NHS
South Sefton
Clinical Commissioning Group

AGENDA

Governing Body Meeting in Public
Agenda

Date: Thursday, 31 July 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 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

Linda Williams	Safeguarding Clinical Lead Edge Hill University	(LW)
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	(TJ)
Karl McCluskey	Chief Strategy & Outcomes Officer	(KMcC)

Apologies

Dr Paul Thomas	GP	(PT)
Graham Morris	Vice Chair, Lay Member, Financial Management and Audit	(GM)
Dr Craig Gillespie	Clinical Vice-Chair, GP	(CG)
Roger Driver	Lay Member, Engagement and Patient Experience	(RD)
Dr Andrew Mimnagh	GP	(AM)

No	Item	Lead	Report	Receive/ Approve	Time
Governance					
GB14/94	Apologies for Absence	Chair		R	13.30
GB14/95	Declarations of Interest regarding agenda items	All		R	
GB14/96	Register of Interests	-	✓	R	
GB14/97	Hospitality Register	-	✓	R	
GB14/98	Minutes of Previous Meeting	Chair	✓	A	13.25
GB14/99	Action Points from Previous Meeting	Chair	✓	R	
GB14/100	Business Update	Chair	✓	R	13.30
GB14/101	Chief Officer Report	FLC	✓	R	13.35
GB14/102	Governing Body Assurance Framework	TJ	✓	A	13.40
GB14/103	Annual Governance Statement	MMcD	✓	R	13.50
Finance and Quality Performance					
GB14/104	Corporate Performance and Quality Report	KMcC	✓	R	14.00
GB14/105	Financial Performance Report Month 3	MMcD	✓	R	14.10
GB14/106	Annual Audit Letters 2013/14	MMcD	✓	R	14.20
Service Improvement / Strategic Delivery					
GB14/107	Peer Style Safeguarding Review	DF/LW	✓	A	14.30
GB14/108	Safeguarding Policy	DF	✓	A	14.40
For information					
GB14/109	Emerging Key Issues			R	14.50
GB14/110	Key issues reports from committees of Governing Body:- - Quality Committee - Audit Committee - Finance & Resource Committee	DF Chair Chair	✓	R	15.00
GB14/111	Audit Committee Minutes	Chair	✓	R	
GB14/112	Quality Committee Minutes	-	✓	R	15.10
GB14/113	Finance & Resource Committee Minutes	-	✓	R	
GB14/114	Merseyside CCG Network Minutes	-	✓	R	
GB14/115	Health and Wellbeing Board Minutes	-	✓	R	
GB14/116	Locality Meetings - (i) Seaforth & Litherland Locality (ii) Bootle Locality (iii) Crosby Locality (iv) Maghull Locality	-	✓	R	
Closing Business					

No	Item	Lead	Report	Receive/ Approve	Time
GB14/117	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting.*				15.20
GB14/118	Date, Time and Venue of Next Meeting of the Governing Body to be held in Public *Thursday, 25 September 2014 at 1.00pm at Merton House*				-
Estimated meeting close					15.30

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 6: June 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	
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	

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
			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	
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	

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
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
June 2014

NHS
South Sefton
Clinical Commissioning Group

Recipient:	Nature of Gift / Hospitality:	Date Received	Approximate Value	Donated by:
Martin McDowell	2 tickets for exhibition at Tale Liverpool	5 June 2014	£20.00	Liverpool Sefton Health Partnership

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public Minutes

Thursday, 29 May 2014 at 1.00pm to 4.00pm
The Boardroom, Third Floor, Merton House, Bootle L20 3DL

Present		
Graham Morris	Vice Chair, Lay Member, Financial Management and Audit (acting as Chair)	(GM)
Dr Craig Gillespie	Vice-Chair, Clinical Director	(CG)
Dr Andrew Mimnagh	Clinical Director	(AM)
Dr Paul Thomas	Clinical Director	(PT)
Dr Dan McDowell	Secondary Care Doctor	(DMcD)
Roger Driver	Lay Member, Engagement and Patient Experience	(RD)
Lin Bennett	Practice Manager	(LB)
Margaret Jones	Public Health Representative, Sefton MBC	(MJ)
Fiona Clark	Chief Officer	(FLC)
Martin McDowell	Chief Finance Officer	(MMcD)
Debbie Fagan	Chief Nurse & Quality Officer	(DF)
Also in attendance		
Stephen Astles	Head of CCG Development	(SA)
Jan Leonard	Chief Redesign and Commissioning Officer	(JL)
Brendan Prescott	Deputy Chief Nurse/Head of Quality and Safety	(BP)
Apologies		
Dr Clive Shaw	Chair, Clinical Director	(CS)
Dr John Wray	Clinical Director	(JW)
Sharon McGibbon	Practice Manager	(SMcG)
Maureen Kelly	Healthwatch Sefton	(MK)
Peter Morgan	Deputy Chief Executive, Sefton MBC (co-opted member on behalf of Margaret Carney)	(PM)
Carol Bernard	Director of Commissioning, Mersey Care NHS Trust	(CBe)
Tracy Jeffes	Chief Corporate Delivery and Integration Officer	(TJ)
Minutes		
Jayne Byrne	Office Manager/PA to Chief Nurse and Quality Officer	(JB)

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	May 2014	July 2014	Sep 2014
Dr Clive Shaw	Chair	A	✓	✓	A	A	L	A	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	✓	Sabbatical			A		
Dr Paul Thomas	GP	✓	✓	A	✓	✓	A	✓	✓	✓		
Dr John Wray	GP	A	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	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			✓	✓	✓	✓	✓	A		
Margaret Jones	Public Health Representative, Sefton MBC	N/A				✓	A	✓	A	✓		
Maureen Kelly	Healthwatch Sefton	N/A				A	A	A	A	A		

The meeting was preceded by a presentation by Nanette Mellor, Chief Executive Officer, Neuro Support.

NanetteMSeftonCCG Pres.pptx

No	Item	Action
GB14/61	**Apologies for Absence** were noted as above. *Note: Dr Sinha has now returned from sabbatical but sent his apologies for today's meeting.*	
GB14/62	**Declarations of Interest regarding agenda items** There were no declarations.	
GB14/63	**Register of Interests** was received.	
GB14/64	**Hospitality Register** was received.	
GB14/65	**Minutes of Previous Meeting** The minutes of the previous meeting were approved as an accurate record of the previous meeting once the following amendment was made: • the attendance tracker should be revised to show Dr Sinha as on 'sabbatical' instead of 'resigned'.	
GB14/66	**Action Points from Previous Meeting** *14/41 Quality performance report* – Miss Fagan has actioned this through the quality contract. 1*4/45 Strategic Financial Plan 2014/15 to 2018/19* – on agenda.	
GB14/67	**Business Update** Mrs Clark gave a brief update in the Chair's absence. Useful meetings had been held with co-commissioners in other CCGs in relation to systems leadership. A Wider Constituency group meeting had taken place last week where the CCG's aspirations in relation to primary care were discussed. A meeting had been held with Liverpool Community Health to discuss the CCG's aspirations in terms of community services and it was encouraging that their ideas regarding the way forward were in line with the CCG's aspirations and feedback from Wider Constituency meetings. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	

No	Item	Action
GB14/68	**Chief Officer Report** *Constitution* - an updated Constitution had been submitted to NHSE and early indications were they were satisfied with it. Once it had been received back from NHSE it would be distributed amongst the practice membership. *National CCG 360^{o} survey* - the results of the 2nd 360^{o} survey were now on the website. There were some areas that needed addressing, nothing of surprise and most of which was covered in this year's organisation development plan. Mrs Clark and Mrs Jeffes would revisit the survey to ensure that everything had been captured for development. *Aintree CQC quality report* - Aintree was now scoring 'good' in all key areas. *Co-commissioning of primary care services* - Mrs Clark will be doing a SWOT analysis ahead of the response from the membership on 20th June. Mr Driver acknowledged the discussions that had taken place and thanked Mrs Clark. *Nurse staffing levels* - Miss Fagan confirmed nurse staffing levels had been discussed at a recent Chief Nurse's meeting and she would be working in partnership with NHS (Merseyside) to address this issue. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/69	**Corporate Performance Report** Mr McCluskey highlighted the main aspects of the report and confirmed he was working with Miss Fagan to see how quality and performance could be brought together into a single report. With reference referral to treatment times, Mrs Clark added Aintree had reported a significant improvement in response rates by utilising a text messaging service so there was evidence that providers are looking at different methodologies to improve targets. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/70	**Quality Performance Report** Miss Fagan highlighted the main aspects of the report. Miss Fagan had been notified that AUH were reporting an incidence of MRSA at Aintree against a zero tolerance for 2014/15 so she would ensure CCG representation at the post infection review as part of the CCG's assurance processes.	

No	Item	Action
	Dr Gillespie added the improvement at Aintree was very encouraging and wanted to congratulate all CCG personnel who were directly involved. *Sickness absence rates amongst providers* - Mrs Clark asked if we were probing deeper into sickness absence as a recent leadership programme she had attended confirmed there was a correlation between happy staff leading to happy patients. Miss Fagan confirmed this was addressed as part of CQPG meetings, the Friends and Family test and conversations had also been held with Trusts where schemes had been introduced. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/71	**Financial Performance Report – Month 12 – 2013/14** Mr McDowell was pleased to report a strong financial performance by the CCG in its first year of operation. He believed the CCG had proved it had been able to respond to pressures in a flexible manner and had held reserves back to do that. The results were still subject to final Audit opinion which he expected to receive next week. Mr Morris congratulated Martin and all involved for a good first year and the hard work that had gone into achieving that result. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/72	**2014/15 Revised Financial Budgets** The Governing Body was asked to approve the revised financial budgets for financial year 2014/15. The Governing Body was also asked to note that the revised budgets delivered the key metrics required by NHS England in terms of 1% surplus and that the CCG planned running cost expenditure was within its running cost target. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/73	**(a) 5 Year Strategic Plan** The paper detailed the joint five year strategic plan for South Sefton and Southport and Formby CCGs and covered the same footprint as the local authority. The paper enabled the CCG to meet the requirements laid down by NHSE and to complete its required submission to NHS England on 20th June. It was noted the table under section 9.3 on p126 had lost the heading “South Sefton CCG” and the table on p132 was incorrect and should refer to South Sefton CCG, not Southport and Formby, the table of p239 should be substituted. Mr Driver asked when the Council would formally agree to the plan. Mrs Clark confirmed it was already going through the sign off process and believed the formal sign off would take place at the next Health and Wellbeing Board meeting on 18th June. She confirmed that the Council’s plans were aligned with the CCG’s as part of the integration programme. Mrs Clark said it was important to note any potential co-commissioning that may or may not occur and the health and wellbeing document should be included.	

No	Item	Action
	Actions taken by the Governing Body The Governing Body received the report by way of assurance and: • Endorsed the five year strategic plan as set out in the report; • Recognised and supported the augmentation of the strategic programmes with three additional programme areas having been identified through engagement and consultation; • Endorsed the outlined governance and reporting arrangements; • Provided the delegate 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 the report; • Supported the financial enhancement of the strategic plan, in integrating the financial and quality strategy.	
	(b) 5 Year Financial Plan The strategic financial plan complements the work done on the strategic plan and makes a number of assumptions that are likely to change during the time period but these will be reviewed on a regular basis. Since the papers were issued the CCG had received additional information in relation to the section heading "other NHS mandate pressures" in table 3 on page 139 and his initial assessment was that not all of the £1,091 earmarked for this area would be required. Mr McDowell needed to confirm this but on this basis he recommended the plan should be approved. Mr McDowell felt it advisable to work on both these plans and apprise both the F&R Committee and Governing Body members regularly of any developments. Actions taken by the Governing Body The Governing Body approved the financial strategy and noted: • 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.	
GB14/74	**Prescribing Performance Report** The CCG position for month 11 (February 2014) is a forecast overspend of £255,968 against the same period in 2012/13, comprising an increase of 1.14% in the number of items prescribed and a cost increase of 0.45%. The Medicines Management team is working closely with finance to explore factors that have affected spend. Mrs Clark asked Mr Prescott to ensure any Governing Body members' concerns were taken into account at year end, eg in-year adjustments in relation to population shifts and Dr Thomas's concerns relating to this should be fed into Medicines Management. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	

No	Item	Action
GB14/75	**Annual Report and Accounts** Mr McDowell briefed the Governing Body on the main aspects of the report. Actions taken by the Governing Body The Governing Body: • Noted the process for approval of NHS South Sefton CCG Annual Accounts and the Report; • Noted their invitation to the Audit Committee meeting, convened to consider approval of annual accounts and report; • Formally declared that: *"so far as the member was aware, there was no relevant audit information of which the CCG's external auditor was unaware;* and *that the member had 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 CCG's auditor was aware of that information".*	
GB14/76	**Audit Committee Annual Report** Mr Morris provided assurance to the Governing Body that in the CCG's first full financial year: • An effective system of integrated governance, risk management and internal control was in place to support the delivery of the CCG's objectives and that arrangements for discharging the CCG's statutory financial duties were now established; • There were no areas reported by MIAA where weaknesses in control, or consistent non-compliance with key controls, could have results in failure to achieve the objective; ISA260 Audit Highlights Memorandum would be reported by PWC to the June meeting as part of the Annual Accounts approval process. This would be followed by the publication of the Annual Audit Letter to the Governing Body in its July 2014 meeting. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/77	**Francis Report and Action Plan** Miss Fagan updated the Governing Body on the latest version of the Francis action plan, updated to reflect "Hard Truths" (DoH Nov 2013) and robustly monitored at the Quality Committee. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	

No	Item	Action
GB14/78	**Sefton Strategy for Older Citizens 2014 - 2018** In view of Sefton's ageing population, it was vital to make strategic plans to deal with its impact and to develop a collaborative approach from all agencies and service providers. The report had been out for wide consultation and was now going through the formal sign off process. Dr Gillespie asked, if Sefton is in a unique position within the UK, whether there was there any merit in putting it forward to the DoH as a pilot. Mrs Clark believed a lot of information needed pulling together before they could approach DoH and said this was a conversation that could be taken to a SLT meeting. Mrs Jones added they also had an older population of substance misusers who may have started over 20 years ago and were now entering nursing homes in the area, so that also had to be taken into account. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/79	**Virtual Ward Quarterly Update** Mrs Clark highlighted the ongoing work being done by Steve Astles and Debbie Harvey. There needed to be more understanding of the complete model and some of the recurrent themes seemed to be problems with the cascading of information. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/80	**Primary Care Update** The report gave the Governing Body an update of the work being undertaken by the Primary Care Quality Strategy Board and laid the groundwork for the work still to be done. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/81	**Revised Governance Structures 2014** Mrs Clark highlighted the changes to the governance structures. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/82	**Mental Health Services Review Briefing** Mental health service provision has been fragmented over the last few years and the strategic plan identified the need to give mental health the same parity as physical health. A mental health task group had been set up to address this, chaired by Dr Hilal Mulla which was currently drafting a mental health plan to identify steps needed. The task group will report into the Service and Redesign Committee**.** Actions taken by the Governing Body The Governing Body received the report by way of assurance.	

GB14/83	**Out of Hours Pharmacy Engagement** Mr Prescott gave the Governing Body an update on the planned engagement regarding the out of hours pharmacy service provision. The CCG were looking to consult with users and the wider public throughout June in a review of service hours and accessibility. Actions taken by the Governing Body The Governing Body received the report by way of assurance.	
GB14/84	Key issues reports from Committees of Governing Body and Audit Committee were received.	
GB14/85	Audit Committee minutes were received.	
GB14/86	Quality Committee minutes were received.	
GB14/87	Finance and Resource Committee minutes were received.	
GB14/88	Merseyside CCG Network minutes were received.	
GB14/89	Health and Wellbeing Board minutes were received.	
GB14/90	Medicines Optimisation Operational Group minutes were received.	
GB14/91	Locality Meeting minutes were received for Seaforth & Litherland, Bootle, Crosby and Maghull.	
GB14/92	**Any Other Business** Rev Driver expressed his concern that Healthwatch had not been present at Governing Board meetings. Mrs Clark has raised this and is awaiting a response.	
GB14/93	**Date, Time and Venue of Next Meeting of the Governing Body to be held in Public** Thursday, 31st July 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, 29 May 2014 at 1.00pm to 4.00pm

No	Item	Action
GB14/68	**Chief Officer Report** *National 360° Survey* Fiona Clark and Tracy Jeffes to revisit the survey to ensure that everything had been captured for development.	FLC/TJ
	Co-commissioning of primary care services Fiona Clark to conduct a SWOT analysis ahead of the response from the membership on 20th June.	FLC
GB14/73(b)	**5 Year Financial Plan** Mr McDowell to work on both plans (strategic and financial) and appraise both F&R Committee and Governing Body members regularly of any developments.	MMcD
GB14/74	**Prescribing Performance Report** Medicines Management team to work with Finance to explain forecast overspend of £255,968 against the same period in 2012/13. BP to ensure Governing Body members' concerns are taken into account at year end, eg in year adjustments in relation to population shifts.	SL/JB BP
GB14/78	**Sefton Strategy for Older Citizens 2014 – 2018** Needs to be discussed at SLT.	FLC

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2014

Agenda Item: 14/	**Author of the Paper:** Fiona Clark Chief Officer fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7061
Report date: July 2014	
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	
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
July 2014

1. NHSCC – Board Elections

1.1. NHS Clinical Commissioners (NHSCC) are supporting CCGs to be the best they can be by ensuring an effective voice and influencing in the national debate on clinical commissioning and how it moves forward, demonstrating CCG success visibly to the 'system', to politicians and to patients/public, reinforcing the system leadership role of clinical commissioning to best meet the needs of patients, and providing clarity on what needs to happen to strengthen and augment that role as well as raising the visibility of NHSCC as the 'go to' authoritative place to speak with clinical commissioners at a national level. Membership continues to be very strong at > 80% across the country and growing.

1.2. NHSCC was originally established & governed by the 3 founding partner organisations with a selected Leadership Group helping to shape and steer with Dr Amanda Doyle & Dr Steve Kells playing an increasingly key role since late 2012. It published the manifesto – *'Making change happen : A CCG Manifesto for a high quality, sustainable NHS'* launched on 1 May is also a key way in which we bring a number of these to life and will govern our work programme & focus for this year.

1.3. NHSCC is now in 'new mode' being fully member led, governed & focused, with a new NHSCC Board established in July 2014- Dr Steve Kells and Dr Amanda Doyle as Co-Chairs and former interim President & Chair now operating as Senior Advisors. The new Board members meet on the 24 July for the inaugural Board meeting. The places on the Board are based on the Current co-Chairs of the Leadership Group (until end June 2015 when up for re-election by the Board). There are now ten geographical constituencies built from natural CCG networks / groupings. Each with one place with the three largest areas having two places each. There is also one Board place for each of our 6 networks/forums Mental Health Commissioners Network (MHCN), Ambulance Commissioners Network (ACN), Core Cities Network, Lay members network, Finance Forum, CCG Leaders Forum, Nurse Forum, the 3 senior advisors from the founding partner organisations and the NHSCC Director – Julie Wood.

1.4. Katherine Sheerin - Chief Officer Liverpool CCG and Dr Gora Bangi have been elected to serve the North West zone.

2. Transforming Localities – Reconnecting Teams

2.1. Work has begun to define this element of the strategic plan to shape the future model of care outside the hospital. One of the aims being to develop GP led localities with a renewed partnership between GP commissioners and providers of community services. Working with Liverpool Community Health NHS Trust, CCG leadership is being provided through the Locality GP Leads, supported by Dr Peter Chamberlain- Clinical Lead for strategy is alongside Karl McCluskey and Stephen Astles and the wider constituent membership.

2.2. The objectives of this work programme are

- Better outcomes for patients/carers/community
- Locality focused care to meet local needs.
- More integrated care across the whole age range and care spectrum
- Clinicians in the driving seat

- Service changes and developments shaped and influenced by the local community
- Involvement of community, voluntary, faith sector
- Improved relationships between care providers
- Integrated commissioning between CCG/Local Authority
- Political 'buy-in'

2.3. The outcomes we would aim to see over the next 5 years will include
- Clear, affordable models of provision designed around localities
- Sustainable change owned by locality
- Improved health and social care outcomes
- Increased staff satisfaction

2.4. This forms part of the schemes of work of the strategic plan and through the Project Management Office (PMO) progress will be reported back to the governing body.

3. Referral to treatment (RTT)

3.1. Nationally, NHSE have identified additional funding support to assist providers in the delivery of 18 weeks waiting times for planned activity. The allocation for Merseyside, including provision for Specialised commissioned services. The allocation is currently being prescribed to providers and is conditional upon targeting patients currently waiting in excess of 18 weeks, with a requirement to deliver this activity across July and August only.

3.2. Aintree have indicated that, given their strong performance on all RTT standards, including 18 weeks, that they do not feel that they are in a position to enhance activity further over July and August. Southport & Ormskirk have developed a plan for additional activity during the two months.

3.3. The national guidance on the RTT allocation has been dynamic and further guidance and direction is expected as we move forward.

4 Workforce Symposium

4.1. On July 9th 2014, I led a workforce symposium for colleagues from all sectors of health and social care within Merseyside. The event was also attended by local colleges, universities and leading workforce development organisations.

4.2. The session looked the challenges we face across the system in terms of workforce planning now and in the future, with a view to identifying actions that we could initiate locally. The event was lively and participative with a wealth of ideas generated.

4.3. A view clearly emerged from the group that there is a real need for us to work collaboratively to bring about changes that as individual organisations would be impossible to make. As a result of the session it was proposed that a working group will be set up to take forward the ideas and develop a plan of action.

5. Quality Items

5.1. CQC **Inspection Judgement – Liverpool Women's Hospital**

5.1.1. The judgements from the recent inspection of Liverpool Women's Hospital have been recently published on the Care Quality Commission (CQC) website. The Trust has been given 2 enforcement actions in the areas of Staffing and Quality &

Suitability of Management. The CCG Quality Team has liaised with Liverpool CCG who are the co-ordinating commissioners for the Trust and will be kept informed of any required actions and next steps. The CCG are represented at the provider Quality Contract Meeting and this recent report has been discussed at the CCG Quality Committee in July 2014.

5.2. **Merseyside Quality Surveillance Process**

5.2.1. A Quality Review Meeting took place with Alder Hey Children's Hospital in June 2014 Chaired by NHS England (Merseyside). The Trust improvement action plan was discussed. A follow-up meeting is scheduled towards the end of July 2014 to coincide with the outcome of the recent CQC inspection. The CCG are represented at the provider Quality Contract Meeting and this recent report has been discussed at the CCG Quality Committee in July 2014.

5.2.2. A Single Item Quality Surveillance Group meeting is scheduled for the beginning of August 2014 to discuss quality issues relating to the Royal Liverpool & Broadgreen University Hospitals NHS Trust. The CCG are represented at the provider Quality Contract Meeting and this development has been discussed at the CCG Quality Committee in July 2014. The outcome of the Single Item Quality Surveillance Group will be reported to the CCG Quality Committee meeting in August 2014.

5.3. **Patient Safety / Safer Staffing / Open & Honest Reporting**

5.3.1. Local acute trust provider information was published in the public domain nationally on NHS Choices for the first time in June 2014. The domains identified were:

- Patient safety reporting
- Infection control and cleanliness
- Patients assessed for blood clots
- NHS England patient safety notices
- Care Quality Commission national standards
- Recommended by staff

5.3.2. Local Trusts were identified as being outliers as follows:

- Southport & Ormskirk Hospitals NHS Trust (Ormskirk site) – Recommended by staff
- Southport & Ormskirk Hospitals NHS Trust (Southport site) – Care Quality Commission standards; Recommended by staff
- Royal Liverpool & Broadgreen University Hospital Trust – Patient safety reporting
- Aintree University Hospital NHS Foundation Trust – Care Quality Commission Standards

5.3.3. The above has recently been discussed / will be discussed at the next Quality Contract Meetings. Aintree University Hospital NHS Foundation Trust and South Sefton CCG have queried with NHS England (Merseyside) the provider rating for CQC Standards due to the Trust being rated 'GOOD' in the most recent inspection visit that has previously been reported to the Governing Body. This recent provider reporting within the public domain has been discussed at the CCG Quality Committee in July 2014.

5.4. **Continuing Health Care Integrated Workshops – CCG and Sefton Council**

5.4.1. Continuing Health Care (CHC) remains a risk for the CCG as detailed within the Corporate Risk Register. The CCG and Sefton Council have commenced a series of joint workshops to develop an integrated approach to the management of CHC across Sefton. The first workshop took place in June 2014 with the next follow-up event planned for the end of July 2014.

5.5. **Compassion in Practice (6C's)**

5.5.1. The Compassion in Practice 6 C's week of action is scheduled for 21 July 2014 – 25 July 2014. The CCG is able to demonstrate and celebrate their strong commitment and achievements to date in implementing the 6 C's in their daily business. Examples to support this include a presentation to the Health & Wellbeing Board, the development of the CCG Francis Action Plan, the CCG Organisational Development Plan and how we hold our commissioned providers to account for the purposes of assurance through the contracting process. The CCG has also commenced partnership working with local higher education providers regarding gaining the view of Dementia Champions, student quality ambassadors and care makers and building this into the development of the strategic plan.

5.6. **Promoting the Voice of Children and Young People Within the Work of the CCG**

5.6.1. The CCG is further developing the voice of the Children and Young People within the work of the CCG. Recent work has included:

- Evidence of the different mechanisms currently in place within the CCG that support the CCG in obtaining the voice of children and young people and how this is utilised within commissioning is to be presented to the Engagement and Patient Experience Group (EPEG) in August 2014
- The Safeguarding Service have been requested to present information to the EPEG meeting in August 2014 regarding how the voice of children and young people is heard from those who are involved with safeguarding and children looked after services
- The Chief Nurse attended a children and young people's voice celebration event in Southport in July 2014 which was a follow-up event to one that was attended in October 2013. Feedback and updates were provided regarding issues raised relating to car parking charges in Southport & Ormskirk Hospital NHS Trust, actions being taken to reduce the number of fast food outlets across Sefton; school meals – cost and quality; flu clinics for people who don't have English as a first language; substance misuse services

5.6.2. The CCG liaised with key partners such as Sefton Council (Children Services and Public Health Teams) and Southport & Ormskirk Hospitals NHS Trust. The Chief Nurse has committed for the CCG to attend a further event being planned by the Southport Schools later in 2014.

5.7. **Supporting the CCG Aspiration to Become a Teaching CCG**

5.7.1. The process for the CCG to be an accredited site for student placements is progressing well. The CCG are currently on schedule for the first cohort of pre-registration nursing students to gain experience within the CCG as part of their management module during the academic year 2014/15. Initially these students will be placed with the Quality Team. Plans are in place for the team to update their mentorship skills in order to undertake student assessments.

5.7.2. The CCG Research Strategy has been ratified at the Quality Committee in July 2014. This strategy has now been shared with Liverpool Community Health NHS Trust, Southport & Ormskirk Hospitals NHS Trust and West Lancashire CCG as requested by these partner organisations.
The CCG has submitted a formal application for membership of the Collaboration for Leadership in Applied Health Research and Care (CLAHRC). A formal response is being awaited.

5.8. **Corporate Parenting Board**

5.8.1. The CCG attended the Corporate Parenting Board that was held in June 2014. A commissioning update was provided by the CCG regarding the development of the integration Child & Adolescent Health Services (CAMHS) Tier 3 service specification and the development of the multi-agency Children & Young People's Plan which will form part of the Sefton Mental Health Strategy.

5.8.2. Concerns are still being expressed by the elected members of the Corporate Parenting Board that the 'CAMHS' service name remains despite an earlier recommendation from an Overview and Scrutiny Committee Report that recommended a name change. The CAMHS provider representative on the Board took an action to work with the Children & Young People's Making a Difference Group representative to look at the possibility of an alternative name for the service and is also taking this action back to Alder Hey Children's Hospital for further discussion. The Chief Nurse took away an action to discuss within the Senior Management Team within the CCG the possibility of the providing work experience for Looked After Children as part of our Corporate Parenting Board responsibilities.

5.9. **Local Safeguarding Children Board (LSCB)**

5.9.1. The CCG attended the LSCB meeting that was held in June 2014. The LSCB discussed the Board self-assessment document and the progress regarding effectiveness that the members considered had been made to date. Health representatives present at the LSCB are planning to deliver a presentation at the next meeting which will outline health provider governance arrangements regarding safeguarding along with commissioner assurance systems that are in place both internally and with commissioned providers. Work is on-going across the health system to further develop a health performance report that will meet the needs of the LSCB.

5.10. **Local Safeguarding Adult Board (LSAB)**

5.10.1. The CCG attended the LSAB meeting that was held in June 2014. The LSAB were presented with a paper regarding the roll-out across Sefton of the Do Not Attempt Resuscitation Policy (DNAR). The Safeguarding Service has submitted CCG information to be contained within the LSAB annual report and contributions were

acknowledged. The CCG Chief Nurse informed the LSAB that staffing data and patient safety information for acute Trust providers had been published nationally in the public domain and asked if this was something that should be included in the health performance report as this is further developed to meet the needs of the Board.

5.10.2. Health representatives present at the LSCB are planning to deliver a presentation at the next meeting which will outline health provider governance arrangements regarding safeguarding along with commissioner assurance systems that are in place both internally and with commissioned providers.

5.11. **Court of Protection**

5.11.1. The CCG has been named as a third party respondent in two Court of Protection cases to date this financial year. Hill Dickinson has been instructed to act on behalf of the CCG in both instances.

5.11.2. The CCG attended a Court Hearing regarding Case 1 at the end of May 2014 but were not required to give evidence. Both cases are on-going under the management of the Chief Nurse and Deputy Chief Nurse who are being supported by the Commissioning Support Unit.

5.12. **Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLs)**

5.12.1. A Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards paper was recently presented to the June 2014 meeting of the Quality Committee regarding the by the Safeguarding Service. There are also some recommendations from the CCG Peer Review of Safeguarding regarding MCA and DoLs.

5.12.2. The Quality Committee have recommended that specific training be commissioned for the Governing Body as part of the CCG's on-going safeguarding development and appropriate training to be considered for delivery at a Primary Care Protected Learning Time event. The Chief Nurse has liaised with the CCG Chief Delivery & Integration Officer and the CCG Practice Nurse Facilitator to progress the commissioning of appropriate levels of training.

5.13. **CCG Partnership Working to Support the Role of the Student Quality Ambassador / Caremaker Role Input Within Commissioning**

5.13.1. The CCG Chief Nurse and Chief Strategic Planning & Outcomes Officer attended Edge Hill University in June 2014 and presented the CCG Strategic Plan as part of the engagement process in order to gain the views and suggestions from a group of student nurses who also fulfil the role of Student Quality Ambassadors, Caremakers and Dementia Champions.

5.13.2. The CCG received positive feedback regarding the contents of the plan and further feedback has been received for consideration. Plans are in place for the CCG to continue this partnership working and Edge Hill University will be undertaking a formal evaluation of the outcomes and value of the interactions between the students and the CCG at some point in 2015.

6 System Resilience Group (SRG)

6.1. The urgent care working groups have been rebadged as System Resilience Group (SRG) in an effort by NHS England to move winter planning towards whole system resilience. This now focuses on all year round planning and includes the management of elective work in particular the attainment of the 18 week referral to treatment standard. Guidance has been produced which sets out best practice requirements across planned and urgent and emergency care that each local system should reflect in their local plan, and the evolution of Urgent Care Working Groups into SRGs. To this end the urgent care working group, within the care closer to home programme Board in the Southport and Ormskirk health economy has now been rebadged as the Southport and Ormskirk System Resilience Group (SRG).

6.2. CCGs are expected to play a full role in leading these groups, ensuring that all partners across health and social care are included, whether commissioners or providers.

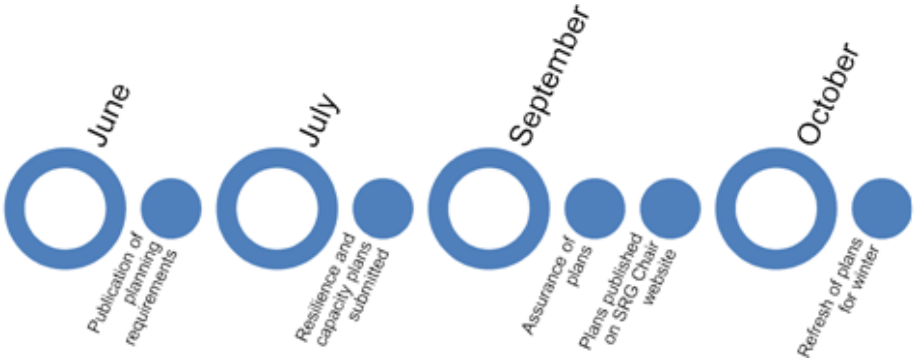
6.3. The Resilience plan is being developed in collaboration with the Urgent Care Working Group across North Mersey, the Group met on the 27th June including all local providers and discussed the plans and potential utilisation of additional funding. The Aintree plan, although this will be focused on the whole health economy not solely the acute Trust, will be developed in draft during July and ratified at the next meeting on the 1st August. Providers have been invited to discuss ideas and have been advised that supporting the whole economy, avoiding emergency admissions and supporting patient flow e.g. discharge to assess models should be the focus for additional resource.

6.4. South Sefton CCG has been allocated funding of £1,213,479.00 subject to successful assurance of the plans by NHSE Merseyside.

6.5. In the main, investment for the plan is likely to be focused on community services and its integration with Social care provision. This includes for example;

- Intermediate care
- Community Emergency response team
- Ambulatory Emergency Care
- Weekend discharge team
- Primary Care capacity
- Discharge to Assess
- Additional resource to manage patients with Dementia

6.6. The full timeline is described below.



Link to full document at http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf

7 GP Survey

7.1. NHS England together with Ipsos MORI, published on the 3rd July 2014 the latest Official Statistics from the GP Patient Survey. The survey provides information on patients' overall experience of primary care services and their overall experience of accessing these services. http://www.england.nhs.uk/statistics/2014/07/03/gp-patient-survey-2013-14/

7.2. The results are based on aggregated data from the two most recent waves of the survey. This aggregation creates sufficiently large sample sizes to publish statistically robust results at GP practice level. Results are also published at national, Clinical Commissioning Group (CCG) and area team level.

7.3. The latest survey consisted of 2.63 million questionnaires sent out across two waves, from July to September 2013 and again from January to March 2014. Of these, 903,357 respondents completed and returned a questionnaire, resulting in a response rate of 34.3%.

7.4. The latest results, for 2013-14, are comparable with the corresponding aggregate results for 2012-13 (published in June 2013), and 2011-12 (published in June 2012).

7.5. The summary of results concludes that while the majority of patients continue to feel that they have a good experience of GP and out-of-hours services, the latest results show a reduction in the proportion of patients reporting on their experiences positively. This finding continues the downward trend in experience of GP and out-of-hours services since 2011-12.

7.6. We will continue to work with NHS England (Merseyside), though llocally our CSU is to compile a report analysing the data, this will be shared via the primary care quality strategy board and considered as part of the CCG primary care transformation work.

8 Healthwatch Sefton's Annual Report 2013/14

8.1. The Healthwatch Sefton's annual report has been received into the CCG on 30th June 2014.

Areas covered in the report include;

- Engaging with local people
- Statutory Activities and use of powers
- Signposting and Information services
- Independent complaints advocacy
- Communications update
- Working with key stakeholders
- The year ahead
- Financial information
- Fact file
- Experience reports

The link for this report is http://www.healthwatchsefton.co.uk/news/healthwatch-sefton-annual-report

9 Integration/Better Care Fund Update

9.1. The BCF provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change. The BCF is a critical part of, and aligned to, the NHS two year operational plans and the five year strategic plans as well as local government planning that have been developed.

9.2. Unplanned admissions are by far the biggest driver of cost in the health service that the Better Care Fund can affect. Plans need to demonstrate clearly how they will reduce emergency admissions, as a clear indicator of the effectiveness of local health and care services in working better together to support people's health and independence in the community.

9.3. The Health and Wellbeing Board will need to propose their own performance reserves based on their level of ambition for reducing emergency admissions – with a guideline reduction of at least 3.5 per cent. A proportion of our current performance allocation (i.e. area's share of the national £1bn performance element of the fund) will be paid for delivery of this target. That proportion will depend on the level of ambition of our target. Where local areas do not achieve their targets the money not released will be available to the CCGs, principally to pay for the unbudgeted acute activity.

9.4. The balance of our area's current performance allocation (i.e. the amount not set against the target for reduced admissions) will be available upfront to areas and not dependent on performance. Under the new framework, it will need to be spent on out-of hospital NHS commissioned services, as agreed locally by Health and Wellbeing Board.

9.5. This change will mean that while it is likely that the local authority will continue to receive the large majority of the Better Care Fund through Section 75 pooling arrangement, the NHS will have the assurance that plans will include a strong focus on reducing pressures arising from unplanned admissions.

9.6. This change also means that, because of its importance in terms of driving wider savings, reductions in unplanned admissions will now be the sole indicator underpinning the pay for performance element of the BCF. Performance against the other existing metrics will no longer be linked to payment. However, there will be a requirement to see evidence of strong local ambition against them as part of the assurance of plans.

9.7. In addition, NHS England will issue a revised plan template which will request additional financial data around metrics, planned spend and projected savings. They will also provide further detailed guidance on the revised pay for performance and risk sharing arrangements.

We expect that areas will be asked to submit revised plans and any further information at the end of the summer.

9.8. The CCG will continue to work closely with the Local Authority and consider its financial strategy accordingly in light of this guidance.

10. Approvals panel

10.1. Due to the triggers of the CCG conflict of interest policy. The approvals panel were required to meet on the 20 May 2014 to approve the local Primary Care Quality Scheme 14/15.

10.2. Work is now underway with CMCSU to issue the NHS standard contracts to commence on the 1st August 2014.

11 SEN legislation

11.1. Special **Education Needs Reforms in Sefton**
Introduction:
The Children and Families Act came into force in March 2014. This introduced a range of reforms, including those for children with special education needs (SEN) 0-25, replacing what was the previous educational statementing process. For 'Health' (CCGs and providers), this will mean considerably more involvement in the assessment of need, planning, joint commissioning of services for children with SEN.

11.2. **State of Readiness:**
The overall programme of reforms is the responsibility of the Local Authority. Partners, including health, are actively involved in the delivery of the reforms. The Sefton CCGs and health provider partners are on target to be compliant with the requirement for the 1st September deadline. However, there will be significant work and development required from all partners from 1st September. In financial terms, the key implications for the CCGs are:

- Resourcing of a DMO
- Contribution where appropriate to the new disputes and mediation process
- Responding to gaps in service provision and capacity pressures, in particular Speech and Language Therapy

12 Update-Development of the North West 5 year Strategic Plan for Specialised Services Commissioning

12.1. NHS England's Executive Team has put additional resources in place to support the existing Specialised Commissioning Teams. Seven work streams, with a particular focus on financial control in 2014-15 and planning for the 2015-16 commissioning round, have been initiated as follows:

- Strategic Projects
- Strategy
- Clinically Driven Change
- Operational Leadership
- Analytics
- Commercial and Technical Delivery
- Strong Financial Control

12.2. Work is continuing on the Public Health analysis of the demographics of the North West and its impact on specialised commissioning. In addition, an analysis of patient flows has been undertaken. The patient flow data has been shared with relevant CCGs and the local Project Teams.

12.3. As part of the turnaround process, the development of the national clinical strategy, led by Dr James Palmer, has been put on hold. This will enable the remaining national turnaround teams to concentrate on financial recovery and a small number of urgent

tasks. The timescale for the development of the national strategy for specialised services has been extended to the autumn.

12.4. The current priorities for service change identified in the North West Specialised Services 2 year Operational Plan will, however, continue to be progressed.

12.5. Account is being taken of the current understanding of the longer term strategic direction in formulating solutions which consolidate expertise and implement network provision. There have been key priority areas identified.
Both providers and public are being update and engaged in the work, with strategic leads now being identified to link with organisations. The link to Merseyside is Phil Dunn.

13 Primary Care Support Services (PCS services)

13.1. NHS England have announced on the 10th July 2014 to stakeholders that they are launching an open market procurement process to select a supplier for PCS services that will ensure safe, sustainable and efficient services.

13.2. In the meantime, services will continue as now and primary care practitioners should continue their existing processes and relationships with the local NHS England PCS teams.

14 Cheshire and Merseyside Commissioning Support unit (CMSU)

14.1. The CCG is still in the process of renegotiating the Service Level Agreement (SLA) with Cheshire and Merseyside Commissioning Support Unit (CMCSU). However as there has been a delay in the CMCSU being able to issue the CCG with revised prices following detailed service discussions, the CCG has written to the CSU to request an extension to our current SLA for a period of at least two months. This would take our current SLA through to the end of November 2014 and will enable the negotiations to take their due course within a sensible time frame.

14.2. Organisational changes to the CMCSU are expected to become clearer over the next few months as the merger between CMCSU and Greater Manchester CSU progresses. The CCG continues to closely monitor CMCSU performance during the transition period and working closely with the CMCSU Head of Client Operations to address areas for improvements and tackle issues as they arise.

15 Liverpool Clinical Laboratories- Aintree based pathology system issues

15.1. Liverpool Clinical Laboratories (LCL) was formed as an organisation on the 1st October 2013 and took over responsibility for the running of the Aintree laboratory from Aintree University NHS Trust (AUH), and the Royal Laboratory from the Royal Liverpool and Broadgreen University NHS Hospital Trust (RLBUHT) as a joint venture across both Trusts.

15.2. It has been identified that there have been historic issues reported by GP practices in relation to small intermittent numbers of missing pathology reports from the laboratory based at Aintree. The timeframe for the issues date back to 2012 and apply to certain practices that currently sit within South Sefton; Liverpool and Knowsley Clinical Commissioning Groups.

15.3. This issue was an agenda item for discussion at the AUH CPQG and a Task and Finish Group has been set up to facilitate the management and monitoring of each of the issue areas. This group is reporting and accountable to the CCGs' Clinical Leads who are then reporting to the Clinical Quality and Performance Group. Informatics Merseyside are facilitating this group from a health economy leadership perspective on behalf of the CCGs. The group's main responsibility areas are to:

- Oversee the resolution of the issues detailed
- Proactively manage risks associated with the issues
- Identify and manage the assessment of any wider implications
- Oversee the resolution of any new issues ascertained throughout this process
- Develop and oversee communications to practices and wider stakeholders as required

15.4. This group has regular scheduled meetings with specific timescales and named accountability. South Sefton CCG has representation on this group in terms of Clinical Lead Primary Care and the Quality team.

15.5. The incident is being performance managed by the Chief Nurse- Debbie Fagan and Clinical Lead Dr Gina Halstead with detailed oversight by the CCG Quality Committee in line with the CCG governance arrangements.

15.6. The CCGs asked NHSE(M) to Chair an extraordinary meeting on 8 July 2014 to review the incidents reported to date, clarify ownership and determine what needs to be reported via the STEIS system and what can be managed under local datix / root cause analysis arrangements. Liverpool Clinical Laboratories have also reported the relevant incident to the HMRA.

15.7. The next scheduled meeting is 31 July 2014 with a de-brief meeting planned for September 2014 to be Chaired by NHSE(M). All GP practices have received written correspondence from the GP Clinical Lead regarding the incident, prioritisation regarding contact from the laboratories to General Practice and details of who to contact if it becomes apparent that a patient may have suffered harm.

16 Well Sefton

16.1. The Well North Programme seeks to improve the health of the poorest fastest through targeting community-based interventions in areas of greatest need, detected using hot spot analysis and appreciative enquiry. The aims of the programme are to deliver the following objectives:

- To improve the health of the poorest fastest
- To reduce premature mortality
- To reduce worklessness

16.2. The Programme is led by Professor Aidan Halligan as Director (Senior Responsible Owner, SRO) and Principal Investigator and is funded by Public Health England. Discussions around developing a 'Well Sefton' project, are taking place, as the Council has been working closely with Aintree Hospital, looking at anonymised hospital data and open source data, and this research and analysis has informed the development of the Well North Project.

16.3. The idea behind the 'Well Sefton' project is to build upon both the experience of similar/complimentary projects (Church Ward Pilot, Litherland Pilot, Norwood Asset Mapping etc.) already taking place in Sefton and projects from around the country (Professor John Earis, Director of Education at Aintree is part of the Mersey Deanery, and is keen to explore opportunities for medical undergraduates at Aintree UHT to undertake projects within community settings, the Collaboration for Leadership in Applied Health Research and Care looks to accelerate the translation of research findings into service improvements, generate wealth and engage industry, and maximise the potential for applied research within the partner organisations to improve care etc.), and draws upon the work of the Well London Project which brings together a number of existing and new public health and wellbeing policy concepts in integrated ways and translates them into effective, on the ground action. The approach has been shown to be effective in engaging the most disadvantaged communities and in delivering measurable impacts and outcomes.

16.4. A 'Living Well in Sefton – Community Initiatives' meeting has been scheduled for the 30th July with key stakeholders invited to attend. The purpose of this meeting is to; learn about what is currently going on in Sefton with regards to community based initiatives that improve health and wellbeing of Sefton residents, to share what worked well and the lessons learned, and to identify any gaps in knowledge (Are there projects out there we need to consider? What are the locality issues?). Following on from this meeting a small programme group will be established to oversee the implementation and delivery of the Well Sefton project and a paper will be taken to the Health and Wellbeing Board.

17 Recommendations

The Governing Body is asked to formally receive this report.

Fiona Clark
July 2014

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2014

Agenda Item: 14/102a	**Author of the Paper:** Tracy Jeffes Chief Corporate Delivery and Integration Officer NHS South Sefton CCG Tel no: 0151 247 7049 E mail address: Tracy.Jeffes@southseftonccg.nhs.uk
Report Date: July 2014	

Title: Quarter 4 - 2013/14 Governing Body Risk Assurance Framework

Summary/Key Issues:

The Quarter 4 Governing Body Assurance Framework and Corporate Risk Register were reviewed by the Quality Committee in April 2014 and recommended to the Governing Body for approval. They are presented to the Governing Body to show the final position at the end of the financial year.

Recommendation

The Governing Body is asked to approve the Governing Body Assurance Framework and the Corporate Risk Register.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Sustain 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.
	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			Review of process has been carried out with SMT and CGSG. GB to receive update on progress of work and risk position.

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

South Sefton CCG Assurance Framework 2013/14
Assurance Rating Summary Quarter 4

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

N/A – Not applicable – assurance not expected

Risk No	Risk Description	Risk Rating (L & C)	Accountable Lead	Assurance Rating Q1	Assurance Rating Q2	Assurance Rating Q3	Assurance Rating Q4	Assurance Rating Key
Corporate Objective 1: To consolidate a robust Strategic Plan within the CCG financial envelope								
Unique Identifier	Strategic risk transposed from Assurance Framework document	Risk rating based on agreed risk matrix	Identified lead on behalf of the CCG who is referred to as the 'Risk Owner' on the Assurance Framework document	These columns will state either 'Limited' 'Reasonable' or 'Significant' assurance has been awarded dependent on the weight of assurance provided				This column will have ▼or ►or ▲ inserted here to demonstrate any changes since last review
1.1	Delay in implementing new pathways due to non-achievement of reductions in admissions will impact on delivery of transformation within financial envelope	1x2 ▼	Stephen Astles	**Reasonable**	**Reasonable**	**Reasonable**	**Reasonable**	►
1.2	Lack of political and/or stakeholder support for changes will affect the ability to deliver effectively & impact on integration at community level	3x3 ►	Stephen Astles	**Reasonable**	**Reasonable**	**Reasonable**	**Reasonable**	►
1.3	Lack of GP engagement and information sharing will affect numbers of patients making projects financially unviable	1x4 ►	Stephen Astles	**Reasonable**	**Reasonable**	**Reasonable**	**Reasonable**	►
1.4	Non-delivery of financial targets due to inadequate financial management within internal CCG expenditure budgets	1x5 ▼	Martin McDowell	**Reasonable**	**Reasonable**	**Reasonable**	**Reasonable**	►
1.5	Non-delivery of financial targets due to over-performance/in-effective demand management of activity levels within acute and community provider contracts	1x4 ▼	Martin McDowell	**Reasonable**	**Reasonable**	**Reasonable**	**Reasonable**	►
1.6	Non-delivery of 2013/14 QIPP Plan which supports transformational change	1x4 ▼	Martin McDowell	**Reasonable**	**Reasonable**	**Reasonable**	**Reasonable**	►
Corporate Objective 2: To enhance systems to ensure quality & safety of patient care								
2.1	Lack of capacity within CCG to ensure delivery of CQUINS for 2013/14 will lead to insufficient monitoring systems, impacting on quality & health outcomes	1x2 ►	Debbie Fagan	**Reasonable**	**Reasonable**	**Reasonable**	**Reasonable**	►
2.2	CCG will exceed trajectories for HCAI impacting on patient safety & non-achievement of Quality Premium	3x4 ►	Debbie Fagan	**Reasonable**	**Reasonable**	**Reasonable**	**Significant**	▲

South Sefton CCG Assurance Framework 2013/14
Assurance Rating Summary Quarter 4

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

N/A – Not applicable – assurance not expected

Risk No	Risk Description	Risk Rating (L & C)	Accountable Lead	Assurance Rating Q1	Assurance Rating Q2	Assurance Rating Q3	Assurance Rating Q4	Assurance Rating Key
To establish the Programme Management approach and deliver the CCG programmes for whole system transformation, reduction in health inequalities and improved CCG performance								
3.1	Lack of capacity within CCG will restrict delivery of all programmes in 2013/14 impacting on achievement of meeting outcomes framework 2013/14	1x2 ►	Malcolm Cunningham	**Reasonable**	**Reasonable**	**Reasonable**	**Reasonable**	►
3.2	Lack of sufficient financial data for most programmes makes benefits and outcomes difficult to define	2x3 ►	Malcolm Cunningham	**Reasonable**	**Reasonable**	**Reasonable**	**Reasonable**	►
3.3	Lack of KPIs will impact on delivery of some programmes in 2013/14	1x2 ►	Malcolm Cunningham	**Reasonable**	**Reasonable**	**Reasonable**	**Reasonable**	►
Corporate Objective 4: To collaborate with the Cheshire & Merseyside CSU to ensure delivery of successful support to the CCG								
4.1	Lack of capacity and capability of CSU to deliver sufficient support in a responsive manner within resource envelope	2X4 ►	Tracy Jeffes	**Reasonable**	**Reasonable**	**Significant**	**Significant**	►
4.2	Possible requirement to re-procure CSU services. Risk that re-procurement would divert CCG resources away from service delivery	1x1 ►	Tracy Jeffes	**Reasonable**	**Reasonable**	**Reasonable**	**Reasonable**	►
Corporate Objective 5: To strengthen engagement of CCG members, public, partners and stakeholders								
5.1	Inability to maintain active involvement of all constituents and stakeholders	3x4 ►	Tracy Jeffes	**Reasonable**	**Reasonable**	**Reasonable**	**Reasonable**	►
Corporate Objective 6: To drive clinical leadership development through Governing Body, locality and wider constituent development								
6.1	Lack of capacity amongst clinical colleagues to ensure personal development and facilitate active involvement	4x3 ►	Tracy Jeffes/Stephen Astles	**Reasonable**	**Reasonable**	**Reasonable**	**Reasonable**	►

South Sefton CCG Assurance Framework – 1st January 2014 to 31st March 2014 (Quarter 4)

Version 3. Updated 9th April 2014

NHS South Sefton Clinical Commissioning Group

Corporate Objective 1: To Consolidate a Robust Strategic Plan within the CCG Financial Envelope	Governing Body Reports

Lead Officer/Risk Owner: Stephen Astles

Principal Risks *Risk Owner*:	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
1.1 Delay in implementing new pathways due to non-achievement of reductions in admissions will impact on delivery of transformation within financial envelope **Risk score reduced from Q3 update** Clinical Lead: Dr A Mimnagh	**1x2**	1. Virtual Ward development identified as a priority area 2. Action plan in place with Aintree UHT 3. KPIs for all non-elective admissions monitored under contract process via CSU information portals fed into contract meeting 4. Monitoring of A&E attendance conversion rates (non-elective admissions) via CSU information portals in contract meeting 5. Monthly steering groups to evaluate progress 6. Monthly agenda item on contract review meetings with Liverpool Community Health Services	Contract query process reviewed in monthly contract meetings. Minutes received by Governing Body Progress of action plan reviewed by Unplanned Care Network – exception reports produced Minutes of CCG Urgent Care Collaborative meetings Twice weekly teleconferences with NHSE to monitor & assure A&E performance Action plan continues to support on-going Trust achievement (including monthly meetings). Assurance & exception reporting continues via Quality Committee	**Significant** **Reasonable** Quarterly reports/minutes of meetings received by Governing Body for oversight of delivery progress **Limited**		Regularly reviewed by steering group – contract query not lifted in Q4	SA - June 2014

Progress Reports	**Q1**		**Assurance Rating**	**Reasonable**
	Q2	Process mapping for 11/12/2013 to bring partners/stakeholders together to reduce delayed transfers of care.		**Reasonable**
	Q3	Aintree UHT achieved 4hr A&E target for Q3		**Reasonable**
	Q4	Aintree achieved year 95% A&E target. Discussion at CCF relating to closing of contract query – carried fwd to Q1 2014/15.		**Reasonable**

Corporate Objective 1: To Consolidate a Robust Strategic Plan within the CCG Financial Envelope				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
1.2 Lack of political and/or stakeholder support for changes will affect the ability to deliver effectively & impact on integration at community level **No change in risk score from Q3 update due to postponement of 'Mini Chat' & carry forward to 2014/15**	**3x3**	A Steering Group which involves all stakeholders meets on monthly basis (with approved & documented Terms of Reference) Schedule in place for engagement events with patients and public – Big Chat held in July 2013 and feedback from event supports CCG strategic direction. Agenda item for monthly Locality meetings (presented by GP lead) Big Chat public event held on 4th November 2013 - feedback aligned to planning and fed into Commissioning Intention process	Minutes/reports of Steering Group presented by GP Lead to Governing Body Feedback from stakeholder events rationalised & reviewed by Senior Management Team in collaboration with Communications & Engagement Team Implementation of Urgent Care Workstream, Mobilisation Plan discussed and implemented with GP Lead and LCH. Meeting with practices to discuss implementation (scheduled for Q2 2014/15)	**Significant** **Reasonable** Minutes/reports of Steering Group presented by GP Lead to Governing Body **Limited**			

Progress Reports	**Q1**	Stakeholder Event (Big Chat) scheduled for Quarter 2 (July 2013)	**Assurance Rating**	**Reasonable**
	Q2	'Big Chat' planned for November 2013		**Reasonable**
	Q3	'Mini Chats' planned for Feb 2014; Strategic Plan discussed at Stakeholder Event in Jan 2014.		**Reasonable**
	Q4	Mini Chat postponed (Feb 2014) discussed at Wider Stakeholder Group		**Reasonable**

Corporate Objective 1: To consolidate a robust Strategic Plan within the CCG financial envelope				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
1.3 Lack of GP engagement and information sharing will affect numbers of patients making projects difficult to sustain **No change in risk score from Q3 update**	**1x4**	GP engagement, information sharing and risk stratification embedded in CCG Information gathered formally via monthly Locality Meetings Quarterly Report to Governing Body MDT meetings set up in localities on monthly basis from August 2013	Minutes of meetings for all Locality Groups received by Governing Body Attendance records retained for OD/audit purposes Implementation report submitted to Governing Body on quarterly basis GP Lead updating clinical colleagues on regular basis via weekly bulletin. Feedback at Wider Group/Locality meetings	**Significant** **Reasonable** Governing Body receives minutes of all Locality Meetings & exception reports Implementation report submitted to Governing Body on quarterly basis **Limited**			

Progress Reports	**Q1**	Launch of MDT meetings in Quarter 2; launch meetings for Virtual Ward implementation	**Assurance Rating**	**Reasonable**
	Q2	Risk score reduced due to additional control measure of monthly MDT meetings from August 2013		**Reasonable**
	Q3	Communication with practices continuing. Wider Group meeting to be held on 11th Feb 2014 to involve constituent practices.		**Reasonable**
	Q4	On-going engagement. Clinical Lead and Managerial Lead continuing programme of practice visits to seek opinion. Community Services being discussed at AGM in April 2014.		**Reasonable**

Corporate Objective 1: To Consolidate a Robust Strategic Plan within the CCG Financial Envelope				Governing Body Reports			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
1.4 Non-delivery of financial targets due to inadequate financial management within internal CCG expenditure budgets **No change in risk score from Q3 update**	**1x5**	Internal and External Audit Plan in place to review systems of internal control Robust financial management process in place to ensure reserves and contingency are utilised in an appropriate manner Internal budgetary management process in place to support and challenge budget holder to deliver within agreed limit	Financial Plan for 2013/14 signed off by Finance & Resource Committee Monthly Finance performance reports presented to Finance & Resource Committee with reporting to Governing Body by exception report	**Significant** **Reasonable** Governing Body in receipt of Finance & Resource Committee minutes and exception reports Monthly reporting to NHS England as part of the collective NHS Financial position. **Limited**			

Progress Reports	**Q1**		**Assurance Rating**	**Reasonable**
	Q2	Risk reduced from 3x4 to 2x4 due to control measures in place (internal Audit Plan)		**Reasonable**
	Q3	All plans/ targets on track & reported to GB accordingly. Awaiting MIAA report (Q4)		**Reasonable**
	Q4	Risk revised to 1x5. Latest Governing Body papers report on track to deliver financial duties with reserves available to lower identified risks.		**Reasonable**

Corporate Objective 1: To Consolidate a Robust Strategic Plan within the CCG Financial Envelope				Governing Body Reports			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
Finance 1.5 Non-delivery of financial targets due to over-performance/in-effective demand management of activity levels within acute and community provider contracts **No change in risk score from Q3 update**	**1x4**	Provider contracts agreed and signed with specified activity levels and associated costs Robust financial planning and control process in place Internal and External Audit Plan in place to review systems of internal control Contingencies and reserves held to cover overspends during the year.	Agreed provider contracts signed for 2013/14, with robust contract management arrangements in place to maintain/deliver activity and associated costs within agreed limits Monthly provider contract review meetings in place to verify performance and quality (including CQUIN) Financial Plan for 2013/14 signed off by Finance & Resource Committee Monthly Finance performance reports presented to Finance & Resource Committee with reporting to Governing Body by exception report Internal budgetary management process in place to support and challenge budget holder to deliver within agreed limit	**Significant** **Reasonable** Governing Body in receipt of Finance & Resource Committee minutes and exception reports Governing Body approved contract sign-off 2013/14 Monthly reporting to NHS England as part of the collective NHS Financial position. **Limited**			
Progress Reports	**Q1**					**Assurance Rating**	**Reasonable**
	Q2	Risk score reduced due to robust arrangements embedded for monitoring overspend					**Reasonable**
	Q3	Central winter pressures monies allocated to Trust – monitored via reports from Trust (fwd to NHS E)					**Reasonable**
	Q4	CCG holding adequate levels of reserves to deal with this risk.					**Reasonable**

