NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

Date: Thursday, 27 March 2014 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)
Graham Morris	Vice Chair, Lay Member, Financial Management and Audit	(GM)
Dr Craig Gillespie	Clinical Vice-Chair, GP	(CG)
Roger Driver	Lay Member, Engagement and Patient Experience	(RD)
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 on behalf Of Margaret Carney	(PM)

Also in attendance

Catherine Beardshaw	Chief Executive, Aintree Hospitals NHS Trust	(CB)
Stephen Astles	Head of CCG Development	(SA)
Brendan Prescott	CCG Lead for Medicines Management	(BP)
Dr Debbie Harvey	Lead Clinician for Virtual Ward	(DH)
Gaynor Hales	Director of Nursing, NHS England (Merseyside)	(GH)
Hannah Chellaswamy	Deputy Director of Public Health, Public Health Sefton	(HC)
Tracy Jeffes	Head of Delivery and Integration	(TJ)

No	Item	Lead	Report	Receive/ Approve	Time
General business					
GB14/32	Apologies for Absence	Chair		R	13.15
GB14/33	Declarations of Interest regarding agenda items	All		R	
GB14/34	Register of Interests	-	✓	R	
GB14/35	Hospitality Register	-	✓	R	
GB14/36	Minutes of Previous Meeting	Chair	✓	R	13.20
GB14/37	Action Points from Previous Meeting	Chair	✓	R	
GB14/38	Business Update	Chair			13.25
GB14/39	Chief Officer Report	FLC	✓	R	13.30
Reports received by way of assurance (taken as read)					
GB14/40	Corporate Performance Report	MC	✓	R	13.35
GB14/41	Quality Performance	DF	✓	R	13.45
GB14/42	Financial Performance Report	MMcD	✓	R	13.55
GB14/43	Prescribing Performance Report	BP	✓	R	14.00
GB14/44	The CCG 5 Year Strategic Plan and 2 year Operational Plan – Briefing on Progress – Update	KMcC	✓	R	14.10
GB14/45	Strategic Financial Plan 2014/15 - 2018/19	MMcD			14.20
GB14/46	Clinical Director Roles	TJ	✓	R	14.30
GB14/47	2014/15 Provider Contract Update	MMcD	✓	R	14.40
GB14/48	Key issues reports from Committees of Governing Body:- • Finance and Resource Committee • Quality Committee	 MMcD FLC	 ✓ ✓	 R R	14.45
GB14/49	Commissioning Intentions	SA	✓	R	14.50
GB14/50	NHS Constitution Statement of Assurance	DF	✓	R	14.55
Formal approval by Governing Body required					
GB14/51	2014/15 Opening Financial Budgets	MMcD	✓	A	15.05
Minutes of Committees to be formally received (taken as read)					
GB14/52	Quality Committee	-	✓	R	15.15
GB14/53	Finance & Resource Committee	-	✓	R	
GB14/54	Merseyside CCG Network	-	✓	R	
GB14/55	Health and Wellbeing Board	-	✓	R	
GB14/56	Medicines Optimisation Operational Group	-	✓	R	
GB14/57	Health and Wellbeing Board Programme Group	-	✓	R	

No	Item	Lead	Report	Receive/ Approve	Time
GB14/58	Locality Meetings - (i) Seaforth & Litherland Locality (ii) Bootle Locality (iii) Crosby Locality (iv) Maghull Locality	-	✓	R	
Closing business					
GB14/59	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting.*				15.20
GB14/60	Date, Time and Venue of Next Meeting of the Governing Body to be held in Public *Thursday, 29 May 2014 at 1.00pm at Merton House*				-
Estimated meeting close					15.25

The meeting will then be joined by Ms Catherine Beardshaw, CEO, Aintree University Hospitals NHS Foundation Trust.

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 3: March 2014

NHS South Sefton Clinical Commissioning Group

Name	Date	Position/ Role	Interests Declared	Personal interest or that of family, friend or colleague	Potential or actual area where interest could occur	Action taken to mitigate risk	Comments
Dr Clive Shaw	16.05.13	Chair, GP Governing Body Member	GP Partner, 30 Kingsway	Personal	Decision making re remuneration of GPs undertaking CCG work	Exclusion from decision making process around GP remuneration, which will be undertaken by a sub-group of the Governing Body comprised of the lay membership, CO and CFO	
Dr Craig Gillespie	17.03.14	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	
			January 2014 received an honorarium from the Cheshire & Merseyside strategic clinical network	Personal		No action required	
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 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	
			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	

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
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	
Debbie Fagan	13.05.13	Chief Nurse, Governing Body Member	Dual role as CN between Southport & Formby CCG and South Sefton CCG	Personal	None	No action required	
Kevin Thorne	02.07.13	Employee	Nil return	None	None	No action required	
Susanne Lynch	15.07.13	Employee	Employed to run patient clinics at Churchtown Medical Centre	Personal	Decision directly affecting Churchtown Medical Centre	None required, employee does not work in a capacity which can affect decision making in this area	
			Husband employed as superintendant pharmacist for pharmacy owned by Churchtown Medical Centre	Family	Decision directly affecting Churchtown Medical Centre	None required, employee does not work in a capacity which can affect decision making in this area	
			Brother in law (Mark Harrison-North) trustee for Dovehaven Care homes	Family	Decision directly affecting Care Homes	None required, employee does not work in a capacity which can affect decision making in this area	
Malcolm Cunningham	24.06.13	Employee, Committee Member	Practicing Optometrist - Yates & Suddell Optometrists	Family	None	No action required, practising outside of CCG area.	
Sara Boyce	10.07.13	Employee	Nil return	None	None	No action required	
Billie Dodd	15.07.13	Employee, Committee or Sub-Committee Member	Nil return	None	None	No action required	
Chloe Rachelle	09.07.13	Employee	Nil return	None	None	No action required	
Cathy Loughlin	21.06.13	Employee	Nil return	None	None	No action required	
Karen Lloyd	21.06.13	Employee	Nil return	None	None	No action required	
Becky Williams	21.06.13	Employee	Nil return	Personal	None	No action required	
Sandra Craggs	24.06.13	Employee	Nil return	None	None	No action required	
Ruth Menzies	24.06.13	Employee	Nil return	None	None	No action required	
Stephen Astles	24.06.13	Employee	Wife is a ward manager at Broadgreen Hospital	None	None	No action required	
Terry Stapley	24.06.13	Employee	Nil return	None	None	No action required	
Brendan Prescott	25.06.13	Employee, Committee or Sub-Committee Member	Wife is an employee of University Hospitals Aintree NHS Foundation Trust	Family	none	Exclusion from decision making in connection to University Hospitals Aintree NHS Foundation Trust	
Tina Ewart	21.06.13	Employee	Julian Richard Donagh Tuson, Consultant Interventional Radiologist, at Aintree Hospital NHS	Family	none	Exclusion from decision making in connection to University Hospitals Aintree NHS Foundation Trust	
Philippa Rose	27.06.13	Employee	Nil return	None	None	No action required	
Gillian Beardwood	27.06.13	Employee	Nil return	None	None	No action required	

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
Alison Lucy Johnston	01.07.13	Employee	Nil return	None	None	No action required	
Clare Shelley	01.07.13	Employee	Husband employed by neighbouring NHS Organisation CQQ CSU	Family	Decision making regarding CSU SLA.	Exclusion from decision making process around CSU SLA.	
Janet Fay	29.06.13	Employee	Nil return	None	None	No action required	
Jenny Kristiansen	02.07.13	Employee	Nil return	None	None	No action required	
Christine Barnes	25.06.13	Employee	Work as a pharmacist in Boots Store 1152, 31-39 Chapel Street, Southport. 2 days a week	Personal	None	No action required	
Thomas Roberts	08.07.13	Employee	Nil return	None	None	No action required	
Angela Parkinson	15.07.13	Employee	Nil return	None	None	No action required	
Sarah McGrath	15.07.13	Employee	Nil return	None	None	No action required	
Michael Scully	15.07.13	Employee	Nil return	None	None	No action required	
Alain Anderson	15.07.13	Employee	Nil return	None	None	No action required	
Jane Ayres	15.07.13	Employee	Nil return	None	None	No action required	
Jennie Birch	15.07.13	Employee	Nil return	None	None	No action required	
Lyn Cooke	15.07.13	Employee	Nil return	None	None	No action required	
Sue Crump	22.07.13	Employee	Nil return	None	None	No action required	
Tracey Cubbin	15.07.13	Employee	Nil return	None	None	No action required	
Emma Dagnall	15.07.13	Employee	Nil return	None	None	No action required	
Fiona Doherty	15.07.13	Employee	Nil return	None	None	No action required	
Laura Doolan	15.07.13	Employee	Nil return	None	None	No action required	
Sheila Dumbell	25.07.13	Employee	Nil return	None	None	No action required	
Adam Gamston	15.07.13	Employee	Nil return	None	None	No action required	
Paul Halsall	15.07.13	Employee	Nil return	None	None	No action required	
James Hester	15.07.13	Employee	Nil return	None	None	No action required	
Terry Hill	15.07.13	Employee	Nil return	None	None	No action required	
Tracy Jeffes	15.07.13	Employee	Nil return	None	None	No action required	
Zita Johnson	15.07.13	Employee	Nil return	None	None	No action required	
Jennifer Johnston	15.07.13	Employee	Nil return	None	None	No action required	
Nicole Cowan	15.07.13	Employee	Nil return	None	None	No action required	
Gary Killen	23.07.13	Employee	Nil return	None	None	No action required	
Jan Leonard	15.07.13	Employee	Nil return	None	None	No action required	
Suzanne Lynch	15.07.13	Employee	Nil return	None	None	No action required	
Sarah McGrath	15.07.13	Employee	Nil return	None	None	No action required	
Moira McGuinness	15.07.13	Employee	Nil return	None	None	No action required	
Geraldine O'Carroll	15.07.13	Employee	Nil return	None	None	No action required	
Colette Page	15.07.13	Employee	Nil return	None	None	No action required	
Indira Patel	15.07.13	Employee	Nil return	None	None	No action required	
Sejal Patel	25.07.13	Employee	Nil return	None	None	No action required	
Sean Reck	15.07.13	Employee	Nil return	None	None	No action required	
Tracy Reed	15.07.13	Employee	Nil return	None	None	No action required	
Helen Roberts	15.07.13	Employee	Nil return	None	None	No action required	
Shaun Roche	15.07.13	Employee	Nil return	None	None	No action required	
Diane Sander	15.07.13	Employee	Nil return	None	None	No action required	
Jane Tosi	15.07.13	Employee	Nil return	None	None	No action required	
Jane Uglow	03.07.13	Employee	Nil return	None	None	No action required	
Jenny White	15.07.13	Employee	Nil return	None	None	No action required	
Melanie Wright	15.07.13	Employee	Nil return	None	None	No action required	
Christopher Brennan	15.07.13	Employee	Nil return	None	None	No action required	
Caroline Gunson	15.07.13	Employee	Nil return	None	None	No action required	
Dr Damian Navarathnam	07.08.13	Member	Nil return	None	None	No action required	
Dr Nigel Tong	08.08.13	Member	GP Principal Blundelsands Surgery Deputy Medical Director NHS England (Merseyside)	None	None	No action required	
Graham Morris	11.12.13	Member	Nil return	None	None	No action required	
Bal Duper	01.01.14	Employee, Committee or Sub-Committee Member	Full time GP in Manchester	Personal	Personal	No action required at this time	

Hospitality Register
March 2014

NHS
South Sefton
Clinical Commissioning Group

Recipient:	Nature of Gift / Hospitality:	Date Received	Approximate Value	Donated by:
Dr Paul Thomas	Concert at the Philharmonic with canapés and refreshments	7 March 2014		Hill Dickinson Solicitors

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public Minutes

Thursday, 28 November 2013 at 1.00pm to 4.00pm
The Boardroom, Third Floor, Merton House, Bootle L20 3DL

Present

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 John Wray	GP	(JW)
Dr Dan McDowell	Secondary Care Doctor	(DMcD)
Lin Bennett	Practice Manager	(LB)
Sharon McGibbon	Practice Manager	(AF)
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)
Stephen Astles	Head of CCG Development	(SA)
Tracy Jeffes	Head of Delivery & Integration	(TJ)
Malcolm Cunningham	Head of Primary Care	(MC)
Brendan Prescott	CCG Lead for Medicines Management	(BP)
Lyn Cooke	Head of Communications, Cheshire & Merseyside CSU	(LC)

Apologies

Dr Paul Thomas	GP	(PT)
Dr Ricky Sinha	GP	(RS)
Fiona Clark	Chief Officer	(FLC)
Dr Debbie Harvey	Lead Clinician for Virtual Ward	(DH)

Minutes

Melanie Wright	Business Manager

NHS
South Sefton
Clinical Commissioning Group

Attendance Tracker

✓ Present
A Apologies
L Late

Governing Body Member	Designation	Jan 2013	Mar 2013	May 2013	July 2013	Sept 2013	Nov 2013					
Dr Clive Shaw	Chair	A	✓	✓	A	A	L					
Dr Craig Gillespie	Clinical Vice-Chair, GP	✓	✓	✓	✓	✓	✓					
Dr Steve Fraser	GP	✓	✓	✓	✓	A	✓					
Dr Andrew Mimnagh	GP	✓	✓	✓	A	✓	✓					
Dr Ricky Sinha	GP	✓	✓	✓	A	✓	A					
Dr Paul Thomas	GP	✓	✓	A	✓	✓	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	✓	✓	✓	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				✓	A					
Maureen Kelly	Healthwatch Sefton	N/A				A	A					

No	Item	Action
13/145	**Apologies for Absence** Apologies for absence were received. Dr Gillespie thanked Dr Fraser for his commitment and work undertaken on behalf of the CCG, following his formal resignation from the Governing Body. Dr Gillespie also welcomed the new Lay Member of the Governing Body, Graham Morris, who joins the CCG formally on 2 December 2013.	
13/146	**Declarations of Interest regarding agenda items** Declarations of interest were received relating to those with joint posts with NHS Southport & Formby CCG, namely Martin McDowell and Debbie Fagan.	
13/147	**Register of Interests** The Governing Body received the register and the Chair invited Graham Morris to complete a form in time for his pending appointment and noted that the resignation of former Governing Body member, Lynda Elezi.	CL
13/148	**Hospitality Register** The Governing Body received the register.	
13/149	**Minutes of Previous Meeting** On page 16, the date of the next meeting is quoted as Wednesday, when it should be Thursday. Subject to this minor amendment, the Minutes were approved as an accurate record of the meeting.	
13/150	**Action Points from Previous Meeting** All actions were closed down, save for the following note. 13/119 – Corporate Performance Report/Rapid Access TIA clinic at Southport and Ormskirk Hospitals NHS Trust (S&O) - further to the request to keep GPs updated on S&O's performance against the stroke targets, the targets and local Trusts performance against them were now available on the intranet. *13/122 – Virtual Ward Update*: Mr Morgan confirmed that Virtual Ward and the associated restructure of social care was carried out and coordinated with the Local Authority and a formal report was received at the Health and Wellbeing Board last week.	
13/151	**Business Update** Dr Gillespie reflected on recent months following the authorisation process, which had been a steep learning curve, but close working relationships had been developed with the Local Authority and between secondary and primary care. The challenges and risks to the organisation were understood and actions were in place to mitigate those risks. Dr Gillespie asked Governing Body members to consider both their professional and organisational developments required over the coming year in line with forthcoming challenges the organisation is facing and in readiness for their upcoming professional development reviews.	

No	Item	Action
	Action taken by Governing Body The Governing Body received this report.	
13/152	**Chief Officer Report** *Risk Summit:* Miss Fagan advised as to the work undertaken at University Hospitals Aintree NHS Foundation Trust (Aintree) in relation recent the Risk Summit on performance and quality. There is a clear line of sight regarding the actions required and relevant action plans are in place by way of liaison with NHS England. *Advancing Quality:* Mr McDowell went on to provide highlights from the report in relation to Advancing Quality and its impact on provider performance. Mr McDowell referred to the potential cost savings at Southport & Formby CCG included within the report and assured the Governing Body that proportionally similar cost savings could be expected at South Sefton CCG. *Primary Care Strategic Board*: this committee provides an independent review into the decisions made by the CCG without representation by GPs to ensure transparency in decision-making. *Integrated Transformation Fund*: the CCG and local health and social care partners will have to respond to the requirement to change the way services are currently delivered, with more support being placed into the community to provide timely interventions. A formal update will be provided to the Governing Body in January 2014. Ms Jeffes advised that the preliminary timetable had been discussed at the Engagement and Patient Experience (EPEG) group in November and there will be a longer item on the EPEG agenda in December. The timetable has also been discussed with community champions and a piece of work is to be undertaken around ensuring full consultation. *Commissioning Support Unit:* Mr McDowell advised that a line-by-line review of service lines has taken place and a full update will be brought to the Governing Body in January. The current service level agreement runs to December 2014, but a review will take place for March 2014. The importance of considering required outcomes was noted. The Governing Body also expressed its congratulations to the Project Management Office for involvement in national events which showcased the CCG's approach in relation to the Right Care project. **Action taken by Governing Body** The Governing Body received the report of the Chief Officer.	MMcD MMcD
13/153	**Corporate Performance Report** Mr Cunningham outlined current A&E performance at Southport & Ormskirk Hospitals NHS Trust (S&O), which is above target. There is also an action plan in place in relation to 62-day waits on cancer. Ambulance handover times have increased at Aintree over the last month, which the CCG will continue to monitor. Dr Mimnagh asked about ambulance turnaround times at S&O, to which Mr Cunningham responded that performance had improved, but had not yet reached the Merseyside target. Miss Fagan referred the Governing Body to page 31 of the report and advised that positive feedback had now been received in relation to patient experience at S&O. **Action taken by Governing Body** The Governing Body received this report by way of assurance.	

No	Item	Action
13/154	**Quality Report** Miss Fagan drew the Governing Body's attention to healthcare acquired infections at Aintree: the position is that they continue to breach their annual targets in relation to CDifficile. The CCG is working closely with the Trust to address this and a further review is due shortly. The Governing Body noted that Aintree is appealing to the NHS Appeals Panel with regard to some of the cases allocated to that Trust. Cancelled appointments at Aintree are also being considered at the Quality Committee and via contractual channels. There are issues around both patients cancelling appointments and the Trust cancelling appointments, with both being investigated. It was acknowledged that the majority of appointments would appear to have been cancelled by the Trust on the basis of the soft intelligence received from patients and GPs. It was requested, that if possible, the data collected around cancelled appointments in total, should clearly show the distinction between Hospital Trust cancelled appointments and Patient cancelled. Care Quality Commission Unannounced Visits – there have been a number of unannounced visits across the local health economy. The recent visit to Liverpool Women's Hospital is being considered locally, led by Liverpool CCG as the lead commissioner for this provider. The recent unannounced visit to Aintree also formed part of the discussions at the recent Risk Summit at Aintree. Mr McDowell referred to Advancing Quality and Dementia within the report and asked Miss Fagan to consider further. Miss Fagan described the work under way in liaison with local trusts to address this. Dr Gillespie also referred to the recent under-performance of risk assessments for venous thromboembolism at Liverpool Heart and Chest (LHCH). At the November meeting, the LHCH clinical quality and performance group had specifically raised this issue and had been assured that this was as a result of data collection only and will be rectified in time for the next meeting. **Action taken by Governing Body** The Governing Body received this report by way of assurance.	
13/155	**Financial Position of South Sefton Clinical Commissioning Group – Month 7** Mr McDowell advised that financial performance has improved, but funds remain tight. The CCG is £2.090m over-spent prior to the application of reserves. There are further reserves earmarked to cover winter pressures and primary care quality committee recommendations. There is over performance at Aintree, but it has been identified that there has been a greater number of patients being treated under the 18-week rule, meaning that patients are being seen quicker. Clarity should be available in relation to all risks and opportunities by January and Mr McDowell felt that the CCG was on course to deliver its financial targets and obligations. Mr McDowell advised that the Governing Body's approval was sought in relation to the virements detailed within the report.	

No	Item	Action
	Action taken by Governing Body The Governing Body received this report by way of assurance and supported the review of data validation. The Governing Body approved the virements in relation to Liverpool Community Health and Mental Health Services.	
13/156	**Prescribing Performance Report** Optimisation work continues in all practices across South Sefton. In relation to the Community Pharmacy National Contract, some work has been done by the Department of Health to look at clawing back some money, which will result in a reduction in the price of drugs and, therefore, a reduction in cost for the CCG, in the latter part of the year. Mr McDowell noted that any improvement in the position has not yet been factored into the financial plan. Mr Prescott referred to a piece of work considering allocated budgets compared to fair shares. The average overspend is less under fair shares. Dr Mimnagh asked that a report on the strategic work and associated prescribing costs to support the expansion of primary care and community care be available for the next meeting. **Action taken by Governing Body** The Governing Body received this report by way of assurance.	MMcD/BP
13/157	**Commencement of Election Process** Mr McDowell advised that there will be an election in relation to one Governing Body member. **Action taken by Governing Body** The Governing Body received this report.	
13/158	**Winter Plan** The CCG's membership of the North Mersey Urgent Care Network will consider regional providers' winter plans. Mr Astles referenced the recent funding made available by NHS England in the sum of £1.52m to Aintree, to be used to fund a frail elderly unit and frail elderly pathway due to start in January. Acute nurse practitioners in A&E would improve capacity and implementation of an independent ECIST report has been requested. In primary care, additional appointments had been commissioned to improve access to primary care, together with implementation of an acute visiting scheme. Additional end of life care beds and a hospice at home service. Gaynor Hales advised as to the level of scrutiny upon organisations which had received monies nationally. **Action taken by Governing Body** The Governing Body received this report way of assurance.	
13/159	**Organisational Development Plan** Miss Fagan thanked Ms Jeffes for her work in relation to this plan, noting the inclusion of development around the Francis workplan and for the Governing Body in relation to safeguarding. **Action taken by Governing Body** The Governing Body approved the Organisational Development Plan.	

No	Item	Action
13/160	**Communicating Health in South Sefton…a Communications and Engagement Strategy for NHS South Sefton Clinical Commissioning Group** Dr Gillespie congratulated Ms Cooke on the quality of the report.	
	Mr Morgan noted that the report also complements work undertaken by the Health and Wellbeing Board. **Action taken by Governing Body** The Governing Body approved the Communications and Engagement Strategy.	
13/161	**Allocations Report** The proposed changes would result in the CCG being 7.16% above target, compared with the starting position of 15%. The split between the two CCGs will require continual monitoring. Canon Driver asked Mr Morgan to clarify whether the fair shares basis adopted was similar to that utilised by the local authority. Mr Morgan advised that it was likely, given that Sefton had a variety of levels of deprivation and prosperity across the borough. Dr Mimnagh noted that the recent allocations have had the effect of lowering the weighting in relation to deprivation. Mr McDowell confirmed that figures reported under section 2.5.3 should be 15.02% above target, with a forecast position expected to be 7.16% above target. **Action taken by Governing Body** The Governing Body received the following by way of assurance: (1) details of the reviews that have taken place across expenditure headings identified in the report; (2) a report that there are further areas within the CCG's expenditure profile that remain subject to review and updates will be given in future Governing Body meetings; (3) the latest position in respect of the movement to the proposed "formula based" allocation, noting that the CCG's original baseline position is 15.02% above target and its forecast position is expected to be 7.17% above target meaning that there is likelihood that the CCG will have to make savings over and above existing plans. The Governing Body also approved a transfer of £2.984m (as identified in Appendix 1 of the report).	
13/162	Audit Committee (no minutes available)	
13/163	Quality Committee (no minutes available)	
13/164	Finance & Resource Committee (no minutes available)	
13/165	**Merseyside CCG Network** The Minutes were received by the Governing Body.	
13/166	Health and Wellbeing Board (no minutes available)	
13/167	**Medicines Optimisation Operational Group** The Minutes were received by the Governing Body.	
13/168	Health and Wellbeing Board Programme Group (no minutes available)	

No	Item	Action
13/169	**Locality Meetings** The Minutes were received by the Governing Body.	
13/170	**Any Other Business** There was no other business.	
13/171	**Date, Time and Venue of Next Meeting of the Governing Body to be held in Public** Thursday, 30 January 2013 at 1.00pm at Merton House	-

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Action Points

Thursday, 28 November 2013 at 1.00pm to 4.00pm

No	Item	Action	Timescale
13/147	**Register of Interests** Graham Morris to complete a declaration form. Note the resignation of former Governing Body member, Lynda Elezi.	TJ/CL	January 2014
13/152	**Chief Officer Report** *Integrated Transformation Fund*: a formal update will be provided to the Governing Body in January 2014. *Commissioning Support Unit:* a review will take place for March 2014.	MMcD MMcD	January 2014 March 2014
13/156	**Prescribing Performance Report** Dr Mimnagh asked that a report on the strategic work and associated prescribing costs to support the expansion of primary care and community care be available for the next meeting.	MMcD/ BP	January 2014

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2014

Agenda Item: 14/39	**Author of the Paper:**
Report date: 10 March 2014	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
March 2014

1. Annual Report

Production of the CCG's first Annual Report, which will include the organisation's annual accounts, is underway. The contents of this important document will reflect the CCG's progress and achievements during its first year, as viewed through the eyes of the Governing Body and in line with the statutory reporting requirements set out by NHS England. A draft will be submitted to auditors at the end of April, with a final audited version submitted to the Department of Health and NHS England in early June, when the document will be made available to the public.

2. Cheshire & Mersey Commissioning Support Unit Update

2.1. The CCG has recently received a range of service reviews and revised pricing models from Cheshire and Merseyside Commissioning Support Unit (CMCSU) CCG leads for the relevant service line are currently reviewing these with a view to informing re- negotiations of the Service Level Agreement. Initial estimates highlight that the total costs have increased, however it is anticipated that this will be reduced through negotiations and efficiencies gained through the merger of CMCSU and Greater Manchester CSU.

2.2. Our current SLA is in place until October 2014 so prices are fixed at current levels for the first six months of the year. The CCG has confirmed its intention to bring the finance and communication service lines in house from July 2014 and directly manage the SLA with Informatics Merseyside for CCG IM&T services.

3. Child & Adolescent Mental Health (CAMHS)

The Integrated Commissioning Team have been leading on the development of the CAMHS Tier 3 service specification and the development of the children and young people's emotional health and wellbeing plan as part of the Sefton Mental Health Strategy. Performance management of both of these developments is via the Emotional Health and Wellbeing Group which reports to the Early Life Forum of the Health and Wellbeing Board. The draft service specification is near to finalising and the initial draft plan will be shared with the Wider Determinants Forum Mental Health Task Group. The Corporate Parenting Board have requested a briefing at their next scheduled meeting.

4. Corporate Parenting Board

4.1. The Chief Nurse has accepted the invitation to be a member of the Corporate Parenting Board to represent the CCG along with representation from the Designated Professionals for Looked After Children. At the meeting in February 2014 concerns were escalated by the Designated Nurse for Looked After Children regarding possible waiting times for Sefton children to have their initial medicals – this service is provided by Alder Hey Hospital NHS Foundation Trust (AHCH).

4.2. The Chief Nurse has been liaising with AHCH, the Designated Nurse for Looked After Children and the Designated Nurse for Safeguarding Children. As of March 2014, it has been confirmed that currently there are 3 children from Sefton awaiting such initial medicals

and although this situation appears to now be able to be de-escalated the CCG will continue to work with the providers and Local Authority regarding contingency plans.

5. Early Life Forum

The Early Life Forum (sub-group of the Health & Wellbeing Board) has now met on 2 occasions with a third meeting planned for April 2014. In March 2014, the Forum received a presentation from NHSE(M) Direct Commissioning Team regarding the commissioning of the Health Visiting Service and the plans in place for the transition of this responsibility to the Local Authority in October 2015 and the current plans to commission for the delivery of the national operating model within Sefton.

6. Quality Surveillance of Local Providers of Children & Maternity Service Providers

Both the Quality Committee and the Governing Body have received recent updates by way of assurance regarding quality surveillance processes that are in place relating to Southport & Ormskirk Hospitals NHS Trust, Liverpool Community Health NHS Trust, Liverpool Women's Hospital NHS Foundation Trust and AHCH. This has included the current surveillance processes that are in place with each provider, surveillance level as determined at the Merseyside Quality Surveillance Group and the recent outcomes of Care Quality Commission visits.

7. Safeguarding Children

7.1. There are no further updates from the LSCB at this time as both the LSCB and Health Sub-Group are not scheduled to meet until after the deadline for submission of papers.

7.2. The Governing Body are asked to note that the initial draft report from the Peer Review Inspection Team that was commissioned by the CCG has been received. This is currently being considered and will be reported to the Governing Body in due course.

8. Aintree University Hospitals Quality Strategy

8.1. The draft Aintree University Hospital NHS Foundation Trust Quality Strategy 2014 - 17 has been circulated. The Aintree vision is to provide world class services for all patients. Aiming for excellence the strategy describes how Aintree intend to achieve the aspirations they have for patient care over the next three years by getting it right for every patient, every time.

8.2. Comments have been returned by Dr Gina Halstead & Debbie Fagan.

9. NHS 111

9.1. The Department of Health have received the proposed North West Clinical Governance Model favourably and approved it use. Four sub-regional Quality Assurance Committees for the Northwest will service clinical governance, with an intention to meet quarterly.

9.2. Clinical and Business Support personal on behalf of each CCG will be requested to participate in the operation of the Group.

10. Designating Commissioner Requested Services

10.1. Commissioner Requested Services (CRS) are services which the commissioners wish to protect in the event of financial failure by the provider. They apply to FTs, Independent Sector and voluntary third sector providers. They do **not** apply to NHS Trusts for which there is a separate regime.

10.2. Commissioners have until 31.3.16 to complete the process of designating services as CRS. The default position for 2014.15 is

- FTs: all services will be considered as CRS, until such point as the commissioner may determine otherwise
- Other providers: IS/ Third Sector : Not designated as CRS unless specified.

10.3. Commissioners need to designate Commissioner Requested Services to comply with the new regulatory regime. To ease the transition to the new regime, all foundation trusts' mandatory services were automatically designated Commissioner Requested Services on 1 April 2013. Commissioners then have three years to review those services and confirm or reject their designation.

10.4. Commissioners need to identify any services that they commission which would have to remain in the locality should a provider fail because:

a) either there is no alternative provider close enough; or
b) removing them would increase health inequalities; or
c) removing them would make dependent services unviable.

10.5. Commissioners only need to identify Location Specific Services when a provider is in special administration. Formally, it is the Special Administrator who defines which of the failed provider's services should be Location Specific Services, but they do this in consultation with commissioners.

10.6. Following the automatic classification of mandatory services as Commissioner Requested Services (CRS), Monitor has strongly recommended that commissioners review as soon as possible whether this is the correct set of services that would need to be protected in the event of provider failure. When this initial review has been completed, commissioners are then likely to need to reassess periodically which services are designated as CRS, to ensure that the designation remains appropriate in light of any changes in the local health economy.

10.7. Once a service is designated as a Commissioner Requested Service, providers will be required under Monitor's licence to continue to deliver that service and to refrain from making significant changes to it without the agreement of commissioners.

11. May Logan Centre-Transfer of Management Services Agreement

11.1. The Chief Officer has approved the transfer of the management services agreement (the "Agreement") for the May Logan Centre (the "Centre"). The Centre was commissioned by NHS Sefton PCT to provide a range of health and non-health services for the local community.

11.2. Following the winding-down of the PCT, responsibility for commissioning these services has transferred to a combination of the CCG, the Local Authority and NHS England. Of these three organisations the CCG and Local Authority commission almost all of the health services whilst only one service is commissioned by NHS England (newborn hearing).

11.3. The Agreement was transferred as a 'non-clinical contract' from the PCT to NHS England on 1 April 2013 on the Sefton PCT Property Transfer Scheme.

11.4. The Transfer Scheme was drafted on the instructions of the PCT but subsequent experience has shown that these instructions, whilst reflective at the time, have required a modification process in order to transfer relevant items to the correct receiver

11.5. Having reviewed the Agreement in conjunction with NHS Property Services it was recommended by the DH legacy team that based on the information and given the composition of services provided at the Centre, the Agreement should be transferred to the CCG as commissioner of most of the services provided from the Centre with third party rights for the Local Authority and NHS England.

12. Recommendation

The Governing Body is asked to formally receive this report.

Fiona Clark
March 2014

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2014

Agenda Item: 14/40	**Author of the Paper:** Debbie Fagan debbie.fagan@southseftonccg.nhs.uk Malcolm Cunningham malcolm.cunningham@southseftonccg.nhs.uk
Report date: March 2014	

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 10, 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.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
x	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement			x	
Clinical Engagement			x	
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered			x	
Locality Engagement			x	
Presented to other Committees	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
March 2014

1. Executive Summary

This report sets out the performance of the CCG's main acute providers and progress against the National Outcomes Framework at month 10 of the financial year.

2. Introduction and Background

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

This report sets out the CCGs performance against the National Outcomes Framework and the NHS Constitution. It also shows provider performance for the CCG's 3 main providers, Aintree University Hospitals NHS Foundation Trust, Southport and Ormskirk Hospitals NHS Trust and The Walton Centre NHS Foundation Trust.

3. Key Issues

Healthcare Acquired Infections (HCAI) – MRSA
At January 2014, MRSA is above the zero tolerance level for South Sefton CCG patients with 2 cases reported year to date. No new cases for South Sefton CCG patients were reported in January 2014. Aintree University Hospitals NHS Foundation Trust and The Walton Centre NHS Foundation Trust have both reported 1 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 (HCAI) – Cdifficile
Cumulatively to the end of January 2014 there have been 47 cases of Cdifficile infection reported for South Sefton CCG patients against a tolerance of 37. There were 5 cases reported in January 2014 apportioned to non-acute trust (community) at Aintree Hospitals NHS Foundation Trust and 1 acute trust case. Aintree University Hospitals NHS Foundation Trust has reported 71 cases of Cdifficile year to date, 24 of these were South Sefton CCG patients. At the Clinical Quality and Performance Group (CQPG) on 15th January 2014, it was reported that the Trust was 31 days to date, free of Cdifficile cases. Seven appeals have been considered by the appeals panel and 2 cases were upheld at the November panel. The Trust are proposing to submit a further 10 cases for appeal. The Infection Protection and Control Team (IPC) has been strengthened with the recruitment of a senior band 6 nurse. All divisions have been allocated an IPC team member to drive up quality and awareness and the recruitment of a Research Pharmacist has been agreed. As previously reported, an existing action plan is being implemented and further actions include: • the implementation of a 24/7 IPC intensive support team; • enforcement of the isolation policy with escalation to the Chief Operating Officer or

Executive Director on-call;

- the opening of a cohort ward;
- implementation of an enhanced and focused cleaning programme;
- refreshed communications and engagement plan (The bug stops here);
- increased number of senior nurse workarounds and inspections;
- focus on the pathway of the clinically at risk patients within the Trust;
- clarification of all the IPC procedures;
- clarity about holding to account within a zero tolerance culture; and
- focus of the Listening into Action engagement approach on Cdifficile infection high risk areas.

Local data indicates there have been 4 cases in February 2014 which will bring the year to date total to 75.

The Walton Centre NHS Foundation Trust has reported 10 cases to date, 5 above the year to date tolerance of 5.

Southport and Ormskirk Hospitals NHS Trust has reported 23 cases year to date, 10 above the year to date plan of 13.

Mixed Sex Accommodation (MSA)

Southport and Ormskirk Hospitals NHS Trust had 28 breaches of MSA in January 2014. The breaches occurred at a time of escalation and increased bed pressures. All breaches were reviewed using root cause analysis. The breaches all occurred in Critical Care. Seven patients were declared medically fit for discharge to a ward over the month of January 2014 but their discharge was delayed for over 24 hours. These patients shared a bay with critical care patients so they also breached. This took the total number of breaches up to 28. As part of the Escalation Review Process a discussion will take place to determine how the patients from Critical Care are prioritised for wards and a process will be put into place.

Emergency admissions for children with Lower Respiratory Tract Infections (LRTI) (Cumulative)

NB: This indicator will not be updated this month due to the CMCSU Business Intelligence team are carrying out some data quality and methodology validation checks – this will be resolved by next month.

South Sefton CCG reported 52.78 emergency admissions per 100000 as at the end December 2013 over the plan of 37.26. Looking at the emergency admissions figures this equates to 5 extra admissions compared to the same period last year.

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Cumulative)

NB: This indicator will not be updated this month due to the CMCSU Business Intelligence team are carrying out some data quality and methodology validation checks – this will be resolved by next month.

South Sefton CCG has not achieved the target, reporting 656.08 for December 2013 with a planned target of 614.27. Looking at the emergency admissions figures this equates to 65 extra admissions compared to the same period last year.

% who had stroke and spend at least 90% of their time on a stroke unit

This indicator is showing as a red risk for South Sefton CCG patients for January 2014, with

42.86% against the 80% target. This is lower than the November position. Out of a total of 28 patients treated, 12 patients spent at least 90% of their time on a stroke unit.

Aintree University Hospitals NHS Foundation Trust presented with 54.35% at December 2013 against the 80% target. Out of a total of 46 patients treated, 25 patients spent at least 90% of their time on a stroke unit. (Due to technical difficulties there was no data submitted for Aintree Hospitals NHS Foundation Trust for January 2014). A number of keys actions have been put in place to address this issue:

- An external review of their Stroke services has been undertaken and the report and recommendations submitted to the Clinical Business Unit management team. The outcome of the report is to be discussed with clinical teams and actions agreed.
- Consultant of the week rota commenced in January 2014. The new rota releases stroke physicians from other commitments and allows for more rapid assessment and transfer of stroke patients.
- Stroke physician on-call every weekday and on site from 9am to 8pm to further facilitate timely assessment and transfer of stroke patients.
- Revised stroke team alert and bleep system now operational. The team comprises Consultant, Specialist Registrar or Senior House Officer and a House Officer who will assess patients and if necessary clerk them on transfer to the Stroke Unit. This will enable more timely transfer to the Unit.
- Daily consultant ward rounds commenced to facilitate timely discharge of patients.
- Multidisciplinary Team processes reduced from 4 to 2 to free up therapy and nursing time and improve discharges.
- Introduction of weekly breach meeting with Accident and Emergency Department and Medical Assessment Unit colleagues to discuss in a timely manner patients who breach the 4 hour target.
- Trials of electronic data capture system (Capture Stroke) on-going. Feedback to date has been positive and the Cheshire and Mersey Strategic Clinical Network has now agreed to provide funding for the installation of the system across the Cheshire and Mersey patch. Work with Information Governance is on-going to address internal complications.
- Access to Venmore community intermediate care beds with early supported discharge has been agreed and will positively impact the length of stay on the Unit.
- Beds ring-fenced for thrombolysis reduced from two to one to improve access to the Stroke Unit for all admissions.
- Permanent Ward Nurse Manager for Stroke Unit commenced in post on 6th January 2014.

Rate of Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (Males and Females)

For males, South Sefton CCG achieved 1,894.30 in 2012, which was above the planned tolerance of 1,833.68. For females, South Sefton CCG achieved 2,198.60 in 2012, which was above the planned tolerance of 2,128.24. An update will be given as soon as possible as to what measures can be updated and when.

Ambulance Clinical Quality – Category A (Red 1) 8 minute response time

South Sefton CCG failed to achieve the target of 75% for the month of January 2014, reaching 74.66% (cumulative), a slight improvement on the previous month. This was due to low performance in previous months.

Ambulance Clinical Quality – Category A (Red 2) 8 minute response time
South Sefton CCG failed to achieve the target of 75% for the month of January 2014, reaching 74.97% (cumulative). **Please note: the CCG is measured on the North West Ambulance Service (NWAS) figures and NWAS are achieving all 3 indicators, (Category A Red 1, Red 2 and Category 19 Transportation time).**
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%
Southport and Ormskirk Hospitals NHS Trust are underperforming cumulatively to December 2013 on the NHS screening service target with 81.82% against the 90% target. The trust achieved 66.7% during the month of December 2013. For December 2013 there was a 0.5 patient breach, the tertiary referral was sent to St Helens and Knowsley Teaching Hospitals NHS Trust after the patient had already breached, first seen trust was Southport and Ormskirk Hospitals NHS Trust, first treatment trust was St Helens and Knowsley Teaching Hospitals NHS Trust, days waited 96, 'tumour type' being breast.
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%
For the maximum 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms, Southport and Ormskirk Hospitals NHS Trust did not achieve the December 2013 cumulative target for breast symptomatic referrals with 89.6% year to date against the 93% target. In December 2013 there were 6 breaches out of a total of 86 patients, 80 were seen within 14 days. The 6 breaches were between 17 and 28 days. The breach reasons were patient cancellation and patient unable to attend.
Percentage of patients waiting 6 weeks or more for a Diagnostic Test
South Sefton CCG has not achieved the 1% target achieving 1.44% for January. Aintree University Hospitals NHS Foundation Trust has achieved the 1% target achieving 0.92%. Royal Liverpool and Broadgreen University Hospitals Trust (RLBUHT) did not achieve the target with 16.73% of patients waiting over 6 weeks for a diagnostic test. This is deterioration on the November 2013 position, (13.5%). December 2013 performance equates to 533 patients out of a total of 3186. All breaches were in Imaging. All patients were seen within 8 weeks. Further detail is provided below: • CT scans - 37 patients out of 923 did not receive a diagnostic test within 6 weeks (4.0%) • MRI scans – 91 patients out of 614 did not receive a diagnostic test within 6 weeks (14.8%) • Non-obstetric ultrasound – 405 patients out of 773 did not receive a diagnostic test within 6 weeks (52.4%). Local data indicates that the Trust's performance has deteriorated further in January 2014 when 17.1% of patients waited over 6 weeks for a diagnostic test. The Trust has previously reported that this underperformance is due to recruitment issues and the long term sickness of a Senior Sonographer. The breaches in Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) are mainly due to Cardiac Scans and a need for a Cardiologist to be present. A number of clinic sessions had to be cancelled due to the unavailability of a Cardiologist during

the Christmas period. Extra Cardiology lists are planned for the next 3 months which should improve waiting time compliance. The improvement of waiting times for ultrasound tests remains a challenge for the Trust. Extra sessions have been introduced, and from January 2014 the Trust have sub-contracted the Spire Hospital Group to test 20 patients per week.

Friends and Family Test Score – Inpatients and Accident & Emergency (A&E)

The indicator comprises two elements: the test score and the % of respondents who would recommend the services to friends and family – for Inpatient Services and A&E. The national CQUIN requirement is for all providers to achieve a combined 15% response rate by April 2014, the test score is measured against the national average.

For Southport and Ormskirk Hospital NHS Trust the overall combined (A&E and Inpatients) response rate was achieved in Q3 2013/14, 18.5% reported compared to a plan of 15% and 1.6% higher than the England average. However, for A&E alone the provider failed to achieve 15% plan reaching 10.9% making no improvement compared to Q2 2013/14.

Published monthly data shows for January 2013/14, the overall combined (A&E and Inpatients) response rate was achieved with 18.4% reported compared to a plan of 15% and 3.8% higher than the England average.

Patient Safety Incidents

The provider performance dashboard (Appendix 2) shows the number of patient safety incidents reported. Commentary on patient safety incidents is as follows:

Aintree University Hospitals NHS Foundation Trust reported two SI's in January 2014. Year to date, for all patients, there have been 25 SUI's.

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	YTD
Communicable Disease and Infection Issue		1									1
Delayed Diagnosis		1		1		2	1				5
Cdifficile and HAI									1		1
Drug Incident (general)				1					1		2
Failure to act upon test result						1				1	2
RSA Bacteraemia			1								1
Other						1					1
Outpatient Appointment Delay				1	1						2
Pressure Ulcer Grade 3	1		1				1			1	4
Pressure Ulcer Grade 4				1							1
Slips/Trips/Falls			1			2		1			4

Unexpected Death (general)								1			1
Grand Total	**1**	**2**	**3**	**4**	**1**	**6**	**2**	**2**	**2**	**2**	**25**

Southport and Ormskirk Hospitals NHS Trust reported 1 serious untoward incident in January 2014, 11 serious untoward incidents reported year to date.

	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	YTD
Adverse media coverage of public concern about the organisation or the wider NHS				1		1					2
Failure to act upon test results							1				1
Confidential information leak				1				1			2
Communicable Disease and Infection Issue								1			1
Delayed diagnosis										1	1
Safeguarding vulnerable child								1			1
Surgical error				2							2
Maternity services – Intrapartum death									1		1
Grand Total	**0**	**0**	**0**	**4**	**0**	**1**	**1**	**3**	**1**	**1**	**11**

Details of actions taken and reports received as a result of the serious untoward incidents are discussed at the SI/Complaints Monthly Management Groups.

