NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

Date: Thursday, 28 November 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)
Roger Driver	Vice Chair & Lay Member, Engagement and Patient Experience	(RD)
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)
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)
Gaynor Hales	Director of Nursing, NHS England (Merseyside)	(GH)

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					
13/145	Apologies for Absence	Chair		R	5 mins
13/146	Declarations of Interest regarding agenda items	All		R	
13/147	Register of Interests	-	✓	R	

Agenda

No	Item	Lead	Report	Receive/ Approve	Time
13/148	Hospitality Register	-	✓	R	
13/149	Minutes of Previous Meeting	Chair	✓	R	5 mins
13/150	Action Points from Previous Meeting	Chair	✓	R	
13/151	Business Update	Chair		R	5 mins
13/152	Chief Officer Report	FLC	✓	R	5 mins
Reports received by way of assurance (taken as read)					
13/153	Corporate Performance Report	MC	✓	R	10 mins
13/154	Quality Report	DF	✓	R	10 mins
13/155	Financial Position of NHS South Sefton Clinical Commissioning Group – Month 7	MMcD	✓	R	10 mins
13/156	Prescribing Performance Report	BP	✓	R	5 mins
13/157	Commencement of Election Process	FLC	✓	R	5 mins
13/158	Winter Plan	SA	✓	R	5 mins
Formal approval by Governing Body required					
13/159	Organisational Development Plan	TJ	✓	A	5 mins
13/160	Communicating Health in South Sefton…a Communications and Engagement Strategy for NHS South Sefton Clinical Commissioning Group	LC	✓	A	5 mins
13/161	Allocations Report	MMcD	✓	A	5 mins
Minutes of Committees to be formally received (taken as read)					
13/162	Audit Committee (no minutes available)	-			5 mins
13/163	Quality Committee (no minutes available)	-			
13/164	Finance & Resource Committee (no minutes available)	-			
13/165	Merseyside CCG Network	-			
13/166	Health and Wellbeing Board (no minutes available)	-			
13/167	Medicines Optimisation Operational Group	-			
13/168	Health and Wellbeing Board Programme Group (no minutes available)	-			
13/169	Locality Meetings - (i) Seaforth & Litherland Locality (ii) Bootle Locality (iii) Crosby Locality (iv) Maghull Locality	-			
Closing business					
13/170	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting.*				5 mins
13/171	Date, Time and Venue of Next Meeting of the Governing Body to be held in Public *Wednesday, 30 January 2013 at 1.00pm at Merton House*				-

No	Item	Lead	Report	Receive/ Approve	Time
Estimated meeting time					

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: November 2013

NHS
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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	
	12.11.13		Responsible Officer / Medical Director	Personal	Decision making re Aspire Locums Northwest Ltd	Exclusion from decision making re Aspire Locums Northwest Ltd	
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	

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South Sefton
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Hospitality Register
November 2013

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

No hospitality received.

Draft

Governing Body Meeting in Public
Minutes

Thursday, 26 September 2013 at 1.00pm to 4.00pm
The Boardroom, Third Floor, Merton House, Bootle L20 3DL

The Governing Body

Dr Craig Gillespie	Clinical Vice-Chair, GP	(CG)
Roger Driver	Vice Chair & Lay Member, Engagement and Patient Experience	(RD)
Dr Andrew Mimnagh	GP	(AM)
Dr Ricky Sinha	GP	(RS)
Dr Paul Thomas	GP	(PT)
Lin Bennett	Practice Manager	(LB)
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	Clinical Lead for Virtual Ward	(DH)
Malcolm Cunningham	Head of Performance & Health Outcomes	(MC)
Dr Bal Duper	Clinical Lead, Primary Care Development	(BD)
Margaret Jones	Public Health Representative, Sefton Council	(MJ)

Apologies

Dr Clive Shaw	GP Chair	(CS)
Dr John Wray	GP	(JW)
Dr Steve Fraser	GP	(SF)
Dr Dan McDowell	Secondary Care Doctor	(DMcD)
Sharon McGibbon	Practice Manager	(AF)

Minutes

Melanie Wright	Business Manager

South Sefton Clinical Commissioning Group (NHS)

Attendance Tracker

✓ Present
A Apologies
L Late

Governing Body Member	Designation	Jan 2013	Mar 2013	May 2013	July 2013	Sept 2013						
Dr Clive Shaw	Chair	A	✓	✓	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	A						
Roger Driver	Lay Member, Engagement and Patient Experience	✓	✓	✓	✓	✓						
Lin Bennett	Practice Manager	✓	✓	✓	✓	✓						
Sharon McGibbon	Practice Manager	✓	✓	✓	A	A						
Dr Dan McDowell	Secondary Care Doctor	✓	✓	✓	✓	A						
Fiona Clark	Chief Officer	✓	A	✓	✓	✓						
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓						
Debbie Fagan	Chief Nurse	✓	✓	✓	✓	✓						
Peter Morgan	Strategic Director, Sefton MBC	N/A			✓	✓						
Margaret Jones	Public Health Representative, Sefton MBC	N/A				✓						
Maureen Kelly	Healthwatch Sefton	N/A				A						

Draft

Informal Q&A Session

Question 1: Grant Bernard, Citizen's Advice Bureau

An update was sought on a question from the last meeting regarding patients turned down by the Department for Work and Pensions and capability assessments and fitnotes/medical information and whether the GPs had an obligation to provide further medical information

Dr Gillespie clarified that there is no statutory or contractual obligation for GPs to provide additional medical information and GPs may do so on an individual basis for which a charge may be incurred. Further, there is no national guideline or protocol. Dr Mimnagh advised that there is a statutory requirement for the Department of Work and Pensions to seek such information, but there is no statutory duty for practices to provide.

Grant Bernard, Sefton CAB responded that patients' problems could be resolved at an early stage by particular attention to the specific DWP requests of patients at an early stage, the lack of which response results in the necessity for an appeal.

Dr Mimnagh advised that the routine recording of functional capacity is not often recorded in notes, resulting in a disconnect between the DWP's requirements and the type of notes required for a doctor.

There was a discussion around the type of information that GPs might be able to provide and that GPs were permitted only to provide factual information and not 'hazard a guess' as to a patient's abilities.

No	Item	Action
13/111	**Apologies for Absence** were noted.	
13/112	**Declarations of Interest** regarding agenda items Miss Fagan, Mr McDowell and Ms Clark declared a conflict in relation to item 13/134, with their working jointly for Southport & Formby CCG. A further conflict was noted in relation to those working in primary care regarding item 13/124, to include Drs Gillespie, Mimnagh, Sinha and Thomas, together with Lin Bennett.	
13/113	**Register of Interests** Canon Driver asked the meeting to note the departure of Lynda Elezi, which post is currently out to recruitment. **Action taken by the Governing Body** The Governing Body received the register by way of assurance.	
13/114	**Hospitality Register** **Action taken by the Governing Body** The Governing Body received this register by way of assurance..	
13/115	**Minutes of Previous Meeting** **Action taken by the Governing Body** The Governing Body approved the Minutes of the previous meeting as an accurate representation thereof.	

No	Item	Action
13/116	**Action Points from Previous Meeting** All actions from previous meetings have been closed down. Ms Clark reported that Dr Colette McIlroy has taken on the chairmanship of the Seaforth and Litherland Locality.	
13/117	**Business Update** Dr Gillespie advised that Dr Shaw will shortly be returning and thanked the other CCG members for their support during his period of chairmanship.	
13/118	**Chief Officer Report** Ms Clark drew the meeting's attention to specific highlights contained within her report around integration and performance concerns at Aintree. Big Chat 3 will be taking place on 4 November 2013. In relation to the Strategic Plan, Ms Clark apologised for the final draft not yet being available and advised as to the recent recruitment process which will support this piece of work. A Board-to-Board meeting has taken place with University Hospital Aintree which was successful in terms of joint working. A Quarter 1 Checkpoint meeting has taken place with NHS England and the CCG is rated amber-green, subject to national validation and this will be published post 30 September 2013. In relation to 111, the CCG is confident that robust contingency arrangements are in place. Canon Driver referred to the sub-committees of the Health and Wellbeing Board and wished to ensure co-ordination and synergy with the CCG's Engagement and Patient Experience Group and suggested a twelve-month review in this regard may be appropriate. Ms Clark advised as to the CCG's desire to engage on a Sefton-wide basis and that the review will take place on a six-monthly basis. Mr Morgan referred to the outcomes of the recent Peer Review to ensure an enhanced co-ordinated approach and Healthwatch will take a key role in this. **Action taken by the Governing Body** The Governing Body received this report by way of assurance.	
13/119	**Corporate Performance Report** Mr Cunningham drew the meeting's attention to performance in relation to 62-day cancer waits, which relates to one patient and is being managed. Mr Cunningham then discussed the other reds contained within the report and provided the Governing Body with assurance in relation to the actions thereon. Dr Gillespie enquired as to the TIA/High Risk Stroke with one provider where performance was below benchmark and queried whether this had been communicated to GPs to assist with patient choice, which would be helpful. Miss Fagan also advised as to the expectation of an increase as to C Difficile at Aintree. A lengthy discussion has taken place at the CCG's Quality Committee and plans are in place to address this. It was acknowledged that healthcare acquired infections are not the sole responsibility of providers in an acute setting; there is a community element to this.	MC

No	Item	Action
	The CCG have signed up to a Regional Commissioning Network around healthcare acquired infection at which the increasing rates across the Merseyside area will be considered further. An additional case of MRSA has been identified at Aintree but is not included within the pack, due to the time at which the pack was created. This is being proactively managed with a meeting planned during October and reviews with the Trust under way. Lessons learned will be closely examined. Dementia screening has been discussed at length in the Quality Committee and areas of best practice will be considered across the Merseyside area with a view to identifying improvements that can be made. The meeting noted that the Friends and Family Test had produced a good outcome at Aintree. **Action taken by the Governing Body** The Governing Body received this report by way of assurance.	
13/120	**Financial Performance Report** Mr McDowell highlighted key elements of the CCG's performance. The local acute trust is overspent, but this is not a cause for concern at the current time although over-performance in relation to non-elective care is being closely monitored. Mr McDowell also advised as to the current risks in relation to Specialised Commissioning, which had been mitigated. Continuing Healthcare remains the biggest risk to the CCG. The Commissioning Support Unit have reviewed underpinning data, although an overspend is predicted of £600k. A more robust position is anticipated by Month 6. The CCG is on target to deliver financial position for the year to date. In terms of worst-case scenario, the CCG is amber-rated at the current time. Contingency plans are in place although it was noted that these would require co-operation with other organisations. Dr Gillespie recognised how much work has taken place in relation to Specialised Commissioning and CCG Allocations and thanked Mr McDowell and his team. Regarding the proposed transfer, Dr Gillespie asked whether there was any agreement with Southport & Formby CCG that transfer of funds would be returned in the event of any errors being identified. Mr McDowell confirmed that there was and this would be considered further under 13/134 below. **Actions taken by the Governing Body** The Governing Body received the following information by way of assurance: • the CCG remains on target to deliver its financial targets for 2013/14; • the CCG's worst case scenario is "amber-rated" in terms of additional actions required should the CCG position deteriorate. The Governing Body also approved: • all virements that support the financial information presented in report; and • all CCG members be asked to review the information reported on the Mersey Intelligence Portal to support the data checking and validation process.	
13/121	**Prescribing Performance Report** Mr Prescott advised that the position for month 3 (June 2013) with a forecast overspend of circa £57k or 0.2%.	

No	Item	Action
	Factors in relation to this include the error made by Department of Health statisticians which had direct result on the forecast. The optimisation plan continues and has the full engagement of practices, along with support from the Medicines Management Team. Ms Clark asked what remedial actions are planned. Mr Prescott responded that a plan for the Medicines Operational Group is to visit practices whose financial position indicates that cost efficiencies can be made without detriment to patient safety and quality of care. Reviews of cost growth are also taking place on an individual practice basis. Canon Driver queried practices where overspending was occurring. Mr Prescott responded that examination of these practices is taking place to identify why pressures are occurring. Further, the reliability of the figures following the Department of Health review may be subject to further review and smaller practices with a overspend show a higher percentage in relative terms in the report. Ms Clark added that the variances were under consideration and this intelligence does raise questions which were being examined, however, it was early in the financial year. Dr Gillespie asked for an overview of the effect of the fair shares allocation on the position to be produced for the next meeting. Also, the report to demonstrate performance compared to the same point last year. **Action taken by the Governing Body** The Governing Body received this report by way of assurance.	BP
13/122	**Virtual Ward Update** Dr Harvey provided an update in relation to progress on the Virtual Ward project. Dr Gillespie thanked Dr Harvey for her work on this project. Mrs Bennett asked for clarification on referral into the Virtual Ward and the risk stratification process, for which further training is required. GP Champions are in place by way of support. Mr Morgan asked whether there was any impact on the virtual ward with the restructure of the social care. Dr Harvey responded that there had been significant engagement with the Local Authority but Ms Harvey agreed to clarify this. **Action taken by the Governing Body** The Governing Body received this report by way of assurance.	DH
13/123	**Non Recurrent A&E Funding** This paper provides an update to the Governing Body as the allocations received locally, which will be subject to scrutiny on a national level. **Action taken by the Governing Body** The Governing Body received this report by way of assurance.	
13/124	**Primary Care Strategy** Dr Duper described the process followed in relation to the development of the Primary Care Strategy and the engagement with practices and the Governing Body. A Primary Care Quality Strategy Board is in the process of being established which will drive the implementation thereof.	

No	Item	Action
	Dr Duper went onto describe the desire to work collaboratively locally. The consultation paper has received support and it is recommended that the CCG progress this. The membership practices have signed up to this. Dr Duper then ran through the highlights of the proposal.	
	Canon Driver enquired as to whether the funding for this project would be on a quarter share basis across the four localities or whether there would be any consideration of the health inequalities within the localities.	
	Dr Duper responded that the process was being developed from the bottom up and the implementation and operationalisation of the strategy would be considered by the Primary Care Quality Board.	
	Ms Clark drew the meeting's attention to the terms of reference for the Primary Care Quality Board and suggested that both Lay Members be invited, together with representation from Healthwatch. There is an element of the CCG's financial plan which has allocated £3 per head to fund this development.	Dr Duper
	Mrs Jones asked to be included in the membership of this group.	Dr Duper
	Action taken by the Governing Body	
	The Governing Body approved the direction of travel contained within this report.	
13/125	**Equality and Diversity Objectives**	
	Action taken by the Governing Body	
	The Governing Body approved the Equality Objectives Plan.	
13/126	**CCG Constitution – Update**	
	The meeting noted that the Wider Membership were asked to comment on the changes to the Constitution within fourteen days of the meeting on 24 September.	
	Action taken by the Governing Body	
	Subject to any comments received on the Constitution, the Governing Body approved Chair's action to be taken in relation to the approval of the Constitution following comment by the Wider Constituent membership on 24 September 2013.	
	The Governing Body approved clarification being gained regarding delegation of the approval of policies.	
	There was also a desire to ensure quoracy of, particularly, the Audit Committee in relation to conflicts of interest.	
13/127	**Risk Management Strategy**	
	Action taken by the Governing Body	
	The Governing Body approved the Risk Management Strategy.	
13/128	**Commissioning Support Unit Procurement**	
	Action taken by the Governing Body	
	The Governing Body approved the following: • an initial evaluation process be undertaken • expenditure be mapped out in more detail • the results thereof be acted upon to inform possible changes to the current SLA for April 2014.	
13/129	**Disciplinary Policy**	
	Action taken by the Governing Body	
	The Governing Body approved the Disciplinary policy.	

No	Item	Action
13/130	**Annual Leave and Bank Holiday Policy** **Action taken by the Governing Body** The Governing Body approved the Annual Leave and Bank Holiday policy.	
13/131	**Grievance and Dispute Resolution Policy** **Action taken by the Governing Body** The Governing Body approved the Grievance and Dispute Resolution policy.	
13/132	**Attendance Management Policy** **Action taken by the Governing Body** The Governing Body approved the Attendance Management policy.	
13/133	**Remuneration Committee** **Action taken by the Governing Body** The Governing Body approved the temporary appointment of Peter Morgan and Sam Tunney in relation regarding to the inquorate matter only on this occasion.	
13/134	**Baseline Allocations** Mr McDowell reminded the meeting of the conflicts of interest present in relation to this report. Mr McDowell described the outcome of the recent publication of allocations which had resulted in the CCG being 15% above target, meaning it is likely that savings over and above existing plans will become necessary. The pace of change has yet to be established and the implementation date will be influenced by factors such as transfer of part of healthcare budgets to local authorities in 2015/16. Mr McDowell also described the circumstances surround the proposed transfer of £6.4m and the costs neutral implication of this transfer and that further changes may follow following the finalisation of the process and publication of allocations for 2014/15 in December 2013. Dr Gillespie thanked Mr McDowell for his considerable work on this. Canon Driver expressed his concern for absolute clarity over the terms surrounding the proposed transfer. Mr McDowell concurred with these concerns and advised that NHS Southport & Formby CCG is cognisant of the terms proposed. **Action taken by the Governing Body** The Governing Body approved the following a transfer of £6.4m to Southport & Formby CCG.	

No	Item	Action
	The Governing Body is asked to further receive the following by way of key assurances: • NHS England expect all key adjustments to have been agreed and actioned in early October so that future year allocations can be adjusted and accurate "distance from target" figures can be calculated • there remains a further sum of £2.7m which may require further adjustment to baselines but this will not be confirmed until the CCG's final specialised commissioning position has been agreed • there are further areas within the CCG's expenditure profile that remain subject to review and updates, will be available at the next Governing Body meeting • the proposed introduction of "formula based" allocation noting that the CCG's original baseline position is 15.02% above target and its forecast position is expected to be 10.46% above target meaning that there is likelihood that the CCG will have to make savings over and above existing plans but this will be dependent upon the timescales associated with the movement to target (the "pace of change").	
13/135	The minutes of the Audit Committee were not available.	
13/136	The Governing Body **received** the minutes of the Quality Committee.	
13/137	The minutes of the Finance & Resource Committee were not available.	
13/138	The Governing Body **received** the minutes of the Merseyside CCG Network.	
13/139	The Governing Body **received** the minutes of the Health and Wellbeing Board.	
13/140	The Governing Body **received** the minutes of the Medicines Optimisation Operational Group.	
13/141	The Governing Body **received** the minutes of the Strategic Integrated Commissioning Group.	
13/142	**Locality Meetings** Mrs Bennett raised the suggestion of introducing attendance tracking at locality meetings. The Governing Body **received** the minutes of the localities.	MW
13/143	**Any Other Business** Ms Clark advised that the new Out of Hours provider, 'Go To Doc', goes live on 1 October 2013. Ms Clark also advised that from 1 April 2013, the CCG does not hold the contract with practices for the delivery of primary care services. However, anecdotal evidence demonstrates a number of patient safety concerns for patients at practices operated by SSP Healthcare Ltd. Ms Clark attended an urgent meeting with NHS England earlier today at which it was agreed that actions to ensure the CCG's duties in relation to patient safety and quality of care are enacted.	
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.	

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Governing Body Meeting in Public
Action Points

Thursday, 26 September 2013 at 1.00pm to 4.00pm

No	Item	Action
13/119	**Corporate Performance Report** Dr Gillespie enquired as to the TIA/High Risk Stroke with one provider where performance was below benchmark and queried whether this had been communicated to GPs to assist with patient choice, which would be helpful.	MC
13/121	**Prescribing Performance Report** Dr Gillespie asked for an overview of the effect of the fair shares allocation on the position to be produced for the next meeting. Also, the report to demonstrate performance compared to the same point last year.	BP
13/122	**Virtual Ward Update** Mr Morgan asked whether there was any impact on the virtual ward with the restructure of the social care. Dr Harvey responded that there had been significant engagement with the Local Authority but Ms Harvey agreed to clarify this.	DH
13/124	**Primary Care Strategy** Ms Clark drew the meeting's attention to the terms of reference for the Primary Care Quality Board and suggested that both Lay Members be invited, together with representation from Healthwatch. Mrs Jones asked to be included in the membership of this group.	Dr Duper Dr Duper
13/142	**Locality Meetings** Mrs Bennett raised the suggestion of introducing attendance tracking at locality meetings.	MW

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South Sefton
Clinical Commissioning Group

13/152

MEETING OF THE GOVERNING BODY
November 2013

Agenda Item: 13/152	**Author of the Paper:**
Report date: 11 November 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 by way of assurance.

Receive	x
Approve	
Ratify	

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

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement			x	
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
November 2013

1. University Hospitals Aintree NHS Foundation Trust (Aintree) – Quality Surveillance Group Risk Summit

1.1. A Single Item Quality Surveillance Group was held on 14 October 2013 where the decision was made not to escalate to a Quality Risk Summit at this stage – this was reported to the October 2013 meeting of the Quality Committee.

1.2. On 7 November 2013 a teleconference was held with NHS North of England, NHS England (Merseyside) (NHSE(M)), Monitor and the collaborative commissioning CCGs to discuss the subsequent additional information in relation to Aintree.

1.3. The outcome of the teleconference was to escalate to a Quality Risk Summit which will be held on 21 November 2013 with a pre-meet scheduled for 14 November 2013. The outcome of the Quality Risk Summit will be reported to the Quality Committee and the Governing Body.

2. Checkpoint 2-CCG Delivery Dashboard

2.1 A meeting is arranged for 2 December with NHSE(M) to consider the performance of the CCG in Quarter 2 and give assurance.

2.2 All data requirements for the development of the CCG delivery dashboard have been uploaded by the Programme Management Office (PMO) within the necessary timescales.

3. Winter 2013/14

3.1 A significant amount of work has been undertaken for winter planning 2013/14. The CCG Clinical Director for Unplanned Care - Dr Andy Mimnagh has been working closely with Steve Astles (Head of CCG Development) to ensure the CCG has its own robust arrangements, as well as fulfilling its commissioning function across the local system. The CCG are working as part of the Care Closer to Home Network.

3.2 This area is receiving the personal scrutiny of both Prime Minister and Secretary of State for Health and the CCG is supporting NHS England (Merseyside) with the reporting requirements of the NHS.

4. Advancing Quality – Three Year Agreement

4.1 The Advancing Quality Alliance, (AQUA) have approached us to renew the funding for the Advancing Quality programme (AQ). A previous independent evaluation report into AQ[1] concluded that as a result of the AQ programme there was a statistically significant decrease in mortality and reductions in length of stay.

4.2 The latest independent evaluation of AQ2 (a full version of which is available at http://onlinelibrary.wiley.com/doi/10.1002/hec.2978/abstract) explores the cost effectiveness of AQ and concludes that by generating approximately 5,200 quality adjusted life years (QALYs) and £4.4m savings in length of stay, **AQ is a cost effective use of resources.**

4.3 The report estimates the monetary value of the health gain through AQ at £105m, which compared to the overall cost of £13m, equates to a health gain return on investment, of £8 per £1 spent. For Southport and Formby CCG this equates to:

Table 1 – Cost Effectiveness of Advancing Quality – Southport and Formby CCG Cost of AQ £s	QALYs gained	Health Gain3 £S	Bed Days Saved	Length of Stay Savings £s
217,937	87.16	1,750,854	380	73,369

4.4 This data seems to demonstrate the case for the continuation and development of AQ in line with CCGs' requirements and provides the evidence base, that your continued investment in AQ, is delivering measurable health gain for our population.

4.5 To this end the Senior Leadership Team have considered the extension of the scheme funding for the next three years, with a planned review after 12 months.

5. 2014/15 Strategic and Operational Planning Guidance

5.1 NHS England, the Local Government Association, Monitor, and the Trust Development Authority have issued a joint letter providing initial guidance on the 2014/15 strategic and operational planning process. This letter outlined the planning process, objectives, timeline and expectations, prior to full guidance in December which will include a joint set of assumptions agreed by all parties.

5.2 The new planning process will see a move away from incremental one year planning and will focus on the development of bold and ambitious plans which cover the next five years, in response to the challenges detailed in "A Call to Action".

5.3 Commissioners, providers and local authorities are encouraged to start working together over the coming months before final guidance is issued in December. Our first task has been to indicate our unit of planning which has been considered as the Sefton Metropolitan Borough.

5.4 The CCG Strategic plan is now being firmed up and we have been working through the CCG localities and GP Locality leads by the Head of Strategic Planning & Assurance Karl McCluskey with Dr Paul Thomas, the CCG Clinical Director of Strategy & Planning to develop the emergent areas further.

5.4 These are Frail Elderly, Unplanned Care (which we will tie in with the recent Keogh Review of 13 November 2013) and the Transformation of Primary Care. The areas were tested recently at the Big Chat event and received broad support from the attendees, as

well as the CCG EPEG group. They obviously need wider testing and the stakeholder event in January 2014 will also act as a vehicle to further test the CCG plans.

5.5 Sitting alongside this is the Strategic Financial plan which is being worked up at and discussed in the Finance & Resource Committee. The CCG financial allocations will be published in December 2013 and the financial and strategic plan will be worked through January to March 2014. The commissioning intentions ie our 1 year plan for 14/15 are also emerging and being firmed up through this work. A full paper will be brought to the January 2014 CCG Governing Body.

Strategic Plan – Key Dates

Key Action	Date
Submit CCG Planning Unit	14th Nov 2013
Submit initial high level plans to TDA	13th Jan 2014
1st Submission of 1-2, 5yr Plan	14th Feb 2014
Contracts signed	28th Feb 2014
Health & Wellbeing Board to submit ITF Plans Return	15th Feb 2014
Refresh Strategic Plan (Submit??)	5th March 2014
Strategic Plan Approved by Boards	S&F 26th March, SS 27th March 2014 (Plans Required for 14th March)
Submission of Final 2yr Plans & Draft 5yr Plan	4th April 2014
Submission of Final 5 Year Plans (Note: Year 1&2 fixed from 4th April submission) To include ITFM	20th June 2014

6. Primary Care Development

6.1 Work is now underway to consider the transformation of primary care in Sefton. Clinically led by the membership and supported by Dr Bal Duper- the Primary Care Quality lead and the CCG support team through Malcolm Cunningham- Head of Primary Care & Corporate Performance and Angela Parkinson- Programme Manager for primary care quality, a Primary Care Programme Board has been established, following on from the Governing Body approval of the Primary Care Quality Strategy. This comprises of CCG membership balanced with external partners including the Local Medical Committee, Health Watch, NHS England (Merseyside) and Merseyside Property Services.

6.2 The Primary Care Quality Strategy Board will oversee the implementation of the Primary Care Strategy 'A Sense of Purpose' and in doing so, improve health outcomes for patients and reduce inequalities in health across both CCGs in Sefton.

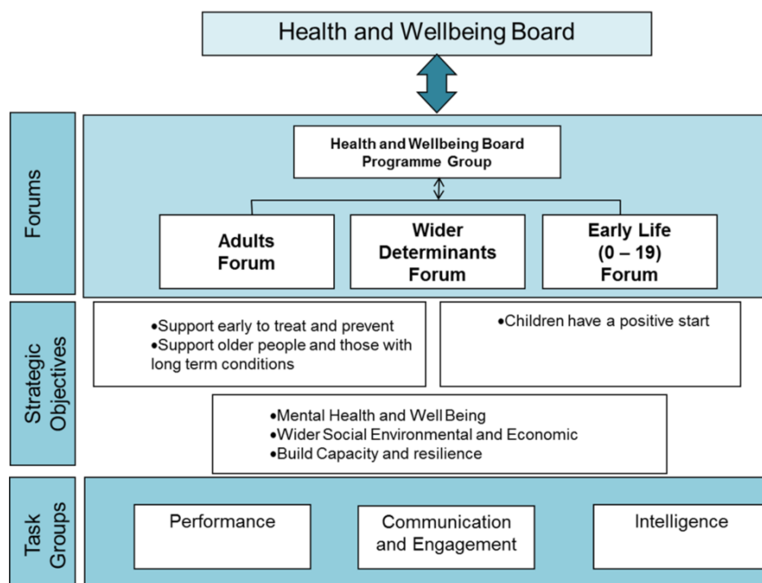
6.3 It has been established as a sub-committee of the Quality Committee to perform the following function on behalf of the CCG Governing Body.

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

6.4 An afternoon event has been planned for 28 January 2014 to allow the CCG membership to consider and debate in greater detail the strategic development and the required actions and implementation plan for the future of Primary Care in South Sefton CCG for our 2020 vision. This work will dovetail with NHS England (Merseyside) and will be mapped against the national call to action for primary care and the opportunities afforded by the introduction of the new GP contract, alongside the opportunities for planned future CCG investment. The work will be reported through to the CCG Governing Body.

7. Health and Wellbeing Board (HWBB)

Following on from the recent Peer Challenge of the Health & Well Being Board, the HWBB has developed an action plan and one of the actions was to consider its functionality in order to deliver the Health & Well Being strategy for Sefton. The following substructure has been created to execute its expanding role. The CCG is an active participant at every level of this sub structure and will continue to shape and influence the integration agenda and the development of the Integrated Transformation Fund spend.



8. Integrated Transformation Fund (ITF)

8.1 The Integrated Transformation Fund (ITF) was announced in the spending review at the end of June 2013. This fund affords the CCG and Local Authority a real opportunity to create a shared plan for the totality of health and social care activity and expenditure that will have benefits way beyond the effective use of the mandated pooled fund. The Health and Wellbeing Boards is being asked to consider extending the scope of the plan and pooled budgets.

8.2 The fund does not in itself address the financial pressures faced by local authorities and CCGs in 2015/16, which remain very challenging. The £3.8bn pool brings together NHS and Local Government resources that are already committed to existing core activity. (The requirements of the fund are likely to significantly exceed existing pooled budget arrangements). Councils and CCGs will, therefore, have to redirect funds from these activities to shared programmes that deliver better outcomes for individuals. This calls for a new shared approach to delivering services and setting priorities, and presents Councils and CCGs, working together through their Health and Wellbeing Board, with an unprecedented opportunity to shape sustainable health and care for the foreseeable future.

8.3 The emphasis should be on using the fund as a catalyst for agreeing a joint vision of how integrated care will improve outcomes for local people and using it to build commitment among local partners for accelerated change. Joint local decision making and planning will be crucial to the delivery of integrated care for people and a more joined up use of resources locally. The ITF is intended to support and encourage delivery of integrated care at scale and pace whilst respecting the autonomy of locally accountable organisations.