Corporate Objective 1: To Consolidate a Robust Strategic Plan within the CCG Financial Envelope				Governing Body Reports			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
QIPP 1.6 Non-delivery of 2013/14 QIPP Plan which supports transformational change **No change in risk score from Q3 update**	**1x4**	QIPP targets identified within the 2013/14 financial plan QIPP plans in place to deliver required financial cost reductions	QIPP financial savings targets and plans signed off by the Governing Body (March 2013) Monthly financial performance reports (including QIPP targets and associated savings) presented to Finance and Resource Committee and reviewed by the Governing Body	**Significant** **Reasonable** Finance Reports produced by/for F&R Committee received & reviewed by Governing Body Paper presented to F&R Committee in January 2014 to update the progress against plan; identified small residual balance to be found but with plans in place to address. **Limited**			

Progress Reports	**Q1**		**Assurance Rating**	**Reasonable**
	Q2	On target to deliver QIPP– expected during Q3		**Reasonable**
	Q3	QIPP - small balance remaining still to deliver, financial plans made provision for this. Risk reduced to 2x4		**Reasonable**
	Q4	QIPP plans on course for delivery in 2012/14		**Reasonable**

Corporate Objective 2: To Enhance Systems to Ensure Quality and Safety of Patient Care				Governing Body Reports			
Lead Officer/Risk Owner: Debbie Fagan							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
CQUINS 2013/14 2.1 Lack of capacity within CCG to ensure delivery of CQUINS for 2013/14 will lead to insufficient monitoring systems, impacting on quality and health outcomes Reviewed February 2014, controls in place and recent appointment has addressed the risk of capacity. Risk rerated to likelihood of 1 and consequence of 2.	**1x2**	1. Regular reporting to Quality Committee 2. Revision of OD Plan for 2013/14 3. Formal exception reporting to Quality Committee from GP Clinical Lead for Quality and CQUIN. 4. Monthly contract meetings is in place to review and verify performance and activity on provider contracts including CQUIN 5. WTE resource Programme Manager – Quality & Safety in post 2nd September 2013. 6. Trust quality & performance submitted to NHS England as part of Risk Summit 7. Discussion re: Trust part of QSG (NHS England) work plan 8. Restructure of Quality Team in Q4 to increase capacity	Bi-monthly performance reports to Quality Committee received by Governing Body Clinical reviews of plans to ensure no adverse effect Chief Nurse leads on Quality to ensure that quality is maintained via established resources Quality reporting standing agenda item for Governing Body Chief Nurse member of Finance & Resource Committee. Senior Finance Team member attached to the Quality Committee to ensure risk is minimised Chief Nurse in attendance at provider quality meetings with provider since October 2012	**Significant** . **Reasonable** Governing Body receipt of Quality Committee minutes/exception reports Chief Nurse has lead for Quality, is Governing Body Member and reports directly to Governing Body on Quality issues MIAA review of Committee Structure in Q3 – amendments made to ToRs in response **Limited**			
Progress Reports	**Q1**	WTE resource identified to support Chief Nurse for Quality portfolio area				**Assurance Rating**	**Reasonable**
	Q2	WTE Programme Manager – Quality & Safety in place in Sept 2013					**Reasonable**
	Q3	Dementia Plan in place – scrutiny at Quality Committee of Provider Quality Dashboards					**Reasonable**
	Q4	Deputy Chief Nurse in post from 1st Jan 2014.					**Reasonable**

Corporate Objective 2: To Enhance Systems to Ensure Quality and Safety of Patient Care				Governing Body Reports			
Lead Officer/Risk Owner: Debbie Fagan							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
HCAIs 2.2 CCG will exceed trajectories for HCAI impacting on patient safety & non-achievement of quality premium **No change in risk score from Q3 update**	**3x4**	1. Regular reporting to Quality Committee on HCAIs 2. CPQG reporting 3. CDIF Task & Finish Group established (progress reports to Quality Committee) 4. Partnership with Public Health England & NHS England revision Community Infection Prevention & Control service specification (Chief Nurses report on progress to Quality Committee 5. Mersey Clinical Commissioning Network established July 2013 (HCAI) 6. CCG Action Plan presented to Quality Committee – Aintree Action Plan monitored via Collaborative Commissioning Forum & CQPG	Minutes of Quality Committee meetings Minutes of CPQG received by Quality Committee Progress/Exception reports by CDIF Task & Finish Group received by Quality Committee Chief Nurse provides monthly reports on HCAIs to Quality Committee & Governing Body HCAI priority area for improvement as part of Quality Review Process/Risk Summit Review of RCAs for MRSA – case reported via Trust (lessons learned fed into Aintree Action Plan)	**Significant** CCG HCAI Action Plan gained positive assurance following NHS England Q3 checkpoint meeting **Reasonable** Quality Committee reports/minutes received by Governing Body (standard agenda item) Chief Nurse has lead for Quality, is Governing Body Member and reports directly to Governing Body on Quality issues Commissioner Support for CDiff appeals process (managed by NHS England) **Limited**			
Progress Reports	**Q1**	Mersey Clinical Commissioning Network will meet in July 2013 (HCAI meeting)				**Assurance Rating**	**Reasonable**
	Q2	CCG HCAI Action plan to be presented to Quality Committee in November 2013					**Reasonable**
	Q3	Health Economy Group to review RCAs for CDiff in Q4.					**Reasonable**
	Q4	Planning workshop held on 31st March 2014 for Sefton health economy led by CCG. CCG HCAI Action Plan shared with NHS England as part of Assurance Process (presented to Quality Committee in Q3)					**Significant**

Corporate Objective 3: To Establish the Programme Management Approach and Deliver the CCG Programmes for Whole System Transformation, Reduction in Health Inequalities and Improved CCG Performance				**Governing Body Reports**			
Lead Officer/Risk Owner: Malcolm Cunningham							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
3.1 Lack of capacity within CCG will restrict delivery of all programmes in 2013/14 impacting on achievement of Outcomes Framework 2013/14 **No change in risk score from Q3 update**	**1x2**	Full capacity of Programme Management Office achieved with no gaps identified Balanced Scorecard produced for each programme PMO reporting to Finance & Resource Committee Programme tracking in place via PMO Head of Strategic Financial Planning in post from August 2013 Head of Strategic Planning and Assurance in post from October 2013	Minutes of Finance & Resource Committee Oversight of Balanced Scorecards by PMO, exception reports to Finance & Resource Committee	**Significant** **Reasonable** Minutes of Finance & Resource Committee received by Governing Body (monthly) **Limited**			

Progress Reports	**Q1**		**Assurance Rating**	**Reasonable**
	Q2			**Reasonable**
	Q3	Delivering Balance Scorecard for Programmes in Q3 – tracking of all programmes in place. Risk reduced		**Reasonable**
	Q4	Continue to deliver balance scorecard for programmes in Q4 – tracking of all programmes in place		**Reasonable**

Corporate Objective 3: To Establish the Programme Management Approach and Deliver the CCG Programmes for Whole Ssystem Transformation, Reduction in Health Inequalities and Improved CCG Performance				**Governing Body Reports**			
Lead Officer/Risk Owner: Malcolm Cunningham							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
3.2 Lack of sufficient financial data for most programmes makes benefits and outcomes difficult to define **No change in risk score from Q3 update**	**2x3**	PMO reporting to Finance & Resource Committee Staff recruitment to Finance Team to improve financial data/information for programmes WTE – Head of Strategic Financial Planning in post from August 2013 Head of Strategy and Assurance in post from October 2013	Minutes of Finance & Resource Committee Information flows established via Finance & Resources Committee	**Significant** **Reasonable** Minutes of Finance & Resource Committee received by the Governing Body (monthly) **Limited**			

Progress Reports	**Q1**	Staff recruitment to Finance Team in Quarter 2 to improve financial data/information for programmes	**Assurance Rating**	**Reasonable**
	Q2	Head of Strategic Financial Planning in post from August 2013		**Reasonable**
	Q3	Implementation of Strategic Planning Process is addressing this risk (risk reduced from 3x3 to 2x3)		**Reasonable**
	Q4	The Strategic Planning process continues to address this risk		**Reasonable**

Corporate Objective 3: To establish the Programme Management approach and deliver the CCG programmes for whole system transformation, reduction in health inequalities and improved CCG performance	**Governing Body Reports**
Lead Officer/Risk Owner: Malcolm Cunningham	

Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
3.3 Lack of KPIs will impact on delivery of some programmes in 2013/14 **No change in risk score from Q3 update**	**1x2**	PMO reporting to Finance & Resource Committee KPIs developed and reported against programmes (Q2) Head of Strategic Financial Planning in post from August 2013 – key role in developing measurable KPIs Head of Strategy and Assurance in post from October 2013	Minutes of Finance & Resource Committee and exception reports Reported via Finance & Resources Committee	Significant **Reasonable** Minutes of Finance & Resource Committee received by the Governing Body bi-monthly **Limited**	Some development required for KPIs	Head of Strategy & Assurance/Head of Strategic Financial Planning will provide senior management support in ensuring measurable KPIs are introduced	April 2014

Progress Reports	**Q1**		**Assurance Rating**	**Reasonable**
	Q2	Risk status reduced from 3x3 to 2x2 due to KPIs developed in Q2		**Reasonable**
	Q3	Risk status reduced to 1x2 due to KPIs developed in Q3 & recruitment to key roles which will develop KPIs		**Reasonable**
	Q4	Risk continues to be managed through the KPIs and recruitment to key roles		**Reasonable**

Corporate Objective 4: To Collaborate with the Cheshire & Merseyside CSU to Ensure Delivery of Successful Support to the CCG				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
4.1 Lack of capacity and capability of CSU to deliver sufficient support in a responsive manner within resource envelope **No change in risk score from Q3 update**	**2x4**	1. SLA in place with Provider 2. Contract/Performance Monitoring Group 3. Exception reporting on performance and delivery is a standing agenda item at SMT 4. Internal review of CSU completed September 2013	Monthly meeting of Performance Monitoring Group Head of Client Operations – CSU to attend weekly SMT meetings to support Specific agreement reached with CSU to ensure continuation of locally based communications and engagement capability. Reports to Finance & Resource Committee on six monthly basis	**Significant** MIAA report (December 2013) offering significant assurance of CCG's performance management of CMCSU **Reasonable** Governing Body receives minutes of Finance & Resource Committee **Limited**			

Progress Reports	**Q1**	Development of KPIs to ensure more robust contract management	**Assurance Rating**	**Reasonable**
	Q2	Develop more systematic reporting on performance for Quarter 3. Internal review of CSU performance com		**Reasonable**
	Q3	Commissioning support commissioning intentions highlighted to CMCSU to indicate planned changes & service lines under review		**Significant**
	Q4	Significant assurance given by MIAA. MIAA recommendation that performance report is aligned to risk management process & further development of KPIs – key recommendations shared with F&R Committee (Jan 2014).		**Significant**

Corporate Objective 4: To Collaborate with the Cheshire & Merseyside CSU to Ensure Delivery of Successful Support to the CCGs				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
4.2 Possible requirement to re-procure CSU services. Risk that re-procurement would divert CCG resources away from key CCG priorities No risk for CCG against delivery for 2013/14 due to updated guidance from NHS England re: procurement	**1x1**	Plan produced in draft for re-procurement identifying timescales, resource requirements, impacts and risks Updated guidance from NHS England, CCGs are now able to re-negotiate SLAs -	Progress reports to SMT Progress/exception reports to Finance & Resource Committee	**Significant** **Reasonable** Minutes of Finance & Resource Committee received by Governing Body **Limited**			

Progress Reports	**Q1**		**Assurance Rating**	**Reasonable**
	Q2	Due to updated guidance from NHS England, CCGs are now able to re-negotiate SLAs		**Reasonable**
	Q3	Commissioning support commissioning intentions highlighted to CMCSU to indicate planned changes & service lines under review		**Reasonable**
	Q4	No action required – risk considered insignificant.		**Reasonable**

Corporate Objective 5: To Strengthen Engagement of CCG Members, Public, Partners and Stakeholders				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
5.1 Inability to maintain active involvement of all constituents and stakeholders **No change in risk score from Q3 update**	**3x4**	Refreshed Communications and Engagement Strategy 2013 Increased development of Locality model & resourcing Effective running of Engagement and Patient Experience Group in place to ensure on-going active involvement of key partners e.g. Sefton Healthwatch, voluntary sector and LA & coordination of local patient and public activities CCG public-facing internet site now live Lead locality GP, Practice Nurse & Practice Manager meetings on monthly basis for each locality Remunerations Committee has agreed financial resourcing for backfill/Clinical involvement	Documented evidence of involvement Quarterly Wider Constituent meetings with GP attendance recorded/minuted	**Significant** **Reasonable** Governing Body receives minutes of Locality Meetings **Limited**			

Progress Reports	**Q1**	Refresh of locality web pages on intranet	**Assurance Rating**	**Reasonable**
	Q2	Quality of conversations with stakeholders having positive effect on improvement		**Reasonable**
	Q3	Election process to commence in Q4 for Governing Body membership		**Reasonable**
	Q4	On-going engagement. Clinical Lead and Managerial Lead continuing programme of practice visits to seek opinion. Community Services being discussed at AGM in April 2014.		**Reasonable**

Corporate Objective 6: To drive clinical leadership development through Governing Body, locality and wider constituent development				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
6.1 Lack of capacity amongst clinical colleagues to ensure personal development and facilitate active involvement **No change in risk score from Q3 update – vacancy affecting risk score**	**4x3**	OD Plan refreshed for 2013/14 Increased development of Locality model and resourcing Monthly joint development session for Governing Body members and clinical leads Documented and robust PDR process for Governing Body members and locality lead roles Primary Care Quality Board established November 2013 – led by clinician GP employed for 4 sessions for advanced care planning – can provide level of support as contingency	Records of developmental sessions for Governing Body members/clinical leads Minutes of Locality Meetings Minutes of Primary Care Quality Board meeting received via Quality Committee (oversight by Governing Body)	**Significant** **Reasonable** Governing Body oversight of PDR process for members/clinical and locality leads via exception reporting Minutes of Locality Meetings received by Governing Body **Limited** GB Vacancy discussed at Wider Group Meeting on 11th Feb 2014	Lead roles not filled Governing Body vacancy not filled in Q4	Advertised & expressions of interest requested. Vacancy to be discussed at April 2014 AGM	April 2014

Progress Reports	**Q1**	Primary Care Quality Strategy in consultation. Governing Body development sessions on-going in 2013/14	**Assurance Rating**	**Reasonable**
	Q2	Primary Care Quality Board established and meeting on 14th November 2013.		**Reasonable**
	Q3	Election process to commence in Q4 for Governing Body membership		**Reasonable**
	Q4	GB Vacancy to be discussed at AGM (April 2014)		**Reasonable**

Principal Risks: are what could prevent key objectives from being achieved. Key risks should be true risks (rather than consequences), and so cannot just be the converse of the objective.

Assurance Rating Section: this shows section seeks to help the Governing Body to 'weight' the assurance provided by Risk Owners. It directs the amount of attention it needs to spend in reviewing entries on the Assurance Framework. The categories are 'Limited', 'Reasonable' and 'Significant'. The Governing Body should be expecting to see 'Reasonable' assurance for the entries in the document unless there is a specific reason for this not to happen. For example, a new care pathway introduced in quarter 1 might only have been given limited assurance as the implementation plan for the pathway has only just begun. As the year progresses the assurance rating should increase with the embedding of the pathway.

Key Controls: are factors, systems or processes that are in place to mitigate the principal risk(s) and assist in securing delivery of the relevant key objective. Key controls should be robust and specific and properly match the associated key objective(s). For example; a sub committee or committee of the Governing Body which is tasked with monitoring the specific risk.

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

Gaps in Control: indicates where the organisation has failed to put key controls in place, or has failed to make key controls effective.

Gaps in Assurance: indicates where the organisation is failing to gain evidence that key controls are effective.

Corrective Action: shows what will or is being done to address the gap(s) in control or assurance.

Responsibility / Target Date: shows the Director (or senior manager) responsible for appropriate and timely implementation of corrective action(s) and the expected date by which actions should be completed.

Progress reports provide a quarterly update on achievement of action plans and identify where gaps in control or assurance have been addressed. They should also indicate where the risk grading has changed for any risks associated with that objective.

Generally, Assurance Frameworks should map key objectives to principal risks, key controls and assurances explicitly. Assurance frameworks should be embedded and dynamic, providing regular Governing Body information and not viewed as year-end exercises.

Assurance Rating

Limited Rating – Insufficient Assurance Provided

A limited assurance rating will be applied where a risk owner has failed to record any evidence within the 'Key Positive Assurance' column during that quarter or where only minimal evidence is provided, all of which is deemed as providing 'limited assurance'.

Reasonable Rating – Adequate Assurance Provided

A reasonable assurance rating will be applied where a risk owner has recorded in the 'Key Positive Assurance' column at least one piece of evidence deemed 'reasonable' assurance together with a number of pieces of evidence deemed 'limited' assurance.

Significant Rating – Substantial Assurance Provided

A significant risk rating will be applied where a risk owner has recorded in the 'Key Positive Assurance' column a minimum of one piece of evidence deemed as providing 'significant' assurance **or** a number of pieces relating to different aspects of assurance deemed 'reasonable'

Examples of what constitutes differing levels of assurance:

Key Positive assurance (** External/Independent) EXAMPLES OF TYPES OF ASSURANCE
**SHA Audit of data quality indicating no significant concerns, reported to Trust Governing Body January 2010, PCT commissioning committee February 2011. (significant assurance)
**CQC indicators met for relevant targets as reported in periodic review, October 2011 (significant assurance)
Performance Report received by the Trust Governing Body, most recent September 2009, showing performance within tolerance for overall achievement of target for Q1 (reasonable assurance)
Contract monitoring report to commissioning committee in September 2010 showing performance within tolerance for overall achievement of target for Q1 (reasonable assurance)
Performance report to Trust Governing Body, most recent September 2010, indicating current position against key targets (limited assurance)

2010/11 prospectus published March 2009, included for information in Governing Body papers May 2010
Uptake report on attendance at Health & Safety courses at Health & Safety working group November 2010 shows 60% of staff have attended relevant courses, compared with 40% last year
Reasonable Assurance
Update report to HR committee September 2010 demonstrating 80% of required courses now established
Limited Assurance
Performance report to Trust Governing Body, most recent September 2010, indicating current position against key targets

Key Positive assurance EXAMPLE OF NEW LAYOUT
Significant Assurance

Risk Grading Matrix

Consequence / Likelihood	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

Risk	Score	Colour
Insignificant	1 - 3	
Low	4 - 6	
Moderate	8 - 12	
High	15 - 25	

Significant risk

Significant Risk

A risk which attracts a score of 8 or above on the risk grading matrix constitutes a significant risk and must be recorded on the Directorate Risk Register.

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

Version 3, Q4 2013/14

Last Saved: 10/04/2014

By User: loughc

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

ID	Principal Risk	Organisational Goal	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Progress against action Plan	L	C	Current Risk Rating	Change Since Last Update
1	CCG fails to balance its budget/hit its financial target	Goal 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Financial Statutory	Governing Body to be advised by Chief Financial Officer Martin McDowell	Financial Reporting - Monthly finance reports - Finance and resources committee overview - Focus on Out-Turn position - Internal Systems - SFIs and SoRD - Review Internal and External audit reports -Use of Contingency Plans/Reserves - Monthly Provider Contract Reviews	2	5	10	(1) Clarify required regarding PCT disaggregation of baselines, particularly in respect of Specialised Commissioning and also intra-Sefton CCG arrangements. (2) Reserves held to offset against operational pressures. (3) Potential to defer investments if position deteriorates Board action should position deteriorate	CCG identified impact of likely baseline adjustments. Latest F & R/GB Finance Reports indicate that CCG is on target to deliver financial duties.	1	5	5	▶
2	Continuing Healthcare Restitution claims exceed available resources	Goal 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Financial	Chief Financial Officer Martin McDowell/ Debbie Fagan /CSU	CMSU have made assessment of claims received at high level - estimate claims for CCG c. £1m having previously estimated. The treatment of prior year legacy provisions has been finalised and there is a potential pressure facing the CCG in 2014/2015 which has been built into opening 2014/15 budgets.	4	4	16	Confirmation of claimants by CMCSU on behalf of CCG/detailed review of claims to aid better forecast of costs. CHC update report received in November 2013	Commissioned CSU to manage and progress quickly, although there are concerns as to capacity to deal with promptly to ensure that potential reputational issues are managed. Ongoing discussions regarding scope of role to CCG.	3	4	12	▶
3	Allocations/Financial Performance	Goal 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Financial	Chief Financial Officer Martin McDowell	CCG has received notification of potential revised allocation based on 'new formula'.	2	4	8	Pace of change policy likely to ensure transition period before introduction	Publication date 16th December. New allocations indicate slow pace of change. CCG needs to develop "worse case scenario" to deal with faster pace of change from 2016/17 onwards.	3	3	9	▼
4	Changes in patient flow causes financial issues, primarily from fixed price to PbR contracts, increase in activity overall and the financial implications on the 13/14 contract negotiations	Goal 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Financial	Governing Body to be advised by Chief Financial Officer Martin McDowell/Brendan Prescott	Review of patient choice procedures within guidance -monthly report - information shared with GP leads - practice level reporting of financial information	4	2	8	None	CCG monitoring performance accordingly. CCG has built impact of changes into contract, no reflected in plans. Reported in financial position	3	2	6	▶

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

Version 3, Q4 2013/14

Last Saved: 10/04/2014

By User: loughc

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

ID	Principal Risk	Organisational Goal	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Progress against action Plan	L	C	Current Risk Rating	Change Since Last Update
5	Increased costs arising from high cost drugs in secondary care	Goal 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Financial	Governing Body to be advised by Chief Financial Officer Martin McDowell / CCG Lead for Medicine Management Brendan Prescott	Review of cost implications Checking patients Liaison with secondary care clinicians	4	2	8	Clear horizon scanning by the CCG in preparation for 13/14 budgets - work with Public Health to determine impact	CCG monitoring performance accordingly - reported in financial position	2	2	4	▶
6	Lack of existing capacity of Hosted Safeguarding Children and Vulnerable Adults Service could impact on CCGs ability to discharge its statutory functions;	Goal 2: Enhance Systems to Ensure Quality and Safety of Patient Care	Quality	Chief Nurse Debbie Fagan	Service Hosted with NHS Halton CCG; Draft SLA in development; regular 1:1 meeting with named designated nurse for Sefton CCGs/Local Authority Area; Chief Nurse attends both Safeguarding Children and Safeguarding Adults Boards; CCG Boards under scheme of reservation and delegation reserve decision making remains at board level;	3	3	9	Service hosted with NHS Halton CCG, who are leading on recruitemnt to posts created to increase capacity and capability within the service. Agree and sign SLA with host CCG. Telecon between Chief Officer and Chief Nurses in August 2013 regarding progress of Safeguarding Hosted Service. Paper to be taken to the CCG Network in October 2013.	Risk to remain the same until sign off of the SLA/recruitment to vacant post completed Draft SOP developed between Safeguarding Service & CSU. To be reviewed in accordance with recommendations from commissioned CQC style peer review of Safeguarding Children and Adult Services. First draft of Safeguarding Adults peer review received 31/03/2014	3	3	9	▶
7	Need for clarity of roles and responsibilities between Safeguarding Hosted Service, CSU CHC team and LCH Provider Safeguarding Team to enable CCG to discharge their safeguarding function. Need for further clarity between health and social care commissioning / safeguarding for vulnerable adults.	Goal 2: Enhance Systems to Ensure Quality and Safety of Patient Care	Quality	Chief Nurse Debbie Fagan	Safeguarding Adults Lead is part of the commissioned service hosted by NHS Halton CCG; CSU CHC Team provide quality assurance / contract management, including safeguarding, for care homes; Safeguarding adults service is commissioned from LCH	4	5	20	Meeting with LA to clarify roles and responsibilities regarding safeguarding adults. (1) Chief Nurses have raised the need to have as an agenda item on the Mersey CCG Safeguarding Steering Group (to be Chaired by a CCG Chief Officer) (2) Draft SOP developed between Safeguarding Service & CSU. To be reviewed in accordance with recommendations from commissioned CQC style peer review of Safeguarding Children and Adult Services. First draft of Safeguarding Adults peer review received 31/03/2014 (3)To facilitate RCA / Lessons Learnt from recent safeguarding incident.	Chief Nurse on-going meetings with LA (Head of Vulnerable Adults Services) - draft SOP shared with LA for comments. Draft SOP shared with provider organisation for comments.	2	4	8	▼

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

Version 3, Q4 2013/14

Last Saved: 10/04/2014

By User: loughc

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

ID	Principal Risk	Organisational Goal	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Progress against action Plan	L	C	Current Risk Rating	Change Since Last Update
8	Unresolved restitution CHC cases may lead to reputational damage to CCG (to be read in conjunction with Risk 2 above)	Goal 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Reputational/Adverse publicity	Chief Nurse Debbie Fagan	Commissioned Service from CMCSU; Standing Agenda Item on Quality Committee; Reports to the Governing Body; Updates received from CHC Team;	4	3	12	Requested monthly performance report and remedial action plan from CHC Team; Locality Team Model for Sefton being developed by CMCSU	Chief Nurse met with COO (CMCSU) & Yvonne Lockhead (March 2014). Change of Leadership within Locality Team. Monthly meetings between Chief Nurse & CMCSU Team scheduled to discuss operational models Discussed complaints management linked to restitution & CHC in general - CMCSU to review how complaints are logged, categorised and managed. CCG has requested more detailed information regarding activity in relation to restitution/closedown. CMCSU will clarify more detail in standard letters (e.g. timeframes) to manage patient/family applicant expectations. Plans for Integrated Model to be delivered locally in Q1/Q2 of 2014/15.	4	3	12	▶
9	Health Economy Urgent Care, 4 hour target may not be achieved	Goal 2: Enhance Systems to Ensure Quality and Safety of Patient Care	Statutory Duty	Head of CCG Development Steve Astles	Daily sitreps, 2 weekly telecon with RUCAT, Urgent care strategy with local health economy, active case management model, consultant in community work; no active case management but has virtual ward management; increased primary care capacity;	4	4	16		Virtual ward action plan in place and reporting weekly to SMT. Aintree achieved year 95% A&E target. Discussion at CCF relating to closing of contract query – risk to be carried fwd to Q1 2014/15. **Comment (SH) - this has been amended based on SA's feedback for GBAF Risk. Need to consider removal if Trust has achieved yearly target.**	1	2	2	▼

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

Version 3, Q4 2013/14

Last Saved: 10/04/2014

By User: loughc

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

ID	Principal Risk	Organisational Goal	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Progress against action Plan	L	C	Current Risk Rating	Change Since Last Update
10	That local residents may experience a fragmentation / less local co-ordination and responsiveness of complaints and patient information services at a local level due to NHS England's national procurement and separate management of these processes.	Goal 5: To Strengthen Engagement of CCG Members, Public, Partners and Stakeholders	Quality	Head of Delivery	Regular feedback from CSU / PALs regarding management of local queries. CSU temporary management and coordination of local primary care complaints.	3	3	9	Liaison with NHS E Merseyside Team regarding co-ordination of arrangements in the future.	CSU still managing NHS E complaints process, so internal sign-posting within CSU has mitigated some of the risks/concerns.	2	3	6	▼
	Contractual Performance													
12	18 week & cancer pathways may not be met due to non delivery of target by provider	Goal 2: Enhance Systems to Ensure Quality and Safety of Patient Care	Business Objective	Head of Performance & Health Outcomes Malcolm Cunningham	monthly contract meetings, Clinical Quality and performance meetings, clinical lead for contracts and for quality, additional funding for RTT, worked closely with providers on cancer pathway. Set up clinical meetings with cancer leads and manager. Managerial lead for cancer has action plan in place.	3	3	9	Use contract levers and clincial interventions, review implementation plans for RTT delivery and monitor on a weekly basis,	Developed a system wide patient education plan regarding the importance of attending appointments and reviewing polices around patient choice. Cancer lead to discuss with colleagues at Protected Learning Time on 18/9 regarding actions when a 2/52 referral patient is about to go on holiday. Drop in performance in Q4 could lead to year and target failure.	3	4	12	▲
13	Attainment of FT status at Liverpool Community NHS Trust	Goal 2: Enhance Systems to Ensure Quality and Safety of Patient Care	Statutory Duty, business objectives	Chief Officer Fiona Clark	IBP submitted with CCG support and caveats,	3	4	12	Workshops with CCG board and stakeholders to understand implications and consequences, frequesnt communication with NHSCB LAT, Trust Board to board sessions. NTDA	Following MIAA's review of the IG Toolkit and 'significant' assurance received, and review of this risk by Quality Committee in January 2014 and Corporate Governance Group and SMT in Februrary 2014 it was considered that the changing NHS environment, National Policy and the role of the Trust Development Agency, it was agreed that this risk should be reduced substantially. **Recommend removal following Q4 review (SH)**	1	2	2	▶

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

Version 3, Q4 2013/14

Last Saved: 10/04/2014

By User: loughc

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

ID	Principal Risk	Organisational Goal	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Progress against action Plan	L	C	Current Risk Rating	Change Since Last Update
14	CSU will not deliver comprehensive service to CCG leading to an inability to deliver key objectives	Goal 4: Collaborate with the Cheshire & Merseyside CSU to Ensure Delivery of Successful Support to the CCG	Statutory Duty	Head of Delivery Tracy Jeffes	SLA in place with provider; Monthly monitoring meetings; formal reporting; identified Head of Cient operations lead appointed to liaise with Head of Delivery;action plan in place to address under performance in relation to business intelligence function	2	3	6	Reporting to Finance & Resource Committee on 6 monthly basis; KPI to be further developed; Joint development work with leads across CCG and CSU to ensure effectively operationalise workstreams	KPIs agreed, Locality Team established, CCG leads meetings with CSU leads on operational matters. Progress in BI in relation to implementation plan of CMIP has reduced risk of delivery.	2	3	6	▼
Governance														
15	Ineffective engagement and communications will impact on the ability to meet statutory duties and possible damage to CCG reputation	Goal 5: To Strengthen Engagement of CCG Members, Public, Partners and Stakeholders	Adverse Publicity /Reputation	Head of Delivery & Integration Tracy Jeffes	Integrated Communications and Engagement Stratey in place including annual action plans; Governance structure identified including Quality Committee, EPEG, Locality Groups	3	4	12	KPIs and dedicated resource for communications and engagement to be defined with C&MCSU including annual review of communications and engagement strategy	Systematic process for engagement and consultation defined, with clear reporting channels from locality level to committee structure (Community Champion, Locality Groups, EPEG, Quality Committee) Plan in place for Strategic Communications to come 'in-house'.	3	3	9	▶
16	Unencrypted pen drives in use within NHS South Sefton CCG which could be accessed if lost	Safety of data/Information Governance	Corporate	SIRO Lead, Martin McDowell	Pen sticks only issued to Admin team who sign a written agreement declaring their understanding that only documentation that is suitable for the public arena maybe saved on these devices. The Admin team does not share these devices. The Admin team does not have access to any patient or staff data.	3	3	9	Reinforement of policy around use of these drives to take place regularly at team meetings. Any new starters to be made aware of the policy before issue of device.	Actions delivered. **Recommend removal from CRR following Q4 review (SH)**	2	2	4	▶
18	111 System Failure	Goal 2: Enhance Systems to Ensure Quality and Safety of Patient Care	Business Objective	Head of Primary Care	Daily teleconference with NHS England and provider, local and regional updates. OOH provider is situ and managing call volume	3	3	9	Controls and systems are in place – OOH is using model 1: medical triage, to manage call volume. OOH call volume is reducing	Plans in place and working well, will monitor with Merseyside lead	2	2	4	▶

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

Version 3, Q4 2013/14

Last Saved: 10/04/2014

By User: loughc

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

ID	Principal Risk	Organisational Goal	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Progress against action Plan	L	C	Current Risk Rating	Change Since Last Update
19	Health and Social Care Act 2012, Section 251 stated that CSU and CCGs do not have a legal right to hold patient confidential data for 2013/14 onwards	Safety of data/Information Governance	Portal development/ contract monitoring	Chief Finance Officer	A legal agreement under Section 251 allows the processing of data to finalise business from 2012/13	4	4	16	To be raised at next CCG Network to look to resolve nationally. MDs raising with NHS England. CSU staff seconded to local DMIC with appropriate certification to process PID CSU has attained ASH status with focus on appropriate individuals having appropriate access to data governed by IG policies CCG working with CSU to ensure that we process data in line with the act – use for direct patient care CCG internal actions include IG policies, incident reporting and senior staff nominated as SIRO / Caldicott Guardian to oversee use of data.	Significant assurance from MIAA received - CCG has achieved level 2 compliance in respect of Information Governance Toolkit in Q4 **Need to consider removal from CRR based on feedback from DF (SH 02/04/2014)**	1	4	4	▼
	Quality													
21	Impact of lab results on patient safety being sent to GP practices where they are not registered. Current IT system only allows GPs to reject results	Enhance Systems to Ensure Quality and Safety of Patient Care	Quality	Chief Nurse	Raised as an isue at the Quality Committee and Contract meetings.	4	3	12	GP Clinical Lead to meet with Acute Trust Provider Lab Team.	3 GP Clinical Quality Lead has set up a Task and Finish Group with the lead for Lab Services . Progress reports to be received by the Quality Committee. National problem - been referred back to system provider & risk will remain the same until further developments.	4	3	12	▶
22	A number of complaints received regarding the quality and capacity of service at a number of newly procured GP practices. Risk in CCG's ability to deliver on reduction in A&E attendances NEWLY IDENTIFIED RISK 16.11.13	Enhance Systems to Ensure Quality and Safety of Patient Care	Quality	Head of CCG Development	Monthly monitoring of A&E attendances for patients of the affected practices ongoing via CMCSU BI Portals	3	3	9	Monthly monitoring of A&E attendances for patients of the affected practices	Data to date shows that there is no signficant risks in A&E attendances in these practices.	3	3	9	▶

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

Version 3, Q4 2013/14

Last Saved: 10/04/2014

By User: **loughc**

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

ID	Principal Risk	Organisational Goal	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Progress against action Plan	L	C	Current Risk Rating	Change Since Last Update
23 New Risk Q3	Aintree University Hospital Trust , Southport & Ormskirk Hospitals, Alder Hey, LCH RAG rating relation to robust Safeguarding systems and processes presents lack of assurance for CCG based upon validation of information presented by the Trust. Risk increased due to interface issues with reporting system between CSU and Safeguarding Hosted Service.	Enhance Systems to Ensure Quality and Safety of Patient Care	Quality and financial	Chief Nurse	RAG rating monitored via Quality Contract meetings. Reported to Quality Committee and escalated to Governing Body as required. Chief Nurse informed NHS England (M) and safeguarding will be included in the quality review process with the Trust. Monitored through quality contract meetings with CSU	4	4	16	Ongoing liaision between Safeguarding Hosted Service and provider. Safeguarding Hosted Service have offered additional support to trusts as a critical friend. Chief Nurse has discussed with Executive Nurse via telephone in November 2013. Chief Nurse arranged urgent meeting between CCG, CSU and Safeguarding Hosted Service - date set for beginning of December.	Update given from Safeguarding Service at March Quality Committee. Discussed at March Governing Body - letter drafted and to be sent to all providers from CCG Chief Officer. Safeguarding Service attending provider Safeguarding Advisory Groups in order to support and monitor progress in order to mitigate risk. Process developed between Safeguarding Service & CSU to ensure timely receipt of provider information in order for it to be analysed by Safeguarding Service to inform RAG rating.	4	4	16	▶
24 New Risk Q3	Absence of a robust process for management of conflict of interests could lead to flawed decision making and/or legal challenge	To Strengthen Engagement of CCG Members, Public, Partners and Stakeholders	Statutory Duty	Head of Corporate Delivery & Integration	Standards of Business Conduct Policy ratified Conflicts of Interest Policy Declarations of Interest at each Committee/Governing Body Agenda Register of Interests in place & publicly available COI Approvals Panel Terms of Reference in Draft	2	4	8	Additional Strategic Governance support in place via CSU to review and enhance management of Conflicts of Interest & embedding process in CCG.	Additional Strategic Governance support in place via CSU to review and enhance management of Conflicts of Interest & embedding process in CCG.	2	4	8	▶
25 New Risk Q3	Comprehensive view of quality issues in Primary Care may not be available if NHS England are unable to share Primary Care Quality Data	Goal 2: Enhance Systems to Ensure Quality and Safety of Patient Care	Quality	Chief Nurse	1.Monthly Checkpoint Meeting with NHS E (issue raised at meetings) Quality Committee oversight of action plan (risk highlighted by Quality Committee) Locality Leads 2. Regular meeting with NHS England to manage the risks which includes Head of Primary Care . Meetings with LMC. NHS England looking at an alternative provider.	2	4	8	Liaise with Practice managers at regular Practice Managers meeting.	NHS E have reported that they are reviewing and re-focussing their internal assurance Group and as information becomes available intelligence will be shared with CCG.	2	4	8	▶

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

Version 3, Q4 2013/14

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By User: **loughc**

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

ID	Principal Risk	Organisational Goal	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Progress against action Plan	L	C	Current Risk Rating	Change Since Last Update
26 New Risk Q4	Adverse CQC report on local practice may result in reputational damage to CCG & impaired access to Primary Care services	Goal 1: To consolidate a robust Strategic Plan within the CCG's financial envelope		Head of Performance & Health Outcomes Malcolm Cunningham	NHSE have asked local providers for expressions of interest in taking over the practice	2	4	8		Out to expressions of interest at present	3	4	12	▲

NHS
South Sefton
Clinical Commissioning Group

14/102b

MEETING OF THE GOVERNING BODY
July 2014

Agenda Item: 14/102b	**Author of the Paper:** Tracy Jeffes Chief Delivery and Integration Officer NHS South Sefton CCG Tel no: 0151 247 7049 E mail address: Tracy.Jeffes@southseftonccg.nhs.uk
Report Date: July 2014	

Title: Quarter 1 - 2014/15 Governing Body Risk Assurance Framework

Summary/Key Issues:

This report provides the Governing Body with an overview of the organisation's risk in relation to the Risk Assurance Framework for Quarter 1 and the Corporate Risk Register, including statutory responsibility and regulatory obligation. It also gives an update on the review of the risk process.

Recommendation

Receive	
Approve	X
Ratify	

The Governing Body is asked to:-

- Receive, review and scrutinise the assurance provided.
- Note the significant amount of scrutiny and review that is undertaken within the organisation including the Senior Management Team, Corporate Governance Group and the Quality Committee.
- Note that the Audit Committee also reviews the processes so in consideration of all the arrangements, that the Governing Body considers receiving a summarised version of the Governing Body Assurance Framework and Corporate Risk Register at future meetings.

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Sustain 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.
	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			Review of process has been carried out with SMT and CGSG. GB to receive update on progress of work and risk position.

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

Report to the Governing Body
July 2014

1. Background – Risk Assurance Responsibility and Obligation

1.1 The CCG has a statutory responsibility and regulatory obligation to ensure that systems of control are in place to minimise the impact of all types of risk, which could affect the proper functioning of the CCG. Risk management and internal controls should be fully embedded at all levels of the organisation: effective risk management arrangements will, in addition to helping ensure goals and objectives are met, help ensure compliance with statutory, mandatory and 'best practice' requirements.

1.2 All committees and sub-committees of the CCG are responsible for ensuring that risks associated with in their areas of responsibility are identified, analysed, evaluated and treated.

1.3 It is the responsibility of the Governing Body to ensure a robust system and process is in place and that risks are being consistently identified and managed.

1.4 The risk review cycle includes:

- identification of new risks relating to the work of the CCG;
- closing of risks that are no longer relevant (or being managed to the extent that the risk is tolerable), and;
- review and assess all open risks and action plans to ensure that they reflect the current status of the risk;
- manage the risks to ensure they do not impede the delivery of team or organisational objectives.

2. Governing Body Assurance Framework (GBAF)

2.1 The Governing Body Assurance Framework provides the Governing Body with assurances that risks to the achievement of the CCGs' organisational objectives have been identified and that robust measures to mitigate those risks have been implemented and managed. It provides a list of the key pieces of evidence that the CCG Governing Body should use to gain this assurance. The Governing Body Assurance Framework is a key element of the CCG's system of internal control and its' primary purpose is to identify, evaluate, track and manage the impact of high-level strategic and operational risks. The GBAF also provides strong evidence and assurance of the effectiveness of the CCG's approach to risk management for the Annual Governance Statement, which is a requirement of the Annual Accounts.

2.2 The framework records the links between strategic objectives, key risks and key controls. It also indicates the sources of evidence or assurance, which support the controls, and identifies any gaps.

2.3 It is reviewed at business meetings of the Senior Management Team and Quality Committee on a quarterly basis and overseen by the Audit Committee. The Corporate Governance Group reviews and scrutinises it before submission to the Quality Committee to ensure the risk scores and assurances are accurate and robust.

2.4 The full document is reviewed twice a year by the Governing Body. Within that timeframe the Governing Body need to ensure that they:

- examine the previous year's final Q4 framework which will identify the final position on the risks for that year and provide the Governing Body with the information to ultimately determine whether the corporate objectives for that year have been met;
- examine the new financial year's Q1 framework which will outline the new organisational objectives and related risks, and identify any changes to the management of the risks, and;
- ensure a robust process is in place for exception reporting.

3. Corporate Risk Register (CRR)

3.1 The Corporate Risk Register (CRR) is a record of all the identified risks presented with details of assessment (the risk score) and actions taken to manage and mitigate the risk. The CRR supports the CCG's Assurance Framework by identifying operational risks which may impact on the ability to provide assurance against strategic risks.

3.2 All new and updated risks are recorded on the CRR on a monthly basis, where they are then reviewed by the Senior Management Team and subsequently the CCG's Governance Support Group as a first line of assurance. The CRR is then submitted to the Quality Committee which has delegated responsibility for receiving, reviewing and scrutinising the CRR.

4. Progress

4.1 A report was presented to the Senior Management Team (SMT) on the 10th June 2014 which outlined the CCG statutory responsibilities and regulatory obligations regarding systems of control, the Corporate Risk Register (CRR) and Governing Body Assurance Framework (GBAF) processes, draft 2014/15 CRR's and GBAF's registers and frameworks including a proposed list of risks for removal and relating rationale.

4.2 SMT members considered the proposal for those risks to be removed from the CRR and GBAF in conjunction with the recommended rationale that the risks had either been (a) managed to an acceptable level or (b) posed no risk to the CCG in 14/15.

4.3 On 10th June 2014 the SMT:

- Agreed the removal of all the proposed GBAF risks for South Sefton (appendix 1) CCG;
- Agreed the removal of all the proposed South Sefton CCG (appendix 2) CRR 'risks for removal'.

4.4 Also presented and discussed:

- confirmed list of leads and deputies so as to ensure continuity of risk management;
- review of CRR and GBAF templates, updated so as to ensure easier to follow and tighter controls and updates.

4.5 South Sefton CCG Senior Management Team (SMT) scrutinised the draft quarter 1 GBAF and CRR at a meeting on 8th July 2014 to ensure action plans were updated, risk leads appropriate, risk scores reflective of current position and additional controls in place were optimal, providing robust mitigation. The report also provided members with an update on the discussions held at the SMT in June and subsequent support provided:

- Merton House based support with 1:1 meetings/telephone conversations with risk leads;
- Previously compiled assurance meeting schedule updated to include Merton based lead support for CRR as well as GBAF updates: meetings being organised with each lead so as to assist in the assurance process and updates.

5. Southport and Formby CCG Position Statements (14th July 2014) – Governing Body Assurance Framework

5.1 The composition of the Governing Body Assurance Framework as at 14th July 2014 / quarter 1 2014/15 is:

- 15 risks recorded against the 7 new corporate objectives for 2014/15;
- 12 amber;
- 3 yellow or green
- no red risks.

6. Corporate Risk Register

6.1 The composition of the Corporate Risk Register as at 14th July 2014 / quarter 1 2014/15 is:

- There are 17 operational risks recorded
- 2 are rated as high level 'Extreme' risk:
    - QUA006: continued from q4 2013/14, providers risk rating in relation to robust safeguarding systems. Performance results for quarter 1 will be reported in quarter 2 and then rating will be reviewed.
    - QUA008: new risk in quarter 1 2014/15. Lb provider system/technical issues having a possible impact on patient safety
- 12 are rated as high level: BUO001; FIN001 & 2; QUA001, 2, 4, 5, 7; REP001, 2; STA001, 2;
- 1 rated as high level has been agreed to be removed by the SMT (REP003) as agreed that incident was isolate and was now managed with support from NHS England;
- 2 are low risk (FIN003 and QUA003).
- 14 risks continue from 2013/14 with no change in risk rating quarter 4 2013/14;
- 1 risk from 2013/14 has been updated for 2014/15 (FIN003);
- 2 new risks for 2014/15 (QUA008 and STA002);
- 2 risks require further review: BUO001 and QUA005;
- The quarter 1 2014/15 CRR document includes the objectives and risk reference for 2013/14 so as to show continuity and an audit trail for the continued risk: will be removed from Q2 document.

7. Conclusion

7.1 South Sefton CCG's 2014/15 Governing Body Assurance Framework and Corporate Risk Register documents highlights the key objective and operational risks as at 14th July 2014, with the majority of risks remaining static in terms of score. Additional controls have been identified where possible, with descriptions of action plans and work programmes intended to close identified gaps. SMT and the Governance Support Group will continue to monitor and assure risk scores and that progress against mitigating actions by Lead Officers will be robustly managed in line with the CCG's Risk Management Strategy.

Appendices

1. Agreed removed risks: GBAF
2. Agreed removed risks: CRR
3. Governing Body Assurance Framework Q1 2014/15
4. Governing Body Assurance Framework Q1 2014/15 Summary
5. Corporate Risk Register Q1 2014/15

Tracy Jeffes
July 2014

South Sefton CCG

Proposed Removed Risks

Lead Officer/Risk Owner: Malcolm Cunningham

Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
Lack of capacity within CCG will restrict delivery of all programmes in 2013/14 impacting on achievement of Outcomes Framework 2013/14 (2013/14 3.1)	1x2	Full capacity of Programme Management Office achieved with no gaps identified Balanced Scorecard produced for each programme PMO reporting to Finance & Resource Committee Programme tracking in place via PMO Head of Strategic Financial Planning in post from August 2013 Head of Strategic Planning and Assurance in post from October 2013	Minutes of Finance & Resource Committee received by Governing Body (monthly) Oversight of Balanced Scorecards by PMO, exception reports to Finance & Resource Committee	Significant Reasonable Limited			
Rationale	Risk has reduced to manageable level. Also CCG has approved new arrangements for Clinical Leadership at every level. CCG leaders are regularly accessing development opportunities.						

Lead Officer/Risk Owner: Malcolm Cunningham

Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
3.3 Lack of KPIs will impact on delivery of some programmes in 2013/14 No change in risk score from Q3 update	1x2	PMO reporting to Finance & Resource Committee KPIs developed and reported against programmes (Q2) Head of Strategic Financial Planning in post from August 2013 – key role in developing measurable KPIs Head of Strategy and Assurance in post from October 2013	Minutes of Finance & Resource Committee and exception reports Reported via Finance & Resources Committee	Significant Reasonable Minutes of Finance & Resource Committee received by the Governing Body bi-monthly Limited	Some development required for KPIs	Head of Strategy & Assurance/Head of Strategic Financial Planning will provide senior management support in ensuring measurable KPIs are introduced	April 2014
Rationale	Risk has reduced to manageable level. Also CCG has approved new arrangements for Clinical Leadership at every level. CCG leaders are regularly accessing development opportunities.						

Lead Officer/Risk Owner: Tracy Jeffes

Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
Possible requirement to re-procure CSU services. Risk that re-procurement would divert CCG resources away from key CCG priorities No risk for CCG against delivery for 2013/14 due to updated guidance from NHS England re: procurement	1x1	Plan produced in draft for re-procurement identifying timescales, resource requirements, impacts and risks Updated guidance from NHS England, CCGs are now able to re-negotiate SLAs -	Progress reports to SMT Progress/exception reports to Finance & Resource Committee	Significant Reasonable Minutes of Finance & Resource Committee received by Governing Body Limited			
Rationale	Risk has reduced to manageable level. Also CCG has approved new arrangements for Clinical Leadership at every level. CCG leaders are regularly accessing development opportunities.						

Lead Officer/Risk Owner: Stephen Astles

Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
Lack of capacity amongst clinical colleagues to ensure personal development and facilitate active involvement No change in risk score from Q3 update – vacancy affecting risk score	4x3	OD Plan refreshed for 2013/14 Increased development of Locality model and resourcing Monthly joint development session for Governing Body members and clinical leads Documented and robust PDR process for Governing Body members and locality lead roles Primary Care Quality Board established November 2013 – led by clinician GP employed for 4 sessions for advanced care planning – can provide level of support as contingency	Records of developmental sessions for Governing Body members/clinical leads Minutes of Locality Meetings Minutes of Primary Care Quality Board meeting received via Quality Committee (oversight by Governing Body)	**Significant** **Reasonable** Governing Body oversight of PDR process for members/clinical and locality leads via exception reporting Minutes of Locality Meetings received by Governing Body **Limited** GB Vacancy discussed at Wider Group Meeting on 11th Feb 2014	Lead roles not filled Governing Body vacancy not filled in Q4	Advertised & expressions of interest requested. Vacancy to be discussed at April 2014 AGM	April 2014
Rationale	Risk has reduced to manageable level. Also CCG has approved new arrangements for Clinical Leadership at every level. CCG leaders are regularly accessing development opportunities.						

