monthly **Limited**			
Progress Reports	**Q1**					**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 4: To Collaborate with the Cheshire & Merseyside CSU to Ensure Delivery of Successful Support to the CCG				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks ***Risk Owner***	**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**
4.1 Lack of capacity and capability of CSU to deliver sufficient support in a responsive manner within resource envelope	**2x4**	1. SLA in place with Provider 2. Contract/Performance Monitoring Group 3. Reporting on performance on a regular basis at Senior Management Team (SMT)	Monthly meeting of Performance Monitoring Group Head of Client Operations – CSU to attend weekly SMT meetings to support and resolve issues Specific agreement reached with CSU to ensure continuation of locally based communications and engagement capability and other support Reports to Finance & Resource Committee on 6 monthly basis	**Significant** **Reasonable** Governing Body receives minutes of Finance & Resource Committee **Limited**			
Progress Reports	**Q1**	Development of Key Performance Indicators to ensure more robust contract management				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 4: To Collaborate with the Cheshire & Merseyside CSU to Ensure Delivery of Successful Support to the CCGs				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks ***Risk Owner***	**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 Future requirement to re-procure Com-missioning Support Unit (CSU) services. Risk that re-procurement would divert CCG resources away from service delivery and create instability	**2x4**	Plan in development for re-procurement identifying timescales, resource requirements, impacts and risks and options	Progress reports to SMT Progress/exception reports to Finance & Resource Committee	**Significant** **Reasonable** Minutes of Finance & Resource Committee received by Governing Body **Limited**	(GIC) Plan currently in development	Final plan timescale December 2013	Tracy Jeffes – December 2013
Progress Reports	**Q1**					**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 5: To Strengthen Engagement of CCG Members, Public, Partners and Stakeholders				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks ***Risk Owner***	**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**
5.1 Inability to maintain active involvement of all constituents and stakeholders	**3x4**	Communications and Engagement Strategy 2013 in place Increased development of Locality model & resourcing Effective running of Engagement and Patient Experience Group in place to ensure on-going active involvement of key partners e.g. Sefton Healthwatch, the voluntary sector and Sefton Council & coordination of local patient and public activities CCG public-facing internet site now live Lead locality GP, Practice Nurse & Practice Manager meetings on monthly basis for each locality	Documented evidence of involvement Quarterly Wider Constituent meetings with GP attendance recorded/minuted Minutes of GP/Practice Manager and Practice Nurse Locality Meetings	**Significant** **Reasonable** Governing Body receives minutes of Locality Meetings **Limited**	Refresh of Communication Strategy in progress	Plan for September Governing Body meeting	Tracy Jeffes/Lyn Cooke – September Governing Body meeting

Progress Reports	**Q1**		**Assurance Rating**	**Reasonable**
	Q2			
	Q3			
	Q4			

Corporate Objective 6: To drive clinical leadership development through Governing Body, locality and wider constituent development				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks ***Risk Owner***	**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**
6.1 Lack of capacity amongst clinical colleagues to ensure personal development and facilitate active involvement	**4x3**	Increased development of Locality model and resourcing Monthly joint development session for Governing Body members and clinical leads Documented and robust PDR process for Governing Body members and locality lead roles	Records of developmental sessions for Governing Body members/clinical leads Minutes of Locality Meetings	**Significant** **Reasonable** Governing Body oversight of PDR process for members/clinical and locality leads via exception reporting Minutes of Locality Meetings received by Governing Body **Limited**	Personal Development Review (PDR) process incomplete for Governing Body and locality leads	PDRs completed by September Organisational Development Plan refreshed for September 2013	Tracy Jeffes September 2013
Progress Reports	**Q1**	Primary Care Quality Strategy in consultation. Governing Body development sessions on-going in 2013/14				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

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 needs 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 Governing Body which is tasked with monitoring the specific risk.

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

Key Positive Assurance: this is the 'evidence' used to show how the key controls are mitigating the principal risks identified and how these are monitored by the Governing Body via internal governance arrangements. For example, exception reporting directly to the Governing Body, receipt and oversight of Committee minutes and reports are accepted as good examples of internal positive assurance. Key external or independent assurances (such as External Audit reports and accreditations) are generally given more weight than internal sources and are the difference between a 'reasonable' rating and a 'significant' assurance rating. Descriptions should provide sufficient details so as to easily identify specific the documentary evidence, e.g. dates of meetings, publications, reviews etc.

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 Governing Body 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) EXAMPLES OF TYPES OF ASSURANCE
**SHA Audit of data quality indicating no significant concerns, reported to Trust Governing Body January 2010, PCT commissioning committee February 2011. (significant assurance)
**CQC indicators met for relevant targets as reported in periodic review, October 2011 (significant assurance)
Performance Report received by the Trust Governing Body, 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 Governing Body, most recent September 2010, indicating current position against key targets (limited assurance)

Key Positive assurance EXAMPLE OF NEW LAYOUT
Significant Assurance
2010/11 prospectus published March 2009, included for information in Governing Body papers May 2010 Uptake 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
Reasonable Assurance
Update report to HR committee September 2010 demonstrating 80% of required courses now established
Limited Assurance
Performance report to Trust Governing Body, most recent September 2010, indicating current position against key targets

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	
Low	4 - 6	
Moderate	8 - 12	
High	15 - 25	

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/Assurance Framework.

Assurance Framework 2013/14
Assurance Rating Summary Quarter 1

NHS
South Sefton
Clinical Commissioning Group

Key:
▼ L – Assurance rating reduced from previous Quarter
► M – Maintained assurance rating from previous Quarter
▲ H - Higher assurance rating than previous Quarter
Blank – No comparable rating

N/A – Not applicable – assurance not expected

hshRisk No	Risk Description	Risk Rating (L & C)	Accountable Lead	Assurance Rating Q1	Assurance Rating Q2	Assurance Rating Q3	Assurance Rating Q4	Assurance Rating Key
Unique Identifier	Strategic risk transposed from Assurance Framework document	Risk rating based on agreed risk matrix	Identified lead on behalf of the CCG who is referred to as the 'Risk Owner' on the Assurance Framework document	These columns will state either 'Limited' 'Reasonable' or 'Significant' assurance has been awarded dependent on the weight of assurance provided				This column will have ▼or ►or ▲ inserted here to demonstrate any changes since last review
Corporate Objective 1: To consolidate a robust Strategic Plan within the CCG financial envelope								
1.1	Delay in implementing new pathways due to non-achievement of reductions in admissions will impact on delivery of transformation within financial envelope	**3x4**	Stephen Astles	**Reasonable**				*New*
1.2	Lack of political and/or stakeholder support for changes will affect the ability to deliver effectively & impact on integration at community level	**3x3**	Stephen Astles	**Reasonable**				*New*
1.3	Failure to maintain financial balance due to increased demand and over activity in providers or failure to manage internal budgets robustly	**3x4**	Martin McDowell	**Reasonable**				*New*
1.4	Inability to deliver 2013/14 QIPP plan which leads transformational change	**3x4**	Martin McDowell	**Reasonable**				*New*
Corporate Objective 2: To enhance systems to ensure quality & safety of patient care								
2.1	Lack of capacity within CCG to ensure delivery of CQUINS for 2013/14 will lead to insufficient monitoring systems, impacting on quality & health outcomes	**3x3**	Debbie Fagan	**Reasonable**				*New*
2.2	CCG will exceed trajectories for HCAI impacting on patient safety & non-achievement of Quality Premium	**3x3**	Debbie Fagan	**Reasonable**				*New*
To establish the Programme Management approach and deliver the CCG programmes for whole system transformation, reduction in health inequalities and improved CCG performance								
3.1	Lack of capacity within CCG will restrict delivery of all programmes in 2013/14 impacting on achievement of meeting outcomes framework 2013/14	**3x3**	Malcolm Cunningham	**Reasonable**				*New*
3.2	Lack of sufficient financial data for most programmes makes benefits and outcomes difficult to define	**3x3**	Malcolm Cunningham	**Reasonable**				*New*
3.3	Lack of KPIs will impact on delivery of some programmes in 2013/14	**3x3**	Malcolm Cunningham	**Reasonable**				*New*
Corporate Objective 4: To collaborate with the Cheshire & Merseyside CSU to ensure delivery of successful support to the CCG								

Assurance Framework 2013/14
Assurance Rating Summary Quarter 1

NHS
South Sefton
Clinical Commissioning Group

Key:
▼ L – Assurance rating reduced from previous Quarter
► M – Maintained assurance rating from previous Quarter
▲ H - Higher assurance rating than previous Quarter
Blank – No comparable rating

N/A – Not applicable – assurance not expected

hshRisk No	Risk Description	Risk Rating (L & C)	Accountable Lead	Assurance Rating Q1	Assurance Rating Q2	Assurance Rating Q3	Assurance Rating Q4	Assurance Rating Key
Unique Identifier	Strategic risk transposed from Assurance Framework document	Risk rating based on agreed risk matrix	Identified lead on behalf of the CCG who is referred to as the 'Risk Owner' on the Assurance Framework document	These columns will state either 'Limited' 'Reasonable' or 'Significant' assurance has been awarded dependent on the weight of assurance provided				This column will have ▼or ►or ▲ inserted here to demonstrate any changes since last review
4.1	Lack of capacity and capability of CSU to deliver sufficient support in a responsive manner within resource envelope	**2X4**	Tracy Jeffes	**Reasonable**				*New*
4.2	Future requirement to re-procure CSU services. Risk that re-procurement would divert CCG resources away from service delivery and create instability	**3x4**	Tracy Jeffes	**Reasonable**				*New*
Corporate Objective 5: To strengthen engagement of CCG members, public, partners and stakeholders								
5.1	Inability to maintain active involvement of all constituents and stakeholders	**3x4**	Tracy Jeffes	**Reasonable**				*New*
Corporate Objective 6: To drive clinical leadership development through Governing Body, locality and wider constituent development								
6.1	Lack of capacity amongst clinical colleagues to ensure personal development and facilitate active involvement	**4x3**	Tracy Jeffes/Stephen Astles	**Reasonable**				*New*

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2013

Agenda Item: 13/98	**Author of the Paper:**
Report date: 17 July 2013	Tracy Jeffes Head of CCG Delivery tracy.jeffes@southseftonccg.nhs.uk Tel: 0151 247 7049

Title: Update of Terms of Reference – Board Committees

Summary/Key Issues:

This paper presents the Governing Body with revised Terms of Reference for each of the Board Committees. The updates to each are identified in turn.

Audit Committee

Where: Clause 3 (Responsibilities of Committee)

Update: Inclusion of final bullet point "*Monitoring and review of the CCG Assurance Framework (BAF) to support the CCG's integrated governance agenda".*

Where: Clause 6 (Quorum)

Update: inclusion of the following paragraph: *"The quorum shall exclude any member affected by a Conflict of Interest. 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".*

Remuneration Committee

Where: Clause 3 (Membership)

Update: Inclusion of additional paragraph: "*Only members of the committee have the right to attend the Committee meetings.*

However, other individuals such as the Accountable Officer, the HR lead and external advisers may be invited to attend for all or part of any meeting as and when appropriate. They should however not be in attendance for discussions about their own remuneration and terms of service.".

GB13/98

Where: Clause 5 (Quorum)

Update: Inclusion of the following paragraph: *"The quorum shall exclude any member affected by a Conflict of Interest. 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".*

Where: Clause 9 (Conduct of the Committees)

Update: Inclusion of the following paragraph: *"All members are required to maintain accurate statements of their register of interest with the Governing Body. Members of the committee 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.".*

Quality Committee

Where: Clause 3 (Membership)

Update: Inclusion to the membership of the Governing Body Lay Member.

Inclusion of additional open invitation: "*The following leads have an open invitation for each meeting of the Quality Committee*

- *Designated Professional Safeguarding Children & Adults".*

Where: Clause 5 (Quorum)

Update: Inclusion of the following paragraph: *"The quorum shall exclude any member affected by a Conflict of Interest. 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".*

Where: Clause 7 (Conduct)

Update: Inclusion of the following paragraph: *"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.".*

Finance & Resource Committee

Where: Clause 2 (Membership)

Update: Members updated as follows:

- *Governing Body Lay Member (Engagement) (Chair)*
- *Governing Body Lay Member (Governance).*

Where:	Clause 3 (Responsibilities of the Committee)
Update:	Inclusion of additional responsibilities as follows: • *"Determining banking arrangements* • *Approving arrangements for exceptional/novel treatments* • *To receive recommendations from the local Individual patient review (IFR) panel and approve as appropriate."*
Where:	Clause 7 (Quorum)
Update:	Inclusion of the following paragraph: *"The quorum shall exclude any member affected by a Conflict of Interest. 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".*
Where:	Clause 10 (Conduct)
Update:	Inclusion of the following paragraph: *"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.".*

Recommendation

The Governing Body is asked to approve the updated Terms of Reference for each committee.