8.4 It will be essential for CCGs and Local Authorities to engage from the outset with all providers, both NHS and social care, likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the fund includes agreement to the service change consequences.

8.5 The NHS contribution to the ITF in Sefton is estimated to reach £21m, of which £13.1m is expected to come from CCG top-slices between the period 2014/15 and 2015/16.

8.6 The South Sefton CCG proportion of this is £11.3m overall, of which £7.3m is expected to come from CCG top-slices.

9. Integration

9.1 Work has started through the role and function of the Health and Wellbeing Board to define the meaning of 'integration' for the CCG and Local Authority and the benefits for Sefton Residents. This work is being supported by the leadership team of the Health & Well Being Programme Board.

9.2 As part of this journey the CCG Governing Body will be invited to debate and consider the opportunities for strengthening the function of the CCG within the context of the integration agenda in its commissioning role of the future. This agenda will very much be enabled by the ITF.

10. Commissioning Support Unit-SLA Renegotiations

10.1 Following an internal review, led by Dr Steve Fraser, the CCG Lead for CSU, supported by Tracy Jeffes, Head of Delivery & Integration. Meetings have taken place with senior CSU colleagues to discuss the commissioning support intentions for 2014/15. Discussions explored services lines within the current SLA that are performing well, those which are in need of improvement and some which may possibly benefit a different approach e.g. being brought in-house.

10.2 CMCSU are currently reviewing all their services, including a more detailed financial analysis and will present the findings for the most critical areas before Christmas and the others by the end of January 2014. This will coincide with our own analysis work using appropriate tools now published by NHS England.

10.3 Our current SLA is in place until October 2014 and we are currently discussing reshaping this SLA from April / June 2014 with the possibility of a full re-negotiation to take us beyond October 2014 into 2015/16. Further formal discussions are planned for early January and an update paper will be presented to the Governing Body at the end of January 2014.

11. Police & Crime Commissioner

The Senior Leadership Team (SLT) recently met with the Police and Crime Commissioner Jane Kennedy to consider the areas of mutual interest. Of particular note was the potential for work across the area of Section 136. Geraldine O'Carroll Head of Integration with the CCG Clinical Director for Mental Health, Dr Ricky Sinha, will be considering this work in more detail.

12. Provider Business

12.1 The Southport & Ormskirk Strategic Partnership Board continue to meet on a monthly basis to drive the care closer to home initiative, receive progress reports on the Foundation Trust application, oversee quality issues and to consider system wide strategic issues for example the Informatics strategy alongside partners from West Lancashire CCG and Local Authorities and other providers with NWAS.

12.2 At University Hospitals Aintree NHS Foundation Trust (Aintree) with our CCG partners at Liverpool and Knowsley CCGs and other stakeholders we have recently established a similar partnership board to consider the strategic issues around the Aintree footprint. One of the

first considerations of this SPB is the challenges of unplanned care and the top 5 things considered to make a difference across the system.

13. Good news

13.1 I am delighted to report that Malcolm Cunningham, Head of Primary Care & Corporate Performance, Becky Williams, Chief Analyst and Fiona Doherty, Transformational Change Manager, were recently asked to present a paper at two national events about the work they have been undertaking in relation to Right Care within the CCG.

13.2 This work has significantly supported the CCG through its wider membership and Governing Body to shape the strategic agenda for the CCG, an example being the development of the CCG local priorities of the Quality premium. I am pleased we have been at the forefront of this initiative and that our PMO team have been recognised and able to showcase this work.

14. Recommendation

The Governing Body is asked to formally receive this report.

Fiona Clark
November 2013

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2013

Agenda Item: 13/153	**Author of the Paper:**
Report date: November 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 6, Liverpool Community Health KPI Report.

Recommendation

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

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.
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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.

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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

Report to the Governing Body
November 2013

1. Executive Summary

This report sets out the CCG's 'performance', the performance of its main acute providers and progress against the National Outcomes Framework at month 6 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 University Hospitals NHS Foundation Trust, Southport and Ormskirk Hospital NHS Trust and The Walton Centre NHS Foundation Trust.

3. Key Issues

Healthcare Acquired Infections – MRSA
At September 2013, MRSA is above the zero tolerance level for South Sefton CCG patients with one case reported. This case was reported in May 2013. Aintree and The Walton Centre have both reported one case of MRSA year to date; this is above the zero tolerance. There have been no new cases since May 2013, this was being reported through the Infection Prevention Committee to the CCGs. Root Cause Analysis (RCA) has been completed.
Healthcare Acquired Infections – Cdifficile
Cumulatively to the end of September 2013 there have been 34 cases of Cdifficile infection reported for South Sefton CCG patients. There were five cases in September with three cases reported at Aintree and two apportioned to Non Acute (Community) at Aintree. Aintree has reported 54 cases of Cdifficile year to date. Local data indicates that there have been five cases in October which will bring the year to date total to 59, above the 2013/14 year-end target of 43. The target is set at a challenging level as described above. The Trust has undertaken a review of its Cdifficile policy and is now appealing a number of cases. The CCG has requested assurance that the Trust complies with national testing and reporting procedures and policies. Southport and Ormskirk Hospitals Trust has cumulatively reported 10 cases of Cdifficile, this is one case above the year to date tolerance of 9. The Walton Centre, at the end of September there have been six cases of Cdifficile reported to date. This is four cases over the year to date tolerance of two cases.
% who had Stroke and spend at least 90% of their time on a stroke unit **% high risk of Stroke who experience a TIA are assessed and treated within 24 hours**
This indicator is showing as a red risk for South Sefton CCG patients for September 2013 with 60% against the 80% target. Six out of a total of 10 patients treated spent at least 90% of their

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time on a stroke unit. Aintree presented with 50% at September 2013 against the 80% target. This is a drop from the previous four months. Actions are being taken to improve future performance for stroke services including a review of the Stroke Pathway, a review of out of hours cover and reasons for delays of review and a weekly breach analysis meeting with Acute and Emergency Medicine.

Southport and Ormskirk are reporting 33% for the TIA indicator for September, against the 60% target. This indicator contained low numbers. Two out of six affected patients were assessed and treated within 24 hours.

Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Females)

For females, South Sefton CCG achieved 2,198.60 in 2012 which was above the planned tolerance of 2,128.24. The data specification is due on 13th November 2013 after which an update will be given as to what measures can be updated and when.

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

South Sefton CCG achieved 85.71% (cumulative to September 2013) which failed to hit the 90% target. South Sefton CCG achieved the monthly target for cancer screening but failed year to date due to previous month's beaches.

Southport and Ormskirk are underperforming cumulatively to September 2013 on the screening target with 76.92% against the 90% target. This is an underperformance by 13.1% year to date. The Trust also failed to achieve the target for the month of September with 71.4%. This underperformance is due to one patient out of a total of 3.5 not being screened within 62 days. This was a patient in Gynaecology but no exception reason was given, first Trust seen and first treatment Trust being Southport and Ormskirk.

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

For the maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms, Aintree Hospital Trust achieved 92.84% cumulatively to September, against the 93% target. This was an underperformance of 0.2% year to date. Actual performance for September was 97.3%, above the target. There were two patient breaches out of a total of 74, 72 patients were seen within 14 days. The first patient rebooked three times due to ill health and waited 34 days. The second patient rebooked and waited 15 days.

Southport and Ormskirk did not achieve the September cancer targets for breast symptomatic referrals with 88.83% year to date and 89.1% for the month of September, against the 93% target. For September, there were nine breaches out of a total of 82 patients, 73 were seen within 14 days. The 9 breaches were between 15 and 27 days. The 9 breaches were patient cancellation and ill health.

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

Southport and Ormskirk did not achieve the maximum 2 week wait for first outpatient appointment for patients referred urgently with suspected cancer at September. The target for this indicator is 93% so the Trust was marginally below this with 92.86%. The Trust achieved the target for the month of September with 94.3%. For September there were 32 breaches out of a total of 564 patients. 532 patients were seen within 14 days. The 32 breaches were between 15

and 54 days. The main reasons for the 32 breaches were patient cancellation, unable to attend appointment and holidays. In line with national guidance the Trust is pursuing a local protocol with primary care for the deferral of referrals where patients have indicated they are not available for an appointment within two weeks despite having been informed of the importance of attendance. The 2 week wait leaflet has been revised and circulated to all GP practices. The Patient Access Centre undertook an audit in August to highlight any issues in referral activity. The audit results are being broken down by GP practice in order to focus attention in these areas.

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. Local Target of 85% for all providers (Cumulative)

There is no operational standard target set for this indicator; however there is locally agreed Monitor target of 85% (cumulative) for all providers. Although Southport and Ormskirk Hospital Trust achieved 100% against this target for the month of September, cumulatively the Trust's achievement stands at 82.14% at September. The year to date under performance is carried forward from previous month's breaches.

Friends and Family Test Score – Inpatients + A&E

This is a quarterly indicator, which was reported for the first time in June. The indicator comprises two elements: the test score and the % of respondents for Inpatient Services and A&E. The national threshold is for all providers to achieve a combined 15% response rate. As this measure is part of the CQUIN scheme for providers, to achieve full payment in Q4 2013/14, they must achieve 20% by Q4.

For Southport and Ormskirk Trust, the overall combined (A&E and Inpatients) response rate was achieved in Q2 2013/14, 20.7% reported compared to a plan of 15% and 3.4% higher than the England average. However, for A&E alone, the provider failed to achieve the England average of 64 and only made a slight improvement compared to Q1 2013/14.

Patient Safety Incidents

The provider performance dashboard shows the number of patient safety incidents reported. Commentary on patient safety incidents is as follows:

Aintree Hospital Trust reported six patient safety incidents in total in September. Year to date, for all patients, there have been 17 incidents.

	Apr	**May**	**June**	**July**	**Aug**	**Sept**	**YTD**
Delayed Diagnosis				1		1	2
Failure to act upon test result						1	1
MRSA Bacteraemia			1				1
Outpatient Appointment Delay				1			1
Slips/Trips/Falls			1				1
Total			**2**	**2**		**2**	**6**

Southport and Ormskirk Hospitals Trust reported one Serious Untoward Incident in September (detail below), a total of five year to date.

	Sept
Adverse media coverage or public concern about the organisation or the wider NHS	1
Grand Total	**1**

Details of actions taken and reports received as a result of the SUIs are discussed at the SUI/Complaints Monthly Management Groups.

4. Recommendations

The Governing Body are asked receive this report by way of assurance

Appendices

Appendix 1 – CCG Corporate Performance Dashboard – South Sefton CCG
Appendix 2 – Corporate Performance Dashboard – Provider Level

Malcolm Cunningham
November 2013

CCG CORPORATE PERFORMANCE DASHBOARD - South Sefton CCG

Baseline as at 07/11/2013 10:54:51

Performance Indicators	Data Period	Current 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 - September	22.02	34.00		
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative)	13/14 - September	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%		
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s(Cumulative)	13/14 - September	180.09	108.67		
Emergency Admissions Composite Indicator(Cumulative)	13/14 - September	916.58	830.39		
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	13/14 - September	374.35	364.06		
Helping people to recover from episodes of ill health or following injury					
Patient reported outcomes measures for elective procedures: Groin hernia	12/13	6.20%	6.20%		
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 readmissions within 30 days of discharge from hospital (Cumulative)	13/14 - September		12.56		
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	13/14 - September	24.84	18.63		
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	13/14 - September	505.57	447.68		
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	13/14 - September	80.00%	60.00%		
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	13/14 - September	60.00%	100.00%		
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)	2012	2,128.24	2,198.60		
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Males)	2012	2,128.24	1,894.30		
Under 75 mortality rate from cancer	2012		165.99		
Under 75 mortality rate from cardiovascular disease	2012		71.75		
Under 75 mortality rate from liver disease	2012		24.40		
Under 75 mortality rate from respiratory disease	2012		32.53		
NHS Constitution					
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 - September	93.00%	96.13%		

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 - September	93.00%	94.14%
Cancer waits – 31 days			
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)	13/14 - September	94.00%	98.63%
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative)	13/14 - September	96.00%	98.32%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative)	13/14 - September	98.00%	98.97%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative)	13/14 - September	94.00%	94.59%
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 - September		89.29%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative)	13/14 - September	90.00%	85.71%
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative)	13/14 - September	85.00%	87.98%
Mixed Sex Accommodation Breaches			
Mixed Sex Accomodation (MSA) Breaches per 1000 FCE	13/14 - September	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 - September	0.00	0.00
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways	13/14 - September	0.00	0.00
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways.	13/14 - September	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 - September	92.00%	98.80%
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	13/14 - September	90.00%	93.88%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	13/14 - September	95.00%	97.39%
A&E waits			
Percentage of patients who spent 4 hours or less in A&E (Cumulative)	13/14 - September	95.00%	96.42%
Diagnostic test waiting times			
% of patients waiting 6 weeks or more for a Diagnostic Test	13/14 - September	1.00%	0.51%
Category A ambulance calls			
Ambulance clinical quality – Category A (Red 1) 8 minute response time (Cumulative)	13/14 - September	75.00%	75.62%
Ambulance clinical quality – Category A (Red 2) 8 minute response time (Cumulative)	13/14 - September	75.00%	76.17%
Ambulance clinical quality - Category 19 transportation time (Cumulative)	13/14 - September	95.00%	96.27%
Everyone Counts - NHS Outcome Measures			
Local Measures			
To reduce by 5 %, Non Elective Admissions to Aintree where source of referral is GP and where the patient has attended A&E on the same day. The current baseline figure will be compared withi the figure in 12 months time (Cumulative)	13/14 - September	1,223.00	735.00

5% reduction in the number of respiratory disease emergency admissions via A&E. (Baseline = 1645 - 5% reduction = 1563) (Cumulative)	13/14 - September	639.00	632.00		
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.(Baseline = 99233)	13/14 - Q1 April - June	94,271.00	82,434.00		

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CORPORATE PERFORMANCE DASHBOARD - PROVIDER LEVEL

South Sefton CCG

Baseline as at 07/11/2013 17:39:57

Performance Indicators		Aintree University Hospitals NHS Foundation Trust	Southport & Ormskirk Hospital NHS Trust	The Walton Centre NHS Foundation Trust
A&E waits				
A&E waits				
Percentage of patients who spent 4 hours or less in A&E (Cumulative)	13/14 - September	95.68%	95.29%	
Ambulance				
Ambulance				
Ambulance handover delays of over 1 hour	13/14 - September	4.00	18.00	
Ambulance handover delays of over 30 minutes	13/14 - September	41.00	91.00	
Crew clear delays of over 1 hour	13/14 - September	0.00	1.00	
Crew clear delays of over 30 minutes	13/14 - September	18.00	12.00	
Cancer waits – 2 week wait				
Cancer waits – 2 week wait				
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 - September	92.84%	88.83%	100.00%
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative)	13/14 - September	97.60%	92.88%	100.00%
Cancer waits – 31 days				
Cancer waits – 31 days				
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative)	13/14 - September	100.00%	100.00%	100.00%
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)	13/14 - September	97.94%	94.64%	100.00%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative)	13/14 - September	100.00%	100.00%	100.00%
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative)	13/14 - September	98.74%	98.13%	100.00%
Cancer waits – 62 days				
Cancer waits – 62 days				
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set. Local Target of 85% for all providers (Cumulative)	13/14 - September	92.77%	82.14%	100.00%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative). Local Target of 81.8% agreed for Aintree (Cumulative)	13/14 - September	83.56%	76.92%	100.00%
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative)	13/14 - September	89.47%	86.11%	100.00%
Diagnostic test waiting times				
Diagnostic test waiting times				
% of patients waiting 6 weeks or more for a Diagnostic Test	13/14 - August	0.14%	0.41%	0.33%
Referral To Treatment waiting times for non-urgent consultant-led				
Referral To Treatment waiting times for non-urgent consultant-led				
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	13/14 - August	94.50%	90.33%	92.55%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	13/14 - August	97.57%	96.01%	96.97%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	13/14 - August	97.10%	93.85%	97.16%
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted)	13/14 - August	0.00	0.00	0.00
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways	13/14 - August	0.00	0.00	0.00

The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways.	13/14 - August	0.00	0.00	0.00
Supporting Measures				
Quality (Safety, Effectiveness & Patient Experience)				
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	13/14 - September	50.00%	84.00%	
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	13/14 - September	100.00%	33.30%	
Treating and caring for people in a safe environment and protecting				
Treating and caring for people in a safe environment and protecting				
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative)	13/14 - September	54.00	10.00	6.00
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative)	13/14 - September	1.00	0.00	1.00
Patient safety incidents reported	13/14 - September	6.00	1.00	
Friends & Family Test				
Friends and Family Test Score - Inpatients + A&E	Q2 13/14 - Eng Av 64	58	57	78
Friends and Family Test Score Inpatients + A&E (% of respondents who would recommend the services to friends & family)	Q2 13/14 - Eng Av 13.3%	24.5%	20.7%	19.0%

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2013

Agenda Item: 13/154	**Author of the Paper:**
Report date: November 2013	Debbie Fagan Chief Nurse debbie.fagan@southseftonccg.nhs.uk Tel: 0151 247 7252

Title: Quality Report

Summary/Key Issues:

This report provides the Governing Body with exception reporting regarding Quality issues pertinent for the CCG making particular reference to Health Care Acquired Infection and cancelled appointments. In addition, information is provided for the Governing Body with regard to recent unannounced visits to local providers by the Care Quality Commission.

Recommendation

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

Receive	X
Approve	
Ratify	

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

Process	Yes	No	N/A	Comments/Detail *(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
Clinical Commissioning Group

Report to the Governing Body
November 2013

1. Executive Summary

This report provides the Governing Body with exception reporting regarding Quality issues pertinent for the CCG. The Governing Body is asked to receive this report by way of assurance.

2. Health Care Acquired Infections

2.1 Aintree Hospitals NHS Foundation Trust continue to breach regarding C-Difficile with 54 cases being reported year to date against a full year target of 43 cases. Commissioners have supported the Trust with the appeals process and 5 cases have been put forward for consideration at an NHS England appeals panel held on 20 November 2013. Both the Trust and the CCG are awaiting the outcome of this appeals panel.

2.2 The Trust have indicated that they wish to put forward a further 12 cases for consideration for support by commissioners at a further appeals meeting. Dates being awaited from NHS England for the next appeal meetings. The CCG continue to work with the Trust regarding the necessary commissioning assurance despite supporting the appeals process for C-Difficile.

3. Cancelled Appointments

Commissioners have raised with Aintree Hospitals NHS Foundation Trust concerns regarding numbers of cancelled appointments and have looked to triangulate this information with Serious Incident Reporting and complaints information so this can be considered intelligently as part of the CCG early warning system. This is being managed as part of the contract process and has been raised at the Single Item Quality Surveillance Group and the pre-meet for the Quality Risk Summit.

4. Care Quality Commission Unannounced Visits

4.1 The Care Quality Commission have undertaken a series of unannounced visits in Q2 and Q3 2013/14 to Southport & Ormskirk Hospitals NHS Trust, Liverpool Women's Hospitals NHS Trust and Aintree Hospitals NHS Trust.

4.2 The resultant action plan for Liverpool Women's Hospital NHS Foundation Trust was an agenda item for discussion at the last Quality Contract meeting with Liverpool CCG as co-ordinating commissioner.

4.3 Southport & Ormskirk Hospitals NHS Trust were found to be meeting the standards at the Ormskirk Site but action is required in relation to the standards regarding staffing and care and welfare of people who use services. This was an agenda item for discussion at the last Quality Contract meeting with Southport & Formby CCG as co-ordinating commissioner.

4.4 The unannounced inspection judgement report for Aintree Hospital NHS Foundation Trust is awaiting publication by the Care Quality Commission.

5. Recommendations

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

Debbie Fagan
November 2013

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE Governing Body
NOVEMBER 2013

Agenda Item: 13/155	**Author of the Paper:**
Report date: November 2013	James Bradley Head of Strategic Financial Planning James.bradley@southseftonccg.nhs.uk Tel 0151 247 7070

Title: Financial Position of NHS South Sefton Clinical Commissioning Group – Month 7

Summary/Key Issues:

This paper presents the Governing Body with an overview of the financial position for NHS South Sefton Clinical Commissioning Group. It provides a summary of the changes to the financial allocation of the CCG, presents the financial position of the CCG as at month 7, and outlines the key risks facing the CCG.

The paper also outlines a number of budget virements for approval by the Governing Body.

Recommendation

The Governing Body is asked to note the finance update.

The Governing Body is asked to approve the virements in appendix 2.

Note	x
Approve	x
Ratify	

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
November 2013

1. Executive Summary

1.1 This report outlines a summary of the changes to the financial allocation of the CCG, and focuses on the financial performance of the CCG at month 7. At the end of October, the CCG is £2.090m over-spent prior to the application of reserves.

The CCG is on target to achieve the planned £2.312m surplus at the end of the year. However, there are risks to achieving this and actions may be required to deliver this position.

This paper also requests approval for a number of virements as outlined in appendix 2.

2. Introduction and Background

2.1 This paper presents the Governing Body with an overview of the financial position for NHS South Sefton Clinical Commissioning Group.

It also details the changes to the financial allocation of the CCG. The paper provides information in relation to the financial position of the CCG as at month 7 and outlines the financial risks facing the CCG.

3. Resource Allocation

3.1 Resource allocation – changes in Month 7

The resource allocation for South Sefton CCG has increased from £228.074m in month 6 to £229.594m in month 7 as a result of winter pressures funding of £1.520m. This funding has been received from NHS England to support Aintree Hospital's Accident and Emergency performance over the winter period.

3.2 Baseline adjustments

The Month 6 position reflected baseline adjustments totalling £6.4m from South Sefton CCG to Southport and Formby CCG. It was noted that the review of baselines was on-going and further transfers of resource may be recommended in the future. There have been no additional baseline adjustments in Month 7, but there will be some further adjustments proposed in Month 8. These are outlined in a separate paper to the Governing Body.

4. Our Position to Date

4.1 Month 7 Financial Performance

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

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

Budget Area	Annual and Year to Date				End of Year	
	Annual Budget	YTD Budget	YTD Actual	YTD Variance	Expenditure Out turn	FOT Variance
	£000	£000	£000	£000	£000	£000
NHS Commissioned Services	162,820	94,377	96,168	1,791	166,350	3,529
Corporate & Support Services	6,836	3,078	2,924	(154)	6,684	(152)
Independent sector	1,502	876	1,203	327	2,062	560
Medicines Management inc Prescribing)	28,893	16,854	16,551	(303)	28,637	(256)
Primary Care	1,260	788	798	10	1,270	10
Commissioning - Non NHS	15,618	8,829	9,248	419	16,714	1,096
Sub Total Prior to Reserves	**216,929**	**124,802**	**126,892**	**2,090**	**221,716**	**4,787**
Total Reserves	10,354	2,103	12	(2,090)	5,567	(4,787)
Grand Total Expenditure	**227,282**	**126,905**	**126,905**	**0**	**227,282**	**0**
RRL Analysis	**(229,594)**	**(128,254)**	**(128,254)**	**0**	**(229,594)**	**0**
(Surplus)/Deficit	**(2,312)**	**(1,349)**	**(1,349)**	**0**	**(2,312)**	**0**

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

The year to date financial position before the application of reserves is a £2.090m overspend (Month 6 £1.929m). The full year outturn forecast is £4.787m (Month 6 £4.224m). The key issues contributing to the position within operational budgets are explained below.

NHS Commissioned Services

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

This budget is showing a year to date position of £1.791m overspend. This has been primarily caused by an over spend on Acute Commissioning at Aintree University Hospital NHS FT (AUH). At month 7, expenditure with AUH is £1.629m higher than planned. The main area of overspend is day cases (£0.718m) and elective activity (£0.510m). The main specialities which are over-performing within planned care are Gastroenterology and Trauma & Orthopaedics. Other areas that are over spending include High Cost Drugs and Age 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 and CCG have carried out further analysis, and have identified that other factors are contributing to the increased activity and costs. CCG representatives have met with the Trust on a fortnightly basis to review the causes of the over-activity on a specialty basis.

The findings have been reported to the Collaborative Commissioning Forum. The forecast assumes that the over spend continues at the current rate.

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

Corporate and Support Services

The CCG is currently operating within its running cost allocation; with a year to date underspend of £0.154m. This has been caused by a number of vacancies, many of which have now been filled and the underspend for the full year is forecast at £0.152m.

Independent Sector

The Independent Sector budget is over spent by £0.327m. This over spend predominantly relates to Spire Liverpool (£0.161m), Renacres Hospital (£0.144m) and I-sight (£0.039m), with the main over-performing specialties for Spire Liverpool and Renacres detailed below:

Renacres	Trauma & Orthopaedics	£0.060m
	General Surgery	£0.013m
Spire Liverpool	Trauma & Orthopaedics	£0.099m
	General Surgery	£0.021m
	Urology	£0.013m

Medicines Management (Including Prescribing)

The Medicines Management budget consists of High Cost Drugs, Oxygen and Prescribing. The overall position is £0.303m underspend in the year to date and £0.256m underspend for the forecast outturn.

Within the overall Medicines Management budget High Cost Drugs is currently showing an underspend of £0.252m. The uncertainties in respect of which commissioning organisation bears the costs of particular drugs have now been resolved and a £0.200m underspend is now the forecast outturn position.

The other major component of the Medicines Management budget is Prescribing. This area is showing a year to date under spend of £0.057m. This is based on Prescription Pricing Authority (PPA) data to the end of August. The PPA also provides a forecast which is used for the forecast outturn and is currently showing a forecast for Prescribing of £0.099m underspend for the year. This forecast has been reflected in the financial position but it is important to note that the forecast position for prescribing expenditure can change significantly and there remains uncertainty in relation to this forecast.

Primary Care

Primary Care is showing a small overspend of £0.010m for the year to date and forecast outturn position. Within this budget there is £0.050m for each locality. It is anticipated that the locality budgets will be spent in full by the end of the financial year.

Commissioning - Non-NHS

Commissioning from Non NHS organisations is overspent by £0.419m (month 6 £0.234m). The forecast outturn position is £1.096m (Month 6 £0.370m). This is currently the area of highest financial risk for the CCG.

The key elements of the increase in reported and forecast overspend from Month 6 are as follows:-

Learning Difficulties – At Month 6 a forecast outturn underspend of £0.577m was reported. This has been adjusted to show a balanced forecast outturn position at Month 7 as the intention is to make an allocation transfer from South Sefton CCG to Southport and Formby CCG to reflect a more accurate split of the budget.

Continuing Healthcare – the forecast outturn overspend has been increased by £0.275m to reflect the latest information from the CSU. There has been a significant increase in costs from the prior year which appears to be due to additional Continuing Care packages approved during 2013/14, although there have been difficulties in investigating the position due to changes in systems and patient confidentiality constraints. The CCG continues to work closely with the CSU to understand the pressures in this area. However, it is anticipated that from Month 8 the CCG will be able to access more detailed information regarding activity so that an explanation for the position can be provided at the next F&R Committee.

4.2 Treasury and Legacy issues

The work to disaggregate the balance sheet of NHS Sefton is continuing, with guidance 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.

The revised deadline for completion of the full disaggregation of the balance sheet by successor organisation is still yet to be formally advised by NHS England. However, recent communications would suggest that this is unlikely to be before Christmas. We are currently awaiting further guidance and will update the committee once this has been received.

Once this work has been approved by the DH, the final PCT balance sheets will be shared with successor organisations and once validated by the CCG's finance team, the inherited opening legacy balances will be brought to the Finance & Resource committee for information.

5. Evaluation of Risks and Opportunities

Many of the risks and uncertainties reported in earlier months have now been clarified, such as the baseline issues with Specialised Commissioners and drugs inflation on high cost drugs. In addition the risk of increased Continuing Health Care (CHC) costs is now reflected in the Forecast Outturn (as noted in "Commissioning – Non NHS" section above) and so can be removed from the risk analysis.

However, there continue to be a number of risks to the CCGs financial position, notably:

- CHC restitution payments – following review of the process, the estimate of the value of the risk is £0.600m. The risk of this potential cost being realised is considered low.
- May Logan – there continues to be uncertainty in the charging arrangements in respect of payment for the May Logan centre.
- Recovery of funds misallocated to NHS England for LCH Primary Care – Funding has been transferred to NHS England to pay for the Darzi primary care centre provided by Liverpool Community Health (LCH). However, the contract with LCH has not been amended to reflect this. The CCG continues to pursue this with both the provider and NHS England.
- Estates - There remains uncertainty in respect of the charging arrangements relating to estates costs led by NHS Property Services. The CCG has made prudent provision for

these costs within its reserves, and is working with key partners to clarify costs for each organisation.

Provision has been made within reserves for the risks outlined above and the CCG remains on target to deliver the planned surplus of £2.312m.

6. Budget virements

In accordance with the Scheme of Delegation all virements over £0.500m require approval by the Governing Body. These are outlined in appendix 2.

7. Recommendations

The Governing Body is asked to note the finance update, particularly that:

- The CCG remains on target to deliver its financial targets for 2013/14
- 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.
- The Governing Body is asked to approve the virements outlined in appendix 2.