Appendix 2

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

Version 1, Quarter 1 2014/2015

Proposal for Removal of Risks

					Initial Risk			2013/14 End of Year risk			
Domain & ID	Principal Risk	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	L	C	Current Risk Rating	Rationale for Removal
1 Q4 2013/14	CCG fails to balance its budget/hit its financial target	Financial	Governing Body to be advised by Chief Financial Officer Martin McDowell	Financial Reporting - Monthly finance reports - Finance and resources committee overview - Focus on Out-Turn position - Internal Systems - SFIs and SoRD - Review Internal and External audit reports -Use of Contingency Plans/Reserves - Monthly Provider Contract Reviews **Additional controls:** (1) Clarify required regarding PCT disaggregation of baselines, particularly in respect of Specialised Commissioning and also intra-Sefton CCG arrangements. (2) Reserves held to offset against operational pressures. (3) Potential to defer investments if position deteriorates Board action should position deteriorate **Progress:** CCG identified impact of likely baseline adjustments. Latest F & R/GB Finance Reports indicate that CCG is on target to deliver financial duties.	2	5	10	1	5	5	Controls in place. Now on target to deliver. Risk reduced and now below CRR threshold.
5 Q4 2013/14	Increased costs arising from high cost drugs in secondary care	Financial	Governing Body to be advised by Chief Financial Officer Martin McDowell / CCG Lead for Medicine Management Brendan Prescott	Review of cost implications Checking patients Liaison with secondary care clinicians **Additional controls:** Clear horizon scanning by the CCG in preparation for 13/14 budgets - work with Public Health to determine impact **Progress:** CCG monitoring performance accordingly - reported in financial position	4	2	8	2	2	4	Controls in place. Performance being monitored accordingly. Risk reduced and now below CRR threshold.
9 Q4 2013/14	Health Economy Urgent Care, 4 hour target may not be achieved	Statutory Duty	Head of CCG Development Steve Astles	Daily sitreps, 2 weekly telecon with RUCAT, Urgent care strategy with local health economy, active case management model, consultant in community work; no active case management but has virtual ward management; increased primary care capacity; **Progress:** Virtual ward action plan in place and reporting weekly to SMT. Aintree achieved year 95% A&E target. Discussion at CCF relating to closing of contract query – risk to be carried fwd to Q1 2014/15. Comment (SH) - this has been amended based on SA's feedback for GBAF Risk. Need to consider removal if Trust has achieved yearly target.	4	4	16	1	2	2	Controls in place. To consider removal if trust has achieved yearly target. Risk reduced and now below CRR threshold.
13 Q4 2013/14	Attainment of FT status at Liverpool Community NHS Trust	Statutory Duty, business objectives	Chief Officer Fiona Clark	IBP submitted with CCG support and caveats, **Additional Controls:** Workshops with CCG board and stakeholders to understand implications and consequences, frequesnt communication with NHSCB LAT, Trust Board to board sessions. NTDA **Progress:** Following MIAA's review of the IG Toolkit and 'significant' assurance received, and review of this risk by Quality Committee in January 2014 and Corporate Governance Group and SMT in Februrary 2014 it was considered that the changing NHS environment, National Policy and the role of the Trust Development Agency, it was agreed that this risk should be reduced substantially. Recommend removal following Q4 review (SH)	3	4	12	1	2	2	Controls in place. Reviews carried out. Significant assurance received from MIAA. Risk significantly reduced. Now below CRR threshold
				SLA in place with provider; Monthly monitoring meetings; formal reporting; identified Head of Cient operations lead appointed to liaise with Head of Delivery;action plan in place to address under							

VERSION 7 – **APPENDIX 3**

South Sefton CCG Assurance Framework – Quarter 1 2014-15: April to June 2014

NHS South Sefton Clinical Commissioning Group

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance				**Governing Body Reports**			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
1.1 Non Delivery of financial targets due to failure to control CCG expenditure budgets	**2 x 5**	Internal and External Audit Plan in place to review systems of internal control Robust financial management process in place to ensure reserves and contingency are utilised in an appropriate manner Internal budgetary management process in place to support and challenge budget holder to deliver within agreed limit	Financial Plan for 2014/15 signed off by Governing Body (May 2014). Monthly Finance performance reports presented to Finance & Resource Committee with reporting to Governing Body by exception report. Monthly reporting to NHS England as part of the collective NHS Financial position.	**Significant** **Reasonable** Robust processes in place and being managed. **Limited**	Additional budget holder training required.	Not required at this stage.	March 2015
Progress Reports	**Q1**	**On target - Robust processes in place and being managed.**				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance				Governing Body Reports			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
1.2 Non-delivery of financial targets due to over-performance/in-effective demand management of activity levels within acute and community provider contracts	**2 x 5**	Provider contracts agreed and signed with specified activity levels and associated costs Robust financial planning and control process in place Internal and External Audit Plan in place to review systems of internal control Contingencies and reserves held to cover overspends during the year.	Agreed provider contracts signed for 2014/15, with robust contract management arrangements in place to maintain/deliver activity and associated costs within agreed limits Monthly provider contract review meetings in place to verify performance and quality (including CQUIN) Revised Financial Plan for 2014/15 signed off by Governing Body (May 2014). Monthly Finance performance reports presented to Finance & Resource Committee with reporting to Governing Body by exception report. Monthly reporting to NHS England as part of the collective NHS Financial position. Internal budgetary management process in place to support and challenge budget holder to deliver within agreed limit	**Significant** **Reasonable** Likely over-performance offset by adequate reserves held at Q1. **Limited**	Better information required at practice level to encourage ownership of management/info improved control of referrals etc.	Not required at this stage.	March 2015.
Progress Reports	**Q1**	**Likely over-performance offset by adequate reserves held at Q1**				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance				Governing Body Reports			
Lead Officer/Risk Owner: Debbie Fagan							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
1.3 Failure of providers to deliver CQUIN targets leading to slow change /transformation of services	**3 x 3**	Regular reporting to Quality Committee. Formal exception reporting to Quality Committee from GP Clinical Lead for Quality and CQUIN. Contract meetings scheduled is in place to review and verify performance and activity on provider contracts including CQUIN Discussion re providers as part of QSG (NHS England) work plan	Bi-monthly performance reports from Quality Committee received by Governing Body. Quality reporting standing agenda item for Governing Body, including Quality Contract updates. Chief Nurse leads on Quality to ensure that quality is maintained via established resources and is a Governing Body member. Chief Nurse member of Finance & Resource Committee. Senior Finance Team member attached to the Quality Committee to ensure risk is minimised Chief Nurse / member of CCG Quality Team, in attendance at provider quality meetings. Clinical Director for Quality/GP Clinical Leads for Quality in place with managerial support from the CCG Quality Team.	**Significant** Regular provider performance reviewed at scheduled Quality Contract meetings. **Reasonable** **Limited**	Review function, roles and capacity of Quality Team Review quality support from CSU		Chief Officer and Chief Nurse – September 2014 Chief Nurse September 2014
Progress Reports	**Q1**	**Regular provider performance reviewed at scheduled Quality Contract meetings.**				**Assurance Rating**	**Significant**
	Q2						
	Q3						
	Q4						

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance				Governing Body Reports			
Lead Officer/Risk Owner: Debbie Fagan							
Principal Risks *Risk Owner*	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
HCAIs **1.4 Exceed trajectories for HCAI impacting on patient safety & non-achievement of quality premium**	**3 X 4**	Regular reporting to Quality Committee on HCAIs CPQG reporting CDIF Task & Finish Group established (progress reports to Quality Committee) Mersey Clinical Commissioning Network Established July 2013 (ToR agreed Sept 2013), HCAIs standing agenda item CCG action plan presented to Quality Committee and shared with HSE. Workshop held 2014. Steering group to meet July 14 Process in place for CCG review of CDIF route cause analysis reports.	Minutes and key actions of Quality Committee meetings reported to Governing Body. Provider performance re HCAI discussed at Quality Committee for purposes of assurance. Key risks identified within quality contract meetings.	**Significant** **Reasonable** Held Health Economy Workshop for CDIF. Date set for inaugural meeting of the steering group for July 2014. Liaising with Public Health to develop CCG process for review of provider CDIF RCA's/CCG CDIF management of provider CDIF 'Appeals process. **Limited**	Role of Sefton Health Economy Steering group being reviewed i.e. key risks to be filtered through this group.		Chief Nurse July 2014
Progress Reports	**Q1**	**Held Health Economy Workshop for CDIF. Date set for inaugural meeting of the steering group for July 2014. Liaising with Public Health to develop CCG process for review of provider CDIF RCA's/CCG CDIF management of provider CDIF 'Appeals process.**				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
1.5 Lack of capacity and capability of CSU to deliver sufficient support in a responsive manner in key risk areas which have been identified as CHC BI delivery, Customer Solutions and CMCSU merger with GMCSU	**3 x 4**	Re-negotiation of SLA in process Contract/Performance Monitoring Group meet monthly and development of more robust KPI's with new service specifications Exception reporting on performance and delivery at SMT	Monthly meeting of Performance Monitoring Group Head of Client Operations – CSU to attend weekly SMT meetings to support Specific assurances obtained CSU to ensure continuation of locally based delivery despite CSU merger Reports to Finance & Resource Committee on six monthly basis	**Significant** MIAA report (December 2013) offered significant assurance of CCG's performance management of CMCSU. SLA renegotiation. Key CCG and CSU leads agreed new service specifications and KPIs around all service areas. **Reasonable** Governing Body receives minutes of Finance & Resource Committee **Limited**	Strategic annual review of CSU service delivery by commissioning support requirements. Specific work and forward plan for future management of CHC to be developed: Sept CMIP roll out plan updated and required to include dates for availability for practice level information CHC information varying on monthly basis Development of KPIs to ensure more robust contract management during Delay in renegotiation of SLA due to lack of financial information from CSU.	aim to extent current SLA beyond end of September	September 2014 September 2014 July 2014 August 2014 End of July 2014 July 2014
Progress Reports	**Q1**	**SLA renegotiation. Key CCG and CSU leads agreed new service specifications and initial KPIs around all service areas pending price discussions**				**Assurance Rating**	**Significant**
	Q2						
	Q3						
	Q4						

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance			Governing Body Reports				
Lead Officer/Risk Owner: Karl McCluskey							
Principal Risks *Risk Owner*	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
QIPP 1.6 Non-delivery of 2014/15 QIPP Plan which supports transformational change	**1 x 4**	QIPP targets identified within the 2014/15 financial plan QIPP plans in place to deliver required financial cost reductions	QIPP financial savings targets and plans signed off by the Governing Body (May 2014) Monthly financial performance reports (including QIPP targets and associated savings) presented to Finance and Resource Committee and reviewed by the Governing Body	**Significant** **Reasonable** QIPP plans and associated finance cost reductions identified within CCG strategic financial plan and approved by governing body in May 2014 **Limited**	Small level of savings required to be delivered to meet target in 2014/15. Current QIPP in reserves (£493,000)	Not required at this stage.	March 2015.
Progress Reports	**Q1**	**QIPP plans and associated finance cost reductions identified within CCG strategic financial plan and approved by governing body in May 2014**				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 2: Achieve a 15% reduction in non-elective admissions across 5 years				Governing Body Reports			
Lead Officer/Risk Owner: Karl McCluskey							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
2.1 Potential for any reduction in non-elective admissions to be offset by increased demand	3x2	Weekly and monthly non-elective performance reviewed by PMO / SMT Bi-monthly performance reports to Governing Body	Exception reporting to Governing Body bi-monthly Exception issues raised and alerted through SMT to be addressed via Head of CCG Development	**Significant** **Reasonable** Annual profile and changes in non-elective activity across five years agreed and developed with governing body and reflected in CCG two year operational plan and five year strategic plan. **Limited**	Need for integrated performance reporting	Development of integrated performance report	Becky Williams Quarter 2 (September 2014)

Progress Reports	**Q1**	**Annual profile and changes in non-elective activity across five years agreed and developed with governing body and reflected in CCG two year operational plan and five year strategic plan.**	**Assurance Rating**	**Reasonable**
	Q2			
	Q3			
	Q4			

Corporate Objective 3: Implementation of 2014-15 phase of Care Closer to Home / Virtual Ward plan				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
3.1 Delay in implementing new pathways due to non-achievement of reductions in admissions needs to draw out requirement to deliver savings. **Clinical Lead: Dr A Mimnagh**	**4 x 3**	Virtual Ward development identified as a priority area Action plan in place with Aintree UHT KPIs for all non-elective admissions monitored under contract process via CSU information portals fed into contract meeting Monitoring of A&E attendance conversion rates (non-elective admissions) via CSU information portals in contract meeting Monthly steering groups to evaluate progress Monthly agenda item on contract review meetings with Liverpool Community Health Services	Contract query process reviewed in monthly contract meetings. Minutes received by Governing Body Progress of action plan reviewed by Unplanned Care Network – exception reports produced Minutes of CCG Urgent Care Collaborative meetings Twice weekly teleconferences with NHSE to monitor & assure A&E performance Action plan continues to support on-going Trust achievement (including monthly meetings). Assurance & exception reporting continues via Quality Committee Quarterly reports/minutes of meetings received by Governing Body for oversight of delivery progress Aintree achieved year 95% A&E target. Discussion at CCF relating to closing of contract query – carried fwd to Q1 2014/15. Q1 not achieved.	**Significant** **Reasonable** Q1 A&E Aintree targets not achieved. Monthly monitoring process being followed. **Limited**	Aintree Q1 not achieved. Need to review activity.	Ongoing monthly performance review meetings to be held	SA - July 2014
Progress Reports	**Q1**	**Q1 A&E Aintree targets not achieved. Monthly monitoring process being followed.**				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 4: Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership and partners				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
4.1 Current provider unable to deliver community service as specified by the CCG.	3x3	Contract meetings monthly Clinical performance and quality meetings monthly Clinical liaison meeting s monthly Interim senior management team attending all locality meetings Meetings with lead GPs to review core delivery	Minutes, clinical and managerial lead feedback to practices and localities. Presentation to Governing Body in May 2014.	**Significant** **Reasonable** Reviewing possible gaps. Engagement with interim senior management team and practices. **Limited**	Reviewing possible gaps.		September 2014
Progress Reports	**Q1**	**Reviewing possible gaps. Engagement with interim senior management team and practices.**				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 5: Implementation of 2014-15 phase of Primary Care quality strategy / transformation				Governing Body Reports			
Lead Officer/Risk Owner: Malcolm Cunningham / Jan Leonard							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
5.1 Lack of capacity amongst clinical colleagues to deliver transformation	**4x3**	Development of Local Quality Contract Primary Care Clinical Lead identified in new GB Documented and robust PDR process for Governing Body members and locality lead roles Locality and practice lead roles clarified Primary Care Quality Board established November 2013 – led by clinician	Monitoring of uptake and performance of LQC, reported via Primary Care Quality Board Regular updates to Senior Leadership Team on LQC Minutes of Locality Meetings received by Governing Body Minutes of Primary Care Quality Board meeting received via Quality Committee (oversight by Governing Body) Governing Body oversight of PDR process for members/clinical and locality leads via exception reporting	**Significant** **Reasonable** Contract is ready pending completion of consultation. **Limited**		Awaiting consultation completion.	July 2014
Progress Reports	**Q1**	Contract is ready pending completion of consultation.				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 5: Implementation of 2014-15 phase of Primary Care quality strategy / transformation				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
5.2 Inability to maintain active involvement of all constituents and stakeholders	**3 x 4**	Refreshed Communications and Engagement Strategy 2013 Increased development of Locality model & resourcing Effective running of Engagement and Patient Experience Group in place to ensure on-going active involvement of key partners e.g. Sefton Healthwatch, voluntary sector and LA & coordination of local patient and public activities CCG public-facing internet site now live Lead locality GP, Practice Nurse & Practice Manager meetings on monthly basis for each locality Remunerations Committee has agreed financial resourcing for backfill/Clinical involvement	Documented evidence of involvement Quarterly Wider Constituent meetings with GP attendance recorded/minuted Listening exercise undertaken with commissioning lead and clinical lead for integrated care model and community services	**Significant** **Reasonable** Governing Body receives minutes of Locality Meetings. Listening Exercise undertaken. **Limited**	Report following listening exercise to be published.	To share report with constituent practices	July 2014
Progress Reports	**Q1**	**Governing Body receives minutes of Locality Meetings. Listening Exercise undertaken.**				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 6: Agreed three year integration plan with Sefton Metropolitan Borough Council and implementation of year one (14/15) to include an intermediate care strategy				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks *Risk Owner*	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
6.1 Inability to deliver system wide change due to failure to shift resource from one part of the health and social care system to another	**3x3**	Regular joint meetings with Sefton Council to develop Integration Plans. Range of task and finish groups established to develop plans for 14/15 and longer term, reporting to HWBB RIG (Resource and Integration Group) and PIG (Programme Integration Group) Provider forum established to explore system-wide change. Key officers assigned from Sefton Council and CCG to develop intermediate care strategy	Documented Evidence of reports and minutes from meetings Development of s256 agreements for 14/15	**Significant** **Reasonable** **Limited** Workshop held in May to agree key areas for Task and Finish Groups to develop integrated working. Programme Integration Group supportive of approach and groups developing short term and longer term plans			
Progress Reports	**Q1**	**Workshop held in May to agree key areas for Task and Finish Groups to develop integrated working. Programme Integration Group supportive of approach and groups developing short term and longer term plans**				**Assurance Rating**	**Limited**
	Q2						
	Q3						
	Q4						

Corporate Objective 6: Agreed three year integration plan with Sefton Metropolitan Borough Council and implementation of year one (14/15) to include an intermediate care strategy				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks *Risk Owner*	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
6.2 Impact of reductions in social care funding on health services	**3x3**	Integrated working through HWBB sub-structure to develop system-wide approaches. Care Closer to Home and Virtual Ward as key programmes to facilitate operational Clear outcomes for s256 agreements and development of future section 75.	Documents and minutes from meetings	**Significant** **Reasonable** **Limited** HWBB supportive of wider –system approach and groups developing short term and longer term plans	Clear measures and processes across system to identity impact		November 2014
Progress Reports	**Q1**	**HWBB supportive of wider –system approach and groups developing short term and longer term plans**				**Assurance Rating**	**Limited**
	Q2						
	Q3						
	Q4						

Corporate Objective 6: Agreed three year integration plan with Sefton Metropolitan Borough Council and implementation of year one (14/15) to include an intermediate care strategy				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks *Risk Owner*	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
6.3 Capacity across CCG and council to deliver a robust and co-ordinated one year and three year plan	**3x3**	Programme and integration group of Health and Well Being Board to sponsor and co-ordinate plans Integration post to co-ordinate and lead the work.	Programme group has already supported the development of the plans. Job description in place for integration post	**Significant** **Reasonable** Plans supported. Integration post to co-ordinate and lead the work. **Limited**	Recruitment to commence		July 14
Progress Reports	**Q1**	**Resources and job outline for role to develop integrated working in place. Functional working group plans received by the HWB programme group.**				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 7: Review the population health needs for all mental health services to inform enhanced delivery				Governing Body Reports			
Lead Officer/Risk Owner: Karl McCluskey							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
7.1 Completion of full scale review across children and adults in year	1 x 2	Additional project resource appointed in quarter 1 Additional clinical leadership appointed quarter 1 Joint mental health task group with Sefton Council in place	Regular progress reporting to Governing Body Progress management and assessment to be undertaken via service improvement and redesign committee from September 2014	**Significant** Detailed demographic and population health needs analysis undertaken as part of 5 year strategic plan and 2014/15 refresh of JSNA with the Local Authority. **Reasonable** **Limited**	Assessment of resource to support breadth and depth of project	Review of resources and development of business case by September 2014	Geraldine O'Carroll September 2014

Progress Reports	**Q1**	**Detailed demographic and population health needs analysis undertaken as part of 5 year strategic plan and 2014/15 refresh of JSNA with the Local Authority.**	**Assurance Rating**	**Significant**
	Q2			
	Q3			
	Q4			

GUIDANCE

Principal Risks: are what could prevent key objectives from being achieved. Key risks should be true risks (rather than consequences), and so cannot just be the converse of the objective.

Assurance Rating Section: this shows section seeks to help the Governing Body to 'weight' the assurance provided by Risk Owners. It directs the amount of attention it needs to spend in reviewing entries on the Assurance Framework. The categories are 'Limited', 'Reasonable' and 'Significant'. The Governing Body should be expecting to see 'Reasonable' assurance for the entries in the document unless there is a specific reason for this not to happen. For example, a new care pathway introduced in quarter 1 might only have been given limited assurance as the implementation plan for the pathway has only just begun. As the year progresses the assurance rating should increase with the embedding of the pathway.

Key Controls: are factors, systems or processes that are in place to mitigate the principal risk(s) and assist in securing delivery of the relevant key objective. Key controls should be robust and specific and properly match the associated key objective(s). For example; a sub committee or committee of the Governing Body which is tasked with monitoring the specific risk.

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

Gaps in Control: indicates where the organisation has failed to put key controls in place, or has failed to make key controls effective.

Gaps in Assurance: indicates where the organisation is failing to gain evidence that key controls are effective.

Corrective Action: shows what will or is being done to address the gap(s) in control or assurance.

Responsibility / Target Date: shows the Director (or senior manager) responsible for appropriate and timely implementation of corrective action(s) and the expected date by which actions should be completed.

Progress reports provide a quarterly update on achievement of action plans and identify where gaps in control or assurance have been addressed. They should also indicate where the risk grading has changed for any risks associated with that objective.

Generally, Assurance Frameworks should map key objectives to principal risks, key controls and assurances explicitly. Assurance frameworks should be embedded and dynamic, providing regular Governing Body information and not viewed as year-end exercises.

Assurance Rating

Limited Rating – Insufficient Assurance Provided
A limited assurance rating will be applied where a risk owner has failed to record any evidence within the 'Key Positive Assurance' column during that quarter or where only minimal evidence is provided, all of which is deemed as providing 'limited assurance'.

Reasonable Rating – Adequate Assurance Provided

A reasonable assurance rating will be applied where a risk owner has recorded in the 'Key Positive Assurance' column at least one piece of evidence deemed 'reasonable' assurance together with a number of pieces of evidence deemed 'limited' assurance.

Significant Rating – Substantial Assurance Provided

A significant risk rating will be applied where a risk owner has recorded in the 'Key Positive Assurance' column a minimum of one piece of evidence deemed as providing 'significant' assurance **or** a number of pieces relating to different aspects of assurance deemed 'reasonable'

Examples of what constitutes differing levels of assurance:

Key Positive assurance (** External/Independent) EXAMPLES OF TYPES OF ASSURANCE
**SHA Audit of data quality indicating no significant concerns, reported to Trust Governing Body January 2010, PCT commissioning committee February 2011. (significant assurance)
**CQC indicators met for relevant targets as reported in periodic review, October 2011 (significant assurance)
Performance Report received by the Trust Governing Body, most recent September 2009, showing performance within tolerance for overall achievement of target for Q1 (reasonable assurance)
Contract monitoring report to commissioning committee in September 2010 showing performance within tolerance for overall achievement of target for Q1 (reasonable assurance)
Performance report to Trust Governing Body, most recent September 2010, indicating current position against key targets (limited assurance)

Key Positive assurance EXAMPLE OF NEW LAYOUT
Significant Assurance
2010/11 prospectus published March 2009, included for information in Governing Body papers May 2010
Uptake report on attendance at Health & Safety courses at Health & Safety working group November 2010 shows 60% of staff have attended relevant courses, compared with 40% last year
Reasonable Assurance
Update report to HR committee September 2010 demonstrating 80% of required courses now established
Limited Assurance
Performance report to Trust Governing Body, most recent September 2010, indicating current position against key targets

Risk Grading Matrix

Consequence / Likelihood	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

Risk	Score	Colour
Insignificant	1 - 3	
Low	4 - 6	
Moderate	8 - 12	
High	15 - 25	

↓ Significant risk

Significant Risk

A risk which attracts a score of 8 or above on the risk grading matrix constitutes a significant risk and must be recorded on the Corporate Risk Register.

South Sefton CCG Assurance Framework 2014/15
Assurance Rating Summary Quarter 1

Key:
▼ L – Assurance rating reduced from previous Quarter
► M – Maintained assurance rating from previous Quarter
▲ H - Higher assurance rating than previous Quarter
N/A – Not applicable – assurance not expected
Blank – No comparable rating

NHS South Sefton Clinical Commissioning Group

Risk No	Risk Description	Current Risk Rating (L & C)	Accountable Lead	Assurance Rating Q1	Q2	Q3	Q4	Assurance Rating Key
Unique Identifier	Strategic risk transposed from Assurance Framework document	Risk rating based on agreed risk matrix	Identified lead on behalf of the CCG who is referred to as the 'Risk Owner' on the Assurance Framework document	These columns will state either 'Limited' 'Reasonable' or 'Significant' assurance has been awarded dependent on the weight of assurance provided				This column will have ▼or ►or ▲ inserted here to demonstrate any changes since last review
Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance								
1.1	Non Delivery of financial targets due to failure to control CCG expenditure budgets	2x5	Martin McDowell	R				
1.2	Non-delivery of financial targets due to over-performance/in-effective demand management of activity levels within acute and community provider contracts	2x5	Martin McDowell	R				
1.3	Failure of providers to deliver CQUIN targets leading to slow change /transformation of services	3x3	Debbie Fagan	S				
1.4	Exceed trajectories for HCAI impacting on patient safety & non-achievement of quality premium	3x4	Debbie Fagan	R				
1.5	Lack of capacity and capability of CSU to deliver sufficient support in a responsive manner within resource envelope. In particular organisational change due to merger, specifically: CHC BI delivery	3x4	Tracy Jeffes	S				
1.6	Non-delivery of 2014/15 QIPP Plan which supports transformational change	1x4	Karl McCluskey	R				
Corporate Objective 2: **Achieve a 15% reduction in non-elective admissions across 5 years**								
2.1	Potential for any reduction in non-elective admissions to be offset by increased demand	3x2	Karl McCluskey	R				
Corporate Objective 3: **Implementation of 2014-15 phase of Care Closer to Home / Virtual Ward plan**								
3.1	Delay in implementing new pathways due to non-achievement of reductions in admissions needs to draw out requirement to deliver savings.	4x3	Stephen Astles	R				

Risk No	Risk Description	Risk Rating (L & C)	Accountable Lead	Assurance Rating				Assurance Rating Key
Corporate Objective 4: **Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership and partners**								
4.1	Current provider unable to deliver community service as specified by the CCG.	3x3	Stephen Astles	R				
Corporate Objective 5: **Implementation of 2014-15 phase of Primary Care quality strategy / transformation**								
5.1	Lack of capacity amongst clinical colleagues to deliver transformation	4x3	Stephen Astles	R				
5.2	Inability to maintain active involvement of all constituents and stakeholders	3x4	Stephen Astles	R				
Corporate Objective 6: **Agreed three year integration plan with Sefton Metropolitan Borough Council and implementation of year one (14/15) to include an intermediate care strategy**								
6.1	Inability to deliver system wide change due to failure to shift resource from one part of the health and social care system to another	3x3	Tracy Jeffes	L				
6.2	Potential of changes to social care funding to have an adverse impact on NHS services	3x3	Tracy Jeffes	L				
6.3	Capacity across CCG and council to deliver a robust and co-ordinated one year and three year plan	3x3	Tracy Jeffes	R				
Corporate Objective 7: **Review the population health needs for all mental health services to inform enhanced delivery**								
7.1	Completion of full scale review across children and adults in year	1x2	Karl McCluskey	S				

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

Version 8, Quarter 1 2014/2015

Last Saved: 14/07/2014

By User: loughc

▼ Risk reduced
► Risk unchanged
▲ Risk increased

Domain & ID	Date Added	Principal Risk	2013/14 Strategic Objectives	2014/15 Strategic Objectives	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	L	C	Current Risk Rating	Change Since Last Update	Risk Ref 2013/14
Business Objective																			
BUO001	Prior Q3 2013/14	18 week & cancer pathways may not be met due to non delivery of target by provider	Objective 2: Enhance Systems to Ensure Quality and Safety of Patient Care	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Business Objective	Karl McCluskey	monthly contract meetings, Clinical Quality and performance meetings, clinical lead for contracts and for quality, additional funding for RTT, worked closely with providers on cancer pathway. Set up clinical meetings with cancer leads and manager. Managerial lead for cancer has action plan in place. Weekly and monthly monitoring through SMT and contractual performance Prospective RTT plans from providers submitted to CCG for assurance in APril 2014 confirming adequacy of plans to deliver across all RTT areas	3	3	9	Use contract levers and clincial interventions, review implementation plans for RTT delivery and monitor on a weekly basis,			Developed a system wide patient education plan regarding the importance of attending appointments and reviewing polices around patient choice. Cancer lead to discuss with colleagues at Protected Learning Time on 18/9 regarding actions when a 2/52 referral patient is about to go on holiday. Drop in performance in Q4 could lead to year and target failure.	3	4	12	►	12
Finance																			
FIN001	Prior Q3 2013/14	Continuing Healthcare Restitution claims exceed available resources	Objective 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Financial	Chief Financial Officer Martin McDowell/ Debbie Fagan /CSU	CMSU have made assessment of claims received at high level - estimate claims for CCG c. £1.004m although there is uncertainty in relation to this figure due to the use of a standardised model which may not accurately reflect historic outcomes in Sefton. The treatment of prior year legacy provisions remains unclear with NHS England risk pooling arrangements not yet finalised. There is likely to be a further top slice in 15/16 and 16/17 which is not yet reflected in the CCG's strategic plans	4	4	16	Confirmation of claimants by CMCSU on behalf of CCG/detailed review of claims to aid better forecast of costs. CHC update report received in November 2013. CN & Finance Team met with CSU DoF/COO to discuss and gain timelines for action from CSU.	June 2014	July 2014	Commissioned CSU to manage and progress quickly, although there are concerns as to capacity to deal with promptly to ensure that potential reputational issues are managed. Ongoing discussions regarding scope of role to CCG.	3	4	12	►	2
FIN002	Prior Q3 2013/14	Allocations/Financial Performance	Objective 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Financial	Chief Financial Officer Martin McDowell	Whilst the CCG has received notification of revised allocation based on 'new formula', which places it significantly above target. The CCG will need to develop a contingency plan which enables it to return to 5% above target by April 2016. This will mean that additional savings of £7.001m will need to be found in plans.	2	4	8	Allocations for 2014/15 and 2015/16 have been confirmed	Sep-14	Oct-14	New allocations indicate slow pace of change. CCG needs to develop "worse case scenario" to deal with faster pace of change from 2016/17 onwards.	3	3	12	▲	3
FIN003	Revised Q1 2014/15	Changes in patient flow causes financial issues, due to increases in activity overall and the financial implications on the 14/15 Financial performance of the CCG	Objective 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Financial	Chief Financial Officer Martin McDowell	Review of patient choice procedures within guidance -monthly report - information shared with GP leads - practice level reporting of financial information	4	2	8	Monthly monitoring of financial position	Monthly		CCG monitoring performance accordingly. CCG has built impact of changes into contract, no reflected in plans. Reported in financial position	3	2	6	►	4
Quality																			

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

Version 8, Quarter 1 2014/2015

Last Saved: 14/07/2014

By User: loughc

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

Domain & ID	Date Added	Principal Risk	2013/14 Strategic Objectives	2014/15 Strategic Objectives	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	L	C	Current Risk Rating	Change Since Last Update	Risk Ref 2013/14
QUA001	Prior Q3 2013/14	Lack of existing capacity of Hosted Safeguarding Children and Vulnerable Adults Service could impact on CCGs ability to discharge its statutory functions;	Objective 2: Enhance Systems to Ensure Quality and Safety of Patient Care	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Nurse Debbie Fagan	Hosted service arrangements in place across Merseyside, hosted by Halton CCG. Arrangements include discussion at CCG Network. Regular 1:1 scheduled between the Chief Nurse and Safeguarding Leads within the service. Regular report to the quality Committee from the Safeguarding service. Commissioned 'CQC style' peer review of CCG Safeguarding arrangements.	3	3	9	**Children's:** The children's team is almost up to full strength: all posts are filled and the person previously off sick is on a staged return **Adults:** One vacancy to be filled following resignation of post holder. Currently reviewing service and awaiting a final decision on funding for a further post from NHSE - is the aim for the posts to be advertised together. Biggest risk currently is some planned sick leave for one member of the team: currently being reviewed for possible support to cover.	TBA TBA	End July 2014 End July 2014	HR issues being managed by Halton CCG.	3	3	9	▶	6
QUA002	Prior Q3 2013/14	Need for clarity of roles and responsibilities between Safeguarding Hosted Service, CSU CHC team and LCH Provider Safeguarding Team to enable CCG to discharge their safeguarding function. Need for further clarity between health and social care commissioning / safeguarding for vulnerable adults.	Objective 2: Enhance Systems to Ensure Quality and Safety of Patient Care	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Nurse Debbie Fagan	Regular 1:1 meetings between safeguarding adults lead in hosted service and CHC locality lead. Identified a single point of contact system for Safeguarding Adults between the Safeguarding Service and hosted service. Draft Standard Operating procedure developed	4	5	20	Review of draft SOP following the recommendations from the safuguarding 'CQC style' peer review. To obtain the recommendations from Liverpool Community Healths internal Safeguarding review that explored the role of the Safeguarding Adults team.	August 2014 August 2014	September 2014 September 2014	Awaiting feedback	2	4	8	▶	7
QUA003	Prior Q3 2013/14	That local residents may experience a fragmentation / less local co-ordination and responsiveness of complaints and patient information services at a local level due to NHS England's national procurement and separate management of these processes.	Objective 5: To Strengthen Engagement of CCG Members, Public, Partners and Stakeholders	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Head of Delivery & Integration Tracy Jeffes	Regular feedback from CSU / PALs regarding management of local queries. CSU temporary management and coordination of local primary care complaints.	3	3	9	Liaison with NHS E Merseyside Team regarding co-ordination of arrangements in the future.			CSU still managing NHS E complaints process, so internal sign-posting within CSU has mitigated some of the risks/concerns.	2	3	6	▶	10

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

Version 8, Quarter 1 2014/2015

Last Saved: 14/07/2014

By User: loughc

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

Domain & ID	Date Added	Principal Risk	2013/14 Strategic Objectives	2014/15 Strategic Objectives	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	L	C	Current Risk Rating	Change Since Last Update	Risk Ref 2013/14
QUA004	Prior Q3 2013/14	Impact of lab results on patient safety being sent to GP practices where they are not registered. Current IT system only allows GPs to reject results	Enhance Systems to Ensure Quality and Safety of Patient Care	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Nurse	Raised as an isue at the Quality Committee and Contract meetings.	4	3	12	Discussed at LCL Incident Meeting on 3 July 2014. I-Merseyside team to send information to NHSE(M). NHSE(M) to liaise with HSCIC due to national issue and feedback. Note: not LCL issue	TBA: national issue	TBA: national issue	3 GP Clinical Quality Lead has set up a Task and Finish Group with the lead for Lab Services . Progress reports to be received by the Quality Committee. National problem - been referred back to system provider & risk will remain the same until further developments.	4	3	12	▶	21
QUA005	Prior Q3 2013/14	A number of complaints received regarding the quality and capacity of service at a number of newly procured GP practices. Risk in CCG's ability to deliver on reduction in A&E attendances	Enhance Systems to Ensure Quality and Safety of Patient Care	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	~~Head of CCG Development Stephen Astles~~ Chief Nurse, Debbie Fagan .	Monthly monitoring of A&E attendances for patients of the affected practices ongoing via CMCSU BI Portals	3	3	9	Monthly monitoring of A&E attendances for patients of the affected practices			Data to date shows that there is no signficant risks in A&E attendances in these practices.	3	3	9	▶	22
QUA006	Q3 2013/14	Providers RAG rating in relation to robust Safeguarding systems and processes presents lack of assurance for CCG based upon validation of information presented by the Trust. Risk increased due to interface issues with reporting system between CSU and Safeguarding Hosted Service.	Enhance Systems to Ensure Quality and Safety of Patient Care	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality and Financial	Chief Nurse	RAG rating monitored via Quality Contract meetings. Reported to Quality Committee and escalated to Governing Body as required. Chief Nurse informed NHS England (M) and safeguarding will be included in the quality review process with the Trust. Monitored through quality contract meetings with CSU	4	4	16	Ongoing liaision between Safeguarding Hosted Service and provider. Safeguarding Hosted Service have offered additional support to trusts as a critical friend. Safeguarding performance discussed at each provider quality contract meeting. Process has been developed between CSU and Safeguarding service to further develop information flow across the two services.	August 2014	September 2014	Following update given at Safeguarding Service at March Quality Committeeand discussion at March Governing Body - letter drafted and to be sent to all providers from CCG Chief Officer. are seeing upwards improvement reported from safeguarding service with regards the majority of provider process, although not enough to improve provider RAG rating in Q4. Chief Nurse and Safeguarding Service have met with aintree and S&O in Q1 to discuss progress/support. Alder Hey Safeguarding performance discussed at the quality review meeting, held in June 2014. Safeguarding Service have met with Liverpool Womens Hospital Director of Nursing in June 2014 with an updated to the Chief Nurses for Liverpool CCG and the Sefton CCG's: to be discussed at the next Quality Committee (Q2). Note: performance results for q1 will be reported in q2 and then RAG rating will be reivewed.	4	4	16	▶	23
QUA007	Q3 2013/14	Comprehensive view of quality issues in Primary Care may not be available if NHS England are unable to share Primary Care Quality Data	Objective 2: Enhance Systems to Ensure Quality and Safety of Patient Care	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance Objective 5 - Implementation of 2014-15 phase of Primary Care quality strategy / transformation	Quality	Chief Nurse	Quarterly Checkpoint Meeting with NHS E (issue raised at meetings) Quality Committee oversight of action plan (risk highlighted by Quality Committee) Locality Leads GP and Practice Nurse members of Quality Committee have opportunity to raise quality issues directly.	2	4	8	Further discussion at quarterly check point meetings as necessary.	TBA: awaiting NHS England	October 2014	Discussed at Q4/annual checkpoint review meeting. Have received complaints information CCG specific, but still requiring triangulated information which also includes incident reporting to inform our quality responsibilities from NHS England. NHS England have reported that the review and refocus of their internal assurance group is work in progress and systems and processes are still being developed. Concerns have been raised with NHS England. Issue remains a risk due to matters boyond the CCG's control. To be discussed at Q2 assurance checkpoint meeting which will take place in October.	2	4	8	▶	25

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QUA008	Q1 2014/15	Lab results not being communicated to GP practices (from the Lab provider) due to IT system/technical issues that may have an impact on patient safety:	x	Objective 2 - Achieve a 15% reduction in non-elective admissions across 5 years	Quality	Chief Nurse	Raised as an isue at the Quality Committee and Contract meetings. Director of Public Health notified. CCG comms notified.	4	5	20	GP Clinical Lead to meet with Acute Trust Provider Lab Team. Action plans sent out to 3 affected CCGs. Prioritisation of impact of results determines action plans. I Merseyside identify outstanding results. RCA to be completed: Level 1 Priority Patients Completed. Prioritised notification to GP's based on risk. Four technical issues identified: 1. Macroprolachin 2. Clinisys (NT-proBNP & other analytes) 3. EPOC/EMIS 4. Clinisys Corrupt Characters/EMIS Web Provider to undertake RCA investigation as per serrious incident process to identify lessons learnt.	September 2014	October 2015	GP clinical lead identified within CCG to supported by quality team. Steering group set-up with reps from lab provider, local CCGs, I-Merseyside, Aintree Hospitals, NHS England and St Helens and Knowsley Informatics. Confirmation received at Steering Group meeting that the high risk/priority patients GP's ahve been notified of.... GP Clinical Lead wrote to all practices informating them of the issues and the system for prioritisation of notification between the lab and GP practices. Outstanding results to be identified, Priority results to be notified to practices in 5 days, second cohort in 2 weeks and all results within one month.	3	5	15		x
Reputation / Adverse Publicity																			
REP001	Prior Q3 2013/14	Unresolved restitution CHC cases may lead to reputational damage to CCG (to be read in conjunction with Risk 2 above)	Objective 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance Objective 6 - Agreed three year integration plan with Sefton Metropolitan Borough Council and implementation of year one (14/15) to include an intermediate care strategy	Reputational/ Adverse publicity	Chief Nurse Debbie Fagan	Commissioned Service from CMCSU; Standing Agenda Item on Quality Committee; Reports to the Governing Body; Updates received from CHC Team. Regular meetings between Chief Officer, Chief Nurse, Chief Finance Office regarding CHC progress.	4	3	12	Linked to restitution and comes through HOCO report. Reviewed the complaints/disputes process between CCG and CSU.	Sep-14	Oct-14	Chief Nurse met with COO (CMCSU) & Yvonne Lockhead (March 2014). Change of Leadership within Locality Team. Monthly meetings between Chief Nurse & CMCSU Team scheduled to discuss operational models Discussed complaints management linked to restitution & CHC in general - CMCSU to review how complaints are logged, categorised and managed. CCG has requested more detailed information regarding activity in relation to restitution/closedown. CMCSU will clarify more detail in standard letters (e.g. timeframes) to manage patient/family applicant expectations. Plans for Integrated Model to be delivered locally in Q1/Q2 of 2014/15: integration workshops held with CCG /CSU/Local authority in June and July 2014.	4	3	12	▶	8
REP002	Prior Q3 2013/14	Ineffective engagement and communications will impact on the ability to meet statutory duties and possible damage to CCG reputation	Objective 5: To Strengthen Engagement of CCG Members, Public, Partners and Stakeholders	All	Adverse Publicity /Reputation	Head of Delivery & Integration Tracy Jeffes	Integrated Communications and Engagement Strategy in place including annual action plans; Governance structure identified including Quality Committee, EPEG, Locality Groups	3	4	12	KPIs and dedicated resource for communications and engagement to be defined with C&MCSU including annual review of communications and engagement strategy			Systematic process for engagement and consultation defined, with clear reporting channels from locality level to committee structure (Community Champion, Locality Groups, EPEG, Quality Committee) Plan in place for Strategic Communications to come 'in-house'. Respecification of comms and engagement service with CMCSU.	3	3	9	▶	15

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REP003	Q4 2013/14	Adverse CQC report on local practice may result in reputational damage to CCG & impaired access to Primary Care services	Objective 1: To consolidate a robust Strategic Plan within the CCG's financial envelope	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Reputation	Head of Performance & Health Outcomes Malcolm Cunningham	NHSE have asked local providers for expressions of interest in taking over the practice	2	4	8				Out to expressions of interest at present. 8/7/14 - SMT agreed removel of risk. Rationale: isolated incident now managed with support from NHS England.	3	4	12	▶	26
	Statutory Duty																		
STA001	Q3 2013/14	Absence of a robust process for management of conflict of interests could lead to flawed decision making and/or legal challenge	To Strengthen Engagement of CCG Members, Public, Partners and Stakeholders	All	Statutory Duty	Head of Corporate Delivery & Integration Tracy Jeffes	Standards of Business Conduct Policy ratified Conflicts of Interest Policy Declarations of Interest at each Committee/Governing Body Agenda Register of Interests in place & publicly available COI Approvals Panel Terms of Reference have now been approved and the group is fully operational.	2	4	8	Additional Strategic Governance support in place via CSU to review and enhance management of Conflicts of Interest & embedding process in CCG.	August 2014	Septembert 2014	Additional Strategic Governance support in place via CSU to review and enhance management of Conflicts of Interest & embedding process in CCG. Review of existing arrangements to take place during July and August. This review and update will involve support from the Chair of the Audit committee aswell as other key CCG leads. Score to remain the same until review complete.	2	4	8	▶	24
STA002	Q1 2014/15	Failure to implement of recommendations and action plan following CQC style Safeguarding Peer Review	x	Objective 5 - Implementation of 2014-15 phase of Primary Care quality strategy / transformation	Statutory Duty	Chief Nurse Debbie Fagan	CCG Authorised without conditions (by NHS England). Identified an internal process of assurance CCG workplan with MIAA in 14/15 to include review of CCG SaFeguarding arrangements	2	4	8	Opportunity for contributors to review/receive/comment on draft report Action plan to be developed from recommendations	July 2014	August 2014	Executive Summary recommendations to Quality Committee for 2014 june 2014 Awaiting final action plan - to then be implemented Share outcome of RIV and CCG Newwork	2	4	8		x

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2014

Agenda Item: 14/103	**Author of the Paper:** Martin McDowell Chief Finance Officer Email: martin.mcdowell@southportandformbyccg.nhs.uk 0151 247 7000
Report date: July 2014	

Title: Governance Statement (2013/14)

Summary/Key Issues:

All NHS CCG Accountable Officers are required to prepare and sign off and annual statement of governance to support the annual accounts submission. The statement records the stewardship of the organisation to supplement the accounts. The statement has been reviewed by internal and external audit and was signed off by the Audit Committee in June before being submitted with the final accounts of the CCG.

Recommendation

The Governing Body is asked to note this report.

Receive	X
Approve	
Ratify	

14/103

Links to Corporate Objectives *(x those that apply)*	
X	Improve quality of commissioned services, whilst achieving financial balance.
	Sustain 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, Safeguarding Team
Equality Impact Assessment			X	
Legal Advice Sought			X	
Resource Implications Considered			X	
Locality Engagement			X	
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

NHS
South Sefton
Clinical Commissioning Group

Governance Statement

Introduction and context

We were licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006.

We operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to us taking on our full powers.

As at 1 April 2013, the clinical commissioning group was licensed **without** conditions.

We are a clinically led membership organisation made up of general practices.

The functions that the group is responsible for exercising are set out in the Health and Social Care Act 2012.

1. commissioning certain health services (where NHS England is not under a duty to do so) that meet the reasonable needs of:
   a) all people registered with member GP practices, and
   b) people who are usually resident within the area and are not registered with a member of any clinical commissioning group
2. commissioning emergency care for anyone present in the group's area;
3. paying its employees' remuneration, fees and allowances in accordance with the determinations made by its Governing Body and determining any other terms and conditions of service of the group's employees
4. determining the remuneration and travelling or other allowances of members of its Governing Body.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's (CCG's) policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

Compliance with the UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice. This Governance Statement is intended to demonstrate the CCG's efforts to work toward complying with the principles set out in the Code.

Our Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L (2) (b) states:
"The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it".

The CCG comprises membership from the following practices:

Aintree Road Medical Centre
Bootle Village Surgery
Moore Street Medical Centre
North Park Health Centre
The Strand Medical Centre
Park Street Surgery
Concept House Surgery
42 Kingsway
Liverpool Rd Medical Practice
Azalea Surgery
Eastview Surgery
Blundellsands Surgery
Crosby Village Surgery
Kingsway Surgery
Thornton SSP Practice
Crossways SSP Practice
Hightown Village Surgery
Broadwood Surgery
High Pastures Surgery
Maghull Health Centre (Dr Sapre)
Westway Medical Centre
Maghull Health Centre
Maghull SSP Practice
Glovers Lane Surgery
Bridge Road Medical Centre
Orrell Park Medical Centre
Ford Medical Practice
15 Sefton Road
Seaforth Village Practice
Litherland Town Hall Health Centre
Rawson Road Medical Centre
Sefton Road Surgery
Netherton SSP Practice
Litherland Primary Care Walk-In Service

Our member practices are responsible for determining the governing arrangements for the organisation which are set out in our Constitution[1]. The Constitution has been developed to

[1] NHS South Sefton Clinical Commissioning Group *Constitution* (July 2013)

reflect and support the objectives and values defined by the CCG and to ensure that all business functions discharged by the CCG are discharged in an open and transparent manner this Constitution has been developed with the member practices and Localities.

We function in respect of the geographical area defined as south Sefton comprising Bootle, Seaforth and Litherland, Maghull, Crosby and Hightown, and is made up of the Members as set out in Schedule 1[2] of our Constitution.

The Governing Body comprises a diverse range of skills from Executive and Lay members and there is a clear division of responsibility between running the Governing Body and running the operational elements of our business. The Chair is responsible for the leadership of the Governing Body and ensures that Directors have had access to relevant information to assist them in the delivery of their duties. The Lay Members have actively provided scrutiny and challenge at Governing Body and sub-committee level. Each committee comprises membership and representation from appropriate officers and Lay Members with sufficient experience and knowledge to support the committees in discharging their duties.

The Governing Body has been well attended by all Directors and Lay Members throughout the year ensuring that the Governing Body has been able to make fully informed decisions to support and deliver the strategic objectives.

The Governing Body is assured of its effectiveness in terms of performance management through the regular corporate performance reports on finance, quality and key performance indicators as set out in national guidance. Throughout the year performance has continued to be maintained or improved which represents a significant achievement.

The Governing Body undertook an assessment of its effectiveness during June 2013. This was by way Review of Performance against Domains for Assurance of Organisational Health and Capability. The assessment took account of clinical focus, stakeholder engagement, planning to meet health and wellbeing needs, governance and capability, partnerships and leadership.

The Governing Body is supported by a sub-committee structure comprising the committees listed below.

Quality Committee

This committee has delegated responsibility for monitoring the quality of commissioned services, considering information from governance, risk management and internal control systems and; provides corporate focus, strategic direction and momentum for governance and risk management.

The Committee reviews and scrutinises the Governing Body Assurance Framework (GBAF) and the Corporate Risk Register. The committee has delegated responsibility for the approval of corporate policies and during the year has received updates and requests for approvals on the key following policies and processes:

[2] *Ibid* at Page 31

- Information Governance
- Serious Incidents
- Health and Safety
- Adult and Children Safeguarding
- Risk Management
- Governing Body Assurance Framework

The committee also reviewed and scrutinised the following:

- Early Warning Dashboards
- Provider Quality Reports
- Safeguarding Arrangements

The committee comprises the Accountable Officer, Chief Nurse, CCG Officers, Lay Members, clinicians and other CCG officers to ensure that the committee is appropriately skilled and resourced to deliver its objectives.

The Quality Committee has been well attended by all CCG Officers, Lay Members and Clinicians throughout the year ensuring that there has been robust scrutiny and challenge at all times. This has enabled the Quality Committee to provide robust assurances to the Governing Body and to inform the Governing Body of key risk areas.

Key highlights: During the year the Quality Committee:

- Provided assurance to the Governing Body on the objectives and controls within the Governing Body Assurance Framework and Corporate Risk Register
- Provided assurance of compliance with the Information Governance Toolkit
- Approved Safeguarding arrangements
- Approved corporate and clinical policies

The committee is supported by a Corporate Governing Sub Group, Engagement and Patient Experience Group and Serious Incident Review Group.

Audit Committee

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 our strategic aims.

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 our activities to support the delivery of our objectives, and

ii) To review and approve the arrangements for discharging our statutory financial duties

Meetings of the committee have been held three times during the financial year ended 31 March 2014 as follows:

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

The Committee comprises three members of our Governing Body:

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

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

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

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 Merseyside Internal Audit Agency (MIAA)
- Audit Manager/Director PwC
- Local Counter Fraud Officer MIAA

Attendance at the meetings during 2013-2014 was as follows:

	2 May 2013	12 Sep 2013	9 Jan 2014
Audit Chair Linda Elizi ***Resigned from office 30/03/2013***	✓	x	n/a
Audit Chair Graham Morris ***– In post from 01/12/2013***	n/a	n/a	✓
Lay Member - Patient Experience & Engagement	✓	✓	x
Practice Manager - Governing Body Member	✓	x	✓
Chief Finance Officer	✓	✓	✓
Chief Nurse	✓	✓	x
Chief Accountant	n/a	✓	✓
Chief Corporate Delivery and Integration Officer	x	x	x
Audit Managers MIAA	✓	✓	✓
Audit Manager/Director PwC	✓	x	✓
Local Counter Fraud Officer MIAA	✓	✓	✓

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. 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 2013-2014 MIAA reviewed our operations and found no major issues, concluding that overall we had met our 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.

2. External Audit

Role - The objectives of the External Auditors are to review and report on our financial statements and on our Statement on Internal Control.

At this stage of the year External Audit (PwC) is in the early stages of its 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.

3. 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.

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

Conclusions

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.

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 by the publication of the Annual Audit Letter to the Governing Body in its July 2014 meeting

Remuneration Committee

The committee ensures compliance with statutory requirements and undertook reviews of Very Senior Managers remuneration and to comply with the requirements set out in the NHS Codes of Conduct and Accountability and the Higgs report.[3] The Committee reviews and agrees appraisal and remuneration of CCG Officers.

During the year the committee has agreed levels of remuneration for GP attendance at meetings.

The Committee has met three times during the year (November 2013, January 2014 and March 2014). For the first two of those meetings the Committee membership was not fully confirmed and the Governing Body approved the co-option of two Sefton Health and

[3] D, Higgs (January 2003) *Review of the Role and Effectiveness of non-executive directors* section 13.8 at page 61 – available at http://www.berr.gov.uk/files/file23012.pdf

Wellbeing Board Strategic Advisers to ensure that the Committee could complete its work. No fee was paid for this advice.

Finance and Resources Sub Committee

The Committee oversees and monitors financial and workforce development strategies; monitors the annual revenue budget and planned savings; develops and delivers capital investment; is responsible for reviewing financial and workforce risk registers; and financial, workforce and contracting performance.

Our Constitution was assessed by competent individuals as part of the CCG Authorisation process and has been subject to review by BMA Law and NHS England. NHS England confirmed that it is compliant with relevant laws and legislation and that there are arrangements in place for us to discharge our statutory duties.

Our arrangements have also been subject to a review by our internal auditors (MIAA) that offered “significant assurance” on the arrangements.

Our Risk Management Framework

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation’s policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically

The Governing Body has developed the corporate objectives, and the evaluation of the risks to achieving these objectives are set out in the Governing Body Assurance Framework which is regularly reviewed and scrutinised by the Senior Management Team, Corporate Governance Sub Group, Quality Committee and the Governing Body.

The Governing Body Assurance Framework is a key document whose purpose is to provide the Governing Body with ‘reasonable’ assurance that internal systems are functioning effectively. It is a high level document that is used to inform and give assurance to the Governing Body that the risks to achieving key objectives are recognised and that controls are in place or being developed to manage these risks.

Risks are rated, and controls that will address these risks are identified, gaps in control or assurance are noted and action plans to close gaps summarised and updated. Potential and actual sources of assurance are identified and the latter are also rated for the level of assurance provided. A summary of the assurance levels for all assurance framework entries is updated each quarter and accompanies the full document.

The Corporate Risk Register provides the Governing Body with a summary of the principal risks facing the organisation, with a summary of the actions needed and being taken to reduce these risks to an acceptable level. The information contained in the Corporate Risk Register should be sufficient to allow the Governing Body to be involved in prioritising and managing major risks. The risks described in the Corporate Risk Register will be more wide-ranging than those in the Governing Body Assurance Framework, covering a number of domains.

Where risks to achieving organisational objectives are identified in the Corporate Risk Register these are added to the Governing Body Assurance Framework; and where gaps in control are identified in the Governing Body Assurance Framework, these risks are added to the Corporate Risk Register. The two documents thus work together to provide the Governing Body with assurance and action plans on risk management in the organisation.

The Corporate Risk Register is updated and presented for review and scrutiny at the same time as the Governing Body Assurance framework.

We commission a range of training programmes that include specific mandatory training for particular staff groups, which aims to minimise the risks inherent in their daily work. Information Governance, Counter Fraud, Fire, Health and Safety, Equality and Diversity and Safeguarding Training are mandatory training requirements for all staff.

Targeted training is provided to designated risk leads to support development of risk registers, and one to one sessions are available for all managers responsible for updating the Governing Body Assurance Framework.

Our Internal Control Framework

A system of internal control is the set of processes and procedures in place to ensure we deliver our policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them, efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Information Governance

All key information assets have been identified by the Information Assets Owners on an Information Asset Register. The data security and confidentiality risks to each asset have been identified, and controls identified to mitigate risks.

The risks to the physical information assets are minimal, and pose no significant Information Governance concern for us.

All inbound and outbound flows of data have been identified through a Data Flow Mapping tool. All data flows are being transferred appropriately.

The risks to the inbound and outbound flows of data are minimal, and pose no significant Information Governance concern for us.

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and we are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

Pension obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, diversity and human rights obligations

Control measures are in place to ensure that we comply with the required public sector equality duty set out in the Equality Act 2010.

Sustainable development obligations

We are required to report our progress in delivering against sustainable development indicators. We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning. We will ensure that the CCG complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012. We are also setting out our commitments as a socially responsible employer.

Risk assessment in relation to governance, risk management and internal control

We have a comprehensive Risk Management Strategy. The following key elements are contained within the Strategy:

- Risk Management Strategy, Aims and Objectives
- Roles, Responsibilities and Accountability
- The Risk Management Process – Risk Identification, Risk Assessment, Risk Treatment, Monitoring and Review, Risk Prevention
- Risk Grading – Criteria
- Training and Support

We have established a number of mechanisms for identifying and managing risks including risk profiling methodology, incident reporting, complaints and litigation data, and staff concerns / whistleblowing.

Risk management and the ensuing development of risk registers is generally achieved using a dual 'top-down' and 'bottom-up' approach to identifying and managing risks. The 'top-down' element has been addressed through the development of a Governing Body Assurance Framework and Corporate Risk Register identifying strategic high-level risks. These two documents are based on models which have previously been accepted as meeting audit requirements.

The 'bottom-up' element of the risk management system best fits with organisational structures and this has therefore been based on the directorate arrangements and subsequently on the NHS Merseyside director portfolios and integrated teams. All functional leads have identified their arrangements for developing and reviewing risk registers and escalating risks.

Key new risks identified during 2013-2014 are:

- Continuing Healthcare Retrospective Claims and the associated financial risk
- Processing of patient identifiable information (which is mitigated by the arrangements with Cheshire and Merseyside Commissioning Support Unit (CSU) and its licence to process and pseudonymisation)
- Safeguarding reporting arrangements between Safeguarding hosted service, providers and the CSU (this has now been resolved and a reporting protocol agreed)

Review of economy, efficiency and effectiveness of the use of resources

We seek to gain best value through all of our contracting and procurement processes. We have approved a Scheme of Delegation, Prime Financial Policies and a Schedule of Financial Limits that ensures there are proper controls in respect of expenditure.

The agreed limits for quotation and tendering are detailed in those policies and staff are required to properly assess bids for services in accordance with the policies.

We buy procurement expertise and support from the CSU and this service is delivered by appropriately trained and accredited individuals.

All newly acquired services are subject to robust assessment to ensure that patients are able to benefit from quality, value for money services.

Review of the effectiveness of governance, risk management and internal control

As Accounting Officer I have responsibility for reviewing the effectiveness of the system of internal control within the CCG.

Capacity to handle risk

The Chief Officer has accountability for ensuring there are robust arrangements in place for the identification and management of risk. The Chief Officer is supported in this role by the Head of Corporate Delivery and Integration. Expertise and support is also procured from the CSU who offers advice to all staff on the identification and management of risk.

The Senior Management Team have received training on the development and management of the Governing Body's Assurance Framework and all staff are able to access "hands on" support at all times. All SMT members have received the Risk Management Strategy and have also had training on incident reporting procedures.

We foster a culture of openness and encourage the sharing of good practice and learning when things go wrong.

Review of effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the Senior Management Team, managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.
The *Governing Body Assurance Framework* itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee, Quality Committee and Finance and Resources Committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Governing Body receives the minutes of all committees including the Audit Committee, Quality Committee and Finance and Resources Committee.

The Quality Committee approves relevant policies and the Audit Committee monitors action plans arising from Internal Audit reviews.

Internal Audit is a key component of internal control. The Audit Committee approves the annual internal audit plan, and progress against this plan is reported to each meeting of the Committee. The individual reviews carried out throughout the year assist the Director of Audit to form his opinion, which in turn feeds the assurance process.

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of our systems of risk management, governance and internal control. The Head of Internal Audit concluded that:

"*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."*

During the year the Internal Audit did not issue any audit report with a conclusion of limited or no assurance.

Data quality

The CSU is commissioned to provide us with *inter alia,* Performance Reports, Contract Monitoring Reports, Quality Dashboards and other activity and performance data. The CSU's Data Management Information Centre (DMIC) processes and quality assures the data that is received from providers and works with us to challenge providers if inconsistencies are identified.

Our Chief Analyst also assesses the quality of the data provided and ensures that concerns are addressed through the provider Information Sub Group meetings.

These processes provide assurances that the quality of the data upon which the Membership and Governing Body rely, is robust.

The DMIC is also licenced by the Health and Social Care Information Centre to lawfully process Patient Identifiable information.

Business critical models

Our Internal Auditors (MIAA) have undertaken a review of management accounting practices including estimation techniques and forecasting and reported that significant assurance is in place in respect of the control environment operating in this area.

Data security

We have submitted a level 2 compliance with the information governance toolkit assessment. Our Internal Auditors provided an assessment of “Significant Assurance” on the submission.

We have put in place policies, procedures, guidance and support to ensure that personal and corporate information is handled legally, securely, efficiently and effectively, in order to deliver high quality services. Performance is monitored through the completion of the annual Information Governance (IG) Toolkit return and reports to the Corporate Governance Group and Quality Committee.

Controls include:

- Mandatory induction and refresher IG training for all staff
- Identifying the movement of personal data and assessing associated risks, and minimising where possible
- Ensuring the encryption of all confidential data stored on portable devices
- Reporting, investigation and escalation of all information governance incidents

Discharge of statutory functions

During establishment, the arrangements we put in place and explained within our Constitution were developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

In light of the Harris Review, we have reviewed all of the statutory duties and powers conferred on us by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG’s statutory duties.

Conclusion

During the year no significant control issues have been identified. This is confirmed by the Head of Audit Opinion and also by the Internal Audit Reviews that have provided the CCG with significant assurance on the arrangements in place.

Fiona Clark
Chief Officer
June 2014

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2014

Agenda Item: 14/104	**Author of the Paper:**
Report date: July 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 and Quality 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 2, 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	Sustain 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.
	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
July 2014

1. Executive Summary

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

2. Introduction and Background

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

This report sets out the CCGs performance against the National Outcomes Framework and the NHS Constitution. It also shows provider performance for the CCG's 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) – Methylicillin-Resistant Staphylococcus Aureus – (MRSA)

South Sefton CCG has reported one MRSA case in May 2014, above the zero tolerance.

The 1 MRSA case was reported at Aintree Hospitals NHS Foundation Trust in May 2014. Following the Post Infection Review (PIR) process, this case was found not to be attributable. As per national guidance this case has been attributed to the CCG due to the organisation being best placed to ensure the lessons learned are adopted across the system. This has been discussed at the Liverpool Community Health (LCH) CQPG and the CCG are awaiting an action plan from LCH which reflects the lessons learned.

Healthcare Acquired Infections (HCAI) – C.difficile

In May 2014 there have been 6 cases of C.difficile infection reported for South Sefton CCG patients giving a cumulative total of 10 against a tolerance for South Sefton CCG patients of 10. The 6 cases were at Aintree Hospitals NHS Foundation Trust, 1 acute trust acquired and 5 community acquired.

As outlined above, Aintree Hospitals NHS Foundation Trust has reported 6 cases of Cdifficile at May 2014, against a tolerance to date for Aintree Hospitals NHS Foundation Trust of 14. The Trust reported an outbreak of 6 cases within one department. Public Health England (PHE) was notified by the Trust and the CCG have been given assurances from PHE on the management of the outbreak. This was discussed at the CQPG meeting in July. The Trust is still on trajectory for the national target for HCAI incidence reporting and the CCG are awaiting cases for appeal. The IPC action plan is being implemented and robustly monitored. The IPC action plan is being implemented and robustly monitored. As previously reported, an existing action plan is being implemented and further actions include:

- the implementation of a 24/7 Infection Prevention and Control (IPC) intensive support team;
- enforcement of the isolation policy with escalation to the Chief Operating Officer or Executive Director on-call;
- the opening of a cohort ward;
- implementation of an enhanced and focused cleaning programme;

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

Southport and Ormskirk Hospital NHS Trust has reported 2 cases in May 2014 taking the cumulative total to 6 against a year to date tolerance of 4. The CCG are awaiting cases that the Trust may wish to appeal as part the local appeals process which will be agreed by all stakeholders by the end of July 2014.

Percentage of patients who spent 4 hours or less in A&E (Cumulative)

South Sefton CCG achieved this target cumulatively to June 2014 with 98.29% against the 95% target.

Performance cumulatively to June 2014 at Aintree University Hospitals NHS Foundation Trust was below the target of 95% with 92.14% a further fall from the figure cumulatively to May 2014. Year to date, of the 28,096 patients attending, 25,888 were seen within 4 hours.

A number of key actions have taken place these included:

- Review by the Emergency Care Intensive Support Team (ECIST) on 17th April 2014 of the action plan developed following their visit in August 2013 and incorporation of actions into existing A&E improvement plan.
- Plan for 'perfect week' in early July 2014 to change processes and implement different ways of working to test performance.
- 5 rapid improvement events within ED processes during June 2014 to look at flows within Triage, Minor Injury, Ambulatory Medicine, Resus and the overall clinical co-ordination of the department.
- Change of Divisional leadership for A&E from 19th May 2014 occurred.
- Establishment of group to review bed management processes, including implementation of IT solution and transfer of site management responsibility to Diagnostic & Support Services Division from 19th May 2014.
- Review of escalation process has been completed and is being trialled.
- Establishment of task & finish group for level 1 facilities – in progress.
- Review of A&E job plans and revised 15 Consultant rota from August 2014.
- Review of the implementation of ambulatory model of care for the Frailty Unit by end of June 2014.
- Review of GP Direct Telephone Access & hot clinic was discussed at June Urgent Care Board & actions agreed
- Participation in NWAS clinical working group from May 2014 – in place.
- Implementation of findings from ward round/EDD audit; use of ECIST "4 questions" used in June.
- Review of "on take" model including ECIST meeting for potential pilot site - GP admissions data is being analysed.
- Participation in Urgent Care Network Discharge Task & Finish Group (in progress)
- Business case for potential expansion of Aintree at Home completed.

Southport and Ormskirk Hospital NHS Trust achieved this target with performance cumulatively to June 2014 at 97.07%.

Mixed Sex Accommodation (MSA)

South Sefton CCG achieved this target for the month of June 2014 and reported zero MSA breaches for South Sefton CCG patients.

There were no Mixed Sex Accommodation breaches in the month of May 2014 in any of the associated providers.

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 1) 8 minute response time

South Sefton CCG failed to achieve the target of 75% for the month of May 2014, reaching 73.12% (cumulative). This is highlighted as an amber risk on the corporate performance dashboard. Within the month of May the CCG achieved the target of 75% with 82.35%.

NWAS catchment failed to achieve the 75% target with cumulative performance of 74.53%. This was due to the low achievement of 73.41% in May 2014.

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

South Sefton CCG failed to achieve the target of 75% for the month of May 2014, reaching 74.86% (cumulative). This is highlighted as an amber risk on the corporate performance dashboard. Within the month of May the CCG achieved the target of 75% with 75.03%.

Please note: the CCG is measured on the North West Ambulance Service (NWAS) figures.

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 93.69% for this indicator during April 2014 against the 93% target.

For the maximum 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms, Aintree University Hospitals NHS Foundation Trust marginally failed to achieve the April 2014 target for breast symptomatic referrals with 92.86% against the 93% target. Of the 224 referrals there were 16 breaches. The reasons for the breaches were mainly patient cancellations due to various reasons.