Note	
Approve	x
Ratify	

GB13/98

Links to Corporate Objectives *(x those that apply)*	
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 *(x those that apply)*
Patient and Public Engagement			x	
Clinical Engagement			x	
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered			x	
Locality Engagement			x	

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Presented to other Committees			x	

Links to National Outcomes Framework *(x those that apply)*	
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

Terms of Reference
Audit Committee

NHS
South Sefton
Clinical Commissioning Group

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 CCG's activities to support the delivery of the CCG's objectives; and

ii) to review and approve the arrangements for discharging the CCG'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 Governing Body 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 Governing Body 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 CCG 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 CCG'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 Accountable Officer and the CCG.

- 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 Counter Fraud and Security Management Service.

- Reviewing findings of other assurance functions (where appropriate) and consider the implications for governance arrangements of the CCG (e.g. NHS litigation authority, Care Quality Commission etc.).

- Monitoring the integrity of the financial statements of the CCG and to consider the implications of any formal announcements relating to the CCG's financial performance.

- Responding on behalf of the Governing Body, to any formal requirements of the CCG in relation to the audit process (e.g. the report from those charged with governance).

- Monitoring and review of the CCG Assurance Framework (AF) 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 CCG's Constitution to the CCG'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 approve the CCG's annual accounts on behalf of the Governing Body

- To review and approve the CCG'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 CCG's statutory financial duties.

- To review and approve the CCG's Counter Fraud and Security Management arrangements.

- To review the circumstances relating to any suspensions to the CCG's Constitution (as set out in the Scheme of Delegation and Reservation) and to report to the Governing Body and Wider Constituent Group 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 members will be necessary for quorum purposes.

The quorum shall exclude any member affected by a Conflict of Interest. 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. Review

Version Number: 2

Review dates
November 2013
March 2014
September 2014
March 2015

Terms of Reference
Remuneration Committee

NHS
South Sefton
Clinical Commissioning Group

1. Authority

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

The principal function of the Committee is to make recommendations to the Governing Body on determinations about pay and remuneration for employees of the CCG and people who provide services to the CCG and allowances under any pension scheme it might establish as an alternative to the NHS pensions scheme.

2. Principal Duties

The principal duties of the Committee are as follows.

a) Determining the remuneration and conditions of service of the senior team.

b) Reviewing the performance of the Accountable Officer and other senior team and determining salary awards.

c) Approving the severance payments of the Accountable Officer and other senior staff

d) Approve disciplinary arrangements for employees, including the Accountable Officer (where he/she is an employee or member of the Group) and for other persons working on behalf of the Group.

e) Approve disciplinary arrangements where the Group has joint appointments with another Group and the individuals are employees of that Group.

3. Membership

The committee shall be appointed by the CCG from amongst its Governing Body members as follows:-

- Lay Member (with a lead role in governance) as Chair
- 2 GP Governing Body Members
- 1 Nurse Governing Body Member
- 1 Practice Manager Governing Body Member.

Only members of the CCG Governing Body may be members of the Remuneration Committee.

The Chair of the CCG's Governing Body shall not be a member of the Committee.

Only members of the committee have the right to attend the Committee meetings.

However, other individuals such as the Accountable Officer, the HR lead and external advisers may be invited to attend for all or part of any meeting as and when appropriate.

They should however not be in attendance for discussions about their own remuneration and terms of service.

4. Chair

The Lay Governing Body Member shall be nominated by the CCG Governing Body to act as Chair of the committee. The Committee shall nominate a Vice Chair from within its membership.

5. Quorum

The quorum will be the Remuneration Committee Chair or Vice Chair plus 3 other members of the Remuneration Committee membership (all of which must be members of Governing Body as per Section 2 of these Terms of Reference)

The quorum shall exclude any member affected by a Conflict of Interest. 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.

6. Frequency of Meetings and Reporting Arrangements

The Committee will meet at least once a year with clear arrangements for calling meetings at additional times, as and when required, with seven working days' notice. The Committee will submit its minutes to the next available CCG Governing Body. In addition the Committee will report annually to the Governing Body.

7. Secretarial arrangements

The Business Manager/PA to the Accountable Officer shall provide secretarial support to the Committee and support the Chair in the management of remuneration business, drawing the Committee's attention to best practice, national guidance and other relevant documents as appropriate.

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 within 10 working days

8. Policy and Best Practice

The Committee will apply best practice in the decision making process. When considering individual remuneration, the committee will:-

- comply with current disclosure requirements for remuneration
- on occasion seek independent advice about remuneration for individuals
- ensure that decisions are based on clear and transparent criteria.

The Committee will have full authority to commission any reports or surveys it deems necessary to help it fulfil its obligations.

9. Conduct of the Committee

The Committee will conduct its business in accordance with any national guidance and relevant codes of conduct / good governance practice, such as Nolan's seven principles of public life.

The Committee will review its own performance, membership and terms of reference on an annual basis and any resulting changes to the terms of reference will be approved by the Governing Body.

All members are required to maintain accurate statements of their register of interest with the Governing Body. Members of the committee 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.

10. Review

Version	2
Future Review:	November 2013 March 2014

Terms of Reference
Quality Committee

NHS
South Sefton
Clinical Commissioning Group

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 CCG'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 safely, 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:

- Clinical Governing Body Member (Chair)
- GP Governing Body Member
- Practice Manager Governing Body Member
- Governing Body Lay 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 Primary Care
- Locality Clinical Representatives (x 4)
- Patient Representative (HealthWatch)
- Head of CCG Development.

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 Clinical GP 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.

The quorum shall exclude any member affected by a Conflict of Interest. 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.

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

The PA to the Chief Nurse 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.

9. Review

Version Number:	3
Future Review dates	November 2013 March 2014 September 2014 March 2015

1. Authority

The Finance & Resource 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:

- Governing Body Lay Member (Engagement) (Chair)
- Clinical Governing Body Member (Vice Chair)
- Clinical Governing Body Member
- Governing Body Lay Member (Governance)
- Practice Manager Governing Body Member
- Locality Clinical Representatives
- Chief Officer
- Chief Financial Officer
- Head of Performance & Health Outcomes
- Head of CCG Corporate Delivery
- Head of CCG Development
- Chief Nurse.

The Chair of the Governing Body 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 Cheshire and Mersey Commissioning Support Unit (C&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) as follows.

- 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; and

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 Governing Body Member, at least one Lay Person and either the Accountable Officer or Chief Finance Officer in attendance shall be quorate for the purposes of the CCG's business.

The quorum shall exclude any member affected by a Conflict of Interest. 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.

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. Review

Version No	2
Review dates	November 2013 March 2014 September 2014 March 2015

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2013

Agenda Item: 13/99	**Author of the Paper:**
Report date: 15 July 2013	Stephen Astles Head of Development SSCCG stephen.astles@southseftonccg.nhs.uk Tel: 0151 2477253

Title: Multi Practice Locality Membership

Summary/Key Issues:

A practice has requested the Governing Body to consider membership of a single locality. The contract holder currently has three practices in two different localities within the CCG.

Recommendation

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

	x
Note	
Approve	X
Ratify	

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.
X	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement			X	
Clinical Engagement	X			

GB13/99

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
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 *(x those that apply)*	
	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
	Ensuring that people have a positive experience of care
	Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
July 2013

1. Background

An application has been received from an individual holding three contracts in two distinct localities to represent all three in one locality. The individual is claiming that this is permissible under the terms of paragraph 15.1 of the CCG's Constitution, as follows:

15.1 All practices are required to be part of a Locality and the agreed membership is detailed in Schedule 1. If a practice operates in more than one locality, it may agree with the Governing Body which of the locality groups it shall be a member of.

2. Considerations

The Governing Body is reminded that paragraph 15.1 was written with individual practices whose practice area extends across more than one locality in mind.

The geographical location of a practice is also the rationale for membership of a locality to prevent a weakening of the CCG's locality model.

3. Recommendations

3.1. The Governing Body is asked to consider the request of the practitioner.

3.2. The Governing Body is asked to decline the request on the basis that:

(a) it does not fall within the remit of paragraph 15.1 of the CCG's Constitution; and

(b) upon consideration of the nature of the patient demography for each of the three practices, the diversity of the populations are such that it would not be in their respective best interests to have sole representation within one locality.

Steve Astles
July 2013

GB13/99

NHS
South Sefton
Clinical Commissioning Group

Quality Committee Minutes

Thursday 23 May 2013
3:00 pm – 5:00 pm
Boardroom, Merton House

Attendees		
Steve Astles	Head of CCG Development	(SA)
Lin Bennett	Board Member	(LB)
Fiona Clark	Chief officer	(FC)
Roger Driver	Lay Member	(RD)
Anne Dunne	Designated Safeguarding Nurse	(AD)
Dr Bal Duper	GP	(BD)
Dr Debbie Fagan	Chief Nurse	(DF)
Dr Anna Ferguson	GP	(AF)
Dr Craig Gillespie	Chair	(CG)
Dr Gina Halstead	GP	(GH)
Tracy Jeffes	Head of Corporate Delivery	(TJ)
Gordon Jones		(GJ)
Dr Andrew Mimnagh	GP	(AM)
Danielle Moroney		
Denise Roberts	Deputy Designated Safeguarding Nurse	
Dr Steevart	GP	(SS)
Apologies		
Debbie Harvey	GP	(DH)
Martin McDowell	Chief Finance Officer	(MMcD)
Dan McDowell	Consultant Member of SS CCG	(DMcD)
Minutes		
Tracey Cubbin	Administrator	(TC)

No	Item	Action
Q13/50	**Welcome and Introductions** CG welcomed the committee and introductions were given.	
Q13/51	**Apologies** As above. CG advised the committee that he would need to leave the meeting early due to other commitments, GH agreed to Chair remainder of the meeting in CGs absence.	
Q13/52	**Declarations of Interest** FLC, TJ and DF are all joint post for both CCGs; all clarified there was nothing on the agenda that will be of any issue.	

No	Item	Action
Q13/53	**Minutes of the last meeting – 21 March 2013** The minutes of the last meeting were recorded as an accurate record.	
Q13/54	**Matters Arising** - **13/40 Membership** Health Watch Representative – DF is due to meet with Diane Blair in the near future to discuss further. DF to update at the next Quality Committee. - **13/44 Performance and Quality Dashboard** The committee discussed Locum cover at GP Practice's; BD suggested we have a standard job description that all practices can utilise outlining what service expected. There was also a brief discussion regarding costing's however the committee felt this was not appropriate and the discussions should focus on quality. BD agreed to draft a job description to support practices and bring back at a later date. - **13/46 Safe Discharge Meeting** GH updated the committee and advised that there is now a Communication CQIN in place to help resolve the issues around IT within Aintree Hospital's. There is no data available for the first quarter of quarter four however; GH is working with Maria Dorpman to try to resolve this. GH to update at a future meeting. - **13/48 Rejected Laboratory Reports** LB carried out an audit with practices, GH advised that not all practices were aware of the recent problems with the laboratory results system, there has been no feedback from the area team regarding this however GH is waiting on information from Paul Shilcock and will feedback at a future meeting. The committee agreed that good practice for managing unnamed reports would be to print off and return to the lab immediately. GH to highlight concerns at the next Care Quality Group (CQG) regarding breach of data and delay in reporting. **Action:** As Caldicott Guardian DF to update and add to risk register. Issue raised and appropriate steps were taken.	DF BD GH/MD GH GH DF
Q13/55	**Chief Nurse Report** - **Matters arising** **Francis Inquiry 2:** Draft action plan to be taken to the Senior Management Team on Tuesday 28 May 2013, item to be discussed at the Quality Committee in June. **Serious Untoward Incidents (SUI) Management:** DF has a meeting with Aintree on Friday 24 May 2013, we will have some support in the future from the Commissioning Support Service and DF will update at the next Quality Committee. **Safeguarding General:** Safeguarding will now be monitored by the Hosted Service; DF has been working closely with Liverpool Community Health Services (LCH), The Commissioning Support Unit (CSU) and Halton CCG regarding this. Halton CCG has recruited to 1 pot and are still currently recruiting to the Safeguarding Adult role. An updated action plan is required which DF will	DF DF

No	Item	Action
	work closely with the Hosted Service to provide. DF to update at a future committee. **Children:** BD gave an update regarding safeguarding children; there have been two recent cases from Sefton however are not classed as at risk. **Continuing Health Care (CHC):** Geraldine O'Carroll will attend the next Quality Committee to give an update and item is currently on the corporate risk register. **Quality Strategy:** BD asked what is the process for GPs highlighting SUI's in primary care. The committee advised that this is not the CCGs responsibility and would be monitored by the Are Team as they are our direct commissioners however we will be supported by the CSU regarding trending. **Action:** GH/AM to go to Locality meetings to clarify above DF to clarify process regarding Primary Care / NHS England	GH/AM DF
Q13/56	**Quality Dashboard Report** DF gave an overview of the dashboard for new members of the committee, and DM and GJ attended to present the dashboard to the committee and discuss in more detail. TJ/RD to take dashboard to the EPEG group for information. GH commented that the report was very useful however we need to know how the competent score is made up., DM advised that the compliance score is something which can be developed and is happy to provide more detail if required. GH asked if we can highlight difficulties that are under the quality premium, DM advised this would be highlighted under a CQIN on the dashboard. DM- Exception Summary not currently included, proposed to update information shortly and provide in due course. DF/CG both thanked DM/GJ and praised the report.	TJ/RD
Q13/57	**Contract Update (Quality)** - **2012/13 / 2013/14** SA discussed LCH and advised there are no issues at present, there is currently three joint meetings between Sefton CCG/LCH/Aintree: - Contract Review - Clinical Liaison Forum - Clinical Performance Quality GH confirmed that the Aintree Quality Contract has now been finalised and signed off and CQIN has been agreed.	
Q13/58	**Primary Care Quality Strategy – Progress** BD advised that a draft paper will be submitted to the Board in September and is hoping to have the draft available for the Quality Committee before then, Bal welcomed any comments. The committee also discussed Health Care Acquired Infections (HCAI). GH suggested addressing this issue within the Locality meetings where a root cause analysis can be completed. Am advised that NHS England are in the process of compiling a report around 'Care in Nursing Homes' and will update DF to also discuss with Public Health regarding research and reporting and update at a future committee.	AM DF