Appendices

- Appendix 1 – Finance position to Month 7
- Appendix 2 – Budget Virements

James Bradley
Head of Strategic Financial Planning

NHS Southport and Formby CCG : Month 7 Financial Position APPENDIX 1

Cost centre Number	Cost Centre Description	Annual Budget £000	YTD Budget £000	YTD Actual £000	YTD Variance £000	Expenditure Out turn £000	FOT Variance £000
		Annual and Year to Date				End of Year	
COMMISSIONING - NON NHS							
603501	Mental Health Contracts	574	335	336	1	574	0
603506	Child and Adolescent Mental Health	979	571	565	(6)	969	(10)
603511	Dementia	86	50	49	(1)	86	0
603516	Improving Access to Psychological Therapies	0	(0)	0	0	0	0
603521	Learning Difficulties	1,302	759	1,000	241	1,302	0
603531	Mental Health Services – Adults	893	521	0	(521)	893	0
603541	Mental Health Services - Collaborative Commissioning	692	404	0	(404)	692	0
603596	Collaborative Commissioning	222	130	114	(15)	218	(4)
603661	Out of Hours	532	89	89	0	532	0
603682	Continuing Care	2,812	1,640	3,932	2,292	5,412	2,600
603684	CHC Adult Joint Funded	0	0	0	0	0	0
603691	Funded Nursing Care	3,558	2,076	1,728	(347)	2,963	(595)
603711	Community Services	390	227	185	(42)	318	(72)
603721	Hospices	768	448	510	62	821	53
603726	Intermediate Care	315	184	223	39	372	57
603731	Long Term Conditions	0	(0)	0	0	0	0
603796	Reablement	912	532	526	(6)	902	(10)
	Sub-Total	**14,037**	**7,966**	**9,258**	**1,292**	**16,056**	**2,019**
CORPORATE & SUPPORT SERVICES							
605251	Administration and Business Support (Running Cost)	77	45	41	(4)	77	0
605271	CEO/Board Office (Running Cost)	408	238	236	(2)	401	(7)
605276	Chairs and Non Execs (Running Cost)	89	52	80	29	138	49
605296	Commissioning (Running Cost)	1,358	792	715	(77)	1,281	(77)
605351	Finance (Running Cost)	993	579	333	(246)	797	(196)
605391	Medicines Management (Running Cost)	55	32	26	(6)	105	50
	Sub-Total Running Costs	**2,980**	**1,738**	**1,431**	**(307)**	**2,799**	**(181)**
603646	Commissioning Schemes (Programme Cost)	689	402	402	(0)	685	(4)
603656	Medicines Management (Programme Cost)	342	199	187	(13)	342	0
603676	Primary Care IT	1,225	0	0	0	1,225	0
605371	IM&T	192	112	112	0	192	0
	Sub-Total Programme Costs	**2,448**	**713**	**700**	**(13)**	**2,444**	**(4)**
	Sub-Total	**5,428**	**2,451**	**2,131**	**(320)**	**5,243**	**(185)**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS							
603571	Acute Commissioning	77,293	45,135	45,397	262	78,268	975
603576	Acute Childrens Services	2,148	1,250	1,176	(74)	2,021	(127)
603586	Ambulance Services	4,596	2,681	2,686	5	4,606	10
603616	NCAs/OATs	1,007	587	794	207	1,121	114
603631	Winter Pressures	4,042	197	197	0	4,042	0
603756	Commissioning - Non Acute	27,300	15,925	15,930	5	27,309	9
603786	Patient Transport	8	5	5	0	8	0
	Sub-Total	**116,393**	**65,780**	**66,185**	**405**	**117,374**	**981**
INDEPENDENT SECTOR							
603591	Independent Sector	3,190	1,861	1,794	(67)	3,075	(115)
	Sub-Total	**3,190**	**1,861**	**1,794**	**(67)**	**3,075**	**(115)**
PRIMARY CARE							
603651	Local Enhanced Services and GP Framework	829	483	540	57	915	86
603791	Programme Projects	504	337	337	0	504	0
	Sub-Total	**1,332**	**820**	**877**	**57**	**1,418**	**86**
PRESCRIBING							
603606	High Cost Drugs	1,560	910	798	(112)	1,460	(100)
603666	Oxygen	256	149	122	(27)	209	(47)
603671	Prescribing	20,599	12,016	11,907	(109)	20,414	(185)
	Sub-Total	**22,415**	**13,075**	**12,828**	**(248)**	**22,083**	**(332)**
RESERVES							
603761	Commissioning Reserve	5,020	1,119	0	(1,119)	2,566	(2,454)
	Sub-Total	**5,020**	**1,119**	**0**	**(1,119)**	**2,566**	**(2,454)**
	Grand Total I & E	**167,815**	**93,073**	**93,073**	**(0)**	**167,815**	**(0)**
	RRL Analysis	**(169,384)**	**(93,988)**	**(93,988)**	**0**	**(169,384)**	**0**
	(Surplus) / Deficit	**(1,569)**	**(915)**	**(915)**	**(0)**	**(1,569)**	**(0)**

Budget Virements - Southport and Formby CCG

Budget Transfer from: / Budget Transfer to:

Cost Centre	Value (£000)	Cost Centre	Value	Reason for virement
Commissioning - Non-acute (Liverpool Community Health)	544	Reserves	544	GP Out of Hours services have been awarded to another provider from October 2013. Therefore, contract with Liverpool Community Health has been decreased.
Mental Health Services – Adults	893	Continuing Care	893	Consolidate budget under one heading for more accurate reporting.
Mental Health Services - Collaborative Commissioning	692	Continuing Care	692	Consolidate budget under one heading for more accurate reporting.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2013

Agenda Item: 13/156	**Author of the Paper:**
Report date: 18th November 2013	Brendan Prescott CCG lead Medicines Management brendan.prescott@southseftonccg.nhs.uk Tel: 0151 247 7093

Title: Prescribing Performance Report

Summary/Key Issues:

This paper presents the Governing Body with an update on prescribing spend for August 2013 (month 5)

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
November 2013

1. Executive Summary

The South Sefton CCG position for month 5 (September 2013) is a forecast underspend of £ 81,934 or -0.3 % from a budget of £25,986,103.

2. Introduction and Background

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

3. Key Issues

The number of items prescribed has increased by 1.74% for 2013/14 to month 5 against the same period for 2012/13

The cost of prescribing has decreased by -1.35% for 2013/14 to month 5 against the same period for 2012/13

4. Content

Optimisation plan work continues in agreement with constituent practices. Scriptswitch will be reinstalled in December into some practices to support this work.

Department of Health assessment of the medicine margin (the difference between the price paid by a pharmacy contractor for a product from their supplier and the price reimbursed by the NHS) for last year indicates that community pharmacies exceeded the £500 million target level of medicine margin for 2012/13. In advance of finalising the overall funding position for the Community Pharmacy Contractual Framework (CPCF) for 2013/14, the Department of Health has agreed with Pharmaceutical Services Negotiating Committee (PSNC) to reduce generic medicine reimbursement prices (Category M) by £40 million for the period October 2013 to March 2014. This equates to £80 million in a full year. The cost of prescribing may fall over the second half of the year but at this stage is hard to calculate by how much.

5. Recommendations

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

Appendices

South Sefton CCG forecast out turn

PBC INFO				SECTION 3: FINANCIAL INFO - Total Prescribing Budget vs Forecast Out-turn			
CCG / Locality / Code	**Prescriber Name**			**Prescribing Budget Total**	**Forecast Out-turn (PPD)**	**Variance**	**% Variance**
NHS South Sefton CCG				**£25,986,103**	**£25,904,168**	**-£81,934**	**-0.32%**
Bootle				**£7,299,563**	**£7,265,657**	**-£33,906**	**-0.46%**
N84002	Aintree Road Medical Centre			£490,082	£486,272	-£3,810	-0.78%
N84015	Bootle Village Surgery			£1,253,740	£1,315,423	£61,683	4.92%
N84016	Moore Street Medical Centre			£1,273,981	£1,244,730	-£29,251	-2.30%
N84019	North Park Health Centre			£1,325,519	£1,256,627	-£68,892	-5.20%
N84028	The Strand Medical Centre			£1,344,059	£1,395,304	£51,245	3.81%
N84034	Park Street Surgery			£1,012,506	£992,975	-£19,531	-1.93%
N84038	Concept House Surgery			£599,676	£574,325	-£25,351	-4.23%
Crosby & Waterloo				**£7,242,202**	**£7,183,634**	**-£58,568**	**-0.81%**
N84001	42 Kingsway			£984,073	£1,003,658	£19,585	1.99%
N84007	Liverpool Rd Medical Practice			£984,576	£986,180	£1,604	0.16%
N84009	Azalea Surgery			£463,929	£449,666	-£14,263	-3.07%
N84011	Eastview Surgery			£1,088,410	£1,122,095	£33,685	3.09%
N84020	Blundellsands Surgery			£1,361,194	£1,318,948	-£42,246	-3.10%
N84026	Crosby - SSP Health Limited			£413,749	£402,307	-£11,442	-2.77%
N84041	Kingsway Surgery			£716,884	£711,557	-£5,327	-0.74%
N84621	Thornton - SSP Health Limited			£455,503	£455,906	£403	0.09%
N84626	Hightown - SSP Health Limited			£376,665	£363,065	-£13,600	-3.61%
N84627	Crossways SSP Health Ltd			£397,219	£370,251	-£26,968	-6.79%
Maghull				**£4,629,804**	**£4,558,195**	**-£71,609**	**-1.55%**
N84003	High Pastures Surgery			£1,752,904	£1,707,333	-£45,571	-2.60%
N84010	Maghull Health Centre (Dr Sapre)			£388,033	£356,225	-£31,808	-8.20%
N84025	Westway Medical Centre			£1,193,833	£1,186,139	-£7,694	-0.64%

N84622	Maghull Health Centre (Dr Thomas)			£373,502	£382,570	£9,068	2.43%
N84624	Maghull Health Centre			£291,724	£266,744	-£24,980	-8.56%
Y00446	Parkhaven SSP Health Ltd			£629,808	£659,185	£29,377	4.66%
Seaforth & Litherland				**£6,814,534**	**£6,896,683**	**£82,149**	**1.21%**
N84004	Glovers Lane Surgery			£1,246,916	£1,254,027	£7,111	0.57%
N84023	Bridge Road Medical Centre			£1,364,244	£1,406,621	£42,377	3.11%
N84027	Orrell Park Medical Centre			£483,979	£481,408	-£2,571	-0.53%
N84029	Ford Medical Practice			£993,022	£988,986	-£4,036	-0.41%
N84035	15 Sefton Road			£824,591	£781,593	-£42,998	-5.21%
N84043	Seaforth SSP Health Ltd			£249,198	£304,420	£55,222	22.16%
N84605	Litherland – SSP Health Limited			£521,501	£498,514	-£22,987	-4.41%
N84615	Rawson Road Medical Centre			£417,669	£425,429	£7,760	1.86%
N84616	Sefton Road Surgery			£337,084	£353,167	£16,083	4.77%
N84630	Netherton - SSP Health Limited			£318,330	£318,651	£321	0.10%
Y02514	Litherland Primary Care Walk-in Service			£58,000	£83,867	£25,867	44.60%

Brendan Prescott,
November 2013

MEETING OF THE GOVERNING BODY
November 2013

Agenda Item: 13/157	**Author of the Paper:**
Report date: 20 November 2013	Fiona Clark Chief Officer fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7061

Title: Commencement of Election Process

Summary/Key Issues:

This paper presents the Governing Body with a formal notification of the commencement of an election process, together with the process and timelines in relation thereto.

Recommendation

The Governing Body is asked to receive this report by way of advice of the pending election process.

Receive	x
Approve	
Ratify	

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

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

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

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

Report to Governing Body
November 2013

1. Background

The Governing Body will recall that, at the Wider Constituent meeting on 14 November 2013, it was advised of the pending resignation of Dr Steve Fraser with effect from 31 December 2013. It will also recall being advised that Dr Fraser's resignation has triggered the requirement for an election progress. The following next steps will now take place:

1.1. services of the LMC to be engaged to manage the election process;

1.2. formal notice of intention to hold an election to be issued;

1.3. nominations to be sought; and

1.4. an election to be held at AGM/Wider Constituent meeting in 2014 (the date of which is to be arranged).

2. Process

In accordance with the CCG's Constitution (Schedule 2), the process surrounding the election process will be:

2.1. an election for the 7 GP Member Practice Representatives will be conducted by secret ballot under the supervision of the LMC;

2.2. 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;

2.3. 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;

2.4. 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.

3. Recommendation

The Governing Body is asked to formally receive this report, noting the election process to follow.

Fiona Clark
November 2013

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2013

Agenda Item: 13/158	**Author of the Paper:**
Report date: November 2013	Stephen Astles Head of Development Dr Andy Mimnagh Urgent Care Lead.

Title: Winter Plan

Summary/Key Issues:

The Health System usually experiences increased demand for services in the Winter Period. This paper outlines the CCG's as part of the Urgent Care Network, plans to ensure, as far as is reasonably practicable, to support the Health economy to maintain services for patients.

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.
	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				
Clinical Engagement	x			
Equality Impact				

13/158

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

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

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
November 2013

1. Introduction and Background

South Sefton CCG, as a member of the North Mersey Urgent Care Network has been involved in assessing health economy plans for winter resilience. This work has involved mainly Aintree University Hospitals NHS Trust, Sefton Local Authority and Liverpool Community Health NHS Trust for South Sefton CCG although we have supported the network relating to other providers in North Mersey.

2. Process

The Urgent Care Network arranged a session with providers on 6 September to advise them on required content of their plans and subsequently met on the 27 September to provide feedback on the reviewed plans. Aintree University Hospitals and Sefton Local Authority plans were agreed as 'assured' but there were issues with the LCH plan and the organisation was not available to discuss.

The Urgent Care managerial and clinical lead then provided feedback to LCH to rectify their plan, which will be returned to the Network on 21 November for approval.

The North Mersey Urgent Care Network template has been completed. There are 8 sections within the template that remain 'not assured'. The plan is for the template to be reviewed at the next CCG Urgent Care Network meeting on 22 November and be ratified at the next Urgent Care Network meeting on 29 November.

The CCG is also providing support to providers across the health sector to provide additional capacity in Primary Care and Community Services, as well as funding a campaign to advise the public on appropriate use of services over the winter period. These are listed below.

Aintree have treasury funding to ensure:

- implementation of a Frail Elderly Unit
- increased provision of Acute Care Practitioner to improve 'see and treat' for Minor patients
- implementation of the ECIST report into the Emergency pathway and Patient flow through the Trust

The aim of this funding is to support Aintree to achieve its 4 - hour target and improve the flow of patients through the hospital by developing long term strategies for patient flow which will support winter pressures. This is being monitored by the Urgent Care Network.

Liverpool Community Health
LCH have been allocated funding to support Community Equipment pressures within the organisation, it is thought that this is required due to the increasing needs of the population to support independent living at home for the frail elderly population. This funding must come with the caveat that patients discharge must not be delayed from an acute Trust due to the unavailability of community equipment.

Primary Care
Additional Primary Care capacity is being funding. These funds will be utilised to allow practices to provide additional appointments for patients outside their normal contracted delivery. This process will be managed by NHS England as the commissioners of Primary Care with the CCG providing the funding.

Acute Visiting Scheme.
This scheme will allow a G.P employed by the out of hours provider {Gotodoc} to visit none urgent patients who have called for an ambulance to assess whether a hospital visit is required or alternative management arrangements can be made. This scheme has occurred in other areas of the North West and has proved successful.

Additional Intermediate Care capacity via 'spot' purchase. This will allow additional capacity to be utilised on an 'ad hoc' basis.

Additional 'end of life' beds via 'spot' purchase. This will allow additional capacity to be utilised on an 'ad hoc' basis for patients required hospice type care.

Patient information publicity campaign 'Examine your options'. This is a joint scheme involving several local CCG including South Sefton to encouraging the public to utilise the appropriate services. This will include adverts in the local press and radio.

Social Services/Local Authority
Funding to support social services in Aintree and the Community to prevent admissions and support discharges.

3. Recommendations

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

Stephen Astles
November 2013

NHS South Sefton Clinical Commissioning Group

MEETING OF THE GOVERNING BODY NOVEMBER 2013

Agenda Item: 13/159	**Author of the Paper:** Tracy Jeffes Head of Delivery and Integration Tracy.Jeffes@southseftonccg.nhs.uk Tel: 0151 247 7049 Alison Johnson Head of Organisational Development Cheshire and Merseyside CSU
Report date: November 2013	

Title: Organisational Development Plan Refresh

Summary/Key Issues:

This refreshed Organisational Development Action Plan sets out how South Sefton Clinical Commissioning Group intends to develop its localities, clinical leaders, Governing Body and staff to become a high performing commissioning organisation. It updates and complements the Organisational Development Strategy approved in July 2012.

This plan aims to:

1. Outline our revised organisational development priority areas.
2. Identify the actions we will take to address our development needs.

Recommendation

The Governing Body is asked to approve revised organisational development priority areas and the proposed action plan.

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			Governing Body members been presented with and have had the opportunity to discuss the draft OD priorities at two informal developments sessions in recent months
Equality Impact Assessment		x		
Legal Advice Sought			x	
Resource Implications Considered	x			
Locality Engagement	x			Actions identified in the plan take forward developments to meet needs identified by locality leads (clinicians) during the locality leadership development programme run earlier this year and at recent Management Team Time out.
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

Organisational Development Plan Refresh

November 2013

13/159

Report to the Governing Body
November 2013

1. Executive Summary

This refreshed Organisational Development Action Plan sets out how South Sefton Clinical Commissioning Group intends to develop its localities, clinical leaders, Governing Body and staff to become a high performing commissioning organisation. Using this document as a guide we will bring together culture, values, structure, process, skills review, training, appraisal and feedback, leadership and good management to enable us to improve the health and wellbeing of our local population.

This document updates and complements the Organisational Development Strategy approved in July 2012 and we recognise that it will continue to evolve and change as we develop and mature as a membership organisation.

Our refreshed plan aims to:

- Outline our updated organisational development priority areas.
- Identify the actions we will take to address our revised development needs.

South Sefton CCG has developed a purposeful vision and a set of values that clearly describe our intentions. Full detail of our vision and values can be found in the comprehensive organisational development strategy. The Governing Body has a critical role in demonstrating commitment to these values. This is central to the development of a cohesive organisation that can project its vision and purpose through its workforce and relationships with stakeholders and local people.

South Sefton CCG has made significant progress in its development journey to date. Our clinical and managerial leads have and are developing their skills and knowledge to ensure the Governing Body has effective governance capability to support the delivery of the CCG's statutory duties and other responsibilities.

Through review of our organisational development diagnostics, discussion at our Governing Body informal meetings and team development sessions, we have refreshed our organisational development priorities into six areas. These are,

1. Leadership, Workforce and Team Development
2. Public and Patient Communications and Engagement
3. Locality Development
4. Strategy and Performance Management
5. Functionality
6. Values, Style and Change Management

What we intend to do

Our Governing Body is aware of the growing evidence of the causal link between board level effectiveness and organisational performance in the NHS. We aim to continue to develop a highly performing Governing Body providing strong clinical leadership, firmly committed to its development, collectively and as individual members.

To support the Governing Body in developing its effectiveness, we will build our long standing commitment to regular development sessions, focused on key areas such as strategy, personal effectiveness, values, and governance. The Organisational Development Action Plan also encompasses both individual and group elements including coaching, mentoring and appraisal. We will also look to benchmark ourselves against high performing boards to continually evaluate our effectiveness.

We are committed to ensuring that our leadership approach involves all within the organisation, across our wider membership, localities and local communities. This is demonstrated in the adoption of the NHS Change Model as our change methodology as we would endeavour to train all staff and clinical leads in the application of this model. Through our commissioning priorities, we have, and continue to develop clinical leaders who can drive change, encourage innovation and increasingly working more closely with our partners.

We will be utilising a range of leadership resources to support our clinical leaders and staff including formal processes, coaching and mentoring, use of 360° feedback diagnostics, and the development of commissioning capability.

We aim to develop our workforce – clinical and non-clinical - at every level through knowledge, skill, insight and ideas to achieve and maintain high performance and achieve our ambitions.

We will ensure that our workforce is compliant with the mandatory and statutory skills required of NHS staff through the NLMS e-learning system that is already in place. The core skills programme encompasses 8 programmes of learning essential for all staff including Fire Safety, Manual Handling, Safeguarding of Adults, Safeguarding of Children, Equality and Diversity, and an introduction to Information Governance.

We will are currently undertaking personal development plan reviews with our entire workforce and once complete, we aim to undertake a Training Needs Analysis of our workforce to better understand the current skills held across South Sefton CCG.

Once the Training Needs Analysis is produced we will develop a Learning and Development Plan for staff outlining the training requirements available to them. The purpose in undertaking both of these actions is twofold; to highlight personal development learning specific to individual roles, and to determine the level of range of programmes required to increase commissioning capability amongst the workforce to support the CCG in delivering its commissioning and statutory objectives.

South Sefton CCG's organisational development plan will continue to evolve as we move forward and we have therefore provided indicative timescales for the development undertakings as outlined within.

The Organisational Development Action Plan it is hoped will be championed at Governing Body level by and its implementation will be overseen by the Accountable Officer. It will be the responsibility of the Head of Integration and Delivery to ensure that the plan remains fit for purpose and that progress and achievement is monitored. Many of the initiatives will be directly delivered by the OD team at Cheshire and Merseyside CSU, who have assisted with the development of this action plan and by maximising the use of our investment in the NHS Leadership Academy.

2. Summary

The refreshed Organisational Development Plan describes the vision for South Sefton CCG in the development of its organisation for 2013/14. Our plan complements the existing Organisational Development Strategy published in July 2012. We recognise that it is imperative that all people who work with us are equipped with the necessary knowledge, skills and competencies to enable us to commission high quality services for our patients and population, and we are committed to developing our organisation through the delivery of our plan.

3. Recommendations

The Governing Body is requested to approve:

- The Organisational Development Priorities (13-14)
- the Action Plan for the Organisational Development Plan 2013-14

Appendices

Appendix 1 – Organisational Development Priorities (13-14)
Appendix 2 – Action Plan for the Organisational Development Plan 2013-14

Tracy Jeffes
Head of Delivery and Integration

Our Organisational Development Priorities (13-14)

Our organisational development (OD) strategic plan has been instrumental in our journey towards authorisation. The OD Plan interrelates to a number of key plans and work programmes, ensuring that the underpinning strategy, structures, systems, staff, skills, shared values and style of working are in place. Our refreshed plan for 2013-14 has two key objectives:-

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

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

1. Leadership, Workforce and Team Development

- Defining future capability and capacity required to develop a truly effective membership organisation (including succession planning)
- Individual (PDPs) and team development plans and performance management in place to achieve objectives for all CCG roles.
- Board, locality and clinical (distributive) leadership plans implemented
- OD and training support commissioned including a clinical leadership programme, managerial assessment centre, PN and PM training needs analysis and mandatory training for CCG staff.

2. Patient and Public Communication and Engagement

- Revise communications and engagement strategy and plan to deliver “Transforming Participation”, in particular personalised care
- Fully embed EPEG (Engagement and Patient Engagement Group) model

3. Locality Development

- Define the locality model further to ensure effective interaction between localities and the CCG Governing Body
- Further define clear roles and accountabilities within the locality model framework
- To continue the development of devolved resources to localities
- To enable and empower localities to understand their local population needs and commission appropriate services accordingly

4. Strategy and Performance Management around Outcomes

- Two / five year strategy to deliver HWBB priorities, developed with broad involvement and communicated effectively
- Delivered through annual plans and programme management approach linked to national and local HWBB outcomes and regular review.
- Development of GP Practice/ PHCT development planning in context of PQ Strategy and productive practice pilots

5. **Functionality**

- Review structures and processes to progress integration with LA
- Effective development and performance management of CSU and planning for future procurement of CSU services
- Development of and strengthening use of the intelligence portal and review of data facilitation
- Integrated commissioning across system inc LA/PH/LAT/CCGs
- Ensure actions from the Quality and Francis action plans are underpinned by the OD plan

6. Values, style and change management

- Ensure CCG vision, values and culture is embedded across whole organisation and that the CSU operates on our behalf in this context through on-going development of effective CSU locality team
- Ensuring innovation and systematic approaches to transformation.

South Sefton CCG
Organisational Development Plan Refresh November 2013-14

[1] The CCG Domains for Assurance of Organisational Health and Capability are:-

1. A clinical and multi-professional focus, with quality central to the organisation
2. Good engagement with patients and the public, listening to what they say and truly reflecting their wishes
3. A clear and credible plan to deliver great outcomes within budget and with partners and reflects the priorities of the health and wellbeing strategy.
4. Proper constitutional and governance arrangements and capability and capacity to deliver all its duties and responsibilities.
5. Collaborative arrangements with other CCGs, LA and NHS England, appropriate commissioning support and good partnership relationships with their providers.
6. Great leaders who individually and collectively make a real difference.

Organisational Development Priority	LINK TO CCG DOMAIN[1]	Agreed Development	Timescales for Delivery	Lead/Methodology
1. Leadership, Workforce and Team Development	1, 3, 4, 6	Effective induction and development plans for new Governing Body members. The Governing Body will participate in regular monthly development sessions which encompass strategy, governance and values. (In essence this sets the tone for the CCG's leadership style, required skill sets, structure and systems in line with the McKinsey 7s model of organisational development). The GB session will also encompass from the MIAA on standards for GB members. Further sessions will be structured around commitment, personal behaviour, technical competence, and business practices. Further 2 sessions of team coaching planned with the Governing Body.	February 2014 Afternoon session every other month and Joint (SS&SF)CCG evening development session every other month March 2014 December 2013/June 2014	Head of CCG Development / Head of Delivery and Integration. Chair/Chief Officer/ Head of Delivery and Integration, Commissioning Support Unit (CSU) Organisational Development Team Workshop style delivery MIAA Team Coach
	1, 6	The Governing Body will undertake an observation/provide feedback on its performance using high performing board indicators. Annual benchmark against the baseline diagnostic assessment will be undertaken to ensure we progress to level 5 against each CCG domain.	Spring 2014 July 2014	Consider the North West Leadership Academy – Board to Board programme (2 day residential) other method. Chief Officer/Head of Delivery and Integration CSU OD Team

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Organisational Development Priority	LINK TO CCG DOMAIN[1]	Agreed Development	Timescales for Delivery	Lead/Methodology
1. Leadership, Workforce and Team Development (cont)	2,4,6	Lay member development to support the knowledge, skills and capabilities in understanding the evolving NHS and their critical role in creating a successful CCG.	Ongoing	North West Leadership Academy – Lay Member programme
	1,6	Executive coaching for Governing Body members either through individual or team coaching. This development offer is open to the Chair, Chief Officer, and Chief Finance Officer currently.	On-going throughout 2013	NW Leadership Academy Follow-up support available through the CSU OD Team
	1, 4,6	Bi-monthly / Quarterly team development sessions/ bespoke leadership programme for all CCG staff to enable access to a range of learning opportunities: - Commissioning skills refreshers - Change management principles - The evolving NHS - Leadership style and team dynamics - Embedding the values and behaviours	From January 2014 onwards	Chief Officer/Head of Delivery and Integration CSU OD Team
	4,6	All GB and staff have access to mandatory training through the NLMS e-learning modules – 8 in total. A monthly performance report is produced demonstrating compliance against each of the modules. Compliance against all modules is 85%	Need to understand current compliance rate to determine realistic timescale for delivery	Chief Officer/Head of Delivery and Integration HR Team, CSU
	4,6	Coaching support sourced and available to senior managers within the CCG who are not covered by the NHS Leadership Academy Offer.	January 2014 onwards	Coachnet tool, NHS Leadership Academy CSU OD team

Organisational Development Priority	LINK TO CCG DOMAIN[1]	Agreed Development	Timescales for Delivery	Lead/Methodology
1. Leadership, Workforce and team development (cont)	4,6	MBTI team dynamic session to be organised for the Finance Team. This session will be offered out to the wider CCG as required.	December / January 14	CSU OD team
	1,6	Development of Clinical Director role for all clinical leads of the Governing Body. Work to be undertaken to revise job descriptions to reflect Clinical Director leadership role and other GB members e.g. Practice Managers.	December 2013	CSU HR Team/Head of Delivery and Integration

Organisational Development Priority	LINK TO DOMAIN[1]	Agreed Development Need	Timescales for Delivery	Lead/Methodology
2. Patient and Public Communications and Engagement	2	Revised Communications and Engagement strategy.	November 2013	Sefton Communications Lead CSU
	2	Delivery of training regarding Transforming public participation. Plan to achieve requirements of Checkpoint 3 in relation to personalisation of care agenda.	January 2014 March 2014	Head of Engagement CSU E&D Lead/ Senior Governance Manager, CSU
	2	Ensure systematic collection of engagement activity (on REACT) to demonstrate depth of engagement and ensure the meeting of key requirements such as the revised Equality and Diversity scheme.	January 2014	Head of Engagement, CSU

Organisational Development Priority	LINK TO CCG DOMAIN[1]	Agreed Development Need	Timescales for Delivery	Lead/Methodology
3. Locality Development	1,2,4,6	To develop a framework for locality development clearly setting out the roles of the localities. The framework to include an identified vision, strategy, objectives and local priorities for 2013/14 and terms of reference for decision making. To ensure strong linkages between the governing body and locality leads to enhance communication channels and key deliverables around strategic priorities and the development of link GB and/or Senior Management Team roles.	Initial meeting December 2013 with Heads of Development Facilitated meetings in each locality meetings in January and February 2014	Chief Officer/Head of Delivery and Integration/Heads of Locality CSU OD Team
	1,4	To develop clear role definitions for all locality based staff including locality chairs, clinical leads, GPs, practice nurses and practice managers.	To commence January 2014	Chief Officer/Heads of Locality HR Team, CSU
	1,4,6	To provide a quarterly development session for each locality on leadership skills, change management best practice, use of the commissioning model and skills development, and the evolving NHS.	To commence January 2014 with the scoping of the locality development framework	Chief Officer/Heads of Locality, CSU OD Team
	1,2	Repeat the 360 stakeholder feedback survey completed pre-authorisation to assess relationships with member practices. The actions arising from the survey will be led by each locality.	February 2014	Accountable Officer/Heads of Locality

Organisational Development Priority	LINK TO CCG DOMAIN[1]	Agreed Development Need	Timescales for Delivery	Lead/Methodology
3.Locality Development (cont)	4,6	Continued work to build relationships with practice staff (including Practice Managers and Practice Nurses) to ensure full collaboration in the vision and objectives of the CCG undertaken through the Protected Learning Time PLT events and other relevant events.	Ongoing calendar of dates for CCG wide PLT Dates for locality PLT to be determined from March 2014 onwards	CCG Chairs/Heads of Locality
	4,6	Undertake a training needs analysis with GP Practice Leads, Clinical Programme Leads, Locality Leads and GB clinical members to understand their leadership development requirements in supporting the CCG whilst maintaining their roles in clinical practice. The training needs analysis will link to the outcomes of the PDR programme for the CCG.	April 2014	CSU OD Team/GB Chairs