4. Recommendations

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

Appendices

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

Malcolm Cunningham
March 2014

CCG CORPORATE PERFORMANCE DASHBOARD - South Sefton CCG

Baseline as at 03/03/2014 10:29:38

		Current Period			
Performance Indicators	**Data Period**	**Target**	**Actual**	**RAG**	**Fore cast**
IPM					
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 - January	37	47		
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative)	13/14 - January	0	2		
Enhancing quality of life for people with long term conditions					
Patient experience of primary care i) GP Services	Jan-Mar 13 and Jul-Sept 13		83.36%		
Patient experience of primary care ii) GP Out of Hours services	Jan-Mar 13 and Jul-Sept 13		72.86%		
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s(Cumulative)	13/14 - December	304.28	239.08		
Emergency Admissions Composite Indicator(Cumulative)	13/14 - December	1,460.74	1,377.12		
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	13/14 - December	614.27	656.08		
Helping people to recover from episodes of ill health or following injury					
Patient reported outcomes measures for elective procedures: Groin hernia	2011/12	6.20%	6.90%		
Patient reported outcomes measures for elective procedures: Hip replacement	2011/12	35.30%	41.30%		
Patient reported outcomes measures for elective procedures: Knee replacement	2011/12	30.30%	34.80%		
Emergency readmissions within 30 days of discharge from hospital (Cumulative)	13/14 - December		13.19		
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	13/14 - December	37.26	52.78		
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	13/14 - December	786.01	687.60		
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	13/14 - January	80%	42.86%		
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	13/14 - January	60%	100%		
Mental health					
Mental Health Measure - Care Programme Approach (CPA) - 95% (Cumulative)	13/14 - January	95%	98.43%		
Preventing people from dying prematurely					
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		
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Males)	2012	1,833.68	1,894.30		
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Females)	2012	2,128.24	2,198.60		
NHS Outcome Measures					
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 - December	93%	96.47%		
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 - December	93%	95.05%		
Cancer waits – 31 days					
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)	13/14 - December	94%	98.29%		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative)	13/14 - December	96%	96.22%		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative)	13/14 - December	94%	98.15%		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative)	13/14 - December	98%	99.34%		

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 - December		92.50%		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative)	13/14 - December	90%	94.12%		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative)	13/14 - December	85%	86.39%		
Mixed Sex Accommodation Breaches					
Mixed Sex Accomodation (MSA) Breaches per 1000 FCE	13/14 - January	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 - January	0.00	0.00		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways	13/14 - January	0.00	0.00		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways	13/14 - January	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 - January	92%	97.01%		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	13/14 - January	95%	97.86%		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	13/14 - January	90%	92.32%		
A&E waits					
Percentage of patients who spent 4 hours or less in A&E (Cumulative)	13/14 - January	95%	95.63%		
Diagnostic test waiting times					
% of patients waiting 6 weeks or more for a Diagnostic Test	13/14 - January	1.00%	1.44%		
Category A ambulance calls					
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	13/14 - January	75%	74.66		
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	13/14 - January	75%	74.97		
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	13/14 - January	95%	96.18		
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	13/14 - January	75%	75.93		
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	13/14 - January	75%	77.78		
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	13/14 - January	95%	95.67		
Everyone Counts - NHS Outcome 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 - January	2,038.00	1,155.00		
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 - Q3 October - December	94,271.00	85,513.00		
5% reduction in the number of respiratory disease emergency admissions via A&E. (Baseline = 1645 - 5% reduction = 1563) (Cumulative)	13/14 - January	1,318.00	1,330.00		

CORPORATE PERFORMANCE DASHBOARD - PROVIDER LEVEL

Baseline as at 10/03/2014 12:45:55

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 - January	95.22%	96.20%	
Ambulance				
Ambulance				
Ambulance handover delays of over 1 hour	13/14 - January	29.00	9.00	
Ambulance handover delays of over 30 minutes	13/14 - January	119.00	49.00	
Crew clear delays of over 1 hour	13/14 - January	1.00	0.00	
Crew clear delays of over 30 minutes	13/14 - January	17.00	27.00	
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 - December	94.26%	89.62%	100.00%
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative)	13/14 - December	97.57%	93.79%	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 - December	100.00%	100.00%	100.00%
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)	13/14 - December	98.70%	96.10%	100.00%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative)	13/14 - December	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 - December	98.89%	98.72%	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 - December	92.58%	88.14%	100.00%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative)	13/14 - December	85.96%	81.82%	100.00%
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative)	13/14 - December	88.03%	86.40%	100.00%

Diagnostic test waiting times				
Diagnostic test waiting times				
% of patients waiting 6 weeks or more for a Diagnostic Test	13/14 - December	0.59%	0.35%	0.32%
Mixed Sex Accommodation Breaches				
Mixed Sex Accommodation Breaches				
Mixed Sex Accomodation (MSA) Breaches per 1000 FCE	13/14 - January	0.00	4.60	0.00
Referral To Treatment waiting times for non-urgent consultant-led treatment				
Referral To Treatment waiting times for non-urgent consultant-led treatment				
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	13/14 - December	94.70%	74.20%	93.59%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	13/14 - December	97.85%	96.13%	98.27%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	13/14 - December	96.98%	95.71%	96.92%
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted)	13/14 - December	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 - December	0.00	0.00	0.00
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways.	13/14 - December	0.00	0.00	1.00
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 - January	54.35%	90.00%	
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	13/14 - January	100.00%	61.54%	
Treating and caring for people in a safe environment and protecting them from avoidable harm				
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 - January	71.00	23.00	10.00
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative)	13/14 - January	1.00	0.00	1.00
Patient safety incidents reported	13/14 - January	2.00	1.00	
Friends & Family Test				
Ensuring people have a positive experience of care				
Friends and Family Test Score - Inpatients + A&E	13/14 - January	64	47	93
Friends and Family Test Score Inpatients + A&E (% of respondents)	13/14 - January	29.70%	18.40%	23.00%

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2014

Agenda Item: 14/41	**Author of the Paper:** Brendan Prescott Deputy Chief Nurse / Head of Quality & Safety brendan.prescott@southseftonccg.nhs.uk Tel: 0151 247 7093 Debbie Fagan Chief Nurse & Quality Officer Debbie.fagan@southseftonccg.nhs.uk Tel: 0151 247 7007
Report date: March 2014	

Title: Quality Performance Report

Summary/Key Issues:

This report provides the Governing Body with an overview position of provider performance in relation to quality and safety since the last meeting of the Governing Body in January 2014. The key issues are identified by exception. The Governing Body are asked to note:

- Recent Mixed Sex Accommodation Breaches that have occurred at Southport & Ormskirk Hospitals NHS Trust (28 breaches in January 2014; 28 breaches in February 2014 – objective is zero tolerance);
- Breach of the full year C-Difficile objective at Southport & Ormskirk Hospitals NHS Trust (reported cases now stand at 23 against a full year objective of 19);
- Breach of full year C-Difficile objective at Royal Liverpool & Broadgreen University Hospitals NHS Trust (RLBUHT) (reported cases now stand at 42 against a full year objective of 35);
- MRSA reported at Aintree University Hospital NHS Foundation Trust;
- 1 Serious Incident reported from Aintree University Hospital NHS Foundation Trust in January 2014 and 2 Serious Incident reported in January 2014 at MerseyCare NHS Trust for CCG patients;
- 30 Serious Incidents reported from Liverpool Community NHS Trust regarding Grade 3 & 4 pressure ulcers (change in provider reporting processes);
- MerseyCare new issue regarding underperformance in relation to length of stay (53.6 days against a plan of 40 days);
- Improved performance at RLBUHT regarding the Friends & Family Test (performance against combined response rate increased by 2.2% compared to Q2).

Performance has been discussed at the Quality Committee meeting in March 2014 in order to provide assurance to the Governing Body.

Recommendation	x
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.
	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			Quality Committee and Provider Contract Meetings
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement	X			Via Quality Committee
Presented to other Committees	X			Quality Committee

Links to National Outcomes Framework *(x those that apply)*	
X	Preventing people from dying prematurely
	Enhancing quality of life for people with long-term conditions
	Helping people to recover from episodes of ill health or following injury
X	Ensuring that people have a positive experience of care
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
March 2014

1. Executive Summary

This report provides the Governing Body with an overview position of provider performance in relation to quality and safety since the last meeting of the Governing Body in January 2014. Performance has been discussed at the Quality Committee meeting in March 2014 in order to provide assurance to the Governing Body. Cancer and A&E performance is addressed within the separate Performance Report presented to the Governing Body.

2. Introduction and Background

2.1 For the purposes of this report, the detail contained within is concentrated on the main CCG commissioned providers as follows:

- Southport & Ormskirk Hospitals NHS Trust (S&O);
- Liverpool Community Health Services NHS Trust (LCH);
- Mersey Care NHS Trust;
- Aintree University Hospital NHS Foundation Trust (AUH).

2.2 Information on the Royal Liverpool & Broadgreen University Hospitals NHS Trust (RLBUHT) has been reported by exception in relation provider performance against the Friends & Family Test and the C-Difficile objective for 2013/14.

2.2 The key issues are identified by exception and presented in accordance with the domains of the National Outcomes Framework.

3. Key Issues – Domain 4: Ensuring people have a positive experience of care

Mixed Sex Accommodation Breaches

3.1 Mixed Sex Accommodation Breaches have occurred at S&O. Twenty eight breaches occurred in January 2014 and 28 breaches in February 2014 (objective is zero tolerance). All occurred in Critical Care during times of escalation and reported bed pressures within the Trust. The CCG have requested assurances regarding processes being put in place to prevent recurrence at the time of notification and during a recent contract meeting. In addition, the CCG were in attendance at the Trust Quality & Safety Committee (sub-committee of the Trust Board) at which this was discussed.

Friends & Family Test

3.2 Challenges exist around performance at S&O in relation to A&E. As previously reported to the Governing Body, S&O were visited by NHS England (North of England) team and this had a positive outcome with the Trust being invited to showcase some of their work at a celebratory event. The Trust was invited to the CCG Engagement and Patient Experience Group (EPEG) where they delivered a presentation. EPEG reported their assurance to the Quality Committee and have invited the Trust to return at a future date to give further updates in relation to 3 specific identified areas. The CCG Programme Manager for Quality & Safety

continues to meet regularly with the Trust team regarding progress with the Friends & Family Test.

3.3 Challenges exist around performance at RLBUHT in relation to the combined response rate (in-patient and A&E). Performance in Q3 has improved by 2.2% compared to Q2, with latest information from January 2014 indicating that the Trust is complaint with a 15% target. The CCG is liaising with Liverpool CCG as co-ordinating commissioning regarding plans that are in place to see continued improvement.

4. Key Issues – Domain 5: Treating and caring for people in a safe environment and protecting from harm

Healthcare Associated Infections (HCAI)

4.1 S&O have breached their full year C-Difficile (C-Diff) objective with reported cases now standing at 23 against a full year objective of 19. The CCG has received assurances regarding remedial action planning within the Trust both at the Quality Contract Meetings and through attendance at the Trust Quality & Safety Committee (Sub-Committee of the Trust Board). The CCG updated HCAI action plan was submitted to NHSE (Merseyside) as part of the evidence for the CCG's recent assurance meeting which was held on 11 March 2014. The CCG action plan will be further updated and presented to the Quality Committee in April 2014.

4.2 The HCAI C-Diff work stream in place at AUH appears to be having a positive impact with the Trust performance showing signs of improvement. However, the provider has still breached their full year C-Diff objective as previously reported to the Quality Committee and Governing Body. AUH have reported a recent case of MRSA but this did not relate to patient from the CCG. The CCG Programme Manager for Quality & Safety attended the Post Infection Review Meeting held at AUH.

4.3 RLBUHT has breached their full year C-Diff objective with reported cases now standing at 42 cases against a full year objective of 35. The CCG is liaising with Liverpool CCG as co-ordinating commissioning regarding plans that are in place regarding remedial action planning within the Trust.

Serious Incident Reporting

4.3 One Serious Incident has been reported from AUH in January & 2014 and 2 Serious Incidents reported in January 2014 at MerseyCare NHS Trust for CCG patients. These will be performance managed via the existing CCG processes.

4.4 Thirty Serious Incidents have been reported from LCH regarding Grade 3 and 4 pressure ulcers which the Trust have stated is due to a change in provider reporting processes. The CCG is awaiting confirmation from Liverpool CCG regarding how many of these incidents relate to our resident population. The CCGs in Sefton are working closely with Liverpool CCG regarding these serious incidents and have requested that the provider undertake an aggregated review. These will be performance managed via the existing CCG processes and was an agenda item for discussion at the recent Quality Review Meeting held with the Trust chaired by NHSE (Merseyside).

5. Additional Quality Information – Mersey Care Length of Stay

Recent contract reporting has highlighted a new issue in Mersey Care regarding underperformance in relation to length of stay (53.6 days against a plan of 40 days). Discussions have taken place with the provider and relevant action plans have been requested.

6. Recommendations

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

Appendices

South Sefton CCG "Provider Performance Reports"

Brendan Prescott
Debbie Fagan
March 2014

NHS
Cheshire and Merseyside Commissioning Support Unit

Aintree University Hospital

Reds - Possibly areas for discussion

Key and Rag Ratings can be found at the end of the dashboard

Domain 1: Preventing People from Dying Prematurely		Reporting Period	Benchmark	Previous Period	Latest Data	Movement	YTD	Trend
Cancer Waiting Times		**Monthly**	**Plan**	**Nov-13**	**Dec-13**	**Change**	**2013/14**	**Over time**
1	Patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	Jan-14	93%	99%	95.6%	Decline	96%	
2	Patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	Jan-14	93%	99%	91.6%	Decline	96%	
3	Patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	Jan-14	96%	98%	98.0%	No Change	99%	
4	Patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	Jan-14	94%	100%	95.2%	Decline	98%	
5	Patients waiting no more than 31 days of subsequent treatment where that treatment is an anti-cancer drug regimen	Jan-14	98%	100%	100.0%	No Change	100%	
6	Patients waiting no more than 31-Day Standard for Subsequent Cancer Treatments-Radiotherapy	Jan-14	94%	0 Patients	0 Patients	No Change	94%	
7	Patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	Jan-14	85%	87%	85.4%	Decline	84%	
8	Patients waiting no more than 62 days from referral from an NHS Screening service to first definitive treatment for all cancers	Jan-14	90%	88%	0 Patients	No Change	93%	
9	Patients waiting no more than 62 days for first definitive treatment following a consultants decision to upgrade the priority of a patient (all cancers)	Jan-14	85%	92%	81.8%	Decline	88%	
Mortality		**Annual**	**Plan**	**Apr 12-Mar 13**	**Jul 12 - Jun 13**	**Change**	**2013/14**	**Over time**
10	Hospital Standardised Mortality Ratio (HSMR)	Jan-14	100	95.3	93.7	No Change	93.74	
11	Summary Hospital-Level Mortality Indicator (SHMI)	Jul 12 - Jun 13	100	1.15	1.13	Improvement	1.13	
12	(SHMI) Deaths occurring in hospital	Jul 12 - Jun 13		72.9%	72.8%	No Change	72.8%	
13	(SHMI) Deaths occurring out of hospital	Jul 12 - Jun 13		27.1%	27.2%	No Change	27.2%	

Domain 2: Quality of Life (Long Term Conditions)								
Stroke		**Monthly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
14	Stroke/TIA - Stroke 90% Stay on ASU	Q3 13/14	80%	77%	61%	No Change	72%	
15	Stroke/TIA - TIA - High Risk Treated within 24Hrs	Q3 13/14	60%	100%	100%	No Change	100%	

Domain 3: Helping People to Recover from Episodes of Ill Health or from Injury								
A&E Quality Measures		**Monthly**	**Plan**	**Oct-13**	**Nov-13**	**Change**	**2013/14**	**Over time**
16	**Overall achievement of A&E Quality Indicators**	Jan-14	Achieved	Achieve	Achieve	No Change	Achieved	
17	Unplanned re-attendance at A&E within 7 days of original attendance	Jan-14	5%	6.7%	7.6%	Decline	6.9%	
18	Patient Impact - Left department without being seen rate	Jan-14	5%	3.1%	3.5%	No Change	3.9%	
19	Timeliness - Time to initial assessment - 95th centile	Jan-14	15	0	0	No Change	4	
20	Timeliness - Total time spent in A&E department - 95th centile	Jan-14	240	238	276	Decline	283	
21	Timeliness - Time to treatment in department - median	Jan-14	60	73	89	Decline	97	
Rapid Access Chest Pain Clinic		**Quarterly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
22	A maximum two-week wait for Rapid Access Chest Pain Clinic (RACPC)	Q3 13/14	100%	83%	91%	No Change	88%	
Smoking		**Quarterly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
23	Smoking Status recorded for all inpatients (exclude critical care)	Q3 13/14	90%	No data	No Data	No Change	62%	N/A
24	All Smokers to be offered Smoking intervention Advice	Q3 13/14	by Q4 13/14	No data	No Data	No Change	71%	N.A
Patient Reported Outcome Measures		**Annual**	**Eng Average**	**Apr 11 - Mar 12**	**Apr 12 - Mar 13**	**Change**	**2013/14**	**Over time**
25	Groin Hernia - Average increase in health gain	Apr 12 - Mar 13	0.086	0.088	0.064	No Change	0.064	
26	Hip Replacement - Average increase in health gain	Apr 12 - Mar 13	0.439	0.395	0.429	No Change	0.429	
27	Knee Replacement - Average increase in health gain	Apr 12 - Mar 13	0.321	0.299	0.296	No Change	0.296	
28	Varicose Vein - Average increase in health gain	Apr 12 - Mar 13	0.094	*	*	No Change	*	

Domain 4: Ensuring People have a positive experience of care								
Referral to Treatment		**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
29	18 Weeks - Admitted - % Compliance - Trust	Jan-14	90%	95%	93%	Decline	93%	
30	18 Weeks - Non Admitted - % Compliance - Trust	Jan-14	95%	98%	97%	Decline	98%	
31	18 Weeks - On-going - % <18 Weeks - Trust	Jan-14	92%	97%	97%	No Change	97%	
32	Zero tolerance RTT Waits over 52 weeks	Jan-14	0	0	0	No Change	0	
A&E Department Measures		**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
33	Percentage of A&E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an a&e department	Jan-14	95%	98%	95.6%	Improvement	95%	
34	Trolley waits in A&E	Jan-14	0	0	0	No Change	0	
35	Handover <15 Minutes. Time taken from HAS notification to clinical handover (Assumed ACUTE responsibility)	Jan-14	15 Mins	00:10:25	00:11:50	Decline	00:10:55	
36	Patients waiting between 30-60 Minutes for Handover	Jan-14	0	61	90	Decline	705	
37	Patients waiting between 60+ Minutes for Handover	Jan-14	0	23	29	Decline	277	
38	Compliance with Recording Patient Handover between Ambulance and A&E	Jan-14	95%	86%	83%	Decline	79%	
Mixed Sex Accommodation Breaches		**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
39	Sleeping accommodation Breach (MSA)	Jan-14	0	0	0	No Change	0	
Diagnostics		**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
40	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	Jan-14	99%	100%	99.4%	Decline	99.4%	
Cancelled Operations		**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
41	All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for nonclinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.	Jan-14	0	2	2	Decline	8	
42	No urgent operation should be cancelled for a second time	Jan-14	0	0	0	No Change	0	
Choose and Book		**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
43	Provider failure to ensure that "sufficient appointment slots" are made available on the Choose & Book system	Jan-14	7%	19%	17%	Improvement	16%	
VTE		**Monthly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
44	Percentage of patients risk assessed for venous thromboembolism who receive appropriate prophylaxis (Local Audits)	Q3 13/14	95%	93%	94.1%	Improvement	93%	
Complaints		**Quarterly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
45	Complaints received at CMCSU (Business Solutions)	Q3 13/14	0	0	0	No Change	0	
46	Complaints received at provider	Q3 13/14	0	Awaiting update			67	

Aintree University Hospital

National Dementia		**Monthly**	**Plan**	**Nov-13**	**Dec-13**	**Change**		**2013/14**	**Over time**
47	National Dementia CQUIN - Screening for Dementia (Find)	Dec-13	90%	58%	52%	Decline		43%	
48	National Dementia CQUIN - Risk Assessed (Assess and Investigate)	Dec-13	90%	52%	59%	Improvement		70%	
49	National Dementia CQUIN - Patients Referred	Dec-13	90%	100%	100%	No Change		100%	
National Friends&Family		**Quarterly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**		**2013/14**	**Over time**
50	National Friends and Family - Phased Expansion (Inpatient,A&E and Maternity)	Q3 13/14	Compliance	Compliance update					
51	National Friends and Family - Increased Response Rate	Q3 13/14	15%	27%	30%	Decline		24%	
52	National Friends and Family - Test Score	Q3 13/14	>2012/13	57	64	Improvement		54.3	
Advancing Quality		**Monthly**	**Plan**	**Sep-13**	**Oct-13**				
53	Advancing Quality Acute myocardial infarction	Oct-13	81.3%	94.4%	87.1%	Decline		91.4%	
54	Advancing Quality Hip and Knee	Oct-13	73.8%	77.3%	77.8%	Improvement		68.5%	
55	Advancing Quality Heart Failure	Oct-13	82.0%	83.3%	83.7%	Improvement		83.7%	
56	Advancing Quality Pneumonia	Oct-13	61.1%	75.7%	60.9%	Decline		72.1%	
57	Advancing Quality Stroke	Oct-13	53.6%	35.7%	53.7%	Improvement		48.1%	
Patient Experience		**Annual**	**England Average**	**Previous Year**	**Latest Year**	**Change**		**Latest Data**	**Over time**
58	Patient experience of hospital care	2012	76.5%	77.5%	77.0%	No Change		77.0%	
59	Patient experience of outpatient services	2011	79.2%	79.0%	80.0%	No Change		80.0%	N/A
60	Patient experience of A&E services	2012	75.4%	76.2%	74.2%	No Change		74.2%	N/A

Domain 5: Treating & Caring for People in a Safe Environment and Protecting from Harm									
Infection Control		**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**		**2013/14**	**Over time**
61	Clostridium Difficile - Trust	Jan-14	3.58	4	1	Improvement		71	
62	Incidence of MRSA - Trust	Jan-14	0	0	0	No Change		1	
63	MRSA Screening - Trust	Dec-13	No Plan	100%	100%	No Change		98%	
64	MSSA	Dec-13	No Plan	2	2	No Change		25	
Hygiene Compliance		**Monthly**	**Plan**	**Nov-13**	**Dec-13**	**Change**		**2013/14**	**Over time**
65	Hand Hygiene Compliance - Trust	Dec-13	No Plan	98%	100%	Improvement		98%	
Incident Reporting		**Monthly**	**Plan**	**Jan-14**	**Feb-14**	**Change**		**2013/14**	**Over time**
66	Never Events - Trust	Feb-14	0	0	0	No Change		1	
67	Steis Reportable Incidents - Trust	Feb-14	0	2	1	No Change		23	
CQC		**Monthly**	**Plan**	**Jan-14**	**Feb-14**	**Change**		**2013/14**	**Over time**
68	CQC Intelligence Tool - Band 1 = Highest Risk Band 6 = Lowest Risk	Feb-14	6	1	1	No Change		1	N/A
69	Compliance against 5 essential standards (✓ = Compliant, × = Not Compliant actions requiring improvement, × = Not Compliant and Enforcement Action Taken)	Feb-14	✓	×	×	No Change		×	29.09.13 Inspection
Central Alerting System		**Monthly**	**Plan**	**Feb-14**	**Mar-14**	**Change**		**2013/14**	**Over time**
70	All CAS alerts outstanding after deadline date	Mar-14	0	4	1	No Change		1	
Sickness Absence		**Monthly**	**Plan**	**Q1 13/14**	**Q2 13/14**	**Change**		**2013/14**	**Over time**
71	Sickness Absence Rates All Staff - National Data	Q2 13/14	4.12%	3.56%	3.85%	Decline		3.7%	
72	Sickness Absence Rates All Staff - Provider internal data	Q2 13/14	4.12%	3.70%	4.10%	Decline		3.9%	
Coronary Heart Disease		**Quarterly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**		**2013/14**	**Over time**
73	Percentage of CHD patients with a primary diagnosis of AMI prescribed ACE Inhibitors on discharge	Q3 13/14	95%	100%	100%	No Change		100%	
74	Percentage of CHD patients with a primary diagnosis of AMI prescribed Clopidogrel on discharge	Q3 13/14	95%	100%	100%	No Change		100%	
VTE		**Monthly**	**Plan**	**Nov-13**	**Dec-13**	**Change**		**2013/14**	**Over time**
75	National CQUIN - VTE Risk Assessments	Dec-13	95%	94.6%	94.8%	Improvement		92.3%	
National Patient Incident Reporting		**Bi Annual**	**Median Average**	**Oct 11 - Mar 12**	**Apr 12 - Sep 12**	**Change**		**Latest data**	**Over time**
76	National Patient Safety Incident Reporting Per 100 admissions	Apr 12 - Sep 12	6.7	8.3	7.2	No Change		7.2	
77	Safety incidents resulting in severe harm or death	Apr 12 - Sep 12	0.8%	0.1%	0.2%	No Change		0.2%	
Staff Survey		**Annual**	**Eng Average**	**2011**	**2012**	**Change**		**2013/14**	**Over time**
78	National Staff Survey	2012	3.69	3.65	3.69	Improvement		3.69	
PLACE Survey		**Annual**	**Eng Average**		**2013**	**Change**		**2013/14**	**Over time**
79	PLACE Survey - Average score of all four areas	2013	90%	N/A	85.2%	No Change		85.2%	N/A
NHS Safety Thermometer		**Monthly**	**Eng Average**	**Dec-13**	**Jan-14**	**Change**		**2013/14**	**Over time**
80	Submission compliance	Jan-14	Compliance			No Change			
81	Total patients surveyed		N/A	607	602			6874	
82	Patients receiving harm free care		93.5%	93.4%	93.0%	No Change		85.7%	
83	Total pressure ulcers (all categories)		4.6%	4.3%	5.5%	Decline		4.1%	
84	Total falls (causing harm)		N/A	0.2%	0.2%	No Change		0.3%	
85	Patients with a catheter and being treated for a UTI		0.9%	1.5%	0.7%	Improvement		0.4%	
86	Number of patients with a new VTE		0.4%	1.0%	0.8%	Improvement		0.8%	

Reporting Period	Period in which the latest data relates to
Benchmark	This will either be threshold/plan, England Average (Eng Average)
Previous Period	Depending on the reporting frequency, this will either be previous month, quarter and year
Latest Data	This is the latest data available to Cheshire and Merseyside CSU
Movement	Change in latest reporting period performance compared to previous reporting period performance
Rag Rating of Movement Column	
No Change	No change in latest performance compared to previous reporting period
Improvement	Improvement in latest months performance compared to previous reporting period
Decline	Drop in latest reporting period performance compared to previous reporting period
Rag Rating of Latest data Column and Year to date Column	
	Equal to or above agreed performance threshold
	Below agreed performance threshold or drop in performance or below England average (Varies across measures)
	Drop in latest reporting period performance compared to previous reporting period

Cheshire and Merseyside Commissioning Support Unit

Aintree University Hospital
March 2014 Key Concerns Update

The following narrative relates to measures which are newly reported as red in the latest months update. All comments relating to previous red measures have been included in previous reports.

Domain 1: Preventing People from Dying Prematurely
Patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment
Patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment – 91.6% reported in January 2014 compared to a plan of 93%, drop in performance compared to previous month. **Provider Comments:** Causes of underperformance - Patient choice of appointment, Patients referred with "non suspicious" symptoms, therefore not wanting to attend within the 2 week time frame. Actions taken • During the period end of December 2013 / beginning of January 2014 a reorganisation of the Breast administration team took place to redefine roles and ensure clarity amongst the cancer services staff. This has ensured that the correct booking processes are now in place with clear lines of responsibility. • In addition an audit has been undertaken by the H&N CBU to identify if the provision of evening / weekend clinics would be more easily accessible for this group of patients. The CBU is currently assessing the feasibility of establishing these clinics, although consideration will need to be given to current job plans and availability of resources. Percentage of patients waiting no more than 62 days for first definitive treatment following a consultant's decision to upgrade the priority of a patient (all cancers) - 81.8% reported in January 2014 compared to a plan of 85%, drop in performance compared to previous month. 2 patients waited more than 62 days following a consultant upgrade. **Provider Comments:** This involved 2 patients and a review of these cases is underway, this is a local target.
Domain 3: Helping People to Recover from Episodes of Ill Health or from Injury
A&E Quality Measures
In order to achieve overall compliance against A&E Quality measures foundation trust must comply with 95% 4hr measure and must not fail three of the quality measures in total. As the provider achieved the A&E 4hr wait target in January 2014 the provider achieved overall compliance, however three measures are reported as red in January 2014. • Patient Impact -Unplanned re-attendance at A&E within 7 days of original attendance – 7.6% compared to 5% threshold. • Timeliness - Total time spent in A&E department (95th centile) – 276 minutes compared to 240 minutes. • Timeliness - Time to treatment in department (Median) – 89 minutes compared to 60 minutes. **Provider Comments:** A reduction in unplanned re attendances for any condition remain a challenge, to which to Trust has now set up a 'frequent attendees' review group. By far the vast majority of patients who attend more than once in 7 days tend to suffer from alcohol, substance misuse or mental health problems. A frequent attenders group involving community care continues to be held monthly to aid improvement. Patients' returning for the same condition is now under target at 3.7%. The Trust is continuing to work to reduce the median wait to see a clinician. The primary focus on this is the adoption of a new see and treat approach meaning patients bypass triage and are immediately treated. This model continues to bed in and improvements should be seen over the next couple of months. In addition to this, the bypassing of GP accepted patients directly to the medical assessment areas should free up consultants in the teams.

Domain 4: Ensuring People have a positive experience of care
Cancelled Operations
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for nonclinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice. 2 breaches reported in January 2014 compared to a plan of 0, 8 breaches reported year to date. **Provider Comments:** 1 patient unable to be brought in any sooner due to capacity issues. 1 patient waiting on lens to be ordered.

Mersey Care NHS Trust - Catchment

Ref	Area	Indicator	Plan	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend
KPI_01	Incidents Reported	Total Serious Untoward Incidents Reported	0	5	9	9	5	5	4	7	5	5	8			
		SUIs reported as never events	0	0	0	0	0	0	0	0	0	0	0			
KPI_04	CAS Alerts	Central Alerting System - Alerts on-going passed deadline date	0	0	0	0	0	0	0	0	0	0	0			
CB_B17	MSA	Sleeping accommodation Breach	0	0	0	0	0	0	0	0	0	0	0			
KPI_02	Infections	MRSA Cases reported	0	0	0	0	0	0	0	0	0	0	0			
		Cdiff Cases reported	0	0	0	0	0	0	0	0	0	0	0			
CB_B19	Care Programme Approach (CPA)	The percentage of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	95%	98.1%	97.6%	98.6%	95.2%	99.2%	95.9%	96.6%	100.0%	95.8%	99.0%			
KPI_05	Flu Campaign	A uptake rate for seasonal flu vaccine amongst prioritised front line Health Care Workers.	70%								34.1%	40.7%	42.7%			
KPI_10	Crisis Resolution Team	The number of separate episodes of home treatment provided by crisis resolution teams	2134	226	457	693	928	1132	1350	1573	808	1960	2198			
KPI_11	Assertive Outreach team	Total caseload	414	433	434	461	488	496	528	557	781	576	588			
KPI_14	Outpatient DNAs	Out Patient DNA rates (excluding addiction services). Percentage of outpatient appointments where the patient DNA a first appointment	15%	16.8%	17.9%	18.1%	18.0%	18.4%	18.1%	17.8%	17.7%	17.8%	18.2%			
KPI_15		Out Patient DNA rates (excluding addiction services). Percentage of outpatient appointments where the patient DNA a follow up appointment	15%	9.8%	10.5%	10.4%	10.6%	10.7%	10.7%	10.6%	10.8%	10.9%	11.0%			
KPI_16	Psychotherapy	Psychotherapy. Assessments taking place within 6 weeks of referral.	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.3%			
KPI_17		Psychotherapy. Treatment commencing within 18 weeks of referrals.	95%	40.63%	34.69%	44.07%	43.86%	42.86%	55.00%	42.19%	40.91%	46.43%	48.57%			
KPI_18	Eating Disorder Service	Eating Disorder Service. Assessments taking place within 6 weeks of referral.	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
KPI_19		Eating Disorder Service. Treatment commencing within 18 weeks of referrals.	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
KPI_21	Optimum Occupancy Levels	Occupancy rate (Including Patients on Leave) - LD	85%	95.2%	97.5%	98.8%	97.7%	97.5%	97.0%	95.4%	95.6%	95.3%	Awaiting data			
KPI_22	Occupancy Rate	Occupancy rate - AMH	85%	94.6%	92.8%	92.9%	93.3%	96.9%	92.3%	92.5%	92.9%	91.5%				
KPI_23		Occupancy rate - Older Peoples	85%	86.4%	85.4%	84.8%	86.2%	86.4%	86.5%	86.5%	87.1%	86.9%				
KPI_24		Occupancy rate- Addictions	85%	79.8%	81.8%	84.0%	91.7%	92.1%	83.3%	83.4%	84.2%	82.8%				
KPI_25		Occupancy rate (Including Patients on Leave) - Brain Injuries	85%	90.8%	92.6%	95.9%	91.7%	90.6%	91.7%	91.7%	92.6%	92.8%				
KPI_26	CPA	CPA Follow up 2 days for higher risk groups	95%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	98.1%	99.1%	99.2%	98.5%			
KPI_27		Care plans. Electronic recording of number of patients on CPA who have been offered a copy of their care plan	95%	97.9%	97.3%	97.4%	96.8%	98.0%	97.5%	98.2%	97.9%	97.4%	97.6%			
KPI_39	Length of Stay	Average spell duration for non-same day Mental Health discharges for each commissioner, PICU Servicce (Days)	40	86.5	37.8	27	26.25	6	1.36	0	22	23.5	53.63			
KPI_40		Average spell duration for non-same day Mental Health discharges for each commissioner, Rehab (Months)	48	6	0	0	565	30.42	0	52.27	15.52	22.26	43.05			
KPI_41	Admissions	Inpatient admissions per 10,000 population - Adult acute	23.3	19.70	20.91	19.93	19.91	20.53	20.93	21.29	21.29	21.43	Awaiting data			
KPI_42		Inpatient admissions per 10,000 population - Older peoples services	25.9	42.73	35.17	41.90	42.70	42.57	43.43	42.89	41.79	40.70				
KPI_44		The ratio of admissions gate kept by crisis resolution teams as a proportion of all admissions (using CQC access to crisis resolution home treatment methodology)	95%	97.9%	96.9%	96.3%	98.3%	98.4%	99.0%	97.7%	98.1%	98.4%	98.4%			

Mersey Care NHS Trust - Catchment

Ref	Area	Indicator	Plan	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend
Quarterly Indicators						Q113/14			Q213/14			Q313/14			Q413/14	Trend
KPI_06	Smoking Indicator	Smoking Status recorded for all service users	90% Q3 13/14			12.3%			18.4%			28.0%				
KPI_07		All Smokers to be offered Smoking intervention Advice	90% Q3 13/14			74.1%			77.0%			83.6%				
KPI_08		All Smokers to be offered referral to a Stop Smoking Specialist Service	90% Q3 13/14			8.1%			14.2%			21.6%				
KPI_09	Every Contact Counts	All appropriate service users to be offered brief intervention advice as per the 'Every Contact Counts' trasining recevied by frontline staff	90% Q3 13/14						34.3%			37.3%				
KPI_20	Delayed Transfers of care	The number of delayed transfers of care;	7.5%			4.9%			2.5%			6.2%				
KPI_28	CPA	Adults on Care Programme Approach receive a review within 12 months.	95%			95.1%			95.8%			98.5%				
KPI_29		CPA Community caseload by ssociate (Working agre adult mental health only)	75%			77.2%			75.3%			75.3%				
KPI_30		Proportion of adults on Care Programme Approach receiving secondary mental health services in settled accommodation	60%			66.9%			70.6%			50.0%				
KPI_31		Proportion of adults on Care Programme Approach receiving secondary mental health services in employment	TBM			3.2%			81.0%			50.9%				
KPI_32	Non CPA	Statement of Care - The Trust is to demonstrate 70% of Older People not on CPA have a statement of care. Excludes Addictions, Brain Injuries and LD	70%			84.7%			84.9%			85.3%				
KPI_33	Data Completeness identifi	Of the MHMDS that applies to the following fields for all records in each reporting period: Date of birth, Patient's current gender, Patient's marital status, Postcode of patient's normal residence, Organisation code of patient's registered General Medical Practice and Organisation code of commissioner	97%			95.2%			98.8%			98.9%				
KPI_34	Physical Assault	Recorded incidents of physical assault on inpatients	TBM			5%			5%			5%				
KPI_36	Brain Injuries	Assessments taking place within 4 weeks of referral	85%			100.0%			100.0%			96.3%				
KPI_37	Dementia	Dementia diagnosis - Number of patients in organic PbR Clusters	TBM			2879			2903			2751				
KPI_38		Memory Service - Individuals attending memory service	TBM			682			1175			1463				
KPI_45	PbR Reporting	Cluster caseloads (% clustered) in scope by cluster by CCG	Q1-50% Q2-75% Q3-85% Q4-90%			92.7%			93.2%			94.4%				
KPI_46		Adherence to cluster reviews periods in scope by cluster by CCG	Q1-25% Q2-50% Q3-75% Q4-80%			67.6%			72.8%			75.3%				
KPI_47	Communication - CQUIN 2012/13 (Inpatients)	Estimated Date of Discharge Discussed.	Q1-50% Q2-70% Q3-80% Q4-95%			88.6%			95.2%			87.6%				
KPI_48		Patients to be offered a copy of discharge notification on day of discharge.	Q1-50% Q2-70% Q3-80% Q4-95%			89.5%			70.5%			80.1%				
KPI_49		Approphiate Supply of Medication on Discharge.	Q1-50% Q2-70% Q3-80% Q4-95%			93.1%			97.5%			100.0%				

Mersey Care NHS Trust - South Sefton CCG

Ref	Area	Indicator	Plan	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend
CB_B19	Care Programme Approach (CPA)	The percentage of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	95%	100.0%	100.0%	100.0%	92.9%	94.4%	100.0%	92.3%	100.0%	100.0%	100.0%			
KPI_10	Crisis Resolution Team	The number of separate episodes of home treatment provided by crisis resolution teams	2134	25	56	94	139	168	198	233	265	293	336			
KPI_11	Assertive Outreach team	Total caseload	414	73	73	65	70	76	84	98	103	107	117			
KPI_14	Outpatient DNAs	Out Patient DNA rates (excluding addiction services). Percentage of outpatient appointments where the patient DNA a first appointment	15%	17.2%	19.8%	18.4%	17.7%	17.9%	16.5%	17.8%	18.5%	18.6%	20.1%			
KPI_15		Out Patient DNA rates (excluding addiction services). Percentage of outpatient appointments where the patient DNA a follow up appointment	15%	7.8%	8.8%	9.0%	9.5%	9.7%	10.1%	10.4%	10.7%	11.1%	11.2%			
KPI_16	Psychotherapy	Psychotherapy. Assessments taking place within 6 weeks of referral.	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
KPI_17		Psychotherapy. Treatment commencing within 18 weeks of referrals.	95%	52.63%	29.41%	23.53%	33.33%	35.29%	38.10%	35.29%	35.71%	41.18%	38.10%			
KPI_18	Eating Disorder Service	Eating Disorder Service. Assessments taking place within 6 weeks of referral.	95%						100.0%	100.0%	100.0%	100.0%	100.0%			
KPI_19		Eating Disorder Service. Treatment commencing within 18 weeks of referrals.	95%						100.0%	100.0%	100.0%	100.0%	100.0%			
KPI_26	CPA	CPA Follow up 2 days for higher risk groups	95%	0 Patients	0 Patients	0 Patients	0 Patients	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
KPI_27		Care plans. Electronic recording of number of patients on CPA who have been offered a copy of their care plan	95%	96.4%	95.9%	95.2%	95.2%	98.8%	98.4%	99.5%	99.1%	98.4%	98.6%			
KPI_39	Length of Stay	Average spell duration for non-same day Mental Health discharges for each commissioner, PICU Servicce (Days)	40	62.1	6.2	0	0	0	0	0	0	35	45			
KPI_40		Average spell duration for non-same day Mental Health discharges for each commissioner, Rehab (Months)	48	0	0	0	0	0	0	0	0	0	0			
KPI_44	Admissions	The ratio of admissions gate kept by crisis resolution teams as a proportion of all admissions (using CQC access to crisis resolution home treatment methodology)	95%	100.0%	96.4%	100.0%	95.5%	97.5%	96.4%	100.0%	97.7%	100.0%	95.0%			
Quarterly Measures						**Q1 13/14**			**Q2 13/14**			**Q3 13/14**			**Q4 13/14**	
KPI_06	Smoking Indicator	Smoking Status recorded for all service users	90% Q3 13/14			14.1%			17.2%			22.4%				
KPI_07		All Smokers to be offered Smoking intervention Advice	90% Q3 13/14			89.1%			88.0%			87.6%				
KPI_08		All Smokers to be offered referral to a Stop Smoking Specialist Service	90% Q3 13/14			6.1%			7.7%			25.1%				
KPI_09	Every Contact Counts	All appropriate service users to be offered brief intervention advice as per the 'Every Contact Counts' trasining recevied by frontline staff	90% Q3 13/14						35.9%			35.2%				
KPI_20	Delayed Transfers of care	The number of delayed transfers of care;	7.5%			5.7%			2.0%			4.4%				
KPI_28	CPA	Adults on Care Programme Approach receive a review within 12 months.	95%			92.8%			97.1%			98.2%				
KPI_29		CPA Community caseload by ssociate (Working agre adult mental health only)	75%			79.9%			75.8%			73.8%				
KPI_32	Non CPA	Statement of Care - The Trust is to demonstrate 70% of Older People not on CPA have a statement of care. Excludes Addictions, Brain Injuries and LD	70%			83.9%			82.2%			82.8%				
KPI_34	Physical Assault	Recorded incidents of physical assault on inpatients							5%							
KPI_36	Brain Injuries	Assessments taking place within 4 weeks of referral	85%			100.0%			100.0%			100.0%				
KPI_37	Dementia	Dementia diagnosis - Number of patients in organic PbR Clusters	TBM			709			709			586				
KPI_38		Memory Service - Individuals attending memory service	TBM			192			192			442				
KPI_45	PbR Reporting	Cluster caseloads (% clustered) in scope by cluster by CCG	Q1-50% Q2-75% Q3-85% Q4-90%			94.7%			93.3%			95.0%				
KPI_46		Adherence to cluster reviews periods in scope by cluster by CCG	Q1-25% Q2-50% Q3-75% Q4-80%			69.0%			73.2%			73.8%				
KPI_47	Communication - CQUIN 2012/13 (Inpatients)	Estimated Date of Discharge Discussed.	Q1-50% Q2-70% Q3-80% Q4-95%			88.6%			94.9%			99.0%				

Cheshire and Merseyside
Commissioning Support Unit

Mersey Care NHS Trust
NHS Standard Contract
Quality Requirements
Month 10 2013/14

Exception Report

Key:	
The following items have been included next to each measure to identify if the issue being reported is a on-going issue or a new issue.	
On-going Issue	On-going issues from previous month.
New Issue	New issue reported in month.

Key Performance Section

1. KPI_01 Serious Untoward Incidents – On-going Issue

The provider reported 8 incidents in January 2014 effecting Liverpool CCG, South Sefton CCG and Southport and Formby CCG patients. The trust has reported 62 incidents year to date.

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	YTD
NHS Liverpool CCG											
Accident Whilst in Hospital							1				1
Admission of under 18s to adult mental health ward										1	1
Allegation Against HC Professional								1			1
Assault by Outpatient (in receipt)					1	1					2
Attempted Suicide by Inpatient (in receipt)								1			1
Confidential Information Leak					1						1
Other					1						1
Safeguarding Vulnerable Adult			2							1	3
Safeguarding Vulnerable Child					1						1
Serious Incident by Inpatient (in receipt)						1					1
Serious Incident by Outpatient (in receipt)						1					1
Serious Incident by Outpatient (not in receipt)			1								1
Slips/Trips/Falls					1						1
Suicide by Outpatient (in receipt)		2					1			1	4
Suspected suicide							2	1	1		4
Unexpected Death of inpatient										1	1
Unexpected Death of Community Patient (in receipt)				1			1	2		1	5
NHS South Sefton CCG											
Attempted Suicide by Inpatient (in receipt)							1				1
Suspected suicide										1	1
Unexpected Death of Community Patient (in receipt)										1	1
NHS Southport and Formby CCG											
Homicide by Outpatient (not in receipt)										1	1
CCG field left blank on STEIS											
Abscond		1									1
Admission of under 18s to adult mental health ward	1			1			1				3
Attempted Suicide by Outpatient (in receipt)	1										1
Confidential Information Leak	1	1									2
Homicide by Outpatient (not in receipt)		1	1								2
Mental Health Act - Class B incident						1					1
Safeguarding Vulnerable Adult		1									1
Suicide		1									1
Suspected suicide	1	2	5	3							11
Unexpected Death of Inpatient (in receipt)	1										1
Merseyside											
Admission of under 18s to adult mental health ward									1		1
Confidential Information Leak									2		2
Unexpected Death of Community Patient (in receipt)									1		1
Grand Total	**5**	**9**	**9**	**5**	**5**	**4**	**7**	**5**	**5**	**8**	**62**

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

2. KPI_05 Flu Vaccinations

An uptake rate for seasonal flu vaccine amongst prioritised front line Health Care Workers – Overall for 2013/14 the trust achieved 42.7% compared to a plan of 70%.

Provider Comments: Vaccinators have been around the trust vaccinating their own working area as well as occupational health staff running clinics additional clinics. These clinics have ran at night in order to capture night workers at secure units, and total over 45 in number. Despite the large resource and opportunity for vaccination staff are reluctant to partake.

3. **KPI_14 Out Patient DNA rates – On-going Issue**

18.2% (936/5151) of patients DNA'd an outpatient appointment in Jan 14, slight reduction in performance compared to previous month. CCG level data provides a breakdown of CCG patients reporting higher rates of DNAs compared to 15% plan

- South Sefton CCG – 20.1% 204 patients DNA'd

Provider Comments: The DNA rate across the trust remains at a static level. The Liverpool Access team has been relocated to Broadoak. The Access team screen referrals and occasionally see patients before an appointment with CMHTs. Appointment reminder letters are sent to all patients and a text messaging system is being rolled out across the patch. This is currently in place at Windsor House.

North Liverpool teams are now supported by the Patient Assessment Centre (PAC) which is based at Aintree Hospital. This has been set up to screen referrals and send reminder letters to patients, and has already made an impact. The service is being rolled out to Sefton and Kirkby teams in phases.

4. **KPI_17 Psychotherapy – On-going Issue**

91.3% of assessments took place within 6 weeks of referral; of the 23 patients referred 21 patients received an assessment within 6 weeks.

48%of patients referred to psychotherapy service received treatment within 18 weeks compared to a plan of 95%. 360 patients waited over 18 weeks for treatment in Jan 14.

- South Sefton CCG – 13 patients waited more than 18 weeks

Provider Comments: The demand for psychotherapy interventions is greater than the team can meet with current resources. A business case has been submitted to Liverpool CCG, and if successful, will address the short fall and enable the 18 week to treatment target to be met. Commissioners are aware of the pressures on the service, and Liverpool CCG will be reviewing counselling and psychological therapies during 2014/15

The same pressures apply to other CCGs and are likely to continue unless additional resources can be put into the service.