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

South Sefton CCG achieved 93.33% for this indicator during April 2014, marginally below 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 92.86% at April 2014. This was 1 patient breach out of a total of 14 patients treated (tumour type: Lower Gastrointestinal). The patient delay (40 days) was due to the patient requiring a Senior Anaesthetist.

The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways

There were 2 South Sefton CCG patients waiting for over 52 weeks in May 2014 against a zero tolerance. Both of these patients were at Royal Liverpool and Broadgreen University Hospitals Trust (RLBUHT) under Trauma and Orthopaedics.

% who had a stroke & spend at least 90% of their time on a stroke unit
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours

These 2 indicators were both achieved for South Sefton CCG patients in May 2014. Out of a total of 26 patients admitted with stroke, 21 spent at least 90% of their time on a stroke unit.

Southport and Ormskirk Hospital NHS Trust failed to achieve the 80% target for the stroke measure, with 78.57% in May 2014, just marginally below target and flagged as an amber risk.

Aintree University Hospitals NHS Foundation Trust achieved the 80% stroke target during May 2014, performance was 80%.

Southport and Ormskirk Hospital NHS Trust failed to achieve the 60% target for the TIA measure, with 46.67% in May 2014, significantly below target and flagged as a red risk.

Aintree University Hospitals NHS Foundation Trust achieved the 60% TIA target during May 2014, performance was 100%.

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

The indicator comprises two elements: the test score and the % of respondents who would recommend the services to friends and family – for Inpatient Services and A&E. Providers are now measured against these separately and not combined as previously measured.

Aintree University Hospitals NHS Foundation Trust – Inpatient test score during May 2014 was 79. Percentage of respondents was 45.37%. A&E test score was 38 during May 2014. Percentage of respondents was 25.00%.

For Southport and Ormskirk Hospital Trust achievement during May 2014 for inpatients was 71. Percentage of respondents was 35.96%. The A&E test score was 48 but the percentage of respondents was 5.10%, below the required 20%.

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

Plans for local measures have yet to be finalised for 2014/15 so the corporate performance dashboard is showing the full year figures (2013/14) as reported in the month 1 report (repeated below):

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 University Hospitals NHS Foundation Trust reported 4 serious untoward incidents in May 2014.

Type of Incident	April 2014	May 2014
Failure to act upon test results	0	3
Pressure Ulcer grade 4	0	1
Grand Total	**0**	**4**

Details of actions taken and reports received as a result of the serious incidents are discussed at the monthly SI Review meetings.

All serious incidents reported by Providers are discussed at the CCG internal SI review meeting, the Quality Committee and Provider Contract meetings as a standard agenda item.

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
Appendix 3 Aintree University Hospital Quality Dashboard
Appendix 4 Southport and Ormskirk Hospital Quality Dashboard

Karl McCluskey
July 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)	14/15 - May	10	10		
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative)	14/15 - May	0	1		
Enhancing quality of life for people with long term conditions					
Patient experience of primary care i) GP Services	Jul-Sept 13 and Jan-Mar 14		83.00%		
Patient experience of primary care ii) GP Out of Hours services	Jul-Sept 13 and Jan-Mar 14		73.00%		
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s(Cumulative)	14/15 - May		40.30		
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	14/15 - May		179.08		
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)	14/15 - May		16.40		
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	14/15 - May		34.10		
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	14/15 - May		207.42		
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	14/15 - May	80%	80.77%		
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	14/15 - May	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)	14/15 - April	93%	95.88%		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative)	14/15 - April	93%	93.69%		
Cancer waits – 31 days					
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative)	14/15 - April	96%	100.00%		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative)	14/15 - April	98%	100.00%		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)	14/15 - April	94%	93.33%		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative)	14/15 - April	94%	95.45%		
Cancer waits – 62 days					
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set (Cumulative)	14/15 - April		100.00%		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative)	14/15 - April	90%	100.00%		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative)	14/15 - April	85%	93.55%		
Mixed Sex Accommodation Breaches					
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE	14/15 - May	0.00	0.00		
Referral To Treatment waiting times for non-urgent consultant-led treatment					
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted)	13/14 - May	0.00	0.00		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways	13/14 - May	0.00	0.00		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways.	13/14 - May	0.00	2.00		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	13/14 - May	90%	94.86%		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	13/14 - May	95%	97.89%		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	13/14 - May	92%	95.90%		
A&E waits					
Percentage of patients who spent 4 hours or less in A&E (Cumulative)	14/15 - June	95%	98.29%		
Diagnostic test waiting times					
% of patients waiting 6 weeks or more for a Diagnostic Test	14/15 - May	1.00%	0.57%		
Category A ambulance calls					

Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	14/15 - May	75%	73.12%		
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	14/15 - May	75%	74.86%		
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	14/15 - May	95%	97.06%		
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	14/15 - May	75%	74.53%		
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	14/15 - May	75%	75.00%		
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	14/15 - May	95%	95.91%		

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 within 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 LEVEL

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)	14/15 - June	92.14%	97.07%	
Ambulance				
Ambulance				
Ambulance handover delays of over 1 hour	14/15 - May	21.00	6.00	
Ambulance handover delays of over 30 minutes	14/15 - May	94.00	44.00	
Crew clear delays of over 1 hour	14/15 - May	1.00	1.00	
Crew clear delays of over 30 minutes	14/15 - May	34.00	19.00	
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)	14/15 - April	92.86%	97.53%	100.00%
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative)	14/15 - April	97.56%	96.63%	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)	14/15 - April	100.00%	100.00%	100.00%
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)	14/15 - April	100.00%	92.86%	100.00%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative)	14/15 - April	100.00%	100.00%	100.00%
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative)	14/15 - April	100.00%	100.00%	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)	14/15 - April	86.67%	100.00%	100.00%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative)	14/15 - April	88.89%	100.00%	100.00%
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative)	14/15 - April	87.50%	93.10%	100.00%

Diagnostic test waiting times				
Diagnostic test waiting times				
% of patients waiting 6 weeks or more for a Diagnostic Test	14/15 - April	0.64%	0.45%	0.32%
Mixed Sex Accommodation Breaches				
Mixed Sex Accommodation Breaches				
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE	14/15 - May	0.00	0.00	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%	14/15 - May	94.50%	94.70%	93.45%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	14/15 - May	98.79%	98.06%	97.68%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	14/15 - May	97.61%	97.87%	98.27%
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted)	14/15 - May	0.00	0.00	0.00
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways	14/15 - May	0.00	0.00	0.00
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways.	14/15 - May	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	14/15 - May	80.00%	78.57%	
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	14/15 - May	100.00%	46.67%	
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)	14/15 - May	6	6	0
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative)	14/15 - May	0	0	0
Patient safety incidents reported	14/15 - May	4	0	0
Everyone Counts - NHS Outcome Measures				
Ensuring people have a positive experience of care				
Friends and Family Test Score - Inpatients	14/15 - May	79	71	96
Friends and Family Test Score Inpatients (% of respondents)	14/15 - May	45.37%	35.96%	25.06%
Friends and Family Test Score A&E	14/15 - May	38	48	
Friends and Family Test Score A&E (% of respondents)	14/15 - May	25.00%	5.10%	

NHS
Cheshire and Merseyside Commissioning Support Unit

Aintree University Hospital

Reds - Possibly areas for discussion

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

	Domain 1: Preventing People from Dying Prematurely	Reporting Period	Benchmark	Previous Period	Latest Data	Movement	YTD	Trend
	Cancer Waiting Times	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
1	Patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	May-14	93%	96.8%	97.8%	Improvement	97.2%	
2	Patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	May-14	93%	92.2%	95.7%	Improvement	94.6%	
3	Patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	May-14	96%	100.0%	99.0%	No Change	99.5%	
4	Patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	May-14	94%	100.0%	100.0%	No Change	100.0%	
5	Patients waiting no more than 31 days of subsequent treatment where that treatment is an anti-cancer drug regimen	May-14	98%	100.0%	100.0%	No Change	100.0%	
6	Patients waiting no more than 31-Day Standard for Subsequent Cancer Treatments-Radiotherapy	May-14	94%	0 Patients	0 Patients	No Change	0 Patients	
7	Patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	May-14	85%	91.8%	78.0%	Decline	84.2%	
8	Patients waiting no more than 62 days from referral from an NHS Screening service to first definitive treatment for all cancers	May-14	90%	80.0%	71.4%	Decline	76.5%	
9	Patients waiting no more than 62 days for first definitive treatment following a consultants decision to upgrade the priority of a patient (all cancers)	May-14	85%	100.0%	100.0%	No Change	100.0%	
	Mortality	**Annual**	**Plan**	**Jul 12 - Jun 13**	**Oct 12 - Sep 13**	**Change**	**2013/14**	**Over time**
10	Hospital Standardised Mortality Ratio (HSMR)	Mar-14	100	93.5	92.0	Improvement	92.01	
11	Summary Hospital-Level Mortality Indicator (SHMI)	Oct 12 - Sep 13	100	1.13	1.13	No Change	1.13	
12	(SHMI) Deaths occurring in hospital	Oct 12 - Sep 13		72.8%	74.0%	No Change	74.0%	
13	(SHMI) Deaths occurring out of hospital	Oct 12 - Sep 13		27.2%	26.1%	No Change	26.1%	

	Domain 2: Quality of Life (Long Term Conditions)							
	Stroke	**Monthly**	**Plan**	**Q3 13/14**	**Q4 13/14**	**Change**	**2013/14**	**Over time**
14	Stroke/TIA - Stroke 90% Stay on ASU	Q4 13/14	80%	61.1%	83.2%	No Change	75.1%	
15	Stroke/TIA - TIA - High Risk Treated within 24Hrs	Q4 13/14	60%	100%	100%	No Change	100%	

	Domain 3: Helping People to Recover from Episodes of Ill Health or from Injury							
	A&E Quality Measures	**Monthly**	**Plan**	**Feb-14**	**Mar-14**	**Change**	**2013/14**	**Over time**
16	**Overall achievement of A&E Quality Indicators**	Mar-14	Achieved	Fail	Achieve	No Change	Achieved	
17	Unplanned re-attendance at A&E within 7 days of original attendance	Mar-14	5%	7.9%	7.6%	No Change	7.0%	
18	Patient Impact - Left department without being seen rate	Mar-14	5%	4.0%	3.3%	No Change	3.9%	
19	Timeliness - Time to initial assessment - 95th centile	Mar-14	15	0	0	No Change	3	
20	Timeliness - Total time spent in A&E department - 95th centile	Mar-14	240	390	239	No Change	288	
21	Timeliness - Time to treatment in department - median	Mar-14	60	99	93	No Change	97	
	Rapid Access Chest Pain Clinic	**Quarterly**	**Plan**	**Q3 13/14**	**Q4 13/14**	**Change**	**2013/14**	**Over time**
22	A maximum two-week wait for Rapid Access Chest Pain Clinic (RACPC)	Q4 13/14	98%	91.0%	98.0%	Improvement	90.9%	
	Smoking	**Quarterly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
23	Smoking Status recorded for all inpatients (exclude critical care)	Q3 13/14	90%	No data	No Data	No Change	62%	N/A
24	All Smokers to be offered Smoking intervention Advice	Q3 13/14	by Q4 13/14	No data	No Data	No Change	71%	N.A
	Patient Reported Outcome Measures	**Annual** **Revised figures*	**Eng Average**	**Apr 11 - Mar 12**	**Apr 12 - Mar 13**	**Change**	**2013/14**	**Over time**
25	Groin Hernia - Average increase in health gain	Apr 12 - Mar 13	0.085	0.088	0.062	Decline	0.062	
26	Hip Replacement - Average increase in health gain	Apr 12 - Mar 13	0.438	0.397	0.438	Improvement	0.438	
27	Knee Replacement - Average increase in health gain	Apr 12 - Mar 13	0.318	0.299	0.291	Decline	0.291	
28	Varicose Vein - Average increase in health gain	Apr 12 - Mar 13	0.093	*	*	No Change	*	

	Domain 4: Ensuring People have a positive experience of care							
	Referral to Treatment	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
29	18 Weeks - Admitted - % Compliance - Trust	May-14	90%	93.8%	94.5%	Improvement	94%	
30	18 Weeks - Non Admitted - % Compliance - Trust	May-14	95%	98.2%	98.8%	Improvement	98%	
31	18 Weeks - On-going - % <18 Weeks - Trust	May-14	92%	97.8%	97.6%	No Change	98%	
32	Zero tolerance RTT Waits over 52 weeks	May-14	0	0	0	No Change	0	
	A&E Department Measures	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
33	Percentage of A&E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an a&e department	May-14	95%	94%	91.4%	Decline	93%	
34	Trolley waits in A&E	May-14	0	1	0	Improvement	1	
35	Handover <15 Minutes. Time taken from HAS notification to clinical handover (Assumed ACUTE responsibility)	May-14	15 Mins	00:11:50	00:12:16	Decline	00:12:03	
36	Patients waiting between 30-60 Minutes for Handover	May-14	0	68	73	Decline	141	
37	Patients waiting between 60+ Minutes for Handover	May-14	0	31	21	Improvement	52	
38	Compliance with Recording Patient Handover between Ambulance and A&E	May-14	95%	85.2%	84.3%	Decline	85%	
	Mixed Sex Accommodation Breaches	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
39	Sleeping accommodation Breach (MSA)	May-14	0	0	0	No Change	0	
	Diagnostics	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
40	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	May-14	99%	100%	99.4%	Decline	99.4%	
	Cancelled Operations	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
41	All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for nonclinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.	May-14	0	0	0	No Change	0	
42	No urgent operation should be cancelled for a second time	May-14	0	0	0	No Change	0	
	Choose and Book	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
43	Provider failure to ensure that "sufficient appointment slots" are made available on the Choose & Book system	May-14	7%	21.1%	18.5%	Improvement	19.7%	
	VTE	**Monthly**	**Plan**	**Q3 13/14**	**Q4 13/14**	**Change**	**2013/14**	**Over time**
44	Percentage of patients risk assessed for venous thromboembolism who receive appropriate prophylaxis (Local Audits)	Q4 13/14	95%	94.1%	96.0%	Improvement	93.1%	
	Complaints	**Quarterly**	**Plan**	**Q3 13/14**	**Q4 13/14**	**Change**	**2013/14**	**Over time**
45	Complaints received at CMCSU (Business Solutions)	Q4 13/14	0	0	0	No Change	0	
46	Complaints received at provider	Q4 13/14	0	Awaiting update			67	

NHS
Cheshire and Merseyside

Aintree University Hospital

National Dementia		**Monthly**	**Plan**	**Mar-14**	**Apr-14**	**Change**		**2013/14**	**Over time**
47	National Dementia CQUIN - Screening for Dementia (Find)	Apr-14	90%	66.7%	69.0%	Improvement		69.0%	
48	National Dementia CQUIN - Risk Assessed (Assess and Investigate)	Apr-14	90%	83.3%	76.3%	Decline		76.3%	
49	National Dementia CQUIN - Patients Referred	Apr-14	90%	100%	100%	No Change		100%	
National Friends&Family		**Quarterly**	**Plan**	**Apr-14**	**May-14**	**Change**		**2013/14**	**Over time**
50	National Friends and Family - Phased Expansion (Inpatient,A&E and Maternity)	May-14	Compliance			Compliant			
51	National Friends and Family - Increased Response Rate Inpatients	May-14	20%	43.5%	45.4%	Improvement		44.5%	
	National Friends and Family - Increased Response Rate A&E	May-14	20%	23.5%	25.0%	Improvement		24.3%	
	National Friends and Family - Test Score Inpatients	May-14		80	79	No Change		80	
52	National Friends and Family - Test Score A&E	May-14		35	38	Improvement		38	
Advancing Quality		**Monthly**	**Plan**	**Jan-14**	**Feb-14**	**Change**		**2013/14**	
53	Advancing Quality Acute myocardial infarction	Feb-14	81.3%	87.50%	100.0%	Improvement		92.58%	
54	Advancing Quality Heart Failure	Feb-14	73.8%	88.46%	58.82%	Decline		69.35%	
55	Advancing Quality Hip and Knee	Feb-14	82.0%	83.67%	79.45%	Decline		84.94%	
56	Advancing Quality Pneumonia	Feb-14	61.1%	83.33%	77.66%	Decline		77.60%	
57	Advancing Quality Stroke	Feb-14	53.6%	56.41%	75.86%	Improvement		47.62%	
Patient Experience		**Annual**	**England Average**	**Previous Year**	**Latest Year**	**Change**		**Latest Data**	**Over time**
58	Patient experience of hospital care	2013	76.5%	77.0%	74.5%	No Change		74.5%	
59	Patient experience of outpatient services	2011	79.2%	79.0%	80.0%	No Change		80.0%	N/A
60	Patient experience of A&E services	2012	75.4%	76.2%	74.2%	No Change		74.2%	N/A
Domain 5: Treating & Caring for People in a Safe Environment and Protecting from Harm									
Infection Control		**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**		**2014/15**	**Over time**
61	Clostridium Difficile - Trust	May-14	6	3	3	Improvement		6	
62	Incidence of MRSA - Trust	May-14	0	0	0	No Change		0	
63	MRSA Screening - Trust	May-14	No Plan	100%	100%	No Change		100%	
64	MSSA	May-14	No Plan	2	2	No Change		2	
Hygiene Compliance		**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**		**2014/15**	**Over time**
65	Hand Hygiene Compliance - Trust	May-14	No Plan	98%	98%	Improvement		98%	
Incident Reporting		**Monthly**	**Plan**	**May-14**	**Jun-14**	**Change**		**2014/15**	**Over time**
66	Never Events - Trust	Jun-14	0	0	0	No Change		0	
67	Steis Reportable Incidents - Trust	Jun-14	0	4	1	Improvement		5	
CQC		**Monthly**	**Plan**	**May-14**	**Jun-14**	**Change**		**2014/15**	**Over time**
68	CQC Intelligence Tool - Band 1 = Highest Risk Band 6 = Lowest Risk	Jun-14	6	Recently checked	Recently checked	No Change		Recently checked	N/A
69	Compliance against 5 essential standards (✓ = Compliant, × = Not Compliant actions requiring improvement, × = Not Compliant and Enforcement Action Taken)	Jun-14	✓	✓	✓	No Change		✓	
Central Alerting System		**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**		**2014/15**	**Over time**
70	All CAS alerts outstanding after deadline date	May-14	0	2	2	No Change		1	
Sickness Absence		**Monthly**	**Plan**	**Q3 13/14**	**Q4 13/14**	**Change**		**Q4 13/14**	**Over time**
71	Sickness Absence Rates All Staff - National Data	Q4 13/14	4.12%	4.06%	Awaiting update	Decline		Awaiting update	
72	Sickness Absence Rates All Staff - Provider internal data	Q4 13/14	4.12%	4.10%	4.32%	Decline		4.32%	
Coronary Heart Disease		**Quarterly**	**Plan**	**Q3 13/14**	**Q4 13/14**	**Change**		**2013/14**	**Over time**
73	Percentage of CHD patients with a primary diagnosis of AMI prescribed ACE Inhibitors on discharge	Q4 13/14	95%	100%	100%	No Change		100%	
74	Percentage of CHD patients with a primary diagnosis of AMI prescribed Clopidogrel on discharge	Q4 13/14	95%	100%	100%	No Change		100%	
VTE		**Monthly**	**Plan**	**Mar-14**	**Apr-14**	**Change**		**2014/15**	**Over time**
75	National CQUIN - VTE Risk Assessments	Apr-14	95%	95.1%	95.5%	Improvement		95.5%	
National Patient Incident Reporting		**Bi Annual**	**Median Average**	**Apr 12 - Sep 12**	**Apr 13- Sep 13**	**Change**		**Latest data**	**Over time**
76	National Patient Safety Incident Reporting Per 100 admissions	Apr 13 - Sep 13	6.7	7.20	7.21	No Change		7.21	
77	Safety incidents resulting in severe harm or death	Apr 13 - Sep 13	0.8%	0.2%	0.1%	No Change		0.1%	
Staff Survey		**Annual**	**Eng Average**	**2012**	**2013**	**Change**		**2013/14**	**Over time**
78	National Staff Survey	2013	3.74	3.69	3.74	Improvement		3.74	
PLACE Survey		**Annual**	**Eng Average**		**2013**	**Change**		**2013/14**	**Over time**
79	PLACE Survey - Average score of all four areas	2013	90%	N/A	85.2%	No Change		85.2%	N/A
NHS Safety Thermometer		**Monthly**	**Eng Average**	**Apr-14**	**May-14**	**Change**		**2014/15**	**Over time**
80	Submission compliance	May-14	Compliance			No Change			
81	Total patients surveyed		N/A	621	637	Improvement		1258	
82	Patients receiving harm free care		94.0%	94.2%	94.4%	No Change		94.3%	
83	Total pressure ulcers (all categories)		4.2%	4.0%	4.1%	No Change		4.1%	
84	Total falls (causing harm)		0.87%	0.2%	0.5%	Decline		0.3%	
85	Patients with a catheter and being treated for a UTI		0.3%	4.5%	0.3%	Improvement		2.4%	
86	Number of patients with a new VTE		0.3%	0.6%	0.6%	No Change		0.6%	

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

NHS
Cheshire and Merseyside Commissioning Support Unit

Southport and Ormskirk Hospital

Reds - Possibly areas for

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

	Domain 1: Preventing People from Dying Prematurely	Reporting Period	Benchmark	Previous Period	Latest Data	Movement	YTD	Trend
	Cancer Waiting Times	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
1	Patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	May-14	93%	96.0%	96.6%	Improvement	96.3%	
2	Patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	May-14	93%	98.4%	97.5%	Decline	97.9%	
3	Patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	May-14	96%	99.0%	100%	Improvement	99.5%	
4	Patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	May-14	94%	100%	92.9%	Decline	96.5%	
5	Patients waiting no more than 31 days of subsequent treatment where that treatment is an anti-cancer drug regimen	May-14	98%	100%	100%	No Change	100%	
6	Patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	May-14	85%	88.6%	93.1%	Improvement	90.8%	
7	Patients waiting no more than 62 days from referral from an NHS Screening service to first definitive treatment for all cancers	May-14	90%	100%	NTR	No Change	100.0%	
8	Patients waiting no more than 62 days for first definitive treatment following a consultants decision to upgrade the priority of a patient (all cancers)	May-14	85%	85.7%	100%	Improvement	92.9%	
	Mortality	**Annual**	**Plan**	**Jul 12 - Jun 13**	**Oct 12 - Sep 13**	**Change**	**2013/14**	**Over time**
9	Hospital Standardised Mortality Ratio (HSMR)	Feb 12-Jan 13	100	99.1	99.3	No Change	99.3	
10	Summary Hospital-Level Mortality Indicator (SHMI)	Oct12 - Sep 13	100	1.06	1.09	Decline	1.09	
11	(SHMI) Deaths occurring in hospital	Oct12 - Sep 13		69.4%	70.1%		70.1%	
12	(SHMI) Deaths occurring out of hospital	Oct12 - Sep 13		30.6%	29.9%		29.9%	
	Domain 2: Quality of Life (Long Term Conditions)							
	Stroke	**Monthly**	**Plan**	**Q3 13/14**	**Q4 13/14**	**Change**	**2013/14**	**Over time**
13	Stroke/TIA - Stroke 90% Stay on ASU	Q4 13/14	80%	83%	85%	No Change	85%	
14	Stroke/TIA - TIA - High Risk Treated within 24Hrs	Q4 13/14	60%	71%	68%	No Change	58%	
	Domain 3: Helping People to Recover from Episodes of Ill Health or from Injury							
	A&E Quality Measures	**Monthly**	**Plan**	**Feb-14**	**Mar-14**	**Change**	**2013/14**	**Over time**
15	**Overall achievement of A&E Quality Indicators**	Mar-14	Achieved	Achieve	Achieve	No Change	Achieve	
16	Patient Impact - Unplanned re-attendance rate - Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health professional)	Mar-14	5%	3%	3%	No Change	5%	
17	Patient Impact - Left department without being seen rate	Mar-14	5%	2%	2%	No Change	2%	
18	Timeliness - Time to initial assessment - 95th centile	Mar-14	15	4	2	No Change	5	
19	Timeliness - Total time spent in A&E department - 95th centile	Mar-14	240	239	239	No Change	265	
20	Timeliness - Time to treatment in department - median	Mar-14	60	37	49	No Change	46	
	Rapid Access Chest Pain Clinic	**Monthly**	**Plan**	**Feb-14**	**Mar-14**	**Change**	**2013/14**	**Over time**
21	A maximum two-week wait for Rapid Access Chest Pain Clinic (RACPC)	Mar-14	100%	100%	98.2%	No Change	100%	
	Smoking	**Quarterly**	**Plan**	**Q3 13/14**	**Q4 13/14**	**Change**	**2013/14**	**Over time**
22	Smoking Status recorded for all inpatients (exclude critical care)	Q4 13/14	90%	71%	50%	No Change	58%	N/A
23	All Smokers to be offered Smoking intervention Advice	Q4 13/14	90%	54%	54%	No Change	55%	N/A
	Patient Reported Outcome Measures ***Revised Data***	**Annual**	**Eng Average**	**Apr 11 - Mar 12**	**Apr 12 - Mar 13**	**Change**	**2013/14**	**Over time**
24	Groin Hernia - Average increase in health gain	Apr 12 - Mar 13	0.086	0.073	0.065	Decline	0.065	
25	Hip Replacement - Average increase in health gain	Apr 12 - Mar 13	0.439	0.348	0.376	Improvement	0.376	
26	Knee Replacement - Average increase in health gain	Apr 12 - Mar 13	0.321	0.297	0.302	Improvement	0.302	
27	Varicose Vein - Average increase in health gain	Apr 12 - Mar 13	0.094	*	0.108	Improvement	0.108	
	Domain 4: Ensuring People have a positive experience of care							
	Referral to Treatment	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
28	18 Weeks - Admitted - % Compliance - Trust	May-14	90%	92.9%	94.6%	Improvement	93.8%	
29	18 Weeks - Non Admitted - % Compliance - Trust	May-14	95%	97.4%	98.1%	Improvement	97.7%	
30	18 Weeks - On-going - % <18 Weeks - Trust	May-14	92%	97.9%	98.0%	Improvement	97.9%	
31	Zero tolerance RTT Waits over 52 weeks	May-14	0	0	0	No Change	0	
	A&E Department Measures	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
32	Percentage of A&E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an a&e department	May-14	95%	96.2%	98.0%	Improvement	97.1%	
33	Trolley waits in A&E	May-14	0	0	0	No Change	0	
34	Handover <15 Minutes. Time taken from HAS notification to clinical handover (Assumed ACUTE responsibility)	May-14	15 Mins	00:15:03	00:12:36	Improvement	00:13:50	
35	Patients waiting between 30-60 Minutes for Handover	May-14	0	50	38	Improvement	88	
36	Patients waiting between 60+ Minutes for Handover	May-14	0	27	6	Improvement	33	
37	Compliance with Recording Patient Handover between Ambulance and A&E	May-14	95%	88.5%	88.7%	Improvement	88.6%	
	Mixed Sex Accommodation Breaches	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
38	Sleeping accommodation Breach (MSA)	May-14	0	2	0	Improvement	2	
	Diagnostics	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
39	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	May-14	99%	99.7%	99.6%	No Change	99.7%	
	Cancelled Operations	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
40	All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for nonclinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.	May-14	0	0	0	No Change	0	
41	No urgent operation should be cancelled for a second time	May-14	0	0	0	No Change	0	
	Choose and Book	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2013/14**	**Over time**
42	Provider failure to ensure that "sufficient appointment slots" are made available on the Choose & Book system	Mar-14	7%	16%	11.9%	Improvement	14%	
	Maternity	**Monthly**	**Plan**	**Feb-14**	**Mar-14**	**Change**	**2013/14**	**Over time**
43	% women who have seen a midwife by 12 weeks and 6 days of pregnancy	Mar-14	90%	92%	92%	No Change	86%	
	VTE	**Monthly**	**Plan**	**Q3 13/14**	**Q4 13/14**	**Change**	**2013/14**	**Over time**
44	Percentage of patients risk assessed for venous thromboembolism who receive appropriate prophylaxis (Local Audits)	Q4 13/14	90%	100%	77%	No Change	93%	
	Complaints	**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
45	Complaints received at CMCSU (Business Solutions)	May-14	0	0	0	No Change	2	
46	Complaints received at provider	Mar-14	0	29	21	Improvement	375	

NHS
Cheshire and Merseyside

Southport and Ormskirk Hospital

National Dementia		**Monthly**	**Plan**	**Mar-14**	**Apr-14**	**Change**	**2014/15**	**Over time**
47	National Dementia CQUIN - Screening for Dementia (Find)	Apr-14	90%	16%	9%	Decline	9%	
47	National Dementia CQUIN - Risk Assessed (Assess and Investigate)	Apr-14	90%	23%	9%	Decline	9%	
48	National Dementia CQUIN - Patients Referred	Apr-14	90%	50%	100%	Improvement	100%	
National Friends&Family		**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
49	National Friends and Family - Inpatient Response Rates	May-14	20%	38%	36%	Decline	37%	
50	National Friends and Family - Inpatient Test Score	May-14	20%	54	71	Improvement	65	
51	National Friends and Family - A&E Response Rates	May-14	Increase	7%	5%	Decline	6%	
52	National Friends and Family - A&E Test Score	May-14	Increase	38	48	Improvement	45	
Advancing Quality		**Monthly**	**Plan**	**Jan-14**	**Feb-14**	**Change**	**2013/14**	**Over time**
52	Advancing Quality Acute myocardial infarction	Feb-14	95.0%	92.86%	93.75%	Improvement	93.29%	
53	Advancing Quality Heart Failure	Feb-14	71.0%	53.85%	76.47%	Improvement	72.33%	
54	Advancing Quality Hip and Knee	Feb-14	82.0%	35.19%	58.82%	Improvement	72.93%	
55	Advancing Quality Pneumonia	Feb-14	65.4%	80.77%	78.38%	Decline	76.04%	
56	Advancing Quality Stroke	Feb-14	53.6%	42.11%	52.38%	Improvement	43.51%	
Patient Experience		**Annual**	**England Average**	**Previous Year**	**Latest Year**	**Change**	**2013/14**	**Over time**
57	Patient experience of hospital care	2013	76.5%	74.1%	74.8%	Improvement	74.0%	
58	Patient experience of outpatient services	2011	79.2%	77.0%	79.0%	No Change	79.0%	N/A
59	Patient experience of A&E services	2012	75.4%	75.0%	77.9%	No Change	77.9%	N/A

Domain 5: Treating & Caring for People in a Safe Environment and Protecting from Harm								
Infection Control		**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
60	Clostridium Difficile - Trust	May-14	4.5	4	2	Improvement	6	
61	Incidence of MRSA - Trust	May-14	0	0	0	No Change	0	
62	MRSA Screening - Trust	May-14	No Plan	92%	92%	No Change	92%	
63	MSSA	May-14	No Plan	1	0	Improvement	1	
Hygiene Compliance		**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
64	Hand Hygiene Compliance - Trust	May-14	No plan	99%	99%	No Change	99%	
Incident Reporting		**Monthly**	**Plan**	**May-14**	**Jun-14**	**Change**	**2014/15**	**Over time**
65	Never Events - Trust	Jun-14	0	0	0	No Change	0	
66	Steis Reportable Incidents - Trust	Jun-14	0	0	2	Decline	3	
CQC		**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
67	CQC Intelligence Tool - Band 1 = Highest Risk Band 6 = Lowest Risk	May-14	6	4	4	No Change	4	N/A
68	Compliance against 5 essential standards (✓ = Compliant, × = Not Compliant actions requiring improvement, × = Not Compliant and Enforcement Action Taken)	May-14	✓	×	×	No Change	×	Aug 13 Inspection
CAS		**Monthly**	**Plan**	**Apr-14**	**May-14**	**Change**	**2014/15**	**Over time**
69	All CAS alerts outstanding after deadline date	May-14	0	0	0	No Change	0	
Sickness Absence		**Monthly**	**Plan**	**Q2 13/14**	**Q3 13/14**	**Change**	**2013/14**	**Over time**
70	Sickness Absence Rates All Staff - provider data	Q3 13/14	4.73%	3.60%	4.00%	Improvement	4.15%	
70	Sickness Absence Rates All Staff - data taken from HSC information centre	Q3 13/14	3.40%	3.90%	3.84%	Improvement	3.84%	
Coronary Heart Disease		**Quarterly**	**Plan**	**Q3 13/14**	**Q4 13/14**	**Change**	**2013/14**	**Over time**
71	Percentage of CHD patients with a primary diagnosis of AMI prescribed ACE Inhibitors on discharge	Q4 13/14	95%	100%	100%	No Change	100%	
72	Percentage of CHD patients with a primary diagnosis of AMI prescribed Clopidogrel on discharge	Q4 13/14	95%	100%	100%	No Change	100%	
VTE		**Monthly**	**Plan**	**Mar-14**	**Apr-14**	**Change**	**2014/15**	**Over time**
73	National CQUIN - VTE Risk Assessments	Apr-14	95%	95.4%	96.2%	No Change	96.2%	
73	Hospital acquired VTE Cases	Feb-14	4 p/m	3	No data	No data	45	
Pressure Ulcers		**Monthly**	**Plan**	**Jan-14**	**Feb-14**	**Change**	**2013/14**	**Over time**
	Incidence of newly-acquired category 2, 3 and 4 pressure ulcers	Feb-14	28	0	No data	No data	21	
National Patient Incident Reporting		**Bi Annual**	**Median Average**	**Apr 12 - Sep 12**	**Apr 13 - Sep 13**	**Change**	**2013/14**	**Over time**
74	National Patient Safety Incident Reporting Per 100 admissions	Apr 13 - Sep 13	6.7	6.9	6.32	TBA	6.32	
75	Safety incidents resulting in severe harm or death	Apr 13 - Sep 13	0.8%	0.8%	0.7%	Improvement	0.7%	
Staff Survey		**Annual**	**Eng Average**	**2012**	**2013**	**Change**	**2013/14**	**Over time**
76	National Staff Survey	2013	3.74	3.63	3.61	No Change	3.61	
PLACE Survey		**Annual**	**Eng Average**		**2013**	**Change**	**2013/14**	**Over time**
77	PLACE Survey - Average score of all four areas	2013	90%	N/A	87.1%	No Change	87.1%	N/A
NHS Safety Thermometer		**Monthly**	**Eng Average**	**Apr-14**	**May-14**	**Change**	**2013/14**	**Over time**
78	Submission compliance	May-14	Compliance			No Change		
79	Total patients surveyed		N/A	881	862	Improvement	1743	
80	Patients receiving harm free care		93.5%	96.3%	96.1%	Decline	96.2%	
82	Total pressure ulcers (all categories)		4.6%	2.0%	3.0%	Decline	2.5%	
84	Total falls (causing harm)			0.3%	0.2%	Improvement	0.3%	
86	Patients with a catheter and being treated for a UTI		0.9%	5.1%	4.0%	Improvement	4.6%	
88	Number of patients with a new VTE		0.4%	0.7%	0.6%	Improvement	0.6%	

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

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
JULY 2014

Agenda Item: 14/105	**Author of the Paper:**
Report date: 16 July 2014	James Bradley Head of Strategic Financial Planning james.bradley@southseftonccg.nhs.uk Tel: 0151 247 7070

Title: Financial Position of NHS South Sefton Clinical Commissioning Group – Month 3

Summary/Key Issues:

This paper presents the Governing Body with an overview of the financial position for NHS South Sefton Clinical Commissioning Group as at Month 3 and outlines the key financial risks facing the CCG.

Recommendation

The Governing Body is asked to receive the finance update.

Receive	X
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
X	Improve quality of commissioned services, whilst achieving financial balance.
X	Sustain 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			
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 Finance & Resource Committee
July 2014

1. Executive Summary

1.1 This report focuses on the financial performance of the CCG at June 2014 (Month 3), which is £0.565m overspent on operational budget areas before the application of Reserves.

The CCG is on target to achieve the planned £2.300m surplus by the end of the year. It also meets the other business rules required by NHS England, as demonstrated in Table A. However, there are risks that require monitoring and managing in order to manage and deliver the target. These are outlined in section 4 of this report.

Table A: Business Rules

Business Rule	14/15
1% Surplus	✓
0.5% Contingency reserve	✓
2.5% Non-recurrent Headroom	✓

2. Resource Allocation

2.1 Resource allocation

The Resource Allocation of £229.250m is the Allocation currently recorded by NHS England for South Sefton CCG. This is a reduction of £0.060m from Month 2 and includes a number of planned adjustments. The adjustments made in Month 3 are identified below:

Adjustment	Recurrent / Non-recurrent	Value
GPIT allocation 2014/15	Non-recurrent	£0.391m
Corrections to NHS England allocations to match agreed plan	Recurrent	(£0.273m)
Specialist Commissioning – RLBUH baseline	Recurrent	(£0.102m)
Specialist Commissioning – Alder Hey Burns	Recurrent	(£0.050m)
Specialist Commissioning – LHCH	Recurrent	(£0.026m)

With the exception of the GPIT allocation received from NHS England, the allocation adjustments outlined above were required to adjust allocations for previously approved changes in 2013/14.

3. Position to Date

4.1 Month 3 Financial Performance

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

Table B: Financial Performance: Summary report to 30 June 2014

Budget Area	Annual & Year to date				End of Year	
	Annual Budget	YTD Budget	YTD Actual	YTD Variance	Expenditure Outturn	FOT Variance
	£'000	£'000	£'000	£'000	£'000	£'000
NHS Commissioned Services	160,139	40,035	40,498	463	161,984	1,845
Corporate & Support Services	6,970	1,410	1,387	(23)	6,929	(41)
Independent Sector	2,304	576	631	55	2,525	221
Medicines Management (inc Prescribing)	29,371	7,220	7,220	0	29,371	0
Primary Care	1,955	488	485	(3)	1,948	(7)
Commissioning - Non NHS	16,901	4,226	4,299	73	17,347	446
SUBTOTAL PRIOR TO RESERVES	**217,639**	**53,955**	**54,520**	**565**	**220,103**	**2,464**
Total Reserves	9,311	565	0	(565)	6,847	(2,464)
GRAND TOTAL EXPENDITURE	**226,950**	**54,520**	**54,520**	**0**	**226,950**	**0**
RRL Allocation	(229,250)	(55,095)	(55,095)	0	(229,250)	0
(SURPLUS)/DEFICIT	**(2,300)**	**(575)**	**(575)**	**0**	**(2,300)**	**0**

Please note, allocations and underspends are shown in brackets.

Overview

The year to date financial position before the application of reserves is an overspend of £0.565m (£0.205m underspend at Month 2).

The full year outturn forecast is £2.464m overspent (Month 2 £2.013m overspent) on operational budgets, before the application of available reserves.

The key issues contributing to the year to date position and the forecast for operational budgets are explained below.

NHS Commissioned Services

Whilst the financial reporting period relates to the end of June, the CCG has based its reported position on information received from Acute Trusts covering activity to the end of May 2014. Month 2 data is limited, and forecasts are expected to move as more data is received during the year.

This budget is showing a year-to-date overspend position of £0.463m (Month 2 £0.223m underspend). There has been a corresponding deterioration of the forecast to an overspend of £1.853m (£1.366m at Month 2). These movements are explained below.

The main risk at this stage is with the CCG's main acute provider; Aintree University Hospitals (AUH). A review of activity in month 2 identified that planned care is a little higher than expected, but emergency care has been significantly higher than planned (8% higher than contracted levels). The forecast of £2.805m over-spend is based upon a continuation of higher than expected activity levels. Activity levels will continue to be monitored with the Trust to understand the causes of activity changes.

Corporate and Support Services

The CCG is currently operating within its running cost target which forms part of this budget area. The forecast for the year is a small underspend on Running Costs and other Corporate and Support Services. There are still a number of vacancies in the staffing structure, and it is expected that these will be filled during quarter 2.

There is a risk associated with estates charges, and this is outlined in more detail in section 4.

Independent Sector

At the end of Month 3 the Independent Sector budget is overspent by £0.055m. The forecast for the year is £0.221m overspent (Month 2 £0.100m overspent).

Activity at Ramsay is the main area of overspend, and we have seen an increasing trend of activity provided by both Spire and Ramsay.

Primary Care

The Primary Care budget is showing a small underspend at Month 3 and is forecast to deliver within the annual budget for the financial year as a whole.

Within this budget there is £0.050m for each locality. It is anticipated that the locality budgets will be spent in full by the end of the financial year.

Funding associated with the Local Quality Contract is currently held in reserves and will be transferred into operational budgets when the scheme starts on 1 August 2014.

Medicines Management (Including Prescribing)

The Medicines Management budget consists of High Cost Drugs, Oxygen and Prescribing. The CCG normally bases year to date expenditure and forecasts on data supplied by the Prescription Pricing Authority (PPA). However data is only available for April 2014 and no forecast for 2014/15 has yet been provided by the PPA. Data supplied for April was within the budgeted allocation.

This is an area of potential risk for the CCG because, due to the size of the budget, a small proportionate change in the forecast can have a significant impact on expenditure.

Commissioning - Non-NHS

Commissioning from Non NHS organisations is overspent by £0.074m at Month 3 (Month 2 £0.960m), with a forecast overspend of £0.446m (Month 2 £0.621m) for the full financial year.

The overspend relates almost entirely to Continuing Care individual packages. This area continues to be a major risk area for the CCG and the overspend in the year-to-date

indicates that there will be pressures on this budget over the coming year. However there has been an improvement in the quality of the data provided by CSU which has enabled the CCG to place greater reliance on the financial information and to reduce its forecast expenditure against this budget. This continues to be closely monitored.

The CCG will continue to work with the CSU to investigate activity and costs in this area and to improve the reliability of the financial information and the forecasting model.

4. Evaluation of Risks and Opportunities

At this early stage of the year, a number of risks have emerged. These are outlined below, and all are included in the forecast:

- Continuing Healthcare – As detailed in the section above, although there has been a significant improvement in the quality of the financial information received from CSU, the CCG cannot yet place full reliance on the figures reported. This risk has been estimated at £0.450m.

- Overspends on Acute cost per case contracts – The CCG has identified some early pressures in a number of providers. This pressure has been calculated at £2.043m (1.6% of the relevant budget).

- Continuing Healthcare restitution claims – there is uncertainty over the process for payment of restitution claims. Provisions made in PCT accounts were transferred to NHS England, but due to technical accounting reasons, they are also expected to top-slice CCG allocations to make these payments in-year. This is still to be confirmed, and in the meantime, CCGs are expected to make payments for restitution claims. An amount has been set aside in reserves to absorb this cost for this financial year.

- Estates – Payments in respect of estates are still unclear. This includes potential liabilities for depreciation. The CCG has set aside an amount in reserves to cover estimated liabilities. We have now received a billing schedule from NHS Property Services, and the charges exceed the amount set aside in our Running Cost Allowance. The proposed billing is being challenged.

- Prescribing / Drugs costs – Only one month's data has been received for this financial year, and the PPA do not produce a forecast for the full year until more activity data is available. Therefore the CCG's best estimate for prescribing spend is consistent with the budget. However, prescribing expenditure can vary significantly in the year.

Reserves are set aside as part of budget setting to reflect planned investments, known risks and an element for contingency. As part of the review of risks and mitigations, the finance team and budget holders reviewed the expected expenditure levels for each earmarked reserve. This is summarised in table C below.

Table C: Reserves analysis

	£'000
Forecast Overspend	2,464
Avaliable reserves	(2,464)
Surplus Reserves	(0)

There are a number of potential risks that are not yet reflected in the forecast (eg. Prescribing), and this indication of surplus reserves should be treated with caution,

especially at this early stage of the year. However, it does indicate at this early stage of the year that the CCG can continue with planned investments.

The CCG remains on course to achieve its planned surplus.

5. Recommendations

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

- The CCG remains on target to deliver its financial targets for 2014/15.

Appendices

- Appendix 1 – Financial position to Month 3

01T NHS South Sefton Clinical Commissioning Group Month 2 Financial Position							
Cost centre Number	Cost Centre Description	Annual Budget	Budget To Date	Actual To Date	YTD Variance	End of Year	
						Expenditure Outturn	FOT Variance
		£000	£000	£000	£000	£000	£000
COMMISSIONING - NON NHS							
598501	Mental Health Contracts	1,058	265	265	0	1,058	0
598506	Child and Adolescent Mental Health	238	60	59	(1)	241	3
598511	Dementia	118	30	30	0	118	0
598521	Learning Difficulties	591	148	148	0	591	0
598596	Collaborative Commissioning	521	130	130	0	521	0
598661	Out of Hours	1,321	330	329	(1)	1,321	0
598682	CHC Adult Fully Funded	5,252	1,313	1,404	91	5,702	450
598683	CHC Adult Fully Funded Personal Health Board	0	0	0	0	0	0
598684	CHC ADULT JOINT FUNDED	1,420	355	354	(1)	1,420	0
598685	CHC Adult joint funded Personal Health Budget	21	5	0	(5)	21	0
598687	CHC Children	675	169	150	(19)	600	(75)
598691	Funded Nursing Care	2,346	586	573	(13)	2,346	0
598711	Community Services	402	100	112	12	448	46
598721	Hospices	1,431	358	368	10	1,453	22
598726	Intermediate Care	211	53	53	0	211	0
598796	Reablement	1,295	324	324	0	1,295	0
Sub-Total		**16,901**	**4,226**	**4,299**	**73**	**17,347**	**446**
CORPORATE & SUPPORT SERVICES							
600251	Administration and Business Support (Running Cost)	127	32	41	9	136	9
600271	CEO/Board Office (Running Cost)	527	132	132	0	527	0
600276	Chairs and Non Execs (Running Cost)	135	34	33	(1)	135	0
600286	Clinical Governance (Running Cost)	29	7	0	(7)	1	(28)
600296	Commissioning (Running Cost)	1,664	416	385	(31)	1,632	(32)
600316	Corporate costs	24	6	6	0	24	0
600346	Estates & Facilities	154	38	36	(2)	154	0
600351	Finance (Running Cost)	730	167	157	(10)	711	(19)
600391	Medicines Management (Running Cost)	55	14	16	2	55	0
600426	Quality Assurance	245	61	60	(1)	245	0
	Sub-Total Running Costs	**3,690**	**907**	**866**	**(41)**	**3,620**	**(70)**
598646	Commissioning Schemes (Programme Cost)	797	199	182	(17)	769	(28)
598656	Medicines Management (Programme Cost)	550	137	117	(20)	527	(23)
598776	Non Recurrent Programmes (NPfIT)	1,267	0	0	0	1,267	0
598676	Primary Care IT	667	167	222	55	747	80
	Sub-Total Programme Costs	**3,280**	**503**	**521**	**18**	**3,309**	**29**
Sub-Total		**6,970**	**1,410**	**1,387**	**(23)**	**6,929**	**(41)**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS							
598571	Acute Commissioning	110,325	27,581	28,229	648	112,917	2,592
598576	Acute Childrens Services	8,699	2,175	1,982	(193)	7,926	(773)
598586	Ambulance Services	5,347	1,337	1,338	1	5,350	3
598616	NCAs/OATs	1,371	343	343	0	1,371	0
598631	Winter Pressures	0	0	0	0	0	0
598756	Commissioning - Non Acute	34,384	8,596	8,605	9	34,414	30
598786	Patient Transport	12	3	1	(2)	5	(7)
Sub-Total		**160,139**	**40,035**	**40,498**	**463**	**161,984**	**1,845**
INDEPENDENT SECTOR							
598591	Clinical Assessment and Treatment Centres	2,304	576	631	55	2,525	221
Sub-Total		**2,304**	**576**	**631**	**55**	**2,525**	**221**
PRIMARY CARE							
598651	Local Enhanced Services and GP Framework	1,309	327	327	0	1,302	(7)
598791	Programme Projects	645	161	158	(3)	645	0
Sub-Total		**1,955**	**488**	**485**	**(3)**	**1,948**	**(7)**
PRESCRIBING							
598606	High Cost Drugs	665	166	166	0	665	0
598666	Oxygen	446	112	112	0	446	0
598671	Prescribing	28,260	6,942	6,942	0	28,260	0
Sub-Total		**29,371**	**7,220**	**7,220**	**0**	**29,371**	**0**
Sub-Total Operating Budgets pre Reserves		**217,639**	**53,955**	**54,520**	**565**	**220,103**	**2,464**
RESERVES							
598761	Commissioning Reserves	9,311	565	0	(565)	6,847	(2,464)
Sub-Total		**9,311**	**565**	**0**	**(565)**	**6,847**	**(2,464)**
Grand Total I & E		**226,950**	**54,520**	**54,520**	**0**	**226,950**	**0**
	RRL Allocation	(229,250)	(55,095)	(55,095)	0	(229,250)	0
	(SURPLUS)/DEFICIT	(2,300)	(575)	(575)	0	(2,300)	0

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2014

Agenda Item: 14/106	**Author of the Paper:** Martin McDowell Chief Finance Officer Martin.mcdowell@southseftonccg.nhs.uk 0151 247 7065
Report date: July 2014	

Title: Annual Audit Letter

Summary/Key Issues:

Annual Audit letter from Pricewaterhouse Coopers LLP summarising the results of the 2013/2014 Audit.

Recommendation

The Governing Body is asked to receive.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
	Sustain 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			
Equality Impact Assessment		x		
Legal Advice Sought		x		
Resource Implications Considered		x		
Locality Engagement	x			
Presented to other Committees	x			Audit Committee 10th July 2014

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

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Government and Public Sector

South Sefton Clinical Commissioning Group

Annual Audit Letter to the Governing Body

2013/14 Audit

25 June 2014

PricewaterhouseCoopers LLP
101 Barbirolli Square
Lower Mosley Street
Manchester
M2 3PW

The Governing Body
South Sefton Clinical Commissioning Group
3rd Floor
Merton House
Stanley Road
Bootle
L20 3DL

25 June 2014

Ladies and Gentleman

We are pleased to present our Annual Audit Letter summarising the results of our 2013/14 audit. We look forward to presenting it to the Clinical Commissioning Group (CCG) Audit Committee on 10 July 2014.

Yours faithfully

PricewaterhouseCoopers LLP

Code of Audit Practice and Statement of Responsibilities of Auditors and of Audited Bodies

In April 2010 the Audit Commission issued a revised version of the 'Statement of responsibilities of auditors and of audited bodies'. It is available from the Chief Officer of each audited body. The purpose of the statement is to assist auditors and audited bodies by explaining where the responsibilities of auditors begin and end and what is to be expected of the audited body in certain areas. Our reports and management letters are prepared in the context of this Statement. Reports and letters prepared by appointed auditors and addressed to members or officers are prepared for the sole use of the audited body and no responsibility is taken by auditors to any member or officer in their individual capacity or to any third party.

Contents

Introduction

The purpose of this letter

This letter provides the CCG's Governing Body with a high level summary of the results of our audit for 2013/14, in a form that is accessible for you and other interested stakeholders.

We have already reported the detailed findings from our audit to the Audit Committee in the following reports:

- Audit opinion for 2013/14 financial statements, incorporating the value for money conclusion and the regularity opinion.
- Report to those charged with Governance (ISA (UK&I) 260).

We have included in this report our significant audit findings. You can find a summary of our key recommendations in Appendix A.

Scope of work

We carry out our audit work in accordance with the Audit Commission's Code of Audit Practice (NHS), International Standards on Auditing (UK and Ireland) and other relevant guidance issued by the Audit Commission.

You are responsible for preparing and publishing the CCG's financial statements, including the annual governance statement. You are also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in your use of the CCG's resources.

As auditors we need to:

- form an opinion on the financial statements;
- form an opinion on the regularity of the CCG's transactions;
- form a conclusion on the arrangements that you have in place to secure economy, efficiency and effectiveness in your use of the CCG's resources;
- review the CCG's annual governance statement; and
- carry out any other work specified by the Audit Commission.

We have carried out our audit work in line with our 2013/14 Audit Plan that we issued in December 2013.

Audit Findings

Accounts

We audited the CCG's accounts in line with approved Auditing Standards and issued an unqualified audit opinion on 10 June 2014.

We identified the following key issues:

- an unadjusted judgemental misstatement of £314,000 relating to an accrual for child and adolescent mental health;
- we noted that management recognised an accrual of £1,072,000 for continuing healthcare; £221,000 for estimated administrative costs for processing pre 2013/14 restitution claims; and made an accrual of £564,000 for partially completed spells; and
- having considered guidance from NHS England and taken advice from NHS Pensions Agency, management opted not to disclose pension related information for non-salaried GP members of the governing body on the basis that their remuneration is not superannuable.

We also noted a number of internal control deficiencies and recommendations – these are summarised in Appendix A.

Our Regularity Opinion

We give our opinion on whether, in all material respects, you have used the CCG's money as Parliament intended and whether you have done so in accordance with the various authorities governing the transactions.

We issued an unqualified regularity opinion on 10 June 2014.

Our value for money conclusion

We carried out sufficient, relevant work, in line with the Audit Commission's guidance, so that we could conclude on whether you had in place, for 2013/14, proper arrangements to secure economy, efficiency and effectiveness in your use of the CCG's resources.

In line with the guidance issued by the Audit Commission in October 2013 we have considered the results of the following:

1) our review of the Annual Governance Statement;
2) the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the CCG; and
3) our locally determined risk-based work on the governance arrangements, financial management, asset and information management and workforce management.

We issued an unqualified value for money conclusion.

Targeted audit work

When planning our audit, we identified the following risk areas, on which we then carried out more detailed work:

- risk of management override of controls; and
- risk of fraud in revenue and expenditure recognition.

We did not identify any significant issues to report on the risks identified above.

Annual Governance Statement (AGS)

The aim of the AGS is to give a sense of how successfully the CCG has coped with the challenges it faces and of how vulnerable the organisation's performance is or might be.

We reviewed the AGS to see whether it complied with relevant guidance and whether it was misleading or was inconsistent with what we know about the CCG. We found no areas of concern to report in this context.

Reports in the public interest

As part of our audit, we have a legal duty to consider:

- whether anything coming to our attention is sufficiently important that we should issue a separate report on the matter, for consideration by the CCG's members or so that the matter can be brought to public attention; and
- whether the public interest in the matter is such that we need to issue a report immediately rather than at the end of the audit.

We did not identify any issues in the public interest to report.

Summary of recommendations

Management are responsible for developing and implementing systems of internal financial control and to put in place proper arrangements to monitor their adequacy and effectiveness in practice. As auditors, we review these arrangements for the purposes of our audit of the financial statements and our review of the annual governance statement.

The deficiencies in the internal control system identified during our audit are summarised below:

Deficiency	Recommendation	Management's response
Reconciling differences between the general ledger and Broadcare report There are a number of reconciling differences between the general ledger and Broadcare due to general ledger accrual for open claims.	We recommend that claims received are logged on to Broadcare to ensure that the appropriate checks are always performed before the claim is processed on the general ledger and the payment is approved.	Management acknowledges the CHC claim processing could be improved by utilising the functionalities of Broadcare. This will also ensure there are no reconciling differences between Broadcare and the general ledger. The CCG will be undertaking a thorough review of the CHC processes, control mechanisms and interrelationships between the CCG, CSU and Council during 2014/15.
Delays in obtaining information from CSU relating to ITGC work The audit team faced delays in obtaining Oracle and ESR access reports from the CSU. The Oracle report was subsequently received from the CCG. However, the ESR access level report was not provided by the CSU and the audit team has not been able to prove the access levels are correct.	We recommend management enforces the SLA with the CSU in order to ensure the CCG understands the controls in operation. We also recommend an action plan is developed and delivered in response to the deficiencies noted in the state of readiness report for the CSU.	The CCG will continue to work with both the CSU and PwC during 2014/15 to facilitate an improved level of information flow both into the CCG and directly between the CSU and PwC.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2014

14/107

Agenda Item: 14/107	**Author of the Paper:** Debbie Fagan Chief Nurse Email: debbie.fagan@southseftonccg.nhs.uk Tel: 0151 247 7000
Report date: July 2014	

Title: CQC-Style Safeguarding Peer Review Reports and Action Plan

Summary/Key Issues:

In Q3 2013/14 both Southport & Formby CCG and South Sefton CCG jointly commissioned a CQC-Style Safeguarding Peer Review which commenced in December 2013. This was to promote the CCGs ongoing development and leadership regarding safeguarding following being authorised without conditions.

The review process has now concluded with participants having the opportunity to be involved in a feedback session in May 2014. A presentation will be given to the Governing Body which sets out a summary of key strengths and summary priorities and areas for consideration. This presentation will be sent along with the Governing Body Report.

The review reports and resulting action plans have been presented to the June 2014 meeting of the Quality Committee, at which going forward, progress against the action plans will be monitored. Failure to deliver against the action plans has been placed on the CCG risk register. An action plan has been developed which will be monitored at the Quality Committee.

Recommendation

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

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
X	Improve quality of commissioned services, whilst achieving financial balance.
	Sustain a 1% reduction in non-elective admissions in 2014/15.
	Implementation of 2014/15 phase of the 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			CCG Safeguarding Service, CCG, NHS England
Equality Impact Assessment			X	
Legal Advice Sought			X	
Resource Implications Considered			X	
Locality Engagement				
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

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2014

Agenda Item: 14/108	**Author of the Paper:** Debbie Fagan Chief Nurse Email: debbie.fagan@southseftonccg.nhs.uk Tel 0151 247 7000
Report date: July 2014	

Title: Safeguarding Service Children & Vulnerable Adults Policy 2014 (Incorporating Safeguarding & Mental Capacity Act Standards for Commissioned Services)

Summary/Key Issues:

The Safeguarding Service has updated the Safeguarding Service Children & Vulnerable Adults Policy for ratification across the Merseyside CCGs. This policy incorporates updated Safeguarding & Mental Capacity Act Standards for Commissioned Services. This policy will be considered by the CCG Quality Committee 24 July 2014 and any recommendations will be verbally presented to the Quality Committee by the Chair or the Chief Nurse.

Recommendation

The Governing Body is asked to approve this report.

Receive	
Approve	x
Ratify	

14/108

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
	Sustain 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, Safeguarding Team
Equality Impact Assessment			X	
Legal Advice Sought			X	
Resource Implications Considered			X	
Locality Engagement			X	
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

South Sefton Clinical Commissioning Group

Safeguarding Children & Vulnerable Adults Policy 2014 (Incorporating Safeguarding and Mental Capacity Act Standards for Commissioned Services)

1.0 Introduction

1.1 South Sefton Clinical Commissioning Group (CCG), has a statutory duty to ensure it makes arrangements to safeguard and promote the welfare of children and young people and to protect vulnerable adults from abuse or the risk of abuse. The arrangements should reflect the needs of the vulnerable population they commission or provide services for. South Sefton CCG is also required to contribute to multi-agency arrangements to protect vulnerable adults and children from radicalisation.