No	Item	Action
	Action: **Draft paper to go to Board to Board then to be rolled out to the following:** **Wider Group meetings** **Locality Meetings** **Practice Nurse and Practice Manager meetings** **Relevant patient Groups**	
Q13/59	**Francis Recommendations – Draft Action plan** The above item was discussed at the Senior Management Team meeting and will be available at the next Quality Committee.	
Q13/60	**Rejected Laboratory Reports**	
Q13/61	**C Diff** DF gave brief update: - Second meeting has taken place - Widened out across Health Economy - Issue raised regarding other HCAI's - Sefton/Liverpool/Knowsley CCG all supported by Aintree - Task and Finish group now set up GH discussed root cause analysis and proposed to look at the above in more detail with DF to clarify what is appropriate and how we can move forward.	
Q13/62	**Aintree Hospital's Quality Review Meeting Action Notes of Meeting held on 23 April 2013**	
Q13/63	**Review Terms of Reference** DF advised the committee that as part of the commissioning support we receive from Merseyside Internal Audit Association (MIAA), we have chosen for MIAA to look at the quality committee terms of reference. **Governance issues – FLC:** - Minutes to be recorded correctly and accurately - Chair to sign and date when minutes are agreed - Draft to be removed from minutes are approved The committee agreed that in the absence of the Chair the Vice Chair will be Roger Driver. The committee also felt that clarity of roles and responsibilities for Locality Leads would be useful. **Action:** Suggested changed to be discussed by committee and agree or, any comments to be signed off by Board on 30 May 13. Suggested recommendations to be submitted to Board to adopt.	
Q13/64	**Corporate Risk Register** TJ suggested that the risk register be presented at each Quality Committee and updated at each Senior Managers Team meeting, a list of corporate risks have been identified by managers from across the organisation and the group noted and discussed accordingly. TJ advised that the latest risk strategy has been to the Board and is now ready to be reviewed. **Action:** P17 to be refreshed NHS 111 – Malcolm Cunningham to liaise with AM to increase risk in this	AM/MC

No	Item	Action
	area, change wording to reflect concerns.	
Q13/65	**Complaints Report** **i. Primary Care** **ii. Non Primary Care**	
Q13/66	**Safeguarding Update** AD gave an update to the committee and confirmed that a formal report will be sub mitted at the next Quality Committee. Summary document provided to the Chief Nurse DF, key points to highlight: - Access to designated members of staff - Designated Drs hosted within Alder Hey Hospital - 2 sessions per week with named Dr Margaret Goddard - Health economy approach DF advised the purpose of this update is to highlight any key issues, any other issues will be picked up outside of the meeting, AD/DF are looking at a specific area action plan regarding working together, which is currently work in progress and will be available at the next quality committee.	AD AD/DF
Q13/67	**Any Other Business** The committee agreed that the Work plan will now be a standing agenda item. No any other business was discussed.	
Q13/68	**Date and Time of Next Meeting** Thursday 20 June 2013 3:00 pm – 5:00 pm Boardroom, Merton House	

NHS
South Sefton
Clinical Commissioning Group

Finance & Resource Committee
Minutes

Thursday, 23rd May 2013 at 1.00pm – 2.30pm Boardroom, Merton House, Bootle

Attended		
Roger Driver (Chair)	Lay Member	RD
Dr Steve Fraser	GP Board Member	SF
Sharon McGibbon	Practice Manager	SMG
Lin Bennett	Practice Manager	LB
Fiona Clark	Chief Officer	FLC
Steve Astles	Head of CCG Development	SA
Malcolm Cunningham	Head of Performance & Health Outcomes	MC
Tracy Jeffes	Head of CCG Corporate Delivery	TJ
Debbie Fagan	Chief Nurse	DF
In attendance		
Indira Patel	Acting Deputy Chief Finance Officer	IP
Brendan Prescott	Head of Medicines Management	BP
Sangeetha Steevart	GP Lead	SS
For Minutes		
Karen Lloyd	PA	

Peter Norman made a 15 minute presentation regarding the AQP Programme

	Item	Action
13/45	**Welcome, introductions and apologies** The Chair welcomed everyone to the meeting and introduced Peter Norman from the Commissioning Support Unit. Linda Elezi (Vice-Chair) — Lay Member Dr John Wray — GP Board Member Martin McDowell — Chief Finance Officer	
13/46	**Declarations of Interest** The following declarations of interest were noted for the minutes: Agenda Item 13/52 – SF (Indirect) Agenda Item 13/56 – SF, SMG (Indirect) GP Sangeetha Steevart declared sessions that she undertakes at Southport and Ormskirk Hospital. Martin McDowell Chief Officer, Malcolm Cunningham Head of Health and Performance Outcomes and Tracy Jeffes Head of CCG Delivery.	

13/47	**Advance notice of items of other business** There was one item of other business: Terms of Reference	
13/48	**Minutes of Previous Meeting** The minutes of the previous meeting were recorded as a true and accurate record pending the addition of the following: TJ Declaration of interest as CCG Officer with a dual role. FD should be removed from declaration of interests. 13.37 Add to note that pilot programme was successful. The Chairman should sign and date all approved minutes.	
13/49	**Action Points of Previous Meeting** The relevant action points of the previous meeting were closed as complete.	
13/50	**Month 12 Finance Report** IP presented this report which presents the F & R Committee 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. 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 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. The final date for CHC claims is 13th May 2013. MMD will meet with CSU to assess final level of claims in relation to South Sefton CCG. **The Finance and Resource Committee noted the contents of this report.**	
13/51	**Quality Premium** MC presented this verbal update on Quality Premium. The Committee noted that there are four national measures: 1. Reducing life years lost through amenable mortality 2. Reducing avoidable emergency admissions 3. Roll out of Friends & Family test 4. Preventing health care infections There are also 3 local measures 1. Reducing life years lost through amenable mortality 2. Reducing avoidable emergency admissions 3. Roll out of Friends & Family test 4. Preventing health care infections To pre-qualify for the premium providers must manage within resource envelope. The premium will be reduced if NHS Constitution pledges are not met. These	

	are: - A&E - 18 weeks- 62 day cancer - ambulance CAT A 3. NHSE reserves the right not to make any payment if there is a significant breach Progress against these measures will be monitored at committee on a monthly basis with action plans put in place as appropriate. **The Finance and Resource committee noted the verbal update.**	
13/52	**GP Framework** AP presented this report which supplied the Finance and Resource Committee with the progress of the General Practice Development Framework. South Sefton Clinical Commissioning Group inherited the commissioning responsibility for the GP Development Framework from NHS Sefton on 1st April 2013. The Framework is a three year Local Enhanced Service (LES) operating on a self- assessment model, 2013/14 is the third year of the scheme. Practice progress reports and re-assessments against the framework for year two were submitted in March 2013. Practices were asked to identify priorities for year three (a minimum of 3 areas to maintain or improve) in April 2013. A clinical verification of practice achievement and year three priorities has been undertaken by Dr Bal Duper (appendix 1). It has been recognised that practices have started from different levels and that priorities would be different in each practice. 100% payment to practices is due in quarter one, 25% payment for achievement against plan for year two (this was originally timetabled for payment in April), and 75% payment to work on year three priorities. The value of the quarter one payment is £499,579. 50% payment to practices is scheduled for May 2013, the outstanding 50% is scheduled for June 2013 following approval by the Finance and Resource Committee. Re-profiling of contract values for 2013/14 is currently being undertaken, a final 25% payment for year 3 achievement is planned for April 2014. **The Finance and Resource Committee noted the clinical verification undertaken and approved 100% payment in quarter one.**	
13/53	**Quarter 3 Prescribing Performance Report** BP presented this report which advised the Committee on prescribing performance for the third quarter of 2012-13 across South Sefton CCG. Management of the prescribing budget and planned efficiencies is a significant financial risk for the CCG. BP noted that it is important to underpin work with comparisons on previous performance to direct future work plans. ePACT data can be utilised to provide information which can help decisions on priority work areas as well as provide more questions to be analysed at practice level to reduce variation in prescribing activity. Actual Cost growth showed a 6.4 % decrease compared with the previous year with a spend of £6.57m compared to £7m. Cost decrease across Northwest England was -4.8 %. This corresponded with an increase of 3.2 %	

	of items dispensed with 903,734 items dispensed in Q3 2012-13 compared with 875,906 items in Q3 2011-12 (appendix 1). Increase in items is reflective on a general increase year on year for items coupled with promotion in practice work of moving items to be prescribed over a 28 day period rather than 56 or 72 days. In relation to level 3 QIPP areas for cost improvement, there has been a reduction of £ 457k in spend with a reduction from £ 6.96m in Q3 2011-12 to £ 5.50m in Q3 2012-13. One area to note is the reduction in spend of statins with a patent expiry having a significant impact in year. Areas for cost improvement will inform work plans in 2013-14. **The Finance and Resource Committee noted the contents of this report.**	
13/54	**Business Case Reviews** **i. NICE Technology Appraisal 274 : Ranibizumab in diabetic macular oedema (DMO)** Following NICE TA 274 approving ranibizumab in diabetic macular oedema (DMO) this paper summarises potential costs to South Sefton CCG**.** **The Finance and Resource Committee approved implementation of NICE TA274 and note the estimated additional associated cost increase, ranging from £5,400 to £300 per 100,000 population.**	
13/55	**Capital Plans and Updates** IP presented this verbal update. She reported that we do not have any capital plans at present, however, there may be some IT investment toward the end of the financial year. An update regarding Merseycare will be included at the next meeting. **The Finance and Resource Committee noted the verbal update.**	
13/56	**Medicines Management Budget Setting** BP presented this report to the Committee with the proposed options for prescribing budget setting to be presented to constituent practices. Budget setting for practice prescribing has undergone incremental changes over the last 4 years with a number of changes applied at either GP constituent request or dependent on practice allocation. Changes to the process have been approved at former Medicines Management Committees or the CCG Medicines Operational Group. With resultant changes some practices feel the process of budget setting is unclear. This report proposes to seek feedback from practices on four options of setting a practice prescribing budget and stripping back some adjustments which have been made in the recent past. It is hoped consultation will provide some clarity to practices on how the practice prescribing budget will be set. The Finance and Resource Committee noted the content of the report and agreed that a letter explaining the four potential models would be sent to practices. The letter will explain that the CCG intends to move towards a Fair Shares Bases and how this will be achieved following nationally recognised guidelines. **The Finance and Resource Committee noted the content of this report.**	

13/57	**Prioritisation Framework** MC presented this report which provides the CCG with a governance framework for Commissioning Decision Making. It identifies CCG priorities and sets out the CCG's decision making criteria and process This tool has been tested by members of the Finance and Resource Committee and will be reviewed later in the year to ensure that it remains fit for purpose. **The Finance and Resource Committee approved the contents of this report.**	
13/58	**Provision and Processes for Restitution Claims** This item was dealt with in the Finance Report	
13/59	**IFR Update Report** IP presented this report and advised the Finance and Resource Committee that going forward this report would be split between the two CCGS. At the earliest opportunity and in conjunction with other CCGs the policy for Procedures of Lower Clinical Priority will be reviewed, approved and adopted. IP requested that the committee note the IEFR Operational Procedures provided by Cheshire and Mersey Commissioning Support unit. The procedures will be adopted by the CCG and will be reviewed at a local level. **The Finance and Resource Committee noted the IFR Report and the adoption of the IEFR Operational Procedure.**	
13/61	**Any Other Business** TJ presented the draft Terms of Reference as amended by the CSU. **The Finance and Resource Committee approved the amended Terms of Reference pending a number of minor amendments.**	
	Review of meeting It was agreed that the Chair would have the final approval of the draft minutes pending a first review by the Chief Finance Officer. **Minutes will be signed and dated in meetings.**	TJ
13/61	**Date and time of next meeting:** **23rd May 2013** **1.00pm – 2.30pm** **3C Merton House**	