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Organisational Development Priority	LINK TO DOMAIN[1]	Agreed Development Need	Timescales for Delivery	Lead/Methodology
4. Strategy and Performance Management	5	Heath and Well Being Board Peer Challenge Review - Implementation of action plan based on the recommendations from the peer challenge including;		
		Development of a joint workshop between members of CCG Governing Body and Overview and Scrutiny Committee Structure to further build relationships.	November 2013	Accountable Officer/Head of Delivery and Integration
		Develop a workshop with major stakeholders to share and develop the learning from the peer stakeholder review and to develop and refresh actions plans.	November 2013	Accountable Officer/Head of Delivery and Integration
		Roll out key messages to residents (as part of Big Chat 3).	November 2013	Head of Delivery and Integration/Engagement Team
	2,3	Development of ambitious and transformational Two and Five year strategy to include: • Integration of current Programme Management Office resource to support the annual business planning cycle • Analysis and implementation of clear planning methodology throughout organisation including utilisation of NHS Change model • Clear performance management and reporting on progress • Engagement of and clarity for Wider Membership • Maximise stakeholder and public and patient engagement through EPEG	March 2014 December 2013	Head Strategic of Planning and Assurance CSU OD Team
	4,6	To establish a programme of work for Productive Practice with 1 pilot practices per locality. Work to commence in the new year to identify the practices through an expression of interest, and to undertake the practice readiness exercise.	January 2014	Each locality to identify a pilot site Heads of Locality/CSU OD Team
		Once identified a workshop will be held for all pilot practices to encourage a community of practice way of learning amongst peers.	February 2014	CSU OD Team
		Pilot Practice Development Planning / Primary Care Team development planning in 2 practices.	March 2014	CSU OD Team / Head of Delivery and Integration

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Organisational Development Priority	LINK TO CCG DOMAIN[1]	Agreed Development	Timescales for Delivery	Lead/Methodology
5. Functionality	3, 5	Initial workshop for Health and Wellbeing Board to develop the vision for integrated working between the CCG and LA. Following this workshop a full action plan will be developed and organisational development actions will be incorporated into this plan ready for delivery.	November 2013 March 2014	Head of Delivery and Integration/, Local Authority
	4, 5	Effective development and performance management of CSU and planning for future procurement of CSU services.	On-going and April 2014	Head of Delivery and Integration
	4,5	Development of and strengthening use of the intelligence portal and review of data facilitation.	December 2014	Chief Finance Officer / CCG lead or IT / CSU BI lead / Informatics Merseyside
	4	Ensure actions from the Quality and Francis action plans are underpinned by the OD plan.	November 2013	Chief Nurse

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Organisational Development Priority	LINK TO DOMAIN[1]	Agreed Development Need	Timescales for Delivery	Lead/Methodology
6. Values, Style and Change Management	2,5,6	Support the developing culture of South Sefton CCG demonstrated through the values, behaviours and methods of operating with public, patients, stakeholders and providers. Suggest a refresher session on "working in a values driven organisation" with all CCG staff.	June 2014	CSU OD Team
	4,6	All CCG staff, Governing Body members and clinical leaders have a personal development plan. Completion of PDR process will enable all development priorities to be collated into a training needs analysis which will support the CCGs in determining their learning and development priorities for 2013/14.	April 2014	Chief Officer/Head of Corporate Services CSU OD Team
	3, 4,6	Development sessions for staff in the use of the NHS Change Model as its method of delivery for change programmes. The NHS Change Model is an evidence based approach to change in a cyclical approach utilising national and international best practice. Team development sessions to be arranged to enable understanding and implementation of the model in line with identification of commissioning priorities for the CCGs.	February 2014	Chief Officer/Head of Corporate Services CSU OD Team
	4,6	Development of a self -assessment "temperature check" across the organisation to understand the health of the organisation and check that the desired culture is being worked to. Development of an organisational development survey to assess the current climate to provide a baseline assessment of future work requirements.	December 2013	Chief Officer/Head of Corporate Services CSU OD Team

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2013

<table>
<tr><td>Agenda Item: 13/160</td><td rowspan="2">Author of the Paper:

Tracy Jeffes
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Tel: 0151 247 7049</td></tr>
<tr><td>Report date: 28 November 2013</td></tr>
<tr><td colspan="2">Title: Communicating health in south Sefton…a communications and engagement strategy for NHS South Sefton Clinical Commissioning Group</td></tr>
<tr><td colspan="2">Summary/Key Issues: This is the first refresh of our integrated communications and engagement strategy, updating our strategic approach in light of new statutory duties and national guidance. This document also gives an overview of activities for 2013 - 2015</td></tr>
<tr><td colspan="2">Recommendation

The Governing Body is asked to approve this strategy and its summary action plan

Receive [ ]
Approve [x]
Ratify [ ]</td></tr>
</table>

	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			Presented to November EPEG and comments incorporated into the strategy

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Clinical Engagement	x			Original strategy developed with involvement of Governing Body members
Equality Impact Assessment	x			Reviewed by equality and diversity lead
Legal Advice Sought			x	
Resource Implications Considered	x			
Locality Engagement			x	
Presented to other Committees			x	Presented to November EPEG meeting

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

South Sefton
Clinical Commissioning Group

Communicating health in south Sefton…

A communications and engagement strategy for NHS South Sefton Clinical Commissioning Group (2013 - 2015)

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Executive summary

NHS South Sefton Clinical Commissioning Group (NHS SSCCG) sets out its approach to communicating, engaging and consulting with everyone it works with and for in this document.

This refreshed version of *'Communicating health in south Sefton'* takes account of our changing role and responsibilities as a new statutory body from 1 April 2013, when we became the main commissioner of the majority of local health services as part of the reforms to the NHS laid out in the Health and Social Care Act (February 2012).

This presents us with new challenges - building relationships, reputation and awareness amongst all its publics and partners and engaging and working with those partners to shape local health services.

Alongside the reforms to the NHS, this strategy responds to the recommendations of two reports into patient safety carried out in 2013 and the subsequent government responses to those reports – The Francis Inquiry into the failings at Mid Staffordshire Hospital[1] and the review of Winterbourne View Hospital[2].

These have brought into sharp focus the need to monitor and manage more rigorously the performance and quality of services and the experience of patients and their families accessing those services. 'Transforming participation in health and care'[3], published in September 2013, presents new guidance for commissioners in supporting them to do this, as well as involving people throughout their work.

Communicating health in south Sefton responds to all these challenges and shows our commitment to involve and inform all our partners in the decisions we make. It also details some of the systems we are putting in place to monitor patient experience, which is important in helping us to spot early any issues that may arise in the services we commission.

Communicating health in south Sefton supersedes the 2012 strategy, and builds on the work began in the 18 months prior to NHS SSCCG becoming a statutory organisation.

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[1] Patients First and Foremost: https://www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report
[2] Transforming Care: A national response to Winterbourne View Hospital https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf
[3] Transforming participation in health and care: http://www.england.nhs.uk/2013/09/25/trans-part/

Introduction

Why we communicate and engage

Communications and engagement is central to delivering our vision, values and aims. An effective, well devised strategy will support the delivery of and contribute to the success of our strategic plans and priorities.

We also recognise that our communications and engagement activities are intrinsically linked, and therefore need to be fully integrated with each other to ensure they are as effective as possible in helping us to achieve our objectives.

We need to communicate and engage effectively with people so we can:

- Talk directly with people about their health, treatments and care
- Share information about our services and performance
- Work with partners to transform health services and promote healthy living
- Ask people for their views and attitudes about current services and involve them in shaping them for the future
- Celebrate success
- Manage difficult situations

What we need to consider

For communications and engagement to be effective, they need to be relevant, appropriate, timely and well informed by local knowledge and evidence. So, it is important that any planned activity considers the following questions:

- What do we want our communications and engagement to achieve?
- Who are we communicating and engaging with?
- What will successful communications and engagement deliver?

Taking a coordinated and inclusive approach also supports the management of risks which may impact on our reputation. Embedding communications and engagement in projects and service developments will help us to identify any issues, providing early support and good understanding of the challenges involved.

Knowing who we need to talk to

Understanding who we need to communicate and engage with is crucial. It will help us to design the best methods for different partners and where to focus and prioritise our efforts.

We have carried out a 'mapping' exercise (Appendix 1) to ensure we continue to engage and communicate with our priority partners.

What communications and engagement can support us to do

We understand the benefits of effective, well-resourced communications and engagement in helping us to:

- Produce better health and care outcomes for local people
- Give a better understanding of the needs and priorities of communities
- Help us to make better commissioning decisions
- Help us to design services that better reflect the needs of local people
- Provide services that are efficient, effective and more accessible
- Give better understanding of why and how local services need to change or be improved
- Give greater choice for patients
- Reduce health inequalities
- Give greater local ownership of health services
- Increase trust and confidence in the NHS
- Create increased satisfaction, resulting in less conflict and adverse media attention

Managing and reducing risk

We cannot know all the risks and issues that may affect our work all of the time. We can, however anticipate many and plan for those we do know about. We will consider and respond to any communications and engagement risks we identify. An analysis can be found in Appendix 2.

Our vision and objectives

Our organisational vision and values[4] shape and define our communications and engagement activities and the key messages we need to communicate to our publics and partners.

Our **communications and engagement vision** provides greater focus:

"We want to be recognised as a people focused organisation, buying the best health services, working with local people and our partners to improve the quality of their lives"

…as do our **communications and engagement objectives** in:

- Engaging and communicating effectively with member practices and our staff, to enable a shared understanding of our work and their role within it
- Supporting the successful delivery of our priority programmes to transform health services and improve people's health
- Increasing recognition of our work and raise our profile amongst all patients, members of the public and other partners
- Working together with our NHS partners, Sefton Council, Healthwatch Sefton and the voluntary, community and faith sector to improve local health services, and increase awareness of those services amongst people in south Sefton
- Encouraging participation of south Sefton residents in shaping and reviewing health services, so they are the best they can be
- Manage and plan for difficult situations

[4] Our organisational vision, values and aims can be found on our website www.southseftonccg.nhs.uk

Our duty to engage and involve

Engaging our public and statutory partners in an open and honest manner and consulting them at the right time in a meaningful way is important to us. Our approach to doing this also reflects the new legal and policy requirements that set out our duty to engage, covered in this section.

Health and Social Care Act 2012

The two main duties within the Act that require us to engage effectively can be summarised as below:

1. **Individual involvement** – requiring us to promote the involvement of patients, carers and members of the public in planning, managing and making decisions about their own care and treatment, or *'Patient Choice'*

2. **Collective involvement** – requiring us to involve the public in the planning of commissioning arrangements, the development of proposals for change and the decisions affecting the operation of commissioning arrangements

1. Individual involvement

Examples of how we can do this include:

Friends and Family Test – we will monitor the results of this national patient experience survey to ensure the services we commission meet expected quality standards

Information for patients – we will look at ways to offer targeted support so that patients can be more in control of their health

Personalised care planning – we will support those eligible to have the option of a personal health budget

Shared decision making – we will promote patients to be involved in decisions about their care

Self-care and self-management – we will look at ways we can provide support to patients to better manage their health and prevent illness

2. Collective involvement

Examples of how we can do this include:

Involving people in the development of our plans – we will ask people for their views about our commissioning plans and how we will propose to spend our money. When we are reviewing the health needs of the area we will ask people what they think should be our priorities. When we are developing new services we will invite views to help shape them.

Involving people in plans to change services – sometimes we may need to make major changes to the services we commission. We will involve people, particularly those who may be affected by change, as early as possible in this process to ensure as many as possible have the chance to give their views.

'Four tests' for commissioners

In 2010 the Secretary of State for Health set out four key tests for service change, which are designed to build confidence with staff, patients and communities. For service reconfiguration proposals it must be demonstrated that there is:

- Support from GP commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base
- Consistency with current and prospective patient choice

NHS Constitution

The Constitution establishes the principles and values of the NHS in England. It sets out the rights of patients, public and staff, as well as pledging what the NHS is committed to achieve. It also gives responsibilities which the public patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies, private and third sector providers supplying NHS services are required by law to take account of this Constitution in their decisions and actions. In 2013, the Constitution was updated[5] to reflect the changing NHS landscape and the strengthened duties required of commissioners.

[5] NHS Constitution: https://www.gov.uk/government/publications/the-nhs-constitution-for-england

Everyone Counts – Planning for patients

The ‘Listening to patients’ section of this guidance[6] for commissioners compels them to ensure:

- The rights for patients set out in the NHS Constitution are delivered
- That the NHS will move to provide services seven days a week access to routine healthcare services
- That real time experience feedback from patients and carers is in place by 2015
- The Friends and Family Test identifies whether patients would recommend their hospital to those with whom they are closest

Equality Act 2010 – Public Sector Equality Duty

The Equality Act 2010 provides a cross-cutting legislative framework to:

- Protect the rights of individuals and advance equality of opportunity for all
- Update, simplify and strengthen the previous legislation, and deliver a simple, modern and accessible framework of discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society

It requires service commissioners to take equality and human rights into account in all its business, including commissioning services, employing people, developing policies, communicating, consulting or involving people in its work.

It sets out the following protected groups or ‘characteristics’ – age, disability, gender (sex), gender reassignment, pregnancy and maternity, race, religion or belief, lack of belief, sexual orientation, marriage and civil partnership.

The Equality Delivery System (EDS) is the means through which we will deliver this duty. The EDS states that organisations should: “Improve accessibility and information, and deliver the right services that are targeted, useful and used in order to improve patient experience”.

[6] Everyone Counts: Planning for Patients 2013-2014 http://www.england.nhs.uk/everyonecounts/

This means that in planning and delivering services we must ensure that:

- Measures are in place to identify and tackle any barriers to using services
- People have the necessary support and information they need to access services in a way that meets and takes account of their individual needs
- People are supported to make informed choices about their care and treatment and understand their rights
- Robust systems are in place to gather feedback and capture experiences from the people who use services and use this intelligence to improve services

Overview and scrutiny

We are accountable to Sefton Council's Overview and Scrutiny Committee for Health and Social Care (OSC). A number of local councillors make up the committee and its purpose is to represent the views and safeguard the interests of local people by:

- Scrutinising NHS policy, service planning and operations
- Being consulted on all proposals for major changes to health services
- Calling commissioners to give information about services and decisions
- Reporting their findings and recommendations
- Referring matters to the Secretary of State where they have not been adequately consulted, or believe that the proposals are not in the best interests of the local health service

The Health and Social Care Act requires us to consult with Sefton Council where we are planning a substantial variation in service, provide it with relevant information, respond to local authority overview and scrutiny committee reports and attend OSC meeting as requested.

Our approach

Our commitment

We recognise the value of meaningful involvement and its integral role in helping us to provide the best possible services for the people we serve. Communicating effectively – at the right time and in the right way - will be central in helping us to do this.

Our principles

Our overall approach to engaging and communicating with our key partners reflects the good practice set out in the Sefton wide Public Engagement and Consultation Framework[7]. We will ensure our activities are:

1. **Planned** – we will firstly establish the need to engage or consult, so we are clear about what we are asking. We will plan our approach, ensure that activities begin early and are timely throughout the process and we will put adequate resources into doing this
2. **Proportionate** – the scale of the activities we plan will be proportionate to the need to engage, consult or communicate
3. **Inclusive** – we will ensure our engagement and communications are appropriate and accessible by all
4. **Coordinated** – our activities will be well organised and well-coordinated with our partners from all other appropriate bodies involved, to reduce the possibility of duplicating effort and resources and streamlining processes whenever we can
5. **Integrated** – our engagement and communications activities will be integrated to get the best results possible
6. **Open and two-way** – we want people to be clear about how their views and experiences are being, or plan to be, used. So feeding back what we're doing and why is important to us. Whenever possible our communications will be clinically led and the messages we communicate will be consistent with our vision, values and objectives.
7. **Used to inform how we do things in the future** – we will manage the outcomes we gain from our activities to ensure this knowledge is used effectively in our decision making, and we will review our systems for engagement and consultation so we can learn from experience when we are devising subsequent activities

[7] The framework was developed jointly and adopted by the local NHS, Sefton Council, Sefton CVS in 2009 to set standards of good practice. Visit www.sefton.gov.uk

Our structures

Our organisational structures illustrate how we are striving to embed systems to achieve good, two-way engagement with key partners – patients, publics and CCG members - into our daily business:

- We have designated **Governing Body** leadership for engagement through our **lay member**.
- Our organisation works across four, well established, **Locality Groups** - Bootle, Crosby, Maghull and Seaforth and Litherland. Each is chaired by a GP and has dedicated support from our Operational Team. Locality groups provide a two way forum, in which our members can hear about strategic and operational progress and participate in and influence shaping this further.
- All member GP practices are invited to **Wider Group Meetings** every quarter. Attendance is strong and the meetings provide a further forum for practices to get involved in how we operate and what our priorities should be.
- We have an **Engagement and Patient Experience Group (EPEG)** which reports to our Governing Body via our **Quality Committee**. It is a Sefton wide group and is jointly chaired by our lay member and their counterpart from NHS Southport and Formby CCG. It includes representation from the patient's champion Healthwatch Sefton, Sefton Council and Sefton CVS, which represents the voluntary, community and faith sector. This group helps us to maximise the opportunities we have to engage across the different sectors in Sefton by working together in a coordinated way. EPEG gives expert advice about how and where to go to engage. It collects the information we gather from all our engagement activities to inform our work, and patient experience to help us to gauge how effective our services are and how we can improve them.
- A number of GP practices in south Sefton have **Patient Groups**[8]. We are providing support to help more practices set up their own group. These groups enable patients to have their say about services at their practice and hear about our wider work. In 2014 we will bring those groups together through regular meetings to provide support and share experiences.
- We hold regular public **Big Chat** events where we bring people together to discuss our work and to ask for their views about our plans. In 2014 we will also begin holding **'mini chats'** when we will go out to groups to ask for comments about different topics and issues.

[8] These are often known as Patient Participation Groups or Patient Reference Groups

Reaching out to involve people and partners

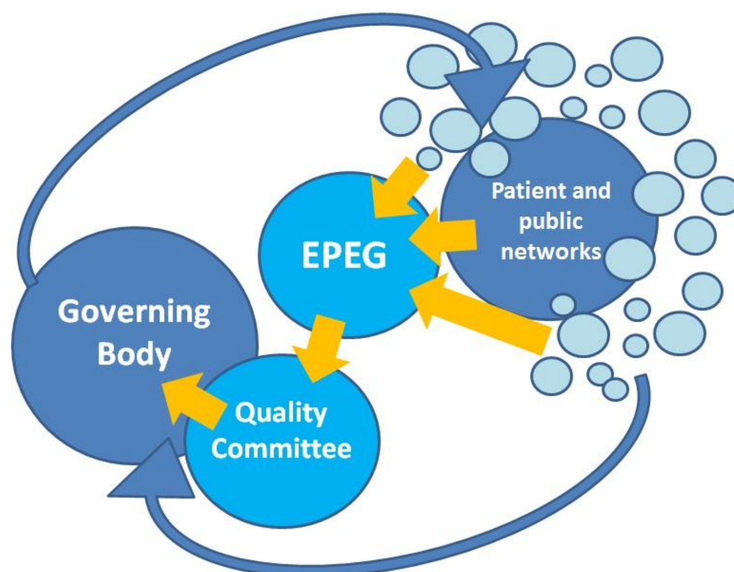
Whilst our organisational structure and systems provide a firm foundation for involving and engaging people, we recognise that we need to do more to make sure as many people as possible have the chance to get involved in our work.

So, we will constantly look for new opportunities to reach out to more people, particularly those who find it difficult to have their say about their health services.

Here are some examples:

- We are active members of **Sefton Health and Wellbeing Board** and work with our partners on the Board to involve people in Sefton's Health and Wellbeing Strategy, which sets out how together, we intend to improve health and social care
- Investing in **Healthwatch Sefton's** 'Community Champion' programme, which aims to increase the involvement of local residents in their NHS and gain their experiences of using health services
- Working with Sefton CVS to gather feedback and experiences and gain involvement from **voluntary, community and faith groups**
- Speaking directly to the **people who use services** we commission, so we can better gauge how effective those services are and how they can be improved

In the next section of this strategy, we look in more detail at how we are doing this. The following diagram shows how these internal and external structures and systems work together:



How we engage and involve

Whilst this section gives an overview of how we seek to involve people in our work, the following list is not exhaustive. We know that we must constantly look for different approaches to ensure we involve as many people as possible - particularly those who may otherwise struggle to have their voice heard.

1. How we plan and shape our services

In order to commission the best services, we need to analyse and assess the effectiveness of what currently exists, identify any gaps, look at ways we can respond to all this information, deliver the results – through new services or changes to existing ones – and then monitor and assess how well they work, so we start this process again. We carry out this **'commissioning cycle'** over the course of each year, and public and partner involvement is central to the process. The diagram below explains how this works.

Transforming participation in health and care

In September 2013, NHS England published this new guidance for commissioners to support them in involving people in planning and shaping services, towards meeting their duties as set out in the Health and Social Care Act. This guidance is supporting us as we work though our commissioning cycle, and we are taking account of its recommendations in our processes and systems.

NHS Call to Action

This is a national involvement programme from NHS England[9] which aims to encourage everyone in the debate about how the NHS can respond to the challenges created by an increasing demand for services and a reduction in public sector finances. We will continue to discuss these issues with patients, the public and other partners through all our local and ongoing activities.

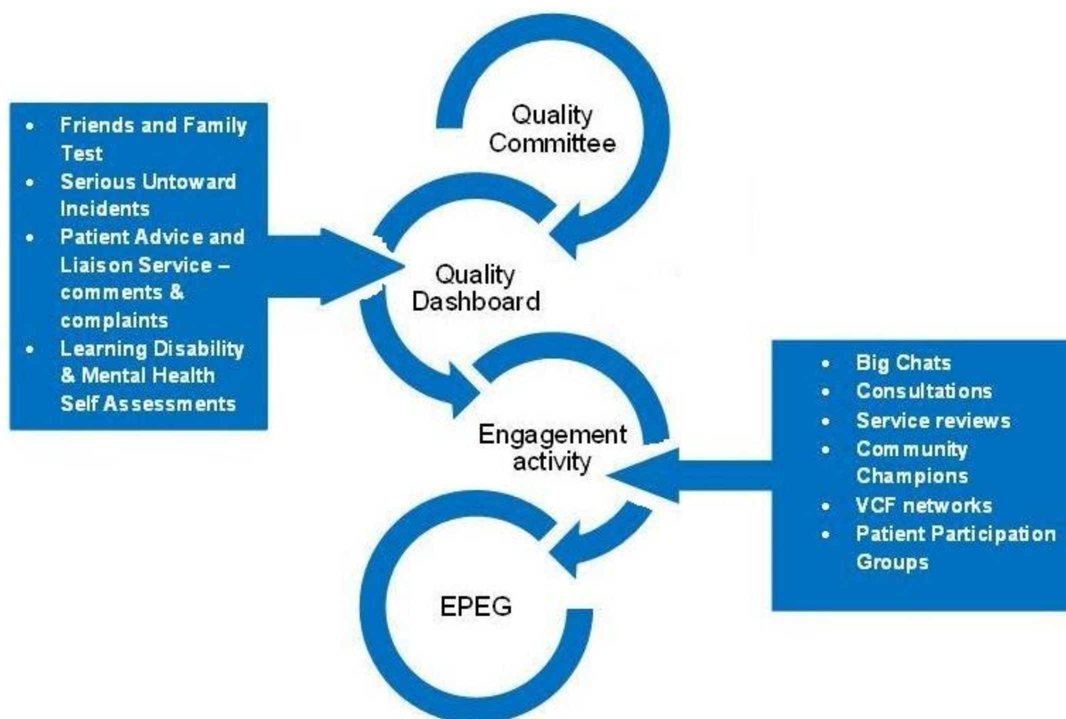
2. How we manage and act on information

Having a systematic approach to collecting all the views and experience we receive from the public and our other partners is vital, if we are to truly commission responsive services that reflect the needs of local people. During 2014 we will be strengthening our systems around managing and acting on the data we gather. Our **EPEG** group coordinates this information and provides the link to all areas of our work, for example when we are developing business cases for service changes or improvements, to ensure we act on this intelligence throughout the commissioning cycle. This intelligence is reported to our **Quality Committee**, to give assurance directly to our **Governing Body**.

Patient experience dashboard

We are developing a 'dashboard' that will bring together all the data we have about patient experience –from hospitals, community services and complaints etc - together with the information we gather from our engagement and consultation activities. This will help us to spot trends and allow us to act early on emerging issues. It will also support us to understand which services work well and where there may be gaps for some groups of people, including those who meet the 'protected characteristics' set out in the Equality Act (p9). The following diagram shows how this will work.

[9] Call to Action http://www.england.nhs.uk/2013/07/11/call-to-action/



3. How we involve our partners

We know we cannot achieve the improvement that we are aiming for in isolation. Having strong partnerships is crucial in helping us to achieve the best possible results for local people by doing more together.

Sefton Health and Wellbeing Board

During 2012-2013, and whilst the Board was preparing to become a statutory body as part of the NHS reforms, we worked together to map and identify any gaps in existing health and social care services. This process is called a 'joint strategic needs assessment'. We involved local people in this, holding a number of public events and associated activities to include as many people as possible in these discussions. The results of this helped us to identify areas for priority action, which form the basis of our Sefton Health and Wellbeing Strategy. At the end of 2012 and early 2013 we held five 'Talking Health and Wellbeing' public events to report back our results so far and involve people in the next steps.

Reflecting the strength of, and our commitment to this partnership, at the end of 2013 we created a new sub group of the Board focusing on communications and engagement. This will look at how, through a single **Sefton Voice**, we can work better together across the different organisations in the borough to involve and inform patients, the public and other partners. In early 2014 this group will lead a review of all our individual organisational systems for involvement to identify future shared opportunities.

Healthcare providers

There are many NHS and non-NHS organisations that provide local health services on our behalf. So, we need to involve these partners early when we are developing our plans. This will be particularly important when considering transformational changes to local healthcare, which will require different and more effective ways of working in order to secure improvements to services that will benefit our local residents.

Healthwatch Sefton

We are working closely with our statutory partner, Healthwatch Sefton[10], which is represented on our EPEG group. The information it collects from patients and the public about the services we commission through its 'Community Champion' network of community centres and organisations, feeds into our information and commissioning systems. We provide support to the Community Champion network, which is split into four geographical areas mirroring our CCG localities. This makes it easier for us to work together. During 2013–2014, the Community Champion network will be further strengthened through the work of the newly elected Healthwatch Locality Representatives. Part of these individuals' role is to work closer with our CCG locality managers and to support us in engaging more widely with local people, particularly those who struggle to give their views. The Community Champion programme will also support us in our work to develop patient groups in GP practices.

Voluntary Community and Faith Sector

Our links with the voluntary community and faith sector (VCF) are extremely important to us. These links support us in providing information to, and gaining feedback from harder to reach groups via the VCF sector. This includes members of the Sefton Equalities Partnership, Sefton Health and Social Care Forum and the Every Child Matters Forum. The VCF sector is represented in the membership of our EPEG group. EPEG receives regular intelligence about services and patient experience from these three forums. As members of EPEG, these forums can see how we respond to the information they provide us with. We will work together to explore how this can be further strengthened in the year ahead to ensure we are reaching the people who may be affected most by our work.

[10] www.healthwatchsefton.co.uk

4. How we involve local people

Big Chats and 'mini chats'

In addition to the public events we organise with Sefton Health and Wellbeing Board, we also invite people to comment on our work at our 'Big Chats'. In 2013 we held two, which were well attended. Whilst we will continue to hold Big Chats we know that it can be difficult for some people to attend these events. So, in 2014 we will begin holding 'mini chats', when we will go out to talk to groups and individuals who often find it difficult to have their say about health and health services.

Patient Groups

A growing number of GP practices are forming patient groups, sometimes known as Patient Participation Groups or Patient Reference Groups. These groups provide a forum for people to get involved in their practice and the services it offers. They also provide us with an opportunity to inform and involve members in our wider CCG work. We will provide more support to practices in 2014 to set up patient groups, and encourage the development of a network where different groups can swap ideas and information. We will extend these quarterly meetings to include members of the public and community organisations, as part of our commitment to involve people in designing and shaping our services.

Talking to patients

It is essential that we gain 'first hand' experience from the patients of specific services when we are planning changes or improvements to them. We need to ensure we have a full understanding of any impact our changes may have on patients, so we can address issues and amend our plans when necessary.

How we communicate

We will use a range of ‘channels’ or methods to inform and encourage involvement with **our members** and **our partners and our local residents**. This section details some of the key people we will communicate and engage with and some of the channels we will use, but these are not exhaustive. It also sets out some of the **underpinning activities** that support our communications and engagement activities.

1. Our members

Strengthening locality working

Our monthly locality group meetings are an important way of involving and engaging our member GP practices.

We will develop communications and engagement activities in line with our Organisational Development Strategy to further strengthen locality working, which is central to how we want our organisation to operate, as detailed in our founding Constitution[11].

Supporting our staff

We have a small Operational Team of around 50 people to help us carry out much of our day to day work. This includes nurses, medicines management and finance specialists, locality managers and those involved in performance and commissioning.

We need to ensure all our staff have a good understanding of, and are engaged in, our work. To do this we will ensure staff have good access to the information they need to work effectively. We will hold regular meetings to bring the team together and we will devise appropriate communications to support the delivery of our Organisational Development Strategy.

[11] Our Constitution can be downloaded from our website

Refining our internal communications channels

In mid-2013 we carried out a communications survey amongst our member GP practices to review our most important channels of communication. Overall the results were positive and have provided useful information which will help us to develop and refine these channels to ensure they continue to meet the needs of our members as follows

e-bulletin

Launched in September 2011, this weekly e-bulletin provides members with news, events and opportunities that are of interest to their own development. There are strong links between this electronic update and our intranet - the e-bulletin helps us to signpost our members and staff to our internal website.

We will refresh the visual appearance of our e-bulletin in line with our corporate identity in early 2014. Alongside this we will review the structure of the bulletin, to make it easier for people to access the information they are interested in, based on the comments we received from the communications review.

Intranet

Practice staff were involved in the design, functionality and content of our intranet, which was launched in January 2012. The site is intended to provide an 'information hub' for our members and staff.

We will review the structure and visual appearance of our intranet in line with our corporate identity in early 2014. We know from the results of the communications review, the content of the site needs to be improved and we will explore ways to ensure more information is available via the site, such as referral forms and care pathways. We will also remodel the locality sections of the site to provide a hub of information for each of our four membership areas.

2. Our partners

Sefton Health and Wellbeing Board

The new communications and engagement sub group of the Board (p16) will support partnership working whenever possible, so we can coordinate our activities, avoid duplication and maximise our resources and capacity.

We will update our joint communications and engagement strategy to reflect the changing needs and duties of the partners who work together through the Board.

Sefton Overview and Scrutiny Committee for Health and Social Care

We will continue to build good relationships with this committee. Our statutory duty to the committee is set out on page 10.

