NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

Date: Thursday, 28th May 2015 at 1300 – 1520 hrs
Venue: Boardroom, 3rd Floor, Merton House, Bootle, L20 3DL

1300 hrs 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.

1315 hrs 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 Craig Gillespie	Chair & GP Clinical Director	CG
Graham Morris	Vice Chair & Lay Member - Governance	GM
Dr Andrew Mimnagh	Clinical Vice Chair & Governing Body Member	AM
Dr Peter Chamberlain	GP Clinical Director & Governing Body Member	PC
Fiona Clark	Chief Officer	FLC
Roger Driver	Lay Member, Patient & Public Involvement	RD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Dwayne Johnson	Director for Older People, Sefton MBC *(co-opted member)*	DJ
Margaret Jones	Consultant in Public Health *(co-opted Member on behalf of Dr Janet Atherton)*	MJ
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Dr Dan McDowell	Secondary Care Doctor	DMcD
Martin McDowell	Chief Finance Officer	MMcD
Sharon McGibbon	Practice Manager & Governing Body Member	SMcG
Dr Clive Shaw	GP Clinical Director & Governing Body Member	CS
Dr Ricky Sinha	GP Clinical Director & Governing Body Member	RS
Dr Paul Thomas	GP Clinical Director & Governing Body Member	PT
Dr John Wray	GP Clinical Director & Governing Body Member	JW
In Attendance		
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC

No	Item	Lead	Report	Receive/ Approve	Time
Governance					
GB15/85	Apologies for Absence	Chair	-	R	3 mins
GB15/86	Declarations of Interest	Chair	Verbal	R	1 mins
GB15/87	Hospitality Register	Chair	✔	R	1 mins
GB15/88	Minutes of the Previous Meeting	Chair	✔	A	5 mins
GB15/89	Action Points from Previous Meeting	Chair	✔	A	5 mins
GB15/90	Business Update	Chair	Verbal	R	5 mins
GB15/91	Chief Officer Report	FLC	✔	R	10 mins
GB15/92	GP Pressures and Supporting Practices	All	Verbal	R	5 mins
GB15/93	Annual Report and Audit Opinion 2014/15	MMcD	Verbal	A	10 mins
GB15/94	Q4 Corporate Risk Register and GB Assurance Framework	MMcD	R	R	10 mins
GB15/95	CCG Corporate Objectives 2015/16	KMcC	R	A	10 mins

No	Item	Lead	Report	Receive/ Approve	Time
Service Improvement/Strategic Delivery					
GB15/96	Strategic Blueprints	KMcC	R	A	10 mins
GB15/97	Shaping Sefton Update	FLC	R	R	10 mins
GB15/98	Refresh of Dementia Strategy	DJ	R	A	10 mins
Finance and Quality Performance					
GB15/99	Integrated Performance Report	KMcC/ MMcD/ DF	✔	R	10 mins
GB15/100	Overview, Quality and Performance – Southport & Ormskirk Hospitals NHS Trust	FLC/ DF/ KMcC	✔	R	10 mins
GB15/101	Revised Budgets for 2015/16 and Transformation Fund	MMcD	✔	A	10 mins
For Information					
GB15/102	Key Issues reports from committees of Governing Body: a) Finance & Resource Committee b) Quality Committee c) SIR Committee		 ✔ ✔ ✔	 R R R	5 mins
GB15/103	Finance & Resource Committee Minutes	-	✔	R	
GB15/104	Quality Committee Minutes	-	✔	R	
GB15/105	Service Improvement Redesign Committee Minutes	-	✔	R	
GB15/106	Locality Meetings: a) Seaforth & Litherland Locality b) Bootle Locality c) Crosby Locality d) Maghull Locality	 - - - -	 ✔ ✔ ✔ ✔	 R R R R	5 mins
Closing Business					
GB15/107	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting.*				5 mins
GB15/108	Date, Time and Venue of Next Meeting *Thursday 30th July 2015 at 13.00 hrs in the Boardroom, Merton House, Bootle*				-
Estimated meeting close					1520 hrs

Motion to Exclude the Public:
Representatives of the Press and other members of the Pubic to be excluded from the remainder of this meeting, having regard to the confidential nature of the business to 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
Attendance Tracker

Membership	Designation	Jan 2014	Mar 2014	May 2014	Jul 2014	Sep 2014	Nov 2014	Jan 2015	Mar 2015	May 2015	Jul 2015	Sep 2015	Nov 2015
Dr Craig Gillespie	Chair & GP Clinical Director	✓	✓	✓	A	✓	✓	✓	✓				
Dr Andrew Mimnagh	Clinical Vice Chair & Governing Body Member	✓	✓	✓	A	✓	✓	✓	✓				
Graham Morris	Vice Chair & Lay Member - Governance	✓	A	✓	✓	✓	✓	✓	✓				
Lin Bennett	Practice Manager	✓	✓	✓	✓	✓	✓	✓	Resigned				
Margaret Carney	Chief Executive, Sefton MBC *(co-opted member)*	A	A	A	A	A	A	A	A				
Fiona Clark	Chief Officer, South Sefton CCG	✓	✓	✓	✓	✓	✓	✓	✓				
Roger Driver	Lay Member, Patient & Public Involvement	✓	A	✓	A	✓	✓	✓	✓				
Debbie Fagan	Chief Nurse & Quality Officer	✓	✓	✓	✓	✓	✓	✓	✓				
Margaret Jones	Consultant in Public Health, Sefton MBC	✓	✓	✓	A	✓	A	✓	✓				
Maureen Kelly	Chair, Healthwatch Sefton *(co-opted member)*	A	A	A	✓	✓	✓	✓	✓				
Dr Dan McDowell	Secondary Care Doctor	✓	✓	✓	✓	✓	✓	✓	✓				
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓				
Sharon McGibbon	Practice Manager & Governing Body Member	✓	A	A	A	✓	✓	✓	✓				
Peter Morgan	Deputy Chief Executive, Sefton MBC *(co-opted member)*	✓	✓	A	✓	✓	A	✓	✓	Retired			
Dr Clive Shaw	GP Clinical Director & Governing Body Member	A	A	A	✓	✓	A	✓	✓				
Dr Ricky Sinha	GP Clinical Director & Governing Body Member	Sabbatical						✓	A				
Dr Paul Thomas	GP Clinical Director & Governing Body Member	✓	✓	✓	A	✓	✓	✓	✓				
Dr John Wray	GP Clinical Director & Governing Body Member	A	A	A	✓	A	A	A	A				

✓ Present
A Apologies
L Late

NHS
South Sefton
Clinical Commissioning Group

Hospitality Register
April 2015

Recipient	Nature of Gift / Hospitality	Date Received	Approximate Value	Donated by
Fiona Clark	Local Medical Council (LMC) Annual Dinner and flowers	13/03/15	£60.00	LMC

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
DRAFT Minutes

Date: Thursday, 26th March 2015 at 1300 – 1520 hrs
Venue: Boardroom, 3rd Floor, Merton House, Bootle, L20 3DL

1300 hrs 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.

1315 hrs 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 & GP Clinical Director	CS
Graham Morris	Vice Chair & Lay Member - Governance	GM
Dr Craig Gillespie	Clinical Vice-Chair & Governing Body Member	CG
Dr Pete Chamberlain	GP Clinical Director & Governing Body Member	PC
Fiona Clark	Chief Officer	FLC
Roger Driver	Lay Member, Patient & Public Involvement	RD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Margaret Jones	Consultant in Public Health *(co-opted Member on behalf of Dr Janet Atherton)*	MJ
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Dr Dan McDowell	Secondary Care Doctor	DMcD
Martin McDowell	Chief Finance Officer	MMcD
Sharon McGibbon	Practice Manager & Governing Body Member	SMcG
Dr Andrew Mimnagh	GP Clinical Director & Governing Body Member	AM
Peter Morgan	Deputy Chief Executive, Sefton MBC *(co-opted member on behalf of M Carney)*	PM
Dr Ricky Sinha	GP Clinical Director & Governing Body Member	RS
Dr Paul Thomas	GP Clinical Director & Governing Body Member	PT
Dr John Wray	GP Clinical Director & Governing Body Member	JW

In Attendance

Malcolm Cunningham	Head of Contracting & Procurement *for Item 15/55*	MC
Jan Leonard	Chief Redesign & Commissioning Officer *for Item GB 15/53*	JL
Karl McCluskey	Chief Strategy & Outcomes Officer *for Items 15/54 and 15/56*	KMcC
Melanie Wright	Lead for Intermediate Care *for Item 15/51*	MW
Brendan Prescott	Deputy Chief Nurse & Quality Officer *(on behalf of Debbie Fagan)*	BP

Presentation on "Mental Health Transformation" by Karl McCluskey

Q: How do the non-usual dementia cases fit into the pathway?
A: We are currently reviewing how we programme in the extended definition of dementia.

Q: What is the timescale?
A: Over the course of the next 12 months so we have a very clear idea of where we're heading by 16/17.

Q: How will the disparities in CCG/provider views be resolved?
A: Through clinical input and work with the Mersey Care Transformation Board.

Dr Shaw thanked Karl and the team for a comprehensive piece of work.

No	Item	Action
GB15/41	**Apologies for Absence** received from Dr Pete Chamberlain, Debbie Fagan, Margaret Jones and Dr John Wray. FLC will write to NHSE to ask if there will be representation at future meetings.	FLC
GB15/42	**Declarations of Interest** All members holding dual roles across both South Sefton CCG and Southport & Formby CCG declared their interest. There were no other declarations made in respect of items of business on the agenda.	
GB15/43	**Hospitality Register** The Governing Body received the Hospitality Register. FLC had recently attended the Local Medical Council's Annual Dinner - FLC to check value and add to register.	FLC
GB15/44	**Minutes of the Previous Meeting** Were approved as a true and accurate record of the previous meeting.	
GB15/45	**Action Points from Previous Meeting** 15*/9a Integrated Performance Report* – remove from tracker. *15/12a Strategic Plan – National Guidance and Implications* - The Governing Body agreed to support the development of a refreshed five year activity, financial and investment plan which addressed identified QIPP shortfall, with a view to approval being sought via Governing Body, as per the planning timetable – FLC to pick up. *15/13 – Out of Hours Pharmacy* - all necessary changes made – remove from tracker. *15/15 Re-procurement of NHS 111 Service* – on Chief Officer's report – remove from tracker. 15/16 – Emerging Issues – for noting – remove from tracker.	FLC
GB15/46	**Business Update** Dr Shaw thanked the Governing Body for their support and commitment over the last seven years during his Chairmanship of the CCG and prior to that the Practice Based Commissioning Group.	
GB15/47	**Chief Officer Report** Mrs Clark thanked Dr Shaw for his tenacity and for acting as an ambassador for the CCG. *CCG Appointments* – NHS England have confirmed it is not possible for the CCG to have Co-Chairs so from 1st April it was proposed that Dr Gillespie would be Acting Chair and Dr Mimnagh would be Acting Vice Chair. Dr Peter Chamberlain has also been appointed to the Governing Body. This will need to be taken to the Wider Constituent meeting for approval. *Practice Manager Job Description* – Sharon McGibbon was currently working with Tracy Jeffes and the Local Medical Council and report back to the Governing Body in due course. *Shaping Sefton* – a successful event was held on 12th February in conjunction with the King's Fund. A transformational board was now being developed to drive the agenda. On behalf of Governing Body, FLC thanked Peter Morgan of Sefton Council for his contribution and congratulated him on his impending retirement at the end March. *Procurement* – the NHS 111 Service contract has been awarded to partner FCMS and Urgent Care 24 and will transfer over in October/November. *Commissioning Support Unit* – it has been confirmed the North West Commissioning Support Unit (NWCSU) did not get on the Lead Provider Framework. NHS England has set up a transformation board, chaired by Simon Banks, Chief Officer of Halton CCG. Mrs Clark will be leading a group from the Merseyside CCG network to determine future requirements.	FLC TJ

No	Item	Action
	Continuing Health Care (CHC) - issues have been added to the risk register as key areas of risk. As a result of weekly meetings, we are now working work plans and actions. *Informatics Mersey Partnership Board* – Mrs Clark will be chairing the board meetings for the next 6 months.	
GB15/48	**GP Pressures and Supporting Practices** Nothing raised.	
GB15/49	**Committee in Common** Committee in Common with Liverpool CCG - Dan McDowell unavailable for next meeting.	
GB15/50	**Draft CCG Quality Strategy** BP advised the Governing Body that the strategy was still in draft form as it had only been presented to the previous week's Quality Committee. He confirmed the strategy was aligned to the CCG strategic plan and reflected local priorities, national drivers and priorities set by the National Priority Board. FLC added that although the CCG did not have contractual responsibility for primary care, it did have a statutory responsibility to ensure that continuous improvement of primary care quality was included in its duties. A workshop had been arranged with NHS England for 21st May 2015 because of the need to be closer to the decision making for our potential future direction of travel. The CQC has published a report on Seaforth Surgery which has been put into 'special measures' so the CCG will need to be closely involved. RD added that the signage at the Seaforth practice still says there are 2 named GPs and it needs to be removed. MMcD has actioned – the SSP Chief Officer and NHS England have been asked to remove the sign. Lyn Cooke to add to CCG website as a stand-alone document. **Action: the GB approved the draft CCG Quality Strategy.**	LC
GB15/51	**Safeguarding Strategy** The CCG had commissioned the peer review as part of its development. The strategy was presented to the Quality Committee prior to Christmas, however, had been re-presented to the Quality Committee as a result of changes to the Care Act. The Quality Committee had requested that the Safeguarding Service develop the strategy so it is more CCG focussed and more aligned to the Health & Wellbeing Board expectations. A local implementation plan is to be developed. AM asked if emphasis was placed on the clarity of terminology around not sharing medical reports. FLC to check with NHS England. **Action: The Governing Body approved the strategy.**	FLC
GB15/52	**Sefton Joint Intermediate Care Strategy** The strategy has been developed in conjunction with Southport & Formby CCG, South Sefton CCG and the Local Authority. The strategy is aligned to the Sefton Health & Wellbeing Board's vision of aligned care. The strategy is also aligned with the CCGs' priorities in relation to the frail and elderly, virtual ward, etc. Dr McDowell raised concerns about bed provision. The CCG would need to be careful that the beds weren't seen as a part of the continuum between community hospital and back into community. The operational detail had been discussed at the Leadership Team meeting this week. **Action: The GB approved the Sefton Joint Intermediate Care Strategy.**	

