NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

Date: Thursday, 29 May 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)
Dr Craig Gillespie	Clinical Vice-Chair, GP	(CG)
Graham Morris	Vice Chair, Lay Member, Financial Management and Audit	(GM)
Roger Driver	Lay Member, Engagement and Patient Experience	(RD)
Dr Andrew Mimnagh	GP	(AM)
Dr Paul Thomas	GP	(PT)
Dr John Wray	GP	(JW)
Dr Dan McDowell	Secondary Care Doctor	(DMcD)
Lin Bennett	Practice Manager	(LB)
Sharon McGibbon	Practice Manager	(SMcG)
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

Jan Leonard	Chief Redesign and Commissioning Officer	(JL)
Stephen Astles	Head of CCG Development	(SA)
Brendan Prescott	Deputy Chief Nurse / Head of Quality and Safety	(BP)
Dr Debbie Harvey	Lead Clinician for Virtual Ward	(DH)
Hannah Chellaswamy	Deputy Director of Public Health, Public Health Sefton	(HC)
Sam Tunney	Head of Business Intelligence and Performance, Sefton MBC	(ST)
Suzanne Lynch	Head of Medicines Management	(SL)
Dr Bal Duper	Primary Care Quality Lead	(BDup)
Karl McCluskey	Chief Strategy and Outcomes Officer	(KMcC)

The meeting will be preceded by a presentation by Nanette Mellor, Neurosupport
On the Sefton Research Report

No	Item	Lead	Report	Receive/ Approve	Time
Governance					
GB14/61	Apologies for Absence	Chair		R	13.30
GB14/62	Declarations of Interest regarding agenda items	All		R	
GB14/63	Register of Interests	-	✓	R	
GB14/64	Hospitality Register	-	✓	R	
GB14/65	Minutes of Previous Meeting	Chair	✓	R	13.25
GB14/66	Action Points from Previous Meeting	Chair	✓	R	
GB14/67	Business Update	Chair			13.30
GB14/68	Chief Officer Report	FLC	✓	R	13.35
Finance and Performance					
GB14/69	Corporate Performance Report	KMcC	✓	R	13.40
GB14/70	Quality Performance Report	DF	✓	R	13.50
GB14/71	Financial Performance Report Month 12 – 2013/14	MMcD	✓	R	14.00
GB14/72	2014/2015 Revised Financial Budgets	MMcD	✓	A	14.10
GB14/73	(a) Five Year Strategic Plan (b) Five Year Financial Plan	KMcC MMcD	✓	R	14.20
GB14/74	Prescribing Performance Report	SL	✓	R	14.30
GB14/75	Annual Report and Accounts	MMcD	✓	R	14.40
GB14/76	Audit Committee Annual Report	HN	✓	R	14.50
Quality and Safety					
GB14/77	Francis Report and Action Plan	DF	✓	R	15.00
Service Improvement / Strategic Delivery					
GB14/78	Sefton Strategy for Older Citizen's 2014 - 2019	KT	✓	A	15.10
GB14/79	Virtual Ward Quarterly Update	DH	✓	R	15.20
GB14/80	Primary Care Update	JL	✓	R	15.30
GB14/81	Revised Governance Structures 2014	TJ	✓	R	15.40
GB14/82	Mental Health Services Review Briefing	KMcC	✓	R	16.00
GB14/83	Out of Hours Pharmacy Consultation	BP	✓	R	16.10
For information					
GB14/84	Key issues reports from committees of Governing Body:- Audit Committee	MMcD	✓	R	16.20
GB14/85	Audit Committee Minutes	MMcD	✓	R	
GB14/86	Quality Committee Minutes	-	✓	R	
GB14/87	Finance & Resource Committee Minutes	-	✓	R	
GB14/88	Merseyside CCG Network Minutes	-	✓	R	

No	Item	Lead	Report	Receive/ Approve	Time
GB14/89	Health and Wellbeing Board Minutes	-	✓	R	16.30
GB14/90	Medicines Optimisation Operational Group Minutes	-	✓	R	
GB14/91	Locality Meetings - (i) Seaforth & Litherland Locality (ii) Bootle Locality (iii) Crosby Locality (iv) Maghull Locality	-	✓	R	
Closing Business					
GB14/92	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting.*				16.40
GB14/93	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					16.50

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 5: May 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	16.04.2014	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	
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	
Alison Lucy Johnston	01.07.13	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
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
May 2014

NHS
South Sefton
Clinical Commissioning Group

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

No hospitality received

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public Minutes

Thursday, 27 March 2014 at 1.00pm to 4.00pm
The Boardroom, Third Floor, Merton House, Bootle L20 3DL

Present

Dr Craig Gillespie	Clinical Vice-Chair, GP (in Chair)	(CG)
Dr Andrew Mimnagh	GP	(AM)
Dr Paul Thomas	GP	(PT)
Lin Bennett	Practice Manager	(LB)
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

Stephen Astles	Head of CCG Development	(SA)
Brendan Prescott	Deputy Head of Quality and Safety	(BP)
Gaynor Hales	Director of Nursing, NHS England (Merseyside)	(GH)
Tracy Jeffes	Head of Delivery and Integration	(TJ)
Catherine Beardshaw	Chief Executive) Aintree University	(CB)
Richard Ward	Medical Director) Hospitals NHS Foundation Trust	(RW)

Apologies

Dr Clive Shaw	Chair, GP	(CS)
Graham Morris	Vice Chair, Lay Member, Financial Management and Audit	(GM)
Roger Driver	Lay Member, Engagement and Patient Experience	(RD)
Dr John Wray	GP	(JW)
Sharon McGibbon	Practice Manager	(SMcG)

Minutes

Melanie Wright	Business Manager

Attendance Tracker

✓ Present
A Apologies
L Late

Governing Body Member	Designation	Jan 2013	Mar 2013	May 2013	July 2013	Sept 2013	Nov 2013	Jan 2014	Mar 2014			
Dr Clive Shaw	Chair	A	✓	✓	A	A	L	A	A			
Graham Morris	Vice Chair, Lay Member FM&A	N/A						✓	A			
Dr Craig Gillespie	Clinical Vice-Chair, GP	✓	✓	✓	✓	✓	✓	✓	✓			
Dr Steve Fraser	GP	✓	✓	✓	✓	A	✓	Resigned				
Dr Andrew Mimnagh	GP	✓	✓	✓	A	✓	✓	✓	✓			
Dr Ricky Sinha	GP	✓	✓	✓	A	✓	A	Resigned				
Dr Paul Thomas	GP	✓	✓	A	✓	✓	A	✓	✓			
Dr John Wray	GP	A	A	A	A	A	✓	A	A			
Roger Driver	Lay Member, Engagement and Patient Experience	✓	✓	✓	✓	✓	✓	✓	A			
Lin Bennett	Practice Manager	✓	✓	✓	✓	✓	✓	✓	✓			
Sharon McGibbon	Practice Manager	✓	✓	✓	A	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	✓	A			
Maureen Kelly	Healthwatch Sefton	N/A				A	A	A	A			

No	Item	Action
GB14/32	**Apologies for Absence** were received.	
GB14/33	**Declarations of Interest regarding agenda items** There were no declarations.	
GB14/34	**Register of Interests** was received.	
GB14/35	**Hospitality Register** was received.	
GB14/36	**Minutes of Previous Meeting** The Minutes were approved as an accurate record of the previous meeting.	
GB14/37	**Action Points from Previous Meeting** All action points have been closed down.	
GB14/38	**Business Update** There was no update due to the absence of the Chair.	
GB14/39	**Chief Officer Report** The Strategic Financial Plan will be presented to the Governing Body in June. The Governing Body also noted the importance of the section of the report dealing with Designating Commissioner Requested Services and noted the timescales in relation thereto. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/40	**Corporate Performance Report** Ms Clark expressed concerns over the Referral Time to Treatment in relation to cancer patients and advised that some of the delay has arisen due to patient choice, but the CCG has commissioned a report from the Cancer Lead to investigate this further. Work also continues across the patch and across the Cancer Network. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/41	**Quality Performance Report** The Quality dashboards have been considered at the Quality Committee. *Friends and Family Test: Royal Liverpool & Broadgreen* – Liverpool CCG is the co-ordinating commissioner for this provider and are liaising closely with them in relation to gaining assurance in relation to their performance on the Friends and Family test. *Southport & Ormskirk Hospitals NHS Trust (S&O) Mixed Sex Accommodation Breaches*– 35 breaches have taken place within the Critical Care Unit when the Trust experienced difficulties in patient flow. Remedial action planning is taking place at the Trust and assurance has been offered to the Trust's Board and Quality Committee.	

No	Item	Action
	S&O: A&E Element, Friends and Family Test – acknowledging the national challenges in relation to this indicator, the Trust had recently attended the CCG's Engagement and Patient Experience Group to advise of the work undertaken in relation to the A&E component and improving care for patients. Aintree University Hospitals NHS Foundation Trust (Aintree) will be similarly presenting in due course. *S&O: CDifficile* – following a breach of the S&O's target, a remedial action plan is in place. The CCG have shared their own action plan and have also shared this with NHS England, who is assured by the CCG's actions and those from a commissioner/ provider perspective. A meeting to examine root cause analysis and the patient journey generally is planned for the following week, with a view to holding a workshop later in the year. *Aintree University Hospitals NHS Foundation Trust (Aintree): MRSA* – this case was not a Sefton patient, but the CCG's Quality Programme Manager has attended the meeting to examine the action plan put in place in relation to this occurrence. *Mersey Care NHS Trust (Mersey Care): Length of Stay* – length of stay appears to have increased and Dr Mulla of Southport and Formby CCG will raise this as lead for Mental Health Services on behalf of South Sefton CCG, but it will also be considered as art of the contract management process. Mr Mimnagh asked about Mersey Care staff declining flu vaccinations and requested assurance from this provider as to the clinical leadership in place to encourage this. Miss Fagan agreed to action. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	DF
GB14/42	**Financial Performance Report** Continuing Healthcare claims remain the most significant issue for the CCG. Work will continue as part of the integration agenda with the Local Council. Mr McDowell advised that the CCG remains on target for the rest of the financial year. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/43	**Prescribing Performance Report** 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. Ms Clark asked the Governing Body to note the volatile nature of prescribing. A detailed analysis is being undertaken at the Senior Leadership Team to understand prescribing activity on a per practice basis. Mr Prescott updated the meeting in relation to Scriptswitch which has been uploaded with a limited profile at the current time, which decision was made to facilitate a quick installation and following feedback from practices about the level of messages they wished to receive. Dr Gillespie felt that repeated messages from Scriptswitch did have a benefit, particularly for new doctors and locums. Scriptswitch will be evaluated in due course. Shared Care Protocols are not reflected in this report and there will be some budgetary adjustment required to accommodate this in the next report to the Governing Body.	

No	Item	Action
	It is desirable to broaden the spectrum of associations around prescribing and individual practices and this piece of work will be completed by September 2014. Mr McDowell suggested that following a quarterly review of practice list size, fluctuations in the population and flow of patients could be considered alongside individual practices and prescribing budgets. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/44	**The CCG 5 Year Strategic Plan and 2 year Operational Plan – Briefing on Progress – Update** Mr McCluskey referenced the first draft of the plans and timetable produced to the Governing Body in January 2014. By way of an update, national guidance continues to evolve and the CCG is working closely with colleagues at NHS England to review that guidance. Mr McCluskey described the evidence, tools and models that have been considered as part of the planning process, noting the 4 April deadline for the CCG to finalise its two-year Operational Plan. The five-year Strategic Plan is also under development and the national guidance produced in December, the Health and Wellbeing Strategy and existing strategic documents for CCGs have been considered as part of the process to produce some commonality in terms of vision and values. The alignment of plans across the health economy is of key importance. The five year plan will be further refined in time for the May meeting of the Governing Body. The Better Care Fund progresses in parallel with the CCG's Strategy and there is little to separate the two in terms of vision and objectives. Miss Fagan noted the reference to the system values and principles and that alignment with compassionate practice is explicit. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/45	**Strategic Financial Plan 2014/15 - 2018/19** Mr McDowell advised felt it was important to take stock at this stage to consider the financial planning process alongside the strategic process. A formal report will be brought back to the Governing Body in May, in advance of the submission date in June.	MMcD
GB14/46	**Clinical Directors Role** The intention to develop Clinical Director roles was signalled in the Governing Body Development session in October 2013. Development of the portfolios will require further consideration and personal development of individuals. A parallel process needs to be developed for other members of the Governing Body. There will be opportunity to consider this further at the Development Session in April 2014. Dr Gillespie expressed some concern at individuals' capacity to undertake these roles, but acknowledged that distributed leadership model will support the development of these roles.	

No	Item	Action
	Actions taken by the Governing Body	
	The Governing Body received the report by way of assurance.	
GB14/47	**2014/15 Provider Contracts Update** Contracts with Merseycare NHS Trust and Liverpool Community Healthcare Services NHS Trust have been concluded. An agreement has also been reached with Southport and Ormskirk Hospitals NHS Trust. Negotiations with Aintree University Hospitals NHS Foundation Trust and Liverpool Women's Hospital NHS Foundation Trust continue. These contracts have not yet been signed, but stability of services under the current contractual arrangements will be retained while the negotiation continues. Dr John Wray is the Governing Body lead on the Aintree contracting process and is involved in the negotiation process. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/48	**Key issues reports from Committees of Governing Body** *Finance and Resource Committee* A correction is required at point 1. At point 4, the Committee reviewed the Operating Financial Review and agreed the content was appropriate. *Quality Committee* Dr Gillespie referenced Safeguarding which relates to assurance from providers of commissioned services providing assurance in relation to safeguarding policies and procedures. Full assurance has not been reached from any providers and this is being addressed by the Safeguarding Team, continues to be monitored by the Quality Committee and is on the CCG's risk register. Miss Fagan referenced the need for providers to produce ratified policies in relation to safeguarding. The Prevent Agenda forms part of the contractual process with providers for the forthcoming financial year. Improvements in communication are required and work with colleagues in NHS England to strengthen this engagement further is ongoing. The organisation's ability to benchmark providers in relation to their performance following Serious Incidents was also discussed at the Quality Committee and development of benchmarks is under way. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/49	**Commissioning Intentions 2014/15** The Commissioning Intentions have been developed following engagement events with stakeholders last year and at Governing Body development sessions. Miss Fagan noted the importance of joint working with other NHS organisations in order to achieve the CCG's objectives. Ms Clark suggested that rather than produce a separate business plan at this time, this would be address in combination with the strategic plans following the June 2014 submission.	

No	Item	Action
	Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/50	**NHS Constitution Statement of Assurance** This document demonstrates the CCG's compliance with patients' rights under the NHS Constitution. Ms Clark asked that Ms Hales provide formal feedback on the CCG's constitutional commitments in due course. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/51	**2014/15 Opening Financial Budgets** The proposed budgets deliver the key metrics required by NHS England in terms of 1% surplus. 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. The CCG has provided a Contingency reserve of 0.5% of resource allocations in accordance with the national guidelines and the CCG planned expenditure is within its running cost target. The CCG has identified Investment schemes using 2.5% of non-recurrent expenditure, in line with NHS England 2014/15 planning guidance. 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. Actions taken by the Governing Body The Governing Body approved the Opening Financial Statements for the year 2014/15.	
GB14/52	Quality Committee minutes were received.	
GB14/53	Finance & Resource Committee minutes were received.	
GB14/54	Merseyside CCG Network minutes were received.	
GB14/55	Health and Wellbeing Board minutes were received.	
GB14/56	Medicines Management Operational Group minutes were received.	
GB14/57	Health and Wellbeing Board Programme Group minutes were received.	
GB14/58	**Locality Meetings** minutes were received. Dr Mimnagh expressed disappointment at the number of non-attendance and apologies from practices at locality meetings. Ms Clark advised that these practices are largely SSP Practices and she has written to the practices to raise this with them.	
GB14/59	**Any Other Business** Ms Clark and Dr Shaw are attempting to visit the membership practices and locality meetings.	
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.	

Motion to Exclude the Public:

Representatives of the Press and other members of the Public to be excluded from the remainder of this meeting, having regard to the confidential nature of the business of be transacted, publicity on which would be prejudicial to the public interest, (Section 1{2} Public Bodies (Admissions to Meetings), Act 1960).

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public Actions

Thursday, 27 March 2014 at 1.00pm to 4.00pm

No	Item	Action
GB14/41	**Quality Performance Report** *Mersey Care NHS Trust (Mersey Care)* Mr Mimnagh asked about Mersey Care staff declining flu vaccinations and requested assurance from this provider as to the clinical leadership in place to encourage this. Miss Fagan agreed to action.	DF
GB14/45	**Strategic Financial Plan 2014/15 - 2018/19** A formal report will be brought back to the Governing Body in May, in advance of the submission date in June.	MMcD

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/68	**Author of the Paper:**
Report date: May 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)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Achieve a 2% reduction in non-elective admissions in 2014/15.
x	Implementation of 2014/15 phase of Care Closer to Home/Virtual Ward plan.
x	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

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
May 2014

1. Internal Audit and Service Auditor Reporting 2013/14 – Cheshire & Merseyside Commissioning Support Unit

1.1. Due to this being a transitional year following a period of significant changes, NHS England have advised on a national basis that where there have been findings from internal audit work commissioned by NHS England, there is no benefit in the same process being audited again by CCGs' internal auditors, as this would be duplication of effort and produce the same results.

1.2. CCGs should therefore not request to send their Internal Auditors into the CSU, if the process has already been audited by NHS England Internal Audit, as this request will be denied.

1.3. On a National basis, NHS England has advised that client side controls in CCGs should be considered as part of the assurance work undertaken by CCG Internal Auditors. These will provide a level of comfort where positive assurance is not possible for part of the year from the CSU due to this transitional year.

1.4. It is recognised that where there have been control weaknesses during the year, CCG External Auditors may wish to perform additional substantive testing for the periods where reliance cannot be placed on controls testing. Where this cannot be performed at CCG level NHS England will permit access to CSUs.

1.5. In a letter from Tim Andrews dated 3 February 2014, Cheshire & Merseyside CSU confirmed that such an audit by NHS England Internal Audit has taken place and, accordingly, the CCG will not be seeking to gain access into the CSU for audit purposes.

2. Hard Truths Commitments Regarding the Publishing of Staffing Data

2.1. The National Quality Board (NQB) issued guidance in November to optimise nursing, midwifery and care staffing capacity and capability. Research demonstrates that staffing levels are linked to the safety of care and that staff shortfalls increase the risks of patient harm and poor quality care. Patients and the public have a right to know how the hospitals they are paying for are being run, and so the Government has made a number of commitments in Hard Truths: The Journey to Putting Patients First to make this information more publically available.

2.2. There are two phases and, in the first phase, there are a number of milestones ahead which will focus on all inpatient areas; including acute, community, mental health, maternity and learning disability. The commitments from Trusts are to publish staffing data from April and, at the latest, by the end of June 2014 in the following ways:

- a Board report describing the staffing capacity and capability, following an establishment review, using evidence based tools where possible. To be presented to the Board every six months;

- information about the nurses, midwives and care staff deployed for each shift compared to what has been planned and this is to be displayed at ward level;

- a Board report containing details of planned and actual staffing on a shiftby- shift basis at ward level for the previous month. To be presented to the Board every month;

- the monthly report must also be published on the Trust's website and Trusts will expected to link or upload the report to the relevant hospital(s) webpage on NHS Choices.

NHS England/Care Quality Commission will be undertaking two stock-takes of progress, which will take place on the dates set out below and will be undertaken jointly with the NHS Trust Development Authority (TDA).

	Date Issued:	Date to be Returned:
Stock-take 1	23rd April 2014	30th April 2014
Stock-take 2	28th May 2014	6th June 2014.

2.3. Trust boards must, at any point in time, be able to demonstrate to their commissioners that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient to provide safe care. All NHS Trusts are accountable to the NHS TDA and, as stated in the Accountability Framework 2014-15, will be expected to provide the NHS TDA with assurance that they are implementing the NQB staffing guidance and that, where there are risks to quality of care due to staffing, actions are taken to minimise the risk. Monitor has worked with us in the development of this guidance and expects Foundation Trusts to have the right staff, in the right place at the right time. The Care Quality Commission will be looking for compliance with all the actions outlined in this letter as part of their inspection regime. Monitor will act where the CQC identifies any deficiencies in staffing levels in Foundation Trusts.

2.4. On 16 May 2014, NHS England sent a letter and guidance to all Trusts with inpatient beds on publishing staffing data on NHS Choices in June 2014. From a CCG assurance perspective, provider staffing is detailed within the quality element of the contract and will be monitored via the Clinical Performance and Quality Group meetings, reported as necessary to the Quality Committee.

3. South Sefton CCG Constitution

3.1. The deadline for the next opportunity for CCGs to update their constitutions closes on 1 June 2014.

3.2. Work has therefore been undertaken to update the Constitution generally and in accordance with the requested changes by NHS England, together with the national requirements for the Governing Body to include a Secondary Care Doctor, a Registered Nurse and Lay Members.

3.3. The changes also incorporate the creation of two new committees of the Governing Body – the Service Improvement and Redesign Committee and the Approvals Committee.

3.4. The changes have now been circulated to the Wider CCG Membership for discussion and are recommended for approval on 22 May 2014.

4. National CCG 360° Survey

4.1. The results of a national survey by Ipsos Mori calling for views about CCGs across the country have shown some positive results for South Sefton CCG. The CCG received its 360° feedback on the 9th May 2014, carried out on behalf of NHS England, the survey aimed at gauging perceptions and working relationships between CCGs and their key local partners.

4.2. As well as member GP practices, bodies like Sefton Health and Wellbeing Board, Sefton CVS and Healthwatch Sefton were also invited to complete the survey. Locally, the overall response rate was 60% for SSCCG.

4.3. A similar exercise was carried out in 2012 prior to the CCG becoming a statutory organisation and these latest findings compare favourably with the baseline results.

4.4. A more detailed analysis is currently being undertaken and this will link in to the CCG Organisational Development plan, overseen by Tracy Jeffes- Chief Delivery & Integration Officer.

4.5. The full and summary reports have been sent via the CCG newsletter to our member practices and are also available on our public website. http://www.southseftonccg.org.uk/?p=530

5. Progress on Strategic Plan

5.1. The CCG first draft strategic plan was submitted by the NHS England deadline on the 4th April 2014.

5.2. Following on from this submission further work has been undertaken through 'mini chats' with our public and recently developed work through the newly established Provider forum to gain feedback and input to the plans are they are evolving.

5.3. Recent feedback from NHS England (Merseyside) has been positive and encouraging, and a acknowledgement that this is the first iteration and part of our journey across our unit of planning-Sefton.

5.4. The areas of feedback and key lines of enquiry from NHS England are now being considered by Karl McCluskey- Chief Strategy & Outcomes Officer and will be incorporated into our submission for the 20th June 2014.

5.5. Work has also been finalised on the CCG structures and governance arrangements in order to drive the strategy effectively into its delivery phase.

6. Aintree University Hospital NHS Foundation Trust -CQC Quality report May 2014

6.1. The Care Quality Commission (CQC) has rated Aintree's services as 'good' following an inspection in March. A team of 30 inspectors spent three days in the hospital and also conducted an unannounced visit.

6.2. Every specialty service has been rated as 'good', including:

- A&E
- Medical Care

- Critical Care
- End of Life Care
- Outpatients
- Surgery.

6.3 Areas highlighted in the report include:

- that all the patients who the inspectors spoke to were positive about their care and treatment at Aintree and felt that they were well cared for and treated with dignity and respect;

- all the wards and departments that were inspected were adequately staffed by staff who were "committed and enthusiastic about their work and worked hard to ensure that patients were given the best care and treatment possible";

- the hospital was clean throughout and there was good practice in the control and prevention of infection;

- Aintree's well-respected Volunteer department which makes a "positive contribution to the patient journey" and provides "development opportunities for the local population."

  http://www.cqc.org.uk/media/englands-chief-inspector-hospitals-has-published-his-first-report-quality-services-provided-ai

7. Co-commissioning of primary care services

7.1 NHS England have written to the CCG to set out how CCGs can submit expressions of interest by the 20th June (see Appendix 1), to develop new arrangements for co-commissioning of primary care services, following Simon Stevens' announcement on 1 May. NHS England have also indicated that the NHS Commissioning Assembly will undertake a rapid piece of work to support CCGs.

7.2 Proposals may be submitted by an individual CCG or by a group of CCGs that wishes to propose co-commissioning arrangements to cover their combined localities.

7.3 Expressions of interest should set out how the proposals fit with the CCG five-year strategic plan, with some specific areas to consider; including what form the CCG would like co-commissioning to take and how they would like this to evolve, including the proposed relationship with any current or proposed joint commissioning with local authorities.

7.4 NHS England envisages that arrangements for managing the Performers List, revalidation and appraisal would fall outside the scope of any co-commissioning arrangements. NHS England cannot delegate responsibility for commissioning of community pharmacy services or dental services. CCGs will be expected to ensure that their proposals take advantage of synergies with existing areas of CCG activity and enable functions to be discharged within existing CCG running costs as far as possible. Expressions of interest will need to indicate where proposals would rely upon area team staff working under the supervision of CCGs.

7.5 Governance frameworks will need to be clear and specific reference made to how any additional proposed safeguards for managing conflicts of interest will be applied and clear timetables for applying any new arrangements detailed.

7.6 Expressions of interest should set out how CCGs have engaged their member practices in developing the proposals and any key issues raised by member practices, together with proposals for how they will further involve member practices. Expressions of interest should provide any initial views of local stakeholders, together with proposals for engaging stakeholders more fully in developing the proposed arrangements more fully. This should, for instance, cover:

- patient groups;
- local authorities and Health and Wellbeing Boards;
- other local provider organisations, e.g. community, mental health, acute trusts.

7.7 Finally, expressions of interest should set out initial proposals for how to monitor and evaluate the impact and effectiveness of the proposed co-commissioning arrangements, in order to ensure that CCGs and area teams can adapt.

7.8 Work is now underway to understand the perspectives of the member practices and other key stakeholders and public.

8. Corporate objectives 14/15

8.1 The following are the proposed CCG corporate objectives for 14/15.

- Improve quality of commissioned services, whilst achieving financial balance.
- Achieve a 1% reduction in non-elective admissions in 2014/15.
- Implementation of 2014-15 phase of Care Closer to Home / Virtual Ward plan.
- Review and Re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
- Implementation of 2014-15 phase of Primary Care quality strategy / transformation.
- Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy.
- Review the population health needs for all mental health services to inform enhanced delivery.

8.2 These will be underpinned by:

- Public and Stakeholder Engagement
- Clinical Leadership
- Locality Working
- Organisational and Workforce Development
- Information Management &Technology.

9. Recommendation

The Governing Body is asked to formally receive this report.

Appendices

Appendix 1 Letter from NHS England dated 9 May 2014.

Fiona Clark
May 2014

Publications Gateway Ref. Number 01599

Commissioning Development Directorate
Room 4N28, Quarry House
Quarry Hill
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9 May 2014

To: CCG Clinical Leads

Area Directors, NHS England

Copy: CCG Chief Officers

Co-commissioning of primary care services

We are writing to set out:

- how CCGs can submit expressions of interest to develop new arrangements for co-commissioning of primary care services, following Simon Stevens' announcement on 1 May (see annex A);
- the work proposed to be done through the NHS Commissioning Assembly to support CCGs and area teams in developing co-commissioning arrangements.

We are inviting CCGs to submit expressions of interest by 20 June. We would encourage CCGs to work with area teams in developing proposals.

Expressions of interest should include at least this information:

A. CCG(s) involved

Proposals may be submitted by an individual CCG or by a group of CCGs that wishes to propose co-commissioning arrangements to cover their combined localities.

B. Intended benefits and benefits realisation

Expressions of interest should set out how the proposals fit with five-year strategic plans and, in particular, how they will help:

- achieve greater integration of health and care services, in particular more cohesive systems of out-of-hospital care that bring together general practice,

community health services, mental health services and social care to provide more joined-up services and improve outcomes;

- raise standards of quality (clinical effectiveness, patient experience and patient safety) within general practice services, reduce unwarranted variations in quality, and, where appropriate, provide targeted improvement support for practices;
- enhance patient and public involvement in developing services, for instance through asset-based community development;
- tackle health inequalities, in particular by improving quality of primary care in more deprived areas and for groups such as people with mental health problems or learning disabilities.

C. Scope

Commissioning of primary care encompasses a wide spectrum of activity, including:

- working with patients and the public and with Health and Wellbeing Boards to assess needs and decide strategic priorities;
- designing and negotiating local contracts (e.g. PMS, APMS, any enhanced services commissioned by NHS England);
- approving 'discretionary' payments, e.g. for premises reimbursement;
- managing financial resources and ensuring that expenditure does not exceed the resources available;
- monitoring contractual performance;
- applying any contractual sanctions;
- deciding in what circumstances to bring in new providers and managing associated procurements and making decisions on practice mergers.

The expression of interest should indicate which aspects of commissioning fall within the scope of the proposed arrangements. CCGs may wish to propose that they take on delegated or joint responsibilities for some aspects, whilst NHS England continues to discharge other responsibilities directly.

We envisage that arrangements for managing the Performers List, revalidation and appraisal would fall outside the scope of any co-commissioning arrangements.

NHS England cannot delegate responsibility for commissioning of community pharmacy services or dental services. CCGs may wish to make proposals for how better to align decisions made by area teams in commissioning of community pharmacy services with CCGs' strategic objectives, provided that NHS England retains its statutory decision-making responsibilities and that there is appropriate involvement of local professional networks.

NHS England could in principle delegate responsibility for commissioning of primary eye care services, but the main services commissioned by NHS England (NHS sight tests) are essentially a demand-led service governed by national regulations.

D. Nature of co-commissioning

There is a spectrum of potential forms that co-commissioning could take, for instance:

- greater CCG involvement in influencing commissioning decisions made by NHS England area teams;
- joint commissioning arrangements, whereby CCGs and area teams make decisions together, potentially supported by pooled funding arrangements;
- delegated commissioning arrangements, whereby CCGs carry out defined functions on behalf of NHS England and area teams hold CCGs to account for how effectively they carry out these functions.

Expressions of interest will need to indicate the form that CCGs would like co-commissioning to take and how they would like this to evolve, including the proposed relationship with any current or proposed joint commissioning with local authorities.

CCGs will be expected to ensure that their proposals take advantage of synergies with existing areas of CCG activity and enable functions to be discharged within existing CCG running costs as far as possible. Expressions of interest will need to indicate where proposals would rely upon area team staff working under the supervision of CCGs.

E. Timescales

Expressions of interest will need to indicate the proposed timescales for applying the new arrangements, including any proposals for phasing (e.g. where some elements of co-commissioning are introduced during 2014/15, followed by a more developed form of co-commissioning during 2015/16).

Any proposals that rely upon setting primary care budgets at a locality level (below that of an area team) would have to be implemented from 2015/16 onwards.

F. Governance

CCGs already have powers to commission services from general practice (or from other primary care providers) in their own right. Where commissioning services from general practice, or from any organisation in which their members or offers have a

material interest, CCGs have a statutory duty to manage conflicts of interest and to have regard to the statutory guidance on managing conflicts of interest published by NHS England[1]. CCGs would need equally to meet these duties and follow the statutory guidance in relation to any functions that they were to carry out jointly with, or on behalf of, NHS England.

Expressions of interest should set out any additional proposed safeguards for managing conflicts of interest.

G. Engaging member practices and local stakeholders

Expressions of interest should set out how CCGs have engaged their member practices in developing the proposals and any key issues raised by member practices, together with proposals for how they will further involve member practices.

Expressions of interest should provide any initial views of local stakeholders, together with proposals for engaging stakeholders more fully in developing the proposed arrangements more fully. This should, for instance, cover:

- patient groups;
- local authorities and Health and Wellbeing Boards;
- other local provider organisations, e.g. community, mental health, acute trusts.

H. Monitoring and evaluation

Expressions of interest should set out initial proposals for how to monitor and evaluate the impact and effectiveness of the proposed co-commissioning arrangements, in order to ensure that CCGs and area teams can adapt

NHS Commissioning Assembly project

The primary care working group of the NHS Commissioning Assembly will undertake a rapid piece of work to identify the key issues that will need to be resolved to support successful co-commissioning, with the aim of supporting area teams and CCGs in working together to refine the proposals that come from expressions of interest and to help spread innovative thinking.

This will include:

- identifying likely success factors for effective co-commissioning;

[1] http://www.england.nhs.uk/wp-content/uploads/2013/03/manage-con-int.pdf

- identifying the different forms that co-commissioning could take – and its potential scope – and the considerations that would need to be applied locally in choosing between them;
- developing a checklist that could guide CCGs and area teams through the steps involved in setting up new arrangements.

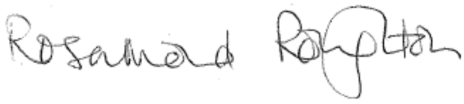
The project will also look, among other issues, at:

- how NHS England can assure itself that delegated functions are being discharged effectively and that any conflicts of interest are being managed appropriately;
- how associated financial resources would be allocated, managed and accounted for;
- any national decisions or approvals that would be needed in relation to information sharing;
- any implications for the public health offer to support primary care commissioning from Public Health England and local authorities.

Conclusion

CCGs are asked to submit expressions of interest, covering the factors set out above (paragraph 8), by 20 June. Please submit expressions of interest to england.co-commissioning@nhs.net.

The relevant Area Team will then discuss each proposal with the applicant CCG(s) and subsequently make a recommendation for approval through the Board governance of NHS England.



Rosamond Roughton
National Director: Commissioning Development

Dame Barbara Hakin
Chief Operating Officer

Annex A

NHS ENGLAND PRESS NOTICE (1 May 2014)

LOCAL HEALTH PROFESSIONALS TO GET MORE POWER TO IMPROVE NHS PRIMARY CARE

Stevens announces new option for local Clinical Commissioning Groups to co-commission primary care in partnership with NHS England

England's 211 clinically-led local Clinical Commissioning Groups will get new powers to improve local health services under a new commissioning initiative announced today by NHS England Chief Executive Simon Stevens.

Speaking to GPs and other NHS health professionals at the Annual Conference of NHS Clinical Commissioners in London, Simon Stevens said:

"England has now taken the bold step – unique in the western world – of putting two thirds of its health service funding under the control of local family doctors and clinicians.

"If we want to better integrate care outside hospitals, and properly resource primary, community and mental health services - at a time when overall funding is inevitably constrained - we need to make it easier for patients, local communities and local clinicians to exercise more clout over how services are developed.

"That means giving local CCGs greater influence over the way NHS funding is being invested for their local populations. As well as new models for primary care, we will be taking a hard look at how CCGs can have more impact on NHS England's specialised commissioning activities.

"So today I am inviting those CCGs that are interested in an expanded role in primary care to come forward and show how new powers would enable them to drive up the quality of care, cut health inequalities in primary care, and help put their local NHS on a sustainable path for the next five years and beyond.

"CCGs are still young organisations at different stages of development, and with different local needs. So rather than specifying a one-size-fits all solution, and having listened carefully to what CCGs have been saying, I'm keen to hear from CCGs themselves about what next steps they would like to explore."

Mr Stevens announced that NHS England will be writing next week to all CCGs in England with details of how to submit expressions of interest in taking on enhanced powers and responsibilities to co-commission primary care.

Applications will need to describe the additional powers and responsibilities the CCG would like to assume. They will need to meet a number of tests, including showing

they will help advance care integration, raise standards and cut health inequalities in primary care.

They will also need to show how they will ensure transparent and fair governance - with a continuing oversight role for NHS England to safeguard against conflicts of interest - all in the context of the CCG's five-year plan for its local NHS services.

NHS England will work with the NHS Commissioning Assembly, NHS Clinical Commissioners and other stakeholders to advance this agenda.

CCG expressions of interest should be developed by June 20, the same date that CCGs will complete their initial five-year 'Forward Views' for local NHS services.

Each proposal will be discussed by the applicant CCG and the local Area Team of NHS England, which will subsequently make a recommendation for approval by the Board of NHS England.

NOTES TO EDITORS

England's 211 CCGs are statutory bodies led by local GPs, alongside hospital doctors, nurses and other health professionals, managers, and independent lay members of the public.

NHS Clinical Commissioning Groups (CCGs) now control £67 billion of NHS funding – about two thirds of NHS spending in England.

Giving CCGs the ability to better influence and shape primary care services requires no further structural reorganisation, and the necessary enabling powers are already included in current legislation.

In accordance with national legislation, NHS England (and its Area Teams) will in all parts of the country continue directly to discharge specific primary care responsibilities, including in respect of community pharmacy, primary dental and ophthalmic services, as well as certain responsibilities in respect of primary medical services.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/69	**Author of the Paper:**
Report date: May 2014	Debbie Fagan debbie.fagan@southseftonccg.nhs.uk Karl McCluskey Karl.McCluskey@southseftonccg.nhs.uk Lisa Leckey Lisa.leckey@cmcsu.nhs.uk

Title: Corporate Performance Report

Summary/Key Issues:

This paper presents the Governing Body with the Performance Dashboard, Quality Report, Family and Friends Inpatient Summary, Friends and Family A&E Summary, Liverpool Community Health Quality Compliance Report for Month 12, 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)*	
X	Improve quality of commissioned services, whilst achieving financial balance
X	Achieve a 1% reduction in non-elective admissions in 2014/15
X	Implementation of 2014-15 phase of Care Closer to Home / Virtual Ward plan
	Review and Re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public
	Implementation of 2014-15 phase of Primary Care quality strategy / transformation
	Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy
	Review the population health needs for all mental health services to inform enhanced delivery

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

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
May 2014

1. Executive Summary

This report sets out the performance of the CCGs main acute providers and progress against the National Outcomes Framework at month 12 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 CCGs 3 main providers, Aintree Hospitals NHS Foundation Trust, Southport and Ormskirk Hospital NHS Trust and The Walton Centre NHS Foundation Trust.

3. Key Issues

Healthcare Acquired Infections (HCAI) – MRSA

At March 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 March 2014.

The Walton Centre NHS Foundation Trust has reported 1 case of MRSA year to date; Aintree Hospitals NHS Foundation Trust has reported 3 cases of MRSA, one of these cases was in March 2014. This was not a South Sefton CCG patient. This is above the zero tolerance. These were 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 March 2014 there have been 55 cases of Cdifficile infection reported for South Sefton CCG patients against a tolerance of 44. Above the year-end tolerance of 11 cases. There were 3 cases reported in March 2014, 2 at Aintree Hospitals NHS Foundation Trust and 1 at Royal Liverpool and Broadgreen University Hospitals Trust (RLBUHT).

Aintree University Hospitals NHS Foundation Trust has reported 76 cases of Cdifficile year to date, 26 of these were South Sefton CCG patients. There was 1 case in March 2014 which will bring the year to date total to 33 cases above the 2013/14 year-end target of 43.

The Walton Centre NHS Foundation Trust has reported 12 cases to date, 1 case was reported in March 2014. This was not a South Sefton CCG patient. This is 7 cases above the year to date tolerance of 5.

Southport and Ormskirk Hospitals NHS Trust has reported 34 cases year to date, 15 above the year to date plan of 19. 4 cases were reported in March 2014.

Mixed Sex Accommodation (MSA)

South Sefton CCG achieved this target in March 2014 and reported zero MSA breaches for South Sefton CCG patients.

Southport and Ormskirk Hospitals NHS Trust have reported a further 16 breaches in March 2014, 79 breaches reported year to date. None of these patients were South Sefton CCG patients. Of the 16 breaches, 10 relate to bed pressures and patient safety being the primary goal. The remaining 6 related to the 'deep cleaning' of ward 14A.

The Trust is currently reviewing the care pathways of patients out of critical care. The Trust is also addressing the root cause of bed pressures through a wide-range of actions under the urgent care action plan. Whilst there are bed pressures across the Trust there is a risk of delayed discharges from critical care which may cause further breaches in the future. The Trust is delivering against the urgent care action plan and progress to date is positive.

Emergency admissions for children with Lower Respiratory Tract Infections (LRTI) (Cumulative)
NB: This indicator's methodology has been updated and backdated to reflect national specification. The plans have also been updated in line with the refresh.

South Sefton CCG reported 461.87 emergency admissions per 100000 as at the end March 2014, above the plan of 357.93. Looking at the emergency admissions figures this equates to 33 extra admissions compared to the same period last year.

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Cumulative)
NB: This indicator's methodology has been updated and backdated to reflect national specification. The plans have also been updated in line with the refresh.

South Sefton CCG has not achieved the target, achieving 1049.36 at the end of March 2014 against a plan of 1010.52. This equates to 56 extra admissions compared to the same period last year. This is highlighted as an amber risk on the corporate performance dashboard.

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

South Sefton CCG did not achieve the stroke indicator target of 80% in March 2014, reporting 66.67%.

Southport and Ormskirk Hospital NHS Trust did not achieve the target for the month of March 2014, achieving 69.2% which is 18 out of a total of 26 patients. There is no further breakdown of the stroke data. The Trust is in the process of improving the data flows for stroke. The national stroke database currently does not hold all of the data needed to perform more granular level analysis on the data and hope to have this rectified in the next couple of weeks.

Aintree University Hospitals NHS Foundation Trust did not achieve the stroke indicator in March 2014, achieving 75.61%, a fall from the 96.88% achieved in February 2014. In March 2014 10 patients out of 31 admitted with a stroke did not spend 90% of their time on a stroke unit. The performance for the year is 74.25%. 61% of patients arrived on the Stroke Unit within 4 hours. A patient transferred to Aintree Stroke Unit (ASU) within 4 hours and discharged early resulting in failing the 90% stay target. Three patients had catastrophic bleeds and were transferred to other areas for palliative care/side rooms and died within 24 hours. No ASU female bed available on one occasion and late referrals to the Stoke team resulted in failure to achieve 90% target.

A number of keys actions have taken place these include:

- consultant of the week rota commenced January 2014. The new rota releases stroke physicians from other commitments and allows for more rapid assessment and transfer of stroke patients. The 4 hour target has persistently been achieved since the changes took place;
- a stroke physician on-call every weekday and on site from 9am to 8pm to further facilitate timely assessment and transfer of stroke patients. Door to needle time achieved persistently between 26 and 33 minutes;
- revised stroke team alert and bleep system now operational. The team comprises a Consultant, Specialist Registrar or Senior House Officer and a Home 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;
- audit of every stroke admission continues to take place.

The team has persistently achieved the 4hr target since the introduction of the new ways of working, 96% achieved against the 90% stay in February 2014 and there is an expectation that going forward the team will achieve all standards. There is a risk that empty bed capacity will be occasionally utilised for medical admissions.

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. This is highlighted as an amber risk on the corporate performance dashboard.

Ambulance Clinical Quality – Category A (Red 2) 8 minute response time

South Sefton CCG narrowly failed to achieve the target of 75% for the month of March 2014, reaching 74.33% (cumulative). This is highlighted as an amber risk on the corporate performance dashboard.

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%

South Sefton CCG successfully achieved 93.02% for this indicator cumulatively to March 2014 against the 90% target.

Southport and Ormskirk Hospital NHS Trust are underperforming cumulatively to February 2014 on the NHS screening service target with 83.33% against the 90% target. The trust achieved the target for the month of February 2014. This underperformance is due to breaches during previous months. Year to date there have only been 12 patients with 2 patient breaches.

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

South Sefton CCG successfully achieved 94.19% for this indicator cumulatively to March 2014

against the 93% target.

For the maximum 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms, Southport and Ormskirk Hospital NHS Trust did not achieve the February 2014 cumulative target for breast symptomatic referrals with 91.06% year to date against the 93% target, although the target was achieved for the month of February 2014 with 100%. This underperformance was due to breaches from previous months.

Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)

South Sefton CCG achieved 98.56% for this indicator cumulatively to March 2014 against the 94% target.

For the maximum 31-day wait for subsequent treatment where that treatment is surgery, Southport and Ormskirk Hospital NHS Trust did not achieve the target of 94% with a cumulative 93.9% to February 2014. The Trust also failed to achieve the target for the month of February 2014. There was 1 patient breach out of a total of 9 patients treated (tumour type breast). The delay was due to the patient having shingles and the days waited were 50.

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

South Sefton CCG achieved 93.26% for this indicator in March 2014 against the 90% target.

Southport and Ormskirk Hospitals NHS Trust did not achieve the 90% target in February 2014 achieving 79.86%. Of the 1013 patients referred, 204 patients were not seen within 18 weeks. The referral to treatment time programme continued during February seeing increased activity and breached patients. In total there were 1014 patients treated 204 of which were from the backlog. This is similar to the average number in longer months and in line with our modelling.

Overall the backlog has reduced significantly down to 106 representing 5.1% of the total list size. All specialties including Trauma and Orthopaedics and Oral Surgery have a backlog below 10% of total list. The Trust will be compliant in March 2014 in line with trajectories previously submitted to the Trust Development Authority (TDA).

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

The indicator comprises two elements: the test score and the percentage 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 Trust, the overall combined (A&E and Inpatients) response rate was achieved in Q4 2013/14, 18.6% reported compared to a plan of 15% but is 4.8% lower than the England average. However, for A&E alone, the provider failed to achieve the 15% plan reaching 11.4% making a very slight improvement compared to Q3 2013/14. Published monthly data shows for March 2014, the overall combined (A&E and Inpatients) response rate was achieved, with 19.1% reported compared to a plan of 15% but is 4.9% lower than the England average. A&E alone was below the 15% for March 2014 at 8.8%.

Local Measure - 5% reduction in the number of respiratory disease emergency admissions via A&E. (Baseline = 1645 - 5% reduction = 1563)

Cumulatively to March 2014, this indicator is showing as adversely above plan for South Sefton CCG. The actual figure is 1,662.00, marginally above the plan figure of 1,563.00.

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 Hospitals NHS Foundation Trust reported 1 serious incident (SI) in March 2014. Year to date, for all patients, there have been 27 SI's.

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	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	2
Sub-optimal care of the deteriorating patient											1		1
Grand Total	**1**	**2**	**3**	**4**	**1**	**6**	**2**	**2**	**2**	**2**	**1**	**1**	**27**

Southport and Ormskirk Hospital NHS Trust reported no serious untoward incidents in March 2014, 14 serious untoward incidents reported year to date.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YT
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			1		3
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
Maternity service											1		1
Pressure ulcer Grade 3											1		1
Grand Total	**0**	**0**	**0**	**4**	**0**	**1**	**1**	**3**	**1**	**1**	**3**	**0**	**14**

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

Karl McCluskey
May 2014

CCG CORPORATE PERFORMANCE DASHBOARD - South Sefton CCG

Baseline as at 07/05/2014 15:41:49

		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 - March	44	55		
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative)	13/14 - March	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 - March	373.35	331.68		
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	13/14 - March	1,010.52	1,049.36		
Emergency Admissions Composite Indicator(Cumulative)					
Helping people to recover from episodes of ill health or following injury					
Patient reported outcomes measures for elective procedures: Groin hernia	12/13	6.20%	6.90%		
Patient reported outcomes measures for elective procedures: Hip replacement	12/13	35.30%	41.30%		
Patient reported outcomes measures for elective procedures: Knee replacement	12/13	30.30%	34.80%		
Emergency readmissions within 30 days of discharge from hospital (Cumulative)	13/14 - March		13.96		
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	13/14 - March	357.93	461.87		
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	13/14 - March	1,260.42	1,211.04		
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	13/14 - March	80%	66.67%		
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	13/14 - March	60%	100%		
Mental health					
Mental Health Measure - Care Programme Approach (CPA) - 95% (Cumulative)	13/14 - March	95%	98.58%		
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 - February	93%	96.59%		
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 - February	93%	94.19%		
Cancer waits – 31 days					
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative)	13/14 - February	96%	97.67%		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative)	13/14 - February	98%	99.19%		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)	13/14 - February	94%	98.56%		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative)	13/14 - February	94%	96.47%		
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 - February		91.30%		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative)	13/14 - February	90%	93.02%		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative)	13/14 - February	85%	86.02%		
Mixed Sex Accommodation Breaches					
Mixed Sex Accomodation (MSA) Breaches per 1000 FCE	13/14 - March	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 - March	0.00	0.00		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways	13/14 - March	0.00	0.00		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways.	13/14 - March	0.00	0.00		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	13/14 - March	90%	93.26%		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	13/14 - March	95%	97.63%		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	13/14 - March	92%	96.57%		
A&E waits					
Percentage of patients who spent 4 hours or less in A&E (Cumulative)	13/14 - March	95%	95.66%		
Diagnostic test waiting times					
% of patients waiting 6 weeks or more for a Diagnostic Test	13/14 - March	1.00%	0.63%		
Category A ambulance calls					
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	13/14 - March	75%	75.60%		
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	13/14 - March	75%	74.33%		
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	13/14 - March	95%	96.21%		
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	13/14 - March	75%	75.83%		
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	13/14 - March	75%	77.42%		
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	13/14 - March	95%	95.79%		

Local Measures					
5% reduction in the number of respiratory disease emergency admissions via A&E. (Baseline = 1645 - 5% reduction = 1563) (Cumulative)	13/14 - March	1,563.00	1,662.00		
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 - March	2,445.00	1,361.00		
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		

CLUSTER CORPORATE PERFORMANCE DASHBOARD - PROVIDER

Baseline as at 01/05/2014 12:28:20

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 - March	95.22%	96.21%	
Ambulance				
Ambulance				
Ambulance handover delays of over 1 hour	13/14 - March	7.00	18.00	
Ambulance handover delays of over 30 minutes	13/14 - March	68.00	63.00	
Crew clear delays of over 1 hour	13/14 - March	1.00	1.00	
Crew clear delays of over 30 minutes	13/14 - March	26.00	18.00	
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 - February	93.92%	91.06%	100.00%
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative)	13/14 - February	97.43%	94.15%	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 - February	100.00%	100.00%	100.00%
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)	13/14 - February	98.67%	93.88%	100.00%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative)	13/14 - February	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 - February	99.00%	98.26%	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 - February	91.76%	89.23%	100.00%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative)	13/14 - February	86.36%	83.33%	100.00%
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative)	13/14 - February	87.03%	86.26%	100.00%

Diagnostic test waiting times				
Diagnostic test waiting times				
% of patients waiting 6 weeks or more for a Diagnostic Test	13/14 - February	0.77%	0.08%	0.10%
Mixed Sex Accommodation Breaches				
Mixed Sex Accommodation Breaches				
Mixed Sex Accomodation (MSA) Breaches per 1000 FCE	13/14 - March	0.00	2.80	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 - February	92.83%	79.86%	93.28%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	13/14 - February	97.58%	97.50%	98.12%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	13/14 - February	97.53%	97.28%	97.78%
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted)	13/14 - February	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 - February	0.00	0.00	0.00
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways.	13/14 - February	0.00	0.00	0.00
Supporting Measures				
Quality (Safety, Effectiveness & Patient Experience)				
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	13/14 - March	75.61%	69.23%	
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	13/14 - March	100.00%	75.00%	
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 - March	76	34	11
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative)	13/14 - March	3	0	1
Patient safety incidents reported	13/14 - March	1	0	
Everyone Counts - NHS Outcome Measures				
Ensuring people have a positive experience of care				
Friends and Family Test Score - Inpatients + A&E	13/14 - March	58	53	91
Friends and Family Test Score Inpatients + A&E (% of respondents)	13/14 - March	32.30%	19.10%	29.20%

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/70	**Author of the Paper:**
Report date: May 2014	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

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 March 2014. The detail contained within this Quality Report and dashboard has been considered at the last meeting of the Quality Committee which took place on 22 May 2014 as part of the CCG assurance process. The key issues are detailed within this report by exception. The Governing Body is asked to note:

- mixed sex accommodation breaches at Southport & Ormskirk Hospitals NHS Trust reported for March 2014 and April 2014;
- Provider and CCG 2013/14 performance relating to C-Difficile and the local health economy work that has commenced around the patient journey and root cause analysis to identify lessons learnt;
- Pressure ulcer aggregated serious incident review being undertaken by Liverpool Community Health and co-ordinated by Liverpool CCG;
- Outcome of the March 2014 Care Quality Commission inspection of Aintree University Hospital NHS Foundation Trust which gave the provider an overall rating of 'good'.

Recommendation

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

Receive	x
Approve	
Ratify	

14/70

Links to Corporate Objectives *(x those that apply)*	
	Improve quality of commissioned services, whilst achieving financial balance.
	Achieve a 1% reduction in non-elective admissions in 2014/15.
	Implementation of 2014/15 phase of Virtual Ward plan.
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
	Review the population health needs for all mental health services to inform enhanced delivery.

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*			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
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Report to the Governing Body
May 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 March 2014. Performance has been discussed at the Quality Committee meeting in May 2014 in order to provide assurance 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 NHS Trust (S&O);
- Liverpool Community Health NHS Trust (LCH);
- Aintree University Hospital NHS Foundation Trust (AUH);

although the detail does cover other providers across the Merseyside area where the CCG may have smaller numbers in terms of patient flow.

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 Further Mixed Sex Accommodation Breaches (MSA) have occurred at S&O in addition to those reported at the last meeting of the Governing Body which occurred in January 2014 and February 2014. 16 breaches occurred in March 2014 and 24 breaches in April 2014. The Trust had reported that these occurred due to bed pressures and fogging of a ward as a result of C-Difficile infection and there was a need to breach in order to maintain patient safety. This was an agenda item for discussion at the last Quality and Contract Performance Meeting that was held in May 2014 whereby the CCG, although acknowledging the patient safety rationale put forward by the Trust, clearly stated that this was also a patient right as detailed in the NHS Constitution. In addition, the CCG was 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 remain around performance at S&O in relation to A&E. The CCG Programme Manager for Quality & Safety continues to meet regularly with the Trust team regarding progress with the Friends & Family Test and this remains a standing agenda item for discussion at the Clinical Performance and Quality Contract Meeting.

3.3 AUH performance in this area remains satisfactory and the Trust attended the CCG Engagement and Patient Experience Group (EPEG) in May 2014. Positive feedback regarding the Trust presentation has been communicated to the Trust from the CCG Chief Officer.

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

Healthcare Associated Infections (HCAI) – C-Difficile (C-Diff)

4.1 As previously reported to the Governing Body, both S&O and AUH have breached their full year C-Diff objective for 2013/14. The CCG has also breached its full year objective for patients with C-Diff, with 55 being reported against a year end plan of 44. Remedial action plans, together with details relating to commissioner assurance, have been fully discussed at provider Clinical Performance and Quality Meetings, the CCG Quality Committee and CCG Assurance Checkpoint Meeting with NHS England (Merseyside). C-Difficile objectives have now been set nationally for both providers and the CCG and 2014/15 Q1 performance will be reported to the next meeting of the Governing Body in July 2014.

4.2 Despite having breached the full year C-Diff objective, the HCAI C-Diff workstream in place at AUH appears to be having a positive impact with the Trust performance showing signs of improvement throughout Q3 and Q4 of 2014/15. The CCG has now been able to indicate to the Trust that the contract query regarding HCAI performance will now be lifted. The CCG will continue to work collaboratively with other local CCGs and the provider to support this continued improvement.

4.3 A Sefton Health Economy Workshop was held on 28 April 2014 hosted by South Sefton CCG and Southport & Formby CCG. This was well attended and the programme was developed in partnership between the CCGs, Public Health, AUH, S&O and LCH. Partners are looking forward to continuing this work around the patient journey and the development of a local system Root Cause Analysis process in order to identify lessons learnt in order to reduce the numbers of Sefton patients who contract C-Diff.

Serious Incident Reporting

4.4 LCH reporting of Grade 3 and 4 pressure ulcers continues and the Trust are undertaking an aggregated review at the request of commissioners. The CCG are working closely with Liverpool CCG who are co-ordinating this review from a commissioning perspective. The CCG Programme Manager for Quality & Safety is liaising with Liverpool CCG regarding this and once completed will be brought to the CCG Internal Serious Incident Review Meeting for consideration in addition to being an agenda item for discussion at the Clinical Performance and Quality Group Meeting.

4.5 S&O have reported a serious incident regarding breast biopsies which resulted in a small number of patients having a managed re-call which resulted in some local media attention. This has been proactively managed by the Trust and the CCG has been present at all the Internal Serious Incident Meetings held regarding this within the Trust in order to identify the root cause for the incident and identify any lessons learnt. The incident has been reported and discussed at the CCG Quality Committee.

5. Other Provider Quality Performance

Although the CCG patient flow to the Royal Liverpool & Broadgreen University Hospitals NHS Trust is smaller in volume than to AUH, discussions have taken place between the CCG, Cheshire & Merseyside Commissioning Support Unit and Liverpool CCG as co-ordinating commissioner with regard to the performance of this provider specifically in the areas relating to HCAIs, Friends and Family Test, Venous Thrombus Embolism Risk Assessments, national dementia screening and Advancing Quality. This has been discussed in May 2014 at the Quality Committee.

6. Provider Quality Surveillance

6.1 A Single Item Quality Surveillance Group Meeting regarding Alder Hey Children's NHS Foundation Trust was chaired by NHS England (Merseyside) on 24 April 2014 in accordance with the process which is set out nationally. The outcome was discussed at the CCG Quality Committee for the purposes of assurance and any further developments will be reported to the Governing Body as appropriate.

6.2 A Joint Care Quality Committee (CQC) Feedback Meeting and Quality Review Meeting was held at AUH on 12 May 2014. This followed on from the previous Risk Summit Meeting that had been held in December 2013 and the recent CQC new in-depth hospital inspection programme visit which took place in March 2014. The meeting had a positive outcome with the following able to be reported to the Governing Body:

- safety, effectiveness, caring and responsiveness of the acute services are rated as 'good' by the CQC. However, some improvement is still required in relation to services being well-led. The CQC have given the Trust an overall rating for acute services as 'good'. The report has been published in the public domain and is accessible on the CQC website;

- the CCG has indicated to the Trust that they will be lifting the contract queries that were in place due to the provider's performance in the identified areas (eg HCAI, A&E, Referral to Treatment) but the query in relation to mortality still remains in place as further work is required due to the Trust's outlier status.

7. Provider Quality Accounts

A collaborative event was held with local CCGs and HealthWatch Sefton on 2 May 2014 in order for relevant providers to present their Quality Accounts. The CCGs are working together to draft a joint response to be sent to providers for inclusion into their Quality Accounts.

8. Commissioner Assurance of Provider Cost Improvement Plans

The CCG has developed and shared its process for commissioner assurance of provider cost improvement plans (CIPs) with NHS England (Merseyside) by the required deadline of the end of March 2014. Working with the Cheshire & Merseyside Commissioning Support Unit, the CCG has requested provider CIPs in order to gain the required commissioner assurance that such CIPs will not have a negative impact on quality of care for patients. The monitoring of possible impact on quality of care will be an on-going process throughout the year which will be reported for assurance purposes to the CCG Quality Committee.

9. Recommendations

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

Appendices

Appendix 1 - South Sefton CCG Quality Reporting May 2014 Update.

Brendan Prescott
Debbie Fagan
May 2014

Cheshire and Merseyside
Commissioning Support Unit

South Sefton CCG
Quality Reporting
May 2014 Update

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CCG Summary of Key Concerns

Indicator: Infections

Indicator: Cdiff Cases

3 cases reported in March 2014 compared to a monthly plan of 3.67 cases, all cases apportioned to Non-acute (Community). Year to date there have been 55 cdiff cases reported relating to South Sefton patients compared to a year-end plan of 44 cases, 28 cases apportioned to acute providers and 27 cases apportioned to non-acute (Community).

Apportioned to Acute Providers

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Aintree University Hospitals NHS Foundation Trust	3	3	2	2	6	3	4	0	1	0	2	0	26
Liverpool Heart & Chest Hospital NHS Trust	0	0	1	0	0	0	0	0	0	0	0	0	1
Southport & Ormskirk Hospital NHS Trust	0	0	0	0	0	0	0	0	0	0	1	0	1
Total	**3**	**3**	**3**	**2**	**6**	**3**	**4**	**0**	**1**	**0**	**3**	**0**	**28**

Apportioned to Non-Acute Community

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Aintree University Hospitals NHS Foundation Trust	4	2	1	1	4	2	3	1	1	2	2	2	25
Royal Liverpool&Broadgreen Hospitals University NHS Trust	0	0	0	0	0	0	1	0	0	0	0	1	2
Total	**4**	**2**	**1**	**1**	**4**	**2**	**4**	**1**	**1**	**2**	**2**	**3**	**27**

Indicator: Serious Incidents Reported

Indicator: SUIs and Never Events

3 Serious Untoward Incidents reported in April 2014 relating to South Sefton CCG patients, all incidents reported by Liverpool Community Health;

Incident Type	Reported within 48 Hours	Provider
Pressure ulcer Grade 3	Yes	Liverpool Community Health
Pressure ulcer Grade 3	Yes	Liverpool Community Health
Pressure ulcer Grade 3	Yes	Liverpool Community Health

All incidents reported throughout 2013/14 can be found within the attached annual SUI report.

SS CCG SUI Report_March 2014.c

Indicator: Complaints Reporting

Indicator: Complaints reported to CMCSU

2 complaints reported in April 2014 relating to South Sefton CCG patient;

Provider	Reported within 48 Hours	Status
South Sefton CCG	This was originally a PALS complaint set up regarding patient on-going review for retrospective CHC. This complaint has been going on since 2013 and has still not been resolved. The complaint has now escalated with the complainant sending a letter to the MP Bill Esterson asking for help on this matter.	Under Investigation
Royal Liverpool Hospital	Constituent written to MP David Pugh as problems sourcing medication and who should provide on-going treatment (GP or Royal Liverpool Hospital). Issues with cost of medication and also shortage of Liothyronine by Mercury Pharma - concern re dependency on one supplier.	Closed No Further Action

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

The following table provides a high level summary of Appropriate Care Score (ACS) for South Sefton CCG Commissioned patients treated at any AQ Provider.

As at December 2013 (Latest data available) South Sefton CCG Cumulative ACS was reported above median for AMI, Dementia and Pneumonia care. Hip and Knee and Heart Failure is reported below median and Stroke care is reported within the bottom quartile.

Clinical Focus Area	AMI	Dementia	First-Episode Psychosis	Heart Failure	Hip and Knee (Combined)	Pneumonia	Stroke
CPS	97.2%	94.0%		86.6%	96.6%	92.7%	89.1%
ACS	94.7%	71.4%		65.2%	85.6%	76.2%	42.0%
Quartile (ACS)	Above Median	Above Median		Below Median	Below Median	Above Median	Bottom Quartile

The table above includes activity for South Sefton CCG patients treated at a AQ provider, below is a summary of providers failing to achieve ACS care bundle targets at trust level.

Heart Failure	Hip and Knee	Stroke
AINTREE has achieved ACS target 3 out of 9 months in Heart Failure and is below target YTD by 5.1%	SOUTHPORT & ORMSKIRK has achieved ACS target 3 out of 9 months in Hip and Knee (Combined) and is below target YTD by 2.8%	AINTREE has achieved ACS target 3 out of 9 months in Stroke and is below target YTD by 9.4% SOUTHPORT & ORMSKIRK has achieved ACS target 2 out of 9 months in Stroke and is below target YTD by 10.8%. ROYAL LIVERPOOL has not achieved ACS target once during the 9 months and is below target YTD by 17.5%

A full summary has been included within the latest quality report.

South Sefton CCG Population Quality Dashboard

Patient Safety Quality Measures				
Indicator	**Reporting Frequency**	**National Average**		**South Sefton CCG**
Hospital Care Acquired Infections				**Actual**
MRSA Cases Reported	Mar-14	0		0
Cdiff Cases Reported	Mar-14	0		3
Incident and Complaints Reporting				**Actual**
Serious Untoward Incidents Reported	Apr-14	0		3
SUIs Reported as Never Events	Apr-14	0		0
Complaints Received to CMCSU	Apr-14	0		2
Mixed Sex Accommodation				**Actual**
Mixed Sex Accommodation Breaches	Mar-14	0		0
Rate per 1,000 FCEs	Mar-14	0		0
Clinical Effectiveness Quality Measures				
Indicator	**Reporting Frequency**	**National Average**		**South Sefton CCG**
Patient Reported Outcome Measures				**Actual**
Groin Hernia - Average increase in health gain	Apr 12-Mar 13	0.086		0.069
Hip Replacement - Average increase in health gain	Apr 12 -Mar 13	0.065		0.413
Knee Replacement - Average increase in health gain	Apr 12 -Mar 13	0.56		0.348
Varicose Vein - Average increase in health gain	Apr 12 -Mar 13	0.837		<5 Modelled Records
Patient Experience Quality Measures				
Indicator	**Reporting Frequency**	**Position**		**South Sefton CCG**
Regional CQUIN - Advancing Quality ACS				**Actual**
Acute myocardial infarction	Apr - Dec 13	85.60%		94.70%
Dementia	Apr - Dec 13	59.20%		71.40%
Hip and Knee	Apr - Dec 13	88.10%		85.60%
Heart Failure	Apr - Dec 13	69.40%		65.20%
Pneumonia	Apr - Dec 13	74.20%		76.20%
Stroke	Apr - Dec 13	66.30%		42.00%

Provider Level Key Concerns

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

Health Care Acquired Infections

NEW Indicator: MRSA Cases

Royal Liverpool and Broadgreen Hospital 1 MRSA case reported in March 2014 compared to a monthly threshold of 0 cases, the Trust stands at 8 cases year to date.

Provider Comments: Clinical measures in place in relation to MRSA include:

- Divisional Medical Directors to attend weekly Bacteraemia meetings
- Supervisor status of Ward Managers with Ward Manager responsible for Infection Prevention and Control KPIs
- Introduction of Divisional Practice Facilitator role with key responsibilities for:
  - Peer Review Process (IV access, Blood Cultures, cannulation)
  - On-going Training
  - Trouble shooting
  - Provide update to Divisional Governance
- Simulation ward based training being trialled with IPC and Skills team
- Trust wide point prevalence covert hand hygiene audit completed in February. This indicates compliance is low in some areas. Individual wards have been informed and required to improve. This audit will be repeated each quarter and results published on the Intranet

NEW Indicator: Cdifficile Cases

Royal Liverpool and Broadgreen Hospital 4 cdiff cases reported in March 2014 compared to a monthly threshold of 2.92 cases, the Trust stands at 50 cases year to date compared to a yearend plan of 35 cases.

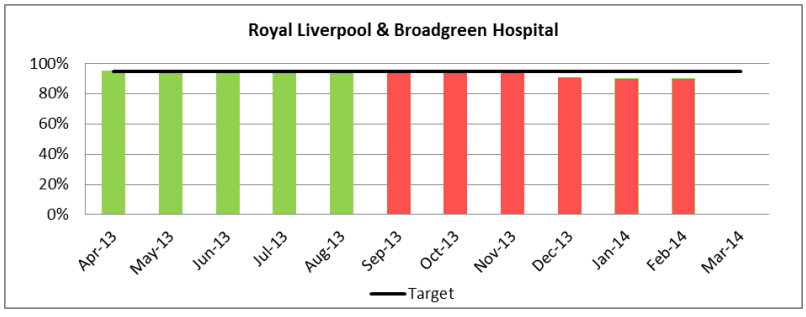
Provider Comments: Clinical measures in place in relation to Clostridium difficile include:

- Fidaxomicin is prescribed for all CDT toxin and GDH patients. Trials on this drug have indicated a reduction in CDT spores, its use is under the guidance if the Infectious Diseases Consultant.
- Daily Antimicrobial reports sent to Consultants and Clinical Directors in High Risk areas.
- Monthly Antimicrobial audits in high risk areas which are reported to DIPC.
- Nutritional/CDT risk assessment now completed on all patients admitted to the Trust.
- Weekly environmental audits in areas that have had CDT
- Trust Deep Clean programme continuing
- Immediate DIPC and IPC review with lead consultant following a positive CDI case

NEW VTE Risk Assessments

Measure: All patients should be risk assessed on admission to hospital. Patients should be reassessed within 24 hours of admission and whenever the clinical situation changes

Royal Liverpool and Broadgreen Hospital 90.3% of admissions received a VTE risk assessment in February 2014 compared to a plan of 95%, similar performance compared to previous month.



Provider Comments: On-going underperformance is reported to be within surgical division and core, clinical support service division.
On-going actions continue to be implemented, it is hoped that by the end of Q4 13/14 the provider will be reporting above 95% following electronic reporting implementation.

Incident Reporting

Measure: Serious Untoward Incidents and Never Events

A full summary of 2013/14 serious incidents reported has been included within the latest quality report.

Royal Liverpool and Broadgreen Hospital reported 5 serious untoward incidents in April 2014.

	Apr-14
Adverse media coverage or public concern about the organisation or the wider NHS	1
Drug Incident (general)	1
Out patient appointment delay	1
Slips/Trips/Falls	2
Grand Total	**5**

Aintree Hospital 0 incidents reported by the provider in April 2014.

Alder Hey Children's Hospital 3 serious incidents reported in April 2014.

	Apr-14
Adverse media coverage or public concern about the organisation or the wider NHS	1
Delayed diagnosis	2
Grand Total	**3**

Liverpool Women's Hospital 3 serious incidents reported in April 2014.

	Apr-14
Delayed diagnosis	1
Maternity Services - Intrauterine death	1
Maternity Services - Unexpected admission to NICU (neonatal intensive care unit)	1
Grand Total	**3**

Liverpool Heart and Chest Hospital 2 serious incidents reported in April 2014.

	Apr-14
Unexpected Death of Inpatient (in receipt)	1
Wrong site surgery	1
Grand Total	**2**

Merseycare NHS Trust 7 serious incidents reported in April 2014.

	Apr-14
Admission of under 16s to adult mental health ward	1
Admission of under 18s to adult mental health ward	3
Allegation Against HC Professional	1
Serious Self Inflicted Injury Inpatient	1
Suicide by Outpatient (in receipt)	1
Grand Total	**7**

Liverpool Community Health 26 serious incidents reported in April 2014.

	Apr-14
Death in custody	2
Pressure ulcer Grade 3	12
Pressure ulcer Grade 4	12
Grand Total	**26**

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

National Patient Safety Data

Measure: All Harms

All provider NPSA incident reports have been included within the latest quality dashboard. A summary has been included below for all providers with reporting rates lower than the national median average.

Royal Liverpool and Broadgreen Hospital reported 2,235 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 5.08 compared to 7.98 (Median for large acute providers). The trust reported significantly more incidents in the following areas compared to other teaching organisations;

- Patient Accidents
- Access/Admissions/Transfer and Discharge incidents

Alder Hey Children's Hospital reported 849 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 5.09 compared to 7.14 (Median for specialist acute providers). The trust reported significantly more incidents in the following areas compared to other acute specialist organisations;

- Clinical Assessments

Liverpool Women's Hospital reported 763 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 3.69 compared to 7.14 (Median for specialist acute providers). The trust reported significantly more incidents in the following areas compared to other specialist organisations;

- Treatment procedures

National Safety Thermometer

Measure: All Harms

Due to a change in national reporting March 2014 data is currently being analysed, an update will follow as soon as data is available.

New! National Dementia – Screening, Assessment and Referral

The goal of the dementia CQUIN is to incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions and to prompt appropriate referral and follow up after they leave hospital. Nationally all providers are to work towards achieving 90% patients identified, 90% of patients assessed and 90% of patients referred over three consecutive months during 2013/14.

Royal Liverpool and Broadgreen Hospital As reported in previous months RLBUH continued to fail all three measures in February 2014.

Provider Comments: ICE screening system has been developed, and latest submission was February data. Of all eligible patients for part 1, the screening component was recorded and achieved for 56.1%. For patients where screening information was recorded, and who were eligible for the diagnostic assessment component, tests were requested in 57.1% of cases. Of those where the assessment was positive or inconclusive, 61.9% were referred for further follow-up. Teaching and awareness, and on-going support, are in place. CQUIN lead team established to ensure clarity and priority.

Liverpool Women's Hospital

Due to low activity being reported at the above provider 1 patient being missed can result in a dramatic drop in performance. Both providers failed to achieve 90% across all areas due to low numbers being reported.

Friends and Family Test

Measure: Response rates and Test Score

Response Rates - Providers will need to achieve a baseline response rate of at least 15% and by Q4 a response rate that is both (a) higher than the response rate for Q1 and (b) 20% or over. A single response rate for each provider will be calculated by combining the response rates from the A&E and acute inpatient areas.

Test Scores - Increasing the score of the Friends and Family Test question within the 2013/14 staff survey compared with 2012/13 survey results or remaining in the top quartile of trusts.

Royal Liverpool and Broadgreen Hospital

Response Rates In Q4 13/14 the provider achieved 13.4 % combined response rate (inpatients and a&e) compared to a yearend plan of 20%, this was an drop in performance compared to the previous quarter.

Combined	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average	13.3%	17.3%	20.1%	23.4%
Royal Liverpool And Broadgreen University Hospitals NHS Trust	6.3%	12.6%	14.8%	13.4%

Provider Comments: The Trust continues to undertake Text based and Volunteers survey based feedback to meet the requirements of the DH friends and family test.

Advancing Quality

Measure: All Care Bundles

The advancing quality programme began in October 2008. Year one of the programme was defined as October 2008 – September 2009 patient discharges. Participation in year one encompassed 24 North West Trusts and each Trust is enrolled in up to five of the eight clinical conditions listed below depending on their patient populations;

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

The programme is based on the concept of quantifying Trust performance on one aggregated measure of quality – The Appropriate Care Score (ACS) - within each of the clinical areas.

Royal Liverpool and Broadgreen Hospital

Pneumonia At December 2013 the trusts cumulative ACS score for Pneumonia care was reported below the CQUIN target, 78.1% reported compared to 78.8%.Lowest performance is reported against the following measure within the pneumonia care bundle;

- Patients given initial antibiotic within 6 hours of hospital arrival - 83.5% reported ytd.

Stroke At December 2013 the trusts cumulative ACS score for stroke care was reported below the CQUIN target, 73.2% reported compared to 89.8%. Lowest performance is reported against the following measure within the stroke care bundle;

- Patients admitted on to a stroke ward within 4hours of arrival – 79.33% reported ytd

Provider Comments: A data recording error has been identified within AQ Pneumonia which has meant that our performance has been over-reported. Error is in relation to recording of CURB-65 scores and consequently a number of records being inappropriately excluded from the AQ Pneumonia population. The Trust's ACS score is now currently below the AQ Pneumonia target ACS. Procedures for data entry have been amended appropriately to prevent similar errors moving forward.

It should be noted that although we are below our target for Stroke, the latest benchmarking data (Apr-December) indicates that we are one of the top 5 Trusts in the Northwest. CQUIN targets have been set at a Trust level, based on our 2012/13 performance. Clinical and operational pathway leads are in place for all focus areas, and an Advancing Quality Steering Group is in place which meets on a monthly basis and discusses the monthly reporting of pathway outcome measures. Actions in place include the production of missed opportunities reports, and liaison on a weekly basis to identify patients outstanding against individual measures.

National Staff Surveys

Measure: All Care Bundles

All providers of interest to South Sefton CCG reported improvements in the overall staff engagement score in 2013 excluding Mersey Care NHS Trust. Mersey Care scored 3.66 compared to the national average score of 3.74 and a reduction in performance of 0.06.

2013 survey results currently being validated and tabled by CMCSU Business Intelligence, a high level summary for all

providers of interest to South Sefton CCG has been included below;

	Overall Staff Engagement					
	Trust Score 2010	Trust Score 2011	Trust Score 2012	Trust Score 2013	Change	National Average (All trusts)
5BOROUGHS	3.69	3.65	3.73	3.76		3.74
Aintree University Hospital	3.64	3.65	3.69	3.74		3.74
Alder Hey Childrens Hospital	3.71	3.65	3.57	3.68		3.74
Bridgewater	3.52	3.60	3.69	3.60		3.74
Liverpool Community Health	3.68	3.61	3.61	3.70		3.74
Liverpool Heart & Chest Hospital	3.78	3.86	3.98	3.96		3.74
Liverpool Womens Hospital	3.59	3.48	3.57	3.73		3.74
Mersey Care NHS Trust	3.59	3.67	3.72	3.66		3.74
Royal Liverpool & Broadgreen Hos	3.60	3.60	3.66	3.73		3.74
Southport & Ormskirk Hospital	3.58	3.57	3.63	3.61		3.74
St Helens & Knowsley Hospital	3.58	3.56	3.70	3.83		3.74
The Walton Centre	3.77	3.70	3.73	3.87		3.74
Warrington & Halton Hospital	3.65	3.58	3.68	3.79		3.74

NEW National Staff Survey – Friends and Family Question

Measure: % to strongly agree / agree with the Q12d. 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'

Liverpool Heart and Chest Hospital, The Walton Centre and St Helens and Knowsley Hospital were all reported within the upper quartile. Aintree Hospital, Liverpool Women's and Royal Liverpool were all reported within the median quartile and all reported improvements in results compared to previous year.

As part of the 2014/15 NHS Standard Contract each provider is expected to identify areas requiring improvement within the Staff Survey, action plans are due to be submitted with Quarter 1 14/15 reporting template.

Ref	Provider	Score (%)	Quartile
RVY	Southport And Ormskirk Hospital NHS Trust	50.67	1st
REM	Aintree University Hospital NHS Foundation Trust	64.73	2nd
RWW	Warrington and Halton Hospitals NHS Foundation Trust	65.25	2nd
REP	Liverpool Women's NHS Foundation Trust	67.43	3rd
RQ6	Royal Liverpool And Broadgreen University Hospitals NHS Trust	71.38	3rd
RBN	St Helens And Knowsley Hospitals NHS Trust	77.41	4th
RET	The Walton Centre NHS Foundation Trust	84.59	4th
RBQ	Liverpool Heart and Chest NHS Foundation Trust	91.85	4th

NEW Central Alerting System

At 01st April 2014 a number of Merseyside providers had on-going alerts open passed deadline date;

1. Aintree University Hospital – 1 On-going alerts. The trust expects to be non-compliant for 12 months due to equipment not being available.
2. Alder Hey Children's Hospital – 2 On-going alerts
3. Liverpool Women's Hospital – 4 On-going alerts

Trust name	Alert title	Alert reference	Issue date	Completion deadline date	Completed Within Deadline	Current Status
AUH	Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors	NPSA/2011/RRR003	28-Nov-11	Apr-12	N	ONGOING
AHCH	Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors	NPSA/2011/RRR003	28-Nov-11	Apr-12	N	ONGOING
AHCH	Window restrictors	EFA/2013/002	23-Jan-13	May-13	N	ONGOING
LWH	Electrosurgical devices.CUSA CEM™ nosecones for use with the CUSA® Excel/Excel+ ultrasonic aspirator.Product codes: C6623 and C6636.Manufactured by Integra Lifesciences.	MDA/2014/006	26-Feb-14	Mar-14	N	ACKNOWLEDGED
LWH	High Voltage Hazard Alert - National Equipment Defect Report (NEDeR) - Areva T&D Automation & Information Services - P122 protection relay	EFN/2014/05	21-Feb-14	Mar-14	N	ACKNOWLEDGED
LWH	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - UPDATE - Hawker Siddeley - URV12 Circuit Breaker	EFN/2014/08	26-Feb-14	Mar-14	N	ACKNOWLEDGED
LWH	High Voltage Hazard Alert - SUSPENSION OF OPERATIONAL PRACTICE (SOP) - UPDATE - Long & Crawford GF3T Fuse Switch	EFN/2014/09	27-Feb-14	Mar-14	N	ASSESSING RELEVANCE

New! Sickness Absence Rates

The latest data relates to sickness absence rates for staff at NHS Organisations on the electronic staff record (ESR) between April 2012 – Dec 2013.