Our Chair and / or Accountable Officer will attend each meeting to update councillors about our work. We will inform and involve the committee early about any relevant plans or changes to services. Other areas of specific work will be supported by members of the Operational Team.

Our NHS partners

We work together with a number of other NHS organisations to either provide services or monitor the quality and performance of the services and care we commission.

We will look to carry out joint communications whenever appropriate with our NHS partners to ensure consistency and support. Partners include NHS England and the many hospitals and community services that provide care on our behalf.

Members of Parliament

MPs are uniquely positioned to provide us with views and perspectives about the services we commission based on the experiences of their constituents. It also means they are able to alert us early to problems, so we can begin to rectify them as soon as possible.

We aim to hold regular meetings between our Chair and / or Accountable Officer and local MPs to develop positive relationships, and we will respond quickly and effectively to requests in relation to parliamentary questions.

Healthwatch Sefton

We will continue to meet regularly with Healthwatch Sefton to discuss health and social care locally. The organisation is a member of the Health and Wellbeing Board, an active member of our EPEG group and its chair has a standing invitation to attend our Governing Body meetings as a co-opted member – all presenting opportunities for Healthwatch Sefton to ensure its patient and public members are kept up to date about our work, and for the organisation to feedback any comments directly to us.

The Community Champion network also presents us with greater opportunities to communicate with patients and local residents, and we will work together in the year ahead to explore how this might be strengthened.

3. Our local residents

Website

During our first year of operation we established an interim website to provide local people and our partners with information about us and what we do.

By the start of 2014 we will replace our interim site with a new permanent public facing website, containing more information and offering more user functionality helping to further build recognition, reputation and understanding of who we are and what we do.

e-bulletin

Over the coming year we will launch an e-bulletin providing updates about our work to members of the public and our partners. It will link to our permanent new website, where people will be able to sign up to the distribution list and leave comments about the items it contains.

Media relations

There remain a number of distinct and well respected media outlets in South Sefton, despite the national contraction of this sector. The majority of newspapers are free sheets, delivered directly to a high proportion of homes in the area. Regional radio stations, such as BBC Radio Merseyside and Radio City, command strong and loyal listenership.

It is essential we manage our media effectively and to support members in doing this we have a media protocol (Appendix 5).

Using new media effectively

With the growing prominence of new and social media, we will look to identify opportunities where we can effectively use these channels of communication in support of our objectives (p6). Specifically, we will explore the benefits of social media as a method for achieving two way dialogue with the public and partners.

We recognise that parts of south Sefton have amongst the lowest rates of home internet access. So, we will also explore the use of other technologies to reach these communities, including promoting our new Looking Local digital information service, available on TV and smartphone. Appendix 5 sets out guidance on the use of social media, based on best practice.

Corporate documents

We are required to produce an annual report in 2014, detailing how well we performed in our first full year of operation. In addition to this we will publish a number of other corporate strategies and reports that will further illustrate our work and performance.

We will only produce new printed materials when absolutely necessary in support of 'greener' working practices. So, whenever possible, corporate documents will be produced electronically, only offering alternative formats on request.

Maximising our public waiting areas

We are working with GP practices to understand how we can better use our public waiting areas. We know these spaces offer great potential to communicate with and engage our patients.

In 2014 we will explore how we can make better use of these assets including notice boards and display areas, as well as scoping the potential of television based information systems, which will begin with a review of current systems in place.

Mapping and maximising partners channels

Our partners use a range of channels to communicate with their staff, service users, members and patients and often include messages on our behalf.

In 2014 we will map these channels, including smaller community based channels to understand where we might reach out more widely to communicate with our patients, the public and other partners.

4. Underpinning activities

Brand management

At the end of 2012 we created a visual identity, which is used across our different channels of communication.

We reviewed this visual identity in 2013, testing it with local people. Whilst the feedback was positive, the exercise highlighted areas for improvement and we have revised our visual identity as a result.

Effective management of our identity and corporate house style is an important element in promoting our reputation - the visual identity is designed to represent the vision and values clearly in all our communications.

In 2014 we will ensure our revised identity and corporate house style are consistently applied.

Crisis and issues management

In the event of a crisis or major incident, effective and timely communications are critical.

We will horizon scan for potential negative or difficult issues and prepare appropriate responses for any emerging problems. This means adopting a whole system overview through information gained through complaints, MP letters, Parliamentary Questions, patient experience etc, ensuring communications is considered as part of our EPEG group.

Delivering this strategy

Members of our Governing Body and Operational Team will take a pro-active approach to carrying out their roles outlined below. They will do this in a timely way and be mindful of external deadlines in support of a positive reputation amongst our stakeholders. In early 2014 we will review our communications and engagement function, which is currently provided by Cheshire and Merseyside Commissioning Support Unit. This review of our current operational model will take account of best practice and the national 'make, share and buy toolkit'[12] for CCGs.

Our Governing Body is responsible for:
Taking the lead and fronting media activity, both in relation to proactive and reactive issues
Lead on the delivery of high level communication to staff, constituent practices, partners and providers
Alerting the lead for communications support to any emerging issues
Attendance and involvement in public events

Our Operational Team is responsible for:
Ensuring communications and engagement are represented in all workstreams and alerting appropriate leads about any emerging issues
Working pro-actively to provide updates to our lead for communication support for inclusion in briefings, press releases, bulletins, websites and newsletters etc

The specialist communications and engagement duties in the following two tables have been indentified to support the success delivery of 'Communicating health in south Sefton'

[12] http://www.england.nhs.uk/2013/11/13/ccg-mk-shr-buy-tool-kit/

Local communications support will be responsible for:
Developing and managing the operational delivery of the communications elements within this strategy and working with the engagement lead to provide an integrated, seamless service
Providing the Governing Body with timely progress reports and ensure that the Chair and Accountable Officer are made aware of any significant issues or risks
Providing strategic communications input and advice to our work
Identifying, planning for and responding to emerging issues which may have a detrimental impact on reputation
Handling of all media activity – including social media and reactive media activity, ensuring appropriate response and timely escalation of issues and, where required, co-ordinate responses with communication leads from partner and provider organisations – to ensure a consistent approach
Oversight of all regulatory and non regulatory communications
Supporting the Operational Team with practical communication support - including the development and implementation of communication plans, website development and management and the appropriate use of social media

Local engagement support will be responsible for:
Delivery of agreed operational engagement activity, as identified in this strategy
Acting as the first point of contact for community and third sector groups in relation to public engagement activity
Work closely with the communications lead to ensure a co-ordinated approach, essential to managing any emerging issues which may impact on our reputation
Being our representative at a variety of third sector and community group meetings and present updates as and when required
Where appropriate, attend and / or represent us at agreed public events across the borough
Providing engagement support to our Operational Team and wider regional or national engagement or consultation exercises
Supporting the development of the patient experience programme, including the EPEG group

Measuring and reviewing this strategy

Our approach

In setting our communications and engagement objectives, we have been mindful of the need to measure their efficiency and effectiveness. Therefore reviewing this strategy and its action plan will be essential in helping us to assess its success.

Below are some of the ways we can do this:

1. **Formal and informal feedback from stakeholders including:**
   - Patient experience feedback and patient surveys
   - Levels of awareness of our work
   - Public perceptions of local NHS services and people's ability to influence the future shape of these services
   - Feedback from members, partner and provider organisations

2. **Formal and informal feedback from staff and members**
   - Views sought through team meetings, staff briefings and other engagement events
   - Survey of staff and members
   - Intranet usage

3. **Favourable media coverage**
   - Media content analysis

4. **Political temperature**
   - Positive political support vs level of political activity (MP letters Parliamentary Questions Feedback from members (including content and volume)

Resourcing this strategy

We will ensure our activities are devised to be cost effective and to make the most appropriate use of our resources.

Specific resources required to deliver ongoing and new programmes will be assessed for their effectiveness and value for money using some of the methods outlined above.

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Appendix 1 - Knowing who we need to communicate with

The table below summarises a mapping exercise to identify our priority audiences. Relationships between different groups are complex – some 'customers' could also be defined as 'oversight' (or providers) or 'enablers'. We will be mindful of these shifting relationships and regularly revisit this mapping exercise to ensure appropriate relationships are maintained with different groups and that it categorises them in order of priority – ie, where our communications and engagement is likely to have the greatest impact due to the power and interest of different groups listed below.

Keep engaged
Patients, carers and patient groups
Wider public
Hard to reach groups
Voluntary, community and faith sector (VCF) organisations
Keep informed
NHS England
Public Health England
Overview and Scrutiny Committee for Health and Social Care (OSC)
Sefton Council Cabinet
Ward councillors
MPs
Local Medical Committee (LMC)
Other medical committees (pharmaceutical , dental, optical etc)
Regulatory bodies (inc CQC, Monitor)
Enablers
Cheshire and Merseyside Commissioning Support Unit (CMCSU)
NHS England Merseyside Area Team
Service providers (inc Community, Acute and VCF)
Our Governing Body / locality groups / wider group / Operational Team
Neighbouring CCGs
Healthwatch Sefton
Sefton CVS
Sefton Health and Wellbeing Board (inc sub structure and task groups)
Sefton Public Health
Sefton Council Executive
MPs
Media
Clinical forums
Limiters
Groups with negative perceptions of the NHS

Appendix 2 – Assessing our strengths and weaknesses to identify risks

An analysis of the strengths, weaknesses, opportunities and threats which may impact on our work are set out below.

Strengths
Leadership demonstrating firm commitment to robust and meaningful engagement and communications
Emerging good relationships and working practices with key partners (statutory and VCF), building on strong foundations established by predecessor organisation
Experienced and skilled communications and engagement function provided by CMCSU with strong local knowledge
Strong history of clinical engagement
Positive media relationships with distinct traditional media outlets
Weaknesses
National perception tracking survey highlights fall in levels of satisfaction in NHS
Key partners reducing capacity and resource in engagement and communications due to wider health and public sector reforms
Continuously changing environment due to ongoing NHS and public sector reforms
Opportunities
Emerging new media channels to engage and communicate with members and stakeholders
Chance to enhance internal and external clinical engagement
Resolve to carry out joint communications and engagement activities between key partners to maximise impact and capacity and resource
The relatively high level of public trust in clinicians continues, making us ideally placed to deliver key messages
Threats
Financial challenge of reduced healthcare budgets impacting on the level and quality of communications and engagement support we are able to secure
Ongoing political challenge associated with reforms
Possible reduced levels of confidence amongst our publics and partners due to national or local factors
Levels of clinical engagement amongst our members and wider clinical groups must remain high if we are to be successful

Appendix 3 – Defining our key messages

The key messages below have been developed to support our objectives. When necessary, we will develop 'sub' messages in line with our vision and objectives.

Objective 1 - Engaging and communicating effectively with member practices and our staff, to enable a shared understanding of our work and their role within it	**Key message**
This is our organisation and we all have a role to play in achieving better health and care for local people	**A**
Objective 2 - Supporting the successful delivery of our priority programmes to transform health services and improve people's health	
We are focused on improving the quality of local health services and improving our patients' experience of these services	**B**
We will be transparent, open and honest about decisions we make	**C**
Objective 3 - Increase recognition of our work and raise our profile amongst all patients, members of the public and other partners	
We are best placed to develop local health services because we are close to patients and know their healthcare needs	**D**
We will communicate effectively, in a range of ways, to ensure people are aware of key issues, progress and our collective successes	**E**
We will support people to access the right care, by providing them with the information they need to help them make the right choice based on their needs	**F**
Objective 4 - Working together with our NHS partners, Sefton Council, Healthwatch and the voluntary, community and faith sector to improve local health services, and increase awareness of those services amongst people in south Sefton	
We are committed to strengthening our work with partners whenever possible to improve services, reduce duplication and increase efficiency, with the aim of achieving more together	**G**
Objective 5 - Encouraging participation of south Sefton residents in shaping and reviewing health services, so they are the best they can be	
We are committed to involving people in our work and for them to influence decisions about their local health services	**H**
We will feed back any changes or improvements we make to services, so people can see where they have influenced this process	**I**
Objective 6 - Manage and plan for difficult situations	
We may have to make tough decisions in this difficult financial climate, but we will involve patients and public in this process to make sure we make the best investments	**J**

Appendix 4 – summary of activity 2013-2015

The table below is designed to give an overview of our work, and is supported by more detailed operational work plans. The messages and objectives below correspond with Appendix 3, and a list of 'audiences' can be seen in Appendix 1. Activity will be carried out during 2013 – 2015.

Objective	Audience	Messages	Methods
Engaging and communicating effectively with member practices and our staff, to enable a shared understanding of our work and their role within it	GP practices	A	Strengthening locality working, linking to and supporting delivery of Organisational Development Strategy (including support for practice learning time programme)
	GP practices / Operational team	A	Refine internal communications channels (intranet / ebulletin) based on feedback, to provide regular updates around key corporate work and opportunities for member / staff involvement
			Support key forums / meetings, including practice manager, practice nurse and wider group meetings
Supporting the successful delivery of our priority programmes to transform health services and improve people's health	Governing Body / Operational team	B-C	Ensure communications and engagement are tied into organisational planning – including development of overarching organisational strategy, annual commissioning cycle and development of business cases through project management office
			Developing bespoke communications and engagement plans for priority work programmes such as urgent care and our primary care quality strategy
			Review how we choose to operate our communications and engagement function against national best practice and using the 'make share and buy' guidance for CCGs
Increase recognition of our work and raise our profile amongst all patients, members of the public and other partners	Operational team	B-F	Embed revised visual identity and corporate style across all materials / templates / reports / strategies etc
	All public audiences	B-F	Launch permanent public facing websites and linked social media channels
			Media planning to support key work programmes / celebrate success
			Launch refreshed Looking Local site early 2014

	Public / partner	B-F	Provide communications for partner internal / external channels
			Mapping wider community channels as potential outlets
	Partner	B-F	Meet regularly with and use appropriate channels to pro actively inform key influencers – such as OSC, MPs, VCF forums, Healthwatch Sefton, LMC etc – and provide them with information when requested promptly
Working together with our NHS partners, Sefton Council, Healthwatch and the voluntary, community and faith sector to improve local health services, and increase awareness of those services amongst people in south Sefton	Governing Body / Operational team / partners	G	Continue to develop and strengthen EPEG
	All public audiences	G	Work collectively through Health and Wellbeing Board – including refresh of Health and Wellbeing Board Communications and Engagement strategy, review of 'patient voice'
			Develop joint communications and engagement strategies / activities to support programmes like Virtual Ward
			Use our public facing communications channels appropriately to promote active involvement in our services, and look to develop other opportunities to do this (including social media)
			Scoping opportunities to improve communications within public waiting areas including review of TV based systems
Encouraging participation of south Sefton residents in shaping and reviewing health services, so they are the best they can be	Patients / public / partners	H-J	Organise programme of Big Chats based on feedback from previous events
	Patients / public		Support GP practices to develop patient participation groups
	All public audiences		Develop other systems to strengthen involvement, particularly amongst hard to reach groups, including 'mini chats'
			Use our public facing communications channels to promote active involvement in shaping our services
Manage and plan for difficult situations	GP practices / Governing Body /Operational team	J	Revised media protocol in place and awareness raised amongst staff / members around responsibilities
	Governing Body /Operational team		Ensure communications is considered in all corporate systems – including Governing Body, Quality Committee and EPEG
			Ensure communications is considered in all key work programmes to ensure emerging issues are spotted and acted upon

Appendix 5

NHS
South Sefton
Clinical Commissioning Group

Media protocol

NHS South Sefton Clinical Commissioning Group

November 2013

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About this media protocol

We aim to maximise opportunities to improve communications with local people and other partners through open, frank and effective media relations - initiating communications and responding to enquiries in a clear, timely and consistent way – to build a better understanding of our work and achievements.

Our central objective is to **ensure a positive media profile - maximise good publicity, minimise the effects of negative publicity and ensure a corporate approach to the media.**

To do this we will:

- Establish and maintain clear and regular channels of communication with the media and create a positive, informed and clear profile of who we are
- Develop and promote consistent key messages
- Respect the right of the media to represent all views
- Seek correction when media coverage is misleading or incorrect

Our media relations standards

1 **Telling our story** - proactive communication through press releases, briefings and opportunities is key to shaping our positive profile and ensuring our publics and partners understand our work and achievements. This requires our staff and member practices to inform the communications support service as soon as possible about the stories they have to tell about our work, new initiatives, successes that should be celebrated and difficult messages that must be communicated. Information must be timely and relevant to ensure media interest. Opportunities to attend events, interview key people and take photography will increase the appeal of our stories.

2 **Media enquiries** - a good relationship with the media is built on trust and responsiveness. We must ensure each issue is handled as well as possible and the media understand we are serious about openness and transparency. Our communications support service will respond to important media enquiries with a target turnaround of 4 hours whenever possible - this requires immediate attention and support from all our staff and members involved.

3 **Management of Information** – our Governing Body and Operational Team will consider communication issues at their regular meetings - discussing communication risks, opportunities and significant planned initiatives.

4 **Effective media communications**– our lead for communications support can offer strategic advice and expertise, supported by analysis of media coverage of our activities and channels, through media monitoring.

Our media protocol

We will handle all media issues and enquiries in the following way:

A All media issues about our organisation are handled by our lead for communications support

- All direct approaches to staff by the media must be referred to the communications lead at the earliest possible opportunity
- The lead will prepare proactive press releases and provide briefings when appropriate, arrange opportunities for media interviews and provide briefings
- The lead will prepare reactive media statements and briefings, arrange media interviews and provide briefings
- The lead will quote the Chair / Accountable Officer / other Board members – who will also represent us as spokespeople for media interviews

B Our members and the Operational Team should proactively inform our communications support about all plans that require or may lead to publicity

- All plans that may lead to publicity - proactive or reactive - must be shared with our communications support at the earliest stage to ensure communications opportunities and risks are identified and managed

C Our communications support will …

- Provide advice on issues and review reports that may lead to media interest
- Provide access to other appropriate communications opportunities
- Attend key internal meetings when required to discuss impending communications issues to identify opportunities and risks

D We will keep our partners informed by...

- Informing NHS England, the Department of Health and other relevant partners – about media issues that may be of regional and national significance
- Liaising with our local partners – like Sefton Council – on issues where we have joint responsibility or our media response may affect them
- Briefing key stakeholders about emerging issues or change - we will endeavour to ensure they hear news first from us

Social media guidance

Facebook, Twitter and You Tube are amongst some of the most well-known examples of social media. Their power is growing and their application can therefore be useful for organisations to use appropriately to engage and inform their audiences. Whilst there are advantages to using social media, there can also be pitfalls which impact on reputation…

Our approach

…therefore, any engagement using these channels on our behalf should be managed by our central communications support. If you have a specific message you would like to cascade via social media, please contact communications who will provide advice and support.

Personal use

The following guidance provides a framework to help members protect themselves and our organisation, without sacrificing the benefits social media can bring to users.

1. Users are personally responsible for what they publish. Remember, anything posted will be published immediately and will be permanently available to a world-wide audience and could be republished in other media
2. Internet postings must respect copyright, privacy, fair use, financial disclosure, and other applicable laws, such as libel and defamation
3. Internet postings should not disclose any information that is confidential or proprietary to the organisation or to any third party
4. If staff or members comment on our business they must clearly identify themselves with the disclaimer - "the views expressed are mine alone and do not necessarily reflect the views of SSCCG." Individuals should neither claim or imply they speak on the organisation's behalf unless they have sought prior agreement via the communications support team
5. Identify yourself – give your full name when you discuss work-related matters. Write in the first person. You must make it clear whether you are speaking for yourself or on behalf of the organisation with approval
6. Be aware of your personal profiles – you may wish to ensure your own personal profile and related content is consistent with how you wish to present yourself to colleagues and stakeholders
7. Be safe – never give out personal details or publish confidential information including that about patients, providers etc
8. Respect your audience - you should show proper consideration for others' privacy and for topics that may be considered objectionable or inflammatory
9. Add value – our brand is best represented by its people and what you publish may reflect on that
10. Social media should only be used in work time if it directly supports you in your employed position, and you have gained approval
11. Compliments and complaints – if you are made aware of any complaints/ criticisms, or if you are made aware of a particularly satisfied service user, inform communications.
12. The organisation reserves the right to request the certain subjects are avoided, withdraw certain posts, and remove inappropriate comments

Our communications service

Press releases

We aim to achieve 100% take up of our press releases by the media, which means only producing releases on issues the media are likely to respond to and publish. Press release should be supported with arrangements for appropriate people to conduct follow-up interviews and photo opportunities. Briefing notes will be prepared if appropriate. Our communications support will produce photography for distribution to the media if appropriate.

Media enquiries

We have highly skilled communications support in helping us to respond to media enquiries. The team relies on people throughout the organisation to respond to their referred enquiries as well and as quickly as possible. Each enquiry is logged and the results evaluated through our media monitoring.

Issue management

It is vital that we identify issues that may provide an opportunity for positive publicity or which may be contentious and plan for them as early as possible. Our communications support will prepare appropriate responses for any emerging problems, anticipating how the CCG will need to deal with criticism.

Nominated spokespeople

Agreeing a small pool of nominated, skilled spokespeople will ensure consistency of key messages. This will help build our reputation.

Rapid response

In cases where attacks on our organisation are made by media channels, our communications support will prepare a response with background notes, rebuttal statements and general advice.

Contacts

Lyn Cooke, lead for communications support service

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Communications – general queries

Tel: 0151 247 7040

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NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2013

Agenda Item: 13/161	**Author of the Paper:** Martin McDowell Chief Finance Officer martin mcdowell@southseftonccg.nhs.uk Tel: 0151 247 7065
Report date: November 2013	

Title: NHS Allocations to CCGs and required baseline adjustments

Summary/Key Issues:

1 At the time that the PCT undertook the dis-aggregation exercise, the underlying information used to support the process was variable in terms of its quality. The process was technically difficult and required a significant degree of estimation. In terms of information quality, it ranged from being able to assign specific units of activity to a GP practice (e.g. most PbR activity) to having to apportion costs based on a crude population basis in which case a rough approximation of 60% to South Sefton CCG and 40% to Southport and Formby CCG was most commonly applied.

2 Since that point, the CCG's joint Finance Team has worked hard to improve the quality and understanding of information and has established that a number of anomalies are included in the CCG initial baseline exercise that require adjustments to reflect the commissioning responsibilities of each CCG. The first paper recommending baseline adjustments was approved by the Governing Body in September. This paper follows the principles established in the initial report and provides a further update on progress.

3. Reports on Fair Shares position using information published by NHS England.

Recommendation

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

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

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
November 2013

1. Introduction and Background

1.1 When the PCT undertook the dis-aggregation exercise, the information used to support the process was variable in terms of its quality. As such, the process was technically difficult and required a significant degree of estimation. In terms of information quality, it ranged from being able to assign specific units of activity to a GP practice (e.g. most PbR activity) to having to apportion costs based on a crude population basis in which case a rough approximation of 60% to South Sefton CCG and 40% to Southport and Formby CCG was most commonly applied.

1.2 Since that point, the CCG's joint finance team has worked hard to improve the quality and understanding of information and has established that a number of anomalies are included in the CCG initial baseline exercise that require adjustments to reflect the commissioning responsibilities of each CCG. The first paper recommending baseline adjustments was approved by the Governing Body in September. Since September, further information has been received and reviewed, and further revisions to allocations are now proposed, following on from the principles established in the original paper.

1.3 NHS England has published a fair shares formula, and this paper provides an update to likely allocations after accounting for the proposed transfer of funds outlined in this paper.

2. Proposed Adjustments

Revisions To Allocations Between Sefton CCGs

2.1 As highlighted in section 1 of this paper, the joint finance team of the Sefton CCGs have undertaken a review of the assumptions used in the PCT baseline disaggregation exercise and have found that they were inaccurately applied in a number of key service line areas. Appendix 1 provides details of the following issues and identifies where baselines have been reviewed in terms of accuracy. The key at the far side of the appendix identifies whether the review has been completed (green) or is still subject to final agreement (red).

2.2 The proposed changes are in the following areas:

- Learning Difficulties
- Mental Health (Merseycare)
- Small value contracts
- More accurate population basis

None of the proposed changes will impact on the forecast surplus because both funding and expenditure will transfer between the two CCGs.

2.3 Learning Difficulties – The CCG now has more accurate patient level expenditure data for Learning Difficulties. This shows that the aggregate budget for the two CCGs is sufficient to cover obligations, but Southport & Formby expenditure is significantly greater than the original budget allocation. South Sefton CCG expenditure is lower, thus highlighting an error in the original budget apportionment. It is therefore proposed that a transfer of allocation of **£0.479m** from South Sefton CCG to Southport and Formby CCG takes place, and the new share is now reflected as a 44:56 split, with the majority of expenditure relating to Southport and Formby.

2.4 Mental Health (Merseycare) – The contract with Merseycare is a fixed price contract. In the original allocations, this was split on a 60/40 basis. However, activity data received from Merseycare identifies that this apportionment is inaccurate. Correcting these inaccuracies, results in a transfer of **£1.906m.** If the allocation transfer is approved then we will seek to action a contract variation consistent with the new balances. The amended proportion allocated to South Sefton CCG is 51.5%

2.5 Small value contracts – A number of small value contracts have been identified as specific to a particular CCG (eg. Home Oxygen Service for South Sefton CCG patients only). Where this has been identified, it is proposed that a full transfer of both allocation and expenditure to the appropriate CCG. In addition, activity information has been received from a range of providers (eg. Assura – Dermatology, IAPT) that show a more accurate split for the budget. Implementing these changes will result in an allocation transfer of **£0.376m** from South Sefton to Southport and Formby.

2.6 In the absence of better information (eg. patient level data), allocations were set on a crude population split of 60% to South Sefton CCG and 40% to Southport and Formby CCG. Where particular service lines are still being reviewed we propose to use a more accurate population split. A review of a range of population bases shows a more appropriate split would be 56% to South Sefton and 44% to Southport and Formby. This is only applied to service line budgets where more accurate data (eg. patient level) is not available. This results in an allocation transfer of **£0.223m**, and applies to the following cost centres:

- Collaborative commissioning
- Dementia
- Mental Health contracts
- Reablement
- Intermediate care (a proportion)
- Out of Hours

3. Impact of changes on proposed "fair shares" formula

3.1 In August, NHS England released a proposed "fair shares" formula for CCG allocations. This formula introduces the concept of a "target allocation" which assesses the theoretical need of a population and then adjusts for key characteristics which are known to have an impact in terms of how individuals access healthcare (e.g. age, health status, proximity to services). The "target allocation" is then compared to the existing allocation received by a CCG and measures how far over or under target the CCG is in terms of the allocation that it currently receives. The impact of the proposed changes outlined in section 2 above is detailed in the table below, with further detail in appendix 2.

CCG	2013/14 Op allocation (£000's)	Indicative Allocation (£000's)	DfT £000's	DfT %
South Sefton CCG	218,909	204,285	14,624	7.16%

3.2 Once the recommended allocation transfers are approved, the CCG will be 7.16% above its indicative allocation. It is important to note that the indicative allocation has not yet been confirmed. The announcement of allocations for 2014/15 and 2015/16 are expected in mid-December.

4. Next Steps – Remaining Areas

4.1 There are a number of areas that are still being reviewed that may result in a further transfer of allocation between the CCGs. The most significant of those are outlined below.

4.2 Continuing Healthcare – there continues to be significant uncertainty in the costs associated with individual packages of continuing healthcare. The CCG is working closely with the CSU to understand the pressures in this area, and to work towards more accurate reporting. When the costs are clarified a revised allocation will be proposed.

4.3 Liverpool Community Health – indicative revisions have been received from the provider, but no formal contract variation has been agreed. The revision to the contract split may also include an impact on other commissioners, principally NHS England. Conversations with the provider and NHS England are on-going, and it is proposed that future changes are reported to the Governing Body in January.

4.4 As outlined in section 2.6, there continues to be a number of cost centres that are split on a 56:44 population split. Those continue to be investigated to see whether available data would suggest a more appropriate split.

4.5 The total allocation (from the brought forward budgets) for the two Sefton CCGs was £2.7m higher than was needed to meet initial contract values. This funding remains allocated to South Sefton CCG pending further review (including the month 8 specialised commissioning reconciliation).

5. Recommendations

The Governing Body is asked to:

5.1 note the details of the reviews that have taken place across expenditure headings identified in this report. On the basis of the findings of these reviews, the Governing Body is asked to approve a transfer of £2.984m (as identified in Appendix 1 of the report), in respect of the issues highlighted in this report;

5.2 note that are further areas within the CCG's expenditure profile that remain subject to review and updates will be given in future Governing Body meetings;

5.3 note the latest position in respect of the movement to the proposed "formula based" allocation noting that the CCG's original baseline position is 1.47% below target and its forecast position is expected to be 2.89% above target meaning that there is likelihood that

the CCG will have to make savings over and above existing plans. This will be dependent upon the timescales associated with the movement to target (the “pace of change”).