Signed …….. Date ……
Chairman

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee

Committee Member	January 2013	February 2013	March 2013	May 2013	June 2013	July 2013	September 2013	October 2013	November 2013
Roger Driver (Chair) Lay Member, SS CCG	✓	✓	✓	✓					
Linda Elezi (Vice-Chair) Lay Member, SS CCG	Apols	Apols	Apols	Apols					
Dr John Wray GP Board Member, SS CCG	Apols	✓	Apols	Apols					
Dr Steve Fraser GP Board Member, SS CCG	✓	✓	Apols	✓					
Sharon McGibbon Practice Manager	✓	✓	✓	✓					
Fiona Clark Chief Officer, SS CCG	Apols	✓	✓	✓					
Martin McDowell Chief Finance Officer, SS CCG	✓	✓	✓	Apols					
Steve Astles Head of CCG Development, SS CCG	✓	✓	✓	✓					
Malcolm Cunningham Head of Performance & Outcomes, SS CCG	✓	✓	Apols	✓					
Tracy Jeffes Head of Delivery, SS CCG	✓	Apols	✓	✓					
Debbie Fagan Lead Nurse SS CCG	✓	✓	✓	✓					
In attendance									
Fiona Doherty Transformational Change Manager (as required)	-	✓	✓	Apols					

NHS
Liverpool
Clinical Commissioning Group

ITEM 3

NOTES OF THE MERSEYSIDE CCG NETWORK MEETING
held on Wednesday 5 June 2013 1.00 – 2.45 PM
Boardroom, Regatta Place
Part 1 – CCG Business Only

PRESENT		
Dr Nadim Fazlani	NF	Chair CCG Network/ Chair Liverpool CCG
Katherine Sheerin	KS	Chief Officer, Liverpool CCG
Dr Andrew Pryce	AP	Chair, Knowsley CCG
Dianne Johnson	DJ	Chief Officer, Knowsley CCG
Paul Brickwood	PB	Chief Finance Officer, Knowsley, Halton & St Helens CCGs
Tom Jackson	TJ	Chief Finance Officer, Liverpool CCG
Sarah Johnson	SJ	Head of Commissioning, St Helens CCG
Dr Niall Leonard	NL	Chair, South Sefton CCG
Fiona Clark	FC	Chief Officer, South Sefton CCG
Martin McDowell	MMc	Chief Finance Officer, South Sefton CCG & Southport and Formby CCG
Dr Clifford Richards	CR	Chair, Halton CCG
Nick Armstrong	NA	Warrington CCG
Craig Gillespie	CG	West Lancashire CCG

IN ATTENDANCE:		
Carol Hughes	CH	PA, Chief Officer & Chair, Liverpool CCG (note taker)

Action:

1	**Welcome & Introductions:**	
	The meeting was opened by Dr Fazlani (NF) who thanked Dianne Johnson and Dr Pryce for hosting the CCG Network for the previous 6 months and for their hard work in making it a success. Around the table introductions were made and NF noted that the change in host was now an opportunity to take stock to look at how to proceed from now on. Katherine Sheerin (KS) referred to her e mail circulated on 23 May which proposed the shape of the Network meetings over the next 6 months and noted that the first part of the meeting would be held with the 6 Merseyside CCGs plus West Lancashire and Warrington, and would be used to focus on operational issues to be resolved together, joint commissioning and development and to understand the new landscape and the roles of how new organisations fit with CCGs. The second part of the meeting would be held with the NHSE team and the 6 Merseyside CCGs and would look at the 3 elements of assurance, development and operational issues of CCGS. The development element would also look at the relationship with the	

		Action:
	area team and consideration would need to be given for an agenda topic. The Second Wednesday of the month meeting would be held with co-commissioners, including relevant Area Teams and Local Authorities and would also include Warrington, West Lancs and Wirral. Providers were involved in this meeting previously and consideration should also be given to whether they would be invited or whether this would be only for particular relevant work being discussed. A copy of the proposed programme for the next 6 months was provided and following discussion it was agreed that this would make sense, but it was unsure how development would be done, given that this is also being done by each CCG. Dr Richards (CR) noted that the structure described is entirely appropriate and refreshing as where we are now does not reflect the position when we first started. It was also suggested that we should take stock about what it is to be a CCG network and how much we are committed to working together and to reinforce the structures made. It was also suggested that Corporate development was also required. Sarah Johnson (SJ) noted that development was important to ensure communication is right, that the one voice of the network is communicated, expected outcomes are achieved, to be more explicit in the relationship of the NHSE and the CCG network and in the difference between assurance and control NF noted that the relationship we currently have is that as statutory bodies but we do have to be clear what will be worked on both together and separately. It was agreed that lessons learned should also be included to share the experiences of all CCGs. It was agreed that the purpose of the second Wednesday meeting should be considered and a TOR agreed. **Action: To agree purpose and TOR for second Wednesday meeting** **To include lessons learned to ensure experiences are shared**	**ALL** **ALL**

		Action:
2	**Apologies for Absence:**	
	Apologies for absence were received from: • Simon Banks (Halton CCG) • Ray Guy (Liverpool CCG) • Dr Clive Shaw (Sefton CCG) • Dr Steve Cox (St Helens CCG) • Dr Sarah Baker (Warrington CCG) • Dr John Caine (West Lancs CCG) • Sarah Baker (Warrington CCG) • Andrew Davies (Warrington CCG) • Dr Fiona Lemmens (Liverpool CCG) • Mike Maguire (West Lancs CCG)	
3	**Notes from the previous meeting:**	
	The minutes of the meeting held on 1 May were agreed as a true and accurate record.	
4	**Matters Arising:**	
	<u>Commissioning Support:</u> It was proposed that this should be discussed at the July meeting. <u>111 Update:</u> KS advised that an e mail had been circulated to all Chief Officers by Ian Davies which confirmed the scale of the problem and the actions being taken. Dr Pryce (AP) confirmed that anecdotal plans had been received about patient transport services which have escalated. KS advised that there was a problem with algorithms which had affected 100 patients due to a fault in the system. Ian Davies had e mailed all CGs regarding this. AP advised that he had recently met with Health Watch and that issues were still on-going. <u>Rehabilitation Pathway:</u> This would be included as an agenda item for the July meeting. KS advised that it is proposed that the Rehabilitation Network is replaced by the Rehabilitation Commissioning Group which will bring together commissioners and providers of the services on a bi-annual basis to ensure they are delivering what is required. It is proposed that at the next Rehabilitation Network meeting in June that the current Network meeting should be disbanded and replaced by the Rehabilitation Commissioning Board. **This was AGREED**.	

		Action:
	Action: Rehabilitation Pathway to be included in July agenda **To disband current Rehabilitation Network and replace with Rehabilitation Commissioning Board.** **All CCGs to be invited to the Rehabilitation Board** IFR/PLCP Policies: It was noted that Dianne Johnson (DJ) and Dr Pryce (AP) were meeting with the CSU to discuss IFR Operational Procedures as the current IFR process is not what is expected. Support had been offered for PLCP by CHAMPS **Action: DJ/AP to provide paper for the next meeting.** EPRR Fiona Clark (FC) updated on the confusion with some providers following the system change on the 31 May, relating to divert and contactable information provided by the NHSE. Clarity was sought and a further communication has been sent out The escalation policy circulated to providers was out of date and referred to PCTs. DJ confirmed that this had now been rectified. As a result of this it was agreed that in future drafts will be circulated for checking and approval prior to distribution. Agreed that a meeting of Urgent Care Leads, Directors of Operations and NWAS will be arranged by the CSU to discuss the CMS system and to ensure people are clear about the divert system. **Action: CSU to arrange meeting.** Future of the I Van: To be discussed by Chief Officers. NHS England Interim Policies: To be discussed at the IFR/PLCP meeting with the CSU **Action: DJ/AP to discuss with CSU at the PLCP/IFR meeting**	**KS** **DJ/AP** **DJ/AP**
5	**Collaborative Commissioning: - NHS 111**	
	KS advised that in accordance with the national directive NHS111 must be operated, in line with the 4 caveats imposed by Dame Barbara Halkin, but that there was more leeway for local flexibility in how the model is delivered. A national meeting will be held today to decide on the future of NHS Direct as an organisation, with the main problem being that although services failed in the North West and West Midlands, it had delivered NHS 111 in other parts of the country, but on a	

		Action:
	smaller scale. A North West Interim Project Board and Clinical Leads Group have been established, which is attended by ID and FC. The local model of service has been discussed by the NW Clinical Leads Group who has identified a NW call handling service with a difference on a local footprint. The NW Project board will focus on delivering on-going performance management of the current service, how to manage the exit of NHS Direct over the next 12 months and the reprocurement of NHS 111. An update and feedback on the outcome of the national decision with regard to NHS Direct as an organisation will be given at the July meeting. **Action: FC or Ian Davies to give an update at the next meeting and feedback on the outcome of the national decision re NHS Direct** NA noted that most of the discussion took place in Merseyside and asked about how relevant this was for Lancashire. Complaints and issues are still coming through mainly around quality of services and time lines of response. NA raised an issue about CCG attendance at this Network and noted that although information discussed is interesting, it was not necessarily directly relevant. He also noted that as he attends the Lancashire network meeting that a shortened meeting would be appreciated	**FC/ID**
6	**Operational Issues:**	
	A E Target: KS noted the need for discussion about proposals around a Merseyside Urgent Care Board and to consider if it does happen, how to ensure it does make sense, how it is handled and where governance lies. DJ advised that the assurance process had not been clear and that this had resulted in significant unnecessary work for the CCG. NF noted that the process was not defined and it was unclear what the examination question was. FC also noted that clarity was required around what was collaborative commissioning as opposed to co-ordinated	

		Action:
	commissioning and if we are not clear, or have not made clear to others, then this should be done. SJ noted that part of the development is to use this item as an example to highlight what could be done differently. KS queried what value has been added from the last 3 weeks. Following discussion it was agreed that clarity was required for a collective stand of CCGs prior to meeting with the NHSE and it was proposed to bring this back to the next meeting and then to share with the Area Team. It was agreed that the Network Chair would seek clarification on behalf of the Network. **Safeguarding Shared Service**: FC requested time to review arrangements currently in place in Halton and to bring back to the network in August. **Action: To be discussed at the August meeting.** **Area Prescribing Committee TOR:** Sara Johnson (SJ) advised that the TOR and decision making process was not completed and the TOR were unclear. It was noted this Committee should be a statutory body with no decision making. Following discussion at the next Prescribing Committee meeting this will be brought to the next Network Meeting. **Action Prescribing Committee TOR to be included on July Agenda.** **SJ to circulate TOR to Chief Officers for discussion**	**FC/KS** **KS** **SJ**
7	**CCG Development:**	
	12 June meeting. A copy of the proposed agenda for the 12 June meeting was provided. KS noted that following earlier discussion about the purpose of the session as this did not reflect what was on the agenda. DJ advised that the Plans on a Page were provided to Aqua to get to the point of overall impact for everyone's plans and to get in an organisation to do that work, thus getting whole system scenarios. In response KS noted that there is a need to identify what needs to be looked at on a bigger footprint than each CCG and what is the	

		Action:
	appropriate footprint. It was agreed that the 12 June meeting would agree the scope of the piece of work of the Co-commissioners, using Aqua time and resources with commissioners to agree up front about what is required. Trust CEOs would be contacted by CCG CO's to advise why they would be stepped down. The outcome of the meeting would be to have a clear brief, to look at outcomes of plans and consider how to move forward. Consideration will also need to be given to how to work with NHSE as Co-commissioners and to give a clear brief of work plans for next year.	
8	**Any Other Business:**	
	Academic Health Science Network: KS asked about representation on the network and it was agreed that this should be done on a rotational basis by the Network Chair.	
9	**Next meeting:**	
	Wednesday, 3 July 2013 1.00 – 2.45 pm Boardroom, Regatta House Lunch will be provided at 12.30	

THIS SET OF MINUTES IS NOT SUBJECT TO "CALL IN".

THE HEALTH AND WELLBEING BOARD

MEETING HELD AT THE TOWN HALL, BOOTLE
ON WEDNESDAY, 22 MAY 2013

PRESENT: Councillor Ian Moncur (in the Chair)

Dr. Janet Atherton, Fiona Clark, Councillor Paul Cummins, Councillor John Joseph Kelly, Maureen Kelly, Colin Pettigrew, Phil Wadeson and Dr. Craig Gillespie.

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Robina Critchley and Dr. Niall Leonard.

The Chair took the opportunity to welcome Dr. Craig Gillespie to the Meeting who was sitting on the Board in place of Dr. Clive Shaw for 3-6 months and asked Mark Turley, representative of the Police Commissioner to introduce himself, and indicated that he was in attendance as an observer.

2. DECLARATIONS OF INTEREST

There were no Declarations of Interest received.

3. MINUTES

RESOLVED:

That the Minutes of the Shadow Health and Wellbeing Board held on 17 April 2013 be received as a correct record and noted.

4. VICE-CHAIR

RESOLVED:

That in the event that the Chair of the Board, Councillor Moncur is unavailable to attend future Meetings of the Board, nominations be taken for a Member to take the Chair for that meeting only.

5. QUORUM

RESOLVED:

That for the purposes of the meeting of the Health and Wellbeing Board the quorum shall be 3, as set out in Chapter 4, Paragraph 29 of the Council's Constitution.

6. PERFORMANCE FRAMEWORK FOR THE HEALTH AND WELLBEING STRATEGY

The Board considered a report from the Head of Business Intelligence and Performance that proposed an approach to managing performance improvement for health and wellbeing throughout the Borough. It was reported that this would be done through the adoption of a set of principles and the development of a performance "dashboard" for health and wellbeing in Sefton.