The RAG ratings included below have been applied by comparing provider performance compared to the England average and compared to the same period in the previous year.

	Q1 12/13	Q2 12/13	Q3 12/14	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14
Engalnd Average	4.02%	4.06%	4.50%	4.38%	3.85%	3.83%	4.12%
5 Boroughs Partnership NHS Foundation Trust	4.52%	5.27%	5.13%	5.35%	4.94%	5.02%	5.69%
Aintree University Hospital NHS Foundation Trust	4.32%	4.18%	4.30%	3.99%	3.56%	3.81%	4.06%
Alder Hey Children's NHS Foundation Trust	4.68%	4.63%	6.56%	5.83%	4.63%	4.59%	4.75%
Bridgewater Community Healthcare NHS Trust	5.01%	4.73%	5.64%	5.25%	4.76%	4.84%	5.05%
Liverpool Community Health NHS Trust	5.37%	5.52%	6.31%	6.30%	5.85%	5.37%	5.53%
Liverpool Heart and Chest NHS Foundation Trust	3.51%	4.09%	4.94%	4.55%	3.22%	3.34%	3.41%
Liverpool Women's NHS Foundation Trust	4.03%	4.16%	6.10%	6.66%	4.53%	4.35%	4.52%
Mersey Care NHS Trust	5.65%	5.72%	6.01%	6.10%	5.48%	5.58%	5.40%
Royal Liverpool and Broadgreen University Hospitals	4.88%	5.09%	6.24%	5.82%	4.71%	4.53%	4.99%
Southport and Ormskirk Hospital NHS Trust	4.49%	4.27%	4.73%	4.84%	4.20%	3.86%	3.84%
St Helens and Knowsley Hospitals NHS Trust	3.27%	3.34%	3.81%	3.72%	3.33%	3.27%	3.50%
Walton Centre NHS Foundation Trust	4.10%	3.81%	4.50%	3.66%	3.61%	3.93%	4.29%
Warrington and Halton Hospitals NHS Foundation	4.09%	4.11%	3.94%	4.40%	4.12%	3.84%	3.97%

All providers of interest to South Sefton CCG reported a reduction in sickness absence rates in Q3 13/14 compared to Q3 12/13. Aintree University Hospital, Liverpool Women's Hospital and Liverpool Heart and Chest all reported lower rates than the England Average and a reduction compared to previous year.

New! CQC Intelligence Tool

CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. CQC judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

Indicators will be analysed and one of the following levels will be applied to each measure; 'No evidence of risk, 'risk' or 'elevated risk'. CQC have then created an overall summary band for each trust, by reviewing the proportion of indicators identified as 'risk' or 'elevated risk'. Band 1 representing the highest risk and band 6 representing the lowest risk.

The table below provide details of the latest report published in March 2014;

	Royal Liverpool Hospital	Liverpool Heart and Chest	Liverpool Womens Hospital	Alder Hey Childrens Hospital	Aintree University Hospital
Has the banding improved or declined since the previous report?	Recently inspected (Previously scored 6)	Declined to 4 from 6	Improved to 6 from 3	No change (1)	Recently inspected (Previously scored 1)
Within the latest CQC report (March 2014) Has the provider been identified as having any **Elevated Risks?**	2 areas	1 area	1 area	3 areas	4 areas
Within the latest CQC report (March 2014) Has the provider been identified as having any **Risks?**	5 areas	2 areas	1 area	5 areas	3 areas

Latest provider reports are included within the latest quality report.

Provider Level Dashboard

NHS
Cheshire and Merseyside Commissioning Support Unit

Patient Safety Quality Measures

Indicator	Data Sheets	Latest Data Available	National Average	Trend line Movement	Royal Liverpool & Broadgreen		Aintree University Hospital		Alder Hey Children's Hospital		Liverpool Women's Hospital		Liverpool Heart & Chest Hospital		Mersey Care		Liverpool Community Health	
Hospital Care Acquired Infections					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
MRSA Cases Reported	Click Here	Mar-14	0	Increase = Bad Decrease = Good	1		1		0		0		0		0		0	
Cdiff Cases Reported	Click Here	Mar-14	0		4		1		0		0		0		0		0	
Venous thromboembolism (VTE) risk assessment					Actual	Trend	Actual	Trend			Actual	Trend	Actual	Trend				
VTE Risk Assessments	Click Here	Feb-14	95.7%	Increase = Good Decrease = Bad	90.3%		95.5%				97.3%		96.7%					
Local Incident Reporting					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Serious Untoward Incidents Reported	Click Here	Apr-14	0	Increase = Bad Decrease = Good	5		0		3		3		2		7		26	
SUIs Reported as Never Events		Apr-14	0		0		0		0		0		1		0		0	
Complaints Received to CMCSU	Click Here	Apr-14	0		1		0		0		0		0		0		0	
National Patient Safety Incident Reporting (*Per 100 admissions, **Per 1,000 bed days)					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Total Incidents Reported	Click Here	Apr 13 - Sep 13	TBD		2235	Latest report included	2602	Latest report included	847	Latest report included	763	Latest report included	540	Latest report included	2559	Latest report included	484	Latest report included
Reporting Rates			TBD		5.0/7.9		7.2/7.9		5.0/7.1		3.6/7.1		7.9/7.1		36.6/26.3		37.82	
% Incidents reported resulting in Severe Harm			TBD		0.4%		0.2%		0.2%		1.6%		0.0%		0.1%		1.5%	
% Incidents reported resulting in Death			TBD		0.0%		0.1%		0.0%		0.3%		0.2%		0.6%		0.0%	
Mixed Sex Accommodation					Actual	Trend	Actual	Trend	⇔	Trend	⇔	Trend	⇔	Trend	Actual	Trend	Actual	Trend
Mixed Sex Accommodation Breaches	Click Here	Mar-14	0	Increase = Bad Decrease = Good	0		0		0		0		0		0		0	
Rate per 1,000 FCEs		Mar-14	0		0.0		0.0		0.0		0.0		0.0		0.0		0.0	
National CQUIN - Safety Thermometer					Actual	Trend	Actual	Trend			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Timeliness submission of data harms data to Unify2	Click Here	Feb-14	Submitted	Increase in Harms = Bad Increase in Harmfree Care = Good	Yes		Yes				Yes		Yes		Yes		Yes	
Pressure Ulcers (All categories)		Feb-14	4.73%		6.12%		3.74%				0.0%		0.00%		1.09%		2.01%	
Falls		Feb-14	2.04%		2.66%		1.71%				1.1%		1.14%		2.19%		8.55%	
Patients with a catheter and being treated for a UTI		Feb-14	0.89%		0.00%		0.78%				3.2%		0.57%		0.55%		0.42%	
VTE - Patients with a new VTE		Feb-14	0.48%		5.32%		0.31%				0.0%		0.57%		0.00%		0.21%	
Harm Free Care		Feb-14	93.34%		87.2%		95.33%				95.7%		98.86%		0.978142		96.6%	
National CQUIN - Dementia					Actual	Trend	Actual	Trend			Actual	Trend	Actual	Trend				
Screening for Dementia (Find)	Click Here	Feb-14	78.3%	Increase = Good Decrease = Bad	56.1%		67.42%				50%		100%					
Risk Assessed (Assess and Investigate)		Feb-14	89.7%		57.1%		83.7%				100%		100%					
Patients Referred		Feb-14	91.7%		61.9%		100%				0 patients		100%					

Clinical Effectiveness Quality Measures

Indicator	Data Sheets	Reporting Frequency	National Average	Trend line Movement	Royal Liverpool and Broadgreen Hospital		Aintree University Hospital		Alder Hey Children's Hospital		Liverpool Women's Hospital		Liverpool Heart and Chest Hospital		Mersey Care		Liverpool Community Health	
Mortality Indicators					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Summary Hospital-Level Mortality Indicator (SHMI)	Click Here	Jul 12 - Jun 13	100	Increase = Bad Decrease =Good	1.07		1.13											
(SHMI) Deaths occurring in hospital			73.4%		74.5%		72.8%											
(SHMI) Deaths occurring out of hospital			26.6%		25.5%		27.2%											
Patient Reported Outcome Measures					Actual	Trend	Actual	Trend										
Groin Hernia - Average increase in health gain	Click Here	Apr 12-Mar 13	0.086	Increase = Good Decrease =Bad	Low Numbers		0.064											
Hip Replacement - Average increase in health gain		Apr 12 -Mar 13	0.439		0.412		0.429											
Knee Replacement - Average increase in health gain		Apr 12 -Mar 13	0.321		0.354		0.296											
Varicose Vein - Average increase in health gain		Apr 12 -Mar 13	0.094		Low Numbers		Low Numbers											

Provider Level Dashboard

NHS
Cheshire and Merseyside Commissioning Support Unit

Patient Safety Quality Measures												
Indicator	Data Sheets	Latest Data Available	National Average	Trend line Movement	Royal Liverpool & Broadgreen	Aintree University Hospital	Alder Hey Children's Hospital	Liverpool Women's Hospital	Liverpool Heart & Chest Hospital	Mersey Care	Liverpool Community Health
Patient Experience Quality Measures											
Indicator	**Data Sheets**	**Reporting Frequency**	**National Average**	**Trend line Movement**	**Royal Liverpool and Broadgreen Hospital**	**Aintree University Hospital**	**Alder Hey Children's Hospital**	**Liverpool Women's Hospital**	**Liverpool Heart and Chest Hospital**	**Mersey Care**	**Liverpool Community Health**
Regional CQUIN - Friends and Family					Actual / Trend	Actual / Trend		Actual / Trend	Actual / Trend		
Response Rate (Combined)	Click Here	Q4 13/14	17.3%	Increase = Good Decrease =Bad	13.4%	31.1%		34.2%	33.7%		
Response Rate (Inpatinet)			28.7%		25.2%	41.6%		25.7%	33.7%		
Response Rate (A&E)			11.6%		9.3%	24.8%		37.6%	n/a		
Test Score (Combined)	Click Here	Q4 13/14	64	Increase = Good Decrease =Bad	53	61		82	91		
Test Score (Inpatinet)			72		60	82		80	89		
Test Score (A&E)			54		44	40		82	n/a		
Regional CQUIN - Advancing Quality					Actual / Trend	Actual / Trend			Actual / Trend	Actual / Trend	
Acute myocardial infarction	Click Here	Apr 13-Dec 13	95%	Increase = Good Decrease =Bad	100%	92.8%			92.2%		
Heart Failure		Apr 13-Dec 13	95%		86.9%	68.7%			69.2%		
Hip and Knee		Apr 13-Dec 13	86%		96.4%	85.9%					
Pneumonia		Apr 13-Dec 13	86%		78.1%	76.0%					
Stroke		Apr 13-Dec 13	90%		73.3%	44.3%					
Coronary Artery Bypass Graft		Apr 13-Dec 13	TBD						98.0%		
Dementia		Apr 13-Dec 13	TBD							51.4%	
First-Episode Psychosis		Apr 13-Dec 13	TBD							50.0%	
National Community Mental Health Survey										Actual / Trend	
Overall Care	Click Here	2012	74.40%	Increase = Good Decrease =Bad						76.67	
Better information more choice			69.10%							69.26	
National Staff Survey					Actual / Trend	Actual / Trend	Actual / Trend	Actual / Trend	Actual / Trend	Actual / Trend	Actual / Trend
Overall Engagement	Click Here	2013	3.74	Increase = Good Decrease =Bad	3.73	3.74	3.68	3.73	3.96	3.66	3.70
f a f ***friend or relative*** *needed treatment I would be happy with the standard of care provided by this organisation'*	Click Here	2013	67%	Increase = Good Decrease =Bad	71.4%	64.7%		67.4%	91.80%		
National Inpatient Survey					Actual / Trend	Actual / Trend		Actual / Trend	Actual / Trend		
Better information more choice	Click Here	2012	68.30%	Increase = Good Decrease =Bad	71.7	68.7		78.4	75.4		
Overall score			76.50%		79.1	76.7		83.3	83.2		

Provider Level Dashboard

NHS
Cheshire and Merseyside Commissioning Support Unit

Patient Safety Quality Measures

Indicator	Data Sheets	Latest Data Available	National Average	Trend line Movement	Royal Liverpool & Broadgreen	Aintree University Hospital	Alder Hey Children's Hospital	Liverpool Women's Hospital	Liverpool Heart & Chest Hospital	Mersey Care	Liverpool Community Health

Organisational Level Quality Measures

Indicator	Data Sheets	Reporting Frequency	National Average	Trend line Movement	Royal Liverpool and Broadgreen Hospital		Aintree University Hospital		Alder Hey Children's Hospital		Liverpool Women's Hospital		Liverpool Heart and Chest Hospital		Mersey Care		Liverpool Community Health	
Care Quality Commission					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Compliance to CQC 5 standards following recent checks	Click Here	May-14	n/a	N/A	●		●		●		●		●		●		●	
Central Alerts System					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Alerts reported as on-going passed deadline date	Click Here	Mar-14	0	N/A	0		1		2		4		0		0		0	
Ambulance Handover Times					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Handover <15 Minutes. Time taken from HAS notification to clinical handover (Assumed ACUTE responsibiility)	Click Here	Mar-14	15 Mins	Increase = Bad Decrease = Good	00:09:48		00:10:27		00:03:14									
Patients waiting between 30-60 Minutes for Handover			0		79		61		0									
Patients waiting between 60+ Minutes for Handover			0		10		7		0									
Compliance with Recording Patient Handover between Ambulance and A&E			90%	Increase = Good Decrease = Bad	81.60%		84.50%		85.70%									
Sickness Rates					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Sickness Absence Rates	Click Here	Q3 13/14	3.88%	Increase = Bad Decrease = Good	4.99%		4.06%		4.75%		4.52%		3.41%		5.40%		5.53%	
Patient Lead Assessment of the Care Enviroment					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Cleanliness	Click Here	2013	95.75%	Increase = Good Decrease = Bad	99.9%	No trend	94.7%	No trend	96.5%	No trend	98.7%	No trend	97.3%	No trend	96.3%	No trend	99.5%	No trend
Food and Hydration			88.78%		92.8%		70.9%		79.0%		87.0%		94.7%		85.2%		90.7%	
Privacy, Dignity and Wellbeing			88.90%		95.8%		87.3%		81.3%		96.0%		95.1%		92.8%		79.3%	
Facilities			85.41%		93.2%		87.8%		90.5%		90.7%		93.5%		88.5%		92.4%	
NHS Litigation Authority					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
NHS Litigation Authority Assessment	Click Here	2012/13	n/a	N/A	2		3		3		3		3		1		1	
Quality Accounts					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Quality Accounts		2013/14	n/a	N/A	●		●		●		●		●		●		●	
CQC Intelligence Tool					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Overall banding relating to five key questions we will ask of all services – are they safe, effective, caring, responsive, and well-led? **Band 1 = High Risk, Band 6 = Lowest risk**	Click Here	Mar-14	Lowest risk = 6	Increase = Good Decrease = Bad	6		1		1		6		4					
Monitor Risk and Financial Rating					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Monitor Risk Rating - *(Awaiting outcome of Monitors newly risk assessment framework_Apr 14)*	Click Here	As of March 2014	Continuity of services	Increase = Good Decrease = Bad			No evident concern		No evident concern		No evident concern		Emerging or Minor Concern					
			Governance				Enforcement		No evident concern		No evident concern		No evident concern					

Measure HCAI MRSA cases
National Requirement: Yes

Provider Level Data

Month	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD	Trend
Royal Liverpool Hospital	0	1	0	0	0	0	2	1	2	0	1	1	8	
Liverpool Womens Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	
Liverpool Heart and Chest	0	0	0	0	0	0	0	0	0	0	0	0	0	
Alder Hey Childrens Hospital	0	0	0	0	0	0	1	0	0	0	0	0	1	
Southport and Ormskirk Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	
St Helens and Knowsley Hospital	0	2	0	0	0	1	0	0	0	1	0	0	4	
Mersey Care NHS Trust	0	0	0	0	0	0	0	0	0	0	0	0	0	
Liverpool Community Health	0	1	0	0	0	0	0	0	0	0	0	0	1	
Warrington and Halton Hospital	1	0	0	0	0	0	0	0	0	1	0	0	2	
Aintree University Hospital	0	1	0	0	0	0	0	0	0	0	1	1	3	
5 Boroughs Partnership	0	0	0	0	0	0	0	0	0	0	0	0	0	
Bridgewater Community	0	0	0	0	0	0	0	0	0	0	0	0	0	
The Walton Cente	0	1	0	0	0	0	0	0	0	0	0	0	1	
Plan	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

CCG Level Data

Month	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD	Trend
South Sefton CCG	0	1	0	0	0	0	0	0	0	0	1	1	3	

MRSA Cases_Data source: Provider HCAI Assurance Framework

Measure **HCAI Cdiff cases**
National Requirement: **Yes**

Provider Level Data

Month	Annual Plan	Monthly 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	YTD	Trend
Royal Liverpool Hospital	35	2.92	4	7	2	7	7	3	3	4	2	4	3	4	50	
Liverpool Women's Hospital	0	0	0	0	0	1	0	0	0	0	1	0	0	0	2	
Liverpool Heart and Chest	4	0.33	0	0	1	0	1	0	0	0	0	1	0	0	3	
Alder Hey Children's Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Southport and Ormskirk Hospital	19	1.58	1	0	1	2	2	4	3	6	2	2	7	4	34	
St Helens and Knowsley Hospital	31	2.58	0	3	2	2	3	2	1	0	0	3	2	8	26	
Warrington and Halton Hospital	19	1.58	5	4	3	0	1	1	4	2	4	4	1	2	31	
Aintree University Hospital	43	3.58	9	11	6	7	11	10	5	7	4	1	4	1	76	
The Walton Center	5	0.42	1	2	1	1	0	1	0	1	1	2	1	2	13	
Mersey Care NHS Trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Liverpool Community Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
5 Boroughs Partnership	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Bridgewater Community	0	0	0	0	1	0	0	0	0	0	0	1	0	0	2	

CCG Level Data

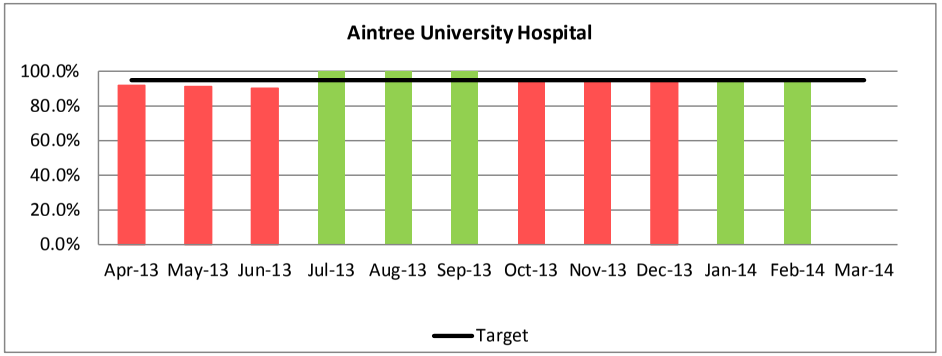
Month	Annual Plan	Monthly Plan	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD	Trend
South Sefton CCG	44	3.67	7	5	4	3	10	5	8	1	2	2	5	3	55	

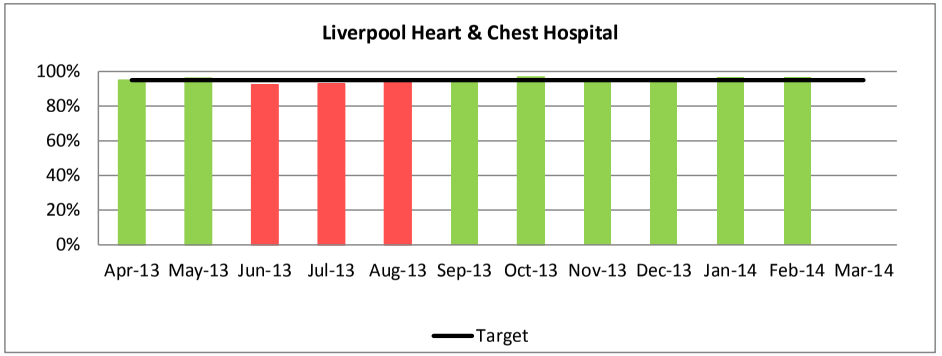
Cdiff Cases_Data source: Provider HCAI Assurance Framework

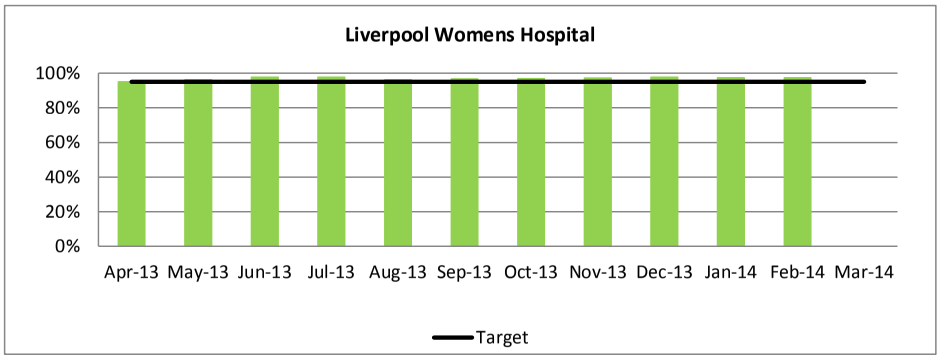
All patients should be risk assessed on admission to hospital. Patients should be reassessed within 24 hours of admission and whenever the clinical situation changes.

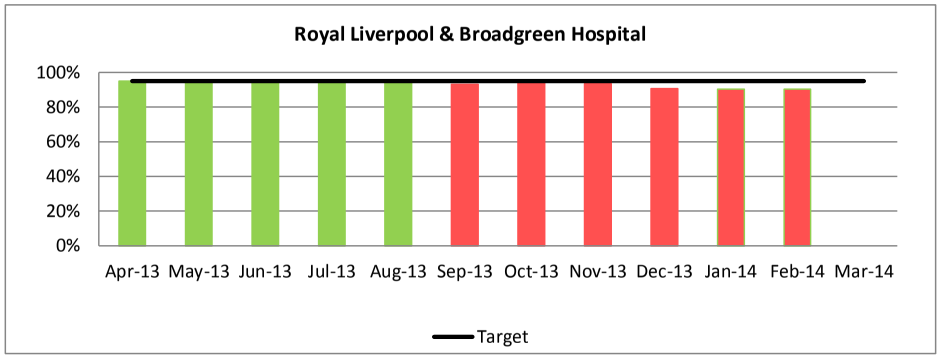
Measure: VTE Risk Assessments
Threshold: National CQUIN
Target: 95%

Trust	2011/12	2012/13	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
Aintree University Hospital	87%	92%	92%	91%	90%	100%	100%	100%	94.9%	94.6%	94.8%	95.5%	95.5%		
Liverpool Heart & Chest Hospital	96%	96%	95%	96%	92%	93%	94%	95%	97%	96.2%	95.8%	96.7%	96.7%		
Liverpool Womens Hospital	95%	96%	95%	96%	98%	98%	96%	97%	97%	97.1%	97.7%	97.3%	97.3%		
Royal Liverpool & Broadgreen Hospital	91%	90%	95%	95%	95%	95%	95%	93%	94%	93.6%	90.7%	90.3%	90.3%		
Southport & Ormskirk Hospital	95%	93%	96%	96%	95%	97%	97%	96%	95%	96.8%	96.0%	95.9%	95.9%		
St Helens & Knowsley Hospital	84%	90%	92%	94%	95%	95%	95%	95%	95%	95.0%	95.0%	94.6%	94.6%		
The Walton Centre	99%	94%	92%	92%	93%	92%	93%	94%	95%	98.5%	96.1%	95.2%	95.2%		
Warrington and Halton Hospital			94%	94%	96%	96%	95%	95%	97%	96.7%	95.2%	95.6%	95.6%		
Target	**90%**	**90%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**

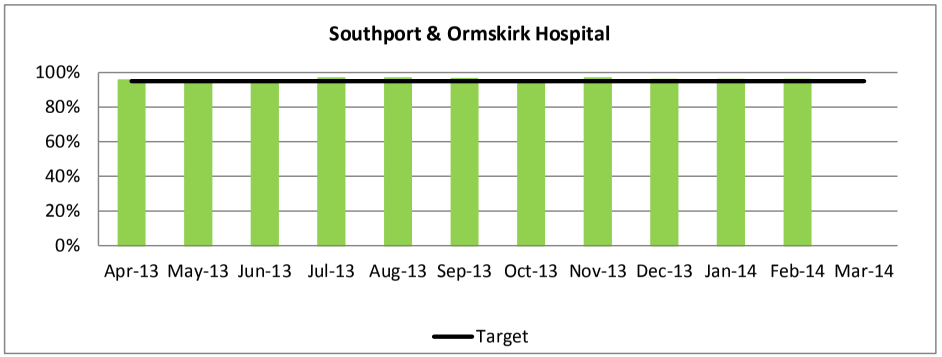


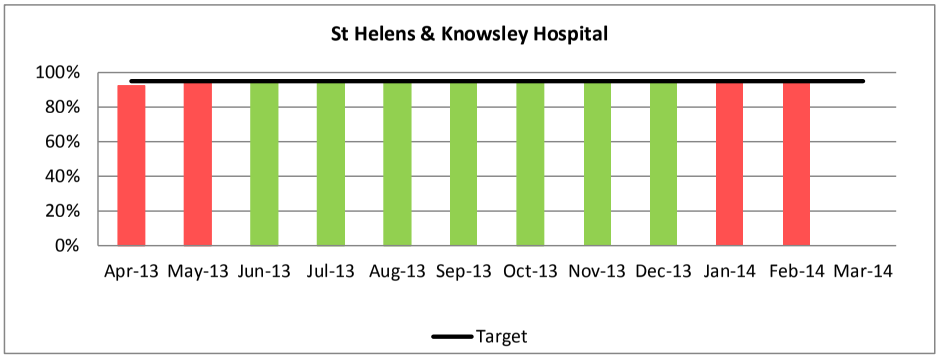


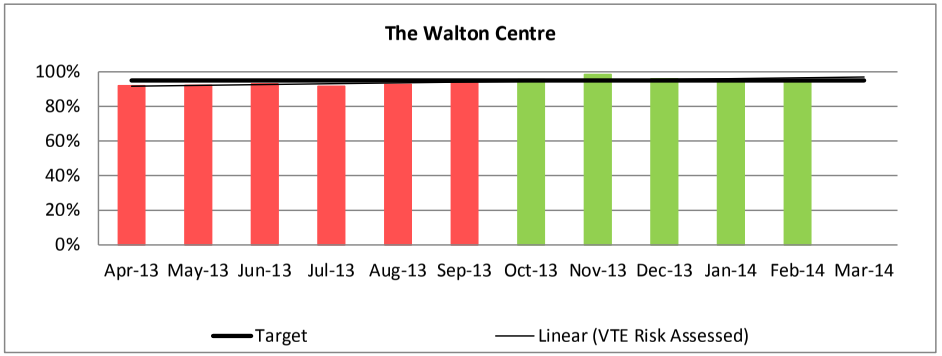


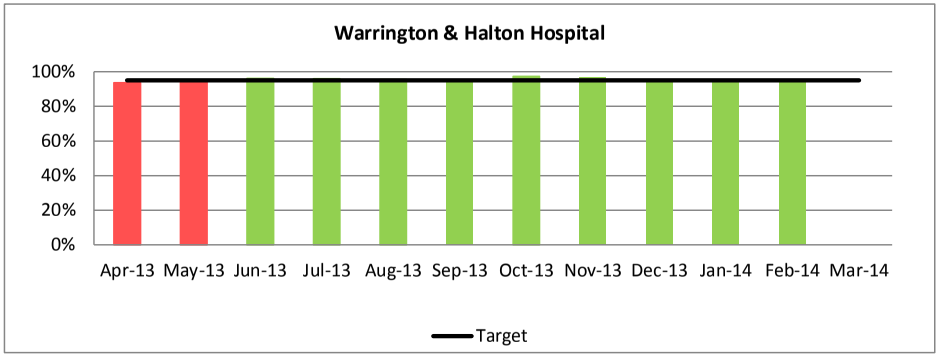


VTE Risk Assessments Data_Unify2 Data source









VTE Risk Assessments Data_Unify2 Data source

Measure: Serious Untoward Incidents
Data Source: STEIS

201314 Provider SUI Tables.pdf

Apr 14 Provider SUIs.pdf

Serious Untoward Incidents

	2013/14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Royal Liverpool Hospital	28	5												5
Liverpool Womens Hospital	17	3												3
Liverpool Heart and Chest	6	2												2
Alder Hey Childrens Hospital	12	3												3
Southport and Ormskirk Hospital	15	2												2
St Helens and Knowsley Hospital	27	1												1
Mersey Care NHS Trust	76	7												7
Liverpool Community Health	95	26												26
Warrington and Halton Hospital	49	0												0
Aintree University Hospital	27	0												0
5 Boroughs Partnership	73	2												2
Bridgewater Community	17	2												2

Never Events

	YTD	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Royal Liverpool Hospital	2	0												0
Liverpool Womens Hospital	1	0												0
Liverpool Heart and Chest	2	1												1
Alder Hey Childrens Hospital	1	0												0
Southport and Ormskirk Hospital	2	0												0
St Helens and Knowsley Hospital	2	0												0
Mersey Care NHS Trust	0	0												0
Liverpool Community Health	1	0												0
Warrington and Halton Hospital	2	0												0
Aintree University Hospital	1	0												0
5 Boroughs Partnership	1	0												0
Bridgewater Community	0	0												0

Measure: Complaints reported to Cheshire and Merseyside Commissioning Support Unit
Latest data: Apr-14

Date Received	CCG	Provider	Complaint Detail	Status
23/04/2014	Sefton CCG	Sefton CCG	This was originally a PALS complaint set up in regarding patient Lawless's review for retrospective CHC. this complaint has been going on since 2013 and has still not been resolved. The complaint has now ecilated in the complainant sending a letter to the MP Bill Esterson asking for help on this matter.	Under Investigation
02/04/2014	Sefton CCG	Royal Liverpool and Broadgreen University Hospitals NHS Trust	Constituent written to MP David Pugh as problems sourcing medication and who should provide ongoing treatment (GP or Royal Liverpool Hospital). Issues with cost of medication and also shortage of Liothyronine by Mercury Pharma - concern re dependency on one supplier.	Closed No Further Action

Measure: National Incident Reporting
Data Source: NRLS
Latest Data: Apr 13 - Sep 13

2014 Provider NPSA Reports.zip

	Reorting Rates		CMCSU Comments
	Apr - Sep 12	Apr - Sep 13	
Royal Liverpool & Broadgreen	**Lowest 25%**	**Lowest 25%**	Royal Liverpool Hospital reported 2,235 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 5.08 compared to 7.98 (Median for large acute providers). The trust reported significantly more incidents in the following areas compared to other teaching organisations; • Patient Accidents • Access/Admissions/Transfer and Discharge incidents
Aintree University Hospital	**Middle 50% of reporters**	**Middle 50% of reporters**	Aintree Hospital reported 2,607 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 7.21 compared to 7.23 (Median for large acute providers). The trust reported significantly more incidents in the following areas compared to other teaching organisations; • Patient Accidents • Documentation (including records/documentation)
Alder Hey Children's Hospital	**Lowest 25%**	**Lowest 25%**	Alder Hey Childrens Hospital reported 849 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 5.09 compared to 7.14 (Median for specialist acute providers). The trust reported significantly more incidents in the following areas compared to other acute specialist organisations; • Clinical Assessments
Liverpool Women's Hospital	**Middle 50% of reporters**	**Lowest 25%**	Liverpool Womens Hospital reported 763 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 3.69 compared to 7.14 (Median for specialist acute providers). The trust reported significantly more incidents in the following areas compared to other specialist organisations; • Treatment procedure
Liverpool Heart & Chest Hospital	**Highest 25% of reporters**	**Middle 50% of reporters**	Liverpool Heart and Chest Hospital reported 540 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 7.93 compared to 7.14 (Median for specialist acute providers). The trust reported significantly more incidents in the following areas compared to other acute specialist organisations; • Implementation of care and ongoing monitoring / review • Medical device / equipment
Mersey Care	**Middle 50% of reporters**	**Highest 25% of reporters**	Mersey Care NHS Trust reported 2559 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 36.64 compared to 26.37 (Median for mental health providers). The trust reported significantly more incidents in the following areas compared to other mental health organisations; • Self-harming behaviour •Disruptive, aggressive behaviour
Liverpool Community Health	**Lowest 25%**	**Middle 50% of reporters**	Liverpool Community Health reported 484 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 37.82 compared to 47.63 (Median for community providers). The trust reported significantly more incidents in the following areas compared to other community organisations; • Implementation of care and ongoing monitoring / review
Southport and Ormskirk Hospital	**Middle 50% of reporters**	**Middle 50% of reporters**	Southport Hospital reported 1916 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 6.32 compared to 7.23 (Median for medium acute providers). The trust reported significantly more incidents catagorised as 'other' compared to other medium acute organisations.

Measure: Sleeping Mixed Sex Accomadation Breaches
Threshold <0 = Green, >0 = Red
Financial Consequence per breach: £250 per breach

Commissioner	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
South Sefton CCG	0	0	0	0	0	0	0	1	0	0	0	0

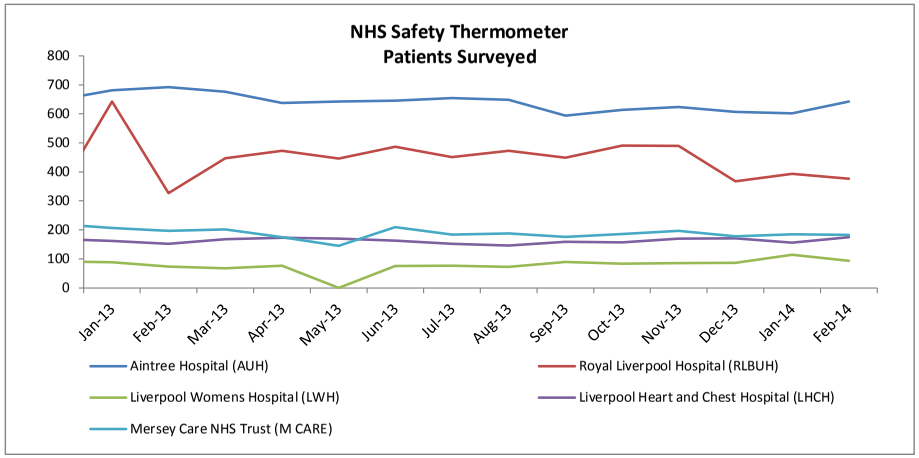
Provider Level	2011	2012	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trust YTD Total	£ Financial Total
5BOURGH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Aintree University Hospital	90	7	0	1	0	0	0	0	0	0	0	0	0	0	1	£250
Alder Hey Childrens Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Bridgewater	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Liverpool Community Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Liverpool Heart & Chest Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Liverpool Womens Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Mersey Care NHS Trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Royal Liverpool & Broadgreen Hospital	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Southport & Ormskirk Hospital	66	10	0	0	0	0	0	0	0	0	0	28	35	16	79	£19,750
St Helens & Knowsley Hospital	14	1	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
The Walton Centre	0	2	0	0	0	0	0	0	0	3	0	0	0	0	3	£750
Warrington & Halton Hospital	7	15	0	0	0	0	0	5	10	1	2	6	0	0	24	£6,000

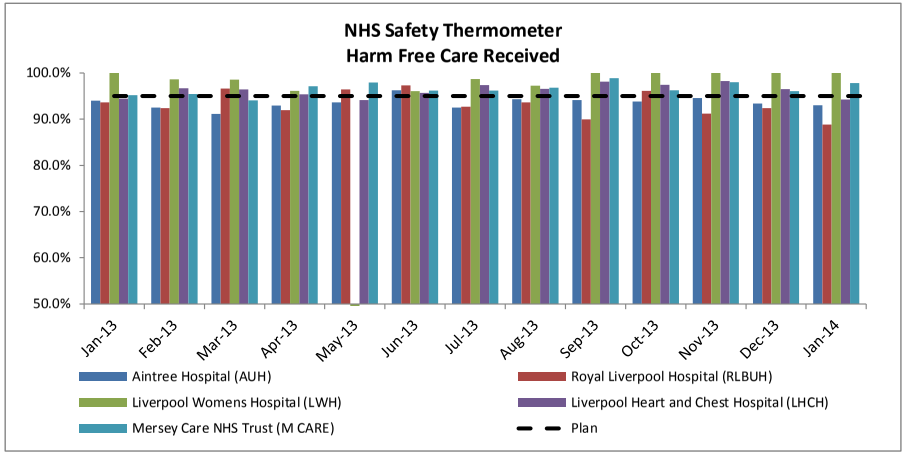
Due to a change in national reporting March 2014 data is currently being analysed, an update will follow as soon as data is available - Sorry for the inconvenience

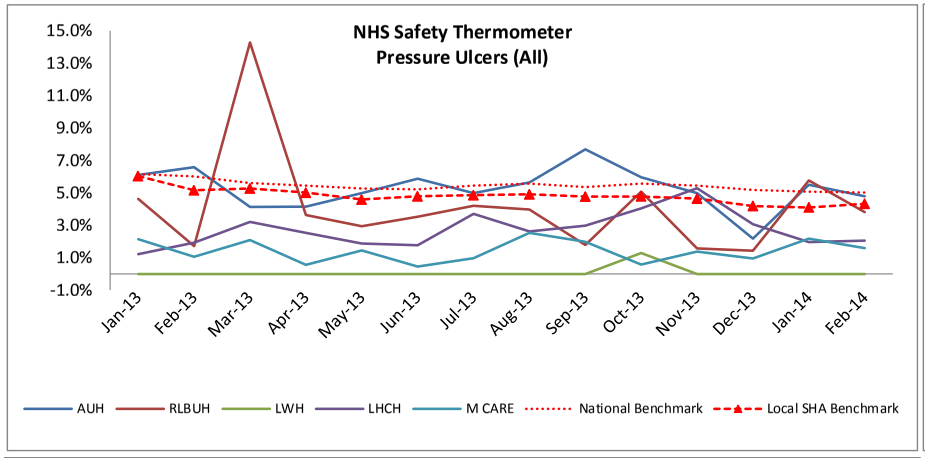
Measure: NHS Safety Thermometer Data

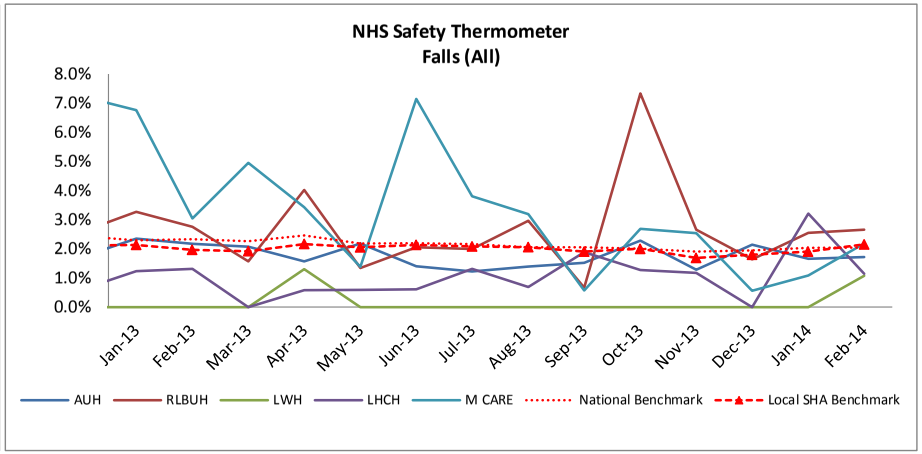
CQUIN: Yes

Part 1. Patients surveyed - All providers survey similar numbers each month, during the year RLBUH reported a slight drop in the number of surveys completed in December 2013.
Part 2. Harm Free Care - LWH report the highest standard of harm free care, RLBUH report the lowest standard of harm free care.
Part 3. Pressure Ulcers -In February 2014 RLBUH reported a reduction in pressure ulcer rates, AUH continue to report higher rates than the national average
Part 4. Falls - RLBUH reported a slight increase in falls rates and continue to report rates higher than the national and regional average.
Part 5. Catherters and UTIs - LWH reported an increase in the number of women with catheters having UTIs, 3 patients reported in February 2014.
Part 6. New VTE Cases - RLBUH continues to be the highest reporter of hospital acquired VTE cases and reports higher rates than the national and regional average



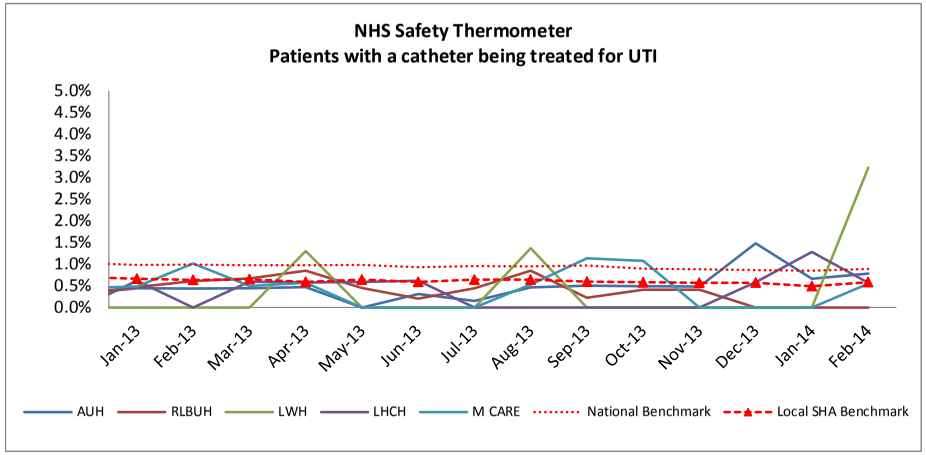


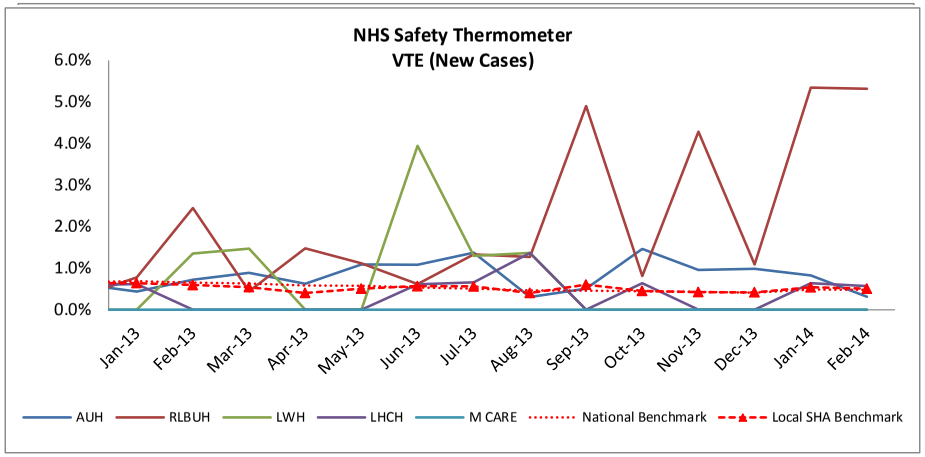




NHS Safety Thermometer_Data source: Quality Observatory

Part 6. New VTE Cases - RLBUH continues to be the highest reporter of hospital acquired VTE cases and reports higher rates than the national and regional average





Due to low numbers being reported against the measure above, 1 patient being treated can result in a significant increase in rates.

Measure: National Dementia Programme
Thresholds: 90% Threshold all areas

** = 0 admissions*

Screening for Dementia (Find)

	2012/13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	2013/14
St Helens & Knowsley Hospital	91.4%	91.9%	90.3%	91.7%	92.5%	93.0%	93.7%	90.5%	91.3%	92.6%	92.6%	96.0%		92.4%
Liverpool Heart & Chest Hospital	87.4%	100.0%	94.4%	100.0%	96.9%	96.9%	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%		98.3%
Aintree University Hospital	19.5%	37.4%	27.9%	46.1%	52.4%	47.0%	43.9%	37.6%	58.2%	52.0%	64.7%	67.4%		47.3%
Liverpool Womens Hospital	42.9%	100.0%	*	*	100.0%	*	*	75.0%	75.0%	66.7%	100.0%	50.0%		76.5%
The Walton Centre	81.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		98.4%
Royal Liverpool & Broadgreen Hosp	48.8%	45.0%	43.0%	42.9%	43.0%	29.2%	47.9%	71.1%	63.3%	57.1%	58.5%	56.1%		50.6%
Southport & Ormskirk Hospital	10.7%	13.3%	16.5%	18.2%	19.1%	11.3%	17.1%	15.2%	7.8%	4.1%	7.0%	5.6%		12.1%
Warrington & Halton Hospital	38.8%	90.4%	92.9%	92.9%	92.9%	95.1%	95.1%	95.2%	95.1%	96.1%	97.9%	97.4%		94.5%

Risk Assessed (Assess and Investigate)

	2012/13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	2013/14
St Helens and Knowsley Hospital	89.7%	94.4%	98.5%	97.8%	100.0%	98.4%	98.4%	100.0%	98.4%	100.0%	96.5%	91.5%		97.6%
Liverpool Heart and Chest	91.2%	100.0%	*	100.0%	83.3%	100.0%	80.0%	80.0%	*	100.0%	100.0%	100.0%		92.3%
Aintree University Hospital	82.4%	81.0%	89.5%	84.2%	75.0%	85.0%	66.7%	40.0%	51.6%	59.4%	56.8%	83.7%		70.3%
Liverpool Womens Hospital	n/a	*	*	*	*	*	*	*	*	*	*	100.0%		100.0%
The Walton Centre	n/a	*	*	*	*	100.0%	*	*	*	*	*	100.0%		100.0%
Royal Liverpool and Broadgreen	41.6%	60.0%	58.0%	58.0%	58.0%	94.3%	100.0%	30.3%	36.8%	34.5%	44.3%	57.1%		55.1%
Southport and Ormskirk Hospital	3.3%	16.7%	66.7%	66.7%	11.1%	18.2%	44.4%	42.9%	40.0%	50.0%	68.8%	80.0%		44.4%
Warrington and Halton Hospital	16.3%	16.1%	67.7%	67.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		86.2%

Patients Referred (Refer)

	2012/13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	2013/14
St Helens and Knowsley Hospital	55.4%	96.0%	94.7%	88.9%	92.9%	95.2%	100.0%	100.0%	100.0%	94.1%	96.4%	100.0%		96.0%
Liverpool Heart and Chest	90.9%	80.0%	*	100.0%	100.0%	100.0%	100.0%	50.0%	*	100.0%	100.0%	100.0%		90.9%
Aintree University Hospital	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
Liverpool Womens Hospital	n/a	*	*	*	*	*	*	*	*	*	*	*		*
The Walton Centre	100.0%	*	*	*	*	*	*	100.0%	*	*	*	100.0%		100.0%
Royal Liverpool and Broadgreen	n/a	*	*	*	*	*	*	57.1%	66.7%	63.6%	77.8%	61.9%		65.8%
Southport and Ormskirk Hospital	72.7%	*	100.0%	100.0%	100.0%	*	66.7%	*	100.0%	83.3%	100.0%	75.0%		86.7%
Warrington and Halton Hospital	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%

Summary Hospital-level Mortality Indicator (SHMI)

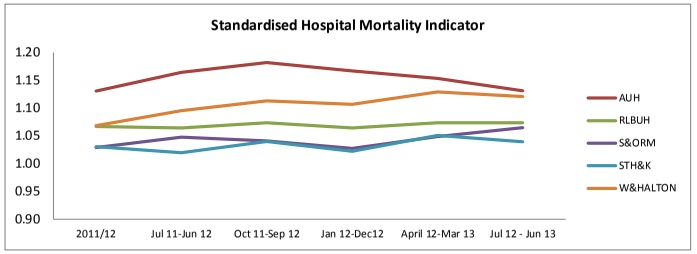
Purpose All deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or <30 days of discharge.

Threshold:
1 – where the trust's mortality rate is 'higher than expected' - Red
2 – where the trust's mortality rate is 'as expected' - Blue
3 – where the trust's mortality rate is 'lower than expected' - Green
Relative risk = Observed number of deaths as a percentage of expected number of deaths
https://indicators.ic.nhs.uk/webview/

Summary Hospital-level Mortality Indicator (SHMI)

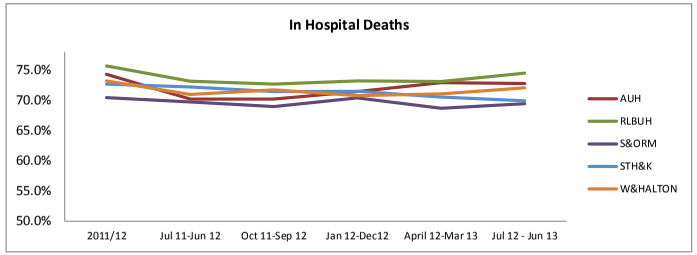
	2011/12	Jul 11-Jun 12	Oct 11-Sep 12	Jan 12-Dec12	April 12-Mar 13	Jul 12 - Jun 13
Aintree University Hospital	1.13	1.16	1.18	1.17	1.15	1.13
Royal Liverpool & Broadgreen Hospital	1.07	1.06	1.07	1.06	1.07	1.07
Southport & Ormskirk Hospital	1.03	1.05	1.04	1.03	1.05	1.06
St Helens & Knowsley Hospital	1.03	1.02	1.04	1.02	1.05	1.04
Warrington and Halton Hospital	1.07	1.10	1.11	1.11	1.13	1.12

Rolling 12 months data



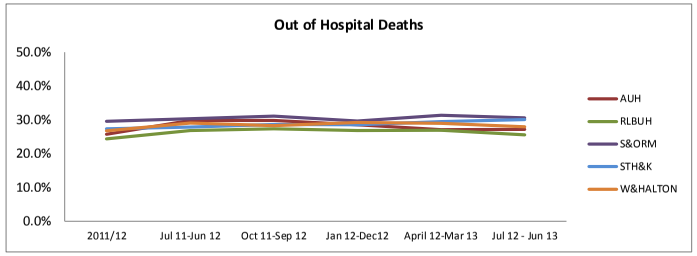
Percentage of deaths that occur in hospital

	2011/12	Jul 11-Jun 12	Oct 11-Sep 12	Jan 12-Dec12	April 12-Mar 13	Jul 12 - Jun 13
St Helens & Knowsley Hospital	72.7%	72.20%	71.43%	71.49%	70.53%	69.91%
Aintree University Hospital	74.3%	70.19%	70.19%	71.45%	72.94%	72.81%
Royal Liverpool & Broadgreen Hospital	75.7%	73.19%	72.67%	73.21%	73.11%	74.49%
Southport & Ormskirk Hospital	70.5%	69.73%	68.95%	70.40%	68.70%	69.43%
Warrington and Halton Hospital	73.2%	70.99%	71.76%	70.80%	71.06%	72.08%



Percentage of deaths that occur outside hospital within 30 days (inclusive) of discharge

	2011/12	Jul 11-Jun 12	Oct 11-Sep 12	Jan 12-Dec12	April 12-Mar 13	Jul 12 - Jun 13
St Helens & Knowsley Hospital	27.3%	27.80%	28.57%	28.51%	29.47%	30.09%
Aintree University Hospital	25.7%	29.81%	29.81%	28.55%	27.06%	27.19%
Royal Liverpool & Broadgreen Hospital	24.3%	26.81%	27.33%	26.79%	26.89%	25.51%
Southport & Ormskirk Hospital	29.5%	30.27%	31.05%	29.60%	31.30%	30.57%
Warrington and Halton Hospital	26.8%	29.01%	28.24%	29.20%	28.94%	27.92%



Measure: Patient Reported Outcome Measures
Level of reporting: Trust Catchment
Indicator: EQ-5D Index Adjusted Average Health Gain
Latest data available Apr - Mar 2013/14 Provisional Data
Threshold Green = Improvement in trust adjusted average heath gain compared to previous reporting and above national average
Amber = Amber = Improvement in trust adjusted average heath gain compared to previous reporting but below national average
Red = No improvement in trusts adjusted average health gain compared to previous reporting and below national average

Groin Hernia		2010/11 Finalised Data	2011/12 Provisional Data	2012/13 (Apr 12 - Mar 12) Provisional Data
Commissioner		Adjusted average health gain	Adjusted average health gain	Adjusted average health gain
England	**England**		**0.087**	**0.086**
01F	NHS HALTON CCG		0.049	*
01J	NHS KNOWSLEY CCG	0.108	0.090	0.058
01T	NHS SOUTH SEFTON CCG		0.055	0.069
01V	NHS SOUTHPORT AND FORMBY CCG		0.080	0.085
01X	NHS ST HELENS CCG		0.085	0.031
99A	NHS LIVERPOOL CCG	0.049	0.056	0.071
Provider				
NT337	SPIRE LIVERPOOL HOSPITAL	0.030	0.045	
NVG01	FAIRFIELD HOSPITAL	*	*	
RBN	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	0.074	0.080	0.042
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	0.034	0.088	0.064
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	0.082	0.057	*
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	0.064	0.073	0.061
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	0.055	0.084	*

Knee Replacement		2010/11 Finalised Data	2011/12 Provisional Data	2012/13 (Apr 12 - Dec 12) Provisional Data
Commissioner		Adjusted average health gain	Adjusted average health gain	Adjusted average health gain
England	**England**		**0.302**	**0.321**
01F	NHS HALTON CCG		0.306	0.298
01J	NHS KNOWSLEY CCG	0.186	0.260	0.347
01T	NHS SOUTH SEFTON CCG		0.303	0.348
01V	NHS SOUTHPORT AND FORMBY CCG		0.295	0.312
01X	NHS ST HELENS CCG		0.293	0.327
99A	NHS LIVERPOOL CCG	0.240	0.309	0.307
Provider				
NT337	SPIRE LIVERPOOL HOSPITAL	*	0.331	
NVG01	FAIRFIELD HOSPITAL	No Data	0.280	
RBN	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	0.288	0.272	0.317
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	0.199	0.299	0.296
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	0.234	0.316	0.354
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	0.325	0.297	0.308
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	0.299	0.302	*

Hip Replacement		2010/11 Finalised Data	2011/12 Provisional Data	2012/13 (Apr 12 - Dec 12) Provisional Data
Commissioner		Adjusted average health gain	Adjusted average health gain	Adjusted average health gain
England	**England**		**0.416**	**0.439**
01F	NHS HALTON CCG		0.422	0.384
01J	NHS KNOWSLEY CCG	0.352	0.474	0.442
01T	NHS SOUTH SEFTON CCG		0.352	0.413
01V	NHS SOUTHPORT AND FORMBY CCG		0.368	0.423
01X	NHS ST HELENS CCG		0.427	0.468
99A	NHS LIVERPOOL CCG	0.381	0.387	0.420
Provider				
NT337	SPIRE LIVERPOOL HOSPITAL	*	0.449	
NVG01	FAIRFIELD HOSPITAL	*	0.422	
RBN	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	0.378	0.443	0.430
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	0.390	0.395	0.429
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	0.363	0.326	0.412
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	0.378	0.348	0.378
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	0.382	0.395	0.407

Varicose Vein		2010/11 Finalised Data	2011/12 Provisional Data	2012/13 (Apr 12 - Dec 12) Provisional Data
Commissioner		Adjusted average health gain	Adjusted average health gain	Adjusted average health gain
England	**England**		**0.094**	**0.094**
01F	NHS HALTON CCG		No Data	*
01J	NHS KNOWSLEY CCG	*	*	*
01T	NHS SOUTH SEFTON CCG		*	*
01V	NHS SOUTHPORT AND FORMBY CCG		*	*
01X	NHS ST HELENS CCG		*	*
99A	NHS LIVERPOOL CCG	0.061	0.065	*
Provider				
NT337	SPIRE LIVERPOOL HOSPITAL	*		
NVG01	FAIRFIELD HOSPITAL	No Data		
RBN	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	*	*	*
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	*	*	*
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	0.045	0.066	*
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	*	*	*
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	*	*	*

Measure: Advancing Quality
Threshold: Various for each measure/provider
Rag Rating: Green = Achieving threshold, Red = Failing threshold

Latest AQ Report 5C4803D1.zip

AMI	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Aintree	81.3	92.0	90.0	95.7	86.7	95.0	94.4	87.1	100.0	100.0				92.8
Liverpool Heart and Che	91.5	91.3	86.3	93.1	92.1	96.0	89.8	93.1	91.4	97.9				92.2
Royal Liverpool	94.9	100.0	100.0	100.0	100.0	100.0	100	100	100.0	100.0				100.0
Southport	95.0	93.8	93.8	90.9	94.1	85.7	100	92.86	91.7	92.9				93.3
St Helen's	95.0	100.0	100.0	100.0	100.0	100.0	100	100	100.0	100.0				100.0
Warrington	91.5	97.1	100.0	96.0	100.0	96.0	100	100	100.0	95.1				98.2

Heart Failure	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Aintree	73.8%	70%	59%	64%	76%	58%	77.3%	77.8%	69.6%	70.0%				68.7%
LHCH	62.2%	100%	67%	67%	50%	67%	0.0%	75.0%	0.0%	100.0%				69.2%
Royal Liverpool	83.4%	100%	89%	89%	83%	100%	71.4%	87.5%	91.7%	75.0%				86.9%
Southport	71.0%	75%	80%	69%	91%	55%	80.0%	85.0%	80.0%	46.7%				73.6%
St Helen's	82.8%	72%	73%	90%	95%	93%	93.8%	76.9%	92.0%	77.8%				85.1%
Warrington	86.9%	85%	96%	92%	91%	84%	85.0%	66.7%	87.5%	85.0%				86.1%

Hip and Knee (Combine	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Aintree	82.0%	82.8%	85.5%	92.4%	93.7%	91.3%	83.3%	83.7%	83%	75%				85.9%
Royal Liverpool	95.0%	94.2%	95.5%	99.0%	96.7%	98.5%	97.7%	95.7%	95%	95%				96.4%
Southport	82.0%	77.6%	71.2%	78.8%	85.4%	76.1%	70.0%	75.9%	91%	87%				79.2%
St Helen's	95.0%	97.9%	94.8%	95.9%	98.5%	100.0%	94.4%	98.6%	100%	100%				97.7%
Warrington	92.2%	97.5%	97.7%	95.3%	94.5%	98.0%	94.3%	98.7%	97%	94%				96.2%

Pneumonia	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Aintree	61.1%	69.5%	80.0%	67.1%	81.7%	75.0%	75.7%	60.9%	83.3%	91.5%				76.0%
Royal Liverpool	78.8%	76.5%	88.0%	84.7%	93.0%	82.3%	80.9%	87.1%	77.8%	82.9%				78.1%
Southport	65.4%	69.2%	70.8%	76.6%	80.6%	70.8%	87.5%	84.6%	65.6%	78.7%				75.2%
St Helen's	91.4%	94.0%	94.0%	91.8%	89.5%	79.1%	76.3%	85.2%	87.1%	92.3%				88.7%
Warrington	75.2%	64.8%	66.7%	74.3%	71.7%	80.4%	71.7%	70.6%	75.9%	79.0%				72.1%

Stroke	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Aintree	53.6%	55.0%	42.9%	59.0%	53.6%	37.1%	35.7%	53.7%	29%	34%				44.3%
Royal Liverpool	89.8%	70.2%	76.9%	80.9%	75.4%	69.6%	71.4%	65.9%	58%	88%				73.3%
Southport	53.6%	18.5%	30.0%	38.1%	58.3%	52.2%	45.5%	57.9%	50%	41%				42.9%
St Helen's	55.1%	32.1%	36.7%	43.2%	63.2%	56.5%	57.1%	59.6%	60%	58%				51.5%
Warrington	62.6%	59.5%	47.8%	50.0%	63.0%	67.7%	54.3%	55.3%	52%	53%				56.2%

CABG	ACS Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
LHCH	95.00	100.00	98.40	97.10	100.00	98.30	97.00	97.00	100.00	98.00				98.00

Dementia	CPS Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
5BP	81.1%	90.0%	89.9%	96.6%	98.0%	89.1%	87%	96%	95%	88%				92.5%
Mersey Care	69.4%	77.2%	77.3%	82.0%	87.3%	84.6%	92%	85%	100%	90%				88.4%

Dementia	ACS Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
5BP	50.0%	68.4%	68.2%	78.3%	92.3%	87.5%	87.5%	88.0%	76%	82%				81.2%
Mersey Care	50.0%	40.9%	7.1%	30.0%	47.1%	44.4%	66.7%	33.3%	100%	44%				51.4%

First-Episode Psychosis	CPS Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
5BP	95.0%	100.0%	100.0%	100.0%	93.1%	97.6%	100%	100%	100%	100%				98.8%
Mersey Care	84.2%	76.6%	86.4%	79.7%	89.3%	85.3%	79%	87%	88%	76%				83.1%

First-Episode Psychosis	ACS Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
5BP	95.0%	100.0%	100.0%	100.0%	86.7%	90.9%	100%	100%	100%	100%				97.1%
Mersey Care	50.0%	50.0%	58.3%	47.4%	60.0%	52.6%	33%	57%	58%	31%				50.0%

Measure: Advancing Quality
Reporting Frequency: Apr 13 - Dec 13
Benchmark: CCG and North West Providers
South Sefton CCG Performance

Clinical Focus Area	AMI	Dementia	First-Episode Psychosis	Heart Failure	Hip and Knee (Combined)	Pneumonia	Stroke
CPS	97.2%	94.0%		86.6%	96.6%	92.7%	89.1%
ACS	94.7%	71.4%		65.2%	85.6%	76.2%	42.0%
Quartile (ACS)	Above Median	Above Median		Below Median	Below Median	Above Median	Bottom Quartile

Provider level summary

AMI	Dementia	First-Episode Psychosis	Heart Failure	Hip and Knee (Combined)	Pneumonia	Stroke
AINTREE has achelved ACS target every month in AMI and is above target YTD SOUTHPORT & ORMSKIRK has achieved ACS target 1 out of 9 months in AMI and is below target YTD by 1.7% ROYAL LIVERPOOL has achelved ACS target every month in AMI and is above target YTD	MERSEY CARE has achieved ACS target 3 out of 9 months in Dementia and is above target YTD MERSEY CARE has achelved CPS target every month in Dementia and is above target YTD	MERSEY CARE has achieved ACS target 6 out of 9 months in First-Episode Psychosis and is above target YTD MERSEY CARE has achieved CPS target 5 out of 9 months in First-Episode Psychosis and is below target YTD by 1.1%	AINTREE has achieved ACS target 3 out of 9 months in Heart Failure and is below target YTD by 5.1% SOUTHPORT & ORMSKIRK has achieved ACS target 6 out of 9 months in Heart Failure and is above target YTD ROYAL LIVERPOOL has achieved ACS target 6 out of 9 months in Heart Failure and is above target YTD	AINTREE has achieved ACS target 8 out of 9 months in Hip and Knee (Combined) and is above target YTD SOUTHPORT & ORMSKIRK has achieved ACS target 3 out of 9 months in Hip and Knee (Combined) and is below target YTD by 2.8% ROYAL LIVERPOOL has achieved ACS target 7 out of 9 months in Hip and Knee (Combined) and is above	AINTREE has achieved ACS target 8 out of 9 months in Pneumonia and is above target YTD SOUTHPORT & ORMSKIRK has achelved ACS target every month in Pneumonia and is above target YTD ROYAL LIVERPOOL has achieved ACS target 3 out of 9 months in Pneumonia and is below target YTD by 0.7%	AINTREE has achieved ACS target 3 out of 9 months in Stroke and is below target YTD by 9.4% SOUTHPORT & ORMSKIRK has achieved ACS target 2 out of 9 months in Stroke and is below target YTD by 10.8% ROYAL LIVERPOOL has not achieved ACS target once during the 9 months and is below target YTD by 17.5%

Latest report:

YTD - April 2013 to December 2013 - (01T) NHS SOUTH

Measure: National Mental Health Survey 2012/13

CQUIN Scheme: No

Threshold: Actual performance compared to england average

Description: Results across North West SHA for the Community Mental Health survey 2012/13

Key	Compared to previous year
☺	Improvement in patients satisfaction
😐	Similar experience reported
☹	Reduction in patients satisfaction

Key	Compared to England Average
	Higher score
	Similar score (Within 2 points)
	Lower score

Natioal Mental Health Survey	Overall score	Access & waiting	Safe high quality coordinated care	Better information more choice	Building closer relationships
England Average	74.4	72.4	71.3	69.1	84.7
SHA average	76.0	73.7	74.3	69.9	86.3
5 Boroughs Partnership NHS Trust	76.6	73.7	76.7	71.2	84.8
Bolton, Salford and Trafford Mental Health NHS Trust	72.5	68.6	71.3	67.0	83.0
Cheshire and Wirral Partnership NHS Trust	79.3	79.5	78.5	70.3	88.8
Cumbria Partnership NHS Trust	73.6	68.1	68.6	70.6	87.1
Lancashire Care NHS Trust	75.1	76.1	73.0	66.8	84.7
Manchester Mental Health and Social Care Trust	77.5	73.7	76.1	71.2	88.9
Mersey Care NHS Trust	76.7	74.4	76.4	69.3	86.7
Pennine Care NHS Trust	77.1	75.2	73.8	72.5	86.7

Indicator National Staff Survey
Latest data available: 2013
Datasource: http://www.nhsstaffsurveys.com/cms/
Threshold: Awaiting CQC confirmation of rag ratings, please see method for rag ratings included below
Green = Improvement compared to previous year and above national average
Amber = Improvement compared to previous year but below the national average
Red = Drop in performance compared to previous year and below national average

	Overall Staff Engagement						KF1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver						KF24. Staff recommendation of the trust as a place to work or receive treatment					
	Trust Score 2010	Trust Score 2011	Trust Score 2012	Trust Score 2013	Change	National Average (All trusts)	Trust Score 2010	Trust Score 2011	Trust Score 2012	Trust Score 2013	Change	National Average (All trusts)	Trust Score 2010	Trust Score 2011	Trust Score 2012	Trust Score 2013	Change	National Average (All trusts)
5BOROUGHS	3.69	3.65	3.73	3.76		3.74	78%	74%	77%	79%		77%	3.55	3.50	3.61	3.67		3.67
Aintree University Hospital	3.64	3.65	3.69	3.74		3.74	81%	77%	82%	82%		77%	3.59	3.66	3.68	3.70		3.67
Alder Hey Childrens Hospital	3.71	3.65	3.57	3.68		3.74	78%	75%	78%	75%		77%	3.75	3.61	3.49	3.65		3.67
Bridgewater	3.52	3.60	3.69	3.60		3.74	77%	73%	80%	77%		77%	3.34	3.47	3.58	3.47		3.67
Liverpool Community Health	3.68	3.61	3.61	3.70		3.74	74%	76%	79%	77%		77%	3.60	3.56	3.52	3.57		3.67
Liverpool Heart & Chest Hospital	3.78	3.86	3.98	3.96		3.74	86%	85%	86%	84%		77%	4.06	4.08	4.20	4.22		3.67
Liverpool Womens Hospital	3.59	3.48	3.57	3.73		3.74	76%	74%	76%	73%		77%	3.48	3.30	3.41	3.67		3.67
Mersey Care NHS Trust	3.59	3.67	3.72	3.66		3.74	81%	80%	79%	81%		77%	3.55	3.56	3.59	3.56		3.67
Royal Liverpool & Broadgreen Hospi	3.60	3.60	3.66	3.73		3.74	75%	77%	81%	81%		77%	3.53	3.52	3.65	3.77		3.67
Southport & Ormskirk Hospital	3.58	3.57	3.63	3.61		3.74	77%	76%	81%	79%		77%	3.46	3.37	3.39	3.46		3.67
St Helens & Knowsley Hospital	3.58	3.56	3.70	3.83		3.74	81%	78%	80%	82%		77%	3.48	3.52	3.74	3.95		3.67
The Walton Centre	3.77	3.70	3.73	3.87		3.74	82%	82%	83%	82%		77%	3.91	3.84	3.92	4.01		3.67
Warrington & Halton Hospital	3.65	3.58	3.68	3.79		3.74	77%	70%	78%	81%		77%	3.51	3.40	3.56	3.67		3.67

2013 NHS Staff Survey - Friends and Family Question

% to strongly agree / agree with the Q12d. 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'

All providers_Acute and Specialist Acute Providers

Ref	Provider	Score (%)	Quartile
RXF	Mid Yorkshire Hospitals NHS Trust	39.57	1st
RNL	North Cumbria University Hospitals NHS Trust	40.26	1st
RJ6	Croydon Health Services NHS Trust	41.03	1st
REF	Royal Cornwall Hospitals NHS Trust	43.03	1st
RWD	United Lincolnshire Hospitals NHS Trust	44.11	1st
RD7	Heatherwood and Wexham Park Hospitals NHS Foundation Trust	47.02	1st
RPA	Medway NHS Foundation Trust	47.28	1st
RXQ	Buckinghamshire Healthcare NHS Trust	47.44	1st
RJL	Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	48.33	1st
RXW	Shrewsbury And Telford Hospital NHS Trust	48.35	1st
RCX	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	49.59	1st
RVY	Southport And Ormskirk Hospital NHS Trust	50.67	1st
RW6	Pennine Acute Hospitals NHS Trust	50.89	1st
RFR	The Rotherham NHS Foundation Trust	51.17	1st
RA3	Weston Area Health NHS Trust	51.24	1st
RXC	East Sussex Healthcare NHS Trust	51.35	1st
RXR	East Lancashire Hospitals NHS Trust	51.49	1st
R1F1	Isle of Wight NHS Primary Care Trust (acute sector)	52.47	1st
RWA	Hull And East Yorkshire Hospitals NHS Trust	52.59	1st
RNQ	Kettering General Hospital NHS Foundation Trust	52.76	1st
RF4	Barking, Havering And Redbridge University Hospitals NHS Trust	53.31	1st
RLQ	Wye Valley NHS Trust	53.46	1st
R1H	Barts Health NHS Trust	53.55	1st
RMP	Tameside Hospital NHS Foundation Trust	54.26	1st
RBK	Walsall Healthcare NHS Trust	55.50	1st
RTX	University Hospitals of Morecambe Bay NHS Foundation Trust	55.63	1st
RTE	Gloucestershire Hospitals NHS Foundation Trust	55.76	1st
RR1	Heart of England NHS Foundation Trust	55.81	1st
RLT	George Eliot Hospital NHS Trust	55.97	1st
RNS	Northampton General Hospital NHS Trust	56.16	1st
RWG	West Hertfordshire Hospitals NHS Trust	56.57	1st
RVV	East Kent Hospitals University NHS Foundation Trust	56.83	1st
RXP	County Durham and Darlington NHS Foundation Trust	56.88	1st
RXH	Brighton And Sussex University Hospitals NHS Trust	56.92	1st
RVW	North Tees and Hartlepool NHS Foundation Trust	57.21	1st
RWE	University Hospitals Of Leicester NHS Trust	57.33	1st
RDD	Basildon and Thurrock University Hospitals NHS Foundation Trust	57.36	1st
RMC	Bolton NHS Foundation Trust	57.41	1st
RR8	Leeds Teaching Hospitals NHS Trust	57.77	1st
RFW	West Middlesex University Hospital NHS Trust	57.96	1st
RVL	Barnet And Chase Farm Hospitals NHS Trust	58.07	2nd
RAP	North Middlesex University Hospital NHS Trust	58.28	2nd
RDE	Colchester Hospital University NHS Foundation Trust	58.45	2nd
RXK	Sandwell And West Birmingham Hospitals NHS Trust	59.02	2nd
RP5	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	59.17	2nd
RLN	City Hospitals Sunderland NHS Foundation Trust	59.26	2nd
RD8	Milton Keynes Hospital NHS Foundation Trust	59.26	2nd
RQQ	Hinchingbrooke Health Care NHS Trust	59.32	2nd
RJF	Burton Hospitals NHS Foundation Trust	59.81	2nd
RBL	Wirral University Teaching Hospital NHS Foundation Trust	59.85	2nd
RHU	Portsmouth Hospitals NHS Trust	59.89	2nd
RN3	Great Western Hospitals NHS Foundation Trust	60.40	2nd
RJN	East Cheshire NHS Trust	60.53	2nd
RGQ	Ipswich Hospital NHS Trust	60.93	2nd
RCB	York Teaching Hospital NHS Foundation Trust	61.09	2nd
RFS	Chesterfield Royal Hospital NHS Foundation Trust	61.23	2nd
RVJ	North Bristol NHS Trust	61.29	2nd
RAS	The Hillingdon Hospitals NHS Foundation Trust	61.32	2nd
RWP	Worcestershire Acute Hospitals NHS Trust	61.52	2nd
RC3	Ealing Hospital NHS Trust	61.69	2nd
RTK	Ashford and St Peter's Hospitals NHS Foundation Trust	62.19	2nd
RQ8	Mid Essex Hospital Services NHS Trust	62.20	2nd
RXL	Blackpool Teaching Hospitals NHS Foundation Trust	62.39	2nd
RKB	University Hospitals Coventry And Warwickshire NHS Trust	62.42	2nd
RAX	Kingston Hospital NHS Trust	62.47	2nd
RC1	Bedford Hospital NHS Trust	62.61	2nd
RK5	Sherwood forest Hospitals NHS Foundation Trust	63.07	2nd
RE9	South Tyneside NHS Foundation Trust	63.61	2nd
RKE	The Whittington Hospital NHS Trust	64.15	2nd
RXN	Lancashire Teaching Hospitals NHS Foundation Trust	64.35	2nd
RFF	Barnsley Hospital NHS Foundation Trust	64.44	2nd
RQW	The Princess Alexandra Hospital NHS Trust	64.47	2nd
RK9	Plymouth Hospitals NHS Trust	64.63	2nd
REM	Aintree University Hospital NHS Foundation Trust	64.73	2nd
RRF	Wrightington, Wigan and Leigh NHS Foundation Trust	64.91	2nd
RV8	North West London Hospitals NHS Trust	65.06	2nd
RWW	Warrington and Halton Hospitals NHS Foundation Trust	65.25	2nd
RWH	East And North Hertfordshire NHS Trust	65.33	2nd
RBD	Dorset County Hospital NHS Foundation Trust	65.95	2nd
RBT	Mid Cheshire Hospitals NHS Foundation Trust	66.08	2nd
RNA	The Dudley Group NHS Foundation Trust	66.26	3rd
RC9	Luton and Dunstable Hospital NHS Foundation Trust	66.74	3rd
RW3	Central Manchester University Hospitals NHS Foundation Trust	66.85	3rd
RAJ	Southend University Hospital NHS Foundation Trust	67.37	3rd
REP	Liverpool Women's NHS Foundation Trust	67.43	3rd
RGP	James Paget University Hospitals NHS Foundation Trust	67.43	3rd
RBZ	Northern Devon Healthcare NHS Trust	67.58	3rd
RVR	Epsom And St Helier University Hospitals NHS Trust	67.59	3rd

Merseyside Providers

Ref	Provider	Score (%)	Quartile
RVY	Southport And Ormskirk Hospital NHS Trust	50.67	1st
REM	Aintree University Hospital NHS Foundation Trust	64.73	2nd
RWW	Warrington and Halton Hospitals NHS Foundation Trust	65.25	2nd
REP	Liverpool Women's NHS Foundation Trust	67.43	3rd
RQ6	Royal Liverpool And Broadgreen University Hospitals NHS Trust	71.38	3rd
RBN	St Helens And Knowsley Hospitals NHS Trust	77.41	4th
RET	The Walton Centre NHS Foundation Trust	84.59	4th
RBQ	Liverpool Heart and Chest NHS Foundation Trust	91.85	4th

Quartile	
Lower Quartile (25th)	58.123
Median Quartile (50th)	66.212
Upper Quartile (75th)	75.887

Average score for each quartile	
Average score for 1st quartile	52.057
Average score for 2nd quartile	62.017
Average score for 3rd quartile	70.569
Average score for 4th quartile	83.781

Trusts in the 4th quartile are the top performers

2013 NHS Staff Survey - Friends and Family Question

% to strongly agree / agree with the Q12d. 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'

All providers_Acute and Specialist Acute Providers

Ref	Provider	Score (%)	Quartile
RJE	University Hospital Of North Staffordshire NHS Trust	67.75	3rd
RWY	Calderdale and Huddersfield NHS Foundation Trust	67.84	3rd
RA4	Yeovil District Hospital NHS Foundation Trust	68.00	3rd
RTP	Surrey And Sussex Healthcare NHS Trust	68.03	3rd
RGN	Peterborough and Stamford Hospitals NHS Foundation Trust	68.23	3rd
RJ7	St George's Healthcare NHS Trust	68.26	3rd
RWF	Maidstone And Tunbridge Wells NHS Trust	68.94	3rd
RTG	Derby Hospitals NHS Foundation Trust	69.04	3rd
RYJ	Imperial College Healthcare NHS Trust	69.08	3rd
RR7	Gateshead Health NHS Foundation Trust	69.70	3rd
RD1	Royal United Hospital Bath NHS Trust	69.96	3rd
RJ2	Lewisham Healthcare NHS Trust	70.79	3rd
RAE	Bradford Teaching Hospitals NHS Foundation Trust	70.87	3rd
RHM	University Hospital Southampton NHS Foundation Trust	71.22	3rd
RN5	Hampshire Hospitals NHS Foundation Trust	71.26	3rd
RDZ	The Royal Bournemouth and Christchurch Hospitals NHS Foundation T	71.37	3rd
RQ6	Royal Liverpool And Broadgreen University Hospitals NHS Trust	71.38	3rd
RL4	The Royal Wolverhampton Hospitals NHS Trust	71.77	3rd
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust	72.18	3rd
RX1	Nottingham University Hospitals NHS Trust	72.32	3rd
RJR	Countess of Chester Hospital NHS Foundation Trust	72.44	3rd
RWJ	Stockport NHS Foundation Trust	72.52	3rd
RYR	Western Sussex Hospitals NHS Trust	72.74	3rd
RCF	Airedale NHS Foundation Trust	72.77	3rd
RJD	Mid Staffordshire NHS Foundation Trust	73.10	3rd
RD3	Poole Hospital NHS Foundation Trust	73.92	3rd
RHW	Royal Berkshire NHS Foundation Trust	74.12	3rd
RA7	University Hospitals Bristol NHS Foundation Trust	74.13	3rd
RA2	Royal Surrey County Hospital NHS Foundation Trust	75.00	3rd
RM1	Norfolk and Norwich University Hospitals NHS Foundation Trust	75.29	3rd
RQX	Homerton University Hospital NHS Foundation Trust	75.72	3rd
RTR	South Tees Hospitals NHS Foundation Trust	75.80	3rd
RLU	Birmingham Women's NHS Foundation Trust	75.92	4th
RAL	Royal Free London NHS Foundation Trust	76.24	4th
RTH	Oxford University Hospitals NHS Trust	76.42	4th
RN7	Dartford And Gravesham NHS Trust	76.79	4th
RCD	Harrogate and District NHS Foundation Trust	77.21	4th
RJC	South Warwickshire NHS Foundation Trust	77.36	4th
RBN	St Helens And Knowsley Hospitals NHS Trust	77.41	4th
RTF	Northumbria Healthcare NHS Foundation Trust	77.46	4th
RGR	West Suffolk NHS Foundation Trust	77.56	4th
RBS	Alder Hey Children's NHS Foundation Trust	77.83	4th
RH8	Royal Devon and Exeter NHS Foundation Trust	77.89	4th
RJZ	King's College Hospital NHS Foundation Trust	78.25	4th
RBA	Taunton and Somerset NHS Foundation Trust	78.42	4th
RM2	University Hospital of South Manchester NHS Foundation Trust	80.84	4th
RRK	University Hospitals Birmingham NHS Foundation Trust	81.76	4th
RNZ	Salisbury NHS Foundation Trust	81.82	4th
RA9	South Devon Healthcare NHS Foundation Trust	81.89	4th
RRJ	The Royal Orthopaedic Hospital NHS Foundation Trust	82.45	4th
RCU	Sheffield Children's NHS Foundation Trust	82.69	4th
RGT	Cambridge University Hospitals NHS Foundation Trust	83.10	4th
RRV	University College London Hospitals NHS Foundation Trust	83.41	4th
RQ3	Birmingham Children's Hospital NHS Foundation Trust	84.16	4th
RET	The Walton Centre NHS Foundation Trust	84.59	4th
RQM	Chelsea and Westminster Hospital NHS Foundation Trust	84.79	4th
RDU	Frimley Park Hospital NHS Foundation Trust	85.00	4th
RP4	Great Ormond Street Hospital for Children NHS Foundation Trust	86.59	4th
RJ1	Guy's and St Thomas' NHS Foundation Trust	86.63	4th
RPY	The Royal Marsden NHS Foundation Trust	86.65	4th
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	87.41	4th
RL1	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundati	88.29	4th
RM3	Salford Royal NHS Foundation Trust	88.51	4th
RBB	Royal National Hospital for Rheumatic Diseases NHS Foundation Trust	89.27	4th
RAN	Royal National Orthopaedic Hospital NHS Trust	89.61	4th
RBV	The Christie NHS Foundation Trust	89.80	4th
RBQ	Liverpool Heart and Chest NHS Foundation Trust	91.85	4th
REN	The Clatterbridge Cancer Centre NHS Foundation Trust	92.22	4th
RP6	Moorfields Eye Hospital NHS Foundation Trust	92.29	4th
RT3	Royal Brompton and Harefield NHS Foundation Trust	93.29	4th
RPC	Queen Victoria Hospital NHS Foundation Trust	93.67	4th
RGM	Papworth Hospital NHS Foundation Trust	93.92	4th

Merseyside Providers

Ref	Provider	Score (%)	Quartile

2013 Results due to be published during April 2014

Measure: National Inpatient Survey
CQUIN Scheme: No
Threshold: Comparison to previous year
Description: Results across North West SHA for the survey Inpatient 2012/13

Key	Compared to previous year
☺	Improvement in patients satisfaction
😐	Similar experience reported
☹	Reduction in patients satisfaction

Key	Compared to England Average
	Higher score
	Similar score (Within 2 points)
	Lower score

National Inpatient Survey	Overall score			Access & waiting			Safe high quality coordinated care			Better information more choice			Building closer relationships			clean comfortable friendly place to be		
	2011/12	2012/13		2011/12	2012/13		2011/12	2012/13		2011/12	2012/13		2011/12	2012/13		2011/12	2012/13	
England Average		76.5			84.3			65.4			68.2			84.6			79.8	
SHA average		77.4			84.6			67.0			68.9			85.5			81.0	
Aintree University Hospitals NHS Foundation Trust	77.5	76.7	😐	86.2	82.4	☹	67.6	67.7	☺	68.0	68.7	☺	84.7	84.6	😐	80.8	80.3	😐
Clatterbridge Centre for Oncology NHS Foundation Trust	86.7	87.2	☺	95.2	95.4	☺	77.7	76.6	😐	82.5	83.6	☺	91.0	92.1	☺	87.2	88.3	☺
Countess Of Chester Hospital NHS Foundation Trust	74.4	76.8	☺	80.0	83.7	☺	64.9	66.0	☺	64.8	69.3	☺	83.1	84.4	☺	79.2	80.5	☺
East Cheshire NHS Trust	76.6	74.8	☹	87.0	83.4	☹	65.0	65.1	😐	66.6	63.3	☹	84.9	82.8	☹	79.5	79.4	😐
Liverpool Heart & Chest Hospital NHS Trust	84.6	83.2	😐	94.1	89.8	☹	74.1	73.7	😐	77.5	75.4	☹	89.5	90.8	☺	87.8	86.4	😐
Liverpool Womens Hospital NHS Foundation Trust	82.3	83.3	☺	90.0	89.8	😐	72.0	76.1	☺	73.9	78.4	☺	89.9	88.7	😐	85.6	83.8	☹
Warrington and Halton Hospitals NHS Foundation Trust	73.8	74.5	☺	77.6	76.3	😐	66.5	65.7	😐	64.2	68.6	☺	83.0	85.1	☺	77.6	76.9	☹
Royal Liverpool and Broadgreen University Hospitals NHS Trust	77.0	79.1	☺	83.0	86.2	☺	67.4	68.2	☺	69.2	71.7	☺	85.2	87.5	☺	80.0	81.9	☺
Southport and Ormskirk Hospital NHS Trust	75.9	74.1	😐	85.6	82.2	☹	66.9	64.4	☹	63.9	62.0	😐	84.8	84.7	😐	78.2	77.0	☹
St Helens and Knowsley Hospitals NHS Trust	75.9	76.3	☺	80.3	83.3	☺	65.0	63.4	☹	67.8	67.1	😐	84.1	85.8	😐	82.4	82.2	😐
The Mid Cheshire Hospitals NHS Trust	73.5	73.9	😐	82.3	82.3	😐	59.7	62.4	☺	64.3	64.8	😐	82.4	83.4	😐	78.8	76.9	☹
Walton Centre for Neurology and Neurosurgery NHS Trust	80.4	79.8	😐	84.4	86.8	☺	69.9	70.3	😐	73.3	68.9	☹	88.1	88.0	😐	86.1	85.0	😐
Wirral University Teaching Hospital NHS Foundation Trust	76.0	78.7	☺	84.1	85.6	☺	67.1	68.4	☺	66.8	70.2	☺	82.1	86.6	☺	79.9	82.6	☺

Indicator: CQC Compliance of standards.