1.2 As a commissioning organisation South Sefton CCG is required to ensure that all health providers from whom it commissions services have comprehensive single and multi-agency policies and procedures in place to safeguard and promote the welfare of children and to protect vulnerable adults from abuse or risk of abuse. South Sefton CCG should also ensure that health providers are linked into the local safeguarding children and safeguarding adult boards and that health workers contribute to multi-agency working.

1.3 This policy has two functions:

a) It details the roles and responsibilities of South Sefton CCG as a commissioning organisation, of its employees and GP practice members;
b) It provides clear service standards against which healthcare providers will be monitored to ensure that all service users are protected from abuse and the risk of abuse.

1.4 This policy should be used in conjunction with the Sefton Safeguarding Children Board (LSCB) and Sefton Safeguarding Adult Board (SAB) guidance.

2.0 Scope

2.1 This policy aims to ensure that no act or omission by South Sefton CCG as a commissioning organisation, or via the services it commissions, puts a service user at risk; and that robust systems are in place to safeguard and promote the welfare of children, and to protect adults at risk of harm.

2.2 Where South Sefton CCG is identified as the co-ordinating commissioner it will notify collaborating commissioners of a provider's non-compliance with the standards contained in this policy or of any serious untoward incident that is considered to be a safeguarding issue.

3.0 Principles

3.1 South Sefton CCG recognises that safeguarding children and vulnerable adults is a shared responsibility and there is a need for effective joint working between agencies and professionals that have differing roles and expertise if vulnerable groups are to be

protected from harm. To achieve effective joint working, there must be constructive relationships at all levels which need to be promoted and supported by:

a) A commitment of senior managers and board members to seek continuous improvement with regard to safeguarding both within the work of South Sefton CCG and within those services commissioned.
b) Clear lines of accountability within South Sefton CCG for safeguarding.
c) Service developments that take account of the need to safeguard all service users, and is informed where appropriate, by the views of service users or advocates.
d) Staff learning and development including a mandatory induction which includes familiarisation with responsibilities and procedures to be followed if there are concerns about a child or adult's welfare.
e) Staff training and continuing professional development so that staff have an understanding of their roles and responsibilities in regards to safeguarding children, adults at risk, looked after children and the Mental Capacity Act (2005).
f) Appropriate supervision and support for the workforce.
g) Safe working practices including recruitment and vetting procedures.
h) Effective interagency working, including effective information sharing.

4.0 Equality and Diversity

4.1 The population of South Sefton is diverse and includes areas of high deprivation. Children and adults from all cultures are subject to abuse and neglect. All children and adults have a right to grow up and live safe from harm. In order to make sensitive and informed professional judgments about the needs of children (including their parents' capacity to respond to those needs) and the needs of adults at risk, it is important that professionals are sensitive to differing family patterns and lifestyles that vary across different racial, ethnic and cultural groups.

4.2 Professionals need to be aware of the broader social factors that serve to discriminate against black and minority ethnic populations. Working in a multi-cultural society requires professionals and organisations to be committed to equality in meeting the needs of all children and adults at risk and to understand the effects of harassment, discrimination or institutional racism, cultural misunderstandings or misinterpretation.

4.3 The assessment process should maintain a focus on the needs of the individual child or adult at risk. It should always include consideration of how the religious beliefs and cultural traditions influence values, attitudes and behaviours and the way in which family and community life is structured and organised. Cultural factors neither explain nor condone acts of omission or commission that place a child or adult at risk of significant harm. Professionals should be aware of and work with the strengths and support systems available within families, ethnic groups and communities, which can be built upon to help safeguard and promote their welfare.

5.0 Definitions

5.1 Children

5.1.1 In accordance with the Children Act 1989 and the Children Act 2004, within this policy, a **'child'** is anyone who has not yet reached their 18th birthday. **'Children'** will mean children and young people throughout.

5.1.2 **'Safeguarding children'** is defined in the Joint Inspectors' report *Safeguarding Children* (2002) as:

a) All agencies working with children, young people and their families take all reasonable measures to ensure that the risks of harm to children's welfare is minimised; and
b) Where there are concerns about children and young people's welfare all agencies take all appropriate actions to address those concerns, working to agreed local policies and procedures in partnership with other agencies.

5.1.3 The phrase **vulnerable child** is multi-factoral and difficult to define. It includes, but not exclusively, those children and young people who are particularly vulnerable due to the following: - age, disability, lack of parental control, children living away from home (including looked after children), migrant children and unaccompanied asylum seekers, children who are missing from home or education, children abused by other children (including bullying), children engaging in anti-social and or criminal activity, young carers, and those living in families where substance misuse, domestic abuse and mental health issues are having an adverse impact on the child. (Working Together 2010; 2013)

5.1.4 **Looked After Children** are those children and young people who are looked after by the state under one of the following sections of the Children Act 1989 including:

- Section 31 - Care Order
- Section 38 - Interim Care Order
- Section 20 - Voluntary accommodation at the request of or by agreement with their parents or carers
- Section 44 - Emergency Protection Order

In addition, the term Looked After Child may also be used to describe the following specific groups of children and young people:

- Children under a criminal law supervision order with a need to reside in local authority accommodation.

- Children who have appeared in court and have been bailed to reside where the local authority directs; and for whom the local authority is funding the placement.
- Children who are remanded to the care of the local authority where bail has not been granted
- Children under a court ordered secure remand and held in council accommodation
- Children who are subject to a secure accommodation order where the local authority is funding the placement. Where this accommodation is due to offending behaviour the cost is funded by the Home Office and these children are not classed as Looked After Children.
- Unaccompanied asylum seeking children are also required to be treated as Looked After Children

5.1.5 Private Fostering – this is a private arrangement made between a child's parents and someone who is not a close relative to care for a child for 28 days or more: where the child lives with the carer. Close relatives include aunt, uncle, brother, sister or grandparents but not a great aunt or uncle. South Sefton CCG staff have a responsibility to notify Children's Social Care of any private fostering arrangements that they become aware of.

5.2 Adults at risk

5.2.1 A person aged 18 or over and who:

a) Is eligible for or receives any adult social care service (including carer's services) provided or managed by the local authority.
b) In receipt of direct payments in lieu of adult social care services.
c) Funds their own care and has social care needs.
d) Otherwise has social care needs that are low, moderate, substantial or critical.
e) Falls within any other categories prescribed by the Secretary of State.
f) Is or may be in need of community care services by reason of mental or other disability, age or illness.
g) Who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation; and is at risk of *significant harm*, where harm is defined as ill-treatment or the impairment of health or development or unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion).

5.2.2 For the purpose of this policy the term adult at risk will be used rather than the term vulnerable adult because it focusses on situations causing risk rather than any characteristic of the adult concerned (Law Commission 2011). **"**Adults at Risk" is the term advised by the law Commission which replaces the previous term "Vulnerable adult" and will be the term used throughout this policy.

5.2.3 Whilst there is no formal definition of vulnerability within health care, some people receiving health care may be at greater risk from harm than others,

sometimes as a complication of their presenting condition and their individual circumstances. The risks that increase a person's vulnerability should be appropriately assessed and identified by the health care professional/ care provider at the first contact and continue throughout the care pathway (DH 2010).

5.2.4 Under Section 59 of the Supporting Vulnerable Groups Act 2006, a person aged 18 years or over is also defined as a vulnerable adult where they are 'receiving any form of health care' and 'who needs to be able to trust people caring for them, supporting them and/or providing them with services'.

5.3 Adult safeguarding

5.3.1 The principles for adult safeguarding are as follows (DH 2011):

a) **Empowerment** – Presumption of person led decisions and informed consent.
b) **Protection** – Support and representation for those in greatest need.
c) **Prevention** – It is better to take action before harm occurs.
d) **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented.
e) **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
f) **Accountability** – Accountability and transparency in delivering safeguarding.

5.3.2 Prevent – Radicalisation of vulnerable people. The government counter terrorism strategy is called **CONTEST** and is divided into four priority objectives:-

Pursue – stop terrorist attacks.
Prepare – where we cannot stop an attack, mitigate its impact.
Protect – strengthen overall protection against terrorist attacks.
Prevent – stop people becoming terrorists and supporting violent extremism.

The Prevent Strategy addresses all forms of terrorism including extreme right wing but continues to prioritise according to the threat posed to our national security. The aim of Prevent is to stop people from becoming terrorists or supporting terrorism and operates in the pre-criminal space before any criminal activity has taken place. Prevent aims to protect those who are vulnerable to exploitation from those who seek to encourage people to support or commit acts of violence.

5.3.3 Definitions of abuse are contained within the glossary section of the policy.

5.4 Specific safeguarding issues

5.4.1 Domestic Abuse

The cross-government definition of domestic violence and abuse is:-

> "Any incident or pattern of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial or emotional". (Home Office circular 003/2013)

This is regardless of race, culture, religion, gender, age and disability. It is also important to note that domestic abuse can also occur in lesbian, gay, bisexual and transgender relationships. Heterosexual females can also abuse heterosexual males and children also abuse adults. Domestic abuse also features highly in cases of child abuse and in an analysis of serious case reviews, both past and present, it is present in over half (53%) of cases. (HM Government 2010) Approximately 200,000 children in England live in households where there is a known risk of domestic violence (Brandon et al, 2009)

The term "domestic abuse" includes issues such as female genital mutilation (FGM), so called honour based crimes, forced marriage and other acts of gender based violence, as well as elder abuse, when committed within the family or by an intimate partner. Family members are defined as mother, father, son, daughter, brother, sister, and grandparents whether directly related or stepfamily.

NB: Whilst an adult is defined as any person aged 18 or over, the new definition has been altered to include 16 and 17 year olds. Despite this change in definition, domestic abuse involving any young person under 18 years, even if they are parents, should be treated as child abuse and the South Sefton Safeguarding Children Board procedures apply.

5.4.2 Forced Marriage

> "marriage shall be entered into only with the free and full consent of the intending spouses" (Universal Declaration of human Rights, Article 16 (2)"

A forced marriage is where one or both people do not (or in the case of people with learning or physical disabilities, cannot) consent to the marriage and pressure or abuse is used. The pressure put on people to marry against their will can be physical, (including threats, actual physical violence and sexual violence), emotional or psychological (for example when a person is made to feel like they are bringing shame on their family) and financial abuse (taking money from a person or not providing money).

5.4.3 Female Genital Mutilation (FGM)

Female genital mutilation is a collective term used for procedures which include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. FGM is typically performed on girls between the ages of 4 and 13 years, although it may also be performed on infants, and prior to marriage or pregnancy. The Prohibition of Female Circumcision Act 1985 made this practice illegal in this country and the Female Genital Mutilation Act 2003 which replaced it has now made it illegal for girls to be taken abroad for the purpose of performing this procedure.

6.0 Roles and Responsibilities

a) Ultimate accountability for safeguarding sits with the Chief Officer for South Sefton CCG. Any failure to have systems and processes in place to protect children and adults at risk in the commissioning process, or by providers of health care that South Sefton CCG commissions would result in failure to meet statutory and non-statutory constitutional and governance requirements.
b) South Sefton CCG must demonstrate robust arrangements are in place to demonstrate compliance with safeguarding responsibilities. The NHS Commissioning Board (NHSCB) monitor compliance with safeguarding as required through authorisation (see appendix 1) and beyond.
c) South Sefton CCG must establish and maintain good constitutional and governance arrangements with capacity and capability to deliver safeguarding duties and responsibilities, as well as effectively commission services ensuring that all service users are protected from abuse and neglect.
d) Establish clear lines of accountability for safeguarding, reflected in governance arrangements.
e) To co-operate with the local authority in the operation of the local safeguarding children and safeguarding adults board.
f) To participate in serious case reviews and domestic homicide reviews.
g) Secure the expertise of a designated doctor and nurse for safeguarding children; a designated doctor and nurse for looked after children (LAC); a designated paediatrician for child deaths; a safeguarding adult lead and a mental capacity act lead.
h) Ensure that all providers with whom there are commissioning arrangements have in place comprehensive and effective policies and procedures to safeguard children and adults at risk in line with those of the South Sefton LSCB / SAB.
i) Ensure that all staff in contact with children, adults who are parents/carers and adults at risk in the course of their normal duties are trained and competent to be alert to the potential indicators of abuse or neglect for children and vulnerable adults, know how to act on those concerns in line with local guidance.
j) Ensure that appropriate systems and processes are in place to fulfil specific duties of cooperation and partnership and the ability to demonstrate that South Sefton CCG meets the best practice in respect of safeguarding children and adults at risk and looked after children.

k) Ensure that safeguarding is at the forefront of service planning and a regular agenda item of South Sefton CCG governing body business.
l) Ensure that all decisions in respect of adult care placements are based on knowledge of standards of care and safeguarding concerns.
m) Ensure that there are robust recruitment and vetting procedures in place to prevent unsuitable people from working with children and adults at risk. These procedures must be in line with national and South Sefton LSCB/ SAB guidance and will be applied to all staff (including agency staff, students and volunteers) who work with or who handle information about children and adults at risk.

6.1 Chief Officer for South Sefton CCG

a) Ensures that the health contribution to safeguarding and promoting the welfare of children and adults at risk is discharged effectively across the whole local health economy through the organisation's commissioning arrangements.
b) Ensures that the organisation not only commissions specific clinical services but exercises a public health responsibility in ensuring that all service users are safeguarded from abuse or the risk of abuse.
c) Ensures that safeguarding is identified as a key priority area in all strategic planning processes.
d) Ensures that safeguarding is integral to clinical governance and audit arrangements.
e) Ensures that all health providers from whom services are commissioned have comprehensive single and multi-agency policies and procedures for safeguarding which are in line with the local safeguarding children and adult board procedures and are easily accessible for staff at all levels.
f) Ensures that all contracts for the delivery of health care include clear standards for safeguarding - these standards are monitored in order to provide assurance that service users are effectively safeguarded.
g) Ensures that South Sefton CCG staff, and those in services contracted by South Sefton CCG, are trained and competent to be alert to potential indicators of abuse or neglect in children and know how to act on their concerns and fulfil their responsibilities in line with the South Sefton LSCB policies and procedures.
h) Ensures South Sefton CCG cooperates with the local authority in the operation of LSCB and LSAB.
i) Ensures that all health organisations with whom South Sefton CCG has commissioning arrangements have links with South Sefton LSCB and SAB; that there is appropriate representation at an appropriate level of seniority; and that health workers contribute to multi-agency working.
j) To ensure that any system and processes that include decision-making about an individual patient (e.g. funding panels) takes account of the requirements of the Mental Capacity Act 2005 – this includes ensuring that actions and decisions are documented in a way that demonstrates compliance with the Act.

6.2 South Sefton CCG Governing Body Lead with responsibility for safeguarding

a) Ensures that South Sefton CCG has management and accountability structures that deliver safe and effective services in accordance with statutory, national and local guidance for safeguarding children and looked after children (LAC)
b) Represents South Sefton CCG on both the LSCB and SAB.
c) Ensures that service plans / specifications / contracts / invitations to tender etc. include reference to the standards expected for safeguarding children and adults at risk.
d) Ensures that safe recruitment practices are adhered to in line with national and local guidance and that safeguarding responsibilities are reflected in all job descriptions.
e) Ensure that staff in contact with children and or adults in the course of their normal duties are trained and competent to be alert to the potential indicators of abuse or neglect and know how to act on those concerns in line with local guidance.

6.3 South Sefton CCG Individual staff members

a) To be alert to the potential indicators of abuse or neglect for children and adults and know how to act on those concerns in line with local guidance.
b) To undertake training in accordance with their roles and responsibilities as outlined by the training frameworks of South SeftonLSCB and SAB so that they maintain their skills and are familiar with procedures aimed at safeguarding children and adults at risk.
c) Understand the principles of confidentiality and information sharing in line with local and government guidance.
d) All staff contribute, when requested to do so, to the multi-agency meetings established to safeguard children and adults at risk.
e) All staff will cooperate with Local Authority solicitors and Merseyside Police as required in order to safeguard and protect children and vulnerable adults.

6.3.1 See appendices for guidance as to what action needs to be taken where there are concerns that a child or an adult at risk is being abused; and information sharing guidance:

a) Appendix 2 – What to do if you are worried a child is being abused
b) Appendix 3 – Possible signs and indicators of child abuse and neglect
c) Appendix 4 – Flowchart of key questions for information sharing
d) Appendix 5 - What to do if an adult is at risk of abuse

6.4 South Sefton CCG GP member practices

6.4.1 South Sefton CCG GP member practices will take account of the safeguarding standards as detailed in Appendix 6; 7; 8; 9. Compliance with the standards will be subject to audit and scrutiny.

6.5 Designated professionals

6.5.1 South Sefton CCG is required to have in place arrangements to secure the advice of Designated Professionals for Safeguarding Children and Looked After Children (LAC) as well as advice for safeguarding vulnerable adults. Access to and support from such professionals will be through the shared Merseyside CCGs hosted team employed by South Sefton CCG. The Designated Professionals, including the lead for Safeguarding Adults, will:

a) Provide strategic guidance on all aspects of the health service contribution to protecting children and vulnerable adults within South Sefton CCG and South Sefton LSCB and SAB area.
b) Work closely in the discharge of their responsibilities – this may include the convening of professional advisory and support groups.
c) Have enhanced Disclosure and Baring Scheme (DBS) clearance renewed every 3 years.
d) Provide professional advice on safeguarding issues to the multi-agency network.
e) Be a member of South Sefton LSCB, SAB and relevant sub-groups as required, delegating to other health professionals as appropriate.
f) Be involved in the appointment of Named Professionals, providing support as appropriate.
g) Provide professional safeguarding supervision and leadership to Named Professionals within the provider organisations.
h) Take the strategic overview of safeguarding arrangements across South Sefton CCG and Local Authority area and assist in the development of systems, monitoring, evaluating and reviewing the health service contribution to the protection of children and adults at risk.
i) Collaborate with the Director of Public Health, LSCB, SAB, South Sefton CCG Chief Nurse and Named Professionals in Provider Trusts in reviewing the involvement of health services in serious incidents which meet the criteria for serious case reviews.
j) Advise on appropriate training for health personnel and participate where appropriate in its provision.
k) Advise on practice policy and guidance ensuring health components are updated.
l) Ensure expert advice is available in relation to safeguarding policies, procedures and the day to day management of safeguarding children and vulnerable adults issues.
m) Liaise with other designated and lead professionals for safeguarding children, looked after children and vulnerable adults across the Merseyside area and beyond as required to do so
n) Attend relevant local, regional and national forums.
o) Take part in an annual appraisal process via the Chief Nurse from the employing CCG.
p)

7.0 Management of Allegations Against a South Sefton CCG Employee

7.1 *Working Together to Safeguard Children* (2013) details the responsibility of all organisations to have a process for managing allegations against professionals who work with children. This requires South Sefton CCG to inform the Local Authority Designated Officer (LADO) of any allegations it becomes aware of within one working day. A parallel process will be followed regarding adults at risk. The Named Senior Manager / Officer will notify and access advice and guidance from the Safeguarding Adult Co-ordinator promptly as per LSAB Safeguarding Adult Policy and Procedures (2011).

8.0 Implementation

8.1 Method of monitoring compliance

8.1.1 Comprehensive service specifications for services for children and adults, of which child & adult protection / safeguarding is a key component, will be evident in all contracts with provider organisations. Service specifications will include clear service standards and KPI's (key performance indicators) for safeguarding Children & Adults and promoting their welfare, consistent with South Sefton LSCB/ SAB procedures.

8.1.2 The standards expected of all healthcare providers are detailed in the appendices. Compliance will be measured by annual audit – an audit tool will be made available to all providers to facilitate the recording of information. The audit tool should be completed using the RAG definitions outlined in the procedures for monitoring safeguarding children and vulnerable adults via provider contracts. This procedure was developed in order to standardise the monitoring and escalation approach across the North West.

8.1.3 Additionally a number of specific quality KPI's will be set for all providers which compliment a number of the existing standards in the afore mentioned audit tool, these will require a detailed response with data and achievements clearly evidenced in the returns. The quality and effectiveness of which will be monitored on a quarterly/ annual basis (dependent on the indicator).

8.2 Breaches of policy

8.2.1 This policy is mandatory. Where it is not possible to comply with the policy, or a decision is taken to depart from it, this must be notified to South Sefton CCG so that the level of risk can be assessed and an action plan can be formulated (see section 8 for contact details).

8.2.2 South Sefton CCG, as a co-ordinating commissioner, will notify collaborating commissioners of a providers' non-compliance with the standards contained in this policy, including action taken where there has been a significant breach.

9.0 Contact details

Designation	Contact Number
Chief Officer	01704 387028/0151 247 7009
Chief Nurse	01704 387028/0151 247 7252
Designated Nurse Safeguarding Children	0151 495 5469 or 5295
Designated Doctor Safeguarding Children	0151 228 4811 Ext 2287
Designated Doctor Looked After Children	0151 228 4811 Ext 2287
Community Paediatrician - CDOP	0151 228 4811 Ext 2287
Head of Safeguarding Adults	0151 495 5469 or 5295
Lead for the Mental Capacity Act	0151 495 5469 or 5295
Prevent Lead	0151 495 5469 or 5295

NB: The Shared Merseyside Safeguarding Service and South Sefton CCG work in conjunction with Sefton Borough Council to safeguard and promote the welfare of children, young people and adults from abuse or risk of abuse, i.e. through adherence to multi-agency policy, collaboration, information sharing and learning and representation at Sefton Safeguarding Children Board and Sefton Executive Board (Safeguarding Adult Board.)

10.0 References

The following statutory, non-statutory, best practice guidance and the policies and procedures of the South Sefton LSCB and South Sefton SAB have been taken into account:

10.1 Statutory Guidance:

a) Department for Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice.* London: TSO
b) Department of Health (2000) *Framework for the Assessment of Children in Need and their Families.* London: HMSO
c) Department of Health, Home Office (2000) *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (issued under Section 7 of the Local Authority Social Services Act 1970)
d) Department of Health et al (2009) *Statutory Guidance on Promoting the Health and Well-Being of Looked After Children.* Nottingham: DCSF Publications
e) HM Government (2007) *Statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004.* DCSF Publications
f) HM Government (2008) *Safeguarding children in whom illness is fabricated or induced.* DCSF Publications
g) HM Government (2009) *The Right to Choose: multi-agency statutory guidance for dealing with forced marriage.* Forced Marriage Unit: London
h) HM Government (2010) *Working Together to Safeguard Children.* Nottingham: DCSF Publications
i) HM Government (2013) Working Together to Safeguard Children – a guide to interagency working to safeguard and promote the welfare of children. DFE. www.education.gov.uk/aboutdfe/statutory
j) Ministry of Justice (2008) *Deprivation of Liberty Safeguards Code of Practice to supplement Mental Capacity Act 2005.* London: TSO
k) Home Office (2012) protecting the UK against terrorism. www.gov.uk/government/policies/protecting-the-uk-against-terrorism
l) Care Quality Commission (2009) Essential Standards of Quality and Safety

10.2 Non-Statutory Guidance:

a) Children's Workforce Development Council (March 2010) *Early identification, assessment of needs and intervention. The Common Assessment Framework for Children and Young People: A practitioner's guide.* CWDC
b) Department of Health (June 2012) *The Functions of Clinical Commissioning Groups* (updated to reflect the final Health and Social Care Act 2012)
c) Department of Health (March 2011) *Adult Safeguarding: The Role of Health Services*
d) Department of Health (May 2011) *Statement of Government Policy on Adult Safeguarding*
e) HM Government (2006) *What to do if you're worried a child is being abused.* DCSF Publications
f) HM Government (2006) Information Sharing: Guidance for practitioners and managers. DCSF Publications
g) Law Commission (May 2011) *Adult Social Care Report*
h) www.justice.gov.uk/lawcommission/publications/1460.htm

i) Royal College of Paediatrics and Child Health et al (2014) *Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Intercollegiate Document*

10.3 Best Practice Guidance:

a) Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services Standard 5* (plus including relevant elements that aren't contained in Core Standard 5)
b) Department of Health (2009) *Responding to domestic abuse: a handbook for health professionals*
c) Ending violence against women and girls. March 2014. www.gov.uk/government/policies/ending-violence-against-women-and-girls-in-the-uk
d) Department of Health (2010) *Clinical governance and adult safeguarding: an integrated approach.* Department of Health
e) HM Government (2009) *Multi-agency practice guidelines: Handling cases of Forced Marriage.* Forced Marriage Unit: London
f) National Institute for Health and Clinical Excellence (2009) *When to suspect child maltreatment.* NICE Clinical Guideline 89
g) Department of Health (2006) *Mental Capacity Act Best Practice Tool.* Gateway reference: 6703

10.4 Sefton Local Safeguarding Children Board:

Sefton safeguarding children board policies, procedures and practice guidance are accessible at:
http://www.liverpoolscb.org/

10.5 Sefton Local Safeguarding Adult Board:

Sefton safeguarding adult board, policies, procedures and practice guidance are accessible at:
http://liverpool.gov.uk/media/102189/safeguarding-policy-february-2013.pdf

10.6 Disclosure and barring

The proposed changes to the vetting and barring scheme should become operational in December 2012. Until they become operational then the October 2009 regulations still apply. Further guidance is available at: www.homeoffice.gov.uk/crime/vetting-barring-scheme/

11. Glossary

CAF	Common Assessment Framework
CCGs	Clinical Commissioning Groups

DCSF	Department for Children, Schools and Families
DH	Department of Health
LAC	Looked After Children
LSAB	Local Safeguarding Adult Board
LSCB	Local Safeguarding Children Board
MCA	Mental Capacity Act
NCB	National Commissioning Board
SUI	Serious Untoward Incident

11.1 Categories of child abuse as per *Working Together to Safeguard Children* (HM Government 2013).

Abuse: A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or an institutional or community setting, by those known to them or, more rarely, by a stranger (eg via the internet). They may be abused by an adult or adults, or another child or children.

Physical abuse: A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Emotional abuse: The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual abuse: Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse

(including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Neglect: The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- Protect a child from physical and emotional harm or danger;
- Ensure adequate supervision (including the use of inadequate care givers); or
- Ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

11.2 Abuse of adults at risk: For safeguarding adults, the definitions of abuse have been taken from *No Secrets* (DH and the Home Office 2000).

Abuse: Abuse is a violation of an individual's human and civil rights by another person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm, or exploitation of, the person subjected to it. Of particular relevance are the following descriptions of the forms that abuse may take:

Physical abuse: Including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions.

Sexual abuse: Including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, could not consent, or was pressured into consenting.

Psychological abuse: Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

Financial or material abuse: Including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Neglect and acts of omission: Including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating. Neglect also results in bodily harm and/or mental distress. It can involve failure to intervene in behaviour which is likely to cause harm to a person or to others. Neglect can occur because of lack of knowledge by the carer.

NB: Self neglect by an adult will not usually result in the instigation of the adult protection procedures unless the situation involves a significant act of omission or commission by someone else with responsibility for the care of the adult. Possible indicators of neglect include:

a) Malnutrition
b) Untreated medical problems
c) Pressure ulcers (Bed Sores)
d) Confusion
e) Over-sedation

Discriminatory abuse: Including racist, sexist, that based on a person's disability; and other forms of harassment, slurs or similar treatment.

Neglect and **poor professional practice** also need to be taken into account. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems and this is sometimes referred to as **institutional abuse**.

APPENDIX 1: Authorisation Criteria for Safeguarding

Domain 4: Proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities including financial control, as well as effectively commissioning all the services for which they are responsible.
Criteria: 4.2 Able to deliver all their statutory functions, including strategic oversight, quality improvement, financial control and probity, innovation and managing risk.
Threshold for authorisation: 4.2.3 CCG has systems and processes in place to fulfil its specific duties of cooperation and partnership, including: • Reducing inequalities in access and to outcomes from healthcare • CCG can demonstrate that it meets best practice in relation to safeguarding.
Evidence for authorisation: **D.** CCG has established appropriate systems for safeguarding. **E.** CCG has established plan to train staff in recognising and reporting safeguarding issues.
Domain 5: Collaborative arrangements for commissioning with other CCGs, local authorities and the NHSCB as well as the appropriate commissioning support.
Criteria: 5.3 Strong arrangements for joint commissioning and cooperation with local authorities to enable integration, deliver shared outcomes and fulfil statutory responsibilities, drawing on public health advice.
Threshold for authorisation: 5.3 Appropriate arrangements are in place to safeguard and promote welfare of children and vulnerable adults.
Evidence for authorisation: **B.** Clear line of accountability for safeguarding is reflected in CCG governance arrangements, and CCG has arrangements in place to co-operate with the local authority in the operation of Local Safeguarding Children Board and the Safeguarding Adults Board. **C.** CCG has secured the expertise of a designated doctor and nurse for safeguarding children and for looked after children, and a designated paediatrician for unexpected deaths in childhood. **D.** CCG has a safeguarding adults lead and a lead for the Mental Capacity Act, supported by the relevant policies and training.

APPENDIX 2: What to do if you are worried a child is being abused.

For advice and support from the Designated Nurse for South Sefton CCG within the Shared Merseyside Safeguarding Service please ring the main contact numbers: 0151 495 5469 or 5295

Any member of staff who believes or suspects that a child may be suffering or is likely to suffer significant harm should always refer their concerns to Children's Social Care. Never delay emergency action to protect a child whilst waiting for an opportunity to discuss your concerns first.

Are you concerned a child is suffering or likely to suffer harm ? eg

- You may observe an injury or signs of neglect
- You may be given information or observe emotional abuse
- A child may disclose abuse
- You may be concerned for the safety of a child or unborn baby

Step 1

Inform parents/ carers that you will refer to Children's social care
UNLESS
The child may be put at increased risk of further harm (eg suspected sexual abuse, suspected fabricated or induced illness, female genital mutilation, increased risk to child, forced marriage or there is a risk to your own personal safety)

Step 2

Make a telephone referral to Sefton's Children's Services on 0845 140 0845 (8 a.m. – 6 p.m.) or for out of hours 0151 920 8234 (Mon – Thurs 5.30 p.m, Friday after 4 p.m and weekends)

- Follow up in writing within 48 hours
- Document all discussions held, actions taken, decisions made, including who was spoken to and who is responsible for undertaking actions agreed.
- For physical abuse document injuries observed

Step 3

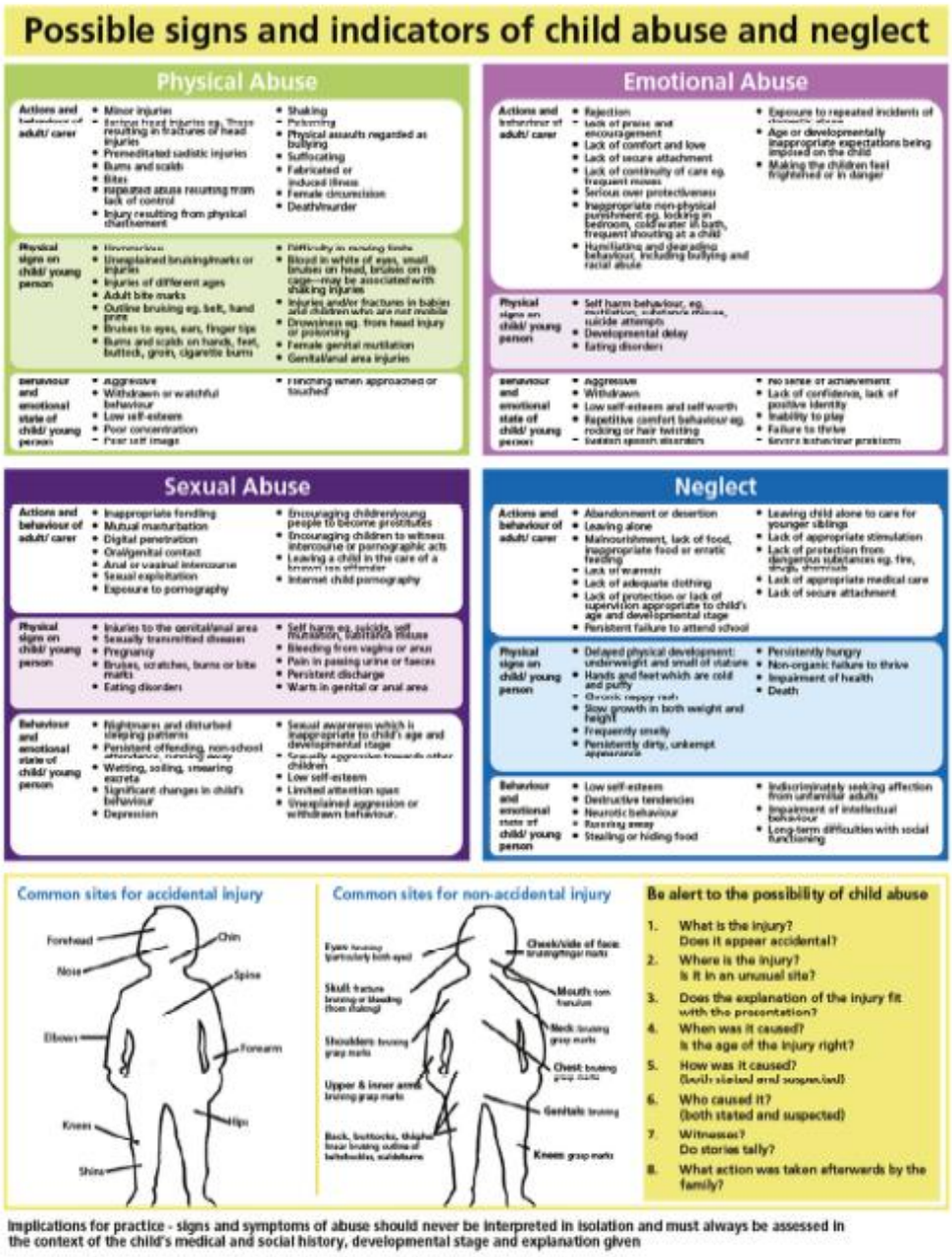
Children's Social Care acknowledges receipt of referral and decides on next course of action. If the referrer has not received an acknowledgement within 3 working days contact Children's Social Care again for an update.

Step 4

You may be requested to provide further reports / information or attend multi-agency meetings

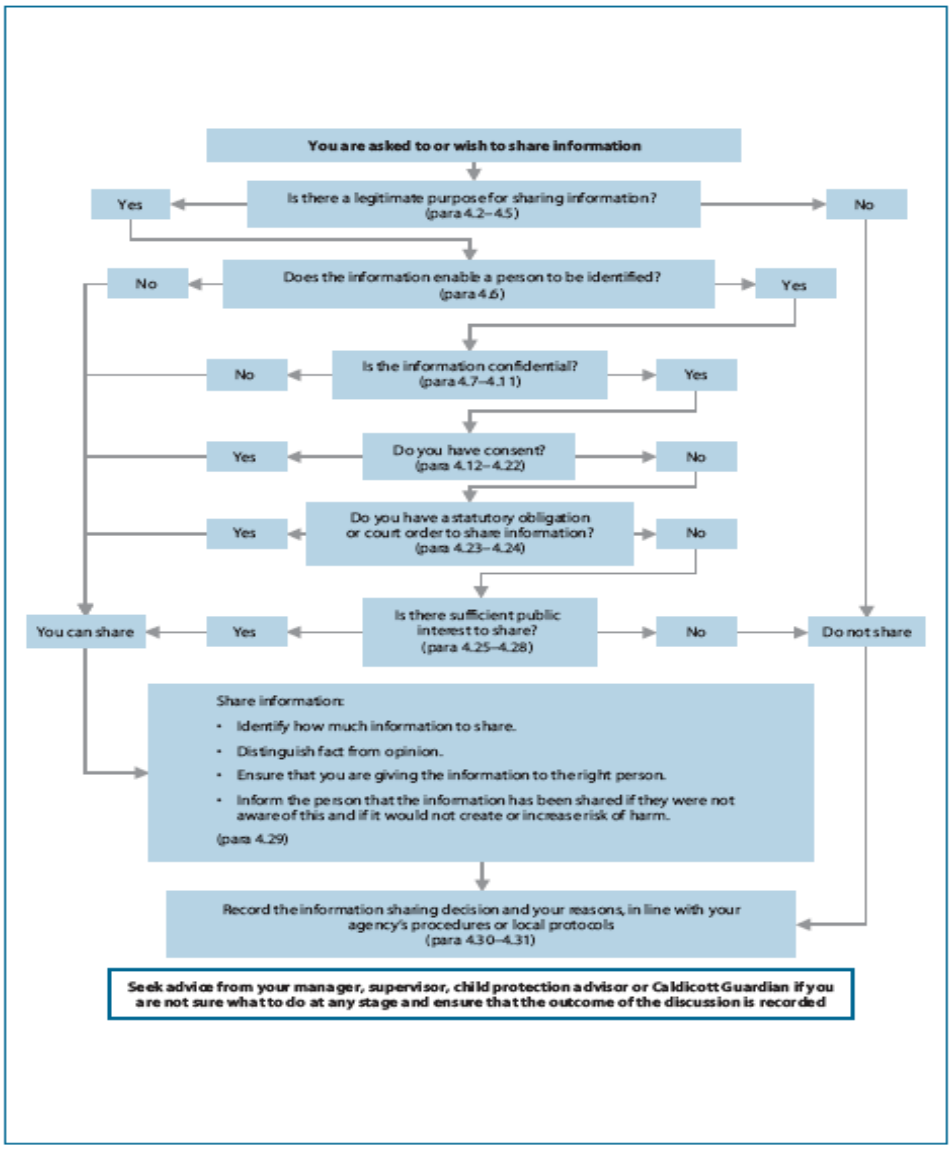
Other important numbers
Police - emergency 999 **Police - non-emergency 101**

APPENDIX 3: Possible signs and indicators of child abuse and neglect



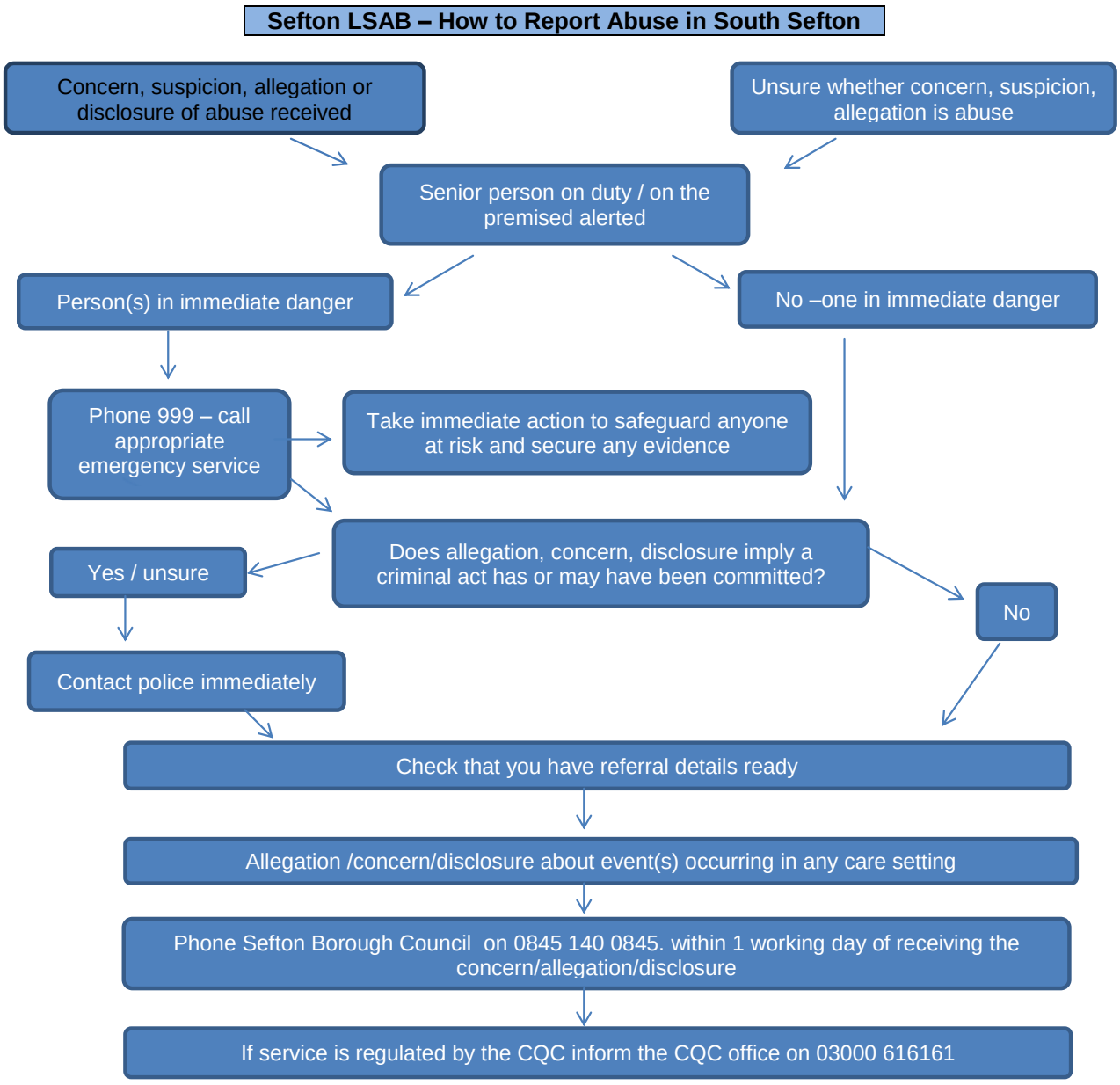
APPENDIX 4: Information Sharing Guidance

Sefton LSCB – Information Sharing Flowchart



For advice and support from the Designated Nurse for South Sefton CCG within the Shared Merseyside Safeguarding Service please ring the main contact numbers: 0151 495 5469 or 5295

APPENDIX 5: What to do if an adult is at risk of abuse



To discuss your concerns with the safeguarding adult lead for South Sefton CCG ring 0151 495 5469 or 5295.

APPENDIX 6: Safeguarding Best Practice Standards for GP member practices

NHS North West

Audit Tool to Monitor Safeguarding Best Practice Standards for GP Practices

RAG Rating Key:

Green		Fully compliant (remains subject to continuous quality improvement)
Amber		Action plans in place to ensure full compliance and progress is being made within agreed timescales
Red		Non-compliance against standards and actions have not been completed within agreed timescales

	Standard	Guidance and links to relevant LSCB/LSAB policies	Evidence	RAG
1. Clear lines of accountability for safeguarding children and vulnerable adults				
1.1	There is a named lead for safeguarding children and vulnerable adults	- Must be included in job description/job plan		
1.2	All staff should know how to act on concerns that a child and or a vulnerable adult may have been abused, or is at risk of abuse or neglect in line with local guidance.	Local Safeguarding Adult policies can be accessed at: http://liverpool.gov.uk/media/102189/safeguarding-policy-february-2013.pdf Local Safeguarding Children policies can be accessed at: http://www.liverpoolscb.org/		
2. Governance arrangements / Quality Assurance				
2.1	An incident reporting system is in place which identifies circumstances/incidents which have compromised the	- All serious untoward Incidents (SUI) compromising the safety and welfare of children and vulnerable adults are to be reported to [insert contact details]		

	safety and welfare of children and or vulnerable adults.	- All complaints that refer to the safety of children and vulnerable adults are referred and investigated thoroughly		
2.2	The Practice regularly reviews cases where there are safeguarding concerns (for both children and vulnerable adults)	- GP will meet regularly with health visitor/midwife/school nurse/ district nurse as appropriate to discuss vulnerable families /adults to see how they can be best supported.		
3. Safeguarding policies, procedures and systems				
3.1	Staff have access safeguarding policies and procedures for both children and vulnerable adults: these policies must be easily accessible by staff at all levels and be consistent with statutory, national and local guidance.	– All policies and procedures must be reviewed at a minimum 2 yearly to evaluate their effectiveness and to ensure they are up to date and working in practice.		
3.2	Safeguarding policy clearly states with whom staff should discuss and to whom staff should report any safeguarding concerns			
3.3.	Safeguarding policy/procedures includes guidance on complaints and whistle blowing policies which offers a guarantee to staff and service users that using these procedures appropriately will not prejudice their own position or prospects.			
3.4	Safeguarding policy/procedures includes guidance on how to respond			

	to a disclosure from a child or a young person and or vulnerable adult.			
3.5	Safeguarding policy/procedures includes a process for resolving cases where there is a difference of opinion in relation to safeguarding concerns for children and vulnerable adults			
3.6	Safeguarding policy/procedures includes clear guidance on managing allegations against staff and volunteers working with children and vulnerable adults in line with policies and procedures of LSCB / LSAB.	- All substantiated cases to be reported to the [insert contact details in PCT] in addition to other regulatory bodies. LSCB guidance can be accessed at: [insert link]		
3.7	When it is known that a child is not accessing education a referral will be made to the Local Authority in which the child lives.	Information on missing education is available at; [insert local link]		
3.8	Safeguarding policy/procedures includes guidance as to the action to take where there is concern a child is being deliberately harmed through fabricating or inducing illness (FII).			
3.9	There is a clear means of identifying in records those children (together with their parents and siblings) who are subject to a child protection plan	List of recommended read codes can be provided [insert contact details in PCT]		

3.10	There is a process for following up children who do not attend appointments.			
4. Parents/carers experiencing personal problems				
4.1	GPs and their practice staff in working with parents or carers who are experiencing personal problems (including substance misuse, mental health issues, domestic abuse and learning disabilities) must give consideration to the needs of the children and where necessary ensure that they are assessed and appropriate referrals are made.	- Where there are concerns in relation to a client's vulnerability that may impact on their parenting capacity it is advisable that discussions take place with the health visitor/school nurse/midwife as appropriate. Outcome of discussions to be recorded in clients record		
5. Sexually Active Young People Under 18yrs				
5.1	Staff working in contact with children and young people will adhere to the LSCB procedure for Working with Sexually Active Young People under 18, which can be accessed at: [insert local link]	– Whilst this procedure applies to all sexually active young people under 18, it is essential that all cases involving under 13s should always be discussed with [insert local information]. However due consideration should be given to children 13-16 years in line with local guidance. - All cases involving under 13s must be fully documented in the clinical record, including detailed reasons where a decision is taken not to share information		
6. Domestic violence (including Honour Based Violence and Forced Marriage)				
6.1	Information about local services on domestic violence is available to all women whether they are	Insert local links		

	affected by domestic violence or not. This information should include Forced Marriage and Honour Based Violence.			
7. Information sharing				
7.1	Information sharing protocols in line with national and local guidance are in place within the practice.	*Information sharing: Guidance for practitioners and managers* (HM Government 2008) at: accessed at: https://www.education.gov.uk/publications/eOrderingDownload/00807-2008BKT-EN-March09.pdf		
8. Inter-agency working				
8.1	The Practice has access to staff who are competent to complete a CAF in their work with children and families; and the single assessment process when working with vulnerable adults	Insert local links		
8.2	The Practice establishes and maintains effective working relationships with health visiting, school nursing, midwifery services, district nurses and other applicable community health staff.			
8.3	GP's works with partners to protect children and vulnerable adults and participates in reviews as set out in statutory, national and local guidance. This includes Serious Case Reviews; Child Death Overview Processes; MARAC; MAPPA			
8.4	GP's invited to attend a multi-agency meeting in relation to			

	safeguarding a child or vulnerable adult must make every effort to attend. But in all cases GPs must make available information to inform decision making at child/adult protection conferences. Information provided to consist of a chronology of their involvement with the child and family/adult, analysis of information and recommendations for action.			
9. Safer Working practices				
9.1	For staff working with children and or vulnerable adults references are always verified, a full employment history is always available with satisfactory explanations for any gaps in employment history, qualifications are checked and the appropriate CRB check is undertaken in line with national and local guidance.	Insert Local Links		
9.2	General guidance is provided to staff on appropriate behaviours when working with children and young people in line with national and local guidance.	Detailed guidance on safe working practices for adults who work with children is available on the DCSF website at http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00311/		
10. Looked After Children				
10.1	Account is taken of local and statutory guidance when	Note best possible medical care requires access to relevant medical records. This is best achieved by accepting the child as a registered		

	working with children who are 'looked after' - clinical record makes the 'looked after' status of the child clear, so that their needs can be acknowledged - ensure that referrals made to specialist services are timely, taking into account the needs and high mobility of children looked after - provide, when requested, summaries of the health history of children looked after, including their family history where relevant and appropriate, subject to appropriate consent - make sure the GP held clinical record is maintained and updated: it is a unique health record and can integrate all known information about health and health events during the life of the child; - regularly review the clinical records of looked after children who are registered with the practice, and make it available for each statutory review of the health plan (Reference: Promoting the Health and Well-being of Looked After Children (DH 2009)	patient and seeking urgent transfer of medical records. Treating as a temporary resident is not ideal and is only intended for those who are to be in an area for less than three months therefore where there is any doubt of the potential length of stay it is advisable to opt for full registration.		

11. Record keeping				
11.1	When a child registers for the first time basic personal information must be recorded. This information includes: full name; address; gender; date of birth; school; names of persons with parental responsibility. Information to be kept up to date			
11.2	All staff maintain an accurate, clear record of their involvement with a child and family on a routine basis. This includes ensuring that where there are concerns about a child's welfare, all concerns, discussions about the child, decisions made and the reasons for those decisions must be recorded in writing in the child's records. When a child dies, this should be noted in the parent(s) GP record.			
11.3	Practices have a clear means of identifying in records those children (together with their parents and siblings) who are subject to a child protection plan.			

12. Supervision and support to staff working with children, parents and carers and vulnerable adults				
12.1	Staff working directly with children and vulnerable adults have access to advice and support	- Advice on the most appropriate methods of advice, support and supervision can be sought from the lead GP for safeguarding		
13. Staff training and continuing professional development				
13.1	Staff in contact with children, adults who are parents/carers and vulnerable adults in the course of their normal duties are trained and competent to be alert to the potential indicators of know how to act on those concerns in line with local guidance.	- Information on training requirements is available from the lead GP for safeguarding. - as per CQC guidance, it is required that at least 80% of staff undertake appropriate training relevant to their role. This is a minimum standard. [PCT to insert % level of training required for their provider]		
Standard 13.2 (is relevant to GPs only)				
13.2	GPs maintain their skills in the recognition of abuse, and are familiar with the procedures to be followed if abuse is suspected.	GPs take part in training about safeguarding and promoting the welfare of children, and have regular updates (at least every 3 yrs) as part of their post-graduate educational programme.		

Practice Name:

Name of person in practice that can be contacted:

Contact details:

Date audit tool completed:

AUDIT TOOL TO MONITOR SAFEGUARDING STANDARDS BASED ON CQC ESSENTIAL STANDARD 7 FOR SAFEGUARDING CHILDREN AND VULNERABLE ADULTS AND SECTION 11 OF THE CHILDREN ACT 2004 (2014/15)

PART 1: MINIMUM DATA SET TO BE SUBMITTED ON A QUARTERLY BASIS

RAG RATING KEY:

	Significant (Green) – evidence to validate a 'significant' rating assessed submission of evidence e.g. policy, procedures, documents, audits where processes, policies and systems meet fully compliant criteria, to mitigate a corporate or strategic risk.
	Reasonable (Amber) – Reasonable ratings in the context of assurance on controls are clear documented processes and systems which are evidenced by receipt and oversight through internal governance systems (e.g. Clinical Governance Committee minutes received by the Board). For example using an action plan e.g subject to progress through a formal committee for and approval as mitigating a corporate or strategic risk.
	Limited (Red) – Limited assurance is usually gained from draft plans, strategies and policies are yet to go through formal ratification, risk assessment or dissemination. These tend to be control documents which spell out what will happen, when things will happen and what resources are needed but do not carry any weight due to the lack of sign off.