It was reported that this approach should provide members of the Health and Wellbeing Board with an overview of health and wellbeing in Sefton, so that areas of achievement could be identified and areas for improvement could inform where the Health and Wellbeing Strategy needed to be refocused.

The report outlined the following set of principles for performance:-

- Be honest, open and communicate our achievements and areas for improvement
- Give direction and trust those responsible for partnerships and service delivery to achieve improved outcomes
- Be accountable for influencing others across the health and wellbeing system to achieve improved outcomes
- Challenge commissioners to account for improving outcomes and being bold in decision making
- Use evidence and listen to people's experiences and views in judging performance and improving outcomes
- Measure ourselves against others in terms of outcomes, productivity and value for money
- Focus on innovation, and managed risk taking, to deliver system change
- Value people through celebrating and sharing the success of individuals, families, communities and organisations.

The report also outlined the aim of the proposed "dashboard" in providing a high level analysis for the Health and Wellbeing Board, coupled with patient and public experience and feedback. The analysis from the dashboard would enable the Board to identify health and wellbeing improvements or issues that needed to be addressed.

It was reported that in developing a "dashboard", Members considered the following:-

- In progressing the principles and metrics, the Board would require a process for Board Members, through its wider stakeholder networks, to escalate issues of performance which may come from soft intelligence.
- A set of measures be developed which are linked to the prescribed outcomes framework and that local measures also be developed.

- The "dashboard" should not duplicate what is already in place across the wider health and wellbeing system, but should be sufficient to enable the Board to undertake its strategic influencing role. Annex C to the report set out potential lead Board Members for each theme and who, within the Cabinet, has accountability for delivery and commissioning within the theme, as those functions relate to the Council. The Clinical Commissioning Group's (CCG's) were invited to identify who within their Boards has a responsibility for shaping commissioning and delivery.
- Examine the way in which the Board ensures that it receives the right information that it needs and explore what processes need to be in place to support the Board to receive intelligence from the wider health, social care and wellbeing system, both hard intelligence (such as measles outbreak) and soft intelligence about quality.
- Investigate what action should be taken to work with stakeholders, organisations and individuals which have a role in the theme, as set out on the stakeholder map previously agreed by the Board.

The report identified the risks associated with not developing an approach to performance improvement.

RESOLVED: That:-

(1) having reviewed the set of principles for managing performance improvement for health and wellbeing, those principles be agreed;

(2) the sub-structure and partnership map attached at Annex A to the report be noted;

(3) having reviewed the proposals for the development of a performance "dashboard", the establishment of a task and finish group to progress that development work and agree the approach; and

(4) having considered the approaches, these be agreed as being sufficient for the Board to have an overview of health and wellbeing in Sefton, and the task and finish group be requested to develop this work further and in particular to ensure the strategy makes a positive impact and identifies where further improvements need to be made.

7. ALIGNING PLANNING APPROACHES

The Board considered a report from the Head of Business Intelligence and Performance which outlined a proposal to align approaches to planning for health and wellbeing by extending the remit of the Sefton Strategic Integrated Commissioning Group to include the management of the operations of the Health and Wellbeing Board.

It was reported that the Sefton Strategic Integrated Commissioning Group was established in April 2012 and oversees the plan for the integrated commissioning of adult and children's care and public health programmes. The Group is made up of Senior Officers from Sefton MBC, Sefton Clinical Commissioning Groups (CCGs), NHS Merseyside and some members of the Health and Wellbeing Board.

It was further reported that the Board had previously agreed that the minutes of the Sefton Strategic Integrated Commissioning Group would be submitted to the Board, but that it would not be a formal sub-committee of the Board.

The report stated that an integrated Commissioning Plan was currently being developed and would be circulated to the Board in due course.

In the aligning of approaches, the Board agreed that there should be a programme management approach to business planning rather than having a separate Operations Group. Members of the Board expressed the view that the functions of such a group should be subsumed into the already established Sefton Strategic Integrated Commissioning Group, thereby aligning approaches to planning, performance management, consultation and engagement with integrated commissioning.

The report suggested that the Sefton Strategic Integrated Commissioning Group should review its Terms of Reference to reflect any additional duties required to provide executive and operational support to the Health and Wellbeing Board and any changes to the reporting lines and timelines. The report also suggested that the Group should review its membership to confirm that the Group consists of appropriate individuals engaged to drive forward system change and the effective delivery and review of the Health and Wellbeing Strategy.

RESOLVED: That

(1) the approach to planning through the Sefton Strategic Integrated Commissioning Group be approved as a means of supporting the improvement of health and wellbeing;

(2) the Sefton Strategic Integrated Commissioning Group be requested to review its Terms of Reference and Membership, so it better reflects the breadth of the Sefton Health and Wellbeing Strategy; and

(3) the Deputy Chief Executive of Sefton Council be appointed as the Chair of the Sefton Strategic Integrated Commissioning Group.

8. COMMUNICATION PLAN 2013-2018

The Head of Business Intelligence and Performance submitted a draft Communication Plan for April 2013 – October 2013. It was reported that the plan had been jointly developed by Sefton Council, the Clinical

Commissioning Groups and the Cheshire and Merseyside Commissioning Support Unit.

The report advised that by adopting the Health and Wellbeing Strategy for Sefton, the Health and Wellbeing Board agreed to formally communicate with service providers, residents and those in receipt of services, to fulfil and achieve the agreed actions and outcomes of the Strategy.

The report stated that to achieve that goal, the Shadow Health and Wellbeing Board had agreed to develop a Communication Plan for the lifetime of the Strategy (2013 – 2018) with the following aims and objectives:-

- To raise the profile and awareness of the Health and Wellbeing Strategy and its actions;
- To gain and maintain people's commitment to the Strategy and priorities;
- To communicate with partners in delivering the actions and outcomes of the Health and Wellbeing Strategy;
- To help recognition of the work of commissioners and deliverers of services for health and wellbeing;
- To inform residents, service users and stakeholders;
- To celebrate success; and
- To help manage and plan forward for potential "wicked problems" and difficulties in delivery against changing priorities.

The report sought to agree an approach for the first six months (April – October 2013). It was reported that the plan had been produced taking into account the agreed communication strategies of Sefton Council, the South Sefton and Southport and Formby CCG's, and links to and supports the delivery of the work on Patient and Public Voice. It was reported that the Communication Plan will be reviewed annually as part of the formal review of the Health and Wellbeing Strategy.

It was also reported that all communication methods will be honest, succinct, use positive images and reflect all sectors of our local community, credible, cost effective, free from political jargon and written in plain English. It was further reported that the approach remained consistent with the principles that the Board had set itself.

A Member of the Board highlighted this as a good example of partners working together and drawing upon existing resources of expertise and utilising the skill set within partner organisations.

RESOLVED:

That the set of principles, methods, frequency, ownership and standards within the Communication Plan for the first six months of the Health and Wellbeing Board be agreed, as set out in the report.

9. PUBLIC AND PATIENT ENGAGEMENT

The Board considered the report of the Head of Business Intelligence and Performance which proposes an approach to public and patient engagement and consultation which includes the role of the Engagement and Patient Experience Group (EPEG) which is managed through the Clinical Commissioning Groups for Sefton and Healthwatch Sefton. The report referred to the EPEG and Healthwatch Sefton as part of a wider system of groups and partnerships that contribute to the delivery of public patient engagement, alongside the Public Engagement and Consultation Standards Panel, the Council's Business Intelligence and Performance Team and the Customer Insight Board.

RESOLVED:

That the approach to Public and Patient Engagement, as detailed in the report be agreed.

10. SUSTAINABLE DEVELOPMENT CONSULTATION

The Board considered the report of the Director of Public Health which provided Members with the draft response to a consultation and engagement exercise to produce a sustainable development strategy for health, public health and social care system.

The report set out seven key questions which were discussed at a stakeholder workshop. A draft response to each of the seven key questions was outlined in the report.

It was reported that the response was required to be submitted to the Sustainable Development Unit by 31 May 2013.

Fiona Clark, Chief Officer for Clinical Commissioning Groups across Sefton, reported that she was delighted to be engaged in the production of a sustainable development strategy and reiterated that this was another piece of work that illustrated the excellent partnership working across partner organisations.

RESOLVED:

That the Director of Public Health be requested to finalise the consultation response, in consultation with the Cabinet Member for Older People and Health, before submission on 31 May 2013.

11. SOUTHPORT AND FORMBY CLINICAL COMMISSIONING GROUP AND SOUTH SEFTON CLINICAL COMMISSIONING GROUP STRATEGIC PLANS

The Annual Plans "Everybody Counts" for 2013-14 for the Southport and Formby Clinical Commissioning Group and the South Sefton Clinical Commissioning Group were presented for approval.

It was reported that both plans set out the vision, values and aims that the CCG's would like to achieve for everyone who lives in Sefton and embody their commitment to their local and statutory duties, and most importantly, to Sefton's people.

RESOLVED:

That the Annual Plans "Everybody Counts" for 2013-14 for the Southport and Formby Clinical Commissioning Group and the South Sefton Clinical Commissioning Group be agreed and endorsed.

12. SEFTON CLEAR SELF-ASSESSMENT (TOOL TO IDENTIFY GAPS AND STRENGTHS IN LOCAL AUTHORITY TOBACCO CONTROL ACTIVITY)

The Board considered the report of the Director of Public Health which updated Members on the CLeaR framework, the national tool devised by Action on Smoking and Health, a national charity, whose aim is to reduce smoking in the UK.

The report explained that the tool examines local priorities and activity and supports the identification of gaps within three areas: Leadership, Challenging Services and Results. It uses a challenging questionnaire for the self- assessment process with an optional review from a team of peers. It is designed for Local Authorities as well as local alliances to assess action on Tobacco Control.

RESOLVED: That

(1) the development of a Sefton Tobacco Control Plan that details across all strands of tobacco control be supported;

(2) the proposed Sefton Tobacco Plan be developed to meet local governance structures prior to agreement by this Board;

(3) the proposed Tobacco Control Plan should include a governance and performance management structure to support its implementation;

(4) the establishment of a multi-agency alliance to oversee development and implementation of the proposed Sefton Tobacco Plan and to oversee performance by partners and facilitate future development of tobacco control objectives for Sefton and support innovation be supported;

(5) the Board will ensure that future tobacco control activity works in synergy with the newly emerging healthy settings approach that is being established across Sefton;

(6) that the tobacco alliance be requested to provide regular information and updates to the healthy settings strategy group, once they have been established;

(7) participation in a peer CLeaR assessment with Sefton tobacco control alliance when established, be supported, in order that Seftons self assessment evidence may be critically appraised and areas of tobacco control activity that need to be developed be identified; and

(8) the following areas be prioritised in the plan, based on local data:-

- Reduce smoking amongst adults within the most deprived areas of the borough.
- Reduce the number of women who smoke during pregnancy.
- Reduce smoking prevalence amongst young people.

13. MINUTES REFERRED FROM SEFTON STRATEGIC INTEGRATED COMMISSIONING GROUP

The Minutes of the Sefton Strategic Integrated Commissioning Group were submitted to the Health and Wellbeing Board for information.

RESOLVED:

That the Minutes of the Sefton Strategic Integrated Commissioning Group be noted.

14. FORWARD PLAN

The Head of Business Intelligence and Performance submitted the Forward Plan of the Health and Wellbeing Board.

The following items were reported as additional items to be considered at future meetings:-

Item	Lead	Date
Local Plan	Jane Gowing, Head of Planning Services	24.7.13
Energy Plan	David Packard, Head of Environment	24.7.13
CCG's Strategic Plans	Fiona Clark, Chief Officer – Southport and Formby CCG and South Sefton CCG	24.7.13
Winterbourne View	Robina Critchley, Director of Older People	24.7.13
Premature Mortality	Janet Atherton, Director of Public Health	24.7.13/ 21.8.13
Sustainability - Discussion	Janet Atherton, Director of Public Health	18.9.13

In addition, it was indicated that the item in the Forward Plan – "Healthwatch Priorities" had been postponed until 18 September 2013.

RESOLVED:

That the Forward Plan for the Health and Wellbeing Board, along with the additional items, as above, be noted.