Detail: The results of CQCs most recent checks showing whether the care service is meeting each of the standards that the governement says the public have the rig

✓	**Compliant**
✖	**Not Compliant (Actions requiring improvement)**
✖	**Not Compliant (Enforcement Action Taken)**

	Treating people with respect and involving them in their care	Providing care, treatment and support that meets people's needs	Caring for people safely and protecting them from harm	Staffing	Quality and suitability of management	Latest Inspection	Report Available to CCG
	✓	✖	✓	✓	✖	29.09.2013	Yes
Royal Liverpool & Broadgreen Hospital	✓	✓	✓	✓	✓	28.11.2013	Yes
Liverpool Heart & Chest Hospital	✓	✓	✖	✓	✓	16.10.2013 - Under review	Yes
Liverpool Women's Hospital	✓	✖	✓	✖	✓	08.07.2014	Yes
Alder Hey Childrens Hospital	✓	✖	✓	✖	✖	02.12.2013	Yes
Mersey Care NHS Trust (Ashworth Hospital)	✓	✓	✓	✓	✓	24.05.2013	Yes
Liverpool Community Health (HQ Wilkinson Place)	✓	✖	✖	✖	✖	02.12.2013	Yes
Spire Liverpool	✓	✓	✓	✓	✓	22.11.2013	Yes

Measure: Patient Safety Alerts ongoing passed deadline date
Threshold: Amber 1 - 4 alerts ongoing passed deadline date, Red 5+ alerst ongoing passed deadline date
Latest Data: Apr-14
Datasource: NHS England

Trust name	Alert title	Alert reference	Issue date	Completion deadline date	Completed Within Deadline	Current Status
AUH	Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors	NPSA/2011/RRR003	28-Nov-11	Apr-12	N	ONGOING
AHCH	Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors	NPSA/2011/RRR003	28-Nov-11	Apr-12	N	ONGOING
AHCH	Window restrictors	EFA/2013/002	23-Jan-13	May-13	N	ONGOING
LWH	Electrosurgical devices.CUSA CEM™ nosecones for use with the CUSA® Excel/Excel+ ultrasonic aspirator.Product codes: C6623 and C6636.Manufactured by Integra Lifesciences.	MDA/2014/006	26-Feb-14	Mar-14	N	ACKNOWLEDGED
LWH	High Voltage Hazard Alert - National Equipment Defect Report (NEDeR) - Areva T&D Automation & Information Services - P122 protection relay	EFN/2014/05	21-Feb-14	Mar-14	N	ACKNOWLEDGED
LWH	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - UPDATE - Hawker Siddeley - URV12 Circuit Breaker	EFN/2014/08	26-Feb-14	Mar-14	N	ACKNOWLEDGED
LWH	High Voltage Hazard Alert - SUSPENSION OF OPERATIONAL PRACTICE (SOP) - UPDATE - Long & Crawford GF3T Fuse Switch	EFN/2014/09	27-Feb-14	Mar-14	N	ASSESSING RELEVANCE

Measure: Time taken from HAS notification to clinical handover (Assumed ACUTE responsibiility)

Handover <15 Minutes. Time taken from HAS notification to clinical handover (Assumed ACUTE responsibiility)

Provider	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Royal Liverpool and Broadgreen Hospital	00:08:31	00:06:37	00:06:08	00:06:26	00:06:05	00:08:13	00:07:49	00:08:43	00:09:04	00:09:34	00:09:32	00:09:48
Alder Hey Childrens Hospital	00:02:56	00:02:38	00:02:38	00:02:42	00:02:17	00:02:01	00:02:13	00:02:40	00:02:37	00:03:00	00:02:29	00:03:14
Aintree University Hospital	00:14:34	00:09:31	00:09:06	00:10:07	00:09:52	00:09:25	00:11:32	00:12:52	00:10:25	00:11:50	00:11:36	00:10:27
Southport and Ormskirk Hospital	00:32:27	00:15:24	00:17:20	00:14:36	00:15:57	00:16:23	00:17:00	00:14:17	00:13:49	00:11:44	00:11:36	00:13:36
St Helens and Knowsley Hospital	00:10:30	00:08:42	00:08:24	00:08:49	00:08:05	00:09:26	00:09:36	00:11:00	00:12:30	00:14:45	00:11:21	00:10:07
Warrington and Halton Hospital	00:07:24	00:07:06	00:06:59	00:06:58	00:07:54	00:09:04	00:09:21	00:09:22	00:08:20	00:09:01	00:08:17	00:08:29

Patients waiting between 30-60 Minutes for handover

Provider		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Royal Liverpool and Broadgreen Hospital	Activity	48	19	14	9	12	48	42	47	54	49	68	79
	Finance	*£9,600*	*£3,800*	*£2,800*	*£1,800*	*£2,400*	*£9,600*	*£8,400*	*£9,400*	*£10,800*	*£9,800*	*£13,600*	*£15,800*
Alder Hey Childrens Hospital	Activity	0	1	2	0	0	1	0	0	2	5	0	0
	Finance	*£0*	*£200*	*£400*	*£0*	*£0*	*£200*	*£0*	*£0*	*£400*	*£1,000*	*£0*	*£0*
Aintree University Hospital	Activity	112	36	55	56	44	37	89	125	61	90	86	61
	Finance	*£22,400*	*£7,200*	*£11,000*	*£11,200*	*£8,800*	*£7,400*	*£17,800*	*£25,000*	*£12,200*	*£18,000*	*£17,200*	*£12,200*
Southport and Ormskirk Hospital	Activity	70	50	62	60	73	73	87	68	65	40	31	45
	Finance	*£14,000*	*£10,000*	*£12,400*	*£12,000*	*£14,600*	*£14,600*	*£17,400*	*£13,600*	*£13,000*	*£8,000*	*£6,200*	*£9,000*
St Helens and Knowsley Hospital	Activity	53	57	30	60	23	49	70	79	148	183	116	83
	Finance	*£10,600*	*£11,400*	*£6,000*	*£12,000*	*£4,600*	*£9,800*	*£14,000*	*£15,800*	*£29,600*	*£36,600*	*£23,200*	*£16,600*
Warrington and Halton Hospital	Activity	19	12	7	13	21	31	33	41	19	23	23	30
	Finance	*£3,800*	*£2,400*	*£1,400*	*£2,600*	*£4,200*	*£6,200*	*£6,600*	*£8,200*	*£3,800*	*£4,600*	*£4,600*	*£6,000*

Patients waiting over 60 Minutes for handover

Provider		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Royal Liverpool and Broadgreen Hospital	Activity	4	0	0	1	1	5	3	6	5	7	5	10
	Finance	*£4,000*	*£0*	*£0*	*£1,000*	*£1,000*	*£5,000*	*£3,000*	*£6,000*	*£5,000*	*£7,000*	*£5,000*	*£10,000*
Alder Hey Childrens Hospital	Activity	0	0	0	0	0	0	0	0	0	0	0	0
	Finance	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*
Aintree University Hospital	Activity	91	19	11	22	4	4	26	48	23	29	9	7
	Finance	*£91,000*	*£19,000*	*£11,000*	*£22,000*	*£4,000*	*£4,000*	*£26,000*	*£48,000*	*£23,000*	*£29,000*	*£9,000*	*£7,000*
Southport and Ormskirk Hospital	Activity	101	13	28	8	24	18	20	20	16	9	10	18
	Finance	*£101,000*	*£13,000*	*£28,000*	*£8,000*	*£24,000*	*£18,000*	*£20,000*	*£20,000*	*£16,000*	*£9,000*	*£10,000*	*£18,000*
St Helens and Knowsley Hospital	Activity	2	8	2	2	0	7	3	16	12	34	18	18
	Finance	*£2,000*	*£8,000*	*£2,000*	*£2,000*	*£0*	*£7,000*	*£3,000*	*£16,000*	*£12,000*	*£34,000*	*£18,000*	*£18,000*
Warrington and Halton Hospital	Activity	0	0	0	5	1	3	2	6	1	4	1	3
	Finance	*£0*	*£0*	*£0*	*£5,000*	*£1,000*	*£3,000*	*£2,000*	*£6,000*	*£1,000*	*£4,000*	*£1,000*	*£3,000*

Compliance with Recording Patient Handover between Ambulance and A&E

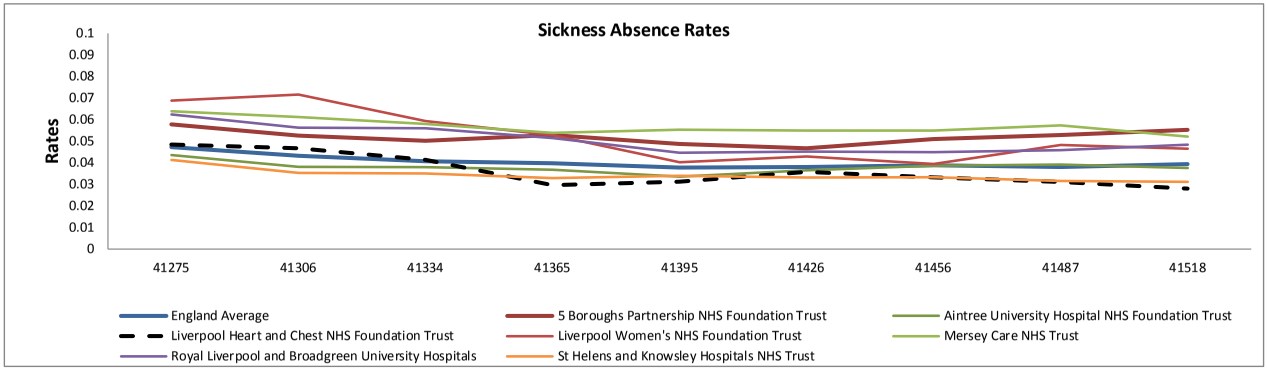
Provider	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Royal Liverpool and Broadgreen Hospital	73.90%	79.20%	82.56%	82.20%	78.90%	73.54%	69.66%	70.46%	70.70%	68.14%	71.50%	81.60%
Alder Hey Childrens Hospital	67.50%	71.60%	79.63%	72.80%	79.20%	77.60%	83.91%	85.42%	81.50%	83.82%	81.40%	85.70%
Aintree University Hospital	77.50%	73.80%	83.10%	77.00%	75.10%	71.80%	74.54%	84.44%	85.60%	83.06%	81.40%	84.50%
Southport and Ormskirk Hospital	51.30%	61.10%	66.70%	74.50%	75.20%	74.00%	76.60%	86.43%	90.20%	91.83%	92.00%	90.40%
St Helens and Knowsley Hospital	56.00%	73.60%	77.00%	75.10%	75.00%	72.20%	74.40%	73.96%	70.90%	71.14%	81.50%	86.50%
Warrington and Halton Hospital	74.80%	77.00%	78.70%	69.80%	62.00%	62.00%	69.60%	70.74%	73.40%	74.62%	79.80%	85.80%

Measure: Sickness Absence Rates
Threshold: National Average
Latest data: Q2 13/14

Green = Rates lower than england average and improvement compared to previous year
Amber = Latest performance lower than england average but is an increase compared to previous year
Red = Latest performance lower than england average and an increase compared to previous year

Monthly Performance

Trust	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13
England Average	**4.72%**	**4.33%**	**4.08%**	**3.98%**	**3.79%**	**3.80%**	**3.88%**	**3.81%**	**3.94%**	**4.18%**
5 Boroughs Partnership NHS Foundation Trust	5.78%	5.25%	5.02%	5.29%	4.87%	4.67%	5.10%	5.29%	5.53%	5.76%
Aintree University Hospital NHS Foundation Trust	4.36%	3.81%	3.80%	3.67%	3.36%	3.65%	3.87%	3.91%	3.76%	4.05%
Alder Hey Children's NHS Foundation Trust	7.19%	5.23%	5.06%	4.74%	4.56%	4.60%	4.68%	4.50%	4.90%	4.47%
Bridgewater Community Healthcare NHS Trust	5.78%	5.33%	4.63%	4.74%	4.81%	4.73%	4.98%	4.83%	5.12%	4.95%
Liverpool Community Health NHS Trust	7.04%	6.20%	5.65%	5.82%	5.82%	5.90%	5.24%	4.97%	4.95%	5.49%
Liverpool Heart and Chest NHS Foundation Trust	4.85%	4.67%	4.14%	2.97%	3.12%	3.58%	3.32%	3.11%	2.81%	3.63%
Liverpool Women's NHS Foundation Trust	6.89%	7.17%	5.94%	5.28%	4.03%	4.29%	3.94%	4.83%	4.66%	4.54%
Mersey Care NHS Trust	6.38%	6.12%	5.80%	5.39%	5.54%	5.50%	5.49%	5.74%	5.21%	5.20%
Royal Liverpool and Broadgreen University Hospitals	6.24%	5.62%	5.61%	5.15%	4.46%	4.53%	4.49%	4.59%	4.84%	4.91%
Southport and Ormskirk Hospital NHS Trust	4.99%	4.94%	4.60%	4.66%	3.96%	3.99%	3.91%	3.68%	3.58%	4.05%
St Helens and Knowsley Hospitals NHS Trust	4.13%	3.53%	3.50%	3.30%	3.39%	3.31%	3.34%	3.16%	3.11%	3.61%
Walton Centre NHS Foundation Trust	4.04%	3.24%	3.71%	3.33%	3.88%	3.64%	4.10%	4.04%	4.56%	4.46%
Warrington and Halton Hospitals NHS Foundation	4.58%	4.40%	4.22%	4.35%	4.10%	3.91%	3.76%	3.85%	3.88%	4.04%

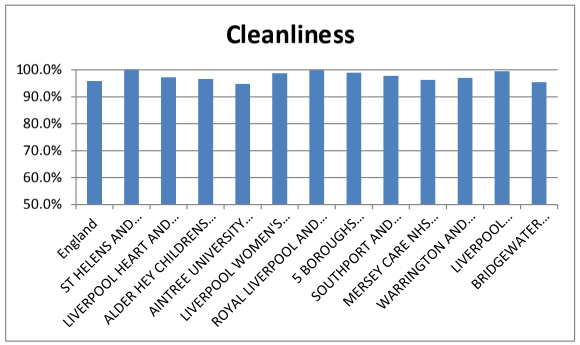


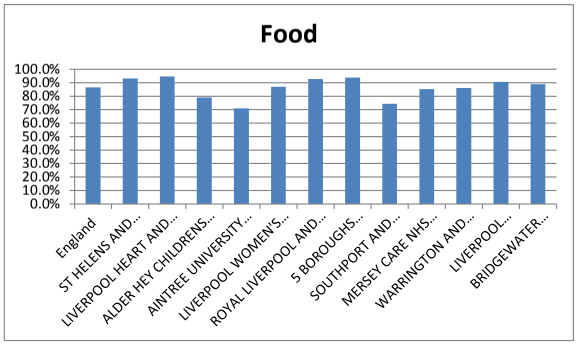
Quarterly Performance

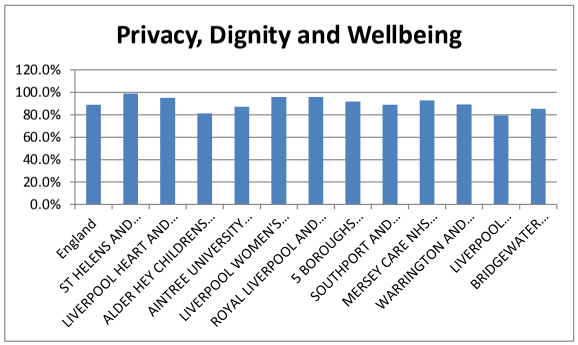
	Q1 12/13	Q2 12/13	Q3 12/14	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14
Engalnd Average	4.02%	4.06%	4.50%	4.38%	3.85%	3.83%	4.12%
5 Boroughs Partnership NHS Foundation Trust	4.52%	5.27%	5.13%	5.35%	4.94%	5.02%	5.69%
Aintree University Hospital NHS Foundation Trust	4.32%	4.18%	4.30%	3.99%	3.56%	3.81%	4.06%
Alder Hey Children's NHS Foundation Trust	4.68%	4.63%	6.56%	5.83%	4.63%	4.59%	4.75%
Bridgewater Community Healthcare NHS Trust	5.01%	4.73%	5.64%	5.25%	4.76%	4.84%	5.05%
Liverpool Community Health NHS Trust	5.37%	5.52%	6.31%	6.30%	5.85%	5.37%	5.53%
Liverpool Heart and Chest NHS Foundation Trust	3.51%	4.09%	4.94%	4.55%	3.22%	3.34%	3.41%
Liverpool Women's NHS Foundation Trust	4.03%	4.16%	6.10%	6.66%	4.53%	4.35%	4.52%
Mersey Care NHS Trust	5.65%	5.72%	6.01%	6.10%	5.48%	5.58%	5.40%
Royal Liverpool and Broadgreen University Hospitals	4.88%	5.09%	6.24%	5.82%	4.71%	4.53%	4.99%
Southport and Ormskirk Hospital NHS Trust	4.49%	4.27%	4.73%	4.84%	4.20%	3.86%	3.84%
St Helens and Knowsley Hospitals NHS Trust	3.27%	3.34%	3.81%	3.72%	3.33%	3.27%	3.50%
Walton Centre NHS Foundation Trust	4.10%	3.81%	4.50%	3.66%	3.61%	3.93%	4.29%
Warrington and Halton Hospitals NHS Foundation	4.09%	4.11%	3.94%	4.40%	4.12%	3.84%	3.97%

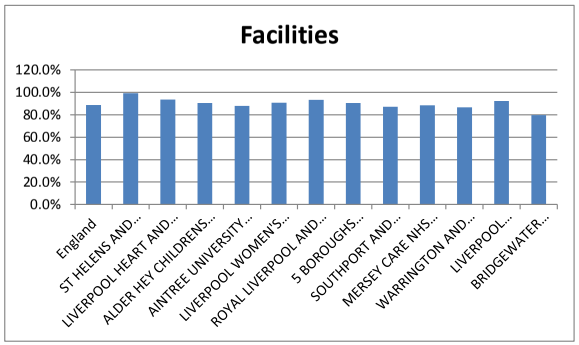
Measure: Patinet Lead Assessments of the Care Enviroment
Latest data available: 2013
Threshold: Compared to national average

Org Code	Organisation Name	Cleanliness	Food	Privacy, Dignity and Wellbeing	Facilities
	England	**95.9%**	**86.5%**	**89.1%**	**88.6%**
RBN	ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	100.0%	93.2%	99.1%	99.4%
RBQ	LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	97.3%	94.7%	95.1%	93.5%
RBS	ALDER HEY CHILDRENS NHS FOUNDATION TRUST	96.5%	79.0%	81.3%	90.5%
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	94.7%	70.9%	87.3%	87.8%
REP	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	98.7%	87.0%	96.0%	90.7%
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	99.9%	92.8%	95.8%	93.2%
RTV	5 BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST	98.9%	93.9%	91.9%	90.4%
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	97.7%	74.3%	89.0%	87.2%
RW4	MERSEY CARE NHS TRUST	96.3%	85.2%	92.8%	88.5%
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	97.1%	86.0%	89.2%	86.6%
RY1	LIVERPOOL COMMUNITY HEALTH NHS TRUST	99.5%	90.7%	79.3%	92.4%
RY2	BRIDGEWATER COMMUNITY HEALTHCARE NHS TRUST	95.4%	89.0%	85.3%	79.7%









Indicator National Health Service Litigation Authority
Datasource: http://www.nhsla.com/Publications/
Threshold: Level indicated that organisation was successfully assessed at, at the time of their most recent assessment.
Monitored against Governance, Competent worksforce,Safe Enviroment, Clinical Care and learning from experience

All the NHSLA Standards are divided into three "levels": one, two and three. NHS organisations which achieve success at level one in the relevant standards receive a 10% discount on their CNST and RPST contributions, with discounts of 20% and 30% available to those passing the higher levels. The CNST Maternity Standards are also divided into three levels and organisations successful at assessment receive a discount of 10%, 20% or 30% from the maternity portion of their CNST contribution.

Organisations at level 1 are assessed against the relevant standard(s) once every two years and those at levels 2 and 3 at least once in any three year period, although organisations may request an earlier assessment if they wish to move up a level. Organisations that drop to Level 0 or fail to attain Level 1 will be placed under improvement measures and must undertake a Level 1 assessment within six months of the date of their unsuccessful assessment. Organisations which fail an assessment and fall to Level 1 or 2 are required to be assessed at the level assigned in the following financial year.

	Aintree University Hospital	Alder Hey Childrens Hospital	Liverpool Heart & Chest Hospital	Liverpool Womens Hospital	Royal Liverpool & Broadgreen Hospital	Southport & Ormskirk Hospital	St Helens & Knowsley Hospital	The Walton Centre	Mersey Care NHS Trust	5Boroughs	Bridgewater	Liverpool Community	Warrington & Halton Hospital
Date of Assessment	Jun-09	Feb-10	Jun-10	May-11	Oct-11	Feb-10	Dec-08	Oct-10	Jan-11	Dec-11	New Organisation	Feb-11	Nov-11
Score	46/50	40/50	43/50	42/50	42/50	40/50	46/50	49/50	48/50	50/50		47/50	50/50
Level Achieved	3	3	3	3	2	2	2	1	1	1		1	1

Reports checked on 25/10/2012

Date of Assessment	Jun-12						Mar-12				Jun-12		
Score	44/50						47/50				46/50		
Level Achieved	3						2				1		

Friends and Family
Response Rates

Providers will need to achieve a baseline response rate of at least 15% and by Q4 a response rate that is both (a) higher than the response rate for Q1 and (b) 20% or over. A single response rate for each provider will be calculated by combining the response rates from the A&E and acute inpatient areas.

Combined	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	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average	10.9%	13.2%	15.9%	16.1%	17.1%	18.6%	19.6%	20.90%	19.90%	22.2%	24.0%	24.0%		13.3%	17.3%	20.1%	23.4%
Countess Of Chester Hospital NHS Foundation Trust	6.7%	8.1%	23.8%	23.2%	28.1%	39.3%	20.3%	23.8%	23.3%	20.8%	21.4%	22.3%		12.9%	30.2%	22.5%	21.5%
East Cheshire NHS Trust	11.2%	23.5%	24.4%	21.7%	22.9%	32.4%	26.0%	26.4%	25.6%	26.7%	24.9%	22.6%		19.7%	25.7%	26.0%	24.7%
Mid Cheshire Hospitals NHS Foundation Trust	17.4%	21.2%	21.4%	20.3%	18.3%	15.4%	22.3%	21.3%	19.8%	26.4%	25.7%	24.7%		20.0%	18.0%	21.1%	25.6%
The Clatterbridge Cancer Centre NHS Foundation Trust	43.8%	36.3%	39.5%	54.0%	49.1%	51.0%	54.0%	56.1%	38.8%	49.4%	31.8%	53.8%		39.8%	51.4%	49.6%	45.0%
Warrington And Halton Hospitals NHS Foundation Trust	9.4%	8.4%	12.6%	13.5%	7.7%	27.4%	31.9%	24.9%	22.9%	22.8%	26.3%	21.9%		10.1%	16.2%	26.6%	23.7%
Wirral University Teaching Hospital NHS Foundation Trust	5.8%	8.1%	16.5%	14.8%	18.8%	21.7%	21.9%	23.5%	25.4%	24.4%	24.4%	25.2%		10.1%	18.4%	23.6%	24.7%
Aintree University Hospital NHS Foundation Trust	14.9%	17.3%	25.3%	24.6%	22.7%	26.4%	25.7%	16.3%	27.3%	29.7%	31.2%	32.3%		19.2%	24.5%	23.1%	31.1%
Liverpool Heart And Chest NHS Foundation Trust	42.4%	30.8%	31.3%	20.9%	35.4%	25.2%	30.0%	34.6%	22.9%	32.0%	35.0%	34.2%		34.8%	27.2%	29.2%	33.7%
Liverpool Women's NHS Foundation Trust	3.2%	1.3%	25.5%	21.9%	18.1%	18.3%	9.2%	11.2%	22.6%	34.2%	37.2%	31.2%		10.0%	19.4%	14.3%	34.2%
Royal Liverpool And Broadgreen University Hospitals NHS Trust	6.9%	5.9%	6.1%	8.3%	15.2%	14.2%	17.7%	14.8%	12.0%	15.1%	15.4%	9.8%		6.3%	12.6%	14.8%	13.4%
Southport And Ormskirk Hospital NHS Trust	16.5%	16.8%	17.8%	20.5%	20.5%	21.1%	22.9%	15.1%	17.5%	18.4%	18.2%	19.1%		17.0%	20.7%	18.5%	18.6%
St Helens And Knowsley Hospitals NHS Trust	9.3%	11.4%	17.2%	15.1%	19.4%	19.5%	19.4%	26.7%	13.9%	18.0%	20.8%	18.1%		12.6%	18.0%	20.0%	19.0%
The Walton Centre NHS Foundation Trust	21.6%	23.7%	17.8%	15.6%	23.5%	17.9%	17.3%	34.2%	20.2%	23.0%	29.3%	29.2%		21.1%	19.0%	23.9%	27.2%

Inpatient	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	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average	21.7%	24.4%	27.1%	27.8%	28.9%	29.4%	30.4%	31.5%	28.8%	31.0%	34.2%	34.8%		24.4%	28.7%	30.2%	33.3%
Countess Of Chester Hospital NHS Foundation Trust	24.0%	27.6%	44.4%	38.2%	44.9%	41.0%	36.0%	33.8%	47.1%	38.9%	34.6%	31.8%		32.0%	41.4%	39.0%	35.1%
East Cheshire NHS Trust	17.4%	20.4%	19.3%	22.0%	18.8%	48.4%	39.2%	30.8%	34.1%	33.4%	33.3%	26.1%		19.0%	29.7%	34.7%	30.9%
Mid Cheshire Hospitals NHS Foundation Trust	35.3%	31.1%	32.9%	32.8%	30.2%	25.5%	33.7%	42.4%	32.7%	39.3%	45.9%	42.3%		33.1%	29.5%	36.3%	42.5%
The Clatterbridge Cancer Centre NHS Foundation Trust	43.8%	36.3%	39.5%	54.0%	49.1%	51.0%	54.0%	56.1%	38.8%	49.4%	31.8%	53.8%		39.8%	51.4%	49.6%	45.0%
Warrington And Halton Hospitals NHS Foundation Trust	20.6%	18.6%	24.3%	25.0%	13.2%	31.6%	35.8%	29.5%	27.9%	29.5%	43.8%	27.5%		21.2%	23.3%	31.0%	33.6%
Wirral University Teaching Hospital NHS Foundation Trust	7.7%	11.9%	18.3%	17.1%	20.6%	24.7%	21.5%	21.4%	31.3%	21.3%	23.3%	30.1%		12.6%	20.8%	24.7%	24.9%
Aintree University Hospital NHS Foundation Trust	23.4%	31.4%	32.2%	30.5%	29.7%	32.6%	33.4%	31.2%	30.2%	39.0%	43.0%	42.7%		29.0%	30.9%	31.6%	41.6%
Liverpool Heart And Chest NHS Foundation Trust	42.4%	30.8%	31.3%	20.9%	35.4%	25.2%	30.0%	34.6%	22.9%	32.0%	35.0%	34.2%		34.8%	27.2%	29.2%	33.7%
Liverpool Women's NHS Foundation Trust	5.8%	0.8%	37.5%	26.1%	17.9%	19.1%	20.0%	20.8%	11.6%	27.4%	25.3%	24.3%		14.7%	21.1%	17.5%	25.7%
Royal Liverpool And Broadgreen University Hospitals NHS Trust	16.3%	19.2%	15.5%	20.9%	31.5%	25.9%	35.1%	24.9%	18.4%	26.0%	28.5%	21.2%		17.0%	26.1%	26.1%	25.2%
Southport And Ormskirk Hospital NHS Trust	23.2%	24.5%	27.0%	32.1%	34.3%	40.1%	45.3%	26.1%	21.4%	23.7%	31.0%	38.0%		24.9%	35.5%	30.9%	30.9%
St Helens And Knowsley Hospitals NHS Trust	19.9%	21.7%	29.4%	30.8%	33.8%	31.1%	34.0%	35.8%	23.9%	30.6%	36.7%	28.0%		23.7%	31.9%	31.3%	31.8%
The Walton Centre NHS Foundation Trust	21.6%	23.7%	17.8%	15.6%	23.5%	17.9%	17.3%	34.2%	20.2%	23.0%	29.3%	29.2%		21.1%	19.0%	23.9%	27.2%

A&E	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	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average	5.6%	7.5%	10.3%	10.4%	11.3%	13.2%	13.8%	15.2%	15.3%	17.4%	18.6%	18.5%		7.8%	11.6%	14.8%	18.2%
Countess Of Chester Hospital NHS Foundation Trust	0.8%	2.2%	17.1%	17.5%	21.9%	39%	14.9%	19.5%	13.4%	12.6%	15.9%	18.3%		6.7%	26.1%	16.0%	15.6%
East Cheshire NHS Trust	8.0%	25.0%	28.5%	21.6%	24.9%	25%	20.4%	24.1%	21.3%	23.0%	20.7%	21.1%		20.5%	23.7%	21.9%	21.6%
Mid Cheshire Hospitals NHS Foundation Trust	11.4%	17.4%	17.4%	16.2%	14.7%	12%	17.7%	14.2%	15.4%	21.4%	18.4%	18.1%		15.4%	14.3%	15.8%	19.3%
Warrington And Halton Hospitals NHS Foundation Trust	2.9%	1.9%	5.5%	6.4%	4.4%	25%	29.6%	21.8%	19.9%	18.7%	15.1%	18.5%		3.4%	11.9%	23.7%	17.4%
Wirral University Teaching Hospital NHS Foundation Trust	4.6%	5.9%	15.4%	13.5%	17.8%	20%	22.1%	25.1%	21.2%	27.0%	25.3%	21.6%		8.6%	17.1%	22.8%	24.6%
Aintree University Hospital NHS Foundation Trust	9.9%	9.9%	21.6%	21.3%	18.6%	23%	21.2%	8.5%	25.5%	24.2%	23.9%	26.4%		13.8%	20.9%	18.4%	24.8%
Liverpool Women's NHS Foundation Trust	2.4%	1.4%	21.8%	20.5%	18.2%	18%	6.0%	7.0%	27.8%	36.3%	42.3%	34.2%		8.5%	18.9%	13.6%	37.6%
Royal Liverpool And Broadgreen University Hospitals NHS Trust	3.4%	1.0%	2.5%	3.2%	9.4%	10%	12.0%	11.4%	9.5%	11.3%	10.7%	6.0%		2.3%	7.7%	11.0%	9.3%
Southport And Ormskirk Hospital NHS Trust	12.5%	12.1%	12.5%	14.2%	13.5%	11%	8.9%	8.8%	15.1%	15.0%	10.5%	8.8%		12.4%	12.8%	10.9%	11.4%
St Helens And Knowsley Hospitals NHS Trust	3.0%	5.3%	10.1%	6.5%	11.5%	13%	11.0%	21.2%	8.0%	10.8%	11.6%	12.5%		6.1%	10.5%	13.4%	11.6%

Friends and Family
Test Score

Increasing the score of the Friends and Family Test question within the 2013/14 staff survey compared with 2012/13 survey results or remaining in the top quartile of trusts.

Combined		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	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average	2012	63	65	64	64	65	63	64	65	64	65	64	63		64	64	64	64
Countess Of Chester Hospital NHS Foundation Trust	71	83	74	78	64	73	61	67	68	69	66	64	71		78	66	68	67
East Cheshire NHS Trust	60	67	64	65	59	56	65	61	66	65	66	64	58		65	60	64	63
Mid Cheshire Hospitals NHS Foundation Trust	61	63	69	68	67	61	61	67	67	65	67	67	68		67	63	66	67
The Clatterbridge Cancer Centre NHS Foundation Trust	93	93	95	84	90	86	91	89	84	86	97	89	93		91	89	86	93
Warrington And Halton Hospitals NHS Foundation Trust	58	76	73	73	70	58	60	63	58	53	60	69	62		74	63	58	64
Wirral University Teaching Hospital NHS Foundation Trust	58	45	31	44	33	40	34	55	49	58	75	81	78		40	36	54	78
Aintree University Hospital NHS Foundation Trust	67	69	66	57	55	60	59	59	66	57	64	60	58		64	58	61	61
Liverpool Heart And Chest NHS Foundation Trust	92	89	90	93	90	97	94	91	95	92	89	88	96		91	94	93	91
Liverpool Women's NHS Foundation Trust	62	85	14	59	69	65	85	79	84	81	79	80	88		53	73	81	82
Royal Liverpool And Broadgreen University Hospitals NHS Trust	66	60	59	48	51	49	41	44	49	51	54	50	54		56	47	48	53
Southport And Ormskirk Hospital NHS Trust	51	51	62	55	57	61	52	49	46	46	47	44	53		56	57	47	48
St Helens And Knowsley Hospitals NHS Trust	70	76	78	78	72	78	79	79	80	78	80	77	79		77	76	79	79
The Walton Centre NHS Foundation Trust	85	86	85	75	84	79	71	76	85	83	93	91	91		82	78	81	92

Inpatient		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	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average		71	72	72	71	72	72	72	73	72	73	73	73		72	72	72	73
Countess Of Chester Hospital NHS Foundation Trust		84	74	79	79	78	83	82	82	77	80	83	82		79	80	80	82
East Cheshire NHS Trust		68	76	77	80	87	77	77	78	77	73	79	82		74	81	77	76
Mid Cheshire Hospitals NHS Foundation Trust		69	75	75	76	71	68	77	74	75	68	76	73		73	72	75	72
The Clatterbridge Cancer Centre NHS Foundation Trust		93	95	84	90	86	91	89	84	86	97	89	93		91	89	86	93
Warrington And Halton Hospitals NHS Foundation Trust		80	76	80	76	76	77	82	75	71	78	81	79		79	76	76	80
Wirral University Teaching Hospital NHS Foundation Trust		77	66	57	52	66	59	68	71	67	67	69	65		67	59	69	68
Aintree University Hospital NHS Foundation Trust		82	76	80	75	76	78	80	76	76	83	81	80		79	76	77	82
Liverpool Heart And Chest NHS Foundation Trust		89	90	93	90	97	94	91	95	92	89	88	96		91	94	93	89
Liverpool Women's NHS Foundation Trust		93	100	61	66	90	77	81	88	90	82	78	89		85	78	86	80
Royal Liverpool And Broadgreen University Hospitals NHS Trust		57	63	52	51	54	51	52	65	67	62	57	63		57	52	61	60
Southport And Ormskirk Hospital NHS Trust		55	66	59	65	63	50	47	42	37	49	46	58		60	59	42	48
St Helens And Knowsley Hospitals NHS Trust		79	82	77	71	74	80	79	80	79	81	77	78		79	75	79	79
The Walton Centre NHS Foundation Trust		86	85	75	84	79	71	76	85	83	93	91	91		82	78	81	92

A&E		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	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average		49	55	54	54	56	52	55	56	56	57	55	54		53	54	56	55
Countess Of Chester Hospital NHS Foundation Trust		72	72	77	53	69	53	55	57	57	49	48	64		74	58	56	54
East Cheshire NHS Trust		66	59	59	49	45	54	49	58	56	60	53	46		61	49	54	53
Mid Cheshire Hospitals NHS Foundation Trust		57	65	64	60	55	56	58	59	58	66	59	63		62	57	58	63
Warrington And Halton Hospitals NHS Foundation Trust		63	52	54	56	20	46	48	42	35	42	45	39		56	41	42	42
Wirral University Teaching Hospital NHS Foundation Trust		10	-15	34	20	23	16	46	34	49	79	90	90		10	20	43	86
Aintree University Hospital NHS Foundation Trust		51	49	38	39	45	44	41	46	44	45	36	38		46	43	44	40
Liverpool Women's NHS Foundation Trust		79	0	58	70	56	88	76	77	80	79	80	87		46	71	78	82
Royal Liverpool And Broadgreen University Hospitals NHS Trust		64	27	37	51	43	34	37	38	39	47	43	42		43	43	38	44
Southport And Ormskirk Hospital NHS Trust		46	57	50	46	58	55	52	52	52	46	41	40		51	53	52	42
St Helens And Knowsley Hospitals NHS Trust		64	68	79	73	83	78	79	80	77	78	77	79		70	78	79	78

Measure: CQC Intelligent Monitoring Report
Data Source: CQC
Threshold: 1 = Highest Risk, 6 = Lowest Risk

CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. CQC judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

	Royal Liverpool Hospital	Liverpool Heart and Chest	Southport and Ormskirk Hospital	Warrington and Halton Hospital	Liverpool Womens Hospital	Alder Hey Childrens Hospital	St Helens and Knowsley Hospital	Aintree University Hospital
Has the banding improved or declined since the previous report?	Recently inspected (Previously scored 6)	Declined to 4 from 6	No Change (4)	Improved to 5 from 3	Improved to 6 from 3	No change (1)	Improved to 5 from 3	Recently inspected (Previously scored 1)
Within the latest CQC report (March 2014) Has the provider been identified as having any **Elevated Risks?**	2 areas	1 area	3 areas	1 area	1 area	3 areas	1 area	4 areas
Within the latest CQC report (March 2014) Has the provider been identified as having any **Risks?**	5 areas	2 areas	1 area	4 areas	1 area	5 areas	3 areas	3 areas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Monitor Financial and Risk Rating

Financial Risk Rating
1 = Highest risk - high probability of significant breach of authorisation in short-term
2 = Risk of significant breach in medium-term, e.g. 12 to 18 months, in absence of remedial action
3 = Regulatory concerns in one or more components. Significant breach unlikely
4 = No regulatory concerns
5 =Lowest risk - no regulatory concerns
Governance Risk Rating
Red = Likely or actual significant breach of terms of authorisation
Amber - Red = Material concerns surrounding terms of authorisation
Amber - Green = Limited concerns surrounding terms of authorisation
Green = No material concerns

Finanical risk

	5 Borough	AUH	AHCH	LHCH	LWH	W&HAL	Walton
Q2 12/13	4	3	4	3	4	3	4
Q3 12/13	4	3	5	3	4	3	4
Q4 12/13	4	3	5	3	3	3	3
Q1 13/14	4	3	4	3	3	2	4
Q2 13/14	4	3	4	3	3	2	4

Governance Risk

	5 Borough	AUH	AHCH	LHCH	LWH	W&HAL	Walton
Q2 12/13							
Q3 12/13							
Q4 12/13							
Q1 13/14							
Q2 13/14							

Aintree Hospital	Monitor has taken action, under the new licence for providers, to ensure that the trust deals with the continuing issues it faces. See the 'Regulatory action' tab for more details
W&Halton Hospital	Monitor is requesting further information following a financial risk rating of 2, before deciding next steps.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/71	**Author of the Paper:**
Report date: May 2014	James Bradley Head of Strategic Financial Planning James.bradley@southseftonccg.nhs.uk Tel 0151 247 7070

Title: Financial Performance Report Month 12 - 2013/14

Summary/Key Issues:

This paper presents the Governing Body with an overview of the financial position for NHS South Sefton Clinical Commissioning Group for the 2013/14 Financial Year.

Recommendation

The Governing Body is asked to receive the finance update.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives	
x	Improve the quality of commissioned services, whilst achieving financial balance.
x	Achieve a 1% reduction in non-elective admissions in 2014/2015.
x	Implementation of 2014/15 phase of Virtual Ward plan.
x	Review and re-specification of community nursing services for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014-15 phase of Primary Care quality Strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery

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
May 2014

1. Executive Summary

1.1 This report outlines a summary of the changes to the financial allocation of the CCG, and describes the financial performance of the CCG at month 12, reflecting the full 2013/14 financial year. At the end of the 2013/14, the CCG was £7.346m (Month 11 £5.493m) over-spent prior to the application of reserves.

1.2 The CCG has delivered its target surplus of £2.312m for 2013/14.

2. Introduction and Background

This paper presents the Governing Body with an overview of the financial position for NHS South Sefton Clinical Commissioning Group as at Month 12 and for the 2013/14 financial year.

3. Resource Allocation

The final Resource Allocation for 2013/14 is £226.151m. There have been no changes to Allocations since the Month 11 report.

4. Our Position to Date

4.1 Month 12 Financial Performance

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

Table A: Financial Performance: Summary report to 31 March 2014

	Annual & Year to date			
Budget Area	**Annual Budget**	**YTD Budget**	**YTD Actual**	**YTD Variance**
	£'000	**£'000**	**£'000**	**£'000**
NHS Commissioned Services	160,461	160,461	164,091	3,630
Corporate & Support Services	6,776	6,776	6,537	(239)
Independent Sector	1,902	1,902	2,829	927
Medicines Management (inc Prescribing)	28,890	28,890	29,025	135
Primary Care	2,117	2,117	2,559	442

Commissioning - Non NHS	16,347	16,347	18,798	2,451
SUBTOTAL PRIOR TO RESERVES	**216,493**	**216,493**	**223,839**	**7,346**
Total Reserves	7,346	7,346	0	(7,346)
GRAND TOTAL EXPENDITURE	**223,839**	**223,839**	**223,839**	**0**
RRL Allocation	(226,151)	(226,151)	(226,151)	0
(SURPLUS)/DEFICIT	**(2,312)**	**(2,312)**	**(2,312)**	**0**

Please note, allocations and underspends are shown in brackets.

Overview

The full year financial position before the application of reserves is an overspend of £7.346m (Month 11 (£5.493m), an increase of £1.853m from the previous month.

This position is an increase of £1.047m on the forecast outturn at Month 11 (£6.299m).

The key issues contributing to the position within operational budgets are described below. It should be noted that, with the application of reserves, the CCG delivered the required surplus for the financial year of £2.312m.

NHS Commissioned Services

This budget is showing a year-to-date position of £3.630m overspend, an increase on the Month 11 position (£3.414m), but £0.163m lower than the Month 11 forecast of £3.793m.

The main contributor to the overspend in Acute Commissioning is activity at Aintree University Hospital NHS FT (AUH), £3.086m over budget. A Year End Settlement Agreement has been agreed with the Trust which was based on month 10 forecast outturn with deductions for CQUIN breaches (£0.211m) and financial penalties (£0.098m). The month 10 forecast outturn showed overspends within day cases (£1.082m), elective activity (£0.763m), outpatients (£0.395m) and High Cost Drugs (£0.357m). Emergency admissions were subject to a block arrangement, but were showing an under-spend of £1.319m. Accident and Emergency attendances are also lower than contracted levels (£0.203m).

There are also overspends on Any Qualified Provider (AQP) audiology and physiotherapy services at Aintree of £0.430m.

Within Acute Commissioning there are also overspends at Southport and Ormskirk NHS Trust of £0.445m. This is based on month 11 activity with a small deduction of £0.013m for CQUIN and Alternative Quality Contract (AQC) breaches. The overspends are PbR activity for within both planned and unplanned care.

Other over spends within NHS Commissioning are non contracted activity, £0.363m over budget. This is due to higher out of area activity occurring than originally anticipated.

Corporate and Support Services

The CCG has operated within its 2013/14 running cost target of £3.680m, included within this budget. The underspend for the year is £0.239m.

The overall underspent position on this budget arises due to vacancies (many of which were filled part way through the year) and the reduction in Estates charges (as notified by NHS Property Services Ltd) compared to plan. These underspends are not expected to continue into 2014/15

Independent Sector

The Independent Sector budget is overspent by £0.927m for 2013/14. This is due to an increase in Trauma & orthopaedic activity at Ramsay Healthcare and Spire Liverpool.

Primary Care

The Primary Care budget is showing an overspend position of £0.442m for the year which is in line with the forecast at Month 11.

This budget area includes £1.2 million for Programme Projects. In addition to the £0.050m per Locality, this budget includes monies moved from Reserves to fund projects initiated at Locality level and approved from the Winter Pressure and Practice Development funds.

Medicines Management (Including Prescribing)

The Medicines Management budget consists of High Cost Drugs, Oxygen and Prescribing. The overall position is £0.135m overspent for 2013/14 which is in line with the forecast outturn at Month 11.

The major component of the Medicines Management budget is Prescribing. This area is showing a year-to-date overspend of £0.323m which is broadly in line with the position at Month 11 and the forecast outturn at Month 11. The forecast and actual charges are based on information supplied by the Prescription Pricing Authority (PPA).

The outturn position for High Cost drugs is an underspend of £0.199m which is in line with the forecast in previous reports.

Commissioning - Non-NHS

Commissioning from Non NHS organisations is overspent by £2.451m (month 11 £1.477m). The forecast outturn position at Month 11 was £1.763m. The higher than forecast overspend is due to:-

The underlying overspent position 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. The provision of data has improved, but further improvements are needed in 2014/15 to further deepen our understanding of the costs associated with this area.

At the end of the financial year the provision for potential package costs has been reviewed on the basis of the information available and the CCG is confident that the financial risk in this area is fully covered.

4.2 Treasury and Legacy issues

As reported previously, the PCT and SHA Legacy balances have been managed centrally by NHS England.

Given this revised direction, the balances transferred to the CCG have been significantly reduced and now consist of a small amount of IT and medical equipment, reported under Non-Current Assets.

In accordance with the guidance received from NHS England the CCG's 2013/14 financial position assumes no costs in relation to brought forward legacy provisions (other than administrative costs associated with resolution of the cases).

5. Evaluation of Risks and Opportunities

Risks have arisen in the last quarter of the year. These include areas like prescribing which has seen an upward trend in costs. The risks will continue to be monitored to ensure that they are reported early and mitigating actions put in place in a timely fashion.

6. Recommendations

The Governing Body is asked to note the finance update, particularly that the CCG has delivered the planned surplus of £2.312m for 2013/14.

Appendices

Appendix 1 – Financial position to Month 12

Appendix 1

01T NHS South Sefton Clinical Commissioning Group Month 13 Financial Position					
Cost centre Number	**Cost Centre Description**	**Annual Budget**	**Budget To Date**	**Actual To Date**	**Full Year Variance**
		£000	**£000**	**£000**	**£000**
COMMISSIONING - NON NHS					
598501	Mental Health Contracts	800	800	903	103
598506	Child and Adolescent Mental Health	1,202	1,202	1,215	13
598511	Dementia	118	118	118	(0)
598521	Learning Difficulties	1,399	1,399	1,342	(58)
598596	Collaborative Commissioning	521	521	521	(0)
598661	Out of Hours	659	659	663	4
598682	CHC Adult Fully Funded	5,010	5,010	6,891	1,881
598683	CHC Adult Fully Funded Personal Health Board	0	0	0	0
598691	Funded Nursing Care	2,021	2,021	2,348	327
598711	Community Services	1,867	1,867	1,804	(63)
598721	Hospices	1,223	1,223	1,201	(22)
598726	Intermediate Care	231	231	291	60
598796	Reablement	1,295	1,295	1,501	206
Sub-Total		**16,347**	**16,347**	**18,798**	**2,451**
CORPORATE & SUPPORT SERVICES					
600251	Administration and Business Support (Running Cost)	103	103	124	22
600271	CEO/Board Office (Running Cost)	632	632	656	25
600276	Chairs and Non Execs (Running Cost)	125	125	141	17
600286	Clinical Governance (Running Cost)	29	29	29	(0)
600296	Commissioning (Running Cost)	1,666	1,666	1,596	(70)
600316	Corporate costs	24	24	23	(1)
600346	Estates & Facilities	167	167	163	(4)
600351	Finance (Running Cost)	860	860	704	(156)
600391	Medicines Management (Running Cost)	74	74	63	(11)
	Sub-Total Running Costs	**3,680**	**3,680**	**3,500**	**(180)**
598646	Commissioning Schemes (Programme Cost)	854	854	805	(49)
598656	Medicines Management (Programme Cost)	489	489	453	(37)
598776	Non Recurrent Programmes (NPfIT)	1,477	1,477	1,477	0
598676	Primary Care IT	276	276	303	27
600371	IM&T	0	0	(0)	(0)
	Sub-Total Programme Costs	**3,096**	**3,096**	**3,037**	**(59)**
Sub-Total		**6,776**	**6,776**	**6,537**	**(239)**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS					
598571	Acute Commissioning	107,303	107,303	110,848	3,545
598576	Acute Childrens Services	8,388	8,388	8,026	(362)
598586	Ambulance Services	5,451	5,451	5,456	5
598616	NCAs/OATs	1,235	1,235	1,598	363
598631	Winter Pressures	1,520	1,520	1,520	0
598756	Commissioning - Non Acute	36,553	36,553	36,631	79
Sub-Total		**160,461**	**160,461**	**164,091**	**3,630**
INDEPENDENT SECTOR					
598591	Clinical Assessment and Treatment Centres	1,902	1,902	2,829	927
Sub-Total		**1,902**	**1,902**	**2,829**	**927**
PRIMARY CARE					
598651	Local Enhanced Services and GP Framework	893	893	1,292	399
598791	Programme Projects	1,224	1,224	1,267	43
Sub-Total		**2,117**	**2,117**	**2,559**	**442**
PRESCRIBING					
598606	High Cost Drugs	935	935	736	(199)
598666	Oxygen	421	421	432	11
598671	Prescribing	27,534	27,534	27,857	323
Sub-Total		**28,890**	**28,890**	**29,025**	**135**
Sub-Total Operating Budgets pre Reserves		**216,493**	**216,493**	**223,839**	**7,346**
RESERVES					
598761	Commissioning Reserves	7,346	7,346	0	(7,346)
Sub-Total		**7,346**	**7,346**	**0**	**(7,346)**
Grand Total I & E		**223,839**	**223,839**	**223,839**	**0**
	RRL Allocation	(226,151)	(226,151)	(226,151)	0
	(SURPLUS)/DEFICIT	(2,312)	(2,312)	(2,312)	0

NHS
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MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/72	**Author of the Paper:** Martin McDowell Chief Finance Officer Martin.mcdowell@southseftonccg.nhs.uk Tel: 0151 247 7065
Report date: May 2014	

Title: 2014/15 Revised Financial Budgets

Summary/Key Issues:

This paper presents the Governing Body with the revised 2014/15 financial budgets for South Sefton CCG.

Recommendation

Receive	X
Approve	X
Ratify	

The Governing Body is asked to:-

- approve the revised financial budgets for the financial year 2014/15.
- note that unidentified QIPP will need to be identified and planned before investment reserves can be fully deployed.

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

- that the revised budgets deliver the key metrics required by NHS England in terms of 1% surplus;
- that the CCG planned running cost expenditure is within its running cost target.

Links to Corporate Objectives *(x those that apply)*	
x	Improve the quality of commissioned services, whilst achieving financial balance.
x	Achieve a 1% reduction in non-elective admissions in 2014/2015.
x	Implementation of 2014/15 phase of Virtual Ward plan.
x	Review and re-specification of community nursing services for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014-15 phase of Primary Care quality Strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

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
May 2014

1 Summary

1.1 The opening financial budgets for 2014/15 were approved at the Governing Body Meeting in March 2014. The March meeting noted that there remained uncertainties in some areas and that an update report would be presented to the Governing Body meeting in May 2014.

1.2 This paper provides details of the CCG's 2014/15 proposed revised financial budgets for consideration and approval.

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

1.4 The financial budgets reflect national guidelines and local arrangements.

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

Table 1 - Summary 2014/15 Revised Financial Budgets

Budget Area	£2014/15 £m		
	Rec	Non Rec	Total
Available Resources	**(226.5)**	**(2.3)**	**(228.8)**
Operational budgets			
NHS Commissioned Services	154.1	6.1	160.1
Corporate & Support Services	6.5	0.1	6.6
Independent Sector	2.2	0.1	2.3
Medicines Management	29.2	0.2	29.4
Primary Care	1.3	0.6	2.0
Non NHS Commissioning	16.8	0.1	16.9
Sub total Operational budgets	**210.1**	**7.1**	**217.2**
Reserves			
Unidentified QIPP	(0.5)	0.0	(0.5)
2.5% Non Recurrent schemes	0.0	3.2	3.2
Investments	1.1	0.2	1.3
Other Committed Plans	1.4	1.6	3.1
Mandate Reserve	1.1	0.0	1.1
Contingency	1.2	0.0	1.2
Sub total Reserves	**4.3**	**5.0**	**9.3**
Total Anticipated Spend	**214.4**	**12.1**	**226.5**
Forecast (Surplus)/Deficit	**(12.1)**	**9.8**	**(2.3)**
Expressed as %			**1%**

2. Changes from Opening Budgets

2.1 Overview

There has been an increase in operational budgets of £1.8m as a result of the review of Opening Budgets. This has been met by a corresponding reduction in Reserves.

Following these revisions, the CCG continues to deliver a planned surplus of 1% (£2.3m).

The detail by cost centre is included at Appendix 1.

The major movements are described under the relevant sections below.

2.2 Resource Allocations and Surplus

The Resource allocation has increased by £0.086m since the March report, to a total Allocation for 2014/15 of £228.846m.

2.3 Key Changes in Operational Budgets

NHS Commissioned Services
Overall the budget for NHS Commissioned Services has increased by £1.0m since the March report. It was noted in the March report that the CCG had not reached agreements with all providers and that this area could change significantly.

£0.8m of the increase relates to the revised contract figures for contracts agreed since March (or the latest offers under negotiation) for Acute Commissioning, Acute Children's services, the Ambulance Service and Non Acute commissioning.

Within Non Contract Activity there is an increase to Opening Budgets of £0.19m to reflect the higher than anticipated activity that was experienced in the final quarter of 2013/14.

Corporate & Support Services
The budget reflects the senior management restructure previously agreed by the Governing Body. This has not resulted in any overall significant change to the budget area and the CCG continues to plan to operate within the allowed Running Cost Allowance of £3.7m for 2014/15.

The budget for Programme costs within the Corporate Budget area has reduced by £0.3m. This is due to a revision of the NPFIT forecast cost which has been reduced by £0.29m, with the reduction in budget cost transferred to a specific reserve.

Independent Sector
This budget area has increased by £0.1m since the March report. This is due to the final sign off of Independent Sector contracts.

Medicines Management
There has been an increase of £0.417m in the Prescribing budget. The budget has been adjusted to reflect the latest information from the Prescription Pricing Authority, forecasting 2014/15 expenditure based on 2013/14 full year data.

In addition, £0.3m of the budget relating to Personally Administered Drugs has been transferred to Local Enhanced Services within the Primary Care cost centre budget, to reflect this being a service provided for the CCGs by GPs.

The Prescribing Budget has also been increased by £0.3m for the drugs cost of the Denosumab development which will see GPs prescribing this drug under a shared care protocol in 2014/15.

Primary Care
This budget has increased by £0.46m since the March report. £0.3m relates to the transfer of the Personally Administered Drugs budget transferred from Prescribing noted above. In addition £0.1m has been included to cover the GP costs of administering Denosumab under the shared protocol arrangement and a revision to reflect the current cost of the GP Framework arrangement.

Non NHS Commissioning
Overall this budget area has increased by £0.1m since the opening budgets were presented. From appendix 1 it can be seen that there are some major movements between cost centre headings – e.g. between "Child and Adolescent Mental Health" and "Child Health CHC Packages" and between CHC Adult Fully Funded and CHC Adult Joint Funded. These changes are to allow better coding and financial monitoring and do not constitute changes to underlying budget values.

In addition to the above, £0.2m has been transferred from CHC Adult Joint Funded to the Hospices cost centre in respect of the Jospice service. This reduction in the CHC cost line has been offset by an increase in CHC budgets to reflect the closing 2013/14 financial position on CHC.

The Learning Difficulty budget line has seen a reduction of £0.139m to reflect the actual value of the active packages at the close of 2013/14.

2.4 **Reserves**

There has been a reduction in the 2014/15 Reserves budget of £1.7m since the opening budgets were presented. This reflects the increase in operational budgets described above, which has been managed by a reduction in the reserves presented to the March Governing Body.

Reserves include £0.493m of unidentified QIPP which will need to be identified and planned before investment reserves can be fully deployed.

3 Key Financial Risks and Pressures

3.1 Outstanding contracts – The contract with Aintree University Hospitals NHS Foundation Trust is not yet finalised. Any further pressures that arise will be funded via commissioning reserves.

3.2 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.

3.3 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.

3.4 The commissioning of individual packages of care within Mental Health and Continuing Health Care (CHC) was identified as a major risk area for the CCG through 2013/14. 2014/15 budgets have been set on the basis of 2013/14 outturn but because there are still some unresolved issues regarding the quality of the underlying data from CSU, there remains some risk around the accuracy of the budget.

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

3.6 Continuing Healthcare (CHC) restitution payments – The CCG has included provision for CHC restitution payments of £0.881m in Reserves. The value of this reserve is based on the most recent guidance from NHS England which indicates that, in 2014/15, CCGs will be charged an amount equal to a notified CHC restitution claim allocation as part of a national pooling arrangement. The CCGs allocation is £0.881m. There is significant concern amongst CCGs regarding the approach being taken by NHS England in this matter and therefore there is a risk that the national pooling approach may change.

3.7 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.

4. Conclusions & Recommendations

4.1 The Governing Body is asked to:-

- approve the revised financial budgets for the financial year 2014/15;and
- note that unidentified QIPP will need to be identified and planned before investment reserves can be fully deployed.

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

- that the revised financial budgets deliver the key metrics required by NHS England in terms of 1% surplus;
- that the CCG planned running cost expenditure is within its running cost target.

5. Appendices

Appendix 1 Analysis by Cost Centre – Revised 2014/15 Budget compared to Opening 2014/15 Budget.

Martin McDowell
May 2014

Appendix 1

South Sefton CCG

Comparison of 2014/15 Opening Budget to Revised Budgets

Cost centre Number	Cost Centre Description	Opening Budget 2014/15	Revised Budget 2014/15	Increase (Decrease)
		£000	£'000	£000
COMMISSIONING - NON NHS				
598501	Mental Health Contracts	1,049	1,058	9
598506	Child and Adolescent Mental Health	920	238	(682)
598687	Child Health CHC Packages	0	675	675
598511	Dementia	118	118	0
598521	Learning Difficulties	730	591	(139)
598596	Collaborative Commissioning	521	521	0
598661	Out of Hours	1,327	1,321	(6)
598682	CHC Adult Fully Funded	6,659	5,252	(1,407)
598684	CHC Adult Joint Funded	0	1,420	1,420
598685	CHC Adult Personal Health Budgets	0	21	21
598691	Funded Nursing Care	2,395	2,346	(50)
598711	Community Services	371	402	31
598721	Hospices	1,232	1,431	200
598726	Intermediate Care	226	211	(15)
598796	Reablement	1,245	1,295	50
Sub-Total		**16,793**	**16,901**	**107**
CORPORATE & SUPPORT SERVICES				
600251	Administration and Business Support (Running Cost)	127	127	0
600271	CEO/Board Office (Running Cost)	538	527	(11)
600276	Chairs and Non Execs (Running Cost)	159	135	(24)
600286	Clinical Governance (Running Cost)	29	29	0
600296	Commissioning (Running Cost)	1,607	1,664	56
600316	Corporate costs	24	24	0
600346	Estates & Facilities	154	154	0
600351	Finance (Running Cost)	784	730	(55)
600391	Medicines Management (Running Cost)	63	55	(8)
600426	Quality	204	245	41
	Sub-Total Running Costs	**3,690**	**3,690**	**(0)**
598646	Commissioning Schemes (Programme Cost)	767	797	29
598656	Medicines Management (Programme Cost)	585	550	(35)
598776	Non Recurrent Programmes (NPfIT)	1,560	1,267	(293)
598676	Primary Care IT	276	276	0
	Sub-Total Programme Costs	**3,188**	**2,889**	**(299)**
Sub-Total		**6,878**	**6,579**	**(299)**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS				
598571	Acute Commissioning	109,618	110,325	707
598576	Acute Childrens Services	8,176	8,699	523
598586	Ambulance Services	5,448	5,347	(101)
598616	NCAs/OATs	1,181	1,371	190
598631	Winter Pressures	0	0	0
598756	Commissioning - Non Acute	34,705	34,384	(321)
598786	Patient Transport	12	12	0
Sub-Total		**159,140**	**160,139**	**998**
INDEPENDENT SECTOR				
598591	Clinical Assessment and Treatment Centres	2,207	2,304	97
Sub-Total		**2,207**	**2,304**	**97**
PRIMARY CARE				
598651	Local Enhanced Services and GP Framework	848	1,309	461
598791	Programme Projects	642	645	4
Sub-Total		**1,490**	**1,955**	**465**
PRESCRIBING				
598606	High Cost Drugs	665	665	0
598666	Oxygen	444	446	2
598671	Prescribing	27,843	28,260	417
Sub-Total		**28,952**	**29,371**	**419**
Sub-Total Operating Budgets pre Reserves		**215,461**	**217,248**	**1,787**
RESERVES				
598761	Commissioning Reserves	11,011	9,297	(1,714)
Sub-Total		**11,011**	**9,297**	**(1,714)**
Grand Total I & E		**226,472**	**226,545**	**73**
Surplus		**2,288**	**2,300**	13
Total		**228,760**	**228,846**	**86**

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/72(a)	**Author of the Paper:**
Report date: May 2014	Karl McCluskey Chief Officer: Strategic Planning & Outcomes South Sefton Clinical Commissioning Group Karl.mccluskey@southseftonccg.nhs.uk

Title: Five Year Strategic Plan

Summary/Key Issues:

This paper details the joint five year strategic plan for South Sefton CCG and Southport and Formby CCG. The footprint for the plan is coterminous with the Borough of Sefton and it is aligned with the Health and Wellbeing Strategy in conjunction with Sefton Metropolitan Borough Council. A clear and distinct strategic vision is outlined, underpinned by defined values. The three strategic schemes are outlined (virtual ward, care closer to home and primary care), together with the strategic programmes.

This strategy is aligned with the financial strategy for the CCG. This paper now enables the CCG to complete its required submission to NHS England on 20th June 2014.

Recommendation

Receive	x
Approve	
Ratify	

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

- endorse the five year strategic plan as set out in this document.
- recognise and support the augmentation of the strategic programmes with three additional programme areas having been identified through engagement and consultation.
- endorse the outlined governance and reporting arrangements.
- provide the delegated authority to submit the final five year strategic plan in the varying template formats required by NHSE, based on the plan and detail contained in this paper.
- support the final enhancement of this strategic plan, in integrating the financial and quality strategy.

Links to Corporate Objectives *(x those that apply)*	
X	Improve quality of commissioned services, whilst achieving financial balance
X	Achieve a 1% reduction in non-elective admissions in 2014/15
X	Implementation of 2014-15 phase of Virtual Ward
X	Review and Re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public
X	Implementation of 2014-15 phase of Primary Care quality strategy / transformation
X	Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy
X	Review the population health needs for all mental health services to inform enhanced delivery

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
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
May 2014

1. Introduction

1.1 This paper sets out and describes the five year strategic plan for the CCG. It reflects the progress and content previously considered by the Governing Body in January and March this year. The content of this plan enables the CCG to meet the requirements set down by NHS England as part of the national planning process and timetable and enables the CCG to complete its required national submission on 20th June 2014.

1.2 Following discussion and consideration at this Governing Body, it is envisaged that a public facing version of this plan will be constructed and completed by 20th June. This will represent a synopsis of this paper for Governing Body consideration and review, with the public version for final agreement and publication by the end of July 2014.

1.3 It should be noted that while the CCG will have developed its five year strategic plan in line with the dates set out above, an annual process of review will be undertaken to re-assess and evaluate the strategic plan priorities and progress, to ensure that the plan remains current and live, focused on delivery and adapts to the environment in which the CCG operates. This process is described in more detail in the governance section of this report.

1.4 This Strategy sets out the strategic direction and describes the high level priorities for the CCG over the next five years. The underlying values and principles that the CCG will adopt in delivering and commissioning the plan are also outlined.

1.5 A strategic vision for the CCG is also described, reflecting the aim and ambition that the CCG has for its role as commissioner, the health & wellbeing of the population and the involvement of its partners.

2. Current Position – Our Profile

2.1 The planning footprint for this five year strategic plan combines the geographical areas served by two Clinical Commissioning Groups:-

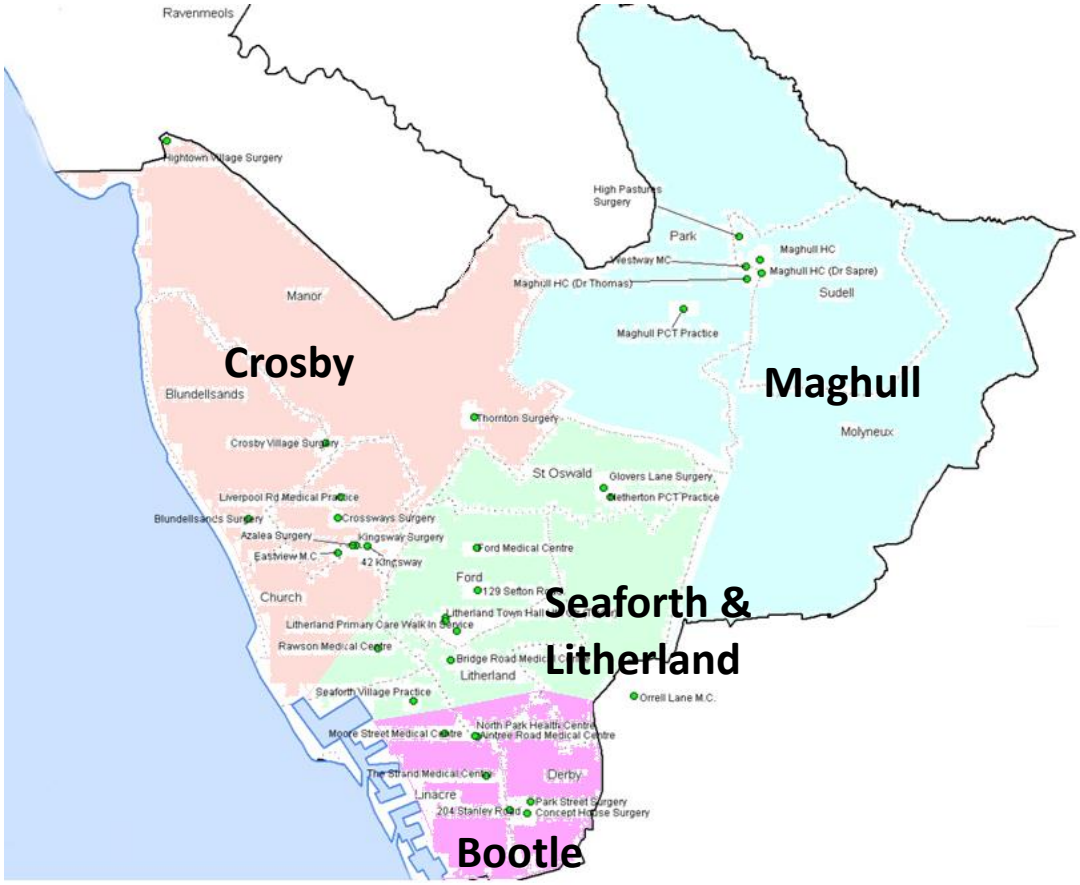
- NHS South Sefton CCG
- NHS Southport & Formby CCG.

2.2 This combined footprint is co-terminus with the geographical area served by Sefton Metropolitan Borough Council. The rationale for adopting this footprint is described in more detail in this paper, however the principle rationale relates to the fact that both CCGs and Sefton Council have developed and have in place a joint Health & Wellbeing Strategy covering all of the Sefton population. Thus the individual and combined CCG strategic plans need to be aligned with this.

2.3 NHS South Sefton Clinical Commissioning Group brings together 33 GP surgeries, serving a population of c155,000 with four distinct localities:-

- Crosby
- Bootle
- Seaforth & Litherland
- Maghull.

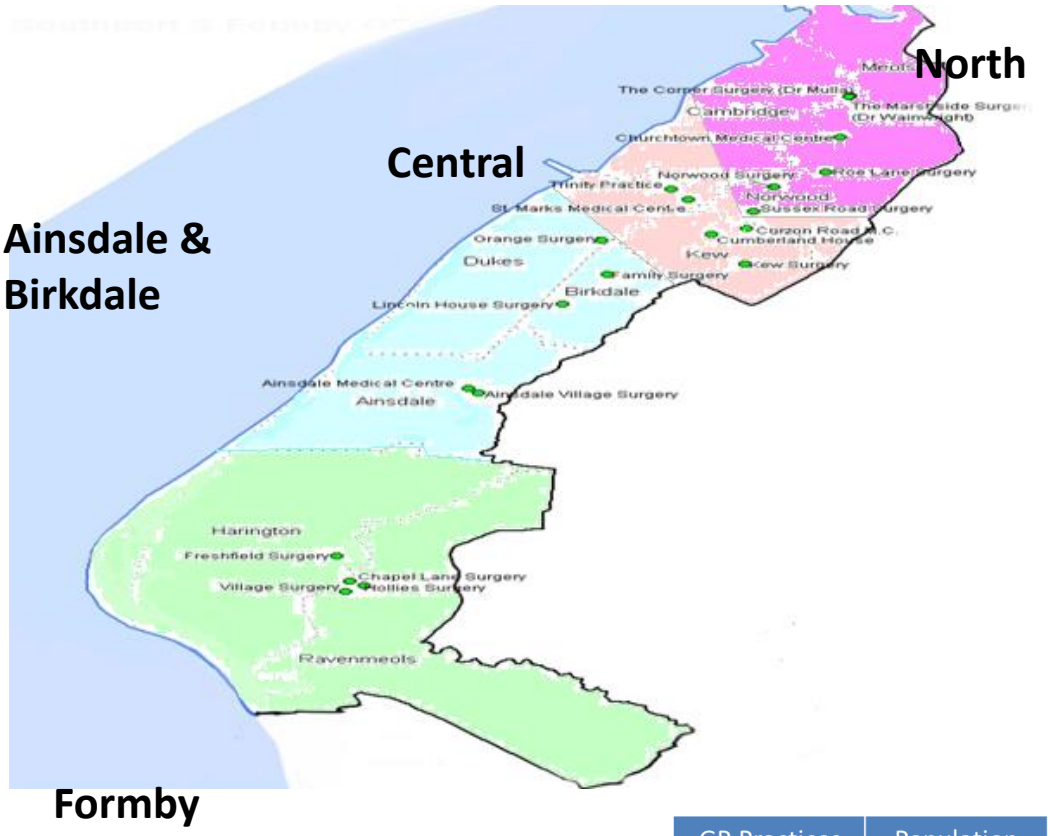
Diagram 1.0 South Sefton CCG



	GP Practices	Population
Bootle	7	39,250
Crosby	10	47,000
Maghull	6	28,500
Seaforth & Litherland	11	40,700
TOTAL	**34**	**155,540**

2.4 NHS Southport & Formby CCG brings together 20 GP surgeries, serving a population of c122,00 stretching from Ince Blundell in the South to Churchtown in the North.