5. **KPI_39 Length of Stay – New Issue**

The average spell duration for non-same day mental health discharges in January 2014 was 53.6 days compared to a plan of 40 days.

CMCSU BI Comments: Awaiting submission of provider comments relating to underperformance.

Quarterly Measures

All measures reported as red/amber at Quarter 3 13/14 can be found within Month 9 Quality and Performance report.

Liverpool Community Health - South Sefton CCG Contract

Ref	Area	Indicator	Plan	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend
Intermediate care - Ward 35	Infection Control	MRSA total cases reported in month *Bed based services only	0	0	0	0	0	0	0	0	0	0	0			
		Cdiff total cases reported in month *Bed based services only	0	0	0	0	0	0	0	0	0	0	0			
		MRSA Screening for all relevant admissions into intermediate care	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%	100.0%			
		Assessment of patients on admission to intermediate care bed for C diff risk	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
		Isolation of intermediate care patients with known or suspected C Diff within 4 hours	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
	Discharge Summaries	Discharge Summaries to be received by the patients GP within 24 hours for all patients admitted and discharged from a community provider setting.	95%	100.0%	100.0%	100.0%	75.7%	84.6%	58.3%	66.7%	63.0%	95.7%	90.0%			
		Patients to have MDT review within 4 working days of admission into community provider settings	90%	100.0%	100.0%	100.0%	67.8%	76.9%	36.4%	68.2%	85.2%	91.3%	86.2%			
		Patients to receive a copy of their Discharge Summary on day of discharge from a community provider setting.	95%	100.0%	100.0%	100.0%	27.0%	92.3%	100.0%	100.0%	85.2%	95.5%	100.0%			
	Falls and Keeping Norished	Percentage FRAT assessements completed	98%	100.0%	100.0%	100.0%	88.5%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%			
		Percentage Falls Care Plans in place for at risk fallers	98%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%	95.2%	95.2%	94.4%	80.0%			
		Percentage MUST assessements completed	95%	100.0%	100.0%	100.0%	80.8%	100.0%	100.0%	100.0%	93.1%	100.0%	100.0%			
		Percentage care plans in place for patients with MUST >=2	98%	66.7%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	33.3%	100.0%			
KPI_28	TB Nurses	Appropriate patients with TB receive assessment and a care/treatment plan within 2 working days from point of referral	95%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	98.9%	100.0%			
TCS_20	Delayed Transfers of Care	The number of bed days lost due to patients whose discharge or transfer from community hospital is delayed, as a percentage of the total bed days available	5%	10%	13.70%	8.40%	6.3%	3.5%	11.60%	5.3%	1.3%	8.8%	7.6%			
TCS_33	Rate of cancelled appointments	The percentage of cancellations by provider services of all specialties contacts in a contracted month, in a clinic setting.	2%	1.71%	4.49%	1.88%	2.50%	2.10%	2.30%	1.50%	2.2%	2.7%	2.4%			
TCS_34	Rate of 'did not attends'	The percentage of appointments that were 'did not attends' (DNAs) in all specialties contacts in a contracted month, in a clinic setting.	5%	6.90%	7.51%	7.62%	6.93%	7.40%	7.06%	7.37%	7.70%	7.96%	7.0%			
TCS_35a	Home Equipment - Priority 1	The percentage of completed priority 1 referrals for home equipment within 2 working days.	85%	76.3%	88.25%	98.87%	91.36%	80.90%	81.64%	70.0%	77.3%	74.8%				
TCS_35b	Home Equipment - Priority 2	The percentage of completed priority 2 referrals for home equipment within 7 working days.	85%	91.4%	100.0%	97.7%	92.7%	96.1%	96.1%	90.2%	90.2%	95.8%				

Cheshire and Merseyside
Commissioning Support Unit

Liverpool Community Health
NHS South Sefton CCG
NHS Standard Contract Report
Month 10 2013/14

Exception Report

Key:	
The following items have been included next to each measure to identify if the issue being reported is a on-going issue or a new issue.	
On-going Issue	On-going issues from previous month.
New Issue	New issue reported in month.

Key Performance Section

1. **KPI_01 Serious Untoward Incidents**
   Liverpool CCG to provide an update on Liverpool Community Health SUIs reported in Month 11.

2. **Discharge Summaries – On-going Issue**
   Discharge Summaries to be received by the patients GP within 24 hours for all patients admitted and discharged from a community provider setting – 90% reported in January 2014 compared to a plan of 95%, drop in performance compared to previous month.

   Patients to have MDT review within 4 working days of admission into community provider settings – 86.2% reported in January 2014 compared to a plan of 95%, drop in performance compared to previous month.

   Provider Comments: Targeted work continues including reviewing audit collection process including agreement and documentation of exception criteria. Launch of new documentation pack to be launched which is expected to ensure improved compliance with these KPIs

3. **Falls**
   Percentage Falls Care Plans in place for at risk fallers – 80% of patients at risk of falls had a care plan in place compared to a plan of 98%, a further drop in performance compared to previous month.

   Provider Comments: Reviewing audit collection process including agreement and documentation of exception criteria. Launch of new documentation pack to be launched which is expected to ensure improved compliance with these KPIs, working with staff to ensure screenings are completed.

   During January 2014, 100% of patients were screened with FRAT however there were 4 patients who did not have a care plan in situ. These cases have been reviewed by service manager to ensure lessons are learned.

4. **Delayed Discharges**
   The number of bed days lost due to patients whose discharge or transfer from community hospital is delayed, as a percentage of the total bed days available – 7.6% reported in January 2014 compared to a plan of 5%, slight improvement in performance compared to previous month.

   Provider Comments: Following full review of process, delays have improved and service expect to achieve monthly target. Daily MDT board rounds in place and those patients delayed through choice are escalated to Divisional Performance Meeting.

5. **DNAs and Cancelled Appointments**
   The percentage of appointments that were 'did not attends' (DNAs) in all specialties contacts in a contracted month, in a clinic setting - 7% reported in January 2013 compared to a plan of <5%, slight improvement in performance compared to previous month.

   See comments included below.

6. **Cancelled appointments**
   The percentage of cancellations by provider services of all specialties contacts in a contracted month, in a clinic setting – 2.4% reported in January 2014 compared to a plan of <2%, similar performance compared to previous month.

   Provider Comments: DNA/Cancellation steering group has been set up, policy has been developed and is currently out for consultation. Specific action plans have been developed for areas with high DNA rates

including the use of text messaging appointment reminders and opt in processes. Also, working with Trainee Public Health Consultant and Analyst to identify areas and characteristics of specific populations with high DNA rates.

7. **Home Equipment - Priority 1**
   74.8% of priority 1 referrals received home equipment within 2 working days in January 2014, slight drop in performance compared to previous month.

   Provider Comments: Significant and sustained increase in demand continues to impact on performance.

NHS
Cheshire and Merseyside Commissioning Support Unit

Aintree University Hospital

Reds - Possibly areas for discussion

Key and Rag Ratings can be found at the end of the dashboard

Domain 1: Preventing People from Dying Prematurely		Reporting Period	Benchmark	Previous Period	Latest Data	Movement	YTD	Trend
Cancer Waiting Times		**Monthly**	**Plan**	**Nov-13**	**Dec-13**	**Change**	**2013/14**	**Over time**
1	Patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	Jan-14	93%	99%	95.6%	Decline	96%	
2	Patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	Jan-14	93%	99%	91.6%	Decline	96%	
3	Patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	Jan-14	96%	98%	98.0%	No Change	99%	
4	Patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	Jan-14	94%	100%	95.2%	Decline	98%	
5	Patients waiting no more than 31 days of subsequent treatment where that treatment is an anti-cancer drug regimen	Jan-14	98%	100%	100.0%	No Change	100%	
6	Patients waiting no more than 31-Day Standard for Subsequent Cancer Treatments-Radiotherapy	Jan-14	94%	0 Patients	0 Patients	No Change	94%	
7	Patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	Jan-14	85%	87%	85.4%	Decline	84%	
8	Patients waiting no more than 62 days from referral from an NHS Screening service to first definitive treatment for all cancers	Jan-14	90%	88%	0 Patients	No Change	93%	
9	Patients waiting no more than 62 days for first definitive treatment following a consultants decision to upgrade the priority of a patient (all cancers)	Jan-14	85%	92%	81.8%	Decline	88%	
Mortality		**Annual**	**Plan**	**Apr 12-Mar 13**	**Jul 12 - Jun 13**	**Change**	**2013/14**	**Over time**
10	Hospital Standardised Mortality Ratio (HSMR)	Jan-14	100	95.3	93.7	No Change	93.74	
11	Summary Hospital-Level Mortality Indicator (SHMI)	Jul 12 - Jun 13	100	1.15	1.13	Improvement	1.13	
12	(SHMI) Deaths occurring in hospital	Jul 12 - Jun 13		72.9%	72.8%	No Change	72.8%	
13	(SHMI) Deaths occurring out of hospital	Jul 12 - Jun 13		27.1%	27.2%	No Change	27.2%	

Domain 2: Quality of Life (Long Term Conditions)								
Stroke		**Monthly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
14	Stroke/TIA - Stroke 90% Stay on ASU	Q3 13/14	80%	77%	61%	No Change	72%	
15	Stroke/TIA - TIA - High Risk Treated within 24Hrs	Q3 13/14	60%	100%	100%	No Change	100%	

Domain 3: Helping People to Recover from Episodes of Ill Health or from Injury								
A&E Quality Measures		**Monthly**	**Plan**	**Oct-13**	**Nov-13**	**Change**	**2013/14**	**Over time**
16	**Overall achievement of A&E Quality Indicators**	Jan-14	Achieved	Achieve	Achieve	No Change	Achieved	
17	Unplanned re-attendance at A&E within 7 days of original attendance	Jan-14	5%	6.7%	7.6%	Decline	6.9%	
18	Patient Impact - Left department without being seen rate	Jan-14	5%	3.1%	3.5%	No Change	3.9%	
19	Timeliness - Time to initial assessment - 95th centile	Jan-14	15	0	0	No Change	4	
20	Timeliness - Total time spent in A&E department - 95th centile	Jan-14	240	238	276	Decline	283	
21	Timeliness - Time to treatment in department - median	Jan-14	60	73	89	Decline	97	
Rapid Access Chest Pain Clinic		**Quarterly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
22	A maximum two-week wait for Rapid Access Chest Pain Clinic (RACPC)	Q3 13/14	100%	83%	91%	No Change	88%	
Smoking		**Quarterly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
23	Smoking Status recorded for all inpatients (exclude critical care)	Q3 13/14	90%	No data	No Data	No Change	62%	N/A
24	All Smokers to be offered Smoking intervention Advice	Q3 13/14	by Q4 13/14	No data	No Data	No Change	71%	N.A
Patient Reported Outcome Measures		**Annual**	**Eng Average**	**Apr 11 - Mar 12**	**Apr 12 - Mar 13**	**Change**	**2013/14**	**Over time**
25	Groin Hernia - Average increase in health gain	Apr 12 - Mar 13	0.086	0.088	0.064	No Change	0.064	
26	Hip Replacement - Average increase in health gain	Apr 12 - Mar 13	0.439	0.395	0.429	No Change	0.429	
27	Knee Replacement - Average increase in health gain	Apr 12 - Mar 13	0.321	0.299	0.296	No Change	0.296	
28	Varicose Vein - Average increase in health gain	Apr 12 - Mar 13	0.094	*	*	No Change	*	

Domain 4: Ensuring People have a positive experience of care								
Referral to Treatment		**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
29	18 Weeks - Admitted - % Compliance - Trust	Jan-14	90%	95%	93%	Decline	93%	
30	18 Weeks - Non Admitted - % Compliance - Trust	Jan-14	95%	98%	97%	Decline	98%	
31	18 Weeks - On-going - % <18 Weeks - Trust	Jan-14	92%	97%	97%	No Change	97%	
32	Zero tolerance RTT Waits over 52 weeks	Jan-14	0	0	0	No Change	0	
A&E Department Measures		**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
33	Percentage of A&E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an a&e department	Jan-14	95%	98%	95.6%	Improvement	95%	
34	Trolley waits in A&E	Jan-14	0	0	0	No Change	0	
35	Handover <15 Minutes. Time taken from HAS notification to clinical handover (Assumed ACUTE responsibility)	Jan-14	15 Mins	00:10:25	00:11:50	Decline	00:10:55	
36	Patients waiting between 30-60 Minutes for Handover	Jan-14	0	61	90	Decline	705	
37	Patients waiting between 60+ Minutes for Handover	Jan-14	0	23	29	Decline	277	
38	Compliance with Recording Patient Handover between Ambulance and A&E	Jan-14	95%	86%	83%	Decline	79%	
Mixed Sex Accommodation Breaches		**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
39	Sleeping accommodation Breach (MSA)	Jan-14	0	0	0	No Change	0	
Diagnostics		**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
40	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	Jan-14	99%	100%	99.4%	Decline	99.4%	
Cancelled Operations		**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
41	All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for nonclinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.	Jan-14	0	2	2	Decline	8	
42	No urgent operation should be cancelled for a second time	Jan-14	0	0	0	No Change	0	
Choose and Book		**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
43	Provider failure to ensure that "sufficient appointment slots" are made available on the Choose & Book system	Jan-14	7%	19%	17%	Improvement	16%	
VTE		**Monthly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
44	Percentage of patients risk assessed for venous thromboembolism who receive appropriate prophylaxis (Local Audits)	Q3 13/14	95%	93%	94.1%	Improvement	93%	
Complaints		**Quarterly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
45	Complaints received at CMCSU (Business Solutions)	Q3 13/14	0	0	0	No Change	0	
46	Complaints received at provider	Q3 13/14	0	Awaiting update			67	

NHS
Cheshire and Merseyside

Aintree University Hospital

	National Dementia	Monthly	Plan	Nov-13	Dec-13	Change	2013/14	Over time
47	National Dementia CQUIN - Screening for Dementia (Find)	Dec-13	90%	58%	52%	Decline	43%	
48	National Dementia CQUIN - Risk Assessed (Assess and Investigate)	Dec-13	90%	52%	59%	Improvement	70%	
49	National Dementia CQUIN - Patients Referred	Dec-13	90%	100%	100%	No Change	100%	
	National Friends&Family	**Quarterly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
50	National Friends and Family - Phased Expansion (Inpatient,A&E and Maternity)	Q3 13/14	Compliance	Compliance update				
51	National Friends and Family - Increased Response Rate	Q3 13/14	15%	27%	30%	Decline	24%	
52	National Friends and Family - Test Score	Q3 13/14	>2012/13	57	64	Improvement	54.3	
	Advancing Quality	**Monthly**	**Plan**	**Sep-13**	**Oct-13**			
53	Advancing Quality Acute myocardial infarction	Oct-13	81.3%	94.4%	87.1%	Decline	91.4%	
54	Advancing Quality Hip and Knee	Oct-13	73.8%	77.3%	77.8%	Improvement	68.5%	
55	Advancing Quality Heart Failure	Oct-13	82.0%	83.3%	83.7%	Improvement	83.7%	
56	Advancing Quality Pneumonia	Oct-13	61.1%	75.7%	60.9%	Decline	72.1%	
57	Advancing Quality Stroke	Oct-13	53.6%	35.7%	53.7%	Improvement	48.1%	
	Patient Experience	**Annual**	**England Average**	**Previous Year**	**Latest Year**	**Change**	**Latest Data**	**Over time**
58	Patient experience of hospital care	2012	76.5%	77.5%	77.0%	No Change	77.0%	
59	Patient experience of outpatient services	2011	79.2%	79.0%	80.0%	No Change	80.0%	N/A
60	Patient experience of A&E services	2012	75.4%	76.2%	74.2%	No Change	74.2%	N/A

	Domain 5: Treating & Caring for People in a Safe Environment and Protecting from Harm							
	Infection Control	**Monthly**	**Plan**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
61	Clostridium Difficile - Trust	Jan-14	3.58	4	1	Improvement	71	
62	Incidence of MRSA - Trust	Jan-14	0	0	0	No Change	1	
63	MRSA Screening - Trust	Dec-13	No Plan	100%	100%	No Change	98%	
64	MSSA	Dec-13	No Plan	2	2	No Change	25	
	Hygiene Compliance	**Monthly**	**Plan**	**Nov-13**	**Dec-13**	**Change**	**2013/14**	**Over time**
65	Hand Hygiene Compliance - Trust	Dec-13	No Plan	98%	100%	Improvement	98%	
	Incident Reporting	**Monthly**	**Plan**	**Jan-14**	**Feb-14**	**Change**	**2013/14**	**Over time**
66	Never Events - Trust	Feb-14	0	0	0	No Change	1	
67	Steis Reportable Incidents - Trust	Feb-14	0	2	1	No Change	23	
	CQC	**Monthly**	**Plan**	**Jan-14**	**Feb-14**	**Change**	**2013/14**	**Over time**
68	CQC Intelligence Tool - Band 1 = Highest Risk Band 6 = Lowest Risk	Feb-14	6	1	1	No Change	1	N/A
69	Compliance against 5 essential standards (✓ = Compliant, × = Not Compliant actions requiring improvement, × = Not Compliant and Enforcement Action Taken)	Feb-14	✓	×	×	No Change	×	29.09.13 Inspection
	Central Alerting System	**Monthly**	**Plan**	**Feb-14**	**Mar-14**	**Change**	**2013/14**	**Over time**
70	All CAS alerts outstanding after deadline date	Mar-14	0	4	1	No Change	1	
	Sickness Absence	**Monthly**	**Plan**	**Q1 13/14**	**Q2 13/14**	**Change**	**2013/14**	**Over time**
71	Sickness Absence Rates All Staff - National Data	Q2 13/14	4.12%	3.56%	3.85%	Decline	3.7%	
72	Sickness Absence Rates All Staff - Provider internal data	Q2 13/14	4.12%	3.70%	4.10%	Decline	3.9%	
	Coronary Heart Disease	**Quarterly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
73	Percentage of CHD patients with a primary diagnosis of AMI prescribed ACE Inhibitors on discharge	Q3 13/14	95%	100%	100%	No Change	100%	
74	Percentage of CHD patients with a primary diagnosis of AMI prescribed Clopidogrel on discharge	Q3 13/14	95%	100%	100%	No Change	100%	
	VTE	**Monthly**	**Plan**	**Nov-13**	**Dec-13**	**Change**	**2013/14**	**Over time**
75	National CQUIN - VTE Risk Assessments	Dec-13	95%	94.6%	94.8%	Improvement	92.3%	
	National Patient Incident Reporting	**Bi Annual**	**Median Average**	**Oct 11 - Mar 12**	**Apr 12 - Sep 12**	**Change**	**Latest data**	**Over time**
76	National Patient Safety Incident Reporting Per 100 admissions	Apr 12 - Sep 12	6.7	8.3	7.2	No Change	7.2	
77	Safety incidents resulting in severe harm or death	Apr 12 - Sep 12	0.8%	0.1%	0.2%	No Change	0.2%	
	Staff Survey	**Annual**	**Eng Average**	**2011**	**2012**	**Change**	**2013/14**	**Over time**
78	National Staff Survey	2012	3.69	3.65	3.69	Improvement	3.69	
	PLACE Survey	**Annual**	**Eng Average**		**2013**	**Change**	**2013/14**	**Over time**
79	PLACE Survey - Average score of all four areas	2013	90%	N/A	85.2%	No Change	85.2%	N/A
	NHS Safety Thermometer	**Monthly**	**Eng Average**	**Dec-13**	**Jan-14**	**Change**	**2013/14**	**Over time**
80	Submission compliance	Jan-14	Compliance			No Change		
81	Total patients surveyed		N/A	607	602		6874	
82	Patients receiving harm free care		93.5%	93.4%	93.0%	No Change	85.7%	
83	Total pressure ulcers (all categories)		4.6%	4.3%	5.5%	Decline	4.1%	
84	Total falls (causing harm)		N/A	0.2%	0.2%	No Change	0.3%	
85	Patients with a catheter and being treated for a UTI		0.9%	1.5%	0.7%	Improvement	0.4%	
86	Number of patients with a new VTE		0.4%	1.0%	0.8%	Improvement	0.8%	

Reporting Period	Period in which the latest data relates to
Benchmark	This will either be threshold/plan, England Average (Eng Average)
Previous Period	Depending on the reporting frequency, this will either be previous month, quarter and year
Latest Data	This is the latest data available to Cheshire and Merseyside CSU
Movement	Change in latest reporting period performance compared to previous reporting period performance
Rag Rating of Movement Column	
No Change	No change in latest performance compared to previous reporting period
Improvement	Improvement in latest months performance compared to previous reporting period
Decline	Drop in latest reporting period performance compared to previous reporting period
Rag Rating of Latest data Column and Year to date Column	
	Equal to or above agreed performance threshold
	Below agreed performance threshold or drop in performance or below England average (Varies across measures)
	Drop in latest reporting period performance compared to previous reporting period

Cheshire and Merseyside Commissioning Support Unit

Aintree University Hospital
March 2014 Key Concerns Update

The following narrative relates to measures which are newly reported as red in the latest months update. All comments relating to previous red measures have been included in previous reports.

Domain 1: Preventing People from Dying Prematurely
Patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment
Patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment – 91.6% reported in January 2014 compared to a plan of 93%, drop in performance compared to previous month. **Provider Comments:** Causes of underperformance - Patient choice of appointment, Patients referred with "non suspicious" symptoms, therefore not wanting to attend within the 2 week time frame. Actions taken • During the period end of December 2013 / beginning of January 2014 a reorganisation of the Breast administration team took place to redefine roles and ensure clarity amongst the cancer services staff. This has ensured that the correct booking processes are now in place with clear lines of responsibility. • In addition an audit has been undertaken by the H&N CBU to identify if the provision of evening / weekend clinics would be more easily accessible for this group of patients. The CBU is currently assessing the feasibility of establishing these clinics, although consideration will need to be given to current job plans and availability of resources. Percentage of patients waiting no more than 62 days for first definitive treatment following a consultant's decision to upgrade the priority of a patient (all cancers) - 81.8% reported in January 2014 compared to a plan of 85%, drop in performance compared to previous month. 2 patients waited more than 62 days following a consultant upgrade. **Provider Comments:** This involved 2 patients and a review of these cases is underway, this is a local target.
Domain 3: Helping People to Recover from Episodes of Ill Health or from Injury
A&E Quality Measures
In order to achieve overall compliance against A&E Quality measures foundation trust must comply with 95% 4hr measure and must not fail three of the quality measures in total. As the provider achieved the A&E 4hr wait target in January 2014 the provider achieved overall compliance, however three measures are reported as red in January 2014. • Patient Impact -Unplanned re-attendance at A&E within 7 days of original attendance – 7.6% compared to 5% threshold. • Timeliness - Total time spent in A&E department (95th centile) – 276 minutes compared to 240 minutes. • Timeliness - Time to treatment in department (Median) – 89 minutes compared to 60 minutes. **Provider Comments:** A reduction in unplanned re attendances for any condition remain a challenge, to which to Trust has now set up a 'frequent attendees' review group. By far the vast majority of patients who attend more than once in 7 days tend to suffer from alcohol, substance misuse or mental health problems. A frequent attenders group involving community care continues to be held monthly to aid improvement. Patients' returning for the same condition is now under target at 3.7%. The Trust is continuing to work to reduce the median wait to see a clinician. The primary focus on this is the adoption of a new see and treat approach meaning patients bypass triage and are immediately treated. This model continues to bed in and improvements should be seen over the next couple of months. In addition to this, the bypassing of GP accepted patients directly to the medical assessment areas should free up consultants in the teams.

Domain 4: Ensuring People have a positive experience of care
Cancelled Operations
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for nonclinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice. 2 breaches reported in January 2014 compared to a plan of 0, 8 breaches reported year to date. **Provider Comments:** 1 patient unable to be brought in any sooner due to capacity issues. 1 patient waiting on lens to be ordered.

Mersey Care NHS Trust - Catchment

Ref	Area	Indicator	Plan	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend
KPI_01	Incidents Reported	Total Serious Untoward Incidents Reported	0	5	9	9	5	5	4	7	5	5	8			
		SUIs reported as never events	0	0	0	0	0	0	0	0	0	0	0			
KPI_04	CAS Alerts	Central Alerting System - Alerts on-going passed deadline date	0	0	0	0	0	0	0	0	0	0	0			
CB_B17	MSA	Sleeping accommodation Breach	0	0	0	0	0	0	0	0	0	0	0			
KPI_02	Infections	MRSA Cases reported	0	0	0	0	0	0	0	0	0	0	0			
		Cdiff Cases reported	0	0	0	0	0	0	0	0	0	0	0			
CB_B19	Care Programme Approach (CPA)	The percentage of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	95%	98.1%	97.6%	98.6%	95.2%	99.2%	95.9%	96.6%	100.0%	95.8%	99.0%			
KPI_05	Flu Campaign	A uptake rate for seasonal flu vaccine amongst prioritised front line Health Care Workers.	70%								34.1%	40.7%	42.7%			
KPI_10	Crisis Resolution Team	The number of separate episodes of home treatment provided by crisis resolution teams	2134	226	457	693	928	1132	1350	1573	808	1960	2198			
KPI_11	Assertive Outreach team	Total caseload	414	433	434	461	488	496	528	557	781	576	588			
KPI_14	Outpatient DNAs	Out Patient DNA rates (excluding addiction services). Percentage of outpatient appointments where the patient DNA a first appointment	15%	16.8%	17.9%	18.1%	18.0%	18.4%	18.1%	17.8%	17.7%	17.8%	18.2%			
KPI_15		Out Patient DNA rates (excluding addiction services). Percentage of outpatient appointments where the patient DNA a follow up appointment	15%	9.8%	10.5%	10.4%	10.6%	10.7%	10.7%	10.6%	10.8%	10.9%	11.0%			
KPI_16	Psychotherapy	Psychotherapy. Assessments taking place within 6 weeks of referral.	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.3%			
KPI_17		Psychotherapy. Treatment commencing within 18 weeks of referrals.	95%	40.63%	34.69%	44.07%	43.86%	42.86%	55.00%	42.19%	40.91%	46.43%	48.57%			
KPI_18	Eating Disorder Service	Eating Disorder Service. Assessments taking place within 6 weeks of referral.	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
KPI_19		Eating Disorder Service. Treatment commencing within 18 weeks of referrals.	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
KPI_21	Optimum Occupancy Levels	Occupancy rate (Including Patients on Leave) - LD	85%	95.2%	97.5%	98.8%	97.7%	97.5%	97.0%	95.4%	95.6%	95.3%	Awaiting data			
KPI_22	Occupancy Rate	Occupancy rate - AMH	85%	94.6%	92.8%	92.9%	93.3%	96.9%	92.3%	92.5%	92.9%	91.5%				
KPI_23		Occupancy rate - Older Peoples	85%	86.4%	85.4%	84.8%	86.2%	86.4%	86.5%	86.5%	87.1%	86.9%				
KPI_24		Occupancy rate- Addictions	85%	79.8%	81.8%	84.0%	91.7%	92.1%	83.3%	83.4%	84.2%	82.8%				
KPI_25		Occupancy rate (Including Patients on Leave) - Brain Injuries	85%	90.8%	92.6%	95.9%	91.7%	90.6%	91.7%	91.7%	92.6%	92.8%				
KPI_26	CPA	CPA Follow up 2 days for higher risk groups	95%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	98.1%	99.1%	99.2%	98.5%			
KPI_27		Care plans. Electronic recording of number of patients on CPA who have been offered a copy of their care plan	95%	97.9%	97.3%	97.4%	96.8%	98.0%	97.5%	98.2%	97.9%	97.4%	97.6%			
KPI_39	Length of Stay	Average spell duration for non-same day Mental Health discharges for each commissioner, PICU Servicce (Days)	40	86.5	37.8	27	26.25	6	1.36	0	22	23.5	53.63			
KPI_40		Average spell duration for non-same day Mental Health discharges for each commissioner, Rehab (Months)	48	6	0	0	565	30.42	0	52.27	15.52	22.26	43.05			
KPI_41	Admissions	Inpatient admissions per 10,000 population - Adult acute	23.3	19.70	20.91	19.93	19.91	20.53	20.93	21.29	21.29	21.43	Awaiting data			
KPI_42		Inpatient admissions per 10,000 population - Older peoples services	25.9	42.73	35.17	41.90	42.70	42.57	43.43	42.89	41.79	40.70				
KPI_44		The ratio of admissions gate kept by crisis resolution teams as a proportion of all admissions (using CQC access to crisis resolution home treatment methodology)	95%	97.9%	96.9%	96.3%	98.3%	98.4%	99.0%	97.7%	98.1%	98.4%	98.4%			

Mersey Care NHS Trust - Catchment

Ref	Area	Indicator	Plan	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend
Quarterly Indicators						Q113/14			Q213/14			Q313/14			Q413/14	Trend
KPI_06	Smoking Indicator	Smoking Status recorded for all service users	90% Q3 13/14			12.3%			18.4%			28.0%				
KPI_07		All Smokers to be offered Smoking intervention Advice	90% Q3 13/14			74.1%			77.0%			83.6%				
KPI_08		All Smokers to be offered referral to a Stop Smoking Specialist Service	90% Q3 13/14			8.1%			14.2%			21.6%				
KPI_09	Every Contact Counts	All appropriate service users to be offered brief intervention advice as per the 'Every Contact Counts' trasining recevied by frontline staff	90% Q3 13/14						34.3%			37.3%				
KPI_20	Delayed Transfers of care	The number of delayed transfers of care;	7.5%			4.9%			2.5%			6.2%				
KPI_28	CPA	Adults on Care Programme Approach receive a review within 12 months.	95%			95.1%			95.8%			98.5%				
KPI_29		CPA Community caseload by ssociate (Working agre adult mental health only)	75%			77.2%			75.3%			75.3%				
KPI_30		Proportion of adults on Care Programme Approach receiving secondary mental health services in settled accommodation	60%			66.9%			70.6%			50.0%				
KPI_31		Proportion of adults on Care Programme Approach receiving secondary mental health services in employment	TBM			3.2%			81.0%			50.9%				
KPI_32	Non CPA	Statement of Care - The Trust is to demonstrate 70% of Older People not on CPA have a statement of care. Excludes Addictions, Brain Injuries and LD	70%			84.7%			84.9%			85.3%				
KPI_33	Data Completeness identifi	Of the MHMDS that applies to the following fields for all records in each reporting period: Date of birth, Patient's current gender, Patient's marital status, Postcode of patient's normal residence, Organisation code of patient's registered General Medical Practice and Organisation code of commissioner	97%			95.2%			98.8%			98.9%				
KPI_34	Physical Assault	Recorded incidents of physical assault on inpatients	TBM			5%			5%			5%				
KPI_36	Brain Injuries	Assessments taking place within 4 weeks of referral	85%			100.0%			100.0%			96.3%				
KPI_37	Dementia	Dementia diagnosis - Number of patients in organic PbR Clusters	TBM			2879			2903			2751				
KPI_38		Memory Service - Individuals attending memory service	TBM			682			1175			1463				
KPI_45	PbR Reporting	Cluster caseloads (% clustered) in scope by cluster by CCG	Q1-50% Q2-75% Q3-85% Q4-90%			92.7%			93.2%			94.4%				
KPI_46		Adherence to cluster reviews periods in scope by cluster by CCG	Q1-25% Q2-50% Q3-75% Q4-80%			67.6%			72.8%			75.3%				
KPI_47	Communication - CQUIN 2012/13 (Inpatients)	Estimated Date of Discharge Discussed.	Q1-50% Q2-70% Q3-80% Q4-95%			88.6%			95.2%			87.6%				
KPI_48		Patients to be offered a copy of discharge notification on day of discharge.	Q1-50% Q2-70% Q3-80% Q4-95%			89.5%			70.5%			80.1%				
KPI_49		Approphiate Supply of Medication on Discharge.	Q1-50% Q2-70% Q3-80% Q4-95%			93.1%			97.5%			100.0%				

Ref	Area	Indicator	Plan	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend
CB_B19	Care Programme Approach (CPA)	The percentage of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	95%	100.0%	100.0%	100.0%	92.9%	94.4%	100.0%	92.3%	100.0%	100.0%	100.0%			
KPI_10	Crisis Resolution Team	The number of separate episodes of home treatment provided by crisis resolution teams	2134	25	56	94	139	168	198	233	265	293	336			
KPI_11	Assertive Outreach team	Total caseload	414	73	73	65	70	76	84	98	103	107	117			
KPI_14	Outpatient DNAs	Out Patient DNA rates (excluding addiction services). Percentage of outpatient appointments where the patient DNA a first appointment	15%	17.2%	19.8%	18.4%	17.7%	17.9%	16.5%	17.8%	18.5%	18.6%	20.1%			
KPI_15		Out Patient DNA rates (excluding addiction services). Percentage of outpatient appointments where the patient DNA a follow up appointment	15%	7.8%	8.8%	9.0%	9.5%	9.7%	10.1%	10.4%	10.7%	11.1%	11.2%			
KPI_16	Psychotherapy	Psychotherapy. Assessments taking place within 6 weeks of referral.	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
KPI_17		Psychotherapy. Treatment commencing within 18 weeks of referrals.	95%	52.63%	29.41%	23.53%	33.33%	35.29%	38.10%	35.29%	35.71%	41.18%	38.10%			
KPI_18	Eating Disorder Service	Eating Disorder Service. Assessments taking place within 6 weeks of referral.	95%						100.0%	100.0%	100.0%	100.0%	100.0%			
KPI_19		Eating Disorder Service. Treatment commencing within 18 weeks of referrals.	95%						100.0%	100.0%	100.0%	100.0%	100.0%			
KPI_26	CPA	CPA Follow up 2 days for higher risk groups	95%	0 Patients	0 Patients	0 Patients	0 Patients	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
KPI_27		Care plans. Electronic recording of number of patients on CPA who have been offered a copy of their care plan	95%	96.4%	95.9%	95.2%	95.2%	98.8%	98.4%	99.5%	99.1%	98.4%	98.6%			
KPI_39	Length of Stay	Average spell duration for non-same day Mental Health discharges for each commissioner, PICU Servicce (Days)	40	62.1	6.2	0	0	0	0	0	0	35	45			
KPI_40		Average spell duration for non-same day Mental Health discharges for each commissioner, Rehab (Months)	48	0	0	0	0	0	0	0	0	0	0			
KPI_44	Admissions	The ratio of admissions gate kept by crisis resolution teams as a proportion of all admissions (using CQC access to crisis resolution home treatment methodology)	95%	100.0%	96.4%	100.0%	95.5%	97.5%	96.4%	100.0%	97.7%	100.0%	95.0%			
Quarterly Measures						**Q1 13/14**			**Q2 13/14**			**Q3 13/14**			**Q4 13/14**	
KPI_06	Smoking Indicator	Smoking Status recorded for all service users	90% Q3 13/14			14.1%			17.2%			22.4%				
KPI_07		All Smokers to be offered Smoking intervention Advice	90% Q3 13/14			89.1%			88.0%			87.6%				
KPI_08		All Smokers to be offered referral to a Stop Smoking Specialist Service	90% Q3 13/14			6.1%			7.7%			25.1%				
KPI_09	Every Contact Counts	All appropriate service users to be offered brief intervention advice as per the 'Every Contact Counts' trasining recevied by frontline staff	90% Q3 13/14						35.9%			35.2%				
KPI_20	Delayed Transfers of care	The number of delayed transfers of care;	7.5%			5.7%			2.0%			4.4%				
KPI_28	CPA	Adults on Care Programme Approach receive a review within 12 months.	95%			92.8%			97.1%			98.2%				
KPI_29		CPA Community caseload by ssociate (Working agre adult mental health only)	75%			79.9%			75.8%			73.8%				
KPI_32	Non CPA	Statement of Care - The Trust is to demonstrate 70% of Older People not on CPA have a statement of care. Excludes Addictions, Brain Injuries and LD	70%			83.9%			82.2%			82.8%				
KPI_34	Physical Assault	Recorded incidents of physical assault on inpatients							5%							
KPI_36	Brain Injuries	Assessments taking place within 4 weeks of referral	85%			100.0%			100.0%			100.0%				
KPI_37	Dementia	Dementia diagnosis - Number of patients in organic PbR Clusters	TBM			709			709			586				
KPI_38		Memory Service - Individuals attending memory service	TBM			192			192			442				
KPI_45	PbR Reporting	Cluster caseloads (% clustered) in scope by cluster by CCG	Q1-50% Q2-75% Q3-85% Q4-90%			94.7%			93.3%			95.0%				
KPI_46		Adherence to cluster reviews periods in scope by cluster by CCG	Q1-25% Q2-50% Q3-75% Q4-80%			69.0%			73.2%			73.8%				
KPI_47	Communication - CQUIN 2012/13 (Inpatients)	Estimated Date of Discharge Discussed.	Q1-50% Q2-70% Q3-80% Q4-95%			88.6%			94.9%			99.0%				

Cheshire and Merseyside
Commissioning Support Unit

Mersey Care NHS Trust
NHS Standard Contract
Quality Requirements
Month 10 2013/14

Exception Report

Key:	
The following items have been included next to each measure to identify if the issue being reported is a on-going issue or a new issue.	
On-going Issue	On-going issues from previous month.
New Issue	New issue reported in month.

Key Performance Section

1. KPI_01 Serious Untoward Incidents – On-going Issue

The provider reported 8 incidents in January 2014 effecting Liverpool CCG, South Sefton CCG and Southport and Formby CCG patients. The trust has reported 62 incidents year to date.

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	YTD
NHS Liverpool CCG											
Accident Whilst in Hospital							1				1
Admission of under 18s to adult mental health ward										1	1
Allegation Against HC Professional								1			1
Assault by Outpatient (in receipt)					1	1					2
Attempted Suicide by Inpatient (in receipt)								1			1
Confidential Information Leak					1						1
Other					1						1
Safeguarding Vulnerable Adult			2							1	3
Safeguarding Vulnerable Child					1						1
Serious Incident by Inpatient (in receipt)						1					1
Serious Incident by Outpatient (in receipt)						1					1
Serious Incident by Outpatient (not in receipt)			1								1
Slips/Trips/Falls					1						1
Suicide by Outpatient (in receipt)		2					1			1	4
Suspected suicide							2	1	1		4
Unexpected Death of inpatient										1	1
Unexpected Death of Community Patient (in receipt)				1			1	2		1	5
NHS South Sefton CCG											
Attempted Suicide by Inpatient (in receipt)							1				1
Suspected suicide										1	1
Unexpected Death of Community Patient (in receipt)										1	1
NHS Southport and Formby CCG											
Homicide by Outpatient (not in receipt)										1	1
CCG field left blank on STEIS											
Abscond		1									1
Admission of under 18s to adult mental health ward	1			1			1				3
Attempted Suicide by Outpatient (in receipt)	1										1
Confidential Information Leak	1	1									2
Homicide by Outpatient (not in receipt)		1	1								2
Mental Health Act - Class B incident						1					1
Safeguarding Vulnerable Adult		1									1
Suicide		1									1
Suspected suicide	1	2	5	3							11
Unexpected Death of Inpatient (in receipt)	1										1
Merseyside											
Admission of under 18s to adult mental health ward									1		1
Confidential Information Leak									2		2
Unexpected Death of Community Patient (in receipt)									1		1
Grand Total	**5**	**9**	**9**	**5**	**5**	**4**	**7**	**5**	**5**	**8**	**62**

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

2. KPI_05 Flu Vaccinations

An uptake rate for seasonal flu vaccine amongst prioritised front line Health Care Workers – Overall for 2013/14 the trust achieved 42.7% compared to a plan of 70%.

Provider Comments: Vaccinators have been around the trust vaccinating their own working area as well as occupational health staff running clinics additional clinics. These clinics have ran at night in order to capture night workers at secure units, and total over 45 in number. Despite the large resource and opportunity for vaccination staff are reluctant to partake.

3. **KPI_14 Out Patient DNA rates – On-going Issue**

18.2% (936/5151) of patients DNA'd an outpatient appointment in Jan 14, slight reduction in performance compared to previous month. CCG level data provides a breakdown of CCG patients reporting higher rates of DNAs compared to 15% plan

- South Sefton CCG – 20.1% 204 patients DNA'd

Provider Comments: The DNA rate across the trust remains at a static level. The Liverpool Access team has been relocated to Broadoak. The Access team screen referrals and occasionally see patients before an appointment with CMHTs. Appointment reminder letters are sent to all patients and a text messaging system is being rolled out across the patch. This is currently in place at Windsor House.

North Liverpool teams are now supported by the Patient Assessment Centre (PAC) which is based at Aintree Hospital. This has been set up to screen referrals and send reminder letters to patients, and has already made an impact. The service is being rolled out to Sefton and Kirkby teams in phases.

4. **KPI_17 Psychotherapy – On-going Issue**

91.3% of assessments took place within 6 weeks of referral; of the 23 patients referred 21 patients received an assessment within 6 weeks.

48%of patients referred to psychotherapy service received treatment within 18 weeks compared to a plan of 95%. 360 patients waited over 18 weeks for treatment in Jan 14.

- South Sefton CCG – 13 patients waited more than 18 weeks

Provider Comments: The demand for psychotherapy interventions is greater than the team can meet with current resources. A business case has been submitted to Liverpool CCG, and if successful, will address the short fall and enable the 18 week to treatment target to be met. Commissioners are aware of the pressures on the service, and Liverpool CCG will be reviewing counselling and psychological therapies during 2014/15

The same pressures apply to other CCGs and are likely to continue unless additional resources can be put into the service.

5. **KPI_39 Length of Stay – New Issue**

The average spell duration for non-same day mental health discharges in January 2014 was 53.6 days compared to a plan of 40 days.

CMCSU BI Comments: Awaiting submission of provider comments relating to underperformance.

Quarterly Measures

All measures reported as red/amber at Quarter 3 13/14 can be found within Month 9 Quality and Performance report.

Liverpool Community Health - South Sefton CCG Contract

Ref	Area	Indicator	Plan	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend
Intermediate care - Ward 35	Infection Control	MRSA total cases reported in month *Bed based services only	0	0	0	0	0	0	0	0	0	0	0			
		Cdiff total cases reported in month *Bed based services only	0	0	0	0	0	0	0	0	0	0	0			
		MRSA Screening for all relevant admissions into intermediate care	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%	100.0%			
		Assessment of patients on admission to intermediate care bed for C diff risk	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
		Isolation of intermediate care patients with known or suspected C Diff within 4 hours	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
	Discharge Summaries	Discharge Summaries to be received by the patients GP within 24 hours for all patients admitted and discharged from a community provider setting.	95%	100.0%	100.0%	100.0%	75.7%	84.6%	58.3%	66.7%	63.0%	95.7%	90.0%			
		Patients to have MDT review within 4 working days of admission into community provider settings	90%	100.0%	100.0%	100.0%	67.8%	76.9%	36.4%	68.2%	85.2%	91.3%	86.2%			
		Patients to receive a copy of their Discharge Summary on day of discharge from a community provider setting.	95%	100.0%	100.0%	100.0%	27.0%	92.3%	100.0%	100.0%	85.2%	95.5%	100.0%			
	Falls and Keeping Norished	Percentage FRAT assessements completed	98%	100.0%	100.0%	100.0%	88.5%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%			
		Percentage Falls Care Plans in place for at risk fallers	98%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%	95.2%	95.2%	94.4%	80.0%			
		Percentage MUST assessements completed	95%	100.0%	100.0%	100.0%	80.8%	100.0%	100.0%	100.0%	93.1%	100.0%	100.0%			
		Percentage care plans in place for patients with MUST >=2	98%	66.7%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	33.3%	100.0%			
KPI_28	TB Nurses	Appropriate patients with TB receive assessment and a care/treatment plan within 2 working days from point of referral	95%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	98.9%	100.0%			
TCS_20	Delayed Transfers of Care	The number of bed days lost due to patients whose discharge or transfer from community hospital is delayed, as a percentage of the total bed days available	5%	10%	13.70%	8.40%	6.3%	3.5%	11.60%	5.3%	1.3%	8.8%	7.6%			
TCS_33	Rate of cancelled appointments	The percentage of cancellations by provider services of all specialties contacts in a contracted month, in a clinic setting.	2%	1.71%	4.49%	1.88%	2.50%	2.10%	2.30%	1.50%	2.2%	2.7%	2.4%			
TCS_34	Rate of 'did not attends'	The percentage of appointments that were 'did not attends' (DNAs) in all specialties contacts in a contracted month, in a clinic setting.	5%	6.90%	7.51%	7.62%	6.93%	7.40%	7.06%	7.37%	7.70%	7.96%	7.0%			
TCS_35a	Home Equipment - Priority 1	The percentage of completed priority 1 referrals for home equipment within 2 working days.	85%	76.3%	88.25%	98.87%	91.36%	80.90%	81.64%	70.0%	77.3%	74.8%				
TCS_35b	Home Equipment - Priority 2	The percentage of completed priority 2 referrals for home equipment within 7 working days.	85%	91.4%	100.0%	97.7%	92.7%	96.1%	96.1%	90.2%	90.2%	95.8%				

Cheshire and Merseyside
Commissioning Support Unit

Liverpool Community Health
NHS South Sefton CCG
NHS Standard Contract Report
Month 10 2013/14

Exception Report

Key:	
The following items have been included next to each measure to identify if the issue being reported is a on-going issue or a new issue.	
On-going Issue	On-going issues from previous month.
New Issue	New issue reported in month.

Key Performance Section

1. **KPI_01 Serious Untoward Incidents**
   Liverpool CCG to provide an update on Liverpool Community Health SUIs reported in Month 11.

2. **Discharge Summaries – On-going Issue**
   Discharge Summaries to be received by the patients GP within 24 hours for all patients admitted and discharged from a community provider setting – 90% reported in January 2014 compared to a plan of 95%, drop in performance compared to previous month.

   Patients to have MDT review within 4 working days of admission into community provider settings – 86.2% reported in January 2014 compared to a plan of 95%, drop in performance compared to previous month.

   Provider Comments: Targeted work continues including reviewing audit collection process including agreement and documentation of exception criteria. Launch of new documentation pack to be launched which is expected to ensure improved compliance with these KPIs

3. **Falls**
   Percentage Falls Care Plans in place for at risk fallers – 80% of patients at risk of falls had a care plan in place compared to a plan of 98%, a further drop in performance compared to previous month.

   Provider Comments: Reviewing audit collection process including agreement and documentation of exception criteria. Launch of new documentation pack to be launched which is expected to ensure improved compliance with these KPIs, working with staff to ensure screenings are completed.