PART 2: ANNUAL AUDIT TOOL TO BE SUBMITTED JULY 2014

	Standard	Components of standard	Evidence for Children	Evidence for Vulnerable Adult	RAG Children	RAG Adults
1. Leadership						
1.1	There is a board lead for safeguarding children and vulnerable adults (these roles can be combined)	- Their job description clearly identifies their safeguarding responsibilities	Submission of the name of the lead and a copy of their job description.			
1.2	The organisation is linked into the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adult Board (LSAB)	- There is representation at a senior level - The organisation contributes to the work of the Safeguarding Boards, including that of its sub groups	Submission of safeguarding organisation chart which clearly denotes who is responsible for attendance at the LSCB / LSAB. Submission of attendance chart to sub groups.			
1.3	There is a named lead for safeguarding children and a named lead for vulnerable adults.	- Roles and responsibilities for the named doctor and nurse for safeguarding children are in line with the Intercollegiate document, Safeguarding children and Young people: *Roles and Competencies for Health Care Staff* (2010) and Working Together to Safeguard Children 2013 - Safeguarding adult lead must have expertise in adult safeguarding and understand the nature of abuse and neglect, adult health services and the local arrangements for safeguarding vulnerable adults.	Submission of the name of the Named Lead for safeguarding Children and a copy of their job description.	Submission of the name of the Named Lead for safeguarding Vulnerable Adults and a copy of their job description.		
2. Governance arrangements / Quality Assurance						
2.1	The Provider board regularly reviews safeguarding across the organisation.	- The board should receive regular reports on their arrangements for safeguarding. At a minimum an annual report should be presented at board level with the expectation that this will be made public.	Evidence of safeguarding with provider governance arrangements. E.g. Safeguarding Assurance Groups to communication at board level. Submission of CQC declaration – declaration is published on intra and internet of Provider Organisation			

			Submission of annual report to the Safeguarding Service (Q2) Submission of board minutes which denote when the annual report has been presented.	**Submission of annual report to the Safeguarding Service (Q2)** Submission of board minutes which denote when the annual report has been presented.		
2.2	An adverse incident reporting system is in place which identifies circumstances/incidents which have compromised the safety and welfare of children and or vulnerable adults	- Commissioners provided with a regular report (interval to be agreed between the provider and the commissioner but be at least annually) of key themes/learning from STEIS that involve safeguarding children and vulnerable adults. - All complaints that refer to the safety of children and vulnerable adults are referred and investigated thoroughly	Submission of annual report which will include section on incident reports **Q2** Submission of safeguarding assurance group minutes where outcomes of audits have been discussed. **Q2**			
			Safeguarding incidents themes and trends to be reported on a quarterly basis at Safeguarding Assurance Meetings – submission of minutes of these meetings.	Safeguarding incidents themes and trends to be reported on a quarterly basis at Safeguarding Assurance Meetings – submission of minutes of these meetings. **Quarterly** reporting of the number of complaints raised relating to safeguarding adult concern.**Q1, Q2, Q3, Q4.**		
2.3	A programme of internal audit and review is in place that enables the organisation to continuously improve the	Audits of safeguarding arrangements to include progress on action to implement recommendations from:	Submission of annual audit plan. Submission of progress	**Quarterly** submission of the number of SUI's raised relating to safeguarding adult		

	protection of all service users from abuse or the risk of abuse.	- Serious Case Reviews - Internal management reviews as a consequence of SUI's compromising the safety/welfare of service users - Reports from national bodies e.g. Ofsted, Care Quality Commission. - Domestic Homicide Reviews	reports against Serious Case Review Action Plans Quarterly. Submission of final RCA reports relating to Safeguarding incidents. Quarterly. Submission of action plan from external audits e.g Ofsted, CQC, MIAA. Quarterly. Submission of audit report pertaining to effective implementation of routine enquiry – **Maternity and Community Providers Only (Q3)** **Additional audit reports for submission in Q3 (see 3.7 and 5.1)**	incidents **Q1, Q2, Q3, Q4.** **Quarterly** submission of data related to number of new Serious Case reviews in quarter **Q1, Q2, Q3, Q4.** **Quarterly** submission of progress reports against Serious Case Review Action Plans, **Q1, Q2, Q3, Q4.** **Quarterly** submission of data in relation to number of new DHR's in quarter **Q1, Q2, Q3, Q4.** **Quarterly** submission of data in relation to number of new in quarter external audits completed e.g. Ofsted, CQC, **MIAA Q1, Q2, Q3, Q4.** **Quarterly** submission of action plan from external audits e.g. Ofsted, CQC, MIAA. **Q1, Q2, Q3, Q4.** **Quarterly-** Numbers of adult safeguarding incidents quarterly count required **Q1, Q2, Q3, Q4.**		

3. Safeguarding policies, procedures and systems						
3.1	Staff at all levels, have easy access to safeguarding children and vulnerable adult policies and procedures. These policies and procedures must be consistent with statutory, national and local guidance. Please refer to Appendix 1 for details of the core requirements of the safeguarding policy	- Policies and procedures are updated regularly to reflect any structural, departmental and legal changes - All policies and procedures must be audited and reviewed at a minimum 3 yearly to evaluate their effectiveness and to ensure they are working in practice. - Policies and procedures to specifically consider children and vulnerable adults in special circumstances, e.g. those with a disability, those who do not speak English as their first language, etc. – Policies take account of the Mental Capacity Act. LSCB policies can be accessed at: [insert link] LSAB policies can be accessed at: [insert link]	Submission of a copy of Safeguarding Policy and procedures.	Submission of a copy of Safeguarding Policy and procedures. **Q2** Policy is current and reviewed in line with trust compliance		
3.2	There is clear guidance on managing allegations against staff and volunteers working with children and or vulnerable adults in line with those of the LSCB and LSAB.	This includes identifying a Senior Officer who has overall strategic responsibility for ensuring the organisation operates the procedures; and a nominated Senior Manager to whom all allegations or concerns are reported; and a deputy in his/her absence. The procedure **must** be followed when there are concerns that any person in a position of trust (whether paid or unpaid) has:- - behaved in a way that has harmed a child and or vulnerable adult, or may have harmed a child and or vulnerable adult - possibly committed a criminal offence against or related to a child or vulnerable adult - behaved towards a child or vulnerable adult in a	Submission of a copy of the Allegations against Professionals policy procedure / highlighted copy of Safeguarding Policy with appropriate reference to section relating to allegations against professionals. Submission of final RCA reports in relation to any StEIS reported allegations against professionals.	Submission of a copy of the Allegations against Professionals policy procedure / highlighted copy of Safeguarding Policy with appropriate reference to section relating to allegations against professionals **Q2** Types of evidence- Submission of final RCA reports in relation to any StEIS reported allegations against		

		way that indicates s/he is unsuitable to work with children or vulnerable adults All cases will be reported through [to be determined locally] and must follow the LADO process for children. All cases will be reported through to the appropriate local authority and must follow the multi- agency adult safeguarding procedures. All substantiated cases to be reported to the CCG [insert contact details of the person in the commissioning organisation] in addition to other regulatory bodies, including professional bodies.	Submission of LADO meeting minutes indicating that cases have been discussed in this forum. Evidence of involvement of appropriate regulatory bodies: i.e. DBS and professional bodies.	professionals. Submission of the minutes from local authority safeguarding adult strategy meetings. Evidence of involvement of appropriate regulatory bodies: i.e. DBS and professional bodies.		
3.3	Robust complaints and whistle blowing policies/procedures are in place	- A guarantee is provided to staff and service users that using the procedures appropriately will not prejudice their own position or prospects.	Submission of a copy of the whistle blowing policy.			
3.4	There is a process for ensuring that patients are routinely asked about dependents such as children, or about any caring responsibilities		Submission of relevant protocol that highlights this practice. **Q2** Submission of audit results which assess whether this has been implemented in practice. **Q2**			
3.5	There is evidence of the implementation of the national Prevent strategy in protecting vulnerable people from being drawn into terrorism.	There are clear procedures in place on the implementation of Prevent that identifies children and vulnerable adults at risk of radicalisation who may be drawn into terrorist activity.	Submission of policy and procedures which reference Prevent strategy **Q2** Identification of a Prevent Lead in place. **Q2** Submission of a training strategy to deliver HealthWRAP programme. **Q2** **Quarterly** submission of training compliance to HealthWRAP programme Comply with the monthly submission of training data of HealthWRAP programme to the regional prevent			

			Co-ordinator - NHS England. **Quarterly-** Submission of data in relation to percentage of staff completed Prevent training in line with TNA & policy (to include denominator and numerator) **Q1** = Submission of training needs analysis, **Q2** = count & % trained, **Q3** count & % trained **Q4** target 40%		
The following policies, procedures and systems apply only to providers of services to children and young people					
3.5	There is a system for flagging children for whom there are safeguarding concerns	- Consideration should be given to Looked After Children.	Submission of protocol / policy which states how the flagging system is implemented.		
3.6	When it is known that a child is not accessing education a referral will be made to the Local Authority in which the child lives.	Where it is discovered a child is not receiving any form of education the Children Missing Education Officer is to be notified. Information on missing education is available at: [insert link]	Submission of protocol/policy which highlights how this is implemented within the organisation. Submission of audit results demonstrating that this system has been tested.		
3.7	There is clear guidance in relation to LAC as to the requirements necessary for the completion of health action plans, including regular health assessments, medicals and reviews. (as per guidance Promoting the Health and Well being of Looked after Children 2009)	Clear protocols and procedures should be in place for LAC demonstrating the interface with the LA and other partner agencies. Clear arrangements in place to support the provision of care for children living in another area/ out of Borough.	Submission of protocol/policy for LAC. Submission of annual audit relating to the quality of health assessments that have been completed (in Borough and out of Borough) with particular reference to the voice of the child. **Annual audit of the above to be submitted with Q3 KPI's** Submission of data returns relating to %of health assessments / medicals that have been completed and within what timescale. Submission of annual data set relating to number of children leaving care who have a comprehensive		

			health summary completed.			
4. Information sharing						
4.1	There are agreed systems, standards and protocols for sharing information within the service and between agencies in accordance with national and local guidance	- Staff understand what to do and the most effective ways of sharing information if they believe a child / vulnerable adult may require particular services in order to achieve their optimal outcomes; - staff understand what to do and when to share information if they believe a child may be at risk of significant harm or an adult is at serious risk of harm; - agency-specific guidance is produced to complement guidance issued by central government and training is made available to existing and new staff as part of their induction programme and ongoing training; - managers are fully conversant with the legal framework and good practice guidance issued for practitioners	Submission of policy / protocol highlighting information sharing arrangements. **Q2**			
			Submission of audit of information sharing arrangements. Submission of training matrix / packages that highlight information sharing arrangements and standards.	Submission of compliance against statutory training. **Q2**		
5. Inter-agency working						
5.1	The organisation embeds the locally agreed assessment process e.g. Common Assessment Framework (CAF) / single assessment processes , within its existing systems and processes	– The principles of early help should be embedded within practice –	Submission of policy that highlights CAF procedures. Submission of data relating to the – Number of CAF's that have been initiated – Of those, the number initiated by the health provider organisation – Number of continuing CAFs within the organisation. – Analysis of outcomes resulting from CAF process (i.e. reduction in escalation of cases to CSC etc.) **Annual audit of outcomes following CAF initiation demonstrating the above to be submitted with Q3 KPI's**			

5.2	The organisation works with partners to protect children and vulnerable adults and participates in reviews as set out in statutory, national and local guidance	– Staff to provide, when requested, information on their involvement with a child and or family to inform the case discussion in relation to Serious Case Reviews, Domestic Homicide Reviews, Child Death Overview Processes, MARAC, MAPPA – Professionals who are invited to attend a multi-agency meeting in relation to safeguarding a child or vulnerable adult must make every effort to attend and will submit a written report if they cannot attend or where requested to do so. The report will include a chronology of their involvement, assessment and analysis of the capacity of parents/carers to meet the needs of the child/vulnerable adult and recommendations for action.	Submission of quarterly data in relation to Attendance at Child Protection conferences and reviews Attendance at LAC reviews Attendance at MARAC / MAPPA meetings	**Quarterly-** submission of data in relation to: Strategy Meetings invited and attended (to include denominator and numerator – target 95% attendance) quarterly count **Q1, Q2, Q3 Q4** Multi- Agency Risk Assesmment Conferences invited and attended (to include denominator and numerator. Quarterly count **Q1, Q2, Q3 Q4**		
6. Supervision and support						
6.1	Staff working directly with children and vulnerable adults have access to advice support and supervision. This includes clinical and safeguarding supervision.	- Access to advice / support is available to all staff working with children and vulnerable adults - For front line practitioners working directly with children, young people and vulnerable adults where there are concerns about harm, self-harm or neglect this will include the supervisor regularly reading the case files to review and record in the file whether the work undertaken is appropriate to the child's/adults current needs and circumstances, and is in accordance with the agency's responsibilities. - Frontline staff to follow their organisation's supervision policy [insert policy link], which should clearly outline those cases that need to be reviewed by the supervisor. - Community staff requirements – case supervision	Submission of supervision policy / protocol Submission of audit of supervision policy / protocol Submission of quarterly data relating to the number of cases that have been supervised. Submission of data relating to the qualifications held by the named supervisor. Can this be more specific to	Provide evidence of safeguarding adult supervision framework. E.g. group supervision, individual supervision, reflective case discussions, audits re: PDR process evidencing safeguarding **Q2**		

		for both CP and LAC / pre-school and school age. - Acute staff (including MH services) evidence of a framework/ flowchart ensuring appropriate supervision arrangements with safeguarding leads are in place.	children only.			
6.2	Named professionals, including MCA leads, seek advice and access regular formal supervision from designated professionals for complex issues or where concerns may have to be escalated.		Submission of minutes of Named Nurse forum demonstrating attendance for supervision. **Q2**	Submission of minutes of Safeguarding Adult Lead Forum demonstrating attendance for supervision. **Q2**		
7. Staff training and continuing professional development						
7.1	There is a training strategy and operational model for safeguarding children and adults	- Training must reflect statutory and local guidance such as Working Together to Safeguard Children; *Intercollegiate Document Safeguarding Children and Young People: Roles and Competencies for Health Care Staff* (2010), Bournemouth: National Competence Framework for Safeguarding Adults (2010) and the LSCB /LSAB training strategies - Training must be audited to ensure its effectiveness and quality assured - Training takes account of emerging messages from national and local reviews of safeguarding - as per CQC guidance, it is required that at least 80% of staff undertake appropriate training relevant to their role. This is a minimum standard. [CCG to insert % level of training required for their provider]	Submission of training strategy. Evidence that there has been approval of training packages by the LSCB. Submission of quarterly data in relation to percentage of staff that have been trained.	Submission of training strategy. **Q2** Evidence that there has been approval of training packages by the LSAB and compliance Bournemouth: National Competence Framework for Safeguarding Adults (2010). **Quarterly** submission of data for safeguarding adult training levels: 1,2,3 against Bournemouth: National Competence Framework for Safeguarding Adults (2010)		

				Level 1 Adult Safeguarding Training Quarterly- Percentage of overall staff who have had training within the past 3 years (to include denominator and numerator) target 90% **Q1, Q2, Q3, Q4.** **Level 2 Adult Safeguarding Training-** **Q1** = Submisison of training needs analysis, **Q2** = count & % trained, **Q3** count & % trained. **Q4-** target 90% **Level 3 Adult Safeguarding Training-** **Q1** = Submisison of training needs analysis, **Q2** = count & % trained, **Q3** count & % trained. **Q4**- target 90% **Domestic Abuse Training-** Percentage of clinical staff completed domestic abuse training in line with Training Needs Analysis (to include denominator and numerator) measured by an end of year count in **Q4**		

8. Applies only to healthcare providers offering in-patient facilities to children under 18 years only					
8.1	There is clear guidance as to the discharge of children for whom there are child protection concerns.	- No child about whom there are child protection concerns is discharged from hospital without a documented plan for the future care of the child. This plan must include follow up arrangements and involve partner agencies as required. - The need to safeguard a child should always inform the timing of their discharge, so that the likelihood of harm can be assessed while he or she is in hospital.	Submission of safeguarding policy which contains the guidance. Submission of audit data of children who have been discharged with safeguarding concerns.		
8.2	Specialist paediatric advice is available at all times		Copy of service specification highlighting arrangements that are in place for paediatric advice.		
8.3	The child's GP and health visitor/school nurse is notified of admissions/discharges	- Where a child is not registered with a GP the parent/carer should be advised to register the child with a local GP practice. - Where the child has no parents in attendance and/or the child is not registered with a GP, it is the provider's responsibility to ensure GP allocation via the locally agreed arrangements with either the CCG or LAT.	Submission of policy that highlights this area of work.		
9. Applies only to A&E Departments, ambulatory care units, walk in centres and minor injury units					
9.1	All attendances for children under 18 years to A&E, ambulatory care units, walk in centres and minor injury units should be notified to the child's GP. Attendances at A&E will also be copied to the health visitor and or school nurse depending on the age of the	– Where a child is not registered with a GP the parent/carer should be advised to register the child with a local GP practice. – Where the child has no parents in attendance and/or the child is not registered with a GP, it is the provider's responsibility to ensure GP allocation via the locally agreed arrangements with either the CCG or LAT.	Submission of service specification for urgent care services. Submission of quarterly data returns stating the number of referrals that have been made for safeguarding children.		

	child.				
10. Applies only to community providers offering services to children / families and adults					
10.1	Community health practitioners should have a clear means of identifying in records those children (together with their parents and siblings) who are subject to a child protection plan		Submission of policy / protocol which states that this needs to take place. Submission of audit data relating to record keeping audit.		
10.2	There is good communication between GPs, community nursing services (i.e. health visiting, school nursing and community midwifery services) in respect of children for whom there are concerns.	- Each GP practice should be informed of who their 'named' health visitor / school nurse / community midwife is and how they can be contacted. - This may include evidence of regular Primary care team meetings/ communication, any child protection referrals should be shared with the GP.	Submission of minutes of meetings with primary care.		
11. Voice of the Child					
11.1	There is evidence that the voice of the child is incorporated within all routine and targeted health assessments, with particular focus on LAC, CPP and CIN/CAF assessments	– A systematic process should be implemented to review the quality of assessments (particularly in relation to listening to the voice of the child), both routine and targeted	Submission of assessment tools used and policy supporting implementation		
11.2	Evidence that the child's voice is heard and has an impact on service development and improvement	– A clear strategy for engaging the views of children should be embedded – Analysis of findings should inform service development proposals	Submission of an annual summary report outlining the organisation engagement strategy and the impact made by listening to the voice of the child on service delivery		
12. applies to NHS commissioned organisations and hospitals providing care for adults					
12.1	There are clear procedures on the implementation and	- Managing authorities, i.e. hospitals providing in-patient facilities for adults, must have in place a	Submission of Deprivation of Liberty policy / procedures. **Q2**		

	management of Deprivation of Liberty Safeguards in line with the Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice.	procedure that identifies whether a deprivation of liberty is or may be necessary; what steps are taken to assess whether to seek an authorisation; whether all practical and reasonable steps have been taken to avoid a deprivation of liberty; what action they should take if they do need to request an authorisation; how they review cases; and who should take the necessary action; - Managing authorities must have in place a procedure that identifies what actions should be taken when an urgent authorisation needs to be made; who should take that action; and within what timescales. - Managing authorities must have in place processes for reviewing deprivation of liberty and reducing the levels of restriction where reasonably possible	Submission of a framework for assessing mental capacity. **Q2** Submission of a framework for conducting Best Interest Meetings. **Q2** **Quarterly** submission of the number of referral for Independent Mental Capacity Advocacy under MCA and DoLS, **Q1, Q2, Q3, Q4** **Quarterly**- submission of data in relation to Deprivation of Liberty Authorisation requests (DoLs) (Hospitals, Mental Health Services, Intermediate Care) submission of quarterly count, **Q1,Q2,Q3,Q4**		
12.2	Staff required to use restrictive physical interventions have received specialist training. Specialist training should include the legal duties enshrined in the Mental Capacity Act 2005 (including the law relating to assault against a person) and national guidance on consent for examination or treatment.	- Staff understand when different types of restraint are or are not appropriate, prioritizing de-escalation or positive behaviour support over restraint where possible - Know whether and what type of restraint should be used in a way that respects dignity and protects human rights where possible - Understand that restraint should only be used as a last resort where it is necessary and proportionate, and that restraint used should be the least restrictive and for the minimum amount of time to ensure that harm is prevented and that the person, and others around them are safe. - Where restraint is used it is documented and followed by an assessment of the person restrained and others involved in the restraint for	Submission of a restraint policy / procedures **Q2** Evidence of approved training in place. **Quarterly-** Submission of data in relation to percentage of identified staff that have been trained in approved physical intervention techniques of identified cohort. **Q1** = Identify those who need training within each quarter, submission of TNA **Q2**= 90% **Q3** 90%, **Q4** 90%		

		signs of injury and any emotional or psychological impact.			
12.3	Rapid tranquilisation will only be used in accordance with NICE clinical guidelines on Violence. Applicable to ***A&E departments and Mental Health Trust only***	- There is clear guidance on the use of rapid tranquilisation in line with NICE clinical guidance on Violence: the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments (2005)	Submission of a rapid tranquilisation policy / procedures **Q2**		
12.4	There are clear procedures on the implementation and management of Mental Capacity Act 2005.	- There are clear procedures in place that identifies what actions should be taken when a Vulnerable adults requires assessment under the Mental Act (2005) - Training must reflect statutory and local guidance such as National Standards Framework for Safeguarding Adults (2005) and the LSAB training strategies	Submission of policy / procedure re assessing mental capacity **Q2** Evidence of approved training in place **Quarterly-** submission of data in relation to percentage of staff completed MCA/DoLS training in line with policy requirements (to include denominator and numerator) threshold- 90% **Q1, Q2, Q3, Q4**. **Quarterly-** Submission of data in relation to number of Independent Mental Capacity Advocate (IMCA) requests **Q1, Q2, Q3, Q4.**		

NB all quarterly identified submissions relate to the required KPI data sets.

Appendix 1:

Policies required by all |Provider Organisations (the policy can be provided via a link to local LSCB and ASB policies

Ratification of all Provider Organisation Safeguarding Policies should include consultation with Designated Safeguarding Service Professionals

Policy	National / Local Policy / Standards Reference where available	Date Reviewed and comments	Expiry Date
Safeguarding Adults Policy Including guidance on: - Abuse and neglect - Female Genital Mutilation - Forced Marriage - Mental Capacity - Deprivation of Liberty Safeguards - Domestic Violence - Human Rights - Terrorism and Radicalisation	 No Secrets guidance (2000), Safeguarding Vulnerable Adults Act (2006), LSAB multi agency policy and procedures Multi-Agency Practice Guidelines: Female Genital Mutilation (2011) HM Government The Right to Choose: Multi-Agency statutory guidance for dealing with forced marriage (2008) HM Government Merseyside Forced Marriage Protocol 2013 Mental Capacity Act (2005) Deprivation of Liberty Safeguards (2007) Domestic Violence, Crime and Victims Act (2013) Human Rights Act (1998) PREVENT strategy		
Safeguarding Children Policy Including guidance on: • Fabricated Illness	 Fabricated or induced illness a rare form of child		

	abuse? (2011) NSPCC Safeguarding children in whom illness is fabricated or induced. (2008) HM Government		
• Forced Marriage	The Right to Choose: Multi-Agency statutory guidance for dealing with forced marriage (2008) HM Government Merseyside Forced Marriage Protocol 2013		
• Disabled Children	Safeguarding disabled children: practice guidance (2009) Department for Education.		
• E-Safety	LSCB E-Safety Standards		
• Sexually Exploited Children / CSE Strategy	LSCB CSE Strategy Safeguarding Children and Young People from Sexual Exploitation (2009) HM Government		
• Female Genital Mutilation	Multi-Agency Practice Guidelines: Female Genital Mutilation (2011) HM Government		
• Working with sexually active young people under the age of 18	Safeguarding Children and Young People from Sexual Exploitation (2009) HM Government. LSCB Procedures		
• Domestic abuse (inclusive of children who are the victims of domestic abuse)	Domestic Violence and Abuse – Professional Guidance (2013) Department of Health. Responding to domestic abuse: a handbook for health professionals (2005) Department of Health. Striking the balance: practical guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACs (2012) Department of Health. NICE Public Health Guidance. Domestic violence and abuse: how social care, health services and those they work with can identify, prevent and reduce domestic violence and abuse (2013).		
• Early help			
• The voice of the child			

	Working Together to Safeguard Children (2013) Working Together to Safeguard Children (2013)		
Whistle Blowing Policy			
Managing allegations of abuse against a person who works with children or vulnerable adults	LSCB Procedures		
Information sharing	Information sharing: Guidance for practitioners and managers (2008) HM Government		
Safe recruitment, including CRB checks where required and taking up of references Appropriate behaviours by staff towards vulnerable adults and children	LSCB Procedures Protection of Freedoms Act 2012 Disclosure and Barring Scheme		
Supervision Policy	LSCB Procedures		
Mental Capacity Act – Deprivation of Liberty Safeguards	Mental Capacity Act (2005) Deprivation of Liberty Safeguards (2007)		

APPENDIX 8: Standards for voluntary, community and faith sector (VCFS) organisations / non-health care providers

NHS North West

Audit Tool to Monitor Standards for Voluntary, Community & Faith Sector (VCFS) Providers

RAG Rating Key:

Green		Fully compliant (remains subject to continuous quality improvement)
Amber		Action plans in place to ensure full compliance and progress is being made within agreed timescales
Red		Non-compliance against standards and actions have not been completed within agreed timescales

	Standard	Guidance and links to relevant LSCB/LSAB policies	Evidence	RAG * (see key below)
1. Clear lines of accountability for safeguarding children and vulnerable adults				
1.1	A safeguarding policy is in place which demonstrates commitment to safeguarding children and safeguarding vulnerable adults (this may be combined into one overarching policy)	- The policy makes it clear who has overall responsibility for the contribution to safeguarding children and vulnerable adults including lines of accountability though to the person with ultimate accountability - The policy sets out key out clear priorities for safeguarding line with those of the local safeguarding boards. [insert link] - The policy clearly states with whom staff should discuss and to whom staff should report any safeguarding concerns in relation to children and vulnerable adults		
1.2	There is a named lead within the			

	service /organisation for safeguarding children and vulnerable adult and arrangements for cover when this person is not available			
1.3	All staff (paid and volunteers) should know how to act on concerns that a child and or a vulnerable adult may have been abused, or is at risk of abuse or neglect in line with local guidance.	Local Safeguarding Adult policies can be accessed at:[insert link here] Local Safeguarding Children policies can be accessed at: [insert link here]		
2. Governance arrangements / Quality Assurance				
2.1	An incident reporting system is in place which identifies circumstances/incidents which have compromised the safety and welfare of children and or vulnerable adults.	– All serious untoward Incidents (SUI) compromising the safety and welfare of children and vulnerable adults are to be reported to [insert link] – All complaints that refer to the safety of children and vulnerable adults are investigated thoroughly		
2.2	The service/organisation regularly reviews cases where there are safeguarding concerns (for both children and vulnerable adults)			
3. Safeguarding policies, procedures and systems				

3.1	All staff (paid and volunteers) have access to safeguarding policies and procedures for both children and vulnerable adults: these policies must be easily accessible by staff at all levels and be consistent with statutory, national and local guidance.	- All policies and procedures must be reviewed at a minimum 2 yearly to evaluate their effectiveness and to ensure they are up to date and working in practice. - There should be local determination whether inclusion of the Mental Capacity Act is applicable to the provider.		
3.2	Safeguarding policy/procedures includes a process for recording and reporting concerns, suspicions and allegations of abuse or harm in line with LSCB and LSAB	[insert links]		
3.3	Safeguarding policy/procedures includes guidance on complaints and whistle blowing policies which offers a guarantee to staff and service users that using these procedures appropriately will not prejudice their own position or			

	prospects.			
3.4	Safeguarding policy/procedures includes guidance on how to respond to a disclosure from a child or a young person and or vulnerable adult.			
3.5	Safeguarding policy/procedures includes clear guidance on managing allegations against staff and volunteers working with children and vulnerable adults in line with policies and procedures of LSCB / LSAB.	[insert links]		
3.6	When it is known that a child is not accessing education a referral will be made to the Local Authority in which the child lives.	Information on missing education is available at; [insert link]		
4. Sexually Active Young People Under 18yrs (this standard relates only to those providing services to young people under 18 years)				
4.1	There is clear guidance for practitioners working with sexually active	[insert links]		

	children under 18 years which is in line with that of LSCB			
5. Domestic violence (including Honour Based Violence and Forced Marriage)				
5.1	The service/organisation takes account of national and local guidance to safeguard those children and adults experiencing domestic abuse.	[insert links]		
6. Information sharing				
6.1	Information sharing protocols in line with national and local guidance are in place within the practice.	- National guidance on information sharing can be accessed at: http://www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/informationsharing/informationsharing/		
7. Inter-agency working				
7.1	The service/organisation works with partners to protect children and vulnerable adults and participates in reviews as set out in statutory, national and local guidance	- the service will provide, when requested, information on their involvement with a child, family and adult at risk of abuse to inform the case discussion in relation to child /adult protection processes, Serious Case Reviews; Child Death Overview Processes, MARAC and MAPPA - the service contributes to the Common Assessment Framework (CAF) as required to do so and with the consent of the individual and or parent/carer.		
8. Safer Working practices				

8.1	Robust recruitment and vetting procedures are in place to help prevent unsuitable people from working with vulnerable adults and children.			
8.2	General guidance is provided to staff on appropriate behaviours when working with children and vulnerable adults in line with national and local guidance	- Detailed guidance on safe working practices for adults who work with children is available on the DCSF website at http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00311/		
9. Record keeping				
9.1	Staff who work with children and vulnerable adults record their work with the child and family in accordance with statutory and best practice guidance.	- All staff maintain an accurate, clear record of their involvement with the child and their family and vulnerable adults on a routine basis. - Where there are concerns about a child's welfare, all concerns, discussions about the child, decisions made and the reasons for those decisions must be recorded in writing in the child's /vulnerable adults records.		
10. Supervision and support to staff working with children, parents and carers and vulnerable adults				
10.1	Staff working directly with children and vulnerable adults have access to advice and support			
11. Staff training and continuing professional development				

11.1	Paid staff and volunteers in contact with children, adults who are parents/carers and vulnerable adults are trained and competent to be alert to the potential indicators of know how to act on those concerns in line with local guidance.	- The level of training an individual requires is dependent on their roles and responsibilities. For this reason training needs should be informed by training strategies of the LSCB / LSAB. [insert link] - Refresher training is undertaken at regular intervals (at a minimum 3 yearly)		
12. Proving safer activities and trips				
12.1 12.1 Cont	All service users are protected when taking part in activities and trips	The service organisation ensures that: - Paid staff and volunteers undertaking specialist roles (e.g. taking children, young people and vulnerable adults off site on trips) are provided with appropriate training; - All activities are risk assessed to ensure that all reasonable steps are taken to prevent children, young people and vulnerable adults being harmed whilst participating in the organisations/services activities; - Takes out employers' liability and public liability insurance to ensure that all activities and services and all people taking part are covered; - All activities being provided are properly planned and organised; - Checks the driver holds the correct driving licence, the vehicle has the correct insurance, tax, MOT, seats, seatbelts and a first aid box; - All computers used by young people are equipped with 'parent controls' to ensure safe internet use; - Staff are equipped to understand, identify and mitigate the risks of new technology		

Name and address of organisation:

Name of person completing audit tool:

Contact details:

Date audit tool completed

APPENDIX 9: Standards for care homes

NHS North West

Audit Tool to Monitor Safeguarding Standards for Care Homes
RAG rating Key:

Green		Fully compliant (remains subject to continuous quality improvement)
Amber		Action plans in place to ensure full compliance and progress is being made within agreed timescales
Red		Non-compliance against standards and actions have not been completed within agreed timescales

	Standard	Guidance and links to relevant LSCB/LSAB policies	Evidence	RAG
1. Clear lines of accountability for safeguarding adults at risk and children				
1.1	A safeguarding policy is in place which demonstrates commitment to safeguarding	– The policy makes it clear who has overall responsibility for the contribution to safeguarding including lines of accountability though to the person with ultimate accountability – The policy sets out key out clear priorities for safeguarding line with those of the LSAB. – The policy clearly states with whom staff should discuss and to whom staff should report any safeguarding concerns		
1.2	There is a named lead for safeguarding. Arrangements for cover are in place when this person is not available	– named lead must have had sufficient training and time to undertake this task, role to be covered in job description, and a clear understanding of the Safeguarding Adult Board procedures		

1.3	All staff (paid and volunteers) should know how to act on concerns that a vulnerable adult may have been abused, or is at risk of abuse or neglect in line with local guidance.	– All staff working under the auspices of the home must have safeguarding adults training and have a training update not less than every three years		
2. Governance arrangements / Quality Assurance				
2.1	The home is registered with the CQC	– The home is fully compliant with outcome 7 'Safeguarding people who use services from abuse': Essential standards for Quality and Safety (CQC 2010). Where a home is not compliant they will notify [insert contact] and inform them of agreed action plans in place		
2.2	The home regularly reviews safeguarding arrangements			
2.3	An incident reporting system is in place which identifies circumstances/incidents which have compromised the safety and welfare of patients /residents.	- All serious untoward incidents (SUI) compromising the safety and welfare of a patient funded by NHS South Sefton CCG is to be notified to [insert contact]. - All complaints that refer to the safety of patients are referred and investigated thoroughly		
2.4	A programme of internal audit and review is in place that enables the organisation/home to continuously improve the protection of all service users from abuse or the risk of abuse.	Audits of safeguarding arrangements to include progress on action to implement recommendations from: – Serious Case Reviews; Internal Management Reviews as a consequence of SUI's compromising the safety/welfare of service users; reports from national bodies e.g. Care Quality Commission		
2.5	Residents are aware of the procedures for reporting abuse and neglect	– The procedure is publicized in appropriate ways e.g. in resident induction, welcome packs, handbooks, notice boards, etc.		
3. Safeguarding policies, procedures and systems				

3.1	All staff (paid and volunteers) have access to safeguarding policies and procedures. Policies must be easily accessible by staff at all levels and be consistent with those of the LSAB	– Policies and procedures are updated regularly to reflect any structural and legal changes – Policies and procedures undergo an equalities impact assessment – Policies and procedures must be audited and reviewed at a minimum 2 yearly to evaluate their effectiveness and to ensure they are working in practice. – Policies and procedures to specifically consider adults in special circumstances, e.g. those with a disability, those who do not speak English as their first language – Policies should take account of the Mental Capacity Act [Insert link to LSAB policies]		
3.2	Safeguarding policy/procedures includes a process for recording and reporting concerns, suspicions and allegations of abuse or harm in line with those of LSAB			
3.3	Safeguarding policy/procedures includes guidance on how to respond to a disclosure of abuse.			
3.4	Safeguarding policy/procedures includes clear guidance on managing allegations against staff and volunteers			
3.5	There are robust complaints and whistle blowing policies/procedures in place	– A guarantee is provided to staff and service users that using the procedures appropriately will not prejudice their own position or prospects.		
3.6	There are clear procedures on the implementation and management	– Care Homes must have in place a procedure that identifies whether a deprivation of liberty is		

	of Deprivation of Liberty Safeguards in line with the Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice	or may be necessary; what steps are taken to assess whether to seek an authorisation; whether all practical and reasonable steps have been taken to avoid a deprivation of liberty; what action they should take if they do need to request an authorisation; how they review cases; and who should take the necessary action; – Care Homes must have in place a procedure that identifies what actions should be taken when an urgent authorisation needs to be made; who should take that action; and within what timescales. – Care Homes must have in place processes for reviewing deprivation of liberty and reducing the levels of restriction where reasonably possible		
3.7	The use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual	– The use of restraint should be discussed, agreed and documented in advance wherever possible; is used as a last resort and is the minimum response necessary for the shortest possible time, to make the individual and others as safe as possible. – Where restraint is used it is documented and followed by an assessment of the person restrained and others involved in the restraint for signs of injury and any emotional or psychological impact		
4. Information sharing				
4.1	There are agreed systems, standards and protocols for sharing information within the service and between agencies in accordance with national and local guidance	– staff understand what to do and when to share information if they believe a vulnerable adult is at risk of harm; – agency-specific guidance is produced to complement guidance issued by central government and training is made available to existing and new staff as part of their induction programme and ongoing training;		

		– managers are fully conversant with the legal framework and good practice guidance issued for practitioners		
5. Inter-agency working				
5.1	The organisation/home works with partners to protect vulnerable adults and participates in reviews as set out in local guidance	– Staff to provide, when requested, information on their involvement with a vulnerable adult to inform the case discussion in relation to multi-agency meetings including Serious Case Reviews; – Professionals who are invited to attend a multi-agency meeting in relation to a vulnerable adult must make every effort to attend and will submit a written report where requested to do so.		
6. Safer recruitment practices				
6.1	Robust recruitment and vetting procedures are in place to help prevent unsuitable people from working with vulnerable adults and children.			
6.2	Safeguarding responsibilities are reflected in all job descriptions relevant to role and responsibilities			
6.3	Staff involved in employing staff are trained in the processes of 'safer recruitment'			
7. Record keeping				
7.1	Staff working record their work in	– All staff maintain an accurate, clear record of		

	accordance with statutory and best practice guidance.	their involvement on a routine basis. The record is clear, accessible, comprehensive and contemporaneous with both judgments made and decisions taken carefully recorded. The record is dated, signed and the persons name legibly written at the end of the record entry; – Where there are concerns about an individuals welfare, all concerns, discussions held and decisions made and the reasons for those decisions must be recorded in writing in the individuals records;		
8. **Supervision and support**				
8.1	Staff working directly with vulnerable adults have access to advice support and supervision to enable them to manage the stresses inherent with this work			
9. Staff training and continuing professional development				
9.1	Paid staff and volunteers in contact with vulnerable adults and children are trained and competent to be alert to the potential indicators of abuse and neglect know how to act on those concerns in line with local guidance.	– The level of training an individual requires is dependent on their roles and responsibilities. For this reason training needs should be informed by Safeguarding Training Strategy of South SeftonSafeguarding Adult Board. – Records are kept of those accessing training – Refresher training is undertaken at regular intervals (at a minimum 3 yearly)		
9.2	Staff required to use restrictive physical interventions have received specialist training. Specialist training should include the legal duties enshrined in the Mental Capacity Act 2005	– Staff understand when different types of restraint are or are not appropriate, prioritizing de-escalation or positive behaviour support over restraint where possible – Know whether and what type of restraint should		

9.2 cont	(including the law relating to assault against a person) and national guidance on consent for examination or treatment.	be used in a way that respects dignity and protects human rights where possible – Understand that restraint should only be used as a last resort where it is necessary and proportionate, and that restraint used should be the least restrictive and for the minimum amount of time to ensure that harm is prevented and that the person, and others around them are safe – Clinical holding policy in place and should take account of what is expected in terms of risk assessment.		
10. Proving safer activities and trips				
10.1	All service users are protected when taking part in activities and trips	The organisation ensures that: – Paid staff and volunteers undertaking specialist roles (e.g. taking vulnerable adults off site on trips) are provided with appropriate training – all activities are risk assessed to ensure that all reasonable steps are taken to prevent adults being harmed whilst participating in the organisations activities – takes out employers' liability and public liability insurance to ensure that all activities and services and all people taking part are covered – that all activities being provided are properly planned and organised – checks that the driver holds the correct driving licence, the vehicle has the correct insurance, tax, MOT, seats, seatbelts and a first aid box.		

Name and address of Care Home: Name of person completing audit tool:

Contact details: Date audit tool completed:

Key Issues
Quality Committee

NHS
South Sefton
Clinical Commissioning Group

Meeting Date April 2014

Chair Craig Gillespie

Key Issues	Risks Identified	Mitigating Actions
1. HCAI Action Plan - Action Plan received which had been updated with local developments and be used as evidence for Q4 checkpoint assurance meeting. - Aintree would not be adhering to the Department of Health guidance for C-Diff as it believed the targets were clinically unjustifiable and had set their own internal targets.	• Nil	•
2. Francis Action Plan	• Nil	• All outstanding actions have been moved to green unless they are to be dealt with in future and remain amber. • It was agreed the plan would be re-presented every 4 months or sooner if required.
3. Corporate Risk Register - The register had been reviewed by the CCG Senior Management Team	• 11 risks were scored as high and one new risk ID26 had been added for the Q4 update.	• Miss Fagan explained the extreme risk regarding safeguarding had been identified in Q3. She was not happy reducing the risk

and also the Corporate Governance Support Group.	• Mr Gillespie commented there appeared to be one extreme risk and all others seemed reasonable with progress being made.	until all actions introduced were having effect and information from providers had been received in Q4
4. Governing Body Assurance Framework Update Q4 - The risk status was considered reasonable	• Nil	• Nil
5. Commissioner Assurance – provider cost improvement plans 2014/15	• NHSE(M) wrote to the CCG asking to see processes by way of assurance.	• The appendices showed draft measures which had been put in place so the provider could be monitored throughout the year as an early warning dashboard for GP clinical leads
6. The following Policies were all approved: - Equality and Diversity Policy - Harassment Policy - Retirement Policy - Secondment Policy - Travel Expenses Policy	• Nil	• Nil

Recommendations to the Governing Body
1. **The governing body is asked to receive this key issues log by way of assurance**

Key Issues
Quality Committee

NHS
South Sefton
Clinical Commissioning Group

Meeting Date	**May 2014**
Chair	**Craig Gillespie**

Key Issues	Risks Identified	Mitigating Actions
1. Provider performance reports - Aintree - Liverpool Community Health - Mersey Care - Mersey Providers	• Scrutiny of providers' quality and performance given by CCG Quality Committee	• Relevant providers to provide clarity and commentary on areas raised by Quality Committee • Areas requiring further clarification for providers where SS CCG are not lead commissioners, the CCG has consulted with other CCGs
2. Serious Incident Update	• Nil	• The CCG have in place robust mechanisms to manage ongoing Serious Incidents involving SS CCG providers and patients through strong collaborative arrangements. The Quality Committee is assured of these processes
3. NHSE 2013/14 annual complaints by CCG - It was noted the CCG appeared comparable with other CCGs	• Nil	• Nil

Recommendations to the Governing Body
1. **The governing body is asked to receive this key issues log by way of assurance**

Key Issues
Quality Committee

NHS
South Sefton
Clinical Commissioning Group

Meeting Date	**June 2014**
Chair	**Craig Gillespie**

Key Issues	Risks Identified	Mitigating Actions
1. **Safeguarding Review**	• CCG in collaboration to re-examine the safeguarding process for the purpose of identifying the next steps required to make improvements.	• CCG Chief Officer will chair a Safeguarding Review Group across the CCG Network.
2. **Joint workshop with the Local Authority to consider the integrated approach to Continuing Healthcare** - Session in July will consider packages of care, before a third workshop will include provider colleagues joint workshop with the Local Authority to consider the integrated approach to Continuing Healthcare. Merseyside will form part of the new pilot around Continuing Healthcare assurance.	•	•
3. **Safeguarding service quarterly assurance report** - The Safeguarding Children Policy is anticipated to be operationalised by July 2014.	• The mandatory training already undertaken by CCG around safeguarding is still valid, however, the current programme will not be fit for purpose beyond this point in time.	• The new training will be available shortly.

4. **Mental Capacity Act, Deprivation of Liberties report**	• The definition of deprivation of liberty has been expanded and clarification is pending on the implementation thereof. Some training will be required at both Protected Learning Time and for the Governing Body.	• It was agreed that when the clarity is available, which is expected at the end of June, this will be brought back to the Committee for further consideration
5. **Research strategy –** Approved by committee	•	•
6. **Complaints policy–** Approved by committee	•	•

Recommendations to the Governing Body
1. **The governing body is asked to receive this key issues log by way of assurance**

Key Issues Report to Governing Body
July 2014

NHS
South Sefton
Clinical Commissioning Group

Audit Committee Meetings held on 3rd June and 10th July 2014	Chair: Graham Morris

Key Issue	Risk Identified	Mitigating Actions
Consultation on Auditor Appointment	Potential for different external auditors to be appointed to each CCG	• FLC has written to Audit Commission requesting that both CCGs have the same External Auditor.

Information for South Sefton CCG Governing Body
• Annual Governance Statement signed off
• Annual Accounts signed off
• Annual Report signed off
• External Audit Report
• Received Annual Audit Committee Letter
• SIRO Briefing Report received

Key Issues
Finance and Resource Committee

NHS
South Sefton
Clinical Commissioning Group

Meeting Date	**22/05/2014, 19/06/2014**
Chair	**Roger Driver**

Key Issues	Risks Identified	Mitigating Actions
1. No issues to report	•	•
2.	•	•
3.	•	•

Information update to the Audit Committee
1. The CCG is on target to achieve the planned £2.300m surplus at the end of the year
2. Annual IFR Report received – current approval rate 22%
3. Quality Premium dashboard -), South Sefton CCG should receive a payment in 2014/15 of £460,519 against a total possible payment (if all indicators were within tolerance) of £736,830
4. PMO Programme Update – all programmes on target

NHS
South Sefton
Clinical Commissioning Group

Audit Committee
Minutes

Thursday 1 May 2014, 1.30pm to 3.00pm
Boardroom, Merton House

Attended		
Graham Morris	Lay Member (Chair)	GM
Lin Bennett	Practice Manager	LB
In Attendance		
Martin McDowell	Chief Finance Officer	MMD
Debbie Fagan	Chief Nurse	DF
Ken Jones	Chief Accountant	KJ
Tracy Jeffes	Head of Corporate Delivery and Integration	TJ
Roger Causer	Local Counter Fraud Specialist, (MIAA)	RC
Adrian Poll	Audit Manager, MIAA	AP
Rachael McIlraith	Audit Manager, Price Waterhouse Coopers	SB

	Item	
A14/19	**Apologies for absence** Apologies for absence were received from Roger Driver and Tracy Jeffes	
A14/20	**Declarations of interest** Declarations of interest were made by CCG Officers who hold dual posts at both South Sefton and Southport and Formby CCGs.	
A14/21	**Advance Notice of items of other business** There was no advance notice of other business.	
A14/22	**Minutes of the Previous Meeting** The minutes of the previous meeting were approved as a true and accurate record.	
A14/23	**Action Points from Previous Meeting** The action notes from the previous meeting were closed as appropriate.	
A14/24	**Review of Conflicts of Interest Register** The Chair referred the committee to the register of conflicts of interest. The committee noted that the register requires updating to include new Governing Body members	D Fairclough
A14/25	**Unaudited Annual Accounts (Draft)** KJ presented the unaudited Annual Accounts and invited the Audit	

	committee to comment as desired. KJ drew attention to the Better Payment Practice Code and MMcD confirmed that the finance team have ensured the appropriate payment runs have continued during the year end close down. KJ will provide performance information to the committee. KJ drew attention to Note 42. This note will be appropriately highlighted in the Annual Report. GM thanked MMcD, KJ and the Finance Team for their work on the annual for his work and detailed report. MMcD advised the Committee that if they wanted to make any amendments to the Annual Report these should be submitted via Lyn Cooke to maintain version control. **The Audit Committee noted the Unaudited Annual Accounts (Draft).**	
A14/26	**Local Counter Fraud Annual Report and work plan for 2014/2015** **The Local Counter Fraud Annual Report 2013/14** RC presented summary of the Annual Report and asked the committee to note the work in the initial year which has focused on the establishment of a sound platform to secure a strong anti-fraud culture. RC updated the committee as to completed actions including reinforcing the counter fraud message to all staff. GM requested a comparison to how the position of South Sefton CCG compares with other CCGs. RC confirmed that South Sefton CCG is in a comparable position with other CCGs. He confirmed that to date South Sefton CCG has had no Counter Fraud Investigations. GM noted that the review of Conflicts of Interest Register had been completed; this will be circulated to all members of the committee. **The Audit Committee noted the Local Counter Fraud Annual Report.** **Local Counter Fraud Work Plan 2014-2015** RC presented the Local Counter Fraud Work Plan for 2014-15 and noted the four key areas. The Committee noted that the Local Counter Fraud Team would be following up on advice given to ensure appropriate action had been taken. The Committee noted that the plan allowed for flexibility in the event that the Crime Standards proposed by NHS England are published. Amendments to the plan will be brought to Audit Committee for approval. The Audit Committee noted that CHC is considered to be a significant risk for fraud particularly in the light of the CSU merger. MMcD thanked RC and the Local Counter Fraud Team for their work to date, the annual report and the draft work plan for 2014/15. **The Audit Committee approved the 25 days Local Counter Fraud Work Plan and approved the fee of £8,000.**	**MMcD**
A14/27	**Internal Audit** **AP presented the Internal Audit reports as listed below.** **a. MIAA Progress Report** AP noted that all audits had proceeded in line with plan and had achieved significant assurance. Action plans have been drafted as appropriate and these will be monitored by the Audit on a composite report compiled by D Fairclough.	

	The Audit Committee noted the MIAA Internal Audit Progress Report **b. MIAA Draft Audit Opinion** AP presented the Draft Audit Opinion and noted that overall Significant Assurance can be given and 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 design or inconsistent application of controls put the achievement of particular objective at risk. **The Audit Committee noted the MIAA Draft Audit Opinion**. c. **MIAA Draft Plan 2014/15** AP presented the draft work plan for 2014/15 and noted the key areas. The committee were advised by AP that the plan is flexible and that MIAA Internal Audit is able to respond quickly as required. The Audit Committee approved the MIAA Draft Plan for 2014/15 and the fee of £24,000. MMcD commented that this was pleasing outcome for the CCG with significant assurance ratings for all audits. The Committee were assured that any issues identified will be addressed. MMcD thanked AP and his team for their work over the past year, and the reports submitted. AP thanked the CCG for accommodating the Audit Team so readily and providing their co-operation. AP further noted that in terms of degree this is a "high-end" significant assurance. GM commented that that this is a satisfactory outcome to the audit but noted that CSU Contract Management will not feature until 2015/16. MMcD explained that this was due to the current reorganisation of services that the CCG requires the CSU to perform and the outcome of the merger with Manchester CSU. **The Audit Committee approved the draft MIAA Internal Audit Work Plan and approved the fee of £24,000.**	
A14/28	**External Audit Progress Report** RMcI gave a verbal progress update in relation to external audit. The Committee noted that PWC officers were currently on site at the CCG. The Audit is currently progressing and is expected to result in a satisfactory outcome. **The Audit Committee noted the External Audit Progress Report**	
A14/29	**Legacy Balances – Update** KJ updated the committee in relation to legacy balances. The committee noted that there are a small number of fixed assets. CHC restitution payments are currently being dealt with by NHS England and will be resolved as appropriate from a central funding pool. MMcD updated the Audit Committee on the current situation and will continue to update the Governing body. **The Audit Committee noted the verbal update on Legacy Balances**.	
A14/30	**2014/15 Committee Work Schedule – revised** The Chair of Audit Committee referred the committee to the revised Committee Work Schedule circulated in advance. The work schedule will be amended to reflect the Local Counter Fraud Annual Report.	

	The Audit Committee noted the revised Committee Work Schedule.	
A14/31	**2014/15 Meeting Dates – revised** The Chair of Audit Committee referred the committee to the revised meeting dates circulated in advance. **The Audit Committee noted the revised meeting dates**.	
A14/32	**Information Governance Toolkit** MMcD presented this report to the committee - based on the assurance received from CMCSU this has been signed off at Level 2. GM requested as to where the CCG is in comparison to other CCGs. MMcD confirmed that South Sefton CCG is in a comparable position to other CCGs. **The Audit Committee noted the CCG compliance with Level 2 of the IG Toolkit.**	
A14/33	**CMCSU Report** KJ/MMcD presented this report. The Committee noted the report in relation to CMCSU readiness to provide the services that it is contracted to do. The committee raised concerns in relation to a number of outstanding actions and the timeframe for resolution, and the merger with Manchester CMCSU. RMcI noted External Audit are not reliant on this report for assurance and will carry out appropriate audit activity to provide the necessary assurance for the CCG and Audit Committee The Audit Committee requested the MMcD advise the relevant parties at the CSU of their concerns in relation to the report. MMcD noted that if any issues arise during the audit they will be escalated to Carol Hill at the CSU. **The Audit Committee noted the CMCSU Report which raised a number of concerns. MMcD, KJ and TJ will consider this through the performance meeting with CMCSU.**	**MMcD/KJ/TJ**
A14/34	**Annual Audit Committee Report** The Chair presented the Annual Audit Committee report which is included in the CCG Annual Report and will be submitted to the Governing Body. GM requested that the Draft Internal Audit Opinion be added to the Annual Audit Committee report. Two minor amendments in relation to attendance were noted and will be rectified. GC requested that the committee forward any comments in relation to the report to him by 9th May 2014. **The Audit Committee noted the Annual Audit Committee Report.**	
A14/35	**Self-assessment of committee effectiveness** GM referred the committee to the National Audit Office Self-Assessment of Effectiveness. GM proposed that this survey is not used and that alternatives should be sought. RMcI/AP will supply sample surveys to GM. GM will compile a composite survey appropriate to the needs of the CCG **The Audit Committee noted the self-assessment of committee effectiveness.**	AP/PMcI/GM
	Review of losses and special payments, tender waivers, aged debt	

A14/36	**and declarations of interest** KJ referred the committee to the nil return report circulated in advance. KJ advised the committee that there are some claims in the system in relation to CHC including some claims for mal administration. The CCG has been recommended to make small payments in relation to one of these claims for less than £500. Appropriate legal advice is being sought and followed. **The Audit Committee noted that there were no losses, special payments, tender waivers, aged debt or declarations of interest to report**.	
A14/37	**Changes to Standing Orders, SFI's, Accounting policies.** MMcD referred the committee to the draft accounting policies that had been previously approved in conjunction with the Chair of the Audit Committee. The amended policies will form part of the annual accounts. **The Audit Committee noted the draft accounting policies**	
A14/38	**Receive updates of other committees and review business inter-relationships** **Finance & Resources Committee** The Audit Committee noted the key risks and issues log from Finance and Resource Committee **Quality Committee** The Audit Committee noted the key risks and issues log from Quality Committee. DF noted the absence of risk and issue logs for March and April 2014 and gave a verbal update. DF commented that the Francis Action Plan including current status of actions will be submitted to the Governing Body for information in May 2014.	
A14/39	**Any other business** There was one items of other business. MMcD noted, that following the correspondence sent to all Governing Body members, which was raised at the Board Development Session all Governing Body members are required to take the necessary steps to appraise themselves with any audit issues and make approach to Governing Body as appropriate. **The Committee noted the requirement of the Governing Body Members**.	
A14/40	**Review of meeting** MMcD noted, that following the correspondence sent to all Governing Body members, which was raised at the Board Development Session all Governing Body members are required to take the necessary steps to appraise themselves with any audit issues and make approach to Governing Body as appropriate.	
	Date and time of next meeting: **Tuesday 3rd June 2014 3rd Floor Merton House 11.00am – 1.00pm**	

NHS
South Sefton
Clinical Commissioning Group

Audit Committee
Minutes

Tuesday 3 June 2014 11.00am to 1.00 pm
Boardroom, Merton House

Attendees		
Graham Morris	Lay Member (Chair)	GM
Roger Driver	Lay Member	RD
Lin Bennett	Practice Manager	LB
Dr Dan McDowell	Secondary Care GP	DMcD
In Attendance		
Fiona Clark	Chief Officer	FLC
Martin McDowell	Chief Finance Officer	MMD
David Bacon	Interim Deputy Chief Finance Officer	DB
Debbie Fagan	Chief Nurse	DF
Ken Jones	Chief Accountant	KJ
Rachael McIlraith	Audit Manager, Price Waterhouse Coopers	SB
Pippa Scarrett		

	Item	Lead
A14/41	**Apologies for absence** Apologies for absence were received from Tracy Jeffes.	
A14/42	**Declarations of interest** Declarations of interest were made by CCG Officers who hold dual posts at both Southport and Formby and South Sefton CCGs.	
A14/43	**Advance Notice of items of other business** There was no advance notice of other business.	
A14/44	**Minutes of the Previous Meeting** The minutes of the previous meeting were approved pending one minor amendment.	
A14/45	**Action Points from Previous Meeting** Action points from the previous meeting were deferred until the meeting in July 2014.	
A14/46	**Approval of Annual Report** An extensive discussion took place in relation to the Annual Report and Annual Accounts. A number of amendments were agreed and will be implemented prior to sign off.	

	RMcI was invited to comment on amendments which were unanimously agreed by the committee. **1. Annual Governance Statement** **The Audit Committee approved the signing of the Annual Governance Statement.** **2. Annual Accounts** **The Audit Committee approved the signing of the Annual Accounts.** **3. Annual Report** **The Audit Committee approved the signing of the Annual Report.**	
A14/47	**External Audit Report** RMcI presented the ISA 260 Report and noted that ***We have completed our audit of the CCG's accounts in accordance with auditing standards, subject to the following outstanding matters:*** • ***approval of the financial statements and letters of representation;*** • ***evidence to support the statement that payments to GP members are not pensionable;*** • ***receipt of CSU ISAE 3402 report;*** • ***related parties note; and*** • ***completion procedures, including going concern and subsequent events review and completion of director and manager file reviews.*** ***Subject to the satisfactory resolution of these matters, the finalisation of the financial statements and their approval*** **by those charged with governance, we expect to issue an unqualified audit opinion** In addition RMcI noted that ***"On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission on 15 October 2013, we have no matters to report with respect to whether, South Sefton CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014".*** The Committee were further advised by RMcI that in relation to GP Pension disclosure the CCG has chosen to interpret the relevant guidance as not requiring disclosure. PWC are comfortable with this interpretation, however, cautioned the Audit Committee that this guidance may be more explicit next year and may require full disclosure. RMCI thanked MMcD and the team at the CCG for their continued co-operation during the audit. **The Audit Committee noted the content of the External Audit Report.**	
A14/48	**Letter of Representation** **The Committee noted one amendment to be made to the letter of representation and authorised the Chief Finance Officer to sign the letter.**	
A14/49	**Any other business** **There were no items of other business.**	

	Date and time of next meeting: **9.30am – 11.00am** **Thursday 10 July 2014 Boardroom Merton House Bootle**	

Quality Committee
Draft Minutes

Date: 17 April 2014, 3.00pm to 5.00pm
Venue: Boardroom, 3rd Floor, Merton House

Present		
Dr Craig Gillespie	GP Governing Body Member (CHAIR)	CG
Dr Gina Halstead	GP Quality Lead	GH
Mrs Lin Bennett	Practice Manager Governing Body Member	LB
Roger Driver	Lay Member	RD
Dan McDowell	Secondary Care Doctor	DMcD
Malcolm Cunningham	Head of Primary Care & Corporate Performance	MC
Debbie Fagan	Chief Nurse	DF
Dr Debbie Harvey	Clinical Lead for Integrated Care	DH
Martin McDowell	Chief Finance Officer	MMcD
In attendance		
James Hester	Programme Manager Clinical Quality & Safety	JH
Apologies		
Dr Andy Mimnagh	GP Governing Body Member	AM
Dr Sunil Sapre	GP Locality Lead - Maghull	SS
Fiona Clark	Chief Officer	FLC
Steve Astles	Head of CCG Development	SA
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Helen Smith	Head of Adult Safeguarding	HS
Ann Dunne	Designated Nurse Safeguarding Children	AD
Tracey Forshaw	Designated Nurse Safeguarding Adults	TF
Minutes		
Jayne Byrne	Officer Manager/PA to Chief Nurse	

	Item	Action
14/40	**Apologies for absence** were noted.	
14/41	**Declarations of interest** Officers holding dual roles in both South Sefton and Southport and Formby CCGs declared their interest.	
14/42	**Minutes of the previous meeting** The minutes were accepted as an accurate record of the previous meeting.	
14/43	**Matters arising/action tracker** *14/18 Francis Action Plan* – remove from tracker. Miss Fagan gave the Committee an update on items contained in the previous minutes. *14/33 reporting of serious incidents* – a meeting had been arranged with Merseycare/RGP clinical leads/CCG to discuss SI reporting within the Trust. *14/40 looked after children medicals* – Miss Fagan reported the CCG had been able to de-escalate this concern in Sefton because the number of children was less than anticipated.	

	Item	Action
14/44	**Chief Nurse Report** *p20 of 167 – Section 3 Research* - the Deputy Chief Nurse had completed the draft of the Research Strategy which will be presented to the Quality Committee in June. *p22 of 167 – Section 8 Sefton Corporate Parenting Board* – Miss Fagan presented a paper on CAMHS to the Corporate Parenting Board, which was in the process of completing a service specification for Tier 3 and the children's element of the Sefton mental health strategy jointly with the Council. *p22 of 167 Section 12 – CMCSU provision of commissioning support re CHC* – Miss Fagan reported NHSE were launching a draft assurance framework around CHC that they wanted to pilot within one area team. The CCG will have to provide evidence back to NHSE around assurance in relation to CHC and Miss Fagan had been in contact with CMCSU colleagues. Miss Fagan had spoken to Tina Wilkins whose team had done some process mapping/service transformation around CHC and she was hoping to hold a joint event between the Council and the CCG in the next 6 weeks or so regarding the integration agenda and future local pathways.	
14/45	**HCAI Action Plan** The Committee was asked to receive the Action Plan which had been updated with local developments and be used as evidence for Q4 checkpoint assurance meeting. It was noted that Aintree would not be adhering to the Department of Health guidance for C-Diff as it believed the targets were clinically unjustifiable and had set their own internal targets.	
14/46	**Safeguarding Report** Miss Fagan had included an update within the Chief Nurse Report.	
14/47	**Francis Action Plan** Mr Hester presented an updated version of the action plan and directed the Committee to p45 of 167, the report's 9 recommendations from the Government's report. All outstanding actions have been moved to green unless they are to be dealt with in future and remain amber. The complaints policy would be presented at the next Quality Committee meeting. Sallyanne Hunter currently ratifying. It was agreed the plan would be re-presented every 4 months or sooner if required.	

	Item	Action
14/48	**Corporate Risk Register** Miss Fagan presented the register in Mrs Jeffes' absence. The register had been reviewed by the CCG Senior Management Team and also the Corporate Governance Support Group. 11 risks were scored as high and one new risk ID26 had been added for the Q4 update. Mr Gillespie commented there appeared to be one extreme risk and all others seemed reasonable with progress being made. Miss Fagan explained the extreme risk regarding safeguarding had been identified in Q3. She was not happy reducing the risk until all actions introduced were having effect and information from providers had been received in Q4. *p63 of 167* - the Committee received the report and approved the recommendation to remove risks ID9, ID13, ID16 and ID19 from the Register.	
14/48	***Governing Body Assurance Framework Update Q4*** The risk status was considered reasonable, however, the different format of the corporate risk register and the governing body assurance framework documents had caused some confusion and it was suggested the author should be invited to the next meeting to explain the format. The Committee received the report.	TJ
14/49	**Commissioner Assurance – provider cost improvement plans 2014/15** NHSE(M) wrote to the CCG asking to see processes by way of assurance. JH was working with Karl McCluskey to develop internal processes and this paper highlighted that process. The appendices showed draft measures which had been put in place so the provider could be monitored throughout the year as an early warning dashboard for GP clinical leads. It was intended the paper should be presented to the Quality Committee on a quarterly basis. No questions or comments were received. The process was approved.	
14/50	**Corporate Governance Support Group – Key Issues Report** *p99 of 167* – this paper was disregarded as it referred to Southport and Formby. It was noted the Corporate Risk Register had been approved without the support of this document.	
14/51	**EPEG – Key Issues Report** EPEG met w/e 11th April, but due to timescales April's meeting wasn't recorded. Providers as well as NHSE would be attending EPEG meetings in the future so information was received and could be used immediately.	
14/52	The Committee were asked to approve the following standardised policies in accordance with the CCG's Constitution.	
14/52	**Equality and Diversity Policy** Approved subject to minor amendment to p6 – the yellow highlighted text should read "Finance & Resource Committee".	
14/53	**Harassment Policy** Approved subject to minor amendment to p117 – the yellow highlighted text should read "Chief Officer".	

	Item	Action
14/54	**Retirement Policy** Approved.	
14/55	**Secondment Policy** Approved subject to minor amendment to Appendix 1 points 1 and 3 – change "host organisation" to "South Sefton CCG". Mr Driver asked what had been agreed at the Southport and Formby CCG Quality Committee meeting. Miss Fagan confirmed a decision would be made at the next meeting on Wednesday 23rd April.	
14/56	**Travel Expenses Policy** Approved.	
14/57	**Any Other Business** It was noted that several Leads were missing and the Chair asked for a deputy to be nominated for future meetings. Miss Fagan informed the Committee that Bernie Cuthel, Chief Executive of Liverpool Community Health NHS Trust and Helen Lockett, Director of Operations/Executive Nurse were leaving. An interim Chief Executive, Sue Page, had been appointed pending the recruitment of a permanent new Chief Executive and an interim Director of Operations/Executive Nurse would be appointed within the next two weeks. Meanwhile, Marie Crofts, Deputy Director of Operations/ Executive Nurse would take over lead responsibility for Operations and Nursing. Patient Safety Incident – Fri 11th – an action plan had been asked for.	
14/58	**Date of next meeting** Thursday 22nd May 2014 3.00pm – 5.00pm Boardroom, 3rd Floor, Merton House	

NHS
South Sefton
Clinical Commissioning Group

Quality Committee
Draft Minutes

Date: 22 May 2014, 3.00pm to 5.00pm
Venue: 3rd Floor Boardroom, Merton House

Present		
Dr Craig Gillespie	GP Governing Body Member (CHAIR)	CG
Dr Gina Halstead	GP Quality Lead	GH
Dr Debbie Harvey	Lead Clinician for Strategy & Innovation	DH
Dr Andy Mimnagh	GP Governing Body Member	AM
Roger Driver	Lay Member	RD
Dan McDowell	Secondary Care Doctor	DMcD
Sharon McGibbon	Practice Manager Governing Body Member	SMcG
Debbie Fagan	Chief Nurse & Quality Officer	DF
Also in attendance		
James Hester	Programme Manager – Quality	JH
Jo Simpson	Quality and Performance Manager, CMCSU	JS
Jayne Byrne	Minutes	JB
Apologies		
Lin Bennett	Practice Manager Governing Body Member	LB
Steve Astles	Head of CCG Development	SA
Fiona Clark	Chief Officer	FLC
Malcolm Cunningham	Head of Primary Care & Contracting	MC
Martin McDowell	Chief Finance Officer	MMcD

Membership Attendance Tracker

Name	Title	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr Craig Gillespie	Chair and GP Governing Body Member	√	√										
Dr Andrew Mimnagh	GP Governing Body Member	A	√										
Dr Gina Halstead	GP Quality Lead	√	√	A									
Dr Dan McDowell	Secondary Care Doctor	√	√										
Roger Driver	Lay Member	√	√										
Lin Bennett	Practice Manager Governing Body Member	√	A										
Fiona Clark	Chief Officer	A	A										
Steve Astles	Head of CCG Development	A	A										
Malcolm Cunningham	Head of Primary Care & Contracting	√	A										
Debbie Fagan	Chief Nurse & Quality Officer	√	√										
Dr Debbie Harvey	Lead Clinician for Strategy & Innovation	√	√	A									
Martin McDowell	Chief Finance Officer	√	√										

✓ Present
A Apologies
L Late or left early

No	Item	Action
14/59	**Apologies for absence** were noted as above.	
14/60	**Declarations of interest regarding agenda items** Members holding dual roles in both South Sefton and Southport & Formby CCGs declared their interest.	
14/61	**Minutes of the previous meeting** The minutes were accepted as a true record of the previous meeting once the amendment was made to: *P2 of 92 - 14/43 – 14/40 looked after children medicals* – Miss Fagan asked for the sentence to be amended and would speak to Ms Byrne re alternative wording. *P5 of 92 – 14/55 Secondment Policy* – Miss Fagan confirmed the policy had been approved at the Southport & Formby Quality Committee on Wednesday 23rd April 2014.	JB
14/62	**Matters arising/action tracker** *13.128 Corporate Governance Support Group Key Notes* – Mr Hester had confirmed this was on the agenda of the next Corporate Governance Support Group meeting on 8th July and Miss Debbie Fairclough would be able to report back to the Quality Committee scheduled for 24th July.	DFai
14/63	**Planned content of future provider performance reports** Miss Fagan confirmed the report was deferred until the next internal meeting in June as further discussions had taken place around duplication of data in the contract performance and quality reports.	DF/JS
14/64	**Provider performance reports** Miss Fagan reported that more data was required in relation to Liverpool Community Health (LCH) and Mersey Care and had actioned Miss Simpson to address. Miss Fagan had identified performance queries in to RLUH which she had asked Miss Simpson to raise with Liverpool CCG. In addition, Mr Hester would attend RLUH quality contract meetings to represent the CCG quality team. *Aintree* *A&E* - experiencing numerous well-documented difficulties, but they were trying to achieve targets. The contract query regarding A&E had been closed but was still being monitored closely. They had achieved the target by including Kirkby Walk In Centre, which had to be included as all A&E activity had to be recorded contractually so there was no way of excluding it. Miss Fagan confirmed Aintree had been red RAG-rated for the first month of the new financial year and Steve Astles was supporting Dr Mimnagh as Clinical Lead in working with the Trust. *Scrutiny of re-admissions* – an incident relating to a re-admission within 7 days was highlighted by Mr Driver. It was agreed to discuss the detail outside of the meeting so it could be raised at the next CQPG meeting to be reviewed at an operational level; possibly should have been identified as a serious incident. *Choose and Book Slot Utilisations* – this related to a small number of specialities where slots weren't offered as there had been difficulties in recruiting staff, although most specialities had now been filled. Aintree were currently using the number of appointments made by telephone call to indicate their 'failure' rate which was believed to be underestimating the figure as it didn't include patients who were referred to other Trusts. Dr Mimnagh pointed out there were no physiotherapy 'Choose and Book' slots except AQP, which were being inappropriately used – Dr Halstead/Miss Simpson to query with Aintree.	JS JH GH/RD GH/JS

No	Item	Action
14/64	*National Dementia CQUIN* – struggling to identify patients who are at risk of dementia by questioning them/their carer or conducting an assessment, but were good at referring everyone who had an assessment indicating they had dementia to the correct services. It was acknowledged that Trusts across the country had also had a lot of difficulty in delivering this target. Financial penalties would continue to be included in the CQUIN. *Advance in Quality (AQuA) CQUINS* – patients attending at the Medical Assessment Unit (MAU) were showing up on their dashboard figures for AQ. Aintree were aware of the problem. *Heart Failure* – they had failed the CQUIN target but were trying to improve their discharge process by including an interview with a student nurse. *Stroke* – they were improving but had failed the AQ target for the year. *MRSA* – there had been a constructive meeting between Dr Halstead, Miss Fagan and the Director of Nursing and Director of Medicine to discuss the 2 or 3 cases of MRSA last year, one of which was the same patient twice. Being dissatisfied with the way in which the analysis of the patient's care had taken place, a selection of South Sefton GPs had also reviewed the case notes, were still not assured and this had been raised with Richard Ward and would be monitored closely. *CQC Intelligence Tool* – CQC had visited Aintree in March and published their final report on 16th May 2014. Miss Fagan informed the committee that following a Risk Summit, they had been rated overall as 'good' for their acute services. All the other sub categories were also rated 'good' with the exception of leadership, where improvement was still required. *Complaints Management* – concern regarding management of complaints patients were unsure about how to make complaints - refer to EPEG for further investigation. *Patients Breaching Cancer Rates* – Dr Harvey reported quarterly meetings were now being held with key people at Aintree to review all cancer breaches which would reveal why the breaches were happening, any common themes and what action had been taken. *HCAI Contract 2014/15* – the Department of Health had suggested that local requirements could be made by CCGs although hospitals now had to adhere to national contracts. Aintree have set an internal target of 37 and Dr Halstead had confirmed that once the target of 37 has been reached they would be subject to far greater scrutiny even though a contract query couldn't be raised. *Provider Performance Reports* - Miss Simpson confirmed the proposal for future provider performance reports would be presented at June's internal meeting of the Quality Committee. *LCH* – the recent Collaborative Forum had discussed the CQC findings and was concerned no action plan had been received. Fiona Clark, SSCCG Chief Officer, Paula Finnerty, LCCG and Gaynor Hales, NHSE had visited LCH and met with LCH's Exec Team to outline what was expected from a commissioning viewpoint and how they would be performance monitored going forward. One of the big issues was their reporting of pressure ulcers. A meeting had been held and an aggregated review conducted. Miss Fagan would be working with GP Clinical Leads to review and feed back to the committee. *South Sefton Quality Report* *C-Diff* – Miss Fagan reported that the CCG had breached their full year objective, but a successful workshop had been held to look at the patient journey and the development of a common RCA tool across acute, community and primary care services.	DF JS DF

No	Item	Action
14/64	Dr Gillespie wondered if clinicians should be encouraged to embed prescribing behaviours in the way it was last year to aid a reduction in rates as he noted if results for the previous 5 months had been replicated all year we would have hit the target. Mr Prescott, Deputy Chief Nurse, to review the contractual position with Steve Astles, Head of SSCCG Development and also ask CSU to provide data analysis to compare prescribing activity for other providers (out of hours would come under this) and report back to the meeting in July so the committee could make recommendations. *Groin/hernia/knee/hip replacement* – Miss Simpson confirmed CSU was currently reviewing Patient Reported Outcome Measures (PROM) data and would report back to the next meeting. *Stroke* - Dr Gillespie noted the results for stroke performance. Dr Halstead to raise the issue at the CQPG as she didn't get sight of some results, eg length of stay. Miss Fagan asked clinical leads to liaise with Miss Simpson for any additional information and Mr Hester would ensure they were added as an agenda item at LCCG. Dr Mimnagh was concerned about the number of red ratings in Mersey Care's report. Miss Fagan assured the committee Mr Hester would be representing the quality team at all Mersey Care CQPG meetings. *S&O* *MSA breaches* – high number of breaches this year which had been raised at the S&O Contract and Quality meeting. Miss Simpson referred back as insufficient information had provided. S&F CCG exploring contract. *Friends & Family* – referred to EPEG as not performing well. Suggested they get in touch with Aintree as an example of good practice regarding the texting service have introduced. *S&O biopsies* – meetings attended by quality team, no patients affected. *Alder Hey* – Wendy Hewitt reported that an action plan was presented at a CQPG meeting the previous day which was an update on progress achieved following a review in December instigated by NHSE.	BP JS GH JS/JH
14/65	**GP Quality Lead Report** Nothing additional to report.	
14/66	**Serious incidents and never events update** Aintree – 41 SI open, 27 occurred in last year. Practice nurses need to be involved in SI discussions.	JH
14/67	**NHSE 2013/14 annual complaints by CCG** It was noted the CCG appeared comparable with other CCGs. *P75 of 99* – first paragraph made reference to the "Knowsley area" and *p79 of 99* detailed "Knowsley Primary Care Complaints Report" – clarification needed from NHSE.	DF

14/68	**Go To Doc complaints (referred by EPEG)** *p86 of 99* - Complaint 2 - Dr Cauldwell, GP Governing Body Member and Chair of SFCCG Quality Committee, to provide written clinical response regarding concern over end of life care. Complaint 3 – Dr Craig Gillespie, GP Governing Body Member and Chair of SSCCG Quality Committee to provide clinical opinion regarding misinformation provided to a patient as it was a South Sefton issue. *Out of Hours Service* - Mr Cunningham to review whether doctors are contracted to make urgent visits between 6am and 8am. Mr McDowell stated that all GPs had a contractual responsibility to report on the Out of Hours Services from 1st April 2014. The Bank Holiday advice line message to be reviewed as it had stated surgeries should be contacted.	MC MC MMcD
14/69	**Minutes of Corporate Governance Support Group meeting 3rd April 2014** – content noted.	
14/70	**Locality Update** Nothing to report.	
14/71	**Any other business** *Provider Quality Accounts* - a presentation to South Sefton, Southport & Formby and West Lancs CCGs was scheduled for the following week.	
14/72	Date of next meeting Wednesday 18th June 2014 3.00pm – 5.00pm Family Life Centre, Southport	

Future Agenda Items

Item	Lead	Date
Operational Governance Group Key Notes	Debbie Fairclough	July 2014

NHS
South Sefton
Clinical Commissioning Group

Quality Committee
Minutes

Date: Thursday 19 June 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
Roger Driver	Lay Member	RD
Fiona Clark	Chief Officer	FLC
Debbie Fagan	Chief Nurse & Quality Officer	DF
Martin McDowell	Chief Finance Officer	MMcD
Steve Astles	Head of CCG Development	SA
Lin Bennett	Practice Manager Governing Body Member	LB
Also in attendance		
Ann Dunne	Designated Nurse Safeguarding Children	AD
Karen Garside	Deputy Designated Nurse Safeguarding Children	KG
Margie Daw	Designated Nurse Safeguarding Children	MD
Sarah Stevenson	GP	SS
James Hester	Programme Manager – Quality	JH
Brendan Prescott	Deputy Chief Nurse	BP
Linda Williams	Edge Hill University	LW
Apologies		
Malcolm Cunningham	Head of Primary Care & Contracting	MC
Dr Gina Halstead	GP Quality Lead	GH
Dr Debbie Harvey	Lead Clinician for Strategy & Innovation	DH
Dr Dan McDowell	Secondary Care Doctor	DMcD
Minutes		
Melanie Wright	Business Manager	

Membership Attendance Tracker

Name	Title	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr Craig Gillespie	Chair and GP Governing Body Member	√	√										
Dr Andrew Mimnagh	GP Governing Body Member	A	√										
Dr Gina Halstead	GP Quality Lead	√	√	A									
Dr Dan McDowell	Secondary Care Doctor	√	√										
Roger Driver	Lay Member	√	√										

Name	Title	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Lin Bennett	Practice Manager Governing Body Member	√	A										
Fiona Clark	Chief Officer	A	A										
Steve Astles	Head of CCG Development	A	A										
Malcolm Cunningham	Head of Primary Care & Contracting	√	A										
Debbie Fagan	Chief Nurse & Quality Officer	√	√										
Dr Debbie Harvey	Lead Clinician for Strategy & Innovation	√	√	A									
Martin McDowell	Chief Finance Officer	√	√										

✓ Present
A Apologies
L Late or left early

	The meeting was preceded by a presentation by Linda Williams of Edge Hill University on Safeguarding Review.  Linda Williams QC June 2014.pptx Miss Fagan acknowledged the timescales for action and advised as to the work underway in response to this report. Ms Clark will chair a Safeguarding Steering Group across the CCG Network. Ms Forshaw also described the work under way by the Safeguarding Team. Miss Fagan described the context of commissioning this report, acknowledging the CCG's journey from authorisation and subsequent leadership in re-examining the safeguarding process for the purpose of identifying the next steps required to make improvements. Dr Gillespie thanked Ms Williams on behalf of the CCG and the Quality Committee.	
	Agreed actions	
	Mr McDowell felt it was important to differentiate between provider safeguarding risks and internal safeguarding risks on the Corporate Risk Register and that internal safeguarding risks should be rated red on the register.	DF
	To be an agenda item at the next meeting of the Governing Body	DF

Main meeting

No	Item	Action
14/84	**Apologies for absence** were received.	
14/85	**Declarations of interest** Declarations were received on behalf of Fiona Clark, Martin McDowell, Brendan Prescott, James Hester and Debbie Fagan as to their joint roles with Southport and Formby CCG.	
14/86	**Minutes of the previous meeting** The minutes were approved as an accurate record of the previous meeting, save for the following notes: • Correction in the date of the previous meeting.	

No	Item		Action
	• 14/67 Go To Doc Complaints – reference to p.86 of 99 Complaint 2. This comment is relevant to Southport & Formby CCG and not to South Sefton CCG		
14/87	**Matters arising/action tracker** All actions have been closed down save for the following points, which should remain on the tracker:		
	13/128	This action is being considered by the Corporate Governance Group and will be brought back to this meeting in July if not resolved - gaps in financial data from Providers (anticipation of treatment costs) / review of commissioning policies which will impact on IFR process	JH
	14/64	*Data analysis* - Mr Prescott to consider contractual position with Steve Astles regarding data analysis.	BP/SA
		Groin/hernia/stroke, Stroke - actions to be carried forward to the July meeting.	JS/GH
	14/68(a)	Carried forward – (Request from EPEG) Go To Doc clinical opinion by Dr Gillespie regarding misinformation provided to a patient. To report back to EPEG.	CG / JH
	14/68(b)	Carried forward. – (Request from EPEG) Go To Doc review of whether doctors are contacted to make urgent visits between 6am and 8am. To report back to EPEG	MC
	13.126a	Carry forward, no completion date identified. This is an issue that is raised at the CCG Checkpoint meeting with NHSE(M)and will be revisited quarterly	DF
	14/31	Carried forward until August 2014 – C-Diff provider year to date figures to be provided by CSU.	
	14/33	Carried forward until August 2014 – SI meeting with Mersey Care. This has been delayed due to availability of clinicians and Mersey Care team. Now scheduled for August 2014.	JS
	14/48	Carried forward until July – revisement of format for GBAF and Corporate Risk Register	TJ
14/88	**Chief Nurse report** Miss Fagan advised that had been a joint workshop with the Local Authority to consider the integrated approach to Continuing Healthcare and some process mapping had taken place. A follow up session in July will consider packages of care, before a third workshop will include provider colleagues. Merseyside will form part of the new pilot around Continuing Healthcare assurance. There was some discussion around the national publication of live nurse staffing data being available in the public domain on NHS Choices and via Trust websites.		
14/89	**Safeguarding service quarterly assurance report**		

No	Item	Action
	Ms Dunne referred to recent discussions with Aintree University Hospitals NHS Trust (Aintree) around the strength of the Safeguarding Children Policy and supervision. The RAG rating has been accepted by the Director of Nursing and the contribution of the named-nurse for safeguarding was acknowledged. The current issues at Aintree and the improvements made so far were discussed in some detail. The Safeguarding Children Policy is anticipated to be operationalised by July 2014. Provider performance regarding safeguarding is discussed at the CPQG meeting.	
	There was also a discussion around the late provision of data from Liverpool Community Healthcare Services NHS Trust (LCH) and Liverpool Women's Hospital (LWH). Ms Dunne referred to the recent structural changes at LCH. At LWH, however, the situation is of concern and a meeting is pending between Ms Dunne and the Chief Nurse at Liverpool CCG to consider matters further. Ms Dunne also informed the Committee that plans were in place to meet with the Director of Nursing for LWH to discuss what support and direction could be given in order to see improvement in the Trust performance in this area so that commissioners could be assured.	AD
	Ms Dunne confirmed that the Annual Safeguarding Report will be available for the September 2014 meeting of the Quality Committee but an update would be given at the August 2014 meeting. Ms Garside referred to the CCG mandatory safeguarding training referenced at paragraph 3.9 provided via the Commissioning Support Unit; and stated that this training is under review. Miss Fagan asked if the training that had currently been undertaken was still valid. Ms Garside confirmed that mandatory training already undertaken is still valid, however, the current programme will not be fit for purpose going forward. The new training will be available shortly which staff will be required to undertake as part of their routine updates.	AD
14/90	**Mental Capacity Act, Deprivation of Liberties report** The definition of deprivation of liberty has been expanded and clarification is pending on the implementation thereof. Some training will be required at both Protected Learning Time and for the Governing Body. It was agreed that when the clarity is available, which is expected at the end of June, this will be brought back to the Committee for further consideration at the August meeting, unless any urgent risks are identified in the meantime, in which case it should be considered at the July meeting. Canon Driver requested that appropriate assurance also be sought from Sefton Council regarding their roles and responsibilities in relation to the Mental Capacity Act.	HS / MD TF
14/91	**CQC-style safeguarding peer review reports and action plan** Considered earlier during Ms Williams presentation.	
14/92	**Research strategy report** Mr Prescott presented the CCG Research Strategy for approval Agreed actions The Committee approved the strategy.	
14/93	**National audit of child health information system providers** The communication was received and the contents acknowledged. Miss Fagan will keep the Committee appraised of developments once the outcome of the national audit is known.	DF
14/82	**Complaints policy**	

No	Item	Action
	The Committee noted that the appropriate scrutiny has taken place at the Corporate Governance Support Group. It was suggested that compliments also be included as part of the reporting process and some definition of the Engagement and Patient Experience Group (EPEG) membership be included Agreed actions The policy was approved. Mr Hester agreed to consider inclusion of compliments and the detail around the EPEG membership in future revisions of the policy. Mr Hester to feedback to the Corporate Governance Group these comments made by the Quality Committee	JH
14/83	**Any other business** *Primary Care Quality Board (PCQB)* The method by which PCQB should report to this Committee was discussed. It was agreed that minutes should be formally received, supported by a bullet pointed list of key notes.	
	Alder Hey Quality Review Meeting Miss Fagan referred to this meeting held last week and support being offered to the Trust by NHS England. The CQC have revisited the Trust and the report is due in July. A meeting will be reconvened at the end of July to consider the outcome. *Liverpool Clinical Laboratories* Two meetings have taken place and a root cause analysis is under way. Four serious incidents have now been reported. Incidence has been detected elsewhere with the clinical system in the UK. The affected clinical system is being replaced later this year. From a quality perspective, Dr Halstead is driving the pace of this investigation and all results are being re-examined; a timeline is being established in relation thereto. Dr Mimnagh reiterated the duty of care to receive an action test results upon the requesting clinician. The issue has been included on the CCG's risk register.	
14/84	**Date, time and venue of next meeting** Thursday 24 July 2014 at 3.00pm, The Boardroom, Third Floor, Merton House.	

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee
Minutes

Date: Thursday 20 March 2014 1.00pm – 3.00pm

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

Attended		
Roger Driver	Lay Member	RD
Graham Morris	Lay Member (Chair, Vice Chair CCG)	GM
Paul Thomas	GP Governing Body Member	PT
Sharon McGibbon	Practice Manager	SMG
Fiona Clark	Chief Officer	FLC
Martin McDowell	Chief Finance Officer	MMD
Debbie Fagan	Chief Nurse	DF
In attendance		
Brendan Prescott	CCG Lead for Medicines Management	BP
James Bradley	Head of Strategic Financial Management	JB
Becky Williams	Chief Analyst	BW

No	Item	Action
FR14/39	**Apologies for absence** Apologies for absence were recorded.	
FR14/40	**Declarations of interest regarding agenda items** The Officers of the CCG who hold joint posts declared their potential conflicts of interest.	
FR14/41	**Minutes of the previous meeting** The minutes of the previous meeting were approved as a true and accurate record of the meeting.	
FR14/42	**Action points from the previous meeting** Action points of the previous meeting were closed as appropriate.	
FR14/43	**Month 11 Finance Report** MMcD referred the committee to the report circulated in advance and reported that at the end of February the CCG is £5.493m over-spent prior to the application of reserves. The CCG has sufficient reserves, and remains on target to achieve the planned £2.300m surplus at the end of the year. MMcD outlined the financial risks facing the CCG noting the continued uncertainty in relation to CHC payments. **The Finance and Resource noted the finance update, particularly that: the CCG remains on target to deliver its financial targets for 2013/14**	

No	Item	Action
FR14/44	**Strategic Financial Plan Update** **(includes QIPP update)** MMcD updated the committee in relation to the Strategic Financial Plan and noted that this would be presented to the Governing Body in May 2014. **The Committee received the verbal Strategic Finance Plan update.**	
FR14/45	**IFR Update Report** MMcD and JL presented this report for information. The Committee noted that JL has met with the CSU and that new procedure for the approval of IFRs is currently being drafted. **The Committee received the Southport and Formby CCG IFR report and noted the content.**	
FR14/46	**Better Care Fund** MMcD presented this verbal update and noted that integration work is ongoing with the council. The committee noted that collaborative working will be key to the success of the Better Care Fund. **The Committee received the verbal update regarding Better Care Fund.**	
FR14/47	**Quality Premium Dashboard** **BW presented this report and asked the committee to note that** Based on the year to date performance (April 2013 – January 2014), South Sefton CCG would receive a payment in 2014/15 of £552,623 against a total possible payment (if all indicators were within tolerance) of £736,830. **The Committee received the Quality Premium Dashboard.**	
FR14/48	**South Sefton PMO programme update and exception report – M11** BW presented this report on behalf of FD The committee noted that the IT issues in relation to the ophthalmology service are now resolved. The committee noted that all schemes are on schedule as per case for change. **The Committee received the PMO programme update and exception report.**	
FR14/49	**Summary of main requirements of Annual Report** MMcD presented this report and asked the committee to note the requirements and agreed approach in relation to the first Annual Report and Annual Accounts for Southport and Formby CCG. The committee noted that the final content of the report would be decided by governing body members. **The Committee received the summary of the main requirements of the Annual Report.**	

No	Item	Action
FR14/50	**Prescribing Q3 report** BP presented this report and asked the committee to note that Actual Cost growth in Q3 showed a 2.4% increase compared with the previous year with spend of £6,717,767 compared to £6,557,172. There was a corresponding increase in items of 0.5% in Q3 2013-14 compared with Q3 2012-13 (908,072 compared to 903,734 see appendix 1). In relation to level 3 QIPP common cost improvement areas, there has been a reduction of £112,290 in spend comparing Q3 2013-14 to Q3 2012-13 (£2,194,229 compared to £2,306,518,. However there has been an increase in spend in all BNF areas as mentioned above. Areas for cost improvement will continue to inform work plans in 2014-15. **The Committee note the content of the prescribing report**.	
FR14/51	**Any other business** There was one items of other business. MMcD requested suggestions from GP colleagues on how to utilise potential additional funding. Suggestions included the potential for setting up a walk in centre in Southport, GP/Nurse representation in A & E departments to divert patients to appropriate provision and the CCG assuming management of A & E departments. MMcD requested that colleagues continue to seek innovative solutions to healthcare provision in Southport and Formby.	
FR14/52	**Date and Time of Next meeting** **Thursday 22 May 2014 1.00pmm – 3.00pm** **3rd Floor Boardroom Merton House**	

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee
Minutes

Date: Thursday 19 June 2014 1.00pm – 3.00pm

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

Attended		
Roger Driver	Lay Member (Chair)	RD
Andy Mimnagh	GP Governing Body Member	AM
Sharon McGibbon	Practice Manager	SMG
Fiona Clark	Chief Officer	FLC
Martin McDowell	Chief Finance Officer	MMD
Debbie Fagan	Chief Nurse	DF
Steve Astles	Head of CCG Development	SA
Tracy Jeffes	Head of Delivery and Integration	TJ
Jan Leonard		
In attendance		
Brendan Prescott	CCG Lead for Medicines Management	BP
James Bradley	Head of Strategic Financial Management	JB
David Bacon	Interim Deputy Chief Finance Officer	DB
Becky Williams	Chief Analyst	BW

No	Item	
FR14/71	**Apologies for absence** Paul Thomas, Gustavo Berni, Suzanne Lynch, John Wray, Graham Morris, Fiona Doherty, Ken Jones	
FR14/72	**Declarations of interest regarding agenda items** The CCG Officers who hold joint posts at both NHS Southport and Formby and NHS South Sefton CCGs declared their potential conflicts of interest.	
FR14/73	**Minutes of the previous meeting** The minutes of the previous meeting were approved as an accurate record.	
FR14/74	**Action points from the previous meeting** The action points from the previous meeting were closed as appropriate.	

No	Item	
FR14/75	**Finance Reports** a. **Month 2 Finance Report** JB presented this report to the committee giving an overview the financial position for NHS South Sefton Clinical Commissioning Group as at Month 2 and outlines the key financial risks facing the CCG. The CCG is on target to achieve the planned £2.300m surplus at the end of the year. It also meets the other business rules required by NHS England. The Resource Allocation of £229.31m is the Allocation currently recorded by NHS England for South Sefton CCG. There are a number of adjustments required to this figure which have been agreed in principle with NHS England and will be corrected through allocation transfers in Month 3. These are known and do not represent a risk to the CCG. JB went on to draw attention to a number of risks and opportunities including: • Continuing healthcare • Overspends on Acute cost per case contracts • Continuing Healthcare restitution claims • Estates • Prescribing/drugs costs The CCG has increased the CHC budget by 4% based on outturn figures for 2013/14; however it is anticipated, based on current trajectory, that this will not be sufficient. RD requested clarification if the additional demand is due to a reduction in social care provision. MMcD noted that some providers are suggesting this as an explanation. Discussion took place in relation to encouraging patients to choose to leave secondary care provision appropriately. JL commented that collaborative working has proved that this can be successfully achieved. RD requested clarification in relation to ceiling for total provision by the CCG for CHC. MMcD responded that this level will be ascertained by benchmarking and collaborative discussion with our Local Authority partners. MMcD noted that funding has been released for system resilience and a framework has been produced for criteria for accessing funding. The CCG will submit their plan by 3rd July 2014. It is anticipated that additional funding may be released to support 18 week target, with an aim to reduce this to 16 weeks. **The Committee noted the contents of the report and that the CCG remains on target to deliver its financial targets for 2014/15.** b. **Quarter 4 Contract Performance Report** JB presented this report that described the financial performance against contracts in 2013/14 and the operational performance of the main provider – Aintree University Hospital. JB noted that the stand out variance was as Aintree NHS FT in Q4. Penalties were applied as part of the assessment which the Trust accepted. NWAS last year there was a block contract and as a result of lower activity values this has been reflected in this year's contract. The improvement in Aintree's RTT performance was noted. The CCG will now monitor GP referrals to Aintree.	

No	Item	
	It was noted that the performance at Liverpool Women's Hospital was reduced and Southport and Ormskirk has increased. From a target perspective Aintree are achieving their targets for Q1. **The committee noted the contents of the Quarter 4 Contract Performance Report.**	
FR14/76	**Annual IFR Update Report** JL presented this report and asked the committee to note that between March 2013 and April 2014 121 requests had been received of which 24 had been approved and 84 have been declined giving an approval rate of 22%, this figure will be reviewed when the final 13 cases have been resolved. JL will discuss potential specialised commissioning issues and signposting of requests with Sally Anne Hunter at CSC. JL will request further narrative in terms of decisions of exceptionality. In relation to IVF a discussion will take place at SLT with a view to bringing this into contract. **The Finance and Resource Committee noted the content of the Annual IFR Update Report**.	JL
FR14/77	**Better Care Fund** MMcD presented a verbal update on the Better Care Fund and noted that the CCG is awaiting a criteria based assessment and prescriptive guidance. Initial modelling has begun with the Sefton MBC. **The Finance and Resource Committee noted the contents of the verbal update in relation to the Better Care Fund.**	
FR14/78	**Quality Premium Dashboard** FD presented the Quality Premium Dashboard and advised the committee that the quality premium is intended to reward clinical commissioning groups for improvements in the quality of the services they commission and for associated improvements in health outcomes and reducing inequalities. Based on local data performance for the confirmed indicators for 2013/14 (April 2013 – March 2014), South Sefton CCG should receive a payment in 2014/15 of £460,519 against a total possible payment (if all indicators were within tolerance) of £736,830. This is due to underperformance in a number of areas which have been described in the previous month's report. However, data is still awaited for a further indicator, which may increase the total amount payable to £552,623 should it be at or below target. There have been changes to a number of indicators for the 2014/15 financial year and a draft dashboard has been produced to display performance. Data to populate the dashboard is expected for the July committee. In relation to IAPT GO'C will take a recommendation to the Service Improvement Redesign Committee. A small non-recurrent investment may be required in this financial year. Plans for this funding should be drafted in anticipation of the funding release in September 2014. FLC suggested that this funding may offer a potential to address gaps and may involve service redesign in addition to additional funding. **The Committee noted the content of the Quality Premium Dashboard report**.	

No	Item	
FR14/79	**South Sefton PMO programme update and exception report – Annual Report** FD presented the Southport and Formby PMO programme update and exception report and reminded the committee that these programmes are being measured against the 2013/14 objectives as per the original business cases. All cases for change are on track in relation to original milestones, waiting times have been reduced and diversions from secondary care as appropriate have been achieved. The PMO will review the parameters in relation to reporting the reduction in outpatient referrals for ophthalmology. **The Finance and Resource Committee noted the contents of the Southport and Formby PMO programme update and exception report – annual report**.	FD
FR14/80	**Any Other Business** **There were three items of other business** **1. Annual Accounts and Report** MMcD noted that The Annual Report and Accounts have been approved by the Audit Committee and have been uploaded to the intranet/internet. PWC have supplied an unqualified audit opinion. **2. Towards Excellence Quality Standard** MMcD noted that the Finance Team are working towards the Towards Excellence Quality Standard and as part of this have attended their 2nd Team away day following which 3 key projects have emerged. • Improved financial awareness - Finance Training for Non-finance professionals. This has been project planned and will be brought to July meeting. • Production of Accounting Instruction Manual • Improved Information and reporting for external customers. **3.** MMcD noted that this was David Bacon's final meeting prior to leaving and thanked him for his work and his support of the team and the committee. The Committee added their thanks and good wishes**.**	
FR14/81	**Date, Time and Venue of next meeting** Thursday 24th July 2014 1.00pm -3.00pm Boardroom 3rd Floor Merton House	

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee
Minutes

Date: Thursday 22 May 2014 1.00pm – 3.00pm

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

Attended

Roger Driver	Lay Member	RD
Graham Morris	Lay Member	GM
Sharon McGibbon	Practice Manager	SMG
Martin McDowell	Chief Finance Officer	MMD
Debbie Fagan	Chief Nurse	DF
Steve Astles	Head of CCG Development	SA
Andy Mimnagh	GP Governing Body Member	AM
Paul Thomas	GP Governing Body Member	PT

In attendance

Brendan Prescott	CCG Lead for Medicines Management	BP
James Bradley	Head of Strategic Financial Management	JB
David Bacon	Interim Deputy Chief Finance Officer	DB
David Smith	Deputy Chief Finance Officer (from 30/06/2014)	DS

FR14/53	**Apologies for absence** Apologies for absence were received from, Tracy Jeffes, Fiona Clark, Gustavo Berni, Ken Jones, Karl McCluskey.	
FR14/54	**Declarations of interest regarding agenda items** The CCG Officers who hold dual roles declared their potential conflict of interest. Drs Andy Mimnagh and Paul Thomas declared their potential conflict of interest in the prescribing quality scheme.	
FR14/55	**Minutes of the previous meeting** The minutes of the previous meeting were approved as a true and accurate record.	
FR14/56	**Action points from the previous meeting** There was one action point from the previous meeting and this was included on the agenda.	

FR14/57	**Year-end Finance Report** JB presented this report which 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 2013/14, the CCG was £7.346m (Month 11 £5.493m) over-spent prior to the application of reserves. After the application of reserves, the CCG has delivered its target surplus of £2.312m for 2013/14. JB further advised the committee that a strategy update will be delivered on a quarterly basis. AM requested clarification as to how the CCG is recovering the pass through prescribing costs from secondary care. JB gave example of Denosumab; where a move has been identified and the pass through costs have been dealt with appropriately in the prescribing budget. MMcD suggested the possibility of setting up a working group to look at general principles in relation to pass through costs, BP or SL, JB, SA and AM will discuss outside of the meeting. MMcD noted that a key priority for the team is to model the impact of a hypothetical 2% increase in expenditure and the potential CCG response to this. The team will also look ahead to the next financial year, and continue to monitor a number of risks. The Committee noted that GM will take part in a finance team away day on 9th June 2014. **The Committee noted the Year End Finance Report.**	BP/SL/JB/SA /AM
FR14/58	**Strategic Financial Plan Update** **(includes QIPP update)** MMcD presented this verbal update and advised the committee that the Finance Team have revisited the planning assumptions and revised the Strategic Financial Plan which will be circulated with the Governing Body papers. A public facing document will be drafted in due course. **The Committee noted the verbal Strategic Financial Plan update.**	
FR14/59	**IFR Update Report** MMcD presented this report for information. CSU will provide a full Annual IFR report for the next meeting in June 2014. **The Committee noted the content of the IFR Update Report**	JL
FR14/60	**Better Care Fund** MMcD noted that the CCG continues to meet with Sefton MBC. The Committee noted that a challenge from HM Treasury to the Department of Health has raised issues of credibility in relation to the plans in general. Going forward there is likely to be a more defined assessment criteria. **The Committee noted the verbal update in relation to the Better Care Fund**.	

FR14/61	**Quality Premium Dashboard** FD presented this preliminary month 12 report, this is based on locally produced data, however, payment will be based on national measures. The indicators show that the payment currently stands at £460K, Public Health England continue to support the team in trend analysis for some of the indicators. Month 12 end of year report will be available for the June meeting. FD further noted that some indicators were missed by a small margin and in these cases the data will be rechecked. GM sought clarity on what could be done in terms of the years of life lost indicator. The Committee noted that this was beyond the control of the CCG at this point as this can relate to long terms conditions developed 20+ years ago. **The committee noted the content of the Quality Premium Dashboard**.	
FR14/62	**South Sefton PMO programme update and exception report – M12** FD presented the PMO programme update and noted that all cases for change are on track in relation to milestones and that an annual report would be provided for the next meeting. **The Committee noted the content of the PMO Programme update**	
FR14/63	**Capital Plan and Updates** MMcD reported that access to capital is extremely limited. The CCG has a bid lodged with NHS England for consideration in relation to IM&T. **The Committee noted the verbal update in relation to capital plans.**	
FR14/64	**Review of Annual Work plan** The Committee reviewed the annual work plan. Any comments in relation to revisions should be sent to Karen Lloyd. **The Committee noted the content of the annual work plan.**	
FR14/65	**GP Framework Report** AP presented this report and noted that final payments have been made. The committee noted that this is a legacy issue from the PCT. The scheme had been intended to end on 31 March 2014; however, there was a requirement for this to be extended into quarter 1 of 2014/15. The committee noted the potential value in sharing this report with practices for the purposes of benchmarking. **The Committee noted the content of the GP framework report.**	
FR14/66	**Gateway 1 Cases for Change** **Case for change for DMARD shared care prescribing for non-rheumatological conditions.** BP presented this case for change, and noted the cost savings and risks to the CCG in the approval of this case. AM noted the clinical quality advantage for this case. BP further commented that from a budgetary perspective the CCG will continue to fund the service, however, when fully operational, the funding will be removed from the budget. MMcD noted that this had the potential to create capacity within the service which in turn could create an overspend going forward. JB will monitor this going forward. **The Committee approved the case for change for DMARD shared care prescribing for non rheumatological conditions.**	**JB**

FR14/67	**Area Prescribing Committee recommendations** BP presented this report and noted that the Pan Mersey Area Prescribing recommends the commissioning of Aflibercept (Eylea®▼) as a treatment option for treating visual impairment caused by macular oedema secondary to central retinal vein occlusion only by ophthalmologists in accordance with NICE TA305. The annual resource impact for the CCG is circa £3,200 **The committee approved the Pan Mersey recommendation.** It was proposed that going forward the Chief Finance Officer and the Head of Medicines Management would review any recommendations requiring resource of <£5k across the CCG and approve as appropriate bringing a retrospective report to the committee. **The committee approved the establishment of a £5k resource impact threshold for future recommendations coming to the committee for approval**	
FR14/68	**Proposed Prescribing Quality Scheme** **Drs Mimnagh and Thomas and Ms McGibbon declared a potential conflict of interest in this item.** BP presented this report which provides the committee with the proposed content of the Prescribing Quality Scheme (PQS) for NHS South Sefton CCG to help performance manage prescribing across constituent practices. The scheme aims to provide incentives to practices to maintain financial balance and optimise prescribing outcomes across NHS South Sefton CCG. In total there are 50 points available under the scheme worth £4,594 for an average sized South Sefton practice of 4,594 patients. The maximum pay out under the scheme would be £154,896. **The committee reviewed the proposed scheme, the allocation of points and granted approval.**	
FR14/69	**AOB meeting with external auditors** MMcD advised the committee that at an update meeting with the External Auditors he had been assured that the audit was progressing as per plan. There are a number of technical issues in relation to disclosure; however, these are expected to be satisfactorily resolved.	
FR14/70	**Date and time of next meeting** **1.00pm Thursday 19th June 2014** **Merton House**	

Attendance Tracker

Committee Member	May 2014	June 2014	July 2014	September 2014	October 2014	November 2014	January 2015	February 2015	March 2015
Roger Driver Lay Member, Vice Chair	Yes								
Graham Morris Lay Member	Yes								
Andy Mimnagh GP Board Member	Yes								
Sharon McGibbon Practice Manager	Yes								
Fiona Clark Chief Officer	Apols								
Martin McDowell Chief Finance Officer	Yes								
Steve Astles Head of CCG Development,	Yes								
Malcolm Cunningham Head of Performance & Outcomes	Apols								
Tracy Jeffes Head of Delivery and Integration	Apols								
Debbie Fagan Chief Nurse	Yes								
GP Locality Members									

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, 7 May 2014, 13.00 to 16.00 (lunch available from 12.30)
Meeting, Boardroom, Third Floor, Merton House, Bootle L20 3DL

Minutes

Present	
Dr Rob Caudwell	Chair, S&FCCG
Dr Clive Shaw	Chair, SSCCG
Fiona Clark	CO, S&FCCG/SSCCG
Jan Snoddon	obo Simon Banks
Dr Nadim Fazlani	Chair, LCCG
Martin McDowell	CFO, S&FCCG/SS CCG
Tom Jackson	CFO, LCCG
Paul Brickwood	CFO, KCCG
Phil Thomas	obo Dianne Johnson
Dr John Caine	Chair, WLCCG
Dr Andy Pryce	Chair, KCCG

Apologies	
Katherine Sheerin	CO, LCCG
Simon Banks	CO, HCCG
Mike Maguire	CO, WLCCG
Dr Steve Cox	CCO, StHCCG
Dianne Johnson	CO, KCCG
Sarah Johnson	Deputy CO, StHCCG
Paul Kingan	CFO, WLCCG
Dr Cliff Richards	Chair, HCCG
John Wicks	Interim CO, WCCG

In attendance	
Clare Duggan	NHS England

Minutes	
Melanie Wright	SSCCG/S&FCCG

No	Item	Action
14/46.	Welcome & Introductions were made.	
14/47.	**Strategic Planning** The strategic session on 14 May will consider interdependencies across the system (in place of the Co-Commissioning Collaborative meeting). *Specialised Commissioning* - it is hoped that key strategic aims will be available by the 20 June deadline for submission of 5-year plans, but it was acknowledged that these will still require further development at this time. The purpose at this point is to develop an understanding of the direction of travel for organisations, acknowledging that a high level of detail will not be available at that point. It will, however, enable some examination of possible avoidable outcomes.	

14/114

No	Item	Action
	Mrs Duggan described the methods utilised by The Boston Group when considering Specialised Commissioning. The task and finish session for Specialised Commissioning will take place on 27 May and a communication on this will follow shortly. Mrs Duggan also sought representation from each CCG to consider the options for a Major Trauma service in Cheshire and Merseyside, the time commitment is likely to be a meeting per month and the dates will follow. CCGs agreed to advise Mrs Duggan of representatives. It was agreed that providers would be invited to the July Co-Commissioning Collaborative. CCGs to provide a schedule of key dates to NHSE for future planning. There was a discussion around 4-hour targets for A&E and the Women's Hospital and it was agreed that Fiona Lemmens could pick this up at the Urgent Care Tripartite.	CCGs MW CCGs LCCG
14/48.	**Recent Changes to the Area Team** John Lawlor and Andy Buck, Area Team Directors, have resigned from Cumbria and Moira Dumma will take over in West Yorkshire. Alison Tonge will now act up into Moira's previous role. Gaynor Hales is supporting a piece of work to understand Specialised Commissioning. Further, Sue Page has taken over the role of Acting CEO to LCH, with the support by secondment of Johanna Reilly. The environment across NHSE is one of help and support to colleagues.	
14/49.	**Assurance** Mrs Duggan wanted the focus to move to joint collaborative work and delivery.	
14/50.	**Annual Reporting Mechanisms** To be considered at the session on 14 May.	
14/51.	**Five Year Plan** Discussed above.	
14/52.	**Apologies for Absence** were received.	
14/53.	**Minutes from the previous meeting** The Minutes were agreed as an accurate record.	
14/54.	**Actions from the previous meeting** Dr Liz Mears to be invited to respond/attend for the next meeting. CLARC – Katherine Sheerin to be invited to update the meeting, 14/33 Dr Fazlani advised as to a meeting that took place last week with the Women's Hospital, together with LCCG and NHSE. The issues are one of finance around tariff and following the publication of the Royal College of Obs and Gynae framework, it has been identified that the hospital is an outlier in terms of outcomes which may impact upon service delivery. A public consultation will be necessary and will require tie-in with the Healthy Liverpool programme. There is a meeting to develop a Clinical Reference Group and terms of reference will be agreed on 23 May. It was acknowledged that there will be other outliers on the patch.	 MW MW

No	Item	Action
	The two major risks for the Women's was the paucity of the tariff and the CNST and claims around a previous consultant. NHSLA have deferred the premium for CNST until next year, but this is unlikely to solve the problem in the longer term.	
14/55.	**EPRR Update** *Surviving Public Enquiries* – all on-call staff are invited to attend, CCGs to proffer representation. This is required by on-call staff as per the NHSE guidance. *Generic email addresses* – ratification given from CCGs. Emails will then be received by all staff who participate in the on-call service. *Hillsborough Report* – from an EPRR perspective, is primary aimed at Safety Advisory Groups, which fall within the remit of NWAS. Ian Davies was due to respond to the LHRP on behalf of CCGs, ensuring that all providers are engaged in the process. Mr Booth agreed to chase Mr Davies for a progress report. Ms Clark asked whether the CCGs were clear what would happen should such an event happen again. Mr Booth advised Safety Advisory Groups are much more active now and how organisations feed in. The major football clubs in Liverpool also have Safety Advisory Groups. Mrs Snoddon asked whether the Creamfields event in Halton was covered as part of this; Mr Booth confirmed that it was and the Police had developed robust schemes in response thereto. *Exercise Palladin* – a list of recommendations has been produced and NHSE/Public Health England will work through these. CSU will attend and understand expectations. A task and finish group will consider emergency communications issues. CCGs' participation in exercises is sought. Mr Booth to write with this request. *Pandemic Flu Planning Group* – there is a discussion about whether providers' contracts need to be more detailed about actions in the event of a pandemic, although there is an argument about the level of detail to be included in the service description. Mr Booth asked CCGs to consider the kind of support required from CSU in relation to Emergency Planning generally. It was agreed that Mr Booth would write to the CCGs formally to generate this conversation. Mr Thomas agreed to raise this with Dianne Johnson. *Resilience Direct* – organisations may express an interest in becoming part of Resilience Direct to access emergency planning documentation on a national basis and it is likely to become a tool for emergency planning. Mr Booth agreed to contact Dianne Johnson with a view to progressing this, *Pandemic Flu Plans* – Mr Booth is in the process of reviewing these and will revert to organisations in due course. *Business Continuity* – an annual review of plans for individual CCGs will be required. Mr Booth will send dates to CCGs to commence this process.	CCGs RB RB RB PT RB RB
14/56.	**NWAS Reconfiguration and Service Reviews** CCGs are asked to review from a Merseyside perspective and provide any comments to Simon Banks.	CCGs
14/57.	**Footprints for Urgent Care Networks**	

14/114

No	Item	Action
	Ms Clark drew the meeting's attention to John Wicks' recent communication (Warrington CCG) as CCG representative on the National Urgent Care Networks. It was felt that the local Urgent Care Networks are the proper venue for this discussion, however, Mr Thomas noted that these networks were not decision-making bodies. The group noted the principle and were happy for Urgent Care Networks to deal with this on behalf of the CCG Network.	
14/58.	**Hillsborough Report** Discussed under 14/55 above.	
14/59.	**Maternity Network – Update** Discussed under 14/54 above.	
14/60.	**Any Other Business** There was a general discussion around the CSU contract, which has not progressed any further. There was also a discussion on Primary Care Commissioning and Specialised Commissioning and the forthcoming deadline for expression of interest by CCGs of 20 June was noted.	
14/61.	**Date of Next Meeting** Wednesday, 4 June 2014, Boardroom, Merton House	

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

HEALTH AND WELLBEING BOARD

MEETING HELD AT THE TOWN HALL, BOOTLE ON WEDNESDAY 18TH JUNE, 2014

PRESENT: Councillor Ian Moncur (in the Chair)
Dr. Janet Atherton, Dr. Rob Caudwell, Fiona Clark, Councillor Paul Cummins, Dwayne Johnson, Councillor John Joseph Kelly, Maureen Kelly, Colin Pettigrew and Dr. Clive Shaw

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr. Niall Leonard, Peter Morgan and Phil Wadeson.

2. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the Minutes of the meeting held on 19 March 2014 be confirmed as a correct record.

3. DECLARATIONS OF INTEREST

No declarations of pecuniary interest were received.

4. CONSOLIDATED CLINICAL COMMISSIONING GROUPS STRUCTURES AND UPDATE

The Board received a presentation "Driving Strategy into Delivery" from Fiona Clark, Chief Officer for South Sefton Clinical Commissioning Group (CCG) and Southport and Formby Clinical Commissioning Group that updated on the Consolidated Clinical Commissioning Groups Structures. The presentation provided information on the following:-

- The three strategic priorities of frail elderly, unplanned care and primary care transformation
- The strategic plan engagement relating to additional programme areas, adult and children mental health services review, the Better Care Fund, the Community Services Review and enhanced primary care
- The organisational structures of the wider constituent CCG and the Medicines Management Team
- The accountability and performance structures of the Southport and Formby and South Sefton CCG's
- The roles and responsibilities of the Southport and Formby and South Sefton CCG governing bodies and clinical leads/locality lead GPs

RESOLVED:

That Fiona Clark be thanked for her informative presentation.

5. REFRESH OF THE HEALTH AND WELLBEING STRATEGY AND SEFTON STRATEGIC NEEDS ASSESSMENT

The Board considered the report of the Head of Business Intelligence and Performance seeking the Board's views and agreement regarding:-

- the process and timetable for refreshing the Sefton Health and Wellbeing Strategy and the Sefton Strategic Needs Assessment as outlined in the report;
- the draft Strategy and high level Needs Assessment, attached to the report; and
- the Better Care Fund Plan.

The report set out the background to the matter together with details of the Sefton Health and Wellbeing Strategy 2013 – 2018; the Sefton Strategic Needs Assessment (SSNA); the context of the review of the Health and Wellbeing Strategy; the Better Care Fund Plan; the Annual Review Process undertaken; inter-connectivity to other Strategies and Plans**;** the Outcomes Framework and Performance Dashboard; and conclusions reached.

Copies of the revised Health and Wellbeing Strategy 2014-20, Better Care Plan for Sefton and the Sefton Strategic Needs Assessment 2014/15 High Level Summary were attached to the report.

RESOLVED: That

(1) the draft iteration of the Health and Wellbeing Strategy, as attached to the report, be approved and that further refinement take place over coming months, with a view to the Strategy being resubmitted to the Board in September 2014 and progressed to the Cabinet and Council and Clinical Commissioning Group (CCG) Governing Bodies in the Autumn of 2014;

(2) the content of the report and the context within which the refresh of the Strategy and the Strategic Needs Assessment is taking place, as described in the report, be noted;

(3) the process for further refreshing the Strategy and Strategic Needs Assessment, as described in the report, be endorsed and the full review of the Sefton Strategic Needs Assessment be published in 2014;

(4) the Celebration Event planned to take place in July 2014 be noted and the publication of an annual report alongside the final version of the next iteration of the Health and Wellbeing Strategy be agreed;

(5) the work being undertaken in developing a performance dashboard be endorsed and that this be discussed at the development workshop for the Health and Wellbeing Board in June 2014;

(6) the second iteration of the Better Care Fund Plan, as attached to the report, be endorsed, the progress in developing a one year integrated transition plan be noted, and that further work on this be progressed by the Board at its development workshop in June, 2014;

(7) subject to work progressing over the next two months through the Forums and Task Groups, the Cabinet and the Council, and the CCG Governing Bodies be recommended to agree that the Strategy becomes the overarching strategic outcomes framework for the Borough, to replace any previous versions of the Sustainable Community Strategy; and

(8) the Council's Overview and Scrutiny Committees be requested to add the Health and Wellbeing Strategy and the Sefton Strategic Needs Assessment to their future work programmes once the documents are developed further over the coming months.

6. SEFTON PHARMACEUTICAL NEEDS ASSESSMENT

The Board considered the report of the Chief Officer for South Sefton Clinical Commissioning Group and Southport and Formby Clinical Commissioning Group summarising the findings of the Sefton Pharmaceutical Need Assessment (PNA) steering group's identification of changes to pharmaceutical services and changes in needs for pharmaceutical services since the publication of the last PNA in 2011. The report also proposed undertaking a revised assessment and publishing a supplementary statement.

The report set out the background to the matter; recent changes in pharmaceutical provision within Sefton; changes in need for pharmaceutical services within Sefton due to housing developments; changes in pharmaceutical and locally commissioned services delivered; and conclusions reached and recommendations made.

RESOLVED: That

(1) a revised assessment is not required prior to publication of the next Sefton Pharmaceutical Needs Assessment (PNA), due by 1st April 2015; and

(2) a Supplementary Statement be issued and uploaded to the Council website detailing changes in pharmacies and opening hours.