Diagram 2.0 Southport & Formby CCG



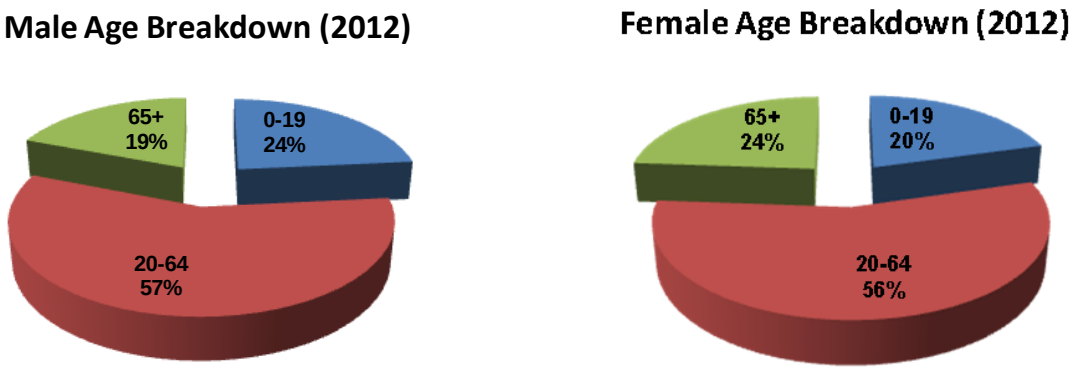
	GP Practices	Population
North	6	31K
Central	5	34K
Ainsdale & Birkdale	5	32K
Formby	4	25K
TOTAL	**20**	**122,000**

2.5 Latest 2012 population estimates show the total population of Sefton to be 273,697.

2.6 2012 mid-year population estimates show a 10 year population reduction of 2.6% since 2002. This goes against both the National and Regional trends which have both seen population increases during the same period. Since 2002 the population of England is estimated to have risen by almost 14% and the population of the North West of England by 4.4%.

2.7 There are 48% (131,144) of the population is male, with 52% (142,553) female. This is fairly similar to National picture where 51% are female and 49% male.

2.8 The age profile of males and females within Sefton shows that, while the 20-64 age group in both genders is similar, amongst females 1 in 4 are aged over 65, compare to 1 in 5 amongst males.

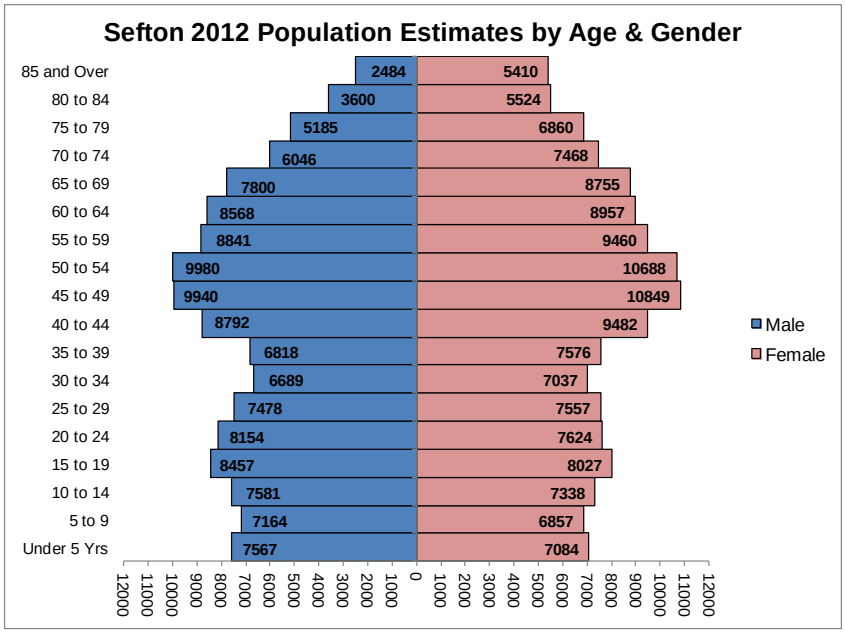


2.9 Across Sefton 58.7% (160,731) residents are working age (18-64), which is lower than both National and across the North West where the work age population account for 62.2% and 62.1% respectively

2.10 Overall the proportion of the population aged over 65 in Sefton is 22%, considerably higher that across England as a whole where over 65's account for 17% of the population.

2.11 The average age of a Sefton resident is 44.9 years, five years older than the average age across the UK, where it is 39.7 years

Diagram 3.0 Sefton Population estimates by Age and Gender



2.12 Although the Borough has become slightly more ethnically diverse between Census 2001 and Census 2011, the area is still predominantly white with more than 97% (266,741 of 273,790) residents from a white background.

Table 1.0 Ethnic Profile for Sefton

Ethincity	2001	2011	Change
White	98.40%	97.30%	-1.10%
Mixed	0.60%	1.10%	0.50%
Asian	0.50%	0.50%	0.00%
Black	0.20%	0.40%	0.20%
Chinese / Other	0.40%	0.70%	0.30%

2.13 259,629 of these are White / British making up 94.8% of the Sefton population.

2.14 In comparison, 90.2% of the North West population are White, and across England & Wales 85.9% are white.

2.15 The table below shows how the number of people from outside the UK entering the Borough has altered.

Table 2.0 Numbers from outside the UK entering Sefton

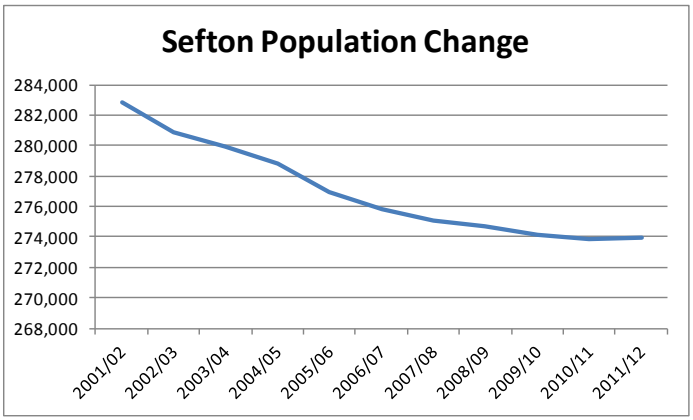
Year	Uk & Ireland	Other EU; Member Countries in March 2001	Other EU; Accession Countries April 2001 to March 2011	Other Countries
2001	274712	1496	368	3885
2011	262234	1815	2734	5273

2.16 In particular from countries that have become part of the EU since the last Census in 2001, where there has been an increase of more than 640%

2.17 Since 2001 the number of people born in the UK residing in Sefton has fallen by 4.5%.

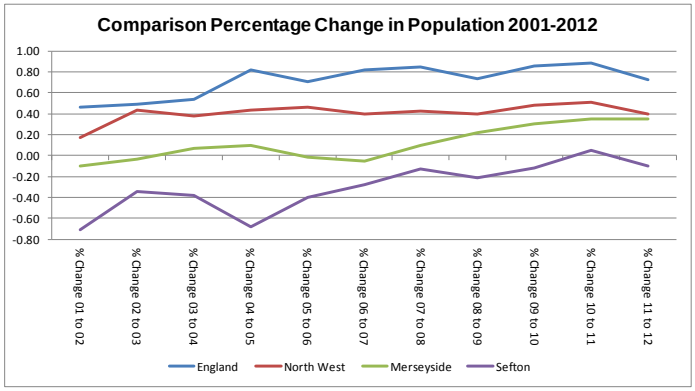
2.18 The above table shows how Sefton's population has been steadily falling. Since 2001 the population has fallen by 3.2%

Graph 1.0 Sefton Population Change from 2001-2012



2.19 The comparison chart shows the year on year percentage change in population since 2001 and compares this with changes at county, region and national level. It shows that of the areas compared Sefton is the only area to have been consistently falling since 2001, with just 2010/11 showing a slight year on year increase (0.05%).

Graph 2.0 Comparison Percentage Change in Population 2001-2012



2.20 For 2011/12 Sefton had the sixth highest reduction in population, and was one of only 25 Local Authorities across England & Wales that had a reduction in total population.

2.21 G.P. registrations since 2004 have increased by around 28%, suggesting that the number of overseas residents arriving in Sefton has been increasing and is going some way to mitigating the natural change reduction in the Borough and the number of people emigrating out. However, since 2009 the number of new registrations has been steadily falling away.

2.22 While the numbers of new immigrants registering with G.P.'s is increasing, the number of migrants requesting National Insurance numbers is falling, down by 18.6% since 2004.

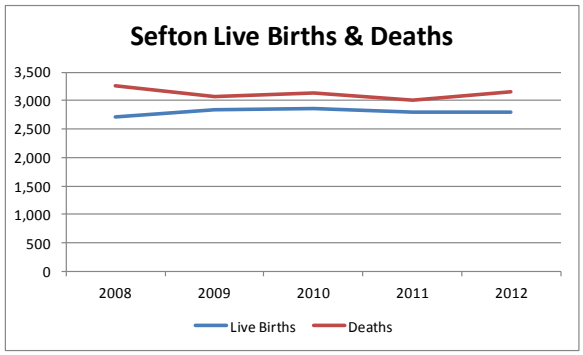
Table 3.0 Immigration Estimates for Sefton

Immigation Estimates	2004	2005	2006	2007	2008	2009	2010	2011	2012
New Migrant GP Registrations	636	867	829	885	919	1,082	1,051	860	814
Migrant NINo Registrations	821	1,672	1,016	1,217	830	822	886	756	668

2.23 This indicates either less work age people are migrating into the area or a proportion of those arriving are not registering to pay national insurance.

2.24 The chart below highlights that within Sefton the number of deaths have consistently been higher than the number of live births, and has been the main contributing factor in the reducing of Sefton's overall population.

Graph 3.0 Sefton Live Births & Deaths



2.25 Over the last two years the annual number of live births has fallen by 2.3% (2,862 in 2010 to 2,795 in 2012).

2.26 In contrast since 2010 the number of deaths in the Borough has risen by 0.9% (3,136 to 3,0163).

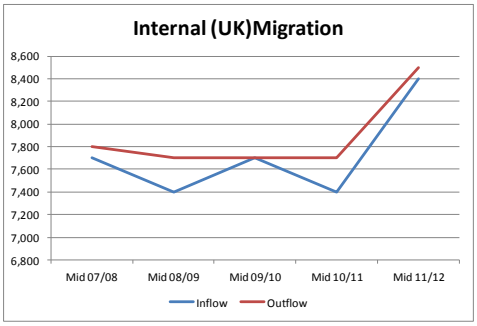
2.27 The accompanying table shows how Sefton has been, and remains out of step with the county, regional and national natural change in population, all of which have had year on year increases in population as a result of natural change.

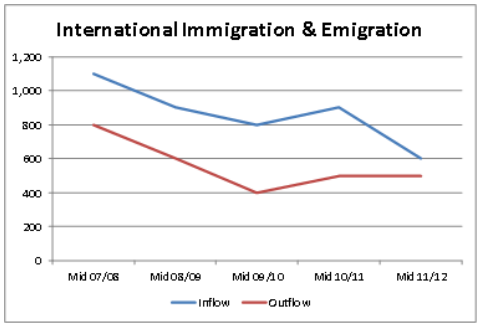
Table 4.0 Sefton Natural Population Changes

Natural Population Change						
Area	2008	2009	2010	2011	2012	Total 5 yr Changes
Sefton	-542	-222	-274	-216	-368	-1622
Merseyside	1435	1730	2081	2880	2504	10630
North West	17427	19612	21461	22380	20949	101829
England	197046	211817	225990	235258	227462	1097573

2.28 The internal migration chart, on the next page illustrates that the number of people leaving Sefton between mid 2007/08 and mid 2011/12 has consistently been higher than the numbers coming into the area, the chart also highlights that the gap between those coming in and those going out of Sefton in 2011/12 has closed.

Graph 4.0 Internal Migration & International Immigration & Emigration





2.29 In 2011/12 Sefton attracted 8,423 new UK residents, while during the same 12 month period 8,452 Sefton residents left the area, a net internal (UK) migration of -29.

2.30 By contrast, although international migration figures are far lower than internal migration, over the same five year period the number of international migrants arriving in Sefton has been consistently higher than the number of Sefton residents emigrating to foreign countries.

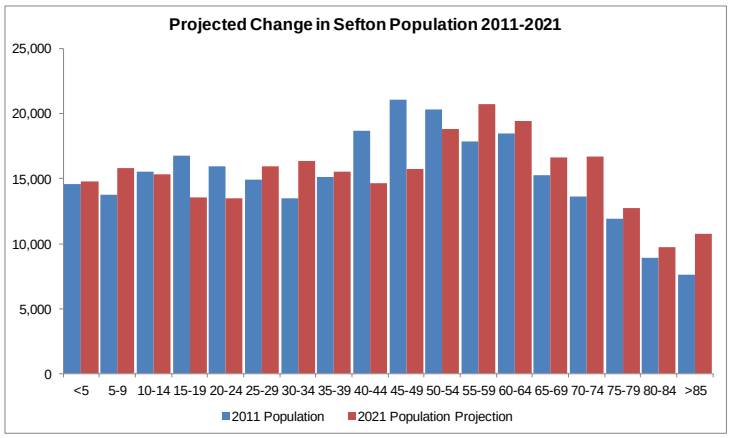
2.31 In 2011/12 630 international migrants chose to move to Sefton, while 522 Sefton residents moved overseas. This gives a net international migration figure of 108.

2.32 Overall for 2011/12 net migration (including "Other Changes") for the Borough has seen a population increase of 84.

2.33 When combined with Live Births and Deaths data for 2011/12 shows the population has an overall net change of -272.

2.34 Sefton's Overall population is predicted to rise by 1% by 2021 to 276,821. The chart breaks down the projection change in Sefton's population by five year age bands. There are increases in each five year band from 55-59 onwards with an increase in resident aged 65 and over of 16%, rising from 57,400 in 2011 to 66,500 in 2021. The biggest increase is projected to be in the number of residents age 85 and above, which is expected to rise by more than 40% from 7,600 in 2011 to 10,700 by 2021.

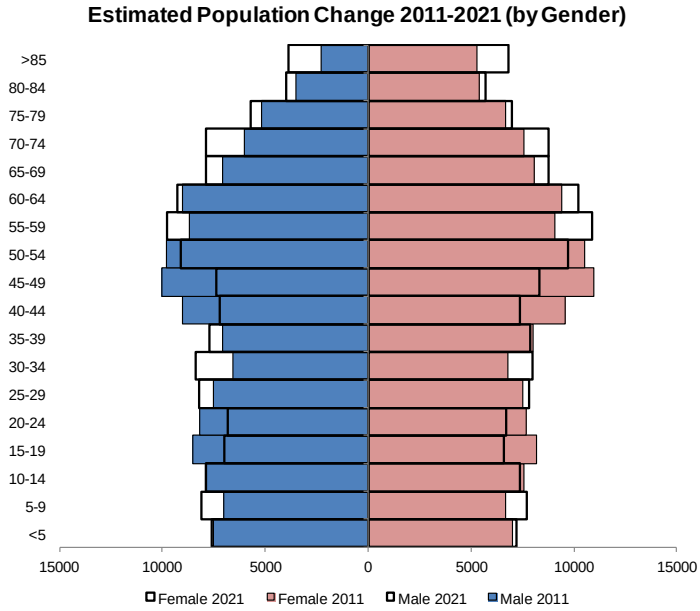
Graph 5.0 Projected Changes in Sefton Population 2011 – 2021



2.35 Despite a reduction of 4% (162,400 to 155,700) in working age population within the borough, there are increases in each of the five year age bands 25-29 (7%), 30-34 (21%) and 35-39 (2%). There are also predicted to be increases in those who are potentially reaching the end of their working life, age 55-59 (16%) and aged 60-64 (5%).

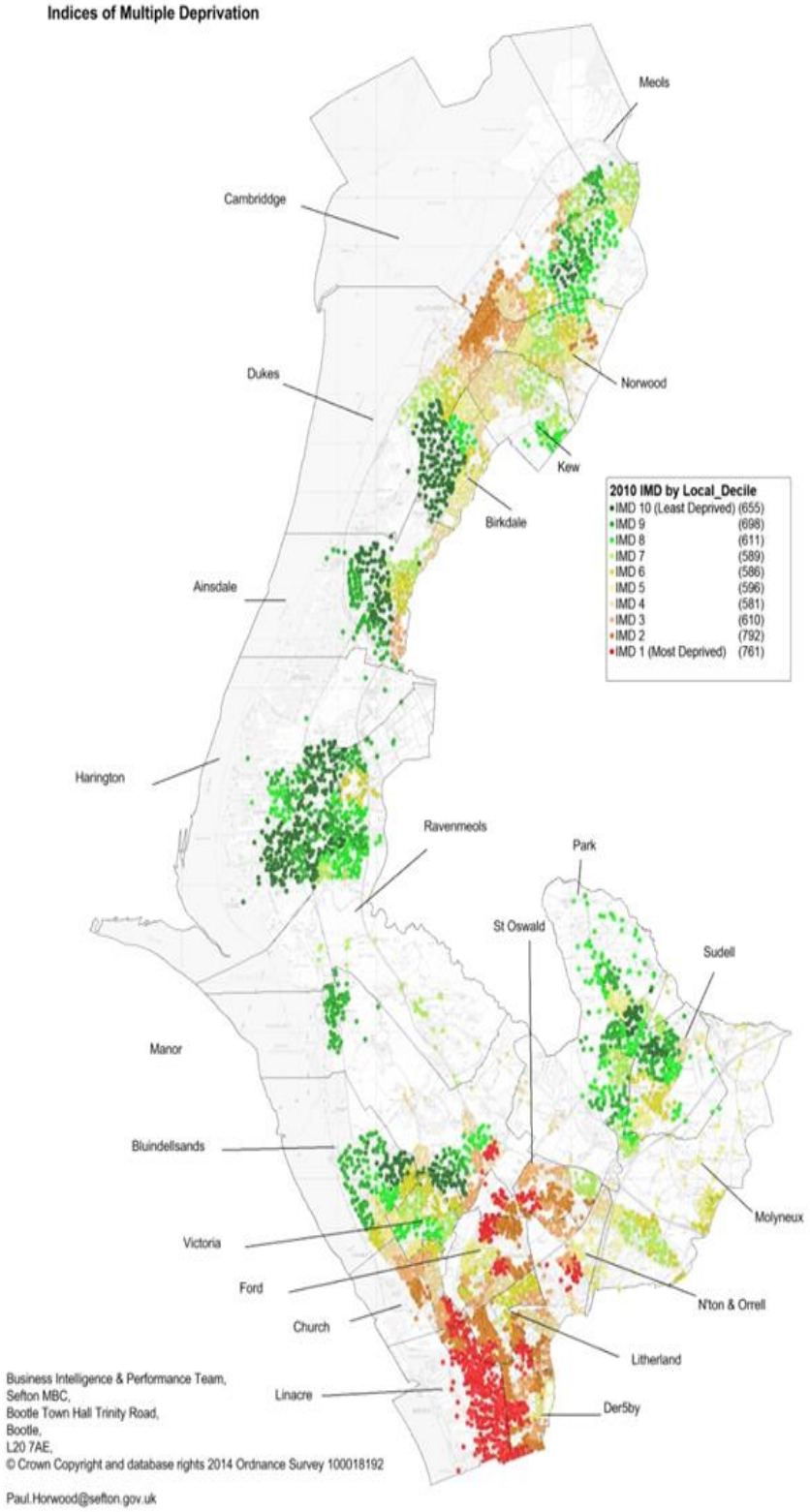
2.36 Amongst younger people it is predicted that there will be an increase in under 10's of 8% rising from 31,300 in 2011 to 33,700 in 2021. However, a reduction in those aged 11-17 of 9% from 22,900 to 20,800, means the number of Sefton residents aged under 18 will remain fairly static, increasing by just 400 from 54,200 to 54,600 or 0.7%.

Graph 6.0 Estimated Population Change 2011 -2021 (by gender)



2.37 The biggest increase for both males and females is amongst those aged 85 and above with the male over 85 population rising by almost 70% and female by 28% over the next 10 years. Across both genders there it is projected that every age band from 55-59 onwards will see an increase.

Diagram 4.0 Indices of Multiple Deprivation



2.38 Changes to Lower Super Output Areas (LSOA) boundaries as a result of the 2011 Census mean the IMD rankings are now based on 32,844 LSOA's (previously 32,482) that make up the 326 English local authorities areas. Each LSOA equates to around 1,500 people. The LSOA ranked one being the most deprived in the country and the LSOA ranked 32,844 being the least deprived. Sefton has 189 LSOA's (previously 190).

2.39 Based on average LSOA scores, Sefton is the least deprived of the six wider Merseyside authorities (inc. Halton). However, of the 326 Local Authorities contained within the IMD Sefton is ranked as the 92nd most deprived in England.

2.40 The national ranking map shows there are 36 Sefton LSOA's in the most deprived 10% of areas within England & Wales, with three of these amongst the most deprived 1% across. All three of these are within Linacre Ward.

2.41 Within the 36 LSOA's within the most deprived decile there are 49,731 residents, this equates to 18% of Sefton's population living in the most deprived 10% of areas.

2.42 Despite more than three quarters of LSOA having reduced levels of deprivation in 2010, there is minimal change in the geographical distribution of the most and least deprived areas within Sefton. However, it is important to make the point that not all individuals living in an area of higher deprivation are or feel deprived

2.43 The most deprived 20% map shows the distribution of Sefton's most deprived 20% of LSOA and highlights the concentration of deprived LSOAs within the south of the borough.

2.44 Of the 38 (20%) most deprived LSOAs in Sefton in 2004, 36 are still among the most deprived 20% in 2010.

2.45 It is likely that no one service provider can address the issues within the most deprived areas. There is a need for partners to work together to ensure that resources are used in the locations of greatest need to ensure greater impact and value for money.

3. Provider Landscape

3.1 The provider landscape is sculpted across Sefton with the following major providers:-

- Aintree University Hospital NHS Foundation Trust
- Southport & Ormskirk Hospital NHS Trust
- Mersey Care NHS Trust
- Liverpool Community Health NHS Trust
- Liverpool Women's NHS Foundation Trust
- The Royal Liverpool and Broadgreen University Hospitals NHS Trust
- The Walton Centre NHS Foundation Trust
- The Clatterbridge Cancer Centre NHS Foundation Trust
- Liverpool Heart and Chest Hospital NHS Foundation Trust.

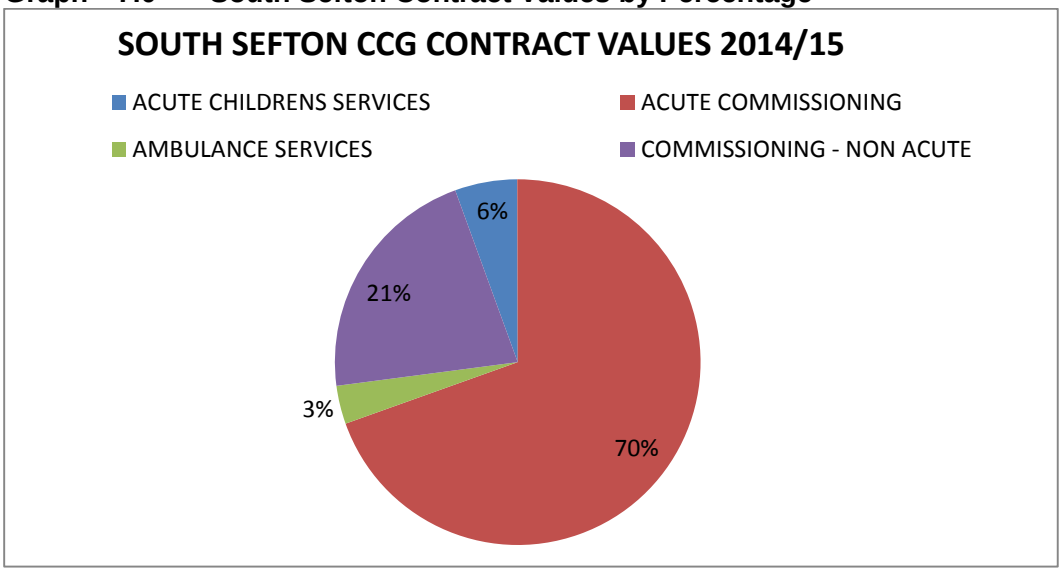
3.2 The vast majority of the Sefton population are served by Aintree Hospitals and Southport & Ormskirk Hospital, against which South Sefton CCG and Southport & Formby CCG is the lead commissioner. Sefton patients are also served by the other specialist hospitals listed above.

3.3 The table below sets out the contracted values for South Sefton CCG for 2014/15, which clearly indicates that the vast proportion of spend, 70% relates to acute services. The major provider of commissioned services is Aintree with 51% of CCG spend.

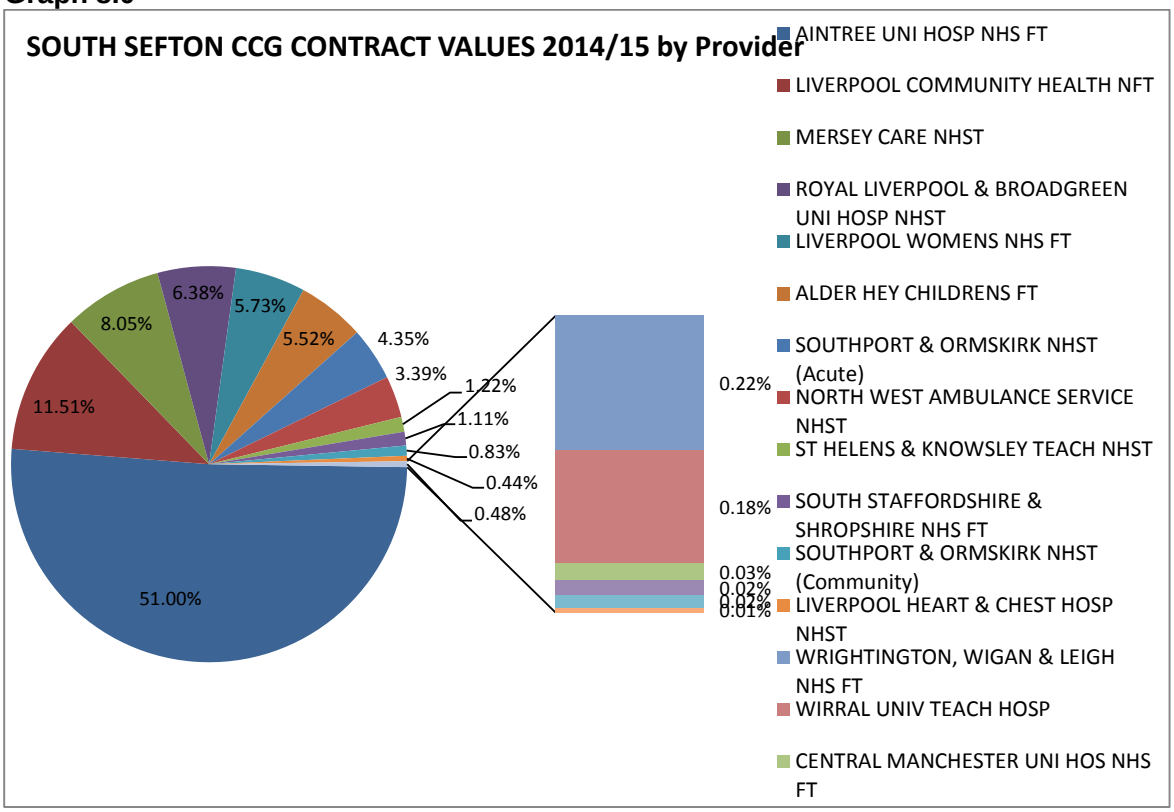
Table 5.0 South Sefton CCG Contract Values 2014/15

SOUTH SEFTON CCG CONTRACT VALUES 2014/15	Totals
ACUTE CHILDRENS SERVICES	£8,699,478
ACUTE COMMISSIONING	£109,706,965
AMBULANCE SERVICES	£5,347,427
COMMISSIONING - NON ACUTE	£33,926,726

Graph 7.0 South Sefton Contract Values by Percentage



Graph 8.0

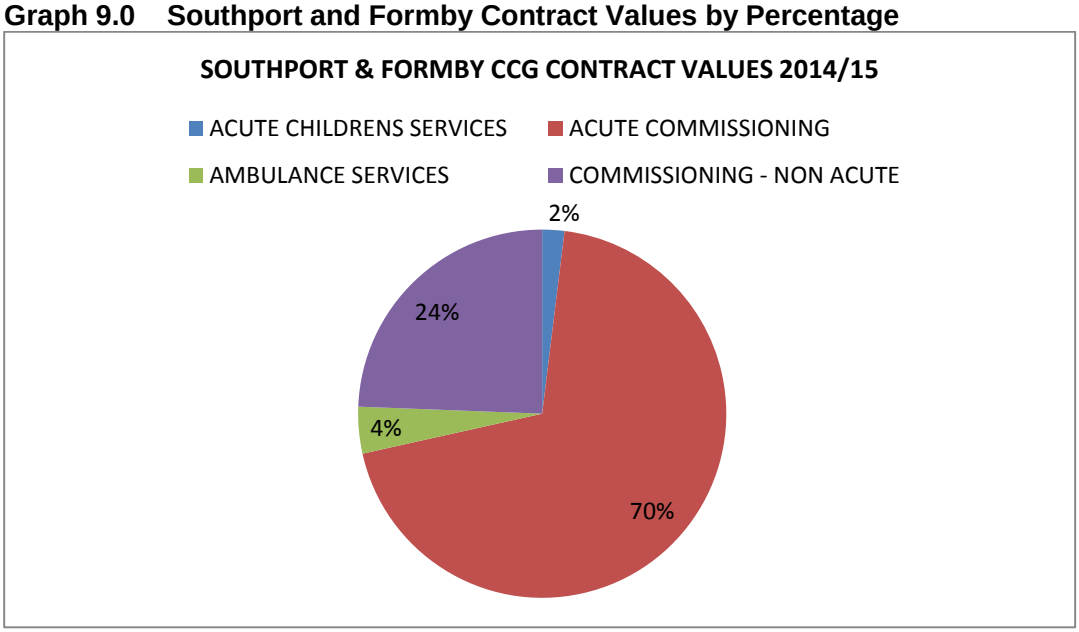


3.4 The table and graphs below set out the contracted values for Southport & Formby CCG for 2014/15, which clearly indicate that the vast proportion of spend, 70% relates to acute services. The major provider of commissioned services is Southport & Ormskirk with 56% of CCG spend.

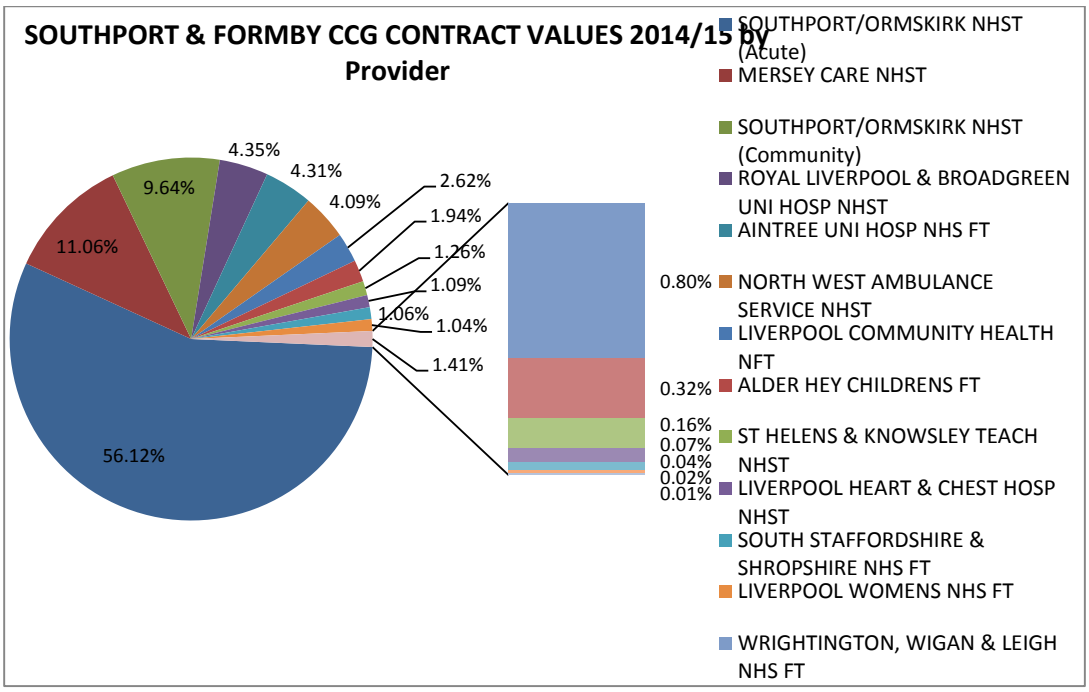
Table 6.0 Southport & Formby CCG Contract Values 2014/15

SOUTHPORT & FORMBY CCG CONTRACT VALUES 2014/15	Totals
ACUTE CHILDRENS SERVICES	£2,148,131
ACUTE COMMISSIONING	£76,926,399
AMBULANCE SERVICES	£4,526,771
COMMISSIONING - NON ACUTE	£26,969,134

Graph 9.0 Southport and Formby Contract Values by Percentage



Graph 10



3.5 The provider landscape can be described against a number of key and significant challenges, although it should be recognised that each provider has its own and unique set of challenges. In summary these can be collectively described as:-

- workforce challenges, particularly in relation to the recruitment highly skilled and professional staff;
- quality challenges related to a number of areas, in particular, emergency care, A&E, Hospital related acquired infection and sustainable access for elective care;
- specialist services configuration;
- continued financial challenges in delivering recurring efficiencies against a heightening demand for quality services.

3.6 The complexity of the extended Health Economy is further compounded given the connectivity between the providers listed above, but also the additional providers outside of the immediate Sefton and Liverpool area, with neighbouring CCGs. These include:-

- Halton CCG
- St Helens CCG
- Knowsley CCG
- Liverpool CCG.

3.7 The Merseyside health economy is challenged with integrating the plans between partner CCGs, so these can be directly related to individual providers of healthcare. In addition the national review of specialised commissioned services by NHS England in conjunction with the Boston Consulting Group has to be considered in shaping commissioning intentions and priorities going forward.

3.8 South Sefton and Southport & Formby CCGs recognise the need to collaborate with both CCG partners and provider partners to work through the implications of combined CCG and Specialised Commissioning Plans. This remains work in progress, with all CCGs developing respective plans by the end of June and clarity on Specialised Commissioning expected thereafter.

3.9 In support of this South Sefton and Southport and Formby CCG have formed a commissioning collaborative with NHS England Merseyside to work through the above. In addition, both CCGs in conjunction with Sefton Council have established a provider forum, as part of the Health & Wellbeing board to consider and understand provider implications in relation to both Health & Local Authority Plans.

3.10 Southport & Formby CCG has been working with West Lancashire CCG to ensure that strategic plans are aligned and reflect a common direction of travel and aspiration.

4. CCG Performance

The table below highlight the Key Performance Categories for both CCGs for the year 2013/14.

Table 7.0 CCG Key Performance Targets

Key Target	South Sefton CCG	Southport & Formby CCG	Reporting Basis
18 weeks referral to treatment times	The CCG achieved 93.26% for admitted patients and 97.63% for non admitted	The CCG achieved 94.29% for admitted patients and 98.07% for non admitted patients,	Monthly (month 12)

Key Target	South Sefton CCG	Southport & Formby CCG	Reporting Basis
	patients, above the 90% and 95% targets required.	above the 90% and 95% targets required.	
6 week diagnostic waiting times	The CCG achieved 0.63%, below the threshold of 1%.	The CCG achieved 0.69%, below the threshold of 1%.	Monthly (month 12)
Cancer waiting times	The CCG achieved in all of the nine waiting times standards	Southport and Formby CCG achieved in 6 of the 9 categories. Achievement to February 2014 was 90.16% against 93% for 2 week wait Breast Referrals. For the 62 day target, 81.84% was achieved cumulatively to February 2014 which failed to achieve the target of 85%.	Monthly (month 11)
Ambulance Services	NWAS achieved 75.3% of Category A calls within 8 minutes, above the 75% target (this target is only applicable and measured to NWAS overall, not CCG level)	NWAS achieved 75.3% of Category A calls within 8 minutes, above the 75% target (this target is only applicable and measured to NWAS overall, not CCG level)	Monthly (month 12)
A&E four hour waiting times	The CCG achieved 95.66% above the 95% target in month 12.	The CCG achieved 95.56% above the 95% target in month 12.	Monthly (month 12)
Mixed Sex Accommodation	No breaches were realised by the CCG.	The target for MSA breaches was breached for 13/14 with 4.1 breaches per 1,000 finished consultant episodes against a target of zero.	Cumulative (year end, month 12)
Infection Control	There have been 55 cases of C-Difficile infections reported for South Sefton CCG patients against a target of 44 for 2013/14. There have been 2 cases of MRSA against a zero target in 2013/14.	The CCG has reported zero MRSA cases at the end of March 2014 (target was zero). There have been 45 cases for C-Difficile against a target of 38 in 2013/14.	Cumulative (year end, month 12)

4.1 Both CCGs have demonstrated a strong performance against the key target areas in 2013/14. The challenge remains to create this on a sustainable basis, enabling the health economy to further innovate and transform services to meet the health needs of the population going forward.

4.2 Addressing C-Difficile rates at both major providers remains an absolute priority. The CCGs continue to work with Aintree Hospital and Southport & Ormskirk to tackle and resolve this issue.

4.3 While it is evident that mixed sex accommodation breaches have occurred at Southport & Ormskirk, this largely relates to intensive care provision. Nonetheless the CCG and the Trust are dedicated to avoiding any mixed sex accommodation breaches and are working together to ensure long term compliance with this standard are met and maintained.

5. Strategic Vision

5.1 Both CCGs have come together to develop a strategic vision that is common across South Sefton and Southport & Formby. This vision has built upon the work undertaken by the respective CCGs in developing their own plans to-date and during the CCG authorisation process. In addition, care and consideration has been taken to ensure

that this vision underpins that which has been jointly developed with Sefton Council as part of the existing Health & Wellbeing Strategy.

5.2 The Health & Wellbeing Strategy for Sefton has described its strategic vision as; **"*Together we are Sefton – A great place to be! We will work as one Sefton for the benefit of local people, businesses and Visitors*".**

5.3 Both CCG have developed this joint vision with the support and engagement of its public and partners in an effort to reflect the health requirements and needs of the population now and for the future.

OUR VISION

To create a sustainable healthy community based on health needs, with partners; focused on delivering high quality and integrated care services to all, to improve the health and well-being of our population

5.4 Both CCGs are focused and committed to ensuring that healthcare provision across Sefton, remains fit for the future and is sustainable on a long term basis to meet the growing demands for services, while maintaining and improving the quality of services. This requires the CCGs to concentrate on ensuring that the health needs of the population are at the heart of everything that we do. In striving to deliver services to meet the health needs of the population, both CCGs recognise the commonalities and variances between localities across the borough. In commissioning health services, we are committed to ensuring sensitivity to these varying populations.

5.5 The CCGs recognise the importance of working in partnership, with major and minor healthcare providers, the voluntary, community and faith sectors, the local authority and others to innovate and optimise the way Healthcare is provided. This is a fundamental commitment as part of our strategic vision.

5.6 There is also recognition in this vision that there needs to be more progress towards integration of services to support the rising demand for health services. Both CCGs are committed to driving collaboration between elements of the health sector and each other along with social care; The aim being to deliver quality and seamless services to our population.

5.7 In recognition of the constitutional requirement, both CCGs have signalled an absolute commitment to ensuring the delivery of high quality healthcare services to the public, in terms of access, equitability, clinical standards and outcomes. We believe that in conjunction with our public and partners we can considerably improve not just the health, but the wellbeing of our population

5.8 Underpinning our strategic vision, the CCGs have robustly developed and described a set of values and principles that will be pursued as part of their operating framework. These values will be evident in everything that we do, how we conduct ourselves, undertake business and engage with our public and partners.

OUR VALUES

- **We will 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 be caring and compassionate.**
- **We will act with integrity, courage, act fairly and with respect.**
- **We will have a person focussed approach to Health Care.**
- **We will develop a culture of challenge, ownership, innovation and improvements.**

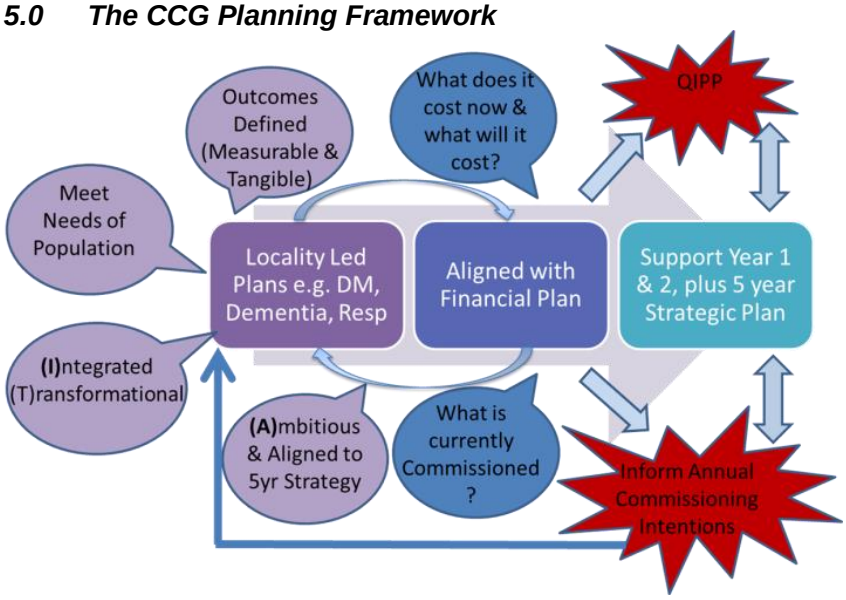
- **We will be accountable for what we do.**
- **We will enable action and prioritise effort to optimum effect.**

6. Strategic Planning Framework

6.1 In an effort to develop a supportive approach to the development of the five year Strategic Plan and two year Operational Plan, significant work with financial, clinical and senior team colleagues has been undertaken to develop a framework for building and delivering the plans. While this framework is sensitive the immediate planning requirements set out nationally, it has been important to put in place a framework that supports the annual iteration of plans that will be required going forward.

6.2 The diagram below describes the framework that has been developed for the CCG and is now in place.

Diagram 5.0 The CCG Planning Framework



6.3 This framework ensures that all the CCG plans are based upon and informed by the needs of the local population and that any outlying health issues are addressed within plans. To assist with this a variety of information and data sources have been used to identify priority areas, service gaps and outstanding health needs. These include:-

- the Joint Strategic Needs Assessment
- the annual public health report for Sefton
- office of National Statistics data and analysis on the local population and disease incidence and prevalence
- right Care analysis, enabling the CCG to identify comparative performance against similar benchmark CCGs, where a further opportunity for improvement is identified
- provider level data on performance and outcomes.

6.4 In addition, the approach to building the CCG plans has been to ensure and identify an element of every plan that is integrative (in terms of optimising the collaborative approach with Sefton Council) and also encompasses the transformation requirements set out nationally.

6.5 Each plan is also being developed, not only by the health needs of the population, but also in terms of a defined set of outcomes. Again, this is in keeping with the

requirements set out nationally. However, many of these outcomes will be more specific than the nationally defined subset and specific to the programme of work within the plan for example the End of Life programme is defining outcomes in terms of deaths in usual place of residence across five years; the aim being to reduce deaths in hospital and enhance and facilitate end of life care in the community. This approach will thus enable a relationship to be established between plans and reductions in unplanned activity (another key national requirement). It will also enable an annual review and iteration of plans to be undertaken against progress and outcomes, requiring plans to be augmented or re-directed as necessary.

6.6 In an effort to ensure absolute alignment with the national requirement on the reduction of unplanned care, all plans have this focus built into them, again attempting to define and describe the associated level of reduction in unplanned care with each programme. Indeed, it is envisaged that any future business cases will need to clearly demonstrate the associated reduction in unplanned care to enable the appropriate investment and commissioning decisions to be made on a robust basis.

6.7 This approach is aligned with the target reduction of 15% in unplanned care being set at a national level and the requirement to transfer activity and resources from acute providers to the community. It also facilitates clear financial alignment, as any planned reduction in acute unplanned activity and value will be clearly and demonstrably evident against any increase in community based activity and value, thus supporting an integrated financial and Strategic Plan.

6.8 An important component of the developing plans is to enhance understanding and definition around services currently commissioned with providers. This comprehension and understanding has naturally increased within the CCG over the last twelve months but, in addition, some very specific priority areas have been identified and singled out for particular focus for example, Mental Health, with a view to describing the model of care the CCG would wish to commission; a recovery model based on outcomes of care, rather than activity and volume. In developing our Strategic Plans on Mental Health, the CCG is exploring collaborative opportunities with Liverpool CCG, with a view to adopting a joint approach. This has been the direct result of identifying strategic priorities for mental health within CCG plans.

6.9 In parallel to the work on building the CCG plans, the 2014/15 contracting exercise has been utilised to support delivery. Some very specific areas that have been reflected in the 2014/15 contract as a means to supporting and enabling CCG plans include the following:

- requirements around data and outcomes to support the assessment of commissioned services
- requirements associated with Choose & Book to enable increased compliance amongst providers
- identification of existing contracts that need to be appropriately addressed to support the Strategic Plan, for example where contracts need to be served notice or ended to enable a more holistic or systematic approach to be taken for example Oxygen Therapy.

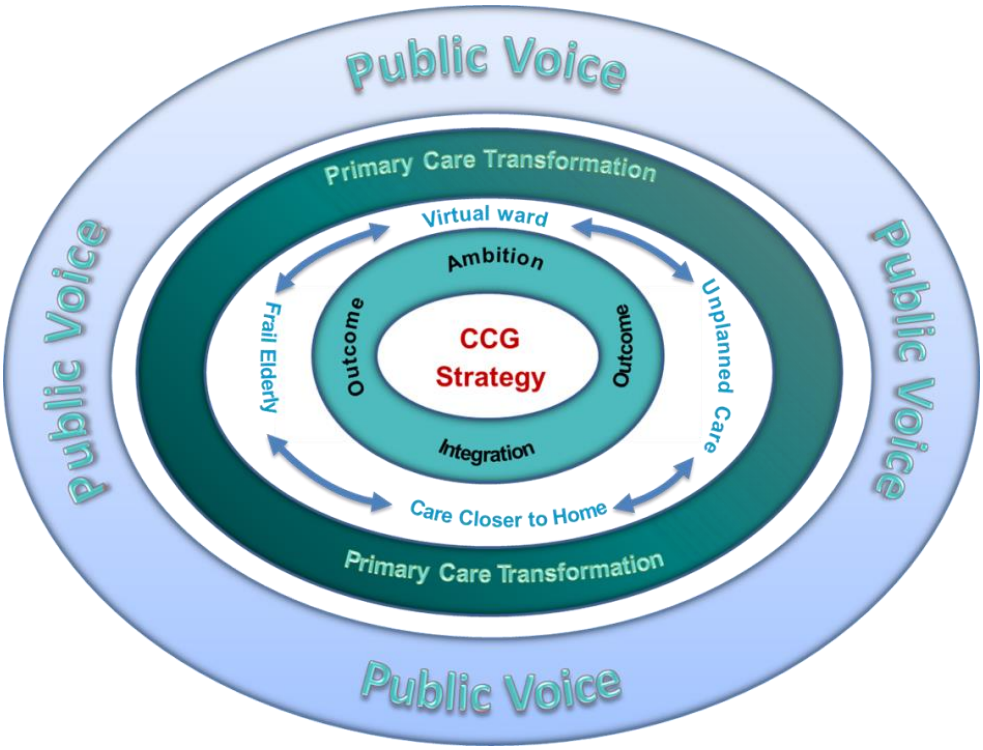
6.10 Commissioning intentions for 2014/15 are also being tested against the developing Strategic Plans, to ensure alignment and to enable any inconsistencies to be addressed. Going forward, it is envisaged that commissioning intentions will be much easier to describe, against the five year Strategic Plan. This should enable the CCG to share indicative commissioning intentions with providers by September each year, supporting providers in terms of their annual business planning cycle and job planning reviews and changes.

6.11 In an effort to adopt an integrated approach to QIPP, the framework is also designed to support the identification, achievement and delivery of QIPP Plans, ensuring that they are a component part of individual plans in addition to the required transfer of activity and value from the acute sector to the community. It is envisaged that this approach will be a transitional approach across the five years of the Strategic Plan, with a more corporate approach to QIPP delivery giving way to individual plans delivering QIPP requirements.

7. Strategic Plan: From Plan to Delivery

7.1 The diagram below reflects the three CCG identified strategic priorities and the transformation schemes as part of the CCG integrated Strategic Plan. It also highlights the importance of public engagement and involvement in developing and refining our plans.

Diagram 6.0 The CCG Integrated Strategic Plan



7.2 The CCG commenced its work on the development of its Strategic Plan in November 2013. Through a series of extensive engagement events and discussions with the public, providers, the Wider Constituent Group, locality leads and Governing Body, the strategic vision and priority areas for the CCG has been clearly defined. As such the CCG has defined three strategic priorities.

OUR STRATEGIC PRIORITIES

1) **Frail Elderly:** To support the frail elderly, with long term conditions, to optimise self-care based in the community or home setting, while preventing unnecessary and unplanned admission to hospital.

2) **Unplanned Care:** To support patients of all ages to manage their healthcare needs at home or in the community setting, while preventing unnecessary and unplanned admission to hospital.

3) **Primary Care Transformation:** To support the healthcare needs of the population through enhanced primary and community care services, supporting

self-care and enabling appropriate intervention at home or in the community and preventing unnecessary and unplanned admission to hospital.

7.3 These priority areas are completely aligned with the national agenda being set by NHS England. At a local level, these priority areas recognise the growing health need of the expanding frail elderly population. It also supports the local requirement and goals associated with reducing unplanned care. Indeed evidence of delivery against this is already apparent in 2013/14 with reduced numbers attending A&E, particularly with respiratory conditions.

7.4 The strategic priority that is primary care is also consistent with the agenda being set by NHS England. The local recognition that primary care has a significant and pivotal role in preventing ill-health, involving patients and carers more fully in managing their health is central to the establishment of this strategic priority within the CCG.

7.5 While these three strategic priorities are aligned with the major health needs and issues for the population of Sefton, there is recognition that other significant areas also need to be addressed within the strategic and operational plans. Three specific areas have been identified for particular focus, in line with the equity of access requirements set out nationally. These are:-

- Children
- Mental health
- Cancer.

7.6 An exclusive focus on the three strategic areas risks the CCG failing to address some very specific health needs in relation to children, mental health and cancer. Indeed, many elements of both the cancer and mental health plans will naturally fall under the three strategic priorities. For example, the dementia component of the mental health plan clearly fits with the frail elderly strategic priority, but additional attention needs to be given to the younger population with mental health conditions. Similarly, cancer is largely associated with the older element of population, but not exclusively, so as such it is right to identify this area for additional focus in an effort to address the wider health needs.

7.7 The children's health agenda is certainly covered in relation to unplanned care and indeed elements of the children's plan for example asthma are very much associated with unplanned care, other issues, like alcohol and ill-health prevention are less so. Thus it is appropriate to identify this are for specific attention in relation to health needs.

7.8 Against the planning footprint of the borough, both Sefton CCGs have identified the major transformation schemes to support realisation of the Strategic Plan. These are:-

OUR TRANSFORMATION SCHEMES

1. **Virtual Ward (South Sefton CCG)**
2. **Care Closer to Home (Southport and Formby CCG)**
3. **Primary Care Transformation**

7.9 Both 1 and 2 above can be described as the locality models for delivery. They have enhanced community support at their heart to enable patients with Long Term Conditions to self-care and to be optimally supported from a health and social care perspective, in a non-acute environment. Their aim is to transform the way in which care is provided in the community and home setting, to build a multidisciplinary team of integrated community resources around individual patients, with the locality General Practitioners central to the clinical management and co-ordination of care. These initiatives have the support of Sefton Council and indeed there is joint agreement between the CCG and the Council that the Better Care Fund should be orientated to

support an enhancement of both of these schemes to further optimise impact on unplanned acute activity.

7.10 Both CCGs have placed a significant emphasis on the role that primary care has to play in transforming the health system across Sefton. This is evident within then CCGs Primary Care Quality Strategy which aims to focus on developing and enhancing the following areas:-

Primary Care Access: Improving access and opening hours of GP practices across the week.

A&E: Review and aftercare of patients attending A&E to assist in future admission avoidance.

Exception Coding: Clinicians reviewing patients who are exception reported from QOF outcome reports, using 13/14 baseline levels with practice plans to review clinical areas where levels exceed 5%.

Public Health: To reduce life threatening illnesses, by increasing uptake of immunisations and smears, reducing health inequalities in preventable illnesses and support practices to achieve good practice comparable to their peers.

Shared Care: Prescribing management under named Consultants for specific conditions, through the GP.

Phlebotomy: Local provision at practice level, avoiding unnecessary requests of secondary care.

Drug Administration: The controlled administration of very specific medication injections with a view to avoiding unnecessary secondary care attendance.

Data Validation: The review of secondary care coding data at a patient level to enable coordinated and appropriate joined up care with primary care.

Travellers / Gypsy Scheme: Focused care on this element of the population, given propensity for illness and development of long term conditions, with a view to avoiding unnecessary unplanned care.

Care Closer to Home / Virtual Ward: Engagement and commitment of GP's in integrating care with community services, based on a locality delivery model.

Practice Development Plan: Support for the development of a strategic plan at practice level, in line with the CCG strategic priorities to ensure sustainable quality primary care services in terms of resources and estate.

OUR STRATEGIC PROGRAMMES

7.11 Seven strategic programme areas have been identified to support the level of planning and delivery detail required in relation to the Strategic Plan. These include:-

1. Mental Health & Dementia
2. Cardiovascular Disease (including stroke)
3. Respiratory Disease
4. Cancer
5. Children's Health
6. End of Life
7. Diabetes.

7.12 The CCG has undertaken an extensive level of engagement and development sessions with the public, providers and other stakeholders to build, shape and inform the strategic programmes. This work has not only been instrumental in driving the content of the strategic programmes, it has assisted in identify three additional programme areas for the CCGs to tailor their plans to. These are-

1. Neurology
2. Liver Disease
3. Kidney Disease.

7.13 While Specialist Neurology and Neurosurgery fall under the commissioning of NHS England, the CCG recognises that particular attention needs to be given to the range of neurological conditions e.g. Motor Neurone Disease, Parkinson's, Epilepsy, Alzheimer's Disease that is evident within our population. Indeed, given the age profile of our population and the growing incidence of neurological conditions, their impact on individuals, families, carers and health services, it is right to provide additional focus on this area as part of the strategic plan.

7.14 The national trend of increasing liver disease, often associated with alcohol abuse is certainly evident within areas of Sefton. Indeed alcohol consumption amongst children has been identified as a challenging area for the CCG to address. The long term health and economic consequences of alcohol abuse and liver disease are well recognised and an area that CCGs wish to target as part of their strategic plans

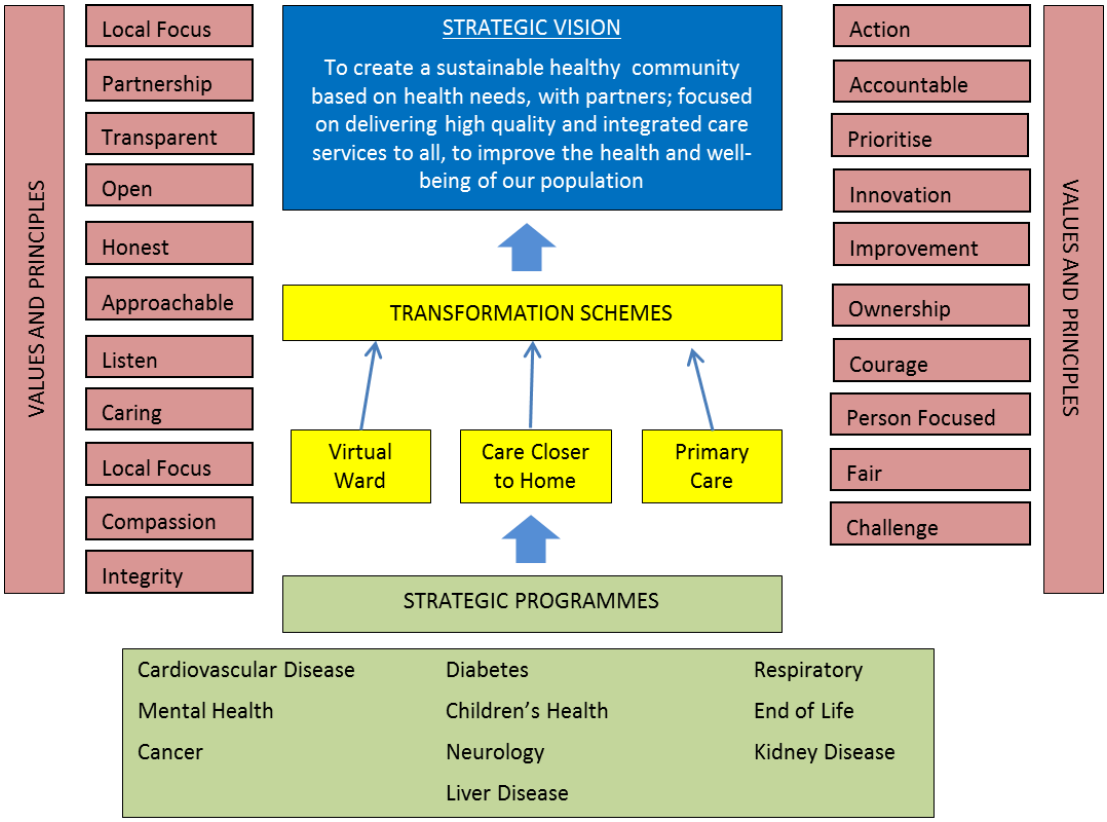
7.15 Specialist Kidney (Renal) Services are commissioned by NHS England, however the CCG recognises that acute kidney injury can be a major factor in elderly patients, resulting in admission and prolonged stay in hospital. If the CCGs are to address the strategic priority of unplanned care, it is right that particular focus and attention be given to this area.

7.16 In developing the strategic programmes above, the CCGs have ensured that each programme addresses the following:-

- population Health Needs
- plans to address and support these across five years
- defined outcomes
- associated reduction in unplanned activity.

7.17 The diagram below describes the way in which the strategic programmes for the CCG support and underpin the three major transformational schemes, contributing to the achievement of the overall strategic vision. The values and principles for the CCGs permeate all aspects of the strategic plan from the strategic programmes to the transformation schemes.

Diagram 7.0 From Strategic Programmes to Transformation and Delivery



7.18 Each of the strategic programmes has a designated clinical and managerial lead focused on development and in particular delivery and implementation. This leadership is focused on progressing plans with a number of key outcomes in mind.

- To reduce unplanned and unnecessary hospital admission.
- To support and promote self-care.
- To develop and support primary care services in enabling individuals to remain well and in their home environment.
- To develop and support community services in enabling individuals to remain well and in their home environment.
- To enhance and enable support from the community, voluntary and faith sectors in promoting self-care and care at home, without the need for unnecessary hospital admission.
- To integrate health and social care in support of self-care and admission avoidance.
- To ensure alignment of plans with public health to optimise health impact.
- To underpin and contribute to the major transformation of primary care and community services.
- To underpin and support the delivery of our locality care clinical model, Virtual Ward and Care Closer to Home.

7.19 The CCGs are reviewing the adequacy of leadership support for the strategic programmes. The table below highlight the latest leadership assignment across the CCGs.

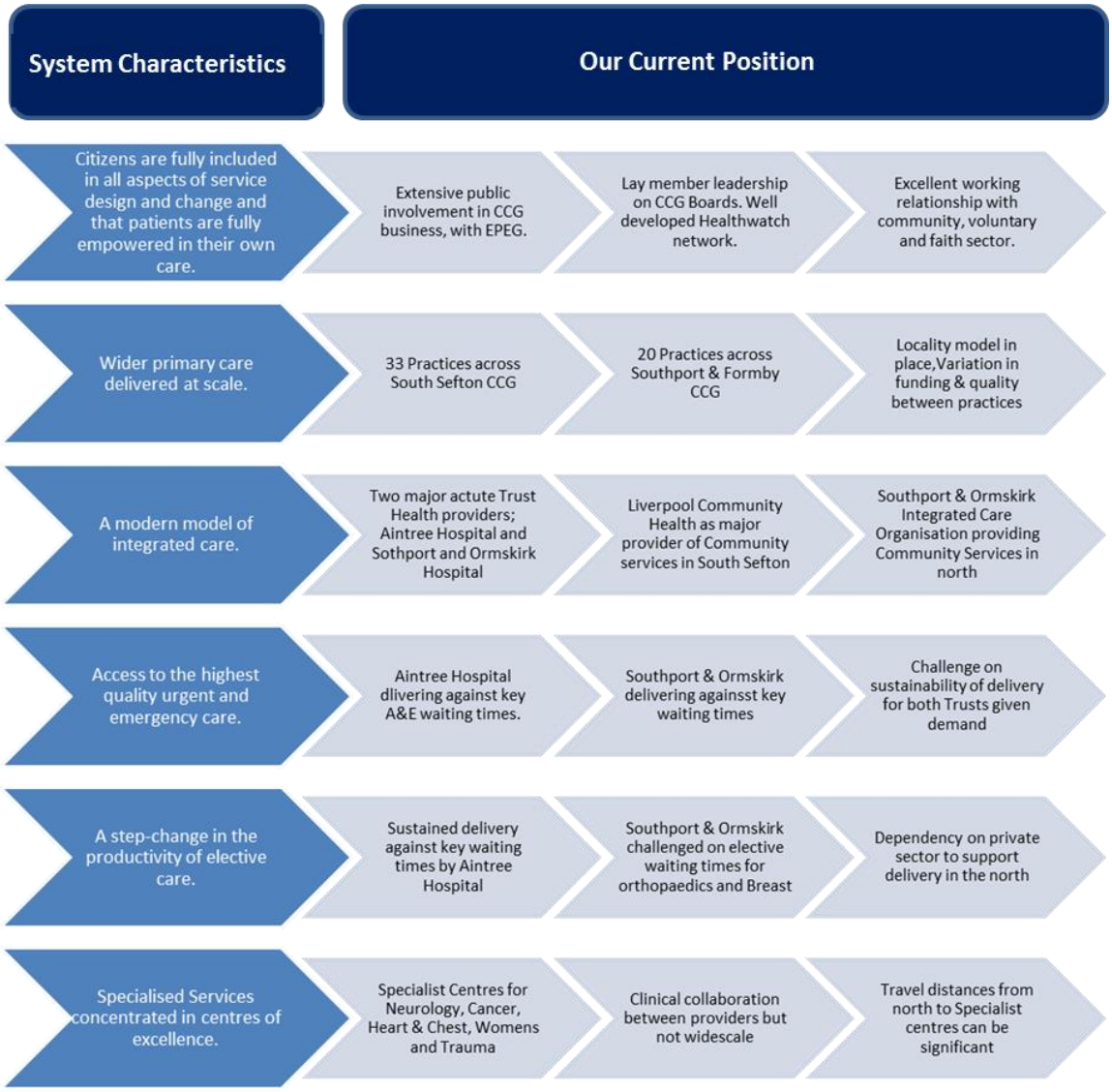
Table 8.0 Strategic Programme Leads

Programme	Clinical Lead S&F CCG	SSCCG	Managerial Lead
CVD	Vacancy	Vacancy	Sharon Forrester
Respiratory	Vacancy	Vacancy	Jenny Kristiansen
Diabetes	Dr Doug Callow	Dr Nigel Taylor	Terry Hill
Cancer	Dr Graeme Allan	Dr Debbie Harvey	Sarah McGrath
Mental Health	Dr Hilal Mulla	Dr Ricky Sinha	Jenny Kristiansen
Children	Dr Rob Caudwell	Dr Wendy Hewitt	Jane Uglow
End of Life	Dr Jackie Reddington	Dr Debbie Harvey	Moira McGuinness
Urgent Care	Dr Niall Leonard	Dr Andy Mimnagh	Terry Hill
Virtual Ward	-	Dr Debbie Harvey	Tina Ewart
Care Closer to Home	Dr Niall Leonard	-	Billie Dodd
Primary Care	Dr Bal Duper	Dr Bal Duper	Angela Parkinson

8.0 System Characteristics

8.1 ***"Everyone Counts: Planning for Patients 2014/15 to 2018/19"***, was published by NHS England in December 2014 and described six system characteristics for a sustainable model of healthcare. As part of the five year strategic plan, both CCGs have assessed their current position against these characteristics and described a future state under the strategic vision. This is depicted in the diagram below.

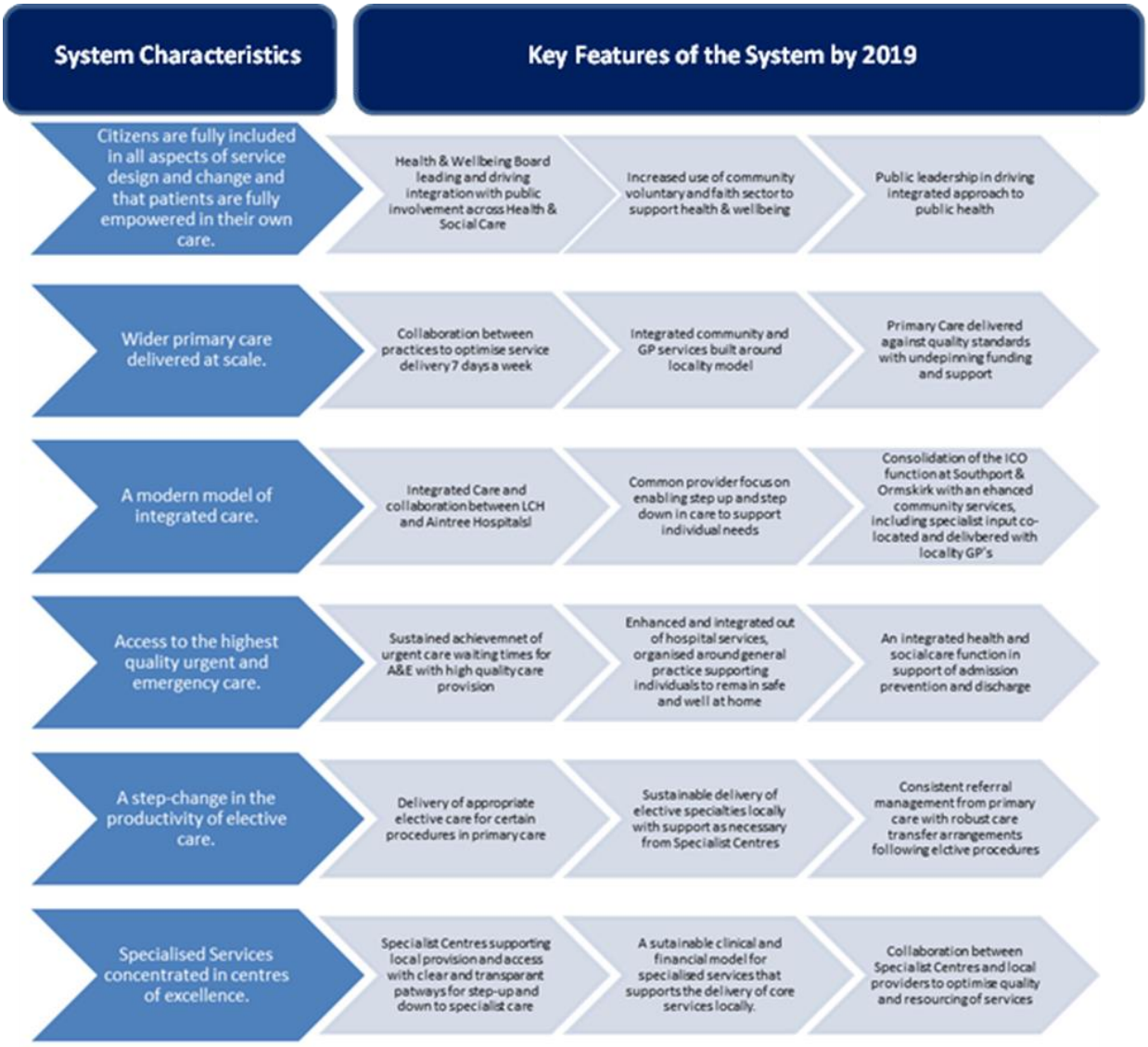
Diagram 8.0 The 6 System Characteristics for a Sustainable Health Economy – Our Current Position.



8.2 This analysis highlights some real significant progress across both South Sefton CCG and Southport & Formby CCG and is testament to the real difference that clinically led commissioning is making, even at this early stage. It is important that both CCGs build upon this early platform of success and achievement, to move into a new phase of enhanced service transformation in support of the three strategic priorities (Frail Elderly, Unplanned Care and Primary Care).

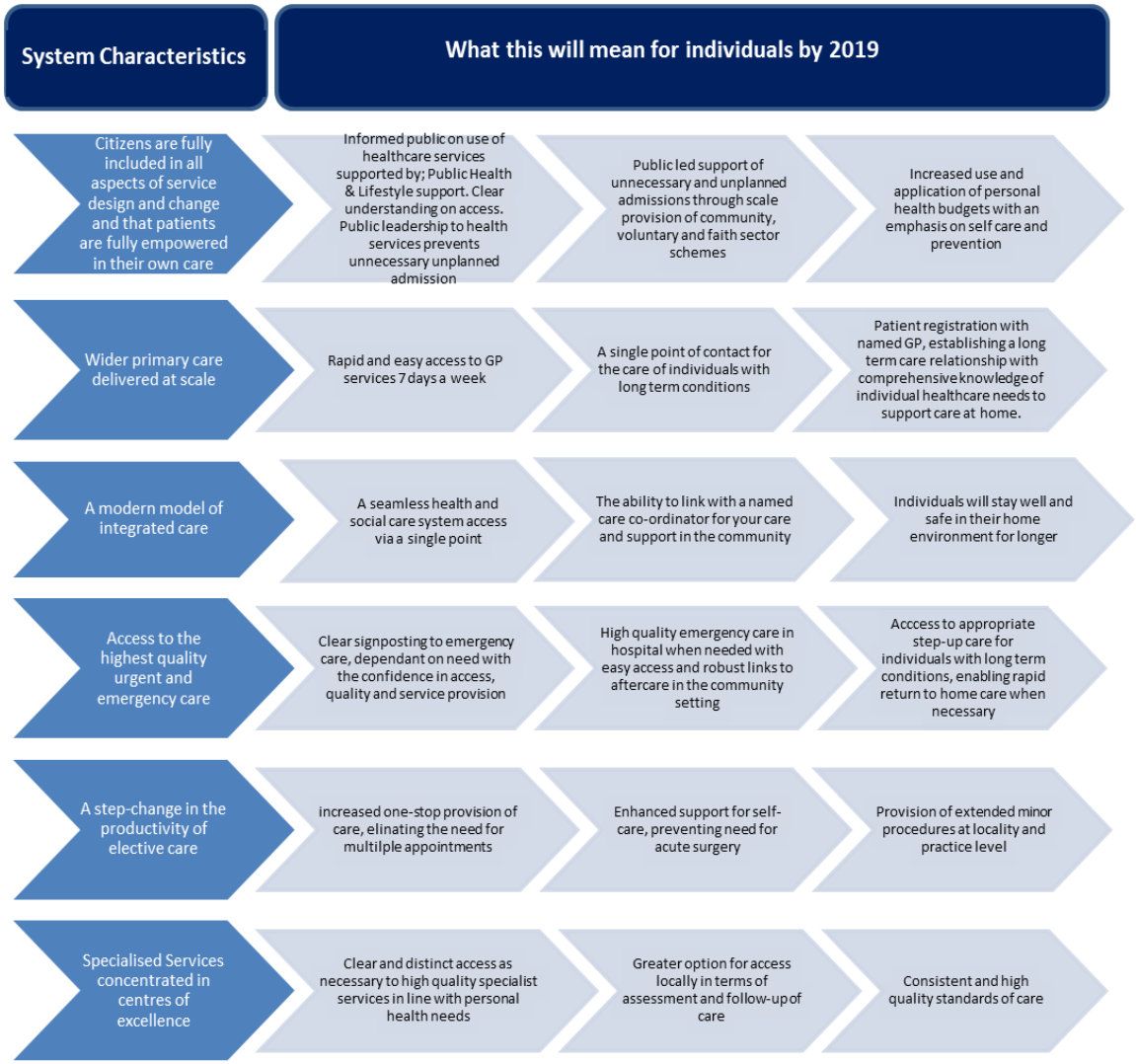
8.3 The diagram below describes the health system features that both CCGs are striving to achieve as part of their five year strategic plan. This places a key emphasis on self care and care closer to home with enhanced public support, novel input from the community, voluntary and faith sector. It also describes an advanced model of primary care, with enhanced and supported GP services working in an integrated way with community services.

Diagram 9.0 Key Features of the Sefton Health System by 2019



8.4 The diagram below begins to describe the difference this will make to individuals and what they can expect to see from their health system by 2019.

Diagram 10.0 What will it mean for individuals: The Sefton Health System by 2019

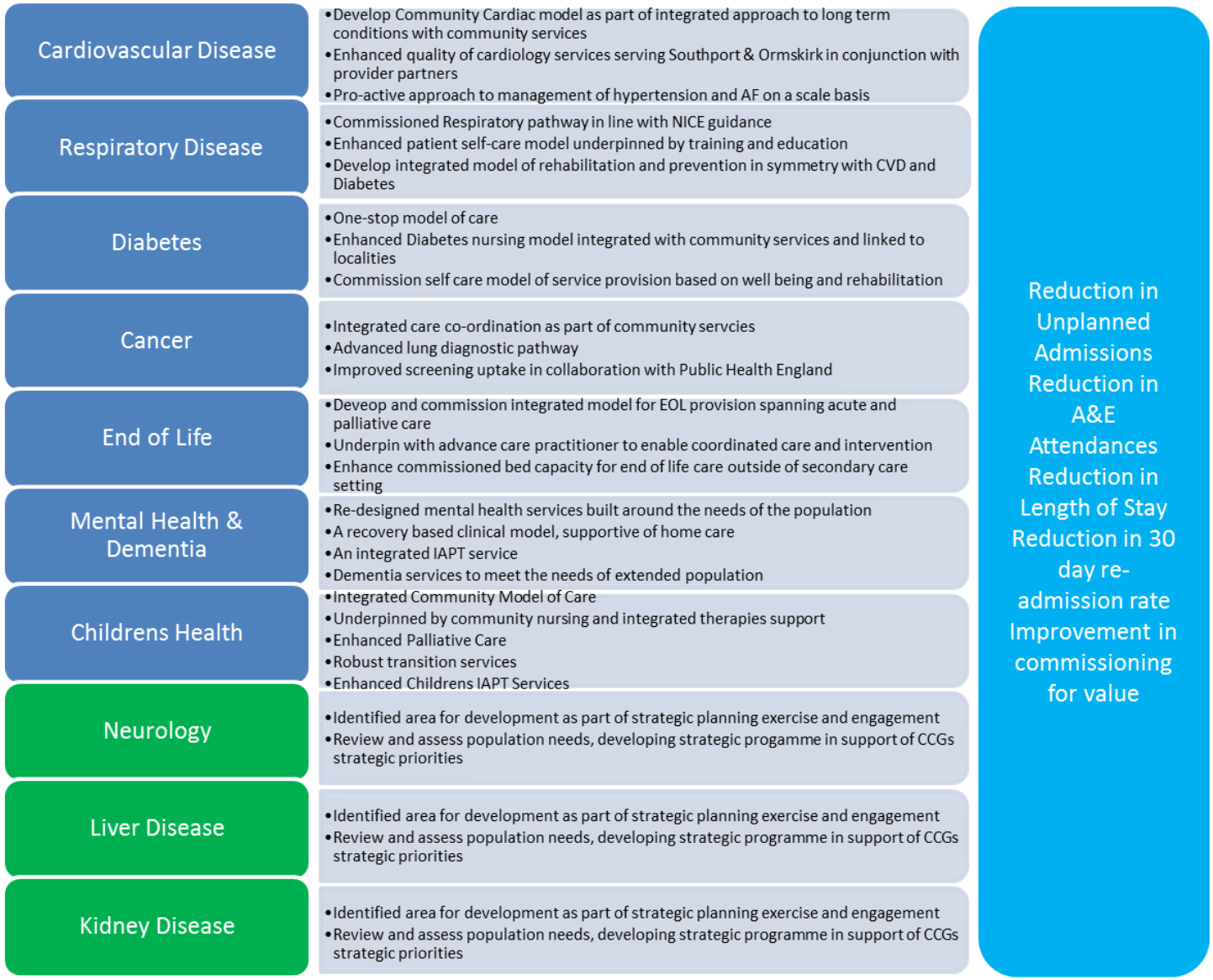


8.5 Implicit within the above is the strong emphasis on individuals, carers and families taking increased responsibility for their own health, with the healthcare provision supporting this at every point. This goal is set against a commitment to deliver enhanced primary and community services, while ensuring that high quality hospital care is accessible when needed and remains free at the point of delivery.

8.6 The diagram below references the key strategic programmes and summarises the key elements of their plans, together with the targeted outcomes for each. Every programme is focused on improving the quality of patient care, but in addition and in line with the strategic vision and priorities, remains absolutely geared towards:-

- A reduction in unnecessary and unplanned care.
- A reduction in the length of stay for patients, relevant to the specific programme.
- A reduction in attendances at A&E.
- A reduction in the 30day re-admission rate for patients discharged from hospital.
- An improvement in the “Rightcare Value”.

Diagram 11.0 Strategic Programmes: Key Elements & Outcomes



8.7 The extensive engagement process that the CCG has undertaken with the public, providers and other stakeholders has identified three additional programme areas for the CCGs to target. Having identified these, the CCGs are now in the process of identifying the necessary leadership to drive progress in these areas forward. This will result in detail plans being developed against these programmes with a similar outcome aim.

9. Outcome Ambitions

9.1 The two year operation plan for the CCG, centres around the development of targets or goals for the six ambition outcomes prescribed by NHSE. The aspiration for the CCGs across five years is set out below.

Outcome Ambition 1 – Partial Years of Life Lost

9.2 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.

9.3 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**			
SFCCG	2009	2010	2011	2012	09-10	10-11	11-12	09-12
	2052	2566	2283	2498	20%	-12%	9%	18%

9.4 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.

Outcome Ambition 2 – To Reduce Unplanned Hospital Admission

9.5 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%

9.6 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

9.7 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

9.8 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.

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

9.10 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

9.11 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

9.12 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.

10. Better Care Fund

10.1 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 and a revision to this on 4th April. Detailed plans continue to be developed jointly, building on the shared vision set out in the Health & Wellbeing Strategy.

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

"Together we are Sefton – a great place to be!
We will work as one Sefton for the benefit of local people, businesses and visitors"

10.2 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.

10.3 **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.*

10.4 **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.

10.5 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.