   During January 2014, 100% of patients were screened with FRAT however there were 4 patients who did not have a care plan in situ. These cases have been reviewed by service manager to ensure lessons are learned.

4. **Delayed Discharges**
   The number of bed days lost due to patients whose discharge or transfer from community hospital is delayed, as a percentage of the total bed days available – 7.6% reported in January 2014 compared to a plan of 5%, slight improvement in performance compared to previous month.

   Provider Comments: Following full review of process, delays have improved and service expect to achieve monthly target. Daily MDT board rounds in place and those patients delayed through choice are escalated to Divisional Performance Meeting.

5. **DNAs and Cancelled Appointments**
   The percentage of appointments that were 'did not attends' (DNAs) in all specialties contacts in a contracted month, in a clinic setting - 7% reported in January 2013 compared to a plan of <5%, slight improvement in performance compared to previous month.

   See comments included below.

6. **Cancelled appointments**
   The percentage of cancellations by provider services of all specialties contacts in a contracted month, in a clinic setting – 2.4% reported in January 2014 compared to a plan of <2%, similar performance compared to previous month.

   Provider Comments: DNA/Cancellation steering group has been set up, policy has been developed and is currently out for consultation. Specific action plans have been developed for areas with high DNA rates

including the use of text messaging appointment reminders and opt in processes. Also, working with Trainee Public Health Consultant and Analyst to identify areas and characteristics of specific populations with high DNA rates.

7. **Home Equipment - Priority 1**
   74.8% of priority 1 referrals received home equipment within 2 working days in January 2014, slight drop in performance compared to previous month.

   Provider Comments: Significant and sustained increase in demand continues to impact on performance.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2014

Agenda Item: 14/42	**Author of the Paper:**
Report date: 11 March 2014	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 11

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 11, and outlines the key risks facing the CCG.

Recommendation

The Governing Body is asked to receive the finance update.

	x
Receive	x
Approve	
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
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
March 2014

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 11. At the end of February the CCG is £5.493m (Month 10 £3.584m) over-spent prior to the application of reserves.

The CCG has sufficient reserves, and remains on target to achieve the planned £2.300m surplus at the end of the year. However, there are risks that require monitoring and managing. These are outlined in section 5 of this report.

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 11 and outlines the financial risks facing the CCG.

3. Resource Allocation

3.1 Resource allocation

The Resource Allocation has reduced to £226.151m following adjustments in Month 11 for the following agreed transfers from the CCG to NHS England:-

- Aintree Hospital NHS Foundation Trust - £0.238m for Diabetic Retinopathy, where the CCG incorrectly retained this budget in the baseline
- Primary Care - £0.318m for services where the CCG incorrectly retained this budget in the baseline.
- Royal Liverpool University Hospital (RLUH) - £0.102m in respect of specialised services provided by RLUH

In addition the CCG has received additional allocations of £30k to fund the Personal Health Budget rollout and to support planning.

4. Our Position to Date

4.1 Month 11 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 28 February 2014

Budget Area	Annual & Year to date				End of Year	
	Annual Budget	YTD Budget	YTD Actual	YTD Variance	Expenditure Outturn	FOT Variance
	£'000	£'000	£'000	£'000	£'000	£'000
NHS Commissioned Services	160,497	147,146	150,560	3,414	164,291	3,793
Corporate & Support Services	6,836	6,396	5,918	(478)	6,308	(528)
Independent Sector	1,902	1,743	2,409	666	2,664	762
Medicines Management (inc Prescribing)	28,841	26,438	26,515	77	28,956	115
Primary Care	1,488	1,334	1,671	336	1,881	393
Commissioning - Non NHS	16,018	14,731	16,208	1,477	17,781	1,763
SUBTOTAL PRIOR TO RESERVES	**215,582**	**197,789**	**203,281**	**5,493**	**221,881**	**6,299**
Total Reserves	8,269	5,493	0	(5,493)	1,970	(6,299)
GRAND TOTAL EXPENDITURE	**223,851**	**203,281**	**203,281**	**0**	**223,851**	**0**
RRL Allocation	(226,151)	(205,390)	(205,390)	0	(226,151)	0
(SURPLUS)/DEFICIT	**(2,300)**	**(2,108)**	**(2,108)**	**0**	**(2,300)**	**0**

Please note, allocations and underspends are shown in brackets.

Overview

The year to date financial position before the application of reserves is an overspend of £5.493m (Month 10 £3.584m), an increase of £1.909m from the previous month.

The full year outturn forecast is £6.299m, an increase of £1.371m on the forecast at Month 10 (4.928m).

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 February, the CCG has based its reported position on information received from Acute Trusts covering activity to the end of January.

This budget is showing a year-to-date position of £3.414m overspend, an increase on the Month 10 position (£3.204m). The main cause of the increase in this area is the transfer of £0.102m to the Royal Liverpool hospital noted in section 3.1.

The main contributor to the underlying overspend on Acute Commissioning is performance at Aintree University Hospital NHS FT (AUH). At month 11, expenditure with AUH is £2.464m higher than planned. As in previous months the main area of overspend continues to be day cases (£0.992m), elective activity (£0.700m) and High Cost Drugs (£0.327m). The forecast assumes that the over spend continues at the current rate.

Unplanned care continues to be under the contracted levels agreed at the beginning of the year. Emergency admissions are subject to a block arrangement, but are showing under-spends of £1.209m. Accident and Emergency attendances are also lower than contracted levels (£0.186m).

Analysis into the causes of the overspends in planned care at Aintree have been presented in previous reports. The 2013/14 experience will inform the current contract negotiations with Aintree for 2014/15.

There have been no other significant movements in month within Acute Commissioning.

The forecast outturn variance for NHS Commissioned Services as a whole for 2013/14 is £3.793m and remains in line with the forecast for this area presented in Month 10's position (£3.796m).

Corporate and Support Services

The CCG is currently operating within its running cost target, included within this budget. The year to date underspend is £0.478m with a forecasted year end position of £0.528m underspend.

The overall underspent position on this budget arises due to vacancies (many of which have been filled part way through the year) and the reduction in Estates charges compared to plan. As noted in the Month 10 report, NHS Property Services Ltd have notified that there will not be any estates charges allocated to the CCG in 2013/14.

Independent Sector

The Independent Sector budget is over spent by £0.666m, year to date. The forecast over-spend for the full year is £0.762m. This is an increase of £0.100m in the position reported in month 10 and is due to increased Orthopaedic activity at Spire Liverpool hospital.

Primary Care

The Primary Care budget is showing an overspend position of £0.336m year to date and £0.393m forecast outturn position. The budget was previously in balance and the change reflects the 2013/14 costs of drugs administered in GP practices (eg. flu vaccines).

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.

Medicines Management (Including Prescribing)

The Medicines Management budget consists of High Cost Drugs, Oxygen and Prescribing. The overall position is £0.077m overspend in the year to date and £0.115m forecast overspend for the full year position.

The major component of the Medicines Management budget is Prescribing. This area is showing a year-to-date overspend of £0.389m and full year forecast overspend position of

£0.425m. This is a deterioration of £0.296m on the forecast position reported at Month 10 and is due to a change in the forecast by the Prescription Pricing Authority, used by the CCG to forecast expenditure in this area. This forecast does tend to fluctuate from month to month, and due to the size of the budget, a small variation in the forecast can have a significant financial impact. This is recognised within the risks to be managed in balancing the overall financial position.

The GP prescribing budget will be amended in month 12 to take account of changes in-year that are not factored into the current budget. These include additional costs of dementia drugs prescribed under a shared care protocol, and amendments in the overall budget as a result of the partial use of the fair shares formula.

There continues to be a significant underspend on the High Cost Drugs budget (forecast £0.319m).

Commissioning - Non-NHS

Commissioning from Non NHS organisations is overspent by £1.477m (month 10 £0.848m). The forecast outturn position is an over-spend of £1.763m (Month 10 £1.415m).

The overspend relates mainly to Continuing Healthcare and Mental Health budgets. Through the year this has been reported as a financial risk area due to incomplete package information available from CSU, which manages the administration of the care packages for the CCG. The reported position has consistently indicated a significant increase in costs from the prior year. However, the explanation for this movement cannot be confirmed until the underlying package data is completely validated by CSU and robust activity information provided to the CCG.

As we approach the end of the financial year the provision for potential package costs has been increased to ensure that the CCG's financial risk in this area is fully covered.

As a consequence there has been an increase of £0.348m in the forecast outturn position reported at Month10.

4.2 Treasury and Legacy issues

As reported previously, NHS England's latest guidance is that PCT and SHA Legacy balances will be managed centrally by NHS England.

Given this revised direction, the balances formally transferable to the CCG will be significantly reduced and now consists of a small amount of IT and medical equipment, reported under Non-Current Assets.

The CCG's current forecast assumes that there will be no impact on the CCG's 2013/14 financial position in relation to the treatment of legacy provisions.

5. Evaluation of Risks and Opportunities

The majority of the risks and uncertainties reported in earlier months have now been clarified.

As outlined in section 4.1, there remains continued uncertainty in the accuracy of the reporting for Continuing Healthcare costs. The forecast has been increased in Month 11 to ensure that the CCG is adequately covered for this uncertainty.

The CCG has sufficient reserves in place to manage its risks, and remains on course to achieve its planned surplus.

6. 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

Appendices

- Appendix 1 – Financial position to Month 11

01T NHS South Sefton Clinical Commissioning Group Month 11 Financial Position							
Cost centre Number	Cost Centre Description	Annual Budget	Budget To Date	Actual To Date	YTD Variance	End of Year	
						Expenditure Outturn	FOT Variance
		£000	£000	£000	£000	£000	£000
COMMISSIONING - NON NHS							
598501	Mental Health Contracts	800	733	714	(19)	777	(23)
598506	Child and Adolescent Mental Health	1,202	1,102	1,117	15	1,210	8
598511	Dementia	118	108	108	0	118	0
598521	Learning Difficulties	1,399	1,283	1,099	(184)	1,198	(201)
598531	Mental Health Services – Adults	0	(0)	0	0	0	0
598541	Mental Health Services - Collaborative Commissioning	0	(0)	0	0	0	0
598551	Mental Health Services - Older People	0	(0)	0	0	0	0
598596	Collaborative Commissioning	521	478	478	0	521	0
598661	Out of Hours	659	549	559	10	671	12
598682	CHC Adult Fully Funded	4,851	4,446	5,953	1,507	6,535	1,684
598683	CHC Adult Fully Funded Personal Health Board	0	0	0	0	0	0
598684	CHC ADULT JOINT FUNDED	0	0	0	0	0	0
598691	Funded Nursing Care	2,021	1,853	1,960	107	2,260	239
598711	Community Services	1,747	1,707	1,628	(79)	1,661	(86)
598721	Hospices	1,223	1,121	1,142	21	1,245	22
598726	Intermediate Care	231	210	266	55	291	60
598796	Reablement	1,245	1,141	1,185	44	1,293	48
Sub-Total		**16,018**	**14,731**	**16,208**	**1,477**	**17,781**	**1,763**
CORPORATE & SUPPORT SERVICES							
600251	Administration and Business Support (Running Cost)	103	94	111	16	121	18
600271	CEO/Board Office (Running Cost)	632	579	591	12	645	13
600276	Chairs and Non Execs (Running Cost)	125	114	130	16	142	17
600286	Clinical Governance (Running Cost)	29	27	27	0	29	0
600296	Commissioning (Running Cost)	1,666	1,527	1,427	(100)	1,556	(110)
600316	Corporate costs	24	22	20	(3)	24	0
600346	Estates & Facilities	106	97	94	(3)	108	2
600351	Finance (Running Cost)	921	844	564	(280)	601	(320)
600391	Medicines Management (Running Cost)	74	68	63	(6)	68	(6)
	Sub-Total Running Costs	**3,680**	**3,373**	**3,025**	**(348)**	**3,294**	**(386)**
598646	Commissioning Schemes (Programme Cost)	831	762	665	(96)	726	(105)
598656	Medicines Management (Programme Cost)	489	449	415	(34)	452	(37)
598776	Non Recurrent Programmes (NPfIT)	1,560	1,560	1,560	0	1,560	
598676	Primary Care IT	276	253	253	(0)	276	0
600371	IM&T	0	0	(0)	(0)	0	
	Sub-Total Programme Costs	**3,156**	**3,023**	**2,893**	**(130)**	**3,014**	**(142)**
Sub-Total		**6,836**	**6,396**	**5,918**	**(478)**	**6,308**	**(528)**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS							
598571	Acute Commissioning	107,165	98,160	101,521	3,361	110,831	3,666
598576	Acute Childrens Services	8,388	7,618	7,353	(265)	8,099	(289)
598586	Ambulance Services	5,451	4,997	5,021	24	5,478	27
598616	NCAs/OATs	1,235	1,132	1,298	166	1,477	242
598631	Winter Pressures	1,520	1,520	1,520	0	1,520	0
598756	Commissioning - Non Acute	36,727	33,708	33,844	136	36,875	147
598786	Patient Transport	12	11	2	(8)	12	0
Sub-Total		**160,497**	**147,146**	**150,560**	**3,414**	**164,291**	**3,793**
INDEPENDENT SECTOR							
598591	Clinical Assessment and Treatment Centres	1,902	1,743	2,409	666	2,664	762
Sub-Total		**1,902**	**1,743**	**2,409**	**666**	**2,664**	**762**
PRIMARY CARE							
598651	Local Enhanced Services and GP Framework	893	777	1,113	335	1,286	393
598791	Programme Projects	595	557	558	1	595	
Sub-Total		**1,488**	**1,334**	**1,671**	**336**	**1,881**	**393**
PRESCRIBING							
598606	High Cost Drugs	935	857	537	(321)	616	(319)
598666	Oxygen	421	386	394	8	430	9
598671	Prescribing	27,485	25,195	25,584	389	27,910	425
Sub-Total		**28,841**	**26,438**	**26,515**	**77**	**28,956**	**115**
Sub-Total Operating Budgets pre Reserves		**215,582**	**197,789**	**203,281**	**5,493**	**221,881**	**6,299**
RESERVES							
598761	Commissioning Reserves	8,269	5,493	0	(5,493)	1,970	(6,299)
Sub-Total		**8,269**	**5,493**	**0**	**(5,493)**	**1,970**	**(6,299)**
Grand Total I & E		**223,851**	**203,281**	**203,281**	**0**	**223,851**	**0**
	RRL Allocation	(226,151)	(205,390)	(205,390)	0	(226,151)	0
	(SURPLUS)/DEFICIT	(2,300)	(2,108)	(2,108)	0	(2,300)	0

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2014

Agenda Item: 14/43	**Author of the Paper:**
Report date: 17 March 2014	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 December 2013 (month 9).

Recommendation

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

	x
Receive	x
Approve	
Ratify	

14/43

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
March 2014

1. Executive Summary

The South Sefton CCG position for month 9 (December 2013) is a forecast overspend of £157,133 or 0.60% 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 1.20% for 2013/14 to month 9 against the same period for 2012/13

The cost of prescribing has increased by 0.01% for 2013/14 to month 9 against the same period for 2012/13

4. Content

Scriptswitch has been installed in 18 practices. The profile continues to be built to optimise quality, cost savings and safety.

The Department of Health Finance and NHS directorate have revised the forecast profile in month 8 which has contributed to the change in FOT.

5. Recommendations

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

Brendan Prescott
17 March 2014

Appendices

South Sefton CCG forecast out turn at Month 9

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**	**£26,143,236**	**£157,133**	**0.60%**
Bootle		**£7,299,563**	**£7,323,605**	**£24,042**	**0.33%**
N84002	Aintree Road Medical Centre	£490,082	£484,167	-£5,915	-1.21%
N84015	Bootle Village Surgery	£1,253,740	£1,321,959	£68,220	5.44%
N84016	Moore Street Medical Centre	£1,273,981	£1,251,389	-£22,592	-1.77%
N84019	North Park Health Centre	£1,325,519	£1,234,379	-£91,140	-6.88%
N84028	The Strand Medical Centre	£1,344,059	£1,431,806	£87,747	6.53%
N84034	Park Street Surgery	£1,012,506	£1,012,320	-£186	-0.02%
N84038	Concept House Surgery	£599,676	£587,584	-£12,092	-2.02%
Crosby & Waterloo		**£7,242,202**	**£7,278,805**	**£36,603**	**0.51%**
N84001	42 Kingsway	£984,073	£1,008,151	£24,078	2.45%
N84007	Liverpool Rd Medical Practice	£984,576	£984,879	£303	0.03%
N84009	Azalea Surgery	£463,929	£454,984	-£8,945	-1.93%
N84011	Eastview Surgery	£1,088,410	£1,134,017	£45,607	4.19%
N84020	Blundellsands Surgery	£1,361,194	£1,355,085	-£6,109	-0.45%
N84026	Crosby - Ssp Health Limited	£413,749	£412,977	-£772	-0.19%
N84041	Kingsway Surgery	£716,884	£711,714	-£5,170	-0.72%
N84621	Thornton - Ssp Health Limited	£455,503	£476,539	£21,036	4.62%
N84626	Hightown - Ssp Health Limited	£376,665	£369,285	-£7,380	-1.96%
N84627	Crossways Ssp Health Ltd	£397,219	£371,172	-£26,047	-6.56%
Maghull		**£4,629,804**	**£4,609,867**	**-£19,937**	**-0.43%**
N84003	High Pastures Surgery	£1,752,904	£1,748,707	-£4,197	-0.24%
N84010	Maghull Health Centre (dr Sapre)	£388,033	£347,943	-£40,090	-10.33%
N84025	Westway Medical Centre	£1,193,833	£1,202,252	£8,419	0.71%
N84622	Maghull Health Centre (dr Thomas)	£373,502	£391,782	£18,280	4.89%
N84624	Maghull Health Centre	£291,724	£272,251	-£19,473	-6.68%
Y00446	Parkhaven Ssp Health Ltd	£629,808	£646,932	£17,124	2.72%
Seaforth & Litherland		**£6,814,534**	**£6,930,959**	**£116,425**	**1.71%**
N84004	Glovers Lane Surgery	£1,246,916	£1,277,891	£30,975	2.48%
N84023	Bridge Road Medical Centre	£1,364,244	£1,388,192	£23,948	1.76%
N84027	Orrell Park Medical Centre	£483,979	£480,824	-£3,155	-0.65%
N84029	Ford Medical Practice	£993,022	£990,671	-£2,351	-0.24%
N84035	15 Sefton Road	£824,591	£797,482	-£27,109	-3.29%
N84043	Seaforth Ssp Health Ltd	£249,198	£298,555	£49,357	19.81%
N84605	Litherland - Ssp Health Limited	£521,501	£495,633	-£25,868	-4.96%
N84615	Rawson Road Medical Centre	£417,669	£431,339	£13,670	3.27%
N84616	Sefton Road Surgery	£337,084	£358,921	£21,837	6.48%
N84630	Netherton - Ssp Health Limited	£318,330	£330,505	£12,175	3.82%
Y02514	Litherland Primary Care Walk-in Service	£58,000	£80,944	£22,944	39.56%

Brendan Prescott,
March 2014

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2014

Agenda Item: 14/44	**Author of the Paper:** Karl McCluskey Head of Strategic Planning and Performance Karl.Mccluskey@southseftonccg.nhs.uk Tel: 0151 247 7006
Report date: March 2014	

Title: The CCG 5 Year Strategic Plan and 2 Year Operational Plan – Briefing on Progress

Summary/Key Issues:

This paper outlines the continued progress on the development of the two year operational plan and five year strategic plan that has been made since last up-dating the Governing Body in January.

The key outcome ambitions are described and set out for agreement to enable final submission of the two year operational plan on 4th April 2014. The CCG has identified some challenges in relation to the outcome ambitions and their application at CCG level. This has been raised locally, regionally and nationally. The CCG continues to work with Public Health England and NHS England to resolve these.

Following The Governing Body development session in February, the first draft plan on a page is outlined for approval. This will require further refinement between now and June 2014.

The draft Better Care Fund has been developed jointly with Sefton Council and it continues to remain aligned to the CCG Strategic Plan.

Recommendation:

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

Receive	X
Approve	
Ratify	

14/44

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			Engagement schedule contained within the paper. Further detail schedule in place with providers, Voluntary Community and Faith Sector and Healthwatch.
Clinical Engagement	X			Strategic and operational plans are being developed in conjunction with clinical leads and members, through the Wider Constituent Group.
Equality Impact Assessment	X			To ensure comprehensive attention equality, the CCG plan is being shared with the Sefton Equalities Partnership at their engagement event on the 6th March 2014.
Legal Advice Sought		X		
Resource Implications Considered	X			The operational and strategic plan relates to contacted and commissioned services, as such resource implications are being considered as part of this process.
Locality Engagement	X			Plans being developed with locality leads with the support of clinical leads. Regular briefing in place for locality meetings.
Presented to other Committees		X		Following consideration at this governing body, proposed to share this briefing with each locality, EPEG, Voluntary Community and Faith Sector, Healthwatch and providers.

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
March 2014

1. Introduction

1.1 This paper builds on the progress report that was considered by the Governing Body in January 2014. It further describes the progress made in developing the five year Strategic Plan for the CCG. Specifically it outlines the detail contained within the two year operational plan that was submitted, in draft to NHS England on 14th February 2014. It confirms the final version and outcome ambitions that will be submitted on 4th April 2014, in the context of the two year operational plan.

1.2 In addition, an overview of first draft of the five year strategic plan is set out, in line with the requirements. This draft has been built following input from the Governing Body at its development session in February 2014. This draft will require further iteration and development with the Governing Body and other stakeholders, between now and June 2014, in time for final submission to NHS England on 20th June 2014.

2. Background – Incorporating the National Agenda into the CCG 5 year Strategic Plan and 2 year operation plan

2.1 The detailed background underpinning the two year operational planning and five year strategic plan for the CCG was set out in the February paper considered by the Governing Body.

2.2 Following submission of the draft two year strategic plan to NHS England, further guidance has been issued to assist CCGs in their planning efforts. This guidance has been tested with NHS England at an area team level and indeed, continues to be reviewed formally with the area team on a fortnightly basis through established planning sessions.

2.3 Nationally, the planning process has been challenged on a number of levels, not least in ensuring alignment and completion of returns from providers. This continues to be a challenge nationally.

2.4 In addition, a number of the nationally prescribed outcome ambitions measure have been found to be problematic in their application at CCG level. In other instances the availability of trend data over a significant period of time has been hindered, with some data only being available at CCG level for one year, given recent NHS reorganisation.

2.5 The CCG continues to plan and conform to all the national planning requirements and is working closely with its CCG partners and stakeholders accordingly.

3. The CCG Planning Framework

3.1 The CCG Planning Framework, described in the February paper received by the Governing Body has now been well established across the CCG, with engagement events held with practices, wider group members and the public. This framework is set out in the diagram below for reference.

Diagram 1.0 The CCG Planning Framework

3.2 Nationally, additional planning tools have become available to support CCGs. In particular, the CCG has referred to the "Anytown Model" to support its work. This model has provided a range of researched case studies, identifying a range of potential High Impact Interventions and Early Adopter Interventions that could help the CCG in its planning approach.

The High Impact Interventions are listed as follows and being tested against each relevant planning programme to explore any potential application.

High Impact Interventions

1. Early diagnosis
2. Reducing variability within primary care by optimising medicines use
3. Self-management: patient-carer communities
4. Telehealth / telecare
5. Case management and coordinated care
6. Mental Health – Rapid Assessment Interface and Discharge (RAID)
7. Dementia Pathway
8. Palliative care.

Early Adopter Interventions

1. Cancer screening programmes
2. GP tele-consultation
3. Medicines Optimisation
   a. Norfolk b. PINCER
4. Safe and appropriate use of medicines
5. Acute visiting service
6. Reducing urgent care demand
7. 24-hour asthma services for children and young people
8. Service user network

9. Reducing elective Caesarean sections
10. Acute stroke services
11. Integration of health and social care for older people
12. Electronic Palliative Care Coordination Systems (EPaCCS)

4. Unit of Planning

4.1 The Unit of Planning remains consistent with the Borough of Sefton. Connectivity and sensitivity remain in relation to West Lancashire CCG in the North of the Borough and Liverpool CCG in the South.

4.2 The 2 year operational and five year strategic plan for the CCG remain complementary to the plans of the neighbouring CCGs.

5. CCG Strategic Plan

5.1 In line with the national planning timetable, the CCG has been required to develop its first draft of its five year strategic plan for submission to NHSE on 4th April 2004.

The plan is required to be summary in format and include the following elements;

1) A long term strategic vision.
2) An assessment of the current state and current opportunities facing the system.
3) A clear set of objectives, that include the locally set outcome ambition metrics.
4) A series of interventions that when implemented, move the health system from the current position to achieving the objectives and implementing the vision.

5.2 It should be noted that in the case of 4 above, these metrics are set nationally and that there is no flexibility for the CCG to choose alternative metrics as part of the national return. As such these metrics form part of the two year operational plan as well as the five year strategic plan.

5.3 "Plan on a page" relates to the Sefton Borough and includes both CCG's, so the figures contained therein related to the combined ambitions for both Sefton CCG and Southport & Formby CCG, see Appendix 1.

6. The Major CCG Mechanisms for Delivery

6.1 Against the planning footprint of the borough, both Sefton CCGs have identified the major delivery mechanisms to support realisation of the Strategic Plan. These are the Virtual Ward for South Sefton CCG and Care Closer to Home for Southport and Formby CCG. Both of these modelled approaches have enhanced community support at their heart to enable patients with Long Term Conditions to be optimally supported from a health and social care perspective, in a non-acute environment.

6.2 It is now important that the CCG reviews the governance and performance arrangements for these respective schemes to ensure that they have the necessary clinical and managerial support and that it is appropriately linked underpinned by the necessary Governance arrangements, linking them to the respective Governing Body.

7. Two Year Operational Plan

7.1 The two year operation plan for the CCG, centres around the development of targets or goals for the six ambition outcomes prescribed by NHSE. As the CCG has analysed and considered its level of ambition, in relation to these outcomes, a number of specific issues have arisen. These issues are reflected in the summary below and indeed reflected to NHSE both locally and nationally. The CCG remains committed to developing a robust two year and five year plan and continues to work with NHSE to this end.

Outcome Ambition 1 – Partial Years of Life Lost

7.2 Each CCG is required to test and review the opportunity for improving the numbers of years of life lost for its population. An initial approach to this has been developed using the NHS Ambitions Atlas to enable the CCG to compare performance against peer CCGs. This approach suggested that Sefton CCG was currently third in terms of performance in its peer group and that an ambition to achieve the best in its peer group across five years would equate to a 19.7% improvement over five years.

7.3 The CCG has tested this data further, reviewing it with Public Health Colleagues in Sefton Council and with NHSE, both at regional and national levels. Current advice is that while this indicator is helpful, it requires a significant population number in order to eliminate significant annual variables. Application of this outcome at a CCG population level is difficult, especially where CCGs are not co-terminus with previous PCT organisations. For illustrative purposes the trend for the CCG is set out below.

	Value				**% change**			
SSCCG	2009	2010	2011	2012	09-10	10-11	11-12	09-12
	2414	2619	2137	2049	8%	-23%	4%	-18%

7.4 While the CCG has described a level of ambition for this outcome, it remains heavily qualified and is subject to further collaborative work with Public Health England. Advice suggests that this ambition will be refined nationally after 4th April 2014 submission. It should be noted that this CCG along with Blackpool CCG are the only CCG's that have raised this issue nationally with PHE and indeed our attention on this has been viewed very positively and considered as real evidence of our engagement on this work.

Outcome Ambition 2 – To Reduce Unplanned Hospital Admission

7.5 The CCG has defined a high level of ambition, to reduce the amount of unplanned hospital admissions and activity by 15% across five years. The trajectory for this is set out in the table below.

	2013/14 (based on month 8 forecast)	2014/ 15	2015/16	2016/17	2017/18	2018/19
South Sefton	-10.5% (-1,865 admissions from 12/13 baseline)	0%	-1.0%	-1.0%	-1.5%	-2.0%
Southport & Formby	-5.8% (-862 admissions from 12/13 baseline)	0.00%	-2.00%	-4.00%	-2.50%	-2.00%

7.6 This requires the CCG to sustain the current evident level of performance in 2013/14 and repeat this in 2014/15. This is deemed to remain challenging, particularly in view of the mild winter experienced this year.

Ambition Outcome 3 – Improving experience of in-patient care

7.7 As part of the Quality Agenda, the annual in-patient survey lends data on the patient experience within our local providers. This is the data source for this ambition. An improvement in performance is considered achievable and desirable, given the emphasis that the CCG places on quality of care and patient experience. The CCG is striving for a 10% improvement as part of its ambition plan.

Ambition Outcome 4 – To improve Patient Experience of Out of Hours Services

7.8 The data informing this ambition is derived from the National GP patient survey. Only one years data is available at CCG level, enabling the robust construction of a CCG level of ambition difficult. An improved performance to realise 5th in peer group equates to an improved position of 2.8% by 2018/19 from current baseline of 6.2%.

Ambition Outcome 5 – Improve the Health Related Quality of Life for people with one or more long term conditions.

7.9 The data underpinning this ambition is also derived from the GP patient survey and as such presents limited trend analysis for planning purposes.

7.10 The CCG has set an improvement in this ambition by 9%. This remains ambitious, given the pressures within primary care, but also is sensitive to the level of historical performance available.

Ambition Outcome 6 – Improve Emergency Ambition Performance

7.11 This ambition is a composite of several other indicators and thus has a degree of complexity to its construct. The key elements include:-

- Ambulatory Care
- Avoidable Admissions
- Asthma, Diabetes and Epilepsy for u19 years
- Lower Respiratory Tract Infections in Children.

7.12 The source data for the above is providers and it should be noted that this has been the subject of changes in coding and coding quality in recent years. This has led to some very fluctuating trends from year to year. Despite this, the CCG has demonstrated some significant improvement, largely assist by the range of Diabetes and Childhood initiatives relating to respiratory. The CCG is aiming to improve this performance by 20% over the duration of its plan.

8. Better Care Fund

8.1 Following on from the briefing provided at the last Governing Body in February, South Sefton CCG and Southport & Formby CCG have worked with Sefton Council to enable the draft Better Care Fund to be submitted on 14th February.

Our Vision for Sefton, as described in our Health and Wellbeing Strategy, is:-

8.2 Our Health and Wellbeing Strategic Objectives are:

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

8.3 **Over the next 5 years,** we will aim to deliver transformed services for the people of Sefton focusing on moving care from hospital to community based resources and supporting people in their own homes. Where care and other support is needed, we will look to make it available *in the right place, at the right time, at the right quality, whilst being cost effective.*

8.4 **In seeking to deliver our 5 year ambition we will focus on:**

- early Intervention and Prevention
- health promotion
- self-care, self-help, self-management, with the longer term aim of reducing reliance on public sector services
- encouraging self-determination and responsibility
- information, advice, signposting and where necessary, redirection to appropriate services
- developing integrated approaches across professional and organisational boundaries e.g. primary and secondary care clinicians working together in the community, assessment, meeting care needs, single gateway, seamless front door
- facilitating a significant shift in culture and behaviours, across professions and organisations, but also in individuals in our community
- innovation and whole system change.

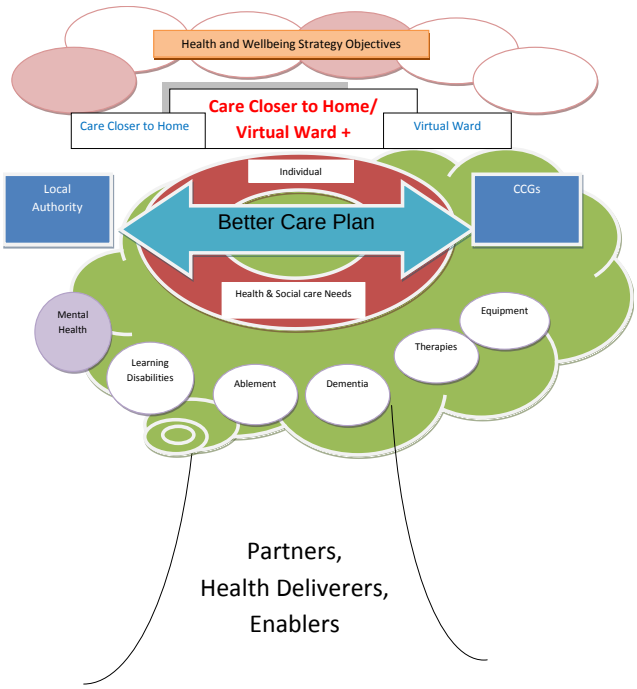
8.5 To achieve this we have committed to the following principles:

- everything we do is to improve outcomes and the experiences of people
- we will engage with the people who use our services as partners, establishing a new and equal relationship with our professional staff in co-designing and continually improving services
- we will provide person centred care that considers an individual's physical and mental health and well-being needs
- we will provide care and services focused around the individual - there is no wrong front door - promoting early intervention and prevention, encouraging people to self-help where possible
- we will ensure the location of services is in, or as close as possible to, people's own homes, with hospital and residential care targeted at those who require that level of care
- we will ensure our workforce is fully engaged and contributes to the development of this vision and the services that are part of it

- we will maximise the opportunities to make an even greater difference to people's lives through working with other sectors e.g. housing, voluntary sector.

8.6 In addition to the above, the BCF has attempted to describe the significant changes to services and patterns of services that are likely to be evident over the next 5-10 years, most notably:-

- an increase in the number of people living independently and receiving care at home when needed.
- families, charities, volunteers and neighbours will increasingly be the providers of services playing a pivotal role in the prevention agenda and promoting dementia friendly communities.
- decreases in unnecessary admission and readmissions to hospital.
- social care focused on enabling people to live independently, rather than on assessing and meeting need: with staff focusing on assessing what people can do for themselves and only meet the needs of the most vulnerable.
- increased use of appropriate home technology, tele-health and telecare
- participation of people in applied research studies, particularly in primary care and related to the acceptability of technology.
- appropriate use of joint Health and Social Care packages.
- young people transitioning seamlessly from Children to Adult Services provision.
- carers supported to continue in their unpaid caring roles.
- a reduction in social isolation.
- effective and appropriate mental health provision.
- end of Life / Palliative Services, where people are treated with dignity and respect.
- enhanced, targeted and focused reablement across community, intermediate and hospital based care.
- 7 day services, where appropriate
- integrated access for all referrals using NHS number as the primary identifier.
- people, partners, providers, the two CCGs and Council working in an integrated way, to reduce the longer term reliance on public sector services.
- people and their families taking primary responsibility for looking after themselves early in order to remain fit and healthy whilst planning how they will personally financially contribute towards any care that may be required.



8.7 Our joint vision, as highlighted in the above figure, has been developed from patient and public participation using a “Fruits” and “Roots” model to deliver better integrated care and improve outcomes.

8.8 The aims are to:-

- **improve the health and wellbeing** of people in our community, with a focus on tackling inequality.
- co-ordinate care around individuals targeted to their specific needs with the ambition of **working towards a single assessment framework** to assess and meet the needs of individuals in their homes and communities, with seamless delivery of health and social care. This means ensuring there is a good quality care plan in place for all those at risk, backed by co-ordinated provision commissioned to deliver on the required support and outcomes envisaged in each and every plan.
- **improve the quality and experience of care**, with the right services available in the right place at the right time and use these experiences to evaluate and improve services.
- **maximise independence** by providing appropriate support at home to those who need it and in the community, and empower all people to self-care and self-manage their own health and wellbeing.
- provide **proactive and common case management**, which avoids unnecessary admissions and readmissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health and self-manage their long term conditions.
- facilitate integrated care through **Primary Care** across the Borough. Our ambition is that community, social care services, specialist mental and physical health services will be organised to work effectively through our model of integrated care, enabling Primary Care to ensure their patients are getting the very best person-centred care.
- collaborate with our **providers** to develop new models of service delivery, driven by clinical and professional staff on the ground.
- adopt national and international best practice and embrace innovation and ideas.

8.9 The key thrust of the joint work with Sefton Council on the Better Care Fund is targeting efficiency in relation to:-

- admissions avoidance
- reduced length of stay
- reduction in delayed discharges.

8.10 The BCF remains aligned with the CCG Strategic Plan and aims to support a reduction in unplanned admissions to hospital by 15%, underpinned with a pooled budget from existing monies of £24m across the borough from 2015/16.

9. Conclusions

9.1 The CCG has progressed the development of its 2year operational plan from its draft submission on 14th February.

9.2 The Board development session in February has enabled refinement and further input into shaping the level of ambition outcomes described in both the 2year and 5year CCG Plan.

9.3 The CCG has been pro-active in testing and validating the outcomes ambitions with significant input from Public Health.

9.4 The CCG has highlight a number of challenges that need to be considered nationally in the use and application of the defined ambitions by NHSE.

9.5 The CCG continues to work with NHSE on developing the CCG Strategic Plan and conforming to the National Requirements.

9.6 The Planning Framework continues to be cemented within the CCG and augmented by the application of the "Anytown" tool to assist in applying a range of identified High Impact Interventions and Early Adopter Interventions to current Plans.

9.7 The CCG has described a combined vision for the future of Health and Health Services it commissions, underpinned by a set of values which are consistent with its partner CCG within the planning footprint.

9.8 The strategic vision and values are in keeping with those set out in the joint Health and Wellbeing Strategy, developed with Sefton Council.

9.9 Care Closer to Home and the Virtual Ward remain central to the delivery of the strategic plan.

9.10 The CCG is reviewing the support for both Care Closer to Home and the Virtual Ward, as well as the underpinning governance arrangements to ensure complete alignments and connectivity with the Strategic Plan.

9.11 The outcome ambitions and their respective targets have been constructed with careful analysis and input from relevant stakeholders.

9.12 The Potential Year of Life indicator and ambition remains to be confirmed by the CCG and the submission scheduled for 4th April will highlight this qualification.

9.13 The CCG will continue to work with Public Health England to develop the Potential Year of Life indicator and ambition with the knowledge and support of NHSE.

9.14 Most significantly the CCG remains committed to a reduction in unplanned activity of 15% over the five years of its strategic plan.

9.15 The Outcome Ambitions which relate to the GP patient survey remain vulnerable to prospective changes, given the limited trend data available.

9.16 The Better Care Fund draft submission was jointly made between Sefton Council and South Sefton CCG and Southport & Formby CCG on 14th February 2014.

9.17 The Better Care Fund remains intrinsically aligned to the CCG Strategic Plan.

10. Recommendations

The Governing Body is asked to receive this report by way of assurance and:-

10.1 to note the detail contained in this paper and in particular the continued progress that the CCG has made in developing it two year operational plan and five year strategic plan.

10.2 to support and agree the outcome ambitions described, enabling them to be finalised as part of the submission on 4th April 2014.

10.3 to Support the first draft of the “Plan on a Page” in line with NHSE requirements, enabling draft submission on 4th April 2014.

10.4 to lend support for further development of the “Plan on a Page” and underlying detail between now and June 2014.

10.5 to receive assurance that the Better Care Fund development has progressed jointly between the CCG and Sefton Council in line with national Requirements.

10.6 to be assured that the Better Care Fund is aligned to the CCG Strategic Plan and that it has the common ambition to reduce unplanned care by 15%.

Karl McCluskey
March 2014

1

The Sefton Health economy is a system comprised of partners from South Sefton CCG and Southport & Formby CCG who have come together with key stakeholders, notably Sefton Council to agree, refine and implement the following vision.

To create a sustainable health community based on health needs, with partners, focused on delivering high quality care services to all((in the community and Hospital Setting) to improve the health and well-being of our population

2

System Objective One

To significantly reduce hospital avoidable deaths by 13%

System Objective Two

To reduce unplanned hospitalisation by 15%

System Objective Three

To improve in-patient experience by 10%

System Objective Four

To improve patient experience of out of hours care by 30%

System Objective Five To improve the health related QOL for people with one or more LTC by 8.5%

System Objective Six To Improve emergency admission performance by 20%

4

Delivered through intervention Care Closer to Home & Virtual Ward

These two programmes focus on delivering enhanced primary and community care with improved access and management of individuals needs with Long Term Conditions.

Delivered through intervention Quality

The Quality programme focuses on delivering high quality care and experience, ensuring no harm is done to patients and addressing areas of any concern promptly and effectively.

Delivered through intervention Primary Care Quality Strategy

Description of the improvement intervention required

Delivered through intervention Virtual Ward & Care Closer to Home, plus Childrens Strategic Programme

These programmes focus on avoidance of hospital admissions for individuals with Ambulatory Care, Long Term Conditions, plus asthma, diabetes and epilepsy for u19's.

5

Overseen through the following governance arrangements

- Shared system leadership with Clinical and Managerial Programme Leads.
- Direct performance and accountability to Governing Body.
- Integrated approach with BCF and Sefton Council through H&WB

3

Measured using the following success criteria

- All organisations within the health economy report a financial balance in18/19
- Delivery of the system objectives
- No provider under enhanced regulatory scrutiny due to performance concerns
- With the expected change in resource profile

6

System values and principles

- Maintain a local focus, working in partnership.
- We will be transparent, open and honest.
- We will be approachable and listen to our public.
- We will enable action and prioritise effort to optimum effect.
- We will act with integrity, act fairly and with respect.
- We will be accountable for what we do.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2014

Agenda Item: 14/46	**Author of the Paper:** Tracy Jeffes Head of Delivery and Integration tracy.jeffes@southseftonccg.nhs.uk Tel: 0151 247 2049
Report date: March 2014	

Title: Clinical Director Roles

Summary/Key Issues:

This paper outlines an approach for strengthening clinical leadership through the development of Clinical Director roles within the CCG. This approach was previously signalled in the Organisational Development strategy approved in November 2013.

Recommendation

The Governing Body is asked to receive the paper and discuss the content in order to shape its further development.

	x
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.
	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
	To sustain engagement of CCG members and public partners and stakeholders.
X	To drive clinical leadership development through Governing Body, locality and wider constituent development.

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

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
March 2014

1. Executive Summary

The further development of clinical leadership is one of the CCG's six strategic objectives and is a key theme within the Organisational Development Plan. This paper outlines an approach for strengthening clinical leadership through the development of Clinical Director roles. It is proposed that these roles will commence in April 2014 and Governing Body members are asked to further shape their development.

2. Introduction and Background

South Sefton CCG has reaped the benefit of strong clinical leadership over recent years, successfully moving the organisation from its shadow form, through authorisation and into a first year of operation as a statutory body. Governing Body members, Locality Leads and Clinical Leads have all contributed to driving this development, ensuring a strong clinical voice at all levels of the organisation and most critically in developing relationships and bringing about change in conjunction with partner organisations and the wider membership. It is the clinical leadership within our organisation that brings the "added value" that previous commissioning organisations did not benefit from.

It is therefore imperative that the CCG continues to strengthen, sustain, broaden and focus the contribution of its clinical leaders. The development of Clinical Director roles is one element of its approach to clinical leadership. The development of clinical leadership at locality level is another key priority and plans are being developed to support this in parallel. It should also be noted that the same clarity of role and opportunity for development for other leaders on the Governing Body (e.g. Practice Manager, Lay, and Secondary Care Doctor) is also equally important and will also be addressed simultaneously.

3. Proposal for the Development of Clinical Director Roles

In addition to their responsibilities as a member on the Governing Body[i], clinical members also currently undertake a range of additional duties related to specific work programmes, specific contract negotiations, serving on committees or leading areas of development. The aim of this proposal is to formalise these duties into a number of Clinical Director posts in order to provide clarity of role for the individual, the organisation and external colleagues. At present four job descriptions have been developed which outline the full responsibilities of the Clinical Director roles along with the desired attributes, competencies and skills. These four roles are:-

1. Clinical Director for Quality
2. Clinical Director for Unplanned Care
3. Clinical Director for Planned Care
4. Clinical Director for Strategy and Planning

It is however envisaged that there may be a need for two or three Clinical Directors for Planned Care, to enable a focus on various aspects of acute, community and mental health commissioning. There is also a possible requirement for a Clinical Director role to support the integration and delivery agenda (connecting into the work of Health and Wellbeing Board, integration with Sefton

Council and supporting the monitoring of the Commissioning Support Unit Service Level Agreement).

Each role is for two sessions a week (a session being 4 hours 10 minutes) as agreed by the Remuneration Committee in January 2014.

It is envisaged that each Clinical Director (in addition to the duties of all Governing Body members) will:

- work closely with the lead manager(s) to drive forward and deliver on key aspects of an agreed work programme for their area, in the context of the 2 and 5 year strategy
- agree a set of related personal objectives through the Personal Development Review (PDR) process
- regularly report on progress to the Governing Body and other groups as appropriate
- identify any relevant development needs related to the role and undertake training as appropriate.

It is also important that that Clinical Directors are able to remain in tune with member practices, truly engage with patients and communities, and actively reflect the Nolan Principles of Public Life in their leadership role, as they work with others to commission high quality services and improve health and wellbeing.

There are also opportunities for non-Governing Body Clinical Leads to undertake aspects of the Clinical Director roles in order to strengthen and broaden clinical leadership and enable succession planning across the CCG.

4. Conclusions and Next Steps

The Governing Body is therefore asked to discuss the proposal to develop Clinical Director roles and in particular consider if the correct roles have been identified and how to best appoint clinical members to the roles. It is possible that some members may see this as an opportunity to take on a new portfolio, whilst others may wish to continue working in an area where they already have experience and knowledge. Consideration also needs to be given to non-governing body clinical leaders who may also be able to support elements of the roles.

In addition to this proposal, the Governing Body is also asked to note and support the parallel development of locality leadership roles (and the localities themselves) and a similar process to ensure clarity of roles and development for all other Governing Body members.

5. Recommendations

The GB is asked to review this report.

Tracy Jeffes
March 2014

[i] All Governing Body members have the responsibility to ensure that the CCG exercises its functions effectively, economically, with good governance and in accordance with the terms of the CCG constitution as agreed by its members.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2014

Agenda Item: 14/47	**Author of the Paper:** David Bacon Interim Deputy Director of Finance David.Bacon@southseftonccg.nhs.uk Tel: 0151 247 7039
Report date: 17th March 2014	

Title: 2014/15 Provider Contract Update

Summary/Key Issues:
This paper provides Governing Body members with an update on progress with regard to the negotiation of 2014/15 contracts with the CCGs main providers.