Southport and Formby
Clinical Commissioning Group

Medicines Management Operational Group (MMOG) Minutes

Held on 7th June 2013 10.30am-12.30pm
Library, 1st floor, Fylde Road Medical Centre, Southport

Present Dr Hilal Mulla (Chair) Jane Ayres (JA) Dr Janice Eldridge Susanne Lynch (SL) Brendan Prescott (BP) Kay Walsh (KW) **Minute Taker:** Ruth Menzies	Board Member – Southport and Formby CCG Senior Practice Pharmacist - Southport and Formby CCG Prescribing Lead - Southport and Formby CCG Senior Practice Pharmacist - Southport and Formby CCG Medicines Management Lead - Southport and Formby CCG Interface Pharmacist - Southport and Ormskirk Hospital Trust

No	Item	Action
13/70	**Apologies** Apologies were received from Helen Stubbs and Malcolm Cunningham.	
13/71	**Minutes of meeting dated 10th May 2013 confirmed via email and sent to Mel Wright** Discussions took place regarding minutes and as they are part of the Board papers and therefore open to public viewing, the Chief Officer has requested that minutes are presented in a standardised manner and are clear and concise to avoid potential confusion/contention. Discussions took place as to how helpful the minutes would be as this is an operational group. It was agreed JA would write detailed action notes for the group's use. The following matters from the minutes not included under Matters Arising were discussed:- Nail Lacquers – JA to send data to go on South Sefton Medicines Optimisation Operational Group (SSMOOG) Agenda.	**JA** **JA**

No	Item	Action
	Duraphat - JA to draft document to send to Phil Radcliffe, Dental Adviser. It was noted the Grey List has been added to the intranet. <u>Riluzole/High cost drugs and NCB (NHS England involvement</u>) (HS) HS emailed the Group as unable to attend the meeting and attached a list of PBR drugs funded by NHS England. It was noted the list is work in progress. Discussions took place regarding adding the "Cost of PBR drugs to the CCGs" to the JMOG Agenda. <u>Care home paper for CCG board</u> (BP) BP tabled a copy of the paper and discussed the content. It is hoped that all care home patients in South Sefton would have had a review by the end of June 2013. It was agreed the paper should go to the Governing body of the S&F CCG with a view to undertaking something similar in S&F. <u>Paediatric specials project – for JMOG</u> It was noted Sandra Craggs will attend the next JMOG and supply further data.	**JA**
13/74	**Shared Care issues (BP)** <u>Denosumab</u> It was noted the budget was due to be agreed yesterday. SL stated other CCGs may be changing their minds and not proceeding with the shared care arrangements <u>Degarelix</u> BP has yet to speak to Joe Chattin, Local Medical Committee (LMC) Chair, regarding the changes. <u>Dementia drugs</u> The Shared Care documentation has been sent to Lee Knowles, Chief Pharmacist at Merseycare who is generally happy with the content but	**BP**

No	Item	Action
	needs a few minor points clarified. The LMC have approved the documentation. Merseycare are now looking at a relaunch date in July.	
13/75	**QoF/PQS** PQS points/payments Janet Fay, Senior Practice Pharmacist, has been collating the points. It is hoped all figures will be in next week in order to get the letters with sample invoices sent out as soon as possible as payments need to be made by the end of June.	
13/76	**Budget Update** Budget setting for 2013/2014 A generalised letter went out via Communications. As yet no feedback has been received. JE confirmed the Formby locality have comments. BP to contact Moira McGuinness. March data Data for the end 2012-13 was attached to the agenda. It was confirmed S&F CCG are showing a £1.2 million underspend.	**BP**
13/77	**NS & WL Medicines Operational Forum (MOF) feedback** Collagenase injection for Dupytren's contracture – F&R decision and how is this communicated (JE) BP confirmed this was a Commissioning Support Unit (CSU) function and Graham Reader has emailed to say he will be contacting CCGs informing them to add the above decision to their intranet.	
13/78	**Pan Mersey APC feedback** No Pan Mersey meetings have taken place recently. KW to email previous set of minutes to JA.	**KW**

13/79	**Items from Pan Mersey subgroups** KW confirmed an email has gone out stating updated information is on the website.	
13/80	**LMWH for prophylaxis during flying in high risk patients** It was noted that the clinicians on the MMOG confirmed that normal practice would be to prescribe. SL to confirm MMOG's response to GP raising concerns.	**SL**
13/81	**Reducing asthma admissions** Discussions took place regarding the aim to reduce admissions by 25% for under 19s and stated that the statistics for avoidable admissions in Sefton was very high. It was noted this has been addressed previously but felt the MMOG should take a lead. Discussions took place regarding incorrect data being recorded for asthma patients and the possibility of putting something together to train nurses on inhaler techniques.	
13/82	**Osteoporosis guidelines** Guidelines almost complete. All to email any comments to KW.	**All**
13/83	**Sefton Prescriber Updates for comment** <u>Sunscreens</u> KW has rewritten the SPU. <u>New medicines</u> BP provided comments to be included in the SPU. *(HM left the meeting)*	

13/84	**Jext (JE)** Discussions took place as to whether practices had started patients on Jext. It was agreed this should be discussed at a team meeting and a workstream produced.	
13/85	**Collagenase injection for Dupytren's contracture – F&R decision and how is this communicated (JE)** Discussed under item 13/77.	
13/86	**AOB** Nothing to report.	
	Date, Time and Venue of Next MMOG — Friday 5th July 2013 at 9.30 am in Conference Room 3A, Merton House (JMOG following at 12 noon)	

Sefton Strategic Integrated Commissioning Group (SSICG)

Minutes of the meeting held on 3rd June 2013

Present :

Peter Morgan	Deputy Chief Executive, Sefton Council CHAIR	PSM
Fiona Clark	Chief Officer – Sefton CCGs	FLC
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
Debbie Fagan	Chief Nurse for Sefton CCGs	DF
Steve Astles	Head of CCG Development South Sefton CCG	SA
Geraldine O'Carroll	Integration Commissioning Lead Sefton Partnership MCSS	GO'C
Martin McDowell	Chief Finance Officer	MMcD
Hannah Chellaswamy – attended on behalf of Janet Atherton	Deputy Director of Public Health	HC
Dr Pete Chamberlain – attended part of the first Session only	SS CCG, Virtual Ward Lead/GP	
Carole White - (Minutes)	Personal Assistant to Peter Morgan	CAW

In attendance for the first Session

Graham Pink	Chief Executive Officer	GP
Wayne Ashton	Head of Strategic Planning at GB Partnerships	WA

Apologies :

Dr Niall Leonard	Chair of Southport & Formby CCG	NL
Dr Clive Shaw	Chair of South Sefton CCG	CS
Janet Atherton	Director of Public Health for NHS Sefton and Sefton Council	JA
Sam Tunney	Head of Business Intelligence & Performance, Sefton Council	ST
Billie Dodd	Acting Head of CCG Development Southport & Formby CCG	BD
Tracy Jeffes	Head of CCG Corporate Delivery – Sefton CCGs	TJ
Malcolm Cunningham	Head of Performance and Health Outcomes – Sefton CCGs	MC

No.	Item	Minute	Action
	Session on – Strategic Estate – Health Asset / Community	• Graham Pinks and Wayne Ashton gave a presentation to the Members of SSICG • The presentation was to go through where the services are being delivered from and then see how things can	

No.	Item	Minute	Action
	Planning	be done differently by commissioners. Look at what we invest our money in, but also what we need to take our money from. Wayne Ashton took colleagues through the presentation (attached) and the following was noted:- • In some cases old data is being used / data sets used not actual. • Data only based on 5 day week – this should be looked across a full 7 day week. • Always would be a need for facilities for everyone to work around a table to undertake care planning. • Councillors and other Stakeholders would need to be involved / their views taken on board. • Commissioners and strategic leads would need to be involved. • John Doyle to attend one of FLC's Management Meetings, in order to look at overlapping Sefton with others re: community care. • Within the recommendations – to be added – require new improved data. Agreed the recommendations:- • CCGs to gather improved contract monitoring reports from Providers to establish patient contacts per location • Centralised resource to manage primary care estate and capacity • Accommodation schedules – maintained and updated with estates changes • Occupancy information – central management of all bookable space and occupiers at CCG level • Cost data – needs revisiting to give a clearer view on retained liabilities. • To improve data collection and analysis. Recommended next steps:- <u>Data Management</u> • Systemised data management to underpin organisational memory • Continue to maintain data and develop simple and robust performance monitoring tools across all levels • Work with CCGs and NCB to get an agreed approach to capturing clinical activity data and associated occupancy data, in order to give true visibility of the productivity of space <u>Strategic Planning</u> • Utilise outputs developed to support commissioning initiatives across all levels	Paper attached

No.	Item	Minute	Action
		• Linking identified capacity with health need • Identify area specific opportunities and develop cases for change including targeted investment in infrastructure <u>Engagement</u> • Supporting partnering approach between NHS commissioners and providers – to facilitate optimisation • Potential to extend to wider public services (eg Local Authorities) <u>Action for SSICG</u> • SSICG to think about pieces of work that they need putting in place.	
1.	Minutes of the previous meeting	Agreed in the main. Amendment to Item 5 : • Should state that Gerald Pilkington has been contacted to provide a proposal. • Meeting on 26th April was only for an initial discussion • Action point – meeting to be arranged, has now been deferred.	
2.	Actions Arising / Update	• None	
3.	Health & Well-Being Board sub structure to incorporate SSICG	• PSM discussed the report with SSICG. • SSICG now to provide operational support to the H&WBB. • Task and Finish Groups to be established – to do the work that would then come back to SSICG. <u>Actions</u> • SSICG asked to consider who needs to be on the SSICG Operational Group. Who should be on the Task and Finish Groups and define what the Group should be. • FLC and PSM to meet to discuss • Item to come back to the next SSICG Meeting	ALL FLC / PSM
4.	Update on Re-ablement	• TW tabled a paper, and discussed the issues with SSICG. <u>Actions</u> • SSICG are asked to look at the report and come directly back to TW by the 10th June. • Governance to come back to SSICG (date yet to be determined) and then to go out to the Constituencies. • TW / MMcD / DF to meet to progress	Attached TW TW / MMcD / DF

No.	Item	Minute	Action
		• Steering Group go to (ASK PETER WHAT DID HE SAY) to ask them for nominations for people to sit on the Group	
	Progress to arrange a meeting	• Meeting deferred	
5.	MASH specification – to be signed off	• DF discussed with SSICG. • Final draft received back, now forwarded to Liverpool Community Health. • Any issues re: governance DF must be informed asap, in order that it can be included. • In view of the impending Inspection CP to liaise with DF should any assistance be needed.	ALL CP / DF
6.	Populated SSICG Work Plan	• Deferred to next SSICG Meeting	
7.	Mental Health Report	• TW tabled a paper (in addition to the paper that had been originally circulated). • TW discussed with SSICG – proposal to take things forward. • Meetings have already taken place with Mersey Care and Public Health. • Workshop / Stakeholders Event to take place early July. Look at issues – identify and prioritise, set 'road map' for next 2 to 3 years. • SSICG are asked to endorse the recommendations – which would then be taken forward to the Workshop / Stakeholder Event. <u>Action</u> • CAMHS to be included.	Attached
8.	Plan on a Page	• FLC tabled 2 documents. • FLC went through the documents with SSICG.	Attached
9.	Adult Social Care Choice Framework	• RC / G'O'C / DF to meet to discuss further.	RC / G'OC / DF
10.	Winterbourne View Concordat (Referred by H&WBB)	• Letter noted. <u>Action</u> • RC to confirm that we are compliant with the report, and then to come back to SSICG.	RC
11.	Any other Business	• FLC had attended a meeting at the Carers Centre – raised Aspergers / CCGs / Map Autism. FLC to meet with them again in 4 weeks time. • FLC raise – Aqua considering work on Pioneer Status.	

No.	Item	Minute	Action
		• Jamie Hester is the lead • FLC to advise looking at integration in the large scale. • Problem is capacity issues within the service, which is the reason why we may not take this forward at present. <u>Action</u> • Jamie Hester to meet with RC and TW etc to start a dialogue. • RC and TW to liaise with FLC	RC / TW / FLC
	Items for the next meeting	• Health & Well-Being Board sub structure to incorporate SSICG – Operational Board / Task and Finish Groups • Populated SSICG Work Plan • Unplanned Care • Public Health Workstreams – Sefton School Nurse specification – Healthy Weight – Sexual Health • Disability Pathway	ALL PM FLC Margaret Jones CP
		Date and time of the next meeting – 22nd July 2013 at 3.30 p.m. – venue – Boardroom, 3rd Floor, Merton House, Stanley Road, Bootle, Merseyside, L20 3JA	

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Engagement and Patient Experience Group

12 June 2013, 10:00 – 12:00 at Merton House

In attendance		
Tracy Jeffes	Head of Corporate Delivery, SS CCG & SFCCG	TJ
Michelle McKeown	Patient and Public Voice Officer, Merseyside CSU	MMcK
Rachel Jones (nee Bridge)	Health, Wellbeing and Older People Lead, Sefton CVS	RJ
Diane Blair	Manager, Sefton Healthwatch	DB
Libby Kitt	Member, Sefton Healthwatch	LK
Sarah McGrath	Locality Lead, Southport and Formby CCG	SMcG
Mick Hanarty	Performance, Consultation, Policy/Strategy Officer, Sefton MBC	MH
Roger Driver	Board Lay Member, South Sefton CCG	RD
Sharon McGibbon	Practice Manager, Board Member, South Sefton CCG	SMcG
Apologies		
Roy Boardman		
Sam Tunney		
Sue Holden		
Jayne Vincent		
Roger Pontefract		
Steve Astles		
Minutes		
Cathy Loughlin		