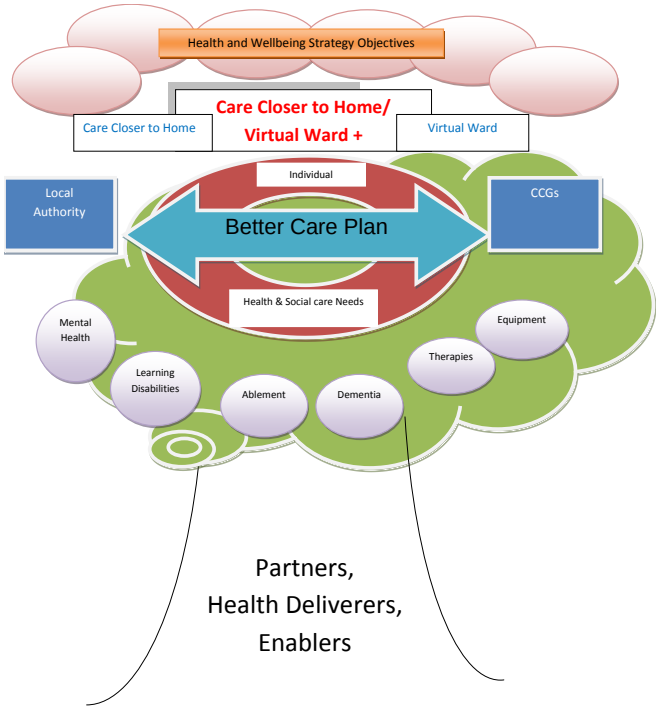
10.6 In addition to the above, the BCF has attempted to describe the significant changes to services and patterns of services that are likely to be evident over the next 5-10 years, most notably:-

- 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 re-ablement 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.

10.7 In terms of alignment and consistency the changes described above are at one with the system characteristics described as part of the CCGs five year strategic plan and support deliver of the major transformation schemes (Virtual Ward, Care closer to home).

Diagram 12.0 The Better Care Fund Model for Sefton



10.8 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.

10.9 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.

10.10 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.

10.11 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.

11. Governance

11.1 In order to drive and support deliver against the strategic vision, the three major transformation schemes (Virtual Ward, Care Closer to Home, Primary Care) and the seven strategic programmes, both CCGs have reviewed infrastructure, performance and leadership arrangements.

11.2 This review has not only focused on accountability and assurance systems, with reporting arrangements to the respective CCG Governing Bodies, but also at a delivery level in terms of the programmes.

11.3 The key governance, performance and delivery enhancements are as follows:

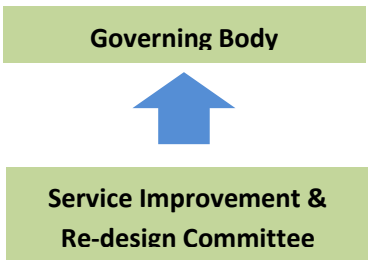
- a clinical and managerial lead for each strategic programme;
- each programme developed in conjunction with the PMO to ensure alignment with core strategic priorities and outcomes;
- the development of key outcome measures for each programme in relation to impact on unplanned admissions, A&E attendances, Length of stay, 30day re-admission rates;
- each programme to report to Service Improvement & Re-design Committee as part of revised Governing Body and committee structure;
- each major transformation scheme and its leadership to report to Service Improvement & Re-design Committee as part of revised Governing Body and committee structure;
- the quality delivery aspects of all programmes and transformation schemes to be tested through Quality Committee;
- a progress report on all programmes and major transformation schemes to be considered at each Governing Body meeting, to enable board members to be sighted on progress, test and assure on delivery and provide support in addressing any complex multi-organisational or political issues;
- the development of performance dashboards for each of the major transformation schemes, supported and overseen by the PMO.

11.4 In addition to the above, both CCGs recognise the integrity of their strategic plan with the Health & Wellbeing Strategy and the Better Care Fund Plan. It is envisaged that the Health & Wellbeing Board will be similarly briefed on progress in relation to the CCGs strategic plan, through representation in the form of the Accountable Officer and the respective CCG Chairs.

11.5 It should be noted that in an effort to refocus and support delivery further, that South Sefton CCG and its two major partners (Southport & Ormskirk Hospital Trust and West Lancashire CCG) are undertaking a review of the Care Closer to Home Programme. This is aimed at gaining further alignment with the respective CCG strategic plans, including West Lancashire CCG. It is also aimed at re-aligning the health system priorities to support and deliver the locality based clinical model, described earlier in this document.

11.6 The diagram below describes the reporting and accountability arrangements for the major transformation schemes and the component strategic programmes

Diagram 13.0 Strategic Programmes and Major Transformation Schemes: Reporting Arrangements



NHS Southport and Formby CCG Governing Body

Audit Committee

SMT: **Martin McDowell**. Chair: **Helen Nichols**

Key functions and responsibilities: To support the establishment of an effective system of integrated governance, risk management and internal control and to review and approve the arrangements for discharging the Group's statutory financial duties.

Remuneration Committee

Chair: **Helen Nichols**

Key functions and responsibilities: Determining the remuneration and conditions of service of the senior team, approval of severance arrangements and approval of disciplinary arrangements for employees, including the Chief Officer

Finance and Resources

SMT: **Martin McDowell**
Chair: **Helen Nichols**
Clinical Director: **Dr Evans**

Key functions and responsibilities

- To advise the Governing Body on all financial matters
- To review and manage the overall financial position
- To ensure that the performance of commissioned services is monitored in line with CCG expectations
- To advise on procurement and contracting arrangements
- To monitor contract and procurement arrangements
- To review and monitor Foundation Trust applications
- To review and monitor CHC financial position
- To determine banking arrangements
- To approve arrangements for exceptional/novel treatments including IFR
- To review and monitor workforce performance
- To review and monitor Commissioning Support Unit performance

Quality Committee

SMT: **Debbie Fagan**
Chair: **Dr Rob Caudwell**
Clinical Director: **Dr Doug Callow**

Key functions and responsibilities

- To monitor standards and provide assurance on the quality of commissioned services
- To review and monitor Serious Incidents
- To promote a culture of continuous improvement and innovation with respect to safely, clinical effectiveness and patient experience
- To provide an assurance to the Governing Body that there are robust processes for managing risk
- To ensure appropriate Safeguarding arrangements are in place
- To provide corporate focus, strategic direction and momentum for quality, and risk management
- To review and monitor medicines management
- To approve corporate and clinical policies

Service Improvement and Redesign

SMT: **Karl McCluskey and Jan Leonard**
Chair: **Dr Niall Leonard**
Clinical Directors: **Dr Kati Scholtz**

Key functions and responsibilities

- To identify potential areas of service improvement
- To establish the rationale and evidence base supporting the need for improvement
- To ensure that localities are fully engaged in processes
- To assess and approve business cases
- To monitor and measure impact of improvements
- To facilitate engagement with stakeholders
- To ensure that all service reviews and the implementation of new services comply with all relevant laws and legislation
- To support improvements in Primary Care
- To monitor programmes including Virtual Ward, Care Close to Home, Children's, Mental Health, planned and unplanned care

Supporting the Quality Committee: The CGSG will provide assurances on the processes for reviewing the GBAF and CRR and make recommendations to the Committee. The group will review policies and procedures and recommend them as appropriate to the committee for approval.
Supporting Audit Committee: The group is part of the CCGs Risk and Control Framework and will enable the Audit Committee to obtain assurances on key internal control requirements.

Corporate Governance Support Group

Chair: **Tracy Jeffes**

Key functions and responsibilities:
Ensuring compliance with relevant legislation and standards, monitoring activity and providing assurances in respect of :

- *Public Sector Equality Duty (PSED)*
- *Health and Safety (Incidents and LSMS)*
- *Third Party Claims*
- *Governing Body Assurance Framework and Corporate Risk Register*
- *Information Governance (IG Toolkit)*
- *Freedom of Information Requests*
- *Subject Access Rights Notifications*

Engagement and Patient Experience Group

Chair: **Tracy Jeffes**

Key functions and responsibilities:
Reviewing relevant data, analysing trends and themes, ensuring compliance and providing advice in respect of:

- *Patient Experience themes and trends*
- *Complaints (secondary)*
- *Complaints (primary care)*
- *PALS*
- *NHS Constitution*
- *Engagement and consultation*
- *Soft Intelligence*
- *Stakeholder Engagement and Involvement*

Supporting the Service Improvement and Re-Design Committee: The EPEG will provide patient experience intelligence to this committee. This provides a framework for enabling patient experience to inform commissioning decisions.
Supporting the Quality Committee: EPEG will provide patient experience intelligence to the quality committee, particularly in respect of quality and safety issues that are signalled through complaints and PALS.

11.7 The key revised committee structure for both South Sefton and Southport & Formby CCG is set out on the diagram on the following page. This adds further context in terms of the accountability and reporting lines for the Transformation schemes and the strategic programmes.

12. Conclusions

12.1 The CCG has a detailed five year strategic plan developed, which has been build with the input of members, the public, providers and the community, voluntary and faith sectors.

12.2 The strategic plan has a clear vision for the health system that is Sefton, which is agreed by both South Sefton CCG and Southport & Formby CCG.

12.3 The key transformation schemes to support delivery of the strategic plan are the Virtual Ward, Care Closer to Home and Primary Care.

12.4 The major transformation schemes are underpinned by seven strategic programmes, with an additional three programmes identified through engagement and consultation.

12.5 Both CCGs have described a clear definition of the Health system now and in 2019, what it will mean for individuals and what the system characteristics will be.

12.6 CCG Governance arrangements have been enhanced to ensure leadership of both the transformation schemes and the strategic programmes.

12.7 The CCG committee structure has been revised to ensure that the necessary progress and monitoring can occur via the Service Improvement & Re-design Committee.

12.8 Regular reporting on scheme and programme progress, together with any issues for escalation will be undertaken at each Governing Body Meeting.

12.9 Outcome and performance metrics have been developed for each Strategic Programme.

12.10 The Better Care Fund Plan does not sit separate to the CCG Strategic Plan and the ambitions described in both are aligned and complementary.

12.11 The financial component of this plan is described in the CCG financial strategy. It is envisaged that this will be integrated into this document by the end of June 2014.

12.12 All the financial detail and structure of the financial strategy is aligned to the content of this strategic plan.

12.13 This strategic plan assumes an underpinning quality strategy which addresses and supports all aspects of the CCG compliance requirements. It is intended that this strategy will be augmented to reflect the integrated quality strategy by the end of June 2014.

12.14 A public facing version of this strategic plan, in summary form will now be developed for the end of June, for publication and dissemination.

13. Recommendations

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

- endorse the five year strategic plan as set out in this document;
- recognise and support the augmentation of the strategic programmes with three additional programme areas having been identified through engagement and consultation;
- endorse the outlined governance and reporting arrangements;
- provide the delegated authority to submit the final five year strategic plan in the varying template formats required by NHSE, based on the plan and detail contained in this paper;
- support the final enhancement of this strategic plan, in integrating the financial and quality strategy.

Karl McCluskey
May 2014

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/73(b)	**Authors of the Paper:**
Report date: May 2014	James Bradley Head of Strategic Financial Planning James.bradley@southseftonccg.nhs.uk Tel 0151 247 7070 Martin McDowell Chief Finance Officer martin.mcdowell@southseftonccg.nhs.uk Tel 0151 247 7065

Title: Five Year Financial Plan

14/73

Summary/Key Issues:

This report sets out a longer term financial strategy and the assumptions which underpin it. It identifies the relationship between the financial plan and the CCG's overarching strategic direction. The underlying risks facing the CCG are also outlined. The report assesses the base case scenario for the CCG and develops a financial strategy for the 5 years up to and including 2018/19.

Recommendation

Receive	x
Approve	x
Ratify	

The Governing Body is asked to approve the financial strategy and note:

- the range of assumptions used to provide estimates for future year planning periods;
- the potential risks concerning future CCG resources;
- that the strategy enables the CCG to deliver its financial targets during the period;
- the requirement to develop robust QIPP plans to address potential downside scenarios.

Links to Corporate Objectives	
x	Improve the quality of commissioned services, whilst achieving financial balance.
x	Achieve a 1% reduction in non-elective admissions in 2014/2015.
x	Implementation of 2014/15 phase of Virtual Ward plan.
x	Review and re-specification of community nursing services for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014-15 phase of Primary Care quality Strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

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	
	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
May 2014

1. Introduction

1.1 The purpose of this paper is to set out a 5 Year Financial Strategy for the CCG for the period between 2014/15 and 2018/19. The paper outlines the key considerations in producing the plan and discusses the key issues, principles and assumptions that underpin it. The Strategy is a dynamic plan that will adjust in line with changes to the external environment such as government policy and the development of the CCG's commissioning plans.

1.2 The first iteration of the Financial Strategy was presented to the Finance and Resource Committee in November 2013, and this report provides an update to that strategy. This iteration incorporates all of the latest guidance and information received from NHS England in terms of financial planning across this timescale.

1.3 The guidance "Everyone Counts: Planning for Patients 2014-15 to 2018/19" sets out the aims for the NHS. The planning guidance also set out the requirements for CCG financial plans for 2014/15:

- To deliver a 1% surplus at year end
- 2.5% non-recurrent spend (including 1% for transformation / "call to action fund")
- A minimum 0.5% contingency reserve is created.

In developing the longer term strategy it has been assumed that the financial planning requirements set out in Everyone Counts should still be applied over the 5 years of the Strategy. The only exception to this is the requirement to hold non-recurrent reserves which reduce to 1% from 2015/16.

1.4 The CCG's Financial Strategy needs to be in line with its commissioning intentions and show integration with key partners. All CCGs are required to submit planning templates that cover the following areas:

- Strategic plan
- Operational plan
- Financial plan
- Better Care Fund

1.5 An initial version of the Financial Strategy was submitted to NHS England on 14th February 2014, and an updated version was submitted on 4th April 2014. A final version will be submitted in June 2014.

2. Key Principles and assumptions

2.1 The Financial Strategy considers the likely funds available to the CCG – the Resource Allocation set by NHSE – against its planned spend on health care services which it is responsible for and its administrative (running) costs. It reflects and supports the CCG's

commissioning intentions. A Financial Strategy may be distinguished from the Annual CCG Budget by attempting to assess resources and spending beyond the next financial year. There are benefits to longer term planning in that commissioning changes may take more than 12 months to implement. It also enables the organisation to identify financial risks early and make plans to address them.

Revenue Allocations

2.2 A new funding formula for CCGs was published by NHS England in December 2013. This identified that South Sefton CCG was considered "over-funded", compared to its target allocation, as identified in Table 2.

Table 2

	£000	
Baseline allocation @ M6 2013/14	£221,894	
Target allocation	£201,119	
Initial Distance From Target (DFT)	£20,775	10.33%

	£000	
Baseline allocation @ M6 2013/14	£221,894	
Approved allocation transfers	-£3,718	
Revised baseline allocation	£218,176	
Target allocation	£201,119	
Revised Distance from Target (DFT)	£17,057	8.48%

2.3 The CCG is estimated to be over target by 8.48% and therefore received the lowest level of funding available to CCGs with confirmed uplifts of 2.14% in 2014/15 and 1.70% in 2015/16. This option was considered by NHS England to provide stability and not expose CCGs to unexpected changes in funding. The CCGs that were most under-funded were given additional increases to their baselines with the highest increase being 4.92% in 2014/15 and 4.79% in 2015/16. There still remains wide variation in terms of levels of CCG distance from target across England ranging from 11.02% under target to 33.49% over target, with those furthest under target lobbying for a quicker pace of change. On this basis, it would be sensible for the CCG to develop a downside scenario which develops a plan to reach its target by the end of 2018/19. This would entail delivering significantly more QIPP savings during this timescale.

2.4 In establishing a DFT figure, NHSE has acknowledged that the formula has a tolerance of +/- 5% in terms of its margin for error. When CCG's fall within this range, they will have been deemed to be "within target", under current policy.

Allocations have been confirmed for 2015/16 financial year, but the CCG should be mindful that the pace of change policy may be accelerated in the period from 2016/17 to 2018/19. The CCG should take advantage of the intervening period to develop robust QIPP plans for the following downside scenarios.

i. the CCG is required to reach 5% above DFT by end of 2018/19.
ii. the pace of change policy is applied so that all CCG's reach target by end of 2018/19 in which case the CCG's expenditure will need to be in line with target.

2.5 NHS funding has been guaranteed real-terms (above inflation) growth during the life of the current parliament and this has been confirmed at national level within NHS England's board paper on financial planning. However, the picture that emerges at local level is

somewhat different. The CCG will have additional expenditure commitments in 2014/15 which will need to be funded from its growth allocation. The table below highlights the key changes which have been factored into the CCG's financial planning strategy.

Table 3

	£000
South Sefton CCG Growth	4,669
Additional commissioning obligations	
CHC restitution payments	(881)
Support for patients aged over 75	(776)
Other NHS Mandate pressures	(1,091)
Remaining growth funding	1,921
Real growth	0.88%

2.6 The estimate of real growth available to the CCG is therefore 0.88% which compares unfavourably with the current GDP deflator of 2.14% and concludes that the CCG did not receive real-terms growth funding when considering the additional expenditure streams outlined above.

2.7 The additional commitments comprise of the following

CHC restitution – CCG's have been notified of a "top-slice" arrangement to create a £250m national pool to deal with outstanding CHC restitution payments. This is subject to ongoing debate across the NHS finance community, particularly given that assurances had been given that CCG's would not inherit PCT legacy debt.

Transforming care of elderly (over 75) and other vulnerable people – CCG's have been asked to earmark funding of £5 per head to reduce avoidable admissions into hospital settings. Whilst this may reduce savings elsewhere in the CCG's budgets, the operational plans for achievement are not fully completed and on this basis, the CCG plans to fund this development through growth funding as opposed to potential QIPP savings.

National Programmes – CCG's have been asked to plan for the roll-out of a number of schemes which will be announced at different stages throughout the year. The amount set aside at national level is £530m and the CCG has yet to receive confirmation as to what programmes will be included against this funding although it would appear that the recent announcement of £90m to support improved diagnosis and care for dementia sufferers will be funded using this resource.

Expenditure assumptions

2.8 The CCG will need to ensure that it contains its expenditure levels within its specified allocation and that it meets its financial targets during the period under review. The bulk of the expenditure will be spent on commissioned health care services whilst a much smaller proportion will be spent on the capped running costs (for South Sefton CCG this is £3.690m in 2014/15).

In terms of the financial strategy, the key issue will be the degree of control that the CCG can exercise on the costs of the services it commissions. These can vary either due to inflationary price changes or changes in activity. The price changes for NHS providers will be set nationally by Monitor in conjunction with NHSE, and guidance is outlined overleaf in Table 4. The application of continued efficiency assumptions in the tariff will pose a significant financial risk to providers of healthcare.

Table 4

Tariff assumptions					
	2014/15	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Secondary care health cost inflation	2.8%	2.9%	4.4%	3.4%	3.4%
Provider sector efficiency	-4.0%	-4.0%	-4.0%	-4.0%	-4.0%
Tariff uplift / deflator	-1.2%	-1.1%	+0.4%	-0.6%	-0.6%

2.9 It should be noted that the NHS faces significant pension cost increases in 2015/16 and 2016/17, which have been factored into the tariff. Other assumptions used in modelling the Financial Strategy are outlined in appendix 1.

3. Investments and QIPP

Investments

3.1 The Financial Strategy is required to support the CCG's overarching strategic direction. Investment plans and QIPP plans support the CCG's strategy to reduce unplanned care and move care from acute to community settings. The following investments support this initiative:

- Virtual Ward
- Accountable professional – support for patients over 75 and those with complex health needs
- Primary Care Quality Strategy
- End of Life Facilitator
- Better Care Fund
- CVS

3.2 Appendix 2 outlines the investments planned by the CCG over the next 5 years. The CCG is required to have a non-recurrent investment reserve of 2.5% in 2014/15, which reduces to 1% thereafter. This reduction in non-recurrent programme spend transfers a number of non-recurrent schemes into recurrent spend from 2015/16. This includes the expenditure associated with the Virtual Ward and the Primary Care Quality Strategy, which the CCG can now develop with greater certainty in respect of funding.

3.3 The investment plan also outlines costs associated with approved business cases. Many of these are expected to deliver cost savings elsewhere in the health system (eg. SIP feeds)

3.4 The CCG has a number of programmes of work that also support the strategic direction of supporting patients with long term conditions, providing care closer to home and thus reducing unplanned episodes of hospital care. These programmes of work are in the following areas:

- Diabetes
- Cardiovascular disease (CVD)
- Respiratory
- Cancer
- Children
- End of Life
- Primary Care
- Mental Health

QIPP

3.5 The level of QIPP efficiency savings within the Financial Strategy is reported in Appendix 3. At this stage it focuses upon the following areas:

- tariff efficiencies,
- reductions in the costs associated with unplanned care.
- reductions in prescribing costs
- management cost reductions from 2015/16.

3.6 The reductions in unplanned care have assumed a 15% reduction in emergency admissions by 2018/19. This uses 2012/13 as the baseline year. A significant reduction has been achieved in 2013/14, and the plan assumes that this is maintained in 2014/15. Smaller reductions are then seen in each subsequent year. Reductions in A&E attendances have also been achieved in 2013/14, and the plan assumes reductions of 2% each year from 2015/16. The investment plans are targeted at achieving these reductions.

3.7 An amount of unidentified QIPP is included in the plan. There is a link between investment plans and cost improvement plans. Full investment plans can only be released when the QIPP plans have been delivered. The CCG has a designated QIPP target to reach each year, and at present the CCG has further cost improvements to identify to reach this target. Work has started to identify additional cost reduction opportunities centred on more efficient provision of healthcare and more effective financial management. The work programmes in paragraph 3.4 are being costed to quantify the opportunities available.

3.8 NHS England has published indicative Running Cost Allowances (RCA) for the 5 year period ending 2018/19. This shows a 10% reduction in 2015/16, with smaller reductions in subsequent years. The CCG plans to hold contingency in 2014/15 to enable it to make a contribution to this target but it is likely that QIPP savings will be required against the RCA in order to deliver the 2015/16 requirement. This has been factored into the model and the CCG will be required to outline its plans to deliver these savings accordingly.

3.9 If NHS allocation uplifts reduce further after 2015/16 then further efficiencies will be needed to ensure that the CCG can deliver its financial duties. Future iterations of the Financial Strategy will model a downside scenario that shows the CCG reach its target allocation by 2018/19.

Better Care Fund

3.10 The allocation information published by NHS England also includes figures in relation to the Better Care Fund (BCF). The BCF (previously referred to as the Integration Transformation Fund) was announced in June 2013 as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with more integrated care and support. It aims to improve the lives of some of the most vulnerable people in society by enabling the provision of the right care, in the right place, at the right time, including through a significant expansion of care in community settings.

3.11 The Fund nationally provides for £3.8 billion worth of funding in 2015/16. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the BCF in 2015/16. The table overleaf summarises the values in terms of South Sefton CCG contributions.

Table 5

	BCF Additional Allocation (A)	Total transfer to BCF (B)	Net contribution to BCF (B-A)
	£000	£000	£000
NHS South Sefton CCG	£4,105	£12,387	£8,282

3.12 In 2015/16, the £12.387m will be transferred to the Better Care Fund, and commissioning plans will be agreed between Sefton MBC and the two Sefton CCGs. The pooled fund with Sefton MBC and Southport and Formby CCG will total £24.032m, and a high level expenditure plan is detailed in table 6:

Table 6

Area of spend	2015/16 planned spend (£000)
Existing section 256 agreements	5,700
Disabled Facilities Grant	1,900
Social Care Capital Grant	900
Carers breaks	500
Reablement	1,800
Demographic pressures on social care	3,000
Transformational schemes	10,232
Total BCF expenditure plans	**24,032**

4. Mitigating Financial Risks

4.1 The key risks to the CCG achieving its financial duties are:

- NHSE policy relating to the Pace of Change for CCG Allocations;
- the relative gap between annual allocation growth and national price or tariff uplifts net of the efficiency factor;
- activity growth for services subject to cost and volume payment systems e.g. PbR and Continuing Healthcare;
- increased costs due to PbR case mix changes or higher cost best practice tariffs;
- national NHS Mandate “must do’s” which require investment, including costs associated with 7 day working;
- failure to deliver the savings from the CCG’s QIPP schemes;
- significant reduction in allocation associated with the Better Care Fund;
- the financial viability of providers.

4.2 The CCG will need to ensure that the risks are managed. One element of the financial system that may reduce risk is to plan not to spend 100% of the CCG allocation but keep some back to use as a contingency reserve to deal with in-year cost pressures. The Financial Strategy builds in a 0.5% contingency reserve to accommodate unforeseen overspends. It is also important that the investment plans associated with the Better Care Fund and reductions in unplanned care are effective. If cost savings are not delivered then investment plans will need to be delayed until the required savings are planned and delivered.

5. Financial Strategy

5.1 The CCG has developed its financial strategy model using both national guidance and locally determined assumptions. The Financial Strategy complies with all national guidelines. The outputs of this model are reflected in the appendices within this paper:

i). Planning assumptions 2014-19
ii). Investment profile 2014-19
iii). QIPP Plans 2014-19
iv). Summary Financial Position 2014-19.

5.2 Appendix 4 shows the draft anticipated financial position to 2018/2019 over the key spending categories. The base budgets for the key expenditure categories are carried forward over the years with adjustments made for activity growth, inflation, QIPP, pricing changes, and other known investments and pressures.

5.3 A number of factors will influence the CCG's financial strategy in terms of changes from its current base model (i.e. projected expenditure for 2013/14). These will include:

i) growth assumptions for individual CCGs;
ii) the introduction of the target allocation and "pace of change" in terms of how quickly CCG's will move towards target;
iii) the CCG's ability to manage in-year pressures particularly in relation to increasing demand for services;
iv) the CCG's planned investment programme;
v) the CCG's ability to deliver QIPP savings both in cash-releasing terms and non-cash releasing terms (e.g. improved quality / managing demand through different service models etc).

All of these issues are interlinked and will need to be carefully monitored and evaluated as part of the strategic planning process. If in-year costs increase at a higher than expected level, then the CCG will either have to deliver more savings through QIPP or alternatively look to defer its planned investment programme.

5.4 Estimates of in-year pressures faced by the CCG have been built into the strategy. Some of the key assumptions involved have been listed in appendix 4 of the report.

5.5 The Financial Strategy demonstrates that the CCG will stay in financial balance over the next 5 years – as limited allocation growth together with tariff efficiency and other CCG QIPP savings combine to give re-investment and development opportunities to the CCG over the period. This strategy is based upon the CCG being able to control expenditure at 13/14 levels, building in planned investments and deployment of contingency. The risks to achieving this are significant, and the CCG needs to continue to monitor expenditure trends on a monthly basis and develop effective QIPP plans.

6. Conclusions

6.1 This paper sets out the key issues behind the creation of a longer term Financial Strategy for the CCG to 2018/2019. In developing the Strategy assumptions need to be made given the significant uncertainties that there are over allocations and spending that will apply to CCGs from 2014/2015.

6.2 The paper proposes that the CCG will need to ensure that it has access to sound financial management and systems coupled with robust governance arrangements if it is to be able to ensure delivery of its financial duties – given the financial risks inherent within the current NHS system.

6.3 The paper sets out the development of a model to support its longer-term goals and duties over the next 5 years to 2018/2019. The modelling suggests that the CCG will meet its financial obligations, but it is important to note that this is subject to a number of assumptions. One assumption is continued growth in funding. Downside scenarios (see section 2.4) will be developed to reflect the changes needed should the CCG be required to meet its target allocation by the end of the planning period (2018/19).

7. Recommendations

The Governing Body is asked to approve the Financial Strategy and note:

- the range of assumptions used to provide estimates for future year planning periods;
- the potential risks concerning future CCG Resources;
- that the strategy enables the CCG to deliver its financial targets during the period;
- the requirement to develop robust QIPP plans to address potential downside scenarios.

Appendices

- Appendix 1 – Planning assumptions 2014-19
- Appendix 2 – Investment profile 2014-19
- Appendix 3 – QIPP Plans 2014-19
- Appendix 4 – Summary Financial Position 2014-19.

	2014 -15	2015 -16	2016 -17	2017 -18	2018 -19
	%	%	%	%	%
Allocation assumptions					
CCG Allocation Growth	2.14%	1.70%	1.80%	1.70%	1.70%
Movement to Target	0.00%	0.00%	0.00%	0.00%	0.00%
Net Growth/(reduction)	**2.14%**	**1.70%**	**1.80%**	**1.70%**	**1.70%**
Running Costs assumptions					
Running Cost Allowance	In line with NHSE reported allocations.				
Cost increase assumptions					
Tariff assumptions - provider inflation	2.80%	2.90%	4.40%	3.40%	3.40%
Tariff assumptions - Efficiency Savings	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
Non-demographic growth - Prescribing	5.00%	5.00%	5.00%	5.00%	5.00%
Non-demographic growth - Acute	0.50%	0.50%	0.50%	0.50%	0.50%
Prescribing Efficiency Savings	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
Non-demographic growth - Continuing Healthcare	4.00%	4.00%	4.00%	4.00%	4.00%
Non-demographic growth - other (non acute)	0.00%	0.00%	0.00%	0.00%	0.00%
Demographic Growth	0.18%	0.15%	0.29%	0.11%	0.25%
Business Rules					
Non Recurrent requirement for CCGs	1.50%	1.00%	1.00%	1.00%	1.00%
CCG Surplus	1.00%	1.00%	1.00%	1.00%	1.00%
Contingency	0.50%	0.50%	0.50%	0.50%	0.50%
"Call to Action" Fund	1.00%				

NHS South Sefton CCG **APPENDIX 2**

Investment Profile 2014-19	2014/15			2015/16			2016/17			2017/18			2018/19		
	Rec £000's	Non-R £000's	Total £000's	Rec £000's	Non-R £000's	Total £000's	Rec £000's	Non-R £000's	Total £000's	Rec £000's	Non-R £000's	Total £000's	Rec £000's	Non-R £000's	Total £000's
Investment Plans															
Mersey Care TIME project	0	170	**170**	1,020	0	**1,020**	0	0	**0**	0	0	**0**	0	0	**0**
NHS COIN Infrastucture Costs	86	0	**86**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Additional Contribution to Aintree CDU	500	0	**500**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
EMIS Web Licences - Support Costs	0	0	**0**	195	0	**195**	0	0	**0**	0	0	**0**	0	0	**0**
Pick-up of MacMillan GP Sessions	0	0	**0**	28	0	**28**	0	0	**0**	0	0	**0**	0	0	**0**
MERIT proposals	43	0	**43**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Adoption of IVF amendments	136	0	**136**	92	0	**92**	46	0	**46**	0	0	**0**	0	0	**0**
Aspergers	92	0	**92**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Virtual Ward	0	0	**0**	1,654	0	**1,654**	0	0	**0**	0	0	**0**	0	0	**0**
Transforming Primary Care	0	0	**0**	466	0	**466**	0	0	**0**	0	0	**0**	0	0	**0**
Care Home Medicines review	73	0	**73**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
SIP Feeds Review	29	0	**29**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Accountable professional - support for over 75s	776	0	**776**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
NHS Mandate investments	1,091	0	**1,091**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Sub-Total - investment plans	**2,826**	**170**	**2,996**	**3,455**	**0**	**3,455**	**46**	**0**	**46**	**0**	**0**	**0**	**0**	**0**	**0**
Non-Recurrent Investment Plan		**1.50%**			**1.00%**			**1.00%**			**1.00%**			**1.00%**	
Virtual Ward	0	1,654	**1,654**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Mersey Rehab Project	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
CVS	0	0	**0**	0	720	**720**	0	720	**720**	0	720	**720**	0	720	**720**
Advancing Quality Infrastructure	0	88	**88**	0	80	**80**	0	72	**72**	0	0	**0**	0	0	**0**
Community Spirometry	0	83	**83**	0	83	**83**	0	83	**83**	0	83	**83**	0	83	**83**
Winter Pressures	0	470	**470**	0	470	**470**	0	470	**470**	0	470	**470**	0	470	**470**
EOL Facilitator	0	44	**44**	0	44	**44**	0	44	**44**	0	0	**0**	0	0	**0**
Intermediate care	0	117	**117**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
CHC Restitution	0	881	**881**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
S&O Winter pressures support	0	90	**90**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Other	0	0	**0**	0	819	**819**	0	867	**867**	0	1,020	**1,020**	0	1,058	**1,058**
Sub-Total - non-recurrent investment plan	**0**	**3,427**	**3,427**	**0**	**2,216**	**2,216**	**0**	**2,256**	**2,256**	**0**	**2,293**	**2,293**	**0**	**2,331**	**2,331**
Call to Action Fund		**1.00%**													
Mersey Rehab Project	0	816	**816**												
CVS	0	720	**720**												
Transforming Primary Care	0	466	**466**												
EMIS Web Licences - Support Costs	0	154	**154**												
Mersey Care TIME project	0	80	**80**												
Sub-Total - Call to Action Fund	**0**	**2,236**	**2,236**												
Total - Investment Plans	**2,826**	**5,833**	**8,659**	**3,455**	**2,216**	**5,671**	**46**	**2,256**	**2,302**	**0**	**2,293**	**2,293**	**0**	**2,331**	**2,331**

Cash Releasing - QIPP Profile 2014-19

	2014/15			2015/16			2016/17			2017/18			2018/19		
	Rec £000's	Non-R £000's	Total £000's	Rec £000's	Non-R £000's	Total £000's	Rec £000's	Non-R £000's	Total £000's	Rec £000's	Non-R £000's	Total £000's	Rec £000's	Non-R £000's	Total £000's
Tariff Saving	6,563	0	6,563	6,523	0	6,523	6,516	0	6,516	6,581	0	6,581	6,566	0	6,566
Prescribing	1,112	0	1,112	1,125	0	1,125	1,138	0	1,138	1,153	0	1,153	1,165	0	1,165
Running Cost Allowance reductions	0	0	0	394	0	394	25	0	25	23	0	23	22	0	22
EOL Facilitator	44	0	44	0	0	0	0	0	0	0	0	0	0	0	0
Care Home Medicines Review - drugs	92	0	92	0	0	0	0	0	0	0	0	0	0	0	0
Care Home Medicines Review - admissions	36	0	36	0	0	0	0	0	0	0	0	0	0	0	0
Stoma Pilot	35	0	35	0	0	0	0	0	0	0	0	0	0	0	0
SIP Feeds review	29	0	29	0	0	0	0	0	0	0	0	0	0	0	0
Ophthalmology - intraocular pressure	48	0	48	0	0	0	0	0	0	0	0	0	0	0	0
Unplanned admissions reduction - Virtual Ward	0	0	0	166	0	166	164	0	164	193	0	193	221	0	221
Unidentified plans	493	0	493	244	0	244	609	0	609	503	0	503	478	0	478
Total	**8,452**	**0**	**8,452**	**8,452**	**0**	**8,452**	**8,452**	**0**	**8,452**	**8,452**	**0**	**8,452**	**8,452**	**0**	**8,452**

Summary of Financial Position 2014-19	2014/15			2015/16			2016/17			2017/18			2018/19		
	Rec £000's	Non-R £000's	Total £000's	Rec £000's	Non-R £000's	Total £000's	Rec £000's	Non-R £000's	Total £000's	Rec £000's	Non-R £000's	Total £000's	Rec £000's	Non-R £000's	Total £000's
Base Allocation	218,175	0	218,175	222,844	0	222,844	218,350	0	218,350	222,281	0	222,281	226,059	0	226,059
Growth	4,669	0	4,669	3,788	0	3,788	3,930	0	3,930	3,779	0	3,779	3,843	0	3,843
Pace of Change impact	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Agreed allocation adjustments	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Better Care Fund - Additional allocation	0	0	0	4,105	0	4,105	0	0	0	0	0	0	0	0	0
Better Care Fund - Transfer to pooled budget	0	0	0	(12,387)	0	(12,387)	0	0	0	0	0	0	0	0	0
PY Surplus / Lodgement returned non-rec	0	2,312	2,312	0	2,300	2,300	0	2,250	2,250	0	2,300	2,300	0	2,350	2,350
Running Cost Allocation	3,690	0	3,690	3,296	0	3,296	3,271	0	3,271	3,248	0	3,248	3,226	0	3,226
Total Resources	**226,534**	**2,312**	**228,846**	**221,646**	**2,300**	**223,946**	**225,552**	**2,250**	**227,802**	**229,307**	**2,300**	**231,607**	**233,128**	**2,350**	**235,478**
Planned Application of Funds															
Acute Health Expenditure	122,074	4,378	126,452	121,451	3,264	124,715	122,781	3,277	126,058	122,606	3,258	125,864	122,573	3,238	125,811
Community Expenditure	19,345	3,165	22,509	20,802	1,502	22,304	20,944	1,505	22,449	20,845	1,500	22,346	20,776	1,496	22,271
Mental Health Expenditure	16,135	694	16,829	17,061	511	17,572	17,210	514	17,723	17,179	510	17,690	17,174	507	17,682
Continuing Care Expenditure	10,164	0	10,164	10,586	0	10,586	11,040	0	11,040	11,494	0	11,494	11,983	0	11,983
Prescribing Expenditure	29,286	49	29,335	29,669	49	29,719	30,101	49	30,151	30,488	49	30,538	30,924	49	30,974
Other Primary Care Expenditure	3,455	1,144	4,599	4,148	516	4,664	4,159	508	4,667	4,164	436	4,600	4,173	436	4,609
Other Costs Expenditure	7,446	184	7,630	7,438	67	7,505	7,471	67	7,538	7,475	23	7,498	7,485	23	7,508
Contingency Reserve	676	479	1,155	1,779	0	1,779	2,902	0	2,902	4,044	0	4,044	5,205	0	5,205
Other Reserves	1,321	170	1,491	1,321	819	2,140	1,321	867	2,188	1,321	1,020	2,341	1,321	1,058	2,379
NHSE Mandate Investments	1,091	881	1,972	1,091	0	1,091	1,091	0	1,091	1,091	0	1,091	1,091	0	1,091
Better Care Fund (investments)	0	0	0	(2,937)	0	(2,937)	(2,937)	0	(2,937)	(2,937)	0	(2,937)	(2,937)	0	(2,937)
Committed reserves	0	1,213	1,213	0	0	0	0	707	707	0	3,291	3,291	0	5,603	5,603
Unidentified QIPP	(493)	0	(493)	(737)	0	(737)	(1,346)	0	(1,346)	(1,849)	0	(1,849)	(2,327)	0	(2,327)
Total Programme Expenditure Commitments	**210,499**	**12,357**	**222,856**	**211,672**	**6,729**	**218,401**	**214,736**	**7,494**	**222,231**	**215,921**	**10,088**	**226,009**	**217,441**	**12,411**	**229,852**
Running cost expenditure	3,690	0	3,690	3,296	0	3,296	3,271	0	3,271	3,248	0	3,248	3,226	0	3,226
Total Expenditure Commitments	214,189	12,357	226,546	214,968	6,729	221,697	218,007	7,494	225,502	219,169	10,088	229,257	220,667	12,411	233,078
Planned Surplus / (Deficit) (£000)	**12,345**	**(10,045)**	**2,300**	**6,679**	**(4,429)**	**2,250**	**7,544**	**(5,244)**	**2,300**	**10,138**	**(7,788)**	**2,350**	**12,461**	**(10,061)**	**2,400**
Planned Surplus / (Deficit) (%)	**5.4%**		**1.0%**	**3.0%**		**1.0%**	**3.3%**		**1.0%**	**4.4%**		**1.0%**	**5.3%**		**1.0%**

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/74	**Author of the Paper:**
Report date: May 2014	Susanne Lynch Deputy Head of Medicines Management slynch@nhs.net Tel: 0151 247 7146

Title: Prescribing Performance Update

Summary/Key Issues:

This paper presents the Governing Body with an update on prescribing spend for February 2014 (month 11)

Recommendation

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

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
	Achieve a 2% reduction in non-elective admissions in 2014/15.
	Implementation of 2014/15 phase of Care Closer to Home/Virtual Ward plan.
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
	Review the population health needs for all mental health services to inform enhanced delivery.

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

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

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

NHS
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Clinical Commissioning Group

Report to the Governing Body
May 2014

1. Executive Summary

The South Sefton CCG position for month 11 (February 2014) is a forecast overspend of £255,968 or 0.99% 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 1.14% for 2013/14 to month 11 against the same period for 2012/13.

The cost of prescribing has increased by 0.45% for 2013/14 to month 11 against the same period for 2012/13.

4. Content

The Medicines Management Team are working closely with finance to explore factors that have affected the prescribing spend for 2013 2014. There are national factors (e.g. budgetary shifts to other organisations, forecasting formula changes by DOH in Q3 and category M drugs tariff changes) that have affected the outturn position as well as local factors (e.g. top slicing of a non-medical prescribing budget, new anti-dementia shared care drug spend).

Medicines Management are working with the operational group GP members to ensure fair adjustments are made to practice out turns where applicable.

5. Recommendations

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

Appendices

Appendix 1 South Sefton CCG forecast out turn at Month 11

Suzanne Lynch
May 2014

Appendix1

South Sefton CCG forecast out turn at Month 11

		SECTION 1: Actual Cost &	SECTION 3: FINANCIAL INFO - Total Prescribing Budget vs Forecast Out-turn			
CCG / Locality / Code	Prescriber Name	Total Act Cost 2013/14	Prescribing Budget Total	Forecast Out-turn (PPD)	Variance	% Variance
NHS South Sefton CCG		**£24,016,744**	**£25,986,103**	**£26,242,071**	**£255,968**	**0.99%**
Bootle		**£6,739,539**	**£7,299,563**	**£7,364,007**	**£64,444**	**0.88%**
N84002	Aintree Road Medical Centre	£442,872	£490,082	£483,907	-£6,175	-1.26%
N84015	Bootle Village Surgery	£1,209,903	£1,253,740	£1,322,010	£68,270	5.45%
N84016	Moore Street Medical Centre	£1,159,451	£1,273,981	£1,266,882	-£7,099	-0.56%
N84019	North Park Health Centre	£1,136,237	£1,325,519	£1,241,517	-£84,002	-6.34%
N84028	The Strand Medical Centre	£1,319,343	£1,344,059	£1,441,590	£97,531	7.26%
N84034	Park Street Surgery	£931,834	£1,012,506	£1,018,176	£5,670	0.56%
N84038	Concept House Surgery	£539,900	£599,676	£589,925	-£9,751	-1.63%
Crosby & Waterloo		**£6,668,426**	**£7,242,202**	**£7,286,305**	**£44,103**	**0.61%**
N84001	42 Kingsway	£919,995	£984,073	£1,005,239	£21,166	2.15%
N84007	Liverpool Rd Medical Practice	£910,650	£984,576	£995,028	£10,452	1.06%
N84009	Azalea Surgery	£419,538	£463,929	£458,411	-£5,518	-1.19%
N84011	Eastview Surgery	£1,031,427	£1,088,410	£1,126,997	£38,587	3.55%
N84020	Blundellsands Surgery	£1,247,637	£1,361,194	£1,363,240	£2,046	0.15%
N84026	Crosby - Ssp Health Limited	£376,932	£413,749	£411,857	-£1,892	-0.46%
N84041	Kingsway Surgery	£653,573	£716,884	£714,131	-£2,753	-0.38%
N84621	Thornton - Ssp Health Limited	£433,372	£455,503	£473,527	£18,024	3.96%
N84626	Hightown - Ssp Health Limited	£337,770	£376,665	£369,067	-£7,598	-2.02%
N84627	Crossways Ssp Health Ltd	£337,533	£397,219	£368,808	-£28,411	-7.15%
Maghull		**£4,232,736**	**£4,629,804**	**£4,624,930**	**-£4,874**	**-0.11%**
N84003	High Pastures Surgery	£1,610,153	£1,752,904	£1,759,346	£6,442	0.37%
N84010	Maghull Health Centre (dr Sapre)	£318,374	£388,033	£347,873	-£40,160	-10.35%
N84025	Westway Medical Centre	£1,103,786	£1,193,833	£1,206,060	£12,227	1.02%
N84622	Maghull Health Centre (dr Thomas)	£355,156	£373,502	£388,064	£14,562	3.90%
N84624	Maghull Health Centre	£252,612	£291,724	£276,018	-£15,706	-5.38%
Y00446	Parkhaven Ssp Health Ltd	£592,655	£629,808	£647,569	£17,761	2.82%
Seaforth & Litherland		**£6,376,042**	**£6,814,534**	**£6,966,830**	**£152,296**	**2.23%**
N84004	Glovers Lane Surgery	£1,178,972	£1,246,916	£1,288,212	£41,296	3.31%
N84023	Bridge Road Medical Centre	£1,259,326	£1,364,244	£1,376,011	£11,767	0.86%
N84027	Orrell Park Medical Centre	£442,116	£483,979	£483,082	-£897	-0.19%
N84029	Ford Medical Practice	£927,259	£993,022	£1,013,176	£20,154	2.03%
N84035	15 Sefton Road	£734,382	£824,591	£802,428	-£22,163	-2.69%
N84043	Seaforth Ssp Health Ltd	£257,706	£249,198	£281,584	£32,386	13.00%
N84605	Litherland - Ssp Health Limited	£454,382	£521,501	£496,484	-£25,017	-4.80%
N84615	Rawson Road Medical Centre	£397,995	£417,669	£434,873	£17,204	4.12%
N84616	Sefton Road Surgery	£344,374	£337,084	£376,282	£39,198	11.63%
N84630	Netherton - Ssp Health Limited	£304,190	£318,330	£332,376	£14,046	4.41%
Y02514	Litherland Primary Care Walk-in Service	£75,340	£58,000	£82,321	£24,321	41.93%

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/75	**Author of the Paper:** Martin McDowell Chief Finance Officer martin.mcdowell@southseftonccg.nhs.uk Tel 0151 247 7065
Report date: May 2014	

Title: Annual Report and Accounts

Summary/Key Issues:

Annual Accounts and Report

Recommendation

Receive	x
Approve	
Ratify	

The Governing Body is asked to:

- note the process for approval of NHS South Sefton CCG Annual Accounts and Report;
- note their invitation to the Audit Committee Meeting, convened to consider approval of annual accounts and report;
- formally declare that:

  "*So far as the member is aware, that there is no relevant audit Information of which they clinical commissioning group's external auditor is unaware; and*

  That the member has taken all the steps that they ought to have taken as a member in order to make them self aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information".

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
May 2014

1. Introduction and Background

1.1 The CCG submitted its draft annual accounts before the specified deadline of 12 noon on 23rd April 2014.

1.2 The CCGs Audit Committee received a narrative report from CCG officers regarding the content of the CCG's accounts in the meeting held on 1st May 2014. The CCGs draft annual report was also presented for comment.

1.3 The CCGs external Auditors were also in attendance at this meeting

2. Approval of the Accounts and Annual Report

2.1 Under the CCGs Scheme of Reservation and Delegation (Schedule 15 of the CCG Constitution) reference is made to the power to approve the annual accounts and report.

2.2 Section 4 delegates responsibility for the approval of the annual accounts and report to the CCG's Audit Committee. The CCGs Audit Committee will meet on 3rd June 2014 at 11.30am to consider findings of the external audit review, with a view to exercising this power. All Governing Body members are welcome to attend this meeting of the Audit Committee.

2.3 In terms of members duties regarding declarations required to support the annual accounts the Chief Finance Officer wrote to Governing Body member on 17th April 2014 (see appendix 1) to advise Governing Body Members of their duties. This was followed up with a verbal briefing in the last Governing Body Development Session held on 24th April 2014.

2.4 Governing body members are now asked to formally declare that as required as part of the CCGs audit process.

3. Recommendations

3.1 Governing Body members are asked to note the process for approval of the Annual Accounts and annual report.

3.2 Governing Body members are asked to note their invitation to the Audit Committee meeting, convened to consider the approval of the annual accounts and annual report.

3.3 Governing Body members are asked to formally declare that:

- *So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware; and,*
- *That the member has taken all the steps that they ought to have taken as a member in order to make them self aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information"*

Appendices

Appendix 1 Communication to GPs from Martin McDowell on 17 April 2014.

Martin McDowell
Chief Finance Officer
May 2014

Emailed to all NHS South Sefton Governing Body Members on 17th April 2014

Sent on behalf of Martin McDowell Chief Officer

Dear All,

The final version of the CCG Annual Reporting Guidance 2013/14 was published on the 27th March 2014. This confirms within the Members Report section of the Guidance (Section 4.7.1.12) that at the meeting of the Governing Body that approves the Annual Report and Accounts, each member must state, and it must be minuted that they have done so, that as far as he/she is aware there is no relevant audit information of which the clinical commissioning group's auditors are unaware. In addition that he/she has taken all steps that he/she ought to have taken as a member of the Governing Body in order to make himself aware of any relevant audit information and to establish that the clinical commissioning group's auditors are aware of that information.

The draft minute that will be discussed and subsequently included in both the relevant Governing Body Meeting Minutes and the Annual Report itself reads as follows:

Each individual who is a member of the Governing Body at the time the Members' Report is approved confirms:

- *So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware; and,*
- *That the member has taken all the steps that they ought to have taken as a member in order to make them self aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.*

In order for Governing Body members to be in a position to confirm this statement I recommend that:

1. There is an initial informal and verbal briefing by me on the Accounts process to the Governing Body at its meeting in April, which is followed up with;
2. A paper to the Audit Committee meeting scheduled for April that covers the process and discussion points raised in the April Governing Body meeting and;
3. A subsequent report back to the full Governing Body meeting in May where I and those on the Audit Committee can provide assurance to the full Governing Body membership before the minute is approved.'

Kind regards,

Martin McDowell
CHIEF FINANCE OFFICER
NHS South Sefton CCG

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/76	**Author of the Paper:**
Report date: May 2014	Graham Morris Chair of Audit Committee Governing Body Lay Member Graham.morris@southseftonccg.nhs.uk Tel: 0151 247 7071 (PA to CFO)

Title: Audit Committee Annual Report 2014

Summary/Key Issues:

In summary the work of the Audit Committee, in the first full financial year in which the CCG has been in existence, can provide assurance to the Governing Body:

- an effective system of integrated governance, risk management and internal control is in place to support the delivery of the CCGs objectives and that arrangements for discharging the CCGs statutory financial duties are now established,
- there were no areas reported by MIAA where weaknesses in control, or consistent non-compliance with key controls, could have resulted in failure to achieve the objective,
- ISA260 Audit Highlights Memorandum will be reported by PWC to the June Meeting as part of the Annual Accounts approval process. This will be followed the publication of the Annual Audit Letter to the Governing Body in its July 2014 meeting.

Recommendation

The Governing Body is asked to receive this report.

Note	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Achieve a 1% reduction in non-elective admissions in 2014/15.
x	Implementation of 2014/15 phase of Virtual Ward plan.
x	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.

x	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
X	Review the population health needs for all mental health services to inform enhanced delivery

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

1. Role of the Audit Committee

1.1. The Codes of Conduct and Accountability, issued in April 1994, set out the requirement for every NHS Board to establish an Audit Committee. That requirement remains in place today and reflects not only established best practice in the private and public sectors, but the constant principle that the existence of an independent Audit Committee is a central means by which a Governing Body ensures effective internal control arrangements are in place. In addition, the Committee provides constructive support to Senior Officers to achieve the strategic aims of the Clinical Commissioning Group.

1.2. The principal functions of the Committee are as follows:

i) to support the establishment of an effective system of integrated governance, risk management and internal control, across the whole of the CCGs activities to support the delivery of the CCGs objectives, and

ii) to review and approve the arrangements for discharging the CCGs statutory financial duties.

1.3. The Committee met as follows:

- 2 May 2013
- 12 September 2013
- 9 January 2014.

1.4. The Committee comprises three members of the Clinical Commissioning Group Governing Body:

- Lay Member (Governance) (Chair)
- Lay Member (Patient Experience & Engagement)
- Practice Manager Governing Body Member.

1.5. The Audit Committee Chair and one other member will be necessary for quorum purposes. Linda Elizi was appointed as the CCGs Lay member for Governance and Audit in September 2012 and resigned in March 2013. Roger Driver deputised as Chair of the committee until Graham Morris was appointed on 1st December 2013

1.6. In addition to the Committee Members, Officers from the CCG are also asked to attend the committee. The core attendance comprises:

- Chief Finance Officer
- Chief Nurse
- Chief Accountant
- Chief Corporate Delivery and Integration Officer.

1.7. In carrying out the above work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions as required. A number of representatives from external organisations attend to provide expert opinion and support:

- Audit Manager MIAA
- Audit Director PWC
- Local Counter Fraud Officer MIAA.

1.8. Attendance at the meetings during 2013/14 was as follows:

Post	Name	2 May 2013	12 Sep 2013	9 Jan 2014
Audit Chair *Resigned from office 30/09/2013*	Linda Elizi	✓	n/a	n/a
Audit Chair *In post from 01/12/2013*	Graham Morris	n/a	n/a	✓
Lay Member - Patient Experience & Engagement (Audit Chair 01/10/2013-31/11/2013)	Roger Driver	✓	✓	x
Practice Manager -Governing Body Member	Lin Bennett/Sharon McGibbon	✓	✓	✓
Chief Finance Officer	Martin McDowell	✓	✓	✓
Chief Nurse	Debbie Fagan	x	✓	x
Chief Accountant From 15 July 2013	Ken Jones	n/a	✓	✓
Chief Corporate Delivery and Integration Officer	Tracy Jeffes	x	x	✓
Internal Audit	Adrian Poll	✓	✓	✓
External Audit	Stuart Baron/Rachel McIlwraith	✓	x	✓
Local Counter Fraud Service	Bernard McNamara/Roger Causer	✓	✓	✓

1.9. The Audit Committee supports the Governing Body by critically reviewing governance and assurance processes on which the Governing Body places reliance. The work of the Audit Committee is not to manage the process of populating the Assurance Framework or to become involved in the operational development of risk management processes, either at an overall level or for individual risks; these are the responsibility of the Governing Body supported by line management. The role of the Audit Committee is to satisfy itself that these operational issues are being carried out appropriately by line management.

1.10. Internal Audit

Role - An important principle is that internal audit is an independent and objective appraisal service within an organisation. As such, its role embraces two key areas.

- The provision of an independent opinion to the Accountable Officer (Chief Officer), the Governing Body, and to the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives.

- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

During 2013/14 Mersey Internal Audit Agency (MIAA) have reviewed the operations of the CCG, have found no major issues and concluded that overall it has met its requirements. They have reported back on a number of areas. In all cases action plans have been implemented and are being monitored. In all areas reviewed to date 'Significant Assurance', has been reported i.e. although some weaknesses their impact would be minimal or unlikely.

There were no areas reported by MIAA where weaknesses in control, or consistent non-compliance with key controls, could have resulted in failure to achieve the review objective. Regular progress reports will continue to be provided to each Audit Committee meeting.

1.11. External Audit

Role - The objectives of the External Auditors are to review and report on the CCG's financial statements and on its Statement on Internal Control.

At this stage of the year External Audit (PWC) are in the early stages of their first audit of the CCGs annual accounts. It is anticipated that the ISA260 Audit Highlights Memorandum will be reported to the June Meeting as part of the Annual Accounts approval process.

This will be followed the publication of the Annual Audit Letter to the Governing Body in its July 2014 meeting.

1.12. Counter Fraud Specialist

Role – To ensure the discharge of the requirements for countering fraud within the NHS, the role is based around seven generic areas, creating an antifraud culture, deterrence, prevention, detection, investigation, sanctions and redress. The Local Counter Fraud Specialist presented the plan for approval in May 2013 and provided regular updates at subsequent meetings.

2. Regular Items for Review

The Audit Committee follows a work plan approved at the beginning of the financial year, which includes, as required:

- losses and special payments;
- outstanding debts;
- financial policies and procedures;
- tender waivers;
- declarations of interest;
- self-assessment of Committee's effectiveness;
- information Governance Toolkit.

3. Conclusions

3.1. The Audit Committee is a key committee of the Governing Body, with significant monitoring and assurance responsibilities requiring commitment from members and support from a number of external parties. The work plan has been developed in line with best practice described in the Audit Committee Handbook and forms the basis of our meetings. In all of these areas the Audit Committee seeks to assure the CCG that effective internal controls are in place and will remain so in the future.

3.2. In summary the work of the Audit Committee, in the first full financial year in which the CCG has been in existence, can provide assurance to the Governing Body:

- an effective system of integrated governance, risk management and internal control is in place to support the delivery of the CCGs objectives and that arrangements for discharging the CCGs statutory financial duties are now established;

- there were no areas reported by MIAA where weaknesses in control, or consistent non-compliance with key controls, could have resulted in failure to achieve the objective;

- ISA260 Audit Highlights Memorandum will be reported by PWC to the June Meeting as part of the Annual Accounts approval process. This will be followed the publication of the Annual Audit Letter to the Governing Body in its July 2014 meeting.

4. Recommendations

The Audit Committee is asked to note the content of this first annual report and approve that this can provide assurance to the next public meeting of the Governing Body.

Appendices

Appendix 1 Director of Internal Audit Opinion

Graham Morris
Lay member - Governance
NHS South Sefton CCG

NHS

Mersey Internal Audit Agency

Director of Audit Opinion and Annual Report (2013/14)

South Sefton

Clinical Commissioning Group

MIAA

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- 1.2 Opinion
- 1.3 Basis for forming the Opinion

Appendix A: Audit Review Outcomes and Delivery

Appendix B: Contribution to Annual Governance Statement

Appendix C: MIAA Quality Service Indicators

1. Director of Audit's Opinion

1.1 Introduction

In accordance with Public Sector Internal Audit Standards, the Director of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance subject to the inherent limitations described below.

The purpose of this Director of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will assist the Governing Body in the completion of its Annual Governance Statement.

1.2 Opinion

My overall opinion is:

Significant Assurance, can be given that that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design or inconsistent application of controls put the achievement of particular objective at risk

1.3 Basis of Forming the Opinion

The basis for forming my opinion is as follows:

Assurance Framework

An Assurance Framework has been established which is designed and operating to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation

Assurance across the organisation's critical business systems:

Access to Services	• Reviews conducted around the controls applied at the CCG in respect of Provider Contract Management and CSU Contract Management were both assessed as significant assurance. • In addition a review conducted on Budgetary Control was also assessed as significant assurance.
Transparency and Governance	• An assessment of the Risk Management arrangements established at the CCG received significant assurance. A review of the arrangements established around the Governing Body Committees also received significant assurance. • We have provided a briefing on the processes established in respect of Conflicts of Interest as well as wider CCG benchmarking in this regard. • We have also reviewed the CCG's Assurance Framework.
Patient Participation and Customer Service	• A review of the activity conducted by the CCG in relation to capturing and reporting Patient Experience received significant assurance.
Informed Commissioning	• An in-year assessment of the policies, systems and processes established to complete the Information Governance (IG) Tollkit received significant assurance.
Higher standards	• A review of the processes established to ensure accuracy, completeness and validation of data with CCG performance reports was assessed as significant assurance.

Contribution to Governance, Risk Management and Internal Control enhancements:

- Insight into the overall governance arrangements gained from liaison throughout the year with the senior management team.
- Review of Constitution ie TORs/SORD etc
- Ongoing discussion with Lead Officers, Lay Members etc.
- Production of Conflicts of Interest Briefing.
- Involvement with the organisation in respect of advice and guidance relating to Governance, including regular review of Governing Body papers.
- Provision of briefings and CCG involvement through MIAA events.

The Opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its Annual Governance Statement.

Tim Crowley

Director of Audit, MIAA
March 2014

Appendix A provides a summary of the Audit Reviews undertaken during the year.
Appendix B provides further information to consider when compiling the Annual Governance Statement (AGS).
Appendix C provides assurance regarding the quality of MIAA's service.

Appendix A: Audit Review Outcomes and Delivery

Performance against Plan

The Internal Audit Plan has been delivered in accordance with the schedule agreed with the Audit Committee at the start of the financial year. This position has been reported within the progress reports across the financial year, with the final report concluding completion of the Internal Audit Plan.

Risk Based Reviews

The audit assignment element of the Opinion is limited to the scope and objective of each of the individual reviews. Detailed information on the limitations to the reviews has been provided within the individual audit reports and through the Audit Committee Progress reports throughout the year. The schedule below provides a summary of the reviews/objectives contributing to this element of the Opinion.

HIGH ASSURANCE	Our work found some low impact control weaknesses which, if addressed would improve overall control. However, these weaknesses do not affect key controls and are unlikely to impair the achievement of the objectives of the system. Therefore we can conclude that the key controls have been adequately designed and are operating effectively to deliver the objectives of the system, function or process
	None of the reviews achieved High Assurance

SIGNIFICANT ASSURANCE	There are some weaknesses in the design and/or operation of controls which could impair the achievement of the objectives of the system, function or process. However, either their impact would be minimal or they would be unlikely to occur

- **Provider Contract Management**
  Objective: To evaluate the effectiveness of contract management in light of the revised contract framework.
- **CSU Contract Management**
  Objective: To provide assurance regarding the mechanisms established at the CCG to support contract management with the CSU.
- **Budgetary Control**
  Objective: To evaluate the systems and processes operating within the CCG in respect of Budgetary Control and Financial Reporting.
- **Risk Management Arrangements**
  Objective: To assess the adequacy of systems and processes in place to ensure that risks are identified and appropriately and accurately escalated through the CCG's risk management structures as documented within the Risk Management Policy.
- **Committee Arrangements**
  Objective: To ensure that the CCG has established committee arrangements and to provide assurance that these are operating effectively to support the Governing Body as required.
- **Patient Experience**
  Objective: To provide an opinion and offer the opportunity to consider how the various activities to explore and improve patient experience are currently configured and develop further activities in this regard.
- **Information Governance**
  Objective: To provide an opinion upon the policies and processes established to collate and submit its IG return and to provide an independent assessment of the validity and accuracy of scores submitted.
- **Data Quality / Performance Management**
  Objective: To evaluate the systems and processes to ensure the accuracy, completeness and validation of data contained in performance reports to the CCGs Governing Body and its standing committees.

LIMITED ASSURANCE	There are weaknesses in the design and / or operation of controls which could have a significant impact on the achievement of the key system, function or process objectives but should not have a significant impact on the achievement of organisational objectives.
	None of the reviews received Limited Assurance

NO ASSURANCE	There are weaknesses in the design and/or operation of controls which [in aggregate] have a significant impact on the achievement of key system, function or process objectives and may put at risk the achievement of organisational objectives.
	None of the reviews received No Assurance.

CONTRIBUTION TO CONTROL ENVIRONMENT	The audit work consisted of advice, guidance or consultancy to support the organisation to strengthen Risk Management, Internal Control & Governance.
	• **Conflicts of Interest** Objective: The overall objective of the review was to evaluate the current systems and processes in place at the CCG to declare and manage conflicts of interest. The scope of was to identify gaps between the prescribed systems and operating processes. • **Conflicts of Interest (Benchmarking)** Objective: Comparison information provided around systems, processes and gaps with peer organisations. • **Assurance Framework** Objective: Review of content and supporting processes.

Appendix B: Contribution to Annual Governance Statement

Roles and Responsibilities

The whole Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is an annual statement by the Accountable Officer, on behalf of the Governing Body, providing assurance on the stewardship of the CCG, including:

- How the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control and governance that supports the achievement of policies, aims and objectives.
- The purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the Annual Governance Statement requirements.

Director of Internal Audit Opinion

The purpose of the Director of Audit Opinion is to contribute to the assurances available to underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control (see figure 1 below). This opinion will therefore assist the Accountable Officer and the Governing Body in the completion of its Annual Governance Statement.

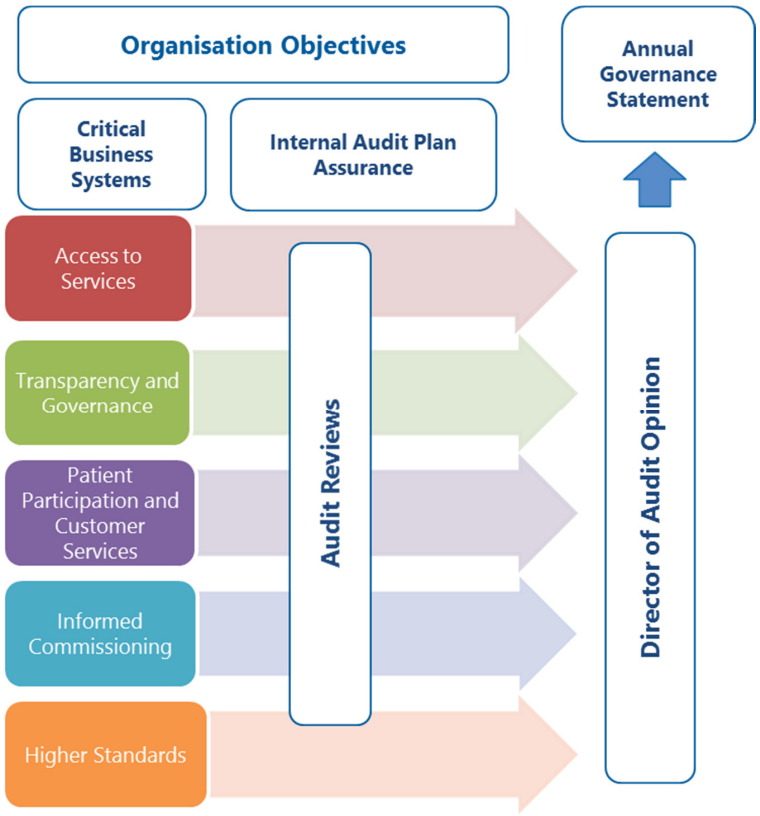

Figure 1 Director of Audit Opinion Contribution to AGS

Completion of the Annual Governance Statement

The Internal Audit opinion provided includes opinion on the Assurance Framework, and the risk based audit assignments across the critical business systems to inform the Annual Governance Statement. In addition, there are a number of other strategic challenges which were outside the scope of the Internal Audit Plan but which the Governing Body should take into consideration, these include:

- Establishment and ongoing development of the CCG as a statutory organisation including any conditions of authorisation, and assessment of compliance with the UK Corporate Governance Code.

- Development of the Governing Body and its Membership throughout the year.
- Organisation performance, including financial position, achievement of financial duties, ongoing financial viability, delivery of QIPP, and key relationships with Providers in the new NHS landscape.
- Wider partnership working across the local health economy, including the management and monitoring of the Commissioning Plans to ensure successful delivery of commissioning outcomes.
- Relationship and management of 3rd party providers upon which the CCG places reliance, and the provision of assurances from these eg. CSU, SBS
- Communication and engagement with the membership, key stakeholders and other partners.
- Information governance arrangements, risks and any associated incidents relating to Patient Identifiable Data.
- Key risks as identified in the Assurance Framework and the on-going management of such risks.
- Any major organisational change, eg. transfer of systems in-house from the Commissioning Support Unit etc.

Appendix C: MIAA Quality Service Indicators

MIAA Compliance with Internal Audit Standards

MIAA comply fully with professional best practice, internal audit standards and legal requirements. This includes guidelines issued by the Auditing Practice Board, professional bodies, MONITOR's Audit Code and the Institute of Internal Auditors.

The Public Sector Internal Audit Standards (wef. 2013) and our operational Internal Audit Manual are central to our continued external quality accreditation (ISO 9001:2000). An independent triennial review also confirmed our ongoing compliance with Standards.

> *"MIAA s overall arrangements meet the standards and support the provision of an independent and satisfactory service to audited bodies, and we can take assurance from internal audit work contributing to an effective internal control environment at these bodies"*
>
> *Grant Thornton, February 2013*

Table 1 below sets out how MIAA complies with these standards, and in many areas, MIAA exceed the basic standards (in particular the quality of our staff, qualifications and provision of an exceptional skill mix recognising the need for this to match the complexity of the organisations with which we work).

Table 1: MIAA's Compliance with the Internal Audit Standards

Internal Audit Standards	MIAA Compliance
1000 - Purpose, Authority & Responsibility	MIAA undertakes audit work to evaluate and improve the effectiveness of risk management, control and governance processes. An annual Director of Audit Opinion is provided to support the Annual Governance Statement.
1100 - Independence & Objectivity	MIAA is managed independently from, and with no executive responsibilities for, the audited body. MIAA have direct access to the Audit Committee Chair and are represented at meetings. All MIAA staff complete an annual declaration of interest, including actions taken to mitigate these.
1200 - Proficiency & Due Professional Care	Professional care is monitored and achieved through compliance with MIAA's quality and review systems. The Director of Audit is a CCAB Qualified accountant and MIAA's staff are either fully or part qualified (including CCAB, IIA, CISA, QICA, and LCFS).
1300 - Quality Assurance & Improvement	MIAA have accreditations for systems, processes and training. We are ISO9001:2000 quality assessed, Investors in People (6th accreditation), Finance Staff Development (Level 3) and training accreditations with CCABs. All reports follow a strict quality assessment process.

Internal Audit Standards	MIAA Compliance
2000 - Managing the Internal Audit Activity	MIAA have a defined approach for risk assessment, planning, performance and reporting. Three year risk based audit plans are developed for our client organisations, with regular progress reported to the Audit Committee.
2100 - Nature of Work	MIAA's internal audit activity evaluates and contributes to the improvement of governance, risk management and internal control. There is regular liaison with the LCFS, External Auditor and other review bodies to facilitate effective coordination of work.
2200 - Engagement Planning	MIAA's work is structured to comply with DH and Monitor requirements and the role as defined in the Audit Committee Handbook. We establish risk based audit plans in conjunction with the organisation and with the approval of the Audit Committee.
2300 - Performing the Engagement	Terms of Reference are established and agreed for each review, including objectives, scope, timing and resource allocations. MIAA staff identify, analyse, evaluate and document sufficient information to achieve the assignment objectives. All assignments are properly supervised.
2400 - Communicating Results	MIAA communicate the results of each assignment. Working with the organisation, the Director of Internal Audit ensures that communications are accurate, objective, clear, concise, constructive, complete and timely.
2500 - Monitoring Progress	MIAA establish follow up processes to monitor and ensure that management actions have been effectively implemented or that senior management has accepted the risk. This is operated alongside the organisations own management follow up and provides independent assurance to the Audit Committee.
2600 – Communicating the Existence of Risks	MIAA recognise the professional role of Internal Audit to challenge the level of risk accepted by management, support resolution and ensure transparency in reporting to Audit Committee.

In terms of background, Tim Crowley (Director, MIAA) led the work on the production of NHS Internal Audit Standards, in addition to being a member of the Public Sector Internal Audit Standards Board which has led on bringing together sector wide standards. MIAA is also at the forefront of shaping professional standards through our national roles; Chair of National Internal Audit Practitioner Group on behalf of the Department of Health, Chair of CIPFA's Audit Panel (cross sector), member of IIA Technical Committee (cross sector) and member of HfMA's Governance and Audit Committee. This puts MIAA in a unique position to provide early insight to our clients and ensures that we keep up to date, adopt and promote current practice within the profession (internal and external to the NHS).

MIAA Quality Service

MIAA continue to ensure that quality remains central to our core objective of providing our clients with the best service. To achieve this we have in place a number of internal and external quality processes. These include:

- Investors in People
- ISO 9000
- Finance Staff Development Level 3
- External Audit Triennial Review
- Comprehensive Internal Quality Assurance
- Continued adoption of the EFQM Business Excellence Model

All of this is supported through our day to day contact with clients and the invaluable feedback that this provides to continually improve. In order to demonstrate to our clients the quality of the service delivered by MIAA assurance is provided in accordance with the measures outlined in the balanced scorecard (see Figure 2 below).

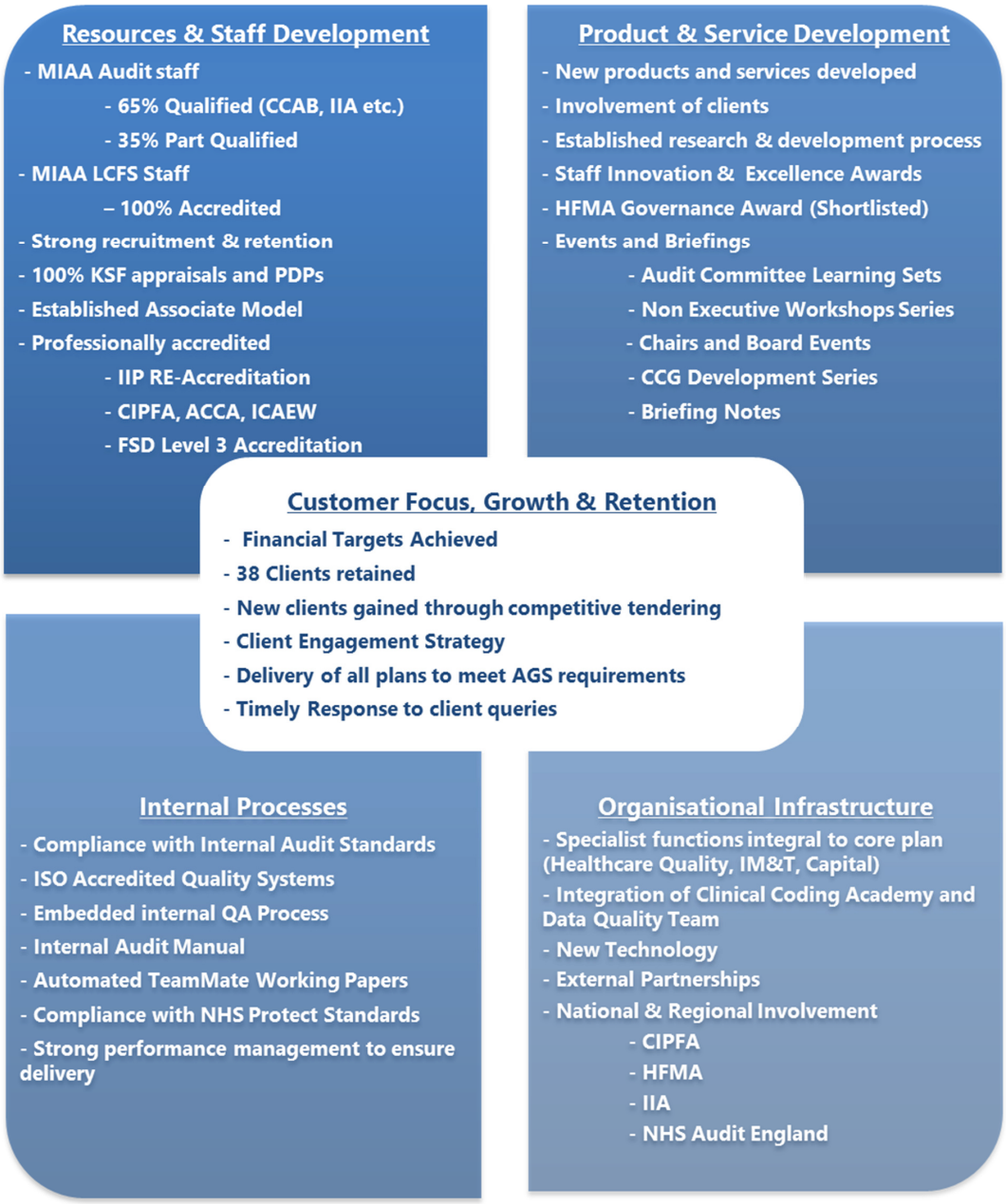

Figure 2 MIAA's Balanced Scorecard Outcomes

NHS
South Sefton
Clinical Commissioning Group

14/77

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/77	**Author of the Paper:**
Report date: May 2014	Debbie Fagan Chief Nurse & Quality Officer debbie.fagan@southseftonccg.nhs.uk Tel: 0151 247 7007

Title: Francis Report and Action Plan

Summary/Key Issues:

This report provides the Governing Body with the latest version of the CCG Francis action plan. The action plan has been updated to reflect 'Hard Truths' (DH November 2013), the Government's response to the Francis Inquiry and the subsequent nationally commissioned independent reviews. The CCG action plan is monitored on a regular basis by the Quality Committee and was last presented in April 2014. Good progress has been made to date and the next version of the action plan which will be able to demonstrate further achievements relating to the areas of the NHS Constitution, complaints, CCG organisational development / culture and the Primary Care Quality Strategy as an example. Although positive progress is being made, the CCG will continue to strive on the sustained achievement and embedding of all aspects of this action plan to ensure it is part of how the organisation conducts its business.

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)*	
	Improve quality of commissioned services, whilst achieving financial balance.
	Achieve a 1% reduction in non-elective admissions in 2014/15.
	Implementation of 2014/15 phase of Virtual Ward plan.
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
	Review the population health needs for all mental health services to inform enhanced delivery.

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

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
X	Ensuring that people have a positive experience of care
X	Treating and caring for people in a safe environment and protecting them from avoidable harm

Report to the Governing Body
May 2014

1. Introduction and Background

1.1 This paper provides a summary of the key points from the document '*Hard Truths - the journey to putting the patient first'* (DH November 2013) Volumes 1&2.

1.2 *'Hard Truths'* sets out the Government's final response to the Francis Inquiry into the care at Mid Staffordshire NHS Trust. The report requires all commissioning, service provision, regulatory and ancillary organisations in healthcare to consider the findings and recommendations and decide how to apply them.

1.3 This document summarises the key points to provide the CCG Quality Committee with an understanding of the main principles within the document. A detailed action plan has also been developed in response to the recommendations relevant to the CCG.

The reports can be found at:

https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response

1.4 The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, published in February 2013, called for a 'fundamental culture change' across the health and social care system to put patients first at all times.

Robert Francis QC, the Inquiry Chair, called for action across six core themes:

- culture;
- compassionate care;
- leadership;
- standards;
- information;
- openness, transparency and candour.

1.5 The Government's initial response, "*Patients First and Foremost"*, set out a plan to prioritise care, improve transparency and ensure that where poor care is detected, there is clear action and clear accountability. The Government's final response '*Hard Truths – the journey to putting patients first'* (November 2013) and its accompanying volumes build on this to provide a detailed response to the 290 recommendations the Inquiry made across every level of the system.

1.6 It also responds to six further independent reviews which the Government commissioned to consider some of the key issues identified by the Inquiry:

- review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England;

- *'the Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings'*, by Camilla Cavendish;

- *'a Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England'*, by Professor Don Berwick;

- *'a Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture'* by Rt Hon Ann Clwyd MP and Professor Tricia Hart;

- *'challenging Bureaucracy'*, led by the NHS Confederation;

- the report by the Children and Young People's Health Outcomes Forum, co-chaired by Professor Ian Lewis and Christine Lenehan.

1.7 Since the Inquiry reported, the Government has already instigated a number of changes that will improve inspection, increase transparency, and put a clear emphasis on compassion, standards and safety. It also addresses increased accountability for failure and building capability.

1.8 The accompanying '*Volume Two: Response to the Inquiry recommendations'* provides a detailed response to each of the 290 recommendations made by the Inquiry across every level of the system. The document makes clear which recommendations have been accepted, by whom and what progress is being made towards their implementation.