At the time of drafting this report, negotiations are still ongoing and the position reflected in this report will be updated verbally in the meeting.

Recommendation

The Governing Body is asked to receive the current provider contract position

Receive	X
Approve	
Ratify	

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

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

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 the Governing Body

1. Introduction and Background

This paper provides Governing Body members with an update on the progress that is being made in the negotiation of 2014/15 contracts with the CCGs main providers.

The CCG is the lead commissioner, acting on behalf of all CCGs across the Health Community for three provider contracts (Aintree University Hospitals NHS FT, Mersey Care NHS Trust and Liverpool Community Health NHS Trust) and progress on these and its other main acute provider (Southport and Ormskirk NHS Trust) is set out in Section 2 below:

Section 3 below sets out details of changes in the commissioning approach with other providers that have an impact on the CCGs contractual position.

2. Main Providers Summary Contract Position

	Aintree University Hospitals NHS FT	Southport and Ormskirk Hospitals NHS Trust	Mersey Care NHS Trust	Liverpool Community Health NHS Trust
Activity and Finance	Initial Trust funding request £83.75m (£208.2m across all CCGs) Revised final technical offer sent by CCG on 13/3/14. £80.24m (£199.9m across all CCGs) Main Gap caused by Trust request for additional funding for • CDU, • Ward Staff investments • Acute Frailty Unit • Therapy Charging Areas which CCGs believe are either already funded through the application of the tariffs or where the amount requested is excessive. Negotiations ongoing around resolving the perceived financial gap Meeting of three main CCG Chairs, AO's and CFO's Wednesday 5/3/14 agreed overall approach.	Trust requested full funding for service changes related to winter pressures. The CCGs (Southport & Formby CCG, West Lancs CCG and South Sefton CCG), have collectively agreed to fund £1.6m of the £2.5m requested (Total funding offer £142.5m across all CCGs). Negotiations ongoing around resolving the recognised financial gap CCGs are working collaboratively to assess the risk levels across the health economy and how the financial contributions and residual risks are matched at a CCG level CCG Chief Financial Officer and Accountable Officers met	Trust funding request £12.89m (£30.4m across all CCGs) which included full re-investment of tariff deflator. CCG offer of £12.69m (£29.9m across all CCGs), which includes investment relating to implementing recommendations from the Francis Report. Trust has accepted CCG offer.	Trust Funding request £19.2m (£22.8m across all CCGs) Revised Financial Offer of £18.15m made by CCG on 14/3/14 (£21.6m across all CCGs) following a delayed (three weeks) response from provider to original offer Most of the outstanding issues on the technical offer are agreed in principle as appropriate to fund but agreement on the financial value not yet reached. Trust has accepted CCG Offer

	Further commissioner discussion took place at the Aintree Collaborative Commissioning forum on 6/3/14.	with Trust Chief Operating Officer and Director of Finance on 13th March to review progress.		
Performance and Quality	Some Minor issues with the Quality Schedule to be resolved	Some Minor issues with the Quality Schedule to be resolved	Some Minor issues with the Quality Schedule to be resolved	Agreed in principle
CQUIN	National elements agreed Some minor issues to be resolved for the local element	National elements agreed Local elements to be based on Alternative Quality Contract (AQC). Agreement process being led by West Lancashire CCG	Agreed	Agreed in principle

3. Changes in Commissioning Approach

For 2014/15 there are some proposed changes in the commissioning approach with other providers that have an impact on the CCGs contractual position. These include:

Maternity Pathway

- 2014/15 sees the adoption of the maternity pathway across providers and the contract negotiations have had to ensure a consistent approach across providers (including Liverpool Women's NHS Foundation Trust and Southport and Ormskirk Hospitals NHS Trust) so that all elements of the pathway are commissioned on a consistent activity basis.

Alder Hey Children's NHS Foundation Trust

- A number of service lines that were previously funded on a block basis have now moved to a cost per case basis as a mandatory tariff has been introduced for 2014/15. The impact of this plus the introduction of Paediatric Best Practice Tariffs is an additional cost of circa £0.6m in 2014/15.

Liverpool Women's NHS Foundation Trust

- CNST Premiums payable by the Trust do not appear to be adequately reflected in the national tariff. The CCGs and the Trust are in discussion with the NHS Litigation Authority.
- Birthrate plus maternity staffing levels have been proposed by the Trust as a basis for funding. The lead CCG is leading the negotiations on this aspect.

Cheshire/Merseyside Rehabilitation Network: Spoke Units

- A continuation of the rehabilitation beds at both Broadgreen and St Helens Hospitals has been included in the CCGs contract with providers for 2014/15. The CCG is working with other CCGs in Merseyside to adopt an equitable funding arrangement on a non-recurrent basis. It is envisaged that responsibility for commissioning these beds will move to Cheshire Warrington and Wirral Area Team of NHS England in 2015/16 as part of the specialised commissioning portfolio.

4. Conclusions

Good progress has been made with agreement reached in respect of Mersey Care NHS Trust and Liverpool Community Health NHS Trust.

Joint negotiations are taking place with CCGs regarding Aintree University Hospitals NHS Foundation Trust

Mature discussions are ongoing across the wider health economy in respect of Southport and Ormskirk Hospitals NHS Trust in terms of consolidating non recurrent schemes

At this stage it is not envisaged that the CCG will enter into any formal arbitration processes.

5. Recommendations

The Governing Body are asked to note the progress that has been made in the negotiation and agreement of 2014/15 Provider Contracts.

Key Issues
Finance and Resource Committee

NHS
South Sefton
Clinical Commissioning Group

Meeting Date **23rd January 2014, 20th February 2014**

Chair **Cannon Roger Driver/Mr Graham Morris**

Key Issues	Risks Identified	Mitigating Actions
1. Incomplete GP referral data	• Impact on performance management	• FLC will progress with CMCSU
2. Contract performance review	• Underperformance in some CQUINs	• CQUIN payments will be withheld as appropriate.
3. NHS England propose initiating a central adjustment to CCG budgets to accommodate CHC payments going forward.	• Impact on budget	• MMcD to approach Katherine Sheerin in her role as a member of NHS Clinical Commissioning Groups Board to record the objection of the CCG to this approach.

Information update to the Governing Body
1. Better Care Fund – Initial payment - potential for this to funded centrally, discussions with Sefton MBC are ongoing.
2. CMCSU Performance Review – a number of business process reviews are outstanding and being prioritised. Indication has been given that finance, IM& T and Senior Comms may be brought in house.
3. Merseyside and Cheshire Commissioning support unit will merge with Greater Manchester CSU from 1st April 2014
4. Summary of main requirements of Annual Report – report to Finance and Resource Committee in March detailing recommended approach which has been proposed and will be implemented by the Senior Management Team/Senior Leadership Team (Governing Body Members/CCG Officers)

Key Issues
Quality Committee

NHS
South Sefton
Clinical Commissioning Group

Meeting Date **Thursday 20 February 2014**

Chair **Dr Craig Gillespie**

Key Issues	Risks Identified	Mitigating Actions
1. Safeguarding	• Lack of verifiable assurance from all providers across Merseyside.	• Verbal reassurance from Safeguarding Hosted Service. • Quality committee have asked that this risk is reflected on the CCG risk register. • The Safeguarding Service has sent full feedback to the Providers and have informed the Directors of Nursing of the lack of assurance being currently provided.
2. Safeguarding Children Management Reviews	• Quality of safeguarding in health provision across the borough. • Poor communication was a feature of both cases both between multi-agency partners and across the health economy	• CCG remain active partners within the LSCB structure • CCG consider, and strengthen where necessary, the arrangements currently in place that enable us to influence the planning, quality and commissioning intentions relating to other key children's services, such as Health Visiting and School Nursing • CCG [in conjunction with NHSE(M) consider a review of communication across the Partnership arrangements to ensure that

		Primary Care are informed of and contribute to safeguarding process within the Borough.
3. Francis Action Plans	• Lack of pace in updating and addressing actions • A need to move away from process driven actions towards more outcome focussed actions	• Updated Francis Action Plans addressing the highlighted risks to be presented at April's Quality Committee meeting
4. Alder Hey Children's Hospital Risk Summit	• CQC highlighted that there were a number of issues in relation to the safety and quality of practice in the Theatre department	• NHSE are supporting the trust with regards theatre safety and additional support that may be needed • Alder Hey Children's Hospital has developed an action plan that is being reviewed by NHSE

Recommendations to the Governing Body
1. **The Governing Body is asked to receive this key issues log as an assurance that the CCG Quality Committee has oversight and assurance that the population the CCG serves is receiving safe, harm free and quality care in provider organisations, and where issues have been raised the Quality Committee has put in place appropriate mitigating actions.**

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2014

Agenda Item: 14/49	**Author of the Paper:** Stephen Astles Head of Development South Sefton CCG
Report date: 27 March 2014	

Title: Commissioning Intentions

Summary/Key Issues:

It is a requirement of the CCG to prepare an annual set of commissioning intentions in order to allow stakeholders to understand what the CCG is planning to review and commission in the future financial year.

This report and the attached document provide the Governing Body with an overview of the CCG's Commissioning Intentions.

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

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

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	x			
Clinical Engagement	x			
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
March 2014

1. Introduction and Background

1.1. The purpose of commissioning intentions is to signal to providers and the public areas that we intend to focus on during the coming twelve months to improve the health and services for our local population. The commissioning intentions deliver against the CCGs priority areas of Frail Elderly, Unplanned Care and Primary Care, which in turn contribute to the delivery of the five year strategic plan.

1.2. In developing the commissioning Intentions the CCG has ensured discussions have been held with our Engagement and Patient Experience Group thorough our 'Big Chat' and 'Mini Chat' events, our constituent practices and providers. Their feedback has helped the CCG to develop these intentions.

2. Key Issues

2.1. The Commissioning Intentions have been developed incorporating the following main themes:

- Primary Care
- Hospital Services
- Community Services and caring for our frail elderly population
- Mental Health
- Child Health
- Specialist Services
- Enabling better health.

2.2. The document has been developed to ensure that it can be read by all stakeholders and the potentially complex finance and commissioning information required to achieve the intentions have not been included and the detailed discussions will be undertaken with our providers. A copy of the document is provided at Appendix 1.

3. Recommendations

The Governing Body is asked to receive the contents of this paper

Appendices

Appendix 1 Commissioning Intentions

Stephen Astles
March 2014

NHS
South Sefton
Clinical Commissioning Group

Commissioning Intentions 2014-2015

NHS South Sefton Clinical Commissioning Group

14/49

Contents

Introduction

Our ‘commissioning intentions’ describe the work we would like to do in 2014 – 2015 to improve health and health services for the residents of south Sefton.

These commissioning intentions are in additional to the wide range of core health services we routinely buy or ‘commission’ - such as operations, blood tests or health visiting services – and which we think will help us to better meet the health needs of the people we care for in south Sefton.

We have not designed our commissioning intentions in isolation. They have been shaped by medical evidence, national guidance, local knowledge, best practice and by views gained from our ongoing discussions and work with our member GP practices, other local clinicians and professionals and partners like Sefton Council, health service providers, south Sefton residents and community, voluntary and faith organisations.

The commissioning intentions in this document will evolve and be refined as the year goes on, as we continue to discuss what is needed locally with our partners, providers, patients and residents.

There will be a chance for everyone with an interest in health in south Sefton to help further shape our commissioning intentions. The last page of this document explains how you can get involved.

How our commissioning intentions have been developed

There are a number of important local and national documents that provide a foundation for our commissioning intentions. They set out guidance, statutory requirements, or our established joint plans with partners across health and social care locally.

Local

- Sefton Joint Strategic Needs Assessment (JSNA) – with the council, we mapped and evaluated existing services to identify gaps and opportunities. This included the views and experiences of patients, local residents, clinicians and other professionals
- Sefton Health and Wellbeing Strategy – the overarching strategy for commissioners of health and social care across the borough, informed by the results of the JSNA
- Views gained from our public Big Chat and Talking Health events

National

- NHS Outcomes Framework[1] – this sets service and quality standards for all NHS services in five key areas of health known as 'domains'
- Everyone Counts – this is a national planning framework for CCGs, closely linking to the five domains set out in the NHS Outcomes Framework, and showing the indicators that CCGs are accountable for and describing how they intend to meet them
- Quality, innovation, productivity and prevention – this programme focuses on improving the quality of health services, whilst at the same time making them more effective and efficient
- Atlas of Variation[2] – a national tool which gathers information about health services and conditions locally, so we can see how good health in south Sefton is compared to other CCG populations, as well as highlighting services and conditions where we are falling behind and need to do more

[1] Domain 1 - Preventing people from dying prematurely; Domain 2 - Enhancing quality of life for people with long-term conditions; Domain 3 - Helping people to recover from episodes of ill health or following injury; Domain 4 - Ensuring that people have a positive experience of care; and Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf
[2] http://www.rightcare.nhs.uk/index.php/nhs-atlas/

Better health now and in the future

Based on all the information we have about health and health services in south Sefton we are focusing our work on three broad strategic areas, which we intend to address over the next five years:

1. Frail elderly care
2. Unplanned care
3. Primary care development

Our commissioning intentions for 2014-2015 are aligned to and consistent with our five year strategic priorities and will contribute to helping us achieve improvements in these areas by 2020, in line with national and local requirements.

You will notice some of our commissioning intentions support more than one or all of our strategic priorities and how many of our intentions will require services to work better together in a more integrated way than ever before.

Our **Virtual Ward** integrated care programme underpins much of our work, addressing all of our priority areas through an integrated approach to the delivery of services across health and social care. You will read more about it later in this document.

Our commissioning intentions for 2014-2015

1. Primary Care

Enhancing primary care

We believe primary care has a central role to play in improving services for south Sefton residents. Whilst we do not commission GP practices, we do have a responsibility for the continuous improvement of primary care.

In 2013 – 2014 we devised a three year strategy focusing on quality areas for improvement based on safety, clinical effectiveness, and patient experience.

Our primary care quality strategy, 'A Sense of Purpose', and the accompanying document 'Energising Primary Care' have been developed setting the context and current challenges, in the following areas for improvement outlined in our local 'Everyone Counts' document:

- Practice demographics
- Workforce development
- Health outcomes
- Clinical outcomes
- Estates / information technology (IT)

A new Primary Care Board has been established and this will oversee this work, providing assurance and transparency as we begin to deliver new services and adopt new ways of working:

- **We will work closely with our member GP practices and NHS England Merseyside (the body responsible for commissioning GP practices) to shape and implement our strategy during 2014-2015.**

Addressing ‘locality’ health needs

Our GP practice membership works in four distinct geographical locality areas, so we can devise services based on the differing and diverse needs of these communities: Maghull, Seaforth and Litherland, Crosby and Bootle.

- **We will support our localities to develop our integrated care program to allow for more services within communities and reduce demand on hospital services or ‘secondary care’**

- **The Governing Body will continue to support local commissioning development. Practices will also be involved in the reforming the primary healthcare team for the 21st Century by shaping the ‘Virtual Ward’ system**

Supporting member practices to make improvements

In order for primary care to work effectively we need to ensure our member practices have the right support and systems in place. This includes effective IT systems and access to high quality training and continuing clinical and professional development.

- **We want every major health service provider to have all services on a cross-sector electronic searchable directory of service available to GPs and other health care professionals**

- **Further develop practice training programme to be clinically and locally relevant**

- **Link GPs to other training opportunities in acute trusts, community, clinical networks and universities**

GP out of hours service

This service ensures people have access to a doctor when their practice is closed at weekends, bank holidays, evenings and overnight.

- **Improve links between the GP out of hours service and Litherland Walk in Centre**

- **Improve links between the GP out of hours service and out of hours nursing**

- **Seek patient experience of the GP out of hours service, so we can be sure it offers them a high quality service**

2. Hospital services

Over 75% of the resources we spend are for services provided by hospital or ‘acute’ trusts, so we need to be assured they provide patients with consistently high quality, effective and efficient services.

There are a number of indicators or standards set out in the NHS Outcomes Framework to provide us with this assurance and we will continue to work with acute trusts to review and implement the indicators which deliver the greatest benefits for our local population, and that they meet those required indictors in domains 3, 4 and 5.

Our local commissioning intentions for hospital services focus on the following areas:

Virtual Ward integrated care programme

Our Virtual Ward programme is central to our vision for healthcare that better meets the needs of our changing population. It sets out an integrated approach, where services right across health and social care work better together, identifying and providing more support to those patients who are at greatest risk of being admitted to hospital, such as those with long term conditions and older, frail patients. Currently the number of over 74 year olds admitted to hospital from nursing and residential homes is amongst the highest in the country.

- **We will work in collaboration with our main hospital to ascertain the impact of Virtual Ward in reducing unplanned admissions and re-admissions**

Urgent care

Non-elective or unplanned admissions to hospital have fallen by 29% from 2008 to 2011 but they are still higher than the national average (120/1000 population compared to 114/1000 population). The number of south Sefton residents attending Accident and Emergency (A&E) departments and who are subsequently admitted to hospital is higher than the national average.

Our aim to reduce urgent care activity in hospital by supporting patients to be cared for in their own homes and community settings, through the following proposed actions:

- **Identify patients who are high users of hospital based urgent care services through risk stratification and pro-actively improving the management of their long term condition**

- **Increase both specialist and generalist community urgent care cover**

- **Work with the acute trust to streamline Accident and Emergency (A&E) urgent care pathways**

- **Facilitate coordination between acute and community urgent care services**

- **Support less than 24 hour hospital stays for patients with specified ambulatory emergency conditions**

- **Support development of cross sector pathways and to increase awareness of alternatives to admission for A&E staff**

- **Facilitate a service level agreement between A&E and urgent care aspects of community services so they work better together and so when it's appropriate, more patients can be treated at home or closer to home**

- **Increase appropriate use of NHS services through pro-active behavioural change programmes**

- **Establish a 7 day urgent care team to investigate, monitor and support patients at risk of deterioration**

- **Ensure that patients approaching the final year of their life have the opportunity to have an advanced care plan**

Ophthalmology

We believe some eye conditions may be better treated by community services making it easier and closer to home for patients to get treatment, whilst at the same time enabling hospital services to concentrate on treating more complex conditions

- **We will carry out a clinical review of the ophthalmology pathway to reduce unnecessary hospital referrals for patients who could be**

treated in primary care and community based optometrist services, particularly those with ocular surface disease

Gastroscopy

This is a very common test to investigate problems with the stomach and upper digestive system. The number of south Sefton residents being referred for this procedure is one of the highest in the country

- **Due to increased adherence to the dyspepsia pathway for both primary and secondary care we expect to see a reduction in referrals for gastroscopy for patients with dyspepsia symptoms**

- **We will work with hospitals to review practice level data for gastroscopy referrals and gastric cancer prevalence and diagnosis and to provide practice feedback**

- **Consultant gastroscopy requests to be in line with dyspepsia local guidance**

Cardiology

- **We will review cardiology services to see if it is feasible to develop a community based service for patients not at need of imminent invasive investigation or intervention. This would include Consultant Clinics, Specialist Nursing services and Rehabilitation**

Stroke

Our local stroke service has already demonstrated quality improvements regarding specialist supported discharge and thrombolysis. In keeping with the NHS Outcomes Framework we would like to see:

- **People with stroke discharged with a joint health and social care plan**

- **Number of people receiving psychological support at 6 months following stroke**

- **Admission to the stroke unit and assessment by a Speech and Language Therapist within 4 hours of admission**

Diabetes

Over 6% of south Sefton residents aged over 17 year olds have been diagnosed with diabetes, compared to 5.9% in similar CCG areas.

Diabetic patients with kidney injuries stay in hospital longer than average and often have duplication of care in the community and hospital.

We treat significantly more cases of diabetic foot disease than the national average, with nearly a quarter of patients needing four or more inpatient hospital stays in a three year period, compared to around 17% in similar CCG areas.

Patients stay in hospital for more nights than we would expect, are less likely to have an elective procedure as a day case and are more likely to be readmitted as an emergency within 28 days.

People with diabetes registered with GPs in South Sefton CCG have 9.2% more emergency bed days when compared to inpatients without diabetes.

- **We will explore the benefits joint kidney and diabetes clinics in the community, this will support care closer to home and avoid duplication of care**

- **We will aim to ensure patients receive foot care/ screening as specified with the aim of reducing minor and major amputations**

- **We will review and improve where necessary community and hospital pathways to support care closer to home, by reviewing the reestablishment of community clinics with consultant support**

Discharge planning

We would like to see a reduction in the time it takes to discharge patients from hospital, as well as improved communication between providers and primary care. We will also:

- **Review and streamline discharge planning process**

- **Continue to monitor, support and develop e-discharging systems**

Cancer

The national NHS cancer strategy, Improving Outcomes, sets out two overarching goals - to improve survival rates in those diagnosed with cancer and to provide better support for those living with cancer. Alongside this we know that earlier detection of cancer greatly contributes to longer survival rates and improved quality of life for those living with the disease.

- **Work with secondary care to expedite cancer pathways through earlier diagnostics**
- **Work collaboratively to identify additional areas in the cancer pathways where other delays can be reduced**
- **In partnership with Macmillan Cancer Care establish the feasibility of setting up a support service for south Sefton residents affected by cancer**
- **Discuss Commissioning for Quality and Innovation (CQUIN) payment scheme with practices to improve cancer pathway breaches**

Radiology

We would like to see a number of improvements in radiology services so that patient can be treated quicker and more effectively. To do this we would:

- **Work with acute trust radiology in improving access to GPs**
- **Work with acute trust radiology in providing clear guidance to GPs to make best judgements regarding appropriate imaging to streamline diagnosis**
- **Work towards electronic requesting of radiology**
- **Improve reporting times for radiology**
- **Review Cancer information recorded in primary care**

Referral Support

We are committed to ensuring patients have choice of where they are treated, as set out in the NHS constitution. Choose and Book is the IT system that supports us to give patients better choice. Currently around 35% of referrals are made via Choose and Book and we would like to see this increase. So we will promote the use of Choose and Book through:

- **Practice training**
- **Surveillance of services**
- **Increase of Choose and Book templates**
- **Dedicated managerial support**

3. Community services and caring for our frail elderly population

In line with the indicators in domain 2 of the NHS Outcomes Framework, we want to ensure community services provide optimal healthcare for our patients, reducing the need for them to be admitted to hospital through high quality services delivered closer to home.

South Sefton's population is growing increasingly older, with the number of over 65 year olds set to increase by 20% from approximately 29,500 in 2011 to 35,400 in 2023 – meaning a rise from 18% of the population to almost 22% in just over a decade. Should current population trends continue, the number of people aged over 85 will increase by more than 50% between 2011 and 2023, when this group will account for 5,400 people. The challenge for us is to ensure that healthcare can match the needs of our older residents.

Virtual Ward integrated care programme

In 2013-2014 we introduced the proactive patient management element of the Virtual Ward focusing on our most vulnerable patients. In 2014-2015 we will further develop the Virtual Ward, with improvements in the following areas:

- **Domiciliary Urgent Care**
- **Pro-active nursing**
- **Re-ablement**
- **Information management and technology and single point of access**
- **Linking of community specialist teams for long term conditions, including respiratory and heart disease**
- **Patients approaching the final year of life will have the opportunity to engage in the process of advanced care plans**

Long term conditions

South Sefton has higher than average numbers of people with conditions like diabetes, chronic heart disease (CHD), chronic obstructive pulmonary disease (COPD), asthma, chronic kidney disease and hypertension. So we plan to:

- **Better identify people with long term conditions, using a tool called 'risk stratification', so we can better monitor and care for them**

- **Develop use of personalised care plans for diabetes/ COPD, heart failure and CKD across primary care, specialist community teams and secondary care**

- **Increase screening of dementia, COPD, diabetes and CKD through: Virtual Ward dementia screening protocol, increasing access to spirometry to test for COPD, promoting healthy living checks**

- **Increase patient understanding of their condition through: the roll out of our 12 week pro-active care education and behavioural change programme, tailored education programmes, increasing patient access to records, linking patients to online education**

Intermediate care

This provides rehabilitation for those patients who need extra support before going home after being discharged from hospital. Our clinical care assessment unit is based on ward 35 in Aintree Hospital.

- **Continue to review utilisation following improved urgent care GP cover and advocate a step-up approach from the community**

- **Improve utilisation of the service towards a robust primary care supportive model**

Respiratory

The number of COPD patients admitted to hospital is remains above average despite a 30% reduction in COPD admissions in the last 5 years. Our plan to reduce this includes:

- **Reviewing the Acute COPD Community Service and its integration into the originating respiratory team, to ensure a minimum of a 10% reduction in admissions for respiratory conditions**

- **Ensuring all patients with COPD and a Medical Research Council Dyspnoea of greater than 3 are referred to a pulmonary rehabilitation programme**

- **Establish primary care respiratory training needs**

- **Improve access to local psychological services for respiratory patients**

- **Develop a COPD/asthma awareness raising programme in partnership with Public Health**

- **Develop a patient led programme to support education and self care, to ensure people with COPD and asthma have the tools they need to better manage their condition and share in decision making about their care**

- **Enhance and re-commission the current Home Oxygen Therapy Service**

Community intravenous therapy

The Community Intravenous (IV) Therapy service allows patients to receive treatment at home that would normally be provided in hospital. The service is relatively underused by the community and we would like to ensure that patients are not hospitalised unnecessarily if they can be treated in the community. We aim to:

- **Improve access to the community IV team following review of the forms, pathway and single point of access**

- **Develop opportunities for other IV treatments in the community including fluids, blood transfusion**

- **Align the cellulitis pathway between community and acute trusts**

- **Increase access to microbiology consultant review through Ward 35 attendance**

Gynaecology

We launched our community gynaecology service in 2010, to provide women with the opportunity to receive their care and treatment closer to home rather than traveling to hospital for a number of appropriate conditions. To ensure the continued efficiency of this service we plan to:

- **Review the impact of this community service on the usage of hospital based services**

Palliative and End of Life care

In 2013-2014 we established a Hospice at Home service to provide people at the end of their life with the opportunity to be cared for at home if they wanted. In 2014-2015 we plan to:

- **Continue to support the Hospice at Home Service delivered by Woodlands Hospice**

- **Increase the number of patients being cared for and dying at home (if this is their choice)**

- **Support Nursing homes to complete education programmes including the six steps to success and gold standard framework**

- **Increase the use of and monitoring of End of Life care tools – such as the Gold Standard Framework and Preferred Place of Care - in the community, care / nursing homes and hospital settings**

Maternal health

The number of women in south Sefton who smoke during pregnancy continues to be high, whilst breastfeeding rates continue to be low. We plan to:

- **Support public health campaigns and continue to promote smoking cessation referral opportunities**

- **Support the continuation of a public health campaign promoting breastfeeding**

- **Carry out an anonymous survey of attitudes of midwives and health visitors to breastfeeding**

- **Carry out a feasibility study for a targeted community breastfeeding support programme**

4. Mental health

Dementia

The current detection rate of early dementia is currently 49%. Alongside this, rates of anti-dementia prescribing are low and may relate to primary care awareness, training and access to memory assessment. We plan to:

- **Improve dementia screening through primary care and the Virtual Ward programme**
- **Increase appropriate early referral to the memory clinic and as a result increase use of anti-dementia prescribing for mild and moderate dementia**
- **Improve dementia end of life care through advance care planning**
- **Facilitate support for patients, families and carers through coordination of agencies**
- **Facilitate further locality based approach of the psycho-geriatrician service**

Psychosexual counselling

- **Review of current services and demand**

Personality disorder

- **Review current support for such patients and possibility of a locally tailored service**

Counselling services

- **Review demand and work with providers around capacity required to bring down waiting lists**
- **Bring counselling towards a more locality based service**

Social prescribing initiatives

- **Review and develop social prescribing initiatives in conjunction with Sefton CVS services**

Severe and enduring mental illness

- **Promotion and standardisation of physical checks**

- **Monitoring of number patients followed up within 7 days of discharge from psychiatric in-patient stay**

5. Child health

Care of neonates

Emergency hospital admissions and readmissions of babies under 14 days old are much higher than the national average, being in the upper quintile of CCG areas. We plan to:

- **Work in partnership with NHS England as commissioners of the health visiting service to integrate the community midwifery and health visiting services and review their quality**

- **Review the Children's Community Nursing Service to support admission avoidance and early discharge where clinically safe to do so**

Palliative Care of Children

The number of children dying in hospital from life limiting conditions is in the top quintile. We plan to:

- **We would work with the Children's Community Nursing Team and other Merseyside CCGs to review the current Children's Palliative Care Pilot Programme which has currently been commissioned**

Asthma

More under 18 year olds in south Sefton are admitted to hospital than many other areas, with the CCG in in the top quintile for this indicator, so we will support:

- **Training and development on more aggressive asthma treatment in the community according to British Thoracic Society guidance**

6. Specialist services

Whilst the majority of services for transgender and military veterans are delivered by specialist health services, we are developing a localised approach to some elements of care in south Sefton. So, when possible our residents are offered treatment and support tailored to their needs.

Military Veteran Health

Our work to support the development of a one stop shop for military veterans is extremely innovative. To do this, we are working with the community voluntary and faith sector via Sefton CVS to do this, and we hope it will provide people with more effective support:

- **Improve access to local psychological services for Military Veterans**
- **Develop a robust partnership working approach with key services to meet the needs of military veterans, as identified in the recent JSNA**
- **Continue to fund a Military Veteran Co-ordinator Post, hosted by Sefton CVS to co-ordinate the Local Military Veteran Partnership Group**

Transgender

From the JSNA, we know that access to health services for the transgender community in south Sefton needs to be better. We have looked at what services we can influence locally and we have identified the following enhancements:

- **Improve access to primary care psychological services for people from the transgender community**
- **Adopt a localised version of the new regional care pathway to improve patient experience and care**
- **Identify and provide awareness training for local Community Mental Health Team and Child and Adolescent Mental Health Service**

7. Enabling better health

Information management and technology

Our Information Management and Technology (IM&T) strategy has been developed by local clinicians, healthcare and IM&T professionals. It plays an integral role in helping us to achieve our strategic goals. We want to:

- **Ensure that IM&T programmes are linked across health care organisations to enable the clinical business needs of Clinical Commissioning Groups**
- **Ensure that high quality clinical information is accessible in an integrated, shared clinical record, in real time, at the point of care**
- **Deliver of modern and innovative technology to support referral management and clinical pathways**
- **Develop and transform informatics in general practice**
- **Enable patient access to health records, health advice and assistive living facilities and technology**
- **Deliver of safe, secure systems in compliance with all relevant information governance and security standards**

Self care

We want to develop more support for patients with long term conditions so they can better manage their illness, helping them to stay as well and as independent as possible for as long as possible through:

- **Public health education campaign on health prevention, minor illness**
- **Better signposting of services**
- **Providing better education, tailored care and behavioural change for those with long term conditions**
- **Reviewing and scoping of expert patient programme**
- **Providing training for health and social care professionals**

Next steps…

We will continue to work with all our partners throughout the course of 2014-2015 to adapt, refine and deliver our commissioning intentions.

The plans set out in this document will also be further shaped by the development of our 5 year strategic plan, which we are required to submit to NHS England in June 2014.

We are continuing to invite feedback about our commissioning intentions and welcome your views. Please send comments to:

Stephen Astles, Head of CCG Development

Email: stephen.astles@southseftonccg.nhs.uk

Telephone: 0151 247 7000

NHS
South Sefton
Clinical Commissioning Group

3rd floor Merton House, Stanley Road, Bootle, L20 3DL

communications@southseftonccg.nhs.uk

NHS
South Sefton
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MEETING OF THE GOVERNING BODY
March 2014

Agenda Item: 14/50	**Author of the Paper:** Debbie Fairclough – Head of Client Operations (CSU)
Report date: 18th March 2014	

Title: NHS Constitution – Statement of Assurance

Summary/Key Issues:
The NHS Constitution came into force in 2009. It sets out what everyone can expect of the NHS and what is expected of them. It specifically sets out the rights and responsibilities of patients, the public and staff as well as pledges that the NHS is committed to achieve.

There is a legal requirement for all NHS organisations to comply with the Constitution and the framework below has been developed to capture how the CCG is complying with each element.

A public consultation in order to strengthen the constitution was held during December 2013 – January 2013. A number of technical changes have also been made to ensure it reflects changes introduced since its launch in January 2009, this includes make clear that the Constitution extends to Local Authorities.

Purpose:
The purpose of this report is to provide assurances to the Governing Body that the CCG is compliant with all rights and pledges.

Recommendation

The Governing Body is asked to ***receive*** and ***note*** the current assessment of compliance.

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.

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				
Clinical Engagement				
Equality Impact Assessment				
Legal Advice Sought	X			Relevant qualified individuals have provided input to the report.
Resource Implications Considered			X	
Locality Engagement				
Presented to other Committees	X			EPEG

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

Access to Health Services	Assurance Statement	Sources of evidence	Compliance Fully: GREEN Partially: AMBER None: RED
RIGHTS: The right to:			
• **Receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.**	*The CCG commissions health services that are free at the point of contact. The details of those services are contained with Contract Schedules and Service Level Agreements with providers of community, secondary, tertiary and voluntary sector services.*	• NHS Provider Contracts • NHS Service Level Agreements • Locally Enhanced Services (LES) agreements	
• **Access NHS services. You will not be refused access on unreasonable grounds**	*The CCG commissions services from community and acute providers to ensure that patients are able to access services. Providers are required to have in place policies and procedures to ensure compliance with their Public Sector Equality Duties. Providers are monitored on their compliance with PSED as part of the contracting monitoring process.*	• Contract Schedules • Performance Reports • Contract Monitoring Reports • Minutes of Meetings	
• **Expect your NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary.**	*The CCG works with the Local Authority to undertake Joint Strategic Needs Assessments which is used to support the development of the Health and Wellbeing Strategy as well as used to inform the development of the Strategic Plan. The Strategic Plan sets out the commissioning priorities of the CCG that are based on the needs of the population.* *EPEG enables the CCG to identify specific barriers that could impact community accessing specific services* *The CCGs is committed to E&D and have developed a Equality Objective plan, E&D Strategy and are embedding improved equality processes for 2014/15 enabling commissioners to consider the needs of their communities across protected groups (Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion, Sex, Sexual Orientation)*	• JSNA • Health and Wellbeing Meeting Agendas Health and Wellbeing Board Meeting Minutes • Strategic Plan • Equality Objective Plan • Equality and Diversity Strategy • Governing Body Minutes • Quality Committee Minues	

• **In certain circumstances, to go to other European Economic Area countries for treatment which would be available to you through your NHS commissioner**	*The CCG commissions comprehensive services, closely monitors waiting time performance via the Quality and Performance Review Groups meeting with providers and provides assurances on this to the Quality Committee.* *In the event that a patient opts to seek treatment abroad the CCG would make arrangements to review the appropriateness of the treatment and consequential funding.* *CCG is working with local Black Minority and Ethnic Community Development team to myth bust around issues such as health tourism.*	• NHS Contracts • Minutes of Contact and Quality Performance Meeting • Choice Arrangements	Gap: CCG needs to ensure that the public can access information on how to claim reimbursement. This is being addressed and will be in place by 31st March 2014.
• **Not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, religion or belief, gender, reassignment, pregnancy and maternity or marital or civil partnership status**	*The CCG has in place Equality and Diversity Policy/ strategy and an Equality Objective Plan in line with statutory requirements these have been approved by the Governing Body.* *The Objective plan addresses key actions across key CCG functions including Commissioning, quality, patient experience, monitoring provider performance, and HR* *The CCG has measured its own performance via Equality Delivery Systems and will undertake its EDS2 assessments from January to March 2015* *EPEG committee and internal Governance group receive E&D updates and reports on progress against delivery of the Objectives Plan* *E&D Training is part of the Statutory and Mandatory Training Programme and all staff are required to undertake E learning E&D training* *Governing Body has undertaken high level E&D training on meeting their requirements as decision makers*	• Equality and Diversity Policy • Equality Objective Plan • HR Policies and Procedures • Minutes of EPEG meetings • E&D Training Records	
• **Access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook**	*The CCG commissions comprehensive services, closely monitors waiting time performance via the Quality and Performance Review Groups meeting with providers and provides assurances on this to the Quality Committee.* *The CCG offers "Choice" to patients*	• NHS Provider Contracts • Corporate Performance Reports • Governing Body reports • Governing Body Minutes • Quality Committee Agendas	

to the NHS Constitution		• Contract and Quality Performance Group Minutes	
PLEDGES: The CCG also commits: • **To provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution;**	*The CCG commissions comprehensive services, closely monitors waiting time performance via the Quality and Performance Review Groups meeting with providers and provides assurances on this to the Quality Committee.*	• NHS Provider Contracts • Corporate Performance Reports • Governing Body reports • Governing Body Minutes	
• **To make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered.**	*The CCG holds "Big Chat" and "mini chat" events and has an Engagement Strategy to ensure that the views of the public inform commissioning decisions. The CCG also works closely with Healthwatch and CVS networks to develop patient and public understanding and is also supporting member practices to develop their Patient Participation groups to support this activity.* *The CCG holds meetings in public 6 times a year and the agenda and papers are published on the CCG website.* *The CCG has approved a Constitution that sets out the governance and decision making processes of the CCG.*	• Big Chat Agendas • Big Chat Event Reports • Minutes of Open Public Meetings • CCG Constitution	
• **To make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them**	*CCG is undertaking a integration programme underpinned by 2 year and 5 year plan setting out key priorities including how services within primary secondary care, social care services and community voluntary sector can work to develop seamless services and pathways* *Providers have in place "patient pathways" that detail the handover and transition process* *The E&D work programme, engagement process and quality contract schedules identify issues gaps and barriers in respect pathways enabling the CCG to agree actions to resolve any issues.*	• Notes of Operational Management Group meetings • Strategic Plan • Patient Pathways	
Quality of Care and Environment			
RIGHTS: • **To be treated with a professional standard of care, by appropriately**	*Providers have in place recruitment processes that ensure staff are employed with current professional registration.*	• Staff appraisal processes in providers	

qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.	*CCG commissions services from providers that are registered with the CQC* *The CCG works with providers to ensure that changes to workforce does not negatively impact on patients.*	• CQC Registration details	
• **Expect NHS organisations to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, clinical effectiveness and experiences of services**	The CCG Chief Nurse and GP Quality Lead meets with providers to discuss quality matters as part of the Quality and Performance Review Group process. The CCG Quality Committee receives and Early Warning Dashboard that signals any areas of concern about the quality and safety of services The CCG is a member of the North West Quality Surveillance Group	• Quality Committee Minutes • Quality Dashboards • CQPG Minutes • NW Quality Surveillance Group Agenda • NW Quality Surveillance Group Minutes	
PLEDGES: The CCG also commits: • **To ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice**	*The CCG Chief Nurse and GP quality lead meets with providers to discuss quality matters as part of the Quality and Performance Review Group process. The CCG Quality Committee receives and Early Warning Dashboard that signals any areas of concern about the quality and safety of services* *E&D work identifies access issues which often equate to issues around patient safety*	• Quality Committee Minutes • Quality Dashboards • CQPG Minutes • NW Quality Surveillance Group Agenda • NW Quality Surveillance Group Minutes	
• **To identify and share best practice in quality of care and treatments**	*The Quality Committee discusses best practice in quality of care and treatments.*	• Chief Nurse Network Meetings • Quality Committee Minutes	
• **If you are admitted to hospital, you will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set in the Handbook of the NHS Constitution**	*The CCG monitors compliance with Mixed Sex Accommodation (MSA) targets and works with providers and NHS England to identify risk of occurrence and to agree remedial actions if a breaches do occur.*	• Corporate Performance Reports • MSA Action Plans • Quality Committee Minutes	
Nationally Approved Drugs and Treatments			
RIGHTS: The right to: • **Drugs and treatments that have been**	*The CCG commissions Medicines Management support and advice from the CSU. The CCG is a member of the*	• APC Minutes • MMOG Minutes	

recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.	*Area Prescribing Committee where such guidance is discussed, recommendation made and CCG approval.*	• SSMOOG Minutes • JMOG Minutes	
• **Expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.**	*The CCG has in place systems and process to review applications for Individual Funding Requests for those cases that are considered to be "exceptional". The panel membership includes clinicians to ensure proper assessment of clinical need.* *All decisions to fund are not to fund are communicated to patients and their clinicians with a clear rationale to support the decision.*	• IFR Policy • Commissioning Policy Review document • IFR Panel Notes	
• **Receive the vaccinations that the Joint Committee on** • **Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme**	*The Vaccinations administered under the National programme is commissioned by the Public Health Team of NHS England*	**NOT APPLICABLE TO CCGs**	
PLEDGES: The CCG also commits to: • **Provide screening programmes as recommended by the UK National Screening Committee**	*NHS England and the Local Authority are responsible for the implementation of screening programmes and the CCG works closely with these organisations*	**NOT APPLICABLE TO CCGs**	
Respect Consent and Confidentiality			
RIGHTS: The right to: • **Be treated with dignity and respect, in accordance with your human rights.**	*CQC and other external regulators require Providers to have in place appropriate policies and procedures.* *The CCG requires providers to have such arrangements in place and these are monitored through the contracting processes.*	• Equality and Human Rights Policies • Consent Policies • Same Sex Accommodation Policies • Patient Information Leaflets • Mental Capacity Act Policy (including Best Interests) • Care of the Dying Policies • Safeguarding Policies and Procedures • Training programmes for staff on	

		Mental Capacity Act, Consent, Safeguarding etc	
• **Accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests**	*CQC and other external regulators require Providers to have in place appropriate policies and procedures.* *The CCG requires providers to have such arrangements in place and these are monitored through the contracting processes.*	• Equality and Human Rights Policies • Consent Policies • Same Sex Accommodation Policies • Patient Information Leaflets • Mental Capacity Act Policy (including Best Interests) • Care of the Dying Policies • Safeguarding Policies and Procedures • Training programmes for staff on Mental Capacity Act, Consent, Safeguarding etc	
• **Given information about the test and treatment options available to you, what they involve and their risks and benefits.**	*CQC and other external regulators require Providers to have in place appropriate policies and procedures.* *The CCG requires providers to have such arrangements in place and these are monitored through the contracting processes.*	• Patient Information Leaflets in a number of formats • Access to translation services	
• **For privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.**	*The CCG have in place a range of Information Governance Policies that were approved by the Quality Committee.*	• Patient Information Leaflets on how their personal data is processed (Fair Processing Notice) • Evidence to achieve a minimum of Level 2 compliance with IG Toolkit. This compliance is audited on an annual basis • Caldicott Guardian • Senior Information Risk Owner (SIRO) • Information Governance or Data Protection Policy • Information Security Policy • Subject Access Request Policy • Procedures to adhere to the Confidentiality: NHS Code of	

		Practice • Procedures to adhere to the Information Security Management NHS Code of Practice • Procedures to adhere to the NHS Records Management • Quality Committee minutes • IG Toolkit Compliance Results	
• **Of access to your own health records. These will always be used to manage your treatment in your best interest**	*The CCG has a policy in place that provides information on the process to follow when requesting records. These arrangements have been approved by the Quality Committee.*	• Subject Access Request Policy and procedures • Quality Committee minutes	
• **To be informed how your information is used**	*The CCG has in place a leaflet that describes these arrangements for*	• Patient Information Leaflets on how their personal data is processed (Fair Processing Notice)	
• **To request that your confidential information is not used beyond your own care and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons including the legal basis**	*The CCG has appropriate arrangements in place*	• Patient Information Leaflets on how their personal data is processed (Fair Processing Notice) • Confidentiality: NHS Code of Practice • Information Security Management NHS Code of Practice • NHS Records Management	
PLEDGES: The NHS also commits to: • **Share with you any correspondence sent between clinicians about your care**	*The CCG monitors compliance with this through the contract monitoring processes.*	• Contract meeting minutes	
Informed Choice			
RIGHTS: The right to:			

• **Choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.**	**NOT APPLICABLE TO CCG** NHS England is responsible for the commissioning and performance management of GP contracts. The CCG works with the Merseyside Area Team to support the development and improvement of quality in primary care.		
• **Express a preference for using a particular doctor within your GP practice and for the practice to try to comply.**			
• **Make choices about the services commissioned by NHS bodies and the right to information to support these choices. The options available to you will develop over time and will be dependent on your individual needs.**	*The CCG has arrangements in place to ensure that patients have "Choice".*	• Choice Policy • NHS Choices Website • Having communications and information in a range of accessible formats	
PLEDGES: The CCG also commits to: • **Inform you about the healthcare services available to you, locally and nationally;**	*The CCG has arrangements in place to ensure that the public are advised about the services available to you.*	• Strategic Plan • Publication of Contracts • Annual Plans • Annual Report • Engagement Events • Prospectus	
• **Offer you easily accessible, reliable and relevant information in a form that you can understand and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available.**	The communications plan includes actions to ensure decision making is communicated and understood.	• Provider Personalised Care Plans	
Involvement in your Healthcare			
RIGHTS: The right to:	*Providers have in place End of Life policies that are developed in conjunction with commissioners*	• End of Life Policies	

• **Be involved in discussions and decisions about your healthcare, including your end of life care and to be given information to enable you to do this**	*Use of translation and interpretation services are monitored through 2104/15 quality contract schedule under compliance with Equality Act 2010 requirements*	• Interpretation Service SLA • Contract Schedule	
• **Be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those Services.**	*The CCG has arrangements in place to ensure that patients and the public are able to contribute to the development of plans.*	• Open Board Meetings • Big Chat Events • Mini Chat Events • Engagement Strategies • Engagement and Patient Experience Group • HealthWatch • CVS Networks • Patient Surveys • Minutes of meetings • EPEG Meetings	
PLEDGES: The CCG also commits to: • **Provide you with the information and support that you need to influence and scrutinise the planning and delivery of NHS Services**	*The CCG has arrangements in place to ensure that patients and the public are able to contribute to the development of plans.*	• Open Board Meetings • Big Chat Events • Mini Chat Events • Engagement Strategies • Engagement and Patient Experience Group • HealthWatch • CVS Networks • Patient Surveys • Minutes of meetings • EPEG Meetings • Overview and Scrutiny meeting notes • Consultation reports • Survey Reports	
• **Work in partnership with you, your family, carers and representative to involve you in discussions about planning your care and to offer you a**	*Providers have appropriate arrangements in place as part of pathway approach.*		

written record of what is agreed if you want one			
• **To encourage and welcome feedback on your health and care experiences and use this to improve services**	*The CCG has appropriate arrangements in place to ensure that patient views inform service improvements.*	• EPEG Terms of Reference • Quality Committee ToR • Complaints Policy • Being Open Policy • Family and Friends Performance Monitoring • Complaints Reports • PALS Reports	
Complaints and Redress			
RIGHTS: The right to: • **Discuss the manner in which the complaint is handled and to know the period within which the investigation is likely to be completed and the response sent** • **Have any complaint that you make about NHS services acknowledged within three working days and to have it properly investigated** • **Be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of any conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.** • • **Take your complaint to the Independent Parliamentary and Health Service Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS.**	*The CCG complies with relevant legislation, guidance and policy and has arrangements in place to manage complaints, concerns and serious incidents.* *The CCG procures support from the Cheshire and Merseyside Commissioning Support Unit for the management of Claims.*	• Complaints Policy • Being Open Policy • PALS • Complaints Support commissioned from the CSU • Membership with NHS Litigation Authority • Incident Reporting Policy • Serious Incident Policy • Quality Committee Review of complaints • EPEG review of complaints • Corporate Governance Group • Quality and Performance Review Group • Complaints Action Plans • Public Sector Equality Duty • Duty to consult and engage • CSU SLA • SI Investigation Reports • STEIS reporting • STEIS review group notes • Incident Action Plan	

• **Make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.** • **Compensation where you have been harmed by negligent treatment.** **PLEDGES: The CCG also commits to:** • **Ensure that you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and that the fact that you have complained will not adversely your future treatment** • **Ensure that when mistakes happen or if you are harmed while receiving health care, you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learnt to help avoid a similar incident occurring again.** • **Ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services**			

Pledges to staff

1. To have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives	Assurance Statement	Sources of Assurance	Compliance– fully GREEN compliant/partially AMBER compliant/not compliant RED
RIGHTS: The right to: • Fair treatment regarding leave, rights and flexible working and other statutory leave requests relating to work and family, including caring for adults with whom you live. • Request 'reasonable' time off for emergencies (paid and unpaid) and other statutory leave (subject to exceptions) • Expect reasonable steps are taken by the employer to ensure protection from less favourable treatment by fellow employees, patients & others (e.g. bullying or harassment)	*The CCG has in place a range of HR and Workforce Policies and procedures.* *The Governing Body has approved an Equality and Diversity Policy*	• Carers Leave Policy • Maternity Leave Policy • Special Leave Policy	
2. To have a fair pay and contract framework			
RIGHTS: The right to: • Pay; consistent with the National Minimum Wage or alternative contractual agreement. • Fair treatment regarding pay.	The CCG has appropriate arrangements in place to ensure compliance with these requirements.	• Agenda for Change Pay Framework • VSM Pay Framework • Employment Contracts	
3. To be involved and represented in the work			

place			
RIGHTS: The right to: • Be accompanied by either a Trade Union official or a work colleague at disciplinary or grievance hearings in line with legislation, your employer's policies or your contractual rights.	*These rights are detailed in relevant policies and procedures.*	• Disciplinary Policy • Grievance Policy • Conduct and Capability Policy	
• Consultation and representation either through the Trade Union or other staff representatives (for example where there is no Trade Union in place) in line with legislation and any collective agreements that may be in force**.**	*Staff are able to access support from Staffside representative and are able to join trade unions.*		
4. To have healthy and safe working conditions and an environment free from harassment, bullying or violence			
RIGHTS: The right to: • Work within a healthy & safe workplace and an environment in which the employer has taken all practical steps to ensure the workplace is free from verbal or physical violence from patients, the public or staff, to work your contractual hours, take annual leave and to take regular breaks from work.	*These rights are detailed in relevant policies and procedures.*	• Health and Safety Policy • Local Security Management Specialist • Incident Reporting procedures • Lone Worker Policy • Risk Management Strategy	
5. To be treated fairly, equally and free from discrimination			
RIGHTS: The right to: • A working environment	The CCG policies and procedures have been developed in accordance with Equality Legislation.	• Equality and Diversity Policy	

(including practices on recruitment and promotion) free from unlawful discrimination on the basis of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity, or marital or civil partnership status.			
6. To take a complaint about their employer to a Tribunal (in certain circumstances)			
RIGHTS: The right to: • Appeal against wrongful dismissal. • Pursue a claim in the employment tribunal, if you meet required criteria, if internal processes fail to overturn a dismissal	*The CCG has appropriate arrangements in place to ensure staff are able to take a complaint about their employer to a Tribunal.*	• Disciplinary Policy • Grievance Policy • Conduct and Capability Policy	
7. Can raise any concern with their employer whether it is about safety, malpractice or other risk, in the public interest			
RIGHTS: The right to: • Protection from detriment in employment and the right not to be unfairly dismissed for 'whistleblowing' or reporting wrongdoing in the workplace.	*The CCG has in place arrangements to ensure that staff can raise concerns with their employer about safety, malpractice or other risk in the public interest.*	• Incident Reporting • Whistleblowing Policy	
8. To have employment protection (NHS employees only)			
RIGHTS: The right to: • Employment protection in terms of continuity of service for redundancy purposes if moving	The CCG has in place arrangements in place to protect employment in appropriate circumstances.	• Managing Organisational Change Policy • TUPE Arrangements	

between NHS Employers.			
9. To join the NHS Pension Scheme (NHS employees and some other groups e.g. GPs)			
RIGHTS: The right to: • Your ability to join the NHS Pension Scheme.	*All CCG Employers have the right to join the pension scheme and are advised of this when joining the CCG.*	• NHS Pension Scheme Leaflets • Communications Bulletins • Induction Pack • Offer letters of employment	
PLEDGES			
The CCG commits to : • Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability • Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential. • Provide support and opportunities for staff to maintain their health, well-being and safety • Engage staff in decisions that affect them and the services	*The CCG has appropriate arrangements in place to ensure that staff are able to benefit from a positive working environment in which the can work flexibility within the needs of the business and can acquire skills to further their development.*	• Personal Development Reviews • Training and development opportunities • Job Descriptions • Personal Development Reviews • Flexible Working arrangements • Health and Safety Policy • Occupational Health Service • SMT meeting notes of discussions • SLT meeting notes of discussions • Wider Management Team meetings • Staff Engagement Events • SMT • SLT • Wider Management Team meetings • Staff Engagement Events • Grievance Policy • Whistleblowing Policy	

they provide, individually, through representative organisations and through local partnership working arrangements • All staff will be empowered to put forward ways to deliver better and safer services for patients and their families • To have a process in place to raise an internal grievance • Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice, or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998			

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2014

Agenda Item: 14/51	**Author of the Paper:** Martin McDowell Chief Finance Officer Martin.mcdowell@southseftonccg.nhs.uk Tel: 0151 247 7065
Report date: March 2014	

Title: 2014/15 Opening Financial Budgets

Summary/Key Issues:

This paper presents the Governing Body with the opening 2014/15 Budget for South Sefton CCG and advises upon outstanding issues and risks.