South Sefton Clinical Commissioning Group

Seaforth and Litherland Locality Meeting

7th May 2014
1 – 3pm
Crosby Lakeside Adventure Centre

Attendees

Practice	GP	Practice Nurse	Practice Manager
Litherland Town Hall (LTH)	Dr Alastair Patrick		
15 Sefton Road	Dr Colette McElroy Dr Terry Thompson Dr Jane Irvine		Alison Harkin
Glovers Lane	Dr Peter Goldstein Dr Hannah Brooks		Louise Taylor
Rawson Road	Dr Fred Cook		Angela Dunne
Seaforth Practice			
Ford Medical	Dr Noreen Williams	Eils McCormick Louise Armstrong	Lin Bennett
Bridge Road Surgery	Dr Martin Vickers		
Netherton Practice	Dr Naresh Choudhary		Lorraine Bohannon
Orrell Park	Dr Ramon Ogunlana		Jane McGimpsey
129 Sefton Road			
Litherland Darzi	Dr Adnan Hameed		

Angela Parkinson (AP)	South Sefton CCG Locality Manager
Tracey Jeffes	Chief Corporate Delivery and Intergration Office
Helen Roberts	Pharmacist SSCCG
Dr Debbie Harvey	Lead Clinician for Strategy and Innovation

Minutes
Angela Parkinson

South Sefton Clinical Commissioning Group

Attendance Tracker

P Present
A Apologies
L Late or left early

Name	Designation	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
Dr T Thompson	GP – 15 Sefton Road Surgery	P	P	P		P							
Dr C McElroy	GP – 15 Sefton Road Surgery	P	P	P	P	P							
Alison Harkin	PM – 15 Sefton Road Surgery	P	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	P							
Dr P Goldstein	GP – Glovers Lane Surgery	P	P	P	P	P							
Dr M Cornwell	GP – Glovers Lane Surgery												
Dr M Vickers	GP – Bridge Road Surgery	P	P	P	P	P							
Lynne Creevy	PM – Bridge Road Surgery	P	P	P	A	A							
Dr E Carter	GP – Bridge Road Surgery												
Dr N Choudhary	GP – Netherton Practice	P	P		P	A							
Lorraine Bohannon	PM – Netherton Practice		P	A	P	P							
Dr N Williams	GP – Ford Medical Practice	P	P	P	P	P							
Lin Bennett	PM – Ford Medical Practice	A	P	P	A	P							
Eils McCormick	PN – Ford Medical Practice	P	P	P	P	P							
Louise Armstrong	PN – Ford Medical Practice		P	P	P	P							
Dr B Fraser	GP – Ford Medical Practice												
Dr G Halstead	GP – 129 Sefton Road Surgery			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
Jane McGimpsey	PM – Orrell Park Medical Centre	P	P	P	P	P							
Dr R Ogunlana	GP – Orrell Park Medical Centre	P	P	P	A	P							
Dr A Hameed	GP – Litherland Darzi	P			P								
Dr B Schoenberger	GP – Litherland Darzi	P											
Pam Maher	PM – Litherland Darzi / Litherland Town Hall	P	A										
Dr A Patrick	GP – Litherland Town Hall	P	P	P	A	P							
Dr F Cook	GP – Rawson Road / Orrell Park Medical Centres		P	P	P	P							
Angela Dunne	PM – Rawson Road / Orrell Park Medical Centres	P	P	A	P	P							
Ian Hindley	PM – Seaforth Practice/ Litherland Town Hall	P		P	P	A							
Dr Jane Irvine	GP – 15 Sefton Road					P							
Dr Hannah Brookes	GP Registrar – Glovers Lane					P							

No	Item	Action
14/39	**Apologies – Ian Hindley, Lynne Creevy, Dr Choudhary**	
14/40	**Declarations of Interest** Dr Noreen Williams – LMC Lin Bennett – Governing Body Member	
14/41	**Minutes of the Last Meeting / Matters Arising** **Cellulitis Service –** Dr Vickers had contacted Alison Smith, no further progress on this issue. **Virtual CRG** – this item had not yet been discussed by the LMC	
14/42	**Virtual Ward – Dr Debbie Harvey** Virtual ward urgent care element to be rolled out, Dr Akpan Community Geriatrician is now in post, roll out to Bootle and Seaforth and Litherland will be in the summer months. VW is taking singular referrals to DNs/MM/HT, and integrated referrals to 1 or more professionals via risk stratification or clinical judgment for a 12 week proactive programme with a view to reducing long term care. The group of patients targeted is long term conditions at risk of unplanned care. LCH are rejecting / not allowing to refer in, this has been highlighted through the operational group. Nursing home patients probably won't be appropriate for a 12 week programme, Dr Nigel Taylor is looking at the care home position. There is scope for changing what VW currently does, it is recognised that there is a lack of support for care homes. The new avoiding unplanned admissions ES risk stratifying the top 2% of patients is not known about by community matrons, there was discussion regarding whether the VW could be linked in with the ES. The referral form has been revised and will be coming out electronically. Recruitment – LCH now have their full compliment of staff, but that is not what we are hearing on the ground. Activity is currently running at 25% of what it should be, there is not enough activity going through, approximately a 3rd is being rejected, VW is geared for 400 patients a month, currently dealing with 100 referrals. The locality highlighted an issue with communication, there is no feedback when a patient is not picked up, feedback seems to be in a black hole, one practice reported receiving good feedback. Practices	

No	Item	Action
	are confused regarding what can be referred in and the community staff seem confused regarding what can be accepted. Issues were also reported with the risk stratification tool. Debbie / Asan need to know about referrals that are being rejected. Debbie will look at link with ES.	 All DH
14/43	**Emis Web Remote Access** This item was not discussed.	
14/44	**Medicines Management** **Budget Data** Month 11 budget data was reviewed at the meeting. **Ivabradi** JMOG have approved a request from the specialist Heart Failure nurses team allowing them to initiate ivabradine, in line with NICE guidance and following discussion with the cardiologist. **NPSA alert regarding Healthcare at home** If practices receive any patient queries regarding the delivery of Metoject from Healthcare at Home, please speak to practice pharmacist.	
14/45	**Finance / Quality Premium** The finance / quality premium paper was circulated to the group for information prior to the meeting. There was a query regarding the process for determining the local priority for 14/15, as 13/14 priorities had been discussed via the constituent practices. TJ thought that the indicator this year was more nationally prescribed with less room to manoeuvre.	
14/46	**NHS Healthchecks/ Locality £50k** The group discussed the option presented by Joanne Ball regarding an NHS Healthchecks pilot. The original idea to purchase Cardiocheck PA and consumables for practices who expressed an interest, was raised to prevent the patient having to attend for two appointments, one for phlebotomy, the second for the NHS Healthcheck, there were issues where patients who work would have difficulty attending twice, and where patients fail to attend for the second appointment. It had become apparent that once the full information was known that there were complexities particularly in terms of quality assurance. The group agreed that at this stage this would not be progressed. **2014/15 Locality Budget** Lin, Noreen and Tracey together with the public health registrar to	LB/NW/

No	Item	Action
	meet to look at a business case for the housebound, prior to the next meeting	TJ
14/47	**Healthwatch** Libby Kitt is the Community Champion for Seaforth and Litherland locality, her background is as a Health Visitor and more recently a member of PBC /CCG Governing Body. AP has met with Libby regarding attendance at the locality meetings. The group were asked to consider how to progress in terms of frequency etc. It was agreed that Libby would be invited to the next meeting where she could talk to the group about her role as Community Champion.	AP
14/48	**Succession Planning** Dr Martin Vickers is currently Chair until August, the GPs were asked to consider who would take over this role on a 6 month basis.	GP Locality Leads
14/49	**Any Other Business** **Locality / Wider Group Payments** Practices queried the correct route to claim payment as practices had had invoices returned from SBS requiring a reference number. AP advised that the number is a number generated by the practice. AP to clarify and circulate template for practices to use.	AP
	Date and Time of Next Meeting 4th June 2014 1 – 3pm Crosby Lakeside Adventure Centre	

South Sefton Clinical Commissioning Group

Seaforth and Litherland Locality Meeting

4th June 2014
1 – 3pm
Crosby Lakeside Adventure Centre

Attendees

Practice	GP	Practice Nurse	Practice Manager
Litherland Town Hall (LTH)	Dr Alastair Patrick		
15 Sefton Road	Dr Colette McElroy Dr Terry Thompson Dr Jane Irvine		Alison Harkin
Glovers Lane	Dr Peter Goldstein Dr Hannah Brooks		Louise Taylor
Rawson Road	Dr Fred Cook		Angela Dunne
Seaforth Practice			
Ford Medical	Dr Noreen Williams	Eils McCormick Louise Armstrong	Lin Bennett
Bridge Road Surgery	Dr Martin Vickers		
Netherton Practice	Dr Naresh Choudhary		Lorraine Bohannon
Orrell Park	Dr Ramon Ogunlana		Jane McGimpsey
129 Sefton Road			
Litherland Darzi	Dr Bettina Schoenberger Dr Adnan Hameed		

In attendance

Angela Parkinson (AP)	Locality Manager, South Sefton CCG
Tracey Jeffes (TJ)	Chief Delivery & Integration Officer, South Sefton CCG
Helen Roberts (HR)	Pharmacist, South Sefton CCG
Libby Kit (LK)	Healthwatch
Dr Bal Duper (BD)	Primary Care GP Lead, South Sefton CCG
Karl McCluskey (KMcC)	Chief Strategy & Outcomes Office, South Sefton CCG
Stephen Astles (SA)	Head of Development, South Sefton CCG
Roz Fallon (RF)	Liverpool Community Health
Ian Senior (IS)	Liverpool Community Health

Minutes

Angela Curran	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
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Dr C McElroy	GP – 15 Sefton Road Surgery	P	P	P	P	P	P						
Dr J Irvine	GP – 15 Sefton Road Surgery					P	P						
Alison Harkin	PM – 15 Sefton Road Surgery	P	P	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	P	P						
Dr P Goldstein	GP – Glovers Lane Surgery	P	P	P	P	P	P						
Dr H Brookes	GP – Glovers Lane Surgery					P	P						
Dr M Cornwell	GP – Glovers Lane Surgery												
Dr M Vickers	GP – Bridge Road Surgery	P	P	P	P	P	P						
Lynne Creevy	PM – Bridge Road Surgery	P	P	P	A	A							
Dr E Carter	GP – Bridge Road Surgery												
Dr N Choudhary	GP – Netherton Practice	P	P		P	A	P						
Lorraine Bohannon	PM – Netherton Practice		P	A	P	P	P						
Dr N Williams	GP – Ford Medical Practice	P	P	P	P	P	P						
Lin Bennett	PM – Ford Medical Practice	A	P	P	A	P	P						
Eils McCormick	PN – Ford Medical Practice	P	P	P	P	P	P						
Louise Armstrong	PN – Ford Medical Practice		P	P	P	P	P						
Dr B Fraser	GP – Ford Medical Practice												

Name	Designation	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
Jane McGimpsey	PM – Orrell Park Medical Centre	P	P	P	P	P	P						
Dr R Ogunlana	GP – Orrell Park Medical Centre	P	P	P	A	P	P						
Dr A Hameed	GP – Litherland Darzi	P			P		P						
Dr B Schoenberger	GP – Litherland Darzi	P					P						
Pam Maher	PM – Litherland Darzi / Litherland Town Hall	P	A										
Dr A Patrick	GP – Litherland Town Hall	P	P	P	A	P	P						
Dr F Cook	GP – Rawson Road / Orrell Park Medical Centres		P	P	P	P	P						
Angela Dunne	PM – Rawson Road / Orrell Park Medical Centres	P	P	A	P	P	A						
Ian Hindley	PM – Seaforth Practice/ Litherland Town Hall	P		P	P	A							

No	Item	Action
14/50	**Apologies –** Louise Taylor, Angela Dunne	
14/51	**Declarations of Interest** Dr Noreen Williams – LMC Lin Bennett – Governing Body Member	
14/52	**Minutes of the Last Meeting / Matters Arising** **Cellulitis Service** – MV reported that Christine Roberts has recruited a prescriber to cover localities for the interim which should cover the IV service. If any problems arise MV asked the group to contact him directly. For accuracy, it was requested that 129 Sefton Road be removed from any locality lists/information as this practice is no longer part of Seaforth & Litherland locality. **Virtual CRG** – this item had not yet been discussed by the LMC. **Community Geriatrician** – MV and AP met with the Dr Asan Akpan (AA), the newly appointed Community Geriatrician. AA will be assisting with the virtual ward referrals and is currently trialling the urgent care element of the virtual ward in the Bootle Locality which commenced on 1st June, with a planned roll-out of 1st September for Seaforth & Litherland. AA is currently taking S&L referrals from domiciliary visits and outreach clinics. In relation to referral rejections, AA is to investigate and MV asked the group if they could pass on any further rejections to AA who will sign post and inform the practice. NW reported that Ford Medical Centre are still getting rejections, MV asked for the details. AA will also be accepting referrals directly and will attend the August locality meeting. **EMIS web / Ericom**– An email had been sent to all practices from Paul Shillcock, Informatics Merseyside but some practices reported that they had not had sight of this. AP agreed to chase and ask Paul to resend. **Healthwatch** – Libby Kit to join the meeting later on the agenda. **Succession Planning** – Although there are no restrictions for the length of tenure for a locality chair, it was agreed that 3 years would be too long and 6 months too short a time. It was therefore agreed that MV would chair for 1 year then a new GP lead for the locality would be sought. It was widely agreed that it will be beneficial to rotate this role for practices to have the opportunity to chair. MV will be in post until February 2015. **Locality/Wider Group Payments** – all payments have now been received.	AP to ask PS to resend details

No	Item	Action
14/53	**Primary Care** Dr Bal Duper (BD), Primary Care GP Lead, SSCCG, gave a presentation to the group on the new Local Quality Contract (LQC) for GPs. SSCCG are investing in primary care for the future and have drawn up a contract with 9 specific indicators with the aim to uplift the baseline for to £87.50, if GPs sign up to the contract. There have been changes nationally to core contracts, the LQC also has a Practice Improvement Goal (PIG) for one year to uplift practices to £75.00 per patient. BD referred to the work that Liverpool PCT/CCG had already untaken a few years ago to uplift practices to a higher level of price per head. BD emphasised that GPs now need to develop a framework for the future of primary care and work together to create a sustainable way forward. The group discussed access to primary care and BD suggested basing access on a proportional basis on list size, ie 60 appointments per 2,000 – 3,000 patients. GPs need to know what is reasonable for them with the possibility of undertaking evening surgeries for smear clinics and telephone consultations. BD added that this is the time for GPs to have conversations to enhance the future of primary care. Use of the locality £50k was discussed as long as ideas demonstrated links with the strategic goals, however all practices in the locality would need to agree that the funding could be used to benefit practices with the lowest contract values. There was a discussion around the use of the £50k in previous years, in terms of ideas that had been disallowed, Karl McCluskey (KMcC) agreed to look at any blocks in the system. BD finished by stating that SSCCG are aiming to make this a more flexible way of working and stressed the importance of GPs working together to create innovative schemes for the future to ensure a long term commitment in primary care. BD outlined the timescales to the locality for the contract and added that the suggested start date is 1st August.	
14/54	**Healthwatch Community Champion** Libby Kit (LK) from Healthwatch attended the meeting. LK is now the Healthwatch locality representative for S&L and provided the group with an overview of the role. LK will provide 2-way communications between patients and the locality as well as taking any locality issues back to Healthwatch. LK explained to the group that Healthwatch gathers data from patients through patient groups and records the outcomes on a database. This data can be broken down to locality level and LK agreed to bring this to the group. Patient access to appointments has been raised as an issue. It was agreed that LK would attend bi-annually, but if any specific issues or developments arose LK would be invited to attend.	

No	Item	Action
14/55	**Liverpool Community Health – Senior Manager Introduction** Two representatives from Liverpool Community Health, Roz Fallon (RF) and Ian Senior (IS), attended the meeting along with Stephen Astles, Head of Development, SSCCG. LCH had come along to update the locality on the current changes and developments taking place in LCH and to outline future plans. Roz Fallon provided a brief overview stating that Sue Page had replaced Bernie Cuthel as the new Chief Executive for LCH and they are currently working through the various issues. RF explained to the group that LCH currently have a £2.8m underspend on the DN budget and the previous leadership had been focussing on foundation trust status for LCH rather than service provision. In light of this, LCH have been meeting with key organisations over the last 6 weeks to ascertain the reasons behind complaints which led the CQC to carry out an inspection. RF outlined the future plans for LCH stating that firstly they are working to fill the huge vacancy rate of DNs and have now began a recruitment drive to fill all vacant posts. This will take time and they are currently recruiting locum DNs but not for every vacant post. Secondly, they plan to create and develop clinical leadership to enhance working with GPs and localities ensuring this is as transparent as possible. There is a lot of work to be done and LCH representatives are going out to meet all staff to discuss and outline future plans and to work on creating the correct patient pathways to breakdown all barriers. The group discussed how to take this forward and it was agreed that this is an opportunity to create a new footprint with LCH and also agreed that it would be beneficial for LCH to meet with each individual practice to draft a new DN service model, hopefully by October and ensure each practice has sight of this before final agreement. RF assured the group that there will be transparency on funding in the future. MV thanked both Roz Fallon and Ian Senior for taking the time to come and update the locality on the current status of LCH.	LCH to meet with practices and draft new DN service model
14/56	**Finance/Quality Premium** TJ updated the group on the quality premium. This is currently on track for £460,519 and there will be a refresh of data at the next committee. It was reported that the MRSA premium will not be met and MV stipulated that this is out of the locality's control. The group asked whether GPs can agree what goes into the quality premium. TJ reported that she is currently working with Debbie Fagan, Chief Nurse for the CCG around infection targets and putting plans in place. The group asked whether the premium was patient and provider specific to take into account any cross boundaries. TJ reported that there is work being done on this point. TJ will ask	

No	Item	Action
	Debbie Fagan to provide an update to the locality via email. TJ also reported on proposed local measures. The BMI had looked at areas for local measures and one proposal for localities was diabetes because this is in the control of primary care and linked to current programmes where data has already been collected. This will also link in with the housebound proposal. This would need approval from NHS England and the group were concerned as to whether the BMI had ensured that this would not be rejected as it is part of QOF. TJ agreed to report back to the locality to confirm that QOF would not be affected. The proposal needs to be CCG wide and not locality based. TJ added that only one local measure is permitted and asked the group whether they were in agreement to proceed with diabetes. The group agreed to accept diabetes as the local measure on the grounds that this is an achievable proposal and not seasonal.	
14/57	**Medicines Management** Due to time constraints this agenda item was deferred to the next meeting.	
14/58	**Housebound Review of Business Case** NW and LB presented the business case for housebound health checks to the group. The plan is pilot the project this year to ascertain its sustainability. There was some discussion around HCAs and how many where employed within the locality in order to deliver this service. NW asked the group to have a look at the business case and feedback any queries. This will need to be agreed at locality level before commencement.	
14/59	**Any Other Business** No further business was discussed.	
14/60	**Date and Time of Next Meeting** 2nd July 2014 1 – 3pm Crosby Lakeside Adventure Centre	

South Sefton Clinical Commissioning Group

Bootle Locality Meeting

Tuesday 15th April 2014
1.00pm – 2.30pm
Park Street Surgery

Chair
Jenny Kristiansen (JK) – South Sefton Clinical Commissioning Group

Attendees
Dr H Mercer (HM) – Moore Street Surgery
Helen Devling (HD) – Moore Street Surgery
Pauline Sweeney (PS) – Park Street Surgery
Dr D Goldberg (DG) – Concept House Surgery
Dr S Sapre (SS) – Aintree Road Medical Centre
Dr K Chung (KC) – Park Street Surgery
Dr A Ferguson (AF) – The Strand Medical Centre
Gerry Devine (GD) – The Strand Medical Centre
R Swiers (RS) – Public Health Sefton MBC
Paul Halsall (PH) – Medicines Management

Apologies
Dr S Stephenson (SS) – Bootle Village Surgery
Dr R Sivori (RS) – Bootle Village Surgery

Guest Speakers
Dr A Akpan **–** Community Geriatrician
Jennifer Johnston – Medicines Management

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	Aug 14	Jul 14	Sept 14	Oct 14	Nov 14	Dec 14
Dr S Sapre	GP – Aintree Road Surgery	P	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	A								
Dr R Sivori	GP – Bootle Village Surgery				A								
Dr C McGuinness	GP – Bootle Village Surgery												
Gill Riley	PM – Concept House Surgery												
Dr D Goldberg	GP – Concept House Surgery	A		A	P								
Dr G Halstead	GP – Concept House Surgery			P									
Dr H Mercer	GP – Moore St Surgery	P	P	P	P								
Dawn Rigby	PM – Moore St Surgery												
Helen Devling	PM – Moore St Surgery	P	A	P	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	P								
Pauline Sweeney	PM – Park St Surgery	P	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	P								
Ronnie Holmes	PM – Strand Medical Centre												
Gerry Devine	PM – Strand Medical Centre		P	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
14/28	**Introductions & Apologies** All apologies were noted	
14/29	**Minutes of last meeting – 18th March 2014** Minutes of the last meeting were agreed as an accurate record	
14/30	**Matters Arising**	
14/31	**Respiratory Project** Jennifer Johnston CCG Respiratory Lead Pharmacist gave an overview of the respiratory pilot project funded by Locality Improvement money. The aim of the project are as follows • Reduced unplanned admissions due to Asthma and COPD • Reduce exacerbations of Asthma and COPD • Improve inhaler techniques • Improve patient education and self-management • Support practices in the continuing management of patients with Asthma and COPD The project will run from May 2014 until February 2015. Patients will be identified by having either COPD or Asthma and will have had 2 or more exacerbations over the past 12 months or one hospital admission or A&E visit due to their condition. The CCG have employed pharmacist Amit Patel for 24 hours per week (6 sessions) and Jennifer Johnston will do 1 session per week. Patients will be seen in their own practice. 20 minutes will be allocated to patients which will involve the following, • Supplying the patient with an Asthma/COPD management plan • Education about the disease • Checking and improving inhaler technique • Provision of a COPD rescue pack for appropriate patients • Medicines optimisation • Referral into spirometry (if required) • Referral into smoking cessation service (if required) • Referral into Pulmonary rehab (if required) The QOF template will be used for the reviews and will be counted as their regular COPD check (for those patients that meet the criteria). It was agreed that Amit will be available to do reviews on housebound patients and those in nursing homes. Amit is familiar with home visits and it was suggested he dealt with these patients first to solve any delays in getting the practice lists up and running The group was asked if they rooms available for the sessions in their practices.	Practices to identify these patients Practices to send JK available times
14/32	**Consultant Community Geriatrician** Dr Akpan gave an overview of the Urgent Care Pilot aimed to be in place across all South Sefton Localities by September 2014. The aim of the service is to keep all appropriate frail and elderly patients out of hospital and in their own homes. There will be scope for educational sessions in	JK to send out Dr Akpans

No	Item	Action
	nursing homes. He stated that he intends to meet as many GP's and practice staff as possible to understand their frustrations and to support any aspirations they may have around care for the frail & elderly. 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. Dr Akpan invited any comments, challenges with other local teams. He went on to say that he is looking for a locality to be a pilot for 4 weeks starting in June 2014. The Bootle locality agreed to be put forward for the pilot.	details
14/33	**Medicines Management Update** Paul Halsall gave a hand out to the group showing the prescribing finance report up to month 10. Discussions are currently ongoing regarding any year-end adjustments. He then addressed the meeting with a couple of points • Medication Reviews - A letter has been sent out to all South Sefton GP practices regarding medication reviews for nursing and residential homes. A team of 5 pharmacists (Sean Reck, Shaun Roche, Christine Barnes, Emma Dagnall and Dominika Jeziorek) will be visiting homes on a regular basis. The will require access to the practices clinical system to complete a full medication review, and code their actions. • Ferrous Fumarate –this will remain the first choice oral iron medication, there is no need to switch any patients from other preparations to this as there are no financial savings to be had. • Doxazosin Modified release. These tablets are now black. A message will be added to script switch. Appropriate monitoring is required if switching. • A letter has been approved by SSMOOG for patients living or travelling abroad or otherwise absent from the UK. (http://www.panmerseyapc.nhs.uk/guidelines/documents/G4.pdf)	
14/34	**Any other business** **LCH Community Dieticians** AF talked to the group about a fax she received regarding a change of medication for one of her patients which significantly increased the monthly cost without consultation. She discussed the patient with the group and wondered where the rationale was as the patient's weight had already increased to a healthy weight. The group discussed the issue about whether dieticians have any education on budgets concerning the financial implications of these changes. Also if prescriptions could be changed from monthly to weekly to cut down on the amount of wastage. JK asked if there is anything the CCG could do? Could there be more discussions between medicines management and the dieticians. **ECG** HM asked if any other practice noticed the reporting of results from Litherland Town Hall. They are sending the print out and the doctor needs to interpret the results themselves. KC has written to Craig Gillespie regarding the clinicians report.	PH to report to JK JK to email CVD lead Sharron Forrester

No	Item	Action
	Locality Development Fund The £50,000 has been agreed for 2014/15. Any ideas how to use this fund (equipment, projects) please contact JK	
14/35	**Date and time of next meeting** Tuesday 20th May 1pm – 2.30pm Park Street Surgery	

Chair Signature ……. Date …….

South Sefton Clinical Commissioning Group

Bootle Locality Meeting

Tuesday 20th May 2014
1.00pm – 2.30pm
Park Street Surgery

Chair : Dr R Sivori – Bootle Village Surgery

Attendees
Pauline Sweeney – Park Street Surgery
Dr K Chung – Park Street Surgery
Dr G Halstead – Concept House
Gerry Devine – The Strand Medical Centre
Dr S Sapre – Aintree Road Medical Centre
Dr A Ferguson – The Strand Medical Centre
Sanju Sapre – Aintree Road Medical Centre
Paul Halsall – Medicines Management
Angela Curran – South Sefton Clinical Commissioning Group
Jenny White – South Sefton Clinical Commissioning Group
Jenny Kristiansen – South Sefton Clinical Commissioning Group

Apologies
Dr H Mercer – Moore Street Surgery
Dr A Roberts – Moore Street Surgery
Helen Devling – Moore Street Surgery
Dr S Stephenson – Bootle Village Surgery
Ryan Swiers – Sefton MBC Public Health

Guest Speakers
Colette Page – South Sefton Clinical Commissioning Group
Dr Debbie Harvey – South Sefton Clinical Commissioning Group

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	Aug 14	Jul 14	Sept 14	Oct 14	Nov 14	Dec 14
Dr S Sapre	GP – Aintree Road Surgery	P	P	P	P	P							
Sanju Sapre	PM – Aintree Road Surgery					P							
Dr S Stephenson	GP – Bootle Village Surgery	P	P	P	A	A							
Dr C McGuinness	GP – Bootle Village Surgery												
Dr R Sivori	GP – Bootle Village Surgery					P							
Gill Riley	PN – Concept House Surgery												
Dr D Goldberg	GP – Concept House Surgery	A		A	P								
Dr G Halstead	GP – Concept House Surgery			P		P							
Dr H Mercer	GP – Moore St Surgery	P	P	P	P	A							
Dr A Roberts	GP – Moore St Surgery					A							
Dawn Rigby	PM – Moore St Surgery												
Helen Devling	PM – Moore St Surgery	P	A	P	P	A							
Dr R Sinha	GP – North Park Health Centre	A											
Pam Sinha	PM – North Park Health Centre	A											
Dr K Chung	GP – Park St Surgery	P	P	P	P	P							
Pauline Sweeney	PM – Park St Surgery	P	P	P	P	P							

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
Dr A Ferguson	GP – Strand Medical Centre	P	P	P	P	P							
Gerry Devine	PM – Strand Medical Centre		P	P	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
14/36	**Introductions & Apologies** All apologies were noted	
14/37	**Minutes of last meeting – 15th April 2014** Minutes of the last meeting were agreed as an accurate record.	
14/38	**Matters Arising** 14/31 Respiratory Project– JK clarified that practices will have one session each per week. Initially Amit will be focusing on home visits. An issue was raised about current waiting time for the spirometry service provided by Aintree Trust. JK informed the group that there may be a bit more of a wait in Bootle due to the referral rate being more than double that of the other localities, she assured the group that she will be looking into this. It was raised that some practices are doing their own annual review spirometry testing (FEV1) even though the CCG is paying Aintree to do so. The service is also not commissioned to do testing for the housebound. JK agreed to take back comments to the meeting with Aintree and look at options for the future and report back to the group. 14/32 – Dr Akpan's details have been sent out. Changes to ECG services– JK spoke to Sharon Forrester, who is not aware of any changes in the contract. GH informed the group that the staff in the ECG has been reduced from 10 to 2. They are now only reporting abnormal ECG's and normal ECGs will be sent though with no report. S&FCCG do their own in house.	
14/39	**CCG Practice Nurse Lead Role** Colette gave an overview of the HCA apprenticeship scheme. RS asked Colette to contact the practice manager at Bootle Village to discuss. Park St, The Strand and Aintree Road were also interested. A PLT event will be held on 16th July to present details of a Practice Nurse mentorship scheme. There are concerns that no new practice nurses are coming through, and that practice nurses are just moving from surgery to surgery. Any questions contact Colette Page or Pippa Rose.	CP to contact intereste d practice.
14/40	**Palliative Care** DH gave an overview of the new DNAR forms. These are now unified, 1 to stay with patient (lilac) 1 for patient's notes in hospital and 1 for audit purposes. New EMIS read codes have been set up (DNR in place) or (DNR cancelled) in most cases these are indefinite. These can be logged with NWAS that there is a DNR in place, it has been agreed to stay in place on ERIS system for 12 months before reviewing. If GP's want to use the (NWAS) Eris system to contact DH. GP's noted the login process is long winded and more admin work for the practice rather than NWAS. This lead to general discussion by the group in regard to the forms and the NWAS System. Patients are advised to make their copy of	

No	Item	Action
	the form visible to the paramedics other wise to keep in the folder of District nurses notes. Any further information please contact DH.	
14/41	**Finance & Quality Premium Update** JW addressed gave an update for the quality premium dashboard for 2013/14. JW then on to give an update of the latest finance information. As at the year end the CCG has met its planned target to achieve a 1% surplus of the resource allocation. On a locality level Bootle is underspent as at the end of month 11 by £0.060m against the 2013/14 plan. The 50K locality funding and the winter pressures CCG allocation of 470K have been built into the CCG financial plans for the next 5 years to enable long term planning.	
14/42	**Medicines Management Update** PH updated the group with the latest issues concerning medicines management, • **Prescribing Finance** – As at month 11 the CCG is showing an overspend of 0.99%. This is due to be reduced when some adjustments are put through. • **Update from JMOG** JMOG have approved a request from the specialist Heart Failure nurses team allowing them to initiate ivabradine, in line with NICE guidance and following discussions with the cardiologist. If practices receive any patient queries/problems regarding the delivery of Metoject from Healthcare at Home, please speak to practice pharmacist and incident should be recorded • Glucophage / metformin suspension sachets have been discontinued. You will need to discuss any options with your practice pharmacist. • Dosulepin There is a supply shortage of this drug in 75mg form. Forecasts are this will affect the supply of 25mg tablets. There is no date for the resolution of shortage. Prescribing of dosulepin requires a review to whether indication is still present and whether a suitable alternative can be used. Discuss any options with your practice pharmacist.	
14/43	**Any Other Business** **IPADS** – Dr Savori asked for an update on the IPad for surgeries. **Meeting Dates** – It was agreed future meetings will be moved forward 1 week to avoid the PLT meetings held at the same time as current meetings. **Locality Chair Role** – It was agreed that Gina Halstead will take over the role of Locality Chair for a six month period starting from July 2014.	JK to feedback next meeting.
14/35	**Date and time of next meeting** Tuesday 24th June 2014	

No	Item	Action
	1.00pm – 2.30pm Park Street Surgery	

Chair Signature ……. Date …….

South Sefton Clinical Commissioning Group

Crosby Locality Meeting

Wednesday 7th May 2014
12:45 – 2.30pm
Crosby Lakeside Adventure Centre (CLAC)

Chair : Dr G Berni

Attendees
Dr G Berni (GB) – 42 Kingsway Surgery
Alan Finn (AF) – 42 Kingsway Surgery
Dr C McDonagh (CM) – 30 Kingsway Surgery
Shelley Keating (SK) – 30 Kingsway Surgery
Dr D Navaratnam (DN) – 20 Kingsway Surgery
Dr G Misra (GM) – 133 Liverpool Road Surgery
Maureen Guy (MG) – 133 Liverpool Surgery
Dr C Gillespie (CG) – Blundellsands Surgery
Colin Smith (CS) – Blundellsands Surgery
Sue Hancock (SH) – Blundellsands Surgery
Dr S Roy (SR) – Crosby Village Surgery
Pippa Rose (PR) – Crosby Village Surgery
Dr P Sharma (PS) – Crossways Surgery
Dr I Breck (IB) – Thornton Surgery
Jennifer Kimm (JK) – Thornton Surgery
Dr S Bussollo (BU) – Hightown Surgery
Pauline Woolfall (PW) – Hightown Surgery
Alison Johnston - South Sefton Clinical Commissioning Group
Tina Ewart - South Sefton Clinical Commissioning Group

Apologies
Sharon McGibbon – Eastview Surgery

Guest Speakers
Richard Harkness & Martin Smith (iMerseyside)
Debbie Harvey, Moira McGuiness (South Sefton CCG)
Graham Whyte, Dawn Porter (Aintree)
Alan McGee (Public Health)

Minutes
Gary Killen

A 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
Pippa Rose	PN – Crosby Village Surgery	P	P	A	P	P							
Dr M Taylor	GP – Crosby Village Surgery	P											
Dr S Roy	GP – Crosby Village Surgery	P	P	P	P	P							
Sharon McGibbon	PM – Eastview Surgery		P	P	P	A							
Dr A Mimnagh	GP – Eastview Surgery	P	P	P	P								
Dr M Hughes	GP – Eastview Surgery												
Dr R Ratnayoke	GP – Eastview Surgery				P								
Dr P Sharma	GP – Crossways Surgery	P		P	P	P							
Jenny Kimm	PM – Thornton Surgery			P	P	P							
Stella Moy	PN – Thornton Surgery			A	A								
Dr R Huggins	GP – Thornton Surgery				P								
Maureen Guy	PM – 133 Liverpool Road	P		P	P	P							
Dr G Misra	GP – 133 Liverpool Road	A	P	P	P	P							
Sandra Holder	PN – 133 Liverpool Road	P											
Dr N Tong	GP – Blundellsands Surgery		P		P								
Dr C Gillespie	GP – Blundellsands Surgery	P	A	P		P							
Sue Hancock	PN – Blundellsands Surgery	P	A	P	P	P							
Colin Smith	PM – Blundellsands Surgery	P	P	P	A	P							
Shelley Keating	PM – 30 Kingsway		A	P	P	P							
Dr C Shaw	GP – 30 Kingsway												

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 McDonagh	GP – 30 Kingsway	P	P	P	P	P							
Dr E Pierce	GP – Hightown Village Practice												
Pauline Woolfall	PM – Hightown Village Practice	P	A	P	P	P							
Dr C Allison	GP – Hightown Village Practice	P											
Dr Ghalib	GP – Hightown Village Practice			P									
Dr S Bussolo	GP – Hightown Village Practice					P							
Dr D Navaratnam	GP – Azalea Surgery	A	P	P	P	P							
Dr C Doran	GP – Azalea Surgery												
Dr G Berni	GP – 42 Kingsway	P	P	P	P	P							
Alan Finn	PM – 42 Kingsway		P	P	P	P							
Dr F Vitty	GP – 42 Kingsway												

No	Item	Action
14/37	**Welcome and Apologies** Sharon McGibbon apologies received.	
14/38	**Declarations of Conflict of Interest** None received	
14/39	**Rollout of Ericom** Richard Harkness & Martin Smith came along to inform the group of the rollout of iPADs for GP use across the patch; ▪ This is being funded by the CCG and delivered under the mobile working/IM&T element of the Primary Care Quality Strategy. ▪ It will give real time access to your patient records on EMIS Web via mobile technology (ERICOM 'Access to Go', 3G mobile data contract, iPAD device with keyboard and stylus). This will allow clinicians to view the full EMIS Web patient record (and update it) real time while out on home/care home visits. ▪ The project team from iMerseyside will be in touch with Practice Managers to gauge expressions of interest from Practices who would like to benefit from the technology. The devices will be rolled out to Practices (no. of devices dependent on list size) over the coming month, with full training from iMerseyside. ▪ The CCG has fully funded (devices and licences for 3G and Ericom) for the first year. Recurring costs after this first year estimated at about £200 (to cover annual licences). There will be a review of the device usage and possible wider rollout (and opportunity for clinicians to bring their own device to install ERICOM on) towards the end of this first year. ▪ There has already been a small pilot of this solution with a handful of GPs across both CCGs and it has been received with success and they continue to derive much benefit from mobile working. It is planned that the rollout will start with a handful of pilot Practices towards the end of May before full rollout in June.	
14/40	**End of Life/Hospice at Home** Graham Whyte gave the group an update; ▪ Site refurbishment ▪ Hospice at Home (was a pilot, now three year contract). Three elements of which are 1. Crisis Prevention/Intervention (access to service on same day as referral being typical) 2. Transfer Home 3. Palliative Care Sitting Service (HCA day/night cover in addition to package of care). 316 referrals have been received, 200 patients have subsequently passed away, only 3% in hospital. Referrals can be taken over the phone ▪ DNA/CPR/ACP/Difficult Conversations training is available for GPs and will be supported by the ACP Facilitator role. ▪ Wellbeing and Support Centre in operation (was the old day therapy unit). The aim is to try to reach more patients than before (including younger people). Benefiting from a new build and new gym etc and operates 5 days per week. Initial therapist assessment then provides access to 1. Therapies 2. Nurse Led Clinics 3. Group Work/Activities (e.g. Bereavement, Creative Therapy, Supportive Living etc. Seen as a route into the Hospice, the feedback so far has been good with a	

No	Item	Action
	plan to introduce more group activities. The service would welcome more **referrals**! Moira McGuiness asked the group to feedback, both positive and negative, in terms of all elements of the services supporting EOL (DN teams/Woodlands/Care Homes/Hospital at Home/Virtual Ward). Debbie Harvey advised the group of the piece of work Dr Nigel Taylor is doing (as part of his CCG role) in terms of an audit of care homes, care home facilitator role and the six steps programme. Recommendations from this audit will be published by way of a paper which will be fed back to the CCG, GP's and Care Homes. Further projects in care homes will come online in the coming year.	
14/	**Alzheimer's Society** Linda Lawson introduced herself to the group and described the role of dementia support workers working across the CCG and how they provide non clinical emotional support to individual clients and carers from diagnosis onwards ▪ This is delivered in various ways, from group activities, signposting service to access legal/benefit system, memory clinics, sitting in on consultations/diagnosis, fact sheets and an e-news service providing links to events and information on dementia. ▪ There are various Memory Café venues across Sefton, including a relatively new café in Crosby. Memory Cafés are informal drop in groups where people living with dementia and their carers can get together to talk about the things that are important to them. Alzheimer's Society staff are on hand to give information and support, and there are often guest speakers on a range of topics. There is no need to book, people can come along and they will be made very welcome. The dates for the Crosby venue can be found here; http://nww.southseftonccg.nhs.uk/Library/CCG_&_locality/Newsletters/Bulletin-documents/March_2014/Crosby%20Cafe%202014%20New%20Logo.pdf ▪ Communications are also going out through the e-bulletin to ensure GPs are engaged and kept up to date with the events going on locally (i.e. dementia awareness week). ▪ The National 'Worried About Memory' campaign has been publicised in an attempt to capture the estimated 50% that are yet to be diagnosed, encouraging them to see their GP. There is a leaflet that can be printed off and shared with patients here; http://nww.southseftonccg.nhs.uk/news/news-2013/alzheimers_memory_loss_information.aspx ▪ Linda distributed information packs out to the group that can be given out to patients. Details of referring into the service can be found on the Practice Support area of the Intranet	
14/41	**Public Health** Alan McGee, Senior Public Health Practitioner in Health Care came along to introduce himself and his liaison role with the Locality; ▪ His area of expertise is the commissioning of drug and alcohol services with an aim to integrating alcohol and substance misuse services, developing an integrated shared care model and bringing more services into the community. ▪ He spoke about the Lifeline service, commissioned from Oct 2013. CG asked if this service replaced the SATINS service and Alan confirmed that it is a new combined service (which was once SATINS, ADDACTION). Alan	

No	Item	Action
	asked that the group feedback to him with regards to access, waiting times and effectiveness of the pathway so they can make improvements to the service. CM and GM expressed concern over the wait times (varying from 5 days to 4 weeks) in referrals being actioned. The Lifeline service take referrals via phone or faxed referral form (details on the Practice Support area of the Intranet) **ACTION** AJ to check how referral management comms has gone out to Practices, including the rollout of the agreed referral proforma onto clinical systems.	AJ
14/42	**Minutes of last meeting** Pippa Rose to be added as attendee for our April meeting **ACTION** AJ to ensure both the minutes and tracker are updated	AJ
14/43	**Matters Arising** None noted	
14/44	**Medicines Management** Budget Update ▪ As at Month 11 2013/14, NHS South Sefton CCG is £234,262 above budget. This represents a 0.99% overspend. Crosby as a locality is forecast £44,103 overspend which represents 0.61% Update from JMOG ▪ JMOG have approved a request from the specialist Heart Failure nurses team allowing them to initiate ivabradine in line with NICE guidance and following discussion with the cardiologist ▪ NPSA alert regarding Healthcare at home: If practices receive any patient queries regarding the delivery of Metoject from Healthcare at Home, please speak to your practice pharmacist MHRA Alert Domperidone ▪ Domperidone is associated with a small increased risk of serious cardiac side effects. Its use is now restricted to the relief of symptoms of nausea and vomiting and the dosage and duration of use have been reduced. Domperidone is now contraindicated in those with underlying cardiac conditions and other risk factors. ▪ All patients receiving long-term domperidone should have their therapy reviewed and risks explained to them. Please liaise with practice pharmacists for course of action within practice. CG raised a query, in light of these changes have the guidelines for dysepsia patients been updated. **ACTION** JJ to check the guidelines as per CG's query	JJ
14/45	**Finance** ▪ Locality investment monies forecast for the next 5 years. ▪ There is 470k of winter monies forecast for 14/15. ▪ Primary Care Quality Strategy investment/Local Quality Contract/Review of LES to be reviewed by the end of May. ▪ Quality Premium payment for 14/15 553k projected, doubtful we'll achieve national domains for 1 and 5	
14/46	**Updates and Feedback to Group** ▪ TE shared the results of the COPD GSK pilot with the group and posed that a wider uptake could take place this year with the support of the locality investment monies. Other areas for consideration based on discussions had so far today could be a focus on improvement to dementia (using risk	

No	Item	Action
	stratification/dementia screening/virtual ward) or alcohol services. **ACTION** The group were urged to come forward with ideas for locality investment so we can start the planning activity earlier than previous years. ▪ TE mentioned to the group that another locality have had LCH representation at their meeting, both for introductions sake and to take feedback in terms of how service provision is going (virtual ward and the wider community services). The group were asked if this should take the form of a regular attendance where senior management representation from LCH comes for the beginning or the end of the meeting (outside of regular locality business). An LCH representative to be invited to the next meeting and regular attendance to be agreed after this. **ACTION** TE/AJ to invite Ian Senior/Karen Riddick to the beginning of the agenda in June.	All TE/AJ
14/47	**AOB** None noted	
	Date and time of next meeting Wednesday 4th June 2014 12:30 lunch 12.45 start – 2.30 Crosby Lakeside Adventure Centre (CLAC)	

South Sefton Clinical Commissioning Group

Crosby Locality Meeting

Wednesday 4th June 2014
12:45 – 2.30pm
Crosby Lakeside Adventure Centre (CLAC)

Chair : Dr G Berni (GB) – 42 Kingsway

Attendees
Pippa Rose (PR) – Crosby Village Surgery
Dr S Roy (SR) – Crosby Village Surgery
Sharon McGibbon (SM) – Eastview Surgery
Dr A Mimnagh (AM) – Eastview Surgery
Dr P Sharma (PS) – Crossways Surgery
Bruce Duncan (BD) – Crossways Surgery
Jenny Kimm (JK) – Thornton Surgery
Dr R Huggins (RH) – Thornton Surgery
Dr G Misra (GM) – 133 Liverpool Road
Dr N Tong (NT) – Blundellsands Surgery
Sue Hancock (SH) – Blundellsands Surgery
Colin Smith (CS) – Blundellsands Surgery
Pauline Woolfall (PW) – Hightown Village Practice
Dr S Bussolo (SB) – Hightown Village Practice
Dr D Navaratnam (DN) – Azalea Surgery
Alan Finn (AF) – 42 Kingsway
Janet Faye (JF) – South Sefton Clinical Commissioning Group
Sean Roach (SF) – South Sefton Clinical Commissioning Group
Tina Ewart (TE) – South Sefton Clinical Commissioning Group
Alison Johnston (AJ) – South Sefton Clinical Commissioning Group

Apologies
Shelley Keating - 30 Kingsway
Stella Moy – Thornton

Guest Speakers
Bal Duper – South Sefton Clinical Commissioning Group
Karl McCluskey – South Sefton Clinical Commissioning group
Roz Fallon – Liverpool Community Health
Ian Senior – Liverpool Community Health

Minutes
Gary Killen – South Sefton Clinical Commissioning Group

A 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
Pippa Rose	PN – Crosby Village Surgery	P	P	A	P	P	P						
Dr M Taylor	GP – Crosby Village Surgery	P											
Dr S Roy	GP – Crosby Village Surgery	P	P	P	P	P	P						
Sharon McGibbon	PM – Eastview Surgery		P	P	P	A	P						
Dr A Mimnagh	GP – Eastview Surgery	P	P	P	P		P						
Dr M Hughes	GP – Eastview Surgery												
Dr R Ratnayoke	GP – Eastview Surgery				P								
Dr P Sharma	GP – Crossways Surgery	P		P	P	P	P						
Bruce Duncan	PM – Crossways Surgery						P						
Jenny Kimm	PM – Thornton Surgery			P	P	P	P						
Stella Moy	PN – Thornton Surgery			A	A		A						
Dr R Huggins	GP – Thornton Surgery				P		P						
Maureen Guy	PM – 133 Liverpool Road	P		P	P	P							
Dr G Misra	GP – 133 Liverpool Road	A	P	P	P	P	P						
Sandra Holder	PN – 133 Liverpool Road	P											
Dr N Tong	GP – Blundellsands Surgery		P		P		P						
Dr C Gillespie	GP – Blundellsands Surgery	P	A	P		P							
Sue Hancock	PN – Blundellsands Surgery	P	A	P	P	P	P						
Colin Smith	PM – Blundellsands Surgery	P	P	P	A	P	P						
Shelley Keating	PM – 30 Kingsway		A	P	P	P	A						

Name	Designation	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
Dr C Shaw	GP – 30 Kingsway												
Dr C McDonagh	GP – 30 Kingsway	P	P	P	P	P	A						
Dr E Pierce	GP – Hightown Village Practice												
Pauline Woolfall	PM – Hightown Village Practice	P	A	P	P	P	P						
Dr C Allison	GP – Hightown Village Practice	P											
Dr Ghalib	GP – Hightown Village Practice			P									
Dr S Bussolo	GP – Hightown Village Practice					P	P						
Dr D Navaratnam	GP – Azalea Surgery	A	P	P	P	P	P						
Dr C Doran	GP – Azalea Surgery												
Dr G Berni	GP – 42 Kingsway	P	P	P	P	P	P						
Alan Finn	PM – 42 Kingsway		P	P	P	P	P						
Dr F Vitty	GP – 42 Kingsway												

No	Item	Action
14/48	**Welcome and Apologies** Shelley Keating - 30 Kingsway Stella Moy – Thornton	
14/49	**Declarations of Conflict Interest** None declared.	
14/50	**Primary Care Quality Strategy** Bal Duper presented the Primary Care Quality Strategy to the group and emphasised that the document recently circulated was indeed a draft with purposeful blanks intended to generate conversation and feedback from practices. It was not meant to challenge practices. Bal also demonstrated a wide variance of monies paid per head of population to practices across South Sefton and emphasised a need of transparency of finances. He recognised that these payments are historically challenging and difficult to unpick however now is the opportunity to make the change and align everyone to a standardised payment rate as they had already done in neighbouring CCGs a couple of years ago. It was noted that South Sefton is most cost efficient primary care organisation in the country. At present the core funding ranges from £67.00 to £97.00. The plan is align practice payments to a minimum of £87.50 per head through the Practice Improvement Goal (PIG) but ideally £90.00 per head. Karl and Bal alluded to a current shortfall of £300K and requested consideration and investigation by practices as to how and where savings and investments can be made from our commissioning with secondary care. Bal is happy to share his information on an individual basis should you wish to discuss. AM Included is access to reduce unplanned care and plough any savings back into primary care. It was recommended to share services across practices. Ideas as a locality but individual practice ideas are also welcome. All Ideas please contact Bal Duper or Karl McCluskey **Contact Details : Dr Bal Duper bal.duper@nhs.net** **Mr Karl McCluskey Karl.McCluskey@southseftonccg.nhs.uk**	
14/51	**Liverpool Community Health** Stephen Astles introduced Roz Fallon (Interim Deputy Chief Executive Officer LCH). Roz is working with Sue Page (Interim Chief Executive Officer LCH). They joined LCH just before Easter. 2 other new staff have been appointed; Director of	

No	Item	Action
	Nursing and Director of Operations. In the last 6 weeks they have undertaking a staff listening exercise in relation to LCH business. Roz stated that GP's are integral to the business of LCH and are seeking to improve the relationships they have with us. LCH are to implement a 3 phase improvement plan: Phase 1 – ironing out short term problems. Phase 2 – improving the infrastructure, getting the organisation to be open and transparent. A forum will be created involving GP's, and other primary care staff to facilitate this. It is planned to be up & running by the autumn. The forum members will automatically include: the present Board representatives and Locality Lead GPs plus at least one other representative from each locality. Roz indicated they will be bringing in a GP from Cumbria to facilitate these sessions looking at care pathways etc. *If you are interested in being part of this forum please contact Stephen Astles in the first instance* AM encouraged colleagues to embrace this opportunity fully AF enquired if Practice managers were to be included – yes	
14/52	**Minutes of last meeting** The minutes following the meeting held on 7th May 2014 were agreed as an accurate record.	
14/53	**Matters Arising** 14/44 Dyspepsia Pathway will be updated but waiting for formal guidelines change	
14/54	**Medicines Management** **Amoxicillin** There have been recent changes in the prescribing of amoxicillin to children over 5 years old. It is the same dose as an adult which is 500mg, 4 times a day. **Tramadol & Temazepam** The restriction of tramadol prescribing has come after the Home Office accepted advice that the drug should become controlled as a class C drug and placed in schedule 3 of the 2001 regulations on drugs misuse. These changes will mean GPs will now have to start providing written prescriptions for both tramadol and temazepam and will only be able to prescribe a month's supply of the drugs at a time. Updates will be put on the Sefton Prescriber link on the intranet. Finance and Medicines Management are currently working on the in-house	

No	Item	Action
	adjustments for last year's prescribing results. Shaun Roche introduced himself as part of the 'care home project' in South Sefton. There are 1 -2 pharmacists allocated per locality Shaun & Chris Barnes are looking after Crosby. They are to review records of Care home patients and visit them at the home, create a specific review form and tidy up records. Practices will note their actions and the pharmacist will re code. They will also check bloods are up to date and discuss with GP's any specific tests patients require. They will need own logins and passwords from the practice managers. Shaun will work with the practices to their individual specifications.	
14/55	**Finance/Quality Premium** Finance to present at the meeting next month regarding the final figures. Updated Finance Report will be circulated with minutes.	
14/56	**Commissioning Priorities** Fiona Clark met with all GP Leads at the last wider group meeting and discussed succession planning for locality leads and the responsibilities that come with the position. Although there are no restrictions for the length of tenure for a locality chair, it was agreed that 3 years would be too long and 6 months too short a time. It was discussed that it would be beneficial to rotate this role for practices to have the opportunity to chair and Gus proposed to renew the role of chair by inviting expressions of interest.	GB/TE
14/57	**Respiratory Project Proposal** TE presented a Respiratory Project idea for the locality, mirroring Bootle locality project. Mainly training and education offered to both patients and practice nurses to review medicines, improve compliance and inhaler techniques etc. Bootle has had excellent response from staff and patients already which should reflect in reducing admissions to A&E. This project would involve ½ day sessions allocated to each practice. The group had a reasoned discussion about the relative merits of investing in a shorter term project such as this as opposed to investing this money into narrowing the gap between the practices with the lowest amount of money per patient and those at the other end of the spectrum, and that this should become a priority for the locality group work. GB,TE, AS to contact SA & Bal Duper to explore options for investing the locality money in the Practice Improvement Goal (PIG)	
14/58	**AOB** Virtual Ward and Liverpool Community Health are looking to map a journey from patient appointment to Virtual Ward with regards to a complex case. This will involve all paper and electronic documentation. Dr Navaratum has volunteered a case from his practice. **ACTION** - TE to discuss with DN	
	Date and time of next meeting Wednesday 2nd July 2014 12:30 lunch	

No	Item	Action
	12.45 start – 2.30 Crosby Lakeside Adventure Centre (CLAC)	

South Sefton Clinical Commissioning Group

Maghull Locality Meeting Minutes

Friday 25th April 2014
1:00pm – 2:30pm
High Pastures Surgery

Chair
Dr J Thomas (JT) – Broadwood Surgery

Attendees
Gillian Stuart (GS) – Westway Medical Centre
Carol Howard (CH) – Westway Medical Centre
Jon Clarkson (JC) - High Pastures Surgery
Gill Kennedy (GK) – High Pastures Surgery
Dr A Banerjee (AB) – Maghull SSP Surgery
Dr S Sapre (SS) – Maghull Health Centre
Dr R Killough (RK) – Westway Medical Centre
Jenny Johnston (JJ) – South Sefton Clinical Commissioning Group
Terry Hill (TH)– South Sefton Clinical Commissioning Group

Apologies
Donna Hampson (DH) – Maghull SSP Surgery
Dr S Gough (SG) – Westway Medical Centre

Guest Speakers
Dr Asan Akpan (AA)– Community Geriatrician
Colette O'Loughlin (CO) – Liverpool Community Health
Veronica Bellis (VB) – Liverpool Community Health

Minutes
Gary Killen – 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	P								
Gillian Stuart	PM – Westway Medical Centre	P			P								
Carole Howard	PM – Westway Medical Centre				P								
Dr S Chandra	GP – Westway Medical Centre												
Dr R Killough	GP – Westway Medical Centre	P			P								
Dr J Wray	GP – Westway Medical Centre												
Dr S Gough	GP – Westway Medical Centre	P	P	P	A								
Jennie Procter	PN – Westway Medical Centre	P											
Gill Kennedy	PM – High Pastures Surgery	P	P	P	P								
Dr P Thomas	GP – High Pastures Surgery		P										
Dr J Clarkson	GP – High Pastures Surgery		P	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	A								
Dr A Banerjee	GP – Maghull SSP Practice	P		P	P								
Dr J Thomas	GP – Broadwood Surgery	P	P	P	P								
Dr B Thomas	GP – Broadwood Surgery												
Judith Abbott	PN – Broadwood Surgery												
Dr S Sapre	GP – Maghull Surgery				P								

No	Item	Action
14/25	**Apologies** All apologies were noted	
14/26	**Declarations of interest** JT – SSMOOG	
14/27	**Action Points** **Ward 35** – The criteria was distributed to the locality by TH. Sarah McGovern is to attend future meetings **Attendances at meetings payments –** No payment issues were received.	
14/28	**Dr Akpan – Community Geriatrician** Dr Akpan (AA) introduced himself and gave a brief description about his role as one of two community geriatricians. AA stated that he intends to meet as many GP's and practice staff as possible to understand their frustrations, to support aspirations, iron out issues and make any amendments to provider contracts to assist in supporting the localities patients. He is based at Litherland Town Hall but also carries out sessions at University Hospital Aintree. The urgent care element of the virtual ward is anticipated to go live on the 2nd June initially in Bootle. The team will provide a 2 hour response with the aim of keeping patients on the caseload for 48-72 hours. For patients needing longer interventions the team is co-located and will link in with other teams such as physio's, OT etc.The plan is to work closely with the community geriatrician and wrap services around the patient in their home were possible. The team has access to ward 35 and can admit if necessary. This will be fully up and running by September 2014. Dr Akpan encouraged all to contact him, please feel free speak with him any time and expect to see him visiting practices with Virtual Ward staff. Dr Akpan contact details are: ASAN.AKPAN@aintree.nhs.uk Mobile : 07964 462754	
14/29	**Medicines Management** JJ updated the group with the latest issues concerning medicines management. • Medication Reviews - A letter has been sent out to all South Sefton GP practices regarding medication reviews for nursing and residential homes. A team of 5 pharmacists (Sean Reck, Shaun Roche, Christine Barnes, Emma Dagnall and Dominika Jeziorek) will be visiting homes on a regular basis. The will require access to the practices clinical system to complete a full medication review, and code their actions. • A letter has been approved by SSMOOG for patients living or travelling abroad or otherwise absent from the UK. http://www.panmerseyapc.nhs.uk/guidelines/documents/G4.pdf • Primary Care Antimicrobial Guidelines – the UTI section has been	

No	Item	Action
	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	
14/30	**HCA Apprenticeship Programme** Pippa gave an update on Health Care Assistant apprenticeship programme: The CCG will fund 50% of their salary. The college will allocate 1 apprentice HCA per average size practice, or 1 between 2 small practices. It is hoped that the practices would continue to employ the student once they have become qualified. The apprenticeship programme will run over a 15 months period. If you have an expression of interest, please contact either Pippa Rose or Terry Hill.	
14/31	**Schedule of Meetings** A consultation process was conducted with all practices within the locality in relation to the days of the month meetings should be held. TH collated responses and fed back the outcome of the consultation to the locality. The collated responses provided no clear consensus between practices on specific days or location of meetings and therefore the group decided to continue with the current arrangements. SS requested that it be noted that he was unhappy with the decision the group had made.	
14/32	**Any other business** Dr Banerjee requested some advice from the group on a couple of points. • Occupational Therapists. The referral form is a number of pages long and AB asked if this could be shortened locally. JC advised there is a multi-disciplinary form that can be used; JC will send one to AB, also advised to attach a letter. • Funding requests. Again the forms are quite lengthy. He was advised to put as much clinical information as possible. There is guidance on the CCG intranet. There is lots of returns between departments, would it be more useful to put the patient criteria on the intranet? **Action** - TH to liaise with Lesley McKinnell to see what criteria is for the funding panel, also to advise when the date of the next funding committee.	
14/33	**Date and Time of next meeting:** 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 22nd May 2014
1:00pm – 2:30pm
Westway Surgery

Chair
Dr J Thomas (JT) – Broadwood Surgery

Attendees
Donna Hampson (DH) – Maghull SSP Surgery
Gillian Stuart (GS) – Westway Medical Centre
Dr S Gough (SG) – Westway Medical Centre
Dr A Banerjee (AB) – Maghull SSP Surgery
Dr S Sapre (SS) – Maghull Health Centre
Carole Morgan (CM) – High Pastures Surgery
Dr J Clarkson (JC) - High Pastures Surgery
Jenny Johnston (JJ) – South Sefton Clinical Commissioning Group
Terry Hill (TH)– South Sefton Clinical Commissioning Group
Angela Curran (AC) - South Sefton Clinical Commissioning Group
Karen Riddick (KR) – Liverpool Community Health

Apologies
Gill Kennedy (GK) – High Pastures Surgery

Guest Speakers
Richard Harkness – iMerseyside
Martin Smith – iMerseyside
Karl McCluskey - South Sefton Clinical Commissioning Group
Jenny White - South Sefton Clinical Commissioning Group
Becky Williams (BW) – South Sefton Clinical Commissioning Group

Minutes
Gary Killen - 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	P	P							
Gillian Stuart	PM – Westway Medical Centre	P			P	P							
Carole Howard	PM – Westway Medical Centre				P								
Dr S Chandra	GP – Westway Medical Centre												
Dr R Killough	GP – Westway Medical Centre	P			P								
Dr J Wray	GP – Westway Medical Centre												
Dr S Gough	GP – Westway Medical Centre	P	P	P	A	P							
Jennie Procter	PN – Westway Medical Centre	P											
Gill Kennedy	PM – High Pastures Surgery	P	P	P	P	A							
Dr P Thomas	GP – High Pastures Surgery		P										
Dr J Clarkson	GP – High Pastures Surgery		P	P	P	P							
Dr P Weston	GP – High Pastures Surgery		P										
Dr N Ahmed	GP – High Pastures Surgery		P										
Carole Morgan	PM - High Pastures Surgery					P							
Lesley Bailey	PN – Maghull SSP Practice												
Donna Hampson	PM – Maghull SSP Practice	P		P	A	P							
Dr A Banerjee	GP – Maghull SSP Practice	P		P	P	P							
Dr J Thomas	GP – Broadwood Surgery	P	P	P	P	P							
Dr B Thomas	GP – Broadwood Surgery												
Judith Abbott	PN – Broadwood Surgery												
Dr S Sapre	GP – Maghull Surgery												

No	Item	Action
14/34	**Apologies** All apologies were noted	
14/35	**Declarations of interest** JT – SSMOOG	
14/36	**Action Points**	
14/37	**Ericom Pilot** Richard Harkness & Martin Smith introduced themselves and gave a brief description about the Ericom project and rollout of Ipads for GP use in South Sefton CCG. This is being funded by the CCG and delivered under the mobile working/IM&T element of the Primary Care Quality Strategy. The Ericom project is designed to give real time access to patient records for practices using EMIS Web via mobile technology. This will allow clinicians to view the full EMIS Web patient record (and update it) real time while out on home visits. The project team from iMerseyside will be in touch via Practice Managers to gauge expressions of interest. The devices will be rolled out to Practices (no. of devices dependent on list size) over the coming months, with full training from iMerseyside. The CCG has funded (devices and licences for 3G and Ericom) the project for the first year. There will be a review of the device usage before possible wider rollout (and opportunity for clinicians to bring their own device to install ERICOM on) towards the end of this first year. There has already been a small pilot with a handful of GPs across both South Sefton and Southport & Formby CCGs which has been well received. It is planned that the rollout will start with a small number of practices towards the end of May before full rollout in June. Concerns were raised over VPN session times. RH stated that this is currently being dealt with by Matt Leigh (IT Helpdesk) and would feedback to TH any resulting actions that have been put in place. **ACTION** – Richard Harkness to feedback to TH.	
14/38	**Medicines Management** JJ updated the group with the latest issues concerning medicines management, • Prescribing Finance – As at month 11 the CCG is showing an overspend of 0.99%. This is due to be reduced when some adjustments are put through. • Dosulepin – There is a supply shortage of this drug in 75mg form. Forecasts are this will affect the supply of 25mg tablets. There is no date for the resolution of shortage. Prescribing of dosulepin requires a review to whether indication is still present and whether a suitable alternative can be used. Discuss any options with your practice pharmacist.	
14/39	**Finance & Quality Premium** BW addressed the group and gave a quality premium dashboard update for 2013/14. The CCG is estimated to receive a payment of £460,519 in 2014/15. There is a further indicator awaiting some data which could see that	

No	Item	Action
	payment rise to £552,623 if the target is met. Areas that let the figures down C-Diff and MRSA these are set nationally, but after concerns raised with NHS England. These could be lifted for 2014/15. JW then addressed the group with an update of the latest finance information. As at the year end the CCG has met its planned target to achieve a 1% surplus of the resource allocation. On a locality level Maghull is underspent as at the end of month 11 by £0.079m against the 2013/14 plan. The 50K locality funding and the winter pressures CCG allocation of 470K have been built into the CCG financial plans for the next 5 years to enable long term planning. Any queries re March data to contact JW.	
14/40	**Strategic Plan** KMc attended the locality meeting to share the progress that has been made in relation to the CCG Strategic Plan. The confirmed priorities are; • Frail Elderly • Unplanned Care • Primary Care The Two major transformation schemes are currently Virtual Ward and Care Closer to Home. The key thrust of work in these areas, related to the establishment of integrated care across a wide multidisciplinary team, based in localities, with the GP and Patient at the centre. The CCG has signalled an intention to reduce the activity and investment in traditional secondary care areas with a shift of resource to primary and community care. The locality was asked to consider ideas and schemes that could be pursued locally to enable either a reduction in unplanned or elective activity in the locality. These schemes could enable the repatriation of secondary care investment into primary care, with consideration by clinicians on alternative clinical models and ways in which the locality might consider to have the biggest impact in reducing unplanned care. Some areas considered were in relation to Dermatology and Mental Health resource based in surgeries. Karl encouraged the locality to consider alternative operating models, given the limitations of GP resource and where the resource may be optimally targeted to best effect. SS raised a query relating to where the additional GP resource will come from considering that there is 15% less applications for GP training. There needs to be more focus on recruiting and training more GP's. JT indicated some of the solutions are to reduce amount of administrative burden put on GP's.	

14/41	**Any other business** • **Unplanned Care Enhanced Service** – The group had a general discussion regarding the enhanced service and likelihood of sign up. SG gave a brief update on the NWAS pathfinder pilot that Westway MC have partaken in.	
14/42	**Date and Time of next meeting:** 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 …….