The Department of Health will lead the system in providing an annual report on progress across the system each autumn.

201 recommendations have been accepted in full, 60 recommendations accepted in principle, 20 accepted in part and 9 not accepted at all.

2. Overview of the Main Chapters of the 'Hard Truths' Report

2.1 Chapter One: Preventing Problems

2.1.1 Patient participation in planning services

The report highlights that there has been statutory guidance published for clinical commissioning groups on involving patients in planning services and their own care, along with a set of supportive tools. 80% of CCGs to be commissioning support for patients' participation and decisions in relation to their own care. Guidance published – '*Transforming Participation in Health and Care'.*

2.1.2 Transparency

The CCG is required to consider how transparency is measured in those provider services commissioned and have assurance about the level of patient safety attained.

2.2 Chapter Two: Detecting Problems Early

2.2.1 Whistleblowing

It is essential to ensure that providers have good and accessible systems in place for whistleblowing. The CCG should also provide easily accessible processes to allow staff to approach them to raise concerns.

2.2.2 National Institute of Clinical Excellence

It remains a key element to ensure that NICE guidance is considered and other best practice standards achieved when commissioning and monitoring providers.

2.3 Chapter Three: Taking Action Promptly

2.3.1 Working together

There is an increased need to work closely with regulators (CQC, Monitor) to ensure that the CCG takes a co-ordinated approach to overseeing quality issues within providers and that information is shared across the system.

2.4 Chapter Four: Ensuring robust accountability *(This chapter places the greatest emphasis on the role of regulators, professional bodies and commissioners)*

2.4.1 The issues identified by the Inquiry's report in relation to commissioning include:

- a lack of clarity about the remit and purpose of commissioning organisations;
- a lack of co-operation and information sharing between commissioners and regulators;
- an excessive focus on the financial bottom line and on the management of what could be easily measured, rather than what mattered to patients; and
- a lack of focus on the quality of care and patient experience.

2.4.2 The report recommends that all organisations in the NHS have to commit to making patient safety a reality and should consider how they make this commitment visible to their staff and to the public in the months and years ahead.

2.4.3 Further points to note for CCGs

- NHS England will explore the development of a parallel set of arrangements (fit and proper person's test for Board level appointments) for clinical commissioning groups.
- clinically-led clinical commissioning groups put doctors, nurses and other health professionals at the heart of commissioning, with an explicit focus on improving health outcomes for the whole population and reducing inequalities in health.
- following authorisation, NHS England will continue to hold clinical commissioning groups to account for quality and outcomes as well as for financial performance, through the clinical commission group assurance framework. NHS England also has powers to intervene where there is evidence that clinical commissioning groups are failing or are likely to fail.
- the basic tool available to commissioners is the contract. NHS England is therefore reviewing the provisions in the standard NHS contract in order to make it easier for commissioners to intervene when they have concerns about patient safety or outcomes. Details will be published in December 2013 as part of the NHS standard contract for 2014/15.

- excellent commissioning can pro-actively address the risk of services becoming unsafe by spotting trends in the population and responding by changing the nature of the services.

2.5 Hard Truths Chapter Five: Ensuring staff are trained and motivated

2.5.1 Recruitment

Human Resource policies need to align more closely with the NHS Constitution and the principles of compassionate care.

2.5.2 Care of the older person

Care of the frail elderly and, in particular, elimination of malnutrition and dehydration should be assured.

2.5.3 Bureaucracy

The report stated that the HSCIC is to act as a 'gateway' for information requests and national bodies are to have a single transparent process, reducing the burden of bureaucracy. NHS England Clinical Bureaucracy Index is to track how well trusts are using digital technology in data collection.

3. Recommendations

Members of the CCG Quality Committee are asked to note the new actions on the following areas as detailed within the action plan.

- safe staffing, from April 2014, all hospitals will publish self-determined staffing levels on a ward-by-ward basis together with the percentage of shifts meeting safe staffing guidelines. This will be based on speciality. This will be mandatory and will be done on a monthly basis. By the end of next year this will be done using models and tools approved independently by the NICE;

- complaints reporting and better complaints information - trusts will report quarterly on complaints data and lessons learned and the Health Service Ombudsman will increase significantly the number of cases she considers. In addition, all hospitals will be required to set out clearly how patients and their families can raise concerns or complain, with independent support available from their Healthwatch or alternative organisations;

- a statutory duty of candour, which will apply to providers, and a professional duty of candour on individuals will be strengthened through changes to professional guidance and codes. NHS England will also review Quality Accounts before the 2014/15 cycle to ensure that they give patients appropriate information about the services they use and that they add value to the quality assurance infrastructure used by Trusts and local and national organisations;

- the Government will consult on proposals about whether trusts should reimburse a proportion or all of the NHS Litigation Authority's (NHSLA) compensation costs when they have not been open about a safety incident;

- a new criminal offence for wilful neglect - the Government will legislate at the earliest available opportunity to make it an offence to wilfully neglect patients so that organisations and staff, whether managers or clinicians, responsible for the very worst failures in care are held accountable;

- a new Fit and Proper Person's Test which will enable the Care Quality Commission to bar unsuitable senior managers who have failed in the past from taking up individual posts elsewhere in the system;

- all arms-length bodies and the Department of Health have signed a protocol in order to minimise bureaucratic burdens on trusts;

- a new Care Certificate, as recommended by the Cavendish Review, to ensure that Healthcare Assistants and Social Care Support Workers have the fundamental training and skills needed to give good personal care to patients and service users. The Chief Inspectors will ensure that employers are using the Disclosure and Barring Service to prevent unsuitable staff from being re-employed elsewhere;

- the Care Bill will introduce a new criminal offence applicable to care providers that supply or publish certain types of information that is false or misleading, where that information is required to comply with a statutory or other legal obligation.

4. Updated Sections

The following sections have been updated since the action plan was circulated in February 2014.

Section 1 - Accountability/oversight and leadership

- this section can be all rag rated green aside from the point relating to CCG being aware of the NHS constitution which is amber. This action has a target date of May 2014 however and there is a clear action plan in place to ensure compliance within agreed timescale.

- significantly the agreement of quality schedules (14/15) with providers and the monitoring of these quality schedules through clinical quality performance groups (CQPGs) ensures that all the proposed actions are embedded and implemented within the organisation and their performance against the implementations are monitored monthly.

Section 3 - A common culture made real throughout the system

- recommendation 17 is now part of the NHS standard contract and a provider quality and performance report is part of that contract, consequently this is now rated as green.

Section 4 - Commissioning for standards

- the CCG Primary Care Quality Strategy has now been developed and is still awaiting implementation. The CCG lead has advised that certain things need to be agreed before implementation can occur – remains amber.

- EPEG is now utilising a range of networks and a wealth of methods to ensure feedback and views from the public are obtained – changed to green.

Section 7 – Implementing the recommendations

- the CCG will be undertaking a survey of organisational culture and will be undertaking a development session with the wider operational team to align work plans with Francis – This remains Amber as this has a target date of May 2014.

James Hester
May 2014

CCG Francis Action Plan April 2014

Theme		Recommendation	Comments/Proposed Actions	Assurance	Responsible Officer	Target date	Status (RAG)
1	**ACCOUNTABILITY/ OVERSIGHT AND LEADERSHIP** Putting the patient first (3-8)	3. Embed values and principles demonstrated within the NHS constitution 4. The core values expressed in the NHS constitution should be given priority of place and the overriding value should be that patients are put first. 7. All NHS staff should be required to enter into an express commitment to abide by NHS values and the Constitution, both of which should be included in contracts of employment 8. Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well	-The CSU to support CCG in ensuring all staff are aware of the NHS Constitution and its ethos , and that it is included in commissioning and work plans -Board Development session - values and assurance -All providers to be asked to embed the CNO strategy of the 6Cs into their culture of care and recruitment -All providers to perform an assessment of organisational culture -Provider Quality Schedules/Reports to refer to nationally mandated components of the NHS Constitution -Workforce indicators included in the Provider Quality Schedules - Feedback from EPEG is incorporated into CCG plans and reported to the Quality Committee -Liaise with CSU to gain assurance from Providers that NHS values and Constitution are included in	-The CCG will be undertaking a development session with the wider operational team to align work plans with Francis. These actions are monitored via the quality schedule (Schedule 4, Part A&C) Any new posts will have the NHS constitution and	DF/TJ FLC SA/BD/JL SA/BD/JL SA/BD/JL SA/BD/JL TJ/JH DFai/TJ	May 2014 October 2013 April 2014 January 2014 January 2014 April 2014 November 2013 October 2013	Amber Green Green Green Green Green Green Green

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			contracts of employment and those of the staff from service providers to whom which they outsource business - Review CCG commissioning plans to ensure they reflect the NHS Constitution	values included in contracts of employment. Existing employees and outsourced employees will demonstrate compliance vicariously through adherence to the providers HR policies. (whistleblowing, being open etc)	Senior Management Team (SMT)	July 2013	Green
2	**COLLATION OF SOFT INTELLIGENCE AND PATIENT FEEDBACK** Effective Complaints Handling / Learning and information from complaints. (109-122) (133-134)	110. Lowering barriers 113. Complaints handling 118. Investigations 119. Support for complainants 120. Learning and information from complaints 133. Role of commissioners in complaints	- CSU to work with CCGs and providers to obtain real time information on complaints -Complaints information to form part of the quality dashboard / performance report for quality committee -CSU to obtain information from NHS England regarding 1º care and assure the CCG of 1º care quality. -Ensure that the CCG have a ratified complaints	These actions are monitored via the quality schedule (Schedule 4, Part C, PS15) Standing agenda item at CQPG Policy is being	DFai/TJ DF DF	November 2013 September 2013 September 2013	Green Green Green

CCG Francis Action Plan April 2014

		134. role of commissioners in provision of support for complaints	policy	reviewed and updated and to be approved by Quality committee	DF	May/June 2014	Amber
3	**A COMMON CULTURE MADE REAL THROUGHOUT THE SYSTEM –** an integrated hierarchy of service (17)	17. Involvement in the design of new quality standards in collaboration with the NHSCB	- Continued collaboration with NHS England to develop new quality standards.Development of narratives between NHS England and CCGs around the five domains of the NHS Outcomes Framework and how commissioners can drive improvement in outcomes. This material will be made available as a resource for CCGs shortly on the NHS England website -A 'framework for improving quality through commissioning' is being developed and additionally the new standard contract has been issued which contains the quality schedule and revised national CQINNs -Inclusion of monitoring of compliance with these standards to be prominent within the performance management framework. To include audit, reviews and potential contract penalties.	Part of the NHS standard contract. A provider Quality & Performance report is part of the contract	DF DF DF	NHS England updated Feb 2014 NHS England updated Feb 2014 NHS England updated Feb 2014	Green Green Green

CCG Francis Action Plan April 2014

4	**COMMISSIONING FOR STANDARDS (123-137)**	123. Responsibility for monitoring delivery of standards and quality 124. Duty to require and monitor delivery of fundamental standards 125. Responsibility for requiring and monitoring delivery of enhanced standards 126. Preserving corporate memory 127. Resources for scrutiny 128. Expert support 129. Ensuring assessment and enforcement of fundamental standards through the contracts 130. Relative position of commissioner and provider 131. Development of alternative sources of provision 132. Monitoring tools 135. Public accountability of commissioners and public engagement 137. Intervention and sanctions for substandard or unsafe services	-A CCG Primary Care Quality Strategy has been developed and is awaiting implementation. -The CCG & CSU will engage with local media to ensure consistent messages to the wider public. -The CCG will ensure views of the public are captured considered and fed into each stage of commissioning and contracts process. -The Governing Body will review its vision and objectives to ensure these are fit for purpose. -The CCG will review its work with providers to commission services that reflect need. -The CCG Patient & Public Engagement strategy will be reviewed to ensure this reflects the need of the public to inform service commissioners. -The CCG will review and agree how safeguarding information is appropriately brought into contractual management processes across Health and Social Care. -Develop a mixed approached of traditional and digital initiatives to engage with and gain feedback from public to ensure that a wide range of views are obtained.	EPEG are utilising a range of networks and a wealth of methods to ensure we have a robust approach	MC DF/TJ/Lyn Cooke DF/TJ FLC SA/BD/JL TJ DF TJ/AJ	Ongoing Ongoing Ongoing March 2013 Ongoing April 2013 April 2013 November 2013	Amber Green Green Green Green Green Green Green

CCG Francis Action Plan April 2014

			-Information from 'friends and family test', information from CQUIN targets and intelligence gathered from GP "Quality Matters" will be reported to the CCG Quality committee via the EPEG report		JH	January 2014	Green
			- Further development of quality standards will build on current best practice and other areas such as workforce, integrated care and collaborative working.		SMT	Ongoing	Amber
			-CQUINs will be further developed to support these.		SA/BD/JL	March 2014	Green
			- Ongoing collaboration with other CCGs in relation to transformation programmes / service		TJ/FLC	Ongoing	Green
			- Where new services are developed, procurement processes will be underpinned by the choice and patient experience.		MC	Ongoing	Green
			- The CCG will at times require providers to produce recovery plans when targets or standards are not being met.		SA/BD/JL	As necessary	Green
			-Quality standards in contracts will continually be reviewed and enhanced.		SA/BD/JL	Ongoing	Green
			-CQUINs will be reviewed annually as part of the contracting process.		SA/BD/JL	Ongoing	Green
			-Ensure the CCG identifies a member of SMT and		SMT	March 2013	Green

CCG Francis Action Plan April 2014

			GP clinical leads as required to represent the CCG at the Merseyside QSG -Ensure a periodic review is in place to give assurance that the CCG structure is fit for purpose to deliver on the functions the CCG need to undertake -Ensure processes are in place and operationalised to performance manage the contract with CSU -Lay members appointed to governing body -The CCG governing body will be held in public from May 2013 onwards		SMT/KM TJ TJ TJ	March 2013 March 2013 October 2012 May 2013	Green Green Green Green
5	**LOCAL SCRUTINY (138)**	138. Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found that they are at risk from substandard or unsafe services	-The CCG will continue to work on its contingency planning and provide an update to the Governing Body.		DF	October 2013	Green
6	**PERFORMANCE MANAGEMENT & STRATEGIC OVERSIGHT (139-143)**	139.The need to put patients first at all times 140.Performance managers working constructively with regulators 141.Taking responsibility for quality 142.Clear lines of responsibility supported by good information flows 143.Clear metrics on quality	-Commissioners to ensure systems are in place for regular quality walkarounds within provider organisation. -Ensure governance arrangements are in place to report on quality and patient safety issues within the CCG -The CCG will ensure it is an active participant across the health and social care system to ensure patients are protected.		DF DF DF	March 2013 March 2013 May 2013	Green Green Green

CCG Francis Action Plan April 2014

			-The CCG will maintain open dialogue with the Regulators and identify key personnel to attend and impart information at the Merseyside Quality Review Meetings -The CCG will ensure it leads action where necessary to protect patients and collaborate with other stakeholders to protect patients. -Quality standards will be reviewed as appropriate to ensure they reflect best practice.		DF/FLC SMT DF	May 2013 Ongoing Ongoing	Green Green Green
7	**IMPLEMENTING THE RECOMMENDATIONS (1-2)**	1.All commissioning organisations in healthcare should consider the findings and recommendations of the report and decide how to apply them to their own work. 2. The NHS and all who work in it must adopt and demonstrate a shared culture in which the patient is the priority in everything done.	-Chief Nurse to be identified as SMT lead on the application of the recommendations to the work of the CCG -SMT to support the GP Clinical Leads in their leadership role to ensure implementation of the recommendations by Providers going forward through effective commissioning -Liaise with the OD Team from the CSU to ensure the CCG OD Plan is reflective of the Inquiry recommendations -Report findings and recommendations to be an agenda item for discussion at SMT, Quality Committee, Audit Committee, Governing Body and Wider Constituent Meeting -Recommendations and resulting action plan to feature as part of the annual workplan of the		SMT SMT TJ DF DF	February 2013 February 2013 June 2013 April 2013 March 2013	Green Green Green Green Green

CCG Francis Action Plan April 2014

			Quality Committee -Audit Committee to consent to receive regular updates on the action plan as part of the assurance process		DF	March 2013	Green
			-Review the CCG common set of core values and standards that are outlined within the CCG Constitution to ensure they are reflective of the culture advocated within the Inquiry recommendations		DF/SA/BD/JL	March 2013	Green
			-Ensure the CCG core values and standards are accessible and explicit on the public website		DF	June 2013	Green
			-Explore ways in which values can be incorporated into PDP/appraisal and wider CCG staff / board development		TJ	July 2013	Green
			-Liaise with CSU OD Lead and Comms Lead for advisement and support on the identification of actions to deliver this recommendation internally within the CCG		DF/TJ	June 2013	Green
			-Explore with CSU OD Lead available tools to support measurement internally within the CCG and externally with commissioned providers	The CCG will be undertaking a survey of organisational culture and will be undertaking a development session with the wider operational team	DF/TJ	May 2014	Amber

CCG Francis Action Plan April 2014

				to align work plans with Francis.			

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/78	**Author of the Paper:**
Report date: May 2014	Kevin Thorne Integrated Commissioning Manager South Sefton CCG

Title: Sefton Strategy for Older Citizen's 2014 - 2019

Summary/Key Issues:

In view of Sefton's ageing population it is vital to make strategic plans to deal with its impact and to develop a collaborative approach from all agencies and service providers.

Recommendation

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

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
	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)*	
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
May 2014

1. Introduction and Background

1.1 Sefton has the highest proportion of residents aged 65+ and 75+ of all metropolitan boroughs in England.

1.2 Sefton's 50+ population is 41.5% of its total population – much higher than the average for England and for the North West.

1.3 The previous strategy for older citizens covered the period 2010 to 2013 and requires updating.

2. Key Issues

2.1 In view of Sefton's ageing population it is vital to make strategic plans to deal with its impact and to develop a collaborative approach from all agencies and service providers.

2.2 The Sefton Partnership for Older Citizen's (SPOC) aims to identify the needs of older citizen's, to bring together networks which provide them with support and to give older citizens the opportunity to be a part of the collaborative planning process that delivers services.

3. Conclusions

The aims of the new strategy are to challenge stereotypes of older people, to set a clear direction for communities with an ageing population and to provide a framework for collaborative planning with older citizen's as equal and key partners.

4. Recommendations

The Governing Body is recommended to:

4.1 approve the Sefton Strategy for Older Citizen's 2014-19; and

4.2 ask the Sefton Partnership for Older Citizen's (SPOC) to prepare an Action Plan, monitor its implications and to present regular progress reports to the Programme Group of Sefton's Health and Wellbeing Board.

Appendices

Appendix 1 Sefton Strategy for Older Citizen's 2014-19.

Kevin Thorne
May 2014

SEFTON STRATEGY FOR OLDER CITIZENS 2014 - 2019

Creating A Place Where Older People Can Live, Work And Enjoy Life As Valued Members Of The Community

Sefton Partnership For Older Citizens

WHY WE NEED A STRATEGY

- In March 2013 the House of Lords published an influential report which concluded that there had been a "collective failure to address the implications" of our rapidly ageing population, and that Government and society were "woefully underprepared".
- By 2030 the 65+ population in England is likely to rise by 50%, and the 85+ population by 100%.
- The challenges arising from this have begun to be addressed by national policy makers in areas such as the age of retirement, pension reform, the funding of residential care and housing policy.
- However a 2013 report on "Delivering Dignity" highlighted the extent of undignified care of older people in hospitals and care homes, where people were "let down when they were vulnerable and most needed help".
- The "demographic time-bomb" is therefore one of the biggest issues faced by society as a whole, and by policy makers at national and local level.
- We must also recognise that we live in a climate of diminishing resources which will require individuals, families and communities to take greater responsibility, with less reliance upon the state. The need to build community resilience to help address the needs of our ageing population will therefore be a key element in the development of this strategy.
- The expectations of people are also changing. We need to plan ahead for the cohort of people who are now in their 40's and 50's whose requirements in later life will differ from those who are currently in their 80's and 90's

SEFTON'S UNIQUE POSITION

- Sefton has the highest proportion of residents aged 65+ and 75+ of all metropolitan boroughs in England.
- Sefton's 50+ population is 41.5% of its total population – much higher than the average for England and for the North West.
- There are 28,400 people in the 75+ age group of whom about half live alone. This is projected to increase as a percentage of the total population and in actual numbers.
- These statistics are highlighted in the Sefton Health and Wellbeing Strategy and give rise to specific concerns about related issues such as the number of older carers and people with depression and dementia in our communities, and inequalities across the borough
- The growth in the number of older citizens in Sefton presents great challenges in terms of its impact on health and social care services, but it also opens up real opportunities to build upon the knowledge, wisdom and contributions of older people in helping to make Sefton a more cohesive community, and one which is a great place in which to live and work.

THE CONTRIBUTION OF OLDER CITIZENS

- The perception in society is that older people are a drain on the country's resources – but the opposite is actually the case.
- A report in 2011 assessed the cost of state pensions, age-related welfare, and use of the NHS – then compared this with the contribution of older people to income taxes, VAT inheritance tax and capital gains tax
- The report also assessed the contribution of the over 65's to volunteering, unpaid caring, and looking after grandchildren.
- The conclusion was that the NET contribution of over 65's to the UK economy in 2010 was £40billion, rising to £75billion per annum by 2030.

- In the promotion and implementation of this strategy an attempt will be made to enhance the profile of older citizens in Sefton, and to change the perception of them as a drain of resources to one of active citizens

SEFTON PARTNERSHIP FOR OLDER CITIZENS (SPOC)

- SPOC is recognised as one of the major and most effective partnership groups in Sefton. Its aim is to identify the needs of older citizens, to bring together the networks which provide them with support, and to give older citizens the opportunity to be part of the planning of services.
- Half of the members of SPOC are elected by the three older people's forums which operate in Southport, Bootle and Maghull. They meet monthly and regularly attract 100+ people. The remaining members of SPOC are the providers of services to older citizens from the public, voluntary, community and faith sectors. This regular exchange of information and views enables SPOC to keep abreast of, and take action upon, the issues which impact on Sefton's older population.
- SPOC will be the lead organization in the monitoring and delivery of the Sefton Strategy for Older Citizens.

EVOLUTION OF OUR OLDER CITIZENS' STRATEGY

- Sefton's first "Strategy for Older Citizens" covered the period 2010-2013 and was prepared following extensive consultation with older citizens.
- It was updated and refreshed in 2011 in conjunction with the members of the three older people's forums.
- The strategic priorities were translated into over 40 specific actions, which were set out in an Action Plan which has been progressed with partner organizations in the public, voluntary, community and faith sectors and has been monitored and updated on a six monthly basis. The majority of the actions have been successfully achieved.
- Following the approval of the new Strategy for 2014-2016 the proposal is to prepare and deliver a similar detailed Action Plan, in order to ensure that the strategic objectives are achieved in a similar way. The new strategy for 2014-2016 incorporates some of the objectives of the first strategy which have not yet been fully achieved, modifies others which have been updated to reflect changing circumstances, and introduces some new objectives which have been identified as a result of SPOC's activities during the past three years.

AIMS OF THE NEW STRATEGY

- To challenge the stereotypes of older people, and to set out how the Sefton community can respond to the opportunities and challenges of an ageing population, whilst recognising the current constraints upon public expenditure;
- To set a clear direction for our communities and strive to ensure that the needs of people aged 50+ are met;
- To provide a framework of joint objectives which organisations and public services should use to shape their own plans to meet the changing needs of an ageing society;
- To identify and recognise the increasingly diverse population of older people in Sefton and work harder to ensure that organisational and service responses are sensitive to their specific needs;
- To bring a shared focus to the work of a wide range of agencies and partners, and strengthen the case for funding from national and regional programmes;
- To involve older people as active and equal partners in the process by enabling them to use their strengths in building community networks and activity.

- To encourage people to plan much earlier for the financial and other implications of their retirement, such as the possible impact of fuel poverty.

OBJECTIVE 1 – TO ADVOCATE THAT THE VOICE OF OLDER CITIZENS IS REFLECTED IN THE PLANNING AND DELIVERY OF SERVICES

In order to achieve this we will strive to:-

- Explain and promote the objectives of the strategy to all major groups, organisations and key individuals responsible for the delivery and "age-proofing" of services.
- Extend the geographical spread and membership of the older people's forums.
- Seek new and user-friendly ways of seeking information from, and communicating information to, community groups and individuals to increase awareness of the services which are available to support their needs.
- Ensure that the views of older citizens are fully taken into account as services are reconfigured to meet public sector financial constraints.
- Maintain membership and links with regional groups which represent older citizens, to ensure that SPOC keeps abreast of emerging national and regional issues.
- Keep under constant review the terms of reference and membership of SPOC, and the structures which it establishes to deliver its objectives, and the need to ensure that it is representative of the diverse population of the borough.

OBJECTIVE 2 – TO REDUCE THE LEVEL OF LONELINESS AND SOCIAL ISOLATION EXPERIENCED BY OLDER PEOPLE IN SEFTON

In order to achieve this we will strive to:-

- Identify those who are socially isolated and/or are experiencing depression who would benefit from support services.
- Encourage older people to build community networks in local areas throughout the borough, including the development of inter-generational activities, and by working with schools
- Support opportunities which help older people to build social contacts and connections, via community and voluntary sector based services, initiatives which build community resilience and utilise existing community assets, alongside the effective promotion of and signposting to relevant activities.
- Participate in the development of the Dementia Action Alliance and support its objectives and work programmes.

OBJECTIVE 3 – TO ENCOURAGE THE PROVISION OF HEALTH AND WELLBEING SERVICES FOR OLDER PEOPLE WHICH ARE EFFECTIVE AND OF HIGH QUALITY

In order to achieve this we will strive to:-

- Translate the high priority given to the needs of older citizens by the Health and Wellbeing Board, and in the Health and Wellbeing Strategy, into effective and innovative actions which will focus upon the "preventative agenda" for the over 50's.
- Promote, publicise and update the brochures on "Five Ways to Wellbeing" and encourage older citizens to participate in activities which will improve their physical and mental health.
- Focus particular attention on the health and wellbeing needs of the older citizens in areas of the borough where life expectancy is lowest.
- Facilitating older people gaining access to green spaces, Sefton's coastline, and a sustainable environment.

- Build partnerships with the clinical commissioning groups, and seek the support of GPs in signposting older citizens to health and wellbeing activities and social networks.
- Ensure that older citizens receive comprehensive information and support about the types of services and the providers available in their local area.
- Work with partners in the public and voluntary sector to identify older citizens or older carers in Sefton with care and support needs which are not being met to enable missing services to be developed and provided.

OBJECTIVE 4 – TO HELP OLDER PEOPLE TO ACHIEVE FINANCIAL SECURITY

In order to achieve this we will strive to:-

- Assist older people to achieve an adequate income by providing more comprehensive pre- and post-retirement advice, information and seeking to maximise the take-up of benefits.
- Liaise with employers to enable older people to continue to work if they wish to do so, through flexible employment opportunities.
- Make applications for external funding to support the needs of older people in Sefton whenever opportunities arise.
- Encourage those over 50 to plan early for the financial implications of retirement.
- Work with partners in the public and voluntary sectors to provide information and improved financial advice to older citizens who may need to raise finance to help fund their care needs.
- In response to the Care Bill, work with partners in the public and voluntary sectors to ensure that following eligibility assessments, older citizens receive an appropriate financial assessment and understand any requirements to contribute to some or all of their care and support plan.

OBJECTIVE 5 – TO WORK WITH LOCAL AGENCIES TO PROVIDE SERVICES WHICH ARE OF HIGH QUALITY, JOINED-UP, AND AGE-PROOFED

In order to achieve this we will strive to:-

- Work with the providers of public transport networks, and community transport providers, to deliver accessible and affordable services which meet the needs of older people in accessing the services which they require.
- Engage actively with the emerging proposals for the transformation of social care, and develop mechanisms which will ensure that the views and concerns of older citizens are fully taken into account.
- Work with partners to ensure that there is a consistent approachfor older citizens with eligible needs to get the care and support they require, and that service provision is better coordinated by the relevant providers.
- Support the work of existing providers and the development of strategies and plans to provide improved services for older citizens e.g. dementia strategy; carers' strategy; plans for end-of-life care; and the "cancer champions" project for older citizens.
- Seek ways of providing training opportunities for older citizens in the use of information communication technology.

OBJECTIVE 6 – TO HELP OLDER PEOPLE TO FEEL SAFE AND SECURE WITHIN THEIR COMMUNITIES

In order to achieve this we will strive to:-

- Strengthen engagement with the police, fire and rescue services, in order to highlight the safety concerns of older citizens, particularly relating to anti-social behaviour.

- Raise awareness of the range of services and initiatives which are available to keep people safe across Sefton, both at home and in their communities.
- Encourage the planning and provision of appropriate housing to meet the changing age profile of the population.
- Assist older citizens who need adaptations to their homes to have access to services to enable them to remain safe and independent.
- Ensure that older citizens who require repairs to enable them to live in a safe and comfortable home have access to advice and support services.
- Encourage partners to work towards providing information and advice to older citizens about their housing options, to help them secure housing suited to their needs.
- Monitor the uptake of safeguarding adults training and safeguarding alerts, and ensure that this remains a high priority in all relevant care settings, and work with Sefton's Adult Safeguarding Board to develop plans which protect vulnerable citizens.

OBJECTIVE 7 – TO CHALLENGE PROVIDERS TO TReAT VULNERABLE OLDER CITIZENS WITH DIGNITY AND RESPECT IN ALL CARE SETTINGS

In order to achieve this we will strive to:-

- Build an effective partnership with "Healthwatch" to ensure that communication with, and the engagement of, older people's groups is maximised in the monitoring of service delivery.
- Monitor the implementation of the recommendations of the "Delivering Dignity" report (Local Government Association, NHS Confederation, and Age UK) and the Francis Report on Mid-Staffordshire Hospital, and keep under constant review the implications for older people in Sefton.
- Provide support and constructive challenge to the commissioners of adult social care, and health services, and bring to their attention any concerns from older citizens about quality standards in hospitals, nursing, residential, and domiciliary care settings.

OBJECTIVE 8 – TO PROMOTE AND RESPOND TO THE IMPACT THAT THE NEW CARE BILL WILL HAVE ON OLDER CITIZENS IN SEFTON

In order to achieve this we will strive to:-

- Monitor the implementation (up to 2016) of the 2013 Care Bill and ensure that its implications for older citizens in Sefton are widely communicated and understood.
- Identify older citizens in Sefton who are currently self-funding their care, and seek intelligence regarding the projected population of older citizens in Sefton, who may be impacted upon by these changes, to ensure anticipated needs are considered and used to inform responses to the implementation of the Care Bill
- Facilitate a clear process for older citizens receiving care and support to move into and/or out of Sefton in line with guidelines detailed in the Care Bill.
- Make older citizens in Sefton aware of the changes proposed within the Care Bill on eligibility criteria, and deferred payment of care home costs, meaning they do not have to sell their home during their lifetime.
- Ensure that any eligible older citizen in Sefton is provided with a care and support plan(or a support plan in the case of a carer) and that those who do not have eligible needs are given support and information to help prevent further needs developing.
- Provide information, as it emerges, on the implementation of the 'Dilnot Social Care Cap' and its possible implications.

OUTCOMES OF THE STRATEGY

- If this strategy is implemented effectively, older people will have access to quality advice, be well informed, be able to make a positive contribution to their community, and will play an active part in decisions which affect their lives.Older citizens will also become free from discrimination in the delivery of services.
- For a minority of people, living longer will mean increased dependence, poor health and frailty – and the strategy addresses the needs of older people who are in this situation.
- The strategy also supports the needs of the majority of older people living in Sefton for whom living longer will mean:-
  - leading full, active and healthy lives for longer;
  - playing a key role in the local community through continued employment or voluntary work;
  - enjoying sport, social and leisure activities; and
  - using computers and other forms of technology to stay in touch with family and friends, to shop and to access information.

CONCLUSION

- The Sefton Partnership for Older Citizens wants Sefton to be a place where old age is enjoyed rather than endured.
- A positive outlook and strong support networks are vital if later life is to be enjoyed to the full. This strategy demonstrates how this can be achieved.

MAKING CONTACT

If you require this document in a different format (large print, audio, language, etc.) please contact:-

Sefton Council for Voluntary Services,
3rd Floor, Burlington House, Crosby Road North, WaterlooL22 0LG
Tel. 0151 928 2233 E-mail: sarah.hurn@seftoncvs.org.uk

GETTING INVOLVED

If you would like to get involved, and to help influence the development of services for older citizens in Sefton, please contact:-

Sefton Pensioners' Advocacy Centre,
Shakespeare Centre, 43/51 Shakespeare Street, Southport PR8 5AB
Tel. 01704 538411 E-mail: info@spacadvocacy.org.uk

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/79	**Author of the Paper:**
Report date: May 2014	Dr.Debbie Harvey Debbie.harvey@southseftonccg.nhs.uk

Title: Virtual Ward Quarterly Update

Summary/Key Issues:

This paper presents the Governing Body with the second agreed quarterly update of 2014. The document encompasses the processes relating to the implementation of the Virtual Ward Model of care.

Recommendation

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

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Achieve a 2% reduction in non-elective admissions in 2014/15.
x	Implementation of 2014/15 phase of Care Closer to Home/Virtual Ward plan.
x	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

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

14/79

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

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
May 2014

1. Executive Summary

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

2. Introduction

The increasing number of frail, elderly and those with long term conditions is increasingly our greatest challenge in healthcare. Within South Sefton over the next 20 years the calculated increase in financial demand from merely demographic change is estimated to be over 20%.

Both healthcare and social care face efficiency savings over the next 5 years with no anticipated increase in resource for the increased demand.

One of the key objectives for the health economy is to reduce the frequency of avoidable unplanned care by managing patients more proactively through community based coordinated systems.

The key areas required include:

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

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

This update is broken down into the following areas

Contents:

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

3. Content

3.1. Commissioning Processes

3.1.1. Strategic Overview

Version 1 was completed in August 2012 and widely circulated within and beyond South Sefton CCG. Version 2 was issued in 2013.It is likely that over the coming months that the strategy will require further revision to reflect wider changes in the health economy.

3.1.2. Business Case

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

3.1.3. Service Specification

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

3.1.4. Commissioning for Quality and Innovation (CQUINs)

Virtual Ward CQUINs will continue 2014/15. These support the function of:

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

3.1.5. Integrated Operating Framework

The Virtual Ward Team continue to work on an integrated operating framework with contributions from all major stakeholders. The Virtual Ward Team is taking initiative on this. It will cover the following areas.

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

3.2. **Project Management**

3.2.1. Project management support

The Virtual Ward has benefitted greatly from the support of PMO in the past few months. This has been critical and highly beneficial in supporting the team particularly with the temporary departure of Dr Peter Chamberlain. The PMO have responsibility for two key areas:

3.2.2. Monitoring work stream progress

The team continue to input into Sharepoint. The work stream leads are tasked with updating their areas of work. The difficulty in using such a system is its dependency on work stream leads to keep their areas of work updated regularly and this has proved to be the biggest challenge. The PMO have endeavoured to improve knowledge and appropriate access to Sharepoint where possible. There remain access issues dependent on provider IT systems.

3.2.3. Collating data and quality improvement

The PMO are now the point of contact for any agreed data from all sources. This continues to be a challenging area as it is currently not possible to obtain data in an integrated manner. Each provider is providing their activity in a differing format.

- VW Consolidated report (which is effectively of project progress on Sharepoint)
- VW activity data
- VW measures data.

Headline dates:

Clinical Integration

1. Recruitment of additional staff for locality based Virtual Wards completed 01.07.13
2. GP enhanced scheme for risk stratification and pro-active care 01.07.13
   this ended March 2014
3. Locality based Virtual Wards formed with full complement and active throughout all localities 01.08.13
4. Virtual Ward Urgent Care Team formed and ready for deployment ~~01.12.13~~
   Reviewed date June 14
5. Full complement Community Geriatricians ~~31.12.13~~ 30.03.14

IMT Integration

1. EMIS Web Community on going rollout > Integrated Community Record 31.07.13
2. Honorary contracts and access to EMIS Community for non LCH staff 31.08.13
3. Access to SMBC social data for specified health staff 31.08.13
4. Process completed for increasing UHA doctor access to brief Summary 30.09.13
5. Mobile working for community staff ?2015
   Community matrons are currently piloting this area of work it is unclear when other community staff will be able to use mobile working
6. Electronic 'My Shared Care Plan' ?2015
   We are yet to agree a shared care record let alone one which is electronic. This is work in progress but likely to take some considerable time to be fully functional.

3.2.4. Work streams

Steering Group
The steering group meets on a bimonthly basis. It provides a critical link between the SSCCG board, Sefton council board, the operational groups, PMO and governance groups. Attendance at the steering group by all critical parties has proved inconsistent and been raised as an area of concern to the CO.

Governance
We have formed a governance group with representation from all providers and SSCCG. It is often difficult to achieve full representation from providers.
The area of information governance in conjunction with the IT solution is highly complex. We await a draft IG paper from LCH to outline proposed recommendations regarding the VW IG framework. This will be based on a collective IG meeting with CSU which took place in April.

Dr Harvey and Alison Johnston are working collaboratively with CSU around the development of a joint accountability statement.

It is envisaged that a proposed governance/IG document be submitted to the Governing Body in July.

Pro-active nursing and re-ablement
The VW referral form has proven problematic due to its length. The form has been reworked. This was seen as an opportunity to re-launch the form as an electronically managed referral. Unfortunately the electronic rollout has been delayed and a paper copy format will have to be released in the interim.

IM&T
iMersey, under the leadership of Paul Shilcock is currently working through the IT solution for the VW. This work stream has been delayed in part due to unresolved issues around data ownership but also because of the more complex concerns directly related to the intricacies of integrated IT systems and access to these from different providers.

Urgent Care
The Urgent Care aspect of the virtual ward was postponed until Dr Asan the Full Time Community Geriatrician came into post. The UC team have agreed a mobilisation plan which supports a gradual roll out of the service over a period of 4 months commencing initially In Bootle locality.

Care Planning
There are a number of key areas with regards to care planning:

The new National enhanced scheme for unplanned care is making it hard to drive change with regards to care planning more broadly. Not all GPs are signing up to the scheme and the care planning described does not fit with the local ambitions of a fluid integrated care plan.

The CCG is facilitating regular quarterly meetings with key providers with regards to care planning in long term conditions and end of life. The next meeting will take place in June.

The unified DNR policy has now been mobilised across South Sefton with accompanying education

Since the last update paper Dr Nigel Taylor (salaried GP) has completed an audit of advanced care planning in care homes. Once submitted this will provide some key recommendations to inform further initiatives and pieces of work in the coming months.

3.2.5. Quality Improvement

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

1. Measures

We continue to receive baseline measures from MCSU on a monthly basis.
The majority of providers now submit data on a monthly basis. We are yet to receive data from the LA. The activity from LCH is still collated manually which encourages the potential for error. It is envisaged with the introduction of electronic referrals on the horizon and the VW IT solution that data collection should improve significantly.

PDSA cycles

A number of PDSA cycles have been completed but there has generally been a lack of activity in this area. The latter has been reviewed by our community geriatrician who at the time of writing this paper is organising an educational event for all staff involved in the VW.

2. Quality Feedback Mechanism

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

We encourage all staff of the VW to provide feedback regarding all process issues, incidents, complaints etc in conjunction with any required governance reporting mechanisms to build a wealth of learning for all those involved. Anonymous reports regarding all of the above are logged on sharepoint to illustrate any particular trends or elements of good practice.

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

3.2.6. GP engagement and enhanced schemes

1. **Engagement through locality meetings**

   Dr Asan, Community Geriatrician, has been involved in locality meetings and has also attended some practices. This has been invaluable and allowed us to understand some of the perceived barriers for GPs when referring to the VW.

2. **Locality based service development GP champions**

We have locality leads in each area who potentially have a key role in engagement, soft intelligence and general feedback.

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

The risk profiling and Pro-Active Management Enhanced Scheme was funded until the end of the last financial year 2013/2014. We are currently assessing the possibility of funding similar work through the enhanced scheme this year. Unfortunately GPs are already cancelling meetings with their community matrons as this area is not currently funded.

4. **Referral numbers and rejected referrals**

This area has been highlighted as a risk area. The overall number of referrals has flat lined over the past 7 months. In addition there have been consistent numbers of 'rejected' referrals. The Virtual Ward specification allows for 400 referrals per month and is therefore running at around 25% capacity. We are currently working with Dr Asan and LCH to review the area of rejected referrals as this is not encouraging new referrals. The 'Listening' exercise (described below) has also allowed us to understand 'problem' areas for GPs trying to refer patients into the virtual ward. This will enable us to examine the model along with operational issues with a view to supporting referrals and increasing activity.

5. **Listening Exercise**

SSCCG have undertaken a 'Listening Exercise' to understand what GPs feel should inform future commissioning intentions for community providers. A document incorporating this piece of work will be presented to the Governing Body in July.

3.3. **Wider aspects relating to the project**

1. **Virtual Ward Plus**
   Discussions with SSCCG and the LA continue with regards to the potential for the Virtual Ward to increase its remit and provide increased support through the Better Care Fund.

2. Intermediate Care

The step up, step down and flex criteria for w35 have been reviewed following a number of incidents. It is hoped that with intermediate care beds will support the urgent care aspect of the VW when launched for step up patients.

Consideration of community based IC beds is also being evaluated at the present time.

3. **Frailty Unit**

The new frailty unit at UHA is now providing a significant short term resource for the elderly frail who require step up medical input from the community. Equally patients discharged from the frailty unit can be supported by the VW. Dr Asan provides a key conduit for integrated working in these areas.

4. Recommendations

The Governing Body is asked to receive this report by way of assurance and provide any comments thereon.

Appendices

APPENDIX A1: *Virtual Ward Business Case Summary 2013/2014 (Graduated Rollout)*
APPENDIX A2: *Virtual Ward Business Case Summary 2014/2015 (Full Roll Out)*
APPENDIX C: *Virtual Ward Measures and Dashboard.*

Dr.Debbie Harvey
May 2014

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

SOUTH SEFTON VIRTUAL WARD BUISNESS CASE 2013-2014 GRADUATED ROLLOUT	WTE	ORGANISATION LCH	UHA	CCG	CVS	SEFTON LA	OTHER	TOTAL
Staff Pay Costs								
Ward Administration	**Jun-13**							
Band 6 - District Nurse (Replace Band 7 Ward Manager)	4	15062						
Band 4 - Care Co-ordinator	4	8 87575						
Proactive Nursing	**Jun-13**							
Band 7 - Community Matron	4	16371 7						
Band 5 - District Nurse	4	12414 4						
PCMM - Pharmacist	1			49393				
PCMM - Technician	1			33979				
Health Care Trainer	4				84910			
Re-Ablement	**May-13**							
Band 7 - OT	1	45022						
Band 7 - Physiotherapy	1	45022						

South Sefton Virtual Ward System

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

Urgent Care Team	**Dec-13**						
Community Geriatrician (2)	1		5333				
Band 7 - Advance Urgent Care Nurse	2	28616					
Band 6 - Urgent Care Nurse	3	35809					
SPC Team	**Jun-13**						
Band 6 - SPC	2	69478					
Total Staff Pay Costs	**124454**	**750011**	**5333**	**83372**	**84910**	**0**	**0**
Non-Pay Costs							
MSSE		33196					
Travel & Subsistence		19008					
Mobile Telephones		5788					
Other Non-Pay		1375					
Total Non-Pay Costs		**59367**	*1000*	*2000*	*4000*	**0**	**0**
TOTAL DIRECT COSTS		**809378**	**5433**	**85372**	**88910**	**0**	**0**	**103799 3**
TOTAL OVERHEADS		**115844**	**6520**	**0**	**9780**	**0**	**0**	**132144**
OTHER RECURRENT							
Training		0	0	0	0	0	5000	

Service Development	0	0	0	0	0	10000	
GP Integrated Care Contract	0	0	91800	0	0	0	
TOTAL OTHER RECURRENT	0	0	91800	0	0	15000	**106800**
NON-RECURRENT							
Ward Round Facilitation	10000						
Administration Facilitation	10000						
IMT Infrastructure Development						50000	
Urgent Care Team Equipment	25000						
TOTAL NON-RECURRENT	**45000**	**0**	**0**	**0**	**0**	**50000**	**95000**
TOTAL COST	**970222**	**60853**	**177172**	**98690**	**0**	**65000**	**1371938**

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

SOUTH SEFTON VIRTUAL WARD BUISNESS CASE 2014-2015		ORGANISATION						TOTAL
FULL OPERATION	WTE	LCH	UHA	CCG	CVS	SEFTON LA	OTHER	
Staff Pay Costs								
Ward Administration								
Band 6 - District Nurse (Replace Band 7 Ward Manager)	4	180754						
Band 4 - Care Co-ordinator	4	105090						
Proactive Nursing								
Band 7 - Community Matron	4	196460						
Band 5 - District Nurse	4	148973						
PCMM - Pharmacist	1			49393				
PCMM - Technician	1			33979				
Health Care Trainer	4				92629			
Re-Ablement								
Band 7 - OT	1	49115						
Band 7 - Physiotherapy	1	49115				In house		

South Sefton Virtual Ward System

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

Urgent Care Team								
Community Geriatrician (2 x 50%)	1		160000					
Band 7 - Advance Urgent Care Nurse	2	85849						
Band 6 - Urgent Care Nurse	3	107427						
SPC Team								
Band 6 - SPC	2	83373						
Total Staff Pay Costs	**24**	**1006156**	**160000**	**83372**	**92629**	**0**	**0**	
Non-Pay Costs								
MSSE		36214						
Travel & Subsistence		20736						
Mobile Telephones		6314						
Other Non-Pay		1500						
Total Non-Pay Costs		**64764**	*1000*	*2000*	*4000*	**0**	**0**	
TOTAL DIRECT COSTS		**1070920**	**161000**	**85372**	**96629**	**0**	**0**	**1413921**
TOTAL OVERHEADS		**145082**	**17710**	**0**	**10629.19**	**0**	**0**	**173421**
OTHER RECURRENT								
Training		0	0	0	0	0	5000	
Service Development		0	0	0	0	0	10000	

GP Integrated Care Contract	0	0	91800	0	0	0	
TOTAL OTHER RECURRENT	0	0	91800	0	0	15000	**106800**
TOTAL COST	**1216002**	**178710**	**177172**	**107258**	**0**	**15000**	**1694142**

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

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

5. Out of Hours activity - Age ≥ 65's	Flat line	Liverpool Community Health	Balancing
D. Measures of Integration			
1. Staff attendance at Virtual ward rounds (CQUIN)	6 LCH types professionals	Liverpool Community Health	Process
2. WM/ CM – GP monthly liaison meeting	100% (35 practices/ month)	Liverpool Community Health	Process
3. Pre/ post change frontline staff integration survey (AQUA)		Liverpool Community Health	Process
4. System integration tool (AQUA)		South Sefton CCG	Process
E. PATIENT ACTIVITY			
1. Demographics (including Name, DOB, NHS number, GP surgery)		Liverpool Community Health	Activity
2. Timing of referral, intervention, discharge		Liverpool Community Health	Activity
3. Type of intervention a) Short term intervention b) Integrated Care **c)** Pro-Active Care Programme		Liverpool Community Health	Activity
4. Types of professionals involved in care		Liverpool Community Health	Activity

South Sefton Virtual Ward ▸ Consolidated Report
Information Management Centre for the South Sefton Virtual Ward

SECTION 1: WORKSTREAMS

Status Updates

Workstream Name	CCG Lead	Workstream Lead	RAG Update (summary of progress, problems and achievements)	RAG Date	Current RAG	Previous RAG	Previous Date
Proactive Care	Debbie Harvey	Tina Ewart	The number of new Pro Active plus Integrated Care referrals across all localities averaged 100 per month in the 6 months to 1 April. Rejected /declined referrals are still a concern with monthly averages in the 6m up to 1 April of 11 in Crosby and 12 in Maghull. Asan, Consultant Community Geriatrician is accompanying the LCH teams to meet with practices to assist identification of patients best suited for VW. The reworked referral form, being installed on practice systems during May, is expected to reduce rejected referrals by defining more specific info to the requested discipline at point of referral. A trial of the electronic Managed Referral functionality with 1 practice has highlighted a couple of issues that need work-round before rolling out electronic sending of referrals in very near future. The H&Wellbeing trainers are averaging just over 30 referrals per month offering signposting and case working with patinets. Of 101 referrals in Qtr 1 , only 8 were declined/innappropriate or not engaging. As of April it was agreed that practices could refer direct to the H&WB service due to concern of insufficient referrals coming via PAC/VW route. Detailed outcomes will be reported in future quarterly reports as agreed provider May 2014. Referral numbers appear to be levelling-off at around 100 per month across the ward as a whole. Looking to increase engagement and activity, plus from other sources eg Discharge Planning Teams. Revision of Referral Form still outstanding. Recent data indicates reduction in NEL attendances & admissions for over 65yrs. Too early to use as accurate indicator but positive direction.	08/05/2014			06/12/2013
Care Planning	Debbie Harvey	Debbie Harvey	An initial meeting took place on 16/10/2013. The workstream will look at developing, agreeing and introducing Care Plans across the CCG patch for both End of Life Care and patients with Long Term Conditions. At this point, work is focussed on understanding what processes and products already exist within the various organisations. Next meeting Jan 15th Meeting postponed as lack of progress across all modalities as follows 1. hopefully ACP template will be ready on EMIS v soon 2.Working on uDNAR across South Sefton - educational events etc - though unlikely to be launched Feb 3rd as per NWAS plan 3. Have meeting with Steph Gallard LCH Jan 10th re using NWAS care planning template Meeting took place March 26th. Explored EPACS and further developments around care planning at UHA. ACP should be available on EMIS in the near future.Further meeting in June 2014 uDNAR educational event May 7th	07/07/2014			26/03/2014
IM&T	Debbie Harvey	Paul Shillcock	The IT solution for Virtual Ward has been approved by all relevant stakeholders. The IM&T Subgroup has been reconvened. An outline project plan has been produced with the IM&T elements divided into 3 distinct sections, configuration, coding and assessment and messaging, all of which are currently being timelined by respective project managers. Several IG issues remain, the main one being Data Ownership of the Virtual Ward and its shared information.	**26/02/2014**			30/01/2014
Urgent Care Service	Debbie Harvey	Stuart Flanagan	Progress has been made on the project since the last update. However this service has been posponed again at the request of SSCCG until at least March 2014 when the new Community Geritrician takes up his post and is available to input into the process. A new go live date has therfore yet to be agreed. Work will continue on the project, Staff already appointed to this service will be utilised at least in part elsewhere and fortnightly meetings with SSCCG will continue. Rag status has returned to Green as project on target to deliver in March 2014 if required	**17/01/2014**			25/11/2013

			The following are completed and still require sign off by SSCCG. It is likely that these however will be reviewed with input from the Community Geritrician in March 2014: 1. Operating Model (Mobilisation Plan) 2. SPC Triage Model & In & Out of Hrs Provision 3. Activity Schedule/Model. 4. Review of activity after 1 mth to compare activity model against actual demand 4. Communication & Engagement Plan				
Re-ablement	Debbie Harvey	Kevin Thorne	Sefton Council is working with it's main provider of reablement services to improve outcomes for people who need reablement services. A NEW approach has been developed and will be known as Sefton Homecare Reablement Service. The new service will become an integral part of the South Sefton Virtual Ward and Southport and Formby - Care Closer to Home approaches adopted by Sefton CCG's. It is envisaged that The Sefton Homecare Reablement Service will begin a phased start on 1st April 2014. Links will be made with other key partners to develop plans to integrate the service with Proactive Care and Reablement. 28th April 2014 - Sefton MBC Quality Assurance Group issued Homecare Reablement 'Making it Happen' doc and pathway for consultation. Meetings to be arranged to progress this work, agree interface with VW.	28/04/2014			24/04/2014
Communications	Debbie Harvey	Lyn Cooke	Information gathering is planned for the coming weeks involving focus group sessions and input from EPEG and LCH's Membership Reading Group. It is anticipated that the recommendations regarding the rebranding of the Virtual Ward will be available for the May Steering Group Meeting.	09/05/2014			11/03/2014
Strategy & Oversight	Debbie Harvey	Debbie Harvey		02/05/2014			02/05/2014

SECTION 2a: MILESTONES ACHIEVED

Milestones achieved since last meeting

Workstream	Task Name	Priority	Assigned to	Start Date	Due Date	Progress Update (summary of activity)
IM&T	GP-LCH-GP EMIS-Web Managed Referral System Technically Available	2	Steven Murray	31/03/2014	31/03/2014	

SECTION 2b: MILESTONES PLANNED

Milestones yet to be achieved

Workstream	Task Name	Priority	Assigned to	Due Date	Progress Update (summary of activity)
IM&T	GP-LCH-GP EMIS-Web System Setup Completed	2	Steven Murray	16/04/2014	Finalising e-referral destination arrangements regarding which of their EMIS-Web 'organisations' the provider wishes referrals to be directed to. Using existing processes, referrals are sent to one of four localities and distributed accordingly. This configuration is not currently replicated on the primary service provider's EMIS-Web system that will be used to operate Managed Referrals.
Proactive Care	GP-LCH-GP EMIS-Web Managed Referral System Pilot Completed	1	Tina Ewart	30/04/2014	Glitches identified in e referral system with testing at one practice - hoping to be resolved in very near future. Decision to install the New referral form to be installed in paper format/template for use on practice systems and continue sending by fax until glitch resolved 8/5/14 Disappointing Delays in E referral form being piloted with 3 practices. iMersey to appraise CCG on delay
Communications	Rebrand Proposals Approved	2	Lyn Cooke	14/05/2014	
Urgent Care Service	Urgent Care Pilot Defined and Approved	2	Lisa Hammond	14/05/2014	
Strategy & Oversight	Privacy Impact Assessment v2 Approved	1	Alison Johnston	29/05/2014	
Strategy & Oversight	Joint Accountability Framework Approved	1	Debbie Harvey	29/05/2014	The JAF is inherently tied in with the IM&T solution and IG agreements - who 'owns' the data for the VW etc. It is anticipated that the IG Group will provide a paper for the May Steering Group meeting outlining recommendations for that group to review and submit to the CCG Board for formal approval at the end of May.
Urgent Care Service	Urgent Care GP Engagement Plan Produced	2	Lisa Hammond	30/05/2014	
Care Planning	NWAS Care Plan Pilot Completed	2	Debbie Harvey	30/05/2014	All 4 localities have assigned practices and community matrons working on the project. It is envisaged that the project should be complete by the end of June 2014.
Care Planning	Unified DNaR Form Available for use	2	Debbie Harvey	02/06/2014	uDNAR forms have been printed educational event organised for May 7th for all GPs
Proactive Care	GP-LCH-GP EMIS-Web Outbound Comms Pilot Completed	2	Tina Ewart	02/06/2014	It's been reported that 1 practice trial was tested and identified issues to be worked through. Quick fix is to install the revised referral form on to practice systems during May to use with the faxed referral process whilst glitches are fixed to enable electronic transmission in the very near future (8.5.14) Test of e-ref form during April 2014 - not commenced to date (7/5/14) Hoping that testing should not delay roll out of use across the CCG.
Urgent Care Service	Urgent Care Pilot Completed	2	Lisa Hammond	16/07/2014	
Urgent Care Service	Urgent Care Pilot Review Completed	2	Lisa Hammond	31/07/2014	
Urgent Care Service	Urgent Care Service Live	2	Lisa Hammond	01/09/2014	
Communications	Rebrand Launch	2	Lyn Cooke	01/09/2014	

Re-ablement	Sefton Homecare Reablement Service Live	2	Kevin Thorne	01/09/2014	Sefton MBC's Quality Assurance Group have produced a first draft "Making it Happen" document and draft Homecare Reablement Pathway for consultation with partners. The Reablement Workstream will now begin work on the pathway and 'making it happen document to integrate referral sytems, and agree process's to support this development. Homecare Reablement is a borough wide initiative and will need to be developed with the Care Closer to Home appraoch in North Sefton.

SECTION 3: RISKS

All risks flagged for escalation to this group for management, a decision or review

Escalation Action	Workstream	Rating	Risk ID	Risk Owner	Risk Description (cause, event, effect)	Risk Response (measures to control this risk)	Response Owner	Latest Update (progress on response)
For information	IM&T		VW3-R016	Paul Shillcock	Failure to have an agreed PIA in place delays the delivery of an IT solution	PIA will be produced and agreed.	Alison Johnston	A new PIA incorporating the agreed interoperable IT solution is to be developed in conjunction with the IM&T Workstream once the IT specification has been shared and fully understood by the IG Lead.

SECTION 4: ISSUES

All issues flagged for escalation to this group for management, a decision or review

Escalation Action	Workstream	Date Raised	Issue ID	Issue Description (inc. cause and impact)	Priority	Severity	Intended Resolution Plan	Resolution Owner	Resolution Due	Resolution Status
Specification sought on definition of a management plan.	Care Planning	27/02/2014	VW2-I014	Clarification is required on what constitutes a management plan so that the solution can be delivered adequately.	3		May be a question for the Operational Group in defining what this consists of clinically.	Debbie Harvey	28/03/2014	In progress
A definitive decision is required on which organisation should be regarded as data owners for information held electronically within the Virtual Ward	IM&T	30/12/2013	VW3-I009	Clarification is required on data ownership under the Virtual Ward and specifically, who is repsonsible for the clinical data and resulting actions arising from the information held in VW.	2		Once solution has been discussed with stakeholders, a clinical decision is required on data ownership and resulting clinical protocols arising from the VW setup.	Debbie Harvey	14/04/2014	Defined but not yet started
GWG to review and revise; StGp to approve final.	Strategy & Oversight	04/02/2014	VW8-I012	Joint Accountability Framework has not been agreed. This is due to concerns of all parties (e.g. the impact on providers' ability to meet llitigation insurance conditions, and the effects on commissioners' ability to maintain clinical responsibility for patients). It represents a gap in the governance arrangements for the Virtual Ward which is in breach of NHSLA (NHS Litigation Authority) guidance on multi-organisational service delivery that stipulates that a single organisation provides this function on behalf of all partners.	1		Develop (or revise existing draft) and agree Joint Accountability Framework for approval at next IGWG meeting.	Debbie Harvey	29/04/2014	Defined but not yet started
Direction on resolution plan required	Strategy & Oversight	20/03/2014	VW8-I015	A need has arisen to 'park' the obtaining of information regarding strategic direction due to non-attendance of partners resulting in delays with progress and reduced oversight	1		TBC	Debbie Harvey	14/05/2014	Not yet defined

SECTION 5: INCIDENTS

Incident Reports added or updated since last meeting

Severity	Detailed Description	Date Raised	Raised by	Locality
	None of the localities are achieving sufficient referral numbers to support an effective caseload ie in order for the VW to be sustainable the model is based on 400 referrals a month. This needs exploring from both a GP referral and triage/provider perspective Approximately a third of referrals are 'rejected' at triage which in turn is having a negative affect regarding referrals. Dr Asan has agreed to review any future referrals deemed to be 'inappropriate'	08/05/2014	Debbie Harvey	Bootle, Crosby, Maghull, Seaforth and Litherland
	On visiting patient, found six months of blister packs in carrier bags untouched. Also numerous bottles of Epilim Syrup untouched and 2x300ml going out of date.	08/05/2014	Shaun Roche	Crosby
	Patient admitted to hospital with ischaemic stroke. Discharged on aspirin 300mg daily for 2/52 then to start clopidogrel 75mg. No consideration in treatment for MI in July 2013. Patient should have been on both clopidogrel and aspirin for 12/12 post MI.	08/05/2014	Shaun Roche	Crosby
	A patient had been referred to medicines management to review the appropriateness of initiating a blister pack. Patient had previously been on blister packs. Patient's brief summary indicated that the patient was taking carbimazole 30mg twice daily with a combination of the 5mg and 20mg strength tablets. However during the visit, the patient had said she was only taking 20mg daily, using either the 20mg or the 5mg strength (patient had not been collecting her carbimazole each month). Before the blister pack was organised, I contacted the patient's surgery to inform the GP of the corrent dose of carbimazole being taken, and to query whether the patient should have her thyroid levels checked. The GP contacted me to thank me as the patient had subclinical hypothyoidism in September, and the carbimazole should have been discontinued in September until further thyroid levels had been checked.	03/04/2014	Sean Reck	Bootle

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/80	**Author of the Paper:**
Report date: May 2014	Jan Leonard Chief Redesign and Commissioning Officer jan.leonard@southportandformbyccg.nhs.uk

Title: Primary Care Update

Summary/Key Issues:

1. The CCG is unable to continue to commission services via Local Enhanced Services within Primary Care. This paper describes the process for changing to an NHS Standard Contract and the financial resource allocation aligned to the Quality Schemes within the contract.

2. This paper also provides progress on the Primary Care Quality Strategy.

Recommendation

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

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
	Achieve a 2% reduction in non-elective admissions in 2014/15.
	Implementation of 2014/15 phase of Care Closer to Home/Virtual Ward plan.
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

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				SLT

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
May 2014

1. Background

South Sefton CCG Governing Body approved a Primary Care Quality Strategy document, 'A Sense of Purpose' in 2013. One of the key actions from this, in line with national drivers, was a plan to transform primary care locally through investment in a local quality contract.
From 1st of April 2014 CCGs have been unable to use Local Enhanced Services (LES's) to commission services from General Practice. This paper sets out the rationale for the CCGs use of the money that was formally commissioned via LESs for General Practice via a Local Quality Contract effective from August 2014.

2. Quality and Strategic Objectives

The schemes within the Local Quality Contract will deliver against the following Corporate Objectives:-

Improved quality of commissioned services, whilst achieving financial balance
In particular the scheme for data validation will review information from Acute services and challenge inaccuracies.

Achieve a 15% reduction in non-elective admissions across 5 years
The schemes to address A&E attendances and primary care access will assist in the delivery of this indicator to reduce secondary care activity.

Implementation of 2014-15 phase of Care Closer to Home / Virtual Ward plan
The Community Health Scheme will support practices to meet with community staff which will develop further the relationships and networks within localities.

Review and Re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership and partners
The Community Health Scheme will enable the membership to contribute to this process

Implementation of 2014-15 phase of Primary Care quality strategy / transformation
The proposed investment will deliver this objective.

Improving Outcomes
We anticipate that the schemes will also deliver against the following outcome ambitions from the strategic plan:

- to Reduce Unplanned Hospital Admissions
- improve the Health Related Quality of Life for people with one or more long term conditions

- improve Emergency Ambition Performance.

3. NHS Standard Contract

The CCG will use an NHS standard contract to commission the schemes from general practice. The contract will be for a three year period with an annual review.

The CCG has reviewed and consulted on the clinical efficacy of all pre-existing LES's and have reduced the number of schemes from 11 in South Sefton to 10. The final list of schemes are:

- A&E attendances
- Primary care access
- Exception coding
- Community health
- Phlebotomy
- Shared Care
- Drug administration
- Data Validation
- Ankle Brachial Pressure Index
- Practice Development plan
- A panel will assess the practice achievement based on practice submissions.

4. Funding

One of the most difficult issues in allocating funding has been the difference in unit price of core funding that currently exists within GMS / PMS and APMS practices. Historically a GP Framework scheme was in operation that, through a practice development scheme, provided additional investment to those practices receiving lower amounts of core funding. This scheme will end with the existing LES's and the money re-invested. Due to the inequity in core funding that exists, a number of different options have been considered to enable the best value for money for investment in improving Primary Care Quality.

The following option has been selected as the preferred option.

Option 6 Local Minimum Income Protection £75

This option applies a Local Minimum Income Protection Guarantee to any contract below £75 per patient for the first year of the contract. The rationale for this is in order to ensure that there is sufficient capacity and resource in primary care in order to deliver improvements in quality. Whilst recognising that this is in excess of previous funding levels under the LES arrangements, there was concern that funding below this level was insufficient and that practices would struggle to achieve the anticipated outcome measures. There is also concern that failure to achieve the anticipated outcome measures could result in additional expenditure being required at a future point to address the unmet need or through more costly patient pathways. Practices in receipt of this payment will be asked to complete a Practice Development Plan to describe how the additional investment will be used to underpin the delivery of the schemes.

This option also identifies areas in current NHS England contracts which may overlap with the requirements of the Local Quality Contract. Where practices are currently receiving payments via their core contract, the local elements will not be applicable.

5. Primary Care Quality Strategy

The Governing Body approved the Primary Care Quality Strategy in September 2013. This document outlined the domains and workstreams for a 3 year period. A Primary Care Quality Strategy Board was established as a sub-committee of the Quality Committee to oversee the implementation of the strategy.

Membership of the Board includes:

- Primary Care Quality Lead (Chair)
- Senior Clinician and Practice Manager from each CCG
- Lay Member from each CCG
- Senior CCG Managers
- Healthwatch
- LMC
- NHS England Merseyside
- Public Health
- Merseyside Property Partnerships.

Year 1 of the strategy is operational from April 2014. An evolving project plan and current rag rated status for the workstreams is attached.

6. Recommendation

The Governing Body are asked to receive the contents of this report.

Appendices

Appendix 1 Project Plan and Rag Rated Status for workstreams.

Jan Leonard
16th May 2014

SS Governing Body Meetings	24		26				30		18				
Primary Care Quality Strategy Board		13											
Quality Committee			12			11		13					
Finance and Resource Committee		13	10	8		9	7	11					
Remuneration Committee													
LMC committee meetings	15	20	17		19	16	21	18	16				
Senior Leadership Team													
Senior Management Team													
Wider Group Meetings													
PLT Forums													
Primary Care Team Meetings													
Locality Meetings													
Operational Team Meetings													
PM Meetings													
NHS England Primary Care Leads Meetings													
PCQS Board Meetings	Identify leads for PCQS domains Agree /develop work programmes for year 1 Local Quality Contract Agree dates for 2014/15 PCQSB meetings identify SS GP for PCQSB forum (google group) Models LMC Discussion Locality Collaborative PCC event												
Demography	Senior GP nominated in each locality 6 /12 work stream to inform model of collaboration	Engagement with localities		Locality Paper re: Scope of Aspiration to PCQSB by July (GP Lead)				Locality report to PCQSB November (GP Lead)					
Workforce Development	Mapping Workforce - demonstration of primary care data capture tool (PCDCT)	Liasion with PM Lead re demonstration of PCDCT to PMs by Health Education North West	PM meetings										
	Locality Clinical Provision of Community Services												
	Peer Review Governance and Performance Review												
Clinical Services	Virtual Ward - Primary care lead input into the scheme in areas such as 'urgent care'	Debbie Harvey input to Virtual Ward											
	Acute Visiting Scheme	GTD pilot scheme costings / meetings											
IT	GP - GP transfer	Superceded by changes to national contract 14/15											
	Ericom (Brought forward from year 3)	Funding for Ericom identifed, work ongoing to implement with iMerseyside											
Premises	Map out with our partner estates capacity	Merseyside Property Parnerships on the PCQSB											
	Publication of funding allocation on practice by practice basis												

Health Outcomes	Local Quality Contract (LQC) Extension of current LES Schemes to July 1st 2014 CSU BI / PMO/Data Facilitor meetings Project plan / options paper / LQC / financial information to SMT/SLT 29th April 2014	Meet LMC PCQSB Send LQC to practices Primary Care Event Devise reporting templates / Quarterly invoice	Practices state intention to sign up Finance set up monthly payments schedules 1 - 4 NHS Standard Contracts issued to practices CSU BI Primary Care dashboards on portal	July 1st LQC operational Quarter 1 LES invoices processed Update PCQSB Plot practice activity	Progress to SS Governing Body	Plan contract review meetings for Oct/Nov/Dec	Contract review meetings Review year 2 specifications PCQSB Agree funding for PC access year 2 Exception Coding Variations to Governing Body Oct 30th			variations to Year 2 LQC to practices	Practices given opportunity to sign up to year 2 - Agree sub group of PCQSB to agree end of year achievments in quarter 1	Annual submissions by GP practice - Outcomes to be determined in quarter 1
	Email to practices to establish practice needs Hugh Baird advertising course / recruiting course tutor Job description / course qualification under discussion	Internal meeting 6th May Discussion at PM meetings Expressions of interest		Potential recruitment/ interviews		Potential start date for HCA's						
NHS England												
Over 75's												
Unplanned Admissions												
Accountable GP												
Choice of GP practice (cross boundary												
Contract Review Litherland Darzi												
Procurement North Park												

South Sefton

Primary Care Qualtity Strategy 2014	year 1 RAG rating	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
PCQS Board Meetings													
Demography	Subscribe to PCC (AP)												
	Look at models of federation												
	GP within each locality to model collaborative working												
Workforce Development	Work with NHSME on mapping programme												
	Each locality to work on one business case to be locality based commissioned and managed (provision of community services)												
	Peer Review Governance and Performance Review												
Clinical Services	PC lead input into the scheme in areas such as urgent care												
	Evaluate acute visiting scheme pilots locally												
IT	GP to GP transfer to be at 100% (in GMS/ PMS contract variation 14/15)												
	Ericom PCQ Budget 2013/14 brought forward from year 3 (AP)												
Premises	Map out with our partner estates capacity												
Health Outcomes	Publication of funding allocation at practice level												
	Local Qualtiy contract												
	HCA Apprentices												
NHS England													
Over 75's													
Unplanned Admissions													
Accountable GP													
Choice of GP Practice (cross boundary)													
Review of Litherland Darzi													
Procurement of North Park													

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/79	**Author of the Paper:**
Report date: May 2014	Debbie Fairclough Debbie.fairclough@cmcsu.nhs.uk

Title: Revised Governance Structures 2014

Summary/Key Issues:

A review of committee structures and associated reporting arrangements has been undertaken to ensure that there is clear, accountable clinical leadership and involvement throughout all decision making processes. Consideration has also been given to the ways in which the CCG can ensure achievement of the strategic objectives as well as exploring opportunities for the improvement and transformation of services.

This paper provides an overview of this work and the changes to the committee structures.

Recommendation

The Governing Body is asked to receive this report and note the changes.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Achieve a 2% reduction in non-elective admissions in 2014/15.
x	Implementation of 2014/15 phase of Care Closer to Home/Virtual Ward plan.
x	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement		N		
Clinical Engagement	Y			
Equality Impact Assessment		N		
Legal Advice Sought	Y			
Resource Implications Considered	Y			Administrative support will be required
Locality Engagement				Locality leads will be involved in meetings
Presented to other Committees				SMT

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
May 2014

1. Introduction and Background

During February and March 2014, a review was undertaken in light of the emergent strategic plan to ensure that the CCGs committee arrangements were fit for purpose in ensuring the CCG achieves its strategic objectives and were operating optimally.

The review also took account of any areas of duplication and refined those Terms of Reference to differentiate between accountability, responsibility, assurance and operational responsibility. This provides a clearer focus for each committee with overlap or duplication reduced to an absolute minimum.

This review coincided with the NHS England timescales for review and updates of CCG Constitutions, and as such all changes to the committee process and the Terms of Reference have been incorporated into the revised CCG Constitution.

2. Key Issues

2.1 Committees

The review took account of the role and responsibilities of the Governing Body, Quality Committee, Finance and Resources Committee, Audit Committee and Remuneration Committee. Whilst it was apparent that the CCG had effectively delegated its functions to the sub committees, and that the sub committees has established appropriate support groups to assist in the discharge of those functions, there was a gap in respect of conflicts of interest and service improvement.

Members of Senior Team considered the challenges facing the CCG in respect of the transformation of services and the associated decision making arrangements and resolved to establish two new committees;

The Approvals Committee (Conflicts of Interest)

Key functions

- To provide neutrality in the evaluation and decision making processes. The committee comprises non-conflicted members of the Governing Body or other committees and its decisions will be noted by the Governing Body.

- Is responsible for ensuring that the CCG applies conflict of interest principles and policies rigorously and provides the CCG with independent advice and judgment where there is any doubt about how to apply them to individual or group cases involving commissioning clinical services

The Service Improvement and Re-design Committee

Key functions

- To identify potential areas of service improvement
- To establish the rationale and evidence base supporting the need for improvement
- To ensure that localities are engaged in processes
- To assess and approve business cases for recommendation to the F&R committee
- To monitor and measure impact of improvements
- To facilitate engagement with stakeholders
- To ensure that all service reviews and the implementation of new services comply with all relevant laws and legislation
- To support improvements in Primary Care
- To monitor programmes including (but not limited to) Virtual Ward, Care Close to Home, Children's, Mental Health, planned and unplanned care.

Whilst the existing committees required changes to their Terms of Reference, these were relatively minor and did not materially change the role and function of those committees. The changes were essentially to clarify roles and responsibilities as well as changes to job titles.

The full committee structure it attached at Appendix A.

2.2 Clinical Leadership

To ensure that clinical leadership is embedded at every level, the CCG will identify Clinical Directors and an associated portfolio for delivery. The Clinical Directors will be responsible for leading specific programmes of work as well as supporting and influencing decision making within the committee and business processes.

The locality lead GPs will also be key members as the CCG drives its Engagement Strategy to a locality level.

Their role in supporting the Service Improvement and Redesign committee will be crucial in ensuring that credible and persuasive proposals and recommendations are submitted to Finance and Resource Committee for financial approval and onwards to the Governing Body. Clinical Director's involvement in the Quality Committee will complement the existing membership by formalising the specialist expertise in a number of areas as well as their general expertise and knowledge of the quality challenges faced by the local health economy.

Their involvement in the Finance and Resources Committee will facilitate in a more meaningful way the bringing together of clinical and financial decisions that will positively impact on our local populations.

2.3 CCG Leads

Each committee is supported by an identified member of the Senior Management Team as well as CCG leads for programme areas. This "matrix" way of working will ensure that there is multi skilled input during all meetings and those areas of complementary work or duplication can be identified.

Whilst leads will retain their specific roles as part their operational "day to day" portfolio for which they are accountable; they are also expected to support the work of committees by sharing their knowledge of the local health system and objectively contributing to the debate.

2.4 Lay Member

Lay Member representation will ensure that there is robust independent challenge and scrutiny throughout business processes. The Lay Member for Patient and Public Involvement will act as the champion for ensuring that patient experience informs all decision making and that there is effective stakeholder engagement throughout all programmes.

The Lay Member for Governance will provide impartial and objective views on the business processes and ensure that all CCG representatives act with utmost probity at all times.

2.5 Work Programme

Each committee will be supported by an agreed work programme that will be reflective of all statutory requirements as well as internal business processes.

The Project Management Office, in conjunction with CCG leads and the Cheshire and Merseyside Commissioning Support Unit (the CSU) will ensure that committees are in receipt of information and intelligence to enable them to effectively discharge their duties.

3. Recommendation

The Governing Body is asked to receive this report and note the changes.

4. Appendices

Appendix 1 Committee Structure.

Debbie Fairclough
May 2014

NHS South Sefton CCG Governing Body

Audit Committee

SMT: **Martin McDowell**. Chair: **Graham Morris**

Key functions and responsibilities: To support the establishment of an effective system of integrated governance, risk management and internal control and to review and approve the arrangements for discharging the Group's statutory financial duties.

Remuneration Committee

Chair: **Graham Morris**

Key functions and responsibilities: Determining the remuneration and conditions of service of the senior team, approval of severance arrangements and approval of disciplinary arrangements for employees, including the Chief Officer

Finance and Resources

SMT: **Martin McDowell**

Key functions and responsibilities

- To advise the Governing Body on all financial matters
- To review and manage the overall financial position
- To ensure that the performance of commissioned services is monitored in line with CCG expectations
- To advise on procurement and contracting arrangements
- To monitor contract and procurement arrangements
- To review and monitor Foundation Trust applications
- To review and monitor CHC financial position
- To determine banking arrangements
- To approve arrangements for exceptional/novel treatments including IFR
- To review and monitor workforce performance
- To review and monitor CSU performance

Quality Committee

SMT: **Debbie Fagan**

Key functions and responsibilities

- To monitor standards and provide assurance on the quality of commissioned services
- To review and monitor Serious Incidents
- To promote a culture of continuous improvement and innovation with respect to safely, clinical effectiveness and patient experience
- To provide an assurance to the Governing Body that there are robust processes for managing risk
- To ensure appropriate Safeguarding arrangements are in place
- To provide corporate focus, strategic direction and momentum for quality, and risk management
- To review and monitor medicines management
- To approve corporate and clinical policies

Service Improvement and Redesign

SMT: **Karl McCluskey and Jan Leonard**

Key functions and responsibilities

- To identify potential areas of service improvement
- To establish the rationale and evidence base supporting the need for improvement
- To ensure that localities are engaged in processes
- To assess and approve business cases
- To monitor and measure impact of improvements
- To facilitate engagement with stakeholders
- To ensure that all service reviews and the implementation of new services comply with all relevant laws and legislation
- To support improvements in Primary Care
- To monitor programmes including Virtual Ward, Care Close to Home, Children's, Mental Health, planned and unplanned care

Supporting the Quality Committee: The CGSG will provide assurances on the processes for reviewing the GBAF and CRR and make recommendations to the Committee. The group will review policies and procedures and recommend them as appropriate to the committee for approval.
Supporting Audit Committee: The group is part of the CCG's Risk and Control Framework and will enable the Audit Committee to obtain assurances on key internal control requirements.

Corporate Governance Support Group

Chair: **Tracy Jeffes**

Key functions and responsibilities:
Ensuring compliance with relevant legislation and standards, monitoring activity and providing assurances in respect of :

- *Public Sector Equality Duty (PSED)*
- *Health and Safety (Incidents and LSMS)*
- *Third Party Claims*
- *Governing Body Assurance Framework and Corporate Risk Register*
- *Information Governance (IG Toolkit)*
- *Freedom of Information Requests*
- *Subject Access Rights Notifications*

Engagement and Patient Experience Group

Chair: **Roger Driver and Roger Pontefract**

Key functions and responsibilities:
Reviewing relevant data, analysing trends and themes, ensuring compliance and providing advice in respect of:

- *Patient Experience themes and trends*
- *Complaints (secondary)*
- *Complaints (primary care)*
- *PALS*
- *NHS Constitution*
- *Engagement and consultation*
- *Soft Intelligence*
- *Stakeholder Engagement and Involvement*

Supporting the Service Improvement and Re-Design Committee: The EPEG will provide patient experience intelligence to this committee. This provides a framework for enabling patient experience to inform commissioning decisions.
Supporting the Quality Committee: EPEG will provide patient experience intelligence to the quality committee, particularly in respect of quality and safety issues that are signalled through complaints and PALS.