No	Item	Action
13/1	**Apologies** Apologies were noted.	
13/2	**Notification of Any Other Business** None.	
13/3	**Action Notes from the Last Development Session** Notes agreed as a correct record. Matters arising: 1. Myers Briggs type indicator has been sent out. 2. Rachael and Diane's updates are on the agenda. 3. Patient reference group item is scheduled for the next agenda. 4. Communications in GP practices report back to next meeting re progress.	
13/4	**Feedback from the Two Task Groups** *a) Emergency Planning* Tracy (on behalf of Steve Astles) and members of the task and finish sub group fedback on progress. There is a meeting taking place on 27thnd June to discuss this further. Tracy shared some suggested questions that could be included in a questionnaire that will be developed for patients to complete regarding their experience of A&E. Diane mentioned that Healthwatch are doing a similar piece of work their intelligence will be used to feedback into the process. Sarah confirmed that the North Locality have been doing surveys or writing to patients re A&E and she will get feedback from them. This will need to be fed into	A&E Group / SA SMcG

	the task and finish group. Questionnaires from Steve will also be circulated. Sarah to bring back intelligence to the group and to ask other Locality Managers across the patch to see if there is any other activity. The task and finish group need to keep a focus on the specific task and there needs to be a clear deadline by the end of June re questionnaire development and a clear date for deadlines for the questionnaires to be returned. Michelle to co-ordinate the above making sure there is a clear plan of how to proceed. It needs to be clearly stated at EPEG who will convene meetings. Michelle to meet people who are producing questionnaires and will produce a note re update. *b) 12 Month Engagement Plan* The timetable proforma has been circulated for the second task and finish group members to complete. Tracy to meet with Jacqui Robinson and Michelle re action plan. Members of the group to contact Tracy to add to the action plan as a priority. Engagement action plan to be populated by 27 th June and placed on the next agenda.	SMcG MMcG TJ / DB/ RJ/MMcK / LC / SH
13/5	**Prospectus** • South Sefton CCG • Southport and Formby CCG Lyn has circulated both CCG prospectuses for comments. Lyn is to speak to the Print Designers re branding. Rachal had attended the focus group and fedback regarding the pictures as they are not suitable. This is a public facing document which would also be used for events and used by GP practices. The group are happy with the document and the context is really clear so that patients and the public can understand it. Once it has been finalized copies will be left in GP practices waiting rooms and it will also be available on the website. Rachel is to speak to the Young Advisors group re this document. Possible circulation: Copies given to stakeholders. Made available to patient reference groups in GP practices. Locality managers to take a few to localities. Send electronically and linked to practices individual websites. Sharon to pick up for practice managers meeting. Sarah for locality managers. Voluntary sector to receive some for notice boards etc. Lyn to co-ordinated The group needs to let Lyn have comments back no later than Friday 21 June. The South Sefton CCG Governing Body membership needs to be updated	RJ LC SMcG LC
13/6	**Update and Reporting from Healthwatch on Key Issues for Local People** Healthwatch Sefton has been working on its commentaries for NHS Quality Account documents and submitted a commentary for Aintree University Hospital NHS Foundation Trust and Southport and Ormskirk Hospital NHS Trust. A position statement was sent to all other NHS Providers to state how Healthwatch Sefton would be keen to work with them over the next twelve months. Healthwatch Sefton has undertaken assessments of all NHS Equality Delivery System outcomes for the period 2012 – 2013 and engagement plans have been put into place to work with all NHS Trusts over the next twelve months. Member's events are being held at the end of June to share volunteering opportunities with members and gain views of the draft role descriptions for the steering group membership. Expressions of interest for the steering group will be	

	shared with members in July when then recruitment process will begin. The Health watch Sefton signposting and information service is in place and members of the public can contact the service on 0800 206 1304. Clare Platt will start with the team on the 1st July and will be the officer who leads on this service and provide admin support for the team. *Summary of issues* a) Norwood GP Surgery, Southport. b) Patient Transport Service – North West Ambulance Service NHS Trust c) Booking Audiology Outpatient appointments – Aintree University Hospital NHS Foundation Trust. d) Car Parking – Southport and Ormskirk Hospital NHS Trust. Press Statement e) Variation in Interpreter Services. f) Southport and Ormskirk Hospital NHS Trust – Quarter 4 Patient Experience Report g) Position Statements – 31st March 2013. It was agreed that all Trust reports would be circulated to EPEG members once they have been signed off. Diane to action. Roger asked if all members in future could refrain from tabling reports and could send them to Cathy so that they can be circulated with the agenda. Copy of this report to be circulated with the notes Sharon attends a well-established patient reference group in Maghull and will invite Diane to one of these meetings. Roger asked if there was any good practice already established in the community and if so could these reports be sent to members of the EPEG as a learning tool. Michelle is attending the next Practice Managers meeting. Diane confirmed that the National Healthwatch hub is up and running and she will log on to see if there is any good practice which she will bring back to EPEG.	DB ALL CL SMcG MMcK DB
13/7	**Review Terms of Reference / Role of the Group** The terms of reference were discussed as they need to be fit for purpose. Tracy to amend terms of reference taking into account what was discussed at the EPEG development sessions as they need to include the broader aspect around the integrated commissioning agenda. A template for Governing Body lead needs to be produced for when colleagues are reporting back to the Governing Body making sure that explicit important items are listed in a concise and succinct way.	TJ TJ/CL
13/8	**Big Chat** Tracy informed the group that Fiona Clark would like to hold two Big Chat events with communities at both end of the patch. Updates would be given around longer term strategy which is being developed and pick up on urgent care, Virtual Ward for South Sefton CCG and Care Closer to Home Strategy for Southport and Formby CCG. Key issues will be presented to allow a significant time for discussion and feedback from the public. Michelle is going to organise these events which are likely to be 10th and 25th July. Tracy has e mailed Sam Tunney to see if there is anything she wants to contribute regarding joint working. Mick felt that it might be an opportunity to provide some feedback on the health and wellbeing strategy. To be discussed further It was confirmed that Voluntary sector providers would find this event useful. It needs to be kept focused for members of the public and key items need to be	TJ/ MH

	discussed and be kept simple. Clear remit for the event so expectations are met. Michelle suggested a survey on line or documentation to be sent in the post to vulnerable people who can not make the event. Sharon feedback from last year and said it was it helpful but that the date was not published early enough. Rachel will facilitate the information to her groups. Michelle to organise event on behalf CCG. Rachel and Libby to advise to engage vulnerable people. Static boards displaying Healthwatch information which will be on show at the events. Branding needs to be produced before Big Chat events. Libby and Rachel to help with this. Community groups to have stands. Michelle to co-ordinate with Rachel. Mick to offer advice. Elected members to be invited.	MMcK / LK RJ MMcK
13/9	**Review of Health and Social Care Forum and CVS Update** Rachel gave an update. Copy of presentation attached for information. Key issues discussed:- The patient experience group has offered their support re templates for service users with Learning Disabilities re hospital appointments etc. Diane to share contacts re acute providers and will attend a practice managers meeting. Sharon will put this on the agenda for practice managers. Jenny Friday co-ordinates this and is based at CVS. Rachel to send contact details. Libby to link with Tracy Reed Simone to be invited to attend a future EPEG meeting. A gap has been identified in mental health services. Intelligence needs to be pulled together and brought back to EPEG. Rachel to contact Geraldine O'Carroll as the lead commissioner for mental health. Sarah will make Jan Leonard aware of this. CVS are developing an electronic directory and will work with Practice managers and locality managers to maximize this. Every Child Matters Forum to make a more effective link with EPEG via Jane Uglow and Debbie Fagan. Rachel will feedback to the group regularly to and from these forums.	RJ DB SMcG LK CL RJ RJ RJ
13/10	**Patient Experience Dashboard Update** The Cheshire and Merseyside Commissioning Support Unit is developing a patient experience dashboard electronically. Tracy to ask CSU to do a presentation for EPEG at the July meeting	TJ / CL
13/11	**Proposal from Healthwatch - Community Champions 2013-14** Diane gave a presentation, copy attached. Diane discussed the proposal / business case being submitted to both CCGs re funding for an Engagement Officer to support this work. Tracy confirmed that the proposal needs go to the F&R committees for approval. Tracy will take this to the committees, but there needs to be some work to strengthen the proposals in relation to measurable key performance indicators. EPEG are supportive in	TJ/DB

	principle, pending further work. SMcG to invite Healthwatch to the practice managers meetings so they can demonstrate what additional value they can provide to GPs with regards to engagement work. .	SMcG
13/12	**LGA Peer Review** Sefton's Health and Wellbeing Board are taking part in Peer Challenge Exercise from 8th to 11th July. Undertaken by the LGA, the review will look at the development of the Board and the Health and Wellbeing Strategy. A draft timetable has been circulated and will involve many partners that make up the EPEG. Further information will be released as decisions are taken.	MH
13/13	**Key Points to Feedback to Others e.g. Report to Governing Bodies / Health and Wellbeing Board etc** It was agreed that any action points from the EPEG needed to be communicated clearly to key stakeholders as relevant. Tracy will produce an action sheet from board meetings which will be circulated to all EPEG members.	TJ
13/14	**Date of Next Meeting** 10th July 2013 10- 12 Venue Board Room, Merton House Possible agenda items :- • Primary Care Quality Strategy consultation • Patient Experience Dashboard presentation • Patient Reference Group Update • Clinical Networks Patient Engagement Sarah McGrath It was agreed that in future timings would be listed on all agendas.	 Bal Duper / Angie P CSU MMcK SMcG CL

NHS
South Sefton
Clinical Commissioning Group

Bootle Locality Meeting Minutes

21st May 2013
1.00 pm – 2:30 pm
Park Street Surgery

Attendees
Dr Pete Chamberlain
Gill Riley
Sarah Gibson
Sue Edmondson
Dr Ricky Sinha
Dr Katie Dutton
Helen Devling
Helen Mercer
Pam Sinha
Dr Sarah Stephenson
Dr A Ferguson
Ronnie Holmes
Pauline Sweeney
Dr S Sapre
Dr Chung
Jenny Kristiansen
Paul Halsall

Guest Speakers
Dr Pete Chamberlain – Item 13/41

Apologies
Gary Killen
Dr Goldberg

Chairperson
Dr Anna Ferguson

Minutes
Jenny Kristiansen

No	Item	Action
13/38	**Apologies**: Noted	N/A
13/39	**Minutes of last meeting**: 11 April 2013	N/A

No	Item	Action
	Minutes from the last meeting were accepted as an accurate record.	
13/40	**Matters arising** Billy Smith from the Out of Hours Service agreed to attend the locality meeting on a regular basis as and when available.	N/A
13/41	**Virtual Ward update –** Dr Peter Chamberlin PC gave a presentation to update the group about the Virtual Ward project. He gave an overview of the reasoning behind the concept, the model of care, the benefits to the patient and described future GP enhanced schemes for high risk patients. PC informed the group that the Virtual Ward Project is due to be implemented in the Bootle Locality in August 2013. PC handed out an information pack for each practice and asked if anyone needed any further information to contact him on the email that can be found in the information packs.	N/A
13/42	**Medicines management –** Paul Halsall PH gave an update on the following areas of medicines management. 13.42.1 SMOOG – PH informed the group that Brendan Prescott will be emailing all practices regarding the options for budget setting. He said that he would welcome comments. 13.42.2 Dementia Shared Care Protocol - PH informed the group that the current protocol has been presented to the LMC and following feedback will require amendments. The amended version will be circulated to practices. 13.42.3 Script switch – PH informed the group that the contract with the company who provide script switch has expired. The company will visit practices to remove the program from the system. 13.42.4 Business case for third party audit – PH asked the group to send the anonymised data to your practice pharmacist, this will enable the information to be pulled together and audited. It was agreed to send a copy to JK. JK to send out a request by email.	13.42.4 JK to send request out to Practice Managers.
13/43	**QOF – QP Indicators for 2013-14** **QOF -** AF produced a document outlining the changes to QOF for 2103-2014. The group discussed the changes and what it means for them in practice. JK agreed to send out the document produced by AF with the minutes. **QP indicators –** JK gave an update regarding current arrangements for administering the QP indicators for 2013.	JK to send out QOF document with the minutes.
13/44	**Any other business** Pam Sinha gave her apologies for the next meeting on the 18th June. AF requested that the Quality Premium is on the agenda for the next meeting. JK agreed to ask Dr Bal Duper to attend.	JK to contact Dr Bal Duper to present at the next locality meeting on 18th June 2013.
13/45	**Date and time of next meeting** Tuesday 18th June 2013	

No	Item	Action
	1pm – 2.30pm Park Street Medical Practice	

NHS
South Sefton
Clinical Commissioning Group

Crosby and Seaforth & Litherland Joint Locality Meeting

Date: Wednesday 5th June 2013
Time: 12:45 pm
Held at Nazareth House, Crosby

Joint Chairs:
Dr Sangeetha Steevart (SS)
Dr Gustavo Berni (GB)

Attendees:

Dr Clive Shaw (CS)
Shelley Keating (SK)
Dr Damian Navaratnam (DN)
Dr Nigel Tong (NT)
Carolyne Miller (CM)
Sue Hancock (SH)
Sharon McGibbon (SMc)
Dr GK Misra (GM)
Maureen Guy (MG)
Dr Fred Vitty (FV)
Alan Finn (AF)
Dr M Taylor (MT)
Lorraine Bohannon (LB)
Pippa Rose (PR)
Dr Prema Sharma (PB)
Dr Debbie Harvey (DH)
Cath Charlton (CC)
Stella Moy (SM)
Pauline Woolfall (PW)
Janet Faye (JF)
Suzanne Lynch (SL)
Sean Reck (SR)
Tina Ewart (TE)
Dr C McDonagh (CMcD)
Caroline Nolan (CN)
Colette Page (CP)
Caroline Nolan (CN)
Dr Colette McElroy (CMcE)
Paula Lazenby (PL)
Alison Harkin (AH)
Angela Dunne (AD)
Dr Steve Fraser (SF)
Dr N Williams (NW)
Eils McCormick (EM)
Lin Bennett (LB)
Dr M Vickers (MV)
Elaine Carter (EC)
L Creevy (LC)
Dr N Choudhary (NC)
Lisa Roberts (LR)
Jane McGimpsey (JMcG)
Dr Anup Sarkur (AS)
Louise Taylor (LT)
Dr Peter Goldstein (PG)
Dr Terry Thompson (TT)
Jenny Kristiansen(JK)
Angela Parkinson (AP)

Also in attendance from Liverpool Community Health were Karen Riddick (KR), Lisa Hammond (LH), Sara Gibson (SG), Alex Clark (AC), Sue

Apologies
Alison Johnston (AJ)

Guest Speakers:
Dr Peter Chamberlain (PC) - Virtual Ward Presentation
Dr Bal Duper (BD) - Quality Premium Presentation
Carol Hughes (CH) - Liverpool Community Health Respiratory Service

Minutes
Tina Ewart

No	Item	Action
1	**Apologies** Noted above **Declarations of Interest** Dr Steevart and Colette Page – clinical sessions at ISIS Sexual Health Clinic. Chairs agreed that matters arising deferred to next meeting to allow time for presentations	
2	**Virtual Ward Presentation from Dr Peter Chamberlain** Peter introduced the Virtual Ward provider team from LCH and gave a valuable and positive update on service model that has been operating in pilot form at Maghull Health Centre. Peter took questions and answers from the floor and informed the team that extra resource has been recruited in preparation for the rollout of the model in each of the other South Sefton localities; launchdate 1/8/13. The Risk Profiling and Care Management DES has been localised to incorporate risk stratifiacation referrals to the Virtual Ward 3/1000 per quarter. Consent and data sharing arrangements were raised for patients with dementia, the clinician needs to make a decision that is in the best interest of the patient. The full Virtual Ward presentation has been attached with circulation of the minutes, and is also available to view on intranet: Please click here for Virtual Ward Presentation hyperlink	
3	**Quality Premium Presentation from Dr Bal Duper** The Quality premium is to be paid as reward in 2014/15 to CCGs for clinical commissioning improvements in service quality and associated outcomes and reducing inequalities commissioned in 2013/14. It will be based on 4 national measures and 3 local measures: The 4 national measures are the domains: • Reducing potential years of life lost (worth 12.5%) • Reducing avoidable emergency admissions based on domains 2&3 (worth 25%) • Rollout of friends and family test and improving pt exp of hospital based on one of objectives for domain 4. (worth 12.5%) • Preventing infections based on one of the objectives domain 5 (worth12.5%) 3 local measures agreed for South Sefton CCG are:	

No	Item	Action
	• 5% reduction in Respiratory admission via A&E • 5% reduction in 3 antibiotics • To reduce by 5%, Non Elective Admissions to Aintree hospital where the source of referral is GP, and patient attended A&E on the same day Bal gave an example of us challenging hospital admission coding whereby a patient with known COPD but the patient is admitted for a differing reason, the hospital would likely code COPD as their primary diagnosis. This has been identified in locality audits previously and is highlighted as a relatively simple quick win for practices and localities to challenge secondary care. <u>The total payment will be reduced if providers do not meet all of the following</u>**:** • 18 weeks wait referral to treatment • Maximum 4hour waits in A&E • Maximum 62 days waits from urgent GP referral to first cancer treatment Maximum 8 minutes responses for category A red1 ambulance calls The total financial envelope will be announced in the new year and will be on top of the CCGs main financial allocation for 2014/15, and on top of the 'per head' running costs. A significant quality failure in-year will automatically debar a clinical commissioning group from receiving a Quality Premium. A clinical commissioning group will not receive any Quality Premium reward if it has overspent its approved Resource Limit in 2013/14. The Quality Premium will be a standing agenda item at each locality meeting together with a RAG rated table. Practices are asked to report back any examples to locality managers, eg poor/ incorrect coding or following the patient journey through A+E for admission. The full Quality Premium presentation has been attached with circulation of the minutes, and is also available to view on intranet: Please click here for Quality Premium Presentation hyperlink	
4	**Liverpool Community Health Respiratory Service,** **From Carol Hughes, Long Term Condition Lead LCH** Carol attended the meeting at the request of the GPs regarding the Community Respiratory service. It was acknowledged that there have been issues with the service since it began and LCH are keen to eliminate any issues and work with practices to develop and deliver according to our needs. Example raised where the service finishes at 6pm but the practices are open until 6.30. Carol agreed to have a look at this with a view to flexing or changing times. There will be new information circulated soon from LCH with forthcoming relaunch of the service. Carol invited your contact regarding any problems or suggestions via : carol.hughes@LiverpoolCH.nhs.uk	

No	Item	Action
	AOB Dr Clive Shaw thanked Peter and Bal for their presentations making reference to the fact that they were presenting “two sides of one coin”; the Risk Stratification/Risk profiling DES will enable the identification of ‘at risk’ patients to feed into the Virtual Ward. These initiatives working hand in hand, will enable us to achieve our targets and priorities of improving health and reducing health inequalities. At this point Crosby Locality members left the meeting to enable Seaforth and Litherland to continue own discussions.	
	Next Crosby Locality meeting to be held: **Date: Wednesday 3rd July** **Time: 12:30 lunch for 12.45 start** **Venue: Crosby Lakeside Adventure Centre (CLAC)** **CPD points will be awarded for attendance to this meeting** Please forward any items for the agenda toTina, Alison or Dr Berni, thankyou	

South Sefton Clinical Commissioning Group

Maghull Locality Meeting Minutes

Thursday 23rd May 2013

13:00 – 14:30pm

Westway Medical Centre

Attendees:

Dr Sunil Sapre (SS)	Maghull Family Health Centre
Gillian Stuart (GS)	Westway Medical Centre
Dr Paul Thomas	High Pastures Surgery
Dr Wendy Coulter (WC)	Formerly Maghull PCT Practice
Dr Gill Thomas (GT)	Broadwood Surgery
Judith Abbott (JA)	Broadwood Surgery
Jenny Johnson (JJ)	NHS South Sefton CCG
Terry Hill (TH)	NHS South Sefton CCG
Dr Peter Chamberlain	NHS South Sefton CCG
Dr Bal Duper	NHS South Sefton CCG

Apologies:
Gary Killen – NHS South Sefton CCG

Minutes:

No	Item	Action
13/26	**Apologies** Apologies were noted. **Welcome** Dr Pete Chamberlain – Clinical Lead for Strategy & Innovation, South Sefton CCG Dr Bal Duper – Primary Care Quality Lead, South Sefton CCG	
13/27	**Minutes – 19th April 2013 & 22nd February** The minutes of the last meeting were agreed as an accurate record.	
13/28	**Quality Premium – Dr Bal Duper** The Quality premium is to be paid as reward in 2014/15 to CCGs for clinical commissioning improvements in service quality and associated outcomes and reducing inequalities commissioned in 2013/14.	

No	Item	Action
	It will be based on 4 national measures and 3 local measures: The 4 national measures are: • Reducing potential years of life lost (worth 12.5%) • Reducing avoidable emergency admissions based on domains 2&3 (worth 25%) • Rollout of friends & family test and improving patient experience of hospital based care is one of the objectives for domain 4. (worth 12.5%) • Preventing infections based on one of the objectives domain 5 (worth12.5%) 3 local measures agreed for South Sefton CCG are: • 5% reduction in Respiratory admission via A&E • 5% reduction in 3 antibiotics • To reduce by 5%, Non Elective Admissions to Aintree hospital where the source of referral is GP, and patient attended A&E on the same day BD gave an example of challenging hospital admission coding. A patient with known COPD but is admitted for a differing reason, the hospital would likely code COPD as their primary diagnosis. This has been identified in locality audits previously and is highlighted as a relatively simple quick win for practices and localities to challenge secondary care. The total payment will be reduced if providers do not meet all of the following: • 18 weeks wait referral to treatment • Maximum 4hour waits in A&E • Maximum 62 days waits from urgent GP referral to first cancer treatment Maximum 8 minutes responses for category A red1 ambulance calls The total financial envelope will be announced in the new year and will be on top of the CCGs main financial allocation for 2014/15, and on top of the 'per head' running costs. A significant quality failure in-year will automatically debar a clinical commissioning group from receiving a Quality Premium. A clinical commissioning group will not receive any Quality Premium reward if it has overspent its approved Resource Limit in 2013/14. It was agreed that the Quality Premium will be a standing agenda item at each locality meeting. Practices to raise examples as part of locality meeting, eg poor/ incorrect coding or following the patient journey through A+E for admission. The full Quality Premium presentation has been attached with circulation of the minutes, and is also available to view on intranet: Please click here for Quality Premium Presentation hyperlink	

No	Item	Action
13/31	**Prescribing update –** Jenny updated all practices on the Prescribing Quality Scheme Peer review topic, which was to reduce prescribing of Cephalosporins and Cefaclor by 10% from baseline or to below the South Sefton baseline average. All practices achieved the targets, with the exception of Parkhaven SSP Health. At year end the Maghull locality were 8.4% underspent, -£428.99, South Sefton CCG as a whole were 13.3% underspent -£81,647. Jenny informed the locality that the dementia shared care agreement was still in the process of being reviewed by Mersey care and the LMC.	JJ
13/32	**Any other business –** No any other business discussed	ALL
13/33	**Date and Time of next meeting:** Friday 21st June 2013 - High pastures Thursday 18th July 2013 – Westway Friday 23rd August 2013 - High pastures Thursday 19th September – Westway Friday 25th October – High Pastures	

Register of Interests

Version: 15 July 2013

NHS South Sefton Clinical Commissioning Group

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 sub-group 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	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	
			Chief Officer, 3TC (Voluntary Sector)	Friend	Decision making re Voluntary Sector	Exclusion from decision making around Voluntary Sector	
			Employed by Liverpool Community Health Services	Friend	Decision making re Liverpool Community Health Services	Exclusion from decision making around Liverpool Community Health Services	
Dr Paul Thomas	20.05.13	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 sub-group of the Governing Body comprised of the lay membership, CO and CFO	
			Director, ENC Medical Services	Personal	None		
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 sub-group of the Governing Body comprised of the lay membership, CO and CFO	
Dr John Wray	06.06.13	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 sub-group of the Governing Body comprised of the lay membership, CO and CFO	
Dr Andy Mimnagh	15.05.13	GP Governing Body Member	GP Partner, Eastview 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 sub-group of the Governing Body comprised of the lay membership, CO and CFO	
			Director of Strategy and Innovation, University Hospital Aintree	Family	Decision making re University Hospital Aintree	Exclusion from decision making re University Hospital Aintree	
			Director of Clinical Strategy at Liverpool Health Partners	Family	Decision making re Liverpool Health Partners	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	
			Interested in natural justice	Personal	None	No action required	
			Practising Member of the Roman Catholic Religion	Personal	None	No action required	
Dr Ricky Sinha	04.05.13	GP Governing Body Member	GP Partner, North Park Health Centre	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	

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
			Elected Member, Sefton Local Medical Committee	Personal	Decision making re Local Medical Committee	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	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	
			Employed by Sefton Council	Family	Decision making re Local Authority	Exclusion from decision making reLocal Authority	
Roger Driver	13.05.13	Lay Member, Governing Body	Ordained as a Minister in the Church of England	Personal	Decision making re Faith Sector	Exclusion from decision making around Faith Sector	
			Chair, Sefton Health & Social Care Forum	Personal	None	No action required	
			Team Rector, Bootle Team Ministry	Personal	None	No action required	
			Area Dean, Bootle Deanery	Personal	None	No action required	
			Hon. Canon, Liverpool Cathedral	Personal	None	No action required	
			Charity Trustee, Together Liverpool	Personal	None	No action required	
			Chair, Sefton Council Independent Remuneration Committee	Personal	None	No action required	
			Administrator, Liverpool Diocesan Board of Education	Family	None	No action required	
Lynda Elezi	16.05.13	Vice Chair, Lay Member, Governing Body	Employed by St Helens & Knowsley NHS Trust	Family	None	No action required	
Dr Dan McDowell	14.05.13	Governing Body Member	Nil return	None	None	No action required	
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	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	
			Employed by Liverpool Community Healthcare Trust	Family	Decision making re Liverpool Community Healthcare Trust	Exclusion from decision making around Liverpool Community Healthcare Trust	

Hospitality Register
July 2013

NHS
South Sefton
Clinical Commissioning Group

Recipient:	Nature of Gift / Hospitality:	Date Received	Approximate Value	Donated by:
-	-	-	-	-

No hospitality received.