Recommendation

The Governing Body is asked to receive the following notes by way of assurance:

- that the proposed budgets deliver the key metrics required by NHS England in terms of 1% surplus;
- that this is reliant upon the delivery of £8.5m worth of QIPP schemes, of which £7.9m has been identified with delivery reflected in opening budgets, and £0.6m is currently not identified;
- that the CCG has provided a Contingency reserve of 0.5% of resource allocations in accordance with the national guideline;
- that the CCG planned expenditure is within its running cost target;
- that the CCG has identified Investment schemes using 2.5% of non-recurrent expenditure, in line with NHS England 2014/15 planning guidance.
- that an update to this opening budget position will be presented to the Governing Body meeting in May, following confirmation of key issues which remain outstanding.

The Governing Body is also asked to approve the opening revenue budget for the financial year 2014/15.

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.
x	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

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

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

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
March 2014

Summary

1.1 This paper provides details of the CCG's 2014/15 proposed opening budgets for consideration and approval.

1.2 At the time of preparing this report, there remain uncertainties in some areas and it is proposed that an update report will be presented to the Governing Body meeting in May 2014.

1.3 The budgets have been prepared in conjunction with budget holders and reflect all available planning guidance and metrics requirements.

1.4 The budgets reflect national guidelines and local arrangements and are based on 2013/14 Forecast Outturn as the start point for operational budgets.

1.5 A summary of the proposed 2014/15 Budget is presented below.

Table 1 - Summary 2014/15 Opening Budgets

Budget Area	£2014/15 £m		
	Rec	Non Rec	Total
Available Resources	**226.6**	**2.2**	**228.8**
Operational Budgets			
NHS Commissioned Services	153.4	5.7	159.1
Corporate & Support Services	6.8	0.1	6.9
Independent Sector	2.2	0.1	2.2
Medicines Management	29.0	0.0	29.0
Primary Care	0.8	0.6	1.5
Non NHS Commissioning	16.8	0.0	16.8
Sub total Operational budgets	**208.9**	**6.6**	**215.5**
Reserves			
QIPP requirement	(8.5)		(8.5)
QIPP planned schemes	7.9		7.9
2.5% Non Recurrent schemes		3.3	3.3
Investments	0.4		0.4
Other Committed Plans	5.0		5.0
Mandate Reserve	1.8		1.8
Contingency	1.1		1.1
Sub total Reserves	**7.7**	**3.3**	**11.0**
Total Anticipated Spend	**216.6**	**9.9**	**226.5**
Forecast Surplus/ (Deficit)	**10.0**	**(7.7)**	**2.3**
Expressed as %			**1%**

2. National Context

2.1 Guidance

The Department of Health (DH) issued its planning guidance for CCG's under the cover of *Everybody Counts:Planning for Patients 2014/15 – 2018/19.* This publication sets out the DH's expectations for health service priorities for the forthcoming year and confirms a number of "business rules" for financial planning purposes.

The CCG's budget setting approach has taken these priorities and business rules into account when establishing the proposed 2014/15 budgets.

2.2 Resource Allocations

The CCG's resource allocation for 2014/15 has been set at £228.8m in total and comprises the following elements:-

a) Baseline allocation £218.2m. This follows the DH exercise to review allocations compared to "fair shares" targets and formulate a mechanism for moving towards target allocations. A detailed paper on this issue was presented to the Board in January 2014.

b) Growth - all CCG's in England received levels of growth that supported the move to "fair shares". South Sefton CCG received growth of 2.14%.which equates to an uplift of £4.7m.

c) The CCG's allocation for 2014/15 also includes the return of the 2013/14 planned surplus of £2.2m as a non-recurrent allocation.

d) The CCG running cost allowance was set at £3.69m based on £24.73 per head for a population of 149,211. This compares to a running cost allocation of £3.68m in 2012/13.

2.3 Business Rules & Metrics

The key business rules prescribed by "Everyone Counts…" and which are met within the proposed 2014/15 budgets are:-

- To produce a surplus of 1% of resource allocation
- To set aside 2.5% of the Recurrent Programme allocation to fund non recurrent schemes. These schemes are listed in section 4.2.
- To set aside a Contingency reserve of at least 0.5% of the total Programme allocation, on a non-recurrent basis.
- To recognise that the allocation includes funding to cover the cost of mandated items.

2.4 Quality, Innovation, Productivity and Prevention (QIPP)

The DH's Quality, Innovation, Productivity and Prevention (QIPP) programme will enter the final year of a five year programme in 2014/15, with its aim to deliver £20 billion worth of savings and efficiencies in this period. Section 4.1 provides further detail regarding CCG plans in this area.

2.5 Inflation & efficiency targets

Monitor, in its role as Tariff Regulator, has set an annual level of planned efficiency within its publication of tariffs for providers. The target has been set at 4% for 2014/15 (2013/14 4%). Monitor also takes expected levels of inflation into account when setting the tariff as described in the table below. The CCG financial plans have been constructed on the basis

of this information, resulting in a 1.2% reduction in NHS Acute contracts and a 1.5% in NHS non Acute contracts.

Table 2 – 2014/15 net price adjustment (mandatory PbR tariff)

	Acute NHS	Non Acute NHS
Pay & Price inflation	2.8%	2.5%
Total national efficiency requirement	-4.0%	-4.0%
Net reduction (prices in scope of mandatory tariff)	-1.2%	-1.5%

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

3 2014/15 Opening Expenditure Budgets

3.1 The opening budgets for the CCG have been constructed using the most accurate and appropriate data currently available to the CCG, for each cost area. This includes 2013/14 budgets, projected out-turn figures from the 2013/14 financial year, 2014/15 activity forecasts and agreed contract values.

3.2 The opening contract figures reflect the efficiency and inflation assumptions outlined in table 2, Section 2. Work is continuing to understand the impact on individual providers, which may differ from the average national assessment.

3.3 The opening budgets will be subject to verification once the final outcome of 2013/14 has been assessed and final 2014/15 contracts have been agreed, with further work and analysis still being undertaken by the CCG finance team. The outcome of this review will be shared with the Governing Body in its May meeting. In particular, further clarification is required of contracts with NHS providers, CHC outturn costs, running costs and the outcome of negotiations with the CSU regarding the provision of services.

3.4 Table 3 below shows the opening budgets for each expenditure area compared to the Forecast Outturn (FOT) 2013/14 position as at Month 10. A more detailed analysis is provided at Appendix 1.The key factors for any variances are described below.

Table 3 – Comparison of Opening 2014/15 Budgets to 2013/14 Forecast Outturn (FOT)

Operating Budgets	**FOT 2013/14 £m**	**BUDGET 2014/15 £m**	**INCREASE/ (DECREASE) £m**
NHS Commissioned Services	163.7	159.1	(4.6)
Corporate & Support Services	6.1	6.9	0.8
Independent Sector	2.5	2.2	(0.3)
Medicines Management	28.7	29.0	0.3
Primary Care	1.4	1.5	0.1
Non NHS Commissioning	16.2	16.8	0.6
Total Operating budgets	**218.6**	**215.5**	**(3.1)**

3.5 The opening budget for NHS Commissioned services is £4.6m lower than 2013/14 forecast outturn. The main factors behind this reduction are:-

- Non Recurrent winter pressures funding of £1.5m included in 2013/14 forecast outturn, not included in 2014/15 opening budgets.
- Within Acute Commissioning there is a reduction of £1.2 million relating to the net efficiency gain required from providers, described in Table 2.
- Within Non Acute Commissioning there is a reduction of £0.4m due to the net efficiency requirement. In addition the Non Acute budget is reduced by £0.6m relating to the full year effect of the service (and budget) transferring from Liverpool Community Health to a non NHS provider during 2013/14. The budget is reduced by a further £0.35m due to the transfer of responsibility of the Darzi Service to NHS England.

3.6 Corporate & Support Services – this budget includes Running Costs which have been set in line with the Running Cost Allocation of £3.7m. The overall budget is higher than 2013/14 forecast outturn due the high level of vacancies during 2013/14 and the inclusion of a budget of £0.2m for expected Estate's costs to be charged in 2014/15 (no charges were received in 2013/14).

3.7 Independent Sector – the 2014/15 opening budget is £0.3m less than 2013/14 FOT. This is largely due to the non-recurrent arrangement made for the funding of the May Logan Centre in 2013/14 which resulted in a charge of £0.4m against this budget, of which £0.2m was funded through an increase in allocation.

3.8 Medicines Management. This budget has been based on forecast outturn. The increase compared to forecast outturn of £0.3m relates to the net 1% drug inflation/prescribing efficiency applied to this cost area.

3.9 Non NHS Commissioning – this budget is predominantly based on forecast outturn. This area includes individual packages of care for Mental Health, Funding Nursing Care and Continuing Health Care. During 2013/14 Continuing Health Care has seen a significant increase in spend compared to 2012/13 and this has been reflected in opening 2014/15 budgets.
The key factors behind the £0.6m increase compared to FOT are a £0.3m inflation uplift on costs relating to packages of care, the £0.6m increase relating to the full year impact of the Out of Hours Service transfer (noted above) and a reduction of £0.3m arising from the transfer of £0.3m children's care packages to Specialist Commissioning funding in 2014/15.

Reablement and Intermediate Care are also included within this budget area. These services are largely based on service level agreements which will be replaced by formal NHS standard contracts for 2014/15, but for which funding will remain at 2013/14 budget levels.

4 2014/15 Opening Reserves

4.1 QIPP Plans

4.1.1 The CCG inherited a share of NHS Sefton's QIPP target and for 2014/15 this figure is set at £8.452m. The CCG's planned schemes to deliver the QIPP requirement are listed in Table 4 overleaf.

Table 4 - QIPP Schemes

QIPP SCHEMES 2014/15	£m
Tariff saving	6.5
Prescribing	1.1
Other identified schemes	0.3
Unidentified QIPP	0.6
Total QIPP requirement	**8.5**

4.2 2.5% Non Recurrent Reserve

4.2.1 As mentioned in section 2.3, CCG's are expected to spend at least 2.5% of their recurrent commissioning baselines on non-recurrent schemes. This equates to £5.590m for the CCG and the schemes are listed in Table 5.

Table 5 - Use of 2.5% Non Recurrent Reserve

NON-RECURRENT INVESTMENT PLAN 2014/15	Total £m	Operational budgets £m	Non Recurrent Reserve £m
Virtual ward	1.7	1.3	0.4
Mersey Rehab Project	0.8	0.8	
CVS	0.7		0.7
Winter Pressures	0.5		0.5
Transforming Primary Care	0.5		0.5
Other schemes	1.4	0.2	1.2
Total non recurrent schemes	**5.6**	**2.3**	**3.3**

4.3 Other Investment Plans

Pending the outcome of contract negotiations, the CCG is hopeful that sufficient additional reserves will be retained to support investment in transformational schemes. The Governing Body will be updated regarding progress at the next formal meeting.

4.4 Contingency Reserve

The contingency reserve has been set at £1.1 m which is the required 0.5% of Programme allocations of £225.1m per NHS England guidelines. The CCG has opted to make this reserve recurrent, as opposed to the guidance which asks for it to be set aside non-recurrently, as this is likely to be more reflective of spending patterns that emerge through the year.

5 Key Financial Risks and Pressures

5.1 At the time of writing this paper, the CCG had not reached agreement with all providers in respect of agreeing 2014/15 contracts. Therefore commissioning budgets remain indicative at this stage, based on the latest contract offers made, and subject to changes arising from final agreements with providers. Any further pressures that arise will be funded via commissioning reserves held in the opening plan.

5.2 The CCG plans have been prepared using 2013/14 financial year out-turn position so any growth in demand will need to be funded using CCG contingency reserves.

5.3 The plans assume that the CCG will recoup 1.2% (Acute) or 1.5% (non Acute) from all NHS Contracts under the planned tariff adjustment. There are a number of separate factors within the construct of the tariff that may mean that this sum is unable to be recouped in full. These all add to the potential risks facing the CCG and more work is required before final agreements can be reached.

5.4 The commissioning of individual packages of care within Mental Health and Continuing Health Care (CHC) has been identified as a major risk area for the CCG through 2013/14. There remain concerns regarding the process and quality of the underlying data and this area will undergo further review before revised budgets are submitted.

5.5 Prescribing - It should be noted that aspects of prescribing remain volatile and this area could present risks to budgets in 2014/15 and will require continued support from community pharmacist teams and practices to deliver a balanced position.

5.6 Continuing Healthcare (CHC) restitution payments – further clarification is being sought regarding the process for managing the risk of prior claims and this will be reflected in the revised budgets presented in May.

5.7 The NHS is likely to require funding to support transformation of its services, to include initiatives such as 7-day working. At this stage, the additional costs of these schemes are unknown, and it is possible that CCG reserves may not be adequate to cover the costs involved.

6. Conclusions & Recommendations

6.1 The Governing Body is asked to receive the following notes by way of assurance:

- that the proposed budgets deliver the key metrics required by NHS England in terms of 1% surplus;
- that this is reliant upon the delivery of £8.5m worth of QIPP schemes, of which £7.9m has been identified with delivery reflected in opening budgets and £0.6m is currently not identified;.
- that the CCG has provided a Contingency reserve of 0.5% of resource allocations in accordance with the national guideline;.
- that the CCG planned expenditure is within its running cost target;.
- that the CCG has identified Investment schemes using 2.5% of non-recurrent expenditure, in line with NHS England 2014/15 planning guidance;
- that an update to this opening budget position will be presented to the Governing Body meeting in May, following confirmation of key issues which remain outstanding.

6.2 The Governing Body is asked to approve the opening revenue budget for the financial year 2014/15.

7. Appendices

Appendix 1 Analysis by Cost Centre - Opening 2014/15 Budget compared to Forecast outturn.

Appendix 1

South Sefton CCG

Comparison of 2014/15 Opening Budget to 2013/14 Forecast Outturn (Month 10)				
Cost centre Number	**Cost Centre Description**	**Forecast Outturn 2013/14**	**Annual Budget 2014/15**	**Increase (Decrease)**
		£000	**£000**	**£000**
COMMISSIONING - NON NHS				
598501	Mental Health Contracts	779	1,049	270
598506	Child and Adolescent Mental Health	1,215	920	(295)
598511	Dementia	118	118	0
598521	Learning Difficulties	1,160	730	(430)
598596	Collaborative Commissioning	521	521	(0)
598661	Out of Hours	671	1,327	656
598682	CHC Adult Fully Funded	6,221	6,659	438
598691	Funded Nursing Care	2,280	2,395	115
598711	Community Services	388	371	(18)
598721	Hospices	1,246	1,232	(15)
598726	Intermediate Care	291	226	(65)
598796	Reablement	1,284	1,245	(38)
Sub-Total		**16,175**	**16,793**	**618**
CORPORATE & SUPPORT SERVICES				
600251	Administration and Business Support (Running Cost)	114	127	13
600271	CEO/Board Office (Running Cost)	544	538	(6)
600276	Chairs and Non Execs (Running Cost)	88	159	71
600286	Clinical Governance (Running Cost)	29	29	0
600296	Commissioning (Running Cost)	1,538	1,607	69
600316	Corporate costs	24	24	0
600346	Estates & Facilities	-43	154	197
600351	Finance (Running Cost)	604	679	76
600391	Medicines Management (Running Cost)	65	63	(3)
600426	Quality	0	204	204
	Contingency		105	105
	Sub-Total Running Costs	**2,963**	**3,690**	**727**
598646	Commissioning Schemes (Programme Cost)	797	767	(29)
598656	Medicines Management (Programme Cost)	492	585	92
598776	Non Recurrent Programmes (NPfIT)	1,560	1,560	0
598676	Primary Care IT	276	276	(0)
600371	IM&T	0	0	0
	Sub-Total Programme Costs	**3,125**	**3,188**	**63**
Sub-Total		**6,088**	**6,878**	**790**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS				
598571	Acute Commissioning	110,761	109,618	(1,143)
598576	Acute Childrens Services	8,178	8,176	(2)
598586	Ambulance Services	5,475	5,448	(27)
598616	NCAs/OATs	1,417	1,181	(236)
598631	Winter Pressures	1,520	0	(1,520)
598756	Commissioning - Non Acute	36,338	34,705	(1,633)
598786	Patient Transport	12	12	0
Sub-Total		**163,701**	**159,140**	(4,560)
INDEPENDENT SECTOR				
598591	Clinical Assessment and Treatment Centres	2,527	2,207	(320)
Sub-Total		**2,527**	**2,207**	(320)
PRIMARY CARE				
598651	Local Enhanced Services and GP Framework	896	848	(48)
598791	Programme Projects	516	642	126
Sub-Total		**1,412**	**1,490**	**78**
PRESCRIBING				
598606	High Cost Drugs	634	665	31
598666	Oxygen	430	444	14
598671	Prescribing	27,614	27,843	229
Sub-Total		**28,678**	**28,952**	**274**
Sub-Total Operating Budgets pre Reserves		**218,580**	**215,460**	(3,120)
RESERVES				
598761	Commissioning Reserves	5,899	11,011	5,112
Sub-Total		**5,899**	**11,011**	**5,112**
Grand Total I & E		**224,479**	**226,471**	**1,992**
Surplus			**2,288**	
Total			**228,759**	

NHS
South Sefton
Clinical Commissioning Group

Quality Committee (DRAFT)
Minutes

Date: Thursday 23 January 2014
Time: 3:00 pm – 5:00 pm
Venue: Boardroom, Merton House

Member/In attendance		
Dr Gina Halstead	GP Vice Chair	(GH)
Dr Anna Ferguson	GP	(AF)
Dr Colette McIlroy	GP	(CM)
Dr Andrew Mimnagh	GP Governing Body Member	(AM)
Debbie Fagan	Chief Nurse	(DF)
Lin Bennett	Practice Manager / Board Member	(LB)
Fiona Clark	Chief Officer	(FC)
In attendance		
James Hester	Programme Manager Quality & Safety	(JH)
Debbie Harvey	Clinical Lead for Integrated Care	(DH)
Tracy Jeffes	Head of Corporate Delivery	(TJ)
Sarah Stephenson	GP	(SS)
Teresa Lewis	Administrator/Note Taker	(TL)
Apologies		
Dr Craig Gillespie	GP Chair	(CG)
Gordon Jones	Quality Manager CSU	(GJ)
Roger Driver	Lay Member	(RD)

No	Item	Action
Q14/1	**Apologies** Dr Craig Gillespie, Gordon Jones, Roger Driver	
Q14/2	**Declarations of Interest** All GP members and Lin Bennett declared their employment with general practice within South Sefton. Debbie Fagan, James Hester, Tracy Jeffes, Fiona Clark declared that they have dual roles at both Southport & Formby and South Sefton CCGs.	
Q14/3	**Minutes of the previous meeting – 21 November 2013** The Quality Committee approved the minutes of the previous meeting as an accurate representation.	
Q14/4	**Matters Arising/Action Tracker** All appropriate actions were closed and the following outstanding actions updated.	
	13.74a – Dementia Champions James Hester reported on behalf of Gordon Jones (Cheshire & Merseyside Commissioning Support Unit, CMCSU) who had emailed an update. Gordon Jones is continuing to liaise with NHSE (Merseyside) to arrange a meeting with regards to dementia screening within secondary care. It was noted that the Royal Liverpool University hospital has robust	

No	Item	Action
	measures in place with regards to screening measures for dementia which will be shared with Aintree Hospital. Working with Mersey Care to improve liaison at Aintree. In October Aintree implemented an electronic FAIR proforma reported to be working well. There are discussions about having a local Dementia CQUIN for Mersey Care combined with proposed "Working Together" CQUIN. Needs to be determined whether dementia is incorporated into advancing quality in addition to the national CQUIN. **Action: Gordon Jones to continue to contact NHSE. Compare screening data across Mersey and report back to this Committee.**	**GJ**
	13.126a Debbie Fagan raised issue with NHSE regarding information at practice/locality level to do some further work but not yet provided. It was noted complaints direct to or from NHSE are bypassing practices. **Action: Debbie Fagan to raise at next Checkpoint Assurance meeting for assurance that practices are informed about complaints sent direct to NHSE so they can be acted on.**	**DF**
	13.126b CQC Peer Review. Both South Sefton and Southport and Formby CCGs are undergoing external peer review to prepare for possible future CQC inspection. GP safeguarding leads will participate in a telephone interview with external reviewers if possible to complete that to prepare for future CQC inspection where GP interviews will take place. A governing Body development session facilitated by the external reviewer and will highlight the governance arrangements to be in place for both Sefton CCGs.	
	13.127 Safeguarding Hosted Service Monthly Assurance Report Debbie Fagan still to discuss with Fiona Clark.	**DF**
	13.128 Operational Governance Group – Key Notes Debbie Fagan to progress with Fiona Clark.	**DF**
	13.132NHSNE DNACPR Policy Debbie Harvey reported Do Not Attempt to Resuscitate (DNAR) policy is now unified and submitted to LMC but also requires ratification by other external groups. Debbie Harvey to Progress with LMC for current position statement.	**DH**
	13.134 –Asthma Management Plan – Brendan Prescott to progress feedback.	**DF**
	13.136 – Data Sharing Breach – Lin Bennett received email from Health Visitor and progressed with Helen Lockett who was not aware of any mandate re not being allowed to enter data on computer system in Liverpool. It would appear there was a misinterpretation of the email, however there are still discrepancies. The Committee agreed there should be data sharing within practices if Health Visitor on premises. Lin Bennett to establish what is happening in other practices and report back to this Committee.	**LB**
Q14/5	**Serious Incidents (SIs)** James Hester presented a report providing a detailed overview/current position of Aintree University Hospital (AUH) and SIs relating to patients of South Sefton CCG. There was a brief commentary and graphical breakdown SUI at provider level. At AUH there were 8 patients involved in incidents and 1 Never Event. There were 14	

No	Item	Action
	incidents relating to patients outside of SSCCG. James Hester also explained the processes in place providing assurance to the Quality Committee that SIs are being managed effectively by the CCG which includes performance management responsibilities as a commissioner but also internal CCG scrutiny from our GP Clinical leads. A SI report will be presented at each externally focussed Quality Committee. The Quality Committee noted the contents of the report and for the following to be actioned: • Gina Halstead asked about data on preventable suicide events at Mersey Care – Action: James Hester to request data from Gordon Jones for next meeting. • Location and type of incidents – clarify if unexpected death in admin office. Confusion on where the event took place. Action: James Hester The internal CCG SUI process is being reviewed and policy is being reviewed with CSU and taken to Operational Governance support group in February to ensure fit for purpose and goes will be submitted to Quality Committee in February for approval **Action: James Hester to liaise with CSU regarding suggested improvements to the report**	**JH** **JH** **JH** **JH**
Q14/6	**Performance & Quality Dashboard (AUH)** DF informed the committee of the background to the development of the new style dashboard and the work that had been undertaken with CSU and the CCG team. DF and CSU colleagues presented the new style Early Warning Dashboard but highlighted that provider narrative was still being awaited at the time of the submission of this report to the Quality Committee. Discussion was held as to whether a contract query should be raised with the Trust re: timeliness of response for providing data / narrative. The Quality Committee discussed the key areas of concern. DF and JH informed the committee of the date of the next Clinical Quality & Performance Group Meeting at the beginning of February where exception reporting would be discussed. Actions arising from key areas: • **Domain 1** - Cancer Waiting Times – Cancer Leads to look at increasing description in S Bar and tie in with quality schedule which will help to understand themes, breaches, admin delays etc. Also consider looking at Choose and Book. **Action: Gina Halstead and Debbie Harvey to review for next meeting.** • **Domain 3** - A&E Quality Indicators – Debbie Fagan reported there will be an action for CCG regarding penalties and CQUIN will bring to this Committee. - Stroke Pathways – review of bed based stroke to be undertaken. Escalate conversation with new AUH Medical Director, Richard Ward (RW). **Action: Gina Halstead to discuss with RW** • **Domain 5** - Safety Incidents resulting in severe harm or death – Oct 12 – Apr13 the reason for the decline was highlighted as not being clear. Committee would like to see breakdown of failings. **Action: Obtain Enhanced report / clarify reason for decline (James Hester).**	**GH** **GH** **JH**

No	Item	Action
	DF discussed the Alder Hey Quality Risk Summit led by NHSE held on 20 December resulting from numerous factors i.e. cardiology, mortality rates and whistle blowing. Minutes were recalled and currently waiting for the revised set/action plan to be shared with Committee when received. Debbie Fagan, Andy Mimnagh and Wendy Hewitt to discuss performance at Alder Hey and actions at CQPG. FC raised the requirement to ensure processes are in place so the governing body has assurance from QC next time it meets. Debbie Fagan to ensure placed on risk register. Still waiting for outcome of CQC regarding Liverpool Community Health	**DF**
Q14/7	**GP Clinical Quality Lead Report –** The GP Clinical Quality Lead chaired the quality committee and as such her update fed into the relevant agenda items throughout the meeting.	
Q14/8	**Locality Update** Cellulitis Service – Colette McElroy reported issue with Cellulitis service in that patients are sent back because they have not been able to get access to a prescriber. Service is running at fifty per cent of its referrals and fifty per cent of commissioning capacity but not clear why this is happening. Colette McElroy currently awaiting response to email from LMC regarding specification, if no response, refer back to Andy Mimnagh and Gina Halstead.. 18 week rule breach Practice has reported Alder Hey were in breach of the 18 week rule. **Action: Obtain acknowledgement by Alder Hey of 18 week pathway and ensure it is being followed. Malcolm Cunningham** Urology Clinic – out of date services on CCG website have been removed for some months and is having an adverse impact. **Action: James Hester liaise with Jenny Kristiansen** Coding issues regarding COPD at UHA were raised and how to access UHA to raise the issue CE also raised the issue of triage MCAS with 48 day wait. LB brought up double payment in terms of Community dexa scan services as patient chose to attend elsewhere but Southport charged for cancellation **Action: Fiona Clark to review Southport contract with Jan Leonard.**	**MC** **JH/JK** **FC**
Q14/9	**Corporate Risk Register** Key risks changes were highlighted – 7 risks decreased since last time. Two have increased – numbers 3 and 14. Additions around safeguarding issues and systems, high risk due to new risk anticipated delivery of the Action Plan. Debbie Fagan –reported about the risk new addition and the high risk linked to safeguarding in terms of the risk due to clarity of roles with provider, hosted services and CSU. Actions have been put in place to mitigate the risk and presented at the second part of the governing body. The risk cannot be reduced until Q3 report is submitted to provide assurance.	

No	Item	Action
	Newly appointed named nurse for safeguarding. Not willing to reduce risk until meet Quarter 3 performance from our providers. Monitor working together on flow through of information and prove working efficiently. 1. Processes we have in place with CSU and Hosted Service 2. It is realistic that is what had been achieved. The process is linked to our provider assurance which is why it is a separate risk.	
Q14/10	**Assurance Framework** This comes to the Governing Body six monthly and is useful to review alongside Corporate Objectives to see if there are any potential overlaps with the risk register What potential risks are to delivering those objectives Look at two together to see if any overlaps Relates to six key corporate priorities.	
Q14/11	**Provider Surveillance Status Report** The group met for the first time at the beginning of January and a report was to highlight the current and previous levels of assurance of our major providers and any CQC interventions and reviews. LCHT recently had CQC unannounced inspection and with a 10 day time frame to report back. LCHT are awaiting report of that inspection. **Action: to put on Enhanced Risk Register.**	**DF**
Q14/12	**Work Plan and Operating Model for QC, Operational Governance Group and EPEG.** Because the Committee was not quorate to make the required amendments to the work plan it was agreed for this item to be re-presented at the next meeting.	
Q14/13	**Key Issues Report of Corporate Governance Support Group** JH summarised key issues point 2 to give QC assurance patients listed A-J have been subject to scrutiny review by qualified individuals and will bring to QC for approval. Advance notice that policies will be coming in February. QC was assured that there is a robust process in place and will received for adoption in February	
Q14/14	**Meeting date discussion –** Not discussed	
Q14/15	**Any Other Business** **Clinical Training for Health Care Assistant** Lin Bennett reported LCH produce all training packages in terms of VitB12s, updaters and fees are high. As a CCG can we provide a quality service so HCA could get involved with LCH. **Action: Lin Bennett email Fiona Clark for consideration.**	LB
Q13/16	**Date and Time of Next Meeting** Thursday 20 February 2014	

No	Item	Action
	3:00 pm – 5:00 pm 3rd Floor Boardroom, Merton House, Bootle L20 3DL	

Signed …….. Date ……

Chair/Vice Chair

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee
Minutes

Date: Thursday 21 November 2013 1.00pm – 2.30pm

Venue: Boardroom 3rd floor Merton House, Stanley Road, Bootle.

Attended

Roger Driver (Chair)	Lay Member(Vice Chair of CCG)	RD
Dr Steve Fraser (Vice Chair)	GP Governing Body Member	SF
Sharon McGibbon	Practice Manager Governing Body Member	SMG
Fiona Clark	Chief Officer	FLC
Martin McDowell	Chief Finance Officer	MMD
Malcolm Cunningham	Head of Performance & Health Outcomes	MC

Also in attendance

Gustavo Berni	GP Lead South Sefton	GB
Anna Ferguson	GP Lead South Sefton	AF
Brendan Prescott	CCG Lead for Medicines Management	BP
James Bradley	Head of Strategic Financial Management	JB
Ken Jones	Chief Accountant	KJ
Colette McIlroy	GP Lead South Sefton	CMI

No	Item	Action
FR13/121	**Apologies for Absence** Apologies for absence were received from: Dr John Wray GP Governing Body Member Steve Astles Head of CCG Development Tracy Jeffes Head of Delivery and Integration Debbie Fagan Chief Nurse Brendan Prescott – Deputy Head of Quality and Safety/ Head of Medicines Management	
FR13/122	**Declarations of Interest regarding agenda items** Martin McDowell, Malcolm Cunningham, James Bradley and Ken Jones all declared dual roles in both Southport and Formby and South Sefton CCGs**.**	
FR13/123	**Minutes of the previous meeting** The minutes of the previous meeting were approved as a true and accurate record	
FR13/124	**Action tracker** All appropriate actions were closed on the action tracker.	

No	Item	Action
FR13/125	**Month 7 Finance Report** MMD presented this paper which presented the F & R Committee with an overview of the financial position for NHS South Sefton Clinical Commissioning Group. It provided a summary of the changes to the financial allocation of the CCG, and presents the financial position of the CCG as at month 7, and outlined the key risks facing the CCG. At the end of October, the CCG was £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. The committee discussed the report and noted the comments of KJ regarding Estates. KMC referred the committee to the additional £150m A & E funding announced at national level. MMD responded that our Trusts had already received additional funding as part of the earlier £250m allocation and that he did not expect further allocations to be made to Aintree in this financial year. RD requested clarification as to lessons learned from this year in terms of income and expenditure. MMD assured that committee that the finance team continue to review financial position and process. KJ updated the committee regarding legacy issues and noted that PWC would act as an arbitrating body between NHS England and successor organisations with regard to legacy issues, although Sefton had not been included in the first tranche selected.. KJ will provide an update report to the committee in January 2014. **The F & R Committee 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**	
FR13/126	**Strategic Financial Plan** MMD and JB presented this report. MMD noted that this is a technical document at this point which will become more focused on service issues when represented in January 2014 following the publication of CCG allocations. This plan will be further strengthened by the work of KMC, who noted that QIPP strategy must be built into all commissioning intentions at the outset. RD requested clarification that this has been communicated at wider group level. AF responded that understanding is increasing; however, a significant amount of data is taken on trust by the GP community in recognition of the expertise at the CCG. RD requested that the financial strategic plan be disseminated in a format that would encourage public engagement. MMD noted that the key risks to note at this point are the issues surrounding the Integrated Transformation Fund and the extent of the proposed “top-slice” to the CCG budgets in 14/15 and 15/16. This report will be brought back to committee in January and thereafter submitted on a quarterly basis. **The Finance and Resource Committee noted the Strategic Financial Plan**	**MMD/JB**

No	Item	Action
FR13/127	**CCG Contracting Strategy Update** JB provided this verbal update. The CSU hosted a contracting workshop attended by a number of CCG leads and KMC has produced timelines which will form part of the next contracting report. **The Finance and Resource Committee noted the CCG Contracting Strategy Update.**	
FR13/128	**QIPP Update** MMD updated the committee that at a recent meeting of the QIPP Think Tank a review of the QIPP opportunities was undertaken. These will be rag rated, risk assessed and presented to the Governing Body for consideration. Current commissioned services will also be analysed to ensure efficiency targets are being achieved. Quick wins will be targeted. MC will provide a regular QIPP update at each meeting. **The Finance and Resource Committee noted the QIPP Update**	
FR13/129	**KPI Exception Reports** MC updated the committee the team is currently working on a KPI dashboard that will be presented to committee in January 2014. MC distributed a dashboard detailing South Sefton Transformational milestones. The Committee noted that there appeared to be a significant number of KPI's. This will be reviewed by SA and Dr Mimnagh. The Governing Body will be provided with a clear indication of the lead for each KPI. **The Finance and Resource Committee noted the KPI Exception Reports**	**SA** **MC**
FR13/130	**IFR Update Report** MMD presented the current IFR report and noted that he continues to discuss the allocation of some requests to Specialised Commissioning. FLC commented that a meeting will be arranged between FLC, MMD and JL to provide assurance surrounding the management of IFR requests. MMD will update the committee at the next meeting. **The Finance and Resource Committee noted the IFR Update Report**	**FLC/MMD**
FR13/131	**Benchmarking VFM Reports** MC presented this report of adverse indicators which will be used to inform future QIPP schemes. This report is presented to Board and will be used to inform commissioning intentions. **The Finance and Resource Committee noted the benchmarking and VFM Reports**	
FR13/132	**Integrated Transformation Fund** **Integrated Transformation Fund** MMD presented this verbal update and noted that the Finance Team continue to work with the Council to discuss the funding arrangements. Further details will be brought back to the committee in January 2014 **The Finance and Resource Committee noted the update regarding the Integrated Transformation Fund**	

No	Item	Action
FR13/133	**Quality Premium Dashboard** MC presented this high level overview of the Quality Premium Dashboard. The committee noted the weighting attached to each area and the possible funding achievable. MMD noted that this revenue is currently unallocated and discussions will take place at locality level to agree plans. **The Finance and Resource Committee noted the Quality Premium Dashboard**	
FR13/134	**Any other business** There were no items of other business	
FR13/135	**Date and Time of next meeting** **1.00pm – 2.30pm** **Thursday 23rd January 2014** **Boardroom Merton House**	

Attendance Tracker

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

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee
Minutes

Date: Thursday 23 January 2014 1.00pm – 2.30pm

Venue: Boardroom 3rd floor Merton House, Stanley Road, Bootle.

Membership

Roger Driver	Lay Member	RD
Paul Thomas	GP Governing Body Member	PT
Graham Morris	Lay member (Vice Chair CCG)	GM
Sharon McGibbon	Practice Manager	SMG
Fiona Clark	Chief Officer	FLC
Martin McDowell	Chief Finance Officer	MMD
Malcolm Cunningham	Head of Primary care and Corporate Performance	MC
Debbie Fagan	Chief Nurse	DF
Tracy Jeffes	Head of Delivery and Integration	TJ
John Wray	GP Governing Body Member	JW

In attendance

Gustavo Berni	GP Lead Crosby Locality	GB
Colette McElroy	GP Lead Seaforth and Litherland Locality	CME
James Bradley	Head of Strategic Financial Management	JB
Ken Jones	Chief Accountant	KJ
Karl McCluskey	Head of Strategic Planning and Assurance	KMC
Brendan Prescott	Deputy Head of Quality &CCG Lead for Medicines Management	BP

No	Item	Lead
FR14/01	**Apologies for absence** Apologies for absence were received from John Wray, Malcolm Cunningham and Karl McCluskey.	
FR14/02	**Declarations of interest regarding agenda items** Declarations of interest as joint point post holders at both CCGs were made by; Fiona Clark, Chief Officer, Martin McDowell Chief Finance Officer, Debbie Fagan, Head of Quality and Chief Nurse, David Bacon Interim Deputy Chief Finance Officer, James Bradley Head of Strategic Financial Planning, Ken Jones Chief Accountant and Fiona Doherty Head of Transformational Change.	
FR14/03	**Minutes of the previous meeting** The minutes of the previous meeting were signed as a true and accurate record.	
FR14/04	**Action points from the previous meeting** The action points of the previous meeting were closed as appropriate.	

No	Item	Lead
FR14/05	**Month 8/9 Finance Report** JB introduced the finance report for Month 9 and reported that overall the CCG position is still on target to meet the planned surplus. The CCG is now receiving more effective intelligence regarding CHC payments which is assisting the planning process. Prescribing continues to be under spent including a significant under spend in the high cost drugs budget. Independent sector budget is overspent and the forecast overspend for the full year has now increased to £0.717m. RD requested that clarification regarding provider use of the May Logan Centre and incorrect public perception relating to which services are supported by the CCG. **The committee noted the Month 9 Finance update.**	
FR14/06	**Strategic Financial Plan Update** JB presented this update and noted that the plan had been drafted taking into consideration the four main areas; resource allocations, better care fund, steps in planning process and assumptions in financial plans. JB further noted that the initial allocation that the CCG had anticipated providing towards the Better Care Fund was now likely to be provided centrally. A final strategic financial plan will be provided to the Governing Body in March 2014. **The Committee noted the Strategic Financial Plan update.**	**MMcD**
FR14/07	**Q2 Contract Performance Review** MMcD introduced this report and noted that presentation of the Q2 Contract Performance Review should have been made in November 2013. This will be rectified going forward and the committee was assured that the Q3 Contract Performance review would be presented in February 2014. Non achievement of CQUIN targets will result in the withholding of CQUIN payments as these are within the remit of the provider. Going forward contract terms and conditions will be drafted appropriately to ensure that were penalties are allowable it is within the remit of the provider to achieve the target. **The Finance and Resource Committee noted the contents of the Q2 Contract Performance Report**	**JB/MC**
FR14/08	**QIPP Update** FD presented the QIPP update and advised the committee that the CCG was on track to meet the QIPP targets. MMCD noted that the report could potentially have been more detailed, describing the journey that has led to the achieved saving and improvements. Future reports will focus on the Right Care journey and the relentless pursuit of value that will be adopted by the CCG. **The Finance and Resource Committee noted the QIPP update**	
FR14/09	**KPI Exception reports (PMO Dashboard)** FD presented this report and referred the committee to his report circulated in advance. The committee noted that a number of schemes had been approved in year and that performance data was being collected. **The Finance and Resource Committee noted the KPI Exception Report.**	

No	Item	Lead
FR14/10	**IFR Update Report** MMcD presented this update and noted that it was for information only. The CCG continues to investigate the protocols applied to reach the reported decisions. MMcD will report back progress on finding to the next meeting. **The Finance and Resource Committee noted the IFR Report**	
FR14/11	**Benchmarking and VFM reports** FD presented this report – and referred the committee to the funded care analysis . MMcD gave detailed explanation of how the report was likely to have been compiled and noted that further benchmarking reports would be brought to the committee as appropriate. MMcD advised the committee that he plans to seek assurance from NHS Somerset as to assumptions made when compiling the report. **The Finance and Resource Committee note the Benchmarking and VFM report.**	**MMcD**
FR14/12	**Better Care Fund** MMcD noted that a stakeholder event had been held on 22nd January that brought together providers to discuss the way forward. MMcD highlighted that areas which need strengthening include, how IT is used as an enabling force, and issues regarding integration of MH Services. Discussions are ongoing with the Council as to what areas of funding will be transferred as part of the Better Care Fund strategy. MMcD will continue to update the committee at each meeting. **The Finance and Resource Committee noted the better care Fund update**.	
FR14/13	**Quality Premium Dashboard** FD presented this report and referred the committee to the report circulated in advance. The committee noted that a number of indicators were expected to become green, however at the time of reporting these had not filtered through to the report. MMcD outlined that his expectation was that funding, as a result of achieving these targets will be recorded in the next financial year. FLC commented that GPs would be integral in the planning of the allocation of any additional funding. **The Finance and Resource Committee noted the Quality Premium Dashboard report.**	
FR14/14	**Prescribing Performance Report** BP presented this report, and noted that item growth continues, but at a reduced rate. In relation to the top therapeutic investment areas, less money has been spent than in same quarter last year. This is part of medicines optimisation plan. The committee noted that there were no significant drugs coming of patent this year. Pregablin will come off patent in the next financial year and this will have an effect. This information is made available at practice level and discussions for further improvements within practice are ongoing. **The Finance and Resource Committee noted the Prescribing Performance Report.**	

No	Item	Lead
FR14/15	**Q2 Capital Plan update** MMcD noted that this update was being presented as a consequence of the original work plan. The CCG has bid for funding to support IMT roll out, however the process by which the CCG would access capital funds is still to clarified. Discussions regarding strategic capital planning continue. MMcD will update the committee as appropriate. **The Finance and Resource Committee noted the Q2 Capital Plan verbal update.**	
FR14/16	**Balance Scorecard** FD presented this report and the committee noted that this document will now be referred to as the Delivery Dashboard. **The Finance and Resource Committee noted the contents of the Delivery Dashboard**.	
FR14/17	**CMCSU Performance Review** TJ presented this report. The committee noted that a lead analyst had been appointed and that initial feedback was positive. The committee were advised that a number of business process reviews for key areas remain outstanding at the time of reporting and therefore negotiation of a new contract will not begin until July 2014. The CCG has indicated that they may provide finance, IM&T and senior comms services in house going forward. This is below threshold set by NHS England for requiring a business case. **The Finance and Resource Committee noted the CMCSU performance report.**	
FR14/18	**Review of framework for commissioning decision making** FD presented this report and noted that a review had taken place of the framework for commissioning decision making. Two gateways are proposed going forward, to ensure proposals are prioritised in line with the strategic financial plan. Provision has been made for opening winter pressures. The approval of APC nice approved drugs will be dealt with separately, post APC. Discussion took place regarding cases that have been approved in principle within the strategic plan and if they need to be submitted to committee for final sign off. The committee discussed the review of continuing significant investments in the main contracts. **The Finance and Resource Committee noted the content and actions arising from the review of framework for commissioning decision making.**	**MC**
FR14/19	**Annual work schedule** The committee reviewed the content of the work schedule. The dates will be confirmed and the work schedule will be approved prior to the beginning of the next financial year.	**MMcD**

No	Item	Lead
FR14/20	**a. Ocriplasmin** BP presented this case for change. The committee noted that whilst this guideline would be adopted the costs incurred need to be reflected in the budget line of high cost drugs and administered by Ophthalmology providers. **The Finance and Resource Committee approve the Case for Change funding for Ocriplasmin** **b. Fluocinolone Acetonide (NICE TA 301)** **BP will present this case at the February meeting.**	**BP** **BP**
FR14/21	**Commissioning Policy Review** MMcD presented this verbal update on behalf of JL and noted that the 90 day consultation had begun in relation to the commissioning policy review. JL will present recommendations to both Finance and Resource Committee in March 2014. **The Finance and Resource Committee noted the Commission Policy review update.**	**JL**
FR14/22	**Any other Business** There were no items of other business.	
FR14/23	**Date and time of next meeting** **Thursday 20th February 2014 1.00pm – 3.00pm** **3rd Floor Boardroom, Merton House**	

NHS Southport and Formby Clinical Commissioning Group
NHS South Sefton Clinical Commissioning Group
NHS Liverpool Clinical Commissioning Group
NHS Knowsley Clinical Commissioning Group

Merseyside CCG Network

NHS West Lancashire Clinical Commissioning Group
NHS Halton Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group

Wednesday, 5 February 2014, 13.00 to 16.00
Boardroom 1, Regatta

Minutes

Present	
Niall Leonard	Chair, S&FCCG
Katherine Sheerin	CO, LCCG
Tom Jackson	CFO, LCCG
Ian Davies	Head of Perf, LCCG
Simon Banks	CO, HCCG
Martin McDowell	CFO, S&FCCG/SS CCG
John Wicks	Interim CO, WCCG
Julie Abbott	Deputy CFO, obo Dr Cox StHCCG/HCCG/KCCGs

Apologies	
Dr Cliff Richards	(standing) Chair, HCCG
Fiona Clark	S&FCCG/SSCCG
Paul Brickwood	CFO, KCCG
Dr Steve Cox	CO, StHCCG
Andy Pryce	Chair, KCCG
Dianne Johnson	CO, KCCG
Mike Maguire	CO, WLCCG
Ray Guy	LCCG
Clive Shaw	Chair, SSCCG
Nadim Fazlani	Chair, LCCG
John Caine	Chair, WLCCG
Paul Kingan	CFO, WLCCG
Sarah Johnson	CFO, StHCCG

In attendance	
Jackie Robinson	CMCSU
Jan Snoddon	Halton CCG
Johanna Reilly	NHSE (M)

Clatterbridge Cancer Centre
Andrew Cannell, CEO
Dr Nicky Thorpe, Associate Medical Director
Fiona Jones, Project Director

Minutes	
Melanie Wright	SSCCG/S&FCCG

No	Item	Action
14/13.	**Welcome and Introductions** were made.	
14/14.	**Clatterbridge Cancer Centre** Andrew Cannell extended an invitation to CCGs to visit and ensure the CCGs understand the developments under way at the Clatterbridge Centre and at the Royal, to move the inpatient bed base from the Wirral with wraparound outpatient services, with close collaboration with the Royal and the clinical reasons for so doing.	

No	Item	Action
	Key points of his discussion included: • contractual sign-off of NHS contracts is due 28 February; • a public consultation for completion by early Autumn to produce a comprehensive business case; • the hope to start on site in 2016; • clinical services commencing in 2018; • satellite services then operating on the Wirral site and at Aintree; • the importance of having a thriving research and development department; • the public engagement exercise already being under way; • a joint Overview and Scrutiny Committee being sought across Sefton, Liverpool and the Wirral; • the importance of the CCGs engaging with the business planning process for the local context. In relation to whether there had been any modelling on the impact upon secondary care partners, conversations are ongoing between the surgical teams and are cognisant of likely future requirements for specialised commissioning services to reduce services. It is proposed to use the Cancer Networks to progress this further. Mr Cannell acknowledged that more work is required on modelling and the intention to remain vigilant of possible consequences, either intended or unintended, together with the service interdependencies. The majority of services will be at the Royal site so patients will no longer be required to attend the Clatterbridge site, although the Aintree site will be retained. There is no current intention to alter the current configuration of service operation in District General Hospitals. In relation to future configuration of services generally, it would be helpful if Clatterbridge could be brought into the conversation with secondary care providers. The requirements for Clatterbridge to replace equipment every ten years, together with desire to have the best equipment, remains challenging, particularly in an environment where demand is increasing but this remains a key focus. Should an increase in capacity be required, it would take Clatterbridge circa 18 months to operationalise. There are negotiations under way considering the availability of expansion space at the Royal site. Mr Wicks referred to a recent attendance at the OSC in Warrington at which the level of public engagement undertaken in relation to this project was commended.	
14/15.	**Strategic Planning** Draft submissions to be reviewed at the Co-Commissioning Collaborative next week. Ms Reilly referenced a document she has today circulated, which is an NHSE(M) Planning Framework for Assurance which contains considerations for the NHSE(M) team. Mrs Reilly agreed to provide Mr Wicks with a copy. Ms Reilly clarified that although a narrative is not required for the 2 year plan, some idea of 'story' will be required. Ms Sheerin advised that the CCGs' Governing Bodies will need to engage in this process and a meaningful narrative is unlikely to be available in the short term until this process has taken place. Ms Reilly as not able to confirm at the	MW

No	Item	Action
	current time whether the narrative will be required for the April submission. Primary care will be considered within the CCGs' units of planning. Direct Commissioning - national commissioning intentions for direct commissioning will be need to be considered within the units of planning. Final strategic plan submission date is 20 June. The submission on 14 February was felt to be slightly less formal than the April submission date and will enable NHSE(M) to identify where any areas of support are required in preparation for the April submission. It was agreed to jointly commission a review of organisational plans following the initial submissions and identify opportunities for services that could be commissioned across Merseyside. The capacity of CSU to undertake this piece of work was discussed. This can be discussed next week at the Co-Commissioning Collaborative next week. Ms Reilly expressed the importance of the collaborative nature of this work. Outcome ambitions to be shared at a future Co-Commissioning Collaborative session in March or April. It was acknowledged that matters could be overtaken by providers' financial positions. There was a discussion around the ability and feasibility of signing contracts by 28 February. Ms Reilly agreed to progress an invitation to a consultant for a further Co-Commissioning Collaborative meeting to progress joint working.	MW MW/FLC JR
14/16.	**Safeguarding Hosted Service - Update** Mrs Snoddon made two additions to the report in that Michelle Creed from NHSE has been involved in the review and in relation to the vulnerable adults service, there are two nurses, not one. An increase in activity in the service has been noticed, particularly in relation to adults, together with an increase in expectations of the service. The service has absorbed support to Specialised Commissioning and Direct Commissioning for NHS England, for which no financial contribution is made. Model 4 contained within the report is recommended as the best option. A review of the designated doctor is under way and a review of the cost associated with this role is also recommended. Model 4 was agreed, albeit without the investment and a request for a review of the designated doctor function. Mrs Snoddon referenced a conversation with NHSE around likely future assurance, which was likely to include declarations of liberty standards and following the recent status review, there are concerns across the patch generally. Ms Sheerin highlighted the need for comprehensive reporting to Chief Nurses in each CCG. Ms Snoddon advised that the staff are aware and, indeed, took part in the review and there is a meeting with them on Friday to communicate the decision of the Network to the team.	JS
14/17.	**Apologies for absence** were noted.	
14/18.	**Minutes from the previous meeting** The minutes were agreed as an accurate record.	

No	Item	Action
14/19.	**Actions from the previous meeting** All actions were closed down save for the following 13/5 (November meeting) AQuA – Liverpool CCG have not signed up to AQuA. Mr McDowell offered to establish who was signed up to the service in the North West. 13/10 (November meeting) Library and Knowledge Services to Support the Work of North West CCGs – Ms Clark to investigate the service being offered. *Carried forward.* *EPRR* – Mr Davies referenced the apparent NHSE desire to move category 1 responder status to CCGs, which was not mandated at the current time.	MMcD FLC
14/20.	**General Practice Workforce** Mr Banks suggested using the Health and Social Care Information Centre website – NHS Staff 2012 General Practice as a baseline for this exercise. It was agreed that each CCG undertake a baseline exercise in time for the next meeting. [Superseded by email circulated by Dr Leonard of 5 February 2014.] A standardised approach is required and a conversation with the membership about their intentions. Dr Leonard agreed to draft a letter to practices and circulate to each CCG for onward transmission to membership practices. [Superseded by email circulated by Dr Leonard of 5 February 2014.] Mr Banks agreed to share the presentation he made to Halton practices.	SB
14/21.	**Ensuring Continuity of Health Services: Designating Commissioner Requested Services and Location Specific Services** CMCSU are seeking a common approach. There was a conversation around what should constitute a requested service. It was agreed that all CCGs would seek clarity from contractual leads and this issue would be discussed at the next meeting in March.	All
14/22.	**Any Other Business** *The Royal CQC Report* – the initial feedback is positive. There are some areas for consideration and an action plan must be produced by 5 March. The CQC will then report to Monitor, who will then make a decision as to whether the FT application can proceed. *LCH CQC Report* - LCH attended at SS CCG's meeting of the Governing Body to discuss. They did acknowledge the areas for concern but were disappointed with some of the findings.	
14/23.	**Date of Next Meeting** Wednesday, 5 March 2014, Boardroom, Merton House, Bootle	

** Dates for the Diary 2014**

MEETING	DATE	TIME	VENUE
Merseyside CCG Network	5 March	12.00 to 13.00 13.00 to 16.00	Informal pre-meeting Meeting, Boardroom, 3rd Floor, Merton House, Bootle L20 3DL
Merseyside CCG Network	2 April	12.00 to 13.00 13.00 to 16.00	Informal pre-meeting Meeting, Regatta

MEETING	DATE	TIME	VENUE
Merseyside CCG Network	7 May	12.00 to 13.00 13.00 to 16.00	Informal pre-meeting Meeting, Regatta
Merseyside CCG Network	4 June	12.00 to 13.00 13.00 to 16.00	Informal pre-meeting Meeting, Regatta Place
		Please note change in start times	Please note change of venue to St Helens Chamber
Merseyside CCG Network	2 July	1.00pm-1.30pm 1.30-4.30pm	Informal pre-meet inc Lunch Meeting, Conference Rooms A&B, St Helens Chamber, Salisbury Street, off Chalon Way, St Helens WA10 1FY
Merseyside CCG Network	6 August	1.00pm-1.30pm 1.30-4.30pm	Informal pre-meet inc Lunch Meeting, Conference Rooms A&B, St Helens Chamber, Salisbury Street, off Chalon Way, St Helens WA10 1FY
Merseyside CCG Network	3 September	1.00pm-1.30pm 1.30-4.30pm	Informal pre-meet inc Lunch Meeting, Conference Rooms A&B, St Helens Chamber, Salisbury Street, off Chalon Way, St Helens WA10 1FY
Merseyside CCG Network	1 October	1.00pm-1.30pm 1.30-4.30pm	Informal pre-meet inc Lunch Meeting, Conference Rooms A&B, St Helens Chamber, Salisbury Street, off Chalon Way, St Helens WA10 1FY
Merseyside CCG Network	5 November	1.00pm-1.30pm 1.30-4.30pm	Informal pre-meet inc Lunch Meeting, Conference Rooms A&B, St Helens Chamber, Salisbury Street, off Chalon Way, St Helens WA10 1FY
Merseyside CCG Network	3 December	1.00pm-1.30pm 1.30-4.30pm	Informal pre-meet inc Lunch Meeting, Conference Room B, St Helens Chamber, Salisbury Street, off Chalon Way, St Helens WA10 1FY

HEALTH AND WELLBEING BOARD

MEETING HELD AT THE TOWN HALL, BOOTLE ON WEDNESDAY 19TH FEBRUARY, 2014

PRESENT: Councillor Moncur (in the Chair)
Dr. Janet Atherton, Fiona Clark, Robina Critchley, Councillor Cummins, Councillor John Joseph Kelly, Maureen Kelly, Dr. Niall Leonard and Dr.Clive Shaw

48. APOLOGIES FOR ABSENCE

Apologies for absence were received from Colin Pettigrew and Phil Wadeson.

49. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the Minutes of the meeting held on 30 October 2013 be confirmed as a correct record.

50. DECLARATIONS OF INTEREST

No declarations of pecuniary interest were made.

51. SEFTON STRATEGY FOR OLDER CITIZENS 2014-2016

The Board considered the draft "Sefton Strategy for Older Citizens 2014-16" (the Strategy) which had been prepared by the Sefton Partnership for Older Citizens (SPOC).

Kevin Thorne, Integrated Commissioning Manager and Roger Pontefract, Chair of SPOC presented the report which indicated that the draft Strategy was considered in detail by the 3 Older Peoples Forums in Sefton during September and October; and was circulated widely for comments to Council Officers, the E-Consult Panel and the Sefton Clinical Commissioning Groups' 'Big Chat" circulation list.

The draft Strategy, attached as an appendix to the report, had a vision of creating a place where older people could live, work and enjoy life as valued members of the community; and detailed the following eight objectives:-

- objective 1 – to advocate that the voice of older citizens is reflected in the planning and delivery of services
- objective 2 – to reduce the level of loneliness and social isolation experienced by older people in sefton
- objective 3 – to encourage the provision of health and wellbeing services for older people which are effective and of high quality

- objective 4 – to help older people to achieve financial security
- objective 5 – to work with local agencies to provide services which are of high quality, joined-up, and age-proofed
- objective 6 – to help older people to feel safe and secure within their communities
- objective 7 – to challenge providers to treat vulnerable older citizens with dignity and respect in all care settings
- objective 8 – to promote and respond to the impact that the new care Bill will have on older citizens in Sefton

The Strategy concluded that SPOC wanted Sefton to be a place where old age was enjoyed rather than endured; stated that a positive outlook and strong support networks were vital if later life was to be enjoyed to the full; and that the Strategy demonstrated how this could be achieved.

The Board also watched a video produced by SPOC on the Strategy.

RESOLVED: That

(1) the "Sefton Strategy for Older Citizens 2014-16" be approved; and

(2) the Sefton Partnership for Older Citizens be requested to prepare an Action Plan to monitor its implications; and to present regular progress reports to the Programme Group of the Health and Wellbeing Board.

52. OLDER PEOPLE'S PILOT - CHURCH WARD

The Board considered the report of the Area Co-ordinator Central Sefton updating on the progress of the Church Ward Older People Pilot (the Pilot).

Councillor Cummins and Alex Spencer, Area Co-ordinator presented the report which indicated that in November 2012, the Cabinet Member - Older People and Health approached officers from the Council in order to develop a pilot which focused on reducing loneliness and social isolation for older people (residents aged 60 and over) living in Church ward; and that in order to support this pilot a meeting was convened with partners working across Church ward at which three discreet work areas were identified, namely:-

(1) the identification of older people living in Church ward who may either experience loneliness/social isolation, or who may be vulnerable to experiencing loneliness/social isolation;

(2) the development of an online directory of services, which could signpost or refer identified older people to services which they may not know are available; and

(3) a mapping exercise of community assets to determine what partner assets and "soft" assets e.g. cafes, social clubs, are available in Church ward.

The report also identified the progress to date on the three workstreams by an established Steering Group; and that the Steering Group would continue to work with the Campaign to End Loneliness to determine examples of national best practice that could be applied locally.

RESOLVED: That

(1) the update on the progress of the Church Ward Older People Pilot be noted; and

(2) further reports on the progress of the Pilot be submitted to future meetings of the Board.

53. UPDATE ON THE WINTERBOURNE REVIEW

The Board considered the report of the Director of Older People that updated on progress with the stocktake undertaken as part of the national Winterbourne View Improvement Programme (WVIP).

The report indicated that the Council had submitted evidence and information as required to WVIP and had used this as an opportunity to understand changes to responsibilities and develop new partnerships following the organisational changes introduced under the Health and Social Care Act 2012; that WVIP had analysed the stocktake return; and Appendix 1b to the report set out the comments taken from Sefton's narrative and summarised to form an outline of key strengths and potential areas for development.

RESOLVED: That

(1) the Winterbourne View Joint Improvement Programme stocktake of progress as detailed in the report and Appendix 1b be noted; and

(2) a further progress report be submitted to the Board in three months on the most pertinent points actioned.

54. LIFESTYLE AND MENTAL WELLBEING SURVEY

The Board considered the report of the Director of Public Health that advised of the findings of two surveys examining different aspects of health and wellbeing in Sefton in 2012.

The report indicated that the first survey, the Merseyside Lifestyle Survey, was jointly commissioned with NHS Halton and St Helens, NHS Knowsley, and Liverpool Primary Care Trust to explore key health behaviours and attitudes across Merseyside and within specific population groups; whilst the second survey, the Mental Wellbeing Survey, was commissioned

across the North West in response to a growing need to understand more about the mental wellbeing of people in the region.

The Appendix to the report provided the key results of the surveys relating to the following topics, general health, healthy weight, smoking, alcohol, mental wellbeing, place and money.

RESOLVED:

That it be noted that the two surveys referred to in the report provide a rich source of intelligence that can be used to inform the development of effective population based interventions to improve health and wellbeing and to reduce inequalities.

55. CLINICAL COMMISSIONING GROUPS DELIVERY DASHBOARD - QUARTER 2

The Board received a presentation from Fiona Clark, Chief Officer for the Southport and Formby and the South Sefton Clinical Commissioning Groups (CCGs) on Checkpoint Quarter 2 CCG Delivery Dashboard.

Ms. Clark detailed the five balance scorecard domains of:-

- Are local people getting good quality care?
- Are patient rights under the NHS constitution being promoted?
- Are health outcomes improving for local people?
- Are CCG's delivering services within their financial plans?
- Are conditions of CCG authorisation being addresses and removed (where relevant)?

together with the CCG assurance framework balance scorecard summary showing the red/amber/green domain status; and concluded by updating on the CCG Delivery Dashboard relating to:-

- Support plan from Q1 agreed and being implemented
- Checkpoint 3 with NHS England (Merseyside) Team – March 2014
- Further update to Health and Wellbeing Board – March 2014

Ms Clark advised that she would bring Q3 performance to the next meeting, to ensure the Board was kept appraised of performance.

RESOLVED:

That Fiona Clark be thanked for her informative presentation.

56. COMMISSIONING INTENTIONS AND FORWARD PLANNING - CLINICAL COMMISSIONING GROUPS

The Board received a presentation from Fiona Clark, Chief Officer for the Southport and Formby and the South Sefton Clinical Commissioning

Groups (CCG) on Commissioning Intentions and Forward Planning of the CCG's.

Ms. Clark detailed the strategic planning framework; the NHS Right Care model which had three basic steps: Where to Look; What to Change; and How to Change; the Strategic Plan that had three strategic priorities (frail elderly, unplanned care and primary care transformation) together with the two delivery mechanisms (Virtual Ward Plus and Care Closer to Home Plus and the Better Care Fund); and the programmes attached to the Strategic Plans relating to cardio vascular disease, respiratory, diabetes, cancer, mental health, children, end of life and urgent care (Virtual Ward /Care Closer to Home).

Ms. Clark concluded by detailing the commissioning intentions of the CCG's for 2014/15 as follows:-

South Sefton CCG

- Hospice at home service
- Community Opthalmology- stage 1
- Community Respiratory Service
- New pathway for G.P accepted patients in A&E

Southport and Formby CCG

- Cardiovascular Disease Strategy
- Lymphoedema/Healthy Legs Service
- Gastroscopy - Access
- Children – Community Nursing
- Section 136

Together with the numerous other schemes under consideration by both CCG's for the period 2014/15 to 2018/19.

RESOLVED:

That Fiona Clark be thanked for her informative presentation.

57. BETTER CARE FUND PLAN

The Board considered the report of the Deputy Chief Executive that provided background information on the Better Care Fund (BCF) (formerly the Integration Transformation Fund) and outlining the approach being taken in developing Sefton's Better Care Plan. The report also noted that the funding within the BCF was not new money. It was a transfer of money from the NHS to Local Authorities which was already committed to services including substantial Local Authority service provision. The funding was intended to be used to support adult social care services which also had a health benefit

The report indicated that BCF required Councils and Clinical Commissioning Groups (CCGs) to deliver five year local plans for integrating health and social care; that the first stage of the process was that a BCF template had to be submitted by 14 February 2014 to NHS England (North), which would then be assured by that organisation, with support from the Local Government Association, to assess whether Sefton's BCF was sufficiently robust to deliver the governments vision for the integration of health and social care; that whilst BCF did not come into full effect until 2015/16, the intention was for CCGs and local authorities to build momentum during 2014/15, using the £200 million (nationally) due to be transferred to local government from the NHS to support transformation; that plans for use of the pooled budgets must be agreed by CCGs and local authorities, and endorsed by the local Health and Wellbeing Board.

The report also detailed how payment of BCF funds would be linked to performance; and recommended that the following metric from the NHS Outcomes Framework be adopted as the local metric for the Sefton Better Care Plan: Proportion of people feeling supported to manage their (long term) condition.

The report concluded that preparations for the development of a Better Care Plan, as part of the Southport and Formby and South Sefton CCG's 5 year Strategic Plans were underway; that once feedback, both from the assurance process and from continued engagement on the first cut of the Better Care template and the CCG's draft 5 year strategic plans was received, a more detailed revised plan would be submitted to the Health and Wellbeing Board and Cabinet; and that the guidance on the BCF had been changed during the process of development, and that it was anticipated that it would continue to be firmed up over coming months as the assurance process validated whether the BCF templates were robust enough in terms of vision, ambition and schemes, to draw down funding.

Attached as an appendix to the report was the BCF planning template that identified the plan details, the vision and schemes, the national conditions and the risks and mitigating actions to be taken.

RESOLVED: That

(1) the first version of the Better Care Plan, as set out in the template attached to the report (and as agreed by the Chair of the Health and Wellbeing Board in consultation with the Cabinet Member - Older People and Health, the Chief Officer of the Southport and Formby and South Sefton CCGs and the respective Chairs of those Boards, and submitted to Government on the 14 February 2014) be approved, subject to confirmation by Cabinet on 27 February 2014; and

(2) it be noted that there is no new money attached to the Better Care Fund.

58. PROGRAMME GROUP MEETINGS - KEY DISCUSSIONS AND DECISIONS

The Board considered the report of the Head of Business Intelligence and Performance that provided a list of key discussions/issues from meetings of the Programme Group since its inaugural meeting on 9 December 2013.

The report reminded the Board that the Programme Group consisted of statutory members of the Board, the Chief Officer of the Clinical Commissioning Groups, the Deputy Chief Executive of the Council and the Chief Executive of Sefton Council for Voluntary Services, with the aim of ensuring the delivery of the Health and Wellbeing Strategy on behalf of the Board, managing the performance of the sub structure's Forums and Task Groups, and providing strategic oversight through reports and managing the Forward Plan and Accountability Framework; that the Programme Group had met on three occasions; and provided details on the following topics that had been considered:-

- Better Care Fund (formerly Integration Transformation Fund)
- Partnerships – Development and Relationships
- Policy Updates/Statutory Roles
- Provision of Mental Health and Wellbeing Services

RESOLVED:

That the range of issues discussed and actions taken by the Programme Group during its monthly meetings be noted.

59. ROBINA CRITCHLEY

The Chair advised that this would be the last meeting of the Board attended by Robina Critchley, Director of Older People as she was due to shortly retire from Sefton Council.

RESOLVED:

That the Health and Wellbeing Board places on record its best thanks and appreciation to Robina Critchley for her many years service to Sefton Council and for her efforts in establishing and serving on the Board; and wishes her a long, healthy and happy retirement.

South Sefton Clinical Commissioning Group

South Sefton Medicines Optimisation Operational Group (SSMOOG) Minutes

Time and Date 10.30am – 12.30pm Tuesday 17th December 2013
Venue: Conference Room 3A, 3rd Floor, Merton House

Members:	**Dr S Fraser (SF)**	**GP Governing Body Member**
	Dr J Thomas (JT)	**GP Representative**
	Helen Roberts (HR)	**Senior Practice Pharmacist**
	Brendan Prescott (BP)	**Lead for Medicines Management**
	Janet Fay (JF)	**Senior Practice Pharmacist**
	James Hester (JH)	**Programme Manager for Quality**
	Helen Stubbs (HS)	**C&MCSU Link**
Minute Taker	**Ruth Menzies (RM)**	**Medicines Management Administrator**

No	Item	Action
13/103	**Apologies** There were no apologies received.	
13/104	**Minutes of the meeting dated 13th November 2013** BP had amendments that needed to be added to the minutes. BP to forward to RM. Once these have been incorporated the minutes were approved as an accurate record.	**BP**
13/105	**Matters arising from minutes dated 13th November 2013** 13.93/13.59 – LPC have reminded all about the agreed principles in their December Newsletter. The matter is still ongoing but the progress is slow. JF spoke to Joe Chattin following the LPC meeting and feels another meeting will take place. It was noted High Pastures are considering refusing third party requests. Discussions took place regarding what the process would be through EPS and problems that can arise. Issues that have occurred out of area regarding forcing patients to sign up to particular pharmacies etc were discussed. It is hoped the EPS Project Manager will attend a future JMOG. Diane Sander is continuing to pursue feedback from Knowsley	

No	Item	Action
	CCG to see how the pilot has been going. BP will speak to JC this afternoon in relation to Medicines Management attending future LPC and LMC meetings. BP confirmed Bullens meeting went well. Bullens confirmed their process is to ensure patients only get what they need. It is hoped that a pharmacist from the team will visit Bullens to observe the process. All phone calls are recorded. At the next team meeting we are to ask if the team can highlight any situations where Bullens does not follow their procedures. Examples to also be requested at locality meetings. The aim is to ensure patients are initially set up correctly. It was noted the Stoma Nurse feels that Bullens are giving a good service. It is hoped an update of the review the Stoma Nurse is undertaking can be given at the next SSMOOG. 13.93/13.66 Tithebarn CDiff Outbreak - HR to liaise with SC and put a paper together for the next Quality Meeting. 13.93/13.67 – A process has yet to be put in place for Sara Boyce to prescribe at the Pain Clinic. 13.95 JF and Jane Ayres have arranged a meeting with Lifeline which will take place in January 2014. HR to supply details of concerns she has come across. Merseycare are concerned regarding the amount of requests for alzheimer's patients that are coming back to them were shared care has been declined. The annualised spend for prescribing in primary care was calculated at around £30,000. 13.96 Formulary and Guidelines – everything that went to the JMOG was agreed. 13.96 HR confirmed the formatting (colours) had been resolved. Denosumab – BP has held discussions in relation to funding for S&O and Aintree budgets.	**BP** **HR** **HR**

No	Item	Action
13/106	**Matters arising from minutes from MMOG – not applicable as last meeting a JMOG** The minutes came out this morning and the following items were discussed:- - Shared care to ADHD – Jane Ayres to review patients. Business case to go to Finance and Resource Committee. - Degaralix – BP has written to the Clinical Director of Aintree to establish where the monitoring will take place as the S&O were clear in their response. - Approval of destruction policy. - Horizon scanning. - Denosumab prescribing will come to primary care from 1st April. - Osteoporosis Guidelines – it is hoped this will go to APC via the Formulary and Guidelines Sub Group. HR to ask Becky Williams to look at referral figures. HS to establish what other CCGs are doing.	
13/107	**Locality updates/ Practice Updates/Feedback** High Pastures: Is uncomfortable prescribing a NOAC, if it wasn't being initiated in secondary care. They appreciate that it is a primary care drug. However, it is currently black triangle. They would be grateful for any comments or feedback from the SMOOG. Other pharmacists have stated their practices are uncomfortable about prescribing and initiating NOACs. The GMCs point of view for prescribers they have to be comfortable and confident prescribing. It was confirmed Sefton are the lowest prescribers in Merseyside. The Decision Making Sessions looked at how decisions are made and whether this should be explored further at locality meetings. SF asked for feedback from Neil Maskrey (NM) once all sessions have taken place and it was noted that NM had felt the last session was very interesting. BP to await further feedback.	
13/108	**APC Minutes** <u>Minutes from the 11th December 2013</u> There is nothing to report as the above meeting did not take place. <u>Pan Mersey APC CCG Report from the 11th December 2013</u> There is nothing to report as the above meeting did not take place.	

No	Item	Action
13/109	**Budget Update YTD and FOT – September data** Month 6 – showing a forecast at outturn with a £254,000 underspend which is an improvement on month 5. There is a similar position in S&F with all bar one practice showing an improved position on the previous month.	
13/110	**Shared Care update** Denosumab prescribing will come to primary care from 1st April. Discussion took place regarding the process practices will have to follow. It was mentioned that in Manchester they have a hub of practices which takes on some of the workload.	
13/111	**Risk Log** Nothing has been added to the log. One item previously on which relates to the CCG coming in under budget. BP to add the introduction of EPS and the risks from a practices and community pharmacy perspective and that we require assurance from iMerseyside that all is working well. It was noted all community pharmacies now have their smart cards.	**BP**
13/112	**Inhaler Technique Project** The above has been agreed at Liverpool CCG with the intention of reducing admissions, cost and ensuring appropriate use. The process is that a patient is identified and a MUR undertaken and assessment carried out with results to be sent back to practice with appropriate follow ups. HR to confirm with Jenny Johnston that the SSMOOG has approved the project. It was noted the Isle of Wight did something similar but across the whole health economy showing significant reduction in waste and patient admissions. It was felt the practice nurses trained up but various issues were raised. Discussed doing in PLT time.	**HR**

No	Item	Action
13/113	**Oral Magnesium** Discussed magnesium supplements (amber unlicensed) and it was felt there was not a huge consensus at the APC. Most patients have already been switched to a cheaper product. It was agreed that supplements should be used in preference to a special order product. Discussed need to review PPI use in patients with low magnesium the team should still keep an eye on patients.	
13/114	**Team actions (MHRA Alerts)** The team have responded to recent MHRA alerts as follows: Free style blood glucose testing strips – sent letters to patients of the effected batch numbers Jext retractable needles – Alder Hey have written to their patients. A supply of epipens has been requested from America. However, they need to know how to use an epipen as they are slightly different. Alder Hey are however asking patients to contact their practices. Aintree and S&O have also sent out letters to their patients. HR to find out who has been written to via Clare Moss, and then contact patients individually.	
13/115	**JMOG Dates** JMOG dates attached for information and will take place on alternative months with MMOG.	
13/116	**Terms of Reference** A few changes have been made and will be circulated once these have been incorporated.	

No	Item	Action
13/117	**AOB** BP confirmed that Dr Anna Ferguson has verbally agreed to one session per week and Medicines Management Clinical Lead. It was confirmed the Antimicrobial Guidelines are due to be added to the APC website this week with the exception of the urology section. RM to circulate the dates for next year's meetings. BP thanked SF for his contribution as Chair to this meeting and support to the team for many years which is really appreciated.	**RM**
	Date of Next Meeting The next meeting is due to take place on 25th February 2014, 12 noon to 2pm, in Conference Room 3B, Merton House.	

Signed : ……..… Date: ……
Chairperson

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	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	NA	NA	NA
James Hester,	NA	NA	NA	NA	NA	NA	NA	NA	✓	✓
Sejal Patel Senior Practice Pharmacist, South Sefton Clinical Commissioning Group	✓	✓	✓	✓	NA	NA	Apols	✓	NA	NA
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	✓	✓	Apols	Apols

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 Jill Thomas, GP Representative, South Sefton Clinical Commissioning Group	✓	✓	✓	✓	NA	NA	✓	✓	✓	✓

Meeting Title: Health & Wellbeing Board - Programme Group			
Date:	11th February 2013	**Time:**	3.30 pm
Venue:	Merton House, Bootle	**Chair:**	Peter Morgan

Attendees:

Health & Wellbeing Board Members and Programme Group Members

(JA) Janet Atherton, Director of Public Health, Local Authority (LA)
(RC) Robina Critchley, Director of Older People, Local Authority (LA)
(FC) Fiona Clark, Chief Officer, Southport & Formby/South Sefton Clinical Commissioning Group (CCGs)

Other Programme Group Members

(PM) Peter Morgan, Deputy Chief Executive (LA)
(AW) Angela White, Chief Executie, Sefton CVS (CVS)

Also in Attendance

(ST) Sam Tunney, Head of Business Intelligence & Performance, Advisor (LA)
(TW) Tina Wilkins, Head of Vulnerable Adults (LA)
(TJ) Tracy Jeffes, Head of Delivery and Integration (CCGs),
(KM) Karl McCluskey, Head of Strategic Planning and Assurance (CCGs)
(MM) Martin McDowell, Chief Finance Officer (CCGs)

Apologies: (CP) Colin Pettigrew, Director of Children's Services, Local Authority (LA)

Key Updates from H&WB Forums:		**Forum**
1.	As contained in the report on the agenda. A key updates paper would be submitted to the next meeting.	All

Action Points:		**Who**	**By When**
1.	**Minutes** Points of Clarification **Minute 5** (AOB) AW made a point of clarification in relation to the reference to Bids and in so doing indicated that she felt there was a benefit in bringing ideas to the group, about where a joint bid could be made, for example a Big Lottery Bid. **Minute 4** (Mental Health Discussion) FC reported that it was Jan Leonard who was attending the specialist commissioning event and as the lead, would provide a link to spec comm. FC advised that a couple of names had been transposed, and that it was Jane Uglow and Debbie Fagan and not Debbie Uglow as indicated in the minutes. **Matters Arising** FC asked for an update on the commissioning of LJMU. SJT advised that she was working with EH and BW to establish if the vulnerability work could be progressed in house, and then as part of this, work out the role for LJMU or for the CLARC.		

Action Points:		Who	By When
	Mental Health – FC advised that a deep dive was needed and KM was working with GO to develop a bid to senior management for additional capacity/support. The CCGs would fund this but the person would work with TW and GO to progress the work on mental health. FC advised that currently they were paying the CSU for specialist support which was helping to inform what the CCGs needed.		
2.	**Better Care Fund** A discussion paper on the BCF was circulated with the agenda, which posed a series of questions/issues. PM stated that the plan was a good piece of collaborative work, and thanked those involved in bringing together a document which gave a broad direction of travel, with sufficient flexibility, to allow for the vision for integration to be more fully developed. The discussion document gave the dates of 3 workshops were planned to inform the development of the vision. A series of workshops was proposed, details of which were set out in the discussion paper. A workshop for elected members was planned, which a small number of council officers would be invited to participate. AW advised that she had been at a meeting with Andy Burnham the previous week and the discussion had been his vision for integration. FC indicated that she would need to get the wider membership up to speed as well. She was thinking around May so that it aligned with the development of the strategic plan which needed to be submitted by June. FC indicated that it would be good to do a joint paper to the Boards. FC advised that she had met with the community geriatrician and he had spoken to wider clinicians, and been quite inspirational. He had recently been at Harvard doing a Masters in Public Health. She anticipated him playing a key role in the integration. PM advised that there was a need to get some pace into the integration. FC indicated that she had sent an article to MC about Sunderland, where they had pooled the social care budget, with the health budget. MM asked at what stage providers would be involved in the discussions as there was a need to engage them in agreeing the impact. Aintree had advised during a recent discussion that if they got their productivity right they could move to top quartile. FC asked those present to think about the key messages for the Chief Executive of Aintree. It was agreed that a copy of the planning template be sent to the Acute Trusts and advised that this was the initial document to secure funding. Further, that a copy of the plan be sent to all those who had attended the workshop on 22nd January, together with a copy of the stakeholder evaluation	ALL ALL FC	22/2/14 11/2/14 12/2/14

Action Points:		Who	By When
	and a generic message on you said and we did.	SJT	14/2/14
	AW asked whether the protection of social care was focused on the most vulnerable, and clarification was given that the section had been rewritten since it had been shared with her.		
	A copy of the draft metrics was tabled. TW referred to the weekly sign off that used to happen with the two main Acute, when she was in the PCT and that more recently, only Aintree continued to do this. FC suggested that it would not be too difficult to reintroduce it.		
	With regards the metrics, it was agreed that RC, TW, KM, meet with BW and RR to agree the targets, denominators etc. prior to submission.	RC/TW/ KM/RR/ BW	12/2/14
	MM advised that the underpinning performance payments had been relaxed, and suggested that the template may well have changed. KM was asked to explain how the metrics sat with the metrics in the Strategic Plan, and he reported that there was one metric which was similar, but not the same. KM had been working that week on the metrics and was asked to share with the rest of the programme group. He was asked when it would be possible to know when the impact on providers would be known. He indicated that when the submission was made that week, and then during the assurance process, NHS England would check and would do an assessment of the impact collectively. This would be shared with providers by 5th March. MM explained that contracts would be issued for signing on 28th February. He had attended the Merseyside Collaborative, and FC indicated that there was a meeting of the Merseyside Co Collaborative the next day.	KM	12/2/14
	A copy of the spreadsheet on financials was tabled showing 3 options for displaying the potential spend. PM suggested that the broad headings needed to be generic as possible to allow maximum flexibility. It was agreed that option 2 on the spreadsheet should be used.	SJT	12/2/14
	PM reminded the Group that the discussion paper made reference to the funding available to support the BCF associated work which MC held on behalf of the region. It was suggested that a bid for resources ought to be made and various ideas for support were put forward. It was agreed that a proposal be put together based on large scale change support, but that it be flexible enough for the resource to be spent on provider engagement/reconfiguration; workforce; and ICT.	SJT/TJ	14/2/14

Action Points:		Who	By When
	The Group was asked to take a view in relation to the creation of an Integration Board, and changes being made to the sub structure of the Board, so that the Performance functions from the Performance and Resources Task Group would go to the Intelligence Group, and that the substantive Group would become an Integration and Resources Task Group. It was felt that there needed to be an Integration Board which would feed into the Health and Wellbeing Board, and potentially comprise the Chief Executive and Deputy Chief Executive of the Council and Chief Officer of the CCG as a minimum. With regards providers, it was felt that there ought to be a provider sub group of the integration board, and which could comprise, the Chief Executives of Aintree, Southport and Ormskirk, LCH, Merseycare and CVS. There would need to be links to the Southport and Ormskirk Partnership Board, but the role would be different as the Southport Board was more about designing their future as a Trust, whereas the Integration Board was substantially different. A map of what existed already was required. In terms of the Integration and Resources Task Group, it was suggested 1 or 2 reps from each of the forums ought to be on the Task Group. This task group could start to have a look at a model locality working. It was agreed that the officer workshop on 25th February, should look at the structural issues for an hour, and would spend two hours looking at integration in its broader sense. A provider engagement plan was needed to ensure that adequate provider engagement took place on the run up to the submission of the revised BCF plan and strategic plan. It was agreed a document of key dates be developed.	SJT TJ/KM SJT SJT TJ SJT/TJ	22/2/14 25/2/14 31/3/14 25/2/14 4/4/14 14/2/14
3.	**Annual Refresh of the Health and Wellbeing Strategy** PM referred to the report circulated with the agenda. SJT suggested that the refreshed strategy needed to align with the BCF Plan, the Strategic Plans of the CCGs the Councils Corporate Plan as developed, and would need to tie in the key strategies. She indicated that the aim was to have a high level strategic document which provided the outcomes framework, a set of underpinning high level metrics, with some high level actions. The underpinning actions would be those such as the Integration Plan, arising from the BCF, the Delivery Plan for the CCG Strategic Plans, for example. There was a need to develop communications around the refresh and to use existing opportunities to engage. It was agreed that the communications and engagement would be looked at by the Communications and Engagement Task Group.	SH/TJ	31/3/14

Action Points:		Who	By When
4.	**Systems Leadership** JA referred to the presentation which had been circulated with the agenda and advised that she and FC were offering to develop a proposal to tie into the national work that JA was undertaking and the Top Leaders Programme that FC was on. It was agreed that JA and FC develop a proposal on systems leadership and bring it back to a future meeting.	JA/FC	31/3/14
5.	**May Logan Centre** MM reported that on the reorganisation of health, £400K which underpinned the core contract with the May Logan Centre had been lost to NHS Property, and it was not the only one that had happened, whereby estate type funding had gone to the wrong host. The May Logan was a valuable community hub, and suggested collectively that this deficit would need to be made good. In 2013/14, NHS England and the CCGs had found the resource to cover the pressure, but a solution needed to be found longer term. MM asked AW to keep an eye on VCF organisations to establish if this had happened to any other organisations and to report back to him. AW raised a separate issues with regards to problems being experienced by her organisations and presumably other smaller organisations, who in order to connect to CSU systems to function, needed to pass the IGG toolkit. It was agreed that AW would liaise with TJ on this.	MM AW AW/TJ	31/3/14 31/3/14 25/2/14

Previous Actions / Issues Log (from minutes)		Status	Who & Deadline
1.	Risk Stratification/vulnerability matrix	O	SJT/TJ– 31/3/14
2.	Health Summit – Review: A copy of the evaluation to be circulated with the Plan to stakeholders	C	SJT – 11/2/14
3.	Acute Meeting – to be picked up under the provider engagement and consultation plan	C	TJ – 11/2/14
4.	Evaluation of virtual ward/earlier model	C/F	KMc/RC – 3/3/14
5.	Consultation and Engagement on BCF – referred to the Communications and Engagement Group	C/F	TJ/SH – 31/3/14
6.	Reablement Plan – RC to bring back to the Programme Group	C/F	RC/TW – 31/3/14
7.	Partnership Structures – each Forum to work out its partnership structures/relationships	C/F	3/3/14
8.	Policy Updates/Statutory Roles – each Statutory Post to be aware of the need to include issues on the agenda	C	Forum Leads/Stat Posts
9.	Revisit in the next Strategy iteration, the Strategic Priority of	O	SJT – 31/3/14

Previous Actions / Issues Log (from minutes)		Status	Who & Deadline
	Older People, to be changed to Adults – to be picked up in the next iteration of the strategy		
10.	Amendments to the Integrated Commissioning Plan (ICP) – meeting organised with Head of Commissioning and Deputy Director of Public Health to progress this work to come back to Programme Group in February.	O	SJT/P Moore/H Chellaswamy – 3/3/14
11.	VCF review – to ascertain if within the ICP.	C/F	PM – 3/3/14
12.	Integration Transformation Fund (ITF) – now Better Care Fund Task and Finish Group – progressing the Plan	O	SJT – 4/4/14

Information Points & Decisions	
1.	None

Key:

Previous Action Status Key: O = Ongoing, C/F = Carried Forward, C = Complete, NR = No Longer Required.

Information Points & Decision Key: I = Information, D = Decision

Officers referred to in the notes: Sue Holden (LA), Geraldine O'Carroll (GO)

South Sefton Clinical Commissioning Group

Seaforth and Litherland Locality Meeting

8th January 2014
1 – 3pm
Crosby Lakeside Adventure Centre

Attendees

Practice	GP	Practice Nurse	Practice Manager
Litherland Town Hall (LTH)	Dr Alastair Patrick		Caroline Nolan
15 Sefton Road	Dr Colette McElroy Dr Terry Thompson		Alison Harkin
Glovers Lane	Dr Peter Goldstein		Louise Taylor
Rawson Road		Ruth Powell	Angela Dunne
Seaforth Practice			Caroline Nolan
Ford Medical	Dr Noreen Williams	Eils McCormick	
Bridge Road Surgery	Dr Martin Vickers		Lynne Creevy
Netherton Practice	Dr Naresh Choudhary		
Orrell Park	Dr Ramon Ogunlana		Jane McGimpsey
129 Sefton Road			
Litherland Darzi	Dr Bettina Schoenberger Dr Adnan Hameed		Pam Maher

Angela Parkinson (AP) South Sefton CCG Locality Manager
Paula Bennetts (PB)
Jenny White (JW)
Helen Roberts (HR)
Geraldine Reilly (GR)
Minutes
Angela Parkinson

South Sefton Clinical Commissioning Group

Attendance Tracker

P Present
A Apologies
L Late or left early

Name	Designation	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
Dr T Thompson	GP – 15 Sefton Road Surgery	P											
Dr C McElroy	GP – 15 Sefton Road Surgery	P											
Alison Harkin	PM – 15 Sefton Road Surgery	P											
Paula Lazenby	PN – 15 Sefton Road Surgery												
Dr A Slade	GP – Glovers Lane Surgery												
Louise Taylor	PM – Glovers Lane Surgery	P											
Dr P Goldstein	GP – Glovers Lane Surgery	P											
Dr M Cornwell	GP – Glovers Lane Surgery												
Dr M Vickers	GP – Bridge Road Surgery	P											
Lynne Creevy	PM – Bridge Road Surgery	P											
Dr E Carter	GP – Bridge Road Surgery												
Dr N Choudhary	GP – Netherton Practice	P											
Lisa Roberts	PM – Netherton Practice												
Lorraine Bohannon	PM – Netherton Practice												
Dr N Williams	GP – Ford Medical Practice	P											
Lin Bennett	PM – Ford Medical Practice	A											
Eils McCormick	PN – Ford Medical Practice	P											
Dr T Danby	GP – Ford Medical Practice												
Louise Armstrong	PN – Ford Medical Practice												
Dr B Fraser	GP – Ford Medical Practice												
Dr G Halstead	GP – Ford Medical Practice												

Name	Designation	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
Dr D Goldberg	GP – 129 Sefton Road Surgery												
Dr A Sarkar	GP – 129 Sefton Road Surgery												
Jane McGimpsey	PM – Orrell Park Medical Centre	P											
Dr Ina Krasauskiene	GP – Orrell Park Medical Centre												
Dr R Ogunlana	GP – Orrell Park Medical Centre	P											
Dr A Hameed	GP – Litherland Darzi	P											
Dr B Schoenberger	GP – Litherland Darzi	P											
Julie Price	PN – Litherland Darzi												
Pam Maher	PM – Litherland Darzi / Litherland Town Hall	P											
Dr A Patrick	GP – Litherland Town Hall	P											
Dr F Cook	GP – Rawson Road / Orrell Park Medical Centres	A											
Angela Dunne	PM – Rawson Road / Orrell Park Medical Centres	P											
Ruth Powell	PN – Rawson Road	P											
Caroline Nolan	PM – Seaforth Practice/ Litherland Town Hall	P											
Dr S Fraser	GP – Seaforth Practice												

No	Item	Action
14/01	**Apologies** Dr Fred Cook, Lin Bennett	
14/02	**Declarations of Interest** Dr Williams (LMC)	
14/03	**Minutes of the Last Meeting / Matters Arising** The minutes of the last meeting were agreed. **Matters Arising** **IV Cellulitis** The cellulitis service has 8 nurses, 3 out of 8 are nurse prescribers, there is not always a guarantee that a nurse prescriber will be available when the patient needs changing over from IV to oral antibiotics. Where there is not a nurse prescriber the GP is being asked to reassess the patient. LCH need to prescribe the whole course of treatment at assessment. The cellulitis specification needs re-assessing, the pathway did not come to the LMC. **Alderhey 18 week target** There are 18 week targets at Alderhey, the appointment centre don't seem to be aware of this, and should be complying. The issue has been flagged to the CCG. **Ward 35/Palliative Care** Debbie Harvey has asked practices to report any issues with regards to ward 35 or end of life services. One practice reported that a patient had been sent into A+E as an emergency from Jospice, the patient came out of hospital back to home to die, the practice queried whether Jospice hold beds for patients who are admitted, and that the contracting process for GP cover at Jospice needed to be explored. Dr Choudhary and Dr Hameed confirmed that 3 GP's cover Jospice Monday to Friday, but there is no GP cover at the weekend. **Pregnancy Tests** Pregnancy tests are available to the locality to confirm a pregnancy where a patient presents with a query ectopic pregnancy (2 tests per practice). This has been implemented following the A+E audit undertaken and 2012 NICE guidance. Arrangements will need to be confirmed when all tests are used. **Winter Pressures** This is being discussed under an agenda item **Attendance**	CMc

No	Item	Action
	Alison Harkin asked for the attendance tracker used for meetings reflects that her apologies were given for the September meeting.	AP
14/04	**Geraldine Reilly – Neurosupport Research** Geraldine attended as she is researching how much is known about the charity who would like to get more satellite centres in Sefton. They can offer advice (not medical) on benefits, carer support etc. GPs who had not already completed a survey where invited to do so.	
14/05	**Medicines Management** **Budget updates** FOT based on October data: • £33,848 overspend for the locality • £209,634 underspend for the CCG • Majority of practices (7) have shown a decrease in prescribing costs over the last 3 months • Out of the overspent practices 3 have shown an increased spend over the last 3 months • Significant reduction in overspend for Bridge Road (35,500 since August) Action • £4,364.16 spent on urology items in Q2 • £10,202 potential quick win savings per quarter • Review high cost drugs **Antimicrobial quality premium target** Improvements shown in the main indicator for each high risk antimicrobial **Update on ED service** There were initial concerns on the number of patients who would be referred in to the ED service at Southport and Ormksirk and the resource to review patients after a number of years without the service. However, the service is happy to be flexible regarding referrals and to discuss any potential referral with the patient's General Practitioner. The service wants to work with the CCGs to provide an accessible service for appropriate patients. **Sefton Prescriber Updates** SPUs on Jext and Omacor have recently been circulated. **Update from the SSMOOG 17th December** • Antimicrobial guidelines are now up on the APC website http://www.panmerseyapc.nhs.uk/formulary.html however the UTI guideline is still under discussion currently • Discussed JEXT recall and felt that letters should be followed up with a phone call bearing in mind potentially catastrophic consequence of device failure. Concerns were raised that letters don't always reach recipients for various reasons. Discussed magnesium supplements (amber unlicensed) and agreed that supplements should be used in preference to a special order product e.g. rx MagnaPhate Tablets. Discussed need to review PPI use in patients with	HR

No	Item	Action
	low magnesium.	
14/06	**Public Health** Paula Bennetts attended the meeting she is the public health representative for the locality to aid communication and can provide health need information for any projects the locality plan. Currently there is a review being undertaken on all public health services since the move to the council. Services will be benchmarked against national guidance to ensure meeting best practice, look at capacity issues and engagement with stakeholders re views of commissioned services. STARS lifeline referral form was discussed as there are issues relating to GP's being asked to note previous convictions, probation and a chosen chemist, all things that would have a legal challenge, also the form for alcohol does not have anywhere to document alcohol use. The LMC have raised these issues, but the referral form still asks for this information. Paula to raise these issues again.	PB
14/07	**Quality Dashboard Premium / Finance** Jenny White attended the locality to provide an update, please see report attached.	
14/08	**Winter Pressures** The additional capacity scheme offered to practices by NHS England has been extended to March. There was some confusion regarding what this meant as no communication had gone to practices from NHS England to confirm. Practices are frustrated by the lack of communication and the problems securing locums when information comes out late. AP to confirm with Alan Cummings what the arrangements are. Housebound reviews / hidden health needs had been discussed by the locality last year, but was not implemented due to employment issues. It was suggested that a 6 week pilot (using winter pressures money) to be completed before the end of March could be done if there were Practice Nurses already in employment interested in more hours, Colette Page and Pippa Rose could take forward. The group agreed that there wouldn't be time to implement and the original scheme was to use HCAs, however there is a lack of HCAs currently in Sefton. The group thought that this could be worked through using 14/15 locality money if there was confirmation at the beginning of the financial year that the money is available. LCH contract would also need to be understood so that duplication does not happen. Rescue pack / education for COPD patients is already being looked at by Jenny Kristiansen, Healthy Sefton for winter would be too late to implement this year. Workforce planning was discussed. The PCT used to have an admin bank staff scheme. Perhaps this idea could be looked at next year to include	AP

No	Item	Action
	admin and practice nurses. **Locality Money 13/14** Equipment for practices was discussed in terms of 24 hour ambulatory BP machine (3 months wait in practices), defibrillators, and a locality spirometer for 14/15 housebound review scheme. Louise Taylor agreed to get quotes for the equipment discussed and work with AP on a business case	AP/LT
14/09	**Any Other Business** **Facilitated Sessions** A CCG Organisational Plan has recently been developed and includes some ideas to help support the further development of localities. One suggested action is to offer each locality a facilitated session (with an experienced external facilitator) to help the locality reflect on how it is working, identify priorities , help clarify any relevant roles and responsibilities and ensure strong lines of communication between localities and other parts of the organisation e.g the Governing Body. This session would ideally be planned with the GP Chair, the Locality Development Manager and anyone else who would be useful to include, and adapted to suit the particular circumstances in the locality. It could last around one and a half to two hours. After a brief discussion it was felt that an external facilitator coming to the locality was unlikely to develop us any better than we are doing ourselves. There were 10 out of the 11 practices at the meeting all 10 practices felt that they did not take up the offer at this time. **Locality Payments** – the remuneration committee met on the 7th January, outcome awaited. A letter is being sent to practices from Martin McDowell. **Caroline Nolan** – this was her last meeting, the locality wished her the best for the future. **IT and Respiratory** – Dr Steve Fraser has left the CCG, expressions of interest were requested for the two areas that Steve used to lead on. **Healthwatch Community Champion** – Libby Kitt is the community champion for Seaforth and Litherland. It was suggested that Libby attends a locality meeting to meet everyone and see how we work together.	AP
	Date and Time of Next Meeting 5th February 2014 1 – 3pm Crosby Lakeside Adventure Centre	

South Sefton Clinical Commissioning Group

Seaforth and Litherland Locality Meeting

5th February 2014
1 – 3pm
Crosby Lakeside Adventure Centre

Attendees

Practice	GP	Practice Nurse	Practice Manager
Litherland Town Hall (LTH)	Dr Alastair Patrick (AP)		
15 Sefton Road	Dr Colette McElroy (CE) Dr Terry Thompson (TT)		Alison Harkin (AH)
Glovers Lane	Dr Peter Goldstein (PG)		Louise Taylor (LT)
Rawson Road	Dr Fred Cooke (FC)		Angela Dunne (AD)
Seaforth Practice	Dr Alastair Patrick (AP)		
Ford Medical	Dr Noreen Williams (NW)	Eils McCormick (EM) Louise Armstrong (LA)	Lin Bennett (LB)
Bridge Road Surgery	Dr Martin Vickers (MV)		Lynne Creevy (LC)
Netherton Practice	Dr Naresh Choudhary (NC)		Lorraine Bohannon (LB)
Orrell Park	Dr Ramon Ogunlana (RO)		Jane McGimpsey (JM)
129 Sefton Road			
Litherland Darzi			

Angela Parkinson (AP) - South Sefton CCG Locality Manager
Jennifer Ginley (JG) – South Sefton CCG Administrator

Minutes

South Sefton Clinical Commissioning Group

Attendance Tracker

P Present
A Apologies
L Late or left early

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Dr N Choudhary	GP – Netherton Practice	P	P										
Lisa Roberts	PM – Netherton Practice												
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Dr N Williams	GP – Ford Medical Practice	P	P										
Lin Bennett	PM – Ford Medical Practice	A	P										
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Julie Price	PN – Litherland Darzi												
Pam Maher	PM – Litherland Darzi / Litherland Town Hall	P	A										
Dr N Taylor	GP – Litherland Town Hall												
Dr S Steevart	GP – Litherland Town Hall												
Dr A Patrick	GP – Litherland Town Hall / Seaforth SSP	P	P										
Dr F Cook	GP – Rawson Road / Orrell Park Medical Centres		P										
Angela Dunne	PM – Rawson Road / Orrell Park Medical Centres	P	P										
Ruth Powell	PN – Rawson Road	P											
Caroline Nolan	PM – Seaforth Practice/ Litherland Town Hall	p											
Dr S Fraser	GP – Seaforth Practice												

No	Item	Action
14/10	**Apologies**	
14/11	**Declarations of Interest** NW – Sefton LMC LB – Board Member	
14/12	**Minutes of the Last Meeting / Matters Arising** The minutes of the last meeting were agreed as an accurate record **Matters Arising** **Alder Hey** – Alder Hey do have an 18 week target. If anyone encounters problems with this and Alder Hey refutes this fact they should refer the issue to Debbie Fagan. **IV Cellulitis Team** – only 3 out of the 8 team members can prescribe, this is the reason they do not automatically prescribe oral antibiotics following IV treatment. The team said they will discuss the possibility of this. **Action** – CM to contact them to get a specification of their role and communicate it back to the locality. **Winter Pressures** – (refer to 14/08) – Alan Cummings has sent an email to practice managers regarding additional capacity. Practices are able to extend the time period to use the allocated sessions to March 2014. Where practices will already have used the original allocation by the end of February, Alan Cummings should be contacted to discuss an allocation for March. **ED Service** – (refer to 14/05) –again there were many queries about the ED service and their remit. They have been invited to the next locality meeting to describe the service they offer. **Public Health –** (STARS referral form) – the adjusted form had been circulated to the group prior to the meeting, details of where/how the form should be returned and version control is still missing. A virtual CRG with LMC representation was discussed; all referral forms would need to go via this process before circulation to practices.	CM
14/13	**Medicines Management** **-** Not covered	

No	Item	Action
14/14	**Locality Budget** Suggestions for the defibrillators and the blood pressure monitoring were accepted. The estimated cost is based on all practices requiring one of each machine, to get the correct costing AP needs the information from all practices. **Action** – All practices to email AP regarding equipment requirements. The possibilities of getting a spirometer for the locality or commissioning Aintree or the COPD/respiratory community service to deliver the COPD review service were discussed in detail. It was decided that costs to commission the service separately by the respiratory/COPD team needed to be sought and considered first. **Action** – AP to retrieve information from Jenny Kristiansen about commissioning the respiratory/COPD service to carry out this work. Practices need to identify numbers of COPD housebound patients. The possibility of funding defibrillator training for admin staff in practices was discussed. **Action** – AP to get a cost for this training, practices to express intentions to participate. It was suggested that practices may require cholesterol testing strips/machine (as part of the health checks) and or pulse oximeters **Action** – AH to send the details regarding these items to AP for her to gather a cost. **Action** – AP will send out an email to get requirements and numbers. LB suggested if there was funding left over educational DVDs could be produced for patients; DVDs could explain correct and ideal pathways, similar to Health Channel. **Action** – AP will also send out a general email detailing what the locality funding can be spent on and all practices can reply if they specifically would like/prefer an item detailed.	ALL PRACTICES AP ALL PRACTICES AP AH AP AP
14/15	**Group Peer Review – see attached spreadsheet**	
14/16	**Any Other Business** The group acknowledged that this was Dr McElroy's last meeting as Chair, and thanked her for her hard work. Dr Vickers will be the Chair from March to August 2014. No nominations have been received from GPs to fill the vacant GP position on the Governing Body. GPs are asked to consider this important role. Dates for 2014/15 locality meetings are available on the intranet. The group will continue to meet the first Wednesday of every month.	GPs

No	Item	Action
	Date and Time of Next Meeting 5th March 2014 1 – 3pm Crosby Lakeside Adventure Centre	

South Sefton Clinical Commissioning Group

Bootle Locality Meeting

21st January 2014
1.00pm – 2.30pm
Park Street Medical Centre

Chair
Dr S Stephenson (SS) – Bootle Village Surgery

Attendees
Dr K Chung (KC) – Park Street Surgery
Helen Devling (HD) – Moore Street Surgery
Dr H Mercer (HM) – Moore Street Surgery
M Hinchliff (MH) – Strand Medical Centre
Dr A Ferguson (AF) – Strand Medical Centre
Dr S Sapre – Aintree Road Surgery
Angela Curran (AC) – South Sefton Clinical Commissioning Group
Jenny Kristiansen (JK) – South Sefton Clinical Commissioning Group
Becky Williams (BW) – South Sefton Clinical Commissioning Group
Ruth Harkin (RH) – South Sefton Clinical Commissioning Group
Paul Halsall (PH) – Medicines Management
Pauline Sweeney (PS) – Park Street Surgery
Dr S Stephenson (SS) – Bootle Village Surgery
R Swiers (RS) – Public Health Sefton Metropolitan Borough Council

Apologies
Dr Ricky Sinha (RS) – North Park Medical Centre
Pam Sinha (PS) - North Park Medical Centre
Dr Goldberg - Concept House

Guest Speakers

Minutes
Jennifer Ginley – South Sefton Clinical Commissioning Group

South Sefton Clinical Commissioning Group

Attendance Tracker

P Present
A Apologies
L Late or left early

Name	Designation	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Aug 14	Jul 14	Sept 14	Oct 14	Nov 14	Dec 14
Dr S Sapre	GP – Aintree Road Surgery	P											
Sarah Gibson	PM – Aintree Road Surgery												
Sue Edmondson	PM – Bootle Village Surgery												
Dr S Stephenson	GP – Bootle Village Surgery	P											
Dr C McGuinness	GP – Bootle Village Surgery												
Gill Riley	PM – Concept House Surgery												
Dr D Goldberg	GP – Concept House Surgery	A											
Dr H Mercer	GP – Moore St Surgery	P											
Dawn Rigby	PM – Moore St Surgery												
Dr J Irvine	GP – Moore St Surgery												
Carol McCormick	PM – Moore St Surgery												
Helen Devling	PM – Moore St Surgery	P											
Dr R Sinha	GP – North Park Health Centre	A											
Pam Sinha	PM – North Park Health Centre	A											
Sharon Copeland	PN – Park Street Surgery												
Dr K Chung	GP – Park St Surgery	P											
Pauline Sweeney	PM – Park St Surgery	P											
Dr K Dutton	GP – Strand Medical Centre												

Name	Designation	Jan 14	Feb 14	Mar 13	Apr 14	May 14	Jun 14	Aug 14	Jul 14	Sept 14	Oct 14	Nov 14	Dec 14
Jade McGregor	PN – Strand Medical Centre												
Dr A Ferguson	GP – Strand Medical Centre	P											
Ronnie Holmes	PM – Strand Medical Centre												
Gerry Devine	PM – Strand Medical Centre												
Dr M Gozzelino	GP – Strand Medical Centre												
Dr S Morris	GP - Strand Medical Centre												
M Hinchliff	PM – Strand Medical Centre	P											

No	Item	Action
14/01	**Apologies** Apologies were noted	
14/02	**Minutes of last meeting – 19 November 2013** The minutes were agreed as an accurate record.	
14/03	**Matters Arising** - Jenny Kristiansen to contact RS – ASAP -Jenny clarified converse with Rickey regarding mental health. She still needs to chase it up. - PH to feedback to Brendan Prescott - PH followed up on the discussion on dressings from the last meeting. There is a pharmacy scheme for providing dressings and blister packs with nursing homes. GPs do not have to prescribe them and district nurses prescribe. This should also be the case for paediatrics, there is a problem when secondary care says no it cannot prescribe, GP then does. Alder Hey should be providing for patients who visit on a regular basis and require dressings – PH will forward this issue to Brendan. - Public health lead R.Swiers was introduced and he will explain more what he can offer next meeting.	
14/04	**Finance & Quality Premium Report** - RH (interim management for James Bradley) and BW presented the new report and highlighted that in future the reports will be out in advance. Any comments or queries about it are appreciated. They contain relevant information to help manage budgets – feedback will help develop this process throughout 2014. - The overall general report – SS CCG has a budget of £277 million and is required to run a 1% surplus, the CCG is on target; 13/14 - £2.2 million surplus. - Key risks are overspend on acute care at Aintree primarily – Up to November £2 million at Aintree. - There was confusion as to the divisions in description of care in the report, it was clarified; acute can be elective or non- elective activity. On planned care the CCG overspent and on unplanned car it underspent but the contract is a bloc contract so effect is limited bloc. - Comparisons were made between Southport and Formby and SS – price per patient rather than bloc contract (Southport and Formby). - The work to understand overspend on gastro has found that limitations may be too low, the opening of the major trauma unit (additional consultants attract more work), the increased work of the gastro outpatient clinic and the bowel cancer campaign could all be contributing factors also a reason for increase. Locality fill portion – appendix 1. Schedules- front overall summary then each individual practice has a separate breakdown. - Portal – re design of portal required 12/13 – want to get it specifically produced, it shows the trend overall but not update. - GPs have access to the portal and can drill down on their own – free to ask questions to finance at CCG.	RH or finance team generally should communicate and clarify spending option situation for each CCG if possible? Could there be an improvement plan with the NW ambulance service?

No	Item	Action
	- Can't do much without specialist information, can't develop strategies and targets. Not a lot of useful information right now. Ruth informed the group that portal can give speciality level in each hospital. **Quality Premium Report** - Performance of CCG in QP national and local measures. Measures against 13/14 - £737,000 CCG, it is forecast to receive £345,000. Pre-qualifying criteria detailed, CCG is produced on target and SS are. - Measured and paid at CCG level, there is no reason to drill down if indications are green. If performing badly finance and analysis would drill into it. - Explanation given on the QP – difficult to carry years of life cost. CCG are working with the public health team to get figures because CCGs aren't able to get own death data, it is a national resource and there is usually a 12 month delay. - Potential payment is highlighted but the CCG is on track for less than that. Red triggers deflation. The reason for respiratory being low could possibly be seasonality and Aintree may not be recording care correctly initially. - Amber indicators -ambulances etc. This is a national target but not in primary care control - NW measure. - NHS England may later revise the criteria of no CCG meets the required zero tolerance target (infectious disease).	
14/05	**Medicines Management** **-** Prescribing financial report - Spending has increased. - Each practice has potential quick win savings – June/July/August data provided in information and the group was informed that what you want to see when looking at the graphs is a gradual reduction for each practice. - Some concerns were raised by the GPs about Script Switch – for example when prescribing pain killers it frequently suggests paracetamol and asks are you sure always. Even in situations where it would not be a usual switch. Sign back up to Switch Script? - Another possible saving – dosage alteration. Two doses instead of three a day for example. - 3 more graphs were given out about specific drugs – about reduction. Local guidance for antibiotics is now on the website, the link will be passed around. UTL guidelines are still under consideration. - Joint Medicines Medicine Optimisation Group Update – Erectile Dysfunction service is happy to discuss referrals with GPs. This was a concern and could maybe be taken up with commissioners – the sexual health lead role in the CCG. They (ED service) have not got the capacity to take patients back who do not just need prescription. The Thursday following the locality meeting Paul is meeting with providers ISIS (Sexual Health), the service has been re-commissioned and the whole service will be reviewed. - It was suggested that there should be a psychosis service- noticed the need since decommissioning. - PH also highlighted the latest NICE guidance – excludes patients under the care of a lipid clinic - recommending that they are not prescribed.	

No	Item	Action
	- There was a recall before Christmas of a new epi pen – Jext. Certain batches of the pen were recalled due to faults. GPs were instructed to phone patients to retrieve the pens. PH made the GPs aware of this. - Magnesium supplements – special unlicensed can be very expensive so a food supplement could be suggested. GPs should prescribe by brand rather than generic due to a lower cost.	
14/06	**QOF/QP External Peer Review**	
14/07	**Any other business** - Stoma Project – evaluating it – Pauline (Aintree PM) is taking up some issues and says it is a very useful exercise. - Changed the date of the next meeting – the next meeting will be held on Wednesday 26th February 2014.	
14/08	**Date and time of next meeting** Wednesday 26th February 1pm – 2.30pm Park Street Medical Practice	

Chair Signature ……. Date …….

South Sefton Clinical Commissioning Group

Crosby Locality Meeting

Wednesday 8th January 2014
12:45 – 2.30pm
Crosby Lakeside Adventure Centre (CLAC)

Chair : Dr G Berni

Attendees
Pippa Rose (PR)
Dr M Taylor (MT)
Dr S Roy (SR)
Dr A Mimnagh (AM)
Maureen Guy (MG)
Sandra Holder (SH)
Dr C Gillespie (CG)
Sue Hancock (SH)
Colin Smith (CS)
Dr C McDonagh (CMc)
Pauline Woolfall (PW)
Dr C Allison (CA)
Janet Faye (JF)
Alison Johnston (AJ)
Dr P Sharma (PS)

Apologies
Dr G Mizra
Tina Ewart
Dr D Navaratnam

Guest Speakers
Pat Nicholl, Acting Head of Health Improvement, Public Health (Review of Healthy Sefton service)
Ged Reilly, Managing Director, Moxie Marketing (Conducting research on behalf of NeuroSupport)

Minutes : Gary Killen

Attendance Tracker

P Present
A Apologies
L Late or left early

Name	Designation	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
Dr S Aylward	GP – Crosby Village Surgery												
Pippa Rose	PN – Crosby Village Surgery	P											
Dr M Taylor	GP – Crosby Village Surgery	P											
Lorraine Bohannon	PM – Crosby Village Surgery												
Dr S Roy	GP – Crosby Village Surgery	P											
Dr A Doerr	GP – Crosby Village Surgery												
Sharon McGibbon	PM – Eastview Surgery												
Dr A Mimnagh	GP – Eastview Surgery	P											
Dr M Hughes	GP – Eastview Surgery												
Donna Hampson	PM – Crossways Surgery												
Dr P Sharma	GP – Crossways Surgery	P											
Cath Charlton	PM – Thornton Surgery												
Stella Moy	PN – Thornton Surgery												
Dr D Harvey	GP – Thornton Surgery												
Dr J Wallace	GP – Thornton Surgery												
Maureen Guy	PM – 133 Liverpool Road	P											
Dr G Mizra	GP – 133 Liverpool Road	A											
Sandra Holder	PN – 133 Liverpool Road	P											
Carolyne Miller	PM – Blundellsands Surgery												
Dr N Tong	GP – Blundellsands Surgery												
Dr C Gillespie	GP – Blundellsands Surgery	P											

Name	Designation	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
Sue Hancock	PN – Blundellsands Surgery	P											
Colin Smith	PM – Blundellsands Surgery	P											
Shelley Keating	PM – 30 Kingsway												
Dr C Shaw	GP – 30 Kingsway												
Dr C McDonagh	GP – 30 Kingsway	P											
Dr E Pierce	GP – Hightown Village Practice												
Pauline Woolfall	PM – Hightown Village Practice	P											
Dr C Allison	GP – Hightown Village Practice	P											
Dr D Navaratnam	GP – Azalea Surgery	A											
Dr C Doran	GP – Azalea Surgery												
Dr G Berni	GP – 42 Kingsway	P											
Alan Finn	PM – 42 Kingsway												
Dr F Vitty	GP – 42 Kingsway												

No	Item	Action
14/01	**Apologies** Apologies noted above.	
14/02	**Minutes of last meeting – 6th November 2013** The minutes of the last meeting were adjusted to reflect the attendance of Janet Faye and Dr N Tong. It was then agreed as an accurate record.	
14/03	**Declarations of interest** None declared.	
14/04	**Matters Arising** **Learning Disabilities** AJ has added the L&D support documentation to the Locality page on the CCG Intranet http://nww.southseftonccg.nhs.uk/ccg-and-locality/localities/crosby/Crosby-Locality-Meetings-2013.aspx Any further queries direct to Tracy Reed; details – Tel No 0151 247 7272 or email tracey.reed@southseftonccg.nhs.uk	
14/05	**Locality Business** **SSCCG Quality Premium Dashboard (Dec) and Locality Finance Report (Month 6)** JW attended the meeting to give an update on the financial projections in relation to the Quality Premium. JW gave a brief overview of the quality premium targets and projected performance based on forecast outturn. In summary, • Crosby locality is overspent at month 6 but more importantly the CCG is on course to achieve financial balance. • The CCG has failed domain 5 (the National Measures for Health Care Acquired Infections) • A&E wait is slightly under at 94%. Provider has been given extra funds from Central Government. The CCG is forecast (all being equal) to receive £345,389 from a potential £736,830. CG asked if there could be more support given to individual Practices in interpretation of budgets. JW and AJ to look at doing a pilot in a Practice to see how support can be best placed. **Medicine Management** JF discussed the prescribing budgets based on the data received from the PPA as at month 7. Overall the locality is looking at an estimated underspend of approx. £60k, however three individual practices are forecast an overspend (42 Kingsway, Eastview and Thornton SSP).	JW/AJ

No	Item	Action
	JF gave an update on SSMOOG and JMOG for December. • Antimicrobial guidelines are now on the APC website (http://www.panmerseyapc.nhs.uk/formulary.html) • JEXT recall – Letters should be followed up with a phone call. Concerns raised that letters don't always reach the recipients for various reasons. • Magnesium supplements – supplements should be used in preference to special order products. • Erectile dysfunction - the ED service based in Southport & Ormskirk Hospital is happy to be flexible regarding referrals and discuss any potential referral with the patients GP. • Alder Hey Torpedo Pilot/Ciprofloxacin - This is a trial where patients with Cystic Fibrosis and P. aeruginosa infection may be allocated to receive Ciprofloxacin treatment for three months and GPs may be requested to prescribe this treatment. Ciprofloxacin is a high-risk antimicrobial and prescribing figures will require adjustment to take account of any primary care prescribing for these patients. The GPs strongly thought that any prescribing should be done by AHCH as part of the trial. JF advised that medicines management had only recently become aware of this trial and had received the protocol. This will be reviewed and discussed with the research manager in Liverpool. • Neuro Trial Co-Amoxiclav - It has come to light that a small number of GPs have been requested to prescribe co-amoxiclav, as part of a trial but that it had not been agreed or even discussed at the Walton D&TC. It was agreed that no further requests should be made to GPs until due process had been followed and the outcome of discussions had been agreed by the Committee. • Cardiology Junior Docs/GP Amlodopine Scripts. - Can we have discussion with secondary care clinicians and request that they issue a prescription for out-patients when a new medication is prescribed at clinic. CG gave an example of cardiologists initiating Amlodipine for a patient and not issuing a prescription. The reality is that patients often request new medications from the GP before any letters arrive and the GP then has to contact secondary care to check what medication has been prescribed and if the patient has received any medication counselling. Obviously, this can take up much of the GPs time and the GPs agreed that this happens on a regular basis. JF to take this to JMOG for discussion. **QOF** Luke Garner from the CSU Business Intelligence Team sent the data out to Practices using the nhs.net email supplied to AJ by Practice Managers in December. AJ handed out the audit template for the group to review which was agreed. Practices are asked to work on their internal Practice audit and to bring the results to the February meeting so we can collate and conduct a Peer Review. The final report will then be produced and agreed at the March meeting. AJ to email the template to practices in excel form so they can begin the necessary audit work. AJ asked the group to contact her should any queries arise.	JF JF AJ

No	Item	Action
14/06	**Neurosupport Research – Ms Ged Reilly** Ms Reilly came to the meeting to ask GP's if they had completed the online survey. Those GP's who hadn't completed a paper version whilst in the meeting.	
14/07	**Healthy weight & lifestyle service review** Pat Nicholl gave a brief overview to the review of the service so far. The Group were asked if they had any suggestions for inclusion in the reviews final stages. AM questioned the role of GPs and general practice in the referring of patients into healthy lifestyle services. MT asked how the service engages already motivated individuals (i.e. those that are accessing the likes of weight watchers) and how the service could be more proactive in targeting this already motivated group.	
14/08	**AOB** **GP IT Lead** AJ asked the group for any expressions of interest in this position and asked them to call upon their Practice members if they are interested. AJ confirmed that it would call upon an estimated and remunerated two sessions per month, to attend CCG IT Leads, wider Local Health Economy programme boards and other IM&T related meetings. The focus of the role is to provide a clinical steer on CCG IM&T strategy, the wider Local Heath Economy Transformation Programme as well as clinical input into individual projects. Any interest to go through AJ. **GTD Ltd – "Please Re-Consult" Coding Issue** Blundellsands Surgery raised an issue regarding the Go To Doc Ltd (GTD Ltd) Out of Hours service. They seem to be getting a higher incidence of "Please Re-consult" on the communications coming out to practice after patients have been seen by the service. It was found to be common throughout locality. AJ to feedback to Terry Hill and Malcolm Cunningham and to liaise directly with the Provider.	All AJ
14/09	**Date and time of next meeting** Wednesday 5th February 2014 12:30 lunch 12.45 start – 2.30 Crosby Lakeside Adventure Centre (CLAC)	

South Sefton Clinical Commissioning Group

Crosby Locality Meeting

Wednesday 5th February 2014
12:45 – 2.30pm
Crosby Lakeside Adventure Centre (CLAC)

Chair: Dr G Berni

Attendees
Pippa Rose (PR)
Dr S Roy (SR)
Dr A Mimnagh (AM)
Sharon McGibbon (SMc)
Colin Smith (CS)
Dr C McDonagh (CMc)
Alan Finn (AF)
Janet Faye (JF)
Dr G Mizra (GM)
Dr D Navaratnam (DN)
Alison Johnston (AJ)

Apologies
Sue Hancock
Tina Ewart
Pauline Woolfall
Shelley Keating
Dr C Gillespie

Minutes
Angela Curran

Attendance Tracker

P Present
A Apologies
L Late or left early

Name	Designation	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
Dr S Aylward	GP – Crosby Village Surgery												
Pippa Rose	PN – Crosby Village Surgery	P	P										
Dr M Taylor	GP – Crosby Village Surgery	P											
Lorraine Bohannon	PM – Crosby Village Surgery												
Dr S Roy	GP – Crosby Village Surgery	P	P										
Dr A Doerr	GP – Crosby Village Surgery												
Sharon McGibbon	PM – Eastview Surgery		P										
Dr A Mimnagh	GP – Eastview Surgery	P	P										
Dr M Hughes	GP – Eastview Surgery												
Donna Hampson	PM – Crossways Surgery												
Dr P Sharma	GP – Crossways Surgery	P											
Cath Charlton	PM – Thornton Surgery												
Stella Moy	PN – Thornton Surgery												
Dr D Harvey	GP – Thornton Surgery												
Dr J Wallace	GP – Thornton Surgery												
Maureen Guy	PM – 133 Liverpool Road	P											
Dr G Mizra	GP – 133 Liverpool Road	A	P										
Sandra Holder	PN – 133 Liverpool Road	P											
Carolyne Miller	PM – Blundellsands Surgery												
Dr N Tong	GP – Blundellsands Surgery		P										

Dr C Gillespie	GP – Blundellsands Surgery	P	A										
Name	**Designation**	**Jan 14**	**Feb 14**	**Mar 14**	**Apr 14**	**May 14**	**Jun 14**	**Jul 14**	**Aug 14**	**Sept 14**	**Oct 14**	**Nov 14**	**Dec 14**
Sue Hancock	PN – Blundellsands Surgery	P	A										
Colin Smith	PM – Blundellsands Surgery	P	P										
Shelley Keating	PM – 30 Kingsway		A										
Dr C Shaw	GP – 30 Kingsway												
Dr C McDonagh	GP – 30 Kingsway	P	P										
Dr E Pierce	GP – Hightown Village Practice												
Pauline Woolfall	PM – Hightown Village Practice	P	A										
Dr C Allison	GP – Hightown Village Practice	P											
Dr D Navaratnam	GP – Azalea Surgery	A	P										
Dr C Doran	GP – Azalea Surgery												
Dr G Berni	GP – 42 Kingsway	P	P										
Alan Finn	PM – 42 Kingsway		P										
Dr F Vitty	GP – 42 Kingsway												

No	Item	Action
14/9	**Apologies** Apologies were noted	
14/10	**Minutes of last meeting** Dr P Sharma pointed out that she had attended the meeting in January, AJ agreed to amend the attendance list. Following this one amendment, the minutes following the meeting held on 8th January 2014 were agreed as an accurate record.	
14/11	**Declarations of Interest** No declarations of interest were recorded.	
14/12	**Matters Arising** AJ provided feedback on the GTD issue raised by Blundellsands Surgery at the last meeting, stating that this had been attributed to one individual GP at GTD. The situation has been addressed and the individual involved provided retraining. Practices should start seeing an improvement over the coming weeks. The group were encouraged to contact GTD if any issues arise at Practice level as GTD are very keen to engage with primary care. The contact for GTD is Matt Lynas.	
14/13	**Medicines Management** Janet Faye provided an update to the group following actions from the last meeting. The recall on medicines will be supported by NHS England. The CSU are looking at alerts for a more structured approach to lessen duplication and offer more clarity. Erectile dysfunction – the Department of Health is carrying out a generic evaluation for all patients with this problem. Alder Hey Torpedo Pilot/Ciprofloxacin trial – discussions are continuing with GPs around prescribing. There are currently discussions taking place with R&D Manager in Liverpool involving pharmacists around what patients want to happen in relation to prescribing this treatment. There was discussion by the group around repeat prescriptions and the issues involved in trying to ascertain the needs of the patient. Suggestions were made that JMOG would be a good forum to look at contracting to provide clarity for consultants issuing prescriptions. The group were encouraged to flag any issues back to the CCG as there is a clear policy and action will be taken.	
14/14	**Locality Budget** AJ asked opened the floor to ideas on how best to spend the £50k locality allocation. The group were informed that Seaforth & Litherland were using their monies to purchase blood pressure monitors and defibrillators. AJ added that the group would need to make a decision within the next two weeks for purchases of equipment as the deadline is 31st March 2014. It is anticipated that for the next financial year the allocations of monies will happen sooner to ensure planning and create effective spending. AJ invited members of the group to email with their ideas for utilising the £50k allocation.	All

No	Item	Action
14/15	**QOF QP Group Peer Review** AJ invited each Practice to provide details of the QOF QP Peer Review which were recorded and will form part of the peer review report which Alan Finn/Shelley Keating will produce once responses have been collated. Some elements were missing due to Practice issues receiving their data in December (as well as a delay in receiving Opthalmology data which is due second week in February). These will be mopped up at our next Locality meeting. AJ asked each Practice to provide their report/narrative via email so that it can be used when collating the final report. Some key points to note from the resulting audit work; Outpatients 1. Pathway/guidelines for referral into community services to be made available in locum/registrar packs 2. Patient choice was a significant reason for patients being sent to secondary care services for Gynaecology (either they have had a negative experience at the community service and did not want to return or they've had previous care in a secondary setting (e.g. at LWH) and preferred to be referred back for continuation of care). 3. The group questioned the routine discharge letter from community Gynaecology. AJ will follow this up with Paula Briggs. The group also raised a very positive aspect of the service in that they've received phone calls back to a practice on occasions where Paula Briggs has been worried about a particular patient. A&E Admissions 4. The group discussed the insufficient detail recorded in discharge letters in both Respiratory and EOL discharges. 5. Members also reported issues around coding at Aintree with regards to Respiratory admissions. 6. The group questioned the strict inclusion/exclusion criteria for step up to the community IV therapy service and access to the team and highlighted that there was a narrow therapeutic window (sick enough to need IV's v's need to go to hospital) as well as restricted hours of operation. Problems were also highlighted with admitting patients into the team at Aintree.	All AJ
14/16	**AOB** AJ reported that Dawn Porter (Well Being & Support Centre at Woodlands Hospice) and Karl McCluskey (Head of Strategic Planning & Assurance CCGs) have asked to attend a Locality meeting in the near future. It was agreed to invite them to the April or May meeting. AJ highlighted that the Locality Managers are being approached by representatives of various providers/services to attend the meeting as well as key members of the CCG. All such requests will be shared with the Locality and the group can review and agree who will be invited to attend future meetings. AJ also informed the group that the next locality meeting would be used to complete the QOF QP Peer Review (for those seven Practices that took part today). Those Practices unable to attend this February meeting will need to	

No	Item	Action
	arrange alternative arrangements between themselves (and with other Practices including cross-Locality if necessary).	
14/	**Date and time of next meeting** Wednesday 5th March 2014 12:30pm lunch 12.45pm start – 2.30pm Crosby Lakeside Adventure Centre (CLAC)	

South Sefton Clinical Commissioning Group

Maghull Locality Meeting Minutes

Thursday 23rd January 2014
1:00pm – 2:30pm
Westway Surgery

Chair
Dr J Thomas (JT) – Broadwood Surgery

Attendees
Donna Hampson (DH) – Maghull SSP Surgery
Jenny Proctor (JP) – Westway Medical Centre
Gillian Stuart (GS) – Westway Medical Centre
Dr S Gough (SG) – Westway Medical Centre
Gill Kennedy (GK) – High Pastures Surgery
Dr A Banerjee (AB) – Maghull SSP Surgery
Dr S Sapre (SS) – Maghull Health Centre
Dr R Killough (RK) – Westway Medical Centre
Jenny Johnston (JJ) – South Sefton Clinical Commissioning Group
Becky Williams (BW) – South Sefton Clinical Commissioning Group
Terry Hill (TH)– South Sefton Clinical Commissioning Group
Angela Curran - South Sefton Clinical Commissioning Group

Minutes
Jennifer Ginley – South Sefton Clinical Commissioning Group

South Sefton Clinical Commissioning Group

Attendance Tracker

P Present
A Apologies
L Late or left early

Name	Designation	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
Dr S Sapre	GP – Maghull Family Health Centre	P											
Gillian Stuart	PM – Westway Medical Centre	P											
Carole Howard	PM – Westway Medical Centre												
Dr S Chandra	GP – Westway Medical Centre												
Dr R Killough	GP – Westway Medical Centre	P											
Dr J Wray	GP – Westway Medical Centre												
Dr S Gough	GP – Westway Medical Centre	P											
Jennie Procter	PN – Westway Medical Centre	P											
Gill Kennedy	PM – High Pastures Surgery	P											
Dr P Thomas	GP – High Pastures Surgery												
Dr J Clarkson	GP – High Pastures Surgery												
Dr P Weston	GP – High Pastures Surgery												
Dr N Ahmed	GP – High Pastures Surgery												
Dr W Coulter	GP – Maghull SSP Practice												
Lesley Bailey	PN – Maghull SSP Practice												
Donna Hampson	PM – Maghull SSP Practice	P											
Dr A Banerjee	GP – Maghull SSP Practice	P											
Dr J Thomas	GP – Broadwood Surgery	P											
Dr B Thomas	GP – Broadwood Surgery												
Judith Abbott	PN – Broadwood Surgery	A											

No	Item	Action
14/01	**Apologies** Apologises were noted - Judith Abbot – Broadwood Surgery Clinical lead – High Pastures Surgery	
14/02	**Declarations of interest** Dr Jill Thomas – SMOOG	
14/03	**Action Points** **Ward 35** JT emailed Dr D Harvey and gave an update of the response. Dr Harvey is currently trying to clarify step up criteria for admission to ward 35, which needs a real discussion. LCH are involved and it was suggested that there should be an education session with staff because they are also unclear. JT suggested that the group have two options – wait for draft criteria and argue on points or send in suggestions prior to draft. Dr Harvey is going to call Ward 35 and arrange for them to come to a locality meeting, possibly in March with community also present.	
14/04	**Locality discussion** JT gave an overview of the split locality lead roles that both herself and SG will be undertaking. JT also gave a brief update on future housekeeping rules for the meeting. JT also described the communications document and the reasons for its distribution. TH requested that if practices required any additional names to be added to the document to let him know. The document is a working document that will be circulated with the minutes.	
14/05	**Quality Premium** BW gave a verbal update on the QP and finance report provided to the group. BW reiterated that the indicators are nationally prescribed. The intelligence portal is in the process of being re-vamped and should be available by April 2014. The new portal will give practices access to these reports and additional information such as referrals data. However in the interim, feedback from the locality is essential for producing reports in a way that is useful to the localities. BW suggested that there should be some commonality amongst the reports as there are limited time and resources, and not enough to reproduce a vastly different report for each locality (All 8 localities). SS asked if it was possible for a dashboard or scorecard to be provided detailing which patients to be targeted? BW explained that since April 2013 access to patient identifiable information is only visible by the 'Data Management Integration team' outside of the GP practice, and that this team is also small. The group discussed what influence it has on the national indicators such as the ambulance target. It was stated that the CCG has both clinical and managerial representatives who meet with its providers regularly at contract	

No	Item	Action
	meetings to discuss and monitor performance. However, as a locality it is expected that concerns with performance are also raised and duly minuted in order for those concerns to be raised with providers. It was suggested that hospital data is not very helpful on its own and that some narrative would help understand why some indicators are deemed as red. It was also stated that coding and data quality was an issue. BW explained that the CCG raises data quality concerns at contract meetings and also attend data quality sub groups to ensure improvements are made. These errors are flagged up at every opportunity. Data quality improvement plans are in place. The role of the informatics facilitators was discussed. It was stated that discussions are ongoing as to how the facilitators will further support practices with the use of the SIP portal. **Action: BW to add exception commentary to QP report**	
14/06	**Medicines Management** JJ explained the budget data for October. Maghull locality are forecast an underspend of -£102,445 (-2.2%). JJ explained that the budget forecast was very tight for November and that practices should carry on with all quick win work in their practices. The quick wins were discussed and explained. Westway and Dr Sapre requested that the laminated aide memoire sheets be distributed to all practices within the locality. Quick win data was handed out to practices and discussed. JJ explained certain drugs weren't reflected in the graphs such as movicol work and pregabalin.	
14/07	**Communications** Agenda item discussed in 14/04	
14/08	**Any other business** **Development Budget** Locality development fund – TH stated that there was a £50,000 development budget for each locality. TH asked the group for any ideas anybody had for how the money could be spent on improving health outcomes for patients in the Maghull locality. JT suggested 24 hour blood pressure monitors should be bought. Although these machines were bought 2 years ago, there are not enough to cover the locality and patients are having to wait. The group agreed with this suggestion. SS suggested also a Pulse Oximeter should be bought. A discussion ensued regarding what should be practice purchases. **Action: TH to seek clarification on Locality development fund criteria.** **Clinical IT lead** TH asked for expressions of interest in the recently vacated clinical IT lead role.	
14/09	**Date and Time of next meeting:** Friday 14th February – High Pastures Thursday 20th March – Westway Friday 25th April – High Pastures	

No	Item	Action
	Thursday 22nd May – Westway Friday 20th June – High Pastures Thursday 24th July – Westway Friday 22nd August – High Pastures Thursday 25th September – Westway Friday 24th October – High Pastures Thursday 20th November – Westway Friday 19th December – High Pastures	

Chair Signature ……. Date …….