Approvals Committee – Conflicts of Interest

- To provide neutrality in the evaluation and decision making processes. Comprises non-conflicted members of the Governing Body or other committee and its decisions will be noted by the Governing Body.
- Responsible for ensuring that the CCG applies conflict of interest principles and policies rigorously and provides the CCG with independent advice and judgment where there is any doubt about how to apply them to individual or group cases involving commissioning clinical services

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/82	**Author of the Paper:**
Report date: May 2014	Gordon Jones Quality and Performance Manager Cheshire and Merseyside Commissioning Support Unit Dr Hilal Mulla Governing Body Member South Sefton CCG Geraldine O'Carroll Senior Integrated Commissioning Team Manager South Sefton CCG

Title: Mental Health Services Review Briefing

Summary/Key Issues:

This paper provides an update on the approach being taken to transform the commissioning of mental health services across South Sefton as an identified CCG priority area within the Strategic Plan.

In South Sefton CCG mental health presents a real challenge to health services and the wider community. Commissioners have identified the urgency to commission services that address the needs of the population of Sefton with a focus on recovery and for mental health services to have clear outcomes leading to equity and consistency across the mental health patient pathway.

Clinical commissioners have a vision to establish cradle to grave mental health and dementia services across Sefton that will be recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. An emphasis will be placed on early intervention, recovery and integrated mental and physical health working to enable patients to be managed better in the community with a reduced reliance on acute interventions.

To deliver this vision the CCG has established a Mental Health Task Group which over 2014/15 will develop a work stream to:

1. identify what is in place – what works and what does not in the mental health pathway
2. identify the gaps in the pathway
3. provide radical solutions which can be implemented from 2015/16 onwards.

The CCG Mental Health Task Group is currently developing an action plan which will be completed by the end of May 2014.

Recommendation	Receive	x
The Governing Body is requested to receive this report by way of assurance	Approve	
	Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
	Achieve a 2% reduction in non-elective admissions in 2014/15.
	Implementation of 2014/15 phase of Care Closer to Home/Virtual Ward plan.
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	x			Mental health work stream will include patient and public engagement.
Clinical Engagement	x			Mental health work stream will include clinical engagement.
Equality Impact Assessment		x		
Legal Advice Sought		x		
Resource Implications Considered				Mental health work stream will include the detailing resource implications for future commissioning of service.
Locality Engagement				Mental health work stream will develop links with locality leads.
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
May 2014

1. Introduction and Background

1.1 This paper provides an update on the approach being taken to transform the commissioning of mental health services across South Sefton as an identified CCG priority area within the Strategic Plan to achieve *parity of esteem for* mental health and physical health, equity and consistency across the mental health patient pathway.

1.2 Mental health commissioning in South Sefton has been fragmented and piece meal in nature and coupled with contracting changes compounded by re-organisation this has led to commissioners being unsure as to how their mental health investment of £31.7 Million (combined South Sefton CCG and Southport and Formby CCG) (2012/13) is being utilised at a service level. In addition GPs are unsure of the pathways that are in place. Commissioners need to be assured that mental health services are able to meet need and they are commissioned in such a way that is recovery focused and outcome led. The move towards greater integration of services across the local health and social care economy coupled with outcome based commissioning mitigates heavily against maintaining the status quo on which is predicated towards outputs.

1.3 The zero growth in health and social care spend with the added pressure of an ageing population makes it imperative that commissioners get more value for their investment and that services are achieving their desired outcomes.

1.4 To meet this challenge a CCG Mental Health Task Group has been established which aims to understand the current system, identify the gaps and risks and offer solutions for implementation in 2015/16 which aims to see mental health integrated with the wider physical health development in Sefton most notably the Care Closer to Home/Virtual Ward initiatives.

1.5 Mersey Care NHS Trust has also embarked on a service transformation programme and it is important that links are forged with the Trust to ensure that their work mirrors that of the CCG.

1.6 The work undertaken by the CCG Mental Health Task Group will contribute to the CCG's commitment to securing a reduction in unplanned activity of 15% across the wider health economy over the five years of its strategic plan.

2. The Vision for Mental Health Services in South Sefton

2.1 The vision is to have cradle to grave mental health and dementia services across Sefton which are recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes.

2.2 An emphasis will be placed on early intervention, recovery and integrated mental and physical health working to enable patients to be managed better in the community with a reduced reliance on acute interventions.

2.3 Mental health will have a higher profile at a strategic level in South Sefton CCG.

3. What Are We Doing

3.1 In April 2014 a CCG Mental Health Task Group was established with a clear remit to making a difference to mental health and dementia commissioning across Sefton. The CCG Task Group will act as a sub-group of the Joint Health and Local Authority Mental Health Task Group which has been established under the auspices of the Sefton Health and Wellbeing Board to develop a common approach to mental health across Sefton whilst CCG oversight will be provided via the newly established Service Improvement and Redesign Committee.

3.2 The CCG Mental Health Task Group is made up of the following members:

- Dr Hila Mulla – Mental Health Clinical Commissioning Lead (2 sessions per week)
- Geraldine O'Carroll - Senior Integrated Commissioning Manager
- Gordon Jones – Senior Quality and Performance Manager - Cheshire & Merseyside Commissioning Support Unit (on secondment)
- Kevin Thorne - Integrated Commissioning Manager - Dementia
- Gillian Bruce - Integrated Commissioning Manager - CAMHS

3.3 A Mental Health Plan for 2014/15 is currently being for drafted for completion by the end of May 2014 and this will outline the steps required to get clinical commissioners into a position by March 2015 whereby they will be able to identify the commissioning developments required for 2015/16 onwards. To help deliver the vision for mental health services the CCG Mental Health Task Group will undertake the following:

- What have we got – what works and what does not?
- What are the gaps in the pathway?
- Explore and provide solutions which can be implemented from 2015/16 onwards

3.4 The CCG Mental Health Task Group will focus (but not solely) on understanding the existing pathways and services within Mersey Care NHS Trust and how they relate to the wider mental health system in Sefton as spending (2012/13) on the Trust accounts for £24.8 Million (78.3%) across the two Sefton CCGs. In addition the Trust is embarking on a transformation programme and it important that this work is reflective of the vision the South Sefton CCG has for mental health services.

4. Engagement

4.1 Patient and clinical engagement will be undertaken in 2014/15 to support the case for radical change and any future mental health development work impacting on patients and service users and their carers will be cognisant of the Government's commitment in the Health and Social Care Act 2012, to: *"No decision about me without me"* which puts them at the centre of the decision making process, and commissioners will operate within the spirit and guiding principle of this commitment.

4.2 The Sefton CCGs have already held "Big Chats" and "Little Chats" where the wider public are welcome to come and discuss a range of concerns or ideas with CCG staff. These events have captured some mental health related feedback however the Mental Health Plan for 2014/15 which is being developed envisages the need for mental health specific

engagement events which will help shape the future composition of mental health services in Sefton.

5. What has been done already?

5.1 The following actions have already taken place to support the delivery of the vision for mental health services.

5.2 Three locally negotiated Commissioning for Quality and Innovation (CQUIN) schemes are in place within the Mersey Care NHS Trust 2014/15 contract.

- Collaborative Working - involving the Trust in working closer with primary care and with Care Closer to Home/Virtual Ward initiatives in respect of dementia patients.
- CAMHS Transition – the development of networks of Youth Mental Health practice to strengthen existing resources and pathways in line with identifying gaps and providing a foundation for new service approaches.
- Communication CQUIN aimed at improving flow and timeliness of data.

5.3 The CCG Mental Health Task Group held its first meeting on 2nd May 2014 and it will meet weekly as part of on-going programme of work identified through the Mental Health Plan.

5.4 The CCG Mental Health Task Group undertook its first visit to the Mersey Care NHS Trust Boothroyd Unit in Southport on 2nd May 2014. All Trust sites/services will be visited and this will enable the CCG Mental Health Task Group to build up a picture of what is working and what is not.

5.5 An information subgroup first met on 6th May 2014. Comprising of CCG, Public Health and CSU representatives the group will develop the Mersey Care NHS Trust related information and outcome measures that commissioners want to collect from 2015/16 via the contract. Commissioners want to move away from reliance on quantitative measures to those which enable them to monitor outcomes and patient throughput through the Trust's services via the contract. This work will be complemented by the work being done by CCG Finance to understand the future implications of mental health Payment by Results.

5.6 A meeting has been arranged with Mersey Care NHS Trust to take place on May 30th to discuss their transformation programme and how it will link in with the vision and the work being undertaken by the CCG Mental Health Task Group.

6. Conclusions

6.1 The CCG has described a vision for the future of mental health services in South Sefton CCG which is consistent with its partner CCG within the local health economy.

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

6.3 Care Closer to Home and the Virtual Ward initiatives will act as catalysts for change in local mental health services within the overall Strategic Plan.

6.4 By adopting a co-ordinated and pro-active approach the CCG Mental Health Task Force will achieve the following by March 2015:

- identified and reviewed current services and pathways
- identified gaps and risks within the current mental health system

- identified and explored future models of delivery to inform commissioning intentions for 2015/16 which have recovery and community based outcomes at their heart and will address parity of esteem between mental and physical health

- developed our information and outcome reporting requirements for 2015/16 contracting and that our providers have a clear a clear expectation of the information and outcomes activity that commissioners require so as to measure performance

- provided assurance to CCG Governing bodies and the Joint Mental Health Task Force that mental health clinical commissioning and service development is co-ordinated and that it is being linked to the integration agenda

- *parity of esteem* for mental health has been achieved at a strategic level.

7. Recommendations

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

- to note the detail contained in this paper and in particular the approach that the CCG is taking to address mental health commissioning

- to support and agree the vision for mental health as described, and the steps that will be undertaken in 2014/15

- to lend support for further development of the 2014/15 Mental Health Plan

- be assured that the work of the CCG Mental Health Task Group is aligned to the CCG Strategic Plan and that it will contribute to securing a reduction in unplanned activity of 15% across the wider health economy over the five years of Strategic Plan

- to make a commitment to ensuring *parity of esteem* for mental health at a Strategic level.

Gordon Jones
Dr Hilal Mulla
Geraldine O'Carroll
May 2014

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/83	**Author of the Paper:**
Report date: May 2014	Brendan Prescott Deputy Chief Nurse brendan.prescott@southseftonccg.nhs.uk Tel: 0151 247 7093

Title: Out of Hours Pharmacy Consultation

Summary/Key Issues:

This paper presents the Governing Body with an update on the review process and consultation regarding the out of hours pharmacy service.

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
X	Improve quality of commissioned services, whilst achieving financial balance
	Achieve a 1% reduction in non-elective admissions in 2014/15
	Implementation of 2014-15 phase of Virtual Ward Plan
	Review and Re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public
	Implementation of 2014-15 phase of Primary Care quality strategy / transformation
	Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy
	Review the population health needs for all mental health services to inform enhanced delivery

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

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

1. Executive Summary

South Sefton CCG is reviewing the provision of medicines in the out of hours period in light of the change of provider for out of hours medical services.

A review of the current provision by community pharmacies near to the out of hours pharmacy has been undertaken.

South Sefton CCG is consulting with users of the current service and the wider public on proposed changes to the provision of medicines in the out of hours period. Engagement officers from Cheshire and Merseyside Commissioning Support unit have provided support to the process.

2. Introduction and Background

In December 2004 the Department of Health published guidance for PCTs and providers of out-of-hours (OOHs) services to support implementation of recommendations 19 and 20 of the Department of Health commissioned independent review of GP out-of-hours services to address the issue of patient access to medicines. The guidance entitled “Delivering the Out of Hours review – Securing Proper Access to Medicines in the Out of Hours Period” contained 13 action points. This along with the changing arrangements for out of hours primary care medical services due to the new GP contract, and the implementation of a new contractual framework for Community Pharmacy prompted an in depth review of access to medicines and pharmaceutical advice out-of-hours across the former Southport & Formby and South Sefton PCTs. Following these reviews systems were established both PCTs to ensure all 13 recommendations were met.

In South Sefton, an out of hours (OOHs) pharmacy was established in 2004 as a Local Pharmaceutical Services (LPS) pilot with an aim of having a single robust, safe, effective service provision for supply of medicines and pharmaceutical advice to a specific group of patients attending the OOHs GP service. The pharmacy was established as a non-contract pharmacy and has no NHS dispensing contract so no payment is made in the dispensing of medicines. The pharmacy is based within Litherland Town Hall Health Centre.

The plan was to run the pharmacy for an initial period of 12 months to assess effective primary care OOHs service provision. The service was extended beyond the initial period, providing a number of others services other than dispensing to patients such as:-

- Supply of medication to OOHs GP medicine cabinets
- Supply of medication to OOHs GP bags
- Supply of medicines OOHs district nurses
- Preparation of pre-pack medication for supply to OOH GP service
- Controlled Drugs supply
- Emergency cupboard stocked by pharmacy for nursing staff to access.

Since 2004, the service has continued through the various organisational changes as well as NHS reconfigurations. The service has never been included in any service specification for OOHs service provision but as a solution to assure provision of medicines in the OOH period.

Since March 2013, the superintendent pharmacist role has been undertaken by the current community service provider in South Sefton (Liverpool Community Health Trust) as this function cannot legally be held within the CCG.

The OOHs pharmacy service came under review in October 2013 on awarding of the new contract for OOHs medical provision where the new provider (GoToDoc) did not require the range of services provided by the OOHs pharmacy. Since October 2013 the main function of the OOHs pharmacy has been the dispensing of medicines. GoToDoc operate a model in other locations in the generation of prescriptions to be dispensed at extended hours contract pharmacies for provision of medicines as well having an increased stock of medicines on site and for domiciliary visits. If any changes to the OOHs service of provision of medicines were made, GoToDoc would increase the amount of stock held on site. The OOHs medical provider does not use any supply functions from the pharmacy as they have their own provision of medicines from a central site.

3. Key Issues

Current Activity at the OOHs Pharmacy

An average of 1,286 items were dispensed on a monthly basis between April and September 2013 Since the OOHs primary medical service was taken over by GoToDoc, the monthly dispensing average has dropped to an average of 980 items between October 2013 and February 2014.

The busiest days of the pharmacy service are Mondays when an average of 30 items will be dispensed, Saturdays when an average of 75 items will be dispensed and Sundays when an average of 80 items will be dispensed.
Over the last 8 Bank Holidays (August 2014 to April 2014), an average of 82 items were dispensed per Bank Holiday. This does not equate to patient numbers as a patient will usually require more than one item per consultation.

Opening Hours in Litherland / Bootle in the out of hours period

The OOHs Pharmacy Opening at Litherland Town Hall Health Centre are:

- Weekdays : 18.30 to 23.00 covered as one shift.
- Saturday and Sunday : 09.00 to 23.00 covered as three shifts.
- Bank holidays : 09.00 to 23.00 covered as three shifts.
- There are a number of pharmacies within South Sefton which provide extended hours provision where there is some overlap with the OOHs pharmacy.
- Bridge Road Pharmacy, Monday – Friday 7.15am – 11.15 pm. Saturday 8am – 8pm. Sun 8.15 am – 3pm. **Distance 640 metres**
- Boots in Sefton Road Litherland, Monday – Friday 9 am – 6.30pm. Sat 9am – 5pm. Closed Sundays. **Distance 100 metres**
- Rowlands in Sefton Road Litherland, Monday – Friday 9am -1pm and 2pm– 6.30pm. Sat 9am-1pm and 2pm – 5pm. Closed Sundays **Distance 640 metres**

- ASDA Bootle, Monday – Friday 7am – 11pm. Saturday 7am – 10pm. Sunday 10am – 4pm **Distance 3.3 kilometres**

- ASDA Aintree, Monday – Saturday 8.30am – 10pm. Sunday 10.30 am – 4.30pm. **Distance 4.8 kilometres.**

4. Content

The OOHs pharmacy service staffing is funded by South Sefton CCG at a cost of £77k per annum. Projected costs submitted by LCHT for Quarter 1 2014-15 is £33k.The provision of medicines is completely covered at other pharmacies on weekdays and for the majority of Saturdays and Sundays. For the 3 hours on Saturday nights and 8 hours on Sunday the OOHs medical service would be able to supply from stocks. Discussions have been taking place with the current OOH provider on the provision of medicines to cover Bank Holiday periods. This would require formal agreement at contract meetings but informal reassurance has been given to supply directly to patients when there are no community pharmacies nearby. Commercially it would be unviable for a community pharmacy to schedule to open as the numbers of dispensed items is relatively low for the amount of time the pharmacy is open. The OOH provider would increase stock over the Bank Holiday period and has confirmed drugs supply would fall under the tariff but would have to look at increase in activity.

The CCG is exploring the possibility of closing the OOHs pharmacy without any loss in quality of provision of medicines to patients in the out of hours period. Savings from the current cost of the service redirecting the saving into commissioning of patient care to ensure better value for money.

A consultation is underway with users of the service and the wider population to gain feedback on the current service and to inform on the proposed changes. A proposal has already been through the Engagement and Patient Experience Group (EPEG) and feedback from members was taken to inform the consultation. There will also be a submission to the Sefton Public Engagement and Consultation Standards Panel as an outcome of EPEG and to ensure a wider consultation as possible.

If the decision to decommission the service was to go ahead the plan would be to close the service by September 30th 2014.

5. Recommendations

The Governing Body is asked to receive this report.

Appendices

Appendix 1 – Out of Hours Pharmacy Brochure
Appendix 2 – Comments section

Brendan Prescott
May 2014

Review of Out of Hours Pharmacy

NHS
South Sefton
Clinical Commissioning Group

We are planning some changes to the Out of Hours Pharmacy at Litherland Town Hall Health Centre and we are inviting your views to help us decide how this service should be provided in the future.

This pharmacy operates differently to a regular high street chemist. It was originally set up to support the Out of Hours GP service, which ensures people can see a doctor when their surgery is closed in the evening, overnight, at weekends and Bank Holidays. It means that the pharmacy has restricted and short opening times and is only for use by patients from the Out of Hours GP service.

Because the pharmacy has limited opening times and because there are a number of other chemists close to Litherland Town Hall Health Centre, we are looking at other more efficient ways to provide medicines to Out of Hours GP patients when they need them.

You can read more details about what we want to do later in this leaflet.

To help us, we would appreciate any comments you have about this service and about the changes we are planning by completing the attached form.

14/83

About the Out of Hours Pharmacy

The pharmacy was set up in 2004 following a national review about how patients receive medicines outside of normal opening hours. At the time there were limited local options where people could obtain their medicines during the out of hours period, so the former Primary Care Trust, which was in charge of commissioning decided to open the pharmacy.

Things have changed since then and there are now many more local pharmacies where people can get prescriptions out of hours. In general, CCGs do not provide an out of hours pharmacy service like this one because there is very little need.

How it works

The Out of Hours Pharmacy is based in the Litherland Town Hall Health Centre and is open Monday to Friday from 6.30pm—11pm, Saturday and Sunday from 9am—11pm and on Bank Holidays from 9am—11pm. The most commonly dispensed items are antibiotics and painkillers.

What changes are being planned?

We are responsible for ensuring that the money we receive to buy or 'commission' nearly all of your local health services is spent wisely, representing the highest possible quality and value for money. We must also ensure that we prioritise our budget on the services that south Sefton residents need the most, and which will make the biggest difference to their health and wellbeing.

So, we have been reviewing the Out of Hours Pharmacy at Litherland Town Hall Health Centre to ensure it represents the best value for money in meeting the needs of local patients.

After looking at the service and the available alternatives, we believe it should be discontinued so the money we currently spend can be used more effectively for patient care in other service areas.

What is the reason for this?

We have found from our review that:

- relatively small numbers of prescriptions are dispensed from this pharmacy
- there are alternative ways that patients using the GP Out of Hours service can get their medicines with little or no inconvenience to them

Several pharmacies close to Litherland Town Hall Health Centre are open at similar times to the Out of Hours Pharmacy - these pharmacies are often open longer and are open to all, unlike the Out of Hours Pharmacy.

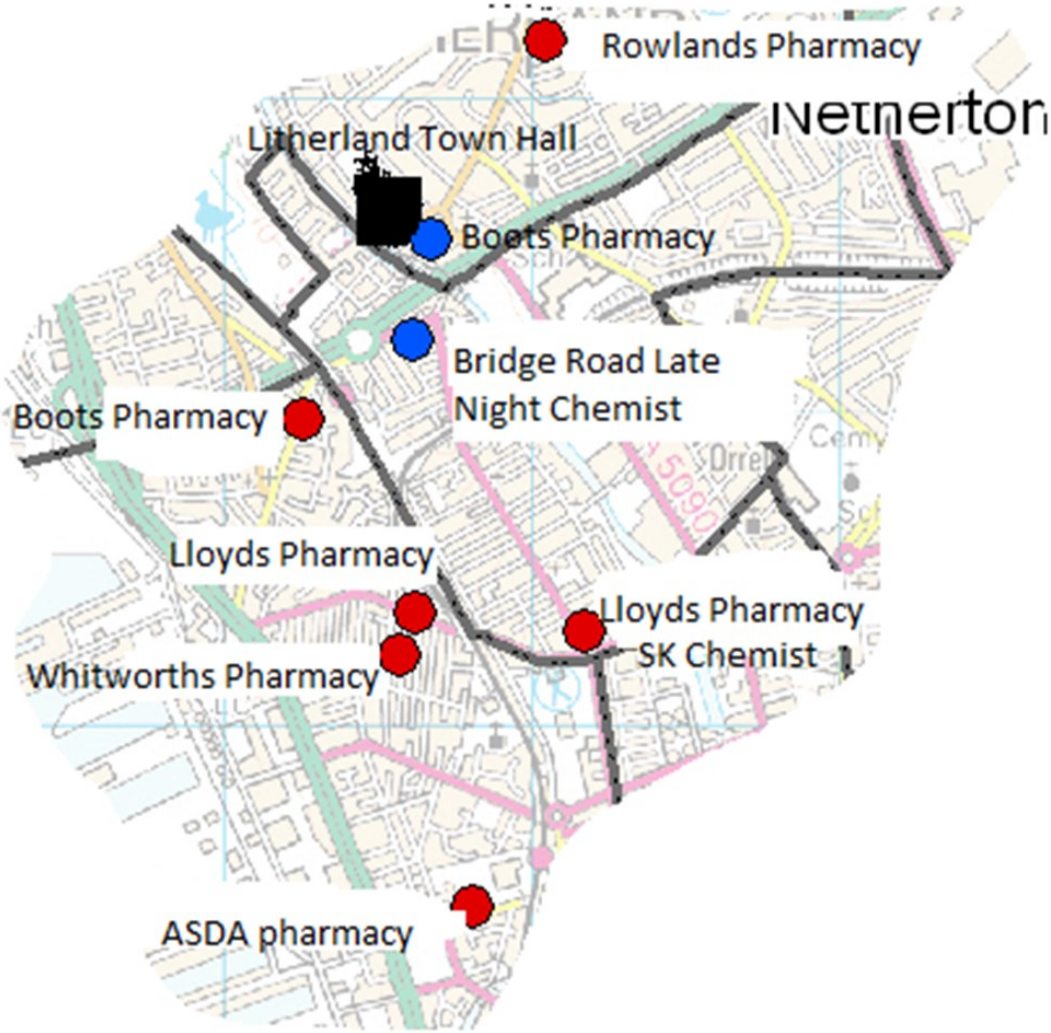
What does this mean for patients?

If the current Out of Hours Pharmacy Service is discontinued patients can:

- Take their prescription to one of the pharmacies nearby during their opening times (see map and opening time information overleaf)
- Receive their medicines from the Out of Hours GP service directly when these local pharmacies are closed

Alternative pharmacies close by

The pharmacies nearest to the Out of Hours Pharmacy are shown on the map below, followed by a list of addresses, opening times and travelling or walking distance in metres.



Pharmacies with closest match to Out of Hours Pharmacy service are:

Bridge Road Late Night Chemist, 54-56 Bridge Road Pharmacy

Open: Monday – Friday 7.15am – 11.15 pm. Saturday 8am – 8pm. Sunday 8.15 am – 3pm. (640 metres from Town Hall Practice)

ASDA Pharmacy, 81 Strand Road

Open: Monday Friday 8am-11pm, Saturday 7am-10pm, Sunday 10am-4pm. (2700 metres away from Town Hall Practice)

Other local Community pharmacies and their opening times are:

Boots Pharmacy, 6 Sefton Road Litherland

Monday – Friday 9 am – 6.30pm. Sat 9am – 5pm. Closed Sundays. (100 metres from Town Hall Practice)

Rowlands Pharmacy, 106 Sefton Road Litherland

Monday – Friday 9am -1pm and 2pm– 6.30pm. Sat 9am-1pm and 2pm – 5pm. Closed Sundays. (640 metres from Town Hall Practice)

Whitworths Pharmacy, 93 Knowsley Road Bootle

Monday – Friday 9am – 6.30pm. Sat 9am – 1pm. Closed Sundays. (1700 metres from Town Hall Practice)

Lloyds Pharmacy, 125 Knowsley Road

Monday – Friday 9am-7pm. Sat 9am-1pm. Closed Sundays. (1700 metres)

SK Chemists, 516 Stanley Road

Monday – Friday 9am- 6pm, Sat 9am-1pm, Closed Sundays. (1700 metres)

We want your views on our proposal for change

You can reply by putting your response in the box here

or online at:

Www.surveymonkey.com/s/……..

Responses need to be received by ……...

How many times have you used the Out of Hours Pharmacy Service at Litherland Town Hall in the past year?

_____

What is the most convenient thing about using the service?

How would you feel about using a local community pharmacy to fill your prescription for you instead?

Happy ☐ **Not sure** ☐ **Not Happy** ☐

Please tell us briefly why you answered this way:

Do you agree with the proposed changes to the way in which you would receive any medicine prescribed out of hours in the future?

Yes ☐ **No** ☐ **Not sure** ☐

Please tell us briefly why you answered this way:

Key Issues Report to Governing Body January 2014

NHS South Sefton Clinical Commissioning Group

Audit Committee Meeting held on 1st May 2014	Chair: Graham Morris

Key Issue	Risk Identified	Mitigating Actions
Conflicts of Interest Register	Incomplete register could give rise to financial and reputational risk	• Debbie Fairclough (CMCSU) will arrange for register to be brought up to date. Audit Committee will review at July meeting.
CMCSU Readiness Report	Concerns noted in relation to merger with CMCSU Manchester and outstanding actions in relation to readiness report.	• Martin McDowell, Ken Jones and Tracy Jeffes will address these issues with CMCSU at the next performance meeting.
CHC Claims for maladministration	A small number of claims have been made in relation to maladministration of CHC claims.	• Recommendation has been made to make payments in the region of £500 to resolve two of the claims. • Appropriate legal advice is being sought and followed.

Information for South Sefton CCG Governing Body
• Unaudited annual accounts received by Audit Committee. Accounts will be signed off at Audit Committee meeting on 3rd June 2014 11.00am – 1.00pm Merton House. All Governing Body members welcome to attend this meeting.
• MIAA Local Counter Fraud Annual Report received, plan for 2014/15 signed off and fees agreed.
• MIAA Internal Audit Progress Report, Draft Audit Opinion and 2014/15 Internal Audit plan received. Fees signed off.
• External Audit progress report received.
• Information Governance Toolkit compliance at level 2 signed off.
• Draft accounting policies have been signed off.
• All Governing Body members have been contacted in writing to confirm that: • So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware; and, • That the member has taken all the steps that they ought to have taken as a member in order to make them self aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

NHS
South Sefton
Clinical Commissioning Group

Audit Committee

Minutes
Thursday 9th January 2014, 1.30pm to 3.00pm
Boardroom, Merton House

Attended		
Graham Morris	Lay Member (Chair)	GM
Sharon McGibbon	Lay Member	SMcG
In Attendance		
Martin McDowell	Chief Finance Officer	MMcD
Ken Jones	Chief Accountant	KJ
Bernard McNamara	Local Counter Fraud Specialist, (MIAA)	BMN
Adrian Poll	Audit Manager, MIAA	AP
Rachael McIlraith	Audit Director, Price Waterhouse Coopers	RMCI

	Item	Action
A14/01	**Apologies for absence** Apologies for absence were received from Lin Bennett Lay Member, Roger Driver Lay Member, Tracy Jeffes Head of Corporate Delivery and Integration and Debbie Fagan Chief Nurse.	
A14/02	**Declarations of Interest** Martin McDowell Chief Officer and Ken Jones Chief Accountant declared dual roles at both Southport and Formby and South Sefton CCGs.	
A14/03	**Advance Notice of items of other business** **MMcD advised that the introduction of the Key Issues Log would be raised as AOB** **KJ advised that adoption of Accounting Policies would be raised as AOB**	
A14/04	**Minutes of the Previous Meeting** The minutes of the previous meeting were signed as a true and accurate record.	
A14/05	**Action Points from Previous Meeting** Action points from the previous meeting were closed as appropriate.	

A14/06	**HFMA CCG Audit Committee Survey** MMcD presented this report. The committee noted that there is an opportunity to invite the Governing Body member /Secondary Care Dr to join the committee. This will extend the pool of members but quoracy will remain at 2 members. RMcI noted that PWC had also completed a survey in relation to CCG Audit Committees that will be circulated and considered as part of the year-end report. **The Committee agreed to invite the Secondary Care Dr for South Sefton CCG to join the Audit Committee. The Committee noted the content of the survey.**	
A14/07	**Local Counter Fraud Progress Report** BP presented this update and referred the committee to his report circulated in advance. He went on to make a presentation on the proposed Anti-Bribery Strategy. BMcN referred the committee to the Anti-Bribery and Corruption policies approved earlier in this financial year. Local Counter Fraud Service (LCF) will complete an exercise reviewing declarations of interest including nil returns**.** MMcD and GM will draft a management response to the proposed strategy **The Committee noted the Local Counter Fraud Progress Report.**	**MMcD/GM**
A14/08	**Internal Audit Progress Report** AP presented this update and referred the committee to his report circulated in advance. KJ has been proactive in ensuring that the team is appropriately resourced to achieve year end deadlines. AP noted the ISA3402 report, which examines how external bodies provide assurance to the CCG. KJ will investigate the impact of the on the CCG. AP and KL will produce composite report of recommendations, management response and progress against action plan. **The Committee noted the Internal Audit Progress Report**	
A14/09	**Legacy Balances – Update** KJ presented this update and referred the committee to the letter from Sheenagh Powell Director of Financial Control, NHS England, circulated in advance of the meeting. **The Committee noted the update regarding the change in approach to accounting for the PCT and SHA legacy balances**.	
A14/10	**2014/15 Committee Work Schedule** MMcD presented this report. **The Committee noted the work schedule for 2014/15.**	
A14/11	**2014/15 Meeting Dates** MMcD presented the meeting dates to the committee. It was agreed that a revised list of meeting dates would be provided in	

	April 2014. **The Committee noted the meeting dates for 2014/15.**	
A14/12	**External Audit Plan** RMcI presented this report and noted the five risks identified. Risks 1-3 are generic to all CCGs. Risks 4 & 5 are risks specific to this CCG. RMcI noted that PWC would be guided by materiality and the financial levels proposed in the report were agreed Assurance was given that if there are a number of issues that give cause for concern, but that are of a financial value less than the deminimus level then this will be brought to committee. The audit fees noted were noted by the committee. PWC have considered their independence in relation to provide external audit services to the CCG and are assured that there are no issues. Level of materiality and deminimus reporting – approved. **The Committee noted the content of the report and approved the levels of materiality and deminimus levels.**	
A14/13	**Review of losses and special payments, tender waivers, aged debt and declarations of interest.** **The Committee noted that there were no losses, special payments, tender waivers, aged debt or declarations of interest to review.**	
A14/14	**Changes to Standing Orders, SFI's, Accounting policies.** The committee noted that the recommendation that the approval for ordering level be reduced to £20k had been addressed. **The Committee noted the amendments to the Scheme of Delegation Signatory List.**	
A14/15	**Information Governance Toolkit** MMcD presented this report and requested that the committee sign off the CCG's IG Toolkit submission (due March 2014) to the Audit Committee Chair and Chief Finance Officer. **The Committee approved the recommendation in the IG Toolkit Report**.	
A14/16	**Receive updates of other committees and review business inter-relationships** **Finance & Resources Committee** MMcD noted that Finance and resource Committee have focused on managing in year finances, forward planning, and the approval of investments in year. **Quality Committee** There were no updates to report.	
A14/17	**Any other business** There were no matters of other business.	

A14/18	**Review of meeting** The committee confirmed that there were satisfied with the conduct and content of the meeting.	
	Date and time of next meeting: **1 May 2014 1.30pm – 3.00pm** **Boardroom, Merton House**	

Post meeting note

The Chair of the Audit Committee and the Chief Finance Officer signed off the Information Governance Toolkit

The Chair of the Audit Committee and the Chief Finance Officer approved the draft Financial Accounting Policies.

NHS
South Sefton
Clinical Commissioning Group

Quality Committee
Minutes

Date: 20 March 2014, 3.00pm to 5.00pm

Venue: Third Floor Boardroom, Merton House, Stanley Road, Bootle

Present		
Dr Craig Gillespie	GP Governing Body Member (CHAIR)	CG
Dr Andy Mimnagh	GP Governing Body Member	AM
Dr Debbie Harvey	Clinical Lead for Integrated Care	DH
Dr Gina Halstead	GP Quality Lead	GH
Mrs Lin Bennett	Practice Manager Governing Body Member	LB
Debbie Fagan	Chief Nurse	DF
Martin McDowell	Chief Finance Officer	MMcD
In attendance		
James Hester	Programme Manager Clinical Quality & Safety	JH
Tracy Forshaw	Deputy Head of Adult Safeguarding	TF
Karen Garside	Deputy Designated Nurse Safeguarding Children	KG
Jo Simpson	Quality and Performance Manager, CMCSU	JS
Dan McDowell	Secondary Care Doctor	DMcD
Lorraine Norfolk	Locality Lead, CMCSU, Complex Care & Clinical Quality	LN
Apologies		
Roger Driver	Lay Member	RD
Dr Sunil Sapre	GP Locality Lead - Maghull	SS
Fiona Clark	Chief Officer	FLC
Steve Astles	Head of CCG Development	SA
Malcolm Cunningham	Head of Primary Care & Corporate Performance	MC
Ann Dunne	Designated Nurse Safeguarding Children	AD
Dr Peter McPherson	Specialist Registrar in Public Health	PH
Hannah Chelleswamy	Director of Public Health, Sefton Council	HC
Minutes		
Jayne Byrne	Officer Manager/PA to Chief Nurse	

	Item	Action
14/25	**Apologies for absence** were noted as above.	
14/26	**Declarations of interest** Officers of the CCG who hold dual roles declared their conflicts of interest.	
14/27	**Minutes of the previous meeting** The minutes were accepted as an accurate record of the previous meeting.	

	Item	Action
14/28	**Matters arising/action tracker** • *13/74a Dementia champions* – It was agreed the majority of providers appear to be struggling with it and therefore it is to be removed from tracker. • *13/126a Complaints in Primary Care and SI Reporting* – discussed at the CCG checkpoint meeting last week with the area team. Bring back to May's Quality Committee and if no response has been received then Miss Fagan will raise at the next Checkpoint Assurance meeting in 3 months' time (May/June). • *13/127 Safeguarding Hosted Service Monthly Assurance Report* - a letter from the Chief Officer to providers expressing concern that the necessary information for safeguarding assurance wasn't being received and that it was expected in a timely manner had been drafted and was awaiting FLC sign off. Remove from tracker. • *13/128 Operational Governance Group Key Notes* – sent back to Corporate Governance Group for re-clarification and report back. Refers to a section in the notes that was presented several meetings ago that mentioned IFRs and timelines relating to policies. Referred back to Corporate Governance Group to provide clarity. • *13/132 DNACPR Policy* – Ms Harvey reported that the policy had gone to the LMC and an educational event was to be held in May for GPs to be trained on its use – remove from tracker. • *14/6 New style dashboard (AUH)* – actioned – remove from tracker. • *14/17 NHSE to submit a revised AHCH Risk Summit action plan* – not yet circulated as on the next AHCH CQPG agenda. Chief nurse to update as appropriate • *14/18 outcome focussed Francis action plan including external reports* – deferred until April 2014. • *14/19* – actioned. Remove from action tracker – will show in updated Risk Register.	DF DF/FLC DF DF JH
14/29	**Aintree SHMI presentation** The presentation was deferred as Dr Peter McPherson and Hannah Chelleswamy were not available to attend the meeting.	
14/30	**Provider Performance Reports** Dr Gillespie asked Clinical Leads to brief the Committee; if action plans were in order and Leads were assured they could say so and move on. If something had changed, the Committee should be informed. Dr Gillespie asked Clinical Leads to take members of the Committee through their dashboards.	

	Item	Action
14/30	*Aintree* Dr Halstead felt there was quite a lot of repetition: main providers we hold a contract for; all providers; CCG population and different percentages for AQCQUIN performance on some of the pages, so sometimes it looks great and sometimes not for the same provider/time period and Dr Halstead thought there may be some difficulty uploading data. Dr Gillespie agreed and asked for future reports to have the South Sefton population dashboard first followed by each individual provider so the Committee could work through it with whoever was the Clinical or Admin lead. Miss Fagan asked for it to be minuted that Dr Halstead's comments regarding the differences was a positive way of seeing the Quality Committee work in its testing and assuring role and although there was work for Miss Simpson to do it was positive that it had been highlighted. Dr Halstead reported she had no serious concerns regarding the Aintree contract, there were some reds but they had all been discussed at the Aintree CPQG and related to either delayed or missed appointments for cancer. 11 out of 12 delayed appointments for breast symptoms were patient choice over the Christmas period and one was an administrative error so she was assured Aintree had good visibility of the problems and was actively managing them. There was particular work being undertaken in A&E to address issues and also a working group looking into cancelled operations/appointments. *Dementia* – The dementia CQUIN was improving dramatically and a dementia matron was championing this. *Summary Hospital Level Mortality Indicator (SHMI)* – there continued to be workstreams related to queries raised through the monitoring of Aintree's performance. The SHMI avoidable mortality group meets monthly and was attended by Dr Paula Finnerty on the CCGs' behalf. There was a reduction seen in SHMI although SHMI is reported almost 9 months out of sync so was currently reporting on June 2013. They have a shadow SHMI that gives more real time data and it appears they are seeing significant reductions. With respect to SHMI commissioning, AQuA were producing some CQUINS that specifically looked at areas where they felt that there was avoidable mortality, eg pneumonia and acute kidney injury so Dr Halstead was also assured there was commissioning going forward to drive through those improvements. *Stroke* – there were difficulties with stroke, primarily with getting people access to a stroke bed within 4 hours and keeping them on a specialised unit. Again data is reported in arrears. This was discussed at the Aintree CPQG and Dr Halstead had reason to believe their performance should significantly improve although they would not meet their target for end of year due to a bad first half year but they now had an On Call Stroke Consultant of the day; they were clearing beds, keeping beds clear in the Stroke Unit and were reporting that real time data showed significant improvement however, she couldn't be certain until the AQCQUIN data was published.	J Simpson

14/30	Dr Gillespie asked if Aintree were going to use thrombolysis beds and if it was reasonable. Dr Halstead confirmed it was good if a thrombolysis bed could be made use of if otherwise it would be empty and they were meeting their thrombolysis targets. Venous thromboembolism – Dr Gillespie commented that it was disappointing that they were failing on it but noted that there was an action plan in place to remedy the situation. Dr Gillespie asked about 79, the annual PLACE survey. Miss Fagan said in regard to the C-Diff improvement action plan that from just a visual inspection the hospital appeared less cluttered, more hygienic and an improvement had also been seen in the reported C-Diff cases. Dr Gillespie noticed that A&E appeared to have stopped doing triage, however further discussion revealed it was a reclassification of the treatment received and Dr Mimnagh explained it is now only classed as triage if there was a clinician break and was dealt with at an operational level throughout the 4 hours. Dr Halstead reported that Time to Treatment was back under target and expected to achieve 18 weeks rather than classic 62 day cancer referral – cancelled 2 operations; 1 was for an understandable reason but the other was due to capacity, although not a trend. Miss Fagan reported that at the last Quality Committee it had been reported that Aintree had reported MRSA which was a Liverpool, not South Sefton, patient and Jamie Hester had represented the CCG at the Trust for the post infection review meeting as is standard practice and he had been involved in that scrutiny. Miss Fagan reported that she, Dr Halstead and Public Health had reviewed the 4 latest appeals for Aintree re C-Diff. They couldn't support all of the appeals but have fed back some concerns, eg one patient should have been discharged but wasn't and contracted hospital acquired pneumonia when they shouldn't have been on the premises to get C-Diff or pneumonia. *Merseycare* Miss Fagan pointed out that a new issue had arisen from information sent through from CSU regarding under performance of the Trust in relation to length of stay which was now at around 53.6 days against a target of 40 days. Gordon Jones from the CSU who supports the CCG around mental health contracts reported at yesterday's Quality Committee at Southport & Formby that there could be various reasons for this, such as the reconfiguration of some of the services which hadn't yet been discussed at the contracts meeting. Miss Fagan had spoken to Dr Hilal Mulla who will raise it at his next meeting with Merseycare and report back. Miss Fagan had no further information at this time. Dr Halstead said she had been speaking to Geraldine O'Carroll (management lead for Merseycare) about treatment commencing within 18 weeks for psychotherapy and apparently there had been some extra money been given by Liverpool CCG and the implication was that South Sefton may want to do the same. Dr Halstead felt this was poor as these were very ill people. Dr Gillespie asked how that was being monitored other than on the dashboard. Dr Halstead confirmed Geraldine was going to investigate further to see whether the CCG needed to commission more.	

14/30	Miss Fagan confirmed it was part of a bigger review and a mental health task force was being set up to understand the data and intelligence around Merseycare as our mental health provider and inform the CCG of services going forward. Dr Gillespie asked for year-to-date information from the CSU to be provided as it was difficult to interpret the information when there were scattered greens and reds. Ms Simpson confirmed there was a rolling programme to circulate a new dashboard to all providers and Merseycare should be using it for May's Quality Committee. *KPI_17 Psychotherapy – Ongoing Issue* – (P17 of 96) Mr McDowell said the second paragraph referred to 48% of patients referred to the service received treatment within 18 weeks compared to a plan of 95% and goes on to say 360 patients waited over 18 weeks for treatment in January and only 13 of those were from South Sefton which seemed to suggest that the bigger issue was outside of South Sefton. Dr Halstead thought the figure of 360 might be a typo and asked Jo Simpson to look into it as 36 would seem more logical. Dr Gillespie commented that there were a lot of Serious Incidents (SIs) and Merseycare's lack of provider comment was concerning. *LCH* Dr Halstead commented that the exception report was not very helpful but there had been a CQPG meeting yesterday so she was able to give the Committee more information. The discharge summaries and MDT review for Ward 35 were consistently improving and had presented fresh data to suggest it was under control. Delayed transfers of care continued to be an issue; it was discussed at the CQPG and some of it was around patient and family choice and was something all the providers were shying away from. Families wanted their relatives to stay where they were and didn't feel any sense of urgency over it which was an issue but it was recognised the first provider to deal with it would attract bad publicity for being heartless. Dr Mimnagh said it was suggested at yesterday's CQPG meeting that it could be taken through the Urgent Care Network saying that we need a major publicity campaign highlighting while your relative is sitting in a bed needing no treatment someone else is dying in an ambulance at the front door.	J Simpson J Simpson

14/30	Dr Halstead reiterated it was a problem across the area for all providers. The other way of dealing with it was to say if you are in an acute hospital you will get C-Diff, MRSA or hospital acquired pneumonia unnecessarily. Dr Halstead reported that a Public Health trainee had produced a paper on cancelled appointments and DNAs which was really excellent and had lots of lessons for primary care in it. Home equipment continued to be an issue and they have had extra funding with this and was dealt with in the contract meeting and Dr Mimnagh had helped them 'see the error of their ways'. Dr Gillespie was confident Dr Mimnagh had the issue in hand. Dr Halstead reported that LCH had been subject to a quality review due to compliance issues as community equipment was one of the areas that was within the Care Quality Commission's (CQC) judgement report and was something that wasn't going to go away because of the focus on it. Dr Halstead, together with Liverpool CCG colleagues, had written jointly to NHSE to agree a process by which the outcomes of the quality review were monitored. Miss Fagan was aware that LCH had reported 30 SIs relating to pressure ulcers. At the quality review meeting it had been highlighted that the Trust had agreed to undertake an aggregated review of pressure ulcers and they had been told the CCG from a commissioning perspective could not support them only reporting on pressure ulcers that they deemed to be avoidable. Dr Gillespie felt it was important to benchmark both LCH and Merseycare as it was difficult to compare when we didn't know what we were comparing to. Mr Hester reported Kellie Connor had started a benchmarking exercise. Dr Halstead believed the problems went back further to reporting and it was becoming obvious that each organisation took its own view on what constitutes, eg a pressure ulcer. She said it was important to understand whether they were reporting in line with DH guidance. The first step would be to get the data set right.	

14/31	**Early Warning Dashboard** Ms Simpson reported that CSU business intelligence had produced a report based on an old SHA quality dashboard which had been developed in line with Chief Nurses which aimed to give an overview of potential risks for Merseyside Trusts. It currently included RLUH, AUH, AHCH, LWH, LHC, Merseycare and LCH. It was noted Aintree's performance had improved compared to its peers. Dr Mimnagh added that for one week in winter they were 2nd in the country for their efficiency of service to casualty. Miss Fagan reported that the RLUH CPQG was taking place today so the dashboard information would be discussed there. Dr Halstead directed the Quality Committee to the national CQUIN for dementia. One of the problems that providers including LCH have is they struggled to identify patients who possibly have dementia and consequently then didn't refer them on. Clearly an issue at RLUH and was a profound concern. Miss Fagan reported that RLUH had breached their C-Diff objective; Liverpool CCG was co-ordinating an appeals process/remedial action plan with them. *S&O* Miss Fagan reported there had been some mixed sex accommodation breaches; 28 reported in January and again 28 in February. Brendan Prescott had attended their internal meeting and stressed that we needed to be assured of remedial plans as the plan initiated in January had obviously failed. The latest information was reporting 35 not 28 breaches in February so CSU were currently checking that data. Miss Fagan was attending a quality and safety meeting on Friday and would be seeing what assurance they were giving to their Governing Body. In Q3 S&O had breached their full year objective for C-Diff and were reporting 23 cases against a full year objective of 19. Miss Fagan had also learned through an escalation report within the last couple of days that S&O had closed its Orthopaedic Ward because of an outbreak of C-Diff. An outbreak meeting had been held within the Trust as part of their recovery plan with regard to shifting admissions for a deep clean of the ward and their executive team supported closure of the ward. They had an issue in that they had no decant area so they had to reduce the number of admissions to clear approximately 7 beds to move the patients around. Southport & Formby Quality Committee had discussed Q3 performance around safeguarding yesterday and it had been confirmed that a query had been raised with the Trust in March's contract meeting regarding the safeguarding performance and it would be raised again at the next meeting at the beginning of April. The Trust would need to report back on safeguarding performance but the safeguarding hosted service were assured the Trust were taking it seriously.	

Q14/31	**Early Warning Dashboard** *South Sefton population* – Dr Halstead said there were mismatches of data; the Regional CQUIN showed 4 out of 5 greens for Aintree and it should only be 3 out of 5 greens and the percentages didn't match. She wasn't sure if it was year to date and if it was then that needed to be specified. CSU to look at it and clarify for next meeting. *P29 of 96* – Dr Gillespie's view was that everything was needed but it was worth highlighting anything new so the Committee could move over anything where actions plans were in place. Dr Gillespie said it was difficult to understand "median" terminology and wondered if the data could be reported in another way, or even if it was worth receiving in a different way as it was also seen in the dashboards. Dr Gillespie suggested it be followed up at the CQPG with the appropriate providers and the Quality Committee's concern was the trend did not seem to be improving and consistently 'below par'. *P30 of 96* – Dr Halstead asked Miss Simpson whether proms should be under patient experience and regional CQUIN under clinical effectiveness (the domains) and if they were the wrong way round. Ms Simpson to change. *MRSA/C-Diff cases reported* – Miss Fagan said if the Committee looked at the full year picture we would be red ragged as it was based on provider not patient and therefore the Committee needed the year to date figure as it didn't currently didn't reflect the population. CSU to action. *P31 of 96* – Healthcare Acquired Infections – Miss Fagan confirmed nothing new had been reported. *P32 of 96* – data collection issue. Miss Fagan asked for assurance at ACQPG that the patients were getting the same quality of care regardless of what was being captured. Dr Gillespie reported that the same question had arisen at LHC who were claiming exactly the same thing as they had changed how they record the data and they assured him by demonstrating there was no increased venous thromboembolism. Dr Halstead and Dr Mimnagh did not believe this was a satisfactory level of assurance as there were relatively few numbers involved and although the move from paper to electronic system data capture was a positive step it was hardly a new indicator. *Friends and Family* – Miss Fagan reported S&O Hospitals Trust attended the last EPEG and gave a presentation on the work they were undertaking. EPEG had tasked them with focussing on 3 areas and reporting back to the Committee. Aintree have been invited to May's meeting to report on their friends and family which will ultimately feed back into the Quality Committee. Mr Hester explained that EPEG was focussing on patient's element of the friends and family survey and not just the percentage response rate.	J Simpson D Fagan J Simpson J Simpson

Q14/31	*P38 of 96* – Dr Halstead wondered why the report for AUH exception reported Sept 13 when December's figures were available and the figures didn't quite match up across the document. *Essential alerting systems* – Miss Fagan confirmed this was being discussed at CQPG meetings and a lot would be outstanding because data isn't available or major. Dr Gillespie noted LHCH had put CAS alert on the risk register. Dr Halstead believed it didn't matter where it was as long as someone had oversight over it. Dr Mimnagh advised caution as it may suggest to the reader that the provider was performing to a higher standard than the others so that consistency in reporting had to be ensured because it could lead someone to believe the risk they've identified and moved to a different place means that risk was not addressed or had been addressed in a better way than the other hospitals. Whatever one has done that has been legitimised should be shared with all providers. Dr Gillespie advised he would refer back to see what they had to say about it. *P40 of 96 – Sickness absence rates* – Dr Halstead commented that LCH sickness and staff turnover rates were very high within the Sefton district nursing team and was a specific area that was a workstream for the quality review meeting. However, it gave a false picture of what the sickness absence was really like as the section of the report that mattered to the Quality committee was very poor.	J Simpson
Q14/32	**GP Quality Lead report** This was covered in the body of the meeting.	
Q14/33	**Serious Incidents and Never Events Update** *P44 of 96* - Mr Hester explained the first 3 pages related to SSCCG patients who had had serious incidents (SIs) anywhere. None of the 5 incidents reported in February were at Aintree, the pressure ulcers had occurred at LCH, the suspected suicide was at Merseycare and the unexpected death was at Lancashire Care. *P47 of 96 – provider level overview* – Dr Halstead and Dr Mimnagh were seeking clarity from the Quality Committee on exactly how many SIs were open and who are they with, where the blockages in the system were. Mr Hester drew the committee's attention to the 28 SIs relating to South Sefton CCG, but a considerable number of them were part of aggregated reviews so not the sole responsibility of South Sefton CCG to close as it required a response from the various CCGs. Miss Fagan added that due to the issues at Aintree and the nature of those SIs the SSCCG wanted to review lessons learnt so brought them into an aggregated review, otherwise more would have been closed by commissioners. Dr Mimnagh felt when deaths were reported they should be recorded as 'unexpected death' and a subsequent amended explanation of 'suicide' if needed.	

Q14/33	Dr Halstead believed the Committee needed more visibility of Merseycare's SIs and she directed the Committee's attention to *P35 of 96 SIs by provider* as there was a CCG field left blank next to 11 suspected suicides. Dr Halstead had spoken to Geraldine O'Carroll, the managerial lead for Merseycare, to ask her to investigate and report back at the monthly SI meeting, as it wasn't clear who was managing those SIs; was it Liverpool CCG or SpecCom? The other problem raised by Dr Mimnagh was that these patients may be under long term care in Ashworth and may not have a CCG allocated to them. Mr Hester added the SIs totalled 24 including the 11 suspected suicides and he would pick it up with Christine Griffiths-Evans of NHSE. Dr Gillespie noted it wasn't just Merseycare who left the field blank; LCH were guilty of doing the same thing. Mr Hester was also in contact with Liverpool CCG because the agreement was that when Merseycare report SIs they go onto Liverpool's StEIS system so there was collaboration between Mr Hester, CSU and Liverpool CCG. Miss Fagan also felt it would be useful to contact Ray Walker, the Director of Nursing at Merseycare and Hilal Mulla to discuss SIs with whoever had responsibility within Merseycare so the Committee could gain that understanding. Dr Halstead to take it up with Craig Gradden, LCH's Medical Director as Dr Gillespie felt it was entirely inappropriate not to have that level of information on there. Dr Gillespie asked that anyone attending CQPGs to raise the point that we expect it to be done in a timely fashion, appropriately and completely. *Merseycare* Dr Gillespie reported there were issues with the number of SIs and the difficulty in understanding where they were. He could understand the difficulties they had with the population they served, but without some sort of benchmarking they could be the country's worst provider in terms of SIs and the Committee would have no idea. Dr Mimnagh had asked for the information in a meeting with Merseycare yesterday and was basically told they had the information but they would let him have it 'at some point' which Dr Gillespie didn't think that was acceptable. He believed if they weren't going to provide the information then the Committee needed to source it itself by identifying another provider that was reasonably similar. Dr Halstead believed Bridgewater could be used as they were an Integrated Care Organisation (ICO) that also did community work. Miss Fagan believed the Committee needed to identify how many SIs were reported within their secure set, ie Ashworth and what SIs were reported within their community provision because otherwise the Committee was not comparing like with like. Dr Gillespie wanted to have taken steps forward by the next internal meeting (May). Miss Fagan had emailed Ray Walker, Director of Nursing, to ask who she should speak to within the Exec/SMT to obtain the information. Ms Simpson to look at using 5 Boroughs' data and report back. How many in/ outpatients' data was needed for both providers.	G O'Carroll CQPG attendees J Simpson

Q14/34	**Locality Update** The Bootle locality had just completed the Stonewell project which improved quality and saved some money on devices. They were interested in the acute end of the Virtual Ward. Lin Bennett reported there were lots of ventures they'd like to do but were quite restricted in terms of funding, eg inequity of housebound provision. She was relieved there would be a COPD community team to take on some housebound calls. Dr Halstead said the money was there but was not recurrent which seemed unfair and asked for it to be minuted that we were good at visiting housebound in an emergency but there was no capacity to offer chronic disease management. We had £50K which would buy 2 HCAs but it was not recurrent so it couldn't be done. Dr Gillespie felt it would be a good business plan to set up as a pilot. Dr Halstead felt the issue would be bigger than the individual and should be organised as a CCG to deal with as it was inequity of care. Dr Halstead suggested discussing it in a wider group in the first instance. Dr Mimnagh added that technically the requirement for it sat within the community nursing specification, however Dr Halstead clarified the community nurses are not responsible for delivering chronic disease management (QOF). Miss Bennett reported that her practice had introduced a generic pro forma for housebound chronic disease reviews being used by their district nursing team which they hoped to roll out to other practices. So as part of the Quality and Outcomes Framework we might get some good information back.	
Q14/35	**Clinician's Voice** Already covered in the meeting.	
Q14/36	**Quality Update and Home by Home Report** *P48 of 96* - the report prepared by Lorraine Norfolk, Locality Lead for CSU, covered the period from April 2013 to January 2014 and was very well received by the Committee. The providers had been commissioned as Miss Fagan wanted to get some idea of quality. Some homes were on the Northwest framework and were subject to an NHS contract and could claim CQUIN. It was the first report and it could be amended as time progressed. There may be some safeguarding elements contained within it that Miss Fagan felt the safeguarding team may want to pick up and asked that they look through the report and take away any necessary action on the Quality Committee's behalf.	T Forshaw

Q14/36	**Quality Update and Home by Home Report** Miss Forshaw reported that she was aware of one safeguarding referral reported yesterday. Dr Gillespie asked if the data was shared between the organisations and felt it would be a good idea as one care home had 6 unscheduled admissions. Miss Fagan explained it was part of the wider intelligence and as they went further down the road of integration with the Local Authority and contract management around single assessment, etc it might signpost the CCG to types of work it might want to do in care homes. Dr Halstead asked if HCAIs were included on the dashboard as one of the homes was a particular cause of concern. Dr Mimnagh believed it was advisable for the event rate to be worked out as an event rate per 100 patients/bed days due to the large variances in care home size. Miss Bennett asked why there were some homes without any data. Dr Gillespie believed it was because they were not obliged to provide the information, it was purely voluntary. The other point was homes like St Nick's where there was a high turnover, if the report was only being conducted quarterly would it give an accurate picture? Dr Gillespie believed there were many things that could be added to the report but it was really good and asked if it was going to be coming back to the committee and if so would it be on a dashboard? Miss Fagan said she thought it should be presented as part of the work plan as for any other providers. As it was the first report it was open for discussion regarding frequency and style and she knew the CSU team had been working extremely hard to pull the information together and it was a work in progress going forward. Dr Mimnagh said from a strategic viewpoint a lot of South Sefton's patients would be in these care homes so relationships would have to change for these homes to include a safety and reporting mechanism and he was a little concerned about presenting information before we had completeness of coverage may act as a punitive discourager and would suggest taking the document away from submission to the full committee but take it to the operations group with clinical input as required so that we get the system change and coverage first.	
Q14/36	**Quality Update and Home by Home Report** Miss Forshaw believed it stood up as a public document but thought the Committee ought to consider from a FOI point of view and whether specific homes could be affected by loss of business. Miss Fagan would ask Geraldine O'Carroll to further conversations surrounding integration and working more closely around the contracts and quality in relation to care homes which is something to be developed going forward. Miss Forshaw added some joint work with safeguarding also needed to be conducted as it wasn't currently reflected in the report.	D Fagan

Q14/37	**Primary Care Update** Mr Hester reported on behalf of Malcolm Cunningham that a Primary Care dashboard will come back in May and will reflect the year end position A Quality Board met last week and there were a number of issues. NHSE are doing some work around workforce development. The standard contract has been delayed for 3 months so the contract can be sorted and there has been a delay on the acute visiting scheme as Go To Doc are struggling to get GPs to run it.	M Cunn'm
Q14/38	**Safeguarding Service Quarterly Assurance Report (Providers)** Miss Forshaw updated the meeting, item 3.2 that process appeared to be in place and in terms that there might be a disparity in terms of the quality reporting for the next financial year as there have been some differences agreed with Liverpool CCG and wouldn't affect reporting into this Committee. 3.3 last month differences that had been KPIs that had been set by SpecCom Services for Cheshire, Warrington and Wirral. This had been escalated to Chief Nurses and NHSE and the Chief Nurse for Halton CCG had spoken to Lisa Cooper the Deputy Director of Nursing at Cheshire, Warrington and Wirral and there had been an agreement where there were general hospitals and SpecCom services are in use there was an agreement that the Merseyside KPIs would be in existence and theirs would only be used at Walton. *Q3 analysis dashboard* – Miss Forshaw apologised for the AHCH nil return as that was just for adults and had been for each quarter but hadn't altered the RAG rating status overall which remained accurate in terms of the Q3 for AHCH. The Adult Safeguarding team will be present at the AHCH CQPG meeting next week to have those discussions with AHCH about the Adult Safeguarding agenda. Miss Forshaw reported they had also tried to put some context around the amber ratings.	

Q14/38	**Safeguarding Service Quarterly Assurance Report (Providers)** Miss Fagan informed the Committee about a useful conversation at the SF QWC the day before where the Safeguarding team had had conversations at other Quality Committees whereby if some of the providers have failed to provide information for whatever reason rather than red RAG rate them they had greyed them out and the Safeguarding team had decided to raise it at the Committee because they asked whether they were red RAG rating them because of poor performance or because you hadn't been able to analyse. How many greys makes a red and it carries a risk when you are unable to assess. Dr Gillespie believed if you failed to declare then you were automatically a red as assurance had not been provided. Miss Fagan asked Miss Forshaw to brief the Committee on 'Prevent', the national strategy from the Home Office for the prevention of vulnerable children and adults being drawn into extremism or terrorism. It went into the NHS contract for 2013/14 and organisations needed to have a policy in place and all their employees needed to have health RAG training. I had gone into the KPIs this year looking for a 40% take up which could impact on providers giving assurance.	
Q14/39	**2013/14 Quarter 3 Provider CQUIN Report** This was the first time all CQUINS had been presented together in a report and the CSU was trying to develop one standard template that would include one target, although not all CQUINS included targets which was why there are gaps in the table. They were looking at standardised a template for next year with possible links to financial values contained within it. Mr McDowell referred to CQUIN national contract penalties and confirmed he expected the year end position to be £772,000 of which our share was just under 40% of which approximately £300,000 was money that would be withheld. He believed it was important the CCG had applied the national contract penalties as that gave a real indicator for next year.	
Q14/40	**Any Other Business** *Q14/22* – Miss Fagan updated the Committee on Looked After Children Medicals (P4 of 96). This had been escalated to the Corporate Parenting Board but when the data had been cleansed it only applied to 3 children across the whole of the Sefton area so it had been de-escalated, although processes were to be put in place to avoid getting in that position in future.	
Q14/41	**Date of next meeting** Thursday 17th April 2014 3.00pm – 5.00pm Boardroom Merton House	

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee
Minutes

Date: Thursday 20 February 2014 1.00pm – 2.30pm

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

Attended

Graham Morris	Lay Member (Chair, Vice Chair CCG)	GM
Roger Driver	Lay Member	RD
Sharon McGibbon	Practice Manager	SMG
Martin McDowell	Chief Finance Officer	MMD
Debbie Fagan	Chief Nurse	DF
Malcolm Cunningham	Head of Primary care and Corporate Performance	MC

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
Dr Susan Stephenson	GP Locality Lead	SS

No	Item	Action
FR14/24	**Apologies for absence** Apologies for absence were recorded from: Fiona Clark John Wray Steve Astles Tracy Jeffes Ken Jones David Bacon Karl McKluskey Brendan Prescott The Committee noted that quoracy had not been achieved and that items for approval could only be recommended pending approval by a GP Governing Body Member.	
FR14/25	**Declarations of interest regarding agenda items** The Officers of the CCG who hold joint posts declared their conflict of interest.	
FR14/26	**Minutes of the previous meeting** The minutes of the previous meeting were approved a true and accurate record of the meeting.	

No	Item	Action
FR14/27	**Action points from the previous meeting** Action points from the previous meeting were closed as appropriate.	
FR14/28	**Month 10 Finance Report** MMcD and JB presented this report which provided the Finance and Resource 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, presented the financial position of the CCG as at month 10, and outlined the key risks facing the CCG. The report focused on the financial performance of the CCG at month 10. At the end of January the CCG is £3.584m over-spent prior to the application of reserves (Month 9 £3.306m). The CCG has sufficient reserves, and remains on target to achieve the planned £2.300m surplus at the end of the year. The committee noted that the prescribing commitments had changed, but the budgets had not been altered to reflect this, which had led to an overspend. BP/MMcD/JB will meet to discuss implications for this at practice level. **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**	
FR14/29	**Strategic Financial Plan Update** **(includes QIPP update)** MMcD presented this verbal update and reported that the Strategic Plan had been submitted to NHS England. The Committee noted that NHS England propose initiating a central adjustment to CCG budgets to accommodate CHC payments going forward. The Committee requested that MMcD 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. GM requested clarification as to how the position at Aintree had been reflected in the plan. JB confirmed that this has been built in at the current rate. MMcD will present the final Strategic Financial Plan and the Governing Body Development session in April 2014 **The F & R Committee noted the verbal Strategic Financial Plan update.**	MMcD
FR14/30	**Q3 Contract Performance Review** JB presented this report to provide the Finance and Resource Committee with a summary of the financial performance against contracts and the operational performance of the main provider Aintree NHS Foundation Trust as at the end of quarter three for 2013-14. 36 The Committee noted that tables 1-3 identified significant variance against plan. JB commented that in the case of Any Qualified Provider (AQP), insufficient funding had been allocated at the outset of the contract. MMcD further advised the Committee that CQUIN incentive payments will be withheld as appropriate this year and that providers will not be able to recoup this funding in other areas as in previous years. **The Finance & Resource Committee noted the content of the paper, notably:** • **Financial risk of contract over performance in 2013-14** • **Operational performance at Aintree University Hospital**	

No	Item	Action
FR14/31	**PMO Dashboard** BW presented this report which provides an update to the F & R Committee on CCG programmes including cases for change. The committee noted that benefits had been postponed due to recruitment issues relating to some of the programmes. **The F & R Committee noted the South Sefton PMO Programme update and exception report.**	
FR14/32	**IFR Update Report** The Committee noted the IFR report presented for information purposes only.	
FR14/33	**Better Care Fund** MMcD gave a verbal update and noted that a meeting had been held with Sefton Council to begin to review in detail systems relating to the Health and Social Care Fund. This will continue to be reviewed over the next 6 weeks along with Governance arrangements. **The F & R Committee noted the verbal update regarding the Better Care Fund**.	
FR14/34	**Quality Premium Dashboard** BW presented this report and noted that **b**ased on the year to date performance (April - December 2013), South Sefton CCG would receive a payment of £552,623 against a total possible payment (if all indicators were within tolerance) of £736,830. **The Finance and Resource Committee noted contents of the Quality Premium Dashboard Report**	
FR14/35	**a. Fluocinolone Acetonide (NICE TA 301)** DF presented this report on behalf of BP. MMcD noted that the CCG prevalence rates were below the national average and requested clarification that this was the case. **b. Development of an Asperger Service in South Sefton** Development of an Asperger Service in South Sefton GO'C presented this case for change and requested approval for a funding for a 12 month pilot programme. The relative benefits of the pilot were discussed including the methodology for evaluation. G O'C clarified recruitment arrangements that would be satisfied by secondment from the existing service. Merseycare are aware that any additional staff recruited will be at their financial risk should the pilot not continue beyond 12 months. MMcD noted that he hoped that this investment would help this client group transition into the workforce by developing opportunities to maximise their skills **The F & R Committee recommended the approval of non-recurrent investment of £55,172 for the 12 month pilot for the development of an Asperger Service in South Sefton.**	

No	Item	Action
FR14/36	**Sefton Council for Voluntary Services – Non recurrent investment 2013/14** GO'C presented this report which recommended the proposed continued support for Sefton Council for Voluntary Services (CVS). The committee discussed the relative benefits and evaluation tools related to this proposed investment. **The F & R Committee recommended the proposed non recurrent investment of £200k for Sefton Council for Voluntary Services.**	
FR14/37	**Any Other Business** There was one item of other business: MMcD noted the Cheshire and Mersey CSU will merge with Greater Manchester CSU from 1st April 2014	
FR14/38	**Date Time and Venue of next meeting** **Thursday 20 March 2014 1.00pm – 3.00pm** **Merton House Bootle**	

Post Meeting Note:

Drs Paul Thomas and John Wray confirmed their approval for items 14/35 a & b and item 14/36.

- Some clarification was requested in relation to finances which have been provided by Martin McDowell Chief Finance Officer.
- Some suggestions relating to service development were raised and have been noted by the leads in these areas.

Attendance Tracker

Committee Member	January 2013	February 2013	March 2013	May 2013	June 2013	July 2013	September 2013	October 2013	November 2013	January 2014	February 2014
Graham Morris (Chair) Lay Member Appointed Octobr									✓	✓	✓
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	Apols	Apols
Dr Steve Fraser GP Board Member, SS CCG	✓	✓	Apols	✓	✓	✓	✓	Apols	✓	Term ended	Term ended
Sharon McGibbon Practice Manager	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Fiona Clark Chief Officer, SS CCG	Apols	✓	✓	✓	✓	✓	✓	✓	Apols	✓	Apols
Martin McDowell Chief Finance Officer, SS CCG	✓	✓	✓	Apols	✓	✓	✓	✓	✓	✓	✓
Steve Astles Head of CCG Development, SS CCG	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols
Malcolm Cunningham Head of Performance & Outcomes	✓	✓	Apols	✓	Apols	✓	✓	✓	Apols	✓	Apols
Tracy Jeffes Head of Delivery and integration	✓	Apols	✓	✓	✓	✓	✓	✓	✓	Apols	Apols
Debbie Fagan Lead Nurse SS CCG	✓	✓	✓	✓	Apols	✓		✓	Apols	✓	✓
In attendance											
Fiona Doherty Transformational Change Manager (as required)	-	✓	✓	Apols	✓	✓		✓	✓	Apols	✓

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, 2 April 2014, 13.00 to 16.00 (lunch available from 12.30)
Meeting, Boardroom, Third Floor, Merton House, Bootle L20 3DL

Minutes

Present	
Niall Leonard	Vice-Chair, S&FCCG
Rob Caudwell	Chair, S&FCCG
Clive Shaw	Chair, SSCCG
Fiona Clark	S&FCCG/SSCCG
John Wicks	Interim CO, WCCG
Jan Snoddon	obo Simon Banks
Dr Cliff Richards	Chair, HCCG
Marcus Stanley	Halton CCG
Tony Woods	LCCG
Linda Bennett	WCCG
Nadim Fazlani	Chair, LCCG

Apologies	
Martin McDowell	CFO, S&FCCG/SS CCG
Steve Cox	CO, StHCCG
Andy Pryce	Chair, KCCG
Dianne Johnson	CO, KCCG
Ian Davies	Head of Perf, LCCG
Simon Banks	CO, HCCG
John Caine	Chair, WLCCG
Mike Maguire	CO, WLCCG
Sarah Johnson	CFO, StHCCG
Ray Guy	Chair, LCCG
Tom Jackson	CFO, LCCG
Katherine Sheerin	CO, LCCG
Paul Brickwood	CFO, KCCG
Paul Kingan	CFO, WLCCG
NHS England	

In attendance	
Dr Liz Mears, Chief Executive, North West Coast Academic Health Science Network	

Minutes	
Melanie Wright	SSCCG/S&FCCG

No	Item	Action
14/37.	**Welcome & Introductions** were made.	
14/38.	**An Introduction to the North West Coast Academic Health Science Network (NWAHSN)** Dr Mears described the following campaigns under way by NWAHSN. *Identifying untreated atrial fibrillation patients*: the CCGs were amenable to technological advances, although there was some discomfort in relation to pharmaceutical company input to boards influencing uptake of drugs. Dr Mears confirmed that such companies could contribute in terms of sponsorship only, but this must be clearly flagged.	

No	Item	Action
	Dr Caudwell felt the application in relation to detection of atrial fibrillation was accurate and helpful, although he expressed caution in terms of its use to patients. Those present did express interest in relation to funding for the strips for use with the application, noting that targeted usage for the tests will be necessary to ensure the correct users are identified. Dr Richards also expressed caution regarding use of the NOAC drugs and its apparent effect on some patients. There is an event being held on 3 May in Liverpool to consider innovation, to which members of the network are invited. *Integrated Patient Records and Big Data* The meeting agreed there was a need to understand 'Big Data'. Dr Mears agreed to send the Terms of Reference to Mel Wright, for onward circulation to the Network. NWAHSN are also meeting up with iLinks to progress this agenda. *Medicines Optimisation/Digital Health* This campaign was in relation to benign tablets containing a microchip to monitor whether patients are taking their medicines at the right dosage at the right time. Dr Mears sought interest from the Network as to participating in the trial. The application of such technology was discussed but there was no firm agreement to participate. *Digital Solutions in Health* A future event is planned, to which the Network will be invited. Mondays/ Fridays not good days for general practice and Dr Mears agreed to take this on board for planning purposes. *CLAHRC* Katherine Sheerin and Dr Andy Davies at Warrington CCG are members of this organisation and Ms Clark agreed to ask for an update at the next Network meeting. Ms Clark also agreed to contact Dr Mears regarding the forthcoming Workforce Symposium. There was a conversation regarding innovation generally and it was felt that the CCGs needed to engage in this agenda more fully. It was felt that this would be a useful topic for discussion at the Co-commissioning Collaborative next week.	Liz Mears FLC
14/39.	**Strategic Planning** Item deferred to Mersey Co-Commissioning Collaborative next week.	
14/40.	**Apologies for absence** were noted.	
14/41.	**Minutes from the previous meeting** The Minutes were agreed as an accurate record of the meeting, save that Simon Banks was in attendance and a mis-spelling of Ms Clark's name.	
14/42.	**Actions from the previous meeting** All actions were closed down.	
	Actions from the November meeting	
	Actions from the February meeting	

No	Item			Action
	14/16	**Safeguarding Hosted Service - Update** Mrs Snoddon agreed to undertake a review of the designated doctor function. A meeting has now been arranged with Chief Nurses and Ms Clark to consider the Safeguarding Service.		
		Actions from the March meeting		
	14/31	**General Practice Workforce – Update** Ms Clark will arrange a Workforce Symposium to consider what is being done and where.		
	14/33	**Liverpool Women's Hospital NHS Foundation Trust** Ms Clark provided an update on behalf of Ms Sheerin in terms of the financial risk present in the organisation, for both CNST and Maternity tariff, with the potential to render it financially unviable. Following a conference call with Monitor on 2 April, these are two major risk issues. A consultancy firm is working with the Trust to provide some clarity. They have invited LCCG to a meeting on 2 May and an update will be provided to the CCG Network on 7 May. Simon Banks to discuss progress in relation to the Maternity Network at the next meeting in May.	KS SB	7 May 2014 7 May 2014
14/43.	**Service Reconfiguration** Ms Clark referred to previous discussions around sharing of strategic plans and it was agreed that this item would also be discussed at the Co-Commissioning Collaborative next week. Ms Clark also referred to recent discussions with LCCG and KCCG around Aintree and LCH. South Sefton CCG are keen to progress open discussions around Aintree and expressed concerns over a Liverpool-centric service. The development of the site at Royal Liverpool and there is a requirement for substantial services to be retained at Aintree needed more exploration over the coming months. Ms Clark also referenced the decision by the Trauma Network had been changed. There followed a discussion around the appropriate location of Trauma services. There was also a discussion around the need for transparency across the CCG Network.			
14/44.	**Any Other Business** It was agree that the Specialised Commissioning be invited to the Co-Commissioning Collaborative to discuss strategic plans, along with NHS England, together with 2-year/5-year plans from CCGs, where available.			
14/45.	**Date of Next Meeting** Wednesday, 7 May 2014, Boardroom, Merton House			

** Dates for the Diary 2014**

MEETING	DATE	TIME	VENUE

Merseyside CCG Network	7 May	12.00 to 13.00 13.00 to 16.00	Informal pre-meeting Meeting, Merton House
Merseyside CCG Network	4 June	12.00 to 13.00 13.00 to 16.00	Informal pre-meeting Meeting, Merton House
		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 19 MARCH 2014

PRESENT: Councillor Moncur (in the Chair)
Dr. Janet Atherton, Fiona Clark, Councillor Cummins, Councillor John Joseph Kelly, Maureen Kelly, Dr. Niall Leonard, Colin Pettigrew and Phil Wadeson

60. APOLOGIES FOR ABSENCE

An apology for absence was received from Robina Critchley.

61. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the Minutes of the meeting held on 19 February 2014 be confirmed as a correct record.

62. DECLARATIONS OF INTEREST

No declarations of pecuniary interest were received.

63. SPECIAL EDUCATIONAL NEEDS REFORM

The Board received a presentation from the Head of Learning and Support in relation to implementing the Reforms to Special Educational Needs and Disability in Sefton.

The presentation set out the following objective conveyed from the Department for Education in relation to the Special Educational Needs Reform:-
"Our vision for children and young people with special needs is the same as for all children and young people – that they achieve well in their early years, at school and in college; lead happy and fulfilled lives; and have choice and control".

The following headlines were presented:-

- How the Special Educational Needs and Disability Reforms had come about, including the journey so far and the proposed journey;
- The Legislation in relation to the new Special Educational Needs Code of Practice;
- Progress in Sefton, to date and the future work to be achieved; and
- The requirements expected for September 2014.

The following progress already achieved in Sefton was reported as:-

- Governance arrangements developed (consultation with the Early Life Group of the Health and Well Being Board)
- Project Groups established
- Awareness raising with Stakeholders (briefings undertaken
- Special Educational Needs Assessment Team Restructure
- Engagement with Joint Strategic Needs Assessment
- Costed action plans developed
- Linking into other agencies
- Meetings with the Department for Education

The next steps were reported as:-

- The development of an Education Health Care Plan model to be processed and piloted.
- To develop a local offer and consult upon it
- To develop dispute resolution procedure
- Preparation for Adulthood – work with Adult Social Care
- To explore joint commissioning opportunities and personalised budgeting

The requirements for September 2014 were reported as being:-

- Published Local Offer
- All new assessments to be Education Health Care Plans
- Local dispute resolution arrangements
- Transitional arrangements for transfer to Education Health Care Plans
- Legislation applies to all named organisations
- The ability to offer personalised budgets

Members of the Board raised concern regarding the issue of establishing local dispute resolution arrangements and how this would smoothly link into the existing tribunal arrangements in different Departments.
Members of the Board agreed that the Council had an opportunity to make appropriate adjustments to the process and that the Early Life sub-group could work with relevant partners in developing a process that smoothly linked into existing complaint procedures required of various legislation across Health and Social Care, in order that there be a single point of access for parents that could help parents navigate through the procedure easily.

RESOLVED: That the Board

(1) agrees the governance arrangements through the Early Life sub-group;

(2) note the progress of work already achieved and the next steps;

(3) endorse the principles adopted in implementing the SEN reforms in Sefton;

(4) note the work required to be completed by September 2014 in order that Sefton MBC are complaint with the new statutory requirements;

(5) requests the Early Life sub-group to carry out further work with relevant partners in the development of a dispute resolution procedure that works in Sefton in an effective way improving outcomes for the Children, Young People and Families throughout Sefton; and

(6) receives an update report at the first Meeting of the Municipal Year 2014/15.

64. UPDATES FROM HEALTH AND WELLBEING FORUMS

The Board considered a report of the Head of Performance and Intelligence which detailed progress being made by the following three Health and Wellbeing Forums:-

- Adults;
- Early Life (0-19); and
- Wider Determinants

The report highlighted that each Forum had met twice each and that theyhad all made good progress, as detailed in the report. It was highlighted that the Adult Forum had requested that the name be changed to “Adult Steering Group” and that the Members of the Programme Group had endorsed that request.

It was reported that the Programme Group had tasked each Forum to take equal ownership of arranging a stakeholder event in June 2014 linked to the publication of the second iteration of the Health and Wellbeing Strategy.

It was further reported that the Board would receive progress reports regarding the work of the Forums, as and when required.

RESOLVED: That

(1) progress on the work of the three Health and Wellbeing Forums be noted; and

(2) the proposal to change the name of the “Adults Forum” to “Adults Steering Group”, with the wider group known as the Forum to support partners to be fully involved, and any implications this may have for other Forums within the Health and Wellbeing Family, be agreed.

65. SEFTON BETTER CARE FUND PLAN - NEXT STEPS

The Board considered the report of the Deputy Chief Executive, Minute No. 57 refers of the meeting held on 19 February 2014 in relation to the development of the Better Care Fund Plan.