6. Appendices

Appendix 1 – Breakdown of revised budgets
Appendix 2 – Anticipated baseline adjustments

Martin McDowell
November 2013

NHS South Sefton CCG - Allocation and budget revisions - Month 8

Cost centre Number	Cost Centre Description	Budget Holder
COMMISSIONING - NON NHS		
598506	Child and Adolescent Mental Health	Debbie Fagan
598596	Collaborative Commissioning	Debbie Fagan
598711	Community Services	Debbie Fagan
598682	Continuing Care	Debbie Fagan
598511	Dementia	Debbie Fagan
598691	Funded Nursing Care	Debbie Fagan
598721	Hospices	Debbie Fagan
598726	Intermediate Care	Debbie Fagan
598521	Learning Difficulties	Debbie Fagan
598501	Mental Health Contracts	Debbie Fagan
598531	Mental Health Services – Adults	Debbie Fagan
598541	Mental Health Services - Collaborative Commissioning	Debbie Fagan
598551	Mental Health Services - Older People	Debbie Fagan
598661	Out of Hours	Malcom Cunningham
598796	Reablement	Debbie Fagan
	Sub-Total	
CORPORATE & SUPPORT SERVICES		
600251	Administration and Business Support (Running Cost)	Melanie Wright
600271	CEO/Board Office (Running Cost)	Fiona Clark
600276	Chairs and Non Execs (Running Cost)	Fiona Clark
600286	Clinical Governance (Running Cost)	Stephen Astles
600296	Commissioning (Running Cost)	Stephen Astles
600351	Finance (Running Cost)	Martin McDowell
600391	Medicines Management (Running Cost)	Brendan Prescott
	Sub-Total Running Costs	
598656	Medicines Management (Programme Cost)	Brendan Prescott
598646	Commissioning Schemes (Running Cost)	Stephen Astles
598676	Primary Care IT	Paul Shilcock
598776	Non recurrent programmes	Martin McDowell
	Sub-Total Programme Costs	
	Sub-Total	
SERVICES COMMISSIONED FROM NHS ORGANISATIONS		
598576	Acute Childrens Services	Debbie Fagan
598571	Acute Commissioning	Stephen Astles

598586	Ambulance Services	Malcolm Cunningham
598631	Winter pressures	Stephen Astles
598756	Commissioning - Non Acute	Stephen Astles
598616	NCAs/OATs	Stephen Astles
598786	Patient Transport	Stephen Astles
	Sub-Total	
INDEPENDENT SECTOR		
598591	Clinical Assessment and Treatment Centres	Stephen Astles
	Sub-Total	
PRIMARY CARE		
598791	Programme projects	Stephen Astles
598651	Local Enhanced Services and GP Framework	Stephen Astles
	Sub-Total	
PRESCRIBING		
598606	High Cost Drugs	Brendan Prescott
598666	Oxygen	Brendan Prescott
598671	Prescribing	Brendan Prescott
	Sub-Total	
RESERVES		
598761	Flexibility Reserve (Budget Setting)	Martin McDowell
598761	Contingency Reserve	Martin McDowell
598761	Committed Reserve	Martin McDowell
598761	General Reserve	Martin McDowell
598761	Investment Reserve	Martin McDowell
598761	Non Rec Reserve	Martin McDowell
598761	Contracting Reserve	Martin McDowell
598761	Unidentified QIPP	Martin McDowell
	Sub-Total	
	Grand Total Expenditure	
	RRL Analysis	
	Surplus / (Deficit)	
	TOTAL PROPOSED ALLOCATION TRANSFER	

Finance Lead	Current Budget 2013/14 - M7			Proposed Bud
	Rec	Non-Rec	Total	Rec
Mike Scully	1,202	0	1,202	
Laura Doolan	320	0	320	304
Laura Doolan	601	(16)	584	506
Laura Doolan	2,984	0	2,984	
Laura Doolan	124	0	124	118
Laura Doolan	2,021	0	2,021	
Les Hayes	1,221	0	1,221	1,179
Les Hayes	260	117	377	116
Laura Doolan	1,874	0	1,874	1,395
Laura Doolan	827	0	827	785
Laura Doolan	860	0	860	
Laura Doolan	951	0	951	
Laura Doolan	300	0	300	
Les Hayes	659	0	659	
Les Hayes	1,312	0	1,312	1,245
	15,517	**101**	**15,618**	
Chloe Rachelle	107	0	107	
Chloe Rachelle	632	0	632	
Chloe Rachelle	125	0	125	
Chloe Rachelle	29	0	29	
Chloe Rachelle	1,644	22	1,666	
Chloe Rachelle	1,031	13	1,044	
Chloe Rachelle	77	0	77	
	3,646	**34**	**3,680**	
Chloe Rachelle	489	0	489	
Chloe Rachelle	831	0	831	
Ken Jones	276	0	276	
James Bradley	1,560	0	1,560	
	3,156	**0**	**3,156**	
	6,801	**34**	**6,836**	
Jenny White	8,438	0	8,438	
Jenny White	105,975	1,197	107,172	

Jenny White	5,451	0	5,451	
Jenny White	0	1,520	1,520	
Jenny White	37,805	1,189	38,993	35,749
Adam Gamston	1,235	0	1,235	
Adam Gamston	12	0	12	
	158,914	**3,906**	**162,820**	
Adam Gamston	1,502	0	1,502	
	1,502	**0**	**1,502**	
Chloe Rachelle	0	412	412	
Michael Scully	848	0	848	
	848	**412**	**1,260**	
Adam Gamston	1,041	0	1,041	
Les Hayes	367	0	367	413
Les Hayes	27,485	0	27,485	
	28,893	**0**	**28,893**	
Clare Shelley	3,574	1,788	5,362	
Clare Shelley	2,605	27	2,632	2,522
Clare Shelley	795	129	924	
Clare Shelley	1,210	(710)	500	
Clare Shelley	160	0	160	
Clare Shelley	0	2,312	2,312	
Clare Shelley	(1,430)	0	(1,430)	
Clare Shelley	(159)	53	(106)	
	6,755	**3,599**	**10,354**	
	219,231	**8,052**	**227,283**	
	225,383	4,212	229,595	
	6,152	**(3,840)**	**2,312**	

get for amended cost centres 2013/14		Movement	Proposed basis of budget
Non-Rec	Total		
			Activity
0	304	(16)	56:44
(16)	489	(95)	Activity
			Estimated
0	118	(6)	56:44
			Activity
0	1,179	(42)	Activity
117	233	(144)	56:44
0	1,395	(479)	Activity
0	785	(42)	56:44
			Estimated
			Estimated
			Estimated
			56:44
0	1,245	(67)	56:44
			Actuals
			Actuals
			Actuals
			Actuals
			Actuals
			Actuals
			Actuals
			Actuals
			Actuals
			56:44
			Activity
			Activity

			Activity
			Actuals
1,189	36,938	(2,056)	Estimated
			Activity
			Activity
			Activity
			Activity
			Activity
			Actuals
0	413	46	Activity
			Activity
			Activity
27	2,549	(83)	Actuals
			Actuals
			Actuals
			Actuals
			Actuals
			Activity
			Actuals
		(2,984)	

APPENDIX 1

Notes
Movement to 56:44 split
Reflects correct split for Dermatology - Assura contract.
Movement to 56:44 split
Movement of £42k Blood and Drug recharge in respect of Queenscourt Hospice.
Budget includes £135k for Chase Heys presently sitting in South Sefton. Remainder of budget is split to 56:44.
Reflects a more accurate split based on patient level data.
Movement to 56:44 split
Movement to 56:44 split

Merseycare contract split according to activity estimates. Rebasing the split for Anti-coagulation services and IAPT.
Home oxygen service - a South Sefton only service.
NPFIT reserve needs £83k alloation transfer from SS to SF

APPENDIX 2

TABLE 1 : OPENING ALLOCATIONS

CCG	2013/14 Op allocation (£000's)	Indicative Allocation (£000's)	DfT £000's	DfT %	Op Allocation per head (£)	Indicative allocation per head (£)
South Sefton	234,963	204,285	30,678	15.02%	1,531	1,331
Southport & Formby	155,791	158,111	(2,320)	(1.47%)	1,256	1,275
Sefton CCG's - Sub-Total	390,754	362,396	28,358	7.83%	1,408	1,306

TABLE 2: CONFIRMED BASELINE ADJUSTMENTS (OTHER NHS ORGANISATIONS)

South Sefton	(6,670)
Southport & Formby	(2,487)
Sefton CCG's - Sub-Total	(9,157)

TABLE 3 : PREVIOUS BASELINE ADJUSTMENTS APPROVED IN SEPTEMBER (INTRA SEFTON CCGs)

South Sefton	(6,400)
Southport & Formby	6,400
Sefton CCG's - Sub-Total	0

TABLE 4: ANTICIPATED BASELINE ADJUSTMENTS (INTRA SEFTON CCGs)

South Sefton	(2,984)
Southport & Formby	2,984
Sefton CCG's - Sub-Total	0

TABLE 5 : REVISED ALLOCATIONS

CCG	2013/14 Op allocation (£000's)	Indicative Allocation (£000's)	DfT £000's	DfT %	Op Allocation per head (£)	Indicative allocation per head (£)
South Sefton	218,909	204,285	14,624	7.16%	1,426	1,331
Southport & Formby	162,688	158,111	4,577	2.89%	1,312	1,275
Sefton CCG's - Sub-Total	381,597	362,396	19,201	5.30%	1,375	1,306

FOR COMPARISON PURPOSES

Merseyside CCG's	1,774,105	1,663,052	111,053	6.68%	1,415	1,326
NHS North of England CCG's	19,520,731	18,789,152	731,579	3.89%	1,240	1,194
NHS England CCG's	63,355,299	63,355,299	0	0.00%	1,137	1,137

NOTES OF THE MERSEYSIDE CCG NETWORK MEETING
Held on Wednesday, 11 September 2013
Boardroom, Bluecoat School, Wavertree, Liverpool

Present:

Dr Nadim Fazlani	NF	Chair GGC Network and Liverpool CCG
Katherine Sheerin	KS	Chief Officer, Liverpool CCG
Diane Johnson	DJ	Chief Officer, Knowsley 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 Steven Cox	SC	Clinical Accountable Officer, St Helens CCG
Dr John Caine	JC	West Lancs CCG
Dr Fiona Lemmens	FL	GP/Governing Body Member, Liverpool CCG
Paul Brickwood	PB	Chief Finance Officer, Knowsley, Halton & St Helens
Dr Niall Leonard	NL	Chair, Southport & Formby CCG

In Attendance:

Tania Openshaw	TO	Senior Regional Manager, Monitor
Jane Keenan	JK	Urgent Care Systems Manager, Liverpool CCG
Dr Sarah McNulty	SMcN	Public Health Consultant, Knowsley MBC
Ray Guy	RG	Governing Body Member Liverpool CCG

Item		Action:
1	**Welcome and Introductions**	
	The Chair welcomed everyone to the meeting and around the table introductions were made.	
2	**Apologies for Absence:**	
	Apologies were noted from: • Sarah Baker • Linda Bennett • Roger Booth • Dr John Caine • Dr Craig Gillespie • Tom Jackson • Sarah Johnson • Martin McDowell • Mike Maguire • Andrew Pryce • Clive Shaw	
3	**Minutes and Actions from the previous meeting**	
	The minutes of the previous meeting held on Wednesday, 7 August 2013 were agreed as a true and accurate record.	

Item		Action:
	Actions: **Item 4: Specialised Commissioning Meeting:** PB advised that the meeting had been held and a further meeting had been arranged on 23 September with the whole of Cheshire and Merseyside Area Team. PB advised that this related to data for Specialised Commissioning not being captured correctly and highlighted the following 2 issues: • Inability of some Trusts to IR rules properly and data is not being submitted correctly or on time. • Issue with pulling together overall position for the Trusts **5c Merseyside Approach:** It was confirmed that following a look at the top 10 tips that Children's, Frail Elderly and Mental health would be addressed locally by each CCG/LA; Urgent Care would be addressed through the Urgent Care Networks; and that Cancer, EOL and Maternity would be discussed with NHSE about an approach on a bigger footprint **Item 5b: Commissioning Policy Development:** It was noted that CCGs had been approached separately and that Liverpool and Knowsley had not signed up to this. **7 LA CEO meetings:** Agreed that the Chair of the CCG Network should attend to represent CCGs. M Carney to be contacted for dates.	**CH to contact M Carney for dates of LA CEO meetings**
4	**Matters Arising not on the agenda**	
	Commissioning Support: Following discussion relating to services offered by CSU an update was given by each CCG: **Liverpool CCG – Katherine Sheerin:** The Governing Body had confirmed the following changes, and a letter sent to the CSU: 1. Finance: To be brought in-house. 2. Procurement: Service no longer to be commissioned from the CSU, but to be commissioned on an 'as and when' basis. 3. IM&T: To be contracted for directly from IM.	

Item		Action:
	4. More in depth reviews of BI and CHC/Complex Commissioning to be undertaken. The following services will continue to be provided: • Strategic Medicines Management – linked with Medicines Management Area Committee • Contract Management (IFRs) • Communications and Engagement **St Helens CCG – Dr Stephen Cox:** It was noted that a paper will be submitted to the Governing Body and would share intentions when formalised. **Knowsley CCG – Dianne Johnson:** Concerns in relation to: • Governance • HR & Complaints • Choose and Book • FOI • CHC • Contract Management • Finance to remain in house DJ suggested that data warehouse should be retained. DJ queried whether there should be a more collaborative approach to medicines management e.g APC cover or strategic management **Sefton CCG – Fiona Clark:** Concerns relating to: • FOI and complaints • CHC and ability to manage systems and process • IM&T • Business Intelligence • Review is currently in process. However, It was noted that the general feeling was that the local team were well integrated into the CCG and are usually responsive. • Biggest issue was understanding the consequences of everyone removing services • TA has assured that this would not have an impact on other CCGs. • Value for money benchmarking is required	

Item		Action:
	PB suggested that once notice letters have been issued it should be considered whether there was any desire for a sharing of function as opposed to re-procurement due to the length process that would take. It was agreed that once recommendations and decisions have been made this could be shared at the October network meeting **Tripartite Meeting:** SC requested a re think in relation to non-attendance by providers at the Tripartite meeting and commented that provider presence was of high value and enabled sharing of best practice. NF summarised the decision made and advised that following discussion it was agreed to revert back to the original terms of reference where the three Urgent Care Networks would be represented by their Chairs. It was noted that the NHSE was represented at all 3 urgent Care Networks. **7b: Development Sessions with Area Team:** Quarterly development sessions agreed with NHSE. First relating to Primary Care Quality to be held tomorrow. SC suggested that development needs identified from CCG quarterly checkpoint meetings should be used to set the agenda in accordance with the needs of CCGs.	**Recommendations and decisions to be shared at October Network meeting**
5	**Presentation by Monitor**	
	A presentation was given by Tania Openshaw, Senior Regional Manager, North, Provider Regulation Team, Monitor, on its role and relationship with CCGS and highlighted the new role of Monitor which had emerged from the Health and Social Care Act 2012 and which would include: • FT Governance • Pricing • Choice and Competition • Integrated Care • Continuity of Services . Core Functions: Assessment, Provider Regulation, Co-operation and Competition had also been established within Monitor's operating model to enable delivery of their expanded remit were highlighted: SC queried why standards and quality was not included. In response TO advised that this was covered in FT Governance which would look at financial viability, targets and leases with external bodies e.g. CCGs and other quality and health trusts targets which indicate governance issues,	

Item		Action:
	staff services, whistle blowers, complaints etc. It was noted that Provider Regulation, an established area of Monitor was also moving to assess providers against the new Risk Assessment Framework and with a new failure and enforcement regime. This would assess and monitor financial strength of commissioner requested services, ensure continuity of services and assess FT governance. PB queried whether a service which was NHS but not a commissioner requested service would be assessed by Monitor. TO to check and report back. KS queried how much involvement would be required from Commissioners. In response TO advised that for Trusts who had breached conditions, as part of the investigation process, a meeting would be held with Trusts, however prior to that Commissioners , CQC and various other parties would be informed and advised if input was required. KS noted that it would be helpful for the involvement of commissioners to be more formally described. KS queried the process when different targets were agreed with Trusts by Monitor and how that would be communicated to Commissioners? In response, TO advised that Trusts were expected to report to Commissioners. FC queried how strong relationships are set up with CCGs and Monitor. TO advised that the move to re-organisation will assist in working more closely with CCGS and have regular conversations. Following discussion it was agreed that a quarterly teleconference should be arranged with Monitor, and CCG Chief Officers, particularly where there are collaborative commissioning arrangements, and to include Spec Comm CWW team.	**Quarterly Teleconf to be arranged with Monitor**
6	**NHS Update – Ian Davies**	
6a	An update was given by ID who highlighted the following areas: • Negotiations continue with NWAS around establishing the stability agreement. Following Dame B Hakin letter advising that NHS Direct will run to April 2014. North West has chosen to maintain this with a 12 month agreement for NWAS which has identified 3	

Item		Action:
	risks: Advice from legal that NWAS should not be automatically given a longer contract as this may increase the risk of a challenge from other potential providers • Concern around sustainability of continuing contingency arrangements with OOH for longer • Cost issue NWAS has been offered a 12 month contract to take over the NHS contract for the North West, with target start date of 29 October, however this may slip. Detica Consultancy has been commissioned to provide assurance to North West CCGs looking at the stability partnership and to provide a level assurance. NHSE check points will be done to ensure transfer to NWAS is safe and appropriate. North West contracts will be first to transfer nationally, one of the issues for CCGs is financial risk: • Transfer of all the staff currently delivering operational services by NHS direct will TUPE to NWAS. Seeking to ensure that re-procurement where possible ensures that all of those staff would TUPE again to the new contract if this was not NWAS to reduce any redundancy risk. CCGs will have to accept the following 2 areas of financial risk: • Leases at Middlebrook and Carlisle call centres (Middlebrook £330k which would be split between 33 CCGs) • Telephone and IT infrastructure. It is unclear which additional costs should be incurred. Costs: first 6 months C&M surplus to just over £500k based on current contract value – by the end of March next year to £163k There will be further costs for taking back 0845 contingency and procurement costs. There may be some additional money to support reprocurement cost but working to absorb that. NHS Direct is currently failing to deliver quality assurance and clinical governance required through LCAGs. NWAS is putting people and a process in place to deliver what is required in terms of the contract.	

Item		Action:
	Areas of concern: • Reprocurement: A meeting will be held with SBS to scope this out. Lancashire has not agreed a future contract footprint, deadline for this is the end of next week, otherwise there is a risk that Lancashire will fragment. • Contract with NWAS by the end of October go live date (25% staff increase in capacity planned through key winter period) • Clinical staffing risk – working with NWAS and agency staff to see how the gap in clinical staffing rota cover can be resolved • Risk if clinical rotas are not covered then switch will not take place by the end of October • Current total cost approximately £8 per call with NWAS £14.75 per call but includes significant over staffing overhead. This is expected to be managed down by a gradual reduction in agency staff over time.	
6b	**Planning for Winter Resilience Communications Proposal**	
	Jane Keenan presented a Communication Proposal for Winter Resilience which outlined 3 options: • Examine Your Options (LCC Social Marketing Campaign) • CMCSU led PR Campaign • Reputation Management Protocol It was noted that implications of out of hours should also be taken into consideration. Following discussion it was agreed that this could be an operational decision within CCGs, however further financial information was required. JK to submit a Merseyside wide proposal based on last years campaign for a decision to be made by each CCG once costs were received. Decision required by the end of September.	**JK to submit proposal** **Decision to be made by CCGs by the end September 2013**
6c	**Healthy Liverpool Programme**	
	It was confirmed that the second accelerated solutions event will be held on 8 and 9 October at Aintree Racecourse.	
6d	**Infertility Policy**	
	A briefing paper was presented by Sarah McNulty to consider NHS Funded treatment for Subfertility and the potential cost implications and impacts for CCGs of adopting NICE guidelines updated February 2013. The key issues and potential impact to CCGs were highlighted by SMcN who recommended that a piece of work should be done collectively by CCGs in close consultation	

Item		Action:
	with providers to reflect some of the complexity, to develop a policy which is fit for purpose, and to analyse whether CCGs wish to adopt some of the NICE changes as they are not being adopted by all CCGs. It was noted that this should also be reviewed in terms of changes in technology and agreed that a piece of work should be done with CCGs with decision made whether to move to 2 – 3 cycles and for a firm definition of childlessness to be identified. CCGs to provide names of staff to be involved to Simon Banks who will liaise with SMcN.	**Work to be done to develop policy in collaboration** **Names to be forwarded to Simon Banks**
6e	**HCAIs**	
	KS advised that this was raised at the Assurance Group and queried whether this should consist of Commissioner only or Commissioners and Provider. It was agreed to feed back from the Network that this should be Commissioner only.	**KS to feed back to G Hales**
6f	**Maternity Services**	
	Agreed to defer to next meeting	**Deferred to October meeting**
7	**CCG Assurance Process**	
	A copy of the NHSE Compact document was provided. Following discussion it was noted that it was felt that this involved commissioning areas which they would not usually be involved in.	
8	**Any other business**	
	Upper GI Procurement: KS advised that LCCG had been approached to ask if they wish to be involved in this on behalf of all CCGs. This was agreed. S Cox to also be involved.	**KS to feed back to CWW AT**
9	**Date and Time of Next Meeting:**	
	Wednesday, 2 October 2013 1 – 4pm Boardroom, Bluecoat School, Wavertree	

NHS

South Sefton Clinical Commissioning Group

Southport and Formby Clinical Commissioning Group

Name of Meeting	**Joint Operational Group** **Incorporating Southport & Formby Medicines Management Operational Group and South Sefton Medicines Optimisation Operational Group**
Time & Date	**5th July 2013 12.00 – 2.00 pm**
Venue	**Conference Room 3A, Merton House**

Present:	
Brendan Prescott (BP)	Medicines Management Lead - Southport and Formby CCG
Jane Ayres (JA)	Senior Practice Pharmacist - Southport and Formby CCG
Malcolm Cunningham (MC)	Head of Performance and Health Outcomes – Southport and Formby CCG
Dr Janice Eldridge (JE)	Prescribing Lead - Southport and Formby CCG
Janet Fay (JF) *(arrived during 13.28)*	Senior Practice Pharmacist – South Sefton CCG
Dr Steve Fraser (SF)	Governing Body Member – South Sefton CCG
Susanne Lynch (SL)	Senior Practice Pharmacist - Southport and Formby CCG
Dr Hilal Mulla (HM)	Governing Body Member – Southport and Formby CCG
Dr Noreen Williams (NW)	LMC Representative and GP within South Sefton CCG
Kay Walsh (KW)	Interface Pharmacist - Southport and Ormskirk Hospital Trust/Southport and Formby CCG
Minute Taker:	
Ruth Menzies (RM)	Medicines Management Secretary
Apologies:	
Dr J Thomas (JT)	Prescribing Lead – South Sefton CCG

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Item		Action
13/27	**Minutes from previous meeting** The minutes of the previous meeting were agreed as an accurate record.	
13.28	**<u>Matters arising from minutes</u>** <u>Shared care for ADHD (JA)</u> JA confirmed she has yet to receive figures from all practices. <u>Dementia drugs shared care (BP)</u> BP thanked NW with regard to the comments received. NW confirmed that JC is happy but the document needs to be protected as he was concerned it could be altered. HS felt this may just be a Sefton Shared Care and will not be taken up by other areas. Agreed to put the two CCG logos on the front. SP to produce a SPU to highlight where items are stored. BP to PDF document and send to JC. RM to check security of PDF. <u>Sealtight Woundcare Protector (BP)</u> A letter has been issued confirming these products are only to be prescribed for high risk podiatry patients. JA to produce a SPU.	**SP** **BP** **RM**

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	EHC BP sent out a letter extending the PGD on the basis of an NHS legacy document. However, various concerns and options were discussed. On discussions with Local Authority Commissioning colleagues, Southport and Ormskirk Integrated Care Organisation were in favour of a short term extension of the PGD. *(JF arrived)* Meningitis C guidance for practices (HS) The PGDs have been sent out.	**JA**
	STANDING ITEMS	
13/29	**APC minutes (To be tabled)** The May APC Report was tabled and agreed. June APC Report Ranibizumab – the Committee confirmed they were happy to approve for further ratification at the F&R. Rituximab – a business case is going to F&R for approval. Blood glucose strips – concerns were raised regarding the guidance on quantities of strips. As we have not seen a consultation document it was agreed to hold and take back to the APC.	**JE**
13/30	**Actions from APC (JE/BP/SF)** APC approval process Discussions took place around timings and the approval process. Apixaban statement for approval Approved by the JMOG. Liraglutide & insulin amber statement JE happy to approve the statement. However, other concerns were raised with regard to having a specialist on board. SL to consult with Dr Callow. It was felt	

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Name of Meeting	**Joint Operational Group Incorporating Southport & Formby Medicines Management Operational Group and South Sefton Medicines Optimisation Operational Group**
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	a decision needs to be made by the MMOG and SSMOOG. *(MC/HM left the meeting)* Exenatide & insulin amber statement JE happy to approve the statement. However, other concerns were raised with regard to having a specialist on board. SL to consult with Dr Callow. It was felt a decision needs to be made by the MMOG and SSMOOG. Azithromycin statement KW to feedback that we require advice on LFT monitoring for patients over 18.	**SL** **SL** **KW**
13/31	**Shared Care (BP)** Denosumab A business case is to be submitted to the Project Management Office and Finance and Resource Committee for extra resource as discussions with Sefton LMC and CCG have led to an agreement of this being classed as a level 2 shared care in Sefton. Degarelix Further discussions took place around what is level 1. It is felt Degarelix and Zoladex are used for the same indication and that Zoladex was moved from level 2 to 1. Some patients on Degarelix will require monitoring but this would be relatively small numbers. BP to ask Martin McDowell to reconsider shared care LES in general which has not been renegotiated since it was originally set up.	**BP**
13/32	**Feedback from Finance & Resource committees (F&R) (JA)** The Committee felt they needed to be aware of what has gone to the F&R. It was then agreed that the F&R minutes should be attached to the agenda future meetings. JA to attach minutes to the agenda.	**JA**
13/33	**Financial Performance** Budgets	

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South Sefton Clinical Commissioning Group

Southport and Formby Clinical Commissioning Group

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	The practice budgets have been agreed. It was confirmed information in relation to practices performance should be available next month.	

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NHS

South Sefton Clinical Commissioning Group

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Venue	**Conference Room 3A, Merton House**

13/34	**Merseyside Dashboard (BP)** The dashboard was discussed and noted that the CSU will be producing it in the new financial year. The following areas were discussed:- A Stoma Nurse, employed by University Hospitals Aintree, is due to start to review practice stoma patients lists in the Bootle locality area and invite appropriate patients for a review. Areas of growth blood glucose testing strips and erectile dysfunction. BP confirmed he is pushing for the erectile dysfunction service to recommence. It is hoped Mike Abbott will start running the service before he is due to retire and the trust will then continue offering the service. Discussions also took place regarding a piece of work undertaken by the Dieticians. Also discussed was the Community Pharmacy Dressing Scheme which provides dressings for care homes in South Sefton and how this affects the prescribing costs.	
13/35	**CSU update (HS/BP)** It was generally felt the processes between the CCG and the CSU were improving.	
13/36	**AHCH Paediatric Specials Pilot (discussed after apologies)** SC gave the Committee some background information regarding the above pilot, stating the idea was to identify patients at Alder Hey that were routinely given specials. The pilot has been going for a year and it is now our decision to see if we want to continue with this service. It was noted, however, the amount for each item has increased to include staffing costs. The options were discussed and various concerns were raised regarding the RAG List, quality of products, ease of collection, length of supply and manufacturing licence NW gave an example were 6 month's supply was given however a monthly charge was applied, which did not seem right.	

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South Sefton Clinical Commissioning Group

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Venue	**Conference Room 3A, Merton House**

	The committee felt the favoured option was to carry on using the service for existing and new Alder Hey patients. Alder Hey will now be informing practices that patients are receiving these specials and that it is clearly stated on the TTO as opposed to seeking a GP's consent.	
13/37	**Private Scripts** JA emailed JC to get the LMC's perspective and circulated JC's response. It was noted the JMOG would not advise to but it was at the GPs discretion. BP to obtain Hill Dickinson and Department of Health's opinion on this.	**BP**
13/38	**Spend on PBR excluded non-NHS England funded drugs** The spend on "high cost "drugs provided by secondary care was discussed. BP to liaise with finance on production of cost information.	**BP**
13/39	**Orlistat Paper** The results of the above audit, which was commissioned by Public Health, were attached. The results showed that 41% of patients were not getting monitored. Discussions took place regarding the findings and various options were discussed. The Committee felt the community pharmacy/weight management services which can be accessed by various means would be the best option for patients to receive orlistat.	
13/40	**Controlled Drugs Accountable Officer (CDAO) responsibility** The interim CDAO is Dr John Hussey at the Local Area Team (LAT). Due to the size of the area he would struggle to provide this service, however, under legislation the responsibility however comes under the LAT. It was noted we will be sending out the CD declaration letters to all Sefton performers. Leads and Heads of Medicines Management will be meeting up to form the Local Intelligence Network (LIN).	
13/41	**Proposed Pain Project**	

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Name of Meeting **Joint Operational Group Incorporating Southport & Formby Medicines Management Operational Group and South Sefton Medicines Optimisation Operational Group**
Time & Date **5th July 2013 12.00 – 2.00 pm**
Venue **Conference Room 3A, Merton House**

	Steve Simpson and Dr Chris Barker from the Pain Service have met with BP recently. It is planned to have a practice pharmacist to attend pain clinics with a view to the pharmacist being able to review patients in primary care. Discussions took place regarding linking in with the service at the Royal. BP to email Chris Barker re linking in with others in the area offering the same service.	**BP**
13/42	**AOB** JF – raised concerns as the new OOHs providers do not have access to the Sefton intranet. It was agreed this should be discussed at the wider group meeting in the north. MC to add to the agenda.	
	Date, Time and Venue of next meeting The next meeting will take place on 10th September at 12.30pm in the Library, Fylde Road Medical Centre, Marshside.	

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South Sefton Clinical Commissioning Group

Southport and Formby Clinical Commissioning Group

Name of Meeting	**Joint Operational Group Incorporating Southport & Formby Medicines Management Operational Group and South Sefton Medicines Optimisation Operational Group**
Time & Date	**5th July 2013 12.00 – 2.00 pm**
Venue	**Conference Room 3A, Merton House**

Committee Member	**March 2013**	**May 2013**	**July 2013**	**September 2013**	**November 2013**	**January 2014**	**March 2014**
Jane Ayres, Senior Practice Pharmacist, SFCCG	✓	✓	✓				
Joe Chattin, LMC Representative	✓	✓	Apol				
Malcolm Cunningham Head of Performance & Outcomes, SF CCG	✓	Apol	✓				
Dr Janice Eldridge GP, Governing Body Member, SFCCG	✓	✓	✓				
Janet Fay Senior Practice Pharmacist, SSCCG	✓	✓	✓				
Dr Steve Fraser, GP, Governing Body Member, SSCCG	✓	✓	✓				
Susanne Lynch Senior Practice Pharmacist, SFCCG	✓	Apol	✓				
Dr Hilal Mulla GP, Governing Body Member, SFCCG	Apol	✓	✓				
Sejal Patel Senior Practice Pharmacist, SSCCG	✓	✓	Apol				
Brendan Prescott, Lead for Medicines Management SS and SFCCG	✓	✓	✓				
Helen Roberts, Senior Practice Pharmacist, SSCCG	Apol	Apol	Apol				
Helen Stubbs Pharmacist, CSU Link	✓	Apol	Apol				
Dr Jill Thomas, GP Representative, SSCCG	✓	✓	Apol				
Kay Walsh, Senior Practice Pharmacist, SFCCG	✓	Apol	✓				

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Name of Meeting	**Joint Operational Group Incorporating Southport & Formby Medicines Management Operational Group and South Sefton Medicines Optimisation Operational Group**
Time & Date	**5th July 2013 12.00 – 2.00 pm**
Venue	**Conference Room 3A, Merton House**

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South Sefton Clinical Commissioning Group

South Sefton Medicines Optimisation Operational Group (SSMOOG) Minutes

Time and Date 12 – 2pm 17th September 2013
Venue: Conference Room 3B, 3rd Floor, Merton House

Members:	**Dr S Fraser (SF)**	**GP Governing Body Member**
	Dr J Thomas (JT)	**GP Representative**
	Sejal Patel (SP)	**Senior Practice Pharmacist**
	Helen Roberts (HR)	**Senior Practice Pharmacist**
	Helen Stubbs (HS)	**Senior Pharmacist, CSU**
	Brendan Prescott (BP)	**Lead for Medicines Management**
Minute Taker	**Ruth Menzies (RM)**	**Medicines Management Administrator**

No	Item	Action
13/69	**Apologies** Apologies were received from Janet Fay.	
13/70	**Minutes of the meeting dated 23rd July (attached)** JT's title to be amended to GP Representative on the previous minutes.	
13/71	**Matters arising from Minutes dated 23 July 2013** 13.56 – Ulipristal – The matter has not yet returned to the APC. HS to contact Sue Forster to see when due to come back to the APC. It was noted however that there seems to be a unilateral decision across the patch. JJ confirmed Sefton Pharmacies are using the Ulipristal as an interim measure. 13.56 - As Steve Astles has been removed from the representative list BP felt we need someone outside Medicines Management to be a member. Jamie Hester has recently been appointed as Programme Manager for Quality and it is hoped he will attend future meetings.	