No	Item	Action
GB15/53	**Breast Care Services Engagement and Equality Report and Recommendations** TJ updated the Governing Body on the results of a recent engagement exercise. Key issues identified were: • Patients disappointment at sudden closure of service; • Lack of communication; • Real concerns about future care and follow up; • Engagement exercise under an equality impact assessment; • Concerns around travelling. The next steps are to review an evidence-based breast care pathway, recognising the strong public views. A report will come back to the Governing Body with final pathway in conjunction with West Lancashire CCG in due course. A meeting has been arranged for Mrs Clark to meet with breast surgeons at Southport & Ormskirk Hospital NHS Trust on 21st April 2015. Dr Chamberlain asked what the percentage increase in Aintree's breast care service was. Tracy Jeffes would ask Jan Leonard to confirm back to him. KMcC indicated some elective work has shifted to neighbouring providers, including breast surgery. RD asked when the report would come back. Mrs Clark confirmed the clinical pathway would be developed taking on board views expressed, so more likely it would be issued in the next quarter. **Action: the GB received the report.**	TJ
GB15/54	**2015/16 Planning Submission** This submission reflects last year's agreement to develop and re-visit its strategic plan, as well as the need to conform to a national reporting plan. Final plans need to be reviewed by 14th May. One of challenges has been shift from data that was used in the 2014/15 plan to something different this year (ie from MARS (Monthly Activity Returns) to SUS (Secondary Uses Service). This is more comprehensive and drills down to episode level enabling the CCG to translate activity/level of service. FLC confirmed the CCG had a very robust plan that responded to recent demands and was achievable given financial constraints this year. **Actions:** **(i) The Governing Body supported the refresh and final submission;** **(ii) Noted the detail contained in the national planning guidance and the implications for the review of existing two year operational and five year operational plans;** **(iii) Approved the submission of 2015/16 plans in relation to NEL activity at 0% and the re-profiled plan for future years;** **(iv) Approved the submission of plans to achieve the various national performance measures including RTT, A&E, Mental Health, HCAI, Cancer and Primary Care; and** **(v) Approved the necessary delegated authority to the CCG Chair, Accountable Officer, Chief Financial Officer and Chief Strategy & Outcomes Officer to progress the necessary work to enable national return requirements to me met in line with the revised planning timetable.**	CG/FLC/ MMcD/K McC

No	Item	Action
GB15/55	**Home Oxygen Assessment Service Contract** The Home Oxygen Assessment Service has been put to tender through a robust and EU compliant process. Liverpool Community Health NHS Trust was the most economically advantageous bid submitted. The Governing Body was asked to approve the award of contract to Liverpool Community Health NHS Trust for a 3-year contract (with the option to extend by a further 1 x 2-year period) commencing on 1st July 2015. **Action: The Governing Body approved the award of the Home Oxygen Assessment Service Contract to Liverpool Community Health NHS Trust.**	
GB15/56	**Integrated Performance Report** KMcC presented highlights from his full report. *Quality* - A single item QSG on cancer had been held last month producing many recommendations from NHS England which Dr Allen had confirmed we were already complying with. Feedback will go through to the Quality Committee. There has been an increased trend in reporting pressure ulcers and as a result the Trust is reviewing their processes. *Finance* – the projected deficit has reduced by £250K, however, there is still overspend which gives cause for concern. Page 369 shows actions that have been put in place throughout year mainly through deferred items. The CCG remains on target to deliver financial duties for financial year. Members noted the progress made in agreeing CVS schemes. **Action: the GB received the report.**	
GB15/57	**Emerging Issues** It was agreed this item would be taken off the agenda as the item 'GP Pressures and Supporting Practices' had been added.	
GB15/58	**Key Issues reports from committees of Governing Body:** a) Finance & Resource Committee b) Quality Committee c) Service Improvement & Redesign Committee d) Audit Committee were received by the Governing Body.	
GB15/59	**Finance & Resource Committee Minutes** were received by the Governing Body.	
GB15/60	**Quality Committee Minutes** were received by the Governing Body.	
GB15/61	**Service Improvement Redesign Committee Minutes** were received by the Governing Body.	
GB15/62	**Audit Committee Minutes** were received by the Governing Body.	
GB15/63	**Locality Meetings:** a) Seaforth & Litherland Locality b) Bootle Locality c) Crosby Locality d) Maghull Locality were received by the Governing Body. RD important to show attendance in same format.	
GB15/64	**Any Other Business** No other business.	
GB15/65	**Date, Time and Venue of Next Meeting** *Thursday 28th May 2015 at 13.00 at Boardroom, Merton House, Bootle*	

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Actions following meeting in March 2015

No	Action	Action
GB15/42	***Hospitality Register*** - FLC had recently attended the Local Medical Council's Annual Dinner - FLC to check value and add to register.	FLC
GB15/45 (15/12(a))	***Strategic Plan: National Guidance & Implications*** - The Governing Body agreed to support the development of a refreshed five year activity, financial and investment plan which addressed identified QIPP shortfall, with a view to approval being sought via Governing Body, as per the planning timetable. FLC to pick up	FLC
GB15/47	***Chief Officer Report*** *CCG Appointments* – NHS England have confirmed it is not possible for the CCG to have Co-Chairs so from 1st April it was proposed that Dr Gillespie would be Acting Chair and Dr Mimnagh would be Acting Vice Chair. Dr Peter Chamberlain has also been appointed to the Governing Body. This will need to be taken to the Wider Constituent meeting for approval. *Practice Manager Job Description* – Sharon McGibbon was currently working with Tracy Jeffes and the Local Medical Council and report back to the Governing Body in due course.	FLC TJ
GB15/50	***Draft CCG Quality Strategy*** Lyn Cooke to add to CCG website as a stand-alone document.	LC
GB15/51	***Safeguarding Strategy*** AM asked if emphasis was placed on the clarity of terminology around not sharing medical reports. FLC to check with NHS England.	FLC
GB15/53	***Breast Care Services Engagement and Equality Report and Recommendations*** TJ to confirm to Dr Chamberlain the percentage increase in Aintree's breast care service.	TJ
GB15/54	***2015/16 Planning Submission*** The Governing Body approved the necessary delegated authority via the CCG Chair, Accountable Officer, Chief Financial Officer and Chief Strategy & Outcomes Officer to progress the necessary work to enable national return requirements to me met in line with the revised planning timetable.	CG/ FLC/ MMcD/ KMcC

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2015

Agenda Item: 15/91	**Author of the Paper:** Fiona Clark Chief Officer Email: Fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7000
Report date: May2015	
Title: Chief Officer Report	
Summary/Key Issues: This paper presents the Governing Body with the Chief officer's monthly update.	
Recommendation The Governing Body is asked to receive this report.	Receive [x] Approve [ ] Ratify [ ]

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.
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

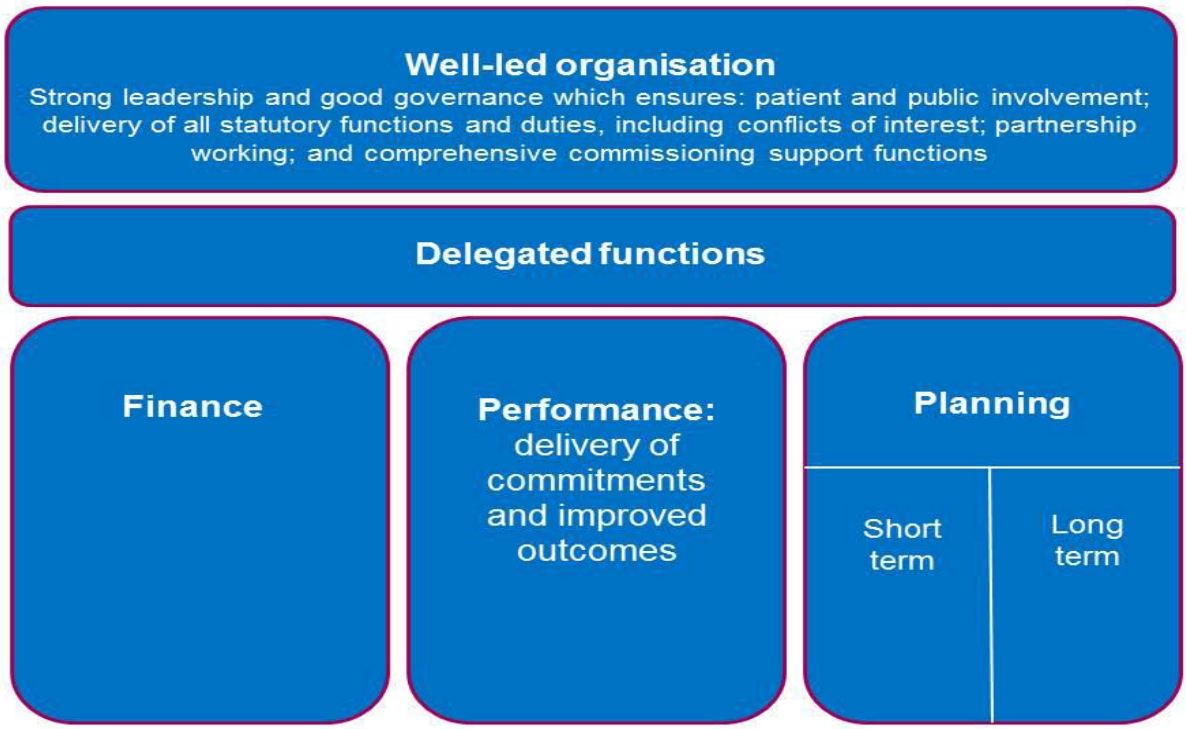
Report to the Governing Body
May 2015

1. CCG Assurance Framework

1.1 Much has changed since CCGs became statutory organisations on the 1st April 2012 and went through the authorisation process, giving rise to the need for a fresh approach to assurance.

1.2 A new assurance framework is therefore required to address these changes. This will strengthen the focus on a CCG's track record and ongoing performance in delivering improvements for patients. It will continue to assess a CCG's capability as well as ensuring its fitness to take on additional roles and responsibilities. To this end NHS England has undertaken a consultation process beginning in January 2015 to produce a new CCG scorecard. This will complement the existing CCG Delivery Dashboard which NHS England uses to undertake the quarterly assurance process.

1.3 This new framework also acknowledges that CCGs have different starting positions, with different populations and challenges, requiring different leadership responses. Some are operating in an extremely difficult environment, within challenged health economies or with legacy financial issues. Assurance covers the overall delivery of a CCG, and will take place continuously throughout the year, rather than as a one-off inspection. This framework describes a continuous assurance process that aims to provide confidence to internal and external stakeholders and the wider public that CCGs are operating effectively to commission safe, high-quality and sustainable services within their resources, delivering on their statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients.



1.4 There will be a risk based approach adopted by NHS England which differentiates high performing CCGs, those whose performance gives cause for concern, and those in between. NHS England intends to publish the CCG scorecard which will inform several of these components on *MyNHS,* through the NHS Choices website. Our performance and delivery commitments will be described in relation to five population groups, the generally well, people with long term conditions, people with mental health problems or learning disabilities, children and young people, and the frail elderly, with an additional focus on planning. The outcome measures in the scorecard will be derived from, and assessed in line with, the NHS Outcomes Framework.

1.5 Other intelligence will be used in the assurance process including the annual CCG 360 survey, as well as local partners and other organisations such as the Health & Wellbeing Board, the Care Quality Commission, NHS Trust Development Authority and Monitor and local Health Watch.

1.6 For co-commissioning functions and for out-of-hours services, CCGs will be required to prepare a quarterly self-certification of compliance against five key areas: governance and the management of potential conflicts of interest, procurement, expiry of contracts, availability of services, and outcomes. For delegated arrangements and out-of-hours services, the self-certification will be required to be signed off by the CCG governing body.

1.7 For joint commissioning arrangements the self–certification will be signed off by the joint committee of the CCGs or of the CCG and NHS England. The process will reflect the flexibility of NHS England to respond differently in different circumstances. A national moderation process will take place to provide confidence that the framework has been applied consistently across all CCGs, and that issues are being handled and escalated using the same approach.

1.8 The conclusion to this process will mean that CCGs are assessed as being in one of four assurance categories, which have been named to make them consistent with those used elsewhere in the NHS, such as the Care Quality Commission, and in other sectors, and to make them more meaningful to patients and the public. The categories are:

- assured as outstanding;
- assured as good;
- limited assurance, requires improvement; and
- not assured.

1.9 The action or intervention from NHS England will be dependent on the outcome and categorisation. This could range from light touch to further assessment and intervention. A new category of special measures has been developed. Alongside the four assurance categories NHS England may apply a new special measures regime designed to address persistent and chronic performance challenges, financial challenges and / or governance difficulties due to the CCG's lack of capability and capacity to provide leadership to deliver sustained improvement. The application of special measures will usually result from issues that have persisted over a period of two quarters, unless action is required sooner, such as when financial problems are identified. It is most likely to be applied to those CCGs in the 'limited assurance' and 'not assured' categories. A CCG placed in special measures will be required to agree with NHS England, and to deliver, a sustainable improvement plan, with the assistance of a range of intensive support options. This could include, for example, support from a well-performing CCG, which could act as a 'buddy' for the CCG in special measures.

1.10 The CCG should have made significant progress in its recovery plan in a maximum of 12 months and, following a review, should exit special measures at this point, if not sooner, even though there may be ongoing deliverables to be achieved as part of the improvement plan.

1.11 At the end of the year all this information will be consolidated into a statutory assurance report to be published by NHS England. CCGs will also be expected to publish their individual assurance reports.

2. CCG 360 Stakeholder Survey 2015

2.1 The CCG has recently received the results of the 2015 survey. These are currently being considered and any necessary actions as a result formulated into the CCG Organisational Development plan for 2015/16.

2.2 In the main the survey provided positive assurance to the CCG. However, there are a number of areas for improvement in line with national benchmarking. Further updates will be provided to the Governing Body and discussed with the CCG membership to then provide a comprehensive action plan for the July Governing Body meeting. The survey will be published on the CCG website.

3. Planning 15/16 Update

3.1 The CCG concluded its planning submission on 14th May to NHSE. This submission was based upon out turn 2014/15 and as such represents a 0% plan for 2015/16. NHSE have discussed with all CCGs jointly, in the days leading up to the submission, and impressed the need for CCGs to commission realistic levels of activity, being mindful that the evident national increase in NEL a is c2.5-3.5%.

3.2 The CCG has also agreed its quality premium categories and submitted confirmation of these as part of the planning submission. These have been clinically agreed within the CCGs and all Localities have contributed to the discussion on quality premium selection. It will be important, going forward that the CCG closely monitors provider performance against plans and addresses any over performance issues on a monthly basis through contract management.

4. Transforming Care for People with Learning Disabilities - Next Steps

4.1 This document has been produced jointly by the following organisations:

- Association of Directors of Adult Social Services (ADASS)
- Care Quality Commission (CQC)
- Department of Health
- Health Education England (HEE)
- Local Government Association (LGA)
- NHS England

4.2 NHS England commissioned Sir Stephen Bubb will produce a report on how to accelerate the transformation that we, people with learning disabilities and their families are looking for.

4.3 Following Sir Stephen's report, NHS England, the Department of Health, the Local Government Association, the Association of Directors of Adult Social Care, the Care Quality Commission and Health Education England are confirming commitment to strengthen the Transforming Care delivery programme by creating a new delivery board, bringing together the senior responsible owners from all the organisations.

4.4 The work to be taken forward through this programme will be wide-ranging and over the coming months it will continue to be co-designed and co-produced in partnership with people with learning disabilities and/or autism, their families, clinicians, commissioners, providers, other national organisations in the health and care system (such as Skills for Care, Skills for Health, Public Health England) and other stakeholders.

4.5 The paper, sets out some early actions to be taken in 2015 following Sir Stephen Bubb's report, and some of the issues required to engage further with stakeholders, as we work together to transform care. The areas covered in the report are:

- Empowering people and families;
- Getting the right care in the right place;
- Regulation and inspection;
- Workforce development.

4.6 The Governing Body will receive an update on further action required by the CCG to meet the requirements and expectations as laid down under each of the headings, in due course.

5. North West Coast Academic Health Science Network (NWCAHSN)

5.1 The NWCAHSN has produced its Business Plan for 2015/16, whilst describing its values and recognising its achievement in 2014/15 it identifies a number of safety and clinical areas as priorities for 2015/16, namely:

- Leadership;
- Paediatric/adult transition;
- Hydration;
- Sepsis;
- Technology for safety;
- Support to avoid frail elderly admissions;
- Good practice care homes programme;
- Health and wellbeing of staff;
- Measurement;
- Medicine optimisation alongside stroke;
- Mental health;
- Musculoskeletal innovation;
- Reduced alcohol-related A&E attendances.

The business plan also has cross-cutting themes and core platforms to support these priority areas which have been identified to maximise the impact of work currently in progress and to take account of other local and national drivers.

6. Care Quality Commission Inspection of GP Practices

6.1 The Care Quality Commission has published a report following inspection of Seaforth Village Surgery which has been rated overall as inadequate. The practice, run by SSP Health Ltd, has been placed into special measures and the CCG is working closely with NHS England to support the practice to deliver an action plan to address the areas of concern.

6.2 The practice will be re-inspected by the CQC in six months to ensure that improvements have been made.

7. Locality development

7.1 We are now focusing on the localities as a key area organisational development in 2015/16. This work includes, providing more useful information for localities to help them commission more effectively, supporting the development of clearer locality priorities to help further shape local services providing additional support to locality lead GPs and managers through the development of a "locality team" improving the links between localities and the Governing Body to improve communications and to enable localities to more directly influencing decision-making.

8. Continuing Health Care (General Update)

8.1 The CCG/CSU Continuing Health Care Steering Group continues to meet and the meeting schedule has moved to monthly. The improvement plan has been rationalised due to the position of NWCSU with regard to the Lead Provider Framework (LPF). The CCG is meeting on 20 May 2015 to discuss with NHSE available support in order to go to the LPF for this service.

9. Continuing Health Care (Retrospective Cases)

9.1 The CCG commissions the CSU to provide the management of Retrospective CHC Cases. Currently the CCG is underperforming against the monthly trajectory that has been set by NHSE for the closedown of such cases. Performance management of CSU is in place and the CCG is due to attend a series of meetings being held by both CSU and NHSE in order to support improved performance.

10. Southport & Ormskirk Hospitals NHS Trust Chief Inspector of Hospitals Visit

10.1 A Quality Summit was held on 7 May 2015 at which the outcome of the Chief Inspector of Hospitals Visit was formally announced. This report was published by the Care Quality Commission on 13 May 2015.

Overall judgement = Requires Improvement

The judgements for the five domains are as follows:

- Safe = Requires Improvement (for acute hospital sites and community)
- Effective = Requires Improvement (for acute and community services)
- Caring = Good (for acute and community services)
- Responsive = Requires Improvement (for acute and community services)
- Well-led = Requires Improvement (for acute and community services)

10.2 Checks on specific services were undertaken and the outcome was as follows:

- Community Health Services for Adults = Requires Improvement
- Community Health Services for Children, Young People & Families = Requires Improvement

10.3 The Trust is required to develop appropriate action plans and submit them to the CQC. At the time of writing this paper, the CCG are in discussion with NHSE regarding the need to hold a Single Item Quality Surveillance Group Meeting. Further information on the outcome of the inspection is detailed in a further paper to be discussed as an agenda item for this meeting.

11. Named GP Safeguarding Children

11.1 The CCG have successfully recruited to the post of Named GP Safeguarding Children. Dr Wendy Hewitt commenced in post on 27th April 2015.

12. North West Commissioning Support Unit Update

12.1 The CCG has been working collaboratively with neighbouring Merseyside CCGs and colleagues from NHS England to agree a collective approach to the future procurement of commissioning support services (CSS.) This follows the announcement that the North West Commissioning Support Unit (NWCSU) was not accepted on to the national Lead Provider Framework (LPF). It is likely that the CCG will be required to use the LPF to secure much of its future commissioning support and meetings are taking place to determine the exact details. NHSE is assisting CCGs with the process and it is proposed that the new arrangements will be put in place in the autumn.

12.2 In the meantime we are working with NWCSU to transfer a small number of service lines in-house as per our agreed intentions from December 2014 and we will sign a new SLA with the CSU commencing in June 2015 to secure their services until the new organisational arrangements for commissioning support services are established.

13. Health Education North West- e-WIN Newsletter

13.1 The innovative work the CCG has been developing regarding student placements has been published in in the latest edition of the e-WIN Newsletter. A link to this can be found below and this good news story has also been publicised in the CCG weekly newsletter.

http://www.ewin.nhs.uk/resources/5627/developing-student-placements-within-a-clinical-commissioning-group-ccg

14. MIAA Safeguarding Review

14.1 MIAA is currently undertaking a Safeguarding Review in the CCG. The outcome of the review will be reported to both the Quality Committee and the Governing Body once completed.

15. Provider Quality Accounts

15.1 The CCG have been presented with relevant provider Quality Accounts. The CCG has worked collaboratively with partners and will be returning a joint response for publication in the Provider Quality Accounts. The CCG is also in the process of supporting both the Health Overview & Scrutiny Committee and the Children's Overview & Scrutiny Committee in their review of the Quality Accounts.

16. Nursing & Midwifery Council - The Code: Professional Standards of Practice and Behaviours of Nurses and Midwives (2015) (the Code)

16.1 The Nursing & Midwifery Council have published a revised 'Code' which presents the professional standards that nurses and midwives must uphold in order to be registered to practice in the United Kingdom. Failure to comply with the code may bring a nurse or midwife's fitness to practice into question. The values and principles set out within the code are not negotiable or discretionary. The code is effective from 31st March 2015 and structured around the following 4 themes:

- Prioritising people;
- Practising effectively;
- Preserving safety;
- Promoting professionalism and trust.

16.2 The standards have been expanded to include:

- A professional duty of candour;
- A requirement to offer help if an emergency arises outside a nurse or midwife's normal area of practice;
- Ensuring the fundamentals of care are delivered effectively during all stages of life;
- New standards on dealing with complaints;
- Use of all forms of communication, including social media;
- More detail about raising concerns and whistleblowing;
- Guidance on effective record keeping;
- Greater clarity on delegation and decision-making;
- Guidance on prescribing and medicines management.

16.3 Understanding and reflecting on the code will be central to compulsory revalidation for nurses and midwives planned for 2015 onwards. The code will be a useful point of reference for embedding professional values and principles in appraisal.

16.4 The Chief Nurse has requested that the Corporate Governance Support Group review and consider what amendments may be necessary to both relevant CCG policies and the CCG appraisal documentation so it reflects the NMC Code (2015).

17. Nurse Revalidation

17.1 Nurse revalidation is a process that all registered nurses and midwives will need to engage with to demonstrate that they practice safely and effectively throughout their career. It will be a continual process not a point in time activity or assessment and will be about promoting good practice across the whole population of nurses and midwives All nurses and midwives are currently required to renew their registration every 3 years and the intention is that revalidation will strengthen this renewal process.

17.2 New requirements will focus on:

- Up-to-date practice and professional development;
- Reflection on the professional standards or practice and behaviour as set out in the NMC Code (2015);
- Engagement in professional discussions with other registered nurses and midwives.

17.3 The NMC is currently piloting the proposals for revalidation with a range of organisations and practice settings across the United Kingdom. The proposals are as follows:

STEP 1: Nurses and midwives need to meet a range of validation requirements designed to show that they are keeping up-to-date and actively maintaining their fitness to practise with evidence being kept in a portfolio. Examples of such requirements include:

- Practising a minimum number of hours;
- Undertaking continuing professional development (CPD);
- Obtaining feedback about own practice;
- Reflecting on the Code, CPD and feedback about own practice – discussing these with another NMC registrant;
- Providing a health and character declaration;
- Having appropriate cover under an indemnity arrangement.

STEP 2: Nurses and midwives need to demonstrate to a third party that they have met their revalidation requirements. This is called obtaining confirmation.

STEP 3: Every three years all nurses and midwives will apply for revalidation. They will need to declare to the NMC that they have met the requirements and obtained confirmation. Verification checks will be undertaken by the NMC.

17.4 The Chief Nurse and Deputy Chief Nurse have been liaising with the CCG HR support from CSU to ensure that plans are in place as appropriate within the organisation. There is still some uncertainty regarding the arrangements which will include what responsibility, if any, the CCG Chief Nurse and Deputy Chief Nurse will have in relation to the revalidation of Practice Nurses. The NMC will finalise the proposals in October 2015.

18. Freedom to Speak Up Review (Robert Francis February 2015)

18.1 The 'Freedom to Speak Up Review' by Robert Francis was published in February 2015. The aim of the review was to provide advice and recommendations to ensure that NHS staff in England feel it is safe to raise concerns, confident that they will be listened to and the concerns will be acted upon.

18.2 The Chief Nurse has requested that the Corporate Governance Support Group reviews and considers what amendments may be necessary to relevant CCG policies. The CCG Programme Manager for Quality & Safety will also be reviewing the recommendations and how they sit alongside the CCG Francis Action Plan. The Government's expected annual Francis response is still being awaited nationally – this was expected November 2014.

18.3 The Chief Nurse and the Chief Delivery & Integration Officer will be considering what impact the recommendations may have on the CCG Organisational Development Plan.

19. Sign Up to Safety Pledge

19.1 The Quality Committee have approved the CCG signing up to the 'Sign Up To Safety' Pledge. The areas the CCG has made pledges against are as follows:

- Health Care Acquired Infections;
- Pressure Ulcers;
- Catheters in Nursing Homes.

19.2 Progress against these pledges will be monitored by the CCG Programme Manager for Quality & Safety. The CCG commitment to the pledges will be uploaded onto the website.

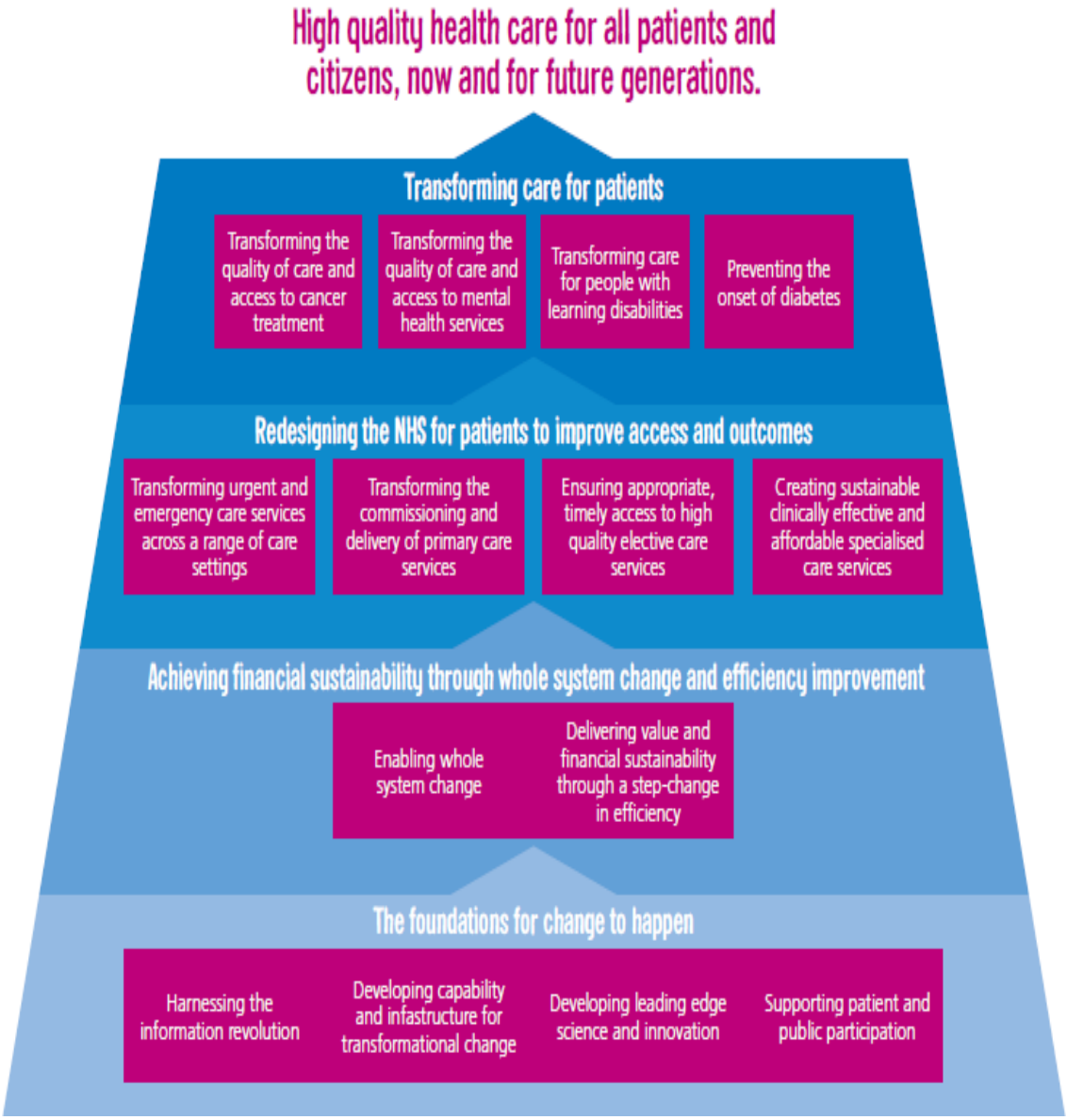
20. CCG Constitutional Change

20.1 The Chief Officer received a letter from NHS England on 1st May 2015, to inform the CCG that they have decided to replace the June and November windows and that future applications for constitutional change can be made at whatever point during the year fits the CCG's business needs.

20.2 There would be one exception, which is that any changes related to CCG boundaries or populations would still need to be submitted during the summer, so that allocations can be adjusted for the following financial year. The existing guidance, 'Procedures for CCG constitution change, merger or dissolution', published in May 2013 otherwise remains in place.

21. NHS Business Plan 2015-2016

21.1 NHS England has published the business plan for 2015/16. Its priorities are highlighted in the below:



22. Recommendations

22.1 The Governing Body is asked to receive this report.

Fiona Clark
Chief Officer
May 2015

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2015

Agenda Item: 15/94	**Author of the Paper:** Judy Graves Governance Facilitator, NWCSU Email: judy.graves@nhs.net Tel: 0151 295 8908
Report date: May 2015	

Title: Quarter 4 2014/15 Risk Assurance Framework & Corporate Risk Register Update

Summary/Key Issues:
To provide members with an update on the organisations final Q4 2014/15 position against the Governing Body Assurance Framework (GBAF), Corporate Risk Register (CRR) and the support provided.

GBAF
South Sefton CCG have a total of 15 risks recorded on the Governing Body Assurance Framework (GBAF) against the 7 corporate objectives for 2014/15:

Risk Rating:
- 4 have decreased risk rating with 11 remaining static, giving:
  - 0 Extreme risks
  - 10 High risks
  - 4 Moderate risks
  - 1 Low risk

Assurance Rating:
- 2 risks improved assurance ratings

CRR
There are 23 operational risks recorded on the South Sefton CCG Corporate Risk Register (CRR) for quarter 4 (March) 2014/15:

- 23 risks continue from February 2015:
  - 21 have stayed the same
  - 2 have reduced
- 0 risks removed
- 0 new risks

Of which:
- 0 Extreme risks (red)
- 14 High level (amber)
- 6 Medium risk (yellow)
- 3 Low risk (green)

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Clinical Commissioning Group

Recommendation

Receive	x
Approve	
Note	

The Governing Body is asked to:

- Receive and note the report and appendices presented;
- Note the work undertaken and progress made on assurance and scrutiny, making comment for any further developments;
- Review Q4 (March) 2015 GBAF positions, specifically the 'GIC' and 'GIA': the Governing Body need to be assured where there are any incidences of an absence of 'Gaps in Control' and/or 'Gaps in Assurance' and consider/comment/ approve accordingly;
- Review Q4 (March) 2015 CRR positions and consider/comment/approve accordingly.

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.
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

Report to the Governing Body
May 2015

1.0 BACKGROUND

Risk Assurance Responsibility & Obligation

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.

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.

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.

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.

Governing Body Assurance Framework (GBAF)

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.

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.
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.

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
- are assured where there are any incidences of an absence of 'Gaps in Control' and/or 'Gaps in Assurance'.

Corporate Risk Register (CRR)

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.

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 Corporate 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.

2.0 Q4 PROGRESS

- Work continues with the SMT and Corporate Governance Support Group to ensure robust assurance processes are in place, continued and reviewed
- 1:1 meetings held with risk leads to discuss and review CRR and GBAF updates
- Monthly and quarterly reports completed and submitted for SMT, Corporate Governance Sub-Group and Quality Committee including highlights for review and scrutiny
- Assurance schedule continues to be reviewed. Draft schedule has now been pulled together for 2015/16.
- SMT reminded of the importance of ensuring all respond accordingly on any changes in risk so as to ensure compliance with the organisations Risk Management Strategy
- GBAF 'Gaps in Control' and 'Gaps in Assurance' reviewed to ensure appropriate
- 'Horizon Scan 15/16' will be used as the basis for 2015/16 CRR.
- Review of risk leads and deputies document so as to ensure current

3.0 SOUTH SEFTON CCG POSITION STATEMENTS (March 2015)

3.1 **Governing Body Assurance Framework *(Appendix B and C)***
South Sefton CCG has a total of 15 risks recorded on the Governing Body Assurance Framework (GBAF) against the 7 corporate objectives for 2014/15:

Risk Rating:
- 11 have stayed the same
- 4 have decreased: 1.1, 1.2, 1.3 and 1.4.

Of which
- 0 Extreme risks
- 10 High risks: 1.4, 1.5, 1.6, 2.1, 4.1, 5.1, 5.2, 6.1, 6.2, 6.3.
- 4 Moderate risks: 1.1, 1.2, 1.3, 3.1
- 1 Low risk: 7.1

Assurance Rating:
- 2 risks improved assurance ratings: 1.1, 1.2,
- 13 remained the same

GBAF	South Sefton CCG
1.1 Non Delivery of financial targets due to failure to control CCG expenditure budgets	Risk rating **reduced** from 3x4 (12) to 1x4 (4) Assurance rating **improved** from reasonable to significant. Robust processes in place. Budget training now delivered to 95%. Remaining 5% being carried out on a rolling programme.
1.2 Non-delivery of financial targets due to over-performance/in-effective demand management of activity levels within acute and community provider contracts	Risk rating **reduced** from 3x4 (12) to 1x4 (4) Assurance rating **improved** from reasonable to significant. Management plan being tracked and on target. Monitored by F & R Committee.
1.3 Failure of providers to deliver CQUIN targets leading to slow change /transformation of services	Risk rating 3x3 (9) **reduced** to 2x3 (6) Assurance **remains** significant Review of Quality team and CSU support completed. Function will become in-house from 1st April. Transition plan in place.

GBAF	South Sefton CCG
1.4 Exceed trajectories for HCAI impacting on patient safety & non-achievement of quality premium *in accordance with national set objectives e.g. CCG/ provider/CDiff trajectory/ zero tolerance for RSA *note: risk reworded	Risk rating 3x4 (12) **reduced** to 3x3 (6) Assurance remains reasonable Quality team continue to liaise with local authority to develop joint KPI's/Quality indicators for Care Homes. Plans in place for a joint Local Quality Surveillance Group for Care Homes and domiciliary providers across Sefton with GP clinical leads. RCA CDIFF tool developed

3.2 **Corporate Risk Register *(Appendix D)***

There are 23 operational risks recorded on the South Sefton CCG Corporate Risk Register (CRR) for quarter 4 (March) 2014/15:

- 23 risks continue from February 2015:
  - 21 have stayed the same
  - 2 have reduced: QUA009, 11
- 0 risks removed
- 0 new risks

Of which:

- 0 Extreme risks
- 14 High risks: BUO001; QUA002, 4, 6, 8, 11, 12, 15, 16; REP001, 4, 5, 6; STA001.
- 6 Medium risks: QUA003, 5, 13; REP002; STA002, 3.
- 3 Low risks: FIN003, QUA001, 9.

CRR Risk	South Sefton CCG
QUA009 Risk that patients could be harmed or receive inadequate care due to failure of GP's to deliver against Primary Care Quality Contract 14/15	2x3 **(6) reduced** to 1x3 **(3)** Some practices had difficulty accessing Dashboard through CMIP. Plan put in place to address, issues now resolved.

CRR Risk	South Sefton CCG
QUA011 Risk that patients could be harmed or receive inadequate care due to failure to deliver against National Key Performance Indicator for IAPT (Improving Access to Psychological Therapies)	4x3 **(12) reduced** to 3x3 **(9)** Target achieved for the first time in Q3 with 3.85%.

4.0 CONCLUSION

South Sefton CCG's 2014/15 Governing Body Assurance Framework and Corporate Risk Register documents highlights the key objective and operational risks as at the end of March 2015, 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, Corporate Governance Support Group and Quality Committee 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.

5.0 RECOMMENDATIONS

As identified on page 1:

The Governing Body is asked to:

- Receive and note the report and appendices presented
- Note the work undertaken and progress made on assurance and scrutiny, making comment for any further developments.
- Review Q4 (March) 2015 GBAF positions, specifically the 'GIC' and 'GIA': the Governing Body need to be assured where there are any incidences of an absence of 'Gaps in Control' and/or 'Gaps in Assurance'. Consider/comment/approve accordingly
- Review Q4 (March) 2015 CRR positions.
  Consider/comment /approve accordingly.

Appendices

A. Risk Matrix (end of report)
B. GBAF Q4 2014/15 Summary (separate document)
C. Governing Body Assurance Framework Q4 2014/15 (separate document)
D. Corporate Risk Register Q4 2014/15 (separate document)

Judy Graves
Governance Facilitator
NWCSU

Appendix A

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.

Consequence Score for the CCG if the event happens		
Level	**Descriptor**	**Description**
1	Negligible	• None or very minor injury. • No financial loss or very minor loss up to £100,000. • Minimal or no service disruption. • No impact but current systems could be improved. • So close to achieving target that no impact or loss of external reputation.
2	Minor	• Minor injury or illness requiring first aid treatment e.g. cuts,bruises due to fault of CCG. • A financial pressure of £100,001 to £500,000. • Some delay in provision of services. • Some possibility of complaint or litigation. • CCG criticised, but minimum impact on organisation.
3	Moderate	• Moderate injury or illness, requiring medical treatment (e.g. fractures) due to CCG's fault. • Moderate financial pressure of £500,001 to £1m. • Some delay in provision of services. • Could result in legal action or prosecution. • Event leads to adverse local external attention e.g. HSE, media.
4	Major	• Individual death / permanent injury/disability due to fault of CCG. • Major financial pressure of £1m to £2m. • Major service disruption/closure in commissioned healthcare services CCG accountable for. • Potential litigation or negligence costs over £100,000 not covered by NHSLA. • Risk to CCG reputation in the short term with key stakeholders, public & media.
5	Catastrophic	• Multiple deaths due to fault of CCG. • Significant financial pressure of above £2m. • Extended service disruption/closure in commissioned healthcare services CCG accountable for. • Potential litigation or negligence costs over £1,000,000 not covered by NHSLA. • Long term serious risk to CCG's reputation with key stakeholders, public & media. • Fail key target(s) so that continuing CCG authorisation may be put at risk.
Likelihood Score for the CCG if the event happens		
Level	**Descriptor**	**Description**
1	Rare	• The event could occur only in exceptional circumstances. • No likelihood of missing target. • Project is on track.
2	Unlikely	• The event could occur at some time. • Small probability of missing target. • Key projects are on track but benefits delivery still uncertain. • Less important projects are significantly delayed by over 6 months or are expected to deliver only 50% of expected benefits.
3	Possible	• The event may occur at some time. • 40-60% chance of missing target. • Key project is behind schedule by between 3-6 months. • Less important projects fail to be delivered or fail to deliver expected benefits by significant degree.
4	Likely	• The event is more likely to occur in the next 12 months than not. • High probability of missing target. • Key project is significantly delayed in excess of 6 months or is only expected to deliver only 50% of expected benefits.
5	Almost Certain	• The event is expected to occur in most circumstances. • Missing the target is almost a certainty. • Key project will fail to be delivered or fail to deliver expected benefits by significant degree.

South Sefton CCG Assurance Framework 2014/15
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
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				Assurance Rating Key
				Q1	Q2	Q3	Q4	
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 in assurance rating 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	~~3x4~~ 1x4	Martin McDowell	R	R	R	S	▲
1.2	Non-delivery of financial targets due to over-performance/in-effective demand management of activity levels within acute and community provider contracts	~~3x4~~ 1x4	Martin McDowell	R	R	R	S	▲
1.3	Failure of providers to deliver CQUIN targets leading to slow change /transformation of services	~~3x4~~ 2x3	Debbie Fagan	S	S	S	S	►
1.4	Exceed trajectories for HCAI impacting on patient safety & non-achievement of quality premium	~~3x4~~ 3x3	Debbie Fagan	R	R	R	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	S	S	S	►
1.6	Non-delivery of 2014/15 QIPP Plan which supports transformational change	3x4	Karl McCluskey	R	R	R	R	►
Corporate Objective 2: **Sustain reduction in non- elective admissions in 2014- 2015**								
2.1	Potential for any reduction in non-elective admissions to be offset by increased demand	4x3	Karl McCluskey	R	L	L	L	►
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.	2x3	Stephen Astles	R	R	R	R	►

15/94 CRR & GBAF

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	R	R	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	3x3	Jan Leonard	R	R	R	R	►
5.2	Inability to maintain active involvement of all constituents and stakeholders	3x4	Stephen Astles	R	R	R	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	L	R	R	►
6.2	Potential of changes to social care funding to have an adverse impact on NHS services	3x3	Tracy Jeffes	L	L	L	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	R	R	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	S	S	S	►

South Sefton Clinical Commissioning Group

South Sefton CCG Assurance Framework – Quarter 4 2014-15: January – March 2015

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	~~3x4~~ 1x4	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. Reported to the Governing Body via Finance & Resource committee minutes. Budget holder training: ongoing rolling programme.	**Significant** **Reasonable** Robust processes in place and continue to be managed. **Limited**	(~~GIA) Additional budget holder training required:~~ completed	~~Not required at this stage.~~ Training now held. Delivered to 95%. Final sessions being carried out for the final 5%. Training will be carried out on a rolling programme.	~~March 2015~~

Progress Reports	**Q1**	**On target - Robust processes in place and being managed.**	**Assurance Rating**	**Reasonable**
	Q2	**On target - Robust processes in place and continue to be managed.**		**Reasonable**
	Q3	**On target - Robust processes in place and continue to be managed.**		**Reasonable**
	Q4	**On target - Robust processes in place and continue to be managed. Additional Budget Holder training delivered: 95% carried out with the remaining 5% being finalised.**		**Significant**

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	~~3x4~~ 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 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** Better information provided at practice level. Targets met and all being managed. **Reasonable** Management plan developed to monitor financial position to ensure stay on target and mitigate over performance for 14/15: on track and robustly managed. Any over performance being adequately managed by reserves. Currently identified schemes to reduce demand in Urgent Care as part of Strategic Plan. **Limited**	~~(GIA) Better information required at practice level to encourage ownership of management/info improved control of referrals etc.~~	~~Currently working through.~~ In place.	~~March 2015.~~
Progress Reports	**Q1**	**Likely over-performance offset by adequate reserves held at Q1**				**Assurance Rating**	**Reasonable**
	Q2	**Management plan developed to manage financial position to ensure stay on target and mitigate over performance for 14/15.**					**Reasonable**
	Q3	**Management plan being tracked and on target. Monitored by F&R committee.**					**Reasonable**
	Q4	**Management plan being tracked and on target. Monitored by F&R committee.**					**Significant**

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~~ 2 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. Reports to the SMT on the Quality Team following review of function, roles, capacity and support. With further report in October. Transition plan in place.	**Significant** Regular provider performance reviewed at scheduled Quality Contract meetings. Transition plan in place for the in-housing of quality services **Reasonable** **Limited**	~~(GIA & GIC) Review of function, roles and capacity of Quality Team needed:~~ completed ~~(GIA) Review of quality support from CSU needed:~~ completed	~~Report being presented to SMT at end of September 2014 following completion of review.~~ ~~Report being presented to SMT at end of September 2014.~~ Workforce paper submitted to SMT as per required timelines in October 2014 and as part of wider corporate review. Quality function currently provided from CSU. Will now become an in-house service from 1st April. - Transition plan in place regarding Transition risks - Meeting held with CSU to discuss transfer for 1st April	~~Chief Officer and Chief Nurse – September 2014~~ ~~Chief Nurse September 2014~~ ~~March 2015~~ April 2015

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
Progress Reports	Q1	Regular provider performance reviewed at scheduled Quality Contract meetings.				Assurance Rating	Significant
	Q2	Provider performance continues to be reviewed. Workforce paper for Quality Team undertaken					Significant
	Q3	Workforce paper submitted as part of wider corporate review. Outcome by end of Q4					Significant
	Q4	Transition discussed at SMT and Governing Body. Governing Body agree proposal take bring in-house.					Significant

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 in accordance with national set objectives e.g. CCG/ provider/CDiff trajectory/ zero tolerance for RSA**	~~3 x 4~~ 3 x 3	Regular reporting to Quality Committee on HCAIs CPQG reporting CDIFF Steering Group established (progress reports to Quality Committee) Local Health Economy Steering Group (workshop planning meeting held March 2014, Workshop held April 2014, Steering Group meetings held July, September, October 2014, February 2015. HCAIs standing agenda item CCG action plan presented to Quality Committee and shared with NHSE: updates received. Process in place for CCG review of CDIF route cause analysis reports. CDIFF appeals process in place and operational. Initial meeting September 2014. Meetings held regularly. Final meeting for 14/15 due to be held 12/03/15.	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. Local system in place and operational for MRSA post infection reviews Common RCA CDIFF tool developed and includes evaluation regarding effectiveness from Higher Education.	**Significant** **Reasonable** Held Health Economy Workshop for CDIFF: outcomes being taken forward and developed. Regular steering group meetings in place and RCA tool for CDIFF developed. Inaugural Local Health Economy Steering Group meetings held July, September, October 2014, telecom February, with next meeting April 2015. Continue to liaise with Public Health to develop CCG process for review of provider CDIFF RCA's/CCG CDIFF management of provider CDIFF 'Appeals process. Appeals process has commenced and working well. **Limited**	~~(GIC) To review the role of the Sefton Health Economy Steering group i.e. key risks to be filtered through this group.~~ ~~(GIC) Workshop identified the absence of a common RCA tool for CDIFF across the health economy:~~ completed with draft finalised. (GIC) Lack of integrated working around quality indicators within care homes.	Review to be held in April 2015 ~~Common RCA CDIFF tool developed and includes evaluation regarding effectiveness from Higher Education. Currently being revised, due for completion January 2015.~~ Meeting held with Sefton Council Director of Adult Services to discuss integrated working around quality indicators with Care Homes which will include IPC/HCAI's. Was agreed to focus on Care Homes in relation to joint quality indicators. Progress to be discussed at next meeting due December 2014.	Chief Nurse ~~July 2014~~ April 2015 ~~January 2015~~

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**
					(GIA) Local Health Economy Steering Group meetings to be scheduled for 2015.	Quality team continue to liaise with local authority to develop joint KPI's/Quality indicators for Care Homes. Plans in place for a joint Local Quality Surveillance Group for Care Homes and domiciliary providers across Sefton with GP clinical leads. Next meeting due to be held April 2015.	~~January~~ April 2015
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	**Workshop outcomes being taken forward and developed. Inaugural Local Health Economy Steering Group meeting held July with a further meeting held September 2014. Common RCA CDIFF tool being developed.**					**Reasonable**
	Q3	**RCA CDIFF tool in final stages of completion. Final changes due January 2015. To be launched at HCAI Steering Group in early 2015.**					**Reasonable**
	Q4	**RCA CDIFF tool developed. Quality team continue to liaise with local authority to develop joint KPI's/Quality indicators for Care Homes and plans in place for a joint Local Quality Surveillance Group for care homes and domiciliary providers.**					**Reasonable**

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 SLA to 2014/15 in place Plan in place CHC.	**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**	(GIA) Strategic annual review of CSU service delivery by commissioning support requirements. ~~(GIC) Specific work and forward plan for future management of CHC to be developed:~~ Completed. (GIA) CMIP roll out plan to be updated and to include dates for availability for practice level information and additional planning to involve locality manager ~~(GIA) CHC information varying~~		September 2014 ~~September 2014~~ October 2014 ~~August 2014~~

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**
					~~on monthly basis~~ (GIC) Financial information received and negotiations now focus on SLA for April 2015 and beyond. (GIA) Failure of NWCSU to be accepted onto LPF increases the risk of maintaining stability of commissioning support service into 15/16.	Current SLA extended to end ~~March~~ April 2015. CSU notified of CCG commissioning intentions for 15/16. ~~Process in place to consider implications of commissioning intentions. To work through solutions for affected service lines.~~ SLA rolled forward to end April to enable implementation of bringing in-house agreed service lines. However working with neighbouring CCG's on a collaborative approach for support services for the future.	~~February 2015~~ April 2015
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	**Current SLA rolled forward to April 2015. Review of all service lines underway.**					**Significant**
	Q3	**Creation of NWCSU now completed.**					**Significant**
	Q4	**SLA rolled forward to end of April 2015 to enable implementation of bringing in-house agreed service lines. Working with neighbouring CCG's on a collaborative approach for support services for the future.**					**Significant**

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	**3 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. Revised Strategic Plan develop Board Development session held on strategic approach to QIPP.	**Significant** **Reasonable** QIPP plans and associated finance cost reductions identified within CCG strategic financial plan and approved by governing body in May 2014 **Limited**	(GIA) Current QIPP in reserves (£493,000) ~~(GIC) Board development session to be held on developing a strategic approach to QIPP:~~ completed.	~~Month 7 review and augmentation of approach to QIPP in year to be undertaken jointly with finance. Working to identify QIPP contributions in year. To be reported to next Finance & Resource Committee in January 2015.~~ Completed. Re-profiled QIPP plan to be presented to March Governing Body. Document identifies a number of approaches to manage gap and schemes. For example outpatient news follow-up and conversion of elective activity - currently pursuing with clinical members of the Governing Body. ~~Development session planned for 18th December. Findings to be pulled together for January 2015.~~ Reworked financial plan to be presented to March Governing Body.	~~January 2015~~ March 2015 ~~January 2015~~ 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**

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**
	Q2	Initial review of project structure and requirements set out. These are to be agreed in Q3. Further potential QIPP areas being considered in conjunction with Finance for targeting					Reasonable
	Q3	QIPP areas being considered. Board development session being held on 18th December to look at developing a strategic approach to QIPP.					Reasonable
	Q4	Revised strategic and financial plan.					Reasonable

Corporate Objective 2: Sustain reduction in non- elective admissions in 2014- 2015				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 Any reduction in non-elective admissions may be offset by increased demand	**4x3**	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. Integrated Performance Report Report presented and approved by both Governing Bodies in September 2014. Minutes of meetings Aintree Contract Query Notice being managed through Collaborative Commissioning Forum includes reporting process.	**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** Report submitted to the Collaborative Commissioning Forum. Feedback being a clearer understanding of the pathway.		Review of non-elective unplanned activity and variance to plan completed. However further clarity has been requested. Still a view that due to change in activity counting. CSU carrying out analysis of emergency activity with common data set. Report to be submitted to next Collaborative Commissioning Forum: completed	~~January~~ April 2015 ~~January 2015~~
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	**New Integrated Performance Report taken to both Governing Body meetings in September in 2014 and approved. Revised Clinical Pathway for emergencies agreed with Aintree for implementation in September. CCG's working with Trust to understand non-elective impact and consequences.**					**Limited**
	Q3	**Assessment concluded. Aintree now issued with Contract Query Notice on heightened level of activity associated with revised clinical pathway. Being managed through the Collaborative Commissioning Forum (CCF).**					**Limited**
	Q4	**Analysis of emergency activity being carried out as a result of the Contract Query Notice.**					**Limited**

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**	**2 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 Monthly performance review meetings.	Aintree achieved year 95% A&E target. Discussion at CCF relating to closing of contract query – carried forward to Q1 2014/15. Q1 not achieved 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 via performance data. Urgent Care referral processes in place and being monitored.	**Significant** **Reasonable** Q1, Q2 & Q3 A&E Aintree targets not achieved. Continue to follow monthly monitoring process. **Limited**	(GIC) Aintree Q3 not achieved. Need to review activity. (GIC) Change in Aintree A&E patient pathway, may lead to increased admission coding.	Ongoing monthly performance review meetings continue. ~~Urgent Care rollout confirmed, to cover whole of CCG by November 2014: now~~ in place with referrals being monitored. ~~Process being established~~: in place.	~~January 2015:~~ ongoing monthly.

Progress Reports	**Q1**	**Q1 A&E Aintree targets not achieved. Monthly monitoring process being followed.**	**Assurance Rating**	**Reasonable**
	Q2	**A&E targets not achieved. Resilience plan in place. Monitor in Q3.**		**Reasonable**
	Q3	**A&E targets not achieved. Resilience plan in place. Continues to be monitored.**		**Reasonable**
	Q4	**A&E targets not achieved. Resilience plan in place. Continues to be monitored.**		**Reasonable**

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. Locality Implementation Group established with recovery plan of work in place: meet on a six monthly basis. Mobilisation reviewed at each meeting. Action tracker in place to record agreements. Service agreed and locality based where appropriate.	**Significant** **Reasonable** Locality Implementation Group established. Group have identified gaps and recovery plan in place with plan of work. Continue engagement with interim senior management team and practices. Service agreed and locality based where appropriate. **Limited**	~~(GIA) Locality Implementation Group to review progress of recovery plan and plan of work~~.	~~Report to be presented to next meeting.~~ Mobilisation reviewed at each meeting. Update to be fed through to the Quality Committee including Action Tracker, Recovery Plan including plan of work, update on service agreement: being presented 19/3/15.	~~March 2015~~ March 2015
Progress Reports	**Q1**	**Reviewing possible gaps. Engagement with interim senior management team and practices.**				**Assurance Rating**	**Reasonable**
	Q2	**Locality implementation Group meeting held, involving GP's and LCA Clinicians. Plan of work in place.**					**Reasonable**
	Q3	**Action tracker in place to record agreements. Service agreed and locality based where appropriate.**					**Reasonable**
	Q4	**Weekly meetings held with LCH mobilisation team. 6 weekly GP Locality Lead meetings. Locality Community Care model under development.**					**Reasonable**

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	**3 x 3**	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. Board continue to meet regularly. - Operational until Q3 2014/15 - Replaced by Service Improvement and Redesign Committee, established Q3 2014/15. Consultation completed. Contract finalised and all practices signed up.	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 Primary Care Quality Board disbanded and now feeds through/replaced by Service Improvement and Redesign Committee: is already established with 2 meetings held to date. Governing Body oversight of PDR process for members/clinical and locality leads via exception reporting	**Significant** **Reasonable** Consultation now completed and contract finalised. All practices now signed up to contact. Local quality contract on-going. **Limited**	(GIC) ~~South Sefton Governing Body vacant posts to be filled including Primary Care Quality Lead :~~ completed	Primary Care Quality Board disbanded and replaced by Service Improvement and Redesign Committee. 2 meetings already held. ~~Any actions being fed through to SLT as an interim measure. Posts to be appointed to by January 2015. Process agreed with LMC.~~ The Governing body clinical lead roles have been realigned and the vacant post filed, this will be subject to ratification by wider constituent group as per constitution.	~~January 2015~~ April 2015
Progress Reports	**Q1**	**Contract is ready pending completion of consultation.**				**Assurance Rating**	**Reasonable**
	Q2	**Practices signed up to contract. Delivery of Quality Contract to commence 1st October 2014.**					**Reasonable**
	Q3	**Contract continues to be monitored. Service Improvement and Redesign Committee established with regular meetings being held.**					**Reasonable**
	Q4	**The Governing body clinical lead roles have been realigned and the vacant post filed, this will be subject to ratification by wider constituent group as per constitution.**					**Reasonable**

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: report and action plan compiled and shared as a result of the events outcomes. Practices updated. Governing Body receives minutes of locality meetings.	**Significant** **Reasonable** Governing Body receives minutes of Locality Meetings. Listening Exercise undertaken: report and action plan compiled as a result of the events outcomes. Locality meetings continue to be well attended. **Limited**	(GIA) Review needed on action plan (from Listening Exercise)	~~Listening Exercise Outcome Report shared at Wider Group meeting in September. Practices updated on progress~~. Further work to confirm for 2015/16	March 2015
Progress Reports	**Q1**	**Governing Body receives minutes of Locality Meetings. Listening Exercise undertaken.**				**Assurance Rating**	**Reasonable**
	Q2	**Locality meetings well attended. Good attendance at Wider Group.**					**Reasonable**
	Q3	**Locality meetings well attended. Listening Exercise Outcome report shared with Wider Group.**					**Reasonable**
	Q4	**Clinical lead roles in Governing Body currently being reviewed in order to consider where else support might be able to be provided.**					**Reasonable**

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 Task and Finish Groups key areas developed at workshop held in May 2014: developing short and long term plans. BCF3 submission highlights 3 main schemes to aim to reduce non-elective activity through development of enhanced community provision. BCF 3 has now been approved following removal of remaining conditions.	**Significant** **Reasonable** NHS E approved BCF plans December 2014 **Limited** Workshop completed key work streams to progress integration agenda. Key work streams have begun to develop plans further.	(GIC) BCF3 submission highlights key risks in relation to achieving the plan.	Health and Wellbeing Board working to explore and mitigate risks where possible. Further work completed on BCF risks, mitigations and assurances from NHS E. Next step is implementation and monitoring of BCF schemes and ongoing report to PIG. 'Shaping Sefton' plan to formalise revised governance arrangement for integrated working. Development of section 75 agreement with local authority drawing to a conclusion.	~~January 2015~~ ~~February 2015~~ April 2015 March 2015
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	**BCF3 submission highlighted potential areas for system change.**					**Limited**
	Q3	**BCF3 now approved without conditions and moved to full implementation.**					**Reasonable**
	Q4	**Section 75 being finalised and governance arrangements reviewed to support implementation in 15/16. 1 scheme in BCF being 'Integrated Wellness Service'.**					**Reasonable**

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. BCF3 enabled the further development of joint plans.	**Significant** **Reasonable** **Limited** HWBB supportive of wider –system approach and groups developing short term and longer term plans. BCF3 submission brought together the work from these groups for key schemes which will be performance managed as part of the BCF3 process.	(GIC) Impact of Council spending plans on Health Services has not yet been fully determined. (GIA) Need for clear measures and processes across system to identity impact	Meetings to be held between Senior Council and Senior CCG Officers to explore impact and identify any mitigations 'Shaping Sefton' plan to formalise revised governance arrangement for integrated working	~~January 2015~~ April 2015
Progress Reports	**Q1**	**HWBB supportive of wider –system approach and groups developing short term and longer term plans**				**Assurance Rating**	**Limited**
	Q2	**BCF3 submission highlighted plans for protection of Social Services however risks remain.**					**Limited**
	Q3	**BCF3 now approved but impact of reductions in resources requires further assessment.**					**Limited**
	Q4	**'Shaping Sefton' plan to formalise revised governance arrangement for integrated working**					**Limited**

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**	(GIC) Recruitment to commence: post not yet advertised, further review of job description required.	Delay due to council reorganisation.	~~January~~ April 2015

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	**Post not advertised, further review of job description required.**		**Reasonable**
	Q3	**Review of requirements pending Council changes.**		**Reasonable**
	Q4	**Council restructuring still progressing.**		**Reasonable**

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. Minutes of meetings	**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. Improving Access to Psychological Therapies (IAPT) awarded to alternative r provider. To commence April 2015. **Reasonable** **Limited**	~~(GIC) Assessment of resource to support breadth and depth of project required:~~ completed.	Review of resources and development of business case completed. Now identifying priority areas for focus and development from the results of the review. First draft ~~expected~~ completed ~~January 2015~~ with final document to be presented to Governing Body in March 2015. Mental Health review and full paper being presented to part 2 Governing Body in	~~January 2015~~

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**
						March 2015: next steps will be identified following Governing Body meeting. Overview of findings being presented to Merseycare Trust in March 2015. Previous reporting issues regarding prevalence rates. Now received a revised report however now have a revised national target. Being monitored with a view to achieving target in Q4. IAPT target likely to be achieved.	March 2015 March 2015 April 2015
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	**Review and assessment of Dementia incidents and diagnosis rates completed in September. Formal review of IAPT performance against access target of 15% initiated. Formal updated received at Governing Body-November 2014.**					**Significant**
	Q3	**Governing Body to be updated and advised on IAPT reporting error and revised performance and national target for Q4**					**Significant**
	Q4	**Mental Health review and full paper being presented to part 2 Governing Body in March 2015.**					**Significant**

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 - CORPORATE RISK REGISTER

Quarter 4 (March) 2014/15

Last Saved: 23/03/2015

By User: Judy.Graves

▼ Risk reduced
► Risk unchanged
▲ Risk increased

Domain & ID	Date Added	Principal Risk	2014/15 Strategic Objectives	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Due	Progress against action Plan	Q1	Q1+1 (July 2014)	Q1+12 (Aug 2014)	Q2	Q2+1	Q2+2	Q3	Q3+1	Q3+2	L	C	Q4	Change Since Last Update
Business Objective																										
BUO001	Prior Q3 2013/14	18 week & cancer pathways may not be met due to non delivery of target by provider	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Business Objective	Chief Strategy & Outcomes Officer (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. RCA for any 62 day breaches RTT plans with Aintree and Southport & Ormskirk agreed and weekly review of performance is in place. Reporting system developed that provides earlier notification of waiting time concerns. Is reviewed on a weekly basis and reported to SMT and SLT (Senior Leadership Team). Integrated Performance Report developed and presented to Governing Body. Action plans in place for failed areas: progress being monitored via SMT, contractual performance and continued reviews.	3	3	9	Suspension of Breast Service in Southport & Ormskirk NHS Trust: closed to new referrals from 1st September: consequence being a higher level of breaches materialising however should resolve as activity being managed. Completion of action plan to improve Aintree RTT position for Admitted Pathways: Ophthalmology Maxillofacial Diagnostic Waiting Time Target failure: Endoscopy	~~February~~ April 2015 ~~February~~ April 2015 March 2015	~~March~~ May 2015 ~~March~~ May 2015 April 2015	Cancer 2 week: Continue to monitor the 2 week wait cancer performance. Systems in place are fit for purpose as the year end target is delivered: achieving. Cancer 62 day target achieving except referral from screening service to fiist definitive treatment. Additional capacity ~~appears to be bringing~~ has brought performance in-line. Other local providers contacted and they have put on additional capacity to meet demand. Will be monitoring and working with providers to identify issues. Longer term we are working With local providers to develop a new pathway and make a sustainable service locally. Aintree University Hospital Trust achieving all categories however referral from NH screening remains below 90%. CCG has achieved all indicators. Aintree have achieved all except 62 day screening target which was narrowly missed by 2.6%.. 18 Week: overall 18 week target was delivered and Southport & Ormskirk trust made significant progress against clearing the backlog of patients waiting 18 weeks continues to be monitored - backlog at low level. Reporting system now developed and continues to be reviewed on weekly basis and reported to SMT and SLT. Feedback received from SMT and SLT who have commented that they are now able to see in context compared to other performance and quality components. RTT: RTT (Referral to Treatment Time) Plans with Aintree and Southport & Ormskirk agreed and weekly review of performance is in place: continues. Concerns have been highlighted regarding Aintree's recent RTT position. Overall RTT position is achieving however Admitted Pathway has been failing the last 5 weeks due to some speciality areas: ENT, Thoracic Medicine, Maxillofacial, Ophthalmology. Aintree have developed action plans which have been approved by their Trust Board and presented to the CCG's SMT and SLT. Performance against the action plans will now be monitored via contract meetings and the continued weekly review. Admitted Pathway is still under performing with non-admitted over performing, therefore giving an overall 'green' on performance. Additional Consultant appointed and already in post which is expected to show an improvement in ENT and Maxillofacial by January 2015. ENT and Thoracic action plans completed. Admitted pathway started to achieve in Febiuary: performance improved and target met for 3 weeks out of 3 in February. Integrated Performance reporting system developed. First report presented to SS & SF Governing Bodies in September 2014. Positive feedback and well received. Members considered provided a more rounded picture and joined up quality and performance issues. Diagnostics waiting time target failed in November as a result of a sickness absence in Echo Cardiology. Resolved in December. This was followed by failed target for non-elective which impacted in December (separate issue). An exception report was received from Aintree in relation to performance and included the areas that had failed (cardiology, MRI and Endoscopy). Aintree have already implemented action plans for all failed areas. Latest update is Echo Cardiology is achieving from January and MRI recovery already achieved. Endoscopy is dependant on recruitment of 3 Consultants and 1 Specialist Registrar. Recruitment is ongoing and being supported by HR. Business cases are in place for each post. Failed target 3rd consecutive month. Target is 1%, actual 1.24%. Extensive action plan in place and ongoing. Note: Aintree have taken up additional RTT. Will need to undertake supplementary activity during October and November 2014. Plan agreed with NHS England.	3x4	2x4	2x4	2x4	2x4	2x4	2x4	2x4	3x4	3	4	12	►
Finance																										
FIN001	Removed and placed on Horizon scan																									
FIN002	Moved to Horizon scan																									
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. Predominant risk areas are: CHC and Urgent Care which have both seen significant growth in demand.	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Financial	Chief Financial Officer (Martin McDowell)	-Monthly contracting meetings with main acute providers - Information shared with GP leads - Practice level reporting of financial information - Monthly monitoring of financial position -Action plan developed to mitigate in short term. - task force with weekly steering group established - Benchmarking review carried out by MIAA	4	2	8	~~Completion of action plan by March 2015 to mitigate short term financial pressure.~~ -Completed. ~~Review of CSU team case management and data quality to better inform cause of increase in demand;~~ completed ~~Benchmarking exercise to be completed by MIAA;~~ completed. Awaiting MIAA benchmarking results.	~~March 2015~~ ~~March 2015~~ ~~March 2015~~ March 2015	~~April 2015~~ ~~April 2015~~ ~~April 2015~~ April 2015	CCG monitoring performance accordingly. CCG has built impact of changes into contract, not reflected in plans. Reported in financial position. Action plan that will mitigate in short term i.e.14/15. now developed: will manage financial overspend. Has been presented to Governing Body. Governing Body agreed action plan and are aware of situation. Confident that will meet all action plan requirements by the end of the financial year (March 15). Delivery of action plan to be monitored. Robust contract management in place. Action plan completed. CHC task force set up with a weekly steering group led by Helen Nicholls with COO of CSU and Chief Nurse, DoF along with wider team commenced December 2014 in order to improve processes around CHC case management and data quality National Benchmarking presented to F&R Committee in January 2015. MIAA commissioned to undertake further benchmarking. Results expected by end of March. Note: - As discussed at SMT 25/11/14, risk has been reviewed and will be used as overall financial risk. - Reduction of risk due to improved financial position for South Sefton	3x2	4x3	4x3	4x3	4x3	4x3	3x3	2x3	1x3	1x3	1	3	3	►
FIN004	Moved to Horizon scan																									
FIN005	Moved to Horizon scan																									
FIN006	Moved to Horizon scan																									
FIN007	Removed																									
Quality																										

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

Quarter 4 (March) 2014/15

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By User: Judy.Graves

▼ Risk reduced
► Risk unchanged
▲ Risk increased

Domain & ID	Date Added	Principal Risk	2014/15 Strategic Objectives	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Due	Progress against action Plan	Q1	Q1+1 (July 2014)	Q1+12 (Aug 2014)	Q2	Q2+1	Q2+2	Q3	Q3+1	Q3+2	L	C	Q4	Change Since Last Update
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 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. Updates presented to and discussed by the Safeguarding Steering Group Regular report to the quality Committee from the Safeguarding service. Commissioned 'CQC style' peer review of CCG Safeguarding arrangements. Children's: all positions filled. New Head posts for Adults and Children.	3	3	9	**Children's:** **Adults:** HR process to conclude: 30 day consultation regarding re-designed structure.	April 2015	April 2015	Children's team now at full strength: person previously off sick is now off of phased return and working their full hours and all posts filled. Formal staff consultation regarding structure now concluded. Interviews for Head of Safeguarding (Children) scheduled to take place. Restructuring has taken place following staff consultation and recruitment. New post for Looked After Children advertised. Childrens element will have reached full establishment once post appointed to. Heads of both Adult's and Children's Safeguarding now recruited to Adults team: work and team supported whilst a member of the team was on planned sick leave: has now returned and normal service level resumed. Review of Adult service carried out. Has resulted in vacancy from redundancy being withdrawn until review finalised. Revised structure for Safeguarding Adults being discussed at Steering Group meeting on 17th November 2014 with a paper to then be presented to the CCG Network in December 2014. Financial viability discussions taking place for proposed statutory changes in view of the Care Act. Steering Group held in November and costings now being worked with finance. Next Safeguarding steering group January 2015. HR process has commenced (30 day consultation) for re-designed structure. Once HR process completed then recruitment can take place (restructure to align with children's and to take into account new Care Act). HR issues being managed by Halton CCG. Update provided to the Safeguarding Steering Group meeting held on 11/8/14. Dates to be set by CCG CO for rest of year. Further update to next Steering Group meeting on 17th November 2014. Meetings also scheduled for 15/16.	3x3	3x3	3x3	3x3	3x3	3x3	3x3	1x3	1x3	**1**	**3**	**3**	►
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 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 and includes recommendations re review.	4	5	20	Awaiting feedback from Quality Committee on draft SOP To obtain the recommendations from Liverpool Community Health's internal Safeguarding review that explored the role of the Safeguarding Adults team. Part 1 received: Awaiting part II which looks at progress against ongoing recommendations.	~~February~~ April 2015 March 2015	~~February~~ April 2015 March 2015	SOP updated following recommendations from safeguarding 'CQC style' peer review. Draft SOP sent to CCG Peer Reviewer for consideration. Item on agenda for December 2014 Quality Committee. Deferred to January 2015 Quality Committee. LCH internal review requested by Chief Nurse. Discussed at Contract meeting. Received LCH Safeguarding Review part 1 , waiting part 2: Chief Nurse has contacted the Deputy Director of Nursing chasing part 2. Awaiting 2nd peer review recommendations. Meeting between Chief Nurse and Deputy Director of Nursing to discuss 2nd peer review recommendations to be re-arranged once the new Nursing Director in post: expected to be arranged for January 2015. Safeguarding meeting to be arranged with new Interim Nursing Director regarding part 2 of the recommendations. Single point of contact in place and safeguarding service can mobilise teams and communicate with the LA.Contacted on 2/2/15 for confirmation of meeting and again 10/02/15 to confirm date with interim Nursing Director but no date set as yet. Plan for SOP review as part of meeting with LCH's review. Still waiting information from LCH in order to finalise SOP. CCG Network Steering Group updated at a meeting on 23rd February. Mitigating actions put in place.	2x4	2x4	2x4	2x4	2x4	2x4	2x4	2x4	2x4	**2**	**4**	**8**	►
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 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Delivery and Integration Officer (Tracy Jeffes)	Regular feedback from CSU / PALs regarding management of local queries. CSU temporary management and coordination of local primary care complaints. EPEG receive a monthly overview from NHS England	3	3	9	Liaison with NHS E Merseyside Team regarding co-ordination of arrangements in the future. Further clarity is required on current and future arrangements in light of the organisational changes in NHS England.	March 2015	April 2015	NHS E now managing own complaints. Seek assurances from NHS England on current and future plans. Ongoing: NHS England re co-commissioning with CCG's - environmental factor to understand the plans and how co-commissioning might affect this risk: on-going discussions regarding plans for co-commissioning with NHS England. Includes discussion regarding the complaints process: ongoing. EPEG is now receiving a monthly report on Primary Care complaints in addition to PALs reports. Healthwatch to report to EPEG on national findings regarding patient experience of complaints management: ongoing.	2x3	2x3	2x3	2x3	2x3	2x3	2x3	2x3	2x3	**2**	**3**	**6**	►
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	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Nurse (Debbie Fagan)	-Raised as an issue at the Quality Committee and Contract meetings. -Steering Group established - Terms of Reference revised	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 HSCSC 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. Further meeting held on 31/7 to discuss. IMerseyside confirmed they have sent information again to HSCIC (Health & Social Care Information Centre). Chief Nurse liaised with I-Merseyside in September 2014. No update yet received form HSCSC/National Level still waiting update. Chief Nurse requested I-Merseyside chase in October. Response not yet received. Chief Nurse has contacted I-Merseyside for a response. Update received from iMerseyside on the 19/12/14 with 2 options presented by HSCIC. NHS England leading on this and to consider which option is most appropriate. Contacted NHS E for update. Steering group revised terms of reference to manage clinical, technical and primary care issues as a result of incident. Still awaiting option from NHSE and group will follow up to NHSE. No update from NHSE. Contacted Kate Warriner & Michelle Creed on 10/02/15 who have responded that it is an ICE issue as such but a risk associated to rejection of pathology reports in GP clinical systems for patients not registered. Chief Nurse is chased and is awaiting a response on the NHSE action.	4x3	4x3	4x3	4x3	4x3	4x3	4x3	3x3	3x3	**3**	**3**	**9**	►
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	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Head of CCG Development (Stephen Astles)	Monthly monitoring of A&E attendances for patients of the affected practices ongoing via NWCSU BI Portals. Updates received by the Primary Care Quality Board and escalated to the Quality Committee via SMT.	3	3	9	Monthly monitoring of A&E attendances for patients of the affected practices: continues. Risk Summit to be held. Waiting instruction from NHS England.	March 2015	April 2015	Data to date shows that there is no significant risks in A&E attendances in these practices. Continues to be monitored on a quarterly basis. Information is provided to the Primary Care Quality Board and escalated to the Quality Committee via the SMT: continues. No issues and attendances maintaining. Single Item QSG convened on 24/2/15, follow up held on 3/3/15. Data to be collected in respect to A&E attendances and Out of Hours attendances. Risk summit to be convened on NHS England instruction by the end of March 2015.	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	2x3	**2**	**3**	**6**	►

SOUTH SEFTON CCG - CORPORATE RISK REGISTER

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▲ Risk increased

Domain & ID	Date Added	Principal Risk	2014/15 Strategic Objectives	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Due	Progress against action Plan	Q1	Q1+1 (July 2014)	Q1+12 (Aug 2014)	Q2	Q2+1	Q2+2	Q3	Q3+1	Q3+2	L	C	Q4	Change Since Last Update
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.	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality and Financial	Chief Nurse (Debbie Fagan)	Assurance process paper presented to LSCB on processes in place. 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 Agenda item for discussion at provider Quality Contract meetings. Safeguarding performance discussed at Quality Committee. Process developed between CSU and Safeguarding service to further develop information flow across the two services. Quality 'Walk Around' carried out with feedback and outcomes reported to Executive Nurse, contract meetings, Quality Committee. Contract reviewed to ensure in line with KPI's	4	4	16	Ongoing liaison between Safeguarding 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. Chief Nurse has confirmed that provider Safeguarding performance across the system would be an agenda item for discussion at next Quality Surveillance: Deferred to November meeting by NHS England. Deferred as a agenda item. Chief Nurse to follow up. 10/02/15 No confirmation for QSG agenda.	Ongoing TBC		Following update given at Safeguarding Service at March Quality Committee and discussion at March Governing Body - letter drafted and to be sent to all providers from CCG Chief Officer: confirmed as sent 11th April 2014. 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. Another meeting held early October. S&O Safeguarding Quality 'Walk Around' Audit held. Feedback to Executive Nurse. Outcome reported to CCG Quality Committee in September including Trust performance: showing positive improvement. Formal feedback given to Trusts at October Contract Meeting. Provider performance will continue to be monitored through the contracting process. Chief Nurse and Safeguarding Nurse met with Aintree to discuss performance of safeguarding services re revalidate of Q1 performance at same time as Q2. Contract variation to be put in place for Q3 in line with expected KPI's. Safeguarding Service have met with Liverpool Women's Hospital Director of Nursing in June 2014 with an update to the Chief Nurses for Liverpool CCG and the Sefton CCG's: to be discussed at the next Quality Committee (Q2). LWH information not validated by Safeguarding Service in time for September Quality Committee. Mitigating action: CCG to present at LWH CQPG where this will be discussed and fed back to QC in November 2014. Teams will be in attendance for Q2 provider performance report update. Chief Nurse presented paper to Sefton LSCB (Local Safeguarding Children's Board) on the assurance processes that the CCG has in place and Q4 2013/14 provider performance: Provider performance data presented in September 2014. Q2 performance data from Safeguarding due: as per reporting schedule. Provider Performance showing an upward trajectory in relation to improvement on training of staff and safeguarding awareness. S&O served with contract query in February, as necessary level of assurance not provided. Safeguarding service reported latest assurance report in Jan 2015. Feedback has been given at appropriate contract meeting. Safeguarding Services due to report Q3 performance at March 2015 Quality Committee. Chief Nurse is awaiting confirmation from LCH on when they will be able to share their 2nd Safeguarding Review so as to enable the CCG to review alongside SOP for Safeguarding Adults in order to ensure no duplication in commissioning in the new system.	4x4	4x4	4x4	3x4	3x4	3x4	3x4	3x4	3x4	2x4	2	4	8	►
QUA007	Removed																									
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.	Objective 2 - Sustain a reduction in non-elective admissions	Quality	Chief Nurse (Debbie Fagan)	Raised as an issue at the Quality Committee and Contract meetings. Director of Public Health notified. CCG comms notified. GP clinical lead identified within CCG Steering group set-up with reps from lab provider, local CCGs, i-Merseyside, Aintree Hospitals, NHS England and St Helens and Knowsley Infomatics. Remains agenda item for discussion at Aintree CQPG and Aintree Collaborative forum. Task and Finish Group established and receive progress and lessons learnt are discussed.	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. Macropriolachin 2. Clinisys (NT-proBNP & other analyses) 3. EPOC/EMIS 4. Clinisys Corrupt Characters/EMIS Web ~~RCA Investigation outcome to be presented to next Task and Finish Group. Deferred to March 2015.~~ Meeting held 02/03/15. ~~NHS England (M) arranging meeting to discuss lessons learnt from RCA's. Need to confirm position with NHS E. NHSE didn't attend meeting.~~ Decision to commission external review in relation to lessons learnt discussed and agreed. Further discussed 24/3/15. Full agreement needed on the proposal for an external review to look at 'Lesson's Learnt'. ~~To be put on next ladders meeting agenda for March 2015.~~ on LCL agenda 02/03/15	~~March 2015~~ ~~TBA~~ March 2015 ~~March 2015~~	~~March 2015~~ ~~TBA~~ March 2015 ~~March 2015~~	GP clinical lead identified within CCG, to support 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, regarding the high risk/priority patients GP's had been notified of, the GP Clinical Lead had written to all practices informing them of the issues and the system for prioritisation of notification between the lab and GP practices: CCG has received information from LCL regarding number of patients and GP practices they belonged to as part of assurance that practices have been notified. Followed-up with 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. - Extra-ordinary meeting held by NHS England in July: Task & Finish group last met 31/7. Plans in place to follow-up potential patient safety issue with practices in November 2014; letters sent to practices in November. To date no feedback received on whether any patient harmed as a consequence. - Next Task & Finish Group scheduled for September 2014 where progress and lessons learnt from provider RCA's to be discussed. ~~Waiting next meeting date for the Task and Finish Group.~~ Further meetings held in December. - Lessons Learnt event held and Chaired by NHS England in October 2014. CCG represented by Clinical Lead for Quality. Some suggestions made. Taking Lessons Learnt through to sub meetings of LCL Steering Group: ~~waiting next meeting date for the~~ Task and Finish Group held 2/3/15. Will be presented to Quality Committee once formal feedback through. - Remedial software introduced to capture any further incidents by the provider. LCL have reported issue nationally to MHRA. - CCG quality team undertaken risk assessment of each individual risk to demonstrate how actions that have been undertaken have mitigated ongoing risks in each of the identified 4 areas. CCG quality team continue to monitor. - Initial agreement made in August 2014 to commission external review. Being led by Knowsley CCG Chief Officer and the Trust. To be discussed further at a meeting of Aintree Collaborative Commissioning Forum 27th March 2015: need agreement of all CCG's (Liverpool, Knowsley and Sefton CCG's) in order to take forward. Review to look at Lesson's Learnt in relation to the incident investigation process. Meeting held. technical aspects of 3 incidents closed. However still open as clinical risk is still present. 4th incident is ongoing with majority of practices addressed with no errors at majority of practices. TOR of group revised to address and provide actions to resolve from a clinical risk perspective. Next meeting January 2015. Action chased up with CEO at Knowsley in January 2015. Software now working to prevent repeat of incident. Steering group revised terms of reference to manage clinical, technical and primary care issues as a result of incident. Still awaiting option from NHSE and group will follow up to NHSE. ~~Needs to be on next ladders meeting agenda for March 2015.~~ On LCL agenda 2/3/15. Incidents were discussed further regarding progress. LCL looking to confirm close down on outstanding patient query's.	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	2x5	2	5	10	►
QUA009	Jul-14	Risk that patients could be harmed or receive inadequate care due to failure of GP's to deliver against Primary Care Quality Contract 14/15	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality (also Finance and Performance)	Chief Strategy & Outcomes Officer (Karl McCluskey)	-Regular practice and GP visits Primary Care dashboard Updates to SMT - Dashboard in place and available for locality use	3	5	15	Locality level to test and assess practice performance.	February 2015	March 2015	Local Quality Contract 14/15: Primary Care dashboard which triangulates practice performance, quality and finance: will measure against other practices and highlight areas of differences and underpin Primary Care Contract with formal assessments now completed. Process for Primary Care Dashboard roll out and application at locality level presented to SMT on 3rd November 2014: Completed and available for locality use. Some practices had ~~having~~ difficulty accessing Dashboard through CMIP. Plan put in place to address: issues resolved. Latest version presented to Service Improvement and Re-design Committee in February 2015. Note: - Original consequence was rated as 5, now rated as 3 in view of shared risk between NHSE and CCG. - risk reduced due to 15/16 work being removed to Horizon Scan: 14/15 contract in place and well managed.	N/A	3x5	3x5	3x3	3x3	3x3	1x3	1x3	2x3	1	3	3	▼

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QUA010	Horizon Scan																									
QUA011	Q3+1 January 2015	Risk that patients could be harmed or receive inadequate care due to failure to deliver against National Key Performance Indicator for IAPT (Improving Access to Psychological Therapies)	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Strategy & Outcomes Officer (Karl McCluskey) and Chief Redesign & Commissioning Officer (Jan Leonard)	- Investigation completed: established that provider had made a local interpretation of target resulted in an over inflation of position. Situation has been notified to NHS England - Remedial action plan in place - Performance and contractual meetings and reporting process in place - paper presented to Governing Body November 2014 - Contract awarded to another provider effective April 2015.	4	3	12	- Continue to monitor position until end of financial year.	Mar-15	Mar-15	- Financial consequence as a result of over inflated position. Allowance made of £116,000. Continues to be monitored. Target achieved for the first time in Q3 with 3.85%.	x	x	x	x	x	x	x	4x3	4x3	3	3	9	▼
QUA012	Q3+1 January 2015	Increase in pressure on Primary Care and A&E as a result of the decommissioning of the Darzi Centre.	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality (also Reputation/Adverse Publicity)	Head of CCG Development (Stephen Astles)		3	3	9	- Service Review to be completed - consultation process to be completed: confirmation needed extension.	TBA March 2015	TBA March 2015	- Service review of Walk In Centre pending devolved financial position. - Provider are aware of situation. - Discussion held with GP Leads and LCH on 28th January 2015 - NHS England currently consulting on options around contract which is due to expire 31at March 2015 Consultation process is ~~ongoing until March 2015~~. underway. Initially until end March 2015, however CCG have requested an extension of 3 to 6 months. Meetings have been held with local practices to discuss dispersal. Plan to be presented to NHS England circa March 2015.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3x3	3x3	3	3	9	►
QUA013	Q3+1 January 2015	Impact on services for local community as a result of GP surgery closure following planned retirement of GP	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Redesign & Commissioning Officer (Jan Leonard)		3	2	6	Work with NHS England to understand their obligations	March 2015	April 2015	Wait NHS England response. LMC are progressing plans for the future of the practice and will liaise with NHSE. CCG are monitoring the progress of this.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3x2	3x2	3	2	6	►
QUA014	Horizon Scan																									
QUA015	Q3+2 February 2015	Risk to sustainability for commissioning support services due to unsuccessful application of NWCSU to be accepted onto LPF	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Delivery and Integration Officer (Tracy Jeffes)	- Merseyside CCG Network exploring alternative support options - sub group meetings established	4	3	12	Review opportunities presented by LPF ~~Sub-group of Merseyside CCG Network to be developed~~: developed.	March 2015 ~~March 2015~~	April 2015 ~~April 2015~~	- Discussion with Merseyside CCG Network regarding collaborative approaches to explore alternative support options - New sub-group ~~being~~ developed to look at proposals. Proposals in development. - NWCSU have identified sustainability partner to assist in maintenance of current service provision.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4x3	4	3	12	►

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QUA016	Q3+2 February 2015	High volume of over 60 minute AMB turnaround times result in patients not receiving appropriate care	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Head of Primary Care & Contracting (Malcolm Cunningham)	- Regular feedback to monthly contract meetings - Regular communication with Blackpool CCG (lead commissioner)	3	3	9	Review to be completed on what can be done to improve turnaround times. Findings from review to be presented at next contract meeting.	March 2015 March 2015	April 2015 April 2015	- Work ongoing to review what can be done to improve turnaround times: rolling programme. Findings to be presented to next contract meeting. Long turnaround relates to physical capacity issue and lack of available beds.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3x3	3	3	9	►
	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	Reputational/ Adverse publicity	Chief Nurse (Debbie Fagan)	Commissioned Service from NWCSU; 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. Letters reviewed by Chief Nurse before sign off by Chief Officer. Regular meetings held with CSU Complaints Team to keep track of complaints. Information feeds through to EPEG and Quality Committee.	4	3	12	Linked to restitution and comes through HOCO report. Review Restitution progress. Letter from Chief Nurse to complete all restitution cases by March 2017. Plans in place to performance manage via contracts.	March 2015	March 2015	Chief Nurse met with COO (NWCSU) & 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 - NWCSU to review how complaints are logged, categorised and managed. CCG has requested more detailed information regarding activity in relation to restitution/closedown. NWCSU will clarify more detail in standard letters (e.g. timeframes) to manage patient/family applicant expectations: Completed. Chief Nurse checks each complaint letter before going to the Chief Officer for sign-off. ~~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.~~ ~~Integration Workshop held July 2014.~~ Note: Original restitution risk has been split from other CHC risks: REP 001 & REP 003 - green strikethrough font is split from original risk and into new risk - grey stays with main risk (1) - blue font: newly updated this month. - black = same for both Meeting held in December with CSU. CSU have undertaken a procurement process to commission support to undertake this function. Restitution forms part of the CCG / CSU /CHC Steering Group. This has been established in December and is meeting weekly to address operational issues. Plan received however further information on restitution cases still required. Requested further information from CSU by 02/02/15. Steering Group updated on operational issues and restitution cases at a meeting on 23rd February 2015. Quality Team presented with an update position on 02/02/15. Assurance given to be on track on meeting trajectories. Performance of CSU in relation to restitution discussed formally at SLA meeting.	4x3	4x3	4x3	4x3	3x3	3x3	3x3	3x3	3x3	3	3	9	►
REP002	Prior Q3 2013/14	Ineffective engagement and communications will impact on the ability to meet statutory duties and possible damage to CCG reputation	All	Adverse Publicity /Reputation	Chief Delivery and Integration Officer (Tracy Jeffes)	Integrated Communications and Engagement Strategy in place including annual action plans; Governance structure identified including Quality Committee, EPEG, Locality Groups Strategic commas role now in-house	3	4	12	KPIs and dedicated resource for communications and engagement to be defined with NWCSU including annual review of communications and engagement strategy.	February 2015	March 2015	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': now in-house. In-housing of services is enabling additional capacity to be available in CCG. Respecification of comms and engagement service with NWCSU. Review of service being carried out. Benchmarking of comms and engagement capacity across Merseyside completed. Proposals for future capacity developed for discussion with SMT. Will form part of discussion for CSU commissioning intentions for 15/16: meetings ongoing through January and February 2015. Funded some additional engagement capacity. Being delivered through CSU to help manage high volume of engagement activity through December to March 2015.	3x3	3x3	3x3	3x3	3x3	3x3	3x3	2x3	2x3	2	3	6	►
REP003	Removed																									
REP004	Oct 2014 Split out from REP001	Local CHC process being fit for purpose to manage local demands Further work to be carried out on the definition of the risk, which will then have an impact on the controls and rating.	Objective 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Reputational/ Adverse publicity	Chief Nurse (Debbie Fagan)	Commissioned Service from NWCSU; 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. Regular meetings held with CSU Complaints Team to keep track of complaints. Information feeds through to EPEG and Quality Committee. Project plan developed Process for exception reporting developed. MIAA review.	4	3	12	Steering group to address all identified issues as per external review. Review of risk to be carried out following CSU service meeting in December 2015. External review of high cost cases commenced with data provided by CSU. Steering group to address all issues	March 2015	March 2015	Chief Nurse met with COO (NWCSU) & Yvonne Lockhead (March 2014). Change of Leadership within Locality Team. ~~Monthly meetings between Chief Nurse & NWCSU Team scheduled to discuss operational models~~ Discussed complaints management linked to restitution & CHC in general - NWCSU to review how complaints are logged, categorised and managed. CCG has requested more detailed information regarding activity in relation to restitution/closedown. NWCSU will clarify more detail in standard letters (e.g. timeframes) to manage patient/family applicant expectations: Completed. Chief Nurse checks each complaint letter before going to the Chief Officer for sign-off. ~~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.~~ ~~Integration Workshop held July 2014.~~ Note: Original restitution risk has been split from other CHC risks: REP 001 & REP 003: - green strikethrough font is split from original risk and into new risk - grey stays with main risk (1) - blue font: newly updated this month. - black = same for both External review of high cost cases commenced with data provided by CSU. Steering group to address all issues. Weekly meetings of CSU /CCG now ongoing with work plans for service improvement. New CHC specification being redrafted for completion 02/02/15. New plan in place and new specification to be presented on 16/02/15 to Steering Group. Project plan developed and exception reporting developed. Option paper for reviews presented for discussion within CCG. Assurance to complete CHC reviews backlog by March 2015. CSU continue reporting weekly . CSU option paper regarding Reviews for Funded Nursing Care and Joint Packages of Care presented to the 24th February 2015 SMT. MIAA had requested further documentation. Review commenced Q3 on systems and processes. MIAA review being presented to SMT 10th March and Quality Committee in April 2015.	N/A	N/A	N/A	N/A	4x3	4x3	4x3	3x3	3x3	3	3	9	►

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REP005	Q3 Dec 2014	The closure of Breast Surgery Service (for new patients) at Southport & Ormskirk poses a risk to the CCG and concerns for local residents.	Objective 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Reputational/ Adverse publicity	Chief Delivery and Integration Officer (Tracy Jeffes)	- pro-active engagement exercise with effective public and key stakeholders - safe services have been put in place via Aintree Hospital Trust Patient Safety maintained throughout - Equality Impact Assessment	4	4	16	- Change of services as a result of Clinical Safety to be communicated effectively ~~- Engagement with patients to understand experiences of old and new services in order to improve patient experience where possible.~~ completed - draft pathway redesign, incorporating the findings of the engagement, to be presented to the Governing Body	~~March 2015~~ June 2015	~~April 2015~~ June 2015	Engagement consultation from January to Febraury 2015. Engagement process now completed. Report to be presented to Governing Body in March. The next stage will be to redesign the pathway taking into account the findings of the engagement exercise. This will be presented back to the GB by end Quarter 1 15/16. Risk to South Sefton patients is not as great.	N/A	N/A	N/A	N/A	N/A	N/A	4x3	4x3	4x3	**4**	**3**	**12**	►
REP006	Q3 Dec 2014	Local residents may be concerned by possible closures of Litherland Town Hall OOH Pharmacy Service	Objective 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Reputational/ Adverse publicity	Chief Delivery and Integration Officer (Tracy Jeffes)	-Equality Impact Assessment completed - Initial consultation undertaken and completed - alternative service provision has been identified and communicated in order to gain feedback on alternative option	3	4	12	-Further engagement exercise to provide further information and gain better understanding of options and mitigations available to the CCG. This will inform the Full EIA doc - feedback needed on alternative service option	March 2015 March 2015	March 2015 March 2015	Outcome of all work presented to Governing Body for a decision in January 2015. Decision taken at Governing Body to close service. No adverse publicity yet however further communication is needed. Governing Body approved closure of service subject to key recommendations (a) ensuring medical supplies to those that may have difficulty in getting (b) clear communication to the public for signposting to alternative services. Next step is implementation of plan of alternative service for supply of medication and communicating position to the public: (a) GOTODOC, the out of hours provider, has agreed to the supply of medicines to those who have difficulty travelling to pharmacies at time of consultation. (b) communications have now gone out to inform residents of changes.	N/A	N/A	N/A	N/A	N/A	N/A	3x3	3x3	3x3	**3**	**3**	**9**	►
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	All	Statutory Duty	Chief Delivery and Integration Officer (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. Additional Strategic Governance support in place via CSU to review and enhance management of Conflicts of Interest & embedding process in CCG.	2	4	8	Final policy to be developed and presented to the Audit Committee meeting in March 2015.	March 2015	March 2015	Review and update of existing arrangements continue and involves support from the Chair of the Audit committee as well as other key CCG leads and additional Strategic Governance support via CSU. The Conflicts of Interest review took place during September and a progress update was presented to Audit Committee in October. The Audit Committee Chair is involved in this process (as well as the MIAA) and the Audit Committee welcomed progress so far. Recommendations were made in respect of improvements to the Register of Interests and these are being implemented. The work will also be linked into the Anti Bribery policy work that MIAA are undertaking and was agreed that the review would extend to November. At the end of December 2015 NHS England issued new guidance for CCGs in respect of Conflicts of Interest. The guidance was amended to better deal with conflicts of interest that may arise under new co-commissioning arrangements and the associated joint committee decision making. In order to ensure the guidance was captured in the updated policy, the submission of the new policy will now take place in March in time for implementation in 15/16. Draft Policies have now been developed in accoidance with NHSE guidance and will be available for approval by Audit Committees in March	2x4	2x4	2x4	2x4	2x4	2x4	2x4	2x4	2x4	**2**	**4**	**8**	►

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Domain & ID	Date Added	Principal Risk	2014/15 Strategic Objectives	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Due	Progress against action Plan	Q1	Q1+1 (July 2014)	Q1+12 (Aug 2014)	Q2	Q2+1	Q2+2	Q3	Q3+1	Q3+2	L	C	Q4	Change Since Last Update
STA002	Q1 2014/15	Risk that patients could be harmed or receive inadequate care due to failure to implement recommendations and action plan following CQC style Safeguarding Peer Review	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 work plan with MIAA in 14/15 to include review of CCG Safeguarding arrangements Outcomes shared with RIV and CCG network. Priority area re Voice of Children and Young People's/Vulnerable Adults is an agenda item for EPEG Recommendations and updates regularly reported to the Quality Committee. Steering Group established. Review and updates presented to the Safeguarding Adults Board and Safeguarding Children's Board. A finalised Memorandum of Understanding A finalised Service Specification	2	4	8	~~Draft Memorandum's of Understanding (MoU) specification to be presented to Safeguarding Steering Group for sign off November/December 2014.~~ completed Position going to advert February 2015.	~~December 2014~~ March 2015	~~January 2015~~ April 2015	Executive Summary recommendations to Quality Committee June 2014., with updated action plans presented August and October 2014. Share outcome of RIV and CCG Network: fed back re establishment of Steering Group. Steering Group now set-up and dates set for forth coming meetings. Peer review presented to CCG Governing Body in July 2014. Chief Nurse met with Safeguarding with CCG 1/8/14 to discuss progress in order to update action plan. Priority area re Voice of Children and Young People's/Vulnerable Adults discussed at EPEG meeting in August 2014. Further work and meeting with LA to further strengthen what available locally. Review presented to Safeguarding Adult Board in October 2014. Date set to present to local Safeguarding Children's Board in December 2014 - Action plan presented to Quality Committee (QC) in October 2014. QC requested EPEG lead on Voice of Child and Young Person's action plan; QC expressed concern regarding the host's progress against their actions identified in the action plan and highlighted the need for partners to deliver against their actions. Next update to QC in January 2015: requires agreement prior to project plan rollout. - Liaison with host CCG regarding deliverables that are dependent on hosted services - continues. - Draft Memorandum's of Understanding (MoU) specification to be presented to Safeguarding Steering Group for sign off November/December 2014. Service specification to inform MoU developed and awaiting finalisation. Updated CCG action plan shows positive improvement against action plan. Position of MoU to be confirmed. MoU and service specification now finalised. - Job Descriptions for named GP finalised: waiting confirmation of contractual issues, then out to advert. Finance confirmed, going to advert February 2015. Recruitment has commenced. Update received at Steering Group in February 2015. Will inform the update of the CCG Action Plan. Safeguarding Strategy approved by Quality Committee who have recommended it be approved by the Governing Body.	2x4	2x4	2x4	2x4	2x4	2x4	2x4	2x4	2x4	1x4	**1**	**4**	**4**	►
STA003	Q1+2 (August) 2014/15	Risk that patients could be harmed or receive inadequate care due to failure to implement CCG statutory requirements detailed within the new Special Education needs Code of Practice for Children and Young People	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Statutory Duty	Chief Nurse (Debbie Fagan)	Commissioned CSU to support the CCG to develop systems and processes. CCG are part of the local partnership in delivering this agenda: sit as part of the Steering Group. Chief Nurse Chairs Joint Commissioning Task and Finish Group. SMT receiving progress updates on delivery. Provider performance also on agenda and discussed at Quality Contract meetings. Chief Nurse undertaking role of designated Medical Officer. Jointly commissioned arrangements in place for Health Co-ordinator. Updates received by Governing Body Provider performance discussed at Quality Committee	3	4	12	Highlight the issues at SMT and Governing Body	Ongoing		CSU team have presented at SMT progress to date on delivery with a further update given in August 2014. Governing Body have been provided update in Chief Officer report Identified Chief Nurse to undertake role of designated Medical Officer while further models are considered: implemented 1st September 2014. Discussed provider performance at the Quality Contract meeting and linked waiting times for specified services to what may be required as part of Health & Education Plan. Links between requirements for SEN and personalisation made to general work being undertaken within CCG around personal health budgets. Jointly commissioned arrangements in place at LCCG for a Health Co-ordinator post within LCH to co-ordinate health needs to be part of Educate and Health Care Plan (EHCP). Awaiting confirmation from Sefton council of transition funding that may be made available to CCG to commission the health input into the transitioning of statements for children and young people to EHCP: expected October/November 2014. Still waiting confirmation from the local authority (LA) regarding transition funding: Chief Nurse has requested information from LA however not received. Has been escalated to Chief Officer. Still awaiting confirmation. 02/02/15 - e-mail received from CSU confirming the role of the project management function of the LA. Narrative has been provided to the LA to support the request for funding for transition plans. Awaiting response from LA. Still awaiting final agreement for funding to be given to CCG from Local Authority: to commission support for transition plans i.e. statements to Education Health Care Plan.	N/A	N/A	3x4	1x4	1x4	1x4	1x4	1x4	1x4	1x4	**1**	**4**	**4**	►

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MAY 2015

Agenda Item: 15/95	**Author of the Paper:** Tracy Jeffes Chief Delivery and Integration Officer Email: Tracy.Jeffes@southseftonccg.nhs.uk Tel: 0151 247 7049
Report date: May 2015	

Title: Proposed Corporate Objectives 2015/16

Summary/Key Issues:

The CCG has revisited its current Corporate Objectives and developed a proposal for 2015/16.

The proposed Corporate Objectives were discussed and agreed at the CCG Senior Leadership Team and Operational Team meeting in May 2015.

Recommendation

The Governing Body is asked to approve this report.

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.
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)*

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

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

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
May 2015

1. Introduction and Background

The CCG has revisited its current Corporate Objectives and developed a proposal for 2015/16.

The proposed corporate objectives were discussed and agreed at the CCG Senior Leadership Team and Operational Team meetings in May 2015.

2. Proposed Corporate Objectives 2015/16

1 To place clinical leadership at the heart of localities to drive transformational change.

2 To develop the integration agenda across health and social care.

3 To consolidate the Estates Plan and develop one new project for March 2016.

4 To publish plans for community services and commission for March 2016.

5 To commission new care pathways for mental health.

6 To achieve Phase 1 of Primary Care transformation.

7 To achieve financial duties and commission high quality care.

3. Recommendations

The Governing Body is asked to approve the proposed Corporate Objectives for 2015/16.

Tracy Jeffes
Chief Delivery and Integration Officer
May 2015

15/95 Corporate Objectives

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2015

Agenda Item: 15/96	**Author of the Paper:** Karl McCluskey Chief Strategy & Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk Tel: 0151 247 7006
Report date: May 2015	

Title: Draft Commissioning Strategy, Vision and Blueprints for Transformation Programmes

Summary/Key Issues:

This paper sets out a clear commissioning strategy vision and blueprints in support of the CCG strategic plan. One year in to the five year strategic plan, the CCG has undertaken a review of its priorities, approach and direction of travel. While the priorities remain the same, the CCG has recognised the need for increased focus on delivery, with a much greater emphasis on locality working. The blueprints have been developed in conjunction with the respective clinical and managerial leads and include high level plans which are integrated with each other to progress the transformation of commission services that the CCG aspires to as part of its overall strategy.

The CCG has affirmed its focus on the two strategic programmes of CVD and respiratory. It has now cemented blueprints (primary care, community support, intermediate care, mental health and unplanned care). These are all locality facing and aimed at building services at a local level to support localities in providing the optimum care closer to home and avoiding unnecessary hospitalisation.

Recommendation

The Governing Body is asked to approve the commissioning strategy and endorse the prioritisