NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

Date: Thursday, 26 September 2013 at 1.00pm to 4.00pm

Venue: The Boardroom, Third Floor, Merton House, Bootle L20 3DL

13.00 Members of the public may highlight any particular areas of concern/interest and address questions to Board members. If you wish, you may present your question in writing beforehand to the Chair.

13.15 Formal meeting of the Governing Body in Public commences. Members of the public may stay and observe this part of the meeting.

The Governing Body

Dr Clive Shaw	Chair	(CS)
Dr Craig Gillespie	Clinical Vice-Chair, GP	(CG)
Dr Steve Fraser	GP	(SF)
Dr Andrew Mimnagh	GP	(AM)
Dr Ricky Sinha	GP	(RS)
Dr Paul Thomas	GP	(PT)
Dr John Wray	GP	(JW)
Roger Driver	Lay Member, Engagement and Patient Experience	(RD)
Lin Bennett	Practice Manager	(LB)
Sharon McGibbon	Practice Manager	(AF)
Dr Dan McDowell	Secondary Care Doctor	(DMcD)
Fiona Clark	Chief Officer	(FLC)
Martin McDowell	Chief Finance Officer	(MMcD)
Debbie Fagan	Chief Nurse	(DF)
Peter Morgan	Deputy Chief Executive, Sefton MBC (co-opted Member)	(PM)

Also in attendance

Stephen Astles	Head of CCG Development	(SA)
Brendan Prescott	CCG Lead for Medicines Management	(BP)
Dr Debbie Harvey	Lead Clinician for Virtual Ward	(DH)

No	Item	Lead	Report	Receive/ Approve	Time
General business					
13/111	Apologies for Absence	Chair		R	5 mins
13/112	Declarations of Interest regarding agenda items	All		R	
13/113	Register of Interests	-	✓	R	
13/114	Hospitality Register	-	✓	R	

No	Item	Lead	Report	Receive/ Approve	Time
13/115	Minutes of Previous Meeting	Chair	✓	R	5 mins
13/116	Action Points from Previous Meeting	Chair	✓	R	
13/117	Business Update	Chair		R	5 mins
13/118	Chief Officer Report	FLC	✓	R	5 mins
Reports received by way of assurance (taken as read)					
13/119	Corporate Performance Report	MC/DF	✓	R	20 mins
13/120	Financial Performance Report	MMcD	✓	R	10 mins
13/121	Prescribing Performance Report	BP	✓	R	5 mins
13/122	Virtual Ward Update	DH	✓	R	5 mins
13/123	Non Recurrent A&E Funding	FLC	✓	R	5 mins
Formal approval by Governing Body required					
13/124	Primary Care Strategy	Dr Duper	✓	A	10 mins
13/125	Equality and Diversity Objectives	MW	✓	A	10 mins
13/126	CCG Constitution – Update	MW	✓	A	10 mins
13/127	Risk Management Strategy	TJ	✓	A	10 mins
13/128	Commissioning Support Unit Procurement	TJ	✓	A	10 mins
13/129	Disciplinary Policy	MW	✓	A	10 mins
13/130	Annual Leave and Bank Holiday Policy	MW	✓	A	
13/131	Grievance and Dispute Resolution Policy	MW	✓	A	
13/132	Attendance Management Policy	MW	✓	A	
13/133	Remuneration Committee	MW	✓	A	5 mins
13/134	Baseline Allocations (to follow)	MMcD	✓	A	5 mins
Minutes of Committees to be formally received (taken as read)					
13/135	Audit Committee (no minutes available)	-			5 mins
13/136	Quality Committee	-	✓	R	
13/137	Finance & Resource Committee (no minutes available)	-			
13/138	Merseyside CCG Network	-	✓	R	
13/139	Health and Wellbeing Board	-	✓	R	
13/140	Medicines Optimisation Operational Group	-	✓	R	
13/141	Strategic Integrated Commissioning Group	-	✓	R	
13/142	Locality Meetings - (i) Seaforth & Litherland Locality (ii) Bootle Locality (iii) Crosby Locality (iv) Maghull Locality	-	 ✓ ✓ ✓ ✓	 R R R R	
Closing business					

No	Item	Lead	Report	Receive/ Approve	Time
13/143	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting.*				5 mins
13/144	Date, Time and Venue of Next Meeting of the Governing Body to be held in Public *Wednesday, 28 November 2013 at 1.00pm at Merton House*				-
Estimated meeting time					150 mins

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).

Register of Interests

Version: 16 September 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	
			Self-Employed Contractor, Driver Trainer/Risk Assessor, Sefton Council	Family	Decision making re Local Authority	Exclusion from decision making re Local Authority	
Roger Driver	13.05.13	Lay Member, Governing Body	Ordained as a Minister in the Church of England	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
Septmeber 2013

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Recipient:	Nature of Gift / Hospitality:	Date Received	Approximate Value	Donated by:
Westway Medical Practice	Cash gift of £200 from patient for practice patient group.	September 2013	£200	Patient

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Minutes

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.

Present		
Dr Craig Gillespie	Clinical Vice-Chair, GP Board Member (in Chair)	(CG)
Dr Steve Fraser	GP Board Member	(SF)
Dr Paul Thomas	GP Board Member	(PT)
Roger Driver	Lay Member	(RD)
Lin Bennett	Practice Manager - Board Member	(LB)
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)
Apologies		
Dr Clive Shaw	Chair, GP Board Member	(CS)
Lynda Elezi	Vice Chair, Lay Member	(LE)
Dr John Wray	GP Board Member	(JW)
Dr Andrew Mimnagh	GP Board Member	(AM)
Dr Ricky Sinha	GP Board Member	(RS)
Sharon McGibbon	Practice Manager - Board Member	(AF)
In attendance		
Malcolm Cunningham	Head of CCG Performance and Health Outcomes	(MC)
Steve Astles	Head of CCG Development	(SA)
Tracy Jeffes	Head of Delivery	(TJ)
Brendan Prescott	CCG Lead for Medicines Management	(BP)
Tony Kneebone	Member of the Public	
Wendy Anderson	Healthwatch Sefton	
Diane Blair	Healthwatch Sefton	
Minutes		
Melanie Wright	Business Manager	

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Record of Attendance

✓ Present
A Apologies
L Late

Governing Body Member	Designation	Jan 2013	Mar 2013	May 2013	July 2013							
Dr Clive Shaw	Chair	A	✓	✓	A							
Dr Craig Gillespie	Clinical Vice-Chair, GP	✓	✓	✓	✓							
Dr Steve Fraser	GP	✓	✓	✓	✓							
Dr Andrew Mimnagh	GP	✓	✓	✓	A							
Dr Ricky Sinha	GP	✓	✓	✓	A							
Dr Paul Thomas	GP	✓	✓	A	✓							
Dr John Wray	GP	A	A	A	A							
Roger Driver	Lay Member, Engagement and Patient Experience	✓	✓	✓	✓							
Lin Bennett	Practice Manager	✓	✓	✓	✓							
Sharon McGibbon	Practice Manager	✓	✓	✓	A							
Dr Dan McDowell	Secondary Care Doctor	✓	✓	✓	✓							
Fiona Clark	Chief Officer	✓	A	✓	✓							
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓							
Debbie Fagan	Chief Nurse	✓	✓	✓	✓							
Peter Morgan	Strategic Director, Sefton MBC (co-opted Member)	A	A	A	✓							

The Chair welcomed everybody to the meeting.

Question - Diane Blair, Healthwatch

There are concerns from Healthwatch Sefton and members of the Health and Social Care Forum about the impact of the benefits reform and the requests being made for GP letters.

Response

By way of context for CCG colleagues, Dr Gillespie advised that this question relates to patients who have gone to the Department for Work and Pensions and have been turned down for a Working Capability Assessment, which patients can then appeal.

GPs are contractually obliged to produce fit notes, but not any additional medical information to the Department of Work and Pensions regarding the patients' medical history. The question relates to how GPs can assist their patients.

Traditionally the Citizen's Advice Bureau have paid £25 to GPs for this service, but now that this funding for this has ended, this service has ceased. GPs are not contractually obliged to provide this service and it also increases GPs' workload.

Dr Gillespie felt it would be helpful, in the absence of national guidance, for the CCG to come to a consensus as to how to deal with these requests, considering all the facts.

Roger Driver queried whether this related to a patient's rights to access their medical records, which right patients have for an administrative fee, noting that the fee is be waived on occasion. However, some practices also charge up to £50 which covers production of a medical summary. The difference between a medical report and copy records is down to interpretation as to the contents of those medical records, especially if an explanation of the disabling effects of medical conditions is required.

Dr Gillespie agreed that advice would be sought from the Local Medical Committee (LMC) and NHS England, who are the contract holders with medical practices. In the meantime, the LMC's advice is for practices to display a notice in surgeries the advice that medical reports cannot be produced for this purpose.

Dr Thomas's opinion was that there is a list in practices of the private medical services offered, for services which fall outside the medical contract. Some GPs may waive the cost, but that is a personal decision for each GP and is not one that can be decided by the LMC or NHS England.

Dr Fraser added that the service provided by Citizen's Advice cannot be underestimated, both to GPs and patients.

Ms Clark invited Ms Blair to direct any further questions in this regard either to herself or Canon Driver.

Action: response to be sought from the Local Medical Committee – Fiona Clark.

Question - Tony Kneebone, Member of the Public

Mr Kneebone asked why, in the interests of public engagement, today's Big Chat and this meeting are in different locations?

Response

Ms Clark advised that Merton House is the head office of the CCG and, in the interests of public spending, it makes sense to hold the meeting here to save costs. Also, a larger venue is required for the Big Chat. As GPs are already available for this session, it also maximises the use of their time to hold the session on the same day.

Ms Clark apologised for any difficulties caused, which were unintentional.

Question – Tony Kneebone, Member of the Public

Has the CCG been involved with Sefton Council in developing a 'through plan' for the health and wellbeing of people in Sefton and if not, why not?

Response

An extensive piece of work in the SSNA has been undertaken over the last twelve months in partnership with the Council and both organisations work closely together as 'one voice'. The Health and Wellbeing Board minutes are received by the Governing Body. At the Big Chat later today, there is a discussion planned to take this further and work on Health and Wellbeing is part of the CCG's core strategy.

In the CCG's 'Plan on a Page', the six key priorities of the Health and Wellbeing Strategy form a key part thereof and are a golden thread that runs throughout. It is Ms Clark's duty as Chief Officer to ensure wider elements of health remain a key focus.

Mr Kneebone also queried the prominence of healthcare in relation to Cycle Path Scheme by Sefton Council.

Peter Morgan responded that one of the key items was the local plan and its relationship to the health and wellbeing objectives. There has been enormous consultation in relation to the local plan and with the health and wellbeing strategy generally. The recent Big Chat progressed this further.

The documentation in relation thereto is voluminous and covers all health-related elements, which could not be published as part of the publication referred to, so it is merely a summary.

The main meeting was preceded by a presentation on Merseycare NHS Trust's application for Foundation Trust status by Fleur Blakeman.

Dr Gillespie thanked Ms Blakeman for her presentation and referred the a recent presentation to the Governing Body by John Doyle in relation to the TIME Project, acknowledging the benefit of the therapeutic environment, which should not be underestimated.

The presentation on Public Health was deferred to a later date.

No	Item	Action
GB13/87	**Apologies for Absence** were noted.	
GB13/88	**Declarations of Interest** Item 13/95 (Prescribing Quality Scheme) relates to general practice. Conflicts were therefore noted for Drs Fraser, Thomas and Gillespie, together with Lin Bennett. These Governing Body Members are therefore prohibited from the decision-making process in relation to this item on the agenda.	
GB13/89	**Minutes of Previous Meeting** The Minutes were agreed as a true and accurate record of the previous meeting.	

No	Item		Action
GB13/90	**Action Points from Previous Meeting** All actions were closed out, save for the following notes.		
	13/60	**Action Points from Previous Meeting** 13/33 *Constitution*: Ms Clark provided an update in relation to the position on final sign-off, which were shortly to be reviewed by Dr Pfeiffer and the LMC, for ultimate sign-off by NHS England. 13/41 *Summary Care Records:* Dr Thomas advised that 97% of patients have accepted the inclusion of their summary care records, the other 3% having recorded objections. Ms Bennett agreed to discuss further communication with patients with Practice Manager colleagues. Ms Bennett also considered asking patients to specifically express their consent and it was agreed that this would be considered further by Steve Astles and communicated via the Quality Committee.	LB SA
	13/72	**Register of Interests** DF noted that her declaration needed to be added to the register.	MW
GB13/91	**Business Update** Dr Gillespie referred to the recent Health and Wellbeing Peer Review Challenge, which considered the current position of the health and wellbeing strategy in Sefton and the Health and Wellbeing Board's understanding of the challenges. Some formative feedback had been provided, which noted the strong leadership and engagement of all stakeholders, particularly with the community, voluntary and faith sector. There is also evidence of cross-council working. Dr Gillespie reflected on the importance of engagement and the future integration of health and social care. Mr Morgan advised that the formal report from the peer review is expected shortly. In the six health and wellbeing objectives, the aspirations are well-defined, but in order to achieve them, partnership working is required. Ms Clark also referred to a recent meeting with Margaret Carney and advised that work is under way to consider the vision for future integration. <u>Action taken by the Governing Body</u> The Governing Body noted the Chair's Business Update.		
GB13/92	**Chief Officer Report** Ms Clark asked the meeting to take the report as read, but particularly highlighted the implications at 12.9 for the CCG following the Keogh Review. By way of update, Ms Clark advised that a contract query has been raised in relation to A&E performance at Southport Hospital. This means that both acute trusts in Sefton are experiencing challenges and the CCG is working closely with both organisations towards developing and sustaining an improvement. <u>Action taken by the Governing Body</u> The Governing Body noted the contents of the Chief Officer's report.		
GB13/93	**Portfolio Leads Update**		

No	Item	Action
	Medicines Management Dr Fraser provided an update in relation to work undertaken by Medicines Management Operational Group. *Virtual Ward* Dr Thomas advised that the rollout to all four localities commences in August, which has generally been well-received. Dr Thomas felt that the success of the project depended on GP engagement and communication. In the pilot, some GPs had engaged positively but there are lessons to be learned. It is hoped, however, that admissions to Aintree will be reduced. Dr McDowell advised that it is hoped an additional physician can be recruited in relation to care of the elderly. *District Nursing* Lin Bennett updated the Governing Body as to ongoing discussions with Liverpool Community Health Services in relation to district nursing services. *Engagement and Patient Experience* Canon Driver reported on work taking place at the Engagement and Patient Experience Group, particularly around the Primary Care Strategy. There is another Big Chat event later today at Crosby Lakeside. Canon Driver also referred to discussions with Professor Grey at The Deanery in relation to improving access to GPs by way of engagement.	
GB13/94	**Performance Reports** **(a) Finance Update** Mr McDowell highlighted the key issues raised within his report, in particular, the virement from operational budgets to reserves. Mr McDowell also reported that some baseline issues remained unresolved with the issues regarding specialised commissioning being particularly complex although both the CCG and NHS England CWW have been working together and progress has been made in terms of understanding the issues. The main overspend in operational budgets related to increase costs against the contract at UHA FT and the Finance and Commissioning teams are reviewing this alongside other commissioning partners to understand and mitigate the financial impact on the CCG. Mitigation plan – Appendix 2 refers to funds of £1m to deal with pressures and make investments, but Mr McDowell noted that it was still early in the financial year. In the event of a 'worst case scenarios', the CCG is amber-rated. Mr McDowell also referred to potential future pressures over the next three years and the need to monitor the system to see if work undertaken makes the necessary impact. Mr Morgan asked for clarity around quantification of restitution claims. Mr McDowell felt that this was close: cases are now coming through the system which will enable clarification. However, it is likely to take in the region of two years to resolve these claims. <u>Actions taken by the Governing Body</u> (1) It was **noted** that the CCG remains on target to deliver its financial targets for 2013/14. (2) The Chief Finance Officer's recommendation in terms of virements as outlined in section 3.2 were **approved**.	

No	Item	Action
	(3) It was **noted** that the CCG's likely case scenario predicts that the CCG has £1.042m to address unforeseen issues/approve investments during the year. (4) It was **noted** that the CCG's worst case scenario is "amber-rated" in terms of additional actions required to deliver financial targets should the CCG financial position deteriorate.	
	(b) Prescribing Update Mr Prescott joined the table and advised that no forecast was available at the current time, as practice budgets were not posted to the Business Services Authority until 30 June. Actions taken by the Governing Body The Governing Body **noted** the contents of Mr Prescott's report.	
	(c) Corporate Performance Report Dr McDowell sought clarification on the figures in relation to healthcare acquired infections. Miss Fagan advised that the current information is that Aintree are on trajectory at the current time. Miss Fagan agreed to take an action in relation to the production of this data, which was reflective of infections demonstrated by way of a Trust figure and Sefton population data.	DF
	Miss Fagan also referred to the recent meeting of the CCG Quality Committee last week. Aintree have reported one case of MRSA, a post infection review has been undertaken and the case has been identified as being acquired at Aintree. Miss Fagan went on to describe the action plan in progress at Aintree in this regard. Dr Gillespie asked the Governing Body to note the level of scrutiny that takes place at Quality Committee, with high level information only being brought to this meeting. Actions taken by the Governing Body The Governing Body **noted** the contents of the corporate performance report.	
GB13/95	**2012/13 Results of Prescribing Quality Scheme** **Drs Fraser, Gillespie and Thomas, together with Lin Bennett were excluded from the discussion and decision making, due to a conflict of interests. Canon Driver assumed the chair for this part of the meeting.** Mr Prescott talked through the highlights of the scheme around quality, safety and finance, with a view to delivering better health outcomes for patients. Ms Clark enquired whether the awards proposed were in line with available resources, to which Mr Prescott confirmed that they were. Bearing in mind the conflict of interest, Ms Clark asked that the scheme and accompanying information be published on the CCG's website. Actions taken by the Governing Body The Governing Body (excluding those prevented from voting due to conflict of interests) **approved** the proposed awards.	BP
GB13/96	**Community Anti-Coagulation Service Procurement - Update** Mr McDowell asked what the process is for tendering, to which Mr Cunningham responded that the CSU would be providing support. Actions taken by the Governing Body	

No	Item	Action
	The Governing Body **approved** the procurement of the community anti-coagulation service via full tender.	
GB13/97	**Assurance Framework** Mrs Jeffes presented the Governing Body with the new Assurance Framework, which is based on the CCG's corporate objectives, with the intention of providing the Governing Body with assurance that the risks had been duly identified and actions put in place by way of mitigation. Ms Clark added that the Assurance Framework was an important part of managing risk for the organisation and provided the Governing Body with the best available knowledge with which to discharge their duties. Canon Driver noted the need for the Governing Body to engage with the risks identified and ensure that where mitigating actions are detailed, that these are being carried out operationally in the areas in which Governing Body members are involved. The framework is reviewed quarterly by the Quality Committee and will be brought back to the Governing Body on a six-monthly basis. <u>Actions taken by the Governing Body</u> The Governing Body **noted** the risks identified in the Assurance Framework.	
GB13/98	**Update of Terms of Reference – Board Committees** The terms of reference have been updated in response to NHS England's recommendations around quoracy, conduct in meetings and conflicts of interest, together with a review of the membership. Mrs Bennett queried the attendance levels in relation to quoracy and queried why these were different for each committee. Ms Clark responded that there was no precedent in relation to this and each had been considered independently. Canon Driver queried whether there was sufficient mechanism available in the event that several members of the Audit Committee were unable to attend, for the purposes of co-opting members. Ms Jeffes agreed to take this action and revert to the Governing Body. <u>Actions taken by the Governing Body</u> The Governing Body **approved** the suggested updates to each of the terms of reference in relation to the Quality Committee, Audit Committee, Finance & Resource Committee and Remuneration Committee.	TJ
GB13/99	**Multi Practice Locality Membership** Mr Astles discussed the approach by one practice that operates throughout a number of localities and whether this practice could be represented at a single locality. Mr Astles reminded the Governing Body of dynamics behind the locality model. Dr Thomas felt that given the nature of the localities and their population, that this action was not appropriate. Canon Driver also felt it was not a pragmatic option in relation to the population's requirements. Under the terms of the Constitution, the Governing Body will consider requests of this nature individually. Dr Fraser also referred to this situation being present in other circumstances and approaches of this nature had not been made to the Governing Body. <u>Actions taken by the Governing Body</u>	

No	Item	Action
	The Governing Body **approved** the recommendations contained within the report that the request be declined. The Chair agreed to formally communicate the decision of the Governing Body to the applicant.	CG
GB13/100	**Minutes of Committees** 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 The Governing Body noted that there is locality lead for Seaforth and Litherland, which Ms Clark agreed to consider further. <u>Actions taken by the Governing Body</u> The Governing Body **received** the Minutes of the Committees referred to above.	FLC
GB13/101	**Register of Interests** <u>Actions taken by the Governing Body</u> The Governing Body **received** and noted the Register of Interests and noted the addition of Debbie Fagan's declaration, which will be included on the register for the next meeting.	
GB13/102	**Hospitality Register** <u>Actions taken by the Governing Body</u> The Governing Body **received** and noted the Hospitality Register.	
GB13/103	**Any Other Business** Mr McDowell referred to the Merseycare presentation and specifically the TIME Project. The CCG has been asked to write a supporting letter in relation to this project, which is of particular significance for South Sefton CCG. Ms Clark proposed that a draft letter will be circulated via email next week seeking views, for subsequent collation of views and Chair's action to formally respond for the 31 July deadline. <u>Actions taken by the Governing Body</u> The Governing Body **agreed** to this course of action.	MMcD
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
Action Points

Thursday, 25 July 2013 at 1.00pm to 4.00 pm

Question - Diane Blair, Healthwatch

There are concerns from Healthwatch Sefton and members of the Health and Social Care Forum about the impact of the benefits reform and the requests being made for GP letters.

Action: response to be sought from the Local Medical Committee – Fiona Clark.

No	Item		Action
GB13/90	**Action Points from Previous Meeting**		
	13/60	**Action Points from Previous Meeting** 13/41 *Summary Care Records:* Dr Thomas advised that 97% of patients have accepted the inclusion of their summary care records, the other 3% having recorded objections. Ms Bennett agreed to discuss further communication with patients with Practice Manager colleagues. Ms Bennett also considered asking patients to specifically express their consent and it was agreed that this would be considered further by Steve Astles and communicated via the Quality Committee.	LB SA
	13/72	**Register of Interests** DF noted that her declaration needed to be added to the register.	MW
GB13/94	**Performance Reports** **(c) Corporate Performance Report** Dr McDowell sought clarification on the figures in relation to healthcare acquired infections. Miss Fagan advised that the current information is that Aintree are on trajectory at the current time. Miss Fagan agreed to take an action in relation to the production of this data, which was reflective of infections demonstrated by way of a Trust figure and Sefton population data.		DF
GB13/95	**2012/13 Results of Prescribing Quality Scheme** Bearing in mind the conflict of interest, Ms Clark asked that the scheme and accompanying information be published on the CCG's website.		BP
GB13/98	**Update of Terms of Reference – Board Committees** Canon Driver queried whether there was sufficient mechanism available in the event that several members of the Audit Committee were unable to attend, for the purposes of co-opting members. Ms Jeffes agreed to take this action and revert to the Governing Body.		TJ

No	Item	Action
GB13/99	**Multi Practice Locality Membership** The Chair agreed to formally communicate the decision of the Governing Body to the applicant.	CG
GB13/100	**Minutes of Committees** a) Locality Meetings The Governing Body noted that there is locality lead for Seaforth and Litherland, which Ms Clark agreed to consider further.	FLC
GB13/103	**Any Other Business** Mr McDowell referred to the Merseycare presentation and specifically the TIME Project. The CCG has been asked to write a supporting letter in relation to this project, which is of particular significance for South Sefton CCG. Ms Clark proposed that a draft letter will be circulated via email next week seeking views, for subsequent collation of views and Chair's action to formally respond for the 31 July deadline.	MMcD

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/118	**Author of the Paper:**
Report date: 16 September 2013	Fiona Clark Chief Officer fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7061
Title: Chief Officer Report	
Summary/Key Issues: This paper presents the Governing Body with the Chief Officer's monthly update.	
Recommendation The Governing Body is asked to receive this report.	Receive [x] Approve [ ] Ratify [ ]

GB13/118

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	
Clinical Engagement			x	

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)*	
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
September 2013

1. Quality Surveillance Group

The Quality Surveillance Group (QSG) facilitated by NHS England (Merseyside) has met on a monthly basis. The key purpose is to ensure the essential standards of quality and safety are maintained across Merseyside. It brings together a wide variety of key stakeholders around the quality agenda, including CCGs, Health Watch, Mersey deanery, CQC, Local Authority, Public Health England, NHS Trust Development Authority, Health education Northwest and Monitor across Merseyside.

It complements the statutory roles of the Clinical Commissioning groups and aims by drawing membership from the above to undertake surveillance of quality across NHS commissioned services. It acts as a proactive forum for collaboration and provides the health economy with

- a shared view of risks to quality through shared intelligence
- an early warning mechanism of risk about poor quality
- opportunities to coordinate actions to drive improvement.

To date, the QSG has covered a wide variety of topic areas with SSCCG membership drawn from the Chair, Chief Officer, Chief Nurse and Lead GP for Quality of the CCG.

2. Developing the Integration Agenda

Following on from the recent Health & Wellbeing Board peer challenge in Sefton, work is underway to consider the recommendations.

The Strategic Integrated Commissioning Group, which is part of the CCG governance structure has been revised to now function as the Health & Wellbeing Board-Programme group. This streamlining has allowed for greater clarity of roles and membership.

There are now three main forum of this programme group:

- Early Life Forum
- Adults Forum
- Wider Determinates Forum.

With 3 enabling task groups:

- Resources & Performance
- Communication & Engagement
- Intelligence.

These changes create the opportunity to further integrate the thinking of the CCG with the Local Authority in line with national policy direction and in order to maximise the resources locally. The management support team has been strengthened with Tracy Jeffes now having a remit for integration as Head of Delivery & Integration. The Governing Body will continue to receive specific updates.

3. University Hospitals Aintree NHS Foundation Trust

Work continues following on from the contract query raised with Aintree in July 2013. Assurance is being sought on the following areas:

- Mortality rates
- Referral to Treatment times (RTT)
- Accident & Emergency 4 Hours waits
- Health Care Acquired Infection (HCAI)
- Alongside Patient Experience (from the quality risk review).

Each of these areas is being performance managed through the clinical leadership of the Aintree Collaborative Commissioning Forum (ACCF). The ACCF incorporates Knowsley CCG, Liverpool CCG and South Sefton CCG. Sub groups for each of these areas have been established and action plans are in place, with progress being made.

NHS South Sefton CCG under the terms of the risk sharing agreement work on behalf of NHS Southport & Formby CCG, with the Chief Officer, Chief Finance Officer and Chief Nurse acting as the bridge across the two CCGs. The ACCF are working closely with Monitor and NHS England (Merseyside) colleagues.

4. Quality Issues

4.1. Francis 2 Public Inquiry

The Chief Nurse attended the Health and Wellbeing Board on 21 August 2013 and delivered a presentation to raise the awareness of the members regarding the Francis 2 Public Inquiry and other national strategies and reports that have been produced as a result.

4.2. Aintree University Hospital C-Difficile Protocol & Trajectory

A meeting was held on 21 August 2013 Chaired by the GP Clinical Quality Lead with Aintree University Hospital to discuss their revised C-Diff protocol that had previously been supported by the collaborative CCGs. In attendance were CCGs, local Public Health and NHSE(M) along with Trust representation. The outcome of the meeting was that the Trust were informed that although the CCGs acknowledged that the protocol was safe (as had been advised by PH England) that the CCGs could no longer support the protocol as it was not in line with the most recent DH guidance. The Chief Nurse has forwarded the Trust the appeals information as provided by NHSE(M) and Public Health and the Trust are going to engage with this process. The CCGs will be working with the local Public Health team to inact the appeals process locally as the Trust will require CCG support / sign-off for the individual cases to be considered. The Trust are in the processes of retrospectively reporting all C-Diff toxin positive cases from April 2013 which will see a year to date increase to approximately 47 cases which above the full year trajectory of 43 cases. The expected increase in the numbers to be reported does not have any impact on the care patients have received.

5. The Big Chat

At the end of July, NHS South Sefton Clinical Commissioning Group (NHS SSCCG) invited local residents to come along to its Big Chat event to gain views about health services. It was also a chance to update people about the CCG's work in the first four months since it became a statutory body. Around 65 people attended the event, which focused on their experiences of using urgent or emergency healthcare. Feedback from the events will be used to help further shape the CCG's winter plans, when health services are traditionally under the most pressure. A summary report of the event is being produced and will be available to members of the public shortly. There will be a further Big Chat in the autumn, hosted jointly with Sefton Council, to share their overarching strategic plans with local residents.

6. Strategic Plan Update

The development of the strategic plan requires further consideration. The deadline for the draft to be received by the Governing Body was anticipated to be the September meeting. Recent reflections following the Health & Wellbeing Board peer challenge recommendations have led to the following actions.

- To consider the six key priorities of the Health & Well Being strategy as a framework for the CCG.
- To gain further broader involvement in shaping the strategic plan
- To increase the capacity in the CCG support team through a Head of Strategic Planning & Assurance role
- To strengthen the clinical leadership at governing body by a dedicated role for strategy & planning.

The plan has therefore been deferred for this meeting and a full report on progress will be brought to the November 2013 Governing Body meeting.

7. CCG Development Framework

Co-produced with CCGs and open to continuous improvement as we learn more together, the CCG Development Framework supports CCGs in developing themselves and is a key part of NHS England's commitment to support CCG development nationally. CCGs' emerging identity as clinically led organisations will doubtless produce innovative new strengths that need to be encouraged, supported and spread.

The framework, developed and overseen by the NHS Commissioning Assembly CCG development working group, sets out how further insight into what constitutes a great CCG will be gained and how every CCG will be supported to access development support that recognises its local circumstances and differing stages of maturity.

It also identifies a clear direction of travel, rooted in achieving CCG ambitions for improvement in health outcomes and the quality and safety of care, and focused on developing healthy, vibrant, clinically led commissioning organisations.

The intention is that the framework will offer CCGs, and all those with an interest in CCGs improving lives locally, an effective way of making their contribution and working together for success. A copy of the framework can be located at:

http://www.england.nhs.uk/wp-content/uploads/2013/08/20130829-CCG-Development-Framework-final-v5.0.pdf.

8. Board to Board

A meeting was held on 5 September 2013 with the Board of University Hospitals Aintree and the Governing Body of NHS South Sefton CCG.

The discussions were an opportunity to focus on the recent dip in some areas of performance, the wider strategic issues facing the Health & Social Care economy and the clinical areas ripe for considering development. Some practical actions will be taken forward between the two organisations as a result of this meeting.

9. Directory of CCG Support

CCGs have said they need greater visibility of the range of development support that is available to equip them to achieve their ambitions for local service improvement.

In response, NHS England are developing a directory of support which captures a wide range of support currently available and in many cases free of charge to CCGs. This is at an early stage of development and NHS England are requesting feedback on the content and format of this version so that it can be developed in a way that is relevant, useful and shaped in response to CCG preferences.

Looking ahead, there are plans to make the directory available as an online searchable tool, which will be updated as new offers of support are made. The Directory will be a key support to the CCG and will be considered in light of the CCG Organisational Development plan and on-going CCG development needs.

10. Recommendation

The Governing Body is asked to formally receive this report.

Fiona Clark
September 2013

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/119	**Author of the Paper:**
Report date: 16 September 2013	Debbie Fagan debbie.fagan@southseftonccg.nhs.uk Malcolm Cunningham malcolm.cunningham@southseftonccg.nhs.uk

Title: Corporate Performance Report

Summary/Key Issues:

This paper presents the Governing Body with the Performance Dashboard, Quality Report, Family and Friends Inpatient Summary, Friends and Family A&E Summary, Liverpool Community Health Quality Compliance Report for Month 4, Liverpool Community Health KPI Report.

Recommendation

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

Receive	x
Approve	
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.
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.

GB13/119

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	YES			Quality Report has previously been submitted to Quality Committee

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

Contents

CCG CORPORATE PERFORMANCE DASHBOARD - South Sefton CCG

Baseline as at 28/08/2013 11:51:42

		Current Period			
Performance Indicators	**Data Period**	**Target**	**Actual**	**RAG**	**Forecast**
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 - July	14.68	12.00		
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative)	13/14 - July	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 - June	476.62	412.94		
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (Cumulative)	13/14 - June	62.1	71.41		
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Cumulative)	13/14 - June	208.4	191.03		
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 - June	256.64	211.62		
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI) (Cumulative)	13/14 - June	15.52	18.63		
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	13/14 - June	60.00	75.00		
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	13/14 - June	80.00	94.74		
Mental health					
Mental Health Measure - Care Programme Approach (CPA) - 95% (Cumulative)	13/14 - April - June	95.00	100.00		
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		

		Current Period			
Performance Indicators	Data Period	Target	Actual	RAG	Forecast
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 - June	98.00	97.89		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative)	13/14 - June	94.00	96.25		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)	13/14 - June	94.00	100.00		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative)	13/14 - June	96.00	98.45		
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 - June		83.33		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative)	13/14 - June	90.00	66.67		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative)	13/14 - June	85.00	86.81		
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 - June	93.00	97.19		
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 - June	93.00	96.10		
Mixed Sex Accommodation Breaches					
Mixed Sex Accomodation (MSA) Breaches per 1000 FCE	13/14 - July	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 completed admitted pathways (un-adjusted)	13/14 - July	0.00	0.00		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways	13/14 - July	0.00	0.00		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways.	13/14 - July	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 - July	92.00	97.45		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	13/14 - July	90.00	93.66		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	13/14 - July	95.00	97.79		
A&E waits					
Percentage of patients who spent 4 hours or less in A&E (Cumulative)	13/14 - July	95.00	95.53		

		Current Period			
Performance Indicators	**Data Period**	**Target**	**Actual**	**RAG**	**Forecast**
Diagnostic test waiting times					
% of patients waiting 6 weeks or more for a Diagnostic Test	13/14 - July	1.00	0.97		
Category A ambulance calls					
Ambulance clinical quality – Category A (Red 1) 8 minute response time - CCG (Cumulative)	13/14 - July	75.00%	78.02%		
Ambulance clinical quality – Category A (Red 2) 8 minute response time - CCG (Cumulative)	13/14 - July	75.00%	77.05%		
Ambulance clinical quality - Category 19 transportation time CCG - (Cumulative)	13/14 - July	95.00%	96.54%		
Local Measures					
5% reduction in the number of respiratory disease emergency admissions via A&E.(cumulative)	13/14 - May	214	226		
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		

Performance Dashboard – Exception Report

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 4 of the financial year

2. Introduction and Background

CCG's have a statutory duty to improve health outcomes and ensure that the NHS constitution pledges are being delivered.

This reports 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

Healthcare Acquired Infections – MRSA
As at July 2013, MRSA is above the zero tolerance level for South Sefton CCG patients with one case reported. This case was reported in May 2013. With regards to MRSA, Aintree Hospital Trust reported one incident of MRSA in May which makes Aintree over tolerance for the year to date at July 2013. This is being reported through the Infection Prevention Committee to the CCGs. Root Cause Analysis (RCA) has been completed. The Walton Centre is also reporting 1 case, above a zero tolerance. All other providers are within plan.
Healthcare Acquired Infections – Cdifficile
The Walton Centre - As at the end of July there have been five cases of Cdifficile reported to date. This is above the tolerance of 2.
Monthly Activity Return (MAR): All first outpatient attendances in general &acute (G&A) specialties (Cumulative). Total number of G&A elective FFCE's
For All First Outpatient Attendances, cumulatively at July 2013 South Sefton CCG is over plan by 12.4%. For Elective FFCEs as at July 2013 South Sefton CCG is over plan by 4.6%. Validations are on-going with providers to ensure data submitted reflects activity that needs to be recorded under specialist commissioned, dental & GUM.
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (Cumulative)
For this indicator, performance in June shows the indicator as being at 71.41 which is adversely above the plan of 62.1. South Sefton CCG reported more unplanned hospital admissions than the same period in 2012.

Emergency Admission for Children with Lower Respiratory Tract Infections

For this indicator, performance in June shows the indicator as being at 18.63 which is adversely above the plan of 15.52. South Sefton CCG reported more emergency admissions than the same period in 2012.

Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative)

The maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers indicator for South Sefton CCG patients is showing as 66.67% against the 90% target, at June 2013. This was due to a patient breach at Aintree Hospitals Trust. However, only one CCG patient was scheduled to be seen in June and this patient cancelled the appointment due to holidays. Cumulatively, to the end of June, South Sefton achieved 66.67% compared to the target of 90%. In addition to the breach in June, the target was also breached in May when one patient out of a total of four was seen outside of the target time at Aintree Hospital Trust as the patient required further investigations.

In June Southport & Ormskirk achieved 100% compared to the target of 90%. However, the Trust's poor performance in April (50%) means that cumulatively, the Trust is only achieving 80% compared to the target of 90%.

% High risk of Stroke who experience a TIA are assessed and treated within 24 hours

For the percentage of patients at high risk of Stroke who experience a TIA, who are assessed and treated within 24 hours, Southport and Ormskirk Hospitals Trust performance was below the target for June with 44.44% against 60%. June performance had worsened due to delays between patients seeing a GP and the referral reaching the stroke team, also attendance at weekends when the Trust do not have access to duplex scans and patient choice (patient's declining an appointment at Ormskirk and wanting to be seen at Southport).

In July the Stroke team developed a number of initiatives to address performance concerns including increased capacity from the Stroke Specialist Nurse on a Monday to improve waits for patients accessing A&E on Sunday. Further communication to be sent to GPs to reiterate the importance of immediate onward referral by GPs. The Trust has reported at the Contract Meeting on the 4th September that the TIA KPI is showing as above the target for July 2013, showing 66.7%.

Friends and Family Test Score – Inpatients + A&E

This new quarterly provider level indicator has been published for the first time this month for Q1and measures:

- the test score; and
- the % of respondents who would recommend the services to friends and family – for Inpatient Services and A&E.

The national CQUIN requirement is for all providers to achieve a combined 20% response rate by April 2014.

Southport and Ormskirk Hospitals Trust Hospital Trust achieved a test score of 56 against the Q1 2013/14 England average of 64. The Trust are currently developing an action plan regarding Family and Friends results, this will be discussed at the next CQPG meeting. The Trust have already produced a briefing regarding Ward 9b, which was identified as an outlier as part of the National Family and Friends Test Scores published in July.

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, 226 against the plan of 214.

Cheshire and Merseyside
Commissioning Support Unit

South Sefton CCG

Quality Reporting

August 2013 Update

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CCG Summary of Key Concerns

Indicator: Health Care Acquired Infections

Measure: Cdiff Cases

In month 4 (July 2013) there was one case of cdifficile relating a South Sefton CCG patient, all cases apportioned to non acute (community). Year to date South Sefton CCG stand at 12 cases, 4 apportioned to acute providers and 8 apportioned to the community.

(SOUTH SEFTON CCG) Apportioned to Acute Trust	April	May	June	July	YTD
Aintree University Hospitals NHS Foundation Trust	1	2	0	0	3
Liverpool Heart & Chest Hospital NHS Trust	0	0	1	0	1
Total	**1**	**2**	**1**	**0**	**4**

(SOUTH SEFTON CCG) Apportioned to Non Acute (Community)	April	May	June	July	YTD
Aintree University Hospitals NHS Foundation Trust	4	2	1	1	8
Total	**4**	**2**	**1**	**1**	**8**

Indicator: Incident Reporting

Measure: Serious Untoward Incidents

Due to a number of providers in Merseyside not stating patient CCG details within the required field on STEIS means it is not possible for CMCSU to provide the actual numbers of SUIs reported that relate to South Sefton CCG patients. For the providers who have used the required field on STEIS, 2 SUIs were reported in July 2013 which relate to South Sefton CCG patients. 4 SUIs reported year to date.

South Sefton CCG Patients at provider	Apr	May	Jul	Jul
Aintree University Hospital NHS Foundation Trust	0	0	2	2
Grand Total	**0**	**0**	**2**	**2**

All incident investigations and action plans will be discussed in detail at SUI/Complaints Monthly Management Group.

Indicator: Complaints

Indicator: Complaints received at CMCSU relating to South Sefton CCG patients at Merseyside Provider Hospitals

The following data only relates to complaints made to CMCSU Business Solutions team regarding main hospital providers in Merseyside.

Zero complaints received by CMCSU Business Solutions team in July 2013 relating to South Sefton patients at any Merseyside hospital provider.

All hospital, mental health and community provider complaints reports are currently being reviewed by CMCSU to ensure data is provided at CCG level.

Indicator: Patient Reported Outcome Measures

Indicator: Groin Hernia, Knee Replacement, Hip Replacement and Varicose Vein

The patient reported outcome measures assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures. PROMS calculate the health gains after surgical treatment using pre- and post-operative surveys.

It should be noted that the latest data is provisional and maybe incomplete or contain errors for which no adjustments have yet been made. Counts produced from provisional data are likely to be lower than those generated for the same period in the final dataset. The latest data published in August 2013 relates to April 2012 – March 2013 data.

Groin Hernia A total of 44 modelled records were completed in 2012/13, South Sefton CCG patients reported on average a 6.2% health gain following surgery compared to a national average of 8.8%. This is an increase in performance when compared to 2011/12 average health gain of 5.5%.

Knee Replacement Low numbers – to protect respondent confidentiality, figures between 1 and 5 have been supressed and replaced with '*' (an asterisk). **Hip Replacement** Low numbers – to protect respondent confidentiality, figures between 1 and 5 have been supressed and replaced with '*' (an asterisk). **Varicose Vein** Low numbers – to protect respondent confidentiality, figures between 1 and 5 have been supressed and replaced with '*' (an asterisk).
Indicator: Advancing Quality
Indicator: Groin Hernia, Knee Replacement, Hip Replacement and Varicose Vein
Awaiting publication of CCG split level data.

Patient Safety Quality Measures			
Indicator	**Reporting Frequency**	**National Average**	**South Sefton CCG**
Hospital Care Acquired Infections			**Actual**
MRSA Cases Reported	Jul-13	0	0
Cdiff Cases Reported	Jul-13	0	1
Incident and Complaints Reporting			**Actual**
Serious Untoward Incidents Reported	Jul-13	0	2 (See Narrative)
SUIs Reported as Never Events	Jul-13	0	0
Complaints Received to CMCSU	Jul-13	0	0
Mixed Sex Accommodation			**Actual**
Mixed Sex Accommodation Breaches	Jul-13	0	0
Rate per 1,000 FCEs	Jul-13	0	0.0

Clinical Effectiveness Quality Measures			
Indicator	**Reporting Frequency**	**National Average**	**South Sefton CCG**
Patient Reported Outcome Measures			**Actual**
Groin Hernia - Average increase in health gain	Apr 12-Mar 13	8.8%	6.2%
Hip Replacement - Average increase in health gain	Apr 12 -Mar 13	42.6%	Low Numbers
Knee Replacement - Average increase in health gain	Apr 12 -Mar 13	32.0%	Low Numbers
Varicose Vein - Average increase in health gain	Apr 12 -Mar 13	9.2%	Low Numbers

Patient Experience Quality Measures			
Indicator	**Reporting Frequency**	**National Average**	**South Sefton CCG**
Regional CQUIN - Advancing Quality			**Actual**
Acute myocardial infarction	Mar-13	98.48%	No split available from 2012/13. Awaiting publication of April 2013 data with CCG split.
Hip and Knee	Mar-13	97.26%	
Heart Failure	Mar-13	81.68%	
Pneumonia	Mar-13	89.22%	
Stroke	Mar-13	90.31%	
Coronary Artery Bypass Graft	Mar-13	97.11%	
Dementia	Mar-13	86.07%	
Psychosis	Mar-13	95.61%	

Provider Level Key Concerns

NEW	*Indicates any changes that have been made from previous update. Not all indicators will be updated due to the reporting frequency of individual measures.*

Health Care Acquired Infections

NEW Indicator: Cdifficile Cases

Royal Liverpool and Broadgreen Hospital reported 7 Cdiff cases in July 2013, 20 cases YTD.

Month	April	May	June	July	YTD
NHS HALTON CCG	0	0	0	0	0
NHS KNOWSLEY CCG	1	0	0	0	1
NHS LIVERPOOL CCG	2	6	2	6	16
NHS SOUTH SEFTON CCG	0	0	0	0	0
NHS SOUTHPORT AND FORMBY CCG	0	0	0	0	0
NHS ST HELENS CCG	0	0	0	1	1
NHS WEST CHESHIRE CCG	1	1	0	0	2
Total	4	7	2	7	20

The Trust has advised that the following action are in place to address this issue:

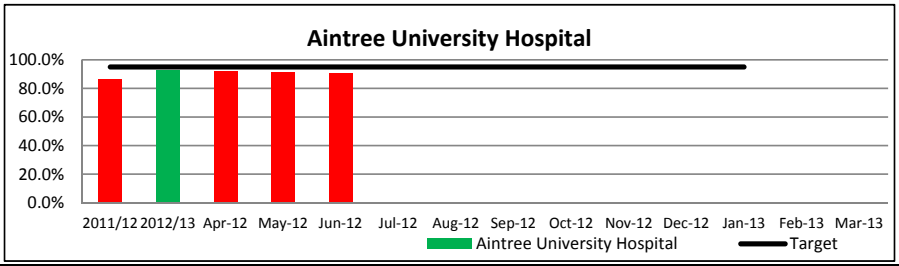
- E Coli bacteraemia are subject to root cause analysis review at a weekly meeting and Divisions provide weekly updates;
- Specific attention is focused on areas with more than one case. An extensive deep clean across the 5th floor (Gastroenterology/General Surgery) has taken place and the frequency of mattress audits has been increased.
- Risk assessment document has been put in place;
- An infection control pocket guide has been given to all ward nurses;
- A Trust-wide mattress audit is planned for the first week of September; and
- Joint Medical/Microbiology consultation rounds are in place.

Liverpool Womens Hospital 1 case of Cdifficile in July 2013 compared to a monthly plan of 0, year to date the provider stands at 1 case compared to a year to date plan of 0.
A formal review was completed and led by the Infection, Prevention and Control Team who concluded that we have not established yet how this patient acquired the infection, however no Trust attributable factors have currently been identified and appropriate nursing and medical care of the patient was promptly instituted.
Antimicrobial prescribing at LWH was good and in compliance with the Trust formulary, however there was concern over antimicrobial prescribing prior to the patient being admitted to LWH.
Liverpool Community Health 1 case of cdifficile reported in July 2013, compared to a monthly plan of 0, year to date the provider stands at 1 case compared to a year to date plan of 0.
CMCSU BI Analyst Comments: The patient is reported to a be a Liverpool CCG patient, no details of root cause analysis included within provider submission of HCAI assurance framework. Details requested from provider on 02/09/2013 by CMCSU.

NEW Venous thromboembolism (VTE) risk assessment

The goal of this measure is to reduce avoidable death, disability and chronic ill health from VTE. For 2013/14 all providers are to work towards achieving 95% of all adult inpatients to have a VTE risk assessment on admission to hospital.

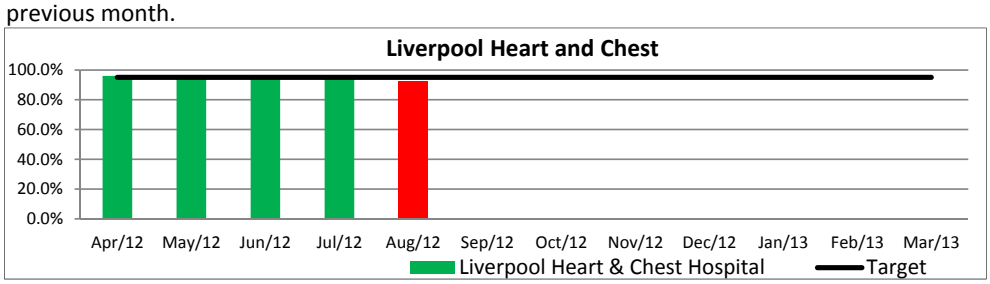
Aintree University Hospital reported 90.3% in July 2013 compared to a plan of 95%, slight drop in performance compared to previous month.



The provider has put the following actions in place to ensure that performance improves;

- Mid-month VTE performance reports and missed assessments broken down by consultant sent to CHoDs, ADNs and DCOOs
- Clinical Lead emails consultant colleagues where performance is below target.
- New - weekly ward level patient tracker reports are sent out at the beginning of each week to ward managers and matrons to encourage the medics to complete a risk assessment for those patients not having one completed.
- Quality Lead to attend Junior Doctors Forum to ascertain what further support is required.

Liverpool Heart and Chest Hospital reported 92.3% in July 2013 compared to a plan of 95%, drop in performance compared to previous month.



CMCSU BI Analyst has requested commentary from the provider to support actions in place to address underperformance. Issue to be discussed in detail at the provider clinical quality and performance group meeting.

NEW Incident Reporting

Measure: Serious Untoward Incidents

Royal Liverpool and Broadgreen Hospital The provider reported 0 incidents in July 2013, 2 incidents reported year to date. One incident reported in April 2013 related to assault by an inpatient (in receipt) and one incident in June 2013 relating to adverse media coverage or public concern about the organisation or the wider NHS.

Aintree University Hospital The provider reported 4 SUIs in July 2013, 10 SUIs reported year to date. The highest reporting incident type has been due to 3x pressure ulcers (grade 3&4) followed by 2x patients reporting a delayed diagnosis. All cases are reported as on-going at the end of July 2013.

CCG/Incident Type	Apr	May	Jun	Jul
NHS Knowsley CCG		1		1
Delayed diagnosis		1		
Drug Incident (general)				1
NHS Liverpool CCG		1		
Communicable Disease and Infection Issue		1		
NHS South Sefton CCG			2	2
Delayed diagnosis				1
MRSA Bacteraemia			1	
Outpatient appointment delay				1
Slips/Trips/Falls			1	
NHS Southport and Formby CCG			1	
Pressure ulcer Grade 3			1	
NHS St Helens CCG				1
Pressure ulcer Grade 4				1
CCG Not Specified on STEIS	1			
Pressure ulcer Grade 3	1			
Total SUIs Reported	1	2	3	4

Alder Hey Hospital The provider has reported 1 serious untoward incident (SUI) in July 2013 and year to date. The SUI relates to the Cdifficile case reported above (Refer to the infection control section for provider actions).

Liverpool Women's Hospital The provider reported 1 SUI in July 2013, 4 SUIs year to date and 1 Never event in May 2013.

CCG/Incident Type	Apr	May	Jun	Jul
No CCG Breakdown				
Child Death				1
Failure to act upon test results		1		
Maternity Services - Unexpected neonatal death	1			
Transfusion Incident		1		

Liverpool Heart and Chest Hospital 0 SUIs reported in July 2013, 1 SUI reported in May 2013 which was categorised as 'other'. No CCG details entered on to STEIS by the provider.

Mersey Care NHS trust reported 4 SUIs in July 2013, 27 SUIs year to date. The highest reporting incident type has been due to 10 suspected suicides.

CCG/Incident Type	Apr	May	Jun	Jul
No CCG Breakdown				
Abscond		1		
Admission of under 18s to adult mental health ward	1			1
Attempted Suicide by Outpatient (in receipt)	1			
Confidential Information Leak	1	1		
Homicide by Outpatient (not in receipt)		1	1	
Safeguarding Vulnerable Adult		1	2	
Serious Incident by Outpatient (not in receipt)			1	
Suicide		1		
Suicide by Outpatient (in receipt)		2		
Suspected suicide	1	2	5	2
Unexpected Death of Community Patient (in receipt)				1
Unexpected Death of Inpatient (in receipt)	1			

Liverpool Community Health reported 3 SUIs in July 2013, 12 SUIs year to date. The highest number of incidents reported are due to Pressure Ulcers Grade 3&4.

CCG/Incident Type	Apr	May	Jun	Jul
No CCG Breakdown				
Other		1		
Pressure ulcer Grade 3	4		2	2
Pressure ulcer Grade 4			1	1
Unexpected Death of Inpatient (not in receipt)	1			

CMCSU BI Comments: As highlighted above a number of providers are submitting CCG information into the required field on STEIS. The issue has been raised direct from CMCSU business solutions team to the provider and to Liverpool CCG as the issue appears to be at the majority of Liverpool providers. All incident investigations and action plans will be discussed in detail at SUI/Complaints Monthly Management Group.

NEW National Safety Thermometer

Measure: Pressure Ulcers

The following providers are compliant in submitting July 2013 survey results to NHS Safety Thermometer;

1. Royal Liverpool Hospital
2. Aintree University Hospital
3. Liverpool Womens Hospital
4. Liverpool Community Provider

A summary of each provider Safety Thermometer results can be found in **Appendix 1.**
The following providers are not compliant in submitting July 2013 survey results to NHS Safety Thermometer;

1. Liverpool Heart and Chest – **Provider Comments:** July's submission failed at provider end, July's data has since been submitted with August 2013 data on 22nd August.
2. Mersey Care NHS Trust – **Provider Comments:** Due to a HSCIC changing submission email address meant the provider submitted July's data to the wrong email address, July's data has now been submitted with August's submission.

NEW National Dementia – Screening, Assessment and Referral

The goal of the dementia CQUIN is to incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions and to prompt appropriate referral and follow up after they leave hospital. Nationally all providers are to work towards achieving 90% patients identified, 90% of patients assessed and 90% of patients referred within each quarter.

Screening

Royal Liverpool and Broadgreen Hospital achieved 43.7% in Q1 13/14, of the 1429 patients eligible only 624 patients were identified with a diagnosis of dementia or were asked the awareness question '"have you/has the patient been more forgetful in the past 12 months to the extent that it has significantly affected your/their daily life" within 72 hours of admission.

Aintree University Hospital achieved 35.6% in Q1 13/14, of the 1611 patients eligible only 574 patients were identified with a diagnosis of dementia or were asked the awareness question '"have you/has the patient been more forgetful in the past 12 months to the extent that it has significantly affected your/their daily life" within 72 hours of admission. The provider did report an increase in June 2013 compared to May 2013.

Assessed

Royal Liverpool and Broadgreen Hospital achieved 58.7% in Q1 13/14, of the 300 patients eligible only 174 patients had a diagnostic assessment including investigations to determine whether the presence of dementia is possible carried out.

Aintree University Hospital achieved 84.7% in Q1 13/14, of the 59 patients eligible only 50 patients had a diagnostic assessment including investigations to determine whether the presence of dementia is possible carried out.

Referred

Liverpool Heart and Chest Hospital achieved 85.7% in Q1 13/14, low performance reported in April 2013 has resulted in under performance being reported overall for Q1 13/14. The trust achieved 100% against the measure in June 2013.

See Appendix 2 for Merseyside Provider Summary.

NEW Mortality

Measure: SHMI

The purpose of this indicator provides an indication for each hospital trust in England whether the observed number of deaths within 30 days of discharge from hospital were higher than expected, lower than expected or as expected when compared to the national baseline. The SHMI is a ratio of the observed number of deaths in a trust over a period of time divided by the expected number given the characteristics of patients treated by a trust.

Aintree University Hospital For January 2012 – December 2012 the trusts SHMI ratio is reported as statistically higher than expected, with a ratio 116.7% (Observed deaths 1,979, expected deaths 1,696). This was an increase in performance compared to the previous reporting period.

The SHMI indicator includes deaths from palliative care patients (even though these deaths are expected), deaths for up to 30 days following discharge from hospital and is not adjusted for levels of deprivation in the communities which a hospital serves. Given the specialist palliative care services with Aintree University Hospital and how it serves some of the most deprived communities, with poor levels of health should be taken into account when reviewing the data.

NEW Patient Reported Outcome Measures – Provider Level

Indicator: Patient Reported Outcome Measures

As mentioned within Section A The patient reported outcome measures assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures. PROMS calculate the health gains

after surgical treatment using pre- and post-operative surveys.

It should be noted that the latest data is provisional and maybe incomplete or contain errors for which no adjustments have yet been made. Counts produced from provisional data are likely to be lower than those generated for the same period in the final dataset. The latest data published in August 2013 relates to April 2012 – March 2013 data.

Groin Hernia

Royal Liverpool and Broadgreen Hospital Low numbers – to protect respondent confidentiality, figures between 1 and 5 have been supressed and replaced with '*' (an asterisk).

Aintree University Hospital A total of 79 modelled records were completed in 2012/13, Groin Hernia patients treated at the provider reported on average a 6.8% increase in their health gain following surgery compared to a national average of 8.8%. This is a reduction in performance when compared to 2011/12 average health gain of 8.8%.

Knee Replacement

Aintree University Hospital A total of 41 modelled records were completed in 2012/13, knee replacement patients treated at the provider reported on average a 27.7% increase in their health gain following surgery compared to a national average of 32%. This is a reduction in performance when compared to 2011/12 average health gain of 29.9%.

Hip Replacement

Royal Liverpool and Broadgreen Hospital A total of 44 modelled records were completed in 2012/13, hip replacement patients treated at the provider reported on average a 39.2% increase in their health gain following surgery compared to the national average of 42.6%. Although the provider is reporting below the England average they have reported an increase in patients average health gain following surgery compared to the previous year.

Aintree University Hospital A total of 38 modelled records were completed in 2012/13, hip replacement patients treated at the provider reported on average a 41.5% increase in their health gain following surgery compared to the national average of 42.6%. Although the provider is reporting below the England average they have reported an increase in patients average health gain following surgery compared to the previous year.

Varicose Vein

All Providers Low numbers – to protect respondent confidentiality, figures between 1 and 5 have been supressed and replaced with '*' (an asterisk).

NEW Advancing Quality

Measure: AMI

The advancing quality programme began in October 2008. Year one of the programme was defined as October 2008 – September 2009 patient discharges. Participation in year one encompassed 24 north west trusts and each trust is enrolled in up to five clinical conditions depending on their patient populations. The five clinical conditions for which quality measures exist are;

1. Acute myocardial infarction (AMI)
2. Isolated coronary artery bypass graft (CABG)
3. Heart Failure (HF)
4. Pneumonia (PN)
5. Hip and Knee replacement surgery (Hip/Knee)
6. Stroke
7. Dementia
8. First episode of psychosis

The programme is based on the concept of quantifying Trust performance on one aggregated measure of quality – the Composite Quality Score (CQS) - within each of the five clinical areas.

Heart Failure

Royal Liverpool and Broadgreen Hospital 94.44% reported in March 2013 compared to a plan of 95%, this was a increase in performance compared to previous month. The summary below shows the measures within the overall bundle which are failing 95% threshold.

Heart Failure			
NHS-24	LV function evaluation	13	100.00%
NHS-25	ACEI or ARB at discharge	6	100.00%
NHS-26	Discharge Instructions	15	86.67%
NHS-27	Adult Smoking Cessation Advice/Counselling	2	100.00%
	COMPOSITE PROCESS SCORE	36	**94.44%**
	APPROPRIATE CARE SCORE	16	87.50%

Liverpool Heart and Chest Hospital 83.3% reported in March 2013 compared to a plan of 95%, similar performance compared to previous month. The summary below shows the measures within the overall bundle which are failing 95% threshold.

Heart Failure				
NHS-24	LV function evaluation	6	7	85.71%
NHS-25	ACEI or ARB at discharge	4	4	100.00%
NHS-26	Discharge Instructions	5	7	71.43%
NHS-27	Adult Smoking Cessation Advice/Counselling	0	0	
	COMPOSITE PROCESS SCORE	15	18	**83.33%**
	APPROPRIATE CARE SCORE	4	7	57.14%

Pneumonia

Royal Liverpool and Broadgreen Hospital 91.27% reported in March 2013 compared to a plan of 95%, slight drop in performance compared to previous month. The summary below shows the measures within the overall bundle which are failing 95% threshold.

Pneumonia				
NHS-33	Oxygenation Assessment	92	92	100.00%
NHS-34	Initial Antibiotic Selection for CAP in Immunocompetent Patients	64	67	95.52%
NHS-35	Blood cultures performed prior to initial antibiotic	0	0	
NHS-38	Initial Antibiotic Received Within 6 Hours of Arrival	54	80	67.50%
NHS-39	Adult Smoking Cessation Advice/Counselling	24	24	100.00%
NHS-50	CURB-65 score	69	69	100.00%
	COMPOSITE PROCESS SCORE	303	332	**91.27%**
	APPROPRIATE CARE SCORE	70	98	71.43%

Stroke

Aintree University Hospital 85.29% reported in March 2013 compared to a plan of 95%, this was a drop in performance compared to previous month. The summary below shows the measures within the overall bundle which are failing 90% threshold.

Stroke				
STK-1	Stroke Unit Admission	14	27	51.85%
STK-2	Swallowing screening	21	24	87.50%
STK-3	Brain scan	27	28	96.43%
STK-4	Received aspirin	17	17	100.00%
STK-5	Physiotherapy assessment	23	25	92.00%
STK-6	Occupational assessment	22	24	91.67%
STK-7	Weighed	21	25	84.00%
	COMPOSITE PROCESS SCORE	145	170	**85.29%**

National Patient Experience Surveys

Measures: National Mental Health Survey, A&E Survey, Staff Survey, Inpatient Survey

No change in performance from previous reporting period. All measures are annual indicators and only likely to change once in a 12 month period. Please refer to previous report narrative for update.

Compliance with CQC Standards, Notices or Enforcements

The latest information made available by CQC provides the outcome of the most recent checks carried out at each

provider organisation showing whether the care service is meeting each of the standards that the government says patients have the right to expect.

Aintree University Hospital Following an inspection carried out at Aintree University Hospital in November 2012, two of the five outcomes were reported as non-compliant, with actions requiring improvement. The areas are summarised below;

Outcome 9 People should be given the medicines they need when they need them, and in a safe way - CQC Judgement; Patients were not always protected against the risks associated with medicines because the Trust did not have appropriate arrangements in place to safely manage them.
Outcome 21 People's personal records, including medical records, should be accurate and kept safe and confidential. CQC Judgment; People were not adequately protected from the risk of unsafe or inappropriate care or treatment due to inadequate care records.

The outcome from the Monitor investigation in relation to the Trust breaching the terms of their License is awaited. A follow-up visit has not yet been carried by CQC to evaluate Outcome 9 – Medicine Management and Outcome 21 – Records. All action plans have been provided by the Trust and are reviewed at the Collaborative Forum.

NEW Central Alerting System

Aintree University Hospital The provider currently has 3 on-going alerts which have now passed deadline date;

1. Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors
2. Safer spinal (intrathecal), epidural and regional devices Part A: update
3. Safer spinal (intrathecal), epidural and regional devices - Part B

Trust has submitted an update report which highlights plans in place which are to be monitored by the Safety and Risk Sub Committee.

Alder Hey Hospital The provider currently has 2 on-going alerts which have now passed deadline date;

1. Window restrictors
2. Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors

Liverpool CCG have been made aware of the on-going alerts passed deadline date, awaiting feedback from Liverpool CCG.

Liverpool Women's Hospital The provider currently has 13 on-going alerts which have now passed deadline date;

1. Orthopaedic instrument.Flexible handle (part no. 355.280), used with the Simplified Universal Nail System (SUN) and the Universal Nail System (UNI).Manufactured by Synthes GmbH.
2. High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) update - getra SpA â€“ 33/11 kV TRANSFORMER
3. High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - yorkshire switchgear â€“ tyke mk iiA â€“ ring main unit
4. High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - long & crawford â€“ j4 (11 kV) switch
5. Intra-oral dental X-ray units:IRIX 70, IRIX 708, Oramatic 558 or Novelix 6510.Manufactured by Trophy (now owned by Carestream Health).Models manufactured from November 1990 to November 1994 inclusive.
6. High Voltage Hazard Alert - NATIONAL EQUIPMENT DEFECT REPORT (NEDeR) - schneider electric â€“ genie evo circuit breaker
7. Safety blood collection and infusion sets. Various item and lot numbers. Manufactured by Greiner Bio-One.
8. Window restrictors
9. VIE (Vacuum insulated evaporator) Main storage vessel for bulk medical oxygen supply.
10. Safer spinal (intrathecal), epidural and regional devices Part A: update
11. Reducing harm from omitted and delayed medicines in hospital
12. Safer spinal (intrathecal), epidural and regional devices - Part B
13. PROMOTING SAFER MEASUREMENT AND ADMINISTRATION OF LIQUID MEDICINES VIA ORAL AND OTHER ENTERAL ROUTES

All on-going alerts are discussed at provider clinical quality and performance group meeting. Awaiting submission of action plan detailing how they plan to close alerts.

Liverpool Heart and Chest The provider currently has 12 on-going alerts which have now passed deadline date;

1. Infusion pumps: GemStar infusion system. Manufactured by Hospira. All list numbers are affected.

2. Safer spinal (intrathecal), epidural and regional devices - Part B
3. ELECTRICALLY OPERATED BEDS
4. ARJO ALENTI LIFT HYGIENE CHAIR.
5. FIRE EXTINGUISHER (WATER & FOAM) HOSES
6. UNIVERSAL HOSPITAL SUPPLIES LTD., GUEDEL AIRWAYS SIZES 2 AND 3.
7. ENTERAL FEEDING TUBES (NASOGASTRIC)
8. PEAK EXPIRATORY FLOW METER (PFM) ALL MAKES.
9. VYGON (UK) LTD BIONECTOR NEEDLEFREE IV ACCESS CONNECTOR
10. INVACARE LIMITED 'SPECTRA PLUS' POWERED WHEELCHAIR.
11. REUSABLE NEBULISERS
12. AUTOMATIC DOOR RELEASE MECHANISMS / HOLD OPEN DEVICES

Liverpool CCG has raised an issue to NHS England as all of the above alerts were closed by the provider over two years ago. Awaiting response from NHS England.

NEW Quality Risk Profiles

The QRP enables Care Quality Commission (CQC) to assess where risks lie and prompt any front line regulatory activity, such as an inspection. QRPs support CQC teams to make robust judgments about the quality of services, and will develop over time as we gather more information about a provider. The CQC's quality and risk profiles (QRPs) bring together information about a care provider and provide an estimate of risk of non-compliance against each of the 16 essential standards of quality and safety.

Royal Liverpool and Broadgreen Hospital Of the 16 outcomes, 1 outcome (Outcome 8; Cleanliness and infection control) has moved from High green to Low yellow in July 2013. This may relate to the number of cdiff cases which have been reported by the trust between April 13 – July 2013. Actions in place (see comments above under infection control). The provider continues to be rated as high yellow against 1 outcome (Outcome 7 Safeguarding people who use services from abuse).

Outcome Desc	May-13	Jun-13	Jul-13
Outcome 1 (R17) Respecting and involving people who use services	Low Green	Low Green	Low Green
Outcome 2 (R18) Consent to care and treatment	Low Green	Low Green	Low Green
Outcome 4 (R9) Care and welfare of people who use services	Low Yellow	Low Yellow	Low Yellow
Outcome 5 (R14) Meeting nutritional needs	High Green	High Green	High Green
Outcome 6 (R24) Cooperating with other providers	High Green	High Green	Low Green
Outcome 7 (R11) Safeguarding people who use services from abuse	High Yellow	High Yellow	High Yellow
Outcome 8 (R12) Cleanliness and infection control	High Green	High Green	Low Yellow
Outcome 9 (R13) Management of medicines	Low Yellow	Low Yellow	Low Yellow
Outcome 10 (R15) Safety and suitability of premises	Low Green	Low Green	Low Green
Outcome 11 (R16) Safety, availability and suitability of equipment	Low Green	Low Green	Low Green
Outcome 12 (R21) Requirements relating to workers	Low Yellow	Low Yellow	Low Yellow
Outcome 13 (R22) Staffing	Low Yellow	Low Yellow	Low Yellow
Outcome 14 (R23) Supporting staff	Low Yellow	Low Yellow	High Green
Outcome 16 (R10) Assessing and monitoring the quality of service provision	Low Yellow	Low Yellow	Low Yellow
Outcome 17 (R19) Complaints	Low Yellow	Low Yellow	Low Yellow
Outcome 21 (R20) Records	Low Green	Low Green	Low Green

Aintree University Hospital Of the 16 outcomes, 3 outcomes continue to be reported as high yellow in July 2013;
Outcome 4 (R9) Care and welfare of people who use services
Outcome 9 (R13) Management of medicines
Outcome 13 (R22) Staffing
All of the above outcomes are what alerted the CQC to carry out an inspection in January 2013 (See comments above under CQC inspection measures).

Outcome Desc	May-13	Jun-13	Jul-13
Outcome 1 (R17) Respecting and involving people who use services	Low Yellow	Low Yellow	Low Yellow
Outcome 2 (R18) Consent to care and treatment	High Green	Low Green	Low Green
Outcome 4 (R9) Care and welfare of people who use services	High Yellow	High Yellow	High Yellow
Outcome 5 (R14) Meeting nutritional needs	Low Yellow	Low Yellow	Low Yellow
Outcome 6 (R24) Cooperating with other providers	Low Yellow	Low Yellow	High Green
Outcome 7 (R11) Safeguarding people who use services from abuse	Low Yellow	Low Yellow	Low Yellow
Outcome 8 (R12) Cleanliness and infection control	High Green	High Green	High Green
Outcome 9 (R13) Management of medicines	High Yellow	High Yellow	High Yellow
Outcome 10 (R15) Safety and suitability of premises	Low Green	High Green	Low Green
Outcome 11 (R16) Safety, availability and suitability of equipment	Low Green	Low Green	Low Green
Outcome 12 (R21) Requirements relating to workers	Low Green	High Green	High Green
Outcome 13 (R22) Staffing	High Yellow	High Yellow	High Yellow
Outcome 14 (R23) Supporting staff	High Yellow	Low Yellow	Low Yellow
Outcome 16 (R10) Assessing and monitoring the quality of service provision	Low Yellow	Low Yellow	Low Yellow
Outcome 17 (R19) Complaints	Low Yellow	High Green	High Green
Outcome 21 (R20) Records	High Green	High Green	High Green

Mersey Care NHS Trust The Quality Risk Profile for June and July 2013 demonstrated that Mersey Care had made improvements against Outcome 6 – Cooperating with other providers, moving from high red in May 13 to low red in June and again in July.

Outcome Desc	May-13	Jun-13	Jul-13
Outcome 1 (R17) Respecting and involving people who use services	Low Green	Low Green	Low Green
Outcome 2 (R18) Consent to care and treatment	No Data	No Data	No Data
Outcome 4 (R9) Care and welfare of people who use services	High Green	Low Yellow	Low Yellow
Outcome 5 (R14) Meeting nutritional needs	Low Green	Low Green	Low Green
Outcome 6 (R24) Cooperating with other providers	High Red	Low Red	Low Red
Outcome 7 (R11) Safeguarding people who use services from abuse	Low Yellow	Low Yellow	Low Yellow
Outcome 8 (R12) Cleanliness and infection control	Low Green	Low Green	Low Green
Outcome 9 (R13) Management of medicines	Low Green	Low Green	Low Green
Outcome 10 (R15) Safety and suitability of premises	Low Green	Low Green	Low Green
Outcome 11 (R16) Safety, availability and suitability of equipment	Low Green	Low Green	Low Green
Outcome 12 (R21) Requirements relating to workers	High Yellow	High Yellow	High Yellow
Outcome 13 (R22) Staffing	Low Green	Low Green	Low Green
Outcome 14 (R23) Supporting staff	High Yellow	Low Yellow	Low Yellow
Outcome 16 (R10) Assessing and monitoring the quality of service provision	Low Yellow	High Green	Low Yellow
Outcome 17 (R19) Complaints	Low Yellow	Low Yellow	Low Yellow
Outcome 21 (R20) Records	Low Green	Low Green	Low Green

Further improvements are required from the trust to address this issue of delayed transfers of care however working in collaboration with Liverpool City Council and the creation of a social worker allocated to the wards is having a positive impact on transfer of care. The task and finish group continues with representation from both organisations. The trust is also working towards implementing robust processes and systems to prepare for the winter period.

NWAS Handover time and Time banding breaches

As outlined within 2013/14 NHS Standard Contract all A&E providers must work to the following thresholds;

1. CB_S7a All handovers between ambulance and A & E must take place within 15 minutes
    a. Threshold 15 Minutes – Consequence of breach £200 per patient waiting over 30 minutes
2. CB_S7b All handovers between ambulance and A & E must take place within 15 minutes
    a. Threshold 15 Minutes – Consequence of breach £1,000 per patient waiting over 60 minutes (in total, not aggregated with CB_S7a consequence)

Following publication of thresholds and penalties it was agreed by the Ambulance Strategic Partnership Board, CCGs, Acute representatives and NHS North England, that financial penalties are to be held in abeyance if improvements in recording and handover compliance are seen. The NHS Commissioning Board has reserved the right to accelerate implementation of fines if improvements are not in evidence.

Although financial penalties are to be held in abeyance providers achievement of the measures are to be monitored,

reported and discussed at all providers Clinical Quality and Performance Group Meetings.

Royal Liverpool and Broadgreen Hospital

	July 13	Year to Date
Patients waiting between 30-60 Minutes for Handover	10	100
Finance (If applied)	*£2,000*	*£20,000*
Patients waiting between over 60 minutes for handover	5	11
Finance (If applied	*£5,000*	*£11,000*

Provider Comments: We have requested assistance from NWAS in attempting to get more detail for patients who are waiting over 30 minutes and 60 minutes as we cannot access approaching patient level. We will update CMCSU and Liverpool CCG when we have received a response from NWAS.

Aintree University Hospital

	July 13	Year to Date
Patients waiting between 30-60 Minutes for Handover	57	261
Finance (If applied)	*£11,400*	*£52,200*
Patients waiting between over 60 minutes for handover	22	143
Finance (If applied)	*£22,000*	*£143,000*

CMCSU BI Analyst Comments: AED action plan received from provider and discussed within June 2013 quality and performance group meeting. It has been noted that there is a difference in figures reported by provider and those available to CMCSU – DM to discuss with provider lead.

Monitor Governance and Risk Rating

Monitor publishes two risk ratings for each NHS foundation trust:

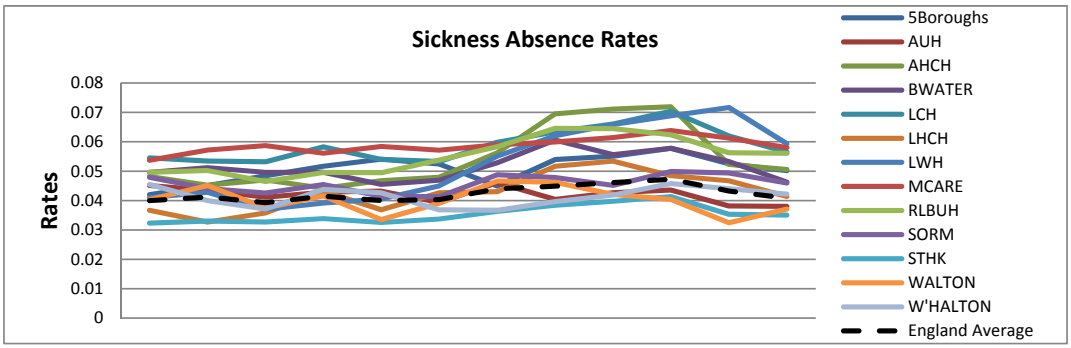
- Financial Risk Rating (rated 1-5, where 1 represents the highest risk and 5 the lowest); and
- Governance risk rating (rated red, amber-red, amber-green or green)

When assessing financial risk, Monitor assigns a risk rating using a scorecard which compares key financial metrics on a consistent basis across all NHS foundation trusts. The risk rating is intended to reflect the likelihood of a financial breach of the authorisation.

Aintree University Hospital In quarter four 2012/13 The governance risk rating for this foundation trust was amended from AMBER-RED to RED in May 2013 due to deterioration in the trust's service performance score.
In terms of the Financial Risk Rating, the Trust has a score of 3 (regulatory concerns in one or more components, although significant breach is unlikely).

Sickness Absence Rates

The latest data relates to sickness absence rates for staff at NHS Organisations on the electronic staff record (ESR) between April 2012 – March 2013. Although a number of providers are reported as amber at March 2013 all providers in Merseyside have reported a reduction against the previous reporting period.



GB13/119

Patient Safety Quality Measures

Indicator	Reporting Frequency	National Average	Royal Liverpool & Broadgreen		Aintree University Hospital		Alder Hey Children's Hospital		Liverpool Women's Hospital		Liverpool Heart & Chest Hospital		Mersey Care		Liverpool Community Health	
Hospital Care Acquired Infections			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
MRSA Cases Reported	Jul-13	0	0		0		0		0		0		0		0	
Cdiff Cases Reported	Jul-13	0	7		3		0		1		0		0		1	
Venous thromboembolism (VTE) risk assessment			Actual	Trend	Actual	Trend			Actual	Trend	Actual	Trend				
VTE Risk Assessments	Jun-13	95.7%	95.3%		90.3%				97.6%		92.3%					
Local Incident Reporting			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Serious Untoward Incidents Reported	Jul-13	0	0		4		1		1		0		4		3	
SUIs Reported as Never Events	Jul-13	0	0		0		0		0		0		0		0	
Complaints Received to CMCSU	Jul-13	0	0		0		0		0		0		0		0	
National Patient Safety Incident Reporting (*Per 100 admissions, **Per 1,000 bed days)			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Total Incidents Reported	April12-Sep12	TBD	1938		2692		792		1270		564		2082		170	
Reporting Rates		TBD	4.5/6.8		7.2/6.7		4.7/5.8		8/5.8		8.6/5.8		30.7/23.8		14.78	
% Incidents reported resulting in Severe Harm		TBD	0.20%		0.20%		0.00%		1.30%		0.00%		0.20%		0.60%	
% Incidents reported resulting in Death		TBD	0%		0.00%		0.00%		0.20%		0.00%		0.10%		0.00%	
Mixed Sex Accommodation			Actual	Trend	Actual	Trend	↔	Trend	↔	Trend	↔	Trend	Actual	Trend	Actual	Trend
Mixed Sex Accommodation Breaches	Jul-13	0	0		0		0		0		0		0		0	
Rate per 1,000 FCEs	Jul-13	0	0.0		0.0		0.0		0.0		0.0		0.0		0.0	
National CQUIN - Safety Thermometer			Actual	Trend	Actual	Trend			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Timeliness submission of data harms data to Unify2	Jul-13	Compliance														
Pressure Ulcers (All categories)	Jul-13	5.10%	6%		5.5%				0%		Awaiting confirmation of provider submission		Awaiting confirmation of provider submission		3.38%	
Falls	Jul-13	2.32%	2%		1.30%				0%						1.90%	
Patients with a catheter and being treated for a UTI	Jul-13	0.96%	0%		0.2%				0%						0.1%	
VTE - Patients with a new VTE	Jul-13	0.51%	1%		1.40%				1%						0.10%	
Harm Free Care	Jul-13	92.81%	93%		92.51%				99%						94.10%	
National CQUIN - Dementia			Actual	Trend	Actual	Trend			Actual	Trend	Actual	Trend				
Screening for Dementia (Find)	Q1 13/14	73.7%	44%		35.60%				0 Patients		98%					
Risk Assessed (Assess and Investigate)	Q1 13/14	87.8%	59%		85%				0 Patients		100%					
Patients Referred	Q1 13/14	90.2%	0 Patients		100%				0 Patients		86%					

Clinical Effectiveness Quality Measures

Indicator	Reporting Frequency	National Average	Royal Liverpool and Broadgreen Hospital		Aintree University Hospital		Alder Hey Children's Hospital		Liverpool Women's Hospital		Liverpool Heart and Chest Hospital		Mersey Care		Liverpool Community Health	
Mortality Indicators			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Hospital Standardised Mortality Ratio (HSMR)	Apr 12-Nov 12	100	91.00%		96.50%		96.5%		40.20%		80.30%		89.6%		27.8%	
Summary Hospital-Level Mortality Indicator (SHMI)	Oct 11-Sep 12	100	106.42		116.66											
(SHMI) Deaths occurring in hospital		73.5%	72.7%		70.2%											
(SHMI) Deaths occurring out of hospital		26.5%	27.3%		29.8%											
Patient Reported Outcome Measures			Actual	Trend	Actual	Trend										
Groin Hernia - Average increase in health gain	Apr 12-Mar 13	8.8%	Low Numbers		6.8%											
Hip Replacement - Average increase in health gain	Apr 12 -Mar 13	42.6%	39.2%		41.5%											
Knee Replacement - Average increase in health gain	Apr 12 -Mar 13	32.0%	32.8%		27.7%											
Varicose Vein - Average increase in health gain	Apr 12 -Mar 13	9.2%	Low Numbers		Low Numbers											

Patient Experience Quality Measures

Indicator	Reporting Frequency	National Average	Royal Liverpool and Broadgreen Hospital		Aintree University Hospital		Alder Hey Children's Hospital		Liverpool Women's Hospital		Liverpool Heart and Chest Hospital		Mersey Care		Liverpool Community Health	
Regional CQUIN - Advancing Quality			Actual	Trend	Actual	Trend					Actual	Trend	Actual	Trend		
Acute myocardial infarction	Mar-13	95%	98.5		98.1						99.3					
Heart Failure	Mar-13	95%	94.4		87.0						83.3					
Hip and Knee	Mar-13	86%	99.1		96.2											
Pneumonia	Mar-13	86%	91.3		88.6											
Stroke	Mar-13	90%	93.6		85.3											
Coronary Artery Bypass Graft	Mar-13	TBD									99.6					
Dementia	Mar-13	TBD											86.00%			
First-Episode Psychosis	Mar-13	TBD											91.1%			
National Community Mental Health Survey													Actual	Trend		
Overall Care	2012	TBD											7.7/10			
Involving Family and Friends		TBD											6.6/10			
National Staff Survey			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
KF1 % Staff feeling satisfied with the quality of work and patient care they are able to deliver	2012	TBD	81%/78%		82%/78%		78%/82%		76%/82%		86%/82%		79%/78%		79%/76%	
KF34 Staff recommendation of the trust as a place to work or receive treatment		TBD	3.65/3.57		3.68/3.57		3.49/4.06		3.41/4.06		4.20/4.06		3.59/3.54		3.52/3.58	
National Inpatient Survey			Actual	Trend	Actual	Trend			Actual	Trend	Actual	Trend				
Q41: Involved satisfaction in decisions about care & Treatment	2012	TBD	79%		71%				78.40%		79.30%					
Q73: Overall level of respect & Dignity		TBD	92%		89%				89.07%		94.60%					

Organisational Level Quality Measures

Indicator	Reporting Frequency	National Average	Royal Liverpool and Broadgreen Hospital		Aintree University Hospital		Alder Hey Children's Hospital		Liverpool Women's Hospital		Liverpool Heart and Chest Hospital		Mersey Care		Liverpool Community Health	
Care Quality Commission			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Compliance to CQC 5 standards following recent checks	Jul-13	n/a	●		●		●		●		●		●		●	
Central Alerts System			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Alerts reported as on-going passed deadline date	Jul-13	0	0		3		2		13		12		0		0	
Quality Risk Profiles			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
The Care Quality Commission's quality and risk profiles (QRPs) bring together information about a care provider and provide an estimate of risk of non compliance against each of the 16 essential standards of quality .	Jul-13	High/Low Green	8		8		9		12		14		8		10	
		High/Low Yellow	8		8		7		4		2		6		6	
		Low Amber														
		Low Red/Red											1			
Ambulance Handover Times			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Handover <15 Minutes. Time taken from HAS notification to clinical handover (Assumed ACUTE responsibiility)	Jul-13	15 Mins	00:06:26		00:10:07		00:02:42									
Patients waiting between 30-60 Minutes for Handover		0	10		57		0									
Patients waiting between 60+ Minutes for Handover		0	5		22		0									
Compliance with Recording Patient Handover between Ambulance and A&E		85%	81.60%		77.00%		72.80%									
Monitor Risk and Financial Rating			Actual	Trend	Actual	Trend			Actual	Trend	Actual	Trend				
Monitor Risk Rating - *(Source Monitor)*	Q4 12/13	n/a			3				3		3					
		n/a			●				●		●					
Sickness Rates			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Sickness Absence Rates	Q4 12/13	4.61%	5.61%		3.80%		5.06%		5.94%		4.14%		5.80%		5.65%	
Patient Environment Assessment Team (PEAT)			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Patient Environment Assessment Team (PEAT)	2012	n/a	Excellent		Excellent		Excellent		Excellent		Excellent		Excellent		Excellent	
NHS Litigation Authority			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
NHS Litigation Authority Assessment	2012/13	n/a	2		3		3		3		3		1		1	
Quality Accounts			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Quality Accounts	2011/12	n/a	●		●		●		●		●		●		●	

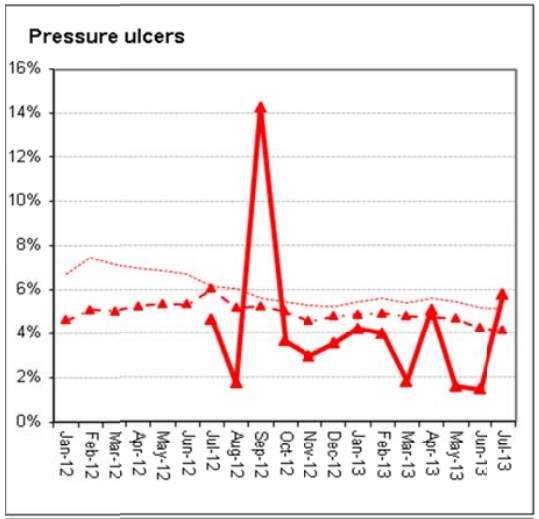
Appendices

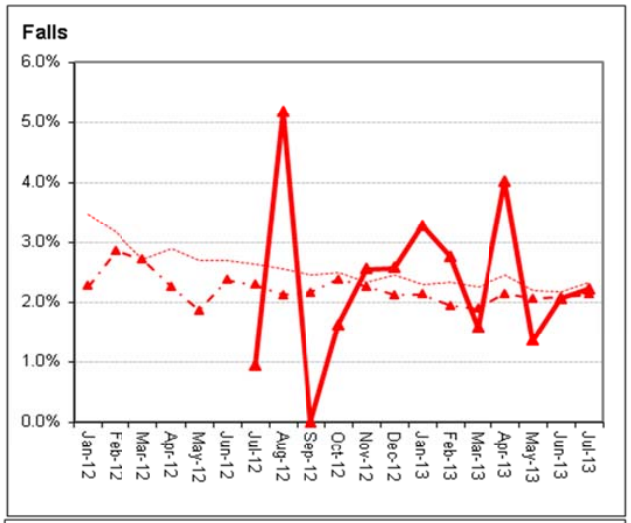
Appendix 1. NHS Safety Thermometer – Royal Liverpool and Broadgreen Hospital

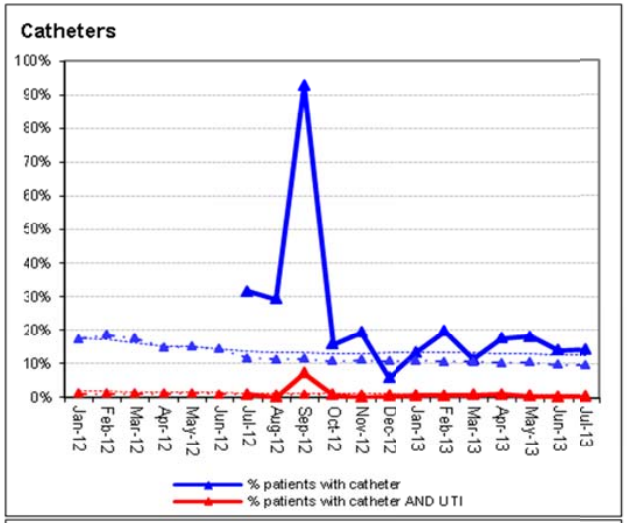
Safety Thermometer Results Dashboard

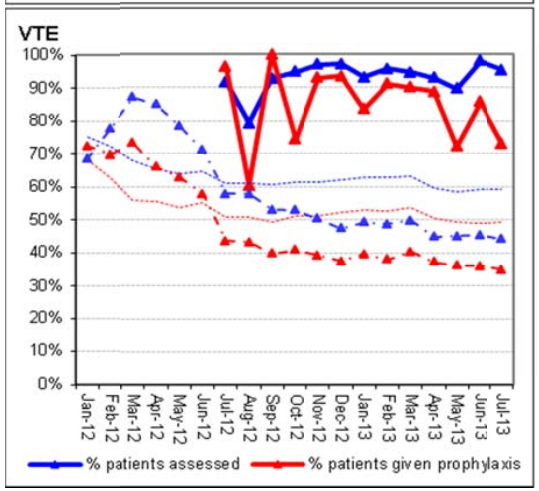
Step 1: select SHA **Step 2: select organisation**

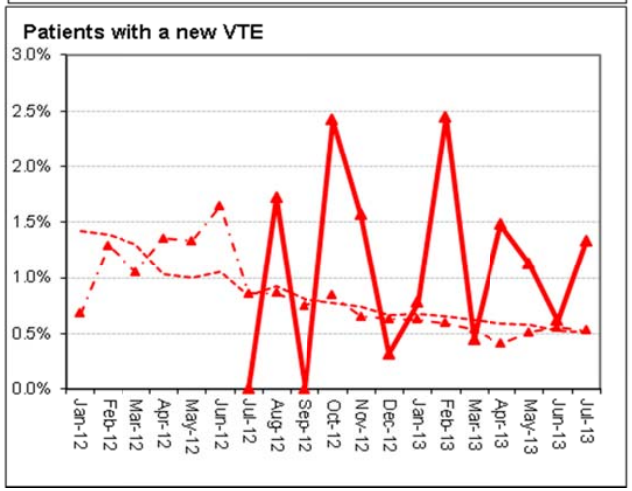
Total number of patients a: selected organisation surveyed from Jan-2012 to date: **5,551**

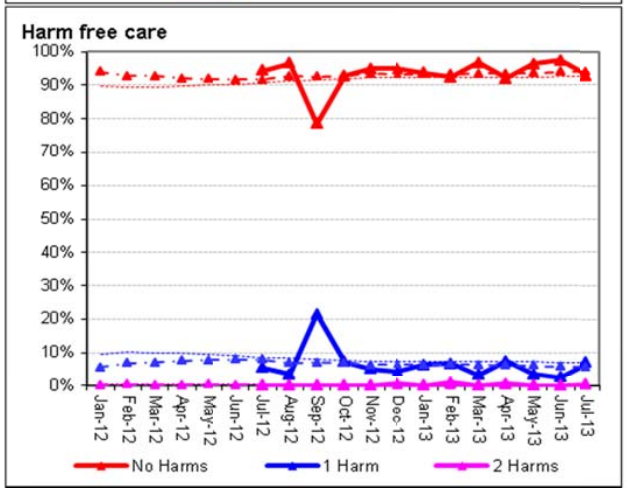












Safety Thermometer Results Dashboard

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Step 2: select organisation

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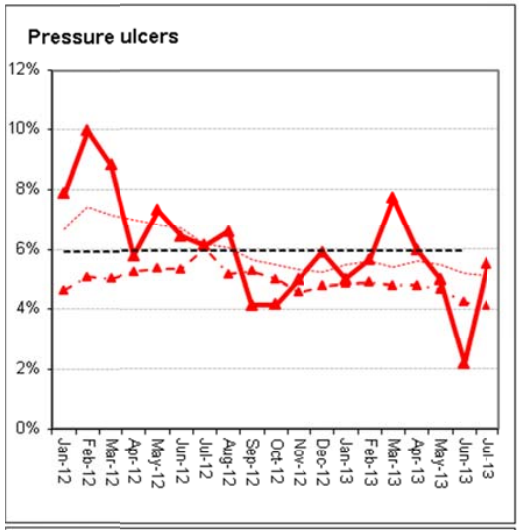
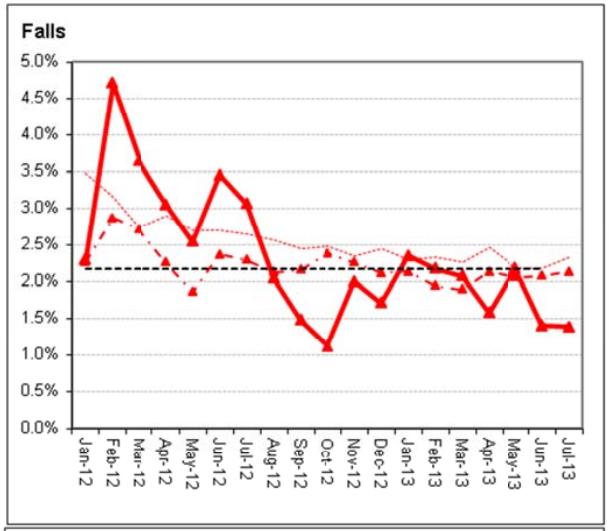
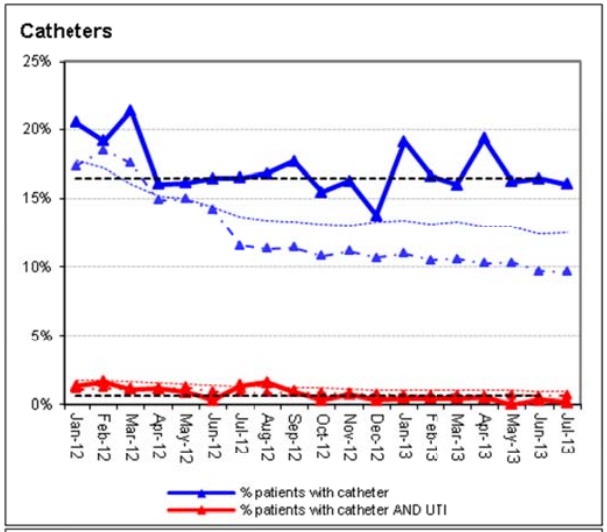
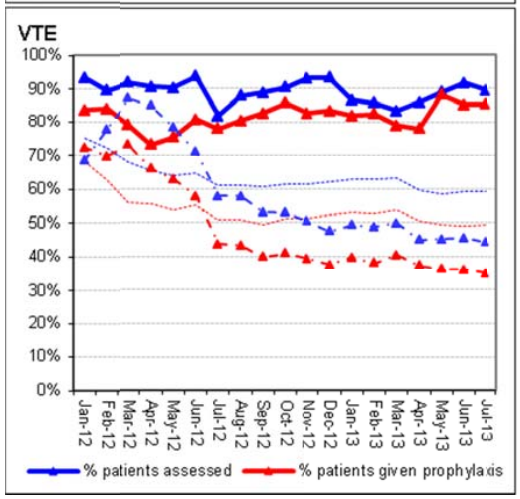
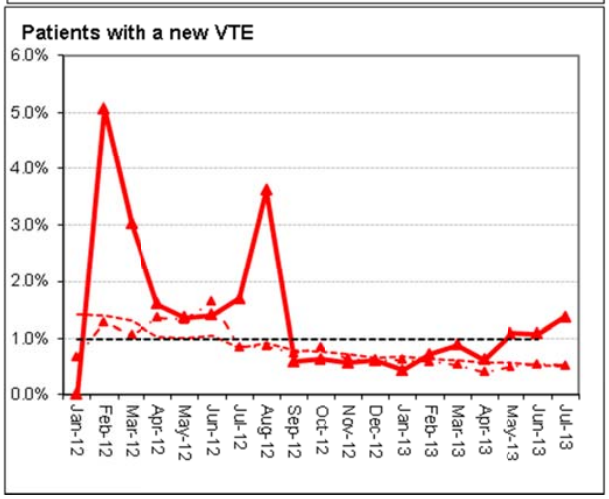
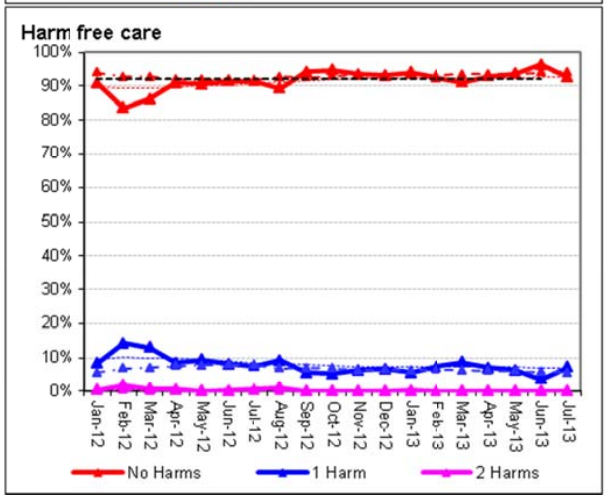










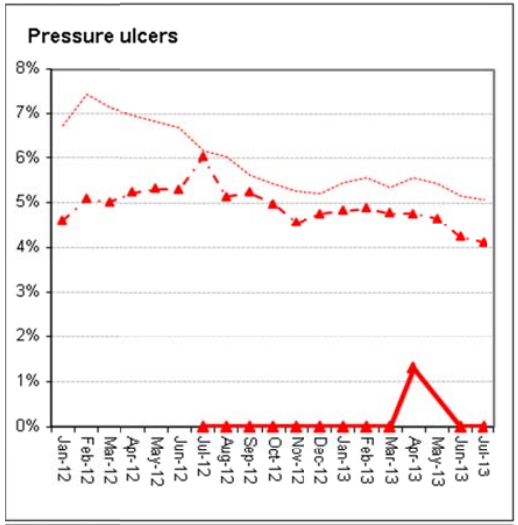


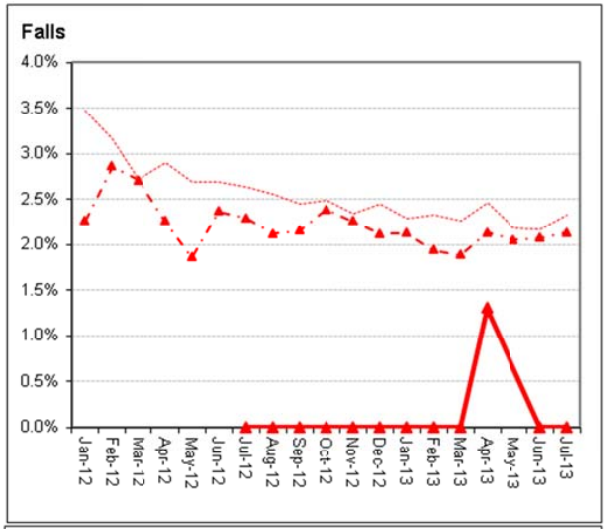
Safety Thermometer Results Dashboard

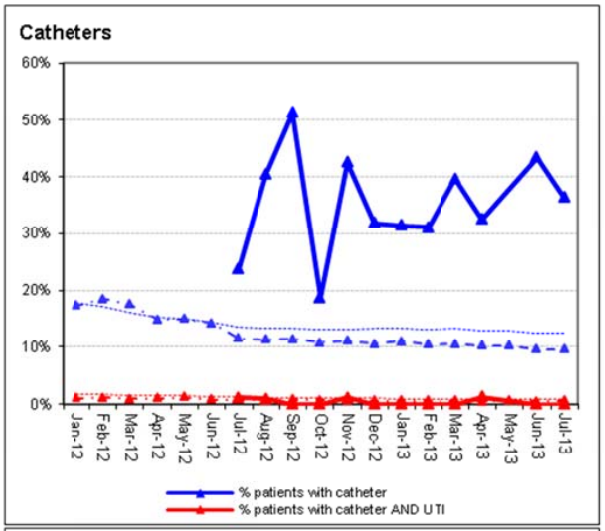
Step 1: select SHA

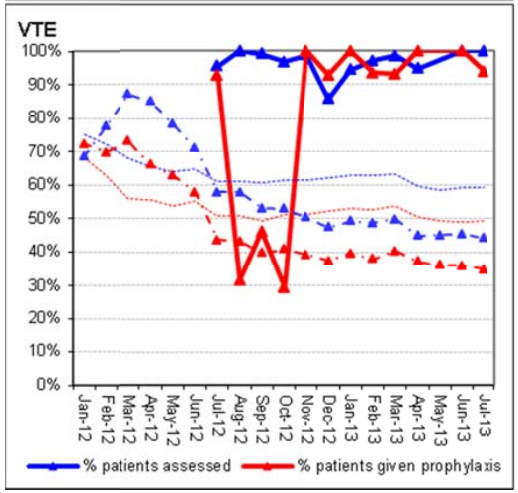
Step 2: select organisation

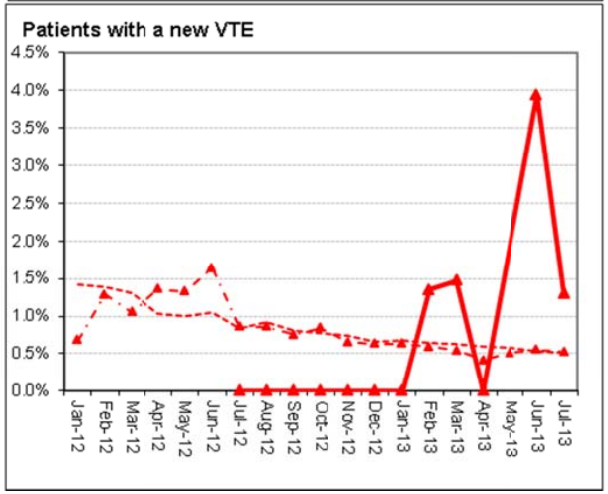
Total number of patients at selected organisation surveyed from Jan-2012 to date: **5,551**

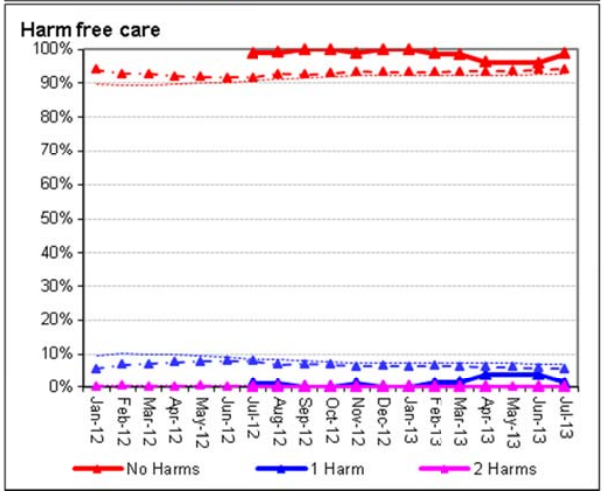












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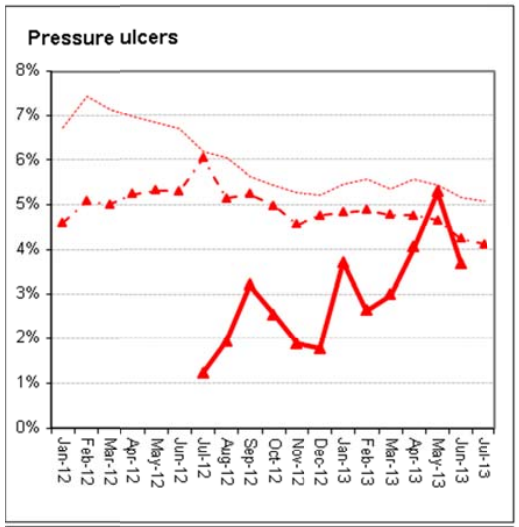

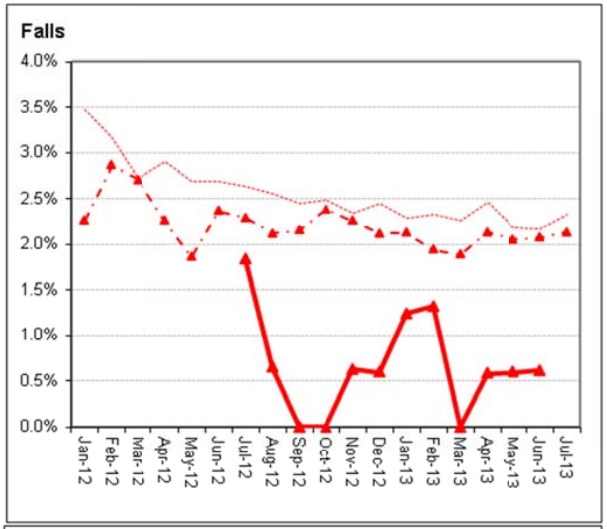

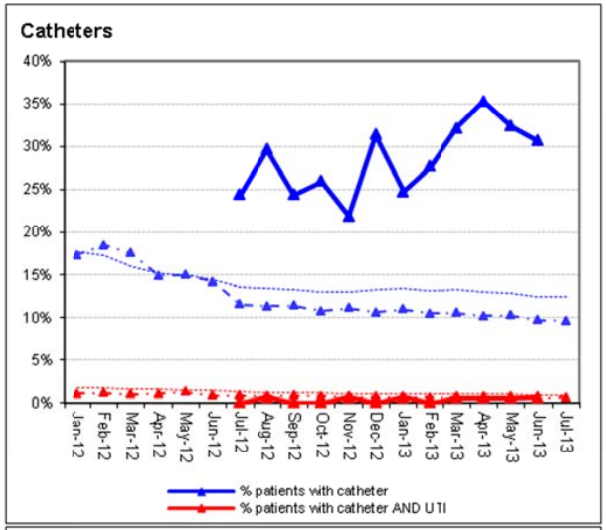

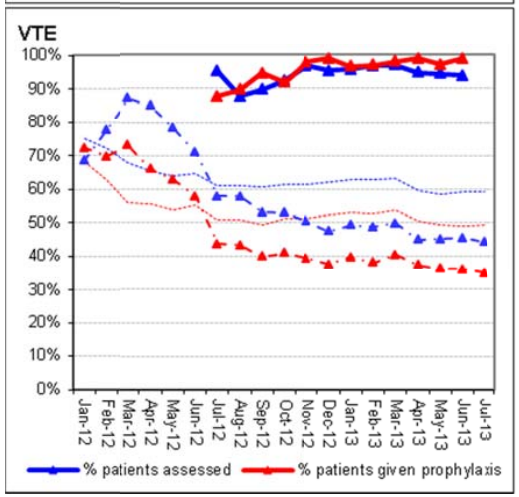

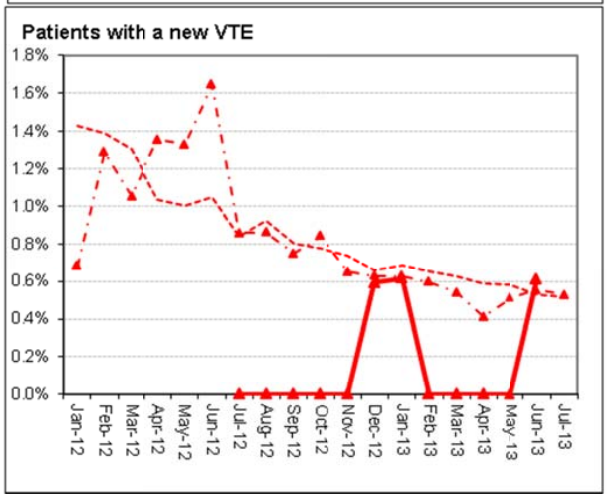

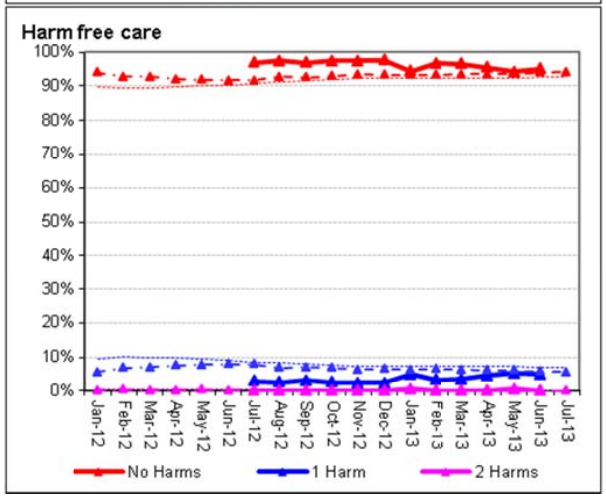

Safety Thermometer Results Dashboard

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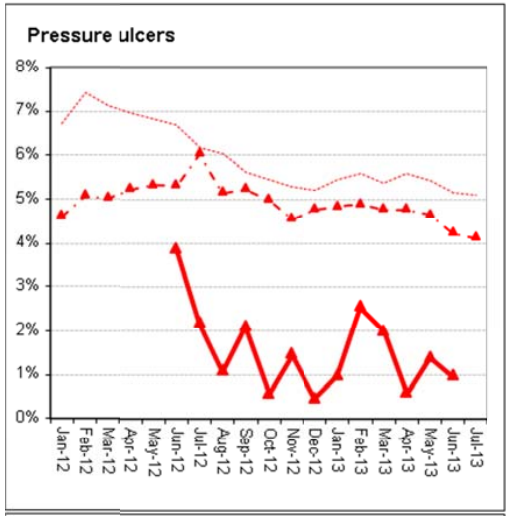
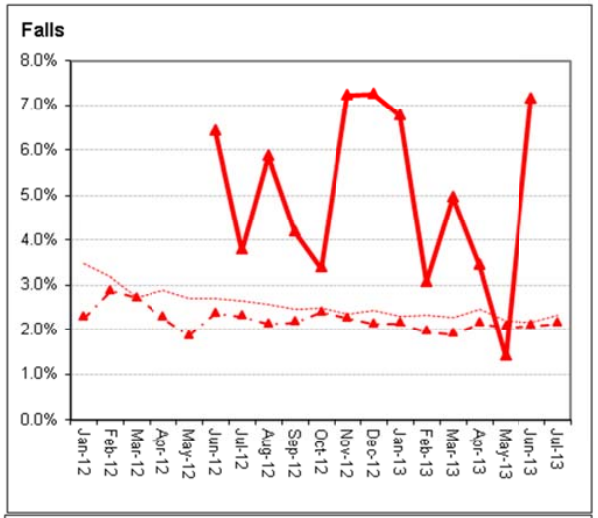
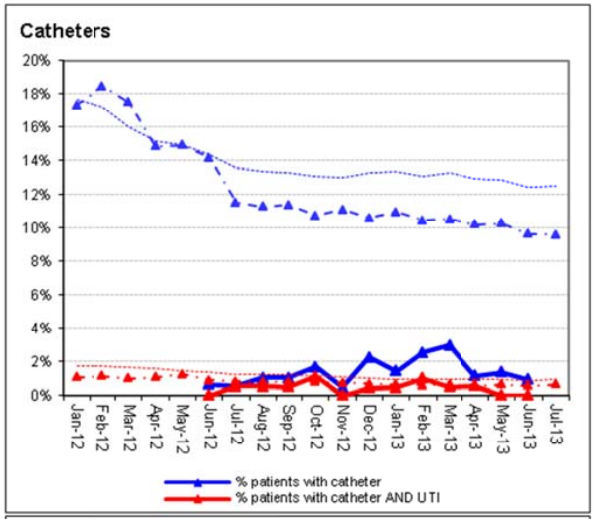
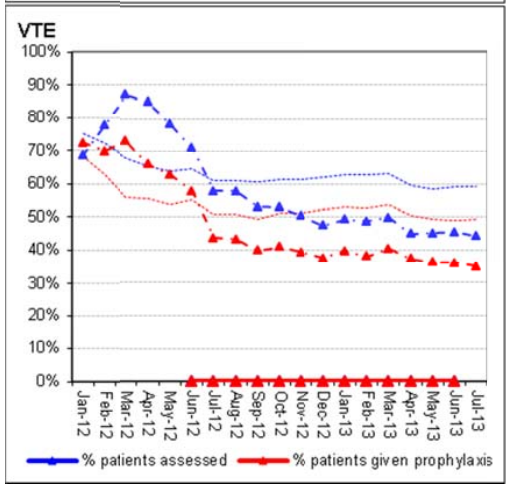
Step 2: select organisation

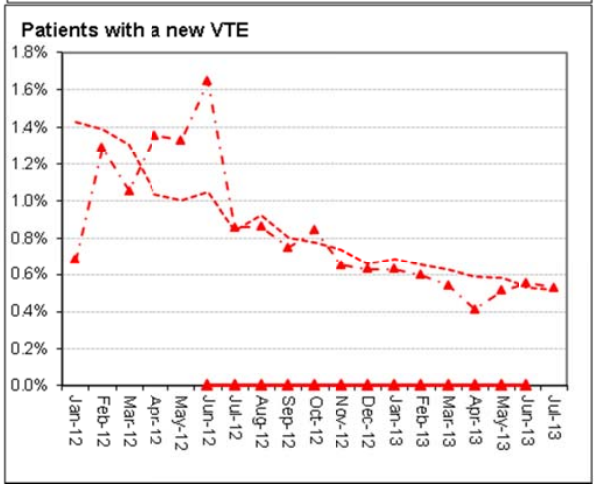
Total number of patients at selected organisation surveyed from Jan-2012 to date: **5,551**

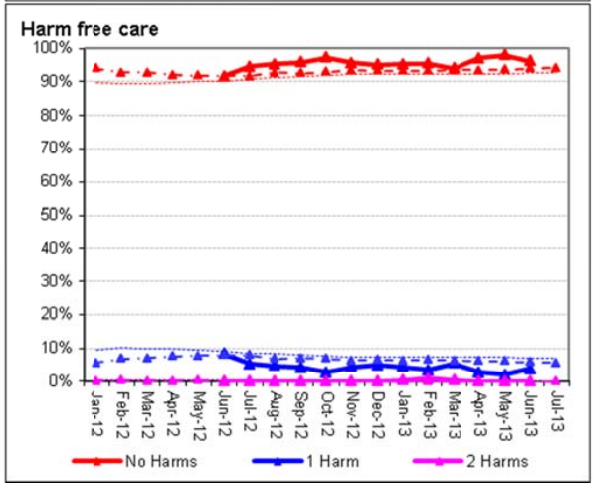












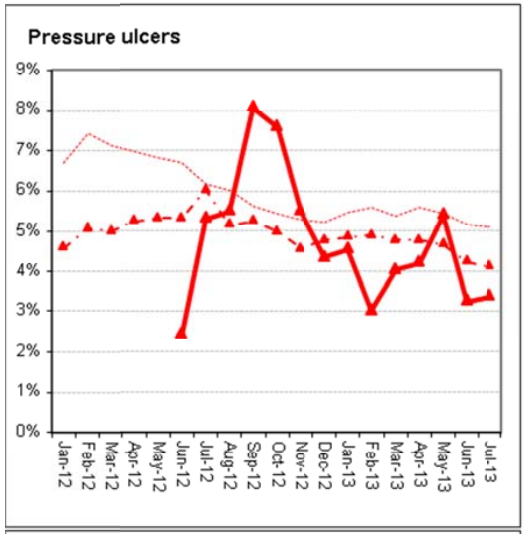
NHSSafety Thermometer – Liverpool Community Health

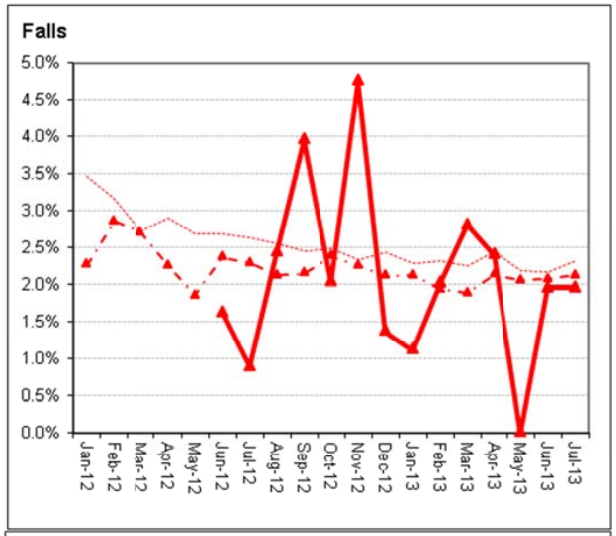
Safety Thermometer Results Dashboard

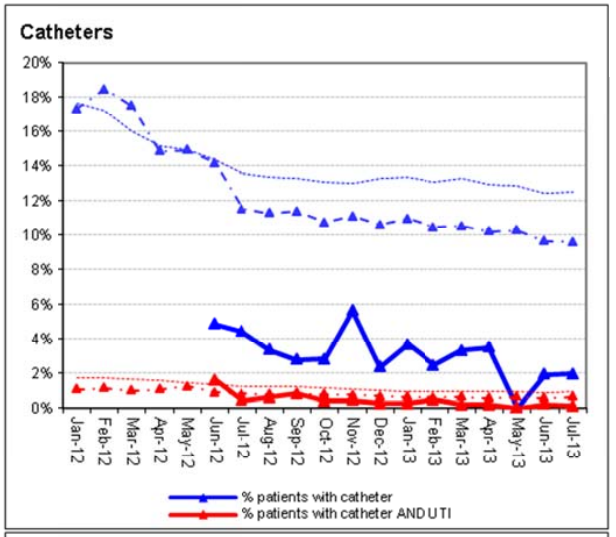
Step 1: select SHA

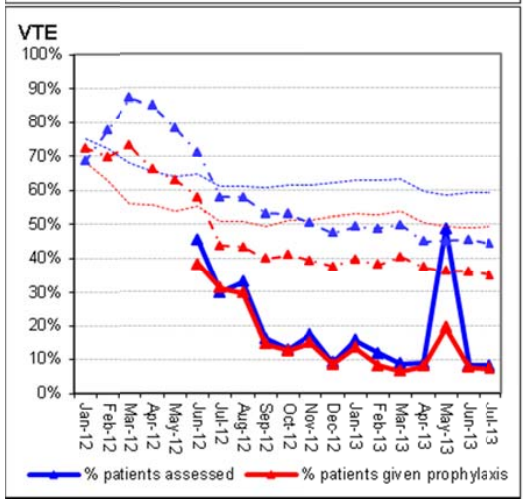
Step 2: select organisation

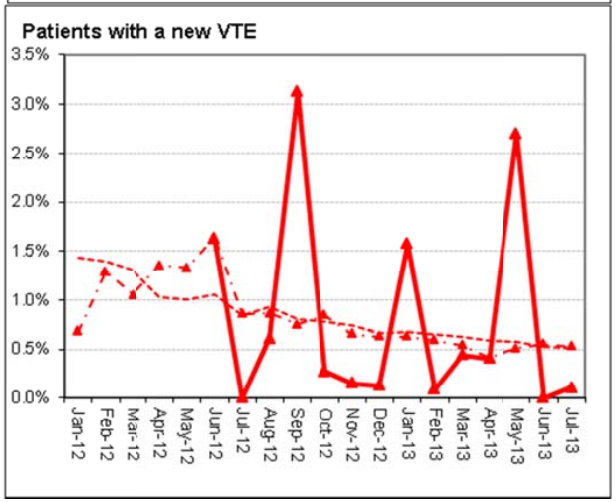
Total number of patients at selected organisation surveyed from Jan-2012 to date: **5,551**

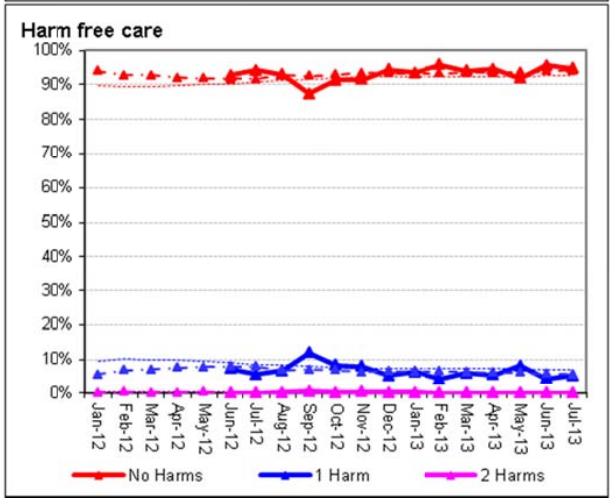












Appendix 2. National Dementia Scheme

Screening for Dementia	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	2013/14
St Helens & Knowsley Hospital	91.9%	90.3%	91.7%	-	-	-	-	-	-	-	-	-	91.3%
Liverpool Heart & Chest Hospital	100.0%	94.4%	100.0%	-	-	-	-	-	-	-	-	-	98.0%
Aintree University Hospital	37.4%	27.9%	46.1%	-	-	-	-	-	-	-	-	-	35.6%
Liverpool Womens Hospital	100.0%	*	*	-	-	-	-	-	-	-	-	-	100.0%
The Walton Centre	87.5%	100.0%	100.0%	-	-	-	-	-	-	-	-	-	95.2%
Royal Liverpool & Broadgreen Hospital	45.0%	43.0%	42.9%	-	-	-	-	-	-	-	-	-	43.7%
Southport & Ormskirk Hospital	13.3%	16.5%	18.2%	-	-	-	-	-	-	-	-	-	15.8%
Warrington & Halton Hospital	90.4%	92.9%	-	-	-	-	-	-	-	-	-	-	91.7%

Assessed for Dementia	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	2013/14
St Helens and Knowsley Hospital	94.4%	98.5%	97.8%	-	-	-	-	-	-	-	-	-	96.7%
Liverpool Heart and Chest	100.0%	*	100.0%	-	-	-	-	-	-	-	-	-	100.0%
Aintree University Hospital	81.0%	89.5%	84.2%	-	-	-	-	-	-	-	-	-	84.7%
Liverpool Womens Hospital	*	*	*	-	-	-	-	-	-	-	-	-	*
The Walton Centre	*	*	*	-	-	-	-	-	-	-	-	-	*
Royal Liverpool and Broadgreen	60.0%	58.0%	58.0%	-	-	-	-	-	-	-	-	-	58.7%
Southport and Ormskirk Hospital	16.7%	66.7%	66.7%	-	-	-	-	-	-	-	-	-	33.3%
Warrington and Halton Hospital	16.1%	67.7%	-	-	-	-	-	-	-	-	-	-	41.9%

Referred	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	2013/14
St Helens and Knowsley Hospital	96.0%	94.7%	88.9%	-	-	-	-	-	-	-	-	-	93.5%
Liverpool Heart and Chest	80.0%	*	100.0%	-	-	-	-	-	-	-	-	-	85.7%
Aintree University Hospital	100.0%	100.0%	100.0%	-	-	-	-	-	-	-	-	-	100.0%
Liverpool Womens Hospital	*	*	*	-	-	-	-	-	-	-	-	-	*
The Walton Centre	*	*	*	-	-	-	-	-	-	-	-	-	*
Royal Liverpool and Broadgreen	*	*	*	-	-	-	-	-	-	-	-	-	*
Southport and Ormskirk Hospital	*	100.0%	100.0%	-	-	-	-	-	-	-	-	-	100.0%
Warrington and Halton Hospital	100.0%	100.0%	-	-	-	-	-	-	-	-	-	-	100.0%

Appendix 3. Quality Risk Profiles

Due to size of reports, all reports have been emailed to chief nurse on 30.08.2013. A summary of the providers achievement against QRP can be found within key concerns section and in provider dashboard report.

CQUIN Scheme: **Friends and Family (Inpatients)**

Catchment: **Cheshire and Merseyside Providers (Inc England Average)**

Response Rate

All providers across England were set a target to achieve a 15% response rate for Q1 13/14, all but one of the main Cheshire and Merseyside providers achieved this target. Although Liverpool Women's Hospital failed to achieve 15% overall in Q1 13/14 they did achieve 37.5% in June 2013.

The following providers are reported within the top 20% of reporters across England:

- Fairfield Independent Provider – **48.1%** Response Rate
- Liverpool Heart and Chest – **34.7%** Response Rate

The following providers are reported within the bottom 20% of reporters across England:

- Royal Liverpool and Broadgreen Hospital – **17%** Response Rate.
- Liverpool Women's Hospital – **14.7%**

Test Score

The average test score reported across England stood at 73 for Q1 13/14, All but three providers in Cheshire and Merseyside achieved a higher or similar test score compared to the England average.

The following Cheshire and Merseyside main providers are reported within the top 20% of reporters across England:

- Liverpool Women's Hospital - **85**
- Liverpool Heart and Chest Hospital - **91**
- Nuffield Health - **91**
- Fairfield Hospital – **95**

The following Cheshire and Merseyside main providers were reported within the bottom 20% of reporters across England:

- Royal Liverpool and Broad green Hospital - **57**
- Southport and Ormskirk Hospital - **60**

Test Score Categories

Additional analysis has been included to provide further insight in to provider test scores. The following formula is used to calculate Friends and Family Test Score:

Proportion of patients extremely likely to recommend	Divided by	The total number of responses	Multiple by 100	Numerator
Proportion of patients who would not recommend (Neither likely nor unlikely) and Extremely unlikely	Divided by	The total number of responses	Multiple by 100	Denominator

Test Score = Denominator (Minus) Numerator

In Q1 13/14 the England average for patients stating they were extremely likely to recommend the provider as a place to receive treatment stood at 75%. The following providers are reported within the top 20% of reporters:

- Fairfield Hospital – **96.2%**
- St Helens and Knowsley Hospital – **81.7%**

- The Walton Centre – **84.5%**

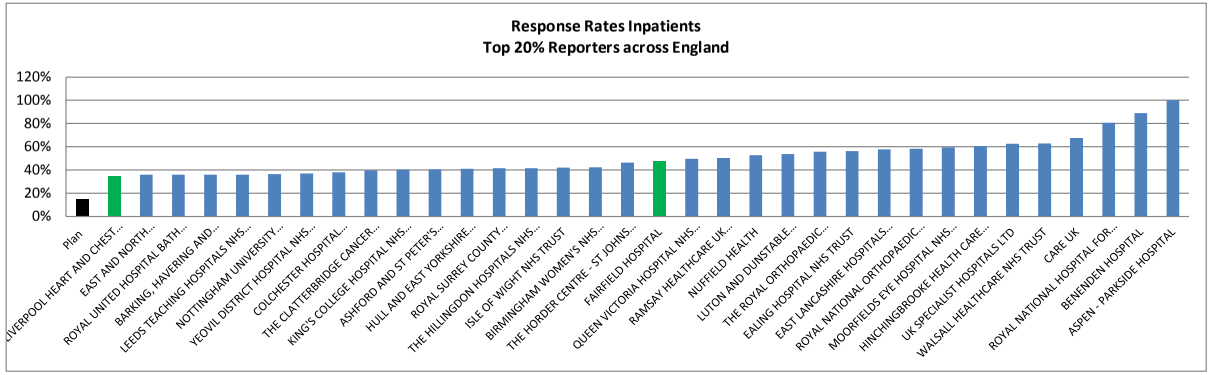
For the same period the England average for patients stating they were extremely unlikely to recommend the provider stood at 1%, the following providers are reported within the bottom 20% of reporters across England;

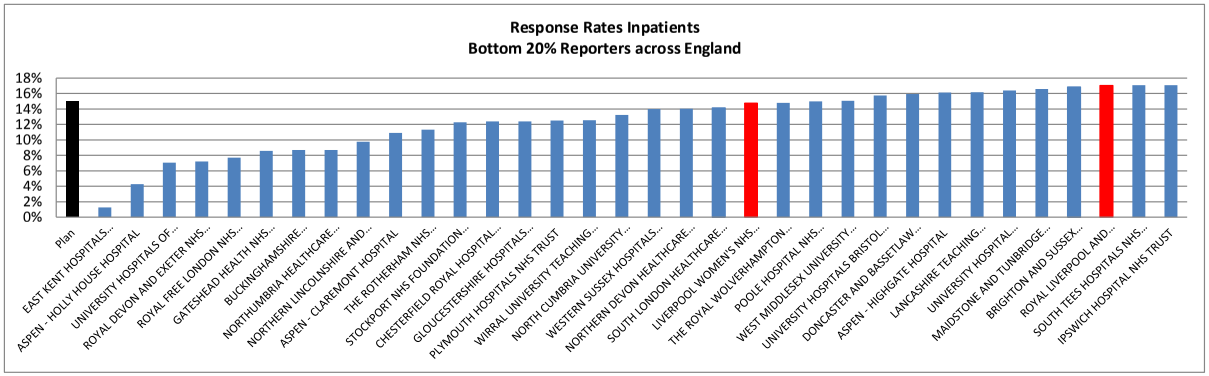
- Liverpool Women's Hospital – **3.4%**
- Southport and Ormskirk Hospital – **2.3%**
- Wirral University Hospital – **2.4%**

Response Rates (Inpatient) — Within the Top 20% of reporters nationally

Main Providers — Within the bottom 20% of reporters nationally

Provider	Apr-13	May-13	Jun-13	YTD
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	23.4%	31.4%	32.2%	29.0%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	24.0%	27.6%	44.4%	31.7%
FAIRFIELD HOSPITAL	53.8%	48.1%	42.9%	48.1%
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	42.4%	30.8%	31.3%	34.7%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	5.8%	0.8%	37.5%	14.7%
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	35.3%	31.1%	32.9%	33.0%
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	16.3%	19.2%	15.5%	17.0%
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	23.2%	24.5%	27.0%	24.9%
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	19.9%	21.7%	29.4%	23.7%
THE WALTON CENTRE NHS FOUNDATION TRUST	21.6%	23.7%	17.8%	21.1%
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	20.6%	18.6%	24.3%	21.1%
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	7.7%	11.9%	18.3%	12.5%
England Average	**25.7%**	**27.8%**	**30.3%**	**27.8%**

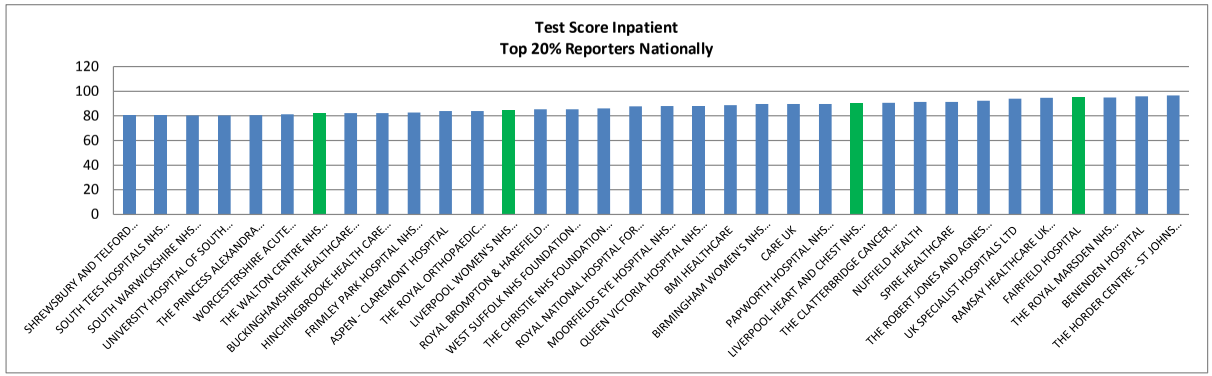


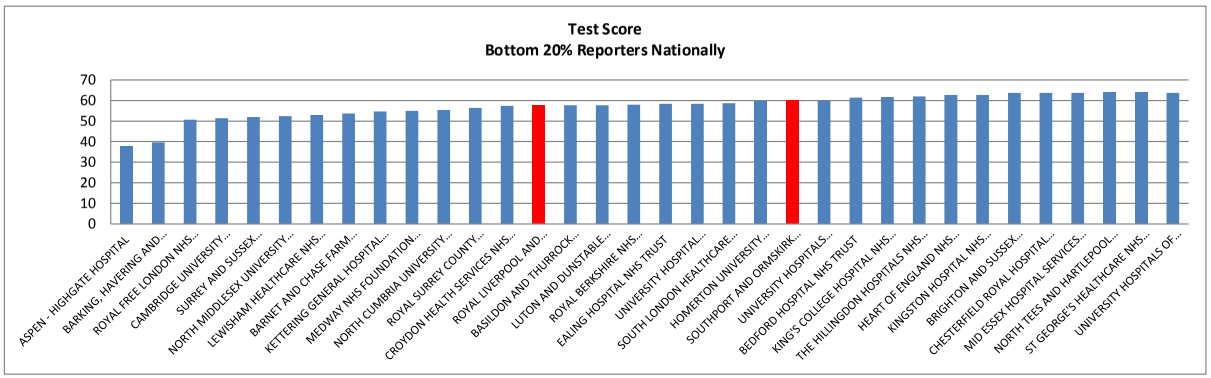


Test Score Inpatients — Within the Top 20% of reporters nationally

Main Providers — Within the bottom 20% of reporters nationally

Provider	Apr-13	May-13	Jun-13	Trend	YTD
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	57	63	52		57
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	55	66	59		60
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	77	66	57		67
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	69	75	75		73
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	80	76	80		79
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	84	74	79		79
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	82	76	80		79
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	79	82	77		79
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	93	100	61		85
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	89	90	93		91
NUFFIELD HEALTH	91	91	92		91
FAIRFIELD HOSPITAL	100	85	100		95
England Average	**72**	**73**	**73**		**73**





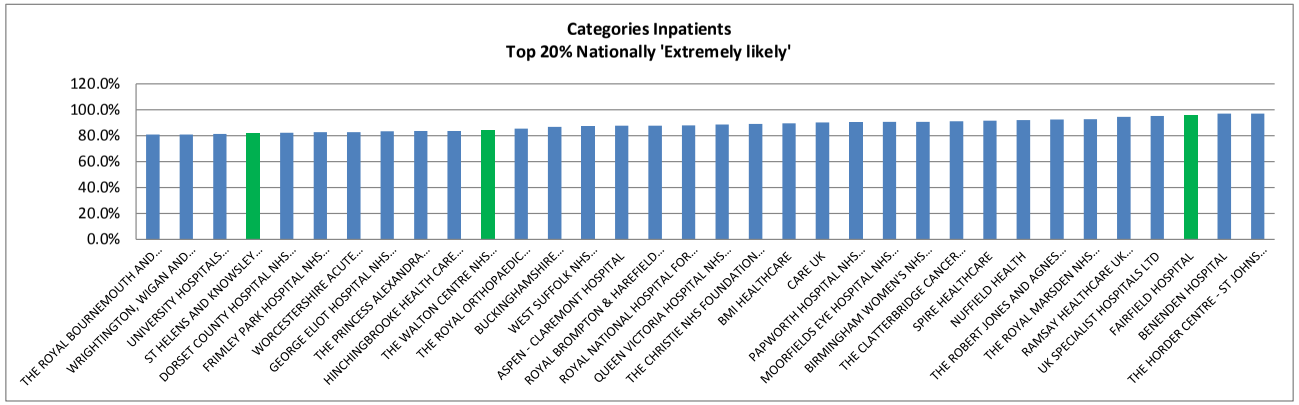
Test Score Categories Inpatients

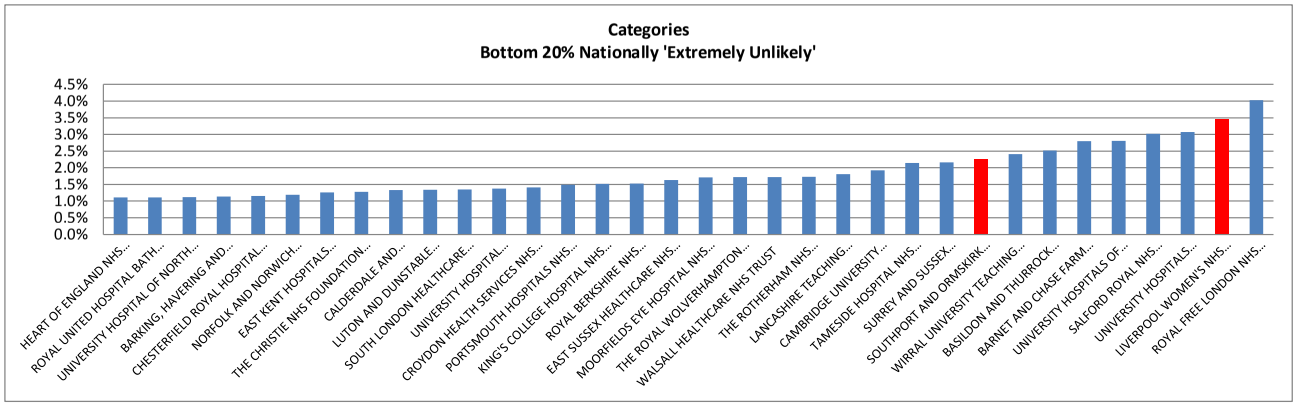
Main Providers

Within the Top 20% of reporters nationally

Within the bottom 20% of reporters nationally

Row Labels	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	80.3%	17.3%	0.7%	0.5%	0.6%	0.6%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	76.8%	15.6%	1.6%	0.2%	0.2%	5.7%
FAIRFIELD HOSPITAL	96.2%	3.8%	0.0%	0.0%	0.0%	0.0%
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	79.7%	7.4%	0.2%	0.3%	0.2%	12.2%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	70.7%	13.8%	1.7%	4.3%	3.4%	4.3%
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	76.4%	19.5%	2.5%	0.6%	0.7%	0.4%
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	64.0%	27.2%	3.6%	2.7%	0.8%	1.7%
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	68.9%	19.3%	4.5%	3.0%	2.3%	1.9%
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	81.7%	14.9%	1.8%	0.5%	0.8%	0.3%
THE WALTON CENTRE NHS FOUNDATION TRUST	84.5%	8.6%	0.9%	2.6%	0.9%	2.6%
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	77.7%	16.7%	1.1%	0.5%	0.3%	3.7%
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	67.9%	15.3%	5.6%	1.0%	2.4%	7.8%
England Average	**75.0%**	**19.0%**	**2.0%**	**1.0%**	**1.0%**	**2.0%**





CQUIN Scheme: **Friends and Family (A&E)**

Catchment: **Cheshire and Merseyside Providers (Inc England Average)**

Response Rate

All providers across England were set a target to achieve 15% response rate for Q1 13/14, Although the majority of providers failed to achieve 15% overall. All but two providers reported an increase within June 2013.

The following providers failed to achieve 15% throughout Q1 13/14:

- Royal Liverpool and Broadgreen Hospital – **2.3%** (Bottom 20% of reporters nationally)
- Warrington and Halton Hospital – 3.4%

The following providers failed to achieve 15% overall in Q1 13/14, however are reported within the top 20% of reporters in England.

- Aintree University Hospital – **13.8%**
- Mid Cheshire Hospital – **15.3%**

Test Score

The average test score reported across England stood at 53 for Q1 13/14, Four of the 9 main Cheshire and Merseyside providers achieved a test score higher than the England average.

The following Cheshire and Merseyside main providers are reported within the top 20% of reporters across England:

- St Helens and Knowsley Hospital - **70**
- Countess of Chester Hospital - **74**

The following provider was reported within the bottom 20% of reporters across England:

- Wirral University Hospital - **10**

Test Score Categories

Additional analysis has been included to provide further insight in to provider test scores. The following formula is used to calculate each providers test score:

Proportion of patients extremely likely to recommend	Divided by	The total number of responses	Multiple by 100	Numerator
Proportion of patients who would not recommend (Neither likely nor unlikely) and Extremely unlikely	Divided by	The total number of responses	Multiple by 100	Denominator

Test Score = Denominator (Minus) Numerator

In Q1 13/14 the England average for patients stating they are extremely likely to recommend the provider's A&E department to friends and family stood at 75%. The following providers are reported within the top 20% of reporters:

- Countess of Chester Hospital – **75.8%**
- St Helens and Knowsley Hospital – **78.7%**

For the same period the England average for patients stating they were extremely unlikely to recommend the provider's A&E department to friends and family stood at 1%, the following providers are reported within the

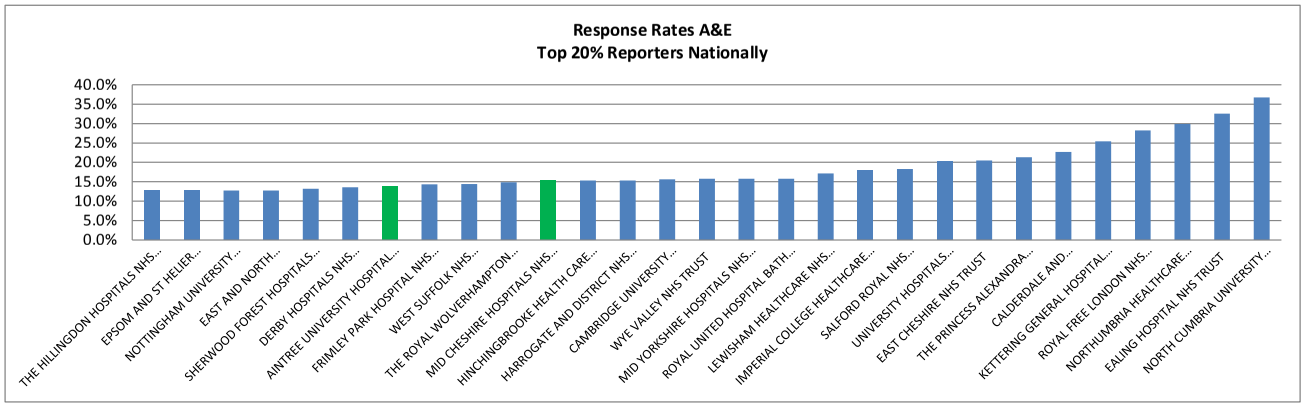
bottom 20% of reporters;

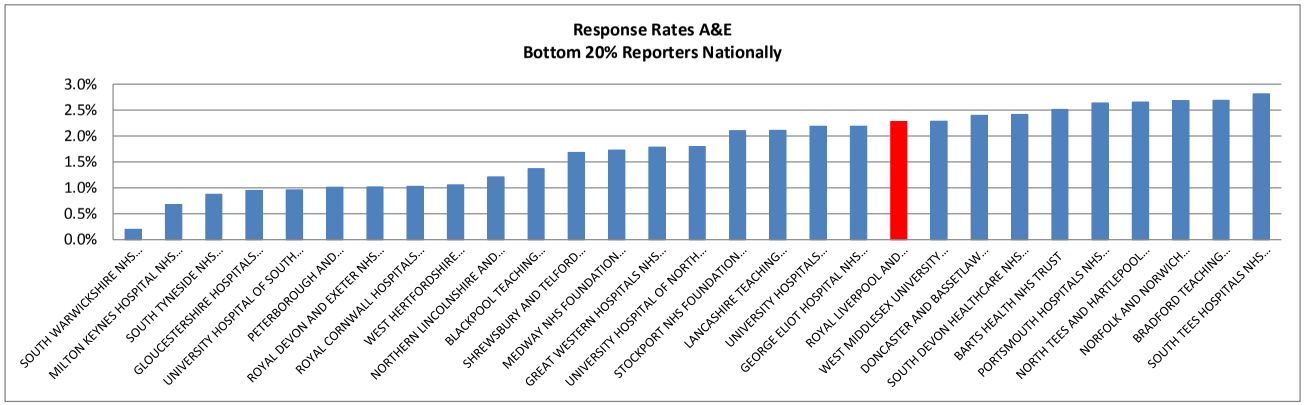
- Wirral University Hospital – **12.6%**
- Southport and Ormskirk Hospital **– 6.2%**

Response Rates (A&E) — Within the Top 20% of reporters nationally

Main Providers — Within the bottom 20% of reporters nationally

Provider	Apr-13	May-13	Jun-13	YTD
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	3.4%	1.0%	2.5%	2.3%
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	2.9%	1.9%	5.5%	3.4%
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	3.0%	5.3%	10.1%	6.2%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	0.8%	2.2%	17.1%	6.6%
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	4.6%	5.9%	15.4%	8.6%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2.4%	1.4%	21.8%	8.6%
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	12.5%	12.1%	12.5%	12.4%
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	9.9%	9.9%	21.6%	13.8%
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	11.4%	17.4%	17.4%	15.3%
England Average	**5.8%**	**7.9%**	**10.7%**	**8.1%**

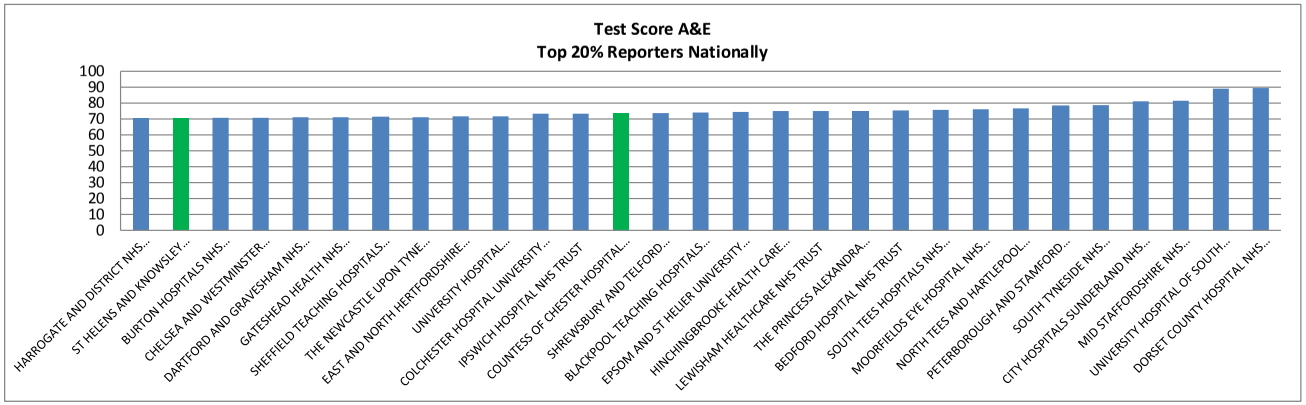


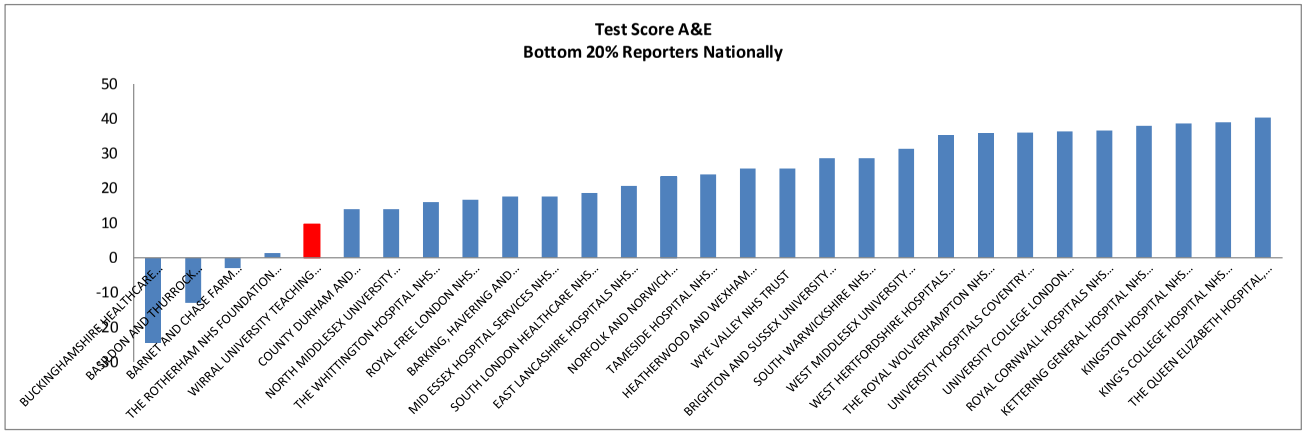


Test Score (A&E) Within the Top 20% of reporters nationally

Main Providers Within the bottom 20% of reporters nationally

Provider	Apr-13	May-13	Jun-13	Trend	YTD
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	10	-15	34		10
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	64	27	37		43
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	79	0	58		46
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	51	49	38		46
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	46	57	50		51
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	63	52	54		56
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	57	65	64		62
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	64	68	79		70
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	72	72	77		74
England Average	**50**	**53**	**56**		**53**

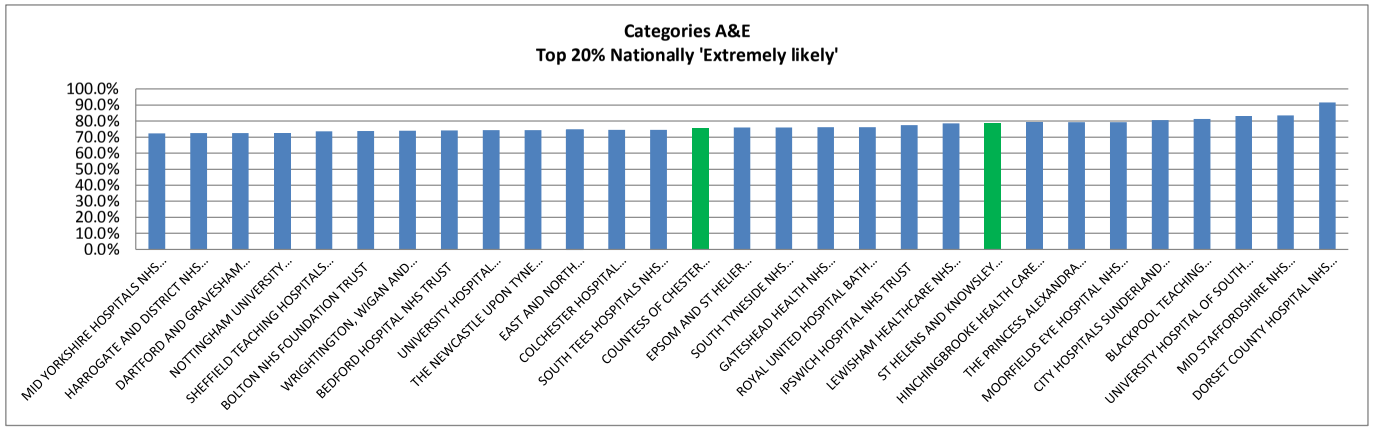


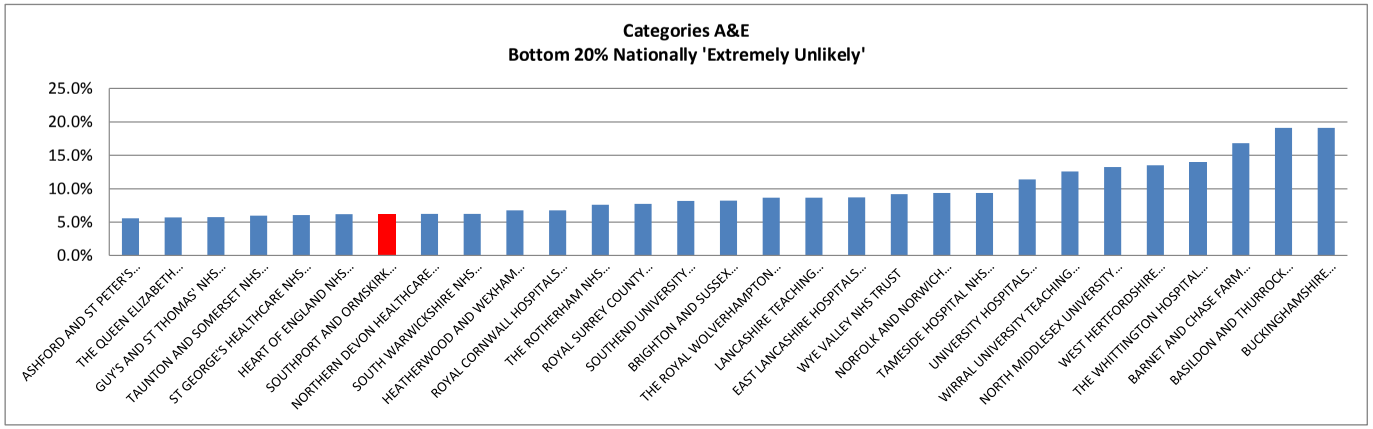


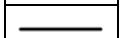
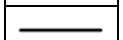
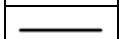
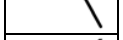
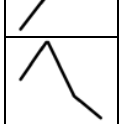
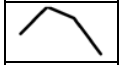
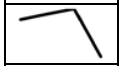
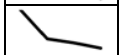
Test Score Categories (A&E) — Within the Top 20% of reporters nationally

Main Providers — Within the bottom 20% of reporters nationally

Row Labels	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	43.6%	21.7%	5.8%	7.3%	12.6%	9.1%
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	54.2%	32.0%	4.3%	3.4%	3.7%	2.4%
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	60.8%	27.8%	4.1%	5.1%	2.2%	0.0%
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	62.2%	19.8%	4.5%	1.3%	4.5%	7.7%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	66.1%	22.5%	2.8%	1.8%	5.5%	1.4%
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	66.1%	15.2%	6.0%	4.2%	6.2%	2.4%
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	68.9%	23.1%	3.3%	1.8%	2.0%	0.9%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	75.8%	17.0%	0.9%	0.9%	1.0%	4.3%
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	78.7%	15.7%	0.8%	1.9%	2.6%	0.4%
England Average	**62.4%**	**23.8%**	**4.0%**	**2.5%**	**3.6%**	**2.5%**





Ref	Area	Indicator	Plan	Apr-13	May-13	Jun-13	Jul-13	Trend
CB_B17	Mixed Sex Accommodation	Sleeping accommodation Breach	0	0	0	0	0	
	Breastfeeding	Infants being breastfed at 6–8 weeks	TBA	29.4%	30.5%	29.8%	30.1%	
KPI_22	Infection Control	MRSA total cases reported in month *Bed based services only	0	0	0	0	0	
KPI_23		Cdiff total cases reported in month *Bed based services only	0	0	0	0	0	
KPI_24		MRSA Screening for all relevant admissions into intermediate care	100%	100.0%	100.0%	100.0%	100.0%	
KPI_25		Assessment of patients on admission to intermediate care bed for C diff risk	100%	100.0%	100.0%	100.0%	100.0%	
KPI_26		Isolation of intermediate care patients with known or suspected C Diff within 4 hours	100%	100.0%	100.0%	100.0%	100.0%	
KPI_27	Treatment Rooms	Patients offered appointment time within 2 weeks from referral received by the service, unless deferred due to patient request. This is dependent on the clinical need of the	95%	-	-	-	-	
KPI_28	TB Nurses	Appropriate patients with TB receive assessment and a care/treatment plan within 2 working days from point of referral	95%	99.7%	100.0%	100.0%	100.0%	
KPI_29	Discharge Summaries	Discharge Summaries to be received by the patients GP within 24 hours for all patients admitted and discharged from a community provider setting.	95%	100.0%	100.0%	100.0%	TBC	
KPI_31		Patients to have MDT review within 4 working days of admission into community provider settings	90%	100.0%	100.0%	100.0%	TBC	
KPI_32		Patients to receive a copy of their Discharge Summary on day of discharge from a community provider setting.	95%	100.0%	100.0%	100.0%	TBC	
TCS_05	HPV; The percentage of 12/13-year-old girls who receive all 3 doses of the human papilloma virus (HPV) vaccination for cervical cancer;	HPV; Dose 1	95%	94.7%	94.7%	94.7%	95.1%	
TCS_05		HPV; Dose 2	95%	93.7%	93.9%	94.2%	94.2%	
TCS_05		HPV; Dose 3	95%	54.9%	88.5%	91.0%	92.6%	
TCS_20	Delayed Transfers of Care	The number of bed days lost due to patients whose discharge or transfer from community hospital is delayed, as a percentage of the total bed days available	5%	10%	13.70%	8.40%	6.3%	
TCS_33	Rate of cancelled appointments	The percentage of cancellations by provider services of all specialties contacts in a contracted month, in a clinic setting.	2%	1.71%	4.49%	1.88%	2.50%	
TCS_34	Rate of 'did not attends'	The percentage of appointments that were 'did not attends' (DNAs) in all specialties contacts in a contracted month, in a clinic setting.	5%	6.73%	7.30%	7.06%	6.30%	
TCS_35a	Home Equipment - Priority 1	The percentage of completed priority 1 referrals for home equipment within 2 working days.	85%	76.3%	88.25%	98.87%	-	
TCS_35b	Home Equipment - Priority 2	The percentage of completed priority 2 referrals for home equipment within 7 working days.	85%	91.4%	100.0%	97.7%	-	
HV_01	Health Visitors	Increase in the number of Health Visitors	116.7	51.3	49.1	48.8	48.4	
		Smoking status recorded	95%	-	-	-	-	

Ref	Area	Indicator	Plan	Apr-13	May-13	Jun-13	Jul-13	Trend
KPI_06	Child immunisation take-up;	Smokers offered smoking intervention advice	95%	-	-	-	-	———
		Smokers offered referral to stop smoking specialist clinic	50%	-	-	-	-	———

Quality Compliance Dashboard

Compliant
Partial Compliant
Non compliant

To note all Bi-Annual and Annual indicators have been hidden due to information not yet being available

		Provider				CMCSU	CCG
Ref	**Local Quality Compliance Indicators**	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**	**Validated Rag Rating**	**Overall rating**
Exception Reporting							
PS02	Provider to respond to any in year alerts or concerns and provide assurance of appropriate systems in place to demonstrate compliance with essential standards of quality and safety as outlined by CQC						
PS04	Serious Untoward Incidents: Actions plans produced as a result of SUI investigations and are executed within the timescales set by the reporting organisation.						
PS06	Statutory Notices - The Trust must notify Local Commissioner within 48 hours of receipt of any statutory improvement notice that is served on the Trust from External Organisations						
PS11	NHS Litigation Authority (NHSLA) Assessment Outcome - Report of outcomes of informal visits by NHSLA for trusts preparing for assessment and reassessment including NHSLA accreditation awarded to trust (Level 1,2,3).	Annual Report in Schedule					
Monthly Reporting		**Apr-13**	**May-13**	**Jun-13**	**Jun-13**	**Validated Rag Rating**	**Overall rating**
NAT01	Failure to publish Formulary						
NAT02	Duty of Candour						
PS01	Provider to maintain registration with routine restrictive conditions as agreed by CQC						
PS03	Serious Untoward Incidents: Investigation reports relating to incidents are received by Local Commissioner within 45 working days or agreed extension.						
Quarterly Reporting				**Q1 13/14**		**Validated Rag Rating**	**Overall rating**
IND02	Directory of service for NHS 111			Confirmation needed formally about sub indicators which are relavant to LCH. Jayne Hulme (CCG) and Johnathan Durrant (LCH) discussed.			
PS05	Low to Moderate Incidents: Evidence of timely reporting, analysing and learning from low to moderate incidents resulting in demonstrable service improvements. Compliance with required elements of reports submitted by trust to commissioner.						
PS07	Quality Risk Profiles - Trust to respond to commissioner with details of actions in place to address latest quality risks published within CQC monthly QRP reports including.						
PS08	Central Alerting System (CAS) - Trust to provide a quarterly update of actions in place to close alerts reported as on-going within the quarter. This indicator links to CAS indicator within performance						
PS09	Central Alerting System (CAS) - On selection of closed alerts details of actions taken by the provider in order to satisfy compliance and demonstrate appropriate management and consequent completion of safety notice.						

Quarterly Reporting			Q1 13/14		Validated Rag Rating	Overall rating
PS13	Trust to submit the HCAI Assurance Framework to the Commissioning Organisation within the agreed timescales.					
PS14	Health & Social Care Learning Disabilities Self Assessment		See Exception			
PS15	Complaints and Patient Feedback provider compliance with required elements of reports submitted by trust to commissioner.					
PS16	Mental Capacity Act - Appropriate trust staff to be trained and evidence provided by the Trust that training is targeted at staff involved in clinical decision making		See Exception			
CE01b	Clinical Audit Programme; 2. Summary of audit outcomes and changes made/planned					
CE04a	Military and Veterans Health; Compliance with 'The Ministry of Defence/NHS Transition Protocol' Pages 13 & 14 as outlined in 2012/13 Operating Framework.		As per previous reporting, LCH requirement is to monitor complaints from Military Complaints - this is rated as at present			
CE04b	Military and Veterans Health;Develop systems to identify secondary care contract activity by service (e.g.mental health), specialty/HRG,value, provider in order to allow 2013/14 contracts to separately identify shadow NCB/CCG responsibilities.					
CE04c	Military and Veterans Health; Provide priority treatments including appropriate mental health treatment for veterans with conditions related to their service, subject to the clinical needs of others.					
CE04d	Military and Veterans Health; Identify a named Veteran Lead with the trust					
PE01	National Staff Survey; Action plans relating to latest annual survey. Review of quarterly action plans in place addressing areas of non-compliance and targets in line with National Standards and Reporting. Including areas; Overall staff engagement, Staff ability to contribute towards improvements at work, Staff recommendation of the Provider as a place to work or receive treatment and Staff motivation at work					
PE04	Local patient experience surveys - Provider Wide Surveys to be undertaken over a 12 month period with a representative patient sample size and to capture equality target groups and the views of carers.					
PE07	NHS Equality Delivery System (EDS); Compliance with all elements of the EDS Framework - Provider to provide action plans to improve the score on all aspects of the EDS Framework					
Annual Reporting			**Jun-13**		**Validated Rag Rating**	**Overall rating**
CE01a	Clinical Audit Programme; 1. Clinical Audit Forward Plan					
CE03	NICE Quality Standards; Provider to demonstrate compliance with all relevant NICE Quality standards, including achievement of specified processes and structure outcomes.					
CE05	Provider Quality Account - Compliance to National Health Service (Quality Accounts) Regulations 2010. - Published by 30th June 2013					
PE03	National Inpatient Survey; Provider to demonstrate methods to improve survey results within the areas identified. Including areas; Treated with respect and dignity while in hospital, Rate of care received, Local Patient Experience Intelligence					

NOTE: Ward 35 based in Aintree Hospital continues to have 12 beds closed on due to staffing issues. This is being monitored via the Contract meeting and the Clinical Performance and Quality Group and the Trust have completed an action plan to rectify the situation. A quality 'walk around' will take place before the end of the month led by Lead Nurse Debbie Fagan.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY SEPTEMBER 2013

Agenda Item: 13/120	**Author of the Paper:** Martin McDowell Chief Finance Officer Martin.mcdowell@southseftonccg.nhs.uk Tel:0151 247 7065
Report date: 16th September 2013	

Title: Financial Performance Report

Summary/Key Issues:

This paper presents the Governing Body with an overview of the financial position for NHS South Sefton Clinical Commissioning Group. It details information in relation to the budget setting process, how the budgets link into the baseline exercise, the financial position of the CCG as at month 5, and an evaluation of risks.

Recommendation

	x
Note	x
Approve	x
Ratify	

The Governing Body is asked to receive the finance update by way of assurance, in particular, that:

- that the CCG remains on target to deliver its financial targets for 2013/14;
- that the CCG's worst case scenario is "amber-rated" in terms of additional actions required should the CCG position deteriorate

The Governing Body is also asked to approve:

- all virements that support the financial information presented in this paper; and
- that all CCG members are asked to review the information reported on the Mersey Intelligence Portal to support the data checking and validation process.

GB13/120

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			

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
September 2013

1. Executive Summary

This report outlines the budget setting process and focuses on the financial performance of the CCG at month 5. At the end of August, the CCG is £1.848m over-spent prior to the application of reserves.

The CCG is on target to achieve the planned £2.313m surplus at the end of the year. However, there are risks to achieving this and actions are required to deliver this position.

2. Introduction and Background

This paper presents the Governing Body with an overview of the financial position for NHS South Sefton Clinical Commissioning Group. It details information in relation to the budget setting process and describes the steps taken in formulating the budgets for 2013/14 along with detail of how the budgets link into the baseline exercise. The paper also provides information in relation to the financial position of the CCG as at month 5 and a risk evaluation surrounding the financial position of the CCG.

3. Budgets

Members of 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 in financial year 2013/14, with a surplus target of £2.313m.

The budget setting process for 2013/14 has been complicated by the changes in commissioning structures and the delay in agreeing contracts with a number of providers. Much of the uncertainty has now been clarified, and budgets have been revised accordingly. Budget holders have signed off the revised values at cost centre level.

Due to the values of the changes, the governing body are now asked to approve the changes in line with the scheme of delegation. All changes to budgets need to be approved in line with the scheme of delegation prior to the action of any budget virements.

Appendix 1 highlights the movements between budgets presented to the Governing Body in May and the current budgets. The main reasons for movements is predominantly due to the application of the budget setting principles (outlined in appendix 2) combined with rebasing activity budgets from original assumptions to actuals as better information is received.

Following the budget setting process, it has been possible to identify how much of the CCG spend is based on true activity and how much remains on a 60:40 fair share split with NHS Southport and Formby CCG. This is outlined in appendix 1.

Of the total spend for the CCG, 67% of the expenditure is based on activity and 33% remains on a 60:40 split. Of the areas which remain on the 60:40 split, 23% of the spend (approx. 16% community contracts and 6% Continuing Healthcare (CHC) / Learning Disability (LD)) is being

reviewed, and it is anticipated that these budgets will be revised in month 6 as new information continues to be received.

With improved information it has been possible to set budgets based on activity by CCG. This has identified an imbalance in the resources allocated between South Sefton CCG and Southport and Formby CCG. To correct this imbalance, a transfer of resources from South Sefton CCG to Southport and Formby CCG is recommended. This transfer of resource requires Governing Body approval. Further transfers of resource may be necessary as budgets are refined and more data becomes available. This is outlined in more detail in the report entitled *'NHS Allocations for CCGs'* to be presented to the Governing Body in September. The reported allocations at month 6 will be used as the baseline for future allocations. It is therefore recommended that these changes take place for inclusion in the Month 6 Accounting Period.

4. Review of Baselines

A detailed review of baselines has been carried out to analyse the split of resources between commissioner organisations. This analysis has identified a number of areas where funding has erroneously transferred to the wrong organisation. The CCG continues to engage with other commissioners to rectify the errors.

A review of budgets and baselines has also identified inaccuracies in the baseline exercise between CCGs. This has generally led to an overstated allocation for South Sefton and an understated allocation for Southport & Formby. This is outlined in more detail in the report entitled *'NHS Allocations for CCGs'*. A transfer of funding between CCGs requires Governing Body approval.

5. Our Position to Date

5.1 Month 5 Financial Performance

Please refer to Table A overleaf which shows a summary position for the CCG.

Table A: Financial Performance: Summary report to 31 August 2013

		Year to Date			End of Year	
Budget Area	**Annual Budget £000**	**YTD Budget £000**	**YTD Actual £000**	**YTD Variance £000**	**Expenditure Outturn £000**	**FOT Variance £000**
NHS Commissioned Services	161,738	67,391	68,761	1,370	165,014	3,276
Corporate and Support Services	4,567	1,903	2,006	103	5,422	855
Independent Sector	1,501	626	840	214	2,016	515
Medicines Management (Inc Prescribing)	29,819	12,425	12,728	303	29,497	(322)
Primary Care	1,260	600	555	(45)	1,303	43
Commissioning - Non NHS	16,554	6,897	6,800	(97)	16,652	98
Sub Total Prior to Reserves	**215,439**	**89,842**	**91,690**	**1,848**	**219,904**	**4,465**
Total Reserves	**16,100**	**1,911**	**62**	**(1,848)**	**11,635**	**(4,465)**
Grand Total Expenditure	**231,539**	**91,753**	**91,752**	**0**	**231,539**	**0**

		Year to Date			End of Year	
Budget Area	**Annual Budget £000**	**YTD Budget £000**	**YTD Actual £000**	**YTD Variance £000**	**Expenditure Outturn £000**	**FOT Variance £000**
RRL Analysis	**233,852**	**0**	**0**	**0**	**0**	**0**
(Surplus) / Deficit	**(2,313)**	**(962)**	**(962)**	**(962)**	**0**	**(2,313)**

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

The over spent position within operational budgets is attributable to number of items as outlined below.

NHS Commissioned Services

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

This budget is showing a year to date position of £1.37m overspend. This has been primarily caused by an over spend on Acute Commissioning in particular Aintree University Hospital NHS FT (AUH). At month 5, expenditure with AUH is £1.25m higher than planned. The largest area of overspend is day cases (£0.598m) and elective activity (£0.405m). The main specialities which are over performing within planned care are Gastroenterology Diagnostic Scopes, Trauma & Orthopaedics and Colorectal Surgery. Other areas that are over spending include High Cost Drugs and Aged Related Macular Degeneration (ARMD).

In respect of planned care over-spends, the Trust originally stated that it was driven by progress against the 18 weeks RTT standards. Although this is an important factor, the Trust has carried out further analysis, and believes that many more factors are contributing to the increased activity. CCG representatives are meeting with the Trust every 2 weeks to review causes of the over-activity on a specialty basis. The forecast assumes that the over-spend continues at the current rate.

The level of overspending at the start of the year raises some 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.

Corporate and Support Services

The CCG is currently operating within its running cost target with a year to date underspend of £0.23m and a forecasted year end position of £0.31m underspend. The under spend has arisen due to a number of vacancies.

This underspend will be used to offset an element of the forecast overspend against corporate programme costs.

Independent Sector

The Independent Sector budget is over spent by £0.214m. This over spend predominantly relates to Spire Liverpool (£0.092m), Renacres Hospital (£0.091m) and I-sight (£0.036m).

Medicines Management (Including Prescribing)

The Medicines Management budget consists of High Cost Drugs, Oxygen and Prescribing. High Cost Drugs is currently showing a breakeven year to date position, as there are a number of uncertainties in relation to the invoices received and the baseline budgets. This is explored in more detail in the risks section below (section 5).

Oxygen has a small over-spend of £7k in the year to date performance.

Prescribing is showing a year to date over spend of £0.296m. This is based on Prescription Pricing Authority (PPA) data to the end of June. The PPA also provides a forecast, which predicts a £0.340m underspend for the year. However, it is important to note that the forecast position for prescribing expenditure can change significantly in the early part of the year and there remains a significant degree of uncertainty in relation to the forecast out-turn assessment.

Primary Care

Primary Care is currently showing a year to date position of £0.045m underspent. This has been caused by underspend against locality investments for which spend plans are currently being devised. It is anticipated that the locality budget will be spent in full by the end of the financial year.

Commissioning - Non-NHS

Commissioning from Non NHS organisations is underspent by £0.097m, but there are a number of risks in relation to this area of expenditure. A large area of spend relates to Continuing Healthcare and Funded Nursing Care, where there continues to be a significant degree of uncertainty over expenditure. 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. This is explored in more detail in the risks section below.

5.2 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) advising 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 November.

Once this work has been approved by the DH, the final balance sheets will be shared with successor organisations.

6. Evaluation of Risks

The CCG has analysed the risks, and put in place plans to mitigate them. These risks have been reported these through the Finance & Resource Committee. The risk analysis is subject to scenario planning and a best, likely and worst case scenario is explored.

The CCG can achieve financial balance in its worst case scenario by instigating a number of mitigating actions. These actions are predominantly “amber-rated” as they will require co-operation from other bodies to enact.

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.

7. Recommendations

The Governing Body is asked to receive the finance update by way of assurance, in particular, that:

- that the CCG remains on target to deliver its financial targets for 2013/14;
- that the CCG's worst case scenario is "amber-rated" in terms of additional actions required should the CCG position deteriorate.

The Governing Body is also asked to approve:

- all virements that support the financial information presented in this paper; and
- that all CCG members are asked to review the information reported on the Mersey Intelligence Portal to support the data checking and validation process.

Appendices

- Appendix 1 – Revised budgets
- Appendix 2 – Budget setting principles

NHS South Sefton CCG Budget Book - Overall Summary

NHS South Sefton Clinical Commissioning Group

Cost centre Number	Cost Centre Description	Budget Holder	Finance Lead	Financial Plan : Operational Budgets APP 4 to Board			Revised Budget Setting 2013/14			Variance			Basis of budget
				Rec	Non-Rec	Total	Rec	Non-Rec	Total	Rec	Non-Rec	Total	
COMMISSIONING - NON NHS													
598506	Child and Adolescent Mental Health	Debbie Fagan	Laura Doolan	1,605	0	1,605	1,202	0	1,202	(403)	0	(403)	Activity
598596	Collaborative Commissioning	Debbie Fagan	Laura Doolan	327	0	327	320	0	320	(7)	0	(7)	60:40
598711	Community Services	Debbie Fagan	Laura Doolan	751	0	751	648	0	648	(103)	0	(103)	60:40
598682	Continuing Care	Debbie Fagan	Laura Doolan	3,202	0	3,202	3,346	0	3,346	144	0	144	60:40
598511	Dementia	Debbie Fagan	Laura Doolan	125	0	125	124	0	124	(1)	0	(1)	60:40
598691	Funded Nursing Care	Debbie Fagan	Laura Doolan	3,334	0	3,334	3,311	0	3,311	(23)	0	(23)	60:40
598721	Hospices	Debbie Fagan	Laura Doolan	1,191	0	1,191	1,221	0	1,221	30	0	30	Activity
598516	Improving Access to Psychological Therapies	Debbie Fagan	Laura Doolan	1,494	0	1,494	0	0	0	(1,494)	0	(1,494)	N/A
598726	Intermediate Care	Debbie Fagan	Laura Doolan	222	0	222	164	0	164	(57)	0	(57)	60:40
598521	Learning Difficulties	Debbie Fagan	Laura Doolan	1,884	0	1,884	1,874	0	1,874	(10)	0	(10)	60:40
598501	Mental Health Contracts	Debbie Fagan	Laura Doolan	920	0	920	900	0	900	(20)	0	(20)	60:40
598531	Mental Health Services – Adults	Debbie Fagan	Laura Doolan	875	0	875	880	0	880	5	0	5	60:40
598541	Mental Health Services - Collaborative Commissioning	Debbie Fagan	Laura Doolan	938	0	938	951	0	951	13	0	13	60:40
598551	Mental Health Services - Older People	Debbie Fagan	Laura Doolan	265	0	265	300	0	300	35	0	35	60:40
598682	Personal Health Budgets	Debbie Fagan	Laura Doolan	31	0	31	0	0	0	(31)	0	(31)	N/A
598796	Reablement	Debbie Fagan	Laura Doolan	3,223	0	3,223	1,312	0	1,312	(1,911)	0	(1,911)	60:40
	Sub-Total			**20,388**	**0**	**20,388**	**16,555**	**0**	**16,555**	**(3,833)**	**0**	**(3,833)**	
CORPORATE & SUPPORT SERVICES													
600251	Administration and Business Support (Running Cost)	Melanie Wright	Chloe Rachelle	79	0	79	107	0	107	28	0	28	60:40
600271	CEO/Board Office (Running Cost)	Fiona Clark	Chloe Rachelle	672	0	672	632	0	632	(40)	0	(40)	60:40
600276	Chairs and Non Execs (Running Cost)	Fiona Clark	Chloe Rachelle	97	0	97	125	0	125	28	0	28	60:40
600286	Clinical Governance (Running Cost)	Stephen Astles	Chloe Rachelle	151	0	151	29	0	29	(122)	0	(122)	60:40
600296	Commissioning (Running Cost)	Stephen Astles	Chloe Rachelle	1,433	0	1,433	1,647	0	1,647	214	0	214	60:40
600351	Finance (Running Cost)	Martin McDowell	Chloe Rachelle	842	0	842	1,063		1,063	221	0	221	60:40
600391	Medicines Management (Running Cost)	Brendan Prescott	Chloe Rachelle	55	0	55	77	0	77	22	0	22	60:40
598646	Commissioning Schemes (Running Cost)	Stephen Astles	Chloe Rachelle	352	0	352	0	0	0	(352)	0	(352)	60:40
	Sub-Total Running Costs			**3,680**	**0**	**3,680**	**3,680**	**0**	**3,680**	**(0)**	**0**	**(0)**	
598656	Medicines Management (Programme Cost)	Brendan Prescott	Chloe Rachelle	440	0	440	489	0	489	49	0	49	60:40
598646	Commissioning Schemes (Running Cost)	Stephen Astles	Chloe Rachelle	0	0	0	398	0	398	398	0	398	60:40
	Sub-Total Programme Costs			**440**	**0**	**440**	**887**	**0**	**887**	**447**	**0**	**447**	
	Sub-Total			**4,120**	**0**	**4,120**	**4,567**	**0**	**4,567**	**447**	**0**	**447**	
SERVICES COMMISSIONED FROM NHS ORGANISATIONS													
598576	Acute Childrens Services	Debbie Fagan	Jenny White	7,377	0	7,377	8,438	0	8,438	1,061	0	1,061	Activity

598571	Acute Commissioning	Stephen Astles	Jenny White	116,951	354	117,305	106,438	982	107,420	(10,513)	628	(9,884)	Activity
598586	Ambulance Services	Malcolm Cunningham	Jenny White	5,807	0	5,807	5,451	0	5,451	(356)	0	(356)	Activity
598756	Commissioning - Non Acute (Community)	Stephen Astles	Jenny White	13,094	0	13,094	21,106	1,080	22,186	8,012	1,080	9,092	60:40
598756	Commissioning - Non Acute (Mental Health)	Malcolm Cunningham	Jenny White	15,066	0	15,066	16,778	32	16,810	1,712	32	1,744	60:40
598756	Commissioning - Non Acute (Specialist)	Stephen Astles	Jenny White	468	1,227	1,695	16	0	16	(452)	(1,227)	(1,679)	60:40
598761	Commissioning Reserve	Stephen Astles	Jenny White	208	0	208	0	0	0	(208)	0	(208)	N/A
598616	NCAs/OATs	Stephen Astles	Adam Gamston	1,389	0	1,389	1,406	0	1,406	16	0	16	Activity
598786	Patient Transport	Stephen Astles	Adam Gamston	12	0	12	12	0	12	0	0	0	Activity
	Sub-Total			**160,372**	**1,581**	**161,953**	**159,644**	**2,094**	**161,738**	**(728)**	**513**	**(215)**	
INDEPENDENT SECTOR													
598591	Renacres	Stephen Astles	Adam Gamston	2,387	0	2,387	1,029	0	1,029	(1,358)	0	(1,358)	Activity
598591	Spire - Liverpool	Stephen Astles	Adam Gamston	609	0	609	353	0	353	(256)	0	(256)	Activity
598591	I-Sight	Stephen Astles	Adam Gamston	398	0	398	28	0	28	(370)	0	(370)	Activity
598591	Other	Stephen Astles	Adam Gamston	20	0	20	91	0	91	71	0	71	Activity
	Sub-Total			**3,414**	**0**	**3,414**	**1,501**	**0**	**1,501**	**(1,913)**	**0**	**(1,913)**	
PRIMARY CARE													
598791	Development Funding	Stephen Astles	Chloe Rachelle	616	439	1,055	0	412	412	(616)	(27)	(643)	Activity
598651	Local Enhanced Services and GP Framework	Stephen Astles	Michael Scully	1,538	0	1,538	848	0	848	(690)	0	(690)	Activity
	Sub-Total			**2,154**	**439**	**2,593**	**848**	**412**	**1,260**	**(1,306)**	**(27)**	**(1,333)**	
PRESCRIBING													
598606	High Cost Drugs	Brendan Prescott	Adam Gamston	1,967	0	1,967	1,967	0	1,967	0	0	0	60:40
598666	Oxygen	Brendan Prescott	Laura Doolan	326	0	326	286	0	286	(40)	0	(40)	60:40
598671	Prescribing	Brendan Prescott	Laura Doolan	27,706	0	27,706	27,485	0	27,485	(221)	0	(221)	Activity
	Sub-Total			**30,000**	**0**	**30,000**	**29,738**	**0**	**29,738**	**(261)**	**0**	**(261)**	
RESERVES													
600961	Risk Share Reserve	Martin McDowell	Clare Shelley	662	0	662	0	0	0	(662)	0	(662)	N/A
600961	Flexibility Reserve (Budget Setting)	Martin McDowell	Clare Shelley	0	0	0	7,576	1,788	9,364	7,576	1,788	9,364	Activity
600961	Contingency Reserve	Martin McDowell	Clare Shelley	2,360	0	2,360	3,497	150	3,647	1,137	150	1,287	Actuals
600961	Committed Reserve	Martin McDowell	Clare Shelley	3,238	129	3,367	2,528	129	2,657	(710)	0	(710)	Actuals
600961	General Reserve	Martin McDowell	Clare Shelley	1,860	(560)	1,300	1,360	(710)	650	(500)	(150)	(650)	Actuals
600961	Investment Reserve	Martin McDowell	Clare Shelley	732	0	732	181	0	181	(551)	0	(551)	Actuals
600961	Non Rec Reserve	Martin McDowell	Clare Shelley	0	4,699	4,699	0	2,425	2,425	0	(2,274)	(2,274)	Actuals
600961	Contracting Reserve	Martin McDowell	Clare Shelley	(3,261)	0	(3,261)	(2,637)	0	(2,637)	624	0	624	Activity
600961	Unidentified QIPP	Martin McDowell	Clare Shelley	(840)	53	(787)	(159)	53	(106)	681	0	681	Actuals
	Sub-Total			**4,751**	**4,321**	**9,072**	**12,346**	**3,835**	**16,181**	**7,595**	**(486)**	**7,109**	
	Grand Total Expenditure			**225,199**	**6,341**	**231,540**	**225,199**	**6,341**	**231,540**	**(0)**	**0**	**0**	
	RRL Analysis			231,351	2,501	233,852	231,351	2,501	233,852	0	0	0	
	Surplus / (Deficit)			**6,152**	**(3,840)**	**2,312**	**6,152**	**(3,840)**	**2,312**	**0**	**(0)**	**(0)**	

Budget setting principles

NCB planning guidance "Everyone Counts Planning for Patients 2013/14" was released on 18th December 2012, along with CCG allocations.

The document provides guidance on the following assumptions for planning purposes for 2013/14:

1) CQUIN – remains at 2.5%

2) Surplus policy – cumulative surplus of 1%

3) Non-recurrent headroom – 2% of resource limit to be set aside

4) Contingency – minimum requirement of 0.5% of resource limit

5) Running cost allowance - £25 per head of population

6) National provider efficiency requirement – 4%

7) Estimated provider cost inflation – 2.9% has been applied to PbR prices, 1% applied to prescribing and remaining budget areas.

The main principle adopted for budget setting for 2013/14 is to use 2012/13 forecast outturn as the starting point. This approach means that cost pressures incurred throughout the previous year are already recognised in the budgets.

With the forecast outturn established for each cost centre, the next steps are as follows:

1) Identify and remove any non-recurrent expenditure in 2012/13.

2) Remove CQUIN out of any budgets which contain a contract CQUIN target.

3) Apply the national provider efficiency requirements and estimated provider cost inflation (using the figures provided above).

4) Add in known cost pressures not captured in 2012/13 outturn.

5) Pay budgets have been costed at point of scale at 2013/14 pay scale rates incorporating any in year incremental drift.

6) Finalise QIPP schemes and apply each scheme at cost centre level (i.e. identify by provider where the contract reductions are going to be applied).

7) Finalise investment plans and apply at cost centre level (i.e. identify by provider where the investments are going to be made).

8) Add 2.5% to revised contracts in respect of CQUIN targets.

7) Set a contingency budget of 1%.

8) Set a reserve for the 2% non-recurrent headroom requirement (as above).

Through steps 1-8 above budget setting control totals for each area are established. The concept of a budget setting control total is that commissioners work within the specified total, but have discretion and flexibility around individual contracts and allocation of funding.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/121	**Author of the Paper:**
Report date: 13 September 2013	Brendan Prescott CCG lead Medicines Management brendan.prescott@southseftonccg.nhs.uk Tel: 0151 247 7093

Title: Prescribing Update

Summary/Key Issues:

1. This paper presents the Governing Body with an update on prescribing spend for June 2013 (month 3),

Recommendation

The Governing Body is asked to receive the contents of this report by way of assurance.

Receive	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	

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
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
September 2013

1. Executive Summary

The South Sefton CCG position for month 3 (June 2013) is a forecast overspend of £ 57,489 or 0.2%.

2. Introduction and Background

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

3. Key Issues

For June 2013 data the Department of Health used an incorrect value for one of the historical data points used in the analysis for forecasting at out turn. As a result the figures were too low. This forecast is based on amended figures but as a result is unreliable at this time. This is compounded by the volatility of forecasting over the beginning of the year i.e. the first quarter.

4. Content

Medicines management team members have met with practices to agree on work priorities for 2013-14. Work has been undertaken to analyse where the common cost growth areas are for practices.

In June 2013 all Merseyside CCGs showed less negative cost growth on a year on year comparison and cost per item is increasing. In summary prescribing costs are increasing. However it is difficult to confirm why this is at this time. It may be due to a re correction of prices after the patent expiry of high volume / high cost drugs last financial year or an increase in Category M prices.
This will be monitored as the year progresses but forecasting will be subject to further changes such as Category M pricing changes in October.

5. Recommendations

The Governing Body is asked to receive the contents of this report by way of assurance.

Appendices

Appendix 1: South Sefton CCG Forecast Out Turn

Appendix 1

CCG Practices INFO		SECTION 3: FINANCIAL INFO - Total Prescribing Budget (Annual Amount) against Forecast Outturn		
Prescriber Code	Prescriber Name	Forecast Out-Turn (£)	Variance Over/Under spend (forecast outturn against budget) (£)	Variance Over/Under spend (forecast outturn against budget) (%)
N84001	42 KINGSWAY	£1,014,240	£30,167	3.1%
N84002	AINTREE ROAD MEDICAL CENTRE	£495,300	£5,218	1.1%
N84003	HIGH PASTURES SURGERY	£1,736,920	-£15,984	-0.9%
N84004	GLOVERS LANE SURGERY	£1,261,299	£14,383	1.2%
N84007	LIVERPOOL RD MEDICAL PRACTICE	£997,279	£12,703	1.3%
N84009	AZALEA SURGERY	£454,926	-£9,003	-1.9%
N84010	MAGHULL HEALTH CENTRE (DR SAPRE)	£356,035	-£31,998	-8.2%
N84011	EASTVIEW SURGERY	£1,128,190	£39,780	3.7%
N84015	BOOTLE VILLAGE SURGERY	£1,332,940	£79,200	6.3%
N84016	MOORE STREET MEDICAL CENTRE	£1,249,876	-£24,105	-1.9%
N84019	NORTH PARK HEALTH CENTRE	£1,270,992	-£54,527	-4.1%
N84020	BLUNDELLSANDS SURGERY	£1,338,812	-£22,382	-1.6%
N84023	BRIDGE ROAD MEDICAL CENTRE	£1,405,411	£41,167	3.0%
N84025	WESTWAY MEDICAL CENTRE	£1,193,689	-£144	0.0%
N84026	CROSBY - SSP HEALTH LIMITED	£401,536	-£12,213	-3.0%
N84027	ORRELL PARK MEDICAL CENTRE	£477,164	-£6,815	-1.4%
N84028	THE STRAND MEDICAL CENTRE	£1,384,989	£40,930	3.0%
N84029	FORD MEDICAL PRACTICE	£992,117	-£905	-0.1%
N84034	PARK STREET SURGERY	£1,005,075	-£7,431	-0.7%
N84035	15 SEFTON ROAD	£787,842	-£36,749	-4.5%
N84038	CONCEPT HOUSE SURGERY	£568,405	-£31,271	-5.2%
N84041	KINGSWAY SURGERY	£699,485	-£17,399	-2.4%
N84043	SEAFORTH SSP HEALTH LTD	£292,710	£43,512	17.5%
N84605	LITHERLAND - SSP HEALTH LIMITED	£515,081	-£6,420	-1.2%
N84615	RAWSON ROAD MEDICAL CENTRE	£416,657	-£1,012	-0.2%
N84616	SEFTON ROAD SURGERY	£362,044	£24,960	7.4%
N84621	THORNTON - SSP HEALTH LIMITED	£465,054	£9,551	2.1%
N84622	MAGHULL HEALTH CENTRE (DR THOMAS)	£379,343	£5,841	1.6%
N84624	MAGHULL HEALTH CENTRE	£270,381	-£21,343	-7.3%
N84626	HIGHTOWN - SSP HEALTH LIMITED	£362,779	-£13,886	-3.7%
N84627	CROSSWAYS SSP HEALTH LTD	£374,029	-£23,190	-5.8%
N84630	NETHERTON - SSP HEALTH LIMITED	£332,217	£13,887	4.4%
Y00446	PARKHAVEN SSP HEALTH LTD	£662,778	£32,970	5.2%
CCG South Sefton Subtotal		**£25,985,592**	**£57,489**	**0.2%**

Brendan Prescott
September 2013

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/122	**Author of the Paper:**
Report date: 13 September 2013	Dr.Debbie Harvey Clinical Lead, Virtual Ward Debbie.harvey@southseftonccg.nhs.uk

Title: Virtual Ward Update

Summary/Key Issues:

This paper presents the Governing Body with the third agreed quarterly update of the processes relating to the implementation of the Virtual Ward Model of care. The next report will be January 2014.

Recommendation

The Governing Body is asked to receive the contents of this report by way of assurance.

Receive	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.
	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			

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)*	
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
September 2013

1. Executive Summary

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

2. Introduction

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

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

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

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

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

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

2.6. This update is broken down into the following areas

Contents:

A. Commissioning Processes
B. Project Management
C. Quality Improvement

D. GP Engagement and Enhanced Schemes
E. Wider aspects relating to the project.

3. Content

3.1. Commissioning Processes

3.1.1. Strategic Overview

Version 1 was completed in August 2012 and widely circulated within and beyond South Sefton CCG. Version 2 has subsequently been circulated over recent weeks.

3.1.2. Business Case

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

3.1.3. Service Specification

The initial Virtual Ward Specification for Liverpool Community Health (major provider) has been completed and ratified.

3.1.4. Commissioning for Quality and Innovation (CQUINs)

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

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

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

3.1.5. Integrated Operating Framework

An integrated operating framework is being brought together with contributions from all major stakeholders. The Virtual Ward Team is taking initiative on this. It will cover the following areas.

1) Governance: Model oversight and clinical
2) Staff Roles
3) Day to day working
4) Performance: Targets, Capacity, copy of CQUINS
5) Specific Virtual Ward Processes
6) IMT operation and function of honorary contracts
7) Incident, Complaint and Compliments procedure
8) Assessment and Screening Protocols
9) Urgent Care Team: Patient Pathways.

3.2. Project Management

3.2.1. Project management support

The Virtual Ward project has gained the support of PMO in the past few weeks. This has been critical and highly beneficial in supporting the team particularly with the temporary departure of Dr Peter Chamberlain. Systems are currently being developed to engage and map the progress of both commissioners and providers. Different systems have been tested including the West Lancs commissioning toolkit and Wordpro. The Gantt chart remains in operation and is assisting in accountability. However, in order for the PMO to keep track of the VW project it is vital that all workstreams keep the PMO updated. This is currently work in progress and will be presented at the next steering group at the time of writing this paper.

3.2.2. Headline dates

Clinical Integration

1.	Recruitment of additional staff for locality based Virtual Wards completed	01.07.13
2.	GP enhanced scheme for risk stratification and pro-active care	01.07.13
3.	Locality based Virtual Wards formed with full complement and active throughout all localities	01.08.13
4.	Virtual Ward Urgent Care Team formed and ready for deployment	01.12.13
5.	Full complement Community Geriatricians	31.12.13.

IMT Integration

1.	EMIS Web Community on going rollout > Integrated Community Record	31.07.13
2.	Honorary contracts and access to EMIS Community for non LCH staff	31.08.13
3.	Access to SMBC social data for specified health staff	31.08.13
4.	Process completed for increasing UHA doctor access to brief summary	30.09.13
5.	Mobile working for community staff	30.09.13
6.	Electronic 'My Shared Care Plan'	30.03.14

3.2.3. Work streams

Steering Group: The steering group meets on a bimonthly basis. It provides a critical link between the SSCCG board, Sefton council board, the operational groups, PMO and governance groups.However, we also suggest that additional areas for integration should be shared by providers in this forum with respect to future projects and strategic planning in the months ahead. We propose that a separate governance subgroup along with communications subgroup feed into the steering group. This needs to be agreed at the next steering group meeting Sept 18th 2013.

Pro-active nursing and re-ablement: These areas have successfully moved to all localities as of August 1st with the oversight of Tina Ewart and Kevin Thorne.

IM&T This area remains complex for a variety of reasons including ownership of systems and data sharing agreements. The project is being managed with iMerseyside with oversight from Paul Shillcock.

Quality Improvement: This area is currently facilitated through James Hester. We currently have all baseline measures from MCSU. PDSA cycles are being facilitated through LCH. The operational team have also been promised 'real time' activity data for individual localities to respond to over and under use of the virtual ward promptly.

Urgent Care The Urgent Care aspect of the virtual ward is due to be launched on 1 December[t] 2013.The project is led by LCH with oversight from SSCCG.

Care Planning: An enhanced service had been proposed and had been shared with the LMC. The decision was made not to proceed with the project for a number of reasons including:

- the lack of agreement regarding shared paperwork with our providers
- The fact that a unified DNAR form is to be launched later this year (so all of the above can be incorporated together)
- Lack of any education for GPs regarding care planning
- The contentious issue with regards to paying GPs to complete EOL documentation in view of the recent LCP review.

It is proposed that options around EOL care planning (particularly in care homes) will be shared with the wider group at the wider group meeting in September.

A wider group meeting will be held in October with all main providers with regards to care planning with the aim of reaching agreed documentation for all.

A SWOT analysis of the project so far has been undertaken.

3.3. Quality Improvement

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

(i) Measures

We now have baseline measures from MCSU who will continue to provide a report on a monthly basis.

Measures from LCH have been slow due predominantly to issues with IT systems.

We have agreed that real time activity measures will be provided at the operational meetings every 2 weeks in order to keep track of referral rates and overall numbers

(ii) PDSA cycles

There are 3 cycles currently running.

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

LCH have promised to provide this data by engaging band 4 staff to complete the cycles.

3.3.2. Quality Feedback Mechanism

This aspect of the virtual ward remains as per the last board report.

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

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

3.3.3. GP engagement and enhanced schemes

(i) Engagement through locality meetings

All of the localities received a face to face brief prior to launching the 3 remaining localities 1 August 2013.

Dr Pete Chamberlain also presented to the wider group meeting prior to his secondment.

(ii) Locality based service development GP champions

Having a local GP champion on hand to influence the Maghull locality based virtual ward was found to be invaluable. Such a person will be required to attend and give their opinion to the 2-monthly development session. Locum rates at the CCG hourly rate will be reimbursed to the individual.

We have GPs in all localities with whom we are working closely.

3.3.4. Uptake of risk profiling

Agreement to use of primary care non-personal data is required for (4).

As of 1 September 2013, 82% of practices in South Sefton have signed up to risk stratification. We continue to be at the bottom of the table amongst neighbouring CCGs and the percentage of participating practices but the increase in numbers is really encouraging (previously 20% at last board update).

The concept of risk stratification was introduced through wider group, promoted at PLT, all practices were sent detailed information in December, locality managers have promoted it in locality meetings and all practices in Maghull have been offered individual visits to explain the reasoning and demonstrate the tool.

The IMT development currently means only EMIS practices may sign up to the primary care aspect. It takes 1-2 months following sign up to convert from SUS to SUS+ Primary care data. The iSoft practices across the patch are scheduled to move to EMIS Web by the end of May. A solution is being sought for the one practice on Vision through an IT solution called Graphnet.

3.3.5. Risk profiling and Pro-Active Management Enhanced Scheme (National with local top-up)

This scheme incentivises practices to pro-actively identify patients at high risk of admission as per the Kaiser triangle and refer pro-actively to the Pro-active Care Program, focussing on optimisation of long term conditions, carer support, self-care and linking with third sector services through the respective integrated locality based Virtual Ward.

Summary of the scheme:

- £1 per patient paid to a practice

  (£0.74 from NHS England (NCB)
  (£0.26 from GP Integrated Care Monies agreed within the Virtual Ward Business Case to enable the Enhanced Scheme to mirror the LCH Virtual Ward CQUIN requirements) – total maximum cost to CCG £30,000).

Practice Requirements

a) Sign up to CCG selected risk stratification tool
b) Review of stratified population and referral in batches to integrated Virtual Ward pro-active care program every 3 months
c) Monthly 1.5h liaison meeting with the senior clinicians of the respective Virtual Ward (mirrors LCH CQUIN)
d) Identification of a practice lead for integrated care to feed opinions into the development of the system.

3.3.6. Shared Care Planning Enhanced Scheme (Local)

This scheme aimed to reward practices for co-ordinating a shared care plan for patients within their last year(s) of life which, following sharing with the patient and key health care professionals, may be used to ensure appropriate care and reduce inappropriate admissions.

The scheme was due to launch in July but on reflection we felt there were too many unresolved issues which are yet to be addressed. This scheme and the money attached to it are currently on hold. In summary these included:

1. Following the LCP review any payment for the completion of any EOL related paperwork is potentially contentious

2. Lack of any agreed paperwork to perform the above

3. The proposed unified DNAR form later this year (best to integrate this into anything we do)

4. Lack of education for GPs in EOL communication, capacity issues etc

5. The fact that this area of work needs to be on-going and whether a one off payment will really ensure on-going work in this area.

We propose to share a number of different ideas with the wider group in September to include:

1. Do nothing. GPs continue to complete EOL plans in an ad hoc fashion or not at all or manage to include all care home patients. We think the latter highly unlikely based on anecdotal experience.

2. Use the above enhanced service but role out with education etc. However, this is not in keeping with the recommendations of the LCP review as already suggested

3. We have a salaried GP to provide holistic assessments for care home patients – focusing on 2-3 of the larger homes in South Sefton.

4. We include the above in the work of a community geriatrician. There is a similar project in Liverpool but they also have 10's of community matrons to facilitate the project. This potentially takes the community geriatrician away from the virtual ward.

5. We identify willing practices who provide a full service for care home patients – much like a LES (Sheffield have a good example of this). By way of example we currently have a local home with 176 beds and there are 15 different surgeries providing primary care services.

Whatever is agreed as a way forward we will ensure that a PLT later in the year covers all issues around EOL care planning.

3.4. Wider aspects relating to the project

3.4.1. Urgent Care

LCH are leading this workstream but updates with regards to progress have been limited. Issues have arisen with regards to difficulty with all providers.More regular meetings will be required with PMO input to keep this workstream on track. In addition SSCCG need to engage fully with UHA and any developments planned in AED.

3.4.2. Intermediate Care

There have been significant and worrying issues on W35 which has left the unit unable to accept GP referrals. This area remains one for debate. It would be an ideal resource for the virtual ward IF it worked well.

3.4.3. Re-ablement

This aspect of the VW is developing and progressing well.

4. Recommendations

The Governing Body is asked to formally this report by way of assurance.

Appendices

APPENDIX A1:	Virtual Ward Business Case Summary 2013/2014 (Graduated Rollout)
APPENDIX A2:	Virtual Ward Business Case Summary 2014/2015 (Full Roll Out)
APPENDIX B:	Abbreviated Gantt Chart and implementation plan (representative sample – detailed chart available on request)
APPENDIX C:	Virtual Ward Measures and Dashboard
APPENDIX D:	Risk Profiling and Pro-active Care Management Enhanced Scheme 2013-2014

Dr Debbie Harvey
Sept 2013

APPENDIX A1: *Virtual Ward Business Case Summary 2013/2014 (Graduated Rollout)*

SOUTH SEFTON VIRTUAL WARD BUISNESS CASE 2013-2014 GRADUATED ROLLOUT	WTE	ORGANISATION LCH	UHA	CCG	CVS	SEFTON LA	OTHER	TOTAL
Staff Pay Costs								
Ward Administration	**Jun-13**							
Band 6 - District Nurse (Replace		150						
Band 7 Ward Manager)	4	628						
		875						
Band 4 - Care Co-ordinator	4	75						
Proactive Nursing	**Jun-13**							
		163						
Band 7 - Community Matron	4	717						
		124						
Band 5 - District Nurse	4	144						
PCMM - Pharmacist	1			49393				
PCMM - Technician	1			33979				
Health Care Trainer					8491			
	4				0			
Re-Ablement	**May-13**							
		450						
Band 7 - OT	1	22						
		450						
Band 7 - Physiotherapy	1	22						
Urgent Care Team	**Dec-13**							
			53					
			33					
Community Geriatrician (2)	1		3					
Band 7 - Advance Urgent Care		286						
Nurse	2	16						
		358						
Band 6 - Urgent Care Nurse	3	09						
SPC Team	**Jun-13**							
		694						
Band 6 - SPC	2	78						

Note: Top-up commissioning for staff investment only
Full staffing of model available on request
Black relates to a definitive/ grey relates to an estimation

South Sefton Virtual Ward System

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Total Staff Pay Costs	**12445411**	**7503333**	**83372**	**84910**	**0**	**0**	
Non-Pay Costs							
MSSE		33196					
Travel & Subsistence		19008					
Mobile Telephones		5788					
Other Non Pay		13705					
Total Non-Pay Costs		**59367**	*1000*	*2000*	*4000*	**0**	**0**	
TOTAL DIRECT COSTS		**80937833**	**85372**	**88910**	**0**	**0**	**10379933**
TOTAL OVERHEADS		**11584420**	**0**	**97800**	**0**	**0**	**13214400**
OTHER RECURRENT							
Training		0	0	0	0	0	5000	
Service Development		0	0	0	0	0	10000	
GP Integrated Care Contract		0	0	91800	0	0	0	
TOTAL OTHER RECURRENT		0	0	91800	0	0	15000	**106800**
NON-RECURRENT							
Ward Round Facilitation		10000					
Adminstration Facilitation		10000					
IMT Infrastructure Development							50000	
Urgent Care Team Equipment		25000					
TOTAL NON-RECURRENT		**45000**	**0**	**0**	**0**	**0**	**50000**	**95000**
TOTAL COST		**97022223**	**608532**	**177172**	**98690**	**0**	**65000**	**13719380**

APPENDIX A2: ***Virtual Ward Business Case Summary 2014/2015 (Full Roll Out)***

SOUTH SEFTON VIRTUAL WARD BUISNESS CASE 2014-2015 FULL OPERATION	WTE	ORGANISATION LCH	UHA	CCG	CVS	SEFTON LA	OTHER	TOTAL
Staff Pay Costs								
Ward Administration								
Band 6 - District Nurse (Replace Band 7 Ward Manager)	4	1807 54						
Band 4 - Care Co-ordinator	4	1050 90						
Proactive Nursing								
Band 7 - Community Matron	4	1964 60						
Band 5 - District Nurse	4	1489 73						
PCMM - Pharmacist	1			49393				
PCMM - Technician	1			33979				
Health Care Trainer	4				9262 9			
Re-Ablement								
Band 7 - OT	1	4911 5						
Band 7 - Physiotherapy	1	4911 5				In house		
Urgent Care Team								
Community Geriatrician (2 x 50%)	1		160 000					
Band 7 - Advance Urgent Care Nurse	2	8584 9						
Band 6 - Urgent Care Nurse	3	1074 27						
SPC Team								
Band 6 - SPC	2	8337 3						
Total Staff Pay Costs	**24**	**1006 156**	**160 000**	**83372**	**9262 9**	**0**	**0**	

Note: Top-up commissioning for staff investment only
Full staffing of model available on request
Black relates to a definitive/ grey relates to an estimation

GB13/122

Non-Pay Costs							
MSSE	3621 4						
Travel & Subsistence	2073 6						
Mobile Telephones	6314						
Other Non Pay	1500						
Total Non-Pay Costs	**6476 4**	*100 0*	*2000*	*4000*	**0**	**0**	
TOTAL DIRECT COSTS	**1070 920**	**161 000**	**85372**	**9662 9**	**0**	**0**	**1413 921**
TOTAL OVERHEADS	**1450 82**	**177 10**	**0**	**1062 9.19**	**0**	**0**	**1734 21**
OTHER RECURRENT							
Training	0	0	0	0	0	500 0	
Service Development	0	0	0	0	0	100 00	
GP Integrated Care Contract	0	0	91800	0	0	0	
TOTAL OTHER RECURRENT	0	0	91800	0	0	150 00	**1068 00**
TOTAL COST	**1216 002**	**178 710**	**177172**	**1072 58**	**0**	**150 00**	**1694 142**

APPENDIX B: ***Abbreviated Gantt Chart and implementation plan (representative sample – detailed chart available on request)***

APPENDIX C: ***Virtual Ward Measures and Dashboard***

Measure	Target (2012 baseline)	Responsible Organisation	Type of Measure
A. Population Health*			
1. 30 day readmissions rate Age ≥ 65 years	16% > 10%	MCSU	Outcome
2. Dementia diagnosis rate	53% > 75%	Alzheimers Society	Outcome
3. Dementia screening rate aged ≥ 65 years new patients	90%	Liverpool Community Health	Process
4. % of patients ≥ 65y requiring permanent residential/ nursing care	Flat line	Sefton Council	Outcome
5. % of patients ≥ 65 y remaining in their own home 6 months after admission	Flat line	Sefton Council	Outcome
6. Admission rate to permanent residential/ nursing care (council funded)	Flat line	Sefton Council	Outcome
B. Experience of Care*			
1. LTC-6 questionnaire (care coordination & self-care)	90% completed 0 and 12w	Liverpool Community Health	Outcome
2. % of patients who die in their registered place of residence	36% > 66%	Public Health	Outcome
3. Bed days (Length of Stay) - Total - Age ≥ 65 years (Medical Specialities)	Reduction 10%	MCSU	Outcome
C. Per Capita Cost*			
Hospital			
1. Unplanned admissions - Age ≥ 65 years - Medical Specialities	Reduction 20%	MCSU	Outcome
2. A&E attendance age - ≥ 65 years	Reduction 15%	MCSU	Outcome
Balancing Measures			
3. Medical OPD appointment rate - Age ≥ 65's	Flat line	MCSU	Balancing
4. Walk In Centre activity - Age ≥ 65's	Flat line	Liverpool Community Health	Balancing
5. Out of Hours activity - Age ≥ 65's	Flat line	Liverpool Community Health	Balancing
D. Measures of Integration			

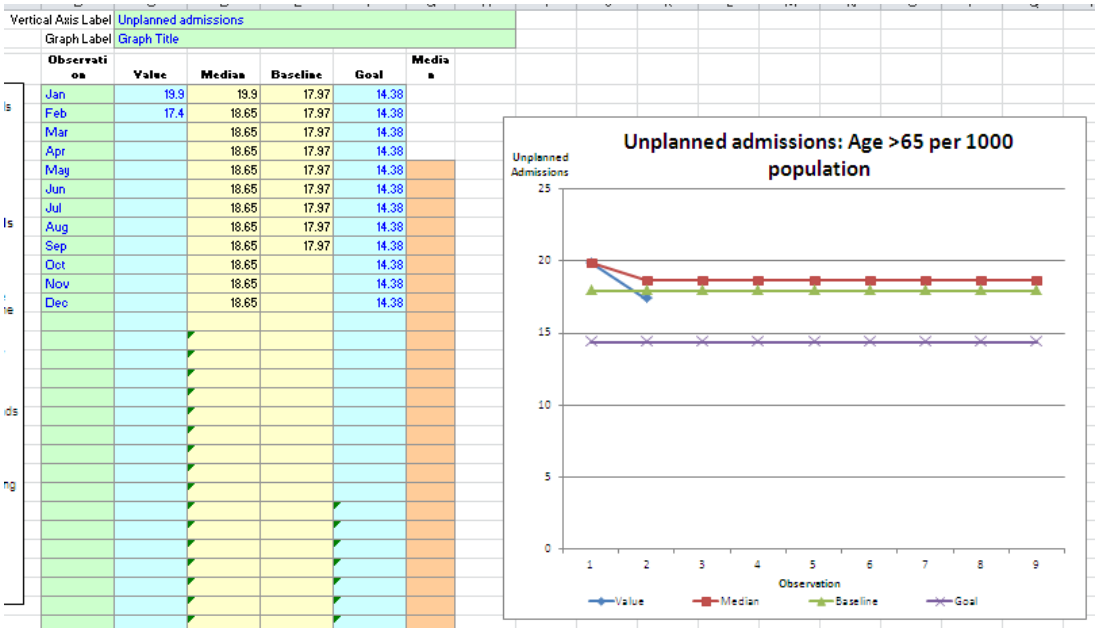
1. Staff attendance at Virtual ward rounds (CQUIN)	6 LCH types professionals	Liverpool Community Health	Process
2. WM/ CM – GP monthly liaison meeting	100% (35 practices/ month)	Liverpool Community Health	Process
3. Pre/ post change frontline staff integration survey (AQUA)		Liverpool Community Health	Process
4. System integration tool (AQUA)		South Sefton CCG	Process
E. PATIENT ACTIVITY			
1. **Demographics** (including Name, DOB, NHS number, GP surgery)		Liverpool Community Health	Activity
2. **Timing** of referral, intervention, discharge		Liverpool Community Health	Activity
3. **Type of intervention** a) Short term intervention b) Integrated Care **c)** Pro-Active Care Programme		Liverpool Community Health	Activity
4. **Types of professionals involved in care**		Liverpool Community Health	Activity

GB13/122

Example of dashboard

	Baseline	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**
Per Capita Cost					
Unplanned admissions					
- Total					
- Age ≥ 65 years	17.97/1000	19.9/1000	17.4/1000		
A&E attendance age					
- Age ≥ 65 years	7.58/1000	7.3/1000	7.6/1000		
Walk In Centre activity					
- Total	2841	2877	2825	3183	
- Age ≥ 65's	11.80%	8.10%	9.80%	10.60%	
Out of Hours activity					
- Total	1608	1804	1502	1821	
- Age ≥ 65's	28.10%	26%	26.80%	30.40%	

Example of measures run chart used in Quality Improvement work stream.



Vertical Axis Label	Unplanned admissions				
Graph Label	Graph Title				
Observation	Value	Median	Baseline	Goal	Median
Jan	19.9	19.9	17.97	14.38	
Feb	17.4	18.65	17.97	14.38	
Mar		18.65	17.97	14.38	
Apr		18.65	17.97	14.38	
May		18.65	17.97	14.38	
Jun		18.65	17.97	14.38	
Jul		18.65	17.97	14.38	
Aug		18.65	17.97	14.38	
Sep		18.65	17.97	14.38	
Oct		18.65		14.38	
Nov		18.65		14.38	
Dec		18.65		14.38	

Risk Profiling and Pro-active Care Management Enhanced Scheme 2013-2014

Background and purpose

This enhanced service is designed to encourage practices to identify patients at risk of emergency hospital admission through a ratified process. Practices will be expected to refer patients pro-actively and collaborate with their locality based integrated multi-disciplinary teams (Virtual Wards) tasked with assisting practices in reducing the risk of admission through holistic assessment, coordination in care, optimisation of long term conditions and step up in self-care.

Introduction

The aims of this enhanced service are to encourage practices to undertake risk profiling and stratification of their registered patients. Practices will be expected to work within a local multi-disciplinary approach to identify from the list produced, those patients who are at high risk (top 5%) of emergency hospital admission and to co-ordinate with other professionals the care management of those patients identified in a proactive and integrated manner.

NHS England has asked South Sefton CCG to take responsibility for designing and managing this enhanced scheme, to ensure it is locally and clinically driven. This enhanced scheme is therefore brought together by South Sefton CCG, while maintaining all the key aspects stipulated by NHS England.

The specification sets out the minimum requirements that all local schemes will need to meet and the funding that will be available. South Sefton CCG is required to invite and agree arrangements with practices under this enhanced service by 30 June 3013.

Requirements for General Practices

A. Population Risk Profiling

The practice carries out, on at least a quarterly basis, risk profiling of its registered patients to identify those who are predicted of becoming or are at significant risk of emergency hospital admission.

As part of this process:

1. The practice will be required to sign up to enabling primary care data extraction of the Merseyside Shared Intelligence Portal Risk Stratification Module. Combining

this with secondary user service data, which is already streamed into the module, increases accuracy and validity.

Guidance on use of the tool may be found within the accompanying support documents.

2. Using clinical judgement, assess the stratified list of patients provided by the Risk Stratification Module and identify patients applicable for the three month pro-active care program run by the respective Virtual Ward. Practices will be expected to work down the risk scores, including patients with modifiable potential (the majority) and excluding those with a severe, complex and an unmodifiable clinical situation.

The criteria for active case management through the pro-active care program:

- Initially patients who fall into the top 5% of risk of admission within the practice registry (it is advisable to work down through the scores)
- Patients who are residents within their own home and not a resident within a nursing home.
- Patients who have an element of holistic modifiable potential and can engage with staff personally.
- Patients of whom the GP or practice nurse believes would benefit from the pro-active care program and focussed integrated care.

3. Following liaison with the Virtual Ward, refer patients in batches. It is expected that practices will need to refer 3 /1000 per practice population every quarter. Practices will be required to provide or allow the Virtual Ward to baseline clinical information.

4. Keep a list of patients who have been identified, referred and completed the 12 week proactive care program. The respective Virtual Ward is also required to keep such a list.

The Pro-Active Care Program:

- *Is operated by the respective locality based integrated Virtual Wards*
- *Is coordinated by community matrons*
- *Involves a holistic assessment and coordinated integrated care*
- *Focusses on optimisation of long term conditions, medication support, goal setting, self-care, empowering carers, reducing health service dependency and improving the appropriate use of services*
- *Opportunity to directly enlist other community specialist teams*
- *Link the patient with re-ablement, para-health, voluntary sector organisations.*
- *Refer and involve the input from the community geriatrician where appropriate*
- *Is time limited to ensure a clinical check point and to avoid blocking of the system and patient dependency.*

B. Practice and Virtual Ward liaison and face to face communication

GPs from the practice work with their locality based Virtual Ward and meet with senior members of the respective Virtual Ward (i.e. Ward Manager and/or Community Matron) on a monthly basis for a minimum of 1.5 hours proactively to:

- Discuss prospective referrals for the 12 week Pro-Active Care Programme
- Discuss current relevant patients under the Virtual Ward (as deemed by the practice or Virtual Ward). This may involve all or any patients ie.
    - Pro-active care patients,
    - Integrated care (2 or more types professional involved)
    - Short term intervention from one type of professional
- Direct and advise the Virtual Ward on what care planning, interventions and goal setting is required.
- Receive updates on relevant patients being discharged from the Virtual Ward (maximum length of stay 12 weeks)

The focus of the above will be to achieve a shared and integrated approach to the case management of patients to improve the quality of care and reduce their individual risk of emergency hospital admission. In addition, having planned meetings will improve the face to face relationship between practices and their respective virtual ward while enabling a planned approach to care as opposed to mere 'fire-fighting'.

Practices should note that there is a mirror CQUIN (Commissioning for Quality and Innovation) arrangement with Liverpool Community Health regarding the above. Monitoring of referrals and meetings will therefore apply to both the CQUIN and the GP enhanced scheme.

C. Nominated individuals

1. There is a nominated lead professional within the practice who is responsible for each patient identified for case management, including undertaking a review and care planning discussion with each patient at a frequency agreed with the patient.

2. There is a nominated lead professional within the practice who is responsible for liaising with their respective Virtual Ward in assisting in service development and ongoing quality improvement by helping shape their local service to be aligned with the requirements of the practice and needs of the local population. The focus of such development should be aligned to:

1. Fostering an integrated and coordinated approach to care across organisations
2. Improving communication between health care professionals both physically and electronically
3. Pro-active case management
4. Goal setting and improving patient self-care
5. Input into locality based commissioning decisions as deemed necessary.

Such input would be expected to be in an advisory capacity. Locality level commissioning decisions would be made through the established locality model.

Validation

South Sefton CCG will be responsible for specifying the necessary audit information to be submitted by practices on a quarterly basis. This will include:

1. Review of the number of risk-profiled pro-active referrals made to the respective Virtual Ward.

2. Review of the number of monthly meetings occurring between the practice and the respective Virtual Ward.

South Sefton CCG will be responsible for satisfying itself that practices are meeting the requirements agreed on the basis of this information including assurance for payments.

It is expected that referral numbers will reasonably be agreed between practices and the respective Virtual Ward according to the progressive development of the model and consequently increasing capacity.

Full capacity per locality based Virtual Ward will be 100 patients per 12 week block participating on the pro-active care program. On full virtual ward complement practices therefore will need to refer a minimum of 3/1000 patient population every quarter to ensure an adequate flow of patients

Payment

Payment will be made by NHS England based on £0.74 per registered patient, which represents a payment of £5,175 for an average-sized practice nationally (registered population of 6,911).

Due to the priority of long term conditions, integrated care and pro-active management, South Sefton CCG is adding a further £0.26 per registered patient to ensure practices can achieve their requirement of the monthly liaison meetings, which represents an additional payment of £1,382 for an average-sized practice nationally (registered population of 6,911).

Practices that fulfil all the above minimum requirements above, but only meet quarterly for 1.5 hours with their respective Virtual Ward will be eligible for the NHS England rate of the enhanced scheme i.e. £0.74 per patient.

Practices that fulfil all the above minimum requirements above, and meet each month will be eligible for the additional £0.26 per patient (total £1 per patient).

South Sefton CCG will be responsible in providing assurance to NHS England that the minimum requirements of this enhanced service have been satisfied before payments under this enhanced service will be made.

Part payment regarding practices that withdraw from the scheme or practices that split or merge are stipulated in the full document referenced below[1]

This assurance must be given within 28 days of the end of the financial year.

NHS England will be responsible for post-payment verification. This may include the audit of the number of patients who have been predicted to be at significant risk of unplanned hospital admission through a risk profiling tool and for whom care management arrangements have been put in place.

Other provisions relating to this enhanced service

The full scheduled roll out of the locality based Virtual Wards is the end of July. Practices that sign up to the enhanced scheme by the June 30th deadline will therefore have one month before referrals should start. It takes one month, from submission of the risk stratification data sharing agreement, to add primary care data to the model. Practices that decide to sign up are therefore encouraged to submit the risk stratification data sharing agreement as soon as possible. Meetings may commence following the June deadline with community matrons of the preliminary Virtual Wards in preparation.

Payments will be made to practices by NHS England on the last day of the month following the month during which South Sefton CCG (or the practice directly) provides assurance that the minimum requirements were met (i.e. payment by 31 May 2014).

1NHS CB. 2013/14 enhanced service specifications. www.england.nhs.uk/resources/resource-primary/

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/122	**Author of the Paper:**
Report date: 16 September 2013	Fiona Clark Chief Officer fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7061

Title: Non Recurrent A&E Funding

Summary/Key Issues:

This paper presents the Governing Body with an overview of the recently announced non-recurrent A&E funding.

This funding has a local impact as both Southport & Ormskirk NHS Trust and University Hospitals Aintree Foundation Trust have been allocated some of the national funding.

- Aintree - £1.520 million
- Southport & Ormskirk - £ 4.042 million.

The report presents the Governing Body with the background and next steps for utilisation of the non-recurrent funding allocation.

Recommendation

The Governing Body is asked to receive this report, by way of assurance.

Receive	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			Care Closer to Home Network-Southport & Ormskirk North Mersey Urgent Care Network
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

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
September 2013

1. Background

It was announced on the 10th September that an extra £500 million non-recurrent funding was to be made available over the next two years, to support the attainment of the A&E 4 hour standard. The Secretary of State for Health set out how the £250 million for 13/14 would be used by 53 Trusts identified this winter.

The funding being specifically directed in the following areas.

- £62 million for additional capacity in hospitals
- £57 million for community services
- £51 million for improving the urgent care services
- £25 million for primary care services
- £16 million for social care
- £9 million for other measures i.e ambulance services
- £15 million was also earmarked for NHS 111.

This money was tied into a 75% target for staff vaccinated against flu.

2. Local Impact

As a result of this announcement, both University Hospitals Aintree NHS Foundation Trust and Southport & Ormskirk NHS Trust received funding, as they had both failed to reach the 4 hour A&E target in quarter 1 of 13/14.
The amounts received are

- Aintree - £1.520 million
- Southport & Ormskirk - £4.042 million.

The local funding is badged against the national criteria and will support the successful delivery of the 4 hour A&E target through the wider health and social care system. The funding bid was supported by the Local Authority and CCGs alongside the Hospitals Trust.

3. Next Steps

The implementation plan will now be finalised and performance managed through the two Urgent Care networks responsible for Southport and Ormskirk NHS Trust and University Hospitals Aintree NHS FT.

The Governing Body will receive regular updates on progress and delivery.

4. Recommendation

The Governing Body is asked to formally receive this report.

Fiona Clark
September 2013

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
September 2013

/	**Author of the Paper:**
Report date: September 16th 2013	Dr Bal Duper Primary Care Quality Lead bal.duper@nhs.net Tel: 0151 247 7251

Title: Primary Care Quality Strategy

Summary/Key Issues:

From the 1st April 2013, Clinical Commissioning Groups (CCGs) have a statutory duty regarding the continuous improvement of primary care. A three year strategy focusing on quality areas for improvement based on safety, clinical effectiveness, and patient experience is being developed for South Sefton CCG.

A draft Primary Care Quality Strategy – 'A Sense of Purpose' has been developed setting the context and current challenges, which outlines the areas identified in our 'Everyone Counts' document (practice demographics, workforce development, clinical outcomes, estates /IT and health outcomes). The document has been circulated and discussed locally with a request for feedback on areas of prioritisation. Stakeholder responses have been received and evaluated (Appendix A) to progress and shape the proposals within this report. The Governing Body are asked to approve these proposals.

Further development, implementation and Governance for delivery of the strategy will be through a Primary Care Quality Strategy Board.

Next Steps

- Attendance at Local Medical Committee meeting September 2013
- Establishment of a Primary Care Quality Strategy Board
- PMO involvement

Recommendation

The Governing Body is asked to approve the proposals within this report

Note	
Approve	X
Ratify	

GB13/124

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			Healthwatch / Community Champion Network, EPEG, Health and Social Care Forum
Clinical Engagement	x			Senior LeadershipTeam, Board to Board, Wider Group Meeting, Practice Nurse Group
Equality Impact Assessment	x			Recommendations to draft document initiated
Legal Advice Sought		x		
Resource Implications Considered	x			Vary current resources, plus primary care investment
Locality Engagement	x			Via Wider Group
Presented to other Committees	x			Quality Committee, Local Medical Committee, Practice Manager Group, Medical Directorate NHSE Merseyside, Liverpool and Sefton Health Partnership, iMerseyside

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

Dr Bal Duper
Primary Care Quality Lead
September 2013

NHS
South Sefton
Clinical Commissioning Group

Primary Care Quality Strategy;
'Energising Primary Care in South Sefton'
Proposal Document

1. Introduction

This paper outlines the proposals to be recommended to the Governing Body following the initial Primary Care Quality Strategy document, 'A Sense of Purpose'. Additionally, the paper recommends the establishment of a 'Primary Care Quality Strategy Board'.

The consultation document, 'A Sense of Purpose', has now undertaken the consultation process outlined and agreed by our Governing Body earlier in the summer.

All partners have responded positively and constructively within the time scale anticipated.
The detailed responses, and their ownership, are compiled in Appendix A.

These responses have been evaluated in the light of local, regional and national priorities and also with a view to realistic implementation within a restricted resource, personnel and financial, framework.

Recent regional and national drivers, 'Call to action' document, A+ E/Urgent Care crises, have prioritised certain areas for urgent action. This was described in the original paper.

This paper reflects a recent regional view, described by NHS England Merseyside (NHSE M), of a radical and immediate approach to transforming primary care within the next 3 years.

A recent regional strategy event also allowed our aspirations and ambitions to be shared with other Merseyside Clinical Commissioning Groups (CCG's). Real possibilities have emerged for collaborative working.

However, the consultation process has re-affirmed that all of our partners and members agree that the aims and objectives of our 'Everyone Counts' document remain true and worthwhile.
The proposals are formulated to reflect the specific areas of that document;

- Demography
- Workforce Development
- Clinical Services
- Premises/IT
- Health Outcomes of Primary Care.

An additional work stream for the Primary Care Development team was to scope and formulate the proposals for the Terms of Reference and Membership of the Primary Care Quality Strategy Board (PCQSB). An implementation plan will be devised which will need approval in the future once its developed in detail.

These are attached in Appendix B.

A timetable of delivery to be overseen by our Project Management Office (PMO) is attached in Appendix C.

2. DEMOGRAPHY

2.1. Collaborative working

- There is a real desire for practices to develop the Locality model into a substantive model not only for primary care delivery, but for provision of services which have historically been provided by community and secondary care services such as dieticians and diagnostics.

- There are many models with success elsewhere including 'Federations', 'Clusters' and larger Limited Liability Partnership (LLP) Provider companies.

2.2. Proposal

A six month time-limited work stream for a nominated senior GP within each locality to spend 1 session weekly to inform a model of collaborative working to deliver the above, but reflect local needs such as geography/clinical demographic similarity/locality.

2.3. Outcomes

- PCQSB to receive proposal paper for TOR/membership/scope of aspiration by April 2014.

- Single model , or mosaic, of collaborative working within locality umbrella to 'engines' and 'incubators' for driving Clinical Commissioning by years 2-3.

- Increased primary care capacity.

- Share good practice.

3. WORKFORCE DEVELOPMENT

3.1. Mapping what we have and what we will need

- A mapping process of our present capacity, the job plans of professionals and the CCG's needs for the next 5 years needs to be undertaken. This should be on frontline clinical staff of GPs and Practice nurses. The CCG needs to be informed of changes anticipated (such as how many GPs plan to retire within the next 3-5 years), capacity issues (such as how many practices are 'under-doctored' compared to national averages) and what capacity is needed to deliver radical changes (such as 8am- 8pm access).

3.2. Proposal

- Year 1; work with NHSE M on their workforce mapping programme
- Year 2; jointly work with the Local Medical Committee (LMC) on a detailed mapping process which is more reflective of a local picture
- Year 3; inform and work with NHSE M on commissioning needs plan for our CCG.

3.3. Outcomes

- Year 1; receipt of NHSE M report
- Year 2; receipt of joint LMC-CCG report
- Year 3; proposal paper to NHSE M.

3.4. **Locality Clinical Provision of Community Services**

- The flexibility of the commissioning of community services could be enhanced if localities embrace the commissioning of these services. Enthusiasm for change and planning for transferring services into localities and nearer practices becomes quickly diminished for various legacy issues. Having a locality clinician to initiate this change needs to be reinvigorated.

3.5. **Proposal**

- Year 1; each locality to work on one business case to be locality based, commissioned and managed, e.g. employment of dietician or a pharmacist.
- Year 2; implementation of agreed schemes based on footprint of either 'collaborative model' or locality.
- Year 3; transfer of substantial commissioning resources to rollout of successful schemes throughout all localities.

3.6. **Peer Review Governance and Performance Review**

- The provision of the simple areas of primary care such as continuity of care and reasonable access to a named GP remains an issue in our CCG. The areas around the details remain core to our quality agenda and ethos of a membership CCG.

3.7. **Proposal**

- The Governing Body to identify gaps in areas of clinical provision throughout the CCG from historical reports from members, patients and other organisations in individual practices.
- Year 1; PCQSB to identify performance and governance elements to continuation within CCG based on models in other CCGs
- Year 2; implement performance element of CCG membership
- Year 3; implement with substantive authority consequences of no compliance.

4. CLINICAL SERVICES

4.1. **Virtual Ward**

- There has been substantial investment in this area. Primary care is a commissioner and financial partner in this scheme. An alignment of the work stream to place primary care outcomes should be enhanced.

4.2. **Proposal**

- Year 1; primary clinical lead input into the scheme in areas such as 'Urgent Care'
- Year 2; commissioning of a 'critical friend' report to clarify if objectives are consistent and being achieved for investment
- Year3; Governing Body to agree if continued investment 'value for money'.

4.3. **Outcomes**

- Review of substantial investment in, and clinical outcomes of scheme
- Primary care re-sited at heart of scheme
- Clearer feedback if scheme has further value

4.4. **Acute Visiting Scheme**

- Visiting schemes have shown to have value in nearby areas both in primary care provision as well as in specified clinical areas, e.g. Out of Hours (OOHs) teams for North West Ambulance Service (NWAS) callouts, Nursing home patients or even End-of-Life. Clinical capacity in the short term would be enhanced if implemented.

4.5. **Proposal**

- Year 1; PCQSB to evaluate 'pilot' scheme locally, or services provided within North of England CCGs.
- Year 2; business case to localities and Governing Body on preferred option.
- Year 3; implementation of agreed acute visiting scheme.

4.6. **Outcomes**

- Locally based primary care clinical provision enhancing primary care services.
- Quality based outcomes as per specification for certain patient groups.
- Enhance Winter Pressures plan and Urgent Care schemes.

5. PREMISES/IT

5.1. **Premises**

- The development and maturing of collaborative and locality working, and hopefully, clinical services provision will allow a fulfilment of the historic estates plan provisionally agreed by the Primary Care Trust (PCT) with a local priority.

5.2. **Proposal**

- Year 1; map out, with our partner, a detailed estates capacity based on what capability there is to transfer community and secondary care services into localities , e.g. diagnostics, treatment rooms.
- Year 2; identify gaps in the above map and business plan for investment in focused prioritised practices.
- Year 3; substantive implementation of the 'Hub-and spoke' model previously agreed with local needs prioritised as above.

5.3. **Outcomes**

- Invigoration of previously agreed estates plan.
- Updated local needs analysis prioritised.
- Enhancement and support of locality based commissioning of community services.

5.4. **IT**

- IT remains an area where primary care excels in both implementation and enhancement of quality care to NHS patients. The fragmented and isolated approach by other providers in the NHS needs to be aligned to a patient-centred approach. The evidence is compelling that primary care has, does and will do that with IT.

5.5. **Proposal**

- Year 1; GP – GP transfer implementation to be 100%
- Year 2;
    - Data sharing agreement in place with primary care systems at heart of governance areas.

- All commissioned areas/schemes to identify differences in clinical IT systems provision and timetable to resolve.
- Primary care and patient's needs to be written specifically in all new commissioned schemes, not needs of Providers solely.
- Year 3; Implementation of innovative clinical IT usage, e.g. remote clinical working, practice web/App pilots.

5.6. **Outcomes**

- Integrated IT strategy which prioritises patient safety and primary care as basis of IT strategic aims
- Removal of governance hindrance in clinical care such as End-of-Life or Urgent Care.
- Statement of intent to all providers that integrated care needs integrated IT

6. HEALTH OUTCOMES

6.1. **Primary Care Investment**

- There is no doubt that primary care capacity is moving beyond what is envisaged to deliver its present contract outcomes. In order to undertake the move to transfer of services from secondary and community providers to primary care needs not only a radical change but a substantial movement of resources within the NHS
.
- Other areas locally have shown the way in supporting this investment in primary care in a real financial sense. Transparency and openness in local practice funding has been identified as an immediate objective.

- Financial insecurity and an inability to plan beyond even a few months destabilise any motivation to change primary care provision.

- Access and substantive Primary Care Clinician led commissioning has been identified by NHSE M, and our partner CCG's in Merseyside, as priority areas to focus any substantive investment.

- Substantial resources remain within our control, and a prioritisation to 'Energising Primary Care' could deliver real change and financial benefit.

6.2. **Proposal**

- Substantial and sequential investment in practice funding over a 3 year programme to allow an increase in GP capacity in areas of access and commissioning over 5 year period.

- The sequential investment in direct funding to practices would be aligned with movement from unstable funding sources including Local Enhanced Services (LES's) 'not fit for purpose', non-recurrent funding, dividends from Quality Premium, decommissioning of services, and Winter Pressure Plan funds.

- **Year 1**

  - Publication of funding allocation on practice by practice basis.

- Direct funding for 30% reduction in LES schemes and implementation of Practice Access Scheme.
- Practice Access Scheme.
- No lunchtime / half day closing.
- 1 day/week opening 6.30-8pm.
- 10 face-face consultations.
- 90% of annually available weeks per 3000 patients.
- 90% attendance of 50% clinicians per practice at all CCG commissioning events-locality/wider group.

- **Year 2**

  - Direct funding for further 30% reduction in LES schemes / Practice Access Scheme.
  - Practice Access Scheme.
  - No lunchtime / half day closing.
  - 2 days/week opening 6.30 – 8pm.
  - 20 face-face consultations.
  - 90% of annually available weeks per 3000 patients
  - Commissioning attendance as year 1.

- **Year 3**

  - Direct funding of Primary Care Access Scheme (increase to 3 days opening 6.30 – 8pm – rest as per year 1 – 2).
  - Cessation of LES's in current format.
  - Commissioning attendance as year 1 – 2.
  - Any investment required will be approved via the Finance and Resource Committee.

6.3. **Proposal - Health Care Assistant Scheme**

- A substantive and detailed business plan, in partnership with a large local educational provider, has been drawn up to support practices' to increase primary care clinician capacity in the area of Health Care Assistants (HCA)Whilst innovative, the scheme is based on the financial models of previous NHS organisations such as Family Health Services Authorities (FHSAs) who co-funded initial implementation. This allowed practices' at the end of the scheme to decide on the financial viability of continued employment.
- The CCG would become the first CCG in the country to be a teaching CCG.
- Year 1; proposal to be presented.
- Year 2-3; implementation of Health Care Assistants Scheme.
- Year 3 onwards; practices' to decide own needs and financial case for continuation of employment.

7. Summary

It is clear that the process undertaken, which was informed by ' A Sense of Purpose', has not only validated the Governing Body's commitment to quality, but re-iterated to local and regional partners the prioritisation of primary care in the 'Everyone Counts ' documents implementation.

This has been received with real interest and a genuine reflected support, from every single one of our partners, that this is the right thing, and the right time.

Primary care, despite some of its' national detractors is not only valued but has a depth of support particularly within South Sefton.

It is within our realistic scope to redefine ourselves locally, so that what we value most about General Practice remains stronger. General Practice will change when the evidence and resources establish the framework to put our patients first.

We are capable of delivering our aims outlined in ‘Everyone Counts’ to a level which would be a model of ‘Gold’ General Practice, not only for our CCG but any other CCG within the Mersey area. We are in a position to answer the NHS ‘Call To Action’, and deliver it.

This paper recommends to the Governing Body to support the proposals above and its’ schedule of delivery.

Dr Bal Duper
Primary Care Development Lead
September 2013

Appendix A

Southport and Formby	Appendix A Stakeholder Involvement	
Meeting Name	Attendees	
Senior Leadership Team	Dr Niall Leonard, Dr Craig Gillespie, Fiona Clark, Martin McDowell, Helen Nicholls, Debbie Fagan, Lynda Elezi	BD / AP
Board to Board	Dr Nial Leonard, Dr Rob Caudwell, Roy Boardman, Karen Leverett, Roger Pontefract, Dr Graeme Allan, Dr Clive Shaw, Dr Craig Gillespie, Dr Andy Mimnagh, Dr Paul Thomas, Dr Steve Fraser, Lin Bennett, Sharon McGibbon, Lynda Elezi, Fiona Clark, Martin McDowell, Tracy Jeffes, Malcolm Cunningham, Melanie Wright	BD/AP
Quality Committee	Helen Nichols, Dr Rob Caudwell, Karen Leverett, Fiona Clark, Martin McDowell, Debbie Fagan, Dr Doug Callow, Dr Kati Scholtz, Billie Dodd, Anne Dunne	AP
iMerseyside	Paul Shillcock, Alison Johnston	BD/AP
Healthwatch	Diane Blair, Wendy Carruthers	BD/AP
PM Meeting	Gillian Roberts, Paul Ashby, Karen Ridelagh, Stewart Eden, Debbie Elliott, Nina Price, Colette Riley, Rachel Pinedo, Janice lloyd, Lydia Hale, Joyce Lloyd, Roy Boardman, Ann Marie Woolley, Dawn Bradley Jones, Karen Leverett	BD/AP
Wider Group Meeting	Member practices	BD/AP
EPEG	Steve Astles, Diane Blair, Roy Boardman, Lyn Cooke, Tracy Jeffes, Rachel Jones, Libby Kitt, Michelle McKeowan, Sarah McGrath, Sharon McGibbon, Roger Pontefract, Ray Murphy, Gloria Payne, Hilda Yarker	AP
Practice Nurse	Judith Abbott, Maggi Bradley, Sue Brennan, Pam Bruce, Stephanie Harrison, Lorraine Mitchell, Stella Moy, Colette Page, Carol Reddaway, Peter Reddaway, Rachel Redman, Pippa Rose, Yvonne Sturdy, Marie Wallace	BD

Health and Social Care Forum	Roger Driver, Chair (Bootle Team Ministries), Rachel Jones (Sefton CVS), Alison Ayres (Sefton Advocacy), Jackie Hughes, Helen Flett (People First Merseyside), Charley Wilkinson, Adrian Lee (Galloway's Society for Blind), Stuart Ingham, Michael Porter (CRI), Steve McDermott, Colin Clarke, Dave Smith (Expect Ltd), Dawn Stewart, Dil Daly (Age Concern Liverpool & Sefton), Jo Harrison-Smith (Nugent Care), Jane Groves (Citizens Advice Sefton), Deborah Wolff (The Abbeyfield Society Formby & Crosby), George Loughlin (Caring for Carers, Sefton), Mark Watts (The Positive Fitness Foundation), Sarah Nock (Wellbeing Sefton Project), Diane Eastaway (Abbeyfield Southport Society), Samantha Morley (Southport Community Service Station), Sarah Dodgson (British Red Cross), Bev Wells (Sefton CVS), Ian Jones (Scope), Debbie Wright (PSS), Diane Blair (Healthwatch Sefton), Keith Cawdron (Jospice), Val Bayliff (Sefton Older Peoples Enabling Resource and Action), Brenda Dodd (Sefton Helping Hand Services), Andrew Booth (Sefton Pensioners Advocacy Centre), Sarah Dodgson (British Red Cross), Dr Bal Duper, Angela Parkinson (Clinical Commissioning Group)	BD/AP
LMC	Joe Chattin	BD/AP
Estates	Wayne Ashton	BD/AP
Member Practices	GP Leads from each practice via Email	BD/AP
Equality and Diversity	Andrew Woods	AP

Southport and Formby

Demographics

Board to Board	1. Prioritise Health Inequalities. 2. Anticipate and plan population changes e.g housing estates/ migrant workers. 3. Map out Nursing / Care Homes (local authority). 4. Prioritise Carers , map Carers distribution both CCGS / Practices.
Healthwatch	1. GPs working in larger fit for purpose premises with other colleagues in Primary Care would offer patients a full range of services and provides better opportunities for continuity of care, improved communication. 2. The whole Primary care system needs to be built around patients rather than provided from single units / components of care.
Member Practice	1 Elder care equals harder and more intensive work but funding still follows deprivation formulae. 2 Continuity of care key as consequence more intensive work. OOHs WICs strip resources from primary care 3 Sessional Drs a must to cover leave or illness perhaps employed by CCG, half of the year we are running under capacity due to leave. 4Win hearts and minds ahead of any national quality to release funding from NHSm to "prop up" North Sefton which is as your evidence indicates under resourced and ill prepared to cope with increasing demand.

Workforce Development

Board to Board	1.Workforce needs analysis in terms of age and special interests - Local Area Team / LMC / GPs/PNs/PMs each CCG. 2. Health Care Assistant development programme. 3. Feasibility of CCG clinical workforce to support backfill and mentoring/ link in with wider OD plan.
Healthwatch	1. Practice Nurses are important members of primary care and should work alongside their nursing colleagues e.g District Nurses offering drop-in and appointment clinics.
Member Practice	1.CCG clinical workforce to ensure support, back fill and mentoring work around workforce resilience. 2.Ensure PLT allows work to complete a suite of agreed pathways and standardised care. 3.Every practice should have a self care nurse practitioner, training and coaching patients away from being a cost centre and looking after themselves.
PMs	1. When investing in primary care workforce the investment recognises those practices who have invested and ensures that they are not financially disadvantaged as a result. 2. Quality is not just Clinicians. To improve the patient experience Practice Managers and Clerical Staff should also be provided with development opportunities.
Practice Nurse	1. Practice Nurse Leads an absolutely invaluable resource. The two leads have provided excellent service for Practice Nurses. Not only are we more informed, we are working more as one and we have two expert people to direct any queries to. I would say that if the role was not continued it would be hugely detrimental to Practice Nurses. I would like to extend my thanks to Pippa and Colette who have done a most excellent job and have supported me greatly.

Clinical Services

Board to Board	1. LES review/ alternative use of resources. 2. Prioritise review of OOH/ Urgent Care Contract/ increase local GP input / patient group input. 3. Integrate care closer to home / Virtual Ward. 4. Federation of clinical services. 5. Quality Investment programme.

LMC	1. Collaboration of services between willing practices. 2. Resourcing of primary care development / vary present resource.
Healthwatch	1. From its work in gathering experiences from patients and local residents we have an overview of experiences of primary care in that we have patients who have long term conditions voicing their frustrations that they can't get an appointment to see their GP who knows about their condition but it is this GP that they have built up a relationship with. Other people who are not regular attendees at their practice become ill and just want to see any GP who may be able to diagnose and prescribe if needed. 2. One of our community champions (a local Children's Centre) in South Sefton asks about the feasibility of immunisations at Children's Centres as this would be welcomed by local parents. Child health surgery clinics for under 5's could be extended to all children with input from School Nurses and Health Visitors. 3. Flexibility within the system is important for patients i.e appointments, timing and availability. For those with Long Term Conditions, continuity of care with a trusted clinician is important but for other patients the availability at a time that suits may be of equal importance i.e those who are working. Primary care sites should be able to offer a range of diagnostic tests where appropriate. For example patients should be able to have a simple blood test on primary care premises without having to make an appointment at another venue.

Health and Social Care Forum	1. People in Sefton experience problems getting prescriptions filled out of hours, particularly on a Sunday, as emergency clinics often do not have required medication. It might be worthwhile to review stocking policies. 2. People experience difficulties getting a GP appointment, some GP practices ask patients to telephone for appointments from a set time in the morning, this creates problems for people who need help to use a telephone. 3. Some problems have been observed regarding district nursing services. Firstly with teams regarding the location of services and visiting patients attached to particular practices, which aren't always the ones closest to them. In addition, some cause for concern has been the criteria told to some patients to access district nurse services, that being patients need to be 'housebound and without any relatives or friends'. This approach excludes some people with mental health problems and assumes that people's families are willing and able to support them with health appointments. 4. There is not much support available to people in Sefton diagnosed with Asperger's Syndrome. Diagnosis is done by the Liverpool Asperger's Team and their support ends with diagnosis. 5. Services such as counselling, physiotherapy and district nurse visits are limited to six sessions/ treatments - whilst this approach does not reflect individual needs, it also reviews patient progress, which leaves some patients feeling under pressure to agree that they are better than they really are and so agreeing to fewer sessions that they really need. 6. It would be useful if more GPs had an awareness of social prescribing and the benefits to people with low mental health and wellbeing. 7. It would be beneficial to have a single point of contact for the Voluntary, Community and Faith Sector. 8. There is a need for informal social provision for those experiencing poor levels of mental health and wellbeing in the North of Sefton. 9. It would be useful if the possibility of establishing an emergency, non-nursing home support service to both prevent the need for hospital admission and facilitate quicker discharge for some patients, who don't require an overnight hospital stay, yet need some monitoring and low-level support. Further information and details on these comments were submitted by organisations and can be provided on request. In addition, some organisations have offered proposals to address these concerns which can be shared with Sefton Clinical Commissioning Groups separately.

Member Practice	1. Funding for a full time pharmacist each practice. Give GPs headroom Quality work. 2. LES's can be supported by pharmacists for best outcome. 3. Federation Buddy practice and inter- practice referral schemes . 4. Develop on a locality basis a **community hub** idea around each locality creating a local community centre, which could incorporate welfare and social prescribing – in addition map current service provision made by Voluntary, Community and Faith Sectors and encourage inclusivity. 5. Over time look at the feasibility of catering in the hubs for drop-in places, child-care schools for mums, places where people can go and learn to turn ingredients into healthy meals. IT teach-ins, health and wellbeing workouts. Workshops for the new generation of retirees to potter, repair, make and meet without having to play bingo and sing the songs that made Vera Lyn famous. U3A Local web based service directory. Identify the isolated and support offer alternatives for the lonely to help stop them becoming isolated. Coffee shops, book exchanges. Social services, CAB, job-centres, physio's and rehab, just down the corridor. Consider whether we could tie in private sector charities to make use of libraries under threat of closure. 6. Retain **LES's by rebranding** under quality investment into primary care. OOH local procurement.
PMs	1. Work around the LES financial envelope recognises that some practices have invested their own money in additional staffing resources. We would not like to see those practices who have not invested be rewarded by gaining a share of a service that is now being partly paid for at the expense of those practices that have invested.

Premises /IT

Board to Board	1. Primary care premises fit for purpose. 2. Timetable of primary care estates. 3. I.T Leads should prioritise patient and primary care I.T over secondary care commissioning of I.T systems. 4. Prioritise data sharing between organisations.
Healthwatch	1. GPs working in larger fit for purpose premises with other colleagues in primary care would offer patients a full range of services and better opportunities for continuity of care, improved communication. 2. Primary care system needs to be built around patients rather than provided from single units / components of care.

gb partnerships	1. Review and update property condition data. 2. Address shortfalls in community clinical accommodation. 3. Work in collaboration with NHS England.
iMerseyside	1. GP to GP transfer of records. 2. Data sharing community – GP. 3. Virtual Access - remote access to information for clinicians. 4. Information Facilitator workstreams. 5. Dashboard of projects mapped through locality/CCG.
Member Practice	1. Revisit estates strategy and allow localities to redefine use location of stock. If agreed sell off and make new premises solution fit for purpose with focus on community hub (see 4 clinical services). 2. Needs analysis and a business case model around quality improvement plans. 3. Where ever possible **long-term conditions** should not be clogging up waiting rooms. They need where possible to be telecare maintained on the web, self-managed and supervised by locality or CCG wide health and wellness call-centres (ideally locality based), funded and run by GP federations - the centres work for the practices and are controlled and managed by them. 4. **Run Elder-Care and Long Term Conditions (QOF)** on separate, discrete care-pathways. The assumption to be; GPs see QOF related stuff only when they have to , the rest of the time it is down to nurses HCA's pharmacists and properly organised practice admin and oh yes self – reporting and where it makes sense fiscally / quality wise use of telecare. 5. **IT** must be mobile.

Health Outcomes

Board to Board	1. Prioritise areas. 2. Re-energise primary care priorities. 3. Commitment to GP Framework investment. 4. Quality Premium. 5. Agreement in 3 year plan.

Member Practice	1. **Commitment and expansion of present GP framework** investment programme. For too long now in North Sefton primary care investment has lagged behind that of other PCTs/now CCG's. We have the least well funded of Merseyside CCG's. The increased demand is stretching primary care. We provide very good quality but primary care risks falling over as demand outstrips resources. 2. Quality Committee to include Primary Care quality areas of NHSE Framework / local dashboard to be part of remit. 3. Local ownership of Quality Premium work stream and if any more funding for care closer to home then we define what services look like and configure them around primary care. Current model is nowhere near responsive enough led by secondary care ICO. 4 Quality and Performance Assurance framework and any QIP must address and highlight any shortfall in provision and funding and flag this up to NHSE.

Appendix B

Terms of Reference Primary Care Quality Strategy Board

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

1. Authority

The Primary Care Quality Strategy Board shall be established as a sub-committee of the Quality Committee to perform the following function on behalf of the CCG Governing Body.

The principal function is to oversee the implementation of the two Primary Care Strategies 'A Sense of Purpose' and in doing so, improve health outcomes for patients and reduce inequalities in health across both CCGs.

2. Membership

The following will be members:

- Primary Care Quality Lead (Chair)
- Senior Clinician from each CCG (non Governing Body)
- Head of CCG Development from each CCG
- Head of Performance and Health Outcomes
- Primary Care Development Manager
- Locality Manager
- LMC
- Representative from NHS England Merseyside
- Lay Member from each CCG

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

Other senior members of the CCG may be invited to attend, particularly when the Sub-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 Sub-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 Primary Care Quality Strategy Board.

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. Duties of the Primary Care Quality Strategy Board

- To implement the vision for the futures of primary care in Sefton as described in the strategy
- Devise an implementation plan for delivery of the strategy
- To prioritise the Governing Body approved workstreams and agree timescales
- To act as professional advisors to ensure that the workstreams can be practically delivered
- To oversee the investment in primary care as funded by the Quality Premium, monies currently invested in Local enhanced schemes (LES's) and primary care investment funding
- To have a discriminatory role in deciding funding to GP practices
- To agree a communication strategy with member practices.

4. Administration

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

The agenda for the meetings will be agreed by the Chair of the Sub-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.

5. Quorum

The Chair (or Vice Chair) plus three 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.

6. Frequency and Notice of Meetings

The Primary Care Quality Strategy Board shall meet monthly during the financial year. Internal Audit and External Audit may request an additional meeting if they consider that one is necessary.

7. Reporting

The ratified minutes of the Primary Care Quality Board will be submitted to the Quality Committee.

8. Conduct

All members are required to maintain accurate statements of their register of interest with the Governing Body. Members should notify the 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 and NHS Southport and Formby CCG procedures 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.

9. Review

Version Number: 1

Review dates March 2014

Appendix C

OCTOBER 2013	• Agreement with LMC • TOR/Membership of PCQS Board agreed by SMT • Finance team to identify funding streams to deliver 'Energising Primary Care:'
NOVEMBER 2013	• Finance and Resource Committee to approve funding outlined in finance team report. • PMO to confirm gant programme for PCQS Board
DECEMBER 2013	• First PCQS Board meeting
JANUARY 2012	• Progress report to Governing Body
APRIL 2014	• Implementation and delivery of Primary Care Quality Strategy

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/125	**Author of the Paper:** Andy Woods Andy Woods Senior Governance Manager (Equality& Diversity) 0151 285 4644 07825111596 andrew.woods@cmcsu.nhs.uk
Report date: 25 September 2013	

Title: Equality and Diversity Objectives

Summary/Key Issues:

This paper highlights the key Equality objectives that Southport and Formby CCG has produced to progress the equality agenda. The objectives are a specific requirement stipulated by the Equality Act 2010.

Recommendation

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

Note	
Approve	x
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.
	To drive clinical leadership development through Governing Body, locality and wider constituent development.

GB13/125

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	x			Patient and Public engagement across protected groups is a requirement of the Equality Act 2010
Clinical Engagement				
Equality Impact Assessment	x			Equality Objectives are specific compliance requirement of the Equality Act 2010
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement				
Presented to other Committees	x			The Equality Objectives report was presented to EPEG 11/9/13

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
September 2013

1. Executive Summary

This paper highlights the key Equality Objectives Southport and Formby CCG has produced to progress the equality agenda (Appendix 1). The objectives are a specific requirement stipulated by the Equality Act 2010. This paper outlines what informed the development of the Objectives Plan, including the Equality Delivery Systems self-assessment framework, how the objectives can support the CCG to improve access and outcomes, meet a range of requirements and how the plan will be monitored.

2. Introduction and Background

2.1. The objectives are a specific requirement stipulated by the Equality Act 2010.

2.2. The Objectives Plan (Appendix 1) was informed by the following.

- The NHS Equality Delivery Systems (EDS): this is a self-assessment that is graded across 4 areas – undeveloped, developed, achieving and excelling and maps equality performance against the NHS Outcomes Framework. It is broken into 4 goals with 18 outcomes (Appendix 2).
- Equality performance of providers.
- Commissioning priorities and the Joint Strategic Needs Assessment.
- Other wider intelligence including the Equality and Diversity Strategy, national policy and intelligence from communities and representative groups.

3. Key Issues

3.1. The objectives also support the CCG to:

- evidence how it is working towards meeting the wider Public Sector Equality Duty (PSED) to eliminate discrimination, advance equality or opportunity and foster good community relations
- meet the NHS England Assurance Framework
- be more responsive to community and patient needs
- provide a level of assurance against the commissioning practice of the CCG
- improve access and health and wellbeing outcomes for protected groups and communities

- be vigilant to poor standards of care
- address health inequalities
- deliver against the commissioning priorities; and
- provide a clear line of sight on any potential legal and financial risks.

3.2. The Objectives Plan provides clarity on where the CCG intends to focus its efforts around the agenda and provides a clear insight into where improvements are needed in relation to making commissioning decisions and monitoring the performance of its main providers.

3.3. The key four Equality Objectives are to:

1. to improve how we make fair and transparent commissioning decisions
2. improve outcomes and access for people who face inequality and disadvantage
3. improve the equality performance of our main providers
4. to empower and engage our workforce.

3.4. The action plan in has been mapped against EDS outcomes and goal and against the Public Sector Equality Duty. Key heads of service have been assigned as responsible people.

3.5. EDS assessment took place between June and September 2013. This involved a series of one to one meetings, interviews and briefings with services leads, senior managers, programme teams, commissioners and key corporate and quality leads and officers. This evidence was benchmarked against the EDS framework and was discussed and agreed at the Engagement and Patient Experience Group (EPEG) on 11 September 2013.

3.6. The organisation has been assessed as **Developing** and the Objective Plan demonstrates how the CCG intends to improve over this score over next 4 year (Appendix 2).

3.7. Furthermore, EDS is changing significantly and EDS 2 will be launched by NHS England in November 2013 and the CCG' will work toward the new framework from 2014 onwards.

4. Monitoring and Assurance

4.1. Quarterly updates will be made to the Corporate Governance Support Group on progress against the Objectives Plan and Equality and Diversity Strategy Plan.

4.2. Bi-annual progress reports will be presented at EPEG.

4.3. The Governing Body will receive an annual update report.

5. Conclusions

The Equality Objective report and plan ensures that the CCG are compliant with their specific duties under the Equality Act 2010 and supports the CCG in meeting the Public Sector Equality Duty.

6. Recommendations

The Governing Body are asked to approve the Equality Objectives Plan.

Appendices

Appendix 1 Equality Objectives Plan
Appendix 2 Equality Delivery Self-Assessment

Andy Woods
Senior Governance Manager (Equality& Diversity)
Cheshire & Merseyside Commissioning Support Unit
September 2013

Appendix 1 - Equality Objectives Report and Plan

South Sefton CCG Equality Objective	Key Areas of Work	Lead Responsible Officer	Target Dates	Public Sector Equality Duty	Equality Delivery System (EDS)
1. To make fair and transparent commissioning decisions	1. Embed equality analysis into business planning / options appraisal (Equality and Governance Guidance document). 2. Embed equality analysis into committee reporting structures (Equality and Guidance document). 3. CMCSU to continue to build skills and knowledge of the team. Leadership and report into relevant committees 4. Ensure systems are in place to ensure intelligence of patient barriers and/or gaps are reflected and addressed in priorities and plans.	Head of Delivery & Integration	Jan 2014 November 2013	• Eliminate Discrimination • Advance Equality of Opportunity • Foster Good Community Relations	Goals 1, 4
2. To improve access and outcomes for patients and communities who experience disadvantage	1. Ensure CCG and key providers undertake EDS 2 and Healthwatch Sefton continue to play key assurance role 2. Ensure CCG works closely with protected groups and their representatives in the commissioning and quality agenda to address disadvantages and gaps in priorities and plans • Trans and BME access to primary and secondary care 3. Develop further guidance and support and identify resources for commissioners to address barriers and disadvantages 4. Develop and explore solutions to improve analysis and trends across patient experience	Head of Delivery & Integration	March 2015 EDS2 April 2014 onwards	• Eliminate Discrimination • Advance Equality of Opportunity • Foster Good Community Relations	Goal 2

South Sefton CCG Equality Objective	Key Areas of Work	Lead Responsible Officer	Target Dates	Public Sector Equality Duty	Equality Delivery System (EDS)
	particularly those who experience disadvantage				
3. To improve the equality performance of our providers through robust procurement and monitoring practise	1. Raise profile of equality agenda at key providers CQPG to develop and implement plans to address key areas of disadvantage. 2. Review the Equality KPI requirements of the Quality contract schedule to ensure instructions are clear, focussed and addresses Public sector Equality Duty 3. Maintain the Equality provider forum 4. Connect equality implications of Keogh and Francis report via quality schedule (EDS2 and above CQPG plan above) 5. Explore options to improve analysis of patient experience across protected groups where needs are greatest	Chief Nurse	February 2014 March 2014 On going March 2014 March 2015	• Eliminate Discrimination • Advance Equality of Opportunity • Foster Good Community Relations	Goals 1,2,4
4. To empower and engage our workforce	1. CSU to refresh and standardise key workforce policies in conjunction with Southport and Formby CCG 2.HR and Remuneration committee to ensure robust commitment to equality and workforce issues 3. Act upon NHS England equality related workforce recommendations	Head of Delivery & Integration	April 2014 March 2015 April 2014	• Eliminate Discrimination harassment and victimisation • Advance Equality of Opportunity • Foster Good Community Relations	Goal 3

Appendix 2 - Equality Objectives Plan October 2013 to March 2015

Goal	Narrative	Outcome	Developing
1. Better Health Care Outcomes for all	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities	
		1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways	
		1.3 Changes across services for individual patients are discussed with them and transitions are made smoothly	
		1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all	
		1.5 Public Health, vaccination and screening programmes reach and benefit all local communities and groups	
2. Improved Patient Access and Experience	The NHS Should Improve accessibility and information and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	2.1 Patients, carer and communities can readily access services and should not be denied access on unreasonable grounds	
		2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment	
		2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised	
		2.4 Patients and carers complaints about services and subsequent claims for redress should be handled respectfully and efficiently	
3. Empowered, engaged and well-supported Staff	The NHS should increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients and community's needs.	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades	
		3.2 The NHS is committed to equal pay audits to help fulfil their legal obligations	
		3.3 Through support, staff are confident and competent to do their work so that services are commissioned or provided appropriately	
		3.4 Staff are free from abuse, harassment, bullying, violence from other patients and their relatives and colleagues, with redress being open and fair to all	
		3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way people lead their lives.(flexible working may be a reasonable adjustment for disabled members of staff or carers)	
		3.6 The workforce is supported to r4main healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population	
4. Inclusive Leadership at all levels	NHS organisations should ensure that equality is everyone's business and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced and good relations fostered within their organisations and beyond	
		4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination	
		4.3 The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes	

NHS
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MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/126	**Author of the Paper:**
Report date: 4 September 2013	Melanie Wright Business Manager melanie.wright@southseftonccg.nhs.uk

Title: Constitution Update

Summary/Key Issues:

This paper presents the Governing Body with recommendations of amendments required to the CCG's Constitution, details of which are set out below.

The Constitution has been resubmitted to both the LMC and BMA and Dr Pfeiffer has also reviewed and approved the amendments suggested herein.

(1) Section 19 – Conflict of Interest

Amended to include reference to the CCG's Policy on Managing Conflicts of Interest, which was approved by the Governing Body on 30 May 2013.

(2) Section 24 – Confidentiality

Inclusion of an additional paragraph at 24.5 in relation to 'whistleblowing'.

(3) Schedules 9-12 - Terms of Reference, Committees of the Governing Body

The Governing Body approved the updated Terms of Reference for the Audit Committee, Quality Committee, Finance and Resource Committee and Remuneration Committee on 25 July 2013 and these approved Terms of Reference have now been formally appended to the Constitution.

(4) Schedule 7 - Terms of Reference, Locality Groups

These terms of reference have been updated to reference the CCG's Policy on Managing Conflicts of Interest, together with Standards of Business Conduct expected by members of those committees. These amendments mirror the standards expected of formal committees of the Governing Body at (2) above.

Recommendation

The Governing Body is asked to approve the amendments suggested to the Constitution.

Receive	
Approve	x
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	
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

NHS
South Sefton
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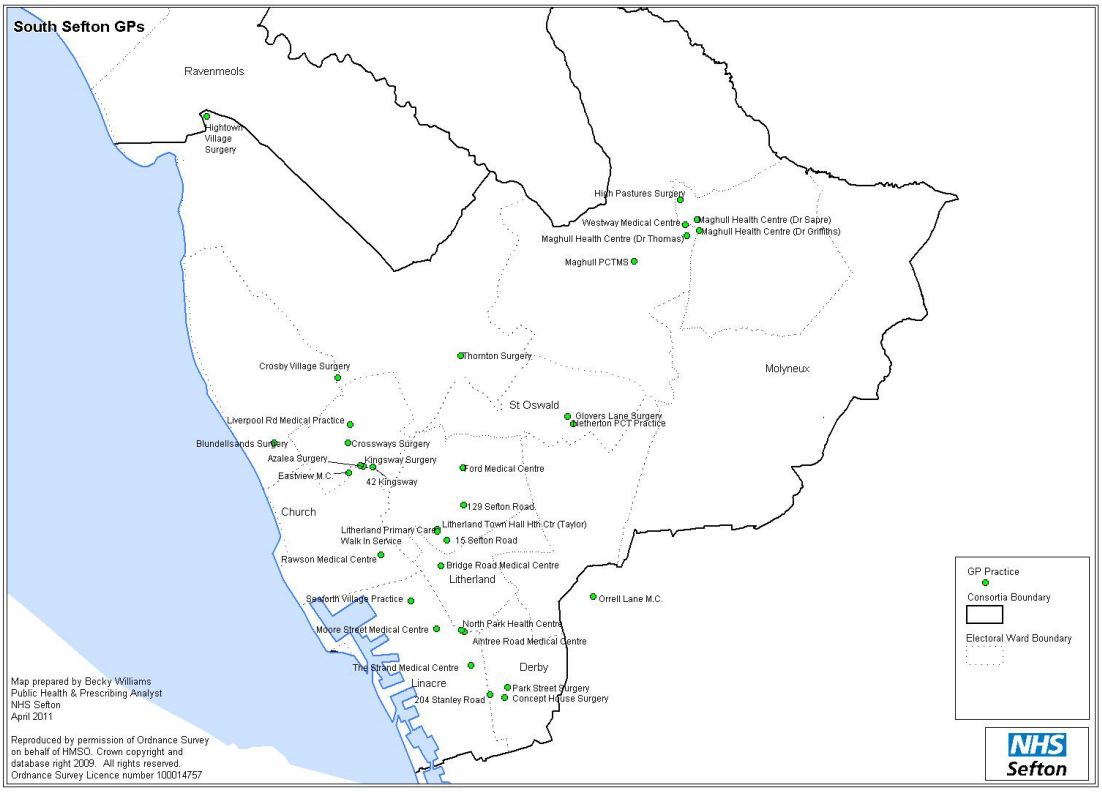
NHS SOUTH SEFTON CLINICAL COMMISSIONING GROUP CONSTITUTION

BMA template version: 6.11 30/07/2013

Passed by the Wider Constituent Meeting

On TBA



NHS
South Sefton
Clinical Commissioning Group

This Constitution is the constitution of NHS South Sefton Clinical Commissioning Group, hereinafter referred to as the "Clinical Commissioning Group".

General

The Clinical Commissioning Group is a clinically led membership organisation made up of general practices. The member practices of the CCG are responsible for determining the governing arrangements for the organisation which are set out in this Constitution. This Constitution has been developed to reflect and support the objectives and values defined by the CCG and to ensure that all business functions discharged by the CCG are discharged in an open and transparent manner this Constitution has been developed with the member practices and Localities.

This Constitution sets out the terms on which the Clinical Commissioning Group through its elected and/or appointed and/or co-opted Governing Body (the Governing Body) shall implement all statutory obligations including but not limited to commissioning of secondary health and other services in the Geographical Area . This Constitution shall also contain the main governance rules of the Clinical Commissioning Group and its Governing Body.

This Constitution, and the functions of the Clinical Commissioning Group, are subject to the Health and Social Care Act 2012.

Engaging the public and how we conduct our business

In line with the CCG Communications and Engagement Strategy which will be developed with public consultation and engagement, the public voice will be able to influence decision making through:

- Patient Participation Groups
- Health & Wellbeing Board (H&WBB)
- Public Involvement Network (Subcommittee of the H&WBB)
- Healthwatch
- Two Lay members of the Governing Body

The CCG will operate in a way which is consistent with the seven key principles of the NHS Constitution e.g., "*The NHS belongs to the people" (The NHS Constitution)* the Nolan Principles on Standards in Public Life (Schedule 16) and the Code of Conduct & Accountability for NHS Boards

Equality and Diversity

The CCG is committed to meeting its duties under the Equality Act (2010) by having due regard in all they do to the need to eliminate unlawful discrimination: advance equality of opportunity and to foster good relations across all protected groups.

Vision Objectives and Values

The agreed Vision Objectives Values for the CCG have been developed through a process of engagement with member practices.

Vision: By working together practices within the CCG we will have a healthier population, with fewer inequalities, and health services that are high quality, cost effective ad sustainable

Objectives: The CCG will work with the people of South Sefton to develop quality health services, fit for the future. Through clinical leadership, the CCG will:

- Achieve good health outcomes for us all within the funding and resources available to it:
- Balance the needs individuals with the needs of the whole community.

Values: "The NHS belongs to the people" (The NHS Constitution): the CCG will act at all times to ensure that this important principle is advanced and safeguarded.

Configuration and Membership of the CCG

The CCG shall function in respect of the geographical area defined as South Sefton comprising Bootle, Seaforth & Litherland, Maghull, Crosby & Hightown, and shall be made up of the Members as set out in Schedule 1 of this Constitution.

Each Member has agreed to the terms of this Constitution with the intention that by no later than April 2013 a formal statutory Clinical Commissioning Group shall have been established along similar terms of reference in accordance with, and subject to, any relevant legislation pertaining to govern and regulate the same.

Each Member by its signature to this Constitution shall agree that it is a member of the Clinical Commissioning Group and will adhere to, and work in accordance with its terms.

DEFINITIONS

Accountable Officer	means an individual who is appointed by NHS England and who may be a member or employee of the Clinical Commissioning Group or of anybody who is a Member of the Clinical Commissioning Group and whose duties and responsibilities are set out in Clause 10 herein.
Advisor	means a non-voting member of the Governing Body.
Any Qualified Provider (AQP)	means the Any Qualified Provider principle to be applied by the Governing Body, when engaging in the commissioning of health care services.
Budget	means the financial resources delegated to the Governing Body for the purposes of commissioning and all relevant and related services and functions including, but not limited to, the responsibilities as set out in Clause 7 herein and any relevant legislation
Business Day	means 9.00am until 5.00pm (other than a Saturday or Sunday or a Bank or Public Holiday).
Chief Officer	another term for Accountable Officer, where the senior manager fulfils the Accountable Officer role
Clinical Commissioning Group /CCG	means the NHS South Sefton Clinical Commissioning Group formed in accordance with and approved by NHS England.
Commencement Date	means the date of commencement of this Constitution being 1st April 2013.
Conflict of Interest	means any conflict of interest as set out in Clause 19.
Constitution	means this Constitution as amended from time to time in accordance with its terms.
Governing Body	means the elected and/or appointed and/or co-opted members of the Clinical Commissioning Group as set out in Schedule 3 herein and having the duties and responsibilities as set out in Clause 7.
Localities	The local areas that constitute South Sefton area, notably, Bootle, Seaforth & Litherland, Crosby and Maghull
Local Authority	means the administrative offices that are officially responsible for all the public services and facilities within the Geographical Area

Local Delivery Plan	means the local delivery plan as set out in Schedule 6.
Local Medical Committee	means the Sefton Local Medical Committee as recognised by the NHS Act 1977 and currently recognised by NHS South Sefton Clinical Commissioning Group
Member	means the Members of the Clinical Commissioning Group (which may change from time to time); being a primary care services provider holding a contract for the provision of primary medical services i.e. General Medical Services, Personal Medical Services or Alternative Personal Medical Services contract.
Member Practice Lead GP	means the GP nominated by the member practice to vote in elections, also referred to as Member
NHS England	means the body corporate as identified in the Health and Social Care Act 2012.
Performers List	means a medical performers list prepared and published by NHS England Local Area Teams
Provider	means any company, partnership, voluntary organisation, social enterprise, charity or organisation which may from time to time enter or seek to enter or have entered into arrangements to provide secondary medical services or social care services or any other goods and services by virtue of being commissioned by the Clinical Commissioning Group.
Voting	Voting by the Member Practice Lead GPs in the election of the Governing Body or in meetings of the Wider Constituent Group, AGM and EGM will be on the basis of one vote per 100 patients registered with the practice on the first day of the quarter in which the vote is being held. Voting in meetings of the Governing Body or other Committees will be by one vote per voting member, the chairman having the additional casting vote.
Wider Constituent Group	means the assembly of all Member Practice Lead GPs with the Governing Body

Contents

1. INTERPRETATION

In this Agreement:

1.1. words importing the singular include, where the context so admits, the plural and vice versa;

1.2. words importing the masculine include the feminine and the neuter;

1.3. references to any person shall include natural persons and partnerships, firms and other incorporated bodies and all other legal persons of whatever kind and however constituted and their successors, permitted assigns or transferees;

1.4. references to any statute, enactment, order, regulation or other similar instrument shall be construed as a reference to the statute, enactment, order, regulation or instrument as amended by any subsequent enactment, modification, order, regulation or instrument as subsequently amended or re-enacted;

1.5. headings are included in this Agreement for ease of reference only and shall not affect the interpretation or construction of this Agreement; and

1.6. reference to a Clause is a reference to the whole of that Clause unless stated otherwise and in the event and to the extent only of any conflict between the Clauses and the Schedules, the Clauses shall prevail over the Schedules.

2. COMMENCEMENT AND DURATION

2.2 This Constitution shall commence on the Commencement Date and shall continue in force unless otherwise terminated in accordance with the provisions of this Constitution.

2.3 This Constitution shall be reviewed at least every two years from the date of commencement and necessary variations tabled and voted on at an AGM or EGM of the Wider Constituent Group. Change of the Constitution requires a 75% majority.

2.4 The Health and Social Care Act 2012 allows for specified circumstances under which NHS England may institute variation of this Constitution. Before varying this Constitution NHS England must consult the CCG and its member practices on any specific changes that affect the local area.

3. FUNCTIONS OF THE CLINICAL COMMISSIONING GROUP

3.1 The Clinical Commissioning Group shall primarily be required to commission secondary care health services within the Locality to:-

3.1.1 all patients registered with Members who are GP Practices;
3.1.2 individuals who are resident within the Locality but not registered with Member Practices;
3.1.3 commissioning emergency care for anyone present in the CCG's area;
3.1.4 paying its employees' remuneration, fees and allowances in accordance with the determinations made by its Governing Body and determining any other terms and conditions of service of the CCG's employees;
3.1.5 determining the remuneration and travelling or other allowances of members of its Governing Body, locality groups and wider constituent group.
3.1.6 The CCG is a statutory body therefore it will discharge in addition to the above a range of functions, powers and duties which are set out in legislation and guidance:

- Statutory duties which must be carried out by law.
- Statutory powers which enable the organisation to undertake particular courses of action. These include powers to delegate functions.
- Non-statutory functions which NHS organisations are tasked with delivering. These are not set in statute but organisations are required to deliver them as part of fulfilling their role as local commissioners of the NHS.

The functions and general duties that the CCG is responsible for that are set out in legislation are summarised in the document 'The Functions of Clinical Commissioning Groups DOH June 2012'.

3.2 Primary Care Quality

3.2.1 There is an explicit Duty on the CCG to support NHS England (NHSCB) in continuously improving the quality of primary care medical services.
3.2.2 The Governing Body shall agree annually the format of performance monitoring and reviews but will adhere to the following principles:
3.2.3 The system of performance management will be supportive in nature and based on the principles of peer review and shared learning
3.2.4 The performance of practices will be monitored by means of regular meetings and data returns based at a locality level.
3.2.5 Any disagreement over issues arising as part of the performance management process will be dealt with in accordance with the CCG's Dispute Resolution Process (Schedule 14).

4. APPLICATION FOR MEMBERSHIP OF THE CLINICAL COMMISSIONING GROUP

4.1 A body which is a provider of primary care services (holding a General Medical Services, Personal Medical Services or Alternative Personal Medical Services Contract) in the Locality shall apply to become a Member of the Clinical Commissioning Group under the following conditions:

a) if the provider holds a contract for the provision of primary medical services;
b) it is a primary care services provider in the relevant Locality (as illustrated in the map on page 2 of this Constitution); and
c) it has duly submitted an application to NHS England for Membership to the Clinical Commissioning Group in the relevant Locality, such Membership having been approved.

4.2 Upon receiving a valid application the Clinical Commissioning Group may apply to NHS England, on behalf of the proposed new Member, for permission to amend the Constitution in order to admit the proposed new Member.

5. GOVERNANCE AND REPRESENTATION OF THE CLINICIAL COMMISSIONING GROUP

5.1 Each Member as set out in Schedule 1 shall be eligible to vote to elect a Clinical Commissioning Governing Body. Elections shall be conducted by the Local Medical Committee in accordance with the procedures as set out in Schedule 2 attached. Individuals elected, nominated or co-opted to the Governing Body shall be eligible in accordance with the following criteria:

a) they shall be an active Partner, a Sessional GP or Locum, of the practice or primary care services provider;
b) an individual shall not be eligible if they are, or subsequently are, retired from the practice or primary care services provider, suspended by either the General Medical Council or the Primary Care Trust or any other such successor body;
c) if the individual is a Sessional GP, he shall not be eligible in the event that he is suspended from his employment or subject to grievance or disciplinary proceedings; and
d) for those individuals (including those stated at (c) above) who are not party to direct contractual arrangements for the provision of primary medical services, they must be on a Performers List.

5.2 The Governing Body shall consist of a maximum of 13 voting members (listed at Schedule 3 herein), of whom at least 3 shall be non-clinical members to achieve the correct balance, representation and expertise. The Governing Body shall comprise of a Chair, Deputy Chair (the Lay Member with responsibility for Governance if a GP is operating as Chair), Clinical Vice Chair (who deputises in the absence of the GP Chair

to provide clinical input), Chief Finance Officer, Accountable Officer together with a maximum of a further 8 voting members and as Advisors a LMC Representative, Practice Manager representative and a Practice Nurse representative. At all times the number of the voting members of the Governing Body shall be no fewer than 11.

5.3 The Chair and Clinical Vice Chair shall serve on the Governing Body for a period of 3 years after which the position shall be subject to election. No Chair or Vice Chair shall serve on the Governing Body for a term exceeding 2 terms without a break of at least 2 years.

5.4 Other elected members shall hold office for a period of 3 years, after which their positions shall be subject to election, subject to section 6.5.

5.5 The Governing Body may meet together for the dispatch of such business as it is entitled to transact and may adjourn and otherwise regulate its meetings as it thinks fit. The quorum necessary for the transaction of business shall be a simple majority of voting members. The Governing Body will seek to make decision by consensus and agreement of its members; however on the occasions when there is no consensus decisions will be made by a simple majority according to the voting arrangements set out in section 5.2. In the case of equality of votes, the Chair will have an additional casting vote.

5.6 The Governing Body may from time to time appoint a member of the Governing Body to fill a casual vacancy where the Governing Body numbers fail to make up a quorum. Any Governing Body member so appointed shall only retain his position on the Governing Body for as long as the member who has been replaced would have held office if that office had not been so vacated, subject to confirmation by majority vote at the next quarterly wider constituent group meeting.

5.7 In the event that the quorum for the Governing Body cannot be met for any casual appointment the Governing Body shall have full authority to appoint new members of the Governing Body to fill such vacancies, subject to confirmation by majority vote at the next quarterly wider constituent group meeting.

5.8 Any quorum shall exclude any member of the Governing Body or a sub-committee affected by a Conflict of Interest under Clause 19. If this Clause 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.

5.9 Every term of office shall commence on announcement of the outcome of any vote/ballot which shall take place at the outset of the meeting of the AGM of the Wider Constituent Group. Any term of office shall also subsequently cease after the announcement of the new Officers.

5.10 The Governing Body shall have the authority to engage, employ or appoint any consultant, employee or private contractor in order to facilitate the performance of its duties. Such individuals may be present at any Governing Body meetings at the discretion of the Governing Body but shall not be entitled to any voting rights.

5.11 The Governing Body shall have the authority to delegate any of its activities to a sub-committee. Such sub-committee shall be made up of either members of the Governing Body, any consultants and/or employees approved by the Governing Body.

5.12 Any elected member of the Governing Body shall be entitled to nominate a proxy to vote on his behalf in the event that he cannot attend a meeting of the Governing Body. In those circumstances the Chair (or acting Chair), should be informed 1 week prior to the meeting of the non-attendance and shall receive a duly completed and authorised proxy form in the format as set out in Schedule 4.

5.13 No meeting of the Governing Body shall be held without either the Chair or Deputy Chair being present. If a Chair or Deputy Chair is not present, the meeting can proceed if a temporary Chair is elected from the remaining Governing Body members.

5.14 The Governing Body shall meet as often as is necessary to conduct its business. Every Governing Body member shall be given at least 10 business days' notice to attend.

5.15 The Governing Body shall meet in public at least 3 times per year. Every Governing Body member shall be given at least 10 business days' notice to attend. Meetings will be held in public except where the Governing Body considers that it would not be in the public interest to permit members of the public to attend a meeting or part of the meeting.

5.16 The date, time and venue of all Governing Body meetings will be made public with at least 7 business working days' notice on the Clinical Commissioning Group website. The notice shall include the agenda and papers related to the agenda.

5.17 All members of the Governing Body, whether elected or appointed or co-opted members, shall be permitted to carry a vote on any decision of the Governing Body. For the avoidance of doubt no Advisor shall carry a vote.

5.18 In the case of an equality of votes, the Chair shall carry the additional casting vote.

5.19 The Governing Body shall keep records and proper minutes of all resolutions and business conducted. Minutes of all formal meetings will be a matter of public record.

5.20 The Clinical Commissioning Group shall hold quarterly meetings of the Wider Constituent Group including an AGM once in each year provided that not more than 15

months shall elapse between the date of one Annual General Meeting and that of the next.

5.21 The Wider Constituent Group ordinary meeting or AGM shall be held in publicly accessible premises within the geographical area of the Clinical Commissioning Group.

5.22 The Governing Body shall give at least twenty eight days' notice in writing of every Wider Constituent Group meeting or AGM, specifying the place, day and the hour of the meeting.

5.23 No business shall be transacted at any Wider Constituent Group meeting or AGM unless a quorum is present when the meeting proceeds to business. A simple majority of Members' (weighted) votes personally represented shall constitute a quorum. Voting will be by the nominated Member Practice Lead GP on the basis of one vote per 100 patients registered with the practice on the first day of the quarter in which the vote is being held.

5.24 Members attending a Wider Constituent Group meeting or an AGM shall be entitled to vote on any question either personally or by proxy or as proxy for another Member. Voting will be by the nominated Member Practice Lead GP on the basis of one vote per 100 patients registered with the practice on the first day of the quarter in which the vote is being held.

5.25 The instrument appointing a proxy shall be in writing and signed by the appointer (the Member unable to attend the AGM) and delivered to the Clinical Commissioning Group not less than forty-eight hours before the date of the AGM.

5.26 The Governing Body shall publish all relevant financial reports (including those from the Audit and Remuneration Committees) and a consultation report at the AGM setting out in detail all the consultations it has undertaken and the findings and actions resulting, and a report setting out in details the commissioning plans for the coming year, where known.

5.27 An EGM can be called by constituent practices having at least one quarter of the (weighted) vote, by writing to the Accountable Officer and requesting a meeting within 28 days of which the constituent practices will be given 21 days' notice or by a majority vote of the Governing Body proposed by the Chair or any Governing Body member. Voting will be by the nominated Member Practice Lead GP on the basis of one vote per 100 patients registered with the practice on the first day of the quarter in which the vote is being held.

6. STRUCTURE OF THE GOVERNING BODY

6.1 The membership of the Governing Body is in line with the requirements of the Health and Social Care Act 2012 and supporting regulations. Following consultation with member practices the agreed composition of the Governing Body is as described hereafter.

The Governing Body shall consist of a maximum of 13 voting positions:

6.1.1 The Chair

6.1.2 The Accountable Officer

6.1.3 The Chief Finance Officer

6.1.4 The Clinical Vice Chair (If the GP Chair is unavailable, the Deputy Chair will defer matters relating to clinical issues to the Clinical Vice Chair)

6.1.5 7 GP representatives of Member Practices (which include the Chair and / or Clinical Vice Chair if so elected)

6.1.6 The Deputy Chair (if a GP Chair is elected, this role would be filled by the lay person in charge of governance)

6.1.7 A registered nurse;

6.1.8 2 lay members

- one to lead on audit, governance, remuneration and conflict of interest matters
- one to lead on patient and public participation matters;

6.1.9 A secondary care specialist doctor.

The Governing Body shall admit the following non-voting advisors to all its meetings:

6.1.10 a Local Medical Committee representative

6.1.11 a Practice Manager representative

6.1.12 a Practice Nurse representative

6.2 The Chair, Clinical Vice Chair and the GP representatives of Member Practices shall be elected positions. The positions of Chair, Accountable Officer and Chief Finance Officer are subject to national eligibility criteria. The Governing Body will ratify the appointment of the Chair in its first meeting following the declaration of the outcome of the election process.

6.3 The positions as stated in Clause 6.1.2, 6.1.3 and 6.1.6 - 6.1.9 shall be nominated or appointed by the Governing Body.

6.4 The Lay Members, Registered Nurse and Secondary Care Specialist Doctor will be appointed through an open selection process. This will comprise of wide advertisement followed by selection through interview. The interview panel will include Clinical Leaders from the CCG supported by individuals with relevant experience to ensure that specific competencies required to carry out duties are assessed.

6.5 The Governing Body shall hold elections for the positions as set out in Clause 6.2 above, every 3 years in accordance with the principles as set out in Schedule 2. Half the elected members of the Governing Body shall stand for re-election 2 years after the first election, which half shall be determined by lot.

6.6 In order to maintain fairness and equality during the electoral process the elections shall be conducted by the Local Medical Committee.

6.7 Any individual wishing to stand for election to the Governing Body, in respect of the positions as set out in Clause 6.2 above, shall do so in accordance with the criteria as set out in Schedule 2. The Local Medical Committee shall announce 3 months before the Governing Body elections the positions available to be filled and shall thereafter be open to receive nominations from appropriate candidates.

6.8 Though the Accountable Officer and Chief Finance Officer are permanent appointments it is important that they retain the confidence of the member practices. If member practices feel that this is not the case they should raise it at a Wider Constituent Meeting or call an EGM. If there is a 75% majority in a vote of no confidence then the ability of the Accountable Officer / Chief Finance Officer to continue in post would be reviewed by the Chair of the Governing Body. This proviso also extends to all other appointed positions on the Governing Body.

6.9 All elected positions on the Governing Body including the position of Chair can be terminated by a vote of no confidence with a 75% majority at a Wider Constituent Meeting or EGM.

7. ROLE OF THE GOVERNING BODY

The Governing Body shall:-

7.1 Ensure that all providers of primary medical services in the Locality are Members of the Clinical Commissioning Group, and shall keep up to date registers of the same.

7.2 Recognise where a Member who is a provider of primary medical services is a party to more than one contract for primary medical services, then that Member is to be treated as a separate provider in respect of each contract.

Commit to the principles of devolved responsibility for commissioning decisions across the health community in the relevant Locality.

7.3 Support a variety and diverse approach to commissioning, particularly for practices to work proactively to improve efficiency and value.

7.4 Encourage innovation by enabling and supporting practices and clinicians in creating changes.

7.5 Engage in a collaborative approach with the local NHS in securing new services for patients fully responsive to local health needs.

7.6 Ensure that there are robust plans and responsibilities assigned to manage staff engagement, external relationships and communications.

7.7 Facilitate the delivery of the required management cost savings whilst ensuring sustainable functions.

7.8 Facilitate the delivery and implementation of any guidance or standards issued by any relevant regulatory body including but not limited to the Care Quality Commission (CQC) or any successor bodies or their authorised assignees.

7.9 Apply the principle contained within the World Class Commissioning Agenda to the extent that it remains in force and relevant during the period of this Constitution including the broad principles set out in the White Paper entitled “Equity and Excellence – Liberating the NHS” and “Liberating the NHS Commissioning for Patients”.

7.10 Work with all local stakeholders to achieve delivery of the targets, policies and standards.

7.11 Work with and/or have any joint arrangements with any organisation or third party which are involved at any relevant time, in commissioning or provision of primary and secondary care services.

7.12 Work collaboratively to deliver the outcomes and milestones set out in any Business Plan.

7.13 Ensure effective liaison with and reporting to Members of the Clinical Commissioning Group, and NHS England (as appropriate).

7.14 Develop and keep under review robust governance arrangements that shall be complied with by all Members within the Clinical Commissioning Group.

7.15 Comply with all relevant procurement law and policy and adhere to the obligations placed on the Governing Body and Clinical Commissioning Group with regard to all Providers applying the following principles of:

a) transparency and openness
b) support and assistance and training so as to permit compliance with the procurement law, competition law and any relevant policies
c) application of guidance "procurement guide for commissioners of NHS funded services" and the "principles and rules for co-operation and competition".
d) equality of treatment
e) application of the principle of 'Any Qualified Provider'.

7.16 Ensure that all decisions made in relation to commissioning are fully recorded and auditable.

7.17 Be engaged in the day to day management and application of commissioning and related activity in the Local and Geographical Area and shall operate in good faith using all due skill and diligence.

7.18 Provide full reports of all activity including financial activity at all meetings. The reports shall be available to all Members prior to the Governing Body's quarterly meetings and form part of the main agenda.

7.19 Ensure that all the Clinical Commissioning Group's policies and procedures with regard to the involvement and consultation of patients and other relevant bodies are fully complied with at all times.

7.20 Fairly and equitably advertise any specific salaried posts.

7.21 Ensure that members of the Governing Body are informed in writing or covering email 10 business days before any meeting of the Governing Body. A monthly update report will be compiled and will include reporting of performance, activities, actions, forward planning and risks.

7.22 Ensure that the Governing Body approves any relevant business case and that any business case is duly considered by the Governing Body for approval before implementation. Stakeholder Members who are also members of the Governing Body or the Governing Body shall be identified and policies with regard to conflict or potential conflict shall be applied as set out in Clause 19 below.

7.23 Adhere to any other obligations as set out in statute, regulation and/or direction.

7.24 Implement all processes required to comply with any regulation, direction or internal governance where relevant.

7.25 Keep an up-to-date list of all committees, sub-committees and joint working arrangements.

8. EMPLOYMENT, REMUNERATION AND EXPENSES

8.1 The Governing Body shall be permitted to employ or engage the services of any individual if it reasonably believes that the employment or engagement of such an individual shall be of benefit to the Clinical Commissioning Group as a whole.

8.2 Any employment or engagement of any individual shall include but not be limited to attendance at meetings of the Governing Body and/or the Wider Constituent Group; the preparation and delivering of any relevant professional advice as so instructed by the Governing Body and/or the Wider Constituent Group; the discharge of their responsibilities as indicated by the Governing Body and/or the Wider Constituent Group from time to time in relation to the Clinical Commissioning Group.

8.3 In the event of such employment or engagement, the Remuneration Committee shall reasonably decide and agree the remuneration with such an individual or organisation on a case by case basis.

8.4 The Governing Body shall engage with the Local Medical Committee in respect of its functions as these affect their constituent members and to assist, in particular in the overseeing and conducting of elections at all levels within the Clinical Commissioning Group.

8.5 The Governing Body shall engage with the LMC regarding the remuneration of its constituent members for carrying out CCG work and for attending meetings which shall include but not be limited to meetings of the Governing Body, any committees, Wider Constituent Group or Locality Groups.

8.6 The Remuneration Committee shall be permitted to reasonably decide the remuneration payable in respect of the duties undertaken by the Accountable Officer.

8.7 Any remuneration as above may take any mutually acceptable form and may or may not also include any arrangements in connection with the payment of a pension, allowance, or death, sickness or disability benefits to or in respect of that individual, as the Remuneration Committee thinks fit.

9. DISQUALIFICATION OF MEMBERS OF THE GOVERNING BODY

Members of the Governing Body shall vacate their office:-

9.1 If a receiving order is made against him or he makes any arrangement with his creditors.

9.2 If in the opinion of the Governing Body (having taken appropriate professional advice in cases where it is deemed necessary) he becomes or is deemed to have developed mental or physical illness which prohibits or inhibits their ability to undertake their role.

9.3 If he ceases to be a provider of primary medical services, or engaged in or employed to deliver primary medical services (excluding lay members of the Governing Body who have been duly appointed by the Governing Body).

9.4 If he is suspended from providing primary medical services in which case the removal or suspension from the Governing Body shall be at the discretion of the Governing Body. The Governing Body shall take into account the circumstances of any individual before a decision is made. In the event the Member is disqualified from the Governing Body and is subsequently reinstated onto the Performer List or reinstated with conditions, he shall be entitled to resume his position on the Governing Body.

9.5 If he shall for a period of 5 consecutive meetings of the Governing Body have been absent and shall at the discretion of the Governing Body be vacated from his office.

9.6 If he shall be convicted of a criminal offence whereby the sentence imposed shall be for a minimum of 6 months imprisonment (whether such sentence is held to be suspended or conditional). The Governing Body shall take into account the circumstances of the offence in relation to the individual before a decision is made.

9.7 If he shall have behaved in a manner or exhibited conduct which in the opinion of the Governing Body has or is likely to be detrimental to the honour and interest of the Governing Body or the Clinical Commissioning Group and is likely to bring the Governing Body and/or Clinical Commissioning Group into disrepute. This includes but is not limited to dishonesty, misrepresentation (either knowingly or fraudulently), defamation of any member of the Governing Body (being slander or libel), abuse of position, non-declaration of a known conflict of interest, seeking to lead or manipulate a decision of the Governing Body in a manner that would ultimately be in favour of that member whether financially or otherwise.

9.8 Where he has become ineligible to stand for a position as a result of the declaration of any Conflict of Interest under Clause 19.

10. ACCOUNTABLE OFFICER

10.1 The Governing Body shall appoint or nominate an Accountable Officer.

10.2 The responsibilities of the Accountable Officer shall be primarily governed by the Health and Social Care Act 2012.

10.3 The primary obligations and liabilities of the Accountable Officer shall be to ensure that the Governing Body has a full commissioning policy whilst ensuring that:

10.3.1 all obligations of the Clinical Commissioning Group are fulfilled economically and in a transparent manner; and

10.3.2 to maintain any Conflict of Interest registers of the Clinical Commissioning Group.

10.4 The Accountable Officer shall report directly to the Governing Body of the Clinical Commissioning Group.

11. CHIEF FINANCE OFFICER

11.1 The Governing Body shall appoint or nominate a Chief Finance Officer.

11.2 The responsibilities of the Chief Finance Officer shall be primarily governed by the Health and Social Care Act 2012.

11.3 The obligations and liabilities of the Chief Finance Officer are set out below:

11.3.1 to be responsible for all financial strategy, financial management, governance and regulation of the Clinical Commissioning Group, including maintaining adequate recording, invoicing and receipt of money and the review of any fees or charges made;

11.3.2 to maintain and regulate relevant budgetary controls, in particular with regard to any directions issued by NHS England;

11.3.3 to produce, when required, any reports and/or reconciliations of any expenditure made in relation to the performance of any of the functions under this Constitution; and

11.3.4 to ensure compliance with any other relevant regulations, directions and/or guidance.

11.4 The Chief Finance Officer shall report directly to the Governing Body of the Clinical Commissioning Group.

11.5 The Chief Finance Officer will also act as Deputy Accountable Officer for the CCG.

12. DELEGATION OF FUNCTIONS OF THE GOVERNING BODY

12.1 The Governing Body has the authority to delegate any of its functions to either a properly constituted committee or sub-committee, in so far as the creation of those committees complies with the arrangements as set out in this Constitution.

12.2 Any committee and/or sub-committee shall operate in accordance with formal terms of reference as agreed by the Governing Body.

12.3 Such terms of reference as referred to in Clause 12.2 above, shall in particular:

12.3.1 identify any budget allocated to that committee including any management of the same;

12.3.2 set out how reports shall be submitted to the Governing Body including frequency of submission;

12.3.3 have a robust procedure to manage and resolve disputes and any termination procedures with regard to the dissolution of the relevant committee; and

12.3.4 expressly set out any authority to any committee in respect of the establishment of any sub committees. Any terms of reference in relation to any sub-committee shall be in the same or similar format as the terms of reference of the main committee.

13. COMMITTEES OF THE GOVERNING BODY

13.1 **Audit Committee** – the audit committee, which is accountable to the CCG's Governing Body, provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance. The Governing Body has approved and keeps under review the terms of reference for the audit committee, which includes information on the membership of the audit committee. Schedule 9

13.2 **Remuneration Committee** – the remuneration committee, which is accountable to the CCG's Governing Body makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the CCG and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme. The Governing Body has approved and keeps under review the terms of reference for the remuneration committee, which includes information on the membership of the remuneration committee. Schedule 10

13.3 **Quality Committee** –which is accountable to the CCG's Governing Body, will monitor the quality of commissioned services, consider information from governance, risk management and internal control systems and; provide corporate focus, strategic direction and momentum for governance and risk management. The Governing Body has approved and keeps under review the terms of reference for the Quality Committee which includes information on the membership of the Quality Committee, referenced at Schedule 11.

13.4 **Finance and Resource Committee** which is accountable to the CCG's Governing Body, will oversee and monitor financial and workforce development strategies; monitor the annual revenue budget and planned savings; develop and deliver capital investment; financial and workforce risk registers; financial, workforce and contracting performance. The Governing Body has approved and keeps under review the terms of reference for the Finance and Resource Committee which includes information on the membership of the Finance and Resource Committee. Schedule 12

14. WIDER CONSTITUENT GROUP

14.1 The Wider Constituent Group will consist of all member practices within the CCG, represented by their Lead GPs. It will act as a forum in order to hold to account the Governing Body for the decisions made on behalf of the constituent practices.

14.2 The Governing Body is directly responsible to the Wider Constituent Group and is directed to seek the member's views and approval regarding its activities at these meetings.

14.3 Only Member Practice Lead GPs have voting rights at the meetings of the Wider Constituent Group. Voting will be by the nominated Member Practice Lead GP on the basis of one vote per 100 patients registered with the practice on the first day of the quarter in which the vote is being held.

14.4 Decisions reached at the meetings of the Wider Constituent Group including the AGM are binding on the Governing Body.

14.5 Attendance at meetings of the Wider Constituent Group is remunerated as determined in section 8.4.2.

15. LOCALITY GROUPS

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.

15.2 Attendance at meetings of the Locality Groups is remunerated as determined in section 8.4.2.

15.3 There are four locality groups; **Bootle, Crosby, Maghull** and **Seaforth & Litherland**, or as determined by the Governing Body. Their role is as determined by the Governing Body. The Lead GPs of the locality groups report to the Wider Constituent Group and the Quality Committee. Terms of reference under Schedule 7.

16. INDEMNITY

16.1 The NHS SSCCG, as a statutory body established under the Health and Social Care Act 2012, is a separate legal person from its member practices, and all property, assets and liabilities of the CCG are distinct and separate from those of member practices. Any rights, assets and liabilities of member practices, in their capacity as general practices, are distinct from those of the CCG. This provision is without prejudice to any statutory obligations of the CCG and the member practices.

16.2 The CCG indemnifies its Officers, employees and members from having to meet out of their personal resources any civil liability which is incurred in the execution or purported execution of their functions, provided they have acted bona fide, which has been defined as acting honestly and in good faith on behalf of the CCG, unless they have acted recklessly.

17. OTHER COMMITTEES

The establishment of any other committees or sub-committees by the Governing Body shall be authorised and approved by the Governing Body and shall be reflected in separate standing orders or terms of reference which shall include (but not be limited to), the following:-

- a clear mandate, summarising the responsibilities of the committee;
- processes with regard to internal governance and decision making identifying individual roles and responsibilities of the committee or sub-committee;
- details of how the committee or sub-committee shall be held to account;
- a summary of membership of the committee; and any termination provisions.

18. JOINT WORKING ARRANGEMENTS

18.1 The Governing Body may collaborate or enter into any joint working arrangements with any other Clinical Commissioning Group or Local Authority, third sector and community voluntary organisations.

18.2 Any joint arrangement in respect of Clause 18.1 above shall be evidenced by a formal agreement approved by the Governing Body and signed by both parties.

18.3 Any functions of the Clinical Commissioning Group as delegated to any committee, sub-committee, joint working arrangement and/or engagement of any person or organisation shall remain the responsibility of the Clinical Commissioning Group and its Governing Body.

18.4 Joint working arrangements currently in force are listed in Schedule 13.

19. CONFLICT OF INTEREST

The Chair of the meeting, supported by the Lay member with the lead role for overseeing financial management and audit, has the responsibility for deciding whether there is a conflict of interest and the course of action to take. All decisions will be considered in accordance with the CCG's Policy on Managing Conflicts of Interest approved from time to time by the CCG and recorded in the minutes of the meeting.

19.1 A Conflict of Interest may include but shall not be limited to:

19.1.1 a member of the Governing Body or any of its sub-committees holding partnership in, employment in, directorship or trusteeship of or majority or controlling shareholdings in or other significant associations with any Provider. For the purposes of this clause, "significant associations" may include, but shall not be limited to, a family member/partner holding partnership in, employment in, directorship or trusteeship of or majority or controlling shareholdings in or other significant associations with any Provider;

19.1.2 a member of the Governing Body or its sub committees holding simultaneous office in both a Local Medical Committee and the Clinical Commissioning Group on completion of the transition stage of development / after April 2013;

19.1.3 any interest the member or its sub-committees if registered with the General Medical Council (GMC) would be required to declare in accordance with paragraph 55 of the GMC's publication "Management for Doctors or any successor code" including the referral of any patient by a member to a Provider or the Governing Body or its sub-committees in which the member has a Conflict of Interest; and

19.1.4 any interest that the member of the Governing Body or its sub-committees if registered with the Nursing and Midwifery Council (NMC) would be required to declare in accordance with paragraph 7 of the NMC's publication Code of Professional Conduct or any successor code including the referral of any patient by a member to a Provider in which the member has a Conflict of Interest.

19.1.5 any duty whatsoever imposed on any member of the Governing Body or its sub-committees Clinicians or any other codes of conduct to which the member is subject;

19.1.6 any other interest whatsoever that should be dutifully declared under The Health and Social Care Act 2012 and guidance issued by Department of Health from time to time;

19.1.7 any interest which may or will result in a member of the Governing Body obtaining a monetary benefit; and

19.1.8 any interest which may or will result in a member of the Governing Body obtaining a non-monetary benefit.

20. DECLARATION OF CONFLICT OF INTEREST

20.1 The Accountable Officer of the Clinical Commissioning Group shall maintain a register of interests of all members of the Governing Body or its sub-committees recording all declarations of Conflicts of Interest in the forms set out in Schedule 5.

20.2 The Accountable Officer shall include and update any Conflicts of Interest in the register of interests together with any conditions the Governing Body, its Committees or sub-committees, may impose on the member or any relevant Contract.

20.3 The register of interests shall be kept by the Governing Body and shall be made available on written request.

20.4 Any member of the Governing Body, its sub-committees or wider membership subject to a Conflict of Interest or to any change in circumstances which may bring to light a potential future Conflict of Interest or any previous or current Conflict of Interest shall:

20.4.1 declare the nature and extent of any Conflicts of Interest (including any benefit already or expected to be received) to the Accountable Officer for inclusion on the register, in the form set out in Schedule 5 prior to any relevant discussion regarding any specification for or award of the goods or services to which the Conflict of Interest relates; within 28 days of appointment or as soon as such Conflict of Interest becomes apparent- whichever is the sooner;

20.4.2 declare the nature and extent of any Conflict of Interest at the beginning of any meeting in which relevant discussion regarding any specification for or award of the goods or services to which the Conflict of Interest relates;

20.4.3 if the member of the Governing Body or its sub-committees seeks to refer a patient to a Provider must in addition to Clauses 20.4.1 and 20.4.2 declare the nature of any Conflict of Interest to the patient and note the nature of the Conflict of Interest related to any referral on the patient's medical record as suggested by Paragraph 76 of GMC's Good Medical Practice code; and

20.4.4 be refrained from discussing or voting on any matters related to such Conflict of Interest.

20.5 All invitations to tender or contract issued by the Clinical Commissioning Group shall require any tendered or potential contractor to declare any Conflicts of Interest within 28 days in the form set out in Schedule 5.

20.6 WHERE the declaration of a Conflict of Interest results in an inquorate Governing Body, the responsibility shall rest with the Chair/acting Chair as to whether:

20.6.1 the meeting can proceed; or

20.6.2 the meeting should be postponed and reconvened at such time when new temporary members may be appointed to take the place of the conflicted members.

20.7 The Governing Body shall ensure that all decisions and processes undertaken in managing a particular conflict are open, transparent and recorded.

21. FAILURE TO DISCLOSE CONFLICT OF INTEREST

21.1 Failure to disclose any Conflict of Interest by any member of the Governing Body may result in the disqualification of that member by special resolution of the Governing Body under the disqualification provisions detailed in Clause 9.

21.2 Failure to disclose any Conflict of Interest by any member of the Governing Body regarding a bid from a potential Provider, will not necessarily render any decision made by the Governing Body or its properly constituted sub committees as invalid. Although the Governing Body shall reserve the right to declare any such contract invalid or impose such requirements or conditions upon that member or any contract to which the Conflict of Interest pertains, as it sees fit.

22. QUORUM

22.1 Any quorum of the Wider Constituent Group, the Governing Body, its Committees or its sub-committees shall exclude any member affected by a Conflict of Interest under Clause 19. If this Clause has the effect of rendering the meeting inquorate, then the Chair shall decide whether to adjourn the meeting to permit the appointment or co-option of additional members.

22.2 The conflicted member may make representations to the Governing Body, its Committees or sub-committees regarding the manner in which any Conflict of Interest is dealt with or in relation to any issues relevant to that Conflict of Interest, provided always that any requirement as to the quorum at the meeting at which the Conflict of Interest is considered shall except the conflicted member.

23. TERMINATION OF MEMBERSHIP OF THE CLINICAL COMMISSIONING GROUP

23.1 The only ground on which the CCG would terminate the membership of an individual practice is when the practice ceases to hold a contract for the provision of primary medical services as referred in Clause 4.

23.2 In the event of a practice wishing to leave the CCG the matter will be referred to NHS England.

24. CONFIDENTIALITY

24.1 The expression “Confidential Information” as used in this Constitution means any information which any Member may have or acquired in relation to the Clinical Commissioning Group or another Member and is in addition to any statutory, professional or other duty of confidence to which the Member is subject including but not limited to the NHS Code of Confidentiality, the Data Protection Act 1988, Caldicott and Safe Havens, the Access to Health Records Act 1990, the Human Rights Act 1998 and the Computer Misuse Act 1990; General Medical Council (2000) Confidentiality: Protecting and Providing Information; and the BMA (1999) Confidentiality and Disclosure of Health Information guidance.

24.2 Confidential Information excludes information that was not provided when subject to any duty of confidence and which has become public knowledge other than as a direct or indirect result of a breach of this confidentiality provision.

24.3 Each Member shall at all times use best endeavours to keep confidential any Confidential Information and shall not use or disclose Confidential Information except as required by law or regulation.

24.4 No Member of the Governing Body or any authorised Committee of the Governing Body shall make or permit or authorise the making of any press release or other public statement or disclosure concerning any commissioning aspect of the Clinical Commissioning Group or any Members without the prior written consent of the Governing Body. For the avoidance of doubt, this clause is not intended to override any NHS policy in respect of ‘whistleblowing’ and individual Members must comply with any current applicable GMC guidance.

24.5 The group further recognises and confirms that nothing in or referred to in this constitution (including in relation to the issue of any press release or other public statement or disclosure) will prevent or inhibit the making of any protected disclosure (as defined in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the group, any member of its governing body, any member of any of its committees or sub-committees or the committees or sub-

committees of its governing body, or any employee of the group or of any of its members, nor will it affect the rights of any worker (as defined in that Act) under that Act.

25. VARIATION

25.1 This Constitution may be extended or varied by the agreement or consent of at least 75% of its current Membership vote as set out in Schedule 1.

25.2 The Health and Social Care Act 2012 allows for specified circumstances under which NHS England may institute variation of this Constitution. Before varying this Constitution NHS England must consult the CCG and its member practices on any specific changes that affect the local area.

25.3 Any change to this Constitution is subject to approval by NHS England.

26. NOTICES

26.1 Any notice or other communication required to be given to the Clinical Commissioning Group shall be in writing and shall be delivered by hand or sent by pre-paid first-class post or other next working day delivery service at its principal place of business, or sent by fax to the Clinical Commissioning Group's main fax number.

26.2 Any notice or communication shall be deemed to have been received if delivered by hand, on signature of a delivery receipt, or if sent by fax, at 9.00 am on the next Business Day after transmission, or otherwise at 9.00 am on the second Business Day after posting or at the time recorded by the delivery service.

SCHEDULE 1
LIST OF MEMBERS OF THE CLINICAL COMMISSIONING GROUP

PRACTICE CODE	PRACTICE NAME	PRACTICE ADDRESS	LOCALITY LEAD GP	LOCALITY	PRACTICE LIST SIZE 01.10.12
N84001	VITTY & PTNRS	42 Kingsway Waterloo L22 4RQ Tel: 0151 928 2415	Fred.Vitty@gp-n84001.nhs.uk	CROSBY	6706
N84002	SAPRE S.S	1B Aintree Road Bootle L20 9DN Tel: 0151 922 1768	Sunil.Sapre@gp-n84010.nhs.uk	BOOTLE	2484
N84003	THOMSON & PARTNERS	High Pastures Surgery 138 Liverpool Road North Maghull L31 2HW Tel: 0151 526 2161	jon.clarkson@gp-n84003.nhs.uk	MAGHULL	10933
N84004	GOLDSTEIN & PARTNERS	Glovers Lane Surgery Magdalen Square Netherton L30 5TA Tel: 0151 524 2444	Peter.Goldstein@gp-n84004.nhs.uk	SEAFORTH/ LITHERLAND	7255
N84007	MISRA & BIRD	131 Liverpool Road Crosby L23 5TE Tel: 0151 931 3197	grahambird@nhs.net	CROSBY	5299

PRACTICE CODE	PRACTICE NAME	PRACTICE ADDRESS	LOCALITY LEAD GP	LOCALITY	PRACTICE LIST SIZE 01.10.12
N84009	DORAN C L	Azalea Surgery 20 Kingsway Waterloo L22 4RQ Tel: 0151 920 9000	Clare.Doran@gp-n84009.nhs.uk	CROSBY	3136
N84010	SAPRE S.S	Maghull Family Surgery Maghull Health Centre Westway L31 0DJ Tel: 0151 520 2487	Sunil.Sapre@gp-n84010.nhs.uk	MAGHULL	2910
N84011	HUGHES & PTNRS	Eastview Surgery 81 Crosby Road Waterloo L22 4QD Tel: 0151 928 8849	andrew.mimnagh@gp-n84011.nhs.uk	CROSBY	6697
N84015	STEPHENSON & PARTNERS	Bootle Village Surgery 204 Stanley Road Bootle L20 3EW Tel: 0151 922 5719	sarah.stevenson@gp-n84015.nhs.uk	BOOTLE	6156
N84016	ROBERTS & PTNRS	Moore Street Medical Centre 77 Moore Street Bootle L20 4SE Tel: 0151 944 1066	Carol.McCormick@gp-n84016.nhs.uk	BOOTLE	7446
N84019	SRIVASTAVA & PARTNERS	North Park Health Centre 290 Knowsley Road Bootle L20 5DQ Tel: 0151 922 3841	Ritesh.Sinha@gp-y00359.nhs.uk	BOOTLE	7566

PRACTICE CODE	PRACTICE NAME	PRACTICE ADDRESS	LOCALITY LEAD GP	LOCALITY	PRACTICE LIST SIZE 01.10.12
N84020	TONG & GILLESPIE	Blundellsands Surgery 1 Warren Road Blundellsands L23 6TZ Tel: 0151 924 6464	craig.gillespie@nhs.net	CROSBY	10035
N84023	VICKERS & PARTNERS	Bridge Road Medical Centre 66/68 Bridge Road Litherland L21 6PH Tel: 0151 949 0249	Naveen.Sahu@gp-n84023.nhs.uk	SEAFORTH/ LITHERLAND	7513
N84025	WRAY & PTNRS	Westway Medical Centre Maghull L31 0DJ Tel: 0151 526 1121	john.wray@nhs.net	MAGHULL	6986
N84026	CROSBY - SSP HEALTH LTD	3 Little Crosby Road L23 2TE Tel: 0151 924 2233	Dr Albert Doerr	CROSBY	2881
N84027	PITALIA & PTNRS	Orrell Park Medical Centre Trinity Church Orrell Lane L9 8BU Tel: 0151 525 3051	bal.duper@nhs.net	SEAFORTH/ LITHERLAND	3854
N84028	MORRIS & PTNRS	The Strand Medical Centre 272 Marsh Lane Bootle L20 5BW Tel: 0151 922 1600	Anna.Ferguson@gp-n84028.nhs.uk	BOOTLE	7148

PRACTICE CODE	PRACTICE NAME	PRACTICE ADDRESS	LOCALITY LEAD GP	LOCALITY	PRACTICE LIST SIZE 01.10.12
N84029	WILLIAMS & PTNRS	Ford Medical Practice 91/93 Gorsey Lane Litherland L21 0DF Tel:0151 949 2000	Noreen.Williams@gp-n84029.nhs.uk	SEAFORTH/ LITHERLAND	6060
N84034	STANLEY & PTNRS	Park Street Surgery Park Street Bootle L20 3RF Tel: 0151 922 3577	Kong.Chung@gp-n84034.nhs.uk	BOOTLE	5811
N84035	MC ELROY & PTNRS	15 Sefton Road Litherland L21 9HA Tel: 0151 928 4820	Colette.McElroy@gp-n84035.nhs.uk	SEAFORTH/ LITHERLAND	4759
N84038	DR GOLDBERG	Concept House 17 Merton Road Bootle L20 3BC Tel: 0151 476 7962	David.Goldberg@gp-n84038.nhs.uk	BOOTLE	2614
N84041	SHAW & MCDONAGH	30 Kingsway Waterloo L22 4RQ Tel: 0151 928 8668	clive.shaw@gp-n84041.nhs.uk	CROSBY	4777
N84043	SEAFORTH - SSP HEALTH LTD	20 Seaforth Road L21 4LF Tel: 0151 949 1717	Steve.Fraser@gp-n84043.nhs.uk	SEAFORTH/ LITHERLAND	1824
N84605	LITHERLAND - SSP HEALTH LTD	Litherland Town Hall, Hatton Hill Road L21 9JN Tel: 0151 475 4831	Nigel.Taylor@gp-n84605.nhs.uk	SEAFORTH/ LITHERLAND	2651

PRACTICE CODE	PRACTICE NAME	PRACTICE ADDRESS	LOCALITY LEAD GP	LOCALITY	PRACTICE LIST SIZE 01.10.12
N84615	PITALIA S & SK	Rawson Road Medical Centre 136 - 138 Rawson Road Seaforth L21 1HP Tel: 0151 928 7576	bal.duper@nhs.net	SEAFORTH/ LITHERLAND	2218
N84616	GOLDBERG D.O	Sefton Road Surgery 129 Sefton Road Litherland L21 9HG Tel: 0151 928 5515	Anup.Sarkar@gp-n84038.nhs.uk	SEAFORTH/ LITHERLAND	2066
N84621	THORNTON - SSP HEALTH LTD	Thornton PCTMS Bretlands Road L23 1TQ Tel: 0151 247 6365	Debbie.Harvey@sefton.nhs.uk	CROSBY	2484
N84622	THOMAS B & PJ	Maghull Health Centre Westway Maghull L31 0DJ Tel: 0151 520 2488	Jill.Thomas@gp-n84622.nhs.uk	MAGHULL	2024
N84624	SAPRE S & SAPRE	Maghull Health Centre Westway Maghull L31 0DJ Tel: 0151 526 5453	Sunil.Sapre@gp-n84010.nhs.uk	MAGHULL	2043
N84626	HIGHTOWN - SSP HEALTH LTD	1 St. Georges Road L21 9JN Tel: 0151 929 3603	elsbeth.pierce@gp.southsefton.nhs.uk	CROSBY	2211
N84627	CROSSWAYS - SSP HEALTH LTD	168 Liverpool Road l23 0QB Tel: 0151 293 0800	prema.sharma@gp-n84627.nhs.uk	CROSBY	2770

PRACTICE CODE	PRACTICE NAME	PRACTICE ADDRESS	LOCALITY LEAD GP	LOCALITY	PRACTICE LIST SIZE 01.10.12
N84630	NETHERTON - SSP HEALTH LTD	Magdalen Square L30 5SP Tel: 0151 247 6098	Naresh.Choudhary@gp-n84630.nhs.uk	SEAFORTH/ LITHERLAND	2317
Y00446	PARKHAVEN - SSP HEALTH LTD	Parkhaven Trust L31 8BP Tel: 0151 283 0400	susan.coulter@gp-Y00446.nhs.uk	MAGHULL	3596
Y02514	LITHERLAND	Litherland Town Hall, Hatton Hill Road L21 9JN Tel: 0151 475 4831	Adnan.Hameed@sefton.nhs.uk	SEAFORTH/ LITHERLAND	383
	TOTALS				**155613**

SCHEDULE 2
ELECTION PROCESS TO THE GOVERNING BODY

1 The election for the 7 GP Member Practice Representatives will be conducted by secret ballot under the supervision of the LMC.

2 Nominations will be sought 3 months prior to the AGM. Each candidate must be nominated by two GP Member Practice Leads and indicate if he is willing and eligible to stand for the position of GP chair.

3 Each Member Practice casts one (weighted) vote for each of the 7 positions and additionally one (weighted) vote to choose between the candidates that have declared their intention and eligibility for the position of GP Chair.

4 Voting will be by the nominated Member Practice Lead GP on the basis of one vote per 100 patients registered with the practice on the first day of the quarter in which the vote is being held.

SCHEDULE 3
GOVERNING BODY MEMBERS

The Governing Body shall consist of 13 voting positions:

1 The Chair

2 The Accountable Officer

3 The Chief Finance Officer

4 The Clinical Vice Chair (If the GP Chair is unavailable, the Deputy Chair will defer matters relating to clinical issues to the Clinical Vice Chair)

5 7 GP representatives of Member Practices (which include the Chair and / or Clinical Vice Chair if so elected)

6 The Deputy Chair (if a GP Chair is elected, this role would be filled by the lay person in charge of governance)

7 A registered nurse;

8 2 lay members

- one to lead on audit, governance, remuneration and conflict of interest matters
- one to lead on patient and public participation matters;

9 A secondary care specialist doctor.

The Governing Body shall admit the following non-voting advisors to all its meetings:

10 a Local Medical Committee representative

11 a Practice Manager representative

12 a Practice Nurse representative

SCHEDULE 4
PROXY FORM

I, ...,……. nominated Lead GP for

Name of Practice: ……..

Hereby appoint ……

As my proxy for ……

To be entitled to represent me and vote on my behalf.

Date: …….. Signature: ……

NHS
South Sefton
Clinical Commissioning Group

SCHEDULE 5
DECLARATION OF INTERESTS

Declaration of Financial and Other Interests for Members/Employees

Name	
Position or role within NHS South Sefton CCG	Member / Employee/ Governing Body Member / Committee or Sub-Committee Member (including Committees and Sub-Committees of the Governing Body) [*delete as appropriate*]
Date	

This form is required to be completed in accordance with the CCG's Constitution and Section 14O of *The National Health Service Act 2006.*

Before completing this form, please note:

- Each CCG must make arrangements to ensure that the persons mentioned above declare any interest which may lead to a conflict with the interests of the CCG and the public for whom they commission services in relation to a decision to be made by the CCG.
- A declaration must be made of any interest likely to lead to a conflict or potential conflict as soon as the individual becomes aware of it, and within 28 days.
- If any assistance is required in order to complete this form, then the individual should contact Tracy Jeffes (**tracy.jeffes@southseftonccg.nhs.uk**).
- The completed form should be sent by both email and signed hard copy to Melanie Wright (**melanie.wright@southseftonccg.nhs.uk**).
- Any changes to interests declared must also be registered within 28 days by completing and submitting a new declaration form.
- The register will be published as part of the CCG's Governing Body meeting papers and will be available on the website.

- Any individual – and in particular members and employees of the CCG - must provide sufficient detail of the interest, and the potential for conflict with the interests of the CCG and the public for whom they commission services, to enable a lay person to understand the implications and why the interest needs to be registered.
- If there is any doubt as to whether or not a conflict of interests could arise, a declaration of the interest must be made.

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

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

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

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

Declaration

Type of Interest	Details	Personal interest or that of a family member, close friend or other acquaintance?
Roles and responsibilities held within member practices		
Directorships, including non-executive directorships, held in private companies or PLCs		

Type of Interest	Details	Personal interest or that of a family member, close friend or other acquaintance?
Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG		
Shareholdings (more than 5%) of companies in the field of health and social care		
Positions of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care		
Any connection with a voluntary or other organisation contracting for NHS services		
Research funding/grants that may be received by the individual or any organisation in which they have an interest or role		
Any other specific interests?		
Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the CCG		

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

Signature	
Date	

SCHEDULE 6
LOCAL DELIVERY PLAN

The local delivery plan is produced by the CCG from time to time and published on its website.

SCHEDULE 7

Draft Terms of Reference Locality Groups

NHS South Sefton Clinical Commissioning Group

December 2011

South Sefton Clinical Commissioning Groups

(Bootle, Crosby, Seaforth and Litherland, Maghull)

Due to the developmental nature of CCGs, these terms of reference are broad in nature and aimed at enabling some common understanding of the role, purpose and nature of the group, as opposed to establishing a constraining set of rules to govern the group. The purpose and nature of the group will be under continual review and development throughout the transition to CCG authorisation.

1 Principal Functions

Each constituent practice will be a member of a locality group, based on a natural community of practices, and would participate in locality decision making.
The Locality Groups will be supported in the interim by a PCT Locality Lead until formal transition of budgets.

2 Principal Duties

- To raise awareness of priorities at local level in order to inform commissioning decisions or service redesign.
- To develop local business cases for consideration to SSCCG Governing Body.
- Support peer review of prescribing within the localities
- Support peer review of secondary care outpatient referral data within the localities
- Support the comparisons of data on emergency admissions within the localities
- Support group peer review as applicable in QOF
- Local implementation of QIPP plans
- Each practice representative ensures that information discussed at the locality meeting is disseminated to the primary healthcare team
- Engagement with stakeholders including patients, public and local authorities.

3 Locality Groups

Each Locality will include a Lead GP, Practice Nurse and Practice Manager from the locality area, supported by a PCT Locality Lead.

4 Membership

The precise membership is for local determination however each constituent practice should have clinical representation at Locality Group meetings

All members are required to attend 75% of meetings.

In the absence of practice clinical representation at locality meetings, decisions will be made with the majority in attendance.

5 Chairmanship

The Locality Lead GP from each locality will chair Locality meetings

6 Quorum

A quorum shall consist of four members to include Chair or Deputy; the Deputy could be Lead Practice Nurse or Practice Manager.

7 Frequency of Meetings and Reporting Arrangements

The Locality Group will meet monthly in the first instance.

The Locality Group is accountable to SSCCG Governing Body.

8 Secretarial Arrangements

Secretarial *support to be determined.*

8 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.

9 Review Date

These Terms of Reference will be reviewed in every 12 months however it may require a review earlier to respond to the dynamic environment in which CCGs are developing.

SCHEDULE 8
PRIME FINANCIAL POLICIES

1. INTRODUCTION

1.1. General

1.1.1. These prime financial policies and supporting detailed financial policies shall have effect as if incorporated into the CCG's Constitution.

1.1.2. The prime financial policies are part of the CCG's control environment for managing the organisation's financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration; lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the Accountable Officer and Chief Finance Officer to effectively perform their responsibilities. They should be used in conjunction with the scheme of reservation and delegation found at Schedule 15.

1.1.3. In support of these prime financial policies, the group has prepared more detailed policies, approved by the [Accountable Officer /Chief Financial Officer – clinical commissioning group to select], known as *detailed financial policies*. The group refers to these prime and detailed financial policies together as the clinical commissioning CCG's financial policies.

1.1.4. These prime financial policies identify the financial responsibilities which apply to everyone working for the group and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed financial policies. The Chief Finance Officer is responsible for approving all detailed financial policies.

1.1.5. A list of the CCG's detailed financial policies will be published and maintained on the CCG's website at www.[insert CCG's website].

1.1.6. Should any difficulties arise regarding the interpretation or application of any of the prime financial policies then the advice of the [Accountable Officer /Chief Financial Officer] must be sought before acting. The user of these prime financial policies should also be familiar with and comply with the provisions of the CCG's Constitution, standing orders and scheme of reservation and delegation.

1.1.7. Failure to comply with prime financial policies and standing orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.2. **Overriding Prime Financial Policies**

If for any reason these prime financial policies are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Governing Body's audit committee for referring action or ratification. All of the CCG's members and employees have a duty to disclose any non-compliance with these prime financial policies to the Chief Finance Officer as soon as possible.

1.3. **Responsibilities and Delegation**

1.3.1. The roles and responsibilities of CCG's members, employees, members of the Governing Body, members of the Governing Body's committees and sub-committees, members of the CCG's committee and sub-committee (if any) and persons working on behalf of the group are set out in chapters 6 and 7 of this Constitution.

1.3.2. The financial decisions delegated by members of the group are set out in the CCG's scheme of reservation and delegation (see Schedule 14).

1.4. **Contractors and their Employees**

Any contractor or employee of a contractor who is empowered by the group to commit the group to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Accountable Officer to ensure that such persons are made aware of this.

1.5. **Amendment of Prime Financial Policies**

To ensure that these prime financial policies remain up-to-date and relevant, the Chief Finance Officer will review them at least [annually]. Following consultation with the Accountable Officer and scrutiny by the Governing Body's audit committee, the Chief Finance Officer will recommend amendments, as fitting, to the [Governing Body] for approval. As these prime financial policies are an integral part of the CCG's Constitution, any amendment will not come into force until the group applies to NHS England and that application is granted.

2. INTERNAL CONTROL

POLICY – the group will put in place a suitable control environment and effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies

2.1. The Governing Body is required to establish an audit committee with terms of reference agreed by the Governing Body (see Schedule 9).

2.2. The Accountable Officer has overall responsibility for the CCG's systems of internal control.

2.3. The Chief Finance Officer will ensure that:

a) prime financial policies are considered for review and updated when appropriate annually;

b) detailed financial policies are considered for review and updated where appropriate at least bi-annually;

c) a system is in place for proper checking and reporting of all breaches of financial policies; and

d) a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

3. AUDIT

POLICY – the group will keep an effective and independent internal audit function and fully comply with the requirements of external audit and other statutory reviews

3.1. In **line** with the terms of reference for the Governing Body's audit committee, the person appointed by the group to be responsible for internal audit and the Audit Commission appointed external auditor will have direct and unrestricted access to audit committee members and the chair of the Governing Body, Accountable Officer and Chief Finance Officer for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

3.2. The person appointed by the group to be responsible for internal audit and the external **auditor** will have access to the audit committee and the Accountable Officer to review audit issues as appropriate. All audit committee members, the chair of the Governing Body and the Accountable Officer will have direct and unrestricted access to the head of internal audit and external auditors.

3.3. The Chief Finance Officer will ensure that:

a) the group has a professional and technically competent internal audit function; and

b) the Governing Body approves any changes to the provision or delivery of assurance services to the group.

4. FRAUD AND CORRUPTION

POLICY – the group requires all staff to always act honestly and with integrity to safeguard the public resources they are responsible for. The group will not tolerate any fraud perpetrated against it and will actively chase any loss suffered

4.1. The Governing Body's audit committee will satisfy itself that the group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

4.2. The Governing Body's audit committee will ensure that the group has arrangements in place to work effectively with NHS Protect.

4.3. The Governing Body shall ensure that its members and, as far as reasonably practicable the CCG as a whole, conduct all business with due consideration of general duties and obligations arising from the Bribery Act 2010.

5. EXPENDITURE CONTROL

5.1. The group is required by statutory provisions to ensure that its expenditure does not exceed the aggregate of allotments from NHS England and any other sums it has received and is legally allowed to spend.

5.2. The Accountable Officer has overall executive responsibility for ensuring that the group complies with certain of its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

5.3. The Chief Finance Officer will:

a) provide reports in the form required by NHS England;

b) ensure money drawn from NHS England is required for approved expenditure only is drawn down only at the time of need and follows best practice;

c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the group to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of NHS England.

6. ALLOTMENTS

The CCG's Chief Finance Officer will:

6.1. periodically review the basis and assumptions used by NHS England for distributing allotments and ensure that these are reasonable and realistic and secure the CCG's entitlement to funds;

6.2. prior to the start of each financial year submit to the Governing Body for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and

6.3. regularly update the Governing Body on significant changes to the initial allocation and the uses of such funds.

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

POLICY – the group will produce and publish an annual commissioning plan that explains how it proposes to discharge its financial duties. The group will support this with comprehensive medium term financial plans and annual budgets

7.1. The Accountable Officer will compile and submit to the Governing Body a commissioning strategy which takes into account financial targets and forecast limits of available resources.

7.2. Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Accountable Officer, prepare and submit budgets for approval by the Governing Body.

7.3. The Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Governing Body. This report should include explanations for variances. These variances must be based on any significant departures from agreed financial plans or budgets.

7.4. The Accountable Officer is responsible for ensuring that information relating to the CCG's accounts or to its income or expenditure, or its use of resources is provided to NHS England as requested.

7.5. The Accountable Officer will approve consultation arrangements for the CCG's commissioning plan.

8. ANNUAL ACCOUNTS AND REPORTS

POLICY – the group will produce and submit to NHS England accounts and reports in accordance with all statutory obligations, relevant accounting standards and accounting best practice in the form and content and at the time required by NHS England

8.1. The Chief Finance Officer will ensure the group:

a) prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Governing Body;

b) prepares the accounts according to the timetable approved by the Governing Body;

c) complies with statutory requirements and relevant directions for the publication of annual report;

d) considers the external auditor's management letter and fully address all issues within agreed timescales; and

e) publishes the external auditor's management letter on the CCG's website at www.[insert CCG's website].

9. INFORMATION TECHNOLOGY

POLICY – the group will ensure the accuracy and security of the CCG's computerised financial data

9.1. The Chief Finance Officer is responsible for the accuracy and security of the CCG's computerised financial data and shall

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the CCG's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as theChief Finance Officer may consider necessary are being carried out.

9.2. In addition the Chief Finance Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

10. ACCOUNTING SYSTEMS

POLICY – the group will run an accounting system that creates management and financial accounts

10.1. The Chief Finance Officer will ensure:

a) the group has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of NHS England;

b) that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

10.2. Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

11. BANK ACCOUNTS

POLICY – the group will keep enough liquidity to meet its current commitments

11.1. The Chief Finance Officer will:

a) review the banking arrangements of the group at regular intervals to ensure they are in accordance with Secretary of State directions, best practice and represent best value for money;

b) manage the CCG's banking arrangements and advise the group on the provision of banking services and operation of accounts;

c) prepare detailed instructions on the operation of bank accounts.

11.2. The Chief Finance Officer shall approve the banking arrangements.

12. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS.

POLICY – the group will

- operate a sound system for prompt recording, invoicing and collection of all monies due
- seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the group or its functions
- ensure its power to make grants and loans is used to discharge its functions effectively

12.1. The Chief Finance Officer is responsible for:

a) designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due;

b) establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;

c) approving and regularly reviewing the level of all fees and charges other than those determined by NHS England or by statute. Independent professional advice on matters of valuation shall be taken as necessary;

d) for developing effective arrangements for making grants or loans.

13. TENDERING AND CONTRACTING PROCEDURE

POLICY – the group:

- will ensure proper competition that is legally compliant within all purchasing to ensure we incur only budgeted, approved and necessary spending
- will seek value for money for all goods and services
- shall ensure that competitive tenders are invited for
    - the supply of goods, materials and manufactured articles;
    - the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); and
    - for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals

13.1. The group shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists or where necessary a framework agreement. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Accountable Officer or the CCG's finance and remuneration committee

13.2. Contracts may only be negotiated on behalf of the group by those committees or individuals authorised to do so in the CCG's scheme of reservations and

delegation, and the group may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

a) the CCG's Constitution;

b) the Public Contracts Regulation 2006, any successor legislation and any other applicable law; and

c) take into account as appropriate any applicable NHS England or the Independent Regulator of NHS Foundation Trusts (Monitor) guidance that does not conflict with (b) above.

13.3. In all contracts entered into, the group shall endeavour to obtain best value for money. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the group. The scope of individual responsibilities in relation to contracting and contract values shall be set out in the CCG's detailed scheme of reservation and delegation which will be published on the CCG's website [insert CCG's website].

14. COMMISSIONING

POLICY – working in partnership with relevant national and local stakeholders, the group will commission certain health services to meet the reasonable requirements of the persons for whom it has responsibility

14.1. The group will coordinate its work with NHS England, other clinical commissioning groups, and local providers of services, local authority (les), including through Health & Wellbeing Boards, patients and their carers and the voluntary sector and others as appropriate to develop robust commissioning plans.

14.2. The Accountable Officer will establish arrangements to ensure that regular reports are provided to the Finance and Resources committee detailing actual and forecast expenditure and activity for each contract. The Accountable Officer will also ensure that the CCG's Wider Constituent Group is kept informed of the CCG's expenditure against contracts in accordance with arrangements for reporting agreed with the Wider Constituent Group.

14.3. The Chief Finance Officer will maintain a system of financial monitoring to ensure the effective accounting of expenditure under contracts. This should provide a suitable audit trail for all payments made under the contracts whilst maintaining patient confidentiality.

15. RISK MANAGEMENT AND INSURANCE

POLICY – the group will put arrangements in place for evaluation and management of its risks. Where available and appropriate insurance arrangements will support evaluated key risks.

15.1. The CCG's Accountable Officer will ensure that the group has a robust and effective risk management policy, which has been approved by the CCG's Governing Body. This will include;

a) a procedure for identifying and qualifying risks and potential liabilities throughout the group;

b) suitable management procedures to mitigate all significant risks and potential liabilities; and;

c) arrangements to review risk management procedures periodically.

15.2. The CCG's Accountable Officer will ensure that a report will be presented to the Governing Body's Audit Committee at least bi-annually on the key risks and the procedures for managing them. The Chief Finance Officer will undertake to present this report on behalf of the Accountable Officer.

15.3. The Governing Body's Audit Committee must approve any significant changes to insurance arrangements that increase the risk to the group.

16. PAYROLL

POLICY – the group will put arrangements in place for an effective payroll service

16.1. The Chief Finance Officer will ensure that the payroll service selected:

a) is supported by appropriate (i.e. contracted) terms and conditions;

b) has adequate internal controls and audit review processes;

c) Has suitable arrangement's for the collection of payroll deductions and payment of these to appropriate bodies.

16.2. In addition the Chief Finance Officer shall set out comprehensive procedures for the effective processing of payroll.

17. NON-PAY EXPENDITURE

POLICY – the group will seek to obtain the best value for money goods and services received

17.1. The Governing Body will approve the level of non-pay expenditure on an annual basis and the Accountable Officer will determine the level of delegation to budget managers.

17.2. The Accountable Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

17.3. The Chief Finance Officer will:

a) advise the Governing Body on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the scheme of reservation and delegation;

b) be responsible for the prompt payment of all properly authorised accounts and claims;

c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

18. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

POLICY – the group will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place polices to secure the safe storage of the CCG's fixed assets

18.1. The Accountable Officer will

a) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges;

d) be responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register

and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

18.2. The Chief Finance Officer will prepare detailed procedures for the disposals of assets.

19. RETENTION OF RECORDS

POLICY – the group will put arrangements in place to retain all records in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance

The Accountable Officer shall:

19.1. be responsible for maintaining all records required to be retained in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance;

19.2. ensure that arrangements are in place for effective responses to Freedom of Information requests;

19.3. publish and maintain a Freedom of Information Publication Scheme.

20. TRUST FUNDS AND TRUSTEES

POLICY – the group will put arrangements in place to provide for the appointment of trustees if the group holds property on trust

The Chief Finance Officer shall ensure that each trust fund which the group is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

SCHEDULE 9

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 (BAF) to support the CCG's integrated governance agenda.

4. Duties of the Committee

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

- To review and recommend approval of the detailed financial policies that are underpinned by the Prime Financial Policies within the 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 member 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

SCHEDULE 10

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

SCHEDULE 11

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
- 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
- A clinical lead from each locality (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

SCHEDULE 12

Terms of Reference
Finance & Resource Committee

NHS
South Sefton
Clinical Commissioning Group

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:

- Lay Member (Governance) (Chair)
- Clinical Governing Body Member (Vice Chair)
- Clinical Governing Body Member
- Lay Member (Patient Experience & Engagement)
- 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

SCHEDULE 13

1 JOINT WORKING ARRANGEMENTS

1.1 The group has entered into joint arrangements with the following clinical commissioning groups:

1.2 South Sefton CCG has entered into a joint arrangement with respect to a shared management team, under the terms of a memorandum of understanding with Southport and Formby CCG.

1.3 The Merseyside CCG network has been established consisting of the following CCGs:

1.3.1 Halton CCG
1.3.2 Knowsley CCG
1.3.3 Liverpool CCG
1.3.4 Southport & Formby CCG
1.3.5 South Sefton CCG
1.3.6 St Helens CCG
1.3.7 Warrington CCG
1.3.8 West Lancashire CCG.

The Merseyside CCG network will act as an advisory committee to each of the named CCGs.

2 The group has joint committees with the following local authority(ies):

Health and Wellbeing Board, Sefton Metropolitan Borough Council

Strategic Integrated Commissioning Group, Sefton Metropolitan Borough Council

Schedule 14
Dispute Resolution Process

1 Purpose

This paper outlines the approach South Sefton Clinical Commissioning Group (CCG) will adopt to address concerns/disputes raised by member practices in either of the following areas:

- The CCG's approach to delivery of its commissioning responsibilities
- The CCG's approach to delivery of its duty to support NHS England in continuously improving the quality of primary care medical services as it materially affects a member practice(s).

2 Background

It is expected that dispute will be the route of last resort. The CCG, Localities and practices will make all efforts to resolve issues locally in conjunction with the LMC (as appropriate), and demonstrate effective processes have been engaged at all levels in the CCG. This may include the following:

- Escalating the seniority of the review process, for example by involving the Locality Lead GP during the review process
- Involving third parties to ensure that acceptable standards are met, who could also act as advisors, conciliators or arbitrators.
- Externalising all or part of the review process, and using by mutual agreement members of another CCG

Where agreement cannot be reached using informal resolution processes it will be necessary to invoke the local CCG resolution process outlined below.

3 Local Resolution Process

3.1 Stage 1 Informal Process:

Individual member practice concerns should be raised in the first instance with the Locality Lead GP This should be in writing clearly stating the basis of the dispute, including where applicable the concerns and the rationale behind the dispute.

The Locality Lead GP should endeavour to find an informal resolution to the problem through discussion and mediation, involving others (for example, the LMC) as necessary. The Locality Lead GP will review concerns/evidence relative to the dispute and will try to find a resolution within 14 days.

The member practice may submit evidence in support of the dispute or the CCG may request further evidence/clarification from them.

If no resolution is found within 14 days the matter is to be referred by either party for consideration by the Local Dispute Resolution Panel see below.

At this stage the formal process will commence

3.2 Stage 2 The Formal Local Process:

If a member practice is not satisfied that their issues have been satisfactorily addressed through the informal process they may lodge a request for "Formal Local Dispute Resolution" in writing, including the grounds for the request, to the Medical Chair of the CCG. Under these circumstances the CCG will set up a Local Dispute Resolution Panel (LDRP) to hear the dispute and resolve the dispute where possible.

The local dispute panel should consist of:

- Governing Body lay member (Chair)
- Locality Lead GP from a different locality from the practice
- Chief Financial Officer OR Director of Partnerships and Development OR Director of Quality and Innovation (what are the equivalent posts ?)
- LMC Representative not having been involved in any prior informal resolution process

Should any members of the LDRP find it necessary to declare an interest in a dispute that is being considered, the Chair will seek to approach another CCG/LMC representative to nominate alternative panel members.

If a member practice requests a formal dispute resolution, the CCG shall acknowledge receipt of the request in writing within 2 working days. The acknowledgement will explain the procedure to be carried out by the CCG.

The Hearing

The Chair of the LDRP, on being satisfied that all attempts at local resolution have been exhausted will arrange a meeting of the LDRP to hear the dispute as soon is practically possible. All parties shall be notified of the date and time of the LDRP meeting. The hearing shall be held within 25 working days of the request being lodged (where possible) by the member practice to the CCG. The Chair of the LDRP will ensure that at least 10 working days' notice of the date of the hearing will be given to all participants.

Documentation

All the relevant documentation, including the request for Formal Local Dispute Resolution will be passed to the chair and then to panel members before the hearing. The Chair will, where necessary seek relevant documentation from the parties involved at least 5 working days before the hearing. Documentation that is received late will not be considered. Any documentation will be shared with all relevant panel members.

Procedure at LDRP Meeting

- The Discussions of the panel shall remain confidential
- The Chair of the panel will ensure written record/minutes are kept of the meeting
- All written and verbal evidence will be considered.
- The member practice may attend the LDRP to present their case and may call witnesses. Members of the panel will be given the opportunity to ask any questions relevant to the case.
- Following the presentation of their case the member practice and shall withdraw and the panel will deliberate.
- The panel will reach a decision on the case before them and notify the member practice in writing, including any recommendations within 7 working days of the hearing.
- Where appropriate the decision will be reported to a meeting of the CCG Governing Body for information.

3.3 Stage 3 Appeal Panel

The Appeals panel will be convened when necessary to consider appeals against LDRP decisions. The Appeals panel should consist of the following (none of whom should have been previously involved in the case)

- Chair of CCG Governing Body (or Lay member as nominated deputy)
- Accountable Officer (or nominated deputy)
- A Clinical member of the Governing Body (Clarify that not been involved in process to date)

Process

- The member practice wishing to appeal against a LDRP decision must notify the CCG Accountable Officer of their intention, in writing, within one month of their receipt of the decision.
- The Appeals Panel will consider whether the original decision of the LDRP followed due process.
- The Appeals Panel will only consider written evidence.
- The Appeals Panel will consider if:
    i. The CCG correctly followed its own procedures (all received documentation was available and considered within a reasonable timescale) and/or
    ii. All important facts were taken into account when the decision was made
- If these criteria are met the Panel will dismiss the appeal
- If the criteria are not met then the following actions are available:
    i. If the Panel finds that some aspect of the procedure was not followed, they will assess the significance of the procedural breach and decide on the appropriate action
    ii. If the Panel finds that important facts were not taken into account, they shall refer the case back to the original LDRP for re-consideration.
- If the case is referred back to the LDRP following re-consideration of the case, the LDRP decision will then be final.
- The Chair of the Appeal Panel will write to the member practice within five working days of the hearing setting out the Appeal Panel's decision.

July 2012 – to be reviewed July 2013

SCHEDULE 15– Scheme of Reservation and Delegation

Schedule of Matters Reserved to the Clinical Commissioning Group and Scheme of Delegation

1 The arrangements made by the Group as set out in this scheme of reservation and delegation of decisions shall have effect as if incorporated into the CCG's Constitution.

2 Nothing in the scheme of reservation and delegation should impair the discharge of the direct accountability to the Wider Constituent Group or Governing Body of the Chief Finance Officer (CFO). Outside of these requirements the Chief Finance Officer shall be accountable to the CCG's Accountable Officer.

3 The Clinical Commissioning Group remains accountable for all of its functions, including those that it has delegated.

4 Unless stated in the CCG's Constitution or in its Scheme of Reservation and Delegation, the CCG's Accountable Officer has responsibility for the operational management of the Group.

Reserved or Delegated Matter		Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
				Governing Body or Committee	Individual Member or Officer		
1	**Regulation and Control**						
1.1.	Determine the arrangements by which the members of the Group approve those decisions that are reserved for the membership.	Wider Constituent Meeting			Chair		Accountable Officer
1.2.	Consideration and approval of applications to NHS England on matters concerning changes to the CCG's Constitution, including proposed changes to the appendices to the Constitution.	Wider Constituent Meeting				Governing Body	Accountable Officer

Reserved or Delegated Matter	Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
			Governing Body or Committee	Individual Member or Officer		
1.3. Exercise or delegation of those functions of the Clinical Commissioning Group which have not been retained as reserved by the Group or delegated to the Governing Body or to a committee or sub-committee of the Group or to one of its members.				Accountable Officer		Accountable Officer
1.4. Approval of the CCG's overarching scheme of reservation and delegation, which sets out those decisions that are in statute the responsibility of the Group and that are reserved to the membership and those delegated to the: • Governing body • Committees, sub committees • Its members or employees.	Wider Constituent Meeting				Governing Body	Accountable Officer
1.5. Final authority on interpretation of the CCG's Constitution and supporting appendices (i.e. standing orders, prime financial policies and scheme of reservation and delegation).				Chair		Accountable Officer
1.6. Prepare the Scheme of Reservation and Delegation, which sets out those decisions that are in statute, and are the responsibility of the Governing Body, those reserved to the Governing Body and those delegated to the • Governing body • Committees, sub committees • Its members or employees.		Governing Body			Accountable Officer	Accountable Officer
1.7. Disclosure of non-compliance with the CCG's Constitution (incorporating the standing orders, prime financial policies and scheme of reservation and Delegation).				All Staff All Members		Accountable Officer

Reserved or Delegated Matter		Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
				Governing Body or Committee	Individual Member or Officer		
1.8.	Suspension of provisions within the Constitution (incorporating the standing orders, prime financial policies and Scheme of Reservation and Delegation) due to extreme cause or emergency.				Chair and either Accountable Officer or CFO together	Accountable Officer	Accountable Officer
1.9.	Review of any such suspensions of the Constitution.			Audit C'ttee		Head of Internal Audit	Head of Internal Audit
1.10.	Approval of the CCG's operational scheme of delegation that underpins the CCG's Scheme of Reservation and Delegation within the Constitution.		Governing Body			Accountable Officer	Accountable Officer
1.11.	Approval of the CCG's detailed financial policies that are underpinned by the Prime Financial Policies within the Constitution including • thresholds above which quotations or formal tenders must be obtained • arrangements for seeking professional advice regarding the supply of goods and services • delegated limits for the certification of invoices • raising of orders.		Governing Body	Audit C'ttee		CFO	CFO
1.12.	Executing a document by signature or use of the CCG's seal.				Chair or CFO or Accountable Officer		Accountable Officer
2	**Practice Member Representatives & Members of the Governing Body**						
2.1.	Approve the arrangements for identifying practice representatives for the Wider Constituent Meeting	Wider Constituent Meeting				Chair	Accountable Officer

Reserved or Delegated Matter		Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
				Governing Body or Committee	Individual Member or Officer		
2.2.	Approve the arrangements for appointing clinical leaders to the CCG's Governing Body.	Wider Constituent Meeting				Chair	Accountable Officer
2.3.	Approve the arrangements for appointing the non-GP members to the CCG's Governing Body (other than Accountable Officer).	Wider Constituent Meeting				Chair	Accountable Officer
2.4.	Approve arrangements for recruiting the CCG's Accountable Officer.	Wider Constituent Meeting				Chair	Chair
3	**Strategy and Planning**						
3.1.	Approve the CCG's vision, values and overall strategic direction.	Wider Constituent Meeting				Chair	Accountable Officer
3.2.	Approve the CCG's Operating Structure.		Governing Body			Accountable Officer	Accountable Officer
3.3.	Approve the CCG's Commissioning Plan.	Wider Constituent Meeting				Accountable Officer	Accountable Officer
3.4.	Approve the CCG's Financial Strategy and Annual Budget which meet the financial duties of the Group.		Governing Body			CFO	CFO
3.5.	Approve the CCG's arrangements for engaging the public and key stakeholders in the CCG's planning and commissioning arrangements.		Governing Body			Accountable Officer	Accountable Officer
3.6.	Approve variations to the approved budgets where variation would impact on the overall approved levels of income and expenditure or the CCG's ability to achieve its strategic aims.		Governing Body			CFO	CFO

Reserved or Delegated Matter		Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
				Governing Body or Committee	Individual Member or Officer		
3.7.	Approve a recovery plan where the CCG is faced with a deficit in excess of 1% or poor performance puts the CCG's continued authorisation in doubt.		Governing Body			Accountable Officer and CFO	Accountable Officer and CFO
4	**Annual Reports and Accounts**						
4.1.	Approval of the CCG's Annual Accounts.			Audit C'ttee		CFO	CFO
4.2.	Approval of the CCG's Annual Report.			Audit C'ttee		Accountable Officer	Accountable Officer
4.3.	Approval of appointment of auditors and their annual audit plans.			Audit C'ttee		CFO	CFO
4.4.	Approval of arrangements for discharging the CCG's statutory financial duties.			Audit C'ttee		Accountable Officer	CFO
5	**Human Resources and Organisational Development**						
5.1.	Approve the terms and conditions, remuneration and travelling or other allowances for governing body members and including pensions and gratuities.	Wider Constituent Meeting				Accountable Officer (exc. own post)	Accountable Officer (exc. own post)
5.2.	Approve other terms and conditions of service for all employees of the Group including pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the Group.		Governing Body			Accountable Officer	Accountable Officer
5.3.	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.			Remunerat' n C'ttee		Accountable Officer / Chair (if Accountable Officer)	Accountable Officer / Chair (if Accountable Officer)

Reserved or Delegated Matter		Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
				Governing Body or Committee	Individual Member or Officer		
5.4.	Approve disciplinary arrangements where the Group has joint appointments with another Group and the individuals are employees of that Group.			Remunerat' n C'ttee		Accountable Officer	Accountable Officer
5.5.	Approve the CCG's succession planning for elected members on the Governing Body.	Wider Constituent Meeting				Accountable Officer	Accountable Officer
5.6.	Approve the arrangements for discharging the CCG's statutory duties as an employer.		Governing Body			Accountable Officer	Accountable Officer
5.7.	Approve Organisational Development Plans.		Governing Body			Accountable Officer	Accountable Officer
5.8.	Approve HR policies.		Governing Body			Accountable Officer	Accountable Officer
6	**Quality and Safety**						
6.1.	Approve arrangements including supporting policies to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.			Quality C'ttee		Accountable Officer	Chief Nurse
6.2.	Approve the arrangements for handling complaints.			Quality C'ttee		Chief Nurse	Chief Nurse
6.3.	Approve arrangements for safeguarding children and adults.		Governing Body			Chief Nurse	Chief Nurse
6.4.	Approve the CCG's arrangements for engaging patients and their carers in decisions concerning their healthcare.			Quality C'ttee		Chief Nurse	Chief Nurse

Reserved or Delegated Matter		Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
				Governing Body or Committee	Individual Member or Officer		
6.5.	Approve arrangements for supporting the NHSCB in discharging its responsibilities to secure continuous improvement in the quality of general medical services.			Quality C'ttee		Accountable Officer	Chief Nurse
7	**Operational and Risk Management**						
7.1.	Approve counter fraud and security management arrangements.			Audit C'ttee		CFO	CFO
7.2.	Approve risk management arrangements			Quality C'ttee		Chief Nurse	Chief Nurse
7.3.	Approve arrangements for risk sharing and or risk pooling with other organisations including Section 75 agreements.		Governing Body	Governing Body		Accountable Officer	Accountable Officer
7.4.	Approve a comprehensive system of internal control, including budgetary control, which underpins the effective, efficient and economic operation of the Group.			Audit C'ttee		Accountable Officer	CFO
7.5.	Approve the thresholds above which quotations or formal tenders must be obtained.		Governing Body			CFO	CFO
7.6.	Approve the arrangements for seeking professional advice regarding the supply of goods and services.		Governing Body			CFO	CFO
7.7.	Approve proposals for action on litigation against or on behalf of the Group.				Accountable Officer and CFO together	Accountable Officer	Accountable Officer
7.8.	Approve arrangements for emergency planning and business continuity.			Quality C'ttee		Accountable Officer	Accountable Officer
7.9.	Approve banking arrangements.			Finance & Resource C'ttee		CFO	CFO

Reserved or Delegated Matter		Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
				Governing Body or Committee	Individual Member or Officer		
7.10.	Approve the arrangements for the proper safekeeping of records in accordance with NHS procedures and information governance requirements.			Quality C'ttee		Chief Nurse	Chief Nurse
8	**Partnership, Joint and Collaborative Working**						
8.1.	Approve the arrangements governing joint or collaborative working between the Group and other statutory bodies where those arrangements incorporate decision making responsibilities.		Governing Body			Accountable Officer	Accountable Officer
8.2.	Approve the delegated decision making responsibilities of individuals who represent the Group in joint or collaborative arrangements with other statutory bodies.		Governing Body			Accountable Officer	Accountable Officer
8.3.	Review the minutes of meetings of, or reports from, joint or collaborative arrangements with other statutory bodies.		Governing Body			Accountable Officer	Accountable Officer
8.4.	Authorise an individual to act on behalf of the Group in discharging the CCG's duty in respect of statutory and local joint working arrangements within the financial limits determined under sections 9 and 10 of this scheme of reservation and delegation.		Governing Body			Accountable Officer	Accountable Officer
9	**Tendering**						
9.1.	Approve the CCG's tendering arrangements for any commissioned or corporate support service in excess of £500,000 per annum.		Governing Body			CFO	CFO
9.2.	Approve the CCG's tendering arrangements for any commissioned or corporate support service with a value below £500,000 per annum.				Accountable Officer and Chair together	CFO	CFO
9.3.	Approve the award of tender for any service or contract in excess of £500,000 per annum.		Governing Body			CFO	CFO

Reserved or Delegated Matter		Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
				Governing Body or Committee	Individual Member or Officer		
9.4.	Approve the award of tender for any service or contract less than £500,000 per annum.				Accountable Officer and Chair together	CFO	CFO
10	**Commissioning and Contracting for Clinical Services**						
10.1.	Approve arrangements (including individual authority to act, where appropriate) for discharging the CCG's statutory responsibilities for commissioning clinical services including collaborative arrangements with • other CCGs • NHS England • Local Authorities.		Governing Body			Accountable Officer	Accountable Officer
10.2.	Sign off annual contract renewals for clinical services with health care providers.				Chair or CFO or Accountable Officer	CFO	CFO
10.3.	Determine arrangements for handling requests for exceptional or "novel" individual patient treatments.			Finance & Resources C'ttee		Accountable Officer	CFO
11	**Commissioning and Contracting for Non-Clinical Services**						
11.1.	Approve arrangements (including individual authority to act, where appropriate) for discharging the CCG's statutory responsibilities for commissioning clinical services including collaborative arrangements with • other CCGs • NHS England • Local Authorities.		Governing Body			Accountable Officer	Accountable Officer

Reserved or Delegated Matter		Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
				Governing Body or Committee	Individual Member or Officer		
11.2.	Sign off annual contract renewals for non-clinical services with providers.				Chair or CFO or Accountable Officer	CFO	CFO
12	**Communications**						
12.1.	Approve arrangements and policies for communication including • handling Freedom of Information requests • public engagement on commissioning decisions • press enquiries.		Governing Body			Accountable Officer	Accountable Officer

Delegated Authority

If the Accountable Officer is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, 2 from the following list will be required to ratify any decisions within the Accountable Officers thresholds – The Chief Finance Officer, The Chair, The Chief Nurse.

Table A - Delegated Authority

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1. **Audit Arrangements**		
a) Advise the Governing Body on Internal and External Audit Services.	Audit Committee	Chief Finance Officer
b) Monitor and review the effectiveness of the internal audit function.	Audit Committee	Chief Finance Officer
c) Review, appraise and report in accordance with Government Internal Audit Standards (GIAS) and best practice.	Audit Committee	Head of Internal Audit
d) Provide an independent and objective view on internal control and probity.	Audit Committee	Internal Audit / External Audit
e) Ensure cost-effective audit service	Audit Committee	Chief Finance Officer
f) Implement recommendations	Accountable Officer	Relevant Officers
2. Bank/GBS Accounts/Cash (Excluding Charitable Fund (Funds Held on Trust) Accounts**)**		
a) Operation: • Managing banking arrangements and operation of bank accounts (Governing Body approves arrangements)	Chief Finance Officer	Finance Manager, Cheshire, & Merseyside Commissioning Support Unit
• Opening bank accounts	Chief Finance Officer	Chief Finance Officer
• Authorisation of transfers between CCG bank accounts	Chief Finance Officer	To be completed in accordance with bank mandate/internal procedures. Finance Manager, Cheshire, & Merseyside Commissioning Support Unit
• Approve and apply arrangements for the electronic transfer of funds	Chief Finance Officer	To be completed in accordance with bank mandate/internal procedures Finance Manager, Cheshire, & Merseyside Commissioning Support Unit
• Authorisation of: – GBS schedules – BACS schedules – Automated cheque schedules – Manual cheques	Chief Finance Officer	To be completed in accordance with bank mandate/internal procedures Finance Manager, Cheshire, & Merseyside Commissioning Support Unit
b) Petty Cash	Chief Finance Officer	**Refer To Table B Delegated Limits (Section D)**

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
3. Capital Investment – subject to CCG Delegated Limits		
a) Programme:		
• Ensure that there is an adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans / Service development Strategy	Heads of Development	Chief Finance Officer
• Preparation of Capital Investment Programme	Chief Officer	Chief Finance Officer
• Preparation of a business case	Chief Officer	CCG Head of Development (with advice from Chief Finance Officer)
• Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Chief Finance Officer	Chief Accountant
• Authorisation of capital requisitions	Chief Officer	**Refer to Table B Delegated Limits**
• Assessing the requirements for the operation of the construction industry taxation deduction scheme.	Chief Officer	Chief Accountant
• Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost.	Head of Development	Chief Finance Officer
• Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences.	Chief Officer	Chief Finance Officer
• Issue procedures to support: – capital investment – Staged payments	Chief Officer	Chief Finance Officer
• Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.	Chief Officer	Chief Finance Officer
• Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the SO's and SFI's	Chief Officer	Chief Finance Officer
b) Private Finance: • Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector. Proposal to use PFI must be specifically agreed by the Governing Body.	Chief Officer	Chief Finance Officer
c) Leases (property and equipment)		
• Granting and termination of leases with Annual rent < £100k	Chief Officer	Chief Finance Officer
• Granting and termination of leases of > £100k should be reported to the Governing Body.	Governing Body	Chief Officer/ Chief Finance Officer.
4. Commercial Sponsorship		
• Agreement to proposal	Chief Officer	Approval and registration in line with South Sefton CCG Standards of Business Conduct and relevant policy.
5. Commissioning and Service Agreements		
a) Commissioning of Acute and Community Services from both NHS and non NHS providers, having regard for quality, cost effectiveness, and CCG strategic commissioning plan.	Chief Officer	Chief Finance Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
b) Commissioning of Mental Health, Learning Disability and Continuing / Intermediate care services from both NHS and non NHS providers, having regard for quality, cost effectiveness, and CCG strategic commissioning plans	Chief Officer	Chief Finance Officer
c) Negotiation of all other contracts	Chief Officer	Chief Finance Officer
d) Signing of Contracts	Chief Officer	**Refer to Table B Delegated Limits**
e) Quantifying and monitoring of Non Contracted Activity	Chief Officer	Contract Accountant
f) Costing SLA Contract and Non Commercial Contracts	Chief Finance Officer	Head of Strategic and Financial Planning
g) Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Chief Finance Officer	Head of Strategic and Financial Planning
h) Sound system of financial monitoring to ensure effective accounting of expenditure under the contract/ SLA. Including suitable audit trail but maintaining patient confidentiality.	Chief Finance Officer	Head of Strategic and Financial Planning
Complaints		
a) Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Officer	Chief Nurse
b) Responsibility for ensuring complaints are investigated thoroughly.	Chief Officer	Chief Nurse
c) Medico - Legal Complaints Coordination of their management.	Chief Officer	Head of Corporate Delivery
7. Confidential Information		
• Review of the PCT's compliance with the Caldicott report on protecting patients' confidentiality in the NHS	Chief Officer	Calidicott Guardian (Chief Nurse)
• Freedom of Information Act compliance code • Responses to letters from MP's, PQ and Treat Officials	Chief Officer	Chief Officer
8. Data Protection Act		
• Review of CCG compliance	Chief Officer	Head of Client Operations (MCSU)
• Undertake duties and responsibilities of Senior Information Risk Officer	Chief Officer	Chief Finance Officer (SIRO)
9. Declaration of Interest		
a) Maintaining a register of interests	Chief Officer	Chief Finance Officer
b) Declaring relevant and material interest	Chief Officer	All Staff
10. Disposal and Condemnations		
• Items obsolete, redundant, irreparable or cannot be repaired cost effectively • Develop arrangements for the sale of assets	Chief Officer	Chief accountant in accordance with agreed policy **Refer to Table B Delegated Limits**
11. Environmental Regulations		
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Officer	Chief Finance Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
12. Financial Planning / Budgetary Responsibility		
a) Setting:		
• Submit budgets to the Governing Body	Chief Finance Officer	Head of Financial Management and Planning.
• Submit to Governing Body financial estimates and forecasts	Chief Finance Officer	Head of Financial Management and Planning.
• Compile and submit to the Governing Body a business plan which takes into account financial targets and forecast limits of available resources.	Chief Officer	Chief Finance Officer
• The Business Plan will contain: – a statement of the significant assumptions on which the plan is based; – details of major changes in workload, delivery of services or resources required to achieve the plan.		
b) Monitoring:	Chief Finance Officer	Head of Financial Management and Planning.
• Devise and maintain systems of budgetary control.		
• Monitor performance against budget	Chief Finance Officer	Head of Financial Management and Planning.
• Delegate budgets to budget holders	Chief Officer	Chief Finance Officer
• Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget.	Chief Officer	Chief Finance Officer
• Submit in accordance with NHS England's requirements for financial monitoring returns	Chief Officer	Chief Finance Officer
• Identify and implement cost improvements and QIPP activities in line with the Business Plan	Chief Officer	Chief Finance Officer
c) Preparation of: • Annual Accounts	Chief Officer	Chief Finance Officer
• Annual Report	Chief Officer	Head of Corporate Delivery
d) Budget Responsibilities Ensure that • no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Governing Body; • approved budget is not used for any other than specified purpose subject to rules of virement; • no permanent employees are appointed without the approval of the Chief Officer other than those provided for within available resources and manpower establishment.	Chief Finance Officer	All budget holders
e) Authorisation of Virement: It is not possible for any officer to vire from non-recurring headings to recurring budgets or from capital to revenue / revenue to capital. Virement between different budget holders requires the agreement of both parties.	Chief Officer	**Refer To Table B Delegated Limits**
13. Financial Procedures and Systems		
a) Maintenance & Update on CCG Financial Procedures	Chief Finance Officer	Chief Accountant
b) Responsibilities:- • Implement CCG financial policies and co-ordinate corrective action. • Ensure that adequate records are maintained to explain CCG transactions and financial position.	Chief Finance Officer	Chief Accountant

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Providing financial advice to members of the Governing Body and staff. • Ensure that appropriate statutory records are maintained. • Designing and maintaining compliance with all financial systems		
14. Fire precautions • Ensure that the Fire Precautions and prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact.	Chief Officer	Business Manager
15. Fixed Assets		
a) Maintenance of asset register including asset identification and monitoring	Chief Officer	Chief Officer
b) Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with CONCODE and ESTATECODE.	Chief Officer	Chief Officer
c) Calculate and pay capital charges in accordance with the requirements if the	Chief Officer	Chief Officer
d) Responsibility for security of CCG's assets including notifying discrepancies to the Chief Finance Officer and reporting losses in accordance with NHS South Sefton CCG's procedures	Chief Officer	All staff
16. Fraud (See also 26, 36)		
a) Monitor and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Chief Finance Officer	Local Counter Fraud Specialist.
b) Notify NHS Protect and External Audit of all suspected Frauds	Chief Finance Officer	Local Counter Fraud Specialist.
17. Funds Held on Trust (Charitable and Non Charitable Funds) NHS South Sefton Clinical Commissioning Group does not plan to hold any funds on trust. The Constitution makes provision for the introduction of a Charitable Funds Committee if this situation changes.		
a) Management: • Funds held on trust are managed appropriately.	Governing Body	Chief Finance Officer
b) Maintenance of authorised signatory list of nominated fund holders.	Chief Officer	Chief Finance Officer
c) Expenditure Limits	Chief Finance Officer	**Refer To Table B Delegated Limits**
d) Developing systems for receiving donations	Chief Finance Officer	Chief Accountant
e) Dealing with legacies	Chief Finance Officer	Chief Accountant
f) Fundraising Appeals	Chief Finance Officer	Chief Accountant
g) Preparation and monitoring of budget	Chief Finance Officer	Chief Accountant
h) Reporting progress and performance against budget.	Chief Finance Officer	Chief Accountant
i) Operation of Bank Accounts: • Managing banking arrangements and operation of bank accounts	Chief Officer	Chief Finance Officer
• Opening bank accounts	Chief Officer	Chief Finance Officer
j) Investments:	Charitable Trustees	Chief Finance Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Nominating deposit taker	Committee	
• Placing transactions	Chief Officer	Chief Finance Officer
k) Regulation of funds with Charities Commission	Chief Officer	Chief Finance Officer
18. Health and Safety		
Review of all statutory compliance with legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Officer	Head of Corporate Delivery
19. Hospitality/Gifts		
a) Keeping of hospitality register	Chief Officer	Business Manager
b) Applies to both individual and collective hospitality receipt items.		**Refer To Table B Delegated Limits** All Staff
20. Infectious Diseases & Notifiable Outbreaks	Chief Officer	Chief Nurse
21. Information Management & Technology		
Finance & Information Systems • Developing systems in accordance with the CCG'S IM&T Strategy. • Implementing new systems ensure they are developed in a controlled manner and thoroughly tested. • Seeking third party assurances regarding financial systems operated externally. • Ensure that contracts for computer services for financial applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage.	Chief Officer	Chief Finance Officer
Information Governance • Ensure that risks to the CCG from use of IT are identified and considered and that disaster recovery plans are in place.	Chief Officer	Chief Finance Officer
• Undertake duties and responsibilities of Senior Information Risk Officer	Chief Officer	Chief Finance Officer
• Ensure compliance with Information Governance requirements and annual completion of IT toolkit	Chief Finance Officer	Information Governance Manager, Cheshire & Merseyside CSU.
22. Legal Proceedings		
a) Engagement of CCG's Solicitors / Legal Advisors	Chief Officer	Chief Finance Officer
b) Approve and sign all documents which will be necessary in legal proceedings, i.e. executed as a deed.	Chief Officer	Chief Finance Officer
c) Sign on behalf of the CCG any agreement or document not requested to be executed as a deed.	Chief Officer	Chief Finance Officer
23. Losses, Write-off & Compensation		
a) Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing NHS Protect of frauds	Chief Officer	Chief Finance Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Losses • Losses of cash due to theft, fraud, overpayment & others. • Fruitless payments (including abandoned Capital Schemes) • Bad debts and claims abandoned • Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson).	Chief Officer	**Refer to Table B Delegated Limits**
Special Payments Compensation payments by Court Order	Chief Officer	**Refer to Table B Delegated Limits**
Ex-gratia Payments:- • To patients/staff for loss of personal effects • For clinical negligence after legal advice • For personal injury after legal advice • Other clinical negligence and personal injury • Other ex-gratia payments		**Refer to Table B Delegated Limits**
b) Reviewing appropriate requirement for insurance claims	Chief Officer	Chief Finance Officer
c) A register of all of the payments should be maintained by the Chief Finance Officer and made available for inspection	Chief Officer	Chief Accountant
d) A report of all of the above payments should be presented to the Audit Committee	Chief Officer	Chief Accountant
24. Meetings		
a) Calling meetings of the Governing Body	CCG Chair	Business Manager
b) Chair all Governing Body meetings and associated responsibilities	CCG Chair	Vice Chair
25. Medical		
• Clinical Governance arrangements	Governing Body	Chief Officer
• Medical Leadership	Chair	Chief Officer
• Programmes of education	Chair	Chief Officer
• Medical Research	Chair	Chief Officer
26. Nursing and Allied Health Professionals		
a) Compliance with statutory and regulatory arrangements relating to professional nursing / midwifery practice	Chief Officer	Chief Nurse
b) Compliance with statutory and regulatory arrangements relating to allied health professionals practice	Chief Officer	Chief Nurse
27. Safeguarding - Adults		
a) Discharge the duties of the Lead Director of Safeguarding Adults	Chief Officer	Chief Nurse/Lead Nurse for Safeguarding, Cheshire, Mersey CSU
b) Ensure compliance with statutory requirements and policies and procedures for Safeguarding Adults	Chief Officer	Chief Nurse/Lead Nurse for Safeguarding, Cheshire, Mersey CSU
c) Comply with statutory requirements and policies for Safeguarding Adults	Chief Officer	Chief Nurse/Lead Nurse for Safeguarding, Cheshire, Mersey CSU
28. Safeguarding - Children		
a) Discharge the duties of the Lead Director of Safeguarding Children	Chief Officer	Chief Nurse/Lead Nurse for Safeguarding, Cheshire, Mersey CSU
b) Review and develop the Strategy for Safeguarding Children	Chief Officer	Chief Nurse/Lead Nurse for Safeguarding, Cheshire, Mersey CSU

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
c) Review and develop the policies and procedures to Safeguarding Children	Chief Officer	Chief Nurse/Lead Nurse for Safeguarding, Cheshire, Mersey CSU
d) Ensure compliance with statutory requirements and policies and procedures for Safeguarding Children	Chief Officer	Chief Nurse/Lead Nurse for Safeguarding, Cheshire, Mersey CSU
e) Comply with statutory requirements and policies for Safeguarding Children	Chief Officer	Chief Nurse/Lead Nurse for Safeguarding, Cheshire, Mersey CSU
29. Non Pay Expenditure		
a) Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with **Table B – Delegated Limits**	Chief Officer	Chief Finance Officer
b) Obtain the best value for money when requisitioning goods / services	Chief Officer	All Staff
c) Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a)	Chief Officer	Chief Finance Officer
d) Develop systems for the payment of accounts	Chief Finance Officer	Chief Accountant
e) Prompt payment of accounts	Chief Finance Officer	Chief Accountant
f) Financial Limits for ordering / requisitioning goods and services	Chief Finance Officer	**Refer To Table B Delegated Limits**
g) Approve prepayment arrangements	Chief Finance Officer	Chief Accountant
30. Personnel & Pay		
a) Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Chief Officer	Chief Finance Officer
b) Develop Human resource policies and strategies for approval by the Governing Body including training, industrial relations.	Chief Officer	HR Manager, Cheshire & Merseyside CSU.
c) Authority to fill funded post on the establishment with permanent staff.	Chief Officer	Chief Finance Officer
d) The granting of additional increments to staff within budget	Chief Officer	Chief Finance Officer
e) All requests for re-grading shall be dealt with in accordance with CCG's procedures.	Chief Officer	Chief Finance Officer
f) Establishments	Chief Finance Officer	Head of Financial Management and Planning
• Additional staff to the agreed establishment with specifically allocated finance.		
• Additional staff to the agreed establishment without specifically allocated finance.	Chief Officer	Chief Finance Officer
• Self financing changes to an establishment	Chief Officer	Chief Finance Officer
g) Pay		
• Presentation of proposals to the Governing Body for the setting of remuneration and conditions of service for those staff not covered by the Remuneration Committee.	Chief Officer	Chief Finance Officer
• Authority to complete standing data forms effecting pay, new starters, variations and leavers	Chief Officer	Head of CCG Development
• Authority to complete and authorise positive reporting forms (SAR's)	Chief Officer	Head of CCG Development
• Authority to authorise overtime	Chief Officer	Chief Finance Officer/Deputy CFO
• Authority to authorise travel & subsistence expenses	Chief Officer	Head of CCG Development

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
h) Leave		*Refer to Annual Leave Policy*
Annual Leave		
• Approval of annual leave	Chief Officer	Chief Finance Officer/Head of CCG Development
• Annual leave - approval of carry forward (up to maximum of 5 days	Chief Officer	Chief Finance Officer/ Head of CCG Development
• Annual leave – approval of carry forward over 5 days (**to occur in exceptional circumstances only)**	Chief Officer	Chief Finance Officer
Special Leave		
• Compassionate leave	Chief Officer	Head of CCG Development/Head of Corporate Delivery
• Special leave arrangements for domestic/personal/family reasons • paternity leave • carers leave • adoption leave (**to be applied in accordance with CCG Policy)**	Chief Officer	Head of CCG Development/Head of Corporate Delivery
• Special Leave – this includes Jury Service, Armed Services, School Governor **(to be applied in accordance with CCG Policy)**	Chief Officer	Head of CCG Development/Head of Corporate Delivery
• Leave without pay	Chief Officer	Head of CCG Development/Head of Corporate Delivery
• Time off in lieu	Chief Officer	Head of CCG Development/Head of Corporate Delivery
• Maternity Leave - paid and unpaid	Chief Officer	Automatic approval with guidance
Sick Leave		
• Extension of sick leave on pay	Chief Officer	Chief Finance Officer
• Return to work part-time on full pay to assist recovery	Chief Officer	Chie Finance Officer
Study Leave		
• Study leave outside the UK	Chief Officer	
• All other study leave (UK)	Chief Officer	Chief Finance Officer/Head of CCG Development/Head of Corporate Delivery
i) Removal Expenses, Excess Rent and House Purchases	Chief Officer	Chief Finance Officer
All staff above Band 5 (agreed at interview) Maximum £8,000		
Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)	Chief Officer	**Refer to Table B Delegated Limits**
j) Grievance Procedure	Chief Officer	As per procedure
k) Authorised - Car Users		
• Leased car	Chief Officer	Chief Finance Officer
• Regular user allowance	Chief Officer	Chief Finance Officer
l) Mobile Phone Users / Mobile Devices	Chief Finance Officer	Business Manager

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
m) Renewal of Fixed Term Contract	Chief Officer	Chief Finance Officer
n) Staff Retirement Policy		
• Authorisation of return to work in part time capacity under the flexible retirement scheme.	Chief Officer	Chief Finance Officer
o) Redundancy	Chief Officer	Chief Finance Officer
p) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department.	Chief Officer	Chief Finance Officer
q) Disciplinary Procedure (excluding Executive Directors)	Chief Officer	To be applied in accordance with the CCG's Disciplinary Procedure
r) Ensure that all employees are issued with a Contract of employment in a form approved by the Governing Body and which complies with employment legislation.	Chief Officer	Head of Corporate Delivery
s) Engagement of staff not on the establishment • Management Consultants	Chief Officer	**Refer to Table B – Delegated Limits**
31. Quotation, Tendering & Contract Procedures		
a) Services: • Best value for money is demonstrated for all services provided under contract or in-house	Chief Officer	Chief Finance Officer
• Nominate officers to oversee and manage the contract on behalf of the CCG.	Chief Officer	Chief Finance Officer
b) Competitive Tenders: • Authorisation Limits	Chief Officer	**Refer To Table B Delegated Limits**
• Maintain a register to show each set of competitive tender invitations despatched.	Chief Officer	Chief Finance Officer
• Receipt and custody of tenders prior to opening	Chief Officer	Chief Finance Officer
• Opening Tenders	Chief Officer	Two officers from the approved list as authorised by the Governing Body
• Decide if late tenders should be considered	Chief Officer	Chief Finance Officer
• Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote.	Chief Officer	Chief Finance Officer
c) Quotations	Chief Officer	**Refer To Table B Delegated Limits**
d) Waiving the requirement to request • tenders - subject to Constitution Schedule 15 (reporting to the Audit Committee)	Chief Officer	**Refer To Table B Delegated Limits**
• quotes - subject to SOs	Chief Officer	Chief Finance Officer
32. Records		
a) Review CCG's compliance with the Records Management Code of Practice	Chief Officer	Head of Corporate Delivery
b) Ensuring the form and adequacy of the financial records of all departments	Chief Officer	Chief Finance Officer
33. Reporting of Incidents to the Police		
a) Where a criminal offence is suspected • criminal offence of a violent nature • arson or theft • other	Chief Officer	All Staff – Informing Manager On-call

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
b) Where a fraud is involved (reporting to the Directorate of Counter Fraud Services)	Chief Officer	Director of Internal Audit Services/ Local Counter Fraud Specialist
c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.	Chief Officer	Chief Finance Officer
34. Risk Management		
• Ensuring the CCG has a Risk Management Strategy and a programme of risk management	Chief Officer	Chief Finance Officer/Head of Corporate Delivery/ Head of CCG Development
• Developing systems for the management of risk.	Chief Officer	Chief Finance Officer/Head of Corporate Delivery/ Head of CCG Development
• Developing incident and accident reporting systems	Chief Officer	Chief Finance Officer/Head of Corporate Delivery/ Head of CCG Development
• Compliance with the reporting of incidents and accidents	Chief Officer	All staff
35. Seal		
a) The keeping of a register of seal and safekeeping of the seal	Chief Officer	Business Manager
b) Attestation of seal in accordance with Standing Orders	Chief Officer	Head of Corporate Delivery
c) Property transactions and any other legal requirement for the use of the seal.	Chief Officer	Chief Finance Officer
36. Security Management		
Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.	Chief Officer	Chief Finance Officer/ Local Security Management Specialist
37. Setting of Fees and Charges (Income)		
a) Non patient care income	Chief Finance Officer	Chief Accountant
b) Informing the Accountable Officer of monies due to the CCG.	Chief Finance Officer	All Staff
c) Recovery of debt	Chief Finance Officer	Chief Accountant
d) Security of cash and other negotiable instruments	Chief Finance Officer	Chief Accountant
38. Stores and Receipt of Goods		
a) Responsibility for systems of control over stores and receipt of goods issues and returns.	Chief Finance Officer	Business Manager

SCHEDULE 16

The Nolan Principles

The Seven Principles of Public Life, known as the Nolan Principles, were defined by the Committee for Standards in Public Life. They are:

1. **Selflessness** Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
2. **Integrity** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
3. **Objectivity** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
4. **Accountability** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
5. **Openness** Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.
6. **Honesty** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
7. **Leadership** Holders of public office should promote and support these principles by leadership and example.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/127	**Author of the Paper:**
Report date: September 2013	Tracy Jeffes Head of Delivery & Integration Tracy.jeffes@southseftonccg.nhs.uk Tel: 0151 247 7049

Title: Risk Management Strategy

Summary/Key Issues:

This report presents a comprehensive risk strategy for the organisation.

Recommendation

Note	
Approve	x
Ratify	

The Quality Committee considered and approved the Risk Management Strategy on 18 July 2013 and now recommends the strategy for formal approval by the Governing Body in line with the CCG's Scheme of Reservation and Delegation.

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.
	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			Through the quality committee
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered	x			
Locality Engagement		x		
Presented to other Committees	x			Approved by the Quality Committee on 18 July 2013.

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

Title: Risk Management Strategy	
Scope: South Sefton	**Classification:** Strategy
Identification No:	**Version No:** 1
Replaces: Is a refresh of the Risk Management Strategy of June 2012	
Author/Originator: Tracy Jeffes **,** Head of Corporate Delivery	
In consultation with: CCG Governing Body and Cheshire and Merseyside Commissioning Support Unit	
Chief Officer: Fiona Clark, Chief Officer	
Authorised by: CCG Governing Body	**Date:** July 2013
To be read in conjunction with: Governance Policies	
Equality Impact Assessment carried out	**Date:** TBC
Issue Date: July 2013	**Review Date:** July 2014

In considering the application of this policy, procedure or function the CCG will ensure that members, staff or patients will not be discriminated against or treated differently on account of any subjective bias in relation to the pillars of equality and diversity: race, disability, gender, age, sexual orientation, religion/belief, transgender.

This document can only be considered valid when viewed via the CCG website or Department Policy Folder. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

This document is available in other formats on request

NHS
South Sefton
Clinical Commissioning Group

Risk Management Strategy 2013/2014

Contents

Appendices

1. Introduction

By its very nature the commissioning of healthcare carries risks. The Governing Body accepts the importance of the principles of risk management and recognises the value of taking a strategic, proactive, and comprehensive approach to the assessment and control of risk. Significant benefits can be achieved from this approach, from improving patient care and the safety of the working environment, to reducing levels of financial risk and loss for the CCG as a whole.

The CCG also recognises that due to a high reliance upon human intervention in the commissioning and provision of care, mistakes and errors can happen. Therefore a strategy and framework is required to deal with the hazards and risks associated with its main functions of commissioning high quality healthcare and improving the health of the local population. The strategy defines the CCGs commitment to developing an open, honest, inclusive and educative 'fair blame' culture which encourages identification, reporting and avoidance of risk. It also brings clinical knowledge, understanding and perspectives to the heart of managing risk within the local health system.

The Risk Management Strategy therefore represents South Sefton CCG's corporate philosophy towards risk management and aims to provide assurance to the CCG Governing Body that risks are being consistently identified and managed.

2. Purpose, Philosophy & Principles

This strategy supersedes the 2012/13 version and is designed to provide a framework for the development of a robust risk management system across the CCG and thereby assisting the CCG in achieving its objectives following authorisation in 2013/14. Each senior manager or clinical lead is expected to systematically identify and assess the risks associated with their key areas of work and manage them to ensure they do not impede the delivery of team or organisational objectives, and to record this activity on the Corporate Risk Register. Major risks identified as part of the risk assessment process will be integrated into the Governing Body Assurance Framework which the CCG Governing Body recognises as a tool to ensure the delivery of organisational objectives.

The CCG is committed to ensuring robust systems are in place to ensure high standards of risk management. A proactive structured and systematic approach supports informed management decision making by providing a greater understanding of risks and their potential impact. Effective management of risks has the potential for reducing the frequency and severity of incidents, complaints and claims. The demarcation of risks into clinical, corporate and financial precludes a holistic view so it is proposed that CCG has a unified strategy for managing all risks. This approach should ultimately form an integral part of the business planning process.

2.1 Scope of the Strategy

This strategy relates to the management of risks faced by the CCG as a commissioner of services and applies during the first year of the CCG's operation as a statutory body in 2013/14.

2.2 Risk Management Objectives

The CCG's specific risk management objectives for 2013/14 are to:

- demonstrate the CCG Governing Body's support and commitment to the risk management agenda
- be a fundamental part of the CCG's approach to integrated governance
- continually develop the Risk Management Strategy and ensure communication throughout the CCG
- clearly define the stages within the risk management process
- ensure compliance with all the relevant statutory and non-statutory standards relating to the assessment and control of risk
- manage risks at a corporate and local level
- develop and maintain risk registers across the CCG by implementing a comprehensive risk assessment and grading system
- provide an effective system to identify and eliminate or mitigate risk by appropriate means
- develop and monitor risk management key performance indicators to assure and measure the effectiveness of risk management throughout the CCG
- ensure all Governing Body Members and staff attend risk management training/development events to ensure full understanding of their responsibilities
- develop a risk aware culture throughout the CCG which will embed the consideration and assessment of risk in all work activities
- encourage a culture of 'fair blame', being transparent when things go wrong
- ensure lessons are learned from good and deficient practice
- agree and firmly establish clearly defined roles and responsibilities for the management of risk within the CCG
- ensure all localities and teams accept their responsibility for managing risk at a local level.

3 Organisation Arrangements and Management of Risk

3.1 Annual Governance Statement Governance Arrangements

As a statutory body from 1st April 2013, South Sefton CCG is required to produce a Annual Governance Statement (or an equivalent statement of governance as may be specified by the Department of Health) which acts as a statement of assurance that appropriate strategies and policies and internal control systems are in place and functioning effectively, so that key risks which may threaten the achievement of strategic objectives are identified, recorded and minimised. Any significant issues identified in the Annual Governance Statement will be recorded on the Governing Body Assurance Framework and/or Corporate Risk Register.

3.2 Governing Body Assurance Framework (AF)

The AF is the process by which the CCG can demonstrate that it is doing its reasonable best to manage itself so as to meet its strategic objectives and protect patients, members, staff, visitors and other stakeholders against risk of all kinds.

The framework records the links between strategic objectives, key risks and key controls. It also indicates the sources of evidence or assurance, which support the controls, and identifies any gaps. The AF will be reviewed at business meetings of the Quality Committee on a quarterly basis, overseen by the Audit Committee and exceptions identified on the AF will be reviewed at public Governing Body meetings, and the full AF will be reviewed twice a year by the Governing Body.

Whilst there are elements of duplication with the Governing Body Assurance Framework and Corporate Risk Register in terms of language and content, the two documents serve different purposes. The AF is a summary document which brings together a significant amount of information relating to strategic objectives. Its purpose is to provide the CCG Governing Body with assurance that risks to the delivery of organisational objectives have been identified and are being managed. It provides a list of the key pieces of evidence that the CCG Governing Body should use to gain this assurance. There is also an assessment of the strength of evidence provided. The ideal AF will contain a list of significant assurance evidence with no gaps identified in control or assurance, and all assurances provided rated as 'significant'.

3.3 Corporate Risk Register (CRR)

The Corporate Risk Register contains high level (red) organisational and escalated (from Team Risks) operational risks that require active management or review at Governing Body Committee level. The risks contained in the CRR are more wide-ranging than those in the AF. The purpose of the CRR is to provide the Governing Body with a summary of the principal risks facing the organisation with a summary of actions needed and being taken to reduce the risks to an acceptable level. Where risks to achieving organisational objectives are identified within the CRR or directorate risk registers, they should be added to the AF. Likewise where gaps in control are identified in the AF these risks should be added to the CRR. The two documents therefore complement each other providing the Governing Body with assurance and action plans on risk management within the CCG.

The CRR is reviewed on a monthly basis by the CCG Senior Management Team, quarterly by the Quality Committee, overseen by the Audit Committee and every 6 months by the CCG Governing Body.

The process for populating and updating the Corporate Risk Register can be found in Appendix G.

3.4 Locality & Team Risk Management Process/Operational Risks

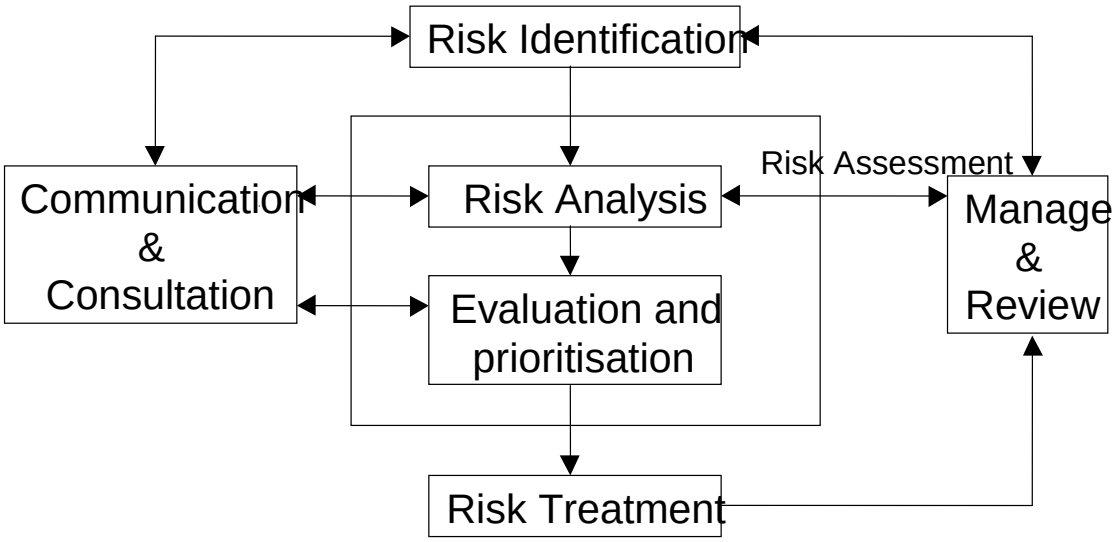
Operational risks that would prevent the Locality or team from meeting its (or another's) objectives will be recorded on the approved Risk Assessment Form and accompanied by an appropriate action plan. Risks that are well managed, do not require escalation and/or do not need further treatment shall be reviewed regularly until such a time as they can be closed. Major risks arising from local risk assessments will be escalated for inclusion in the CCG Corporate Risk Register for the attention of the Quality Committee and ultimately the CCG Governing Body.

The Quality Committee has powers to establish sub groups to review risk registers and other integrated governance matters as appropriate.

Each CCG team will have its own arrangements in place for the monthly review of their operational risks, agreed and overseen by the Senior Management Team.

3.5 The Risk Management Framework

The CCG has adopted the risk management framework described in the NHS Executives Controls Assurance risk management standard. This draws on the main components of risk strategy, that is risk identification, risk analysis, evaluation and prioritisation and risk treatment.



3.5.1 Risk Identification

3.5.1.1 Incident & Near Miss Reporting

The reporting of incidents and near misses by CCG members and staff is an efficient and effective system for identifying risk. This allows rapid alert to ascertain why and how incidents occurred, and facilitates a fast response in the case of adverse events, which may lead to a complaint or litigation. It enables lessons to be learnt and therefore prevent recurrence. This is best achieved in a supportive management environment where a 'fair blame' culture is advocated and makes explicit the circumstances in which disciplinary action may be considered.

All incidents and near misses will be reported and managed using the CCG's incident reporting system in line with the Policy and Procedure for the Reporting and Management of Incidents and Near Misses.

All incidents will be graded at source and as a result of a local investigation, local management (when appropriate) will ensure controls are put into place and advise Senior Management of the risk treatment and controls accordingly. Each incident will be assigned to an incident manager who will be responsible for reviewing the grading applied and ensuring that if necessary the Chief Officer is informed of the incident. Training will be provided to enable staff to grade incidents at source.

3.5.1.2 Risk Assessment

In order to anticipate, rather than react to risks identified, a formal mechanism for risk assessment will be adopted.

The aim of a risk assessment is to determine how to manage or control the risk and translate these findings into a safe system of work that is then communicated to the appropriate level of management.

A risk assessment is a careful examination of what could go wrong. Assessors need to weigh up whether there are sufficient controls in place, and if not they must establish the extent of control and ensure that action is proportionate to the level of risk.

Risk assessments are subjective; therefore, a team of no less than three people should undertake the risk assessment, including preferably the relevant senior manager or lead clinician to ensure ownership of the risks within their own area of responsibility.

All risks are graded using the risk grading matrix.

3.5.2 Risk Grading and Analysis (Acceptable Levels of Risk)

It is accepted that it is neither realistic nor possible to totally eliminate all risk. It is however, feasible to develop a systematic approach to the management of risk so that adverse consequences are minimised, or in some cases, eliminated.

The CCG utilises an accepted system for grading risk (see Appendix B), which takes into account parameters that include probability of occurrence and impact on the organisation. A grading system enables a method of quantification which can be used to prioritise risk treatment at all levels. Incidents and risks are graded according to the CCG's risk grading matrix which considers the actual consequence of the incident or potential consequence of the risk and the likelihood of occurrence or recurrence. The grading results in a level of risk to the organisation.

The risk grading system also covers the different grades of incidents. The level of authority required for managing the different grades of incidents will be described in detail in the incident reporting policy. The following table indicates the authority levels required to act in accordance with the quantification of risk.

	CCG Members / Staff	CCG Locality Leads /Manager	CCG Senior Management	CCG Governing Body Level Management
Insignificant	✓	✓	✓	X
Low	✓	✓	✓	X
Moderate	x	✓	✓	✓
Major	x	x	✓	✓

3.5.3 Risk Evaluation and Prioritisation

The criteria used to evaluate risk covers the following:

- Acceptance criteria within the organisation, i.e., operational standards
- Cost benefit analysis, i.e., balance of cost against the potential benefits
- Human issues, i.e., pain and suffering
- Legislative constraints, i.e., meeting statutory requirements.

3.5.4 Risk Treatment

During the process of risk assessment, analysis and evaluation it is possible to identify controls in place or required to reduce or eliminate risk. These control strategies cover a number of possible solutions, as described below:

- Risk avoidance – discontinuing a hazardous operation/activity
- Risk retention – retaining/accepting risks within financial operations
- Risk transfer – the conventional use of insurance premiums
- Risk reduction – prevention/control of any remaining residual risk.

Once controls, in place or required, have been identified the risk must be re-graded in order to establish whether the action proposed is adequate and will reduce the residual risk to an acceptable level. These controls and further treatments may be cost neutral or require action that requires investment. At this point it is imperative that action plans are submitted as part of the CCG's usual process for service planning.

Risks should continue to be monitored by the relevant Team to ensure that the controls remain effective, once the actions have been implemented and the risk has been eliminated the risk may be closed on the risk register and the reasons for the closure recorded in the narrative of the risk register to provide an auditable trail. The CCG recognises that in some cases high risks may be long standing which cannot be reduced to an acceptable level for a number of reasons, and even having been reviewed and accepted by the Governing Body, these risks shall remain upon the Corporate Risk Register and exception reported to Governing Body to serve as a reminder that the risks are still significant.

3.5.5 Risk Management and Review

Through a process of audit and monitoring the CCG will undertake a review of the risk control measures regularly. It is anticipated that risk control and monitoring measures will include some or all of the following:

- Aggregated statistical and trend reporting of incidents, complaints and claims to the CCG Governing Body and relevant committees
- Audit of implementation of the range of risk management policies, procedures and guidelines throughout the organisation.
- Ongoing review of Risk Register
- Annual review of the Risk Management Strategy
- Bi-annual review of the Risk Management Performance Indicators
- Monitoring of the Audit committee and other minutes
- Audits undertaken by Internal and External Auditors.

3.5.6 Communication and consultation

Advice is available internally through the Head of Corporate Delivery, Chief Nurse, and through the C&M CSU and externally from specialist advisers dependent upon the type of risk being considered. A list of internal specialist advice is available under Section 4 of this policy. For advice regarding external advice, this is available through the Head of Corporate Delivery or Chief Nurse. Consideration should be given as to who needs to be informed of the Risk. Internally this process should following the process detailed within Appendix G. Consideration should also be given as to whether any external stakeholders should also be informed as the impact may affect the achievement of their objectives. i.e. Sefton Council.

3.6 Risk Prevention

It is proposed that the CCG adopts proactive and reactive approaches to risk. The population of risk registers with the further development of appropriate action plans will provide the CCG with greater knowledge of where our risks lie. As our systems and processes become further defined, the CCG will become more sophisticated in its approach to essential risk prevention.

3.7 Legal Liabilities and Property Losses

The CCG is a member of the Clinical Negligence Scheme for Trusts (CNST), Liabilities to Third Parties (LTPS) and Property Expenses Scheme (PES) that are administered by the NHS Litigation Authority (NHSLA). Funding is on a pay as you go basis and contributions are based on a range of criteria such as NHS income, numbers of staff and property values.

Commissioned services such as secondary care providers, independent contractors and their employees are not directly employed by the CCG and therefore are required to make their own indemnity arrangements. However, the CCG has a responsibility to ensure that governance principles and risk management systems are being developed and applied by all providers. It is therefore possible for negligence proven in the course of a claim to in part be attributed to CCG commissioning the care if the CCG has failed to take reasonable steps to assure itself of the quality of standards of its provider. In these circumstances it is important that the CCG is able to demonstrate that it has taken all reasonable steps, i.e., monitoring performance, to assure itself of the quality of care provided. To this end during 2013/14 the Chief Nurse and Head of Corporate Delivery will develop links between the risk and clinical quality agenda, in conjunction with colleagues in C&M CSU, to ensure that the CCG fulfils its obligations as a Commissioner and any areas of concern highlighted through contract performance monitoring inform the wider CCG through risk management framework.

4. Roles and responsibilities

All those working within the CCG have a responsibility to contribute, directly and indirectly to the achievement of the CCG's objectives through the efficient management of risk. It is also important to make explicit how the responsibility of the individual contributes to the lines of management accountability through to the CCG Governing Body.

There are four identifiable tiers within the CCG:

- Governing Body Level Management
- Senior Management
- Locality Leads/ Managers
- All Members and Staff.

4.1 Governing Body Level Management

4.1.1 Chief Officer

The Chief Officer has ultimate responsibility for risk management, for meeting all statutory requirements and adhering to guidance issued by the Department of Health / NHS England in respect of governance. As such, the Chief Officer must take assurance from the systems and processes for risk management. The CCG will ensure that reporting mechanisms clearly demonstrate that the Chief Officer is informed of significant risk issues. The reporting mechanism will include the presentation of minutes and reports to the CCG by the Audit Committee.

It is the responsibility of the Chief Officer and Senior Management Team to ensure that the standards of risk management are applied at all levels within the CCG and that assurance mechanisms are in place to assure the CCG Governing Body that risk is being managed effectively.

4.1.2 Chief Nurse

The Chief Nurse will sit on the CCG Governing Body and have clear responsibility for clinical governance and clinical risk management. In conjunction with the Head of Corporate Delivery they will ensure the development of a comprehensive system of integrated governance across the CCG and that risk management arrangements are controlled and monitored through robust audit processes. The Chief Nurse is a member of the Quality Committee and Audit Committee. They will be supported by the Cheshire and Merseyside Commissioning Support Services (CM CSU) Head of Governance and a team of specialist staff.

4.1.3 Chief Finance Officer

The Chief Finance Officer has overall fiscal responsibility in the CCG and is responsible for ensuring that the CCG carries out its business within sound financial governance and that risk management arrangements are controlled and monitored through robust accounting mechanisms that are open to public scrutiny on an annual basis. They will seek the Chief Internal Auditors opinion on the effectiveness of internal financial control. The Chief Finance Officer is a member of Audit Committee and Quality Committee. In addition they will be ultimately responsible for any financial implications of plans to minimise risk and the method for incorporating these into business planning.

4.1.4 Head of Corporate Delivery & Integration

The CCG Head of Corporate Delivery has managerial responsibility for corporate governance and risk management and the responsibility for ensure effective systems are in place. They are the key contact for the auditors in relation to risk management.

4.1.5 Early Warning System (Senior Management Team)

The CCG operates an 'Early Warning System', which enables any issue with the potential to post a significant risk to the CCG, to be brought immediately to the attention of the Senior Management Team (SMT) without using the formal committee route. The decision to use this route must be approved by a member of the SMT.

4.1.6 CCG Governing Body

The CCG Governing Body recognises that risk management is a fundamental part of good governance and to be effective it is essential that risk management processes are integral to the CCG's culture. The Governing Body is therefore committed to ensuring that risk management forms an integral part of the CCG's philosophy, practices and business plans. Risk management is not viewed or practised as a separate programme and responsibility for implementation is accepted at all levels of the CCG.

The CCG Governing Body will ultimately carry responsibility for monitoring and overseeing risk that is relevant to the nature of its duties and responsibilities; however, the CCG Governing Body has delegated responsibility to the Audit Committee to take an overview of all risk and report directly to the Governing Body. This approach was commended by the Audit Commission in their guidance 'Governing the NHS (June 2003). The CCG will ensure that all Governing Body members receive risk management training both as part of their induction training and refresher training.

4.1.7 Audit Committee

The Audit Committee has delegated authority from the CCG Governing Body to ensure that risk management is embedded throughout the CCG, including monitoring of all specialist groups with responsibility for risk. Under the chairmanship of a the Lay Advisor Governing Body Member with a lead for Governance, with lead clinician input and high level representation from the CCG management team, the Committee is charged with the responsibility for ensuring effective risk management systems are in place across the CCG. The Committee will have the option to establish specialist risk management groups to consider specific areas of risk in more detail on the Committee's behalf if it wishes to do so. The Audit Committee also reports to the Governing Body in terms of information the Audit Committee may wish to consider when deciding on audit forward plans.

The Audit Committee is also responsible for providing the Governing Body with assurance that an effective system of integrated governance, risk management and internal control, across the whole of organisation's activities which supports the achievement of the organisation's objectives is in place. In particular the Committee reviews the adequacy of all risk and control related disclosure statements, particularly the Statement of Internal Control, and the underlying assurance processes which indicate the degree of the effectiveness of the management of principle risks.

For further information regarding the role of the Audit Committee please refer to Appendix E.

4.2 Senior Management Support

The CCG Head of Corporate Delivery & Integration will, in conjunction with the Chief Nurse, commission effective management support for governance and risk from C&M CSU.

4.2.1 Cheshire & Merseyside Commissioning Support Unit (C&M CSU)

The Head of Corporate Delivery has overall operational responsibility for delivery and review of the risk management strategy, however the CMCSU team will be commissioned to support the delivery of risk management systems and policies within the CCG as part of the Core Offer. The Governance Team at CMCSU will also provide advice and support regarding the analysis and evaluation of risk, ensuring that all risk registers across the organisation are 'dynamic' reflecting the changing risk profile of the organisation. They will also be commissioned to ensure systems are in place to achieve and improve compliance with external assessments and for monitoring all internal audit activity on behalf of the Audit Committee, ensuring that gaps in assurance and associated action plans identified through risk based reviews are completed. They also have responsibility for the risk education programme across in the CCG.

CMCSU will support the Head of Corporate Delivery and Chief Nurse by preparing for all external inspections and accreditations. They will support the delivery of the Team/Locality risk management and assessment process and the maintenance of the Corporate Risk Register and Governing Body Assurance Framework.

The CMCSU will provide the Chief Nurse with regular information on Serious Untoward Incidents reported from commissioned services across Sefton. They will also support the Chief Nurse in identifying patient safety issues and health and safety & security. They will also manage the Incident Reporting System for both CCGs in Sefton and report regularly to the Governing Body via the Chief Nurse.

4.2.2 Other Specialist Expertise:

Expertise in specific areas of risk may be obtained from a number of sources, both internal and external, such as:

- Governance / Quality Lead at NHS England /CMCSU
- Health and Safety Lead from CMCSU
- Occupational Health Manager
- Local Counter Fraud Specialist (LCFS)
- NHS Litigation Authority (NHSLA)
- Health & Safety Executive (HSE).

4.2.3 NHS England

As the successor body to the National Patient Safety Agency (NPSA), NHS England co-ordinates the reporting and learning of adverse events occurring in the NHS. The CCG reports all notifiable Patient Safety incidents to NHS England via the National Reporting and Learning System (NRLS) and promotes and monitors compliance with Safety Alerts issued by NHS England. The Chief Nurse will therefore maintain effective liaison with the governance structures, committees and other groups within the Local Office of NHS England and CMCSU.

4.3 Locality Leads/ Managers

They will ensure that:

- The risk management strategy is implemented within their area of control and promotes risk management as a key management responsibility.
- Risk management responsibilities are properly assigned and accepted at all levels.
- All risks associated with their area of responsibility are risk assessed and the results of these assessments and resulting control mechanisms are recorded on the Corporate Risk Registers. Control procedures will be periodically reviewed for continued effectiveness.
- A periodic review of the effectiveness of risk management within their area of responsibility is undertaken and action taken to eliminate deficiencies.
- Information, instruction and training are delivered to members / staff appropriate to the findings of risk assessments.
- Safe systems of work are in place and that effectiveness is periodically monitored.
- Outcomes of risk assessments are used as part of the service planning process to assist with planning and resource allocation.
- Information captured by complaints, litigation and incident reporting is used as a means of continuous monitoring and review, leading to risk reduction in services within their area.
- Bringing any significant risks which have been identified, and where local controls are considered to be potentially inadequate to the attention of the Quality Committee or SMT via the inclusion on the Corporate Risk Register.
- All staff within attend mandatory risk management training in line with the CCG's mandatory training policy.

4.4 All CCG Members and staff

- Risk management will form part of their daily duties. All will be able to identify and assess risk; take action to reduce risks to an acceptable level and inform appropriate lead clinicians and managers of unacceptable risks.
- All will be required to participate in activities, which are commensurate with the CCG's risk management arrangements and statutory requirements.
- All have a responsibility to report incidents, which is a key source of information for clinicians and managers on the nature and level of adverse activity within their sphere of responsibility.
- Be aware of emergency procedures e.g., resuscitation, evacuation and fire precaution procedures.
- Will attend risk management training as relevant to their role set out in the CCG's Mandatory Training Policy/ C&M CSU training policy.

4.5 Commissioned services, Independent Contractors and their Employers

Whilst there is no obligation to adopt the CCG Risk Management Strategy, if they do commissioned services will be contributing to the reduction of risk across the area as a whole, and to the improvement of patient and staff safety. In addition, following these procedures will assist in complaint handling, reduce litigation and may assist in the defence of any claims should they arise.

4.6 Responsibilities of Contractors, agency and locum staff

Contractors and agency staff working for the CCG are bound by the contents of this Strategy and will be expected to comply with all relevant policies and procedures. Information and training will be provided as necessary to enable contractors and agency staff to fulfil this responsibility.

5. Definitions

Risk management:

Risk management is a framework for the systematic identification, assessment, treatment and monitoring of risks. Its purpose is to prevent or minimise the possibility of recurrence of risks and their associated consequences, which have potentially adverse effects on the quality of care, both directly provided and commissioned, and safety of patients, staff and visitors, and the financial management of the organisation. It encompasses culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

Risk:

The possibility of incurring misfortune or loss or failing to take advantage of potential opportunities.

Risk = consequences x likelihood

'Acceptable' risk

It is not feasible to eliminate or avoid all risks and there are some risks identified which require the CCG to go beyond reasonable action to reduce or eliminate. Where the 'cost' to the organisation to reduce the level of risk outweighs the adverse consequences of the risk occurring, the risk would be considered 'acceptable' to the CCG.

'Manageable' risk

Some risks identified can be realistically managed, or reduced, within a reasonable, acceptable timescale through cost-effective measures, these are considered 'manageable' risk.

'High' risk

These are risks which if they occur will have a serious impact on the CCG and threaten the achievement of its objectives. Risks identified as 'high' should always be reported on the Corporate Risk Register, if necessary they should also be highlighted to the SMT via the Early Warning System.

'Risk Appetite' –

The CCG's risk appetite is determined by the amount of risk that the CCG is prepared to accept, be exposed to or tolerate at any point in time. All staff will strive to reduce risks to the lowest possible level (where this is reasonably practical). Where risks cannot be avoided, every effort will

be made to mitigate the residual risk whilst enabling the CCG to support innovation and diversity in our commissioning intentions to ultimately improve the efficiency and value of local health services.

The CCG will not, under any circumstances accept any risk which would potentially/actually result in non-compliance with legislation or statutory responsibilities. Similarly, risks which threaten patient and/or staff safety will not be tolerated and the CCG will endeavour to minimise any risks of this type. The Governing Body will set boundaries in order to guide staff on the limits of risk they are able to in the pursuit of achieving its strategic objectives. The Governing Body will set these limits annually and review them as necessary".

6. Consultation, approval and ratification process

The policy has been developed and based on good practice in the area of risk management and is reviewed by the Quality committee and recommended to the CCG Governing Body. The Audit Committee will also review the policy.

7. Review and revision arrangements

The strategy will be considered and reviewed by the Quality Committee and recommended to the CCG Governing Body annually and / or when there are changes in NHS requirements or best practice.

8. Dissemination and Implementation:

For the strategy to be effective the CCG will:

- review annually its Risk Management Strategy to ensure it meets the needs of the CCG and the changing environment
- ensure the risk management services provided meet the needs of the organisation and develops in line with changing requirements
- continue the development and delivery of an education and training programme which assists members and assist in identifying and managing risk and in complying with the CCG risk management policies. Attendance records will be kept for all risk management training and evaluation forms completed and held by the Workforce Department at CMCSU department
- ensure the CMCSU systems capture data effectively
- monitor risk management key performance indicators, such as those suggested listed in Appendix F, to measure the performance of the CCG's risk management process. The efficacy and usefulness of these indicators will be reviewed by the Chief Nurse and the Quality Committee. Consequently they will continue to be refined and developed
- encourage the flow of information via risk registers, and disseminate good practice in this regard, within and across the CCG
- develop a risk aware culture amongst members and staff through CCG briefings, literature, induction programmes, mandatory training and use of the CCG intranet site.

The Head of Corporate Delivery & Integration will ensure that the Strategy is communicated throughout the CCG via the CCG website and intranet, bulletins, newsletters and in induction and mandatory training/ Core skills sessions. CCG Governing Body members and senior managers will

be responsible for confirming receipt of the Risk Management Strategy and for ensuring its content to their respective teams so that all staff are aware of their responsibilities.

8.1 Education and Training

The following training will be provided by Cheshire & Merseyside Commissioning Support Unit (CMCSU) on behalf of the CCG on an ongoing basis:

- Risk management mandatory training to promote ownership of the Risk Management Strategy, including providing guidance on incident reporting, root cause analysis, risk assessment and the risk registers, and based upon the training needs analysis of all staff.
- Risk management is included in induction training.
- On an ad hoc basis as identified in personal development plans.
- Providing support in response to information notices, i.e., CAS alerts.

The Quality Committee will review progress against the implementation of the strategy. The review will be based on information available from the Governing Body Assurance Framework, risk registers, Audit Commission's Use of Resources assessment and Internal Audit's risk based reviews. In addition the Audit Committee also reviews the efficiency of risk management systems across the CCG on behalf of the CCG Governing Body; this is primarily done by the work of internal and external audit.

9. Document Control

The Head of Corporate Delivery & Integration is responsible for storing current, and archiving, versions of the Risk Management Strategy.

10. Monitoring Compliance with and Effectiveness of the Policy

The success of risk control measures must be monitored in an appropriate manner to provide information to guide future developments. There are various ways in which the CCG assesses and monitors risk supported by systems managed by CMCSU. Reactive monitoring occurs through the incident and near miss reporting and monitoring of complaints and claims. Proactive monitoring of adherence to procedures occurs through audit, workplace inspections, staff surveys and performance indicators.

The CCG committee structure will provide a vehicle for monitoring risk management activity. The Quality Committee is responsible for managing areas of concern on the Corporate Risk Register and will receive information from the incident reporting system and consider policy changes as a result of information from incident reporting. It will also monitor the risk management performance indicators on a 6-monthly basis.

Senior Managers shall hold staff to account for ensuring compliance with the strategy within their locality / service area. An effective way of ensuring the strategy is adopted into the culture of the CCG is via the appraisal process when reviewing performance e.g. against the Knowledge and Skills Framework outline. A suggestion of evidence to be looked for is in KSF Dimension Health Safety and Security Levels 1-3.

11. Associated documentation

The Risk Management Strategy is to be followed within the context of the CCG's overarching strategy.

A range of documents from predecessor organisations have been or will be reviewed, amended and if appropriate adopted by the CCG Governing Body or appropriate Committee. Such policies will include:-

- Policy & Procedure for the Reporting and Management of Incidents & Near Misses
- Policy & Procedure for the Management of Claims
- Complaints Comments & Concerns Policy
- Policy & Procedure for the Root Cause Analysis of Incidents, Complaints and Claims
- Health and Safety Policy
- Moving and Handling Policy
- Lone Workers Policy
- Control of Substances Hazardous to Health (COSHH) Policy
- Management of Violence and Aggression Policy
- Infection Control Strategy
- StEIS reporting procedure
- Whistleblowing Policy
- And any other relevant document.

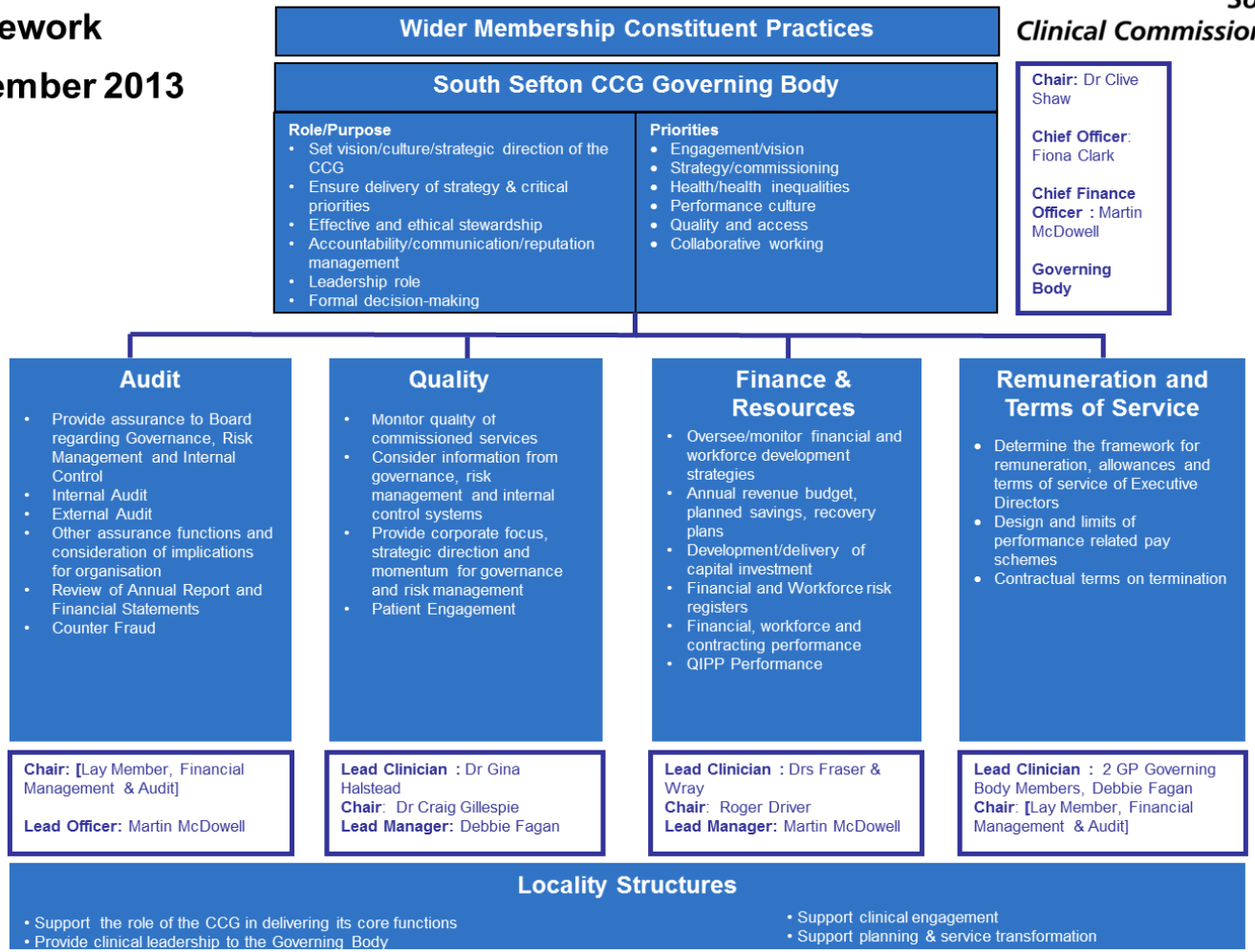
These policies will be published the CCG Intranet site once adopted.

Appendix A

Governance Framework

September 2013

NHS
South Sefton
Clinical Commissioning Group



Appendix B

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

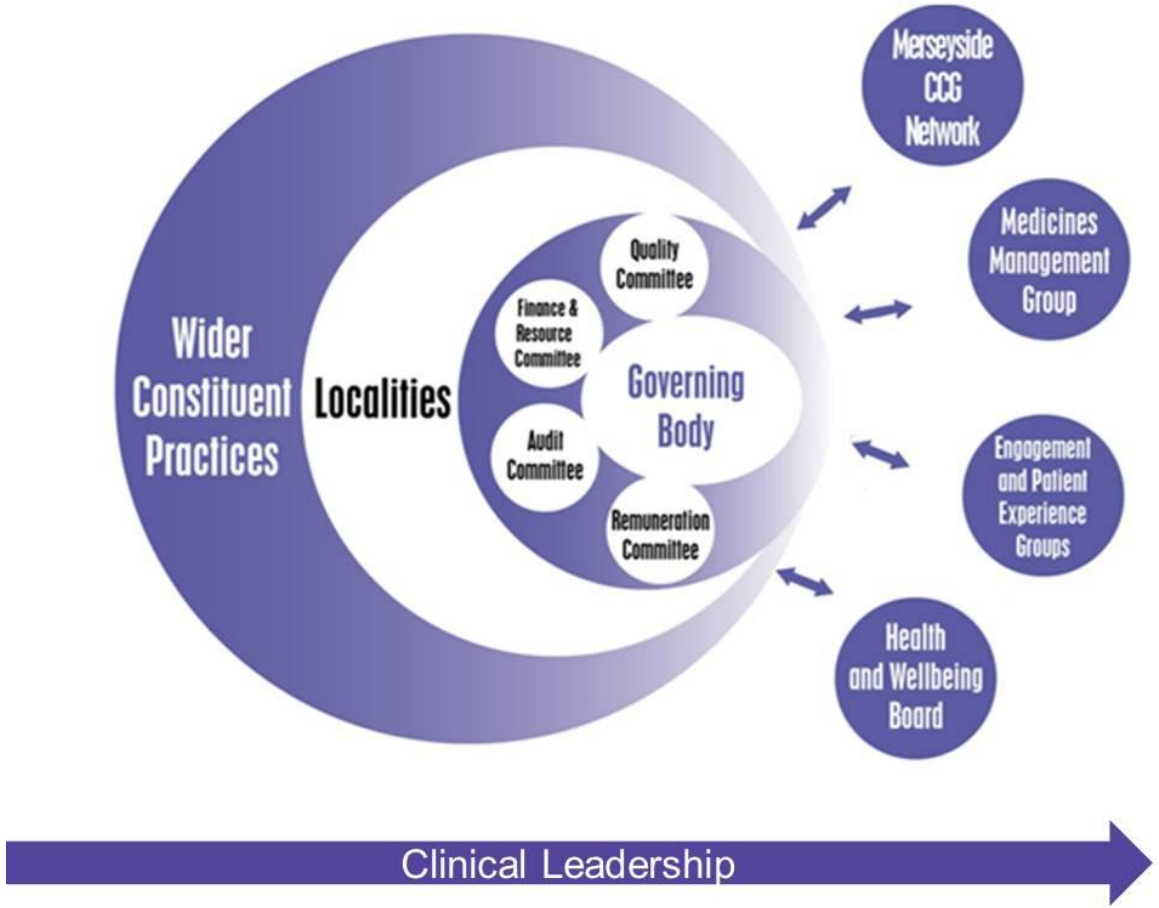
Risk	Score	Colour
Insignificant	1 - 3	
Low	4 - 6	
Moderate	8 - 12	
High	15 - 25	

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 Team Risk Register.

Appendix C


Merseyside CCG Network
Medicines Management Group
Engagement and Patient Experience Groups
Health and Wellbeing Board
Wider Constituent Practices
Localities
Quality Committee
Finance & Resource Committee
Governing Body
Audit Committee
Remuneration Committee
Clinical Leadership

Appendix D

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

Appendix E

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

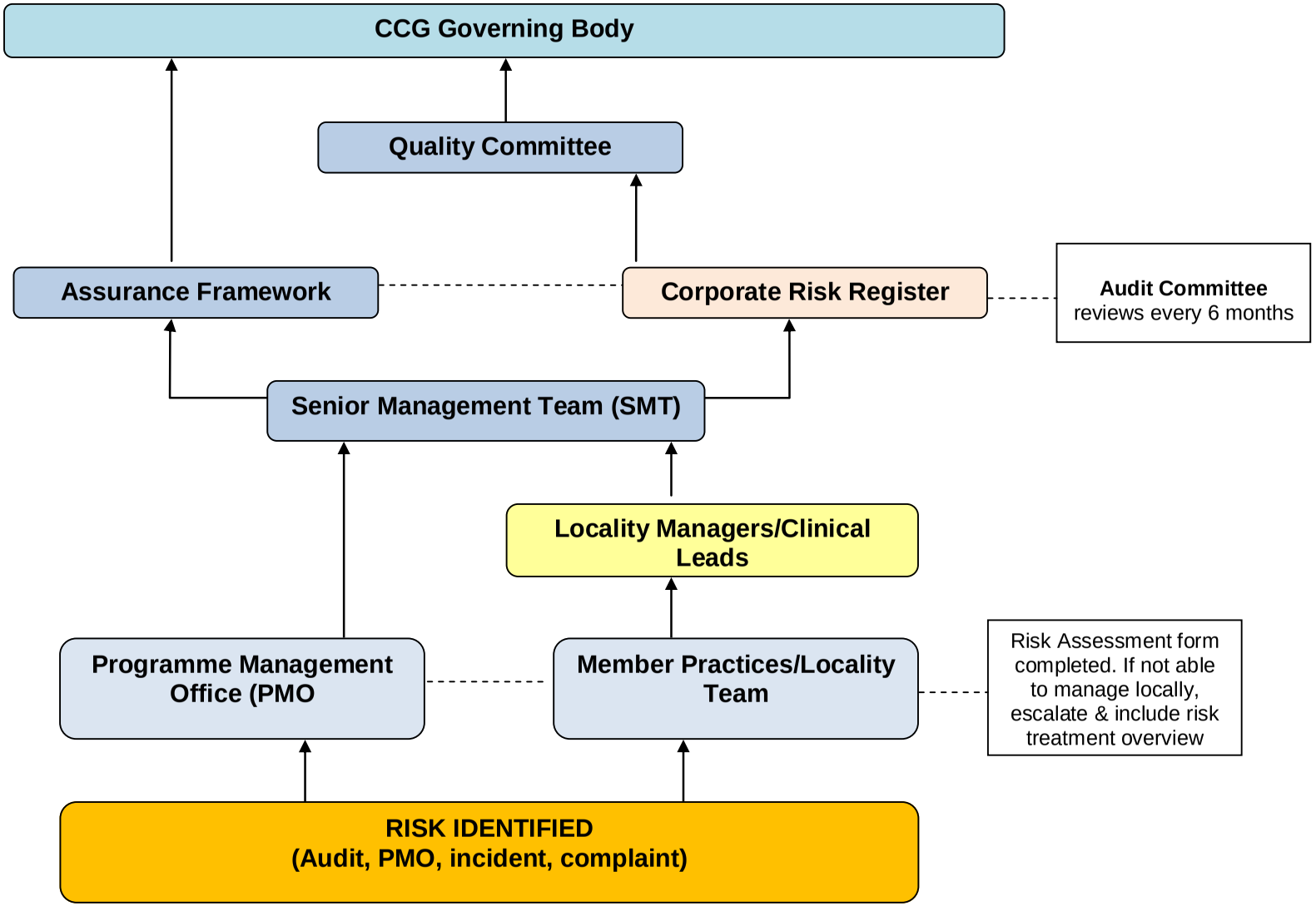
Appendix F

Risk Management Performance Indicators

Performance Indicator	Lead for compiling data
Incident Reporting	
No. of incidents & near misses reported this period compared to previous periods	C&M CSU
% of directorates reporting incidents & near misses	
No. (%) of incidents with actions recorded	
No. (%) of incidents closed with no action recorded	
No. (%) of incidents ongoing for more than 3 months	
Average severity rating of incidents and near misses	
No. (%) of patient safety incidents uploaded to the NPSA NRLS	
Risk Register	
No. of risks added to the Risk Registers	Chief Nurse
No. of risks closed on the Risk Registers	
No. (%) of red risks on the Risk Registers	
No. (%) of Team with 'live' Risk Registers (i.e., reviewed on a monthly basis)	
Risk Management Training	
% of Staff who are up to date with their mandatory risk management training	Workforce at C&M CSU
Complaints	
No. of formal complaints relating to Commissioned Services received (NOTE – as of 1 April 2009 any verbal complaints not resolved within 24 hours are now logged as a formal complaint)	C&M CSU
No. (%) of complaints acknowledged within 3 working days	
No. (%) of complaints answered within an agreed timescale	
No. (%) of complaints with an initial incident reporting form	
No. (%) of complaints referred to the Ombudsman	
Claims	
No. of claims	C&M CSU
No. (%) of claims in which an initial incident form was completed	
No. (%) of letters of claim acknowledged within 14 days	
Central Alert System (CAS)	
No. of alerts received within this period	C&M CSU
No. (%) of alerts responded to within the timescales	
StEIS (Serious Untoward Incidents)	
No. of StEIS incidents reported to the CCG	C&M CSU
No. (%) of StEIS incidents acknowledged within 3 days	
No. (%) of completed investigation reports received within agreed timescales	
No. (%) of investigation reports reviewed within 10 working days	

Appendix G

Risk Escalation Process



Appendix H

CCG Risk Assessment Form

Section 1 – Process Description

Member Practice/Locality Team:
Process/Activity:

Section 2 – Identifying Risks/Hazards

Risk/Hazard	Persons at Risk	Existing Control Measures	Likelihood	Consequence	Risk Level L x C	Risk Register
1						
2						
3						
4						

Is any employee health monitoring required?	**Yes □ No □**
Is a more detailed assessment (e.g. COSHH, Manual Handling) required?	**Yes □ No □**
Is further information or investigation required to complete risk assessment?	**Yes □ No □**

Assessors Name:	**Job Title:**
Date of Assessment:	**Reassessment Date:**
Assessor's Signature:	**Manager's Signature:**

Complete Action Plan and attach to Risk Assessment Form

Risk Action Plan

Risk Reference:

Risk/Hazard Nos	Risk Score[1]	Action Required to Control Risk	Lead Person	Action By	Comments	Residual Risk Score[2]

[1] **Risk score prior to completion of actions**
[2] **Risk score following completion of actions**

Completed By:

Date:

Manager's Signature

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/127	**Author of the Paper:**
Report date: 16 September 2013	Tracy Jeffes Head of Delivery and Integration tracy.jeffes@southportandformbyccg.nhs.uk Tel: 0151 247 7049

Title: Commissioning Support Service (CSU) Procurement

Summary/Key Issues:

1. This paper highlights key messages from the recent NHS England Guidance "Towards Commissioning Excellence: A Strategy for commissioning support services".
2. It also highlights the key themes emerging from engagement with CCGs nationally about the approach to procuring CSU services and further support that will be made available to CCGs
3. The paper provides information on the current local situation in relation to CSU provision.
4. Outlines proposed next steps for the CCG.

Recommendation

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

Receive	
Approve	x
Ratify	

GB13/128

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.
x	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
	To sustain engagement of CCG members and public partners and stakeholders.
	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement		x		
Clinical Engagement		x		
Equality Impact Assessment		x		
Legal Advice Sought		x		
Resource Implications Considered	x			The current review of CSU services will consider financial implications.
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

1. Executive Summary

This paper provides the Governing Body with an overview of the latest NHS England guidance in relation to the procurement of Commissioning Support Unit (CSU) services, gives an update on the current local position and outlines a timetable for future action in order to enable the CCG to exercise an informed choice.

2. Introduction and Background

2.1. In June 2013, NHS England published 'Towards Commissioning Excellence: A Strategy for commissioning support services'. This strategy aims to; enable CCGs to exercise informed choice in how they source their commissioning support and from whom, build a strong cohort of excellent commissioning support providers and to strengthen collaboration between NHS CSUs and the voluntary sector.

2.2. The guidance highlights how NHS England wishes to ensure that CCGs and others can secure the commissioning support services that they need and aims to ensure that the providers available within the market are 'best in class'. The Mandate to NHS England sets out that 'CCGs will be in full control over where they source their commissioning support'.

2.3. There are three key elements to the strategy.

1. Enabling CCGs to exercise informed choice in how they source their commissioning support and from whom.

2. Building a strong cohort of excellent commissioning support providers. NHS Commissioning Support Units (CSUs) are currently the mainstay of commissioning support. NHS England is committed to investing in their development, encouraging and enabling partnership working and collaboration, and assuring their development with the aim of CSUs being autonomous by no later than 2016.

3. Ensuring the establishment of simple, efficient procurement mechanisms which enable fair and open competition. Alongside the strategy, NHS England has also published a procurement guide which explains the process commissioners need to follow should they wish to choose an alternative commissioning support provider.

2.4. Key milestones in the NHS England strategy are highlighted in Appendix 1.

2.5. At the same time, NHS England also launched an engagement exercise with key stakeholders on proposed options to support CCGs and others to procure commissioning support simply and effectively. This engagement exercise now been completed and the key message were published in a letter published on the 22nd August 2013. These findings were as follows.

- Overwhelmingly, CCGs wanted a sensible timetable for procurement which did not divert the focus away from the forthcoming contracting round and as such NHS England is now supporting CCGs who wish to have an opportunity to renegotiate their existing SLAs with CSUs, rather than proceed into a formal procurement process, as per the original timetable in the guidance.

- There were many examples of CCGs and CSUs working well together across the country, however it has been recognised that there have been some “teething problems” which need to be resolved and that priority should be given to forging even greater relationships so that CCG concerns are identified and responded to rapidly.

- Many CCGs wanted support in the development and future procurement of CSU services and as a result NHS England will be launching an “autumn package of support” which will include:-

    - A make/share/buy toolkit co-developed with CCGs
    - A defined set of standards, competences and criteria for excellent commissioning support
    - A “lead provider” framework agreement, where the good practice standards and competences could be applied to organisations in order to create a pre-accredited list of suppliers that CCGs could use to run mini-competitions, rather than undertaking a full OJEU process
    - Standard service specifications and a standard contract (which could be adapted to meet local needs)
    - Options for “non-conflicted” procurement support (as many CCGs obtain their procurement support through CSUs)
    - Peer mentors and networks to share approaches to CSUs across the country.
    - Advice and support regarding securing the best value for money from CSUs.

- The letter strongly encourages CCGs to work together to actively shape development of their local CSUs and also to have early discussions with CSUs, particularly if they wish to renegotiate arrangements so that both CCGs and CSUs are on a more sustainable footing ahead of working together in the contracting period

Current Local Situation

2.6. Southport and Formby CCG currently commission the Cheshire and Merseyside Commissioning Support Unit (CMCSU) to provide a range of services. Appendix 2 provides a summary of each service line.

2.7. Updated service specifications for each service area are now available and KPIs have been agreed or being refined for all areas.

2.8. Monthly CSU performance meetings are held jointly with South Sefton CCG and attended by a Governing Body member from both of the CCGs in Sefton, the Head of Delivery and Integration, (lead commissioner) the Head of Performance and Health Outcomes and the CCG Chief Accountant.

2.9. In addition, the CSU Head of Client Operations (HOCO) and the Head of CCG Delivery and Integration meet regularly to proactively highlight and resolve any issues and the HOCO is invited to attend all Senior Management Team meetings. The HOCO has introduced a CSU locality team model, which meets regularly at Merton House and includes lead CSU colleagues for each of the key service areas, some of whom are based with the CCG or frequently access hot-desks.

2.10. The current service level agreement (SLA) with the CSU ceases at the end of September 2014 and as a result of the recent engagement exercise, CCGs can now extend their SLAs until no later than April 2016, if they wish to do so.

2.11. Discussions have recently taken place at the CCG Network meeting regarding future procurement of CSU services.

3. Key Issues in relation to procurement of CSU services

Although CCGs now have the opportunity to renegotiate their SLAs until 2016, they still have freedom to choose their commissioning support supplier and can exercise this freedom now (although the NHS England autumn support pack is not yet available.) They are also free to provide their commissioning support services in-house either individually or through shared arrangements with other CCGs. If CCGs do wish to exercise their freedoms, certain requirements apply:

3.1. Value for money

- CCGs must be able to demonstrate that their commissioning support services – whether purchased or provided in house – give value for money; delivering the capability/quality they need to achieve their objectives at an affordable cost.

3.2. Service quality and standards

- Services (in-house or procured) must comply with agreed minimum national standards, for example on data security and quality.

3.3. Procurement law and best practice

- All public sector bodies – must comply with EU and UK procurement law and best practice in procuring commissioning support services
- A decision to provide commissioning support services in-house, whether shared or individually, is not subject to procurement law, but must enable the best patient outcomes and demonstrate better value for money than buying commissioning support services.

3.4. NHS Constitution

- All parties will be required to comply with the NHS Constitution.

3.5. Managing risk

- Commissioners will be expected to have regard to the impact of their actions on the wider NHS commissioning system, including collaborating with other commissioners and to enter into constructive dialogue to manage transitional risks
- Commissioners will be required to honour SLA/contractual notice periods
- Commissioners will have the option of using a model contract with suppliers of commissioning support services, which will look to set out a balanced risk approach.

4. Conclusions and Next steps

In order to make informed decisions on future procurement of CSU services, the following next steps are proposed:-

4.1. Assess current service

The CCG is currently undertaking an internal review of the value for money and quality of each of each service areas within the SLA. Neighbouring CCGs are also reviewing CSU provision. This initial assessment will be completed by the end of September 2013

4.2. Explore the way forward through discussion both locally and nationally

Based on the outcomes of the initial assessment, finalise discussions with neighbouring CCGs and identify any risks to CSU provision. Participate in the national working groups developing the products for the “autumn package” of support.

4.3. Develop and consider options

Consider options for action which may include:-

- Renegotiating changes to the current SLA from April 2014 for the remainder of its “life” until October 2014.
- Continue the current SLA in its current form whilst utilising the “autumn support pack” to further assesses the service offer and future make/share/buy options
- Following this work, commence negotiating for an extension/ renegotiation of the SLA beyond October 2014 into 2015 and no later than 2016.
- Consider moving to external procurement from October 2014 or at a future date, not beyond the end of 2015.

4.4. Recommendation Phase

Review proposals and make further updates or recommendations to the Governing Body in November 2013.

5. Recommendations

It is recommended that:-

5.1. The initial evaluation process identified above is actioned.

5.2. The expenditure (by CCG function and CSU provision) is mapped out in more detail than currently available so that value for money can start to be reviewed. This will be supported by the CCG Programme Management Office.

5.3. The results of the initial review be acted upon where appropriate (and following broader discussion with neighbouring CCGs) to inform possible changes to the current SLA for April 2014. This will involve Governing Body lead members for the CSU contract and members of the Senior Leadership Team.

5.4. The Governing Body receive the content of this briefing paper to inform CCG decision making with regard to the future of commissioning support services.

Appendices

Appendix 1 Key Milestones from the NHS Guidance ‘Towards Commissioning Excellence: A Strategy for commissioning support services.’

Appendix 2 Current Provision of Services for Southport and Formby CCG,

Tracy Jeffes
September 2013

Appendix 1

Key Milestones from the NHS Guidance 'Towards Commissioning Excellence: A Strategy for commissioning support services'.

Some of the key milestones identified by NHS England are provided below, but may now be subject to change as a result of the recent engagement exercise with CCGs and the outcomes of planned working groups.

- **12 June 2013** – Publication of strategy, launch of consultation on CCG procurement support options
- **June to August 2013** – Engagement with CCGs and providers on procurement options and assurance of CCG in-house provision
- **September 2013** – Publication of NHS England's approach to supporting procurement and timetable
- **October 2013** – CCGs publish initial procurement intentions and timetable to support discussion with other commissioners and commissioning support providers on how to realise their intentions
- **October 2013** - NHS England publishes its approach to evaluating value for money in commissioning support services and to ensuring continuity of service
- **October 2013** NHS England publishes update on progress, including progress on partnership working with voluntary organisations and local authorities
- **November 2013** – NHS England Publishes its strategy for autonomous Commissioning Support Units
- **December 2013** – Release of upgraded commissioning support choice app
- **April 2014** – Procurement framework goes live with supporting voluntary good practice specifications
- **October 2014** – Update on progress and any necessary fine tuning of implementation.

Appendix 2

Current Provision of Services for Southport and Formby CCG as per the SLA with the CSU for the period of April 2013 to end September 2014.

	External Service Line	S/port & For
1	Equality & Diversity	YES
90	Freedom of Information	YES
3	Information Governance Management	YES
4	Claims Management and escalation	YES
5	Corporate Governance Reviews	YES
250	Counter Fraud Service	YES
251	Internal Audit Independent Assurance	YES
88	Performance Planning	YES
7	Quality Governance	YES
S1	**Governance: Support to ensure compliance**	
8	Assurance Frameworks - development and monitoring	YES
9	Risk Management Systems - development and monitoring	YES
139	Compliance	YES
140	Accident and Incident Reporting Monitoring	YES
141	Local Security Management Specialists	YES
142	HS & FS	YES
143	CAS Alerts	YES
S2	**Risk Management: Assurance**	
15	Regulatory & Statutory Compliance	YES
16	Support to ensure CCGs comply with the principles of the NHS constitution	YES
17	Provide medicines management input into secondary care	YES
18	Pharmaceutical Public Health advice & support	YES
S4	**Medicines Management: Expert Advice**	
20	Facilitation of Contract Management arrangements	YES
25	Individual Funding Requests	YES
S5	**Contract Management: Support to organisation**	
27	Support for Healthcare & non-Healthcare Procurement	YES
28	AQP assessment facilitation service	YES
29	Market Analysis of Commercial Procurements	YES
30	Provision of specialist Procurement IM&T Systems	YES
S6	**Procurement: Support for purchasing**	
98	Choose and Book performance and exceptions	YES
S7	**Commissioning Support: Advice and Guidance**	
132	Complex commissioning and NHS Funded care	YES
35	Compliance with Mental Health Act and Mental Capacity Act	YES
S8	**Complex Commissioning Support**	
36	Children's Universal to Specialist Services	YES
S9	**Children's Commissioning Support**	

	External Service Line	S/port & For
67	Invoice to cash	YES
38	Order to payment	YES
39	Treasury Management and reporting	YES
40	Management of Ledgers	YES
S10	**Finance: Delivery of essential audit**	
42	Data Management Support	YES
45	CCG Specific Reporting Suites Inc. benchmarking	YES
70	Business Analysis Support	YES
S11	**Business Intelligence Support Service**	
51	Media Management	YES
52	Crisis Issues Management	YES
53	Internal/Membership Communications	YES
54	Patient and other Stakeholder Management and Engagement Support	YES
75	Corporate Communication	YES
76	Strategic Communications and Engagement	YES
77	Patient Communications - Services and Choice	YES
S12	**Communication and Engagement**	
55	HR Strategy and policy support	YES
57	OD needs analysis, programme design & delivery	YES
56	Training, Learning & Development programme design & delivery	YES
58	Transactional HR - Employment, Recruitment, Payroll	YES
59	Workforce Performance Management	YES
S13	**Human Resources and Organisation Development**	
60	ICT Services & Support	YES
61	ICT Training	YES
63	Programme and Project Management	YES
252	CCG IM&T Strategy and Development	YES
S14	**Information Management & Technology**	

In addition the CCG has purchased three additional services in year

CHC /Nurse Assessors
EPRR – Emergence Response support
UCAT – Urgent Care Action Team

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MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/129	**Author of the Paper:** Melanie Wright Business Manager melanie.wright@southseftonccg.nhs.uk
Report date: 12 September 2013	

Title: Disciplinary Policy

Summary/Key Issues:

This paper presents the Governing Body with the organisation's Disciplinary Policy, which was prepared by the Cheshire & Merseyside Commissioning Support Unit in collaboration with other local CCGs via the CCG's Partnership Forum, to facilitate uniformity in relation to HR policies and procedures and compliance with Agenda for Change Terms and Conditions.

In accordance with the CCG's Constitution (Scheme of Reservation and Delegation), HR policies require approval by the Governing Body and the Governing Body is therefore asked to approve this policy.

Recommendation

The Governing Body is asked to approve the Disciplinary Policy.

Receive	
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	

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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			Partnership Forum

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

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Disciplinary Policy

Date Impact Assessed:	**Version No: 1 No of pages: 20**
Date of issue:	**Date of next review:**
Distribution: All employees	**Published:**

GB13/129

CONTENTS

1 INTRODUCTION

The overall aim of this policy is to help correct inappropriate behaviour or conduct in a fair and consistent manner.

The Clinical Commissioning Group (the CCG); expects all employees to meet high standards of behaviour. It is important, therefore, that employees understand their obligations and rights regarding this aspect of their employment.

This document sets out the general standards of conduct expected of all employees (see Section 5), identifies the circumstances in which disciplinary action may be taken and explains the sanctions available to Managers.

This policy will apply where an employee's conduct is considered to be unsatisfactory. Where health and performance capability issues are identified, please refer to the CCG Capability and Attendance Management Policies.

Breaches of discipline should be handled constructively and disciplinary decisions should be taken in a consistent, fair and reasonable manner. The aim should always be to encourage improvements in conduct and performance.

This policy will be applied equally to all staff covered by the policy and in accordance with the CCG Equal Opportunities Policy. The fair and equitable implementation of this policy will be monitored by Human Resources.

2. SCOPE

This policy will apply to all employees of the CCG, including Medical and Dental staff where a matter of personal conduct is concerned. Medical & Dental professional misconduct/competency issues will be investigated separately in line with Maintaining High Professional Standards.

3 POLICY STATEMENT

The employee will have the right of representation by a recognised Trade Union Representative or workplace colleague through all formal stages of the disciplinary procedure.

Employees will not normally be dismissed for a first offence except in cases of gross misconduct/negligence.

Employees will have the right of appeal against any disciplinary sanction applied.

The procedure may be implemented at any stage dependent upon the individual circumstances of each case. Sanctions need not be applied sequentially.

4 RESPONSIBILITIES

This policy and related procedures have been written and agreed through a partnership of managers, Trade Union representatives and Human Resources.

4.1 Responsibility of the CCG

The responsibility for the provision of an agreed Disciplinary Policy lies with the CCG Senior Management Team.

The CCG accepts that they will have responsibility for the smooth running of the organisation and to ensure that any such disputes are settled in a fair and consistent manner.

4.2 Responsibility of Human Resources

To provide advice and support to managers in relation to the application of this policy.

To ensure that the Disciplinary procedure is applied fairly, equitably and consistently throughout the CCG.

Human Resources will monitor all formal disciplinary activity across the CCG and organise relevant training sessions.

To provide advice and support at all stages of the formal disciplinary process.

4.3 Responsibility of Managers

It is the responsibility of all managers employed within the CCG to make sure they are aware of the Disciplinary Policy and how to handle disciplinary issues, both informally and through a formal procedure.

Managers should ensure that they follow the guidelines of this policy, paying specific attention to the timescales set out under each stage.

4.4 Responsibility of Employees

Employees should ensure that they are aware of the general standards of conduct as outlined in this policy.

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4.5 Responsibilities of Accredited Trade Union Representatives

Trade Union representatives have a duty to advise and represent their members, when they are subject to disciplinary proceeding or required to provide information as part of a formal disciplinary investigation.

5 GENERAL STANDARDS OF CONDUCT

It is important that all employees are clear about the standards of conduct expected by the CCG. The following list, which is not intended to be exhaustive, outlines some specific examples of the standards required:

- Employees are representatives of the CCG and, as such, it is important to present patients, their relatives, friends and other visitors with a professional and caring image that is reinforced with attitudes and behaviours demonstrating courtesy, responsiveness, friendliness and appropriate work attire.

- Employees should attend work punctually and regularly.

- Reasonable requests/instructions from the employee's Manager should be carried out promptly and efficiently to the required standard.

- Employees must not absent themselves from duty without first gaining appropriate authorisation from their Manager.

- All types of leave must be approved in advance by the appropriate authority, usually the employee's Manager.

- Regarding the notification of sickness absence, employees must comply with the Attendance Management Policy and should follow the local arrangements. Breaches in sickness reporting may result in payments being stopped and could lead to disciplinary action being taken.

- Employees must comply with all CCG policies and procedures, the principles of the NHS Constitution and adhere to professional body guidelines and codes of conduct, as appropriate. Senior managers should abide by the Code of Conduct for NHS Managers (October 2002).

- Health and Safety policies and guidelines must be observed at all times.

- Use of telephones, mobile phones, email and internet must comply with the CCG policies regarding the use of such equipment.

- Employees must comply with the CCG Equal Opportunities Policy and must treat other workers, patients, their relatives, friends and other visitors with dignity and respect, free from intimidation and harassment.

- Employees must treat confidential information responsibly in line with the principles of the Data Protection Act 1998. This includes no misuse or inappropriate access of patient/confidential information systems (such as records held on Contact Point and other patient record keeping systems).

- Any work undertaken outside of the CCG employment must not adversely affect, hinder or conflict with the interests of the CCG.

6 RIGHT TO BE ACCOMPANIED

Employees have the right to be accompanied at any stage of the Formal Procedure by either an accredited Staff Representative(s) or full-time official(s) of a recognised staff organisation, or by a Fellow Worker who must be an employee of the CCG. Where reference is made in the procedure to an "accredited Staff Representative" this should also be taken to mean full-time official as appropriate.

However it would not normally be reasonable for employees to insist on being accompanied by a companion whose presence would prejudice the hearing nor would it be reasonable for an employee to ask to be accompanied by a companion from a remote geographical location if someone suitable and willing was available on site.

The companion should be allowed to address the hearing to present the employee's case, respond on their behalf to any views expressed at the hearing and confer with them during the hearing. The companion does not however have the right to answer questions on the employee's behalf, address the hearing if the employee does not wish it, or prevent the employee from explaining their case.

If an employee's companion is unavailable, it is the responsibility of the employee, so long as it is deemed reasonable to suggest another date which is not more than 5 working days after the original date of the Hearing or Appeal Hearing.

Employees have no right under this procedure to be accompanied by anyone else (e.g. a spouse, partner, other family member, or legal representative) other than those persons previously referred to.

7 ACCREDITED STAFF REPRESENTATIVES

Disciplinary action against an accredited Staff Representative can lead to a serious dispute if it is seen as an attack on their functions. Whilst normal disciplinary standards apply to their conduct as employees, the relevant full-time official must be notified of any action (including suspension) which it is proposed to take. In any event, disciplinary action must not be taken against an accredited Staff Representative until the relevant full-time official can be present at any formal Disciplinary Hearing.

8 TIME LIMITS

It is acknowledged that all action outlined in this procedure should take place in a prompt and timely manner without unreasonable delay. The time limits set out in this procedure are based on working days and may only be varied by mutual agreement. Any investigation and subsequent hearing or appeal should be actioned as soon as is reasonably practicable to ensure the accurate recording of

events. Managers and employees should ensure that they take all reasonable steps to ensure that time delays do not occur.

9 CRIMINAL OFFENCES

An employee who is charged with a criminal offence (including a receipt of a summons) must inform their Manager as soon as possible. Notification about criminal proceedings, or a conviction (including bound over and cautions), will not be treated as automatic reasons for dismissal, or for any other form of disciplinary action being taken. Following disclosure the CCG will determine what action, if any, should be taken after the incident has been thoroughly investigated and facts of the case established.

The main consideration should be whether the charge/conviction is one that makes the employee unsuitable for their job and reference will be made to any reputational issues that may affect the CCG. Similarly, an employee should not be dismissed solely because they are absent from work as a result of being remanded in custody.

If during an investigation, it becomes apparent that an incident needs reporting to the police it is important to maintain confidentiality and ensure that any evidence is made available to the relevant authority.

In situations where the police or any other regulatory body e.g. Health and Safety Executive, Nursing and Midwifery Council, General Medical Council or General Dental Council is investigating an event, it is important that any internal investigation or disciplinary hearing should continue concurrently.

10 FRAUD

If a Manager suspects that fraudulent activity has taken place they should contact Human Resources in the first instance, who will be able to advise on the process for making contact with the Local Counter Fraud Team prior to any informal or formal disciplinary process taking place.

11 POLICY IN PRACTICE: PROCEDURE

11.1 Informal Approach (Outside of Formal Procedure)

Whenever possible, an informal approach should be the first step taken to help, guide or advise employees in improving their conduct or performance. Dealing with minor disciplinary breaches through the formal stages of the procedure should only be considered if misconduct continues.

When dealing with unauthorised absence from work, it is important to determine the reasons why the employee has not been at work. If there is no acceptable reason, the matter should be treated as a conduct issue and dealt with as a disciplinary matter.

If the absence is due to genuine (including medically certified) illness, the issue becomes one of incapacity and the Attendance Management Policy should be followed.

Where levels of performance are unsatisfactory for example poor quality of work, missed deadlines or low volume of work, this needs to be managed in a constructive and supportive framework and the Capability Policy should be followed.

Where managers are addressing minor conduct issues with employees, an informal meeting should take place between an employee and Manager to identify and examine the area(s) of concern, ensure future expectations are clearly understood and, where appropriate, develop an action plan leading to improvements.

Where conduct does not meet acceptable standards, the employee should be advised in writing that the matter will be referred to the formal stages of the disciplinary procedure.

11.2 Formal Stages of the Disciplinary Procedure

Investigation Process

The purpose of the investigation is to:

- Ascertain the facts as far as is reasonably practicable
- Give the employee an opportunity to offer an explanation
- Enquire into the circumstances surrounding the alleged misconduct
- Take a balanced view of the information that emerges
- To prepare an investigation report detailing the main findings

It is important and in the interests of both employer and employee to keep written records during the disciplinary process. These should include:

- The complaint against the employee
- The employee's defence
- Findings made and actions taken
- The reason for actions taken
- Whether an appeal was lodged

The manager leading an investigation will be referred to as the Investigating Manager for the purposes of this procedure. The CCG will appoint an appropriate Investigating Manager with suitable authority who may be from within or external to the CCG. The Investigating Manager should not be directly or personally connected with the issues involved. The Investigating Manager will not sit on the Disciplinary panel, but will be present at the Disciplinary Hearing to present the management case.

A record should be kept of either the date of receipt of a complaint/allegation, or the date when a complaint/allegation is identified as a potential breach of conduct, capability issue or poor performance in line with the Capability Policy.

An employee who has had a complaint/allegation made against them will, as part of the investigation, be invited to attend a fact-finding interview in order to clarify the circumstances and facts relating to the complaint/allegation. A letter detailing the complaint/allegation and the right to be accompanied should be sent to the employee giving her/him a minimum of five days notice of the meeting. Where known, this letter will be copied to the employee's representative. It is important to ensure that the employee understands the allegations made against them particularly if there is a difficulty with reading or English is not their first language.

Confidentiality for all those involved must be respected at all times. However, when conducting an investigation resulting in possible disciplinary action, information must be provided to those involved (which might include non - employees) and employees are obliged to co-operate with these procedures. The investigation should only involve those people necessary in gathering sufficient information to make a decision on the correct course of action, whilst making it clear to those interviewed that a breach of the CCG principles on confidentiality could be a disciplinary offence.

Copies of meeting records should be given to the employee including copies of any formal minutes that may have been taken. In certain circumstances, it may be permissible for the employer to withhold some information e.g. to protect a witness.

The identity of the individual who has raised a concern will be protected upon request and will not be disclosed without consent. However, the employee must be made aware that they may be asked to present evidence to substantiate any allegations made and/or to provide a written statement, without which investigations may not be able to proceed.

Victimisation of staff who raise concerns reasonably and responsibly is prohibited under the Public Interest Disclosure Act and the CCG will ensure that staff are protected from victimisation in these circumstances. Please refer to the Whistleblowing policy for further guidance.

Records should be kept no longer than is necessary in accordance with the Data Protection Act 1998.

Wherever possible, investigations should be completed, including the fact-finding interview with the employee, within a span of twenty working days, unless otherwise mutually agreed.

Statements from any witnesses and any other relevant documentary information should be obtained by the Investigating Manager without delay. Adequate time and notice, however, should be given to employees producing statements, which may include gaining any support/guidance from their accredited Staff Representative, as appropriate.

It is the Investigating Manager's responsibility to investigate and obtain all relevant information and take all reasonable steps to determine the validity and accuracy of the complaint/allegation made against the employee.

It is the Investigating Managers responsibility to advise if there is any case to answer and recommend if the employee should be invited to a disciplinary hearing. The Investigating Manager will clarify the allegations and present the case against the employee at any disciplinary hearing.

11.3 Suspension

The decision to suspend an employee from duty should not be taken lightly or without careful consideration of all the circumstances and the nature of the complaint/allegation made. Suspension is not a disciplinary measure; it is a means of carrying out further enquiries.

During suspension the employee will receive their normal pay in accordance with her/his planned working arrangement, providing they are otherwise available for work.

The following list, whilst not exhaustive, provides an indication of the types of situation when suspension may be appropriate:

- where Gross Misconduct is suspected or alleged;
- where it would not be possible to carry out a thorough investigation with the employee still present; or
- where there is a concern that further offences may occur
- where there is a risk to life or limb
- where a work permit has been suspended or expired

However, such actions should not be taken without advice from Human Resources or consideration of alternative actions which may include:

- assignment in a similar role in another service or location
- restricted duties in existing role or location
- assignment to a different role which is within the knowledge and skills of the employee
- supervision

The authority to suspend staff sits with any manager with line management responsibility. Whenever possible, a meeting should be held with the employee and her/his accredited Staff Representative to advise her/him of the decision to suspend her/him from duty.

The Manager making the decision to suspend an employee must ensure the following steps are taken:

- the employee must be informed of the reason(s) why they are being suspended from duty;
- the employee must be advised that her/his suspension from duty is not a form of disciplinary action;
- that s/he will receive a letter confirming and summarising the reason(s) for the decision to suspend.

The employee should also be advised that:

- they must remain contactable and available during normal daytime hours (i.e. 9.00 a.m. to 5.00 p.m.) in order that they can attend meetings as required and not work for any another employer during the working hours that they would normally work for the CCG;
- they must notify the CCG of any changes of address/telephone number;
- they must not under any circumstances have contact with, or seek to influence, anyone associated with the complaint/allegation, or enter any of the CCG premises without having gained authorisation from the Investigating Manager;
- the suspension will be reviewed every 10 working days by the Investigating Manager in conjunction with Human Resources and that the outcome of the review will be confirmed in writing;
- they can contact a nominated HR representative for support and status updates as appropriate;
- Counselling services via Occupational Health are available.

Suspension will cease in the following circumstances:

- where the Investigating Manager has decided that there is no case to answer and no requirement for the employee to attend a Disciplinary Hearing;
- where the investigation has been concluded and dismissal is not a possible outcome;
- where the Disciplinary procedure has been completed.

11.4 Arranging Disciplinary Hearings

In order to ensure that meetings do not have to be delayed or postponed at the last minute, the Manager hearing the case should agree a mutually convenient time and date for the Hearing with the employee(s) and their accredited Staff Representative or workplace colleague in accordance with the time limits set out in this procedure.

Where the accredited Staff Representative or workplace colleague cannot attend on the date proposed, the employee(s) can offer an alternative time and date so long as it is reasonable and falls before the end of a period of five days. In proposing an alternative date the employee(s) should have regard to the availability of the Manager. For instance it would not normally be reasonable to

ask for a new date for the meeting where it was known the Manager was going to be absent on business or on leave.

A letter containing details of the complaint/allegation, enclosing copies of all statements and/or written material gathered during the investigation, should be sent to the employee at least five working days in advance of the date set for the Disciplinary Hearing, unless otherwise mutually agreed. The letter should also disclose the name of the Manager(s) who will be hearing the case and details of any witnesses who will be present to give evidence at the Hearing. It should also inform the employee that they have the right to be accompanied at the meeting by an accredited Staff Representative or Workplace Colleague and that a possible outcome of the meeting, after due consideration of all the facts and circumstances, may be disciplinary action. The employee should also make available copies of any statements and/or written material which s/he intends to refer to, along with details of any witnesses who will be present to give evidence, no later than 3 working days prior to the Hearing.

Failure by either party to disclose written material in accordance with the above guidelines may result in this information being inadmissible at the Disciplinary Hearing. The Manager hearing the presentations will decide whether to admit information following discussion with the individuals present and having assessed the reason(s) for the late disclosure, including the possible significance of the information.

If the employee continually fails to attend a disciplinary hearing, the case will be heard in the employee's absence and the outcome of the hearing will be confirmed in writing to the employee.

11.5 Departure from CCG employment Mid-Proceedings

Should the employee being investigated leave the CCG's employment midway through the process (either during or pending a full investigation or hearing), depending on the nature of the allegations, the investigation or hearing may be conducted in their absence and the outcome confirmed to the individual in writing.

11.6 Grievances raised during the Disciplinary Process

Where an employee raises a Grievance during any stage of the formal Disciplinary Process, the disciplinary process may be temporarily suspended and the Grievance should be investigated in line with the CCG Grievance and Disputes Policy and Procedure. Where there is clear evidence to suggest that the Disciplinary and Grievance cases are related, it may be appropriate to deal with both issues concurrently.

12 DISCIPLINARY ACTION

Decisions relating to the level of disciplinary action to be taken, if any, will be a matter of judgement for the Manager(s) who has listened to the information

presented during the Disciplinary Hearing. Managers will, however, need to consider:

- the seriousness of the disciplinary breach in question;
- the relevance and context of facts/information presented;
- the employee's previous employment record;
- issues relating to fairness, consistency and the substantial merits of the information presented; and
- whether any relevant disciplinary warnings are currently in existence.

12.1 Scheme of Delegation

DISCIPLINARY SANCTION:	TYPE OF MEETING:	SANCTION ISSUED BY:	WHO TO APPEAL TO:
WRITTEN WARNING	Disciplinary hearing followed by warning	CCG Manager with appropriate authority to issue sanction	CCG Manager with appropriate authority to issue sanction who has not previously been involved in the case
FINAL WARNING	Disciplinary hearing followed by written warning	CCG Manager with appropriate authority to issue sanction	CCG Manager with appropriate authority to issue sanction who has not previously been involved in the case
DISMISSAL	Disciplinary hearing followed by written statement of dismissal	CCG Manager with delegated authority to dismiss	Governing Body Member

It may be necessary for other managers to be present at disciplinary interviews in addition to the above. Individual members of staff and their representatives will be informed of this in the "Notification of Disciplinary Hearing" letter as appropriate.

12.2 Written Warning

Where an informal approach has failed to have the desired affect, or if the infringement is of a more serious nature, the employee should be given a Written Warning. The employee should be advised, in writing within five working days of the hearing, of the reason for the warning, the improvement or change in behaviour required, the consequences of any repetition or failure to improve and of their right of appeal. A copy of the Written Warning should be kept on file but should be disregarded for disciplinary purposes after twelve months from the date of issue.

12.3 Final Written Warning

Where a Written Warning has failed to have the desired effect, or where the infringement is sufficiently serious, the employee should be given a Final Written Warning. The employee should be advised, in writing within five working days of the date of the hearing, of the reason for the warning, the improvement or change in behaviour required, that any repetition or failure to improve or modify their behaviour may lead to dismissal and of their right of appeal. A copy of the Final

Written Warning should be kept on file but should be disregarded for disciplinary purposes after two years from the date of issue.

12.4 Dismissal

The decision to dismiss will only be taken by a Manager with delegated authority to dismiss. Notification of dismissal will be confirmed within five working days of the Disciplinary Hearing. Dismissal on the grounds of lack of capability through ill health will be conducted as per the Attendance Management Policy.

Dismissal is the ultimate sanction against employees and will only be invoked where an employee's record does not improve after reasonable warnings, in accordance with the Disciplinary Policy. Where a single offence warrants dismissal (gross misconduct), this may be immediate with no entitlement to notice. Incorporated in this procedure at Appendix 1 is a list of offences which could, in certain circumstances, lead to dismissal. It is not a fully comprehensive or exhaustive list but is provided as a guide for staff and managers.

Following a Final Written Warning, no employee will be dismissed for disciplinary reasons unless:

- a full investigation into the latest alleged incident(s) has been carried out
- the employee has been given the opportunity of stating their case at a disciplinary hearing.

Where the Final Written Warning has failed to have the desired effect, or where the infringement constitutes a breach of the CCG Disciplinary Rules (see Appendix 1), then the employee should be dismissed with appropriate notice and advised whether or not they are required to work their notice.

Where an employee is accused of an act of Gross Misconduct s/he may be suspended while the alleged offence is investigated. If, on completion of the investigation and the full disciplinary procedure, Management is satisfied that Gross Misconduct has occurred, the result will normally be summary dismissal without notice or payment in lieu of notice. Previous stages need not necessarily have been followed.

12.5 Referral to Professional Bodies

Where appropriate the CCG may consider referring a registered practitioner to a relevant professional body, for example, the General Medical Council, General Dental Council, Nursing and Midwifery Council or other professional body. The employee will be notified in writing of the referral reason.

12.6 Alternative Sanctions to Dismissal

In exceptional circumstances and as an alternative to dismissal under this procedure, Managers may (depending on the offence) consider the following options:

- transfer to another available post within the CCG;
- demotion to another available post within the CCG; and/or
- downgrading

These sanctions would not attract any form of pay protection and each of these measures would be accompanied with a Final Written Warning. The demotion / downgrading will last for a period of 2 years, during which time the employee will not be eligible to apply for any post at the CCG above the pay banding of the post they are in. After this period the employee will be eligible to apply for any post they choose to.

The Final Written Warning should advise the employee of the reason for the warning, the improvement or change in behaviour required, that any repetition or failure to improve or modify their behaviour may lead to dismissal and of their right of appeal. A copy of the Final Written Warning should be kept on file but should be disregarded for disciplinary purposes after two years from the date of issue.

The proposal to transfer the employee to another available post within the CCG when demotion or downgrading is involved must be with the full agreement of the employee. Employees should be placed on the redeployment register by Human Resources for a period of 12 weeks and if no suitable alternative employment is found during this time period, the Employee will be dismissed from the CCG. The Manager cannot impose this decision on the employee. Where the employee does not wish to consider an alternative sanction to dismissal then the Manager hearing the case should confirm the dismissal decision.

13 RIGHT OF APPEAL

An employee may choose to appeal because:

- they think a finding is unfair
- new evidence comes to light
- they believe the process was not followed correctly

Appeals should be made to the relevant person as outlined in the scheme of delegation within ten working days of the date on the letter confirming the disciplinary action clearly stating the grounds for appeal.

13.1 Appeal Process

As far as is reasonably practicable, the appeal will be heard within twenty working days of receipt of the request for an appeal.

The employee will be given ten working days notice of the date of the hearing.

Details of any witnesses the employee may wish to call and any documentation relating to the allegations that they would like the panel to consider should be forwarded at least five working days before the date of the Appeal Hearing.

The CCG Appeal Hearing will follow the procedure set out in Appendix 2.

The decision of the CCG Appeal Hearing will be final. Any sanction or penalty applied as a result of the outcome of the disciplinary hearing can be reviewed by the Appeal Panel but the sanctions cannot be increased by the Appeal Panel.

14 Monitoring

Human Resources will:

- Have responsibility to monitor the effectiveness of this policy on an annual basis.
- Make recommendations to the Governing Body.

APPENDIX 1

DISCIPLINARY RULES

The purpose of this appendix is to give an indication of the standards of behaviour expected of all staff by the CCG. It is not possible to specify all standards and those listed here are intended as a guide and should not be seen as an exhaustive list.

1. Gross Misconduct

It is important that all staff understand that there are certain behaviours that are deemed so serious by the CCG that, if proven, the outcome may be dismissal from CCG. This dismissal may be summarily, that is without notice.

Theft or attempted theft – unauthorised removal with the intent to steal of property or money belonging to the CCG or belonging to other employees, patients or members of the public.
Fraud / Deception – any deliberate attempt to obtain money or goods belonging to the CCG, other employees, patients or members of the public, through the falsification of any records or documents.
Violence or assault – physical, verbal, sexual abuse or harm.
Serious bullying or harassment of others.
Indecency or sexual offences.
Malicious damage – deliberate destruction or damage to CCG property.
Corruption – including receipt of favours for contracts or information.
Failure to disclose a criminal conviction - either at appointment or during employment.
Giving false information and deliberate concealment at selection.
Inappropriate use of computers – the use of computers to access inappropriate websites or the excessive use of computers inappropriately during working hours including accessing pornographic materials.
Contravention of a statutory requirement - working while contravening an enactment, or breach of rules laid down by statutory bodies such as erasure from the General Medical Council register, or the United Kingdom Central Council register, or loss of driving licence where driving is an essential component of the duties of the post.
Unauthorised employment with another organisation whilst on sick leave
Wilful negligence – any action or failure to act that threatens the health and safety of any patient, member of staff or member of the public.
Being unfit for duty – either due to alcohol or substance abuse.
Deliberate disclosure of confidential information - this includes abuse/misuse of patient information systems.
Health and Safety – disregarding safety rules and regulations or serious negligence that endangers self or others.
Discrimination/harassment – actions or language of a discriminatory nature that infringes the CCG Equal Opportunities policy.
Abusive and insulting behaviour – the use of threatening and abusive language to other employees, patients and members of the public.

Criminal convictions outside work – convictions relating to activities outside work that have a direct bearing on an employee's employment with the CCG.
Bringing the CCG into disrepute.
Unauthorised use of CCG Property / Equipment
Any other act of gross negligence – a failure to exercise a duty of care which adversely affects the welfare of others.

2. Examples of Other Standards of Conduct

Poor timekeeping
Being rude to colleagues, patients or members of the public
Failure to follow reasonable management instruction.
Errors
Unauthorised absence
Minor breaches of health and safety
Refusal to work with a colleague for an unacceptable or discriminatory reason
Smoking in contravention of the CCG No Smoking Policy
Engaging in employment outside the normal working hours of the CCG that adversely affects, hinders or conflicts with their work with the CCG and/or the interests of the CCG
Failure to follow CCG policies and procedures

APPENDIX 2

Conduct of Disciplinary Hearings

The Manager(s) hearing the presentations at the Disciplinary Hearing should not have had any prior involvement in the investigation.

The Hearing should be conducted in accordance with the following procedure:

Introductions: The Manager hearing the case should introduce all present, explain the purpose of the meeting (i.e. to consider whether disciplinary action is necessary) and explain how the hearing will be conducted. If the employee is accompanied by a staff side representatives or workplace colleague it should be noted that they will be able to present and sum up the employees case but cannot answer direct questions made to the employee.

Statement Of Complaint/Allegation: The Manager hearing the case should establish precisely what the complaint/allegation is and invite the Investigating Manager to present her/his findings, including the tabling of all previously circulated statements and/or written material gathered during the investigation and the calling of any witnesses.

Employee's Reply: The employee should be given the opportunity to state their case and present evidence, including the tabling of all previously circulated statements and/or written material and the calling of any witnesses.

Civility: The Hearing should be conducted courteously and fairly, with the emphasis being to establish the facts. To this end, all parties should be free to ask questions politely and comment appropriately.

Summing Up: After general questioning and discussion, both parties should be given the opportunity to summarise their main points, with the employee having the right to go last.

Adjournment: The Manager(s) hearing the case should consider their decision in private. If it is necessary to recall one of the parties to clear any points of uncertainty on evidence already given, then both parties should be invited to return notwithstanding only one is concerned with the point giving rise to doubt.

The Decision: All appropriate parties should be recalled and the Manager(s) hearing the case inform them of their decision. This will be confirmed in writing within five working days of the hearing.

Should a decision not be made on the day, the panel will recall and inform all appropriate parties that a decision has not been made, but will confirm the outcome in writing within five working days of the hearing.

The employee should be given a written copy of the notes of the hearing for information purposes only.

CCG APPEAL HEARING

At the hearing of an appeal against dismissal the following procedure shall be observed:

All appeal hearings will be heard by a CCG Appeal Panel as detailed below.

Appellant's Case: The Appellant or the Appellant's Representative will put their case in the presence of the Management Representative and may call witnesses. The Management Representative will have the opportunity to ask questions of the Appellant and the Appellant's Representative and witnesses. The members of the Appeal Panel will have the opportunity to ask questions of the Appellant and the Appellant's Representative and witnesses. The Appellant or the Appellant's Representative will have the opportunity to re-examine witnesses on any matter referred to in their examination by members of the Appeal Panel or the Management Representative.

Management's Case: The Management Representative will state Management's case in the presence of the Appellant and the Appellant's Representative and may call witnesses. The Appellant or Appellant's Representative will have the opportunity to ask questions of the Management Representative and witnesses. The members of the Appeal Panel will have the opportunity to ask questions of the Management Representative and witnesses. The Management Representative will have the opportunity to re-examine witnesses on any matter referred to in their examination by members of the Appeal Panel, the Appellant or the Appellant's Representative.

Summing-Up: Both parties will have the opportunity to sum up their respective cases, with the Appellant having the right to go last. No new information may be introduced or referred to at this point in the appeal procedure.

General: Notwithstanding the above procedure, members of the Appeal Panel may at any time invite either party or a representative to elucidate or amplify any statement they may have made, or may ask questions to ascertain whether or not they propose to call any evidence in respect of any part of their statement. Alternatively, if the parties concerned are in fact claiming that the matters are within their own knowledge, they will be subject to examination as witnesses as described above.

The Panel may, at its discretion, adjourn the appeal in order that further evidence may be produced by either party to the grievance/dispute or for any other reason.

Adjournment: The Management Representative, the Appellant, the Appellant's Representative and witnesses will withdraw. The Appeal Panel will consider their decision in private only recalling both parties to clear points of uncertainty on evidence already given. If recall is necessary both parties shall return even if only one party is concerned with the point giving rise to doubt.

The Decision: When the Appeal Panel has reached its decision both parties will be recalled and the Chair of the Panel will inform them of their decision. The Chair to the Appeal Panel will write to both parties to confirm the Panel's decision within five working days of the Appeal Hearing including a copy of the notes of the meeting for information purposes.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/130	**Author of the Paper:** Melanie Wright Business Manager melanie.wright@southseftonccg.nhs.uk
Report date: 12 September 2013	

Title: Annual Leave and Bank Holiday Policy

Summary/Key Issues:

This paper presents the Governing Body with the organisation's Annual Leave and Bank Holiday Policy, which was prepared by the Cheshire & Merseyside Commissioning Support Unit in collaboration with other local CCGs via the CCG's Partnership Forum, to facilitate uniformity in relation to HR policies and procedures and compliance with Agenda for Change Terms and Conditions.

In accordance with the CCG's Constitution (Scheme of Reservation and Delegation), HR policies require approval by the Governing Body and the Governing Body is therefore asked to approve this policy.

Recommendation

The Governing Body is asked to approve the Annual Leave and Bank Holiday Policy.

Receive	
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	
Clinical Engagement			x	
Equality Impact Assessment	x			
Legal Advice Sought			x	
Resource Implications Considered			x	
Locality Engagement			x	
Presented to other Committees	x			Partnership Forum

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

Annual Leave and Bank Holiday Policy

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CONTENTS

1. Introduction

All contracted staff are entitled to a period of paid annual leave inclusive of bank holidays each year. The individual entitlement is dependent upon the employee's length of service and working hours.

This policy will be applied equally to all staff covered by the policy and in accordance with the CCG Equal Opportunities Policy. The fair and equitable implementation of this policy will be monitored by Human Resources.

The purpose of this policy is to provide managers and employees with guidance on the application and management of all annual leave and bank holiday entitlements to ensure that all staff take adequate rest away from work whilst maintaining the needs of the service.

2. Scope

This policy will apply to all staff employed by the CCG with the exception of:

- Medical and Dental staff who should refer to the Terms and Conditions for Hospital, Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service.
- Staff employed on Very Senior Manager terms and conditions of employment, who should refer to the Pay Framework for Very Senior Managers

3. Policy Statement

Employees should take the full annual entitlement each year and managers should endeavour to ensure that the workloads of employees do not prevent any employee from taking their entitlement to annual leave.

It is the policy of the CCG to ensure that the application and management of annual leave and bank holiday entitlements, is applied fairly to all staff irrespective of their sex, race, belief, religion, disability, age or sexual orientation.

The CCG is committed to improving working lives and as such does not expect any staff to fulfil working commitments during periods of annual leave. Annual leave should enable a member of staff to take time away from work to relax and enjoy a break. If staff feel pressured into fulfilling work commitments during annual leave they should seek advice from their manager or from Human Resources.

4. Responsibilities

4.1 Responsibility of Human Resources

Provide advice, support and training to managers in the application of the Policy.

4.2 Responsibility of the Manager

Ensure that this policy is applied fairly to all, irrespective of their age, sex, religion, belief, disability, age or sexual orientation.

To calculate leave for all direct reports.

Ensure that employees are made aware of the procedure for requesting annual

leave within their own team and to ensure that each employee is aware of their own entitlement.

Keep accurate annual leave records for all employees in their team and to monitor the uptake of annual leave to ensure that employees are taking regular breaks away from work.

4.3 Responsibility of the Employee

Request annual leave in line with local team arrangements.

Manage their annual leave in a reasonable way, ensuring full entitlements are taken over the leave year and requests for leave are submitted in accordance with team procedures.

5. Policy in Practice

5.1 Leave Year

The leave year runs from 1 April - 31 March. Staff should ensure that they take their full entitlement of annual leave in consultation and agreement with their manager.

In exceptional circumstances, with prior agreement of their manager, an employee's leave may be carried into the next year subject to a maximum of 1 week, pro rata to the number of hours worked per week.

Employees who have been unable to take their annual leave as a result of long term sickness absence should refer to the CCG's Attendance Management Policy.

5.2 Entitlement

An employee's annual leave entitlement is determined by the length of aggregated NHS service, with leave entitlements increasing on the completion of 5 and 10 years aggregated NHS service as shown in Appendix 1.

An employee's continuous previous service with an NHS employer will count as reckonable service in respect of annual leave.

In addition, aggregated NHS service, i.e. any period of time that has been worked in the NHS, regardless of whether or not there has been a break in service, will count as reckonable service for annual leave.

For purposes of aggregated service, time spent employed in a **highly relevant** role in organisations other than the NHS, may be counted as aggregated service, i.e. GP Practices, General NHS Dental Practices, relevant overseas employment and local authorities. Locum agency service will not count. Agreement should be reached between the manager and Human Resources, on the application of highly relevant service, to ensure consistent application of this provision.

Any aggregated service should be agreed on appointment to an employee's first post within the CCG. There is no provision for retrospective application of the above.

All annual leave entitlements are calculated in hours for all part-time and full-time employees, rounded up to the nearest full hour, including bank/public holidays.

Employees who wish to take more than 2 weeks leave in any one block must discuss their request in writing to their line manager as early as possible to ensure that adequate cover is maintained.

If any employee falls ill during a period of annual leave, and wishes their annual leave to be recorded as sickness, they must comply with their local sickness absence reporting procedure and produce a medical certificate to cover the period of sickness. In the absence of a doctor's medical certificate the period of absence will continue to be recorded as annual leave. Employees will not be entitled to an additional day off if they are sick on a bank holiday that they would have otherwise have worked as part of their normal pattern of work.

For the purposes of new starters to the CCG, leavers from the CCG and any changes in employment, all annual leave will be calculated in accordance with completed months of service. New starters and employee changes will be calculated with effect from the first of the following month.

Employees who are on sick leave, adoption leave and maternity leave will continue to accrue annual leave in accordance with the relevant policies.

Pay during annual leave will include regularly paid supplements and payment for work outside normal hours. Pay is calculated on the basis of what the employee would have received had he/she been at work.

5.3 Procedure for Booking Annual Leave

Employees must ensure that their line manager has approved all annual leave before they take their leave. If any employee takes a period of annual leave without prior approval then the CCG may consider that the employee has taken unauthorised absence and this may be unpaid.

All requests for annual leave should be made on the appropriate annual leave request form.

Employees should not commit themselves to any holiday plans until they have received approval from their manager.

The employee and line manager should both ensure that they have an up to date copy of the annual leave record.

6. Term Time Staff

Employees on term-time contracts of employment will have their annual leave entitlement abated proportionate to the number of weeks they work per annum.

7. Bank/Public Holidays

The term bank holidays in this policy refer to the eight bank and public holidays that normally occur each annual leave year.

Full-time employees are entitled to all eight bank holidays in the leave year. Part-time employees are entitled to bank holidays pro-rata to the full-time allowance.

The number of bank holidays per year varies dependant when Easter falls. When this occurs, employees should still assume that there has been eight bank holidays in the year and plan their leave accordingly. This will ensure consistency across all leave years.

8. Unpaid Leave

Where a member of staff is given unpaid leave of a month or more in any given leave year (apart from unpaid maternity or adoption leave) this will have the effect of reducing the total entitlement for the year. The entitlement will need to be re-calculated and the number of months of unpaid leave deducted from the full year entitlement.

9. Monitoring

The fair application of this policy will be monitored by Human Resources. The policy will be reviewed every three years unless changes to employment legislation require a review to take place sooner.

Appendix 1

Annual Leave Entitlement

Where staff:

- are not normally required to work on a bank holiday;
- could be required to work on a bank holiday, but are not on that occasion,

then they should record this as the appropriate hours annual leave taken and deduct it from the cumulative total. Staff who do work a bank holiday, (or it is their day off) will take their leave at an alternative date.

All annual leave entitlements are calculated in hours for all part-time and full-time employees, rounded up to the nearest full hour, including bank/public holidays.

Weekly Contracted Hours	On appointment 27 + 8 = 35 days	After 5 years service 29 + 8 = 37 days	After 10 years service 33 + 8 = 41 days
37.5	263	278	308
37	259	274	304
36.5	256	270	299
36	252	267	295
35.5	249	263	291
35	245	259	287
34.5	242	255	283
34	238	252	279
33.5	235	248	275
33	231	244	271
32.5	228	241	267
32	224	237	263
31.5	221	233	258
31	217	230	254
30.5	214	226	250
30	210	222	246
29.5	207	218	242
29	203	215	238
28.5	200	211	234
28	196	207	230
27.5	193	204	226
27	189	200	222
26.5	186	196	217
26	182	193	213
25.5	179	189	209
25	175	185	205
24.5	172	181	201
24	168	178	197
23.5	165	174	193
23	161	170	189
22.5	158	167	185
22	154	163	181
21.5	151	159	176
21	147	156	172
20.5	144	152	168
20	140	148	164

Weekly Contracted Hours	On appointment 27 + 8 = 35 days	After 5 years service 29 + 8 = 37 days	After 10 years service 33 + 8 = 41 days
19.5	137	144	160
19	133	141	156
18.5	130	137	152
18	126	133	148
17.5	123	130	144
17	119	126	140
16.5	116	122	135
16	112	119	131
15.5	109	115	127
15	105	111	123
14.5	102	107	119
14	98	104	115
13.5	95	100	111
13	91	96	107
12.5	88	93	103
12	84	89	99
11.5	81	85	94
11	77	82	90
10.5	74	78	86
10	70	74	82
9.5	67	70	78
9	63	67	74
8.5	60	63	79
8	56	59	66
7.5	53	56	62
7	49	52	58
6.5	46	48	53
6	42	45	49
5.5	39	41	45
5	35	37	41
4.5	32	33	37
4	28	30	33
3.5	25	26	29
3	21	22	25
2.5	18	19	21
2	14	15	17
1.5	11	11	12
1	7	8	8

Appendix 2

Example Annual Leave Calculations

The following examples are provided for illustrative purposes based on the Annual Leave Entitlement table (Appendix 1).

An Annual Leave Calculator is available on the CCG intranet site.

Example One
Employee A works 20 hours per week and is a new starter to the CCG. They have no previous NHS Service. Their annual leave entitlement (inclusive of bank holidays) is 140 hours per year.

Where a bank holiday falls on Employee A's normal working day then they must deduct the hours that they would have normally worked on that day (as if it had not been a bank holiday) from their annual leave entitlement.

Example Two
Employee B works full time and has 5 years NHS Service. Their annual leave entitlement (inclusive of bank holidays) is 278 hours per year. They must deduct 7.5 hours from their annual leave entitlement for each of the 8 bank holidays in the leave year.

Example Three
Employee C works 30 hours per week and has 10 years NHS Service. They join the CCG on 1st June. Their annual leave entitlement for the remainder of the leave year (inclusive of bank holidays) is:

246 / 12 x 10 = 205 hours.

Where a bank holiday falls on Employee C's normal working day then they must deduct the hours that they would have normally worked on that day (as if it had not been a bank holiday) from their annual leave entitlement.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/131	**Author of the Paper:**
Report date: 12 September 2013	Melanie Wright Business Manager melanie.wright@southseftonccg.nhs.uk

Title: Grievance and Dispute Resolution Policy

Summary/Key Issues:

This paper presents the Governing Body with the organisation's Grievance and Dispute Resolution Policy, which was prepared by the Cheshire & Merseyside Commissioning Support Unit in collaboration with other local CCGs via the CCG's Partnership Forum, to facilitate uniformity in relation to HR policies and procedures and compliance with Agenda for Change Terms and Conditions.

In accordance with the CCG's Constitution (Scheme of Reservation and Delegation), HR policies require approval by the Governing Body and the Governing Body is therefore asked to approve this policy.

Recommendation

The Governing Body is asked to approve the Grievance and Dispute Resolution Policy.

Receive	
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	
Clinical Engagement			x	
Equality Impact Assessment	x			
Legal Advice Sought			x	
Resource Implications Considered			x	
Locality Engagement			x	
Presented to other Committees	x			Partnership Forum

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

Grievance and Disputes Policy and Procedure

Date Impact Assessed:	**Version No: 1 No of pages: 14**
Date of issue:	**Date of next review:**
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CONTENTS

1. INTRODUCTION

The Clinical Commissioning Group (the CCG); recognise that an agreed and practical procedure for the settling of grievances and disputes can contribute significantly to promoting and maintaining good employment relations.

The aim of this Policy and Procedure is to promote a working environment that is harmonious with the best possible relations between management and staff by providing an opportunity for the consistent, fair and efficient resolution of grievances as they affect members of staff. This policy will provide a framework which will allow employees, individually or collectively, to raise concerns in an open and fair way, ensuring they can be resolved as quickly as possible and at the lowest possible level.

2. SCOPE

This Policy applies to all members of staff, and can be used to raise grievances concerning terms and conditions of employment, health & safety; employee relations; bullying & harassment (although a separate process is followed in most cases); new working practices; working environment; organizational change and equal opportunities of an employee or a group of employees.

This policy will be applied equally to all staff and in accordance with the CCG Equal Opportunities Policy.

This procedure should be instigated at the lowest appropriate stage depending on the circumstances of the grievance, and resolved informally where possible.

Although formal grievances from staff should be lodged on the Grievance Report Form (Appendix 1), it is acknowledged that grievances can sometimes be raised via letter or exit interview form, as has been highlighted in case law. Therefore any comments made via these methods that could it any way be construed as a grievance should be discussed with Human Resources.

This policy excludes the resolution of the following issues:

- Disciplinary Issues for which a separate procedure exists
- Statutory and Governmental Policy Decisions, for which the CCG has no control
  (e.g. Income Tax, National Insurance, Pension).

Other policies may need to be referred to in light of the grievance being raised:

- Disciplinary
- Whistleblowing
- Equal Opportunities / Dignity at Work
- Bullying and Harassment
- Work-Life Balance

3. POLICY STATEMENT

The objective of this policy is to provide a fair and equitable process for employees to raise their grievances and have them resolved in a timely manner without the fear of recrimination.

The policy applies to all staff employed by the CCG.

Principles:

- The CCG will listen to, and investigate grievance issues raised by its employees
- It is expected that most grievances will be resolved satisfactorily through informal discussions between the employee(s) and their manager
- In some circumstances it may not be appropriate for the line manager to be involved in dealing with the grievance, and another manager from within the CCG may be required in order to assist resolution
- All grievances will be dealt with as promptly as is reasonably possible and within agreed timescales
- Managers should be fully conversant with the Grievance and Disputes Policy and Procedure and the CCG will provide training as appropriate
- Where a grievance is against another member of staff, the CCG will support both the employee(s) raising the grievance and the employee(s) against which the grievance has been taken
- It is recognised that any action taken against an individual or group of staff because they have brought a complaint under the grievance procedure, may amount to victimisation. Any proven action of this nature will be considered a disciplinary matter
- Similarly, failure to take an individual or collective grievance seriously may in itself amount to discrimination and if proven will be considered a disciplinary matter
- It is recognised that in resolving grievances, it may be necessary for either management or staff side to seek expert advice and provision can be made for this where exceptional circumstances deem it is sensible and reasonable.

Definitions:

***Grievances* are concerns, problems or complaints that an employee may raise with the CCG.**

***Disputes* are concerns, problems or complaints where more than one employee within a CCG is aggrieved about the same matter.**

4. RESPONSIBILITIES

This policy and related procedures have been written and agreed through a partnership of managers, staff side representatives and Human Resources.

4.1 Responsibility of the CCG

The responsibility for the provision of an agreed Grievance and Disputes Policy lies with the Senior Management Team.

The CCG accepts that they will have responsibility for the smooth running of the organisation and to ensure that any such disputes are settled in a fair and consistent manner.

4.2 Responsibility of Human Resources

To provide advice and support to managers when an employee or group of employees raises a grievance.

To ensure that the Grievance Procedures is applied fairly, equitably and consistently throughout the CCG. Human Resources will organise relevant training sessions on the handling of grievance.

To provide advice and support at all stages of the formal grievance process, and encourage resolution of grievances via informal routes where possible.

4.3 Responsibility of Managers

It is the responsibility of all managers employed within the CCG to make sure they are aware of the Grievance and Disputes Policy and Procedure and how to begin to resolve employee's grievances, both informally and through a formal procedure.

Managers should ensure that they follow the guidelines of this policy, paying specific attention to the timescales set out under each stage.

Managers should ensure that a copy of the Grievance Report Form is sent to Human Resources, when the grievance is first raised and again when it has been resolved.

4.4 Responsibility of Employees

It is the responsibility of each employee to make their manager (or manager above their line manager) aware of their grievance as soon as possible. The CCG do not believe that it is in anyone's interest to delay when an individual believes that there is an issue that requires resolution.

Employees should outline the nature of the grievance and expected outcome.

Employees should seek to resolve grievances informally in the first instance.

4.5 Responsibilities of Accredited Trade Union Representatives

Trade Union representatives have a duty to advise and represent their members, both when they are instigating a grievance or dispute, or when they are the object of one. This might include guidance on procedure, advice on how or whether to proceed with a case.

5 RIGHT TO BE ACCOMPANIED BY A TRADE UNION REPRESENTATIVE OR WORK COLLEAGUE

Employees have the right to be accompanied at any stage of the Formal Procedure by either an accredited Staff Representative or full-time official of a recognised staff organisation, or by a Fellow Worker who must be an employee of the CCG. Where reference is made in the procedure to an "accredited Staff Representative" this should also be taken to mean full-time official as appropriate.

It would not normally be reasonable for an employee to insist on being accompanied by a companion whose presence would prejudice the hearing.

The companion should be allowed to address the hearing to present the employee's case, respond on their behalf to any views expressed at the hearing and confer with them during the hearing. The companion does not however have the right to answer questions on the employee's behalf, address the hearing if the employee does not wish it, or prevent the employee from explaining their case.

If an employee's companion is unavailable, it is the responsibility of the employee, so long as it is deemed reasonable to suggest another date which is not more than 5 working days after the original date of the Hearing.

Employees have no right under this procedure to be accompanied by anyone else (e.g. a spouse, partner, other family member, or legal representative) other than those persons previously referred to.

6 POLICY IN PRACTICE: PROCEDURE

6.1 Informal Resolution of a Grievance (Complaints)

Most routine complaints and grievances are best resolved informally in discussion with the employee(s) concerned and the manager, or another appropriate manager. Dealing with grievances in this way can usually lead to a speedy resolution as it enables the manager to make decisions on those issues they manage. Both manager and employee(s) should keep an agreed written note of the informal meeting, including details of any action to be taken in resolving the grievance.

If the grievance is not resolved at the informal stage, the employee has the right to follow the formal procedure as outlined below.

6.2 Formal Procedure

It is expected that all grievances will be dealt with speedily, and that the timescales stated in this Policy will generally be held as maxima. However, it is recognised that circumstances may arise where both sides agree to extend the timescales as appropriate.

STAGE 1

All stages of the formal grievance procedure shall commence with the presentation of a completed Grievance Report Form, (Appendix 1) by the employee(s) to their Manager. Where the Manager is the subject of the grievance, the Grievance Report Form should be submitted to Human

Resources. The employee must ensure that they fully explain the nature of the grievance and the reasons they are dissatisfied as well as how they think the grievance can be resolved.

Receipt of this form should be acknowledged in writing within **2** working days by the Manager who should seek HR advice.

The Manager should arrange a meeting with the employee(s) to hear the grievance within **5** working days, supported by HR as appropriate. This should be confirmed in writing (Appendix 2) and should notify the employee of his/her right to be accompanied at the meeting.

Wherever possible it is expected that resolutions will be presented by the Manager at this meeting, however, where further investigation is required, this will be conducted as quickly as practicable, and another meeting arranged.

The hearing should begin with the employee(s) and/or their representative stating their reasons for lodging the grievance and how they think it can be resolved. The Manager will then respond verbally with their decision.

An accurate written record of the meeting will be kept and a copy given to the employee(s) within **3** working days of the meeting (Appendix 3). Human Resources will facilitate the taking of the notes of the meeting.

The timescale for resolution at this stage is **10** working days commencing with the receipt of the Grievance Report Form. If there are exceptional reasons why this cannot be achieved, then these should be presented to the employee(s) and a revised timescale agreed.

If the employee(s) finds the outcome of this meeting unacceptable, they have **10** working days from the receipt of the written record to refer the matter to STAGE 2/Appeal. If the appeal (at stage 2) is not lodged within **10** working days it will be assumed that the employee(s) does not wish to appeal against the STAGE 1 decision and that the matter is closed.

STAGE 2 – APPEAL

If an employee(s) remains dissatisfied by the action taken at STAGE 1, they should present a copy of their original grievance form, the record of the STAGE 1 meeting and their reasons, in writing, for considering the matter unresolved. Following which, a STAGE 2 hearing should take place within **5** working days.

The Grievance will be acknowledged receipt in writing within **2** working days. A meeting will be arranged with the employee(s) within **10** working days of receipt of the grievance, supported by HR as appropriate. This should be in writing and should notify the employee(s) of their right to be accompanied at the meeting.

The Manager who dealt with the grievance at STAGE 1 should be invited to attend to give his/her reasons for the outcome.

The hearing should begin with the employee(s) and/or their representative stating their reasons for lodging the grievance and how they think it can be resolved.

The Line Manager will respond with their views of the employee's grievance and why they made their original decision, ending with how they feel the matter can be best resolved.

The Chief / Accountable Officer will then respond verbally with his/her decision and confirm this in writing within **3** working days of the meeting. A written record of the meeting will be made and a copy will be given to the employee(s), within **5** working days of the meeting.

At this point the CCG internal processes have been exhausted. It is recognised that for certain matters where an employee remains dissatisfied, they may refer the matter to an Employment Tribunal. Their employment arrangements will not be changed, nor will they be disadvantaged if they wish to do so.

6.3 Scheme of Delegation

The Scheme of Delegation as outlined in the table below will be applied during the formal stages of the grievance procedure:

Grievance	**Authorised Manager**	**Appeal**
Stage One	Line Manager or other appropriate CCG Manager (if Grievance relates to Line Manager)	Chief Officer unless the Grievance relates to the Chief Officer when appeal should be directed to the CCG Chair
Stage Two	Chief Officer and Lay Member unless the Grievance relates to the Chief Officer then Grievance will be heard by the Chair and another Governing Body member	N/A

6.4 Disputes (or collective grievances)

At each formal stage of the procedure, the group of employees may nominate two of their group to represent them in the appropriate meeting (i.e. in addition to their accredited Staff Representative if appropriate).

Where several Trade Unions are involved in the same dispute within the CCG, they will be expected to co-ordinate their views, and nominate one representative per trade union plus one full time officer, in addition to two employees involved, to present the case. Other representatives may attend a hearing as witnesses, if desired.

The CCG will attempt to resolve disputes within a maximum of two months of the date when it was first brought to the attention of the immediate line manager.

6.5 Status Quo

For the purposed of the Grievance and Disputes Policy and Procedure, the term “status quo” shall mean the working arrangements or practices which applied immediately prior to the grievance first being raised under this procedure.

Under normal circumstances, no action shall be taken that will affect the status quo until the issue has either been resolved, or the formal stages of the procedure has been completed, however, there will be occasions when the status quo provisions will not apply. These occasions will include circumstances when the CCG may be in breach of its statutory, mandatory or regulatory obligations.

If the time limits for exhausting the procedure are exceeded, the status quo position will be jointly reviewed by the management and staff sides.

7 EMPLOYEES WHO HAVE LEFT THE CCG

Where ever possible a grievance should be dealt with before an employee leaves the CCG. However where an employee has left the CCG and if the grievance procedure has not commenced or been completed prior to the employee’s departure, it must be agreed that the grievance be dealt with through following fast track procedure detailed below:

Step 1
The employee should write to Human Resources setting out the grievance as soon as possible after leaving employment.

Step 2
The Manager will formally respond to the employee’s grievance setting out its response within 10 working days.

8 GENERAL CONDUCT OF MEETINGS

Meetings convened under the Formal Procedure should be conducted in accordance with the following guidelines:

Introductions
The Panel hearing the grievance/dispute should introduce all present, explain the purpose of the meeting (i.e. to consider whether the grievance/dispute can be resolved) and explain how the meeting will be conducted.

Statement Of The Grievance/Dispute
The Panel hearing the case should establish precisely what the grievance/dispute is and invite the employee(s) and/or their representative to present their case and any relevant supporting information.

Manager's Reply
Where the grievance/dispute has previously been heard by a Manager at an earlier stage in the procedure, then that Manager should be given the opportunity to present her/his case and any relevant supporting information.

Civility
The meeting should be conducted courteously and fairly, with the emphasis being to establish the facts. To this end, all parties should be free to ask questions politely and comment appropriately.

Summing Up
After general questioning and discussion, both parties should be given the opportunity to summarise their main points, with the employee having the right to go last.

Adjournment
The Panel hearing the case should consider their decision in private. If it is necessary to recall one of the parties to clear any points of uncertainty on evidence already given, then both parties should be invited to return notwithstanding only one is concerned with the point giving rise to doubt.

The Decision
All appropriate parties should be recalled and the Panel hearing the case should inform them of their decision.

9 MONITORING

This policy will be monitored by Human Resources using the receipt of the Grievance Report Form as the first trigger to commence the monitoring process.

Managers are informed that a copy of the form must be sent to Human Resources when the Grievance is first raised and again when it is resolved. This policy will be reviewed every 3 years by management and staff side representatives in the light of experience and changes in legislation

APPENDIX 1

GRIEVANCE REPORT FORM

The individual raising the grievance should complete this page.

You may wish to seek assistance from your Trade Union Representative when completing this form. Once completed, the form should be passed to your Line Manager who will arrange to hear your grievance within 5 working days.

PERSONAL DETAILS

Name _____ Band _____

Job Title _____ Location _____

Contact Number _____

Address for Correspondence _____

_____

DESCRIPTION OF GRIEVANCE

I wish to raise a grievance for the following reasons: -

I seek the following solution to the grievance: -

My Trade Union Representative is _____ of _____ (union)

Signed _____ Date _____

GRIEVANCE REPORT FORM /continued

STAGE 1

Grievance Heard by _____ on _____.

I am _____'s Line Manager

Grievance Resolved? YES/NO
If no, please state Reason below and attach a copy of the correspondence:

_____

_____

_____

Signature _____ Date _____

STAGE 2

Grievance Heard by _____ on _____.

Job Title _____

Grievance Resolved? YES/NO
If no, please state Reason below and attach a copy of the correspondence:

_____

_____

_____

Signature _____ Date _____

APPENDIX 2

Date:

«Title» «FirstName» «LastName»
«Address1»
«Address2»
«City»
«State»
«PostalCode»

Dear «Title» «LastName»;

Grievance Hearing – dd Month Year

I am in receipt of your Grievance report form. As you are aware the Grievance policy states that your Grievance should be heard within 5/10* working days. I have therefore arranged for the hearing to take place as follows:

Date: dd Month Year

Time: Time a/pm

Venue: Venue address (include map if appropriate)

At this hearing, I would like you to state your grievance and explain why it remains unresolved. You should also indicate how you feel the issue can be resolved. I will consider what you have said and offer you my decision. I will confirm this decision in writing within 3 working days of the hearing.

You have the right to be accompanied by your Trade Union Representative or a workplace colleague at this hearing.

Would you please confirm that you are able to attend the meeting, by telephoning me on *number*.

Yours sincerely,

Name
Job Title

*Delete as appropriate

APPENDIX 3

Contact:
Ref.:
Direct Dial:

Date:

«Title» «FirstName» «LastName»
«Address1»
«Address2»
«City»
«State»
«PostalCode»

Dear «Title» «LastName»;

Grievance Hearing – dd Month Year

Further to our meeting to discuss your grievance I am writing to confirm my decision.

I have read your Grievance Report Form and listened to your statements regarding your grievance and how you felt it should be resolved. It is my opinion that your grievance concerns *outline basis of grievance.*

At the close of the hearing I stated that my decision was *state decision.*

You have the right to appeal against my decision. If you intend to appeal, you should write to *Name, post, and contact address.* If you have not lodged your appeal within 10 working days, it will be assumed that you do not wish to take the Grievance any further and that the matter is closed.

Yours sincerely

Name
Job Title

NHS
South Sefton
Clinical Commissioning Group

GB13/132

MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/132	**Author of the Paper:**
Report date: 12 September 2013	Melanie Wright Business Manager melanie.wright@southseftonccg.nhs.uk
Title: Attendance Management Policy	

Summary/Key Issues:

This paper presents the Governing Body with the organisation's Attendance Management Policy, which was prepared by the Cheshire & Merseyside Commissioning Support Unit in collaboration with other local CCGs via the CCG's Partnership Forum, to facilitate uniformity in relation to HR policies and procedures and compliance with Agenda for Change Terms and Conditions.

In accordance with the CCG's Constitution (Scheme of Reservation and Delegation), HR policies require approval by the Governing Body and the Governing Body is therefore asked to approve this policy.

Recommendation

The Governing Body is asked to approve the Attendance Management Policy.

Receive	
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	
Clinical Engagement			x	
Equality Impact Assessment	x			
Legal Advice Sought			x	
Resource Implications Considered			x	
Locality Engagement			x	
Presented to other Committees	x			Partnership Forum

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

GB13/132

Attendance Management Policy

Date Impact Assessed:	**Version No: 1 No of pages: 17**
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CONTENTS

1 INTRODUCTION

The Clinical Commissioning Group (the CCG) as commissioners of Health Services is committed to developing a high quality and locally accessible service to the local population. In order to achieve this objective, the CCG recognise the importance of retaining a stable workforce and that regular attendance at work is vital in maintaining a quality service.

This policy will be applied equally to all staff covered by the policy and in accordance with the CCG Equal Opportunities Policy.

2 SCOPE

This Policy applies to all CCG Employees.

3 POLICY STATEMENT

The CCG recognise the importance of a positive approach to the management of sickness absence to enable it to operate effectively. The CCG is committed to providing the necessary support to employees for them to attend work regularly and to ensure that all employees are treated in a consistent, fair and sympathetic manner.

The CCG recognise that a level of absence due to sickness does occur and is inevitable but aims to minimise the level and promote a healthy workplace.

The CCG commitment to the welfare of employees includes the following initiatives: counselling, redeployment where appropriate and training for all new employees on health and safety issues. Employees are also encouraged to use the confidential services of the Occupational Health that can be accessed directly.

In cases where the employee is disabled within the meaning of the Equality Act 2010 or where employees become disabled and wish to remain in employment, every effort will be made to make reasonable adjustments or find an alternative post.

The employee may be referred to the Occupational Health to enable a report to be prepared for the CCG. The CCG may consider making reasonable adjustments to the particular job to accommodate the employee's short term or long term requirements and consider offering alternative employment or a shorter working week or other adjustments to the employee's job as may be reasonable.

All employees who suffer from ill health or have sustained an injury will be treated sympathetically and any employee who becomes aware that they have an illness is encouraged to inform their Manager at the earliest opportunity.

This policies should be read in conjunction with section 14 of the NHS Terms and Conditions Handbook.

4 RESPONSIBILITIES

4.1 Responsibility of the CCG

The responsibility for the monitoring and provision of this policy initially rests with the Governing Body of the CCG.

4.2 Responsibility of Human Resources

Human Resources will provide initial training and on-going support in the application of this Policy.

Human Resources will provide reports and analysis of employee's sickness absence in line with agreed reporting schedules.

A Human Resources Representative will be present at all formal stages of this procedure or at the specific request of the Manager.

4.3 Responsibility of Managers

Managers will ensure that this policy is applied fairly to all employees.

Managers will ensure that their employees have regular attendance at work and will monitor the attendance accurately and report weekly.

It is the responsibility of all Managers to ensure that information on all sickness absence for every employee is given to Human Resources and that back to work interviews are conducted after each episode of sickness absence and these interviews are conducted in a supportive environment.

Managers will ensure that an adequate risk assessment is undertaken where appropriate in conjunction with the Occupational Health to facilitate an employee's return to work in a safe environment.

4.4 Responsibility of Employees

All employees have the responsibility to follow the notification procedures in all cases.

All employees have a responsibility to inform their Manager of any condition or illness which may affect their ability to do their job safely.

All employees must maintain regular contact as mutually agreed with their Manager during any period of sickness absence. This may vary depending on individual circumstances.

Employees must inform their Manager of any illness or condition to which they are suffering from or have been exposed to which may present a risk to themselves or others.

4.5 Responsibility of Occupational Health

The CCG Occupational Health have a responsibility to provide a report to Managers when requested giving advice on the health of the employee and long term prognosis of the condition which is affecting the employee's ability to undertake current duties.

Occupational Health will advise Managers on possible or suitable alternative or modified work activities either temporarily or permanently.

Occupational Health will assist in an employee's application for early retirement due to ill health.

Occupational Health will follow all legislation concerning access to medical reports / records on behalf of the CCG.

5.0 NOTIFICATION PROCEDURE

Except in emergency circumstances, or unless previously agreed, all absence from work must be notified to the CCG, through to an employee's Manager by 10am, on the first day of absence, together with reason and likely date of return to work. Contact should be made at regular intervals throughout the period of absence. Anyone not able to telephone personally should ensure that a relative or friend does so on their behalf. Employees should contact their Manager with their date of return as soon as possible. Managers must ensure that all full days of absence, due to sickness, is recorded and reported to Human Resources via ESR Procedures.

6.0 CERTIFICATION OF SICK LEAVE

Self-certified sick leave is permitted for a maximum of seven consecutive days on any one occasion. On calculating length of sick leave intervening Saturdays, Sundays and public holidays count. For absences of between 3 – 7 days employees must complete a self-certification form (Appendix 1).

When returning to work employees are required to notify their Manager of fitness to return and attend a 'return to work' interview with their Manager to complete a 'Return to Work Form', (Appendix 2), agreeing the absence details and any action to be taken if appropriate. Any statement made and recorded on this Certification Form must be true and accurate. Any details given, which are subsequently found to have been false will be dealt with under the disciplinary procedure. The completed form will be kept on the employee's file and will be kept in accordance with Data Protection Principles.

It may be appropriate in certain circumstances for this interview to be conducted over the telephone.

Any sickness/injury absence that lasts beyond the seventh consecutive calendar day must be covered by a medical certificate issued by an appropriate medical practitioner. Thereafter consecutive medical certificates must be provided. Failure to provide consecutive medical certificates may result in loss of payment as any absences not covered by current self-certificates and/or medical certificates may be treated as unauthorised absence and will be unpaid.

An employee who fails to comply with notification or certification procedures or who otherwise abuses the CCG rules on sickness absence may be dealt with under the CCG Disciplinary Policy.

7.0 SICK PAY

7.1 Occupational Sick Pay

Provided employees comply with the notification and certification procedures above, the CCG will pay Occupational Sick Pay during periods of absence due to sickness according to length of service.

An Employee's entitlement to Occupational Sick Pay in accordance with NHS Terms and Conditions is based on completed months / years of service including continuous NHS Service with a break of less than 12 months.

The following table sets out the maximum entitlement to occupational sick pay.

Period of Service	Period of Full Pay	Period of Half Pay
0 – 12 months	1 month	2 months
1 – 2 years	2 months	2 months
2 – 3 years	4 months	4 months
3 – 5 years	5 months	5 months
Over 5 years	6 months	6 months

Entitlement to Occupational Sick Pay will be calculated on the first day of any absence due to sickness or injury. Any days of absence due to sickness or injury in the 12 months prior to the first day of absence shall be deducted from the relevant maximum entitlement above.

The CCG reserve the right to withhold payment of Occupational Sick Pay where, an employee has been found in breach of these procedures under the CCG disciplinary procedure where abuse of the scheme once proven.

7.2 Statutory Sick Pay

Provided employees comply with the notification and certification procedures above and subject to the current statutory provisions, after a period of three days illness they will be entitled to receive Statutory Sick Pay ("SSP"). However, any payment of Occupational Sick Pay will offset any entitlement to Statutory Sick Pay due for the same period.

8. POLICY IN PRACTICE: PROCEDURE

8.1 Persistent Short Term Absence

The aim of these procedures is to ensure fair and effective management of absence due to sickness or injury. Absence management is necessary to ensure that full support is provided by the CCG, together with monitoring where necessary.

An employee is entitled to have a Staff Side Representative or work colleague to accompany them to each of the stages of this procedure if they so wish. A Human Resources Representative will be present at each stage of this procedure.

Managers should exercise discretion to manage situations sensitively when there is an understandable reason for the absence or a defined end to the absence period. It is important for managers to ensure that employees do not feel compelled to attend work when they are unwell and must on no account allow employees to work who are obviously in an unfit state of health. This procedure will be used where an employee's attendance record is giving cause for concern.

Levels of absence become a cause for concern when:

- The total number of days or episodes of absence rise sharply
- There are regular and/or intermittent absences

Managers must ensure that they conduct a Return to Work interview following each period of sickness absence and consider what support (including Occupational Health advice) may be required to assist the employee to remain healthy and at work.

8.2 Stage 1

When an employee's absence meets or exceeds the trigger levels set out below then it is recommended that the manager should meet formally with the employee:

- 3 occasions of absence in a rolling 12 month period
- 12 days absence in the last 12 month rolling period (pro rata for part time staff).
- A regular/intermittent or unacceptable pattern of absence

At this meeting the Manager will discuss the employee's absence and their concerns and provide counselling and support where appropriate. The meeting will aim to identify the frequency and reason for the absences ensuring that the employee is aware that their absence record is giving cause for concern.

At this stage it may be appropriate to agree a 'timescale' for improvement (normally 6 months) and to inform the employee that their attendance is to be monitored. It is recommended the employee will be given an improvement plan. This plan should outline improvement targets. The employee should be made aware that if they meet or exceed this improvement targets then they would be is moved onto the second stage of monitoring.

The recommended improvement targets are:

- No more than 2 occasions of absence and
- No more than 5 days absence

At this stage, a referral to Occupational Health may be considered to check whether there is a single underlying reason for the employee's absences.

Managers should complete the formal meeting pro-forma (Appendix 3). The employee should be provided with a signed copy for their records.

8.3 Stage 2

If the employee does not achieve the improvement targets set out at stage one, the Manager will hold a meeting with the employee to discuss the absences. At this meeting, a further improvement plan may be agreed and improvement targets set. The employee should be made aware that if they meet or exceed the improvement targets then they would be moved onto the third stage of monitoring.

At this stage, a referral to Occupational Health may be considered (if this has not already taken place at stage one) to check whether there is a single underlying reason for the employee's absences.

Managers should complete the formal meeting pro-forma (Appendix 3). The employee should be provided with a signed copy for their records.

8.4 Stage 3

If the employee fails to meet the improvement targets set out at stage two, and if the absence level continues or worsens, the employee will be subject to the third stage of this procedure. At this stage the Manager's next-in-line should formally review the case and chair the stage 3 meeting.

At this point any of the following solutions may be sought:

- Professional counselling
- Further medical advice to be arranged as appropriate
- Consideration for transfer to more suitable duties
- Any course of action deemed appropriate in the circumstances, where there is a clear prognosis that the individual will recover and absence levels improve

A meeting will be held with the employee to consider all the matters above. At this meeting, the employee may be given a final improvement plan and improvement targets set. Employees should be made aware that if they fail to meet or exceed the improvement targets set at stage 3, they may be dismissed.

Managers should complete the formal meeting pro-forma (Appendix 3). The employee should be provided with a signed copy for their records.

8.5 Stage 4

If the employee fails to meet the requirements of the Stage 3 Improvement Plan, the employee will be liable to dismissal.

Prior to dismissal, the CCG may obtain another detailed and updated report from Occupational Health.

At this stage the employee will be invited to attend a meeting in the presence of a Manager with the authority to dismiss. A decision will be taken at this meeting on the continued employment of the employee concerned, after hearing any representations from the employee. The meeting will be attended by a Human Resources Representative.

8.6 Attendance During Review Periods

The key outcome of the above procedure will be an improvement in attendance. Wherever possible Managers should facilitate flexible solutions to achieve regular attendance.

Managers may proceed to the next stage of the procedure before the review period is completed if it becomes apparent that the employees attendance has deteriorated further.

If at any stage in this procedure, the employee achieves a better attendance record than is required by the improvement plan, that employee shall return to the next lower level stage in which the manager will monitor the level or pattern of absence and take no action unless an employee's absence has become a matter for concern.

8.7 Long Term Ill Health

Long-term sickness absence is normally defined as a period in excess of 4 weeks and all absences in excess of 4 weeks will normally result in a referral to Occupational Health,

however Managers need to take an informed decision as to the value of Occupational Health referrals during the period of long-term sickness absence.

Following receipt of the Medical Report the employee and their Manager will meet to discuss its content. At this meeting and subsequent meetings, employees may if they wish to be accompanied by their staff-side representative or work colleague. A representative from Human Resources will also be present.

At this meeting the Manager and the employee should discuss the reasons for the absence and ultimately how the Manager can support the employee back to work. At this stage arrangements should be made for a further meeting to discuss the employee's progress and return to work. The Manager will continue to monitor the situation, and arrange further meetings as necessary with the employee and their representative as appropriate.

It may be necessary for the Manager to continue to refer the employee to Occupational Health in order to gain continuing Occupational Health advice for appropriate management of a particular case. In cases where employees are absent due to stress (irrespective of if the stress is work related or not) or mental illness, at Occupational Health Referral should be sought at the earliest available opportunity.

A meeting between the employee, Manager and Occupational Health may be arranged if thought helpful.

Throughout the period of long-term sickness Managers will ensure that they maintain regular contact with employees via telephone, letter or home visits by agreement. Employees on long term sick leave must be kept informed of any department or service developments and should continue to receive any newsletters or briefings as appropriate.

Employees who fail to attend sickness absence review meetings may be subject to the various sanctions within the Policy. Decisions will be taken in the absence of the employee on the basis of the medical evidence available at that time.

8.8 Long Term Sickness Absence Management Options

Throughout this procedure, it will be necessary for the Manager to consider appropriate options. Following appropriate advice from Occupational Health the employee together with their manager and staff-side representative may agree on one of the following options:

- **Phased Return to Work**

The CCG will support staff in a phased return to work following a prolonged period of ill-health, where the Occupational Health Team advise that a "phased" return is likely to aid rehabilitation and a return to full hours and duties.

To aid rehabilitation Managers have discretion to allow employees to return to work on reduced hours or to be encouraged to work from home without loss of pay to aid rehabilitation. Any such arrangements need to be consistent with statutory sick pay rules

The timescale and basis of a phased return without loss of pay will be determined, in partnership, between the manager and the employee, taking into account the circumstances of the individual case and Occupational Health advice. A phased return to work should not exceed 4 weeks although may be extended in exceptional circumstances, based on Occupational Health advice.

If, at the end of the period determined for phased return, the employee remains unfit to resume full contractual hours and duties, Managers may use their discretion, subject to the needs of the service to agree a further period of reduced hours, with the employee being paid for the hours they work. It is acceptable for employees to request paid annual leave within their entitlement to offset, or partially offset, the reduction in pay.

Where it becomes apparent that there are doubts about the employee's continuing to progress to full hours/duties within this further period, Occupational Health advice will be sought.

- **Redeployment**

Following appropriate Occupational Health advice, consideration may need to be given to redeploying the employee on a temporary/permanent basis to a suitable alternative post. The redeployment register is held by Human Resources.

- **Reasonable Adjustments**

Following Occupational Health advice, it may be possible for the employee to return to their original post with some temporary/permanent adjustments. Examples of these restrictions could include reduced hours, lighter duties or alternative shift patterns.

It may be necessary at this stage to consider the purchase of any specialised equipment that would help the employee to return to their work. In cases where the employee has become disabled during their employment help may be available through 'access to work'.

- **Dismissal**

Where all possible stages of this policy have been exhausted and there is no likelihood of the employee maintaining regular attendance at work it may be necessary for the Manager to consider dismissing the employee on grounds of incapacity/incapability due to ill health.

9. ILL HEALTH RETIREMENT APPLICATIONS

Employees who are members of the NHS Pension Scheme may decide to apply for ill health retirement benefits. Such applications will be facilitated by Occupational Health. Any application for ill health retirement will trigger a dismissal.

There are two tiers of Ill Health benefits:

Tier 1: is entitlement to the retirement to the retirement benefits you have earned to date paid without any actuarial reduction for early payment. This level of benefit is payable if you are:

- A scheme member accepted by our medical advisers as permanently incapable of doing your current NHS Job; or
- A former scheme member accepted by our medical advisers as permanently incapable of earning an income by doing regular work

Tier 2: is entitlement to the retirement benefits you have earned to date enhanced by two thirds of your prospective membership up to reaching your normal retirement age. This level of benefit is payable to you only if you are a scheme member accepted by our medical advisers as permanently incapable of both doing your current NHS job AND permanently incapable of regular employment of like duration to your NHS job, taking into account of your:

- Mental Capacity

- Physical Capacity
- Previous training, and
- Previous practical, professional and vocational experience

The application form once completed must then be sent directly to the Pensions Agency together with details of the employee's current job role by either the employee or their medical representative.

The Pensions Agency will contact the employee directly and will ask for permission to get further medical advice as to the employee's condition from their doctors or consultants where necessary.

The decision whether to permit the employee to retire on the grounds of ill-health rests entirely with the Pensions Agency Medical Advisors.

10. INJURY ALLOWANCE

Injury Allowance (IA) is paid by employers to staff on authorised absence with reduced pay or no pay because of an injury or disease wholly or mainly attributable to their employment. IA tops up the employee's income to 85% of the average they were getting before their pay was reduced as a result of the injury or disease. It is not payable if the employees income is more than 85% of their average pay, and it stops when they return to work or leave employment. IA is subject to income tax and National Insurance deductions but not pension contribution deductions. IA is payable irrespective of whether or not an employee is a member of the NHS Pension Scheme.

To qualify for IA, an employee covered by the scheme must be on leave of absence and be suffering a reduction in their NHS pensionable pay as a result of an injury or disease that is wholly or mainly attributable to their actual NHS duties.

11. APPEAL PROCEDURE

If an employees is dissatisfied about the application of this policy, they may pursue a case under the CCG Grievance and Disputes Policy and Procedure.

Where the appeal is against dismissal employees should address their appeal to the Chief / Accountable Officer outlining the reasons for the appeal within 10 working days.

The appeal hearing will take place within 20 days of the lodged appeal. At the appeal hearing the employee has the right to be accompanied by a staff side representative or colleague not acting in a professional capacity

12. MONITORING

Human Resources in conjunction with the CCG will;

- Have responsibility to monitor the effectiveness of this policy on an annual basis.
- Make recommendations to the Governing Body.

APPENDIX 1

Self-Certified Sickness Notification

SVL…….

To certify up to 7 calendar days sickness absence

PERSONAL DETAILS

Surname:	Mr / Mrs / Miss / Ms
First Names:	
Home Address:	**National Insurance Number**

EMPLOYMENT DETAILS

Job Title:	
Team:	
Assignment Number:	-

DATE OF ABSENCE

Date you became unfit for work	TIME am/pm	DAY	DATE	MONTH	YEAR
Night workers only Your last shift began	TIME am/pm	DAY	DATE	MONTH	YEAR
Date you expect to return to work (if known)	TIME am/pm	DAY	DATE	MONTH	YEAR

DETAILS OF SICKNESS/INJURY

Say briefly why you are unfit for work:
Is absence as a result of an accident at work? YES / NO
If yes, Date and time of accident? Whom did you notify? Has an Accident Report Form been completed? YES / NO
Did you fall ill abroad? YES / NO If yes, which country were you in?

I declare that during the period stated, I have been unfit for work and that information given is complete and correct. I claim any sick pay to which I may be entitled.

Signed…….. Date…….. ……..

When completed and signed, this form should be sent to your Manager as soon as possible and not later than 7 calendar days from the first day off sick.

FOR COMPLETION BY MANAGER

To the best of my knowledge, the information given above is correct.

Additional Information ……
……

Manager Name …… Manager Signature ……

Appendix 2

RETURN TO WORK FOLLOWING A PERIOD OF SICKNESS ABSENCE FORM

(THIS FORM SHOULD BE COMPLETED DURING A BACK TO WORK INTERVIEW FOLLOWING EVERY PERIOD OF SICKNESS ABSENCE)

Name
Department: **Interviewing Manager**
First Notified to Manager **First Day of Absence**
Last Day of Absence
Total number of days of sickness (including non-working days)
Total number of days off work
Total number of days absent in previous 12 months
Number of occasions absent in previous 12 months
Is absence due to an injury at work **YES / NO**
Have you seen a doctor YES / NO?
☐ **Self-Certified** ☐ **Medically Certified** ☐ **Uncertified**
Reason for absence (Please give brief description of illness or other reason for absence……
Action Taken (please give brief description of any action taken to date) Explain sickness absence procedure…….,……
Proposed Course of Action – Managers Comments. Please comment on employee's state of health of return from absence and ability to resume full duties:- **……** **……..**
Occupational Health Referral Required **Yes / No**
I understand that if I knowingly provide inaccurate or false information regarding my absence it may result in disciplinary action:- (Employees Signature)……..
Managers Signature:……

APPENDIX 3

FORMAL SICKNESS MEETING – STAGE 1/2/3

(circle appropriate stage of meeting)

Staff Member Name: ***Job Title:***		***Date of Mtg:***
Rep Name: ***Job Title & Location (if app):***		
Manager Name: ***Title & Location:***		
HR Rep Name: ***Job Title:***		

FORMAT OF MEETING				
Introductions made			***Yes*** ☐	***No*** ☐
Happy to proceed without representation?	***n/a***	☐	***Yes*** ☐	***No*** ☐
Explain that notes will be taken			***Yes*** ☐	***No*** ☐
Explain purpose of mtg – to gain an update as to their health position and/or any support that can be provided			***Yes*** ☐	***No*** ☐
Confirm date sickness absence commenced			***Date:***	***dd / mm / yy***
Confirm date of previous Informal Sickness Meeting			***Date:***	***dd / mm / yy***
Confirm dates/absences and reasons for each absence: ***Trigger points met:***				

Ascertain if there are any changes / improvements / decline in health since the last meeting. ***Ensure a clear picture of their health position is gained by asking the following questions, as appropriate:***
1. Establish how the employee is feeling currently.

2. If an underlying health problem is identified discuss the following points, as deemed appropriate:

- **Establish what health support they are receiving (i.e.: OH, GP, Consultants, Physio, Counselling, etc).**

- **Is a referral to Occupational Health required?** ***Yes*** ☐ ***No*** ☐

- **Ascertain any work and/or personal issues that are contributing to the absence**

- **Discuss any agreed action plans and/or OH recommendations (i.e.: restrictions, redeployment etc), including any previous objectives i.e.: flexible working / modifications etc**

- **Discuss medication prescribed and any side effects etc**

- **Ascertain if a return to work is likely and if so, when. Explain / agree phased return to work plan if appropriate**

- **If appropriate, discuss / explain the redeployment process and / or feasibility of accommodating restrictions or modifications**

- **Is ill health retirement an option? If so, do we have OH support?**

3. If no underlying health problem is identified stress the following points:

- **Advise that an Improvement target (normally 3 months) will be set, during which time their attendance will be monitored, and a marked improvement in attendance is required**

- **Advise that if during the review period their attendance remains a concern and/or unacceptably high, further and progressive sickness meetings will be conducted in line with the Attendance Policy**

- **Re-emphasise their obligations as per the Attendance Policy**

4. Confirm that the employee has understood the purpose of the meeting and that a way forward has been clarified.
5. Is the employee about to exhaust full or half pay? Inform of sick pay position if appropriate.
6. Have there been any issues with timely and accurate sickness reporting? Clarify their responsibility if required.
7. Improvement Target Set? YES ☐ NO ☐ **Duration of Improvement Target:** ***(Months)***   **7.1 If no Improvement Target set, explain why not below:**   **8. Any further comments / questions**   ***Appeal***   *Outline the employees right to appeal as per the Attendance Management Policy giving timescales and who the employee should address the appeal to.*

Employee Signature: .....

Line Manager Signature: .....

Distribution:
Original Copy : retained in employee's personal file
Photocopy : employee

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
September 2013

Agenda Item: 13/133	**Author of the Paper:**
Report date: 12 September 2013	Melanie Wright Business Manager melanie.wright@southseftonccg.nhs.uk Tel: 0151 247 7069

Title: Remuneration Committee

Summary/Key Issues:

This paper presents the Governing Body with a solution to an issue around Conflicts of Interest which have rendered the Remuneration Committee inquorate in terms of decision-making in relation to GP remuneration.

Recommendation

Receive	
Approve	x
Ratify	

The Governing Body is asked to approve the temporary appointment of:

1 Peter Morgan, Deputy Chief Executive, Sefton Council; and

2 Sam Tunney, Head of Performance and Intelligence, Sefton Council;

to the Remuneration Committee and that during this temporary appointment that the meeting be deemed quorate on the basis of their attendance, together with that of the Lay Member.

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.

GB13/133

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

1. Introduction and Background

1.1. In 2012, the North West PCT Clusters agreed to commission a report from the Hay Group to provide guidance on the appropriate level of remuneration for GP Governing Body Members within CCGs.

1.2. This was in recognition of a lack of national guidance in this area and the acknowledgment of a wide range of existing practices within the shadow CCGs.

1.3. The Hay Group report, completed in December 2012 was circulated and recommended to all North West CCGs from the North West Clusters as a sound researched basis for consideration of payments to GP clinicians in the roles they undertake for CCGs.

1.4. As a result of the recommendations contained within the Hay Group Report, it has become necessary for a formal report considering payments to GP clinicians to be taken to the Remuneration Committee, within its delegated responsibility for remuneration under Section 5 of the Scheme of Reservation and Delegation (Appendix D of the Constitution).

2. Key Issues

2.1. Under clause 1.2 of the Terms of Reference, it states: *"The principal function of the Committee is to make recommendations to the Governing Body on determinations about pay and remuneration".*

2.2. The Terms of Reference of the Remuneration Committee are attached at Appendix 1 and the Governing Body's attention is specifically drawn to clause 3 which identifies the membership of that Committee.

2.3. The Governing Body's attention is also drawn to the following:

(a) the nature of the report proposed to be taken to Remuneration Committee;

(b) clause 19 of the Constitution (Conflicts of Interest) and clause 22 (Quorum); and

(c) the CCG's Policy on Managing Conflicts of Interest.

Conflicts of interest have been identified in relation to any discussions and the decision-making process thereon in relation to payments to GPs at both the Remuneration Committee and, in the event of any deferral, with the Governing Body.

2.4. In relation to quoracy, the Terms of Reference of the Remuneration Committee state:

"6.1 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).

6.2 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.

2.5. However, under clause 3.4, the Terms of Reference also state: *"Only members of the CCG Governing Body may be members of the remuneration committee."*.

2.6. The consequence of these matters referred to above renders any current Remuneration Committee inquorate and thereby unable to approve any recommendations made in relation to GP remuneration.

2.7. Similarly, conflicts of interest of a similar nature have also been identified in relation to the membership of Governing Body, which would also be rendered inquorate.

3. Conclusions

3.1. Under the terms of the CCG's Constitution, together with the organisation's Policy on Managing Conflicts of Interest, neither the Remuneration Committee nor the Governing Body can approve the recommendations of any report in relation to GP remuneration.

3.2. It will therefore be necessary to invoke the conditions contained within clause 22 of the Constitution, which makes provision for:

"Any quorum of the Wider Constituent Group, the Governing Body, its Committees or its sub-committees shall exclude any member affected by a Conflict of Interest under Clause 19. If this Clause has the effect of rendering the meeting inquorate, then the Chair shall decide whether to adjourn the meeting to permit the appointment or co-option of additional members.".

4. Recommendation

The Governing Body is therefore asked to approve the temporary appointment of:

4.1. Peter Morgan, Deputy Chief Executive, Sefton Council; and

4.2. Sam Tunney, Head of Performance and Intelligence, Sefton Council;

to the Remuneration Committee and that during this temporary appointment that the meeting be deemed quorate on the basis of their attendance, together with that of the Lay Member.

Appendices

Appendix 1 Terms of Reference of the Remuneration Committee

Melanie Wright
Business Manager
September 2013

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

NHS
South Sefton
Clinical Commissioning Group

Quality Committee Minutes

Thursday 20 June 2013
3:00 pm – 5:00 pm
Boardroom, Merton House

Attendees		
Steve Astles	Head of CCG Development	(SA)
Lin Bennett	Practice Manager / Board Member	(LB)
Fiona Clark	Chief officer	(FC)
Roger Driver	Lay Member	(RD)
Debbie Fagan	Chief Nurse	(DF)
Dr Anna Ferguson	GP	(AF)
Dr Craig Gillespie	GP Chair	(CG)
Dr Gina Halstead	GP Vice Chair	(GH)
Dr Steevart	GP	(SS)
Martin McDowell	Chief Finance Officer	(MMcD)
In attendance:		
Margaret Goddard	Named GP Safeguarding Children & Young People	(MG)
Anne Dunne	Designated Nurse Safeguarding Children	(AD)
Gordon Jones	Quality Manager CSU	(GJ)
Denise Roberts	Deputy Designated Safeguarding Nurse	(DR)
Apologies		
Bal Duper	GP Lead Primary Care Quality	(BD)
Tracey Jeffes	Head of Corporate Delivery	(TJ)
Dr Andrew Mimnagh	GP	(AM)
Minutes		
Tracey Cubbin	Administrator	(TC)

No	Item	Action
Q13/68	**Welcome and Introductions** CG welcomed the committee and introductions were given.	
Q13/69	**Apologies** As above.	
Q13/70	**Declarations of Interest** FLC, MMcD and DF hold joint posts for Southport & Formby CCG and South Sefton CCG. All clarified there was nothing on the agenda that will be of any issue.	
Q13/71	**Minutes of the last meeting – 2O May 2013** Attendees - Dr Debbie Fagan should read Debbie Fagan as she is not a doctor. **Q13/67** – 'BD suggested we have a standard job description' should read	

No	Item	Action
	'LB suggested we have a standard job description'.	
Q13/72	**Matters Arising / Action Tracker** **13.40** Action complete. Meeting arranged between DF and Diane Blair from HealthWatch. **13.40** Action complete. Corporate Risk Registers are updated and reviewed at Senior Management Team. Not required as an agenda item for this meeting. **13.41** Action complete. Detailed in the Chief Nurse Report – telecom taken place and meeting arranged. **13.42** Primary Care Strategy not yet due for presentation (Sept 2013 date). To remain on action tracker. **13.43** Action complete. HCAI detailed in the Chief Nurse Report – proposal to be approved. **13.44** Locum cover in GP practices – BD / LB to feedback in July 2013 **13.48** Rejected lab reports – GH to feed back in July 2013 **13.55** Action complete. Meeting with Aintree Hospitals Risk Management detailed in the Chief Nurse Report **13.55** SUI Management and role of Direct Commissioners / **13.55** Clarification of process with the Area Team – both to be addressed with Direct Commissioners at NHS England (Merseyside) and Director of Nursing and Quality NHS England (Merseyside). DF to raise at Chief Nurse meeting with the Area Team. To stay on action tracker. **13.56** Action complete. Dashboard is an agenda item at the next EPEG meeting. **13.58** Action complete. Consultation commenced on Primary Care Strategy. **13.58** Feedback from HCAI Care Home Research / audit – to be contained in the Chief Nurse Report for the July 2013 meeting. **13.63** Action complete. No further comments received re: Terms of Reference. To be ratified at the next meeting of the Governing Body. **13.64** DF to liaise with Malcolm Cunningham to ensure that NHS 111 has been added to the Risk Register.	DF DF DF
Q13/73	**Chief Nurse Report** - **Matters arising** **Care Quality Commission Meeting:** This meeting has been arranged for 5 July 2013. **Quality Review Meeting Updates (University Hospital Aintree NHS FT):** A Contract Query has been sent to the provider on 19 June 2013. **Health Care Acquired Infections (HCAI):** The Committee approved the proposal for the CCG involvement in a Merseyside Commissioner Network for HCAI. **Public Health Outbreaks:** DF to liaise with Public Health England regarding process for notifying General Practice of outbreaks in the local area. DF to explore with CSU Communications Team outbreak information being included in the CCG newsletter. **Alder Hey – National Institute for Cardiovascular Outcomes Research (NICOR):** DF to clarify if NICOR will be producing another report and to update the committee if the re-submitted data will remove the provider from being	DF DF

No	Item	Action
	considered as within the 'alert zone'.	
Q13/74	**Quality Dashboard and Performance Report** DF introduced the report and asked the committee to note the additional update information contained within the report that was not reflected in the report produced from the Commissioning Support Unit due to reporting timelines. The committee noted the additional information with regard to: • University Hospital Aintree (1 x case of MRSA in June 2013; amended Governance Risk Rating from AMBER/RED to RED and letter from Monitor investigating a possible breach of licence; issuing of the Contract Query) • Jospice (CQC inspection compliance action with minor impact – staff training / mechanisms in place to support staff through formal supervision). A meeting has been arranged between the DF and the CQC Compliance Manager for Sefton to discuss further on 2 July 2013) GJ presented the Quality Dashboard and exception report for the CCG providers. The time period that the data covered was discussed including time lags. GH highlighted that the lack of robust provider electronic patient records in some cases does not readily assist timely data capture in some instances and assured the committee of actions being taken through the quality contract linked to provider data and information / communication. With regard to Mersey Care, GJ highlighted the provider's RED RAG status in relation to Psychosis and their performance in the risk profile in relation to partnership working but this was thought to be due to individual packages of care / complex cases – this will be addressed at the next provider Clinical Quality and Performance Group. DF informed the committee that a meeting has been scheduled with the CSU Complex Case Manager for mental health to review all individual packages of care as part of the CCG assurance process. The committee requested that CSU: • Identify if there are any 'champions / outstanding performers' nationally with regard to performance for Dementia and regionally for Heart Failure and Pneumonia so we can learn any lessons and implement locally in order to improve outcomes locally The committee noted the Alder Hey HSMR RED RAG rating. The committee noted the NICOR information contained within the Chief Nurse Report. DF to clarify with Liverpool CCG what conversations have taken place as part of the commissioning assurance process. The committee noted the RED RAG status of University Hospital Aintree in relation to SHMI which has on-going management and commissioner review. Refer also to information in the Chief Nurse Report and agenda item Q13/77. RD requested if there was any complaint / reflective information available from relatives of deceased patients that could be used as intelligence to improve the quality of care and patient pathways. GH explained the routes that complaints information is received. The committee requested that CSU: • Identify if there are any trends emerging in such information that commissioners have access to. DF to contact AQuA for information on SHMI /HSMR	GJ DF GJ DF
Q13/75	**Safeguarding Hosted Service Monthly Assurance Report** The committee noted the content of the report and supported the recommendation for an audit to be undertaken in relation to provider CRB checks due to the challenges currently in the system regarding legal requirements and best practice guidance. DF formally thanked the service	

No	Item	Action
	for the presentation they gave at the last Sefton Local Safeguarding Children Board detailing the current commissioning landscape post April 2013 and the CCG internal and external assurance processes. DF to contact Sefton LA to ask for clarification around the plans for the likely safeguarding children inspection so that as health partners we can be prepared.	DF
Q13/76	**Contract Update 2013/14** The committee concluded that relevant contract updates had been received from DF, GH, and GJ throughout the meeting. The committee has requested that going forward updates could be included within the Chief Nurse Report and supported by any exception information provided by the GP Clinical Quality Lead for the provider contracts.	
Q13/77	**University Hospital Aintree SHMI Report** GH informed the committee of the recent developments with regard to Aintree and gave an overview as follows: • Ramsden Review Report and Clough Audit Report received by commissioners • Letter from Monitor and change of Monitor Risk Rating • Outcome of discussion at the Aintree Collaborative Commissioning Forum (Contract Query issued on 19 June 2013). The planned follow-up meeting with the Provider is now likely to form the Joint Investigation Meeting as per the contract requirement • Telecom between the CCGs and Monitor scheduled for 4 July 2013 The committee felt assured that they were aware of the issues raised in the letter from Monitor to the provider and had taken a proactive and supportive stance with the provider through the contract process as well as through the facilitation of the Quality Review Meeting held in April 2013. DF stated that she would be contacting the CQC as part of the regulator / commissioner relationship following on from the Quality Committee and now that the Contract Query had been issued.	
Q13/78	**Francis Recommendations Draft Action Plan** The committee approved the action plan. DF to provide a further update at the September 2013 meeting which will be in-line with the timelines for reporting to the Audit Committee and Governing Body	DF
Q13/79	**Role of the Named GP Safeguarding Children and Young People** Dr Margaret Goddard gave a presentation to the committee titled 'Named GP Safeguarding Children and Young People'. The function is currently provided by Liverpool Community Health NHS Trust for 2 sessions per week. It was highlighted that this is not a statutory function but there was reference to the function within recent national guidance. DF informed the committee of the previous e-mail she had sent to NHS England (Merseyside) following seeing the advert from another area team to recruit a Named GP. DF stated that a paper is being drafted by the Area Team and Halton CCG, for comments by the other Merseyside CCG Chief Nurses, to be presented to the CCG Network. The committee discussed the function of the role and what it was intended to do together with the role that the Area Team has as direct commissioners. The committee asked DF to liaise with the Area Team so that mutual assurance could be gained regarding safeguarding in Primary Care.	DF
Q13/80	**Locality Updates** SS will no longer be the GP Locality Lead for Seaforth and Litherland due to changing the area in which she will be working.	

No	Item	Action
	LB informed the committee that some concerns have been expressed from clinicians that nationally some secondary care targets may have been changed as of 1 April 2013 and that the responsibility now lies with the CCG. Part of the concern is the possible impact on the CCG both from a reputation and a remuneration perspective. FLC asked if LB could provide the evidence for this as it would be good to gain a fuller understanding in order for an informed decision to be made as to how this should be taken forward.	LB
Q13/81	**Any Other Business** **Media Attention – CQC:** RD highlighted to the committee the media attention today regarding the CQC report following the inspection at Morecombe Bay Hospital and asked if this would have any implications for the CCG. FLC explained that this had no implications for the CCG at present but would have impact for the regulator. **CQC Thematic Inspection for Children with Complex Needs:** DF stated that the CCG had been sent correspondence from the CQC detailing the intention to undertake a thematic inspection for children with complex needs with a particular focus on transition to adult services. DF has responded back to the CQC with the name of the Children's Commissioner for the CCG, has notified Local Authority, provider and CSU colleagues. The CCG should receive notification within the next 2-3 weeks if they have been identified to take part in this inspection. **Nightshift Handover at University Hospital Aintree:** DF and FLC informed the committee of the night shift handover that they attended on 18 June 2013 at Aintree Hospital. DF and FLC stayed with the team from 1930hrs until 0130hrs on 19 June 2013 and witnessed some positive examples of clinical leadership and compassionate care despite the challenges that are being encountered by the Trust. **Quality Committee Walkaround – Liverpool Community Health:** DF informed the committee that following a discussion with the Director of Nursing at Liverpool Community Health arrangements have been put in place for the Quality Committee to undertake some 'walkarounds' with the provider teams. These will be taking place in the autumn. **GP Practice Visit – NHS England (Merseyside) and CCG** DF reported to the committee that NHS England (Merseyside) had requested the CCG to join them on a visit to a GP practice within South Sefton that morning due to concerns that had come to their attention. DF has briefed FLC but is unable at this time to give any further information to the committee.	
Q13/68	**Date and Time of Next Meeting** Thursday 18 July 2013 3:00 pm – 5:00 pm Conference Room 3C, Merton House, Bootle L20 3DL	

Signed …….. Date ……
Chairman

NHS
Liverpool
Clinical Commissioning Group

NOTES OF THE MERSEYSIDE CCG NETWORK MEETING

Held on Wednesday 7 August 2013 from 1.00 – 4.00 pm
Boardroom 1, Regatta Place, Brunswick Business Park, Summers Road, Liverpool L3 4BL

Present:

Dr Nadim Fazlani	NF	Chair GGC Network and Liverpool CCG
Katherine Sheerin	KS	Chief Officer, Liverpool CCG
Tom Jackson	TJ	Chief Finance Officer, Knowsley CCG
Dr Andrew Pryce	AP	Chair, Knowsley CCG
Diane Johnson	DJ	Chief Officer, Knowsley CCG
Dr Clifford Richards	CR	Chair, Halton CCG
Simon Banks	SB	Chief Officer, Halton CCG
Ian Davies	ID	Head of Operations & Corporate Performance, Liverpool CCG
Fiona Clark	FC	Chief Officer, South Sefton & Southport and Formby CCGs
Dr John Caine	JC	West Lancs CCG
Dr Fiona Lemmens	FL	GP/Governing Body Member, Liverpool CCG

In Attendance:

Roger Booth	RB	Senior Resilience Manager, CMCSU
Rob Forster	RF	Business Development Manager, CMSU
Liz Mear	LM	Managing Director North West Academic Health Science Network
Louise Ward	LW	Director of R & D, Department of Health

GB13/138

Action:

1	**Welcome and Introductions**	
	The Chaired welcomed everyone to the meeting and around the table introductions were made	
2	**Apologies for Absence**	
	Apologies were received from: Dr Stephen Cox (St Helens CCG) Mike Maguire (West Lancs CCG) Sarah Johnson (St Helens CCG) Dr Sarah Baker (Warrington CCG)	
3	**Minutes of the Previous meeting**	
	The minutes of the previous meeting held on the 3 July 2013 were agreed as a true and accurate record subject to the following amendments:	**Changes to be made to the minutes by CH (completed)**

		Action:
	Page 2: **Item 3: Second bullet:** NG to be amended to NL **Item 4: Last bullet:** To amend Hair to read Chair	
4	**Matters Arising not on the agenda**	
	Rehabilitation Commissioning Board: **Feedback re Commissioning Support Services:** Feedback was given by each CCG relating to the services provided by CSU. The main issues highlighted related to data evaluation, particularly 2 significant lines: BI and CHC and value for money overall. TJ highlighted that a meeting had been held with DOFs and a process to review each line had been shared. This will be evidenced and shared with the CSU. CR noted that integration with the Local Authority has a significant impact on this. It was suggested that a decision should now be made to ensure there is a direction of travel linked into true integration with the Local Authority and this could result in commissioning support services being undertaken by the Local Authority. TJ highlighted the issues with data validation and Specialised Commissioning which presents signigicant risks to the CCGs. It was agreed that a meeting would be arranged with Chief Officers, DOFs, Tim Andrews, Moira Dumma and Russ by mid-September CCGs to share Commissioning Support Plans as they emerge. **Merseycare FT Letter:** KS noted that a request had been received for support for the Merseycare FT application. **North West Specialised Commissioning Group**: The lack of clinical representation was noted and it was agreed that NF would attend on behalf of the CCG Network.	**Meeting to be arranged by mid September** **NF to attend on behalf of CCG Network**

5	**COLLABORATIVE COMMISSIONING**	
5a	**NHS 111** ID advised that following the withdrawal of NHS Direct, and direction from NHSE work is being done to negotiate an alternative partner, which is nationally being seen as the Ambulance Service. Negotiation is underway with NWAS to step into 3 contracts which will be brought together in a single contract for that purpose. NWAS will accept staff from NHS Direct under TUPE along with transfer of the asset base (Middlebrook Call Centre, Bolton) **Areas of Risk Identified:** • **Staffing numbers**: View that NHS Direct is overstaffed with call handlers but under resourced with clinicians. • **Payment:** Likely to be increase in 30% being paid to NHS Direct, based on call volume which does not take into account fixed overhead costs • **Contingency Calls:** Likely that will have to take back 0845 contingency calls which are going into the national pooling arrangements and to be filled for second quarter costs of that nationally • **Middlebrook Lease Arrangements:** Element of due diligence to be done • **NWAS FT application deferred:** Monitor is looking at a stability agreement and proposals are expected to CCGs before the end October. **Future Plans:** • Contracts to be taken over by NWAS from 1 October as requested by NHSE. • This will allow gradual financial withdrawal from NHS Direct business. • Likelihood of redundancy costs associated with call handler move and central resources of NHS Direct, however it is unclear where redundancy costs will lie. • Confident that costs can be absorbed in the overall envelope of price agreement for NHS Direct. However it is still expected to be less than the full contract cost which would have been paid to NHS Direct if they were delivering the service. • Re procurement is likely to be late Autumn 2014, which means likely extension of OOH contingency arrangements until Summer 2014. • Problem with adequate reporting of clinical	

		Action:
	governance data, reports and assurance from NHS Direct, sufficiently monthly reports and data unavailable to LCAGs. However they have been assured that there has been a significant reduction in the number of complaints FL advised that from feedback received there is no report of SUI and the vast majority of complaints are process related. Reduction in OOH and A & E reported at Warrington and Salford however it is unsure whether this is due to the negative reports received in relation to NHS 111 service.	
5b	**Commissioning Policy Development** A Commissioning Policy Development document was presented by RF. NF referred to policies which had been available for some time and which were in need of updating, and queried how this would be done with support from CSU. The PLCP Policy would be reviewed collectively. It was noted that a review of corporate policies was required to create a framework to ensure a level of congruency across Cheshire and Merseyside CCGs and to consider how this would be done. DJ noted that this should be done collectively to ensure there was no burden on CCGs for clinicians to do that work and how to make that as efficient as possible in terms of time spent from CCGs plus providers of that work. RF asked if it would be useful to look at scale and scope of policies and to explicitly set out roles and responsibilities. It was agreed that this would help. Following discussion it was agreed that there was a need to decide scope, policies required and dates to be reviewed whilst taking into account input from the different organisations and in terms of costing and breakdown. RF to look at this and bring a report back to a future meeting.	**RF to bring report back to future meeting**

		Action:
5c	**Agreeing a Merseyside Approach:** KS noted that following the Co-Commissioning Forum held in July, where the top 10 tips from each CCG had been discussed for the following areas: • Frail Elderly • Mental health • Children's Services • Cancer Care and Pathway of Care • Urgent Care It was agreed that a local (CCG/LA) approach to implementing the top 10 tips should be applied for: • Frail Elderly • Children's • Maternity. It was agreed that we should work with the NHSE to collectively commission across Cheshire and Merseyside: • Cancer Services/End of Life • Maternity Services It was agreed that collaboration for Urgent Care would be dealt with by the Urgent Care Networks	**KS to confirm this with NHSE.**
5d	**Healthy Liverpool Programme:** Full discussion was deferred until the next meeting.	KS and NF to present
6	**OPERATIONAL ISSUES**	
6a	**EPRR – Roger Booth:** An update was given by RB who highlighted the following areas: **Business Continuity:** An evaluation exercise will be held in October, incident response plans linked to that will be circulated in the near future. **Assurance Process from Providers:** Written assurances to go out from Contracts Teams in respect of business continuity incident response, Pandemic Flu, evacuation etc., to be provided in October and plans will be reviewed against the DOH check list. It was noted that this this would cause significant difficulty for physical reviews at providers.	

		Action:
	ID requested that prioritisation should be agreed with RB as some trusts have bigger risks. Agreed that ID would speak to RB and provide advice **Exercises:** • Strategic Leadership – 3 December • Surviving Public Enquiry – March 2014 • National Power Outage – April 2014 • National Pandemic Exercise – October 2014 • LHRP Team is planning mass casualty exercise • **Proposed Fire Brigade strike:** MFRS is currently completing contingency arrangements and staff training to provide cover during the expected strike(s). • • It was noted that two task and finish groups have been set up for CMS scoring and escalation/diversion policy, supported by Jane Keenan and Donna McLaughlin and these two policies would be brought back to the network meeting for future approval prior to the onset of this winter. • • ID highlighted an issue around the provision of mobile medical cover (MERIT) in the event of a trauma incident and/or major incident and the requirement for onsite medical capacity. Across the North West there is currently no comprehensive mobile medical team response. A proposal is being looked at through NWAS by ambulance commissioning leads via Blackpool with estimated recurrent costs of circa £260k per county area plus non recurrent setup and equipment costs. ID to write out to CCGs with full details seeking approval to fund this development. It was agreed that it was useful for updates to be provided by RB.	**ID to meet with RB**

		Action:
6b	**Urgent Care Network/Tripartite Meeting** NF noted that it was previously agreed that the Tripartite forum would not be operational but a forum to promote shared learning would be time limited and would not cover work being done by Urgent Care Networks. However it was noted that learning was not being shared across networks. KS advised that 3 Urgent Care Networks were already in place and that the tri-partite meeting had been set up by NHSE (Merseyside) at local level and wasnot a national requirement Following discussion it was agreed that a draft of operational work being done by networks would be circulated to give assurance of bi-literal work being done through CCGs It was also agreed that a letter would be prepared by NF and sent to C Duggan to confirm that the Tripartite meeting should return to the agreed objectives and membership, as such providers would be stood down	**NF to circulate draft of work being done by networks** **NF to send letter to C Duggan**
7	**CCG DEVELOPMENT**	
7a	**Co-Commissioning Meeting with Area Team and Local Authority::** KS confirmed arrangements for the September Co - Commissioning and CCG Network meetings: : **Co-Commissioning Meeting:** To be held on 4 September 2013, Local Area Team to be invited. **CCG Network Meeting:** To be held on 11 September With regard to the Co-Commissioning meeting, it was queried why Local Authorities were invited as it was felt that this was a duplication of the Health and Wellbeing Boards. Following discussion it was agreed that: • CCG Chief Officers would contact the CEO of their Local Authority to ask whether they still wanted to attend the meeting. • Responses would be fed back to NF by 1 September. • NF to send a letter to Local Authority CEOs to invite them to the 4 September meeting	**CCG COs to contact LA CEOs and feed response back to NF by 1 Sept.** **NF to write to LA CEOs to to invite to Sept meeting**

		Action:
7b	**Development Sessions with Area Team** The following topics for discussion at the September meeting were agreed: • Primary Care Commissioning • Quality • Sharing of CCG plans, to discuss how to take plans forward across Merseyside and to recognise some of the challenges. NF to discuss with CD/JH	**CCG plans to be presented to the September meeting** **NF to discuss with CD/JH**
7c	**Academic Health Science Network** A PowerPoint presentation was given by Liz Mear on the role of the AHSN and its relationship to the work of CCGs . LM highlighted the 4 national areas of focus for system integration, clinical themes and priorities, clinical governance and delivery structure, forward planning, working groups and potential challenges. It was confirmed that NM and KS attended the AHSN Board meetings on behalf of the CCGs. KS noted that it would be useful to understand existing projects which support delivery of AHSN objectives. LM to map work which is being done.	**LM to provide mapping of work which is being done**
8	**ANY OTHER BUSINESS**	
	It was requested that items from visitors/speakers should be presented at the beginning of the meeting.	
9	**DATE AND TIME OF NEXT MEETING**	
	Wednesday 11 September 2013 1.00 – 4.00 pm (lunch provided from 12.30) Boardroom, Bluecoat School	

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

HEALTH AND WELLBEING BOARD

MEETING HELD AT THE TOWN HALL, BOOTLE ON 24 JULY 2013

PRESENT: Councillor Moncur (in the Chair)

Dr. Janet Atherton, Fiona Clark, Robina Critchley, Councillor Cummins, Councillor John Joseph Kelly, Maureen Kelly, Colin Pettigrew and Dr. Shaw

15. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr. Niall Leonard, Phil Wadeson and Margaret Carney.

16. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the Minutes of the meeting of the Health and Wellbeing Board be agreed as a correct record.

17. DECLARATIONS OF INTEREST

There were no Declarations of Interest received.

18. PHARMACEUTICAL NEEDS ASSESSMENT

The Board considered a report of the Director of Public Health detailing a briefing on the Pharmaceutical Needs Assessment (PNA), which included associated risks and proposed local governance.

The report stated that the PNA was a statutory document that assessed the pharmacy needs of the local population. It highlighted that the PNA included dispensing services as well as public health and other services that pharmacies may provide. The report indicated that the PNA is used as the framework for commissioning pharmacy services.

It was reported that from 1 April 2013 the Health and Wellbeing Board has a statutory duty to publish and keep up-to-date the PNA. The Health and Wellbeing Board is also responsible for producing the Joint Strategic Needs Assessment (JSNA). It was further reported that by giving local authorities the responsibility for conducting both the PNA and JSNA, then the links between the two documents could be strengthened and that opportunities may arise for combined working on both documents.

It was highlighted that the responsibility for making decisions on pharmacy applications based on the PNA has passed from PCTs to NHS England.

The key message to Members was that the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, effective from 1 April 2013, require each Health and Wellbeing Board to:-

- Make a revised assessment as soon as is reasonably practicable after identifying changes to the need for pharmaceutical services which are of a significant extent
- Publish its first PNA by 1 April 2015.

It was reported that each Local Authority should appoint a Board-level sponsor with responsibility for the PNA, but the management of the PNA could be passed to a steering group led by public health. It was further reported that the steering group would be a task and finish group reporting to the Strategic Integrated Commissioning Group. Governance arrangements would be through the Strategic Integrated Commissioning Group reporting back to the Health and Wellbeing Board for approval at strategic stages of the process, such as signing off the revised assessment and first new PNA.

The report also set out the risks associated with failure to comply with the regulatory duties.

The following next steps were reported to be:-

- Nomination of a Board level sponsor for the PNA.
- Agree a chairperson of the steering group from the Local Authority public health team (Consultant in Public Health).
- Agree governance arrangements for the steering group.
- Recruit the steering group which should develop a project plan.

A Member of the Board advised that a Pharmaceutical Needs Assessment had previously been drafted some time ago and would be in existence until 2015. Paragraph 8.2 to the report was referred to and it was requested that it be amended to read “Sefton will have a robust Pharmaceutical Needs Assessment in time for the deadline of 2015”.

RESOLVED: That:

(1) Fiona Clark, Chief Officer for Southport and Formby and South Sefton Clinical Commissioning Groups, be nominated as the Board level sponsor for the Pharmaceutical Needs Assessment;

(2) the risks associated with the Pharmaceutical Needs Assessment be logged through Sefton Council’s risk assessment and risk register process, subject to paragraph 8.2 of the Director of Public Health’s report being amended to “ .....The risk has been worded as “Sefton will have a robust Pharmaceutical Needs Assessment in time for the deadline of 2015 “.....”; and

(3) a local steering group be established to develop the Pharmaceutical Needs Assessment and oversee the statutory consultation.

19. LOCAL PLAN

The Board received a presentation from the Head of Planning Services in relation to Sefton's Local Plan. The Head of Planning Services identified how the Local Plan would specifically link into the Health and Wellbeing Strategy and highlighted the following headlines and key points:-

What is a Local Plan?

- Statutory Development Plan for the Borough
- Framed in Planning legislation and national policy
- Strategic document setting out priorities for regeneration, place shaping etc.
- Must plan for economic growth and development
- Must protect our environment and create opportunities for the residents and businesses of Sefton

What does that mean?

- A Plan for Sefton based on planning legislation – we can't do what we want
- Our Plan will be examined by the Government and has to be robust and withstand scrutiny
- We must set out our stall for regeneration and other priorities
- We must meet our housing, employment and other needs – it is not an opinion
- It is complementary to other corporate strategies
- It makes difficult choices about development at any cost and balances environmental and other issues too
- When adopted it will replace our current Development Plan approved in 2006

What does the Local Plan include?

- Profile, issues and challenges facing Sefton
- Vision for 2030 – what will Sefton be like when the Plan has been implemented
- Objectives
- Strategic Policies
- Detailed policies covering requirements for all new development
- Site allocations – new housing, business parks etc.
- Which options discounted and why

What stage are we up to?

- 2009 Consultation on Issues
- 2011 Consultation on Options
- Summer 2013 Consultation on preferred Option
- August/September 2014 Publication
- October/November 2014 Submission
- January 2015 Examination
- April/May 2015 Adoption

Objectives - 14 listed in the Plan including:-

- To support regeneration and investment priorities in Sefton
- To protect and enhance natural environments and the built environment with emphasis on quality of place
- To meet diverse needs for homes, jobs, services as far as possible close to where they arise
- To allow people to live a healthy life, with access to leisure.and safe environments
- To make sure new developments include essential infrastructure services etc.
- To support town and local centres so they can adapt to wider needs and develop flexible roles

Some issues and challenges – How can we

- Make the best use of assets
- Improve access to facilities, employment, services
- Slow down trend of ageing population
- Meet all needs for new homes
- Provide for new jobs and infrastructure e.g. Port expansion, including more opportunities for local jobs

Strategic Policies

- Spatial Strategy for Sefton
- Sustainable Growth and Regeneration
- Protection and enhancement of Environmental assets
- Climate Change and Carbon Reduction
- People and Places

Spatial Strategy – New Development shall:-

- Meet needs (homes) in the areas where they arise as far as possible
- Make best use of resources – brownfield land
- Be on land with fewest environmental constraints
- In accessible locations – or those which can be made to be accessible

Sustainable Growth and Regeneration

- Plan will meet Sefton's needs for homes, jobs etc. and will identify enough land for this
- Will support Regeneration priorities – town centres, Port expansion, new employment sites, Southport coast/tourism etc.
- Will support town centres
- Will require infrastructure to be delivered
- Over 10,000 new homes and 7,000 new jobs

Environmental Assets

- Protection for natural, heritage and landscape to protect quality of place
- Will require mitigation and replacement of features of environmental interest
- Higher levels of development will result in significant adverse effects to environment (step too far)
- Plan will protect, enhance and possibly increase the amount of "green" infrastructure (coast, parks, paths, cycle ways)

Climate Change

- Reducing and managing flood risk
- Reducing transport emissions
- Improving accessibility and sustainability
- Reducing energy use through energy efficient development to reduce running costs
- Maximising potential of natural energy
- Making best use of development sites
- Increasing use of renewable, decentralised and low carbon energy.

People and Places

- Maximising beneficial impacts of new development including:-
  - Better connected communities (improved access to a choice of, for example, homes, services and jobs)
  - Safe neighbourhoods with reduced fear of crime
  - Minimise pollution and reduce health risk
  - Protecting amenity of residents, protecting community facilities
  - Prevention of take away food outlets near to schools.

How does the Local Plan link to Health & Wellbeing objectives?

1. Addressing Wider Social, Environmental and Economic issues

- Identifies land for 3 new business parks
- Sites for 10,000 new homes to meet range of needs – family, affordable, elderly
- Well designed development – safe, accessible, energy-efficient

- Easily accessible services including leisure and sports
- Flags up need for new health facilities so they can be provided in the right place at the right time.

2. Promotes Positive Mental Health and Wellbeing
(Sefton's Health and Wellbeing Strategy: "mental wellbeing strongly related to deprivation")

- Opportunities for local training and jobs – 7,000 in total
- More choice of suitable accommodation
- Easy access to facilities by range of means of transport
- Protects and improves green spaces/coast/countryside
- Better footpath and cycling links

3. Support Older People to remain Independent and in own homes

- Part of housing provision is specialist accommodation for the elderly
- Flexible design of new dwellings to respond to changing needs
- Design will take account of safety and security issues

4. Support people early to prevent avoidable illnesses and reduce inequalities

- Healthy lifestyles – access by cycling and walking
- Easy access to parks, coast and countryside
- Approach to pollution, hazards and contaminated land
- New buildings: energy efficient and affordable warmth
- Policy to limit hot food takeaways close to schools and parks – required to provide clear evidence such as obesity figures

5. Children to have a positive start in life

- Allocating land for businesses will attract more jobs for Sefton's young people
- Access to opportunities for leisure, parks and greenspaces
- More opportunities to access affordable housing
- Development will be designed to promote safe neighbourhoods

6. Build capacity and resilience
(Outcomes of Health and Wellbeing Strategy similar to some of the outcomes of the Local Plan)

- Improved access to services and facilities including parks and open spaces
- Health benefits of activities in parks, coast and countryside valued and promoted
- Clean, safe and healthy environments, and quality of place
- Increased physical and emotional health and wellbeing.

Risks

- Failure to prepare a "sound" plan – development would be piecemeal – lose many benefits
- Trend towards ageing population exacerbated – fewer people of working age
- Fewer homes – family, affordable and for elderly
- Lost opportunities to attract investment – fewer jobs and less training
- Lost opportunities to improve infrastructure, including green infrastructure

How can the Board help?

- Influencing role
- Help spread the wider messages of the Plan
- Tell us what you think
- Any more information required?
- Any further discussions?

Members of the Board welcomed the presentation and in particular the specific reference to the ways in which the Local Plan contributes to the Health and Wellbeing Strategy. The following points were highlighted:-

- The intention to provide of affordable housing was welcomed.
- That any development should consider links to the cycle network.
- An offer from Members of the Board to publicise the consultation on preferred options in relation to the Local Plan at future public events in order that greater involvement may be provoked.

RESOLVED: That:

(1) the Head of Planning Services be thanked for her informative presentation; and

(2) Members of the Board be advised to contact the Head of Planning Services should they wish to use the promotional materials available for any public events they may be hosting.

20. CLINICAL COMMISSIONING GROUP QUALITY ASSURANCE FRAMEWORK

The Board received a presentation from Fiona Clark, Chief Officer for Southport and Formby and South Sefton Clinical Commissioning Groups in relation to the Quality Assurance Framework.

The presentation highlighted the following points:-

- The Interim Clinical Commissioning Group Assurance Framework was published in May 2013.

- The Framework sets out a nationally consistent approach to the formal interactions between Clinical Commissioning Groups and Area Teams on a quarterly and annual basis.
- The publication of the Interim Assurance Framework kicks off an engagement process with Clinical Commissioning Group staff, patient groups and other key stakeholders.
- A final framework will be published in the autumn.
- The Core Elements of Assurance in terms of delivery, capability and support.
- An overview of the balanced scorecard.
- The Clinical Commissioning Group Assurance Cycle and the "Balanced Scorecard".
- Process within each Quarterly Checkpoint
- Summary of the process
- Red/Amber/Green based conversations.

RESOLVED:

That Fiona Clarke be thanked for her informative presentation.

21. SEFTON BOROUGH COUNCIL - HEALTH PROTECTION RESPONSIBILITIES

The Board considered the report of the Director of Public Health which set out:-

1. The new duty of the Local Authority in relation to protecting the health of the population under the Health and Social Care Act 2012; and
2. The proposal for establishing a Health Protection Forum to provide assurance to the Health and Wellbeing Board that there will be safe and effective plans in place to protect the health of the population, to improve integration and partnership working between health partners and to support the Director of Public Health to fulfil her duty of assurance of the health protection system.

It was reported that heath protection sought to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards and contamination, such as chemicals and radiation. It was reported that as well as major programmes such as the national immunisation programmes and the provision of health services to diagnose and treat infectious diseases, health protection involved planning, surveillance and response to incidents and outbreaks and extreme weather events.

It was further reported that the Director of Public Health was responsible for the Local Authority's contribution to health protection matters, including the Local Authority's role in planning for and responding to, incidents that present a threat to the public's health. As part of the Local Authority's responsibilities the Director of Public Health (DPH) has a duty to prepare for and lead the Local Authority's response to incidents that present a

threat to the public's health. Local Authorities also have existing health protection functions and statutory powers in respect of environmental health.

A Member of the Board requested that in relation to any Committee/Board that the Clinical Commissioning Groups were appointed to serve on, the correct title of "Southport and Formby and South Sefton Clinical Commissioning Groups" be used.

RESOLVED: That:

(1) the new duty of the Local Authority to protect the health of the population under the Health and Social Care Act 2012 be noted;

(2) the establishment of a Health Protection Forum to improve integration and partnership working between health partners and to provide assurance to the Health and Wellbeing Board that there are safe and effective plans in place to protect the health of the population be approved; and

(3) in relation to any Committee/Board that the Southport and Formby and South Sefton Clinical Commissioning Groups are appointed to serve on that the correct title of "Southport and Formby and South Sefton Clinical Commissioning Groups" be used.

22. SEFTON STRATEGIC NEEDS ASSESSMENT - GAP ANALYSIS

The Board considered the report of the Head of Business Intelligence and Performance which detailed the work undertaken in relation to assessing the potential gaps within the existing Sefton Strategic Needs Assessment, following a review against the most recent guidance, and to ensure that the gaps as identified are included in the next iteration of Sefton's Strategic Needs Assessment.

RESOLVED: That:

(1) the fact that Sefton's Strategic Needs Assessment had been heralded as an exemplar in tone, content and style by the LGA Peer Challenge Team be noted;

(2) the next iteration of the Strategic Needs Assessment should include the perceived gaps and areas for development, as identified at Annex 1 and 2 to the report; and

(3) work on the production of the next iteration of the Strategic Needs Assessment be referred to the Strategic Integrated Commissioning Group, to assign to a task group to agree the timing of the production thereof.

23. RESPONSE OF SEFTON CCG'S AND SEFTON LOCAL AUTHORITY TO THE DEPARTMENT OF HEALTH REVIEW: TRANSFORMING CARE: A NATIONAL RESPONSE TO WINTERBOURNE VIEW HOSPITAL, FINAL REPORT. DECEMBER 2012

The Board considered the report of the Adult Social Care Director which presented an overview of the recommendations from the Department of Health Review: Transforming Care: A national response to Winterbourne View Hospital (Final Report); and the organisational responsibilities of Sefton Clinical Commissioning Groups and the Local Authority in relation to the NHS Commissioning Board (Merseyside Area Team) action plan.

It was reported that a BBC Panorama programme "Undercover Care – The Abuse Exposed" highlighted the failings of Winterbourne View arising from events occurring between 2008 and 2011. Winterbourne View was a private hospital for adults with learning disabilities and autism, who also had mental health conditions or behaviours which could be described as challenging; and which was owned and operated by Castlebeck Care Limited. It was designed to accommodate 24 patients and was registered as a hospital with the stated purpose of providing assessment and treatment and rehabilitation of people with learning disabilities. It was further reported that at Winterbourne View, the staff had committed criminal act, and six were imprisoned as a result, but the serious care review identified a wider catalogue of failings at all levels, both by the operating company and across the wider health and social care system.

The report detailed the response, in the form of a review, from the Department of Health and timetabled actions for health and local commissioners working together, to transform care and support for people with learning disabilities and autism who also have mental health conditions or behaviours which could be viewed as challenging.

The report detailed a number of Local Actions for Sefton that the Adult Social Care Director had taken on behalf of the Board.

RESOLVED: That:

(1) the action of the Chair of the Board in signing off the stock take, on behalf of the Board, be noted and endorsed;

(2) the action taken by the Chair on behalf of the Board as detailed in paragraph 3 to the report be endorsed;

(3) the report be noted; and

(4) the Adult Social Care Director be requested to submit a six monthly update report to the Board in relation to the Winterbourne View or sooner should that be necessary.

24. LOCAL SAFEGUARDING CHILDREN BOARD/HEALTH AND WELLBEING BOARD/CHILDREN'S TRUST ARRANGEMENTS/CORPORATE PARENTING BOARD - MEMORANDUM OF UNDERSTANDING

The Board considered the report of the Head of Business Intelligence and Performance which referred to a discussion in relation to ways in which the Board could ensure that it had the "right things" on its radar in progressing the delivery of the Health and Wellbeing Strategy and the relationships to other Boards such as the Local Children's Safeguarding Board, Corporate Parenting Board and the Children's Trust Board.

The report referred to the consultation being undertaken by Ofsted in relation to the proposed Single Inspection Framework for Children's Social Care Services. It was reported that the consultation document set out the way in which Ofsted was proposing to inspect services for vulnerable children. It was further reported that under the proposal, a single inspection Framework for local authority children's social care services for children in need of help and protection, children looked after and care leavers proposes a single framework for inspecting local authority child protection and services for looked after children, including those leaving or who have left care, to be introduced from November 2013.

The report also referred to the current inspection process which highlighted that should an unannounced inspection take place between now and November 2013 then the inspection would be based on the current framework and after November 2013 the inspection would be based on the single inspection framework.

It was reported that a memorandum of understanding between the Local Children Safeguarding Board, Children's Trust Board, Corporate Parenting Board and the Health and Wellbeing Board had been drafted and was attached to the report for the Board to review. It was highlighted that the Local Children Safeguarding Board and the Children's Trust Boards were two of the Boards that the Health and Wellbeing Board could directly influence in the delivery of the Health and Wellbeing Strategy.

It was reported that the Children's Trust Board were holding a workshop on the 25 July 2013 to review the Children's Trust arrangements. It was further reported that a report would be submitted to a future meeting of the Board in relation to the outcome of the workshop and the proposed arrangements for both a Children's Trust and a Children and Young People's Plan.

The report referred to the Early Help Strategy for Sefton. It was reported that the Strategy would be ready to commence public consultation during August and September. It was further reported that the implementation of the Early Help Strategy was the first step in working towards achieving "good or better services" as outlined in the grade descriptions within both the current and proposed inspection frameworks for children's social care services.

It was reported that, in consultation with the Independent Chair of the Local Safeguarding Children Board, agreement was reached to establish a safeguarding sub group to align the work of the various Boards and that of the Health and Wellbeing Board. It was reported that the purpose the group ould be to take a view of across the landscape of Children, Young People and Families, in enhancing outcomes for children, particularly in relation to safeguarding. It was further reported that once the group had been established a similar one be established for Safeguarding Vulnerable Adults.

Paragraph 8 to the report detailed specific amendments to the Health and Wellbeing Strategy. It was reported that the Deputy Chief Executive, Sefton MBC, using his delegated powers would seek final approval by the Council of the amendments referred to in the report.

RESOLVED: That:-

(1) the Memorandum of Understanding between the Local Safeguarding Children Board, Health and Wellbeing Board, Children's Trust Arrangements and Corporate Parenting Board be endorsed;

(2) the arrangements in place in relation to safeguarding and children's outcomes, provide assurance to the Board that Children's outcomes, and particularly the safeguarding of children should be led at a strategic partnership level within Sefton be endorsed;

(3) it be noted that the Children's Trust is reviewing its arrangements and exploring the development of new Children's Trust arrangements and a new Children's Plan, under the auspices of the Health and Wellbeing Strategy be noted;

(4) it be noted that an Early Help Strategy had been developed and consultation and engagement would commence, including a presentation to the Board in August 2013; and

(5) the consultation on the Single Inspection Framework for Children's Social Care Services, and the current arrangements be noted.

25. TALKING HEALTH AND WELLBEING EVENTS - UPDATE ON PLEDGES

The Board considered the report of the Head of Business Intelligence and Performance which detailed the actions taken so far on collating pledges from organisations and individuals showing their commitment to taking forward the work of the Health and Wellbeing Board.

It was reported that throughout each stage of the consultation process in the development of the Sefton Health and Wellbeing Strategy, participants at various events held during the summer and winter were asked to make a "pledge" on what they (as organisations or individuals) would commit to do to assist the Health and Wellbeing Board in achieving the strategic objectives within the Health and Wellbeing Strategy.

Annexes A and B to the report set out details of the pledges made by stakeholders, partners and the public.

It was reported that a recent workshop attended by the Board outlined some of the methodologies of influence through its agreed principle of using Viral Change. The workshop reinforced the use of the six universal principles of influence, prescribed by Robert Cialdini, Regents' Professor Emeritus of Psychology. Correct use of those principles supports the Viral Change methodology and were categorised as:-

- Reciprocation – obligation to return favours
- Authority – expertise
- Commitment/Consistency – acting consistently against commitment and values (especially if it is written)
- Scarcity – availability of resources
- Liking - agreement based on what we like
- Social Proof – doing what others do.

It was highlighted that in looking at the principles above, the use of pledges seemed to fit neatly into the commitment/consistency strand.

It was further reported that the pledges were also heralded at a final workshop meeting in March 2013, at which it was promised that actions and updates for them would form part of the discussions at the planned half yearly workshop, scheduled for October 2013. The meeting forms part of the Communication Plan where it was further envisaged that the pledges would form part of the Health and Wellbeing Web Pages, highlighting the commitment of different partners/stakeholders and members of the public, to the Health and Wellbeing "Movement" in Sefton.

It was suggested that individuals who made a pledge should be asked to promote their actions and to encourage others to join an e-forum where residents could register to complete their own pledges.

It was reported that all stakeholder participants who attended the various events had received a reminder of the pledge they have made, along with a copy of the Health and Wellbeing Strategy. It was further reported that those members of the public who requested to be kept informed had been written to reminding them of pledges made by individuals from their area.

RESOLVED: That:

(1) the pledges made by stakeholders, partners and members of the public, as detailed in Annexes A and B to the report, be published on the appropriate web pages;

(2) the planning of the half yearly event, scheduled for October, should commence and stakeholders, partners and members of the public be asked to highlight progress against their own pledge, and for those to be shared as part of the event; and

(3) a small working group of individuals be established to support a press article on pledges the Board had made and to encourage people to join an e-forum to complete their own pledges.

26. FORWARD PLAN

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

Maureen Kelly, representative from Healthwatch, requested that a standard item be included on future agendas regarding a verbal update in relation to Healthwatch.

Fiona Clark, Chief Officer, Southport and Formby and South Sefton Clinical Commissioning Groups, referred to the scheduled report for August "Results of 2012/13 Prescribing Quality Scheme" and requested that this be removed from the Forward Plan.

Fiona Clark also requested that the timeline of dates be adjusted for the Clinical Commissioning Groups quarterly report to correspond with her update in July.

RESOLVED: That:

(1) the Forward Plan for the Health and Wellbeing Board, as amended above, be noted; and

(2) a request be submitted to the Head of Governance and Civic Services asking that meetings during August be avoided when drafting the timetable of meetings for 2014/15.

South Sefton Medicines Optimisation Operational Group (SSMOOG) Minutes

Time and Date 12 – 2pm 23rd July 2013
Venue: Conference Room 3A, 3rd Floor, Merton House

Members		
Dr Steve Fraser	GP Governing Body Member	SF
Janet Fay	Senior Practice Pharmacist, SSCCG	JF
Brendan Prescott	Lead for Medicines Management	BP
Dr J Thomas	GP Representative	JT
Helen Stubbs	Senior Pharmacist, CSU	HS
Minute Taker		
Ruth Menzies (Minute Taker)	Medicines Management Administrator	RM
In attendance		
Tom Roberts	Prescribing Analyst	TR

No	Item	Action
13/54	**Apologies** Apologies were received from Sejal Patel.	
13/55	**Minutes of the meeting dated 23rd April 2013** The minutes of the above meeting were agreed as an accurate record.	
13/56	**Matters arising from Minutes dated 23rd April 2013** Ulipristal - Public Health have agreed the pathway for ulipristal but it has yet to go back to LMC. Some local authorities have already agreed the pathway. Sue Forster in Halton is leading on the piece of work. A meeting is due to take place at APC next week. It was noted nothing has changed in relation to GP prescribing. It was felt an interim statement should go out saying it can be prescribed from day one. RM to remove Steve Astles from the distribution list for the SSMOOG.	**BP** **RM**

No	Item	Action
	Erectile Dysfunction – it was noted BP has spoken to Jan Leonard regarding the agreement. There is a problem as Dr Mike Abbott is due to retire. It is hoped the service will commence prior to him leaving and clarity is required in relation to the pathway. Budget Setting – the budgets have been agreed at the F&R with 25% being fair share and 75% historical. We are currently looking to populate the portal. It was noted the Necto Portal is due for release in September 2013. Sandra Craggs (SC) has attended the portal meetings. SC to attend the next meeting. Discussions took place regarding the new portal which is felt it is coming very much from a finance point of view and felt it would be more useful to be very clinical. Pat Edgar has now been approached from the NBS to work on the portal from a medicines management perspective. Communications – RM to ask SPPs to inform practices that information from Medicines Management will be included in the Communication bulletin on a weekly basis. Discussions took place regarding the GPs not reading all communication received due to the amount of emails etc they get on a daily basis. Shared Care - BP has spoken to Martin McDowell and James Bradley and they are due to meet next Monday to discuss the principles of shared care. It was felt support should be requested from Pan Mersey as all CCGs are working in isolation around shared care. BP and TR to review what items are in the basket for shared care 1 and bring back to next meeting. Discussions took place regarding the different approaches from other CCGs. NOACs – it was noted the NOAC letter has been issued and a presentation given at the recent PLT. The medicines management team have also held a session regarding identifying patients who may be suitable to receive a NOAC. Reports have been issued to all practices. JA to obtain information from Aintree. Antimicrobial Guidelines – HS confirmed a meeting has taken place to discuss the next edition. SF confirmed he has been approached and will review the guidelines once produced.	**RM** **BP** **JA** **SF**

No	Item	Action
13/57	**Matters arising from MMOG minutes (June Minutes attached)** The above minutes have been noted. JF to email JA in relation regarding the grey list items mentioned under item 13/71.	**JF**
13/58	**Locality updates/ Practice Updates/Feedback** JF - Stoma project starting in Bootle and will be undertaken by a Stoma Nurse employed by Aintree. Audit will be to identify patients who have been stable but slipped through the net. JF confirmed the 3rd party audit results will be available for the next meeting. It was noted varied requests had been received from neurology for GPs to prescribe items on the red list. JF confirmed practices have replied saying no as patients are not stable. SF to discuss with GR to ensure the correct procedures are being followed. JF and HS to discuss further and sample letters to be provided to HS who will in turn contact Walton direct to resolve the issue.	**JF** **SF** **JF/HS**
13/59	**APC minutes** <u>Minutes from the June Meeting (attached)</u> The above minutes were attached for information. July minutes yet to be circulated. Discussions had previously taken place in relation to where business cases should go. It had been discussed at the JMOG and felt they should first come to the local operational groups and then go to F&R. However, there are issues regarding timings as to when these meetings are held. <u>APC Actions July</u> Nothing to report.	

No	Item	Action
13/60	**Budget Update (attached)** Discussions took place regarding spend in April. It is hoped more accurate figures will be circulated once the PPD have populated the portal. Information contained in the Dashboard was discussed, with the monthly annual cost growth, projected outturn and budget uplift not available. A few comparisons in spend have been introduced. TR to discuss further with Pat Edgar.	**TR**
	Quick Wins – TR has introduced a way of monitoring practices progress. It was felt this would be useful if this is presented at a locality level together with a Sefton average at locality meetings on a twice yearly basis. Discussions took place as to the impact this will have on practices and how these can be interpreted. It is hoped the information will encourage practices to ask questions. An estimate of potential savings was also produced.	
13/61	**Shared Care update** Dementia shared care agreement has now been agreed. Denosumab – BP spoken to MM regarding the financial implications which have been included in the business case and now needs to be referred to the Project Management Office. Degaralix – BP to speak with Joe Chattin in LMC and it is hoped a compromise of level 1 unless individual patients need further monitoring can be reached.	
13/62	**Risk Log (attached)** CCG are keen to have a Risk Log and Tracey Jeffes has compiled the attached. Something similar was used under Public Health. It was agreed that Medicines Management will have their own issues which can be discussed at the SSMOOG and as such this item should be added as a standing item on the Agenda. RM to add to the Agenda. It was noted that Stephen Hendry from CSU will be supporting the CCG with this piece of work.	**RM**

No	Item	Action
13/63	**Virtual Ward Update** It was noted that the above will be going life with one patient from each practice to be included. Two of the localities will be meeting up the first week in August and the remaining 2 in the 2nd week. JT felt that patients will become very involved once the service is in operation. Pharmacists and Technicians are in place in each locality. Discussions took place regarding raising awareness with Community Pharmacies.	
	Discussions took place regarding templates used and patient's perspective of the service. Also discussed was what will happen once the 12 weeks are up. It was felt it was work in progress but discussions took place as to whether it would reduce admissions. The importance of the GP completing the referral form correctly was highlighted.	
13/64	**Eclipse update** Susanne Lynch has been in touch with BMJ regarding putting the software on. It was confirmed that money was available and the software should be added to the pilot site systems within the month.	
13/65	**PQS payments (attached)** All payments for last year's PQS have been made.	
13/66	**Tithebarn CDiff Outbreak** SC produced a paper which was sent out prior to the meeting. It is felt the anonymised paper should be discussed at locality meetings. Paper to also go out to S&F practices and care homes. BP to speak to SC regarding the 5 patients with CDiff and the contents of the report.	**BP**
13/67	**Analgesia Management – Protected Learning Time** Looking to do a project with Southport pain clinic to train up NMP pharmacist and use this as a resource for the management of pain. The Pain Clinic are looking to facilitate a session at the PLT. Steve Simpson, (SS) lead pharmacist at Southport DGH, will be supporting the service. BP to ask SS to attend a future JMOG to see what they will do at a PLT.	**BP**

No	Item	Action
13/68	**AOB** EPS - BP to ask DS to update at the next SSMOOG. Drugs on Discharge - It was confirmed patients should be supplied with a 14 day supply on discharge. However an issue had been highlighted where this had not been done and it was suggested the issue should be referred to Dr Gary Francis (GP hotline)	**BP**
	Date and time of next meeting: Tuesday 17th September 2013 12 noon – 2.00 pm Conference Room 3B, Merton House	

Sefton Strategic Integrated Commissioning Group (SSICG)

Minutes of the meeting held on 22nd July 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
Janet Atherton	Director of Public Health for NHS Sefton and Sefton Council	JA
Peter Moore	Head of Commissioning and Partnerships, Sefton Council	PM
Steve Astles	Head of CCG Development South Sefton CCG	SA
Tracy Jeffes	Head of CCG Corporate Delivery – Sefton CCGs	TJ
Malcolm Cunningham	Head of Performance and Health Outcomes – Sefton CCGs	MC
Martin McDowell	Chief Finance Officer	MMcD
Carole White - (Minutes)	Personal Assistant to Peter Morgan	CAW

In attendance for item 4 : Margaret Jones, Consultant in Public Health

In attendance for item 7 : Denise Roberts, Deputy Designated Nurse for Safeguarding

Apologies :

Sam Tunney	Head of Business Intelligence & Performance, Sefton Council	ST
Colin Pettigrew	Director of Young People & Families, Sefton Council	CP
Tina Wilkins	Head of Vulnerable People, Sefton Council	TW
Dr Niall Leonard	Chair of Southport & Formby CCG	NL
Dr Clive Shaw	Chair of South Sefton CCG	CS
Billie Dodd	Acting Head of CCG Development Southport & Formby CCG	BD
Geraldine O'Carroll	Integration Commissioning Lead Sefton Partnership MCSS	GO'C
Debbie Fagan	Chief Nurse for Sefton CCGs	DF

No.	Item	Minute	Action
1.	Minutes of the previous meeting	• Noted	
2.	Actions Arising / Update	• Session on Strategic Estate – Health Asset / Community Planning - FLC stated that a presentation to CCGs took place last week and noted that work needs to be done in the CCG localities. • Peer Challenge – Report expected w/c 29th July. • Re-ablement – TW / GO'C / MMcD have since met to	

No.	Item	Minute	Action
		see how to take plans forward. Phase 4 discussed with Gerald Pilkington – to look at new specifications in order to maximise investments. FLC expressed concerns. £1.8m investment across Sefton for this year. Item on Re-ablement to come back to SSICG in September. • SSICG Work Plan – to come back to SSICG with populated actions. Any comments on the Plan should be fed back directly to PM. • Winterbourne Review – Signed off by H&WBB. 22nd July RC submitted report to the Cabinet Member, Health & Social Care, subsequently approved. • Carers Centre Meeting in relation to support for carers of adults with autism or aspergers syndromes – Meeting taken place. £135k budget. Service specification for the Liverpool Health Aspergers Team to be shared. FLC to attend a further meeting – due to various issues being raised which need to be clarified – Ongoing. <u>Action</u> MMcD and RC to meet to discuss re-ablement and issues. An update document to come back to SSICG. Update should include – list of financial resources, clarity, accountabilities and outline timetable.	ALL MMcD / RC
3.	Health & Well-Being Board sub structure to incorporate SSICG – Operational Board / Task and Finish Groups	• PSM explained that the SSICG had originally focussed on the integrated commissioning of children, adults and Public Health services, as this was clearly a priority within the then emerging health and well-being approach. Now the Health and Well-Being Strategy has been approved and the Health and Well-Being Board was in place the functions undertaken by SSICG need to be incorporated within a coherent structure, which included other elements of the health and well-being strategic leadership and delivery. The proposal was that the Programme Group, which would replace SSICG, would comprise of a relatively tight group of individuals centred around the core Health and Well-Being Members assigned to the group. Under that a number of Sub Groups would operate and it was noted that these included:- – Adults / Wider Determinants / Early Life – Performance / Communication & Engagement / Intelligence SSICG agreed this was a logical approach and noted that all SSICG Members, together with a range of other individuals from key partners, would populate the Membership of the Sub Groups of the Programme Group. It was noted that the Leads of the Sub Groups would be brought together on a regular basis (to be determined), then at least twice a year Members of all Groups would meet with the Programme Group to take stock of progress. • Networking of existing groups to be looked at i.e. will all	

No.	Item	Minute	Action
		the existing groups still be required. Further clarification would also be needed as to what groups report into each Task Group Action • To note the Group to be changed to the Health and Well-Being Programme Group • FLC / RC / CP / JA to look at nominations / suggestions for membership, and come back directly to PSM. • SSICG stands down from the 2nd September and is replaced with the Health & Well-Being Programme Group.	FLC / RC / CP / JA
4.	Public Health Workstreams – Sefton School Nurse specification – Health Weight – Sexual Health	• MJ discussed report with SSICG and noted that:- • Financial issues on school nursing are still to be clarified. • Links with EPEG to be picked up with Consultation and Engagement Group. • Sexual Health – Going to tender in October. Action • JA to be the lead / contact for these areas.	
5.	Disability Pathway	• Report noted.	
6.	Aintree Mortality and Infection	• FLC briefed SSICG on the issues relating to mortality and infection concerns in Aintree Hospital Trust. Action • SA to get notes of the meeting to RC. • Agreed Strategic Partnership Board required, comprising of 3 LAs, 3 CCGs and others. • 4 groups involved - CLF / CPUG / CRM / Urgent Care Network Board. • FLC to send relevant documentation to CAW, in order that it can be cascaded to SSICG • FLC and JA to meet to discuss further Public Health issues. • The Pioneer Bid submitted which incorporates the two Hospitals will contribute going forward • ESIS report due w/c 22nd July	SA FLC / CAW FLC / JA
7.	MASH Health Safeguarding Service Specification	• Approved by SSICG	
8.	Unplanned Care	• Aintree Hospital Trust Specification Plan required for Sefton. • Two 'Big Chat' events to take place w/c 22nd July. Another one to be scheduled for October.	

No.	Item	Minute	Action
		• The September meeting of the Southport Strategic Partnership Board will look at resilience for winter. • Graham Bayliss leading a Sefton group on community resilience theme – PM to feed into that meeting any CCG suggestions etc. PSM explained that the Council's Strategic Corporate Leadership Team has a priority for community resilience, and Mr Bayliss's group was an internal group looking at issues for developing this priority. This will be complementary to the new areas of the proposed Health & Well-Being Programme Board.	
9.	Any other Business	• A CHAMPS document was tabled at a previous SSICG – FLC stated it should be looked at as a useful framework document – going forward. • FLC / PSM noted a motion on pressures relating to accident and emergency in Sefton that had been tabled by Councillor Dawson at a recent Council meeting, which had been subsequently agreed by full Council and FLC had been contacted by the DoH to comment on the issues in the motion / resolution.	
	Items for the next meeting	• Re-ablement • SSICG Work Plan	
		Date and time of the next meeting – 2nd September 2013 at 3.30 p.m. – venue – Boardroom, 3rd Floor, Merton House, Stanley Road, Bootle, Merseyside, L20 3JA	

South Sefton Clinical Commissioning Group

Seaforth and Litherland Locality Meeting

7th August 2013
1.00pm – 3.00pm
Crosby Lakeside Adventure Centre

Attendees

Practice	GP	Practice Nurse	Practice Manager
Litherland Town Hall (LTH)			Pam Maher
15 Sefton Road	Dr McElroy / Dr Thompson		Alison Harkin
Glovers Lane	Dr Goldstein		
Rawson Road			
Seaforth Practice	Dr S Fraser		Caroline Nolan
Ford Medical	Dr Williams Dr T Danby- GP Registrar	Louise Armstrong	Lin Bennett
Bridge Road Surgery	Dr Vickers		
Netherton Practice	Dr Choudhary		Lisa Roberts
Orrell Park			
129 Sefton Road	Dr Sarkar		
Litherland Darzi			Pam Maher

Angela Parkinson (AP) South Sefton CCG Locality Manager
Susanne Lynch (SL) Medicines Management
Becky Williams (PT) Chief Analyst Sefton CCGs
David Beckett (DB) Chief Executive Go To Doc
Chris Cheetham (CC) Project Manager Go To Doc

Minutes
Angela Parkinson

No	Item	Action
13/40	**Apologies** Angela Dunne, Dr Taylor, Jane McGimpsey, Louise Taylor, Lynne Creevy	
13/41	**Declarations of Interest** Lin Bennett - South Sefton Governing Body Member Noreen Williams – LMC Committee Member	
13/42	**Minutes of Last Meeting / Matters Arising** The minutes of the meeting held in May and June were agreed. No meeting was held in July. There were no matters arising.	
13/43	**Locality Lead GP** The group were asked for a volunteer to become the GP lead. Dr McElroy agreed and was voted in by the group. This will be for a six month period,	

No	Item	Action
	following which Dr Vickers will be the lead for the next six months.	
13/44	**Quality Premium Dashboard** Prior to the meeting the locality had received a data report highlighting the top five specialities for hospital activity (per 1000 patients) by practice, and information on indicators for the Quality Premium. The group were asked to respond back to becky.williams@southseftonccg.nhs.uk regarding the format and for any queries on the content. A+ E data on the portal was discussed as currently a quarters data is available to view, there was a discussion regarding seeing previous data to identify trends. Another query was raised regarding Anaesthetics appearing in the data it was thought that this could be related to the pain clinic.	All BW
13/45	.**QOF Group Peer Review** Group peer specialities were discussed and agreed by the group: **Out patients** Urology / Heart Failure / Rheumatology **Emergency admissions** Cellulitis / Nursing and residential home admissions / Childrens Respiratory This will need to be approved by NHS England and make sure that data can be accessed via the Commissioning Support Unit	AP
13/46	**OOH Provision (GTD Limited)** Go To Doc become the provider for Out of Hours from 1st October 2013, and hold the contract for 5 years. This is a GP led organisation based in Denton in Manchester. **Q**: Where will the local centre be? **A**: Locations will stay the same, call handling will operate from Denton, no change in number **Q**: Has there been interest from local GPs? **A**: ICS currently operates with 60 GPs, 35 GPs so far have come forward **Q**: Liverpool OOH get cover from locum agencies, will that happen here? **A**: Not planning to use locums in Sefton **Q**: How many GPs will be needed? **A**: Depends on how many shifts GPs work, try to cap the numbers of shifts **Q**: How will GTD share data with practices? **A**: Adastra web is used which updates in real time, dial in and update from practice (this has been through governance checks), or via NHS mail or fax depending on what the practice wants **Q**: There were quite a few things that GPs working for OOH wanted to change but no change took place and OOH became an extension of a surgery **A**: The definition of urgent care is quite wide, but this is very much an urgent service **Q**: How can GTD communicate / update practices? **A**: Via the CCG intranet page or through the practice manager lead for	

No	Item	Action
	dissementation at practice manager meetings lin.bennett@nhs.net **Q**: Has there been any contact with the medicines management team? **A**: There is a planned meeting with Brendan Prescott and Tracy Jeffes. There is also a meeting arranged with Karen Groves and palliative care. **Q**: Currently ICS take messages for nursing staff and others if someone needs a district nurse OOH? **A**: This hasn't been raised so far so there will be a conversation about that **Q**: Will the ICS information currently being held be transferred over? **A**: the database going back twelve months will be transferred over	
13/47	**Medicines Management** C.Difficile breakout at local care home was discussed. Key finds from audit completed at GP practices involved was the importance of review PPI prescribing, either considering stopping or stepping down if clinically possible. Following local antimicrobial guidelines when prescribing antimicrobials and ensuring that all prescribing is documented within a consultation. Medicines management information will be coming out on the communication bulletins. A document called 'Making decisions better' was circulated prior to the meeting, it was felt that this could be used as part of an appraisal. The group were encouraged to attend. Insulin passports – this should be coded by the practice when given.	
13/48	**Locality Voluntary Community and Faith Update** This item was not discussed and will be deferred to the next meeting	AP
13/49	**Any Other Business** **A+E Group Peer Review -** This will be covered at Septembers locality meeting **Volume of patients registering –** Patients are leaving Litherland Town Hall SSP Health to register at neighbouring practices which is increasing appointment demands etc. It was agreed that the locality should raise concerns. **Virtual Ward referral form** – difficulty typing on the form, version control discrepancies **Practice nurse locality lead** – not many practice nurses attend the locality meeting, it was agreed that Colette Page and Pippa Rose would be contacted to discuss role with nurses	AP AP
13/50	**Date and Time of Next Meeting** 4th September 1 – 3pm Crosby Lakeside Adventure Centre	

South Sefton Clinical Commissioning Group

Bootle Locality Meeting
Minutes

18th June 2013
1.00 pm – 2:30 pm
Park Street Surgery

Attendees
Dr Goldberg – Concept House
Dr Katie Dutton – The Strand Medical Centre
Helen Devling – Moore Street Practice
Dr Helen Mercer – Moore Street Practice
Jade McGregor – The Strand Medical Centre
Dr Sarah Stephenson – Moore Street Practice
Dr A Ferguson – The Strand Medical Centre
Ronnie Holmes – The Strand Centre
Pauline Sweeney – Park Street Practice
Dr Chung –Park Street Practice
Jenny Kristiansen – South Sefton CCG
Paul Halsall – South Sefton CCG

Guest Speakers
Stuart Wragg – Aintree NHS Trust – Item 13/49
Dr Bal Duper – South Sefton CCG - Item 13/52

Apologies
Dr Ricky Sinha – North Park Practice
Pam Sinha – North Park Practice
Dr S Sapre – Aintree Road Practice
Gary Killen – South Sefton CCG

Chair
Dr Anna Ferguson

Minutes
Jenny Kristiansen

No	Item	Action
13/45	**Apologies** - Noted	N/A
13/46	**Minutes of last meeting -** 11 April 2013 Minutes from the last meeting were accepted as an accurate record.	N/A
13/47	**Matters arising**	JK – by next

No	Item	Action
	It was noted that Billy Smith from Out of Hours Service (OOH) has agreed to attend the locality meetings as and when available, although given that there is a new OOH provider this may change in the future. JK to check and feed back at the next meeting.	meeting
13/48	**Medicines management update –** Paul Halsall PH gave an update on the following areas of medicines management: **13.48.1** Care of the Chemist Formulary is under review. PH agreed to send the current formulary to JK to send out to the group for comments and/or suggestions. **13.48.2** Practice Prescribing Budgets will be sent individually to practices. Please email Ruth Menzies by return with any comments. **13.48.3** Prescribing Quality Scheme – PH reminded practices to send claims in ASAP and ensure an invoice number is included. **13.48.4** PH informed the group that the SMOOG meeting for May therefore there is no feedback this month.	13.48.1 PH to send to JK & JK to forward to the group with the minutes. 13.48.2 - Practices 13.48.3 - Practices
13/49	**Spirometry Service** – Stuart Wragg (Aintree Hospital Trust) SW came to update the group about the progress of the Spirometry Service hosted by Aintree NHS Trust that became operational in April 2013. Stuart said that the referral forms are on all GP clinical systems and current waiting times are 2 -3 weeks for new referrals and 4–6 weeks for existing patients requiring annual review. Stuart asked the group for feedback on the current system and said he would send the current report format to JK to circulate. SW went on to say that if there is anything GPs would like included in the current reporting system to feed this back and he would see if it could be incorporated.	SW to send current report format to JK for circulation. JK to collate any additions to the reporting system and send back to SW.
13/50	**QP Indicators Pathways for 2013-14** The following pathways were agreed in principle following guidance from Local Area Team Lead Jackie Pye: **Community pathways** • Urology • IFR – varicose veins - JK to check if viable to conduct • Gynaecology – Community Gynaecology Service/re: screening for ovarian cysts **Emergency admissions** • End of life – District nurse service palliative care • COPD • Virtual Ward **A&E attendances** • Over 65s with co-morbidities • Patients 15 & under who have accessed A&E with minor illness • Patients who frequently attend A&E who could be seen in primary care	JK to check if IFR for varicose veins is viable to conduct and feedback to the group.
13/51	**General update** AF gave an update from the Finance and Quality Meetings she attends on behalf of the locality.	N/A

No	Item	Action
13/52	**Quality Premium Presentation** – Dr Bal Duper Dr Duper gave an overview of the Quality Premium which is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission. 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 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 patient experience 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: • 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 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 prohibit 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	N/A

No	Item	Action
	meeting together with a RAG rated table. Practices are asked to report back any examples to locality managers, e.g. poor/ incorrect coding or following the patient journey through A+E for admission.	
13/53	**Any other business** AF informed the group that she had spoken to Andy Mimnagh about the issue of district nurse capacity. AM said that in order to address the issues he would need examples so he could raise it at the contract meeting. JK agreed to collate examples and forward to AM to action.	JK ASAP
13/54	**Date and time of next meeting** Wednesday 24th July 2013 1pm – 2.30pm Park Street Medical Practice	

South Sefton Clinical Commissioning Group

Crosby Locality Meeting

Wednesday 7th August 2013
12:45 – 2.30pm
Crosby Lakeside Adventure Centre (CLAC)

Chair: Dr Gustavo Berni (GB)

Attendees:
Sharon McGibbon (SMc)
Sue Hancock (SH)
Lorraine Bohannon (LB)
Dr Prema Sharma (PB)
Cath Charlton (CC)
Pauline Woolfall (PW)
Dr C McDonagh (CMcD)
Dr Damian Navaratnam (DN)
Janet Faye (JF)
Shelley Keating (SK)
Maureen Guy (MG)
Pippa Rose (PR)
Dr Craig Gillespie (CG)
Alison Johnston (AJ)
Dr C Allison (CA)
Donna Hampson (DH)
Dr Swapna Roy (SR)

Apologies
Dr Andy Mimnagh
Tina Ewart (TE)
Dr M Taylor (MT)
Dr J Wallace (JW)
Dr GK Misra (GM)
Carolyne Miller (CM)

Guest Speakers:
Becky Williams (BW)
Josie Hughes (JH)
Chris Cheetham (CC)
David Beckett (DB)

Minutes
Terry Stapley Sefton CCG Administrator

No	Item	Action
	Apologies Noted above **Declaration of Interests** None noted	
13/38	**Minutes of last meeting – 07 July 2013** Minutes from the last meeting were agreed as a correct record.	
13/39	**Matters Arising** None noted.	
13/40	**OOH Provision (GTD Limited) – Chris Cheetham, Project Manager** A hand-out was passed to the group and David Beckett presented the introduction to GTD. The following notes were made about GTD; patient complaints are always investigated to help implement change. GTD provide a supportive approach to the GPs wanting to work within the service. GTD have partnerships with multidisciplinary providers. The service is due to start on 1st October 2013, using the same number as is currently used for the OOH service (no change) with practices informed by 8am the next day via fax/DTS/NHS.net. GTD will try and tailor services around the locality from feedback received and are currently looking to recruit a local GP workforce to cover the service. GTD will provide real-time information as well as fax information to practices. GTD have sent out a practice questionnaire via email to all practices, although some in the group hadn't received it. **AJ to resend a copy of the questionnaire along with a copy of the presentation**. Finally GTD have been awarded a 5 year contract with the possibility of an extension of up to 12-24 months.	AJ
13/41	'**Finding your 1%' – Josie Hughes, End of Life Care Home Facilitator** The 6 Steps hand-out was given to the group JH advised the group that this was a North West model and will take 8 months to deliver. The programme is aimed at patients in nursing homes but does link in with residential homes with the community matrons. The programme will help reduce hospital admissions from care homes, and ensure best interest is covered in the best interest of the patient, providing anticipatory drugs rather than calling for the OOH GP. Most nursing homes in the area are signed up with exception to Rivers Leigh (due to management changes and use of bank staff). Training is provided in way of support. With education on symptom control being a large proportion of this support which could be provided by Debbie Harvey.	
13/42	**Quality Premium Locality Data – Becky Williams, Chief Analyst** The data pack detailing the both national and local QP data was given to group. BW requested the group provide feedback on the data and how they would like to see it in the future. The information will also be available (on the new portal) which is to be rolled out over the summer. The group discussed the data and thought that the numbers for nephrology and	

No	Item	Action
	haematology were high for the locality and maybe caused due to miss-coding. BW also asked the group to contact her or the locality managers if they have any data issues, with the locality managers providing support for practices.	
13/43	**QOF Quality & Productivity Domain** GB and AJ asked the group if they were happy to go ahead with the areas proposed for both OP referral and A&E admissions. CG questioned the choice of DVT given that numbers would be so low. **Action – AJ to check the pathway and number of referrals into the DVT clinic.** QP 001-003 – Outpatient Referrals **Gynaecology** **LUTS** **Ophthalmology** QP 004-006 – Emergency admissions **DVT** **Cellulitis** **Children's Respiratory** AJ advised that the data will be brought to the meetings as it becomes available and that in the meantime, the pathways will be shared so the group can have meaningful discussion on the audit criteria for each area at the next meeting. **Action – AJ to send relevant pathways to practices.**	AJ AJ
13/44	**CDiff Audit – Janet Faye, Medicines Management** JF provided an update to the group on the audit which has been carried out at Tithbarn nursing home surrounding the C-Diff outbreak. The localities were advised that public health asked for the audit to be completed, with 38 patients being audited finding 5 patients who had contracted C-Diff. Practice pharmacists will be showing their practices the report and providing recommendations. JF advised the group to follow the guidelines on acid suppression and anti-microbial drugs and advise care homes as to how to use the OOH GP correctly.	
13/45	**Any other business** **CCG Intranet page** – the locality were advised to save this page as their homepage to keep up to date with all goings on in the CCG and local area. **AJ to send out an email with the link and instructions** **Risk Stratification** – CG suggested all practices look at the information for their practice on the Portal, as it will help in notifying practices of their high risk patients with a high risk of admission (linking in to the Virtual Ward project). **Practice Budgets** – CG suggested practices look at this. AJ mentioned that the information for this year (Months 1&2 will be available next week). **GP Portal** – AJ said that the CCG are looking at ways to support practices with the GP reconciliation, Risk Stratification and Practice Budget information on the Portal, including the possibility of incorporating this into the Informatics Facilitators role. Support is also available from TE and AJ on an individual practice basis, so contact them for further information and support. **Referral Proformas** – Work is being carried out to ratify what is currently available and the process for communicating and installing out in practices. When completed it is envisaged that they will be available on the intranet, where they will be version controlled and disseminated in a more rigorous way.	AJ

No	Item	Action
	Date and time of next meeting Wednesday 4 September 2013 12:30 lunch 12.45 start – 2:00 Crosby Lakeside Adventure Centre (CLAC)	

South Sefton Clinical Commissioning Group

Maghull Locality Meeting Minutes

Thursday 18th July 2013

1:00 – 2:30

Westway Surgery

Attendees:

Dr Sunil Sapre (SS)	Maghull Family Health Centre
Gillian Stuart (GS)	Westway Medical Centre
Dr Wendy Coulter (WC)	Maghull SSP Practice
Judith Abbott (JA)	Broadwood Surgery
Terry Hill (TH)	NHS South Sefton CCG
Gill Kennedy (GK)	High Pastures Surgery
Jenny Johnson (JJ)	NHS South Sefton CCG
David Beckett (DB)	GotoDoc
Jane Pugh (JP)	GotoDoc
Chris Cheetham (CC)	GotoDoc

Apologies:
Gary Killen – NHS South Sefton CCG

Minutes: Terry Stapley Sefton CCG

No	Item	Action
13/43	**Apologies** Apologies were noted. **Welcome** David Beckett and Jane Pugh presenting an introduction to GoToDoc.	
13/44	**Minutes of last meeting** The minutes of the last meeting were agreed as an accurate record. The minutes from Aprils meeting had been amended to reflect discussions relating to the Spirometry presentation.	
13/45	**Matters Arising** April's minutes to be distributed to the group after the meeting for people who did not receive the updated copy. **Action – TH to distribute Aprils minutes.**	TH
13/37	**Gotodoc – The new OOH (Out of Hours) provider – David Beckett** David Beckett introduced himself and his team (Chris Cheetham & Jane Pugh) and gave an update on when the new OOH service. This service is	

No	Item	Action
	due to start on 1st October 2013, replacing the outgoing provider ICS OOH. Gotodoc have agreed to use the same number as is currently used by ICS OOH service. DB reiterated that there should not be any noticeable difference between how the services are delivered to the patient, however, gotodoc intent to improve where possible on what is currently being provided. DB provided hand-outs to all attendee's and gave a short presentation to the group outlining the Gotodoc's history, current service provision, population covered and current mobilisation work streams to ensure smooth transition. DB requested feedback from practices on how they could possibly improve the service that is provided. Within the hand-out provided, a practice questionnaire was provided for practices to help encourage feedback and enable gotodoc tailor its services appropriately. DB also reminded the group about appointing a local Associate Clinical Director which has recently been advertised and that Gotodoc endeavour to recruit local GP's into the service. DB asked the group if they had any questions following the presentation; Does GTD provide dental treatment? No, GTD only provide an Out of Hours service. How will cross boarder patients be treated? Patients will be treated the same as those patients within the boundary so long as they are registered at a NHS South Sefton and NHS Southport & Formby CCG practice. Conversations are currently being had with bordering OOH providers to The following notes were made about GTD; patient complaints are always investigated to help implement change. GTD provide a supportive approach to the GPs wanting to work within the service. GTD have partnerships with multidisciplinary providers. . **Action – TH to distribute email and telephone number for GTD.** How will cross boarder patients be treated? These patients will be treated the same as patients within the boundary's so long as they are patients of the practice. What will the OOH times be? Same as current service. Have there been any major incidents? Only one which is currently being investigated. Finally GTD have been awarded a 5 year contract with the possibility of an extension of up to 12-24 months.	TH
13/47	**Quality Premium** TH provided the group with an update on Quality Premiums for staff who had not seen Bal Dupers original presentation. Becky Williams gave a hand-out (Attached) and asked the locality how would they like their data presented in the future? How regular would they like the	Document.pdf

No	Item	Action
	data? It was agreed that providing the practices with the numbers they need to gain the Quality Premium would be helpful. Having data which is understandable would also make it easier for practices to digest the information. It was asked that actions would be brought to the next meeting with suggestions on how to tackle the issues. TH also asked that he be contacted if practices are having any issues with coding which could lead to data being incorrect. TH is also going to look at the price difference between treatments to see what problems coding issues is causing within budgets.	
13/48	**Prescribing Update** Budgets have been decided with a 9% underspend and 1% uplift. This means a smaller budget for the locality. NOAC was discussed with a view to practices pharmacists briefing practices. Issues with prescribing from salaried GPs/ OOH GPs is going onto the practice GPs / Partners budget, this is due to them not having their own prescribing number. **Action – JJ to chase this up with Tom Roberts (Medicines Management Analyst).** **Action – JJ to see what is being top sliced and allocated to the budget.**	JJ JJ
13/41	**Any other business** Add constitution discussion to next month's agenda (Dr Phil Weston) **Action - Spirometry data needs to be chased up with there being at least 4-6 week waiting time for results to come back to the GP.**	TH
13/42	**Date and Time of next meeting:** Friday 23rd August 2013 - High pastures Thursday 19th September – Westway Friday 25th October – High Pastures Thursday 21st November - Westway	