No	Item	Action
	13.56 - Communications - SF to feedback information following the recent Communications survey. Individuals who don't read or who are not included on the circulation list will not have responded or see communications. Practice Pharmacists to highlight issues at locality meetings. Items should also be discussed at practices meetings whereby all clinicians attending practices on a regular basis should attend. 13.56 - NOACs – letters have been sent out to practices. 13.56 - Antimicrobial Guidelines – it was confirmed the next meeting will be held tomorrow. The guidelines have been delayed and will now be taken to the November APC. It was agreed at JMOG to still produce paper copies. BP to raise a business case for F&R for the cost of printing the guidelines. 13.58 - Stomas – lists are being compiled and passed onto the Stoma Nurse to start going through. It is hoped the pilot will be rolled out to other localities. 13.58 JF has yet to forward the letters in relation to the third party requests. 13.60 - Budget Update paper has been sent to go on F&R. 13.62 - Risk log to be added as a standing item to the SMOOG agenda. RM to add to agenda. 13.66 - Tithebarn Cdiff Outbreak – BP attended a meeting yesterday. Outcomes have gone one out to locality meetings and reports have also been produced in relation to patterns. Sandra Craggs is leading on this piece of work. Other work to be addressed outside the CCG and it is hoped a meeting will take place mid-October to move this forward. 13.67 - Analgesia Management - Sara Boyce, Practice Pharmacist, is to start work to be trained as a NMP pharmacist the 1st week in October. A development plan has been drawn up. Steven Simpson (SS) is in close contact with the person running the service in Liverpool. BP to invite SS to the next JMOG. 13.68 - CCG is picking up the bill for the EPS Release 2 for the cost of the 3 smart cards. However, it was felt this should be the responsibility of NHS England. BP to get update from DS.	**BP** **JF** **RM** **BP** **BP**

No	Item	Action
13/72	**Matters arising from minutes from MMOG (July minutes yet to be approved)** The minutes were discussed. Jext – communication was received from the Royal stating they are happy for patients to stay on Epipens if they want. SP to ask practices to get figures for adult patients. Osteoporosis Guidelines – KW/JE have discussed with Niall Leonard. MMOG taking place next week. BP will report back.	**SP** **BP**
13/73	**Locality updates/ Practice Updates/Feedback** Ford – following a meeting at Ford it was noted that they are happy to look at patients on warfarin but are not going to look at patients on the DAWN system. Seaforth – discussions took place regarding the funding of anti-dementia drugs has been placed into the baseline but unsure if this has happened. Request for tapentadol which is currently shown as a black drug has gone to the APC to be reviewed as amber which has not been agreed. It was noted we need to ensure that everything that is recommended at APC actually comes through the Operational Groups. It was noted the RAG list still appears on legacy sites and is currently being updated. Booth CCG websites contain hyperlinks to the website. Discussions took place in relation to a fragmin request from Clatterbridge who state they are unable to do shared care. HS has asked Graham Reader who said they were included. HS to find out what the current situation is.	**HS**
13/74	**APC Minutes** Minutes attached for noting and already gone through the JMOG.	

No	Item	Action
13/75	**Budget Update** Discussions took place in relation to the reliability of the figures. The forecasted outturn showed an underspend of £500,000 with the old figures and the new figures show a £57,000 overspend. Costs and items have increased. Month 3 figures are the first to be publicised as previous figures are very volatile. Discussions took place regarding the atorvastatin coming off patent. Opinion across the North West is that it is going to be a very challenging this year to try and ensure value for money. As such it was felt we need to widen the quick wins as much as possible to ensure a reduction in spend. Quick Win results are to come back to the meeting on a quarterly basis. Discussions took place regarding some practices not being willing to take on these quick wins. Discussions also took place regarding what should happen when community pharmacies do not have particular items in stock.	
13/76	**Shared Care update** • **Low Molecular Heparin** • **DMARDS** • **Apomorphine for Parkinsons** The above shared care guidelines are to be added to the CCG website, however the documents have expired. The Committee agreed to extend the shelf line of these documents for another year. HS thought that Apomorphine for Parkinsons had gone through APC early in the year. HS will check the situation. It was agreed to initially notify LMC. BP to forward to Joe Chattin It was noted DMARDS shared care are currently under review with the APC which will supersede the attached documents.	**BP**
13/77	**Risk Log** Nothing to report.	
13/78	**Nail Lacquers on the Grey List** No longer relevant.	

No	Item	Action
13/79	**Bullens** A letter was tabled that has been sent out to practices wanting them to opt out of a service. The Committee concerned about the previous concerns in relation to retrospective requests for prescriptions. Bullens to be invited to a meeting to discuss the protocol that has been issued. Stoma nurses do not have a preference of supplier but feel they Bullens practices have improved. BP to write to practices stating if practice say they have any issues contact their Practice Pharmacist. SF to attend the meeting. RM to invite SF when arranging the meeting.	**BP** **RM**
13/80	**Practice Visits** Discussions took place in relation to arranging yearly practice visits. This is currently undertaken in the North with Senior Pharmacist or BP and a GP lead attending to discuss operational issues. JT confirmed she had no capacity to attend these visits, however, SF volunteered to attend. Yet to confirm which practices are to be visited as a priority. It was suggested Graham Bird's practice should be visited first.	
13/81	**Virtual Ward Update** No update provided, however, JT confirmed the monthly meetings have been found to be very beneficial. SF confirmed they had had an initial meeting and found it to be useful. Concerns were raised in relation to procedures.	
13/82	**Management of UHA TTO Errors** The above issue whereby the interim TTOs were sent out was discussed. There have been 8 potential serious harm cases with a further 27 that might have been affected by the errors in South Sefton. A list of affected patients has been provided and practice pharmacists contacted BP has received 5 responses back from the team – all patients no harm. 1 no record of patient being in Aintree. Results currently show there are no serious incidents.	

No	Item	Action
13/83	**Update CCG Webpage** SP - Sefton Prescriber Update to be circulated to highlight what is on the medicines management pages. Updates to also be discussed at locality meetings.	
13/84	**AOB** Nothing to report.	
13/85	**Date of Next Meeting** The next meeting has been changed and will now take place at 10.30 am – 12.30 pm on the 5th November.	

Committee Member	January 2013	February 2013	March 2013	April 2013	May 2013 (cancelled)	June 2013 (cancelled)	July 2013	September 2013	November 2013	December 2013
Dr Steve Fraser, GP, Governing Board Member, South Sefton Clinical Commissioning Group (Chair)	✓	✓	✓	✓	NA	NA	✓	✓		
Steve Astles, Head of CCG Development, South Sefton Clinical Commissioning Group	Apols	Apols	Apols	Apols	NA	NA	NA	NA		
Janet Fay, Senior Practice Pharmacist, South Sefton Clinical Commissioning Group	✓	✓	Apols	✓	NA	NA	✓	Apols		
Jennifer Johnston, Senior Practice Pharmacist, South Sefton Clinical Commissioning Group	Apols	✓	✓	NA	NA	NA	NA			
Sejal Patel Senior Practice Pharmacist, South Sefton Clinical Commissioning Group	✓	✓	✓	✓	NA	NA	Apol	✓		
Brendan Prescott, Lead for Medicines Management, South Sefton Clinical Commissioning Group	✓	✓	✓	✓	NA	NA	✓	✓		
Helen Roberts, Senior Practice Pharmacist, South Sefton Clinical Commissioning Group	NA	NA	NA	NA	NA	NA	✓	✓		
Helen Stubbs Pharmacist, CSU Link	Apols			✓	NA	NA	✓	✓		
Dr Jill Thomas, GP Representative, South Sefton Clinical Commissioning Group	✓	✓	✓	✓	NA	NA	✓	✓		

South Sefton Clinical Commissioning Group

Seaforth and Litherland Locality Meeting

4th September 2013
1.00pm – 3.00pm
Crosby Lakeside Adventure Centre

Attendees

Practice	GP	Practice Nurse	Practice Manager
Litherland Town Hall (LTH)			
15 Sefton Road	Dr McElroy / Dr Thompson		Alison Harkin
Glovers Lane	Dr Goldstein		Louise Taylor
Rawson Road	Dr Fred Cook		Angela Dunne
Seaforth Practice			
Ford Medical	Dr Brian Fraser	Eils McCormick Louise Armstrong	
Bridge Road Surgery	Dr Vickers		Lynne Creevy
Netherton Practice			Lisa Roberts
Orrell Park	Dr Fred Cook		Jane McGimpsey
129 Sefton Road	Dr David Goldberg		
Litherland Darzi			

Angela Parkinson (AP) South Sefton CCG Locality Manager
Susanne Lynch (SL) Medicines Management
Alison Farquharson (AF) Primary Care Development
Mike Hammond (MH) Community Respiratory Team Liverpool Community Health

Minutes
Angela Parkinson

No	Item	Action
13/51	**Apologies** Dr Steve Fraser, Caroline Nolan, Dr Gina Halstead, Dr Nigel Taylor, Paula Lazenby, Lin Bennett	
13/52	**Declarations of Interest - None**	
13/53	**Minutes of Last Meeting / Matters Arising** Paula Lazenby Practice Nurse had been missed off the attendees list. A query had been raised regarding Anaesthetics data and whether this is in relation to the pain clinic, at the time of the meeting the query was still outstanding. Monthly data for the Quality Premium dashboard will be available from October onwards. QOF group peer review specialities agreed at last month's meeting have	

13/169

No	Item	Action
	been approved by NHS England Merseyside. Impact on neighbouring practices where patients are leaving Litherland Town Hall - Tony Leo Director of Commissioning Merseyside has thanked the locality for raising concerns, detailed on-going discussions are taking place with the provider. Virtual Ward referral form – issues raised with the form have been passed to Tina Ewart. She has asked that anyone experiencing any further problems should let her know ASAP as the form will be being reveiwed. A couple of people in the group had used the form without a problem **LWI Darzi** The minutes of the last meeting were agreed	
13/54	**Primary Care Development** Alison Farquharson is currently working with Sefton CCGs for an initial 3 month period to develop primary care. The work will include involvement in the Primary Care Quality Strategy, review of Local Enhanced Services and requirements of an NHS standard contract. Alison has previously worked in Knowsley, her last position was Head of Primary Care across Sefton and Liverpool.	
13/55	**Quality Premium – CRT Service Mike Hammond** Mike Hammond attended the meeting to encourage usage of the spirometry service and Community Respiratory Team (CRT) single point of access (SPA) service. Initially there had been problems with the referral process, however no problems have been raised with the clinical service provided. Practice level referral information was available at the meeting (21 patients in quarter 1), referral rates are low making it a very expensive service. Patient satisfaction with the service is high, 600 patients have been seen in Liverpool with 90% being able to stay in their own homes, 97% patient satisfaction rate. Initial problems with the referral process have been worked through, and those that have used the service recently have not reported a problem. Some GPs had not tried to use the service recently as patients have remained well in the summer months. Patients with a confirmed diagnosis of COPD and who can wait a 2 hour period can be referred to the service. Secondary care coding of COPD on discharge is still an issue.	
13/56	**QOF Group Peer Review A+E / QOF Audit Template QP001 –QP006** **A+E** Practice participation from: 15 Sefton Road, Glovers Lane, Rawson Road, Ford Medical, Bridge Road, Orrell Park and 129 Sefton Road. **Over 65's with co-morbidity:** • Lack of information or no information from A+E • Nursing home patients who would be appropriate for WIC are taken to A+E because no transport available to WIC • Majority of patients used A+E OOH	

No	Item	Action
	• Inappropriate attendances from nursing homes UTIs etc • Some patients coded to the wrong GP practice **15 years and under:** • Lack of information / no information from A+E • Majority OOH / weekend • Not all appropriate for A+E, some appropriate for WIC • Multiple attendances same person (appropriate) cystic fibrosis • Multiple attendances same person (inappropriate) constipation • Multiple attendances same person, same day (inappropriate) URTI • Appt booked at practice DNA'd **Frequent Attenders:** • Lack of information / no information from A+E • Alcohol / addiction problems • Carer taking the patient to A+E inappropriately • Repeat attendances for planned reviews • Repeat attendances Liverpool Womens Hospital for gynae symptoms • Appointments available at practice • MCAS appts DNA'd casualty attendances instead • 1 patient has not reattended A+E following GP chat **QOF specialities** An issue was raised with the cardiology / HF audit chosen last month. Outpatient data for Heart Failure would be hard to identify as patients coded as Cardiology. Last Heart Failure audit focused on emergency admissions not outpatients so the group would not be able to compare audits. Gynaecology was selected for outpatients. Although this audit has been done before there has been an expansion in the community service and a talk from Paula Briggs to increase usage. **QOF Audit Template QP001 – QP006** Last year's audit template was circulated, this will need to be reviewed at a future meeting for the specialities selected this year.	AP
13/57	**Medicines Management** Susanne gave a verbal update of the budget information for June and advised that she would send the information to go out with the minutes. However due to a problem with Department of Health calculations these figures are now incorrect. Dr McElroy asked about a flutter device which had been recommended by a physiotherapist for her to prescribe. I advised that I would email her direct once I had confirmed this was not a recommended item as I thought.	
13/58	**Local Community Voluntary Faith Sector Update**	

No	Item	Action
	AP did a 2 day tour of the area accompanied by Roger Driver and Rachel Jones as a pilot to establish what type of services are available in the community. Organisations included: • Parenting 2000 • Feelgood Factory • Venus • Bowersdale Resource Centre • SWACA • Bridge Centre • Sing Plus • L30 Community Centre A snapshot of services included: • Welfare reform changes online support • Use of IT equipment /support / job skills and CV writing • CAB • Job centre / universal job match • Volunteering opportunities • Befriending services • Handyman services • Social activities – drama, singing, knitting, cookery, creative arts, sewing, bingo, library ready group, poetry, keep fit • Courses – budgetary skills, health promotion, English, Spanish, sign language Those present at the meeting were familiar with some organisations but not all. CVS is currently compiling a directory of services with information for GPs.	
13/59	**Any Other Business** **May Logan Hearing Service** – GPs are being asked to refer again for if no audiogram has been carried out in the last two years. In the AQP contract patients who need a new hearing aid need to be offered choice. Ford Medical have asked to have it in writing that a re- referral is required in that situation which has reduced the requests. **Litherland Town Hall** – Dr Patrick started at the practice at the beginning of the week, Nurse Prescribers have been providing cover.	
13/60	**Date and Time of Next Meeting** 2nd October 1 – 3pm Crosby Lakeside Adventure Centre	

Seaforth and Litherland Locality Meeting

2nd October 2013
1.00pm – 3.00pm
Crosby Lakeside Adventure Centre

Attendees

Practice	GP	Practice Nurse	Practice Manager
Litherland Town Hall (LTH)			
15 Sefton Road	Dr McElroy (Chair) Dr Thompson	Paula Lazenby	Alison Harkin
Glovers Lane	Dr Goldstein		Louise Taylor
Rawson Road			
Seaforth Practice			
Ford Medical	Dr Williams	Louise Armstrong	Lin Bennett
Bridge Road Surgery	Dr Vickers		
Netherton Practice	Dr Choudhary		Lisa Roberts
Orrell Park			Jane McGimpsey
129 Sefton Road			
Litherland Darzi			

Angela Parkinson (AP) South Sefton CCG Locality Manager
Helen Roberts (HR) Medicines Management
Yvonne Davies (YD) Merseycare
Delwyn Roberts (DR) Merseycare

Minutes
Angela Parkinson

NHS

South Sefton Clinical Commissioning Group

Attendance Tracker

P Present
A Apologies
L Late or left early

Name	Designation	Jan 13	Mar 13	Apr 13	May 13	Jun 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13
Dr T Thompson	GP – 15 Sefton Road Surgery	P	P	P	P	P	P	P	P		
Dr C McElroy	GP – 15 Sefton Road Surgery	P	P	P	P	P	P	P	P		
Alison Harkin	PM – 15 Sefton Road Surgery	P	P	P	P	P	P		P		
Paula Lazenby	PN – 15 Sefton Road Surgery					P		A	P		
Dr A Slade	GP – Glovers Lane Surgery	P									
Louise Taylor	PM – Glovers Lane Surgery		P	P	P	P	A		P		
Dr P Goldstein	GP – Glovers Lane Surgery		P	P	P	P	P	P	P		
Dr M Vickers	GP – Bridge Road Surgery	P	P	P	P	P	P	P	P		
Lynne Creevy	PM – Bridge Road Surgery			P	P	P	A		A		
Dr E Carter	GP – Bridge Road Surgery					P					
Dr N Choudhary	GP – Netherton Practice	P	P	P	P	P	P		P		
Lisa Roberts	PM – Netherton Practice	P	P	P	P	P	P		P		
Dr N Williams	GP – Ford Medical Practice	P	P	P	P	P	P		P		
Lin Bennett	PM – Ford Medical Practice	P	P	P	P	P	P		P		
Eils McCormick	PN – Ford Medical Practice				P	P					
Dr T Danby	GP – Ford Medical Practice						P				
Louise Armstrong	PN – Ford Medical Practice		P	P	P		P		P		
Dr B Fraser	GP – Ford Medical Practice							P			
Dr D Goldberg	GP – 129 Sefton Road Surgery		P					P			
Dr A Sarker	GP – 129 Sefton Road Surgery		P	P	P	P	P				

Name	Designation	Jan 13	Mar 13	Apr 13	May 13	Jun 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13
Jane McGimpsey	PM – Orrell Park Medical Centre			P		P	A		P		
Dr A Hameed	GP – Litherland Darzi		P		P				A		
Julie Price	PN – Litherland Darzi	P									
Pam Maher	PM – Litherland Darzi / Litherland Town Hall						P		A		
Dr N Taylor	GP – Litherland Town Hall	P	A	A			A	A	A		
Dr S Steevart	GP – Litherland Town Hall		P	P	P	P					
Dr F Cook	GP – Rawson Road / Orrell Park Medical Centres	P						P			
Angela Dunne	PM – Rawson Road / Orrell Park Medical Centres	P	P	P	A	P	A		A		
Caroline Nolan	PM – Seaforth Practice	P	P	P	P	P	P	A	A		
Dr S Fraser	GP – Seaforth Practice	P	P	P	A	P	P	A	A		

No	Item	Action
13/61	**Apologies** Dr Hameed, Pam Maher, Dr S Fraser, Lynne Creevy, Nigel Taylor, Caroline Nolan, Angela Dunne	
13/62	**Declarations of Interest** Dr Williams (LMC), Lin Bennett (Governing Body Member)	
13/63	**Minutes of Last Meeting / Matters Arising** The query regarding Anaesthetics data and whether it relates to the pain clinic has been raised but is still outstanding, this will be raised again. The latest quarters A+E data on the portal can currently be viewed, a query was raised regarding having access to view previous quarters for comparison, and whether the new portal will have data loaded from MSIP. Dr McElroy has met with Tony Leo, Tom Knight and Fiona Clark regarding pressures on the practice due to patients leaving Litherland Town Hall, the increase in patient registration has been evidenced. A Single Item Quality Surveillance Group pre meeting is taking place next week if other practices have similar evidence. Litherland now have a part time GP. GP attendance at locality meetings was raised, as some practices regularly send a GP but attendance at this locality has become an issue with poor GP representation from some practices. There is a requirement in the constitution for 75% attendance; the very last resort for a practice failing to comply with the constitution would be a practice being asked to leave (with interventions before that happened). The group agreed that this would be a bad outcome for patients, and that that was not what was being recommended, but lack of representation was a concern to the locality. AP to look at attendance and bring to group. Practices are reporting problems with the virtual ward referral form (10 page print out), this will be fedback to Tina Ewart. Published figures for referred to virtual ward from this locality show that figures are low. Some patients identified via risk stratification have not been suitable for a 12 week pathway. Colette to speak to Dr Harvey. Nursing home patients have been excluded from the virtual ward as they are high risk and interventions are unlikely to change the outcome of events. There is a community geriatrician (Masroor Diwan), if virtual ward accepted nursing home patients it would be overwhelmed, patients have complicated needs, staff would not be geared up. Locality did not know how to refer to the geriatrician, AP to find out. Treatment rooms should offer same day dressing clinics/ ulcer clinics, where patients are being asked to go back to A+E for a planned attendance we are paying twice.	AP CMc AP

No	Item	Action
	WIC – Suitable referral criteria, nurse prescribing facility and x-ray facility. Under 12 month olds are not treated, referred back to GP. Accuracy , detail of information back to practices Gina Halstead is going to raise the issues regarding lack of information from A+ E attendances and planned A+ E attendances for dressings etc. at the next CQUIN meeting. Pregnancy testing kits – Brendan has been contacted regarding same day pregnancy testing for possible ectopic cases. It has been suggested that the test could be done at a community pharmacy. The locality suggested that a better solution would be that this is done at the practice where a clinical risk had been identified.	
13/64	**Merseycare Community Mental Health Team** Delwyn Roberts and Yvonne Davies attended the meeting in their newly appointed roles as primary care liaison CMHT nurses to introduce themselves and have further discussions regarding their role in helping the links between Primary and Secondary Care. Letters have gone out to practices with follow up contact being made for practice meetings to: • Improve collaborative working between primary care/secondary mental health services (adult and older adult including the Early Interventions and Homeless Outreach Teams and Rehabilitation Services) • Improve health and communication outcomes • Engage with GPs across specific neighbourhoods regarding physical health needs of those with mental illness and other long-term conditions The general health and wellbeing of patients on the practice's SMI (severe mental illness) can be discussed. Communication was raised as an issue in terms of long waits for information, with information being poor when received. A fax is sent if there has been a change in medication, within 48 hours a medical secretary will contact the practice, but sometimes a prescription for medication is needed before the fax arrives. There was a query regarding the GP advice line as this only operates between 10am -1pm, practices were advised to refer to the crisis team when the advice line is not in operation. Referrals in for adults / older adults, an adult is 18+, an older adult is 65+	
13/65	**Medicines Management** Helen shared a paper copy of Sefton Prescriber Update 95: Medicines Management Pages on the South Sefton CCG Intranet	

<table>
<tr><th>No</th><th>Item</th><th>Action</th></tr>
<tr><td></td><td>This highlights what medicines information is available to prescribers on the CCG webpage, which can be found here http://nww.southseftonccg.nhs.uk/patient-care/Medicines/default.aspx

She also presented the latest FOT at June 13 for the locality and explained that this has been amended following a calculation error at the PPD, leading to a bigger overspend. As more data is available the predicted FOT should become more reliable. Currently the position is as follows:

• Locality forecast overspend £29775
• CCG forecast overspend £57489
• Within the locality 3 practices are forecasting an overspend:
    o Seaforth Village £43512
    o Bridge Road £41167
    o Glovers Lane £14383

Helen is the practice pharmacist for Seaforth and Glovers Lane and she is looking in to their overspends. She will also liaise with the pharmacist at Bridge Road to see if any recommendations can be made to reduce their spend.</td><td></td></tr>
<tr><td>13/66</td><td>Practice Level Finance Summary Report
This item was not discussed</td><td></td></tr>
<tr><td>13/67</td><td>Quality Premium Dashboard
A+E data shows an overall reduction in A+ E figures. When looking at the graphs (rates per 1000) there needs to be consideration for practices with small list sizes (Litherland Darzi 430 patients).

The non-elective admissions graph looks very busy, there was a query regarding Trauma & Orthopaedics, and whether this was included or separate to A+E figures.

There was a noticeable reduction in emergency respiratory admissions for Glovers Lane Surgery.

The single point of access for CRT was discussed, as a patient visited at 6.25pm could not be referred as 2 hours' notice is required and the service ends at 8pm. There was a suggestion that instead of the service operating 8 – 8, the times could be altered to 8.30 – 8.30. AP to discuss with Jenny Kristiansen.

Bridge Road is worsening for high risk antibacterial prescribing.
Sefton prescribing is identified on the graph together with SL locality, it was suggested that other South Sefton localities should also be identified.

Admissions direct from GP to Aintree is showing a downward trend.</td><td>AP</td></tr>
</table>

No	Item	Action
	Two week wait rules where a patient is going on holiday were discussed, the clock start is from the date of referral. One GP refers the patient within 24 hours and writes the dates of any holidays on the referral to secondary care, Graeme Allan (Cancer Lead) has a policy where the patient is referred on return from holiday, it was agreed that Sarah McGrath would be contacted to find out whether there was a holiday mechanism in place. One practice commented that they had been contacted from the urology department as a two week referral had been received but the consultant was on holiday, the secretary had said that this was acceptable as the patient does not need to be seen within the two week period. **Corporate Performance Dashboard** Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) is currently red. Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19's (Cumulative) is currently red. It was queried whether Alderhey has an 18 week pathway for any referrals? Is it in a CQUIN? Local measures – 5% reduction in the number of respiratory disease is currently red (at July 2013?) Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) is red, the locality felt that an overall figure is needed.	
13/68	**QOF Audit Template** The QOF audit template was discussed and agreed.	
13/69	**Any Other Business** The latest wider group meeting had a lot of repetition as the leads who attend the locality also attend the wider group, for example the Community Respiratory Team presentation has now been heard twice. Lin Bennett congratulated Dr McElroy on her chairing skills and timekeeping. The practice nurse locality job description is being reviewed and will be circulated when approved.	

No	Item	Action
13/70	**Date and Time of Next Meeting** Wednesday 6th November 1- 3pm Crosby Lakeside Adventure Centre	

NHS

South Sefton Clinical Commissioning Group

Bootle Locality Meeting Minutes

24th July 2013
1.00 pm – 2:30 pm
Park Street Surgery

Attendees
Dr Goldberg – Concept House
Helen Devling – Moore Street Practice
Dr Helen Mercer – Moore Street Practice
Dr A Ferguson – The Strand Medical Centre
Pauline Sweeney – Park Street Practice
Dr K Chung –Park Street Practice
Sharon Copeland – Park Street Practice
Gary Killen – South Sefton CCG
Jenny Kristiansen – South Sefton CCG

Guest Speakers
Jane Pugh – GTD – Item 13/59
Chris Cheetam – GTD – Item 13/59
Tracy Reed – Merseycare – Item 13/60
Becky Williams – South Sefton CCG – Item 13/63

Apologies
Dr Ricky Sinha – North Park Practice
Pam Sinha – North Park Practice
Dr S Sapre – Aintree Road Practice
Paul Halsall – South Sefton CCG

Chair
Dr Anna Ferguson

Minutes
Gary Killen – South Sefton CCG

No	Item	Action
13/55	**Apologies** - Noted	
13/56	**Minutes of last meeting** – 18th June 2013 Minutes from the last meeting were accepted as an accurate record	
13/57	**Matters Arising** **13/47** Billy Smith will endeavour to attend locality meetings on a bi-monthly basis. Any problems to contact JK. **13/49** All feedback from SW update to be sent to JK who will chase	

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	up with the Spirometry Service. **13/50** QP Indicators, The pathways will go out to all localities via the usual system. These will be looked at in the September meeting at locality level.	
13/58	**Medicines Management Update** Janet Faye sent a message to say that practices will receive the allocated drug budget soon.	
13/59	**Go to Doc – New out of hours provider** JP & CC gave a brief presentation on GTD out of hours service they currently provide within Greater Manchester and what plans they have for Sefton. GTD will take over on 1/10/13 and will provide induction sessions for new trainees from Aug 2013. Telephone numbers for the out of hour's service will stay the same, so no disruption to patients. The contract has been awarded for 5 years and GTD will have regular meetings with the CCG and LCH. GTD to send JK posters and leaflets for circulation.	JP to send leaflet/poster to JK for circulation.
13/60	**Learning Disability DES Scheme** TR gave a talk about changes in the learning disability scheme. The introduction of an automatic annual health check will allow people with moderate to severe learning difficulties the same access as people with without learning difficulties. AF asked how the scheme will ensure robustness within the system. TR replied that a facilitator will use the QOF register and cross reference with the local authority register. The facilitator will then liaise with the practices. TR explained that payments for practices will be paid every quarter, as previously they were split. TR will organise a learning disability training session of about 1 -1 ½ hours then roll out to the practices.	
13/61	**CPD points for attending locality meetings** CPD points are awarded to anyone who attends the locality meetings and are written up. If you require certificates contact JK will send out via email.	JK to send CPD certificates to members of the group in attendance.
13/62	**Update from Finance & Quality Committees** AF gave a brief outline to what was passed and suggestions made during the last Finance and Quality Committee, held at the beginning of July. A number of business cases were passed that involved the locality which will generate savings throughout the locality.	
13/63	**Locality data** BW attended the meeting to inform the locality of her job role within the CCG and how she can support practices. BW indicated that patient activity reports can be set up with targets to inform the locality of the current picture. Any feedback to go through JK. There is a meeting with the commissioning unit and the locality mangers on 8th August to see what information is required based on feedback from the practices.	
13/64	**Any other business** **STOMA Prescribing and Review Pilot Project.** JK informed the group that the Stoma Pilot Project is due to commence In the Bootle Locality in the beginning of August, starting with data being collected from practices by a member of Medicines Management Team. The Specialist Stoma Nurse will be invited to the next meeting to introduce herself and answer any questions.	JK to invite SSN to the next meeting.

13/65	**Date and time of next meeting** Wednesday xx[th] September 2013 1pm – 2.30pm Park Street Medical Practice	

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South Sefton Clinical Commissioning Group

Bootle Locality Meeting Minutes

Tuesday 17th September 2013
1.00 pm – 2:30 pm
Park Street Surgery

Attendees
Gary Killen – South Sefton CCG
Alison Farquharsen – Primary Care Development
Dr Helen Mercer – Moore Street Practice
Helen Devling – Moore Street Practice
Dr Anna Ferguson – The Strand Medical Centre
Gerry Devine – The Strand Medical Centre
Dr Steve Morris – The Strand Medical Centre
Dr David Goldberg – Concept House
Dr Sarah Stephenson – Bootle Village Surgery
Dr Kong Chung – Park Street Surgery
Jenny Kristiansen – South Sefton CCG

Guest Speakers
Pauline Little (Specialist Stoma Nurse) - Item 13/69
Paul Skaife (Consultant Colorectal Surgeon) - Item 13/69
Paul Albert (Respiratory Consultant Aintree NHS Trust) – Item 13/70

Apologies
Dr Ricky Sinha – North Park Practice
Pam Sinha - North Park Practice

Chair
Dr Anna Ferguson

Minutes
Gary Killen – South Sefton CCG

No	Item	Action
13/66	**Apologies** - Noted	
13/67	**Minutes of last meeting** – 24th July 2013 Minutes from the last meeting were accepted as an accurate record.	
13/68	**Matters Arising – None**	
13/69	**Stoma Prescribing and Review Pilot Project in partnership with Aintree NHS Trust** JK gave a quick update on the pilot. A business Case is being	JK to send prescribing process and

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	presented at the Finance and Resource Committee on 19/9/13. PL gave a brief overview of how she can support practices through the project and handed out the Colorectal Care Pathway for Aintree NHS Trust and explained how this piece of work will fit into the current pathway. JK said that the project is planned to start mid to the end of September and will produce a report of the findings by January 2014. JK agreed to work up a document to be sent out to practices, outlining the future prescribing process complete with key contact details.	contact details out to practices ASAP.
13/70	**Respiratory Services Update** Paul Albert gave an overview of the enhanced element of the COPD Pathway hosted by Liverpool Community Health which became operational in April 2013. He handed out an update on the usage of the enhanced service and the Spirometry Service hosted by Aintree NHS Trust and encouraged clinicians to refer to the services due to the low referral rate. He acknowledged that there were initial concerns regarding the single point of access (SPA) this has however been streamlined and addressed. He also handed out practice and locality emergency admission rates for practices to look at and consider in relation to the Quality Premium target of a 5% reduction in respiratory admissions via A+E JK informed the group of the Smoking Cessation Pilot in the Bootle Locality – The project aims to work preventatively to capture patients not usually picked up in primary care.	
13/71	**Medicines Management Update –** No Update	
13/72	**Update from Finance & Quality Committees –** No meeting this month.	
13/73	**QP Indicators** It was agreed Ophthalmology would replace Varicose Veins as the Community Pathways QP indicator. The following QP indicators were agreed: **Community Pathways** • Urology • Ophthalmology • Gynaecology **Emergency Admissions** • End of Life • COPD • Virtual Ward It was also agreed to hold the Group Peer Review for A&E attenders at the next meeting. Practices to send audit results to JK and bring their Practice Peer Review findings to the next meeting to be discussed.	Practices to send audit results to JK and bring practice peer review findings to the next meeting.
13/74	**Any other business** **Virtual Ward –** HM raised a number of issues regarding the Virtual Ward project. JK agreed to feed this back to Tina Ewart, the Managerial Lead for the project and ask her to provide a response. **Winter Pressures –** The group asked if there was an update on whether there will be funding for winter pressures this year. JK to check and feedback.at the next meeting. **Lab Links –** HD reported that no data was downloaded on 28, 29	JK to raise VW issues with TE. JK to feedback the query on winter pressures monies at the next meeting.

	and 30 August due to one patient record being corrupted. This was reported as an EMIS issue.	
13/75	**Date and time of next meeting** Tuesday 15th October 2013 1pm – 2.30pm Park Street Medical Practice	

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South Sefton Clinical Commissioning Group

Crosby Locality Meeting

Wednesday 3rd July 2013
12:45 pm
Crosby Lakeside

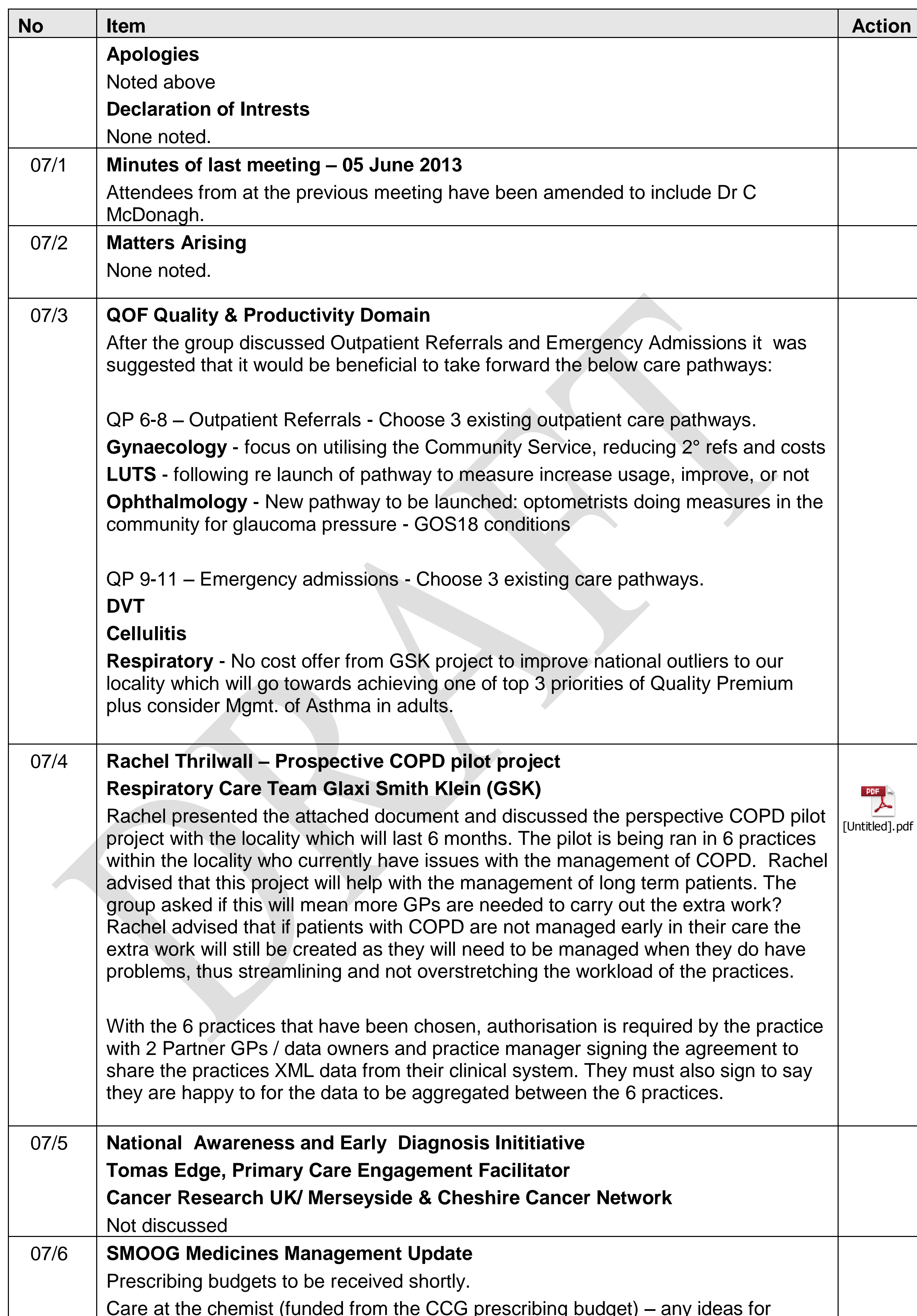
Chair: Dr Gustavo Berni (GB)

Attendees:
Sharon McGibbon (SMc)
Dr GK Misra (GM)
Carolyne Miller (CM)
Sue Hancock (SH)
Dr M Taylor (MT)
Lorraine Bohannon (LB)
Dr Prema Sharma (PB)
Dr Debbie Harvey (DH)
Cath Charlton (CC)
Pauline Woolfall (PW)
Dr C McDonagh (CMcD)
Dr Damian Navaratnam (DN)
Janet Faye (JF)
Alan Finn (AF)
Shelley Keating (SK)
Maureen Guy (MG)
Dr Nigel Tong (NT)
Tina Ewart (TE)
Tabitha Bodger (TB)

Apologies
Dr Andy Mimnagh
Dr Craig Gillespie
Pippa Rose

Guest Speakers:
Rachel Thirlwall (GSK)

Minutes
Terry Stapley Sefton CCG Administrator



No	Item	Action
	Apologies Noted above **Declaration of Intrests** None noted.	
07/1	**Minutes of last meeting – 05 June 2013** Attendees from at the previous meeting have been amended to include Dr C McDonagh.	
07/2	**Matters Arising** None noted.	
07/3	**QOF Quality & Productivity Domain** After the group discussed Outpatient Referrals and Emergency Admissions it was suggested that it would be beneficial to take forward the below care pathways: QP 6-8 – Outpatient Referrals - Choose 3 existing outpatient care pathways. **Gynaecology** - focus on utilising the Community Service, reducing 2° refs and costs **LUTS** - following re launch of pathway to measure increase usage, improve, or not **Ophthalmology** - New pathway to be launched: optometrists doing measures in the community for glaucoma pressure - GOS18 conditions QP 9-11 – Emergency admissions - Choose 3 existing care pathways. **DVT** **Cellulitis** **Respiratory** - No cost offer from GSK project to improve national outliers to our locality which will go towards achieving one of top 3 priorities of Quality Premium plus consider Mgmt. of Asthma in adults.	
07/4	**Rachel Thrilwall – Prospective COPD pilot project** **Respiratory Care Team Glaxi Smith Klein (GSK)** Rachel presented the attached document and discussed the perspective COPD pilot project with the locality which will last 6 months. The pilot is being ran in 6 practices within the locality who currently have issues with the management of COPD. Rachel advised that this project will help with the management of long term patients. The group asked if this will mean more GPs are needed to carry out the extra work? Rachel advised that if patients with COPD are not managed early in their care the extra work will still be created as they will need to be managed when they do have problems, thus streamlining and not overstretching the workload of the practices. With the 6 practices that have been chosen, authorisation is required by the practice with 2 Partner GPs / data owners and practice manager signing the agreement to share the practices XML data from their clinical system. They must also sign to say they are happy to for the data to be aggregated between the 6 practices.	PDF [Untitled].pdf
07/5	**National Awareness and Early Diagnosis Inititiative** **Tomas Edge, Primary Care Engagement Facilitator** **Cancer Research UK/ Merseyside & Cheshire Cancer Network** Not discussed	
07/6	**SMOOG Medicines Management Update** Prescribing budgets to be received shortly. Care at the chemist (funded from the CCG prescribing budget) – any ideas for	

No	Item	Action
	additions / deletions to be sent to Tina or Janet. Virtual Ward roll out to begin from 1st August 2013.	
07/7	**Feedback from the Board – Practice Managers Meeting** Karen Riddick, Sarah Gibson and Gill Rice presented at the practice manager meeting around Virtual Ward. Consent forms / immunisation standardisation. Margaret Goddard from Safeguarding – overview of changes that have happened. NHS 111 – feedback forms should have been received in NHS.net accounts. Communications – any issues relating to communications need to be discussed with Gary Francis at Aintree. Any issues in practices to be sent to Sharon McGibbon.	
07/8	**Any other business** None noted	
	Date and time of next meeting Wednesday 7th August 2013 12:30 Lunch 12:45 start – 2:00 CLAC	

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NHS

South Sefton Clinical Commissioning Group

Crosby Locality Meeting

Wednesday 4th September 2013
12:45 – 2.30pm
Crosby Lakeside Adventure Centre (CLAC)

Chair: Dr Gustavo Berni (GB)

Attendees:
Sue Hancock (SH)
Lorraine Bohannon (LB)
Pauline Woolfall (PW)
Dr Damian Navaratnam (DN)
Janet Faye (JF)
Pippa Rose (PR)
Dr Craig Gillespie (CG)
Dr C Allison (CA)
Donna Hampson (DH)
Dr Andy Mimnagh (AM)
Tina Ewart (TE)
Dr M Taylor (MT)
Carolyne Miller (CM)
Alan Finn (AF)
Dr Clive Shaw (CS)

Apologies
Sharon McGibbon (SMc)
Dr Prema Sharma (PB)
Alison Johnston (AJ)
Stella Moy (SM)

Guest Speakers:
Tony Griffin

Andy Woods CSU
Tomas Edge
Paul Albert
Mike Hammond

Minutes
Gary Killen Sefton CCG Administrator

No	Item	Action
	Apologies Noted above **Declaration of Interests** None noted	
13/48	**Minutes of last meeting – 7 August 2013** Minutes from the last meeting were agreed as a correct record.	
13/49	**Matters Arising** None noted	
13/50	**Community Respiratory Services - Paul Albert & Mike Hammond** The Community Respiratory team now have an enhanced COPD Pathway. The team is now doing a hospital at Home service. Specialist nurses manage patients during an exacerbation enabling them to stay at home. It also supports patients to be optimised for their medication. The nursing staff are contact the patients on a daily basis. GPs can start patients on anti biotics/nebulisers and let the nursing team take over support and review. The service is also supported by the Virtual Ward rounds with daily contact from the hospital chest physician. 90% of patients are successfully managed at home. Patient feedback is positive, they like the service and respond positively to being managed at home rather than at A&E This has been established in Liverpool for over a year and in Sefton for a couple of months. (AM) questioned the point about higher costs for service to practice. Response: The more patients referred to the service the more cost effective this will be. (CS) asked if oxygen assessments are provided. Response: CRT doesn't provide this service. Referrals accepted Mon – Fri 8am – 6pm Care for patients on caseload will be 8am – 8pm 7 days per week If a patient is outside the criteria speak to the hospital team for guidance on: 0300 100 1001 A Spirometry hand out was issued to the group. All are encourage to utilise this service. Need to get numbers up to make it cost effective.	
13/51	**Quality Premium** This year's QP's need to be passed by the Department of Health. TE has offered to contact Jackie Pye at DOH on behalf of the locality to get this passed. TE to also find out which group of people (DOH or CMCSU) to collate and send the data to practices. **QP001-003 Outpatient Referrals:** **Gynaecology** (CG) asked for a clearer pathway for the Community **Urology** **Ophthalmology**	TE

No	Item	Action
	QP004-006 Emergency Admissions: **End of Life** **Cellulitis** **Children's Respiratory** TE to work with GB and DOH. Will agree framework of questions which the group can then use for audit. Any thoughts and suggestions please send to TE or GB	TE GB
13/52	**QOF QP 007-009 A&E Admissions** **Over 65's, Under 15's, Frequent Users of A&E** Peer review was undertaken with all present participating in discussion of the reviews presented by Blundellsands and Crosby Village. Blundellsands Surgery gave their figures for QP 007-009 to the group Crosby Village Surgery gave their figures for QP 007-009 to the group **The rest of the group were requested to complete their audit reviews and bring to the next locality meeting for Peer Review.**	TE agreed to write up peer review on behalf of practices **All practices**
13/53	**Transgender Pilot – Tony Griffin (In Trust Merseyside) Andy Woods (Diversity & Equality Lead C&MCSU)** Tony Griffin from In Trust Merseyside supported by Andy Woods from C&MCSU gave some background information about In Trust Merseyside and the roles and issues experienced within the transgender community and the NHS. This led to a lively discussion and the group asked for definition as to specific support being asked of the group by In-Trust. Tony confirmed that In Trust is seeking for a number of named practices across Sefton are established to provide access to the Transgender Pathway. Further discussion will continue outside of this forum.	
13/54	**National Cancer Awareness and Early Diagnosis Initiative – Tomas Edge, Primary Care Engagement Facilitator, Cancer Research UK / Merseyside & Cheshire Cancer Network** Tomas informed the group that there is a national screening awareness project encouraging practices to undertake initiatives and activity that will help diagnose cancer earlier. The project aims to support primary care to save extra 1 – 2 lives per year per practice across all of Cheshire and Merseyside. Improving awareness of signs and symptoms, earlier detection and diagnosis in primary care. Tomas is keen to get out and meet with practices and is working with Dr Debbie Harvey, Heino Hugel and Macmillan. Please feel free to contact him for support. Tomas was unable to give his full presentation due to over run on time from previous speaker but issued individualised practice information help packs and sent the following message for the locality after the meeting: Thank you for allowing me the time to present to the Crosby Locality Group today. Due to obvious time restraints I felt that I may have rushed my presentation slightly and therefore wanted to take this opportunity to re-affirm my proposal, confirm my contact details and offer my thanks. It would be great to visit all the practices in Crosby individually to have a chat about the Cancer Practice Profile, discuss potential ideas your practice has and share ideas that are currently working across Merseyside & Cheshire. My email address is tomas.edge@cancer.org.uk and my mobile number is 07733451031	

No	Item	Action
13/55	**Strategic Plan –** agenda item no longer required. TE has liaised with Fiona Doherty from senior team on behalf of the locality	
13/56	**Medicines Management** Janet reported Qtr. 1 data is now available and is showing present forecast of a £ ½ million underspend by year end. Acknowledged that this figure is liable to change.	
13/57	**Any other business** Reminder to those outstanding bring for 'QP 7,8,9' findings for work to next meeting for Peer Review	
13/58	**Date and time of next meeting** **Wednesday 4 September 2013** **12:30 lunch** **12.45 start – 2:00** **Crosby Lakeside Adventure Centre (CLAC)**	

NHS

South Sefton Clinical Commissioning Group

Crosby Locality Meeting

Wednesday 2nd October 2013
12:45 – 2.30pm
Crosby Lakeside Adventure Centre (CLAC)

Chair : Dr Gustavo Berni

Attendees
Alan Finn
Dr McDonagh
Dr Misra
Maureen Guy
Dr Gillespie
Carolyne Miller
Dr Roy
Dr Taylor
Lorraine Bohannon
Dr Sharma
Dr Wallace
Stella Moy
Dr Allison
Pauline Woolfall
Cath Charlton
Donna Hampson
Janet Faye
Dr C Doran

Apologies
Alison Johnston

Guest Speakers :

Minutes : Tina Ewart

Attendance Tracker

P Present
A Apologies
L Late or left early

Name	Designation	Feb 13	Mar 13	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13
Dr S Aylward	GP – Crosby Village Surgery	P										
Pippa Rose	PN – Crosby Village Surgery	P				P	A	P	P			
Dr M Taylor	GP – Crosby Village Surgery				P	P	P	A	P	P		
Lorraine Bohannon	PM – Crosby Village Surgery				P	P	P	P	P	P		
Dr S Roy	GP – Crosby Village Surgery							P		P		
Dr A Doerr	GP – Crosby Village Surgery		P									
Sharon McGibbon	PM – Eastview Surgery	P		P	P	P	P	P	A			
Dr A Mimnagh	GP – Eastview Surgery	A		A	P		A	A	P			
Dr M Hughes	GP – Eastview Surgery		P									
Donna Hampson	PM – Crossways Surgery	P	P					P	P	P		
Dr P Sharma	GP – Crossways Surgery	A	P		P	P	P	P	A	P		
Cath Charlton	PM – Thornton Surgery	P			P	P	P	P		P		
Stella Moy	PN – Thornton Surgery	A		P	A	P			A	P		
Dr D Harvey	GP – Thornton Surgery	A	P	P	P	P	P					
Dr J Wallace	GP – Thornton Surgery							A		P		
Maureen Guy	PM – 133 Liverpool Road	P	P		A	P	P	P		P		
Dr G Mizra	GP – 133 Liverpool Road	A	P		P	P	P	A		P		
Caroline Miller	PM – Blundellsands Surgery	P	P	P	P	P	P	A	P	P		
Dr N Tong	GP – Blundellsands Surgery	A	P			P	P					
Dr C Gillespie	GP – Blundellsands Surgery			P	P		A	P	P	P		
Sue Hancock	PN – Blundellsands Surgery				P	P	P	P	P			

Name	Designation	Feb 13	Mar 13	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13
Shelley Keating	PM – 30 Kingsway	A				P	P	P				
Dr C Shaw	GP – 30 Kingsway				P	P			P			
Dr C McDonagh	GP – 30 Kingsway	P	P		P	P	P	P		P		
Dr E Pierce	GP – Hightown Village Practice	P		P	A							
Pauline Woolfall	PM – Hightown Village Practice	P		P	P	P	P	P	P	P		
Dr C Allison	GP – Hightown Village Practice							P	P	P		
Dr D Navaratnam	GP – Azalea Surgery				A	P	P	P	P			
Dr C Doran	GP – Azalea Surgery	P			A					P		
Dr G Berni	GP – 42 Kingsway	P		A	P	P	P	P	P	P		
Alan Finn	PM – 42 Kingsway	P		P		P	P		P	P		
Dr F Vitty	GP – 42 Kingsway					P						

No	Item	Action
13/59	**Apologies** Noted above **Declaration of Interests** None noted	
13/60	**Minutes of last meeting – 4 September 2013** Minutes from the last meeting were agreed as a correct record.	
13/61	**Matters Arising** None noted	
13/62	**QP 007,008,009 A&E attenders Peer Review** TE asked for all practices to send their reports to her for TE and GB to write up Peer Report on behalf of the locality. **Kingsway** Under 15 Injuries and Fractures, also potential drowning, one chronic fatigue and others rashes. Mostly attended just once one frequent (respiratory case) a quarter of attenders had behavioural issues. High frequency of seizure related one of which attended 18 times. All patients were relatively ill, a couple died – in hospital all mainly appropriate, and mainly elderly discharge letter not enough info. Over 65s All seriously ill and some died in hospital 3 stroke, 1 lung cancer Can End Of Life be better managed in Primary care/at home? **Azalea** Over 65s 50% at weekend, all live at home and 30% been seen in primary care >previous to admission ?panic attacks Under 15s 66 were OOH 66% Self refs Frequents 44% were seen OOH 11% EMERGENCY FOLLOW UP AT St Pauls Only 1 could have been seen in primary care **Hightown** Under 15s all appropriate frequents = UTIs , appropriate child, ?pt and parent education Over 65s all appropriate except for young child - 80% self-referral	

No	Item	Action
	Crosby Village Dr Mel Under 15s ALL CASES WERE oohS AND self refs 2 have previously been seen in primary frequent attenders mix of in and out of hours, mostly self refs - one from dialysis unit and one from GP Over 65s most were OOH barr 2 two were from a nursing home, 2 actually died Were acute onset - not palliative **30 Kingsway** Under 15s ALL APPROP BARR 1 SELF REFS ? Practice is one GP down - understand why Frequents anxious parents - child with constipation baby with reflux - phone up , no appt, off to A&e Over 65s 80% were at weekends self ref Blocked catheter from nursing home - new kit should resolve super pubic!! GREENHEYS Craig queried why District nurse can't go in to do this Clare suggested Training need Dr Misra weekend service - should be managed by District Nurse!!Definite pattern on Tues and Thursday - new doctor commencing!! Thornton Over 65s all were appropriate and unavoidable Either admitted or died in A&E or soon after diagnosis Frequents - complex and approp 1 with cellulitis and possibly discharged too soon as re-admitted soon after lack of information from hospital – patients daughter informed us she had died Under 15s chest infections, swallowed a battery, UTI, only one was unavoidable.	
13/63	**QP 001,002,003 Out Patients review** **Gynaecology** Look at all patients attending hospital with no treatment - could have been seen in Community coil fits **Ophthalmology** Qs - Look see how many referred to secondary care October - December 2011/12? look at how many suspected Glaucoma **LUTS** pure usage to see if continue or decommission **Action – TE to share info with GPs about launch**	TE
13/64	**Medicines Management report** The previous figures given have been adjusted because the prescription pricing authority got it wrong. General speaking this locality is ok with the exception Eastview.	

No	Item	Action
	JF brought to the groups attention the excellent resource on Intranet: Tabled: Sefton PRESCRIBER UPDATE 95 is on the intranet, info on RAG list, live doc and is updated all the time, Pan Mersey area prescribing committee, policies, and guidelines, oxygen.	
13/65	**Practice Level Finance Summary Reports** Jenny White - shared finance info to see how practices are performing. When looking over last 2 years, bear in mind 2012/13 was PCT budget and since then there have been many transferring of monies and departments. Jenny asked what kind of data would be most useful for people. Dr Mel and Carolyne suggested: trends for one practice but also useful to see how compare with peers own practice data and then comparing with practices in other localities.	
13/66	**Guest Speakers from Community Mental Health Team CMHT** The guest speakers advised the group that they are hoping to assist in the delivery of CQUINS. There are 4 catchment areas and Crosby. Both delivering for Crosby area, split the role If known already, refer in via CPN Taking on SMI registers and sign posting Improve physical health and encourage engagement Get CPNs involved, latterly engaging everyone involved in the patient health care. Yvonne requested Practice Managers to contact them to arrange one to one visits or practice manager mtg! TE to put info on website when received via Peter Terry.	
13/67	**1.30pm Robert Waugh, Operations Lead – IAPT** **increasing access to Psychological services** Robert Waugh IAPT Inclusion Matters Sefton Presented information and data on patient referral, referral to initial assessment - most getting assessed within 1 week of referral. Practice nurses are a good source of identifying those who are anxious and depressed The CCG need to meet the target. Open up self-referral but prefer to see those who GP are supporting. Need more referrals please. Acknowledge GP are managing many themselves and want to assist relieve burden on GPs. Current delivery capacity means that 3 referrals per month could be made for every 1000 pts on a practice list. Waiting times are minimal - 1 week to initial assessment from referral. Step 2 sessions (45 min) = up to two weeks wait Step 3 (1 hour 1 to 1 sessions) = 28 day wait Direct access to Acute Care teams if pt suicidal Care pathways in place. Secondary care can refer pts directly in - do not need to request GP to make referral.	
13/69	**Any other business** Reminder to those outstanding bring for 'QP 7,8,9' findings for work to next meeting for Peer Review	

No	Item	Action
13/70	**Date and time of next meeting** **Wednesday 6 November 2013** **12:30 lunch** **12.45 start – 2:00** **Crosby Lakeside Adventure Centre (CLAC)**	

South Sefton Clinical Commissioning Group

Maghull Locality Meeting Minutes

Thursday 23rd August 2013

1:00 – 2:30

High Pastures 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
Sheila Dumbell	Prescribing Support Officer
Chris Brennan	Practice Pharmacist
Carole Morgan	High Pastures Surgery
Dr Rauri Killough	Westway Medical Centre
Apologies:	
Gill Kennedy (GK)	High Pastures Surgery
Gary Killen	NHS South Sefton CCG
Dr Weston	High Pastures Surgery
Dr Bernard Thomas	Broadwood Surgery
Dr Jill Thomas	Broadwood Surgery
Jenny Johnson	NHS South Sefton CCG
Minutes: Tracey Cubbin	NHS South Sefton CCG

No	Item	Action
13/51	**Apologies** Apologies were noted as above.	
13/52	**Minutes of last meeting – 18th July 2013** The minutes of the last meeting were agreed as an accurate record.	
13/53	**Matters Arising** - **Gotodoc – The new OOH (Out of Hours) Provider – David Beckett** TH now has contact details for the above and has emailed the locality with an up to date email and telephone number. - **Prescribing update** CB advised that an audit for the month of May around Cephalosporin's is currently being undertaken however details are still being finalised. Jenny Johnson, Senior Practice pharmacist will update at the next Locality meeting.	JJ

13/169

No	Item	Action
13/54	**Community Respiratory Team** Item deferred to September meeting. Although this item has been deferred as above, the group briefly discussed reducing COPD Admissions. Idea's such as education of pathways, the correct use of coding and possibly training reception staff within surgeries to identify high risk patients. Dr Sapre talked about the 'rescue pack' which is available in surgeries and suggested a 'traffic light' system to again identify high risk patients. TH advised that the Community Respiratory Team had extended its service and is now available from 9:00 am to 8:00 pm however, only one surgery within the locality made a referral between 5:00 pm and 8:00 pm within the last three months. A representative from the Community Respiratory Team will present at the next meeting.	
13/55	**QOF** The group decided provisionally to look at the following areas: **Out Patients** - IFR (Varicose Veins) - Cardiology (HF) - Rheumatology (MCAS) **Emergency Admissions** - Respiratory (Adults) - EOL - DVT **A&E Attendances** - Asthma in Children - Over 65's/Dementia - High frequency users TH to email the group with the above information so practices can discuss and confirm they are happy to go ahead with the above, TH has asked that responses be back to him by close of play – **Monday 2nd September 13**	ALL
13/56	**Quality Premium** **Risk Stratification** TH advised that Becky Williams (BW) from Sefton CCG will be attending future locality meetings to discuss reports and outcomes; there has been no progress as yet from the Commissioning Support Unit (CSU) which BW is currently looking into. TH will confirm timescales and update at the next meeting. TH asked the group if the Risk Stratification Tool was being used and who had signed their Data Sharing Agreements as this could support the practices with the quality premium. TH to check who is utilising these agreements and update at the next meeting. Terry to also speak to Bal Duper regarding expectations of localities and how we can implement any changes.	BW/TH

No	Item	Action
13/57	**Any other Business** - **Fax Numbers for Surgeries** Westway Medical Centre:- 0151 527 2631 Maghull SSP:- 0151 283 5043 High Pastures Surgery:- 0151 527 2377 Dr Spare Maghull:- 0151 520 2487	
13/58	**Date and Time of next meeting:** Thursday 19th September – Westway Friday 25th October – High Pastures Thursday 21st November – Westway Friday 20th December – High Pastures Thursday 23rd January – Westway Friday 21st February – High Pastures Thursday 20th March - Westway	