The report referred to the first iteration of the Better Care Fund Plan that was submitted to NHS England on 14 February 2014 and was formally signed off by the Board on 19 February 2014 along with the receiving of Cabinet approval on 27 February 2014.

It was reported that the guidance received from NHS England, suggested that a revised second plan should be submitted to them by 4 April 2014. It was further reported that the second iteration would build on the first iteration already submitted; take into account a RAG (Red, Amber and Green) rating by representatives of Central Government; and would comply with Supplementary Guidance from NHS England. Also reported was the requirement for the Clinical Commissioning Groups to submit their Strategic Plans on 4 April 2014.

RESOLVED: That the Board

(1) agrees that the second iterative return of Sefton Better Care Fund Plan, be a short paper, addressing any issues identified from the assurance process, setting out the proposals of how the requirements set out in the guidance would be met and the intention of the Board to submit further iterations of the Better Care Fund Plan, as the development of schemes arising from the Integration Plan are progressed;

(2) approves the revised Health and Wellbeing Sub Structure arrangements and that the continued development of the Better Care Fund Plan be the responsibility of the Programme Group;

(3) approves the reformatting of the role of the Programme Group, and subsequent changes to the sub structure of the Board to create a Provider Forum, and notes the change in the role of two of the Task Groups;

(4) agreed that the name of “Acute Provider Forum” be shown correctly in the annexe to the report as the “Provider Forum”;

(5) agreed to include a representative from “Healthwatch” on the membership of the Integration and Programme Group;

(6) agrees the development of a draft Integration Plan which would be led by the reformatted Programme and Integration Group and delivered through a reformatted Resources and Integration Task Group;

(7) note that Cabinet will be requested to delegate powers to the Deputy Chief Executive of the Council, in consultation with the Chair of the Board, and the Cabinet Member for Older People and Health to sign the Better Care Fund submission on behalf of the Council;

(8) endorse the intention to seek the delegation in recommendation (7) above and note that a similar delegation be sought from the Clinical Commissioning Group Governing Bodies for the Chief Officer of South Sefton & Southport and Formby Clinical Commissioning Groups, and the two Chairs, to sign the Better Care Fund submission on their behalf; and

(9) requests that the Deputy Chief Executive provides regular progress reports to the Board.

66. CLINICAL COMMISSIONING GROUPS STRATEGIC PLANS

The Board considered a report from the Head of Strategic Planning and Assurance, Clinical Commissioning Groups (CCG) for South Sefton; and Southport and Formby.
The report updated the Health and Wellbeing Board on the approach and progress in relation to the five year strategic plan for South Sefton Clinical Commissioning Group and Southport and Formby Clinical Commissioning Group.

The report featured the following headlines:-

- Background Incorporating the National Agenda into the Clinical Commissioning Group 5 Year Strategic Plan and 2 Year Operation Plan.
- The Clinical Commissioning Group Planning Framework
- Unit of Planning
- Clinical Commissioning Group Strategic Plan
- The Major Clinical Commissioning Group Mechanisms for Delivery
- The Strategic Plan Programmes
- Better Care Fund

The report concluded by setting out the following work that had already been achieved and the work forecast to be achieved:-

- A nationally prescribed set of requirements which CCG Strategic and Operational Plans needs to address, had been clearly defined. That those requirements centre on the five outcome domains, seven measurable ambitions, three additional measures with six models of service provision for the future and four essential delivery elements.
- The preliminary work on developing its Strategic Plans had served it well in terms of readiness for compliance with the end of December 2013 published guidance.

- The CCG had developed a robust planning framework to assist in the immediate planning requirements, but also to support the annual iteration of plans.
- The 2014/15 contract negotiations were being informed by the detail and issues that were forming as part of the programme plans.
- The CCG had established a clear set of planning priorities focusing on Frail Elderly, Unplanned Care and Primary Care. Those strategic priorities support the vision of reducing unplanned care in the acute sector, transferring that to the community setting.
- The CCG Strategic and Operational Plans were being augmented to encompass some very specific needs for Children, Mental Health and Cancer across the Sefton Borough.
- The CCG has a detailed set of planning programmes, where detail plans are being built based on the health needs of the local population.
- The programme plans were describing a set of specific outcomes measures, relevant to the local population across the five year planning horizon.
- Those locally orientated outcomes were being designed to support and underpin an assessment of the level of unplanned activity reduction in the acute sector in conjunction with the associated commission requirements in the community setting.
- A set of nationally prescribed outcomes were to be applied to the CCG, based on and informed by the Outcomes Atlas. Those outcomes, their targets and the associated activity profiles were provided by the CSU at the end of January for CCG consideration, validation and testing.
- A national timetable for the development of the CCG Operational Plan (activity, finance and outcomes) was in place and 14 February 2014 was the first submission date for the two year Operational Plan.
- The development of the draft two year Operational Plan required a draft analysis on the finance, activity and outcomes from the CSU by the end of January.
- A CCG working group had been established to support delivery against the nationally defined timescales, with all the relevant contributors from finance, planning, performance, CSU and delivery.
- The CCG had begun a process of engagement and collaboration on its developing plans with neighbouring CCGs.
- A joint provider engagement event on the Better Care Fund and CCG Strategic Plan was hosted on 22 January 2014, with additional provider specific engagement to be scheduled through to June 2014.
- A comprehensive schedule of engagement with stakeholders and progress reporting from the Governing Body and CCG members had been developed.
- An agreed approach on the Better Care Fund with Sefton Council had been developed.

- Detailed work on the enhancement of the Virtual Ward and Care Closer to Home was in train and being informed by lead clinicians.
- The Health & Wellbeing Board endorsed the Better Care Fund approach in time for the draft national submission deadline of 14 February 2014, with the final version submitted on 4 April 2014.
- The CCG was required to submit its final two year Operational Plan (activity, finance and outcomes) by the 4 April 2014.
- The CCG was required to submit its first draft five year Strategic Plan by the 4 April 2014.
- The final two year Operational Plan (activity, finance and outcomes) and five year Strategic Plan would be submitted on the 20 June 2014.

RESOLVED: That the Health and Wellbeing Board:

(1) receive the report as an outline and approach for the Clinical Commissioning Group Strategic Plan;

(2) note that a process of engagement was in train with Sefton Council, Providers, the Public and Voluntary Community and Faith Sector;

(3) recognise the prospective need for regular progress briefings on the developing strategic and operational plans;

(4) recognised and understood the synergy between the Clinical Commissioning Group Strategic Plan and the Better Care Fund Plan;

(5) receive regular update reports as and when required in relation to Strategic Planning for the Clinical Commissioning Groups; and

(6) agree to refer Appendix A to the report, to the Performance and Intelligence Task Group.

67. HEALTH & WELLBEING BOARD DATES

The Board considered a report of the Head of Business Intelligence and Performance that set out the proposed meeting dates for the Health and Wellbeing Board for the Municipal Year 2014/15.

The report explained that as the Health and Wellbeing Board was a constituted Committee of the Council, the meeting dates for the new Municipal Year were required to be submitted to Council for approval, as part of the Programme of Meetings for the Municipal Year 2014/15.

It was reported that the Chair of the Board, Councillor Moncur had been consulted on the proposed following dates:-

- 18 June 2014
- 17 September 2014

- 3 December 2014
- 18 March 2014

(All the above meetings to commence at 2.00 pm and finish at 4.00 pm)

It was further reported that a Forward Plan would be developed and all scheduled reports should be included on the Plan in order that the Board may organise its work accordingly.

The Head of Business Intelligence and Performance reported on the following dates to be held for meetings of the developmental workshops:-

- 7 May 2014
- 22 October 2014
- 25 February 2015

(All the above meetings to commence at 2.00 pm and finish at 4.00 pm)

It was reported that a couple of the members on the board would struggle with some of the proposed dates. Accordingly the Chair requested that the dates be circulated to the board members and that if necessary depending on the response to existing dates, that some changes may be made prior to being submitted to Council for approval.

RESOLVED: That the Health and Wellbeing Board:

(1) notes the dates for the Health and Wellbeing Board as set out in the report and the requirement for Council to formally endorse the calendar of meetings as part of the programme of meetings report;

(2) note the intention to develop a Forward Plan of items for consideration by the Board, and request that Board members raise future items to be included on the Forward Plan at the appropriate time; and

(3) be consulted on the dates of formal meetings and development workshops and a final set of formal meeting dates be agreed by the Chair prior to submission to the Council for approval.

South Sefton Clinical Commissioning Group

South Sefton Medicines Optimisation Operational Group (SSMOOG) Minutes

Time and Date 25th February 2014, 12 noon – 2 pm
Venue: Conference Room 3B, 3rd Floor, Merton House

Members:	**Janet Fay (JF) Chair)**	**Senior Practice Pharmacist**
	Dr A Ferguson (AF)	**Medicines Management Lead GP**
	Sejal Patel (SP)	**Senior Practice Pharmacist**
	Brendan Prescott (BP)	**Lead for Medicines Management**
	Helen Stubbs (HS)	**C&MCSU Link**
	Dr J Thomas (JT)	**GP Representative**
Minute Taker	**Ruth Menzies (RM)**	**Medicines Management Administrator**

No	Item	Action
14/001	**Apologies** Apologies were received from James Hester. RM to ensure JH and JB are on the distribution list.	**RM**
14/002	**Minutes of the meeting dated 17th December 2013** The minutes were approved once HS's name has been added to the attendees.	
14/003	**Matters arising from minutes dated 17th December 2013 (All)** BP has yet to speak to Joe Chattin regarding attending future LMC meetings. It was noted we do formally get invited to LMC meetings. Tithebarn CDiff Outbreak - a paper has yet to go to the Quality Committee. BP is currently in the process of organising an honorary contract for temporary employment for Sara Boyce to prescribe for the Pain Clinic. SB will be using the Pain Clinic code and be seeing patients prior to them visiting the Pain Clinic. JA/JF did have a meeting with Lifeline which went well. Sarah Austin in Public Health to look at what is being commissioned. It was noted we are developing a good relationship with Lifeline and it is hoped the letters will soon stop.	**BP**

No	Item	Action
	Osteoporosis Guidelines – BP confirmed S&O have responded with a revised figure. An increase in costs of around £200K will be incurred as a result of denosumab being administered in Primary Care. BP has however discussed the situation with JB and it is confirmed this figure will be factored into next year's prescribing budget. Negotiations will continue to take place with Aintree. Inhaler technique – an update was given as the situation had changed to what was said on the previous minutes and it was now felt there would be more value in commissioning a pharmacist who will have access to the patient details in front of them. Discussions took place as to how variable the nurses input/competencies are. A pilot will now take place in the Bootle locality. A pharmacist has been commissioned to work 3 days a week. Details have yet to be finalised.	
14/004	**Matters arising from minutes from MMOG – not applicable as last meeting a JMOG (All)**	
14/005	**Locality updates/ Practice Updates/Feedback (JF)** There is nothing to report.	
14/006	**APC Minutes/report – February 2014 (BP/HS)** The APC minutes have been withdrawn. <u>New Medicines</u> The APC report was tabled and discussed with all new medicines being approved. SP to add as appropriate to the Website. <u>Formulary and Guidelines</u> Doxazosin – discussions took place around the amount of prescribing which is felt to be historic and inadvertent. Also discussed the possibility of it being part of the PQS and adding to scriptswitch. Dexamethasone – The committee agreed an SPU should be produced. SPPs to decide who will complete. JF/AF will discuss outside the meeting in relation to what information should be included at locality meeting.	**SP** **SPPs/ JF/AF**

No	Item	Action
14/007	**Budget Update YTD and FOT – November 2013 (BP)** The December figures were discussed as the monthly allocation has changed and will be weighted more at the start as opposed to the end of the year. The prescribing budget for month 8 was showing a forecasted underspend which has now changed to an overspend for December. It is proposed there will be a 1% increase in the prescribing budget on outturn for this year for 2014-15 prescribing budget. Discussions took place in relation to the significant shift in patient numbers between practices in the Bootle area. Discussions took place as to whether any monies will refunded to the CCG by Public Health in relation to flu vaccines as these have been paid for by the CCG. It is hoped the prescribing budget will balance bearing in mind the contingency sum that is in place and above monies being refunded.	
14/008	**Shared Care update (BP)** <u>Degarelix</u> A letter was received from Aintree Hospital (Dr Baird) who has confirmed he is happy to monitor the LFTs, but if the practice wants to do so he is also happy with that. BP to confirm with Aintree that they will be monitoring patients they have started on degarelix. BP to contact JC to say degarelix will be a level 2 shared care drug.	**BP** **BP**
14/009	**Risk Log (All)** No changes to report. BP will include scriptswitch for those practices who have taken it up.	
14/010	**Horizon Scanning (BP)** The attached report was discussed which details what products are likely to come through this year and the impact this will have on the CCG. BP to send this to Finance to discuss at weekly meetings. Total quantifiable impact of those that could be calculated shows an increase in £335,231.	

No	Item	Action
14/011	**Palliative Care Drugs (JF)** A letter has been sent out asking for volunteers for community pharmacies to hold stock palliative care drugs. The list will also include some items from Liverpool and the service will operate across boundaries. AF mentioned she had heard that sodium chloride should be used instead of water for injections. JF to speak to Steve Simpson in relation to this matter.	**JF**
14/012	**Omacor in IgA Nephropathy (BP)** A statement will be sought from APC saying we want to carry on prescribing. Black statement has come out saying not to prescribe for the above.	
14/013	**Prescribing Quality Scheme 14-15 (BP)** Last year's scheme which has been updated slightly was attached. BP discussed the proposed changes and confirmed further work will be undertaken at the Senior Practice Pharmacist meeting before coming back to this committee for approval. Any ideas for next year's scheme to be emailed to JF. JT felt need to focus more on optimisation rather than budgets and felt this will follow on. It was also suggested having options were practices can chose something that is pertinent to them. This year a lot of practices are over budget and discussions took place regarding allocating the prescribing budgets and increase in resources.	**All**
14/014	**Updated Terms of Reference (to include new member) (BP)** AF happy to chair once she has settled into the post.	

No	Item	Action
	AOB HS confirmed that Cheshire and Mersey CSU and Manchester CSU are scheduled to merge. There will be no changes made to their bases. RM to circulate draft dates for the remainder of the year.	**RM**
	Date of Next Meeting The next meeting is due to take place on 25th March 2014, 12 noon to 2pm, in Conference Room 3B, Merton House. Apologies for the next meeting were received from JF and HR.	

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	February 2014	March 2014
Dr Steve Fraser, GP, Governing Board Member, South Sefton Clinical Commissioning Group (Chair)	✓	✓	✓	✓	NA	NA	✓	✓	✓	✓	NA	
Dr Anna Ferguson, Medicines Management Lead GP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓	
Steve Astles, Head of CCG Development, South Sefton Clinical Commissioning Group	Apols	Apols	Apols	Apols	NA	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	NA	
James Hester, Programme Manager for Quality, South Sefton Clinical Commissioning Group	NA	NA	NA	NA	NA	NA	NA	NA	✓	✓	Apols	

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	✓	✓	✓	✓	Apols	
Helen Stubbs Pharmacist, Cheshire and Mersey CSU Link	Apols			✓	NA	NA	✓	✓	Apols	Apols	✓	
Dr Jill Thomas, GP Representative, South Sefton Clinical Commissioning Group	✓	✓	✓	✓	NA	NA	✓	✓	✓	✓	✓	

South Sefton Clinical Commissioning Group

South Sefton Medicines Optimisation Operational Group (SSMOOG) Minutes

Time and Date 25 March 2014, 12 noon – 2 pm
Venue: Conference Room 3B, 3rd Floor, Merton House

Members:	**Brendan Prescott (BP) (Chair)**	**Lead for Medicines Management**
	Dr A Ferguson (AF)	**Medicines Management Lead GP**
	James Hester (JH)	**Programme Manager for Quality**
	Sejal Patel (SP)	**Senior Practice Pharmacist**
	Graham Reader (GR)	**Pharmacist, C&MCSU (in place of Helen Stubbs)**
	Dr J Thomas (JT)	**GP Representative**
Minute Taker	**Ruth Menzies (RM)**	**Medicines Management Administrator**
In Attendance	**James Ellis (JE)**	**Practice Pharmacist**

No	Item	Action
14/015	**Apologies** Apologies were received from Janet Fay, Helen Roberts and James Bradley	
14/016	**Minutes of the meeting dated 25th February 2014** The minutes were approved as an accurate record.	
14/017	**Matters arising from minutes dated 25th February 2014** 14/011 AF confirmed that sodium chloride will be in stock and it depends what is written on the prescription whether water or sodium chloride used for injections. BP confirmed the Palliative Care Drugs enhanced service whereby the pharmacies running the service will receive a retention fee. The two pharmacies in South Sefton who will offer the service are Bridge Road and Asda, Aintree. Discussions are taking place with Liverpool CCG to ensure we offer the same stock and the service will work across both boundaries. 14/12 Omacor – Black statement states not to prescribe for prevention of cardiovascular disease. Going to look for a statement/change the wording following updated NICE guidance on secondary prevention post MI	

No	Item	Action
14/018	**Matters arising from minutes from MMOG** Discussions took place regarding the dressings scheme and it is hoped a meeting will be set up with Webstar to transfer the administration to them and expand the service across both CCGs.	
14/019	**Locality updates/ Practice Updates/Feedback (BP)** BP confirmed discussions had taken place around the budget setting for 2014/15. Bootle Locality - are due to start a COPD project next week which will include looking at inhaler techniques. The Stoma Project has received very good feedback. BP confirmed we are hoping to receive some support regarding service evaluation from Edge Hill and then look at transferring services across both CCGs.	

No	Item	Action
14/020	**APC Minutes/report – March 2014 (BP/HS)** The above report was discussed and approved. Aflibercept - BP will meet with James Bradley outside the meeting to discuss further. UTI Section – It was noted the UTI section has been uploaded. BP confirmed we are currently looking into obtaining paper copies of the guidelines/bookmarks. There will also be a link from the CCG website to the APC website. Discussions took place regarding secondary care requesting GPs to prescribe pregabalin. GR confirmed the CSU are trying to pull together various guidelines. GPs should contact prescriber if first line medication is not used. Under the contract secondary care should follow guidelines approved by local CCG. SP to draft an SPU on new blood pressure targets in updated Pan Mersey Diabetes management guidelines	**BP/JB**
14/021	**Budget Update YTD and FOT – December 2013 (BP)** BP confirmed that more up-to-date information regarding practices budgets was now available with the situation worsening. It was confirmed the budget set was a valid budget. However, quite a few exercises were undertaken at the beginning of the year to ensure monies went to appropriate organisation. Services have moved across to other organisation but the effect is still being felt in primary care. There will be an in year adjustment that differs from previous years as this year is unprecedented. The situation has been challenging for all CCGs across Merseyside. However, we seem to be performing better than other CCGs.	

No	Item	Action
14/022	**Shared Care update (BP)** BP has yet to speak to Joe Chattin regarding degaralix. ADHD Shared Care to go to May's Finance and Resource Committee. A formal route needs to be put together in relation to using Azathiopride to treat areas other than rheumatology. BP to discuss the process with James Bradley. Discussions took place regarding the uptake of patients who will want to take statins following the pending guidance.	**BP** **BP** **BP**
14/023	**Risk Log (All)** BP to add the management of the prescribing budget and bring back to the next meeting.	
14/024	**Updated terms of reference (to include new member)** Following restructuring within the CCG BP's role will be changed from 1st April and he will become Deputy Chief Nurse and Head of Quality and Safety. Susanne Lynch as Deputy Head of Medicines Management will take on the role of Head of Medicines Management. The transition in roles will not fully take place for the first 6 month to allow SL to gain experience with budget setting/development of PQS etc. and just returning from her 4 months sick leave. BPs roles may change but will still be a member of SSMOOG.	
14/025	**Prescribing advice for patients travelling abroad - PAN Mersey** The above information has already been circulated to GPs.	

No	Item	Action
14/026	**Suggested MMOG/JMOG dates** Dates for future SSMOOG meetings was discussed and the following dates were arranged:- Tuesday 20th May 2014 Tuesday 17th June 2014 Tuesday 21st October 2014 Tuesday 16th December 2014 All meetings are scheduled to take place at 12 noon in Merton House. RM to circulate dates/venues.	**RM**
14/027	**Prescribing quality scheme and medicines optimisation plan** Discussions took place in relation to the above. It was agreed practices would have to complete 3 areas from the optimisation plan which is currently being finalised. Discussions took place in relation to the RCGP prescribing indicators and it was felt all should be undertaken. It was felt it was a lot of work but there would be small numbers. Agreed to test searches at the Strand and Thomas's practice. AF/JT agreed that the antimicrobial audit should only concentrate on care home patients. AF suggested scriptswitch. Discussions had taken place at locality that GPs had experienced problems with EMIS closing down. AF confirmed she had not had any problems. SL to report on scriptswitch savings for JMOG and add as a standard item to future operational meetings.	
	AOB There was nothing further to report.	
	Date of Next Meeting The next meeting will take place on Tuesday 20th May 2014 at 12 noon in the 5th Floor Conference Room 5A.	

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	February 2014	March 2014
Dr Steve Fraser, GP, Governing Board Member, South Sefton Clinical Commissioning Group (Chair)	✓	✓	✓	✓	NA	NA	✓	✓	✓	✓	NA	NA
Dr Anna Ferguson, Medicines Management Lead GP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓	✓
Steve Astles, Head of CCG Development, South Sefton Clinical Commissioning Group	Apols	Apols	Apols	Apols	NA	NA	NA	NA	NA	NA	NA	NA
Janet Fay, Senior Practice Pharmacist, South Sefton Clinical Commissioning Group	✓	✓	Apols	✓	NA	NA	✓	Apols	✓	✓	✓	Apols
Jennifer Johnston, Senior Practice Pharmacist, South Sefton Clinical Commissioning Group	Apols	✓	✓	NA	NA	NA	NA	NA	NA	NA	NA	NA
James Hester, Programme Manager for Quality, South Sefton Clinical Commissioning Group	NA	NA	NA	NA	NA	NA	NA	NA	✓	✓	Apols	✓

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	✓	✓	✓	✓	✓	✓
Graham Reader, Pharmacist, Cheshire and Mersey CSU (representing Helen Stubbs)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
Helen Roberts, Senior Practice Pharmacist, South Sefton Clinical Commissioning Group	NA	NA	NA	NA	NA	NA	✓	✓	✓	✓	Apols	Apols
Helen Stubbs Pharmacist, Cheshire and Mersey CSU Link	Apols			✓	NA	NA	✓	✓	Apols	Apols	✓	Apols
Dr Jill Thomas, GP Representative, South Sefton Clinical Commissioning Group	✓	✓	✓	✓	NA	NA	✓	✓	✓	✓	✓	✓

South Sefton Clinical Commissioning Group

Seaforth and Litherland Locality Meeting

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

Attendees

Practice	GP	Practice Nurse	Practice Manager
Litherland Town Hall (LTH)	Dr Alastair Patrick		Ian Hindley
15 Sefton Road	Dr Colette McElroy Dr Terry Thompson		Alison Harkin
Glovers Lane	Dr Peter Goldstein		Louise Taylor
Rawson Road	Dr F Cook		
Seaforth Practice			
Ford Medical	Dr Noreen Williams	Eils McCormick Louise Armstrong	Lin Bennett
Bridge Road Surgery	Dr Martin Vickers		Lynne Creevy
Netherton Practice			
Orrell Park	Dr Ramon Ogunlana		Jane McGimpsey
129 Sefton Road	Dr Gina Halstead		
Litherland Darzi			

Paula Bennett (PB) – Public Health Specialist – Sefton Council Public Health
Angela Parkinson (AP) - South Sefton CCG Locality Manager
Helen Roberts (HR) – Medicines Management Pharmacist – South Sefton CCG
Brendan Prescott (BP) – Deputy Chief Nurse/Head of Medicines Management - South Sefton CCG

Minutes

Jennifer Ginley (JG) – Administrator – South Sefton CCG

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	P	P									
Dr C McElroy	GP – 15 Sefton Road Surgery	P	P	P									
Alison Harkin	PM – 15 Sefton Road Surgery	P	P	P									
Paula Lazenby	PN – 15 Sefton Road Surgery												
Dr A Slade	GP – Glovers Lane Surgery												
Louise Taylor	PM – Glovers Lane Surgery	P	P	P									
Dr P Goldstein	GP – Glovers Lane Surgery	P	P	P									
Dr M Cornwell	GP – Glovers Lane Surgery												
Dr M Vickers	GP – Bridge Road Surgery	P	P	P									
Lynne Creevy	PM – Bridge Road Surgery	P	P	P									
Dr E Carter	GP – Bridge Road Surgery												
Dr N Choudhary	GP – Netherton Practice	P	P										
Lisa Roberts	PM – Netherton Practice												
Lorraine Bohannon	PM – Netherton Practice		P	A									
Dr N Williams	GP – Ford Medical Practice	P	P	P									
Lin Bennett	PM – Ford Medical Practice	A	P	P									
Eils McCormick	PN – Ford Medical Practice	P	P	P									
Dr T Danby	GP – Ford Medical Practice												
Louise Armstrong	PN – Ford Medical Practice		P	P									
Dr B Fraser	GP – Ford Medical Practice												
Dr G Halstead	GP – 129 Sefton Road			P									

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	P	P									
Dr Ina Krasauskiene	GP – Orrell Park Medical Centre												
Dr R Ogunlana	GP – Orrell Park Medical Centre	P	P	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	A										
Dr N Taylor	GP – Litherland Town Hall												
Dr S Steevart	GP – Litherland Town Hall												
Dr A Patrick	GP – Litherland Town Hall	P	P	P									
Dr F Cook	GP – Rawson Road / Orrell Park Medical Centres		P	P									
Angela Dunne	PM – Rawson Road / Orrell Park Medical Centres	P	P	A									
Ruth Powell	PN – Rawson Road	P											
Ian Hindley	PM – Seaforth Practice/ Litherland Town Hall	P		P									
Dr S Fraser	GP – Seaforth Practice												

No	Item	Action
14/17	**Apologies** Apologies were noted – Angela Dunne and Lorraine Bohannon	
14/18	**Declarations of Interest** NW – Sefton LMC LB – Governing Body Member	
14/19	**Minutes of Last Meeting / Matters Arising** **Refer to 14/12 - 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. **Refer to 14/12 The community IV** spec was received but was not very useful in terms of providing clarity. Practices should continue to report any problems with the service. **Refer to 14/12 Winter pressures** – additional allocations for March has been discussed at the practice managers meeting in terms of communication difficulties with NHS England. **Action** – LB to send AP the minutes of the Practice Managers Meeting and AP will contact Alan Cummings. **Refer to 14/12 - ED Service** – They had been invited to attend this locality meeting to describe the service they offer, AP had not had a response yet. Action – AP will contact them again, and ask if they could come to the next meeting. **Refer to 14/12 - Public Health –** (STARS referral form) – the form went to the LMC and was deemed to be fine. A virtual CRG was discussed, there are currently 2 GPs from Southport and Formby CCG, but no GP identified from South Sefton. Joe Chattin has been contacted to discuss the possibility of an LMC Committee Member being part of the group to review forms, a member from South Sefton would be helpful. It was suggested that there would also need to be another South Sefton GP identified to ensure South Sefton views are represented in case one GP is on leave. **Action** – Feedback from LMC following meeting - AP will discuss with Alison Johnston that there may be two SS representatives required.	All LB & AP AP AP

No	Item	Action
	QOF – refer to February meeting – it was clarified what was to be submitted; internal and external reviews plus evidence. Everyone was provided with the completed external QOF review.	
14/20	**Medicines Management – Helen Roberts – Brendan Prescott** The group will be keep updated with the alerts and all relevant info. HR provided this link to the group for information - http://www.panmerseyapc.nhs.uk/guidelines/documents/G3.pdf The Prescribing Finance Report as at month 8, 2013/2014 was provided. BP also discussed the figures with the group but he had the information at month 9 so went through those figures. The CCG had an overspend; Seaforth and Litherland overspend is 1.7% £121,000. The reasons for the overprescribing/figures were discussed. There have been two national forecast formula changes, this is unprecedented and also there have been population shifts. The further work on shared care prescribing will be analysed at the end of the financial year. There are plenty of factors that come into these figures, so it is important not to be discouraged by the excellent work that has been going on. Concerns were raised about community prescribing and its effects. The factor of generic prescribing codes played a bit part in it and a new way of working, i.e. specific community prescribing codes used. **Action** – BP will work with the finance team to clarify the separation of funding and figures for community care against GPs prescribing.	BP
14/21	**Quality Premium Dashboard** The Finance and Resource Committee, February 2014 report was provided. Included in this was the Quality Premium Dashboard. It was noted that the ambulance figures were raised at a meeting by the Blackpool CCG (Lead Commissioners Report).	
14/22	**Paula Bennett – Sefton Lifestyle Survey** PB was present and she spoke to the group about the results of the Sefton Lifestyle Survey. A generally known conclusion could be drawn from the surveys, with an increase in deprivation, an increase of health issues occurred. It was highlighted that Sefton was actually quite low in Merseyside on the list of smokers in the area. It was clarified by PB that people who used e-cigs were classed as ex-smokers. PB advised the group that if desired the Merseyside Health Life Style results could be drilled down further to give a more local picture.	

No	Item	Action
14/23	**Locality Budget £50K** AP gave out a copy of the plan for the locality budget detailing each of the practices requests thus far. AP went around each practice and made any requested amendments to ordered equipment. **Action** – AP to contact the practices not in attendance to make sure their requirements are also correct. AP is to ensure child and adult pads are supplied with the defibrillators as it is a legal requirement. The group decided they definitely do want to buy, not rent the cholesterol monitors. There was a detailed discussion about the cholesterol monitors and the test strips, how long the strips last and the possibility of having an account with the supplier, ordering as and when needed. The cost would be £4. 83 per test, however there is a current cost via the phlebotomy LES of £2.50 and associated lab costs which have not been identified, and these costs would no longer apply. Aintree have capacity within their present contract to undertake spirometry for housebound COPD patients in Seaforth and Litherland. How practices refer will be determined. For the defibrillator training for the admin staff, a date needs to be agreed across the practices. **Action** – AP will contact Frank and find out the best option for delivering training. There were more ideas discussed in the group; CAB representative coming into practices or delivering sessions elsewhere to provide a service to their patients, it was recognised that some practices would not be able to accommodate in-house CAB sessions, and that there are already different funding streams to deliver. A locality weighing machine for patients in wheelchairs was discussed, however there would be logistical issues identifying staff to operate, where the equipment would be housed etc. There is now a time pressure to implement before the end of March. **Action** – AP to submit the requests by Friday 7th March 2014.	AP AP AP AP
14/24	**Primary Care Quality Strategy** AP spoke about the primary care quality strategy and the various groups it had gone to for discussion including the LMC. A copy of the strategy was also provided. The direction of travel was approved by the Governing Body in September 2013 (not every line in the document which will still evolve). A Sefton wide Board to oversee	

No	Item	Action
	the implementation of the strategies was formed in November. An element of the work was to look at current LES schemes under the health outcomes domain. The group discussed concerns regarding recent communication about new proposals for a local contract. The wording of the communication was poor, and feedback was not possible as financial information was not available. There were fears that practices would not be able to support the proposals without further investment to achieve. This would have implications for the continuation to deliver phlebotomy and shared care. The specifications circulated were for comment on the clinical aspects, although this had not been made apparent on the communication. Finances were not included due to conflict of interest. An approvals panel will be the mechanism for agreeing the funding.	
14/25	**Locality Support** The group were asked about support requirements for the locality to operate. The group voiced their appreciation for the support currently received .The possibility of a senior manager and a lay member (Healthwatch) being attached to each locality was discussed. **Action** – AP to clarify.	AP
1426	**Dr Akpan Community Geriatrician** Dr Akpan was at the meeting to introduce himself to the group and make them aware of his new role and what he can offer to the GPs. His role came about due to a desire to have treatment or advice at the front end and to be generally more proactive with geriatrician work. Dr Akpan has vast geriatrician experience and in this new role he will only carry out one acute session per week, therefore the majority of his time will be spent out assisting primary care providers. He is very open and flexible to help requirements and looks forward to working with everyone. He explained that he will always be available on mobile and email when advice or help is required. The group highlighted to Dr Akpan that there were issues mainly with nursing homes and advanced care planning. **Action** – AP to circulate his contact details to all.	AP

No	Item	Action
14/27	**Practice List** CM, TT and AH spoke to the group about their practice list. 15 Sefton Road is going to apply to NHS England to close their practice list temporarily. They are currently getting lots of requests from new patients to register. The proposition has been received and noted and there were no objections.	
14/28	**Any Other Business** NW and LB spoke to the group about the area chosen for the remote care monitoring DES and highlighted their concerns. They felt it was unfeasible and had chosen hypothyroidism as their area to work on. AP informed the group that the CCG document had been approved by NHS England, and that they should consult NHS England regarding any changes. This DES is finishing on the 31st March 2014.	
	Date and Time of Next Meeting April 2nd 2014 – 1 - 3pm – Crosby Lakeside Adventure Centre	

South Sefton Clinical Commissioning Group

Seaforth and Litherland Locality Meeting

2nd April 2014
1 – 3pm
Crosby Lakeside Adventure Centre

Attendees

Practice	GP	Practice Nurse	Practice Manager
Litherland Town Hall (LTH)			Ian Hindley
15 Sefton Road	Dr Colette McElroy		Alison Harkin
Glovers Lane	Dr Peter Goldstein		
Rawson Road	Dr Fred Cook		Angela Dunne
Seaforth Practice			Ian Hindley
Ford Medical	Dr Noreen Williams	Eils McCormick Louise Armstrong	
Bridge Road Surgery	Dr Martin Vickers		
Netherton Practice	Dr Naresh Choudhary		Lorraine Bohannon
Orrell Park			Jane McGimpsey
129 Sefton Road			
Litherland Darzi	Dr Adnan Hameed		

Angela Parkinson (AP)	Locality Manager, South Sefton CCG
Tracy Jeffes (JP)	Head of Delivery & Integration, South Sefton CCG
James Bradley (JBR)	Finance Team, South Sefton CCG
Joanne Ball (JB)	Senior Public Health Practitioner, Sefton Council
Dominika Jeziorek	Practice Pharmacist, South Sefton CCG
Helen Roberts	Pharmacist, South Sefton CCG

Minutes

Angela Curran (AC)	Locality Development Support, South Sefton CCG

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	P	P									
Dr C McElroy	GP – 15 Sefton Road Surgery	P	P	P	P								
Alison Harkin	PM – 15 Sefton Road Surgery	P	P	P	P								
Paula Lazenby	PN – 15 Sefton Road Surgery												
Dr A Slade	GP – Glovers Lane Surgery												
Louise Taylor	PM – Glovers Lane Surgery	P	P	P	A								
Dr P Goldstein	GP – Glovers Lane Surgery	P	P	P	P								
Dr M Cornwell	GP – Glovers Lane Surgery												
Dr M Vickers	GP – Bridge Road Surgery	P	P	P	P								
Lynne Creevy	PM – Bridge Road Surgery	P	P	P	A								
Dr E Carter	GP – Bridge Road Surgery												
Dr N Choudhary	GP – Netherton Practice	P	P		P								
Lisa Roberts	PM – Netherton Practice												
Lorraine Bohannon	PM – Netherton Practice		P	A	P								
Dr N Williams	GP – Ford Medical Practice	P	P	P	P								
Lin Bennett	PM – Ford Medical Practice	A	P	P	A								
Eils McCormick	PN – Ford Medical Practice	P	P	P	P								
Dr T Danby	GP – Ford Medical Practice												
Louise Armstrong	PN – Ford Medical Practice		P	P	P								
Dr B Fraser	GP – Ford Medical Practice												
Dr G Halstead	GP – Ford Medical Practice			P									

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	P	P	P								
Dr Ina Krasauskiene	GP – Orrell Park Medical Centre												
Dr R Ogunlana	GP – Orrell Park Medical Centre	P	P	P	A								
Dr A Hameed	GP – Litherland Darzi	P			P								
Dr B Schoenberger	GP – Litherland Darzi	P											
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	P	P	P	A								
Dr F Cook	GP – Rawson Road / Orrell Park Medical Centres		P	P	P								
Angela Dunne	PM – Rawson Road / Orrell Park Medical Centres	P	P	A	P								
Ruth Powell	PN – Rawson Road												
Ian Hindley	PM – Seaforth Practice/ Litherland Town Hall	P		P	P								
Dr S Fraser	GP – Seaforth Practice												

No	Item	Action
14/29	**Introduction and Apologies** Apologies were noted from Dr Patrick, Lin Bennett, Lynne Creevy, Dr Ogunlana and Louise Taylor. Tracy Jeffes, South Sefton CCG, introduced herself to the group and explained that following the Wider Group meeting in February, she had been linked from the Senior Management Team to the Seaforth & Litherland Locality to act as a conduit between the locality and the CCG.	
14/30	**Declarations of Interest** Dr Noreen Williams declared that she is a member of the LMC.	
14/31	**Minutes of the Last Meeting / Matters Arising** It was reported that issues around prescribing within the community IV service have not been resolved. AP reported that time has now run out for winter pressures additional allocations. AP reported that she had had no response from the ED service to attend a locality meeting. AP will chase this for the next meeting. NW reported that the virtual CRG had not been on the agenda at the last LMC meeting. AP to contact LMC office. The minutes were agreed as a true record of the meeting.	MV AP AP
14/33	**Finance – GP Locality/Wider Group Payments** JBR provided an overview to the group and identified the payments that will be made to practices for attendance at meetings. Each practice was sent a statement and JBR asked if they could verify and send back to Ken Jones. Practices were then informed that they must raise an invoice to the Accounts Payable Department in Wakefield, this is to ensure financial controls are maintained. The CCG will approve all invoices to ensure they are consistent with attendance records. GPs have an option as to how payments will be received, either through their practice or as direct payments to themselves. An email had been sent to GPs asking them to sign a contract in relation to payment, JBR agreed to check on this and report back to the locality.	
14/34	**Locality £50K – Public Health Joint Working – Joanne Ball** JB was invited to the locality meeting to propose a pilot project for NHS health checks. Public health currently commission cholesterol HbA1C testing, risk to patients and life style referral. Public health use point of care for NHS checks and JB asked the locality if they	

No	Item	Action
	would like to look at a whole system for point of care which public health would be happy to pilot. Practices had agreed to purchase cardiocheck PA devices and consumables with the remainder of the 2103/14 locality development monies (£21K) for 8 practices who were interested, however there became an option to do a pilot with public health who already have a contract with a company to provide this and other equipment (HBA1C disposable units). Public Health had agreed to part fund the project. A pilot would include regular quality assurance checks and training. Public Health can manage the £21k and ordering on behalf of the locality. The aim of the project would be: to increase the number of NHS Healthchecks performed. One appointment for the patient and practice nurse There would also be an option to pilot HbA1C testing through the pilot. The HbA1C testing is 99% accurate. Most practices are doing well screening 50% of the population with high-risk CVD. There could be a possibility to use for home visits. Practices were asked to consider how to progress with the NHS Healthchecks, it was acknowledged that not every practice may want to participate, emails to AP. This will be discussed again at the May meeting.	All
14/35	**Medicines Management – Helen Roberts** HR introduced Dominika Jeziorek, who is the newly appointment Practice Pharmacist for SSCCG. HR reported that the work being carried out by Brendan Prescott with the finance team to clarify the separation of funding for community care against GP prescribing budgets was going. Data is being produced as to how budgets can be amended appropriately and once verified this will be shared with localities.	
14/36	**Quality Premium** JBR discussed the quality premium with the group. The monies available for next year will be £5 per head of population. According to NHS England, South Sefton is currently on target for their budget. There has been a 5% reduction in respiratory admissions to A&E this is currently within the threshold on amber, but could go red. The potential of lives lost is also currently amber but difficult to rate. The quality premium is very positive and the CCG has not made a decision on what happens with the money; JBR suggested that localities should put their ideas forward.	
14/37	**Locality Change**	

No	Item	Action
	It was reported that Dr Goldberg's practice in Sefton Road has become the branch surgery to Concept House and will no longer be part of SL locality as Concept House falls within Bootle locality. AP agreed to contact the Finance Team, CSU, Medicines Management, Communications etc to inform, as this will affect budgets devised for SL locality. Amendments to the constitution will also need to be made.	
14/38	**Any other business** Dr McElroy reported that NHS England have agreed to the temporary closure of Sefton Road practice. This will re-open soon. It was reported that there are doctors available at both Litherland Town Hall Practice and Seaforth Practice. The locality asked for official clarity that there is a locality budget of £50K available from 1st April 2014. AP reported that there is a non-recurrent £50K locality budget available from 1st April 2014 and can now think about how the locality would like to allocate the funding. There was discussion around the housebound project and it was agreed to look at figures for this project. All practices were asked to submit numbers of housebound patients to AP prior to the next meeting A template for collecting data has been devised by Ford Medical. NW agreed to speak to LB regarding sharing with the locality. Public health can provide a registrar to assist in the production of a business case for the project. There was discussion around the virtual ward and the locality felt that there were still issues. It was agreed to invite Dr Debbie Harvey to the next locality meeting.	All NW/LB AP
	Date and Time of Next Meeting 7th May 2014 1 – 3pm Crosby Lakeside Adventure Centre	

South Sefton Clinical Commissioning Group

Bootle Locality Meeting

Wednesday 26th February 2014
1.00pm – 2.30pm
Park Street Surgery

Chair
Dr S Stephenson (SS) – Bootle Village Surgery

Attendees
Dr K Chung (KC) – Park Street Surgery
Pauline Sweeney (PS) – Park Street Surgery
Dr H Mercer (HM) – Moore Street Surgery
Dr A Ferguson (AF) – Strand Medical Centre
Gerry Devine (GD) – Strand Medical Centre
Dr S Sapre – Aintree Road Surgery
Paul Halsall (PH) – Medicines Management
Jenny Kristiansen (JK) – South Sefton Clinical Commissioning Group
Malcolm Cunningham (MC) - South Sefton Clinical Commissioning Group

Apologies

Guest Speakers
Lyndsey Davies (LC) – Clinical Manager (Delphi - Lifeline)
Jo Spencer (JS) – Safeguarding & Governance Manager (Lifeline)

Minutes
Jen Ginley (JG) – 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	P										
Sarah Gibson	PM – Aintree Road Surgery												
Sue Edmondson	PM – Bootle Village Surgery												
Dr S Stephenson	GP – Bootle Village Surgery	P	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	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	A										
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	P										
Pauline Sweeney	PM – Park St Surgery	P	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	P										
Ronnie Holmes	PM – Strand Medical Centre												
Gerry Devine	PM – Strand Medical Centre		P										
Dr M Gozzelino	GP – Strand Medical Centre												
Dr S Morris	GP - Strand Medical Centre												
M Hinchliff	PM – Strand Medical Centre	P											

No	Item	Action
14/09	**Apologies** Apologies were noted.	
14/10	**Minutes of last meeting** Minutes for the last meeting were accepted as an accurate record.	
14/11	**Matters Arising** • 14/03 – On-going discussion regarding dressings - PH informed that paediatrics still requires GPs prescribing for dressings. • 14/03 – Merseycare's request for annual health check information (CQUIN) - the group aired there concerns regarding providing the information requested without consent of the patient. It was suggested that it may be useful to look at the wording of the CQUIN and assessment to establish whether engagement levels and incentives are involved. It was agreed that MC would locate the CQUIN for JK to circulate to the group for feedback.	JK & MC
14/12	**Finance & Quality Premium Report** • MC was present to discuss the Finance & Quality Premium Report. Provided was the Bootle Locality Report Summary Dashboard for February 2014 and Financial Position Summaries for each practice as at month 8 (November). • MC took questions regarding the locality budget. His understanding is that the locality budget of £50k would recur and would be available from April. He explained that the Winter Pressures is a different issue. The group raised concerns about the prescriptive nature of the winter pressures scheme. The group were advised to get in their winter pressure plans ready ASAP. JK was asked to set this as an Agenda item at the July Locality Meeting.	All practice to prepare winter plans. ASAP JK to add the July Agenda
14/13	**Drugs & Alcohol Team** Lyndsey Davies (Clinical Manager - Delphi Lifeline) and Jo Spencer (Safeguarding & Governance Manager - Lifeline) were at the meeting to discuss this new unified, lead drugs and alcohol service and make the GPs aware of the referral procedure. Lifeline is the new unified drugs and alcohol team, when Delphi is referred to, that is the clinical part of the organisation.. Delphi is financially sub contracted but it is a unified service all under Lifeline. This team absorbed all the other pre-existing drugs and alcohol teams: CRI, Addaction, TTP and Saturns. The service has two offices; one is Southport and one in Bootle. They are hoping to build and acquire more bases and	

No	Item	Action
	mobility. The service links in to the criminal justice services. At the first Lifeline appointment the patient will receive a medical assessment. There is a team of 18 clinicians. GPs will receive the information from this assessment. The will retain great links and carry out an annual review of existing patients. They also provide supplementary peer support. Within the recovery groups due to them being in their buildings, the patients feel comfortable to attend. Lifeline has excellent referral to appointment times. The group raised an issue about the lack of communication with Lifeline and preceding services and also the lack of and in some cases, no existence of paperwork coming back to practices following imprisonment or assessment of their patients. The problem with amber drug prescribing was also raised as a concern. It was agreed that LD and JS would feed back the issues raised to their team and respond via JK. JS offered to provide practices with the link to update notices on prescribed drugs that are abused. It was agreed that JS would provide the link to JK so she can share with practices. JS also offered an invitation to practices for Lifeline to deliver recovery groups; 9am – 9pm Monday to Friday and Saturday 9am – 1pm.	LD JS to send response to JK JK to send the link to practices
14/14	**Medicines Management Update** PH gave the medicines management update. He provided the prescribing finance report as at month 9 (2013/2014), and the Bootle Locality Qtr on Qtr Comparison of Quick Wins Potential Savings (3rd Qtr 2013/2014). PH discussed potential quick win figures and it was discussed whether a locality pharmacy team could be developed so that pharmacists moved around to increase efficiency. Some surgeries felt they need more help or quicker turn around in this area. The feasibility and effect of the quick wins work was discussed. It was highlighted that the figures and potential savings in comparison to financial short falls was not that big therefore surgeries should not place too much worry on not achieving the full potential. PH handed out 2 prescribing policy statements from Pan Mersey APC. One was regarding prescribing for patients living or traveling abroad, otherwise absent from the UK and the other was regarding the use of antiplatelet agents for the prevention of OVE. It was advised that with patients abroad and travelling the surgeries should produce a letter explaining the policy. Also, there is a medicines safety group looking at how alerts are handled, and how to get community pharmacies involved in this process.	
14/15	**Primary Care Access Schemes** GD gave a talk and initiated the discussion on increasing primary care access. Trying to address the question is there anything we (in primary care) can do to address the patient demand and provision of appointments. Different solutions were discussed; variations in opening times and type of surgeries e.g. triage types. The types of ailments that are presented at surgery could never be controlled – a	

No	Item	Action
	triage like set up in a surgery could filter the patients. GD identified the company called Project Gateway and met with a representative. It was considered that if it was taken on board GD's surgery, The Strand Medical Centre could take it on as a pilot and then it could be rolled out if successful. After meeting with the representative GD felt that a financial dependency could be created if their services are used but it was also suggested that maybe GP Surgeries could have a one of workshop on their solutions and try and implement them themselves. In the North they have had workshops (primary care fund). The group discussed more ideas including, phone triage etc. It was suggested that a locality wide solution or funding plan could be considered for primary care access and routes for this should be explored. It was agreed that JK would set up a meeting with GD and MC to discuss in more detail.	JK to arrange a meeting for MC & GD. ASAP
14/16	**Any other business** The testing for borderline and pre diabetes risks was discussed. It was raised that this can sometimes seem a huge workload for practices, considering follow up and the effectiveness regarding actual prevention. It was considered whether the existing diabetes clinics could take on this work (Litherland Town Hall), it could become a preventative service as well as treatment/management. The group asked whether Diabetes locality lead could explore this as a possibility. JK agreed to contact the diabetes lead to discuss and feedback to the group.	JK to contact Moira McGuiness and feedback response at the next meeting.
14/17	**Date and time of next meeting** Tuesday 18th March 1pm – 2.30pm Park Street Surgery	

Chair Signature ……. Date …….

South Sefton Clinical Commissioning Group

Bootle Locality Meeting

Tuesday 18th March 2014
1.00pm – 2.30pm
Park Street Surgery

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
Dr A Ferguson (AF) – Strand Medical Centre
Dr S Sapre – Aintree Road Surgery
Jenny Kristiansen (JK) – South Sefton Clinical Commissioning Group
Paul Halsall (PH) – Medicines Management
Pauline Sweeney (PS) – Park Street Surgery
Dr S Stephenson (SS) – Bootle Village Surgery
James Ellis (JE) – South Sefton Clinical Commissioning Group
Jenny White (JW) – South Sefton Clinical Commissioning Group
Gerry Devine (GD) – Strand Medical Centre
Dr G Halstead (GH) – Concept House

Apologies
Dr D Goldberg (DG) - Concept House

Guest Speakers

Minutes
Gary Killen (GK) – 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	P	P									
Sarah Gibson	PM – Aintree Road Surgery												
Sue Edmondson	PM – Bootle Village Surgery												
Dr S Stephenson	GP – Bootle Village Surgery	P	P	P									
Dr C McGuinness	GP – Bootle Village Surgery												
Gill Riley	PM – Concept House Surgery												
Dr D Goldberg	GP – Concept House Surgery	A		A									
Dr G Halstead	GP – Concept House Surgery			P									
Dr H Mercer	GP – Moore St Surgery	P	P	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	A	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	P	P									
Pauline Sweeney	PM – Park St Surgery	P	P	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	P	P									
Ronnie Holmes	PM – Strand Medical Centre												
Gerry Devine	PM – Strand Medical Centre		P	P									
Dr M Gozzelino	GP – Strand Medical Centre												
Dr S Morris	GP - Strand Medical Centre												
M Hinchliff	PM – Strand Medical Centre	P											

No	Item	Action
14/18	**Apologies** All apologies were noted	
14/19	**Minutes of last meeting- 26th February 2014** Minutes of the last meeting were agreed as an accurate record	
14/20	**Matters Arising** **14/15 –Project Gateway** • GD gave an update regarding discussions with a third party organisation offering support to practices to improve patient access. It was agreed that AF and GD could spend a couple of sessions at their practice to look at the model they are using. Initial feedback received has been about the model has been positive. **14/03 Merseycare Health check information.** Discussions still ongoing re patient records.	AF to contact Paul Morris. JK to feed back
14/21	**Medicines Management** Paul Halsall addressed the meeting with two points • Acamprosate prescribing requests -.GPs should be advised to not prescribe acamprosate for maintaining abstinence in people with alcohol dependence if requested to do so. John Richmond, the medical director at Delphi is aware of this. The PAN Mersey Formulary currently states that patients taking acamprosate should stay under supervision, at least for six months and at reduced but regular intervals if continued after six months. There is to be a meeting with the alcohol withdrawal services. GPs are requested to highlight any requests for them to prescribe acamprosate to their practice pharmacists so that the origin of the request can be discussed. • **Prescribing Budgets** - There has been no further update for the prescribing budget data for the Bootle locality from the previous meeting. GPs are asked to continue to discuss/action work which practice pharmacists will be looking at within their practices, including unlicensed (specials) medicines prescribing, urology product prescribing, grey list drug prescribing and the quick win-cost saving work.	
14/22	**Finance & Quality Premium** • JW gave an overview of the Quality Premium Dashboard and the Finance Report submitted to the March 2014 Finance and Resource Committee	
14/23	**Finance & Quality Committee Meetings Feedback** No update available	

No	Item	Action
14/24	**Update on Stoma Review Project** • JK gave each practice the feedback results for the stoma project to date. Currently there are 6 housebound and a small number of DNAs to be contacted before the end of the month. A business case will be submitted to the Finance & Resource Committee to roll out the project across all localities.	
14/25	**QOF QP External Peer Review – Ophthalmology** This will be documented on a separate report. JK will now collate these and compile the report to send to NHS England.	
14/26	**Any other business** • Dr Akpan Consultant Community Geriatrician. JK wants any feedback to what the practices need form Dr Akpan. JK will disseminate his details to the locality. • It was decided that future meetings could be held on Tuesdays, this was agreed. • HM asked the meeting if anyone had feedback on the Go to Doc service. Any problems to speak to Dr A Mimnagh or Steve Astles.	JK to invite to next meeting JK to liaise with HM
14/27	**Date and time of next meeting** Tuesday 15th April 1pm – 2.30pm Park Street Surgery	

Chair Signature ……. Date …….

South Sefton Clinical Commissioning Group

Crosby Locality Meeting

Wednesday 5th March 2014
12:45 – 2.30pm
Crosby Lakeside Adventure Centre (CLAC)

Chair : Dr G Berni

Attendees
Dr S Roy (SR)
Dr A Mimnagh (AM)
Sharon McGibbon
Maureen Guy (MG)
Dr C Gillespie (CG)
Sue Hancock (SH)
Colin Smith (CS)
Dr C McDonagh (CMc)
Shelley Keating (SK)
Janet Faye (JF)
Alison Johnston (AJ)
Dr G Misra
Dr D Navaratnam
Dr P Sharma
Jenny Kimm (JK)
Pauline Woolfall (PW)
Dr Ghalib
Alan Finn (AF)

Apologies
Pippa Rose (PR)
Tina Ewart (TE)
Stella Moy (SM)

Guest Speakers
Dr Asam Akpan

Minutes

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	A									
Dr M Taylor	GP – Crosby Village Surgery	P											
Lorraine Bohannon	PM – Crosby Village Surgery												
Dr S Roy	GP – Crosby Village Surgery	P	P	P									
Dr A Doerr	GP – Crosby Village Surgery												
Sharon McGibbon	PM – Eastview Surgery		P	P									
Dr A Mimnagh	GP – Eastview Surgery	P	P	P									
Dr M Hughes	GP – Eastview Surgery												
Donna Hampson	PM – Crossways Surgery												
Dr P Sharma	GP – Crossways Surgery	P		P									
Jenny Kimm	PM – Thornton Surgery			P									
Stella Moy	PN – Thornton Surgery			A									
Dr D Harvey	GP – Thornton Surgery												
Dr J Wallace	GP – Thornton Surgery												
Maureen Guy	PM – 133 Liverpool Road	P		P									
Dr G Misra	GP – 133 Liverpool Road	A	P	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	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	A	P									
Colin Smith	PM – Blundellsands Surgery	P	P	P									
Shelley Keating	PM – 30 Kingsway		A	P									
Dr C Shaw	GP – 30 Kingsway												
Dr C McDonagh	GP – 30 Kingsway	P	P	P									
Dr E Pierce	GP – Hightown Village Practice												
Pauline Woolfall	PM – Hightown Village Practice	P	A	P									
Dr C Allison	GP – Hightown Village Practice	P											
Dr Ghalib	GP – Hightown Village Practice			P									
Dr D Navaratnam	GP – Azalea Surgery	A	P	P									
Dr C Doran	GP – Azalea Surgery												
Dr G Berni	GP – 42 Kingsway	P	P	P									
Alan Finn	PM – 42 Kingsway		P	P									
Dr F Vitty	GP – 42 Kingsway												

No	Item	Action
14/19	**Apologies** Apologies from Stella Moy, Tina Ewart and Pippa Rose	
14/20	**Minutes of last meeting** The Group agreed that the minutes were an accurate record. Dr N Tong needs to be added as an attendee.	AJ
14/21	**Declarations of interest** No declarations of interest were noted.	
14/22	**Matters Arising** There were no matters arising.	
14/23	**Medicines Management** JF discussed the prescribing budget at month 9 and SSCCG is forecast to be overspent by £121,730 (0.46%) and the Crosby/Waterloo locality by £36,603 (0.51%). JF advised the locality that at the end of the financial year; - the cost of shared-care prescribing of dementia drugs would be taken into account - a re-adjustment of any NMP spend that was attributed to the practice, would be done - any population shifts would be taken in to account - a small contingency fund was available to help mitigate any prescribing overspend Category M medicines were discussed as there have been some significant price increases but overall the CCG is showing a cost reduction of 14.54% on previous year to date. The DOH formula for forecasting practice prescribing spend has changed several times in 2013-14 which has made a reliable report difficult this year. Overall our position in SSCCG remains relatively favourable compared to PAN Mersey prescribing activity. JF also advised on the PAN Mersey advice to only prescribe medication for a maximum of 3 months for patients travelling abroad and to not prescribe for patient living abroad. More information available on the PAN Mersey website, link on the intranet.	
14/24	**Locality Budget** AJ shared with the group the requests for equipment that have come in to date and had been approved; Pulse Oximeters Defibrillators 24hr BP Monitors Handheld ECG Monitors AJ asked the group to contact her via email by COP Friday 7th March with any additional requests as time was pressing, rules for procurement tight and that any quotes needed to be processed by week beginning Monday 10th March.	All

South Sefton Clinical Commissioning Group

No	Item	Action
14/25	**QOF QP Group Peer Review (2nd Round)** 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 once responses from both this meeting and the one in February have been collated. AJ asked each Practice to provide their report/narrative via email to Alan Finn so that it can be used when collating the final report. The final report will then be sent out to Practices for use as evidence to support QOF QP achievements.	Al AJ
14/26	**AOB** **Standing agenda items.** Locality finance report and quality premium dashboard) will resume next month but are available on our locality page for February/March. http://nww.southseftonccg.nhs.uk/ccg-and-locality/localities/crosby/default.aspx **Primary Care Quality Strategy**. Further to wider consultation, Governing Body approval and Board/ToR set-up, a letter has gone out to Practices from Fiona Clark with all the necessary supporting documentation. Any queries should be directed to Malcolm Cunningham. **Virtual Ward Feedback**. Debbie Harvey and Stephen Astles are keen to her feedback on experience of the Virtual Ward so far and ask the Group to invite them along to your Practice meeting when convenient. Practices to contact Angela Curran to arrange an invite.	All
14/27	**Date and time of next meeting** Wednesday 2nd April 2014 12:30 lunch 12.45 start – 2.30 Crosby Lakeside Adventure Centre (CLAC)	

South Sefton Clinical Commissioning Group

Crosby Locality Meeting

Wednesday 2nd April 2014
12:45 – 2.30pm
Crosby Lakeside Adventure Centre (CLAC)

Chair : Dr G Berni – 40 Kingsway

Attendees
Dr A Mimnagh – Eastview Surgery
Dr G Misra – 133 Liverpool Road
Maureen Guy – 133 Liverpool Road
Jennifer Kimm – Thornton Practice
Dr R Huggins – Thornton Practice
Dr N Tong – Blundellsands Surgery
Sue Hancock – Blundellsands Surgery
Alan Finn – 42 Kingsway
Shelley Keating – 30 Kingsway
Dr C McDonagh – 30 Kingsway
Dr P Sharma – Crossways Surgery
Pauline Woolfall – Hightown & Crosby Village
Dr S Roy – Crosby Village
Sharon McGibbon – Eastview Surgery
Dr R Ratnayoke – Eastview Surgery
Dr D Navaratnam – 20 Kingsway
Janet Faye – South Sefton Clinical Commissioning Group
Marian Coyne - South Sefton Clinical Commissioning Group
James Bradley - South Sefton Clinical Commissioning Group
Alison Johnston - South Sefton Clinical Commissioning Group
Tina Ewart - South Sefton Clinical Commissioning Group
Pippa Rose - South Sefton Clinical Commissioning Group

Apologies
Colin Smith – Blundellsands Surgery
Stella Moy – Thornton Surgery

Guest Speakers
Dr A Akpan – Aintree University Hospital

Minutes
Gary Killen 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 Aylward	GP – Crosby Village Surgery												
Pippa Rose	PN – Crosby Village Surgery	P	P	A	P								
Dr M Taylor	GP – Crosby Village Surgery	P											
Lorraine Bohannon	PM – Crosby Village Surgery												
Dr S Roy	GP – Crosby Village Surgery	P	P	P	P								
Dr A Doerr	GP – Crosby Village Surgery												
Sharon McGibbon	PM – Eastview Surgery		P	P	P								
Dr A Mimnagh	GP – Eastview Surgery	P	P	P	P								
Dr M Hughes	GP – Eastview Surgery												
Dr R Ratnayoke	GP – Eastview Surgery				P								
Donna Hampson	PM – Crossways Surgery												
Dr P Sharma	GP – Crossways Surgery	P		P	P								
Jenny Kimm	PM – Thornton Surgery			P	P								
Stella Moy	PN – Thornton Surgery			A	A								
Dr D Harvey	GP – Thornton Surgery												
Dr J Wallace	GP – Thornton Surgery												
Dr R Huggins	GP – Thornton Surgery				P								
Maureen Guy	PM – 133 Liverpool Road	P		P	P								
Dr G Misra	GP – 133 Liverpool Road	A	P	P	P								
Sandra Holder	PN – 133 Liverpool Road	P											
Carolyne Miller	PM – Blundellsands Surgery												
Dr N Tong	GP – Blundellsands Surgery		P		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
Dr C Gillespie	GP – Blundellsands Surgery	P	A	P									
Sue Hancock	PN – Blundellsands Surgery	P	A	P	P								
Colin Smith	PM – Blundellsands Surgery	P	P	P	A								
Shelley Keating	PM – 30 Kingsway		A	P	P								
Dr C Shaw	GP – 30 Kingsway												
Dr C McDonagh	GP – 30 Kingsway	P	P	P	P								
Dr E Pierce	GP – Hightown Village Practice												
Pauline Woolfall	PM – Hightown Village Practice	P	A	P	P								
Dr C Allison	GP – Hightown Village Practice	P											
Dr Ghalib	GP – Hightown Village Practice			P									
Dr D Navaratnam	GP – Azalea Surgery	A	P	P	P								
Dr C Doran	GP – Azalea Surgery												
Dr G Berni	GP – 42 Kingsway	P	P	P	P								
Alan Finn	PM – 42 Kingsway		P	P	P								
Dr F Vitty	GP – 42 Kingsway												

No	Item	Action
14/28	**Apologies** Apologies were noted	
14/29	**Minutes of last meeting – 5th March 2014** Alan Finn and Shelley Keating corrected that they had attended the meeting in March. GK to amend the attendance list. Following this one amendment, the minutes following the meeting held on 5th March 2014 were agreed as an accurate record.	GK
14/30	**Declarations of interest** No declarations of interest were noted.	
14/31	**Matters arising** There were no matters arising.	
14/32	**Medicines Management** Janet Faye gave an update for Medicines management which are detailed below, and will also be uploaded to the intranet page for reference; **APC decisions** • Ferrous fumarate statement removal from website- Ferrous fumerate • to remain 1st choice oral iron, but switching of patients from other preparations no longer advocated as financial savings minimal • Doxazosin modified release (m/r) Black statement (http://www.panmerseyapc.nhs.uk/recommendations/documents/PS42.pdf) - Doxazosin m/r tablets are now black. Doxazosin immediate release preparations are more cost effective. A message will be added to scriptswitch • Prescribing for patients living or travelling abroad or otherwise absent from the UK (http://www.panmerseyapc.nhs.uk/guidelines/documents/G4.pdf) - the APC recommends that prescribers should not supply treatment durations in excess of three months for patients who are going to live or travelling abroad or otherwise absent from the UK. Janet has written a patient letter for GPs to give to patients. The letter has been approved by the SSMOOG and is available to download via our locality intranet page. • Primary Care Antimicrobial Guidelines – the UTI section has been approved and incorporated into the full guidelines. An electronic copy of the guideline is available on the PAN Mersey website and can also be accessed from the CCG intranet via the following link http://nww.southseftonccg.nhs.uk/patient-are/Medicines/Local_Antimicrobial_Guidelines.aspx • Ibuprofen & Naproxen Green statement- Naproxen & low-dose ibuprofen are 1st choice NSAIDs (update of previous statement) http://www.panmerseyapc.nhs.uk/recommendations/documents/PS47.pdf • Pan Mersey Adult Diabetes Management Guidelines - There has been an update to the diabetes management guidelines including changes to BP targets. Several international guidelines (ratified by American Diabetes Association) have recommended abandoning a	

No	Item	Action
	separate (130/80) target for diabetic nephropathy in favour of a single 140/80 target. They maintain there is insufficient evidence for the lower target and indeed evidence against it. Janet will be writing an SPU highlighting the changes to BP targets but recommends prescribers read the full guidance for a complete overview of all the changes **Meds Budget update** Discussions are ongoing with finance regarding in year adjustments. **Medication Review for Care Home Patients** The CCG have funded some extra pharmacists to carry out medicine reviews of Care homes. Will need to request every 12 months to practice managers for access to the EMIS system preferably on smart cards. Janet asked if practices would be willing to do this.	See attached document with mins
14/33	**Finance** James Bradley explained payments for locality attendance. The rules and statements have already been distributed to each practice. He emphasised the need for you to ensure you have signed attendance sheets to qualify for payments. If you have any problems please contact Ken Jones (ken.jones@southseftonccg.nhs.uk) in finance. Please check the statements carefully and if these are correct, raise and send an invoice to SBS in Wakefield.	
14/34	**Locality investment 2014/15 & Commissioning Intentions** The 50K has been put in place for each locality. This is non recurrent. TE stated that the locality managers have been in discussions with Karl McCluskey – Chief Strategy and Outcomes Officer to discuss CCG & localities commissioning needs/plans in relation to how we can best provide care and services for the next 5 years and beyond. Tina advised the group that we have £50k investment money again this year and urged ideas to be put forward that can make a difference to how we deliver services for our population. E.gs: Invest in extra pharmacy time to perform meds reviews, A Clinician to specifically perform care home reviews. Improvement in IV therapies Are all your nurses able to prescribe? If, not let's get them trained to the appropriate level to prescribe? **What would you like to change to make a difference to the care delivered?** Look at your practice performance profiles in the key areas and LTCs on the portal. Is there something that if we made a change, could be greatly improved, if only 'x' was in place? What is costing you too much?	**All to contact TE & AJ with ideas**

No	Item	Action
	What are the unplanned admissions and re-admissions? Could they be prevented if something else was in place? From our previous audit work and knowledge of practice populations Clinicians are best placed to identify how we can invest to make the changes we need to get the best outcomes for our population but we need your help and ideas to make it happen.	
14/35	**Dr Asan Akpan – Community Geriatrician** Dr Akpan introduced himself as the community geriatrician. Asan wants to meet as many GP's and practice staff as possible to understand your frustrations and to support your aspirations. He is in a position to help make amendments to provider contracts to assist in supporting the localities patients. He also discussed the 12 bed acute frailty unit. This has a 48 hour turnaround. It links into the community teams via LCH and the rapid access clinics on ward 35. There are no results as present, but Dr. Akpan invited any comments, challenges with other local teams. He will ensure they will become part of this care model. Asan encouraged all to contact him, please feel free speak with him any time and expect to see him visiting practices with Virtual Ward staff. He is based at Litherland Town Hall but also does hospital sessions at UHA. Asan's contact details are: ASAN.AKPAN@aintree.nhs.uk Mobile : 07964 462754 Dr Navaratnam raised the point that residential care is more challenging due to the lack of equipment and lack of support for medical care coupled with poor communications. Dr Tong asked if Asan would be undertaking domiciliary visits, to which Dr Akan confirmed he would and reiterated his intention to help support necessary changes to support practices and patients.	
14/36	**Practice Health Care Assistant Apprenticeship** Pippa gave an update on this project: All students will be between18-24. The CCG fund 50% of their salary. The college will allocate1apprentice HCA per average size practice, or 1 between 2 small practices. We anticipate that the practices would employ the student once they have become qualified. Any expression of interests is required over the next week to either Pippa Rose or Tina Ewart.	All
	AOB **Guests to future locality meetings** TE & other the managers are concerned with the significant numbers of requests from providers / other organisations wishing to join locality meetings. Nigel suggested we circulate the list for the group to prioritise and decide attendees. **Subsequent to this meeting**, we have been approached by LCH requesting a link person be in attendance at locality meetings in order to be	

No	Item	Action
	a point of contact to field and resolve issues raised on Community Services. Medical Directors Ian Senior (as point of contact) and Steph Gallard (specifically called in for Ward 35 issues) attended Maghull locality meeting in April. Maghull found this exercise very useful. At CCG level, Locality managers have been asked to feedback whether their respective localities are happy for LCH to attend locality meetings. This is being seen as a positive way forward to resolve some of the issues which are shared and seemingly unresolved resulting in lack of confidence service and reluctance to use services.	TE to circ list **All to consider and respond at May mtg please**
	Date and time of next meeting Wednesday 7th May 2014 12:30 lunch 12.45 start – 2.30 Crosby Lakeside Adventure Centre (CLAC)	

South Sefton Clinical Commissioning Group

Maghull Locality Meeting Minutes

Friday 14th February 2014
1:00pm – 2:30pm
High Pastures Surgery

Chair
Dr J Thomas (JT) – Broadwood Surgery

Attendees
Dr S Gough (SG) – Westway Medical Centre
Gill Kennedy (GK) – High Pastures Surgery
Carloe Morgan (CM) – High Pastures Surgery
Dr Phil Weston (PW) – High Pastures Surgery
Dr Najib Ahmed (NA) – High Pastures Surgery
Dr Jon Clarkson – High Pastures Surgery
Dr S Sapre (SS) – Maghull Health Centre
Terry Hill (TH)– South Sefton Clinical Commissioning Group

Apologies
Maghull SSP Surgery

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	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
Dr S Sapre	GP – Maghull Family Health Centre	P	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	P										
Jennie Procter	PN – Westway Medical Centre	P											
Gill Kennedy	PM – High Pastures Surgery	P	P										
Dr P Thomas	GP – High Pastures Surgery		P										
Dr J Clarkson	GP – High Pastures Surgery		P										
Dr P Weston	GP – High Pastures Surgery		P										
Dr N Ahmed	GP – High Pastures Surgery		P										
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	P										
Dr B Thomas	GP – Broadwood Surgery												
Judith Abbott	PN – Broadwood Surgery												

South Sefton Clinical Commissioning Group

No	Item	Action
14/10	**Apologies** Maghull SSP Surgery	
14/11	**Declarations of interest** Dr Jill Thomas - SMOOG	
14/12	**Action Points** From 14/03 – **Ward 35** – all attendees were informed that they should take the information back to their practices from the response emailed to them (Dr Raj) regarding this and the hospices, then come back and feedback any issues with this. Anyone who has the original step up criteria for ward 35 was asked to circulate it. The date for the Ward 35 visit to the locality meeting is yet to be confirmed. From 14/04 – **Locality discussion** – TH updated the locality on the locality funding. TH needs to get the prices of the three valid options and then submit it. The possibility of getting defibrillators was discussed, not all practices expressed a desire so TH would email out to all practices and check requirements for the remaining funding. The possibility of getting forehead pulse oximeters was discussed and GK will email the information and prices regarding this equipment to TH.	ALL TH GK
14/13	**QOF- Peer review** All within a separate document. Action – all practices who have yet to do so need to email TH their internal QOF minutes.	ALL
14/14	**Any other business**	
14/15	**Date and Time of next meeting:** Thursday 20th March - Westway Friday 18th April – High Pastures 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 ……

South Sefton Clinical Commissioning Group

Maghull Locality Meeting Minutes

Thursday 20th March 2014
1:00pm – 2:30pm
Westway Surgery

Chair
Dr J Thomas (JT) – Broadwood Surgery

Attendees
Dr S Gough (SG) – Westway Medical Centre
Gill Kennedy (GK) – High Pastures Surgery
Dr Jon Clarkson (JC) – High Pastures Surgery
Dr S Sapre (SS) – Maghull Health Centre
Dr A Banerjee (AB) – Maghull SSP Surgery
Donna Hampson (DH) – Maghull SSP Surgery
Terry Hill (TH) – South Sefton Clinical Commissioning Group
Angela Curran (AC) – South Sefton Clinical Commissioning Group
Clive Shaw (CS) – South Sefton Clinical Commissioning Group
Jenny Johnston (JJ) – South Sefton Clinical Commissioning Group
James Bradley (JB) – South Sefton Clinical Commissioning Group
Ian Carolan (IC) – Public Health Practitioner (Sefton MBC)

Apologies

Guests
Dr Stephanie Gallard (StG) – LCH
Ian Senior (IS) – LCH
Jane Pye (JP) – LCH Ward 35
Angela Evans (AE) – LCH Ward 35

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	P	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	P	P									
Jennie Procter	PN – Westway Medical Centre	P											
Gill Kennedy	PM – High Pastures Surgery	P	P	P									
Dr P Thomas	GP – High Pastures Surgery		P										
Dr J Clarkson	GP – High Pastures Surgery		P	P									
Dr P Weston	GP – High Pastures Surgery		P										
Dr N Ahmed	GP – High Pastures Surgery		P										
Dr W Coulter	GP – Maghull SSP Practice												
Lesley Bailey	PN – Maghull SSP Practice												
Donna Hampson	PM – Maghull SSP Practice	P		P									
Dr A Banerjee	GP – Maghull SSP Practice	P		P									
Dr J Thomas	GP – Broadwood Surgery	P	P	P									
Dr B Thomas	GP – Broadwood Surgery												
Judith Abbott	PN – Broadwood Surgery												

No	Item	Action
14/16	**Apologies**	
14/17	**Declarations of interest** JT – SSMOOG CS – Board Member	
14/18	**Action Points** Action from last meeting; everyone to email TH their internal QOF review – completed.	
14/19	**QOF** Additional QOF discussions collated in a separate QOF template.	
14/20	**Ward 35 – Dr Stephanie Gallard and Ian Senior (Liverpool Community Health)** StG, IS, JP and AE introduced themselves and were present to take any questions in regards to ward 35. IS gave an overview of Ward 35 and described what it is and how it is has been designed to operate. He detailed the process of development and mentioned his work with Dr Andy Mimnagh and Dr Debbie Harvey. The referral criteria had been recently reviewed as a product of that work. The service is a step up and step down intermediate care unit. It was recognised that a significant issue with the service was that the ward was primarily used for step down patients as it was on the site of Aintree Hospital. IS confirmed that at the moment approximately 90% of the beds are taken by step down patients. It is seen, at times as beds in a very busy acute care hospital. He mentioned that discussions had been held regarding the location and whether that should change, but as of yet it shall stay there and they will work towards better use as a step up ward. The rationale behind the improvements made to the referral criteria is to make it more accessible as a step up ward. The service is partly funded by South Sefton CCG, however, the finance does not literally translate to a set number of beds available for Sefton patients. Beds can be utilised in RLBUHT also. SG stated that as far as she was aware there has never been a time when they have been unable to admit due to bed availability. The first and seemingly most prominent issue the GPs raised is the time aspect of actually dealing with the single point of access (SPC)	

No	Item	Action
	call centre. The GPs described how cumbersome the call can be especially with the time constraints they are under. More specifically that call handlers were asking for too much and unnecessary information. Although the practitioners had been put off by their previous experience (pre refreshed criteria) the group agreed that they would try to refer patients to the service again. GPs discussed other possibilities such as hot clinics and services with a two hour response time. The GPs stated that due to time constraints, the current intermediate care pathway takes too long, and some GP suggested they would just send to A & E if required further care. TH stated that Stephen Astles and Dr Debbie Harvey had started to contact practices as part of a listening exercise, and collating suggestions that would help shape the service for the future. TH stated that any suggestions can be emailed to either Stephen Astles or Dr Debbie Harvey. JT stated that there were some positives to look forward with regard to the appointment of a new community geriatrician. Dr Akpan will be working with both primary care and ward 35 and will be in attendance at the next locality meeting. Going forward actions were agreed and they are listed below. The group thanked SG, IS, JP and AE for coming. **Action** – SG to request the attendance of the single point of contact (SPC) lead at a forthcoming meeting as some issues focused on the phone call/ referral process. **Action** – TH to send ward 35 criteria to locality group	SG TH
14/21	**Quality Premium** Attendees were provided with the Quality Premium Dashboard report (7th March 2014). JB gave a progress update on the quality premium. Estimated to achieve approximately £552,623 from a possible £736,830 but is dependent on confirmation of achievement a year end. NHSE state that the average award to CCG from QP work is 75%; this is not far off what is believed to have been achieved by South Sefton CCG. JB stated that this was a great effort by all. The only category that is definitely gone and cannot be achieved is the 'healthcare acquired infections'. The practices were encouraged to get their ideas in and recorded with regards to the spending of the QP money awarded in the next financial	

No	Item	Action
	year. **Attendance at meetings payments** – JB asked the group for any questions with regards to the framework; after April this will come into effect and the process of invoicing will be clarified. A question regarding invoicing was raised with regards to whether a single invoice for all attendances would be acceptable. JB stated that he didn't see why not as long as each of the dates of attendance was clearly marked. **Action** – anyone with further queries should email them to TH and he can communicate them to the finance team.	ALL PRACTICES AND TH
14/22	**Medicines Management** JJ informed the locality that South Sefton CCG is currently forecast to be overspent by £91,785. Obviously practices may have concerns about payment of the PQS, which stipulates that the scheme cannot pay out if the CCG as a whole are overspent. JJ assured practices that after discussion at SSMOOG and also with CCG Finance colleagues, we will be looking to adjust in year spend versus practice budgets based on a number of factors. 1. Shared care prescribing in year to reflect cost of prescribing as opposed to budgets transferred over from the provider i.e. dementia drugs 2. A re-adjustment of non-medical prescribing spend to reflect costs still being attributed to the practice throughout the year so far. 3. Population shift across the CCG which has significantly affected some practices in South Sefton CCG, normally this isn't done however there have been some big changes this year. JJ thanked all practices for their hard work completing the PQS, particularly with the cost savings work stream which has made a big difference. Update from the Joint medicines operational groups JMOG: • The Pan Mersey have issued a statement with regards to the use of anti-platelets, including the use of clopidogrel in TIA patients please see: http://www.panmerseyapc.nhs.uk/guidelines/documents/G3.pdf • The Safety subgroup are undertaking a mapping exercise to review how MHRA/safety alerts are handled, which will hopefully look at the role of community pharmacies. JJ will keep you updated on this.	JJ

No	Item	Action
14/23	**Any other business** IC introduced himself as the public health locality lead and gave a brief overview of his work. He is leading on at the wider determinants of health and the causes of ill health. He will be looking at alcohol licensing, unemployment, and takeaways etc. TH stated that IC is linking into other projects within the locality such as the farming projects with Maghull High and Sefton East partnership meeting. CS stated that he would attend the locality meetings every other month to give feedback on board issues/work. SS brought an issue to the group - the meeting days. He requested that the meetings fall on one particular day rather than alternate. Various members of the group had issues with choosing one particular day due to the alternating locations, the time aspect and absence.	
14/24	**Date and Time of next meeting:** Friday 25th April – High Pastures 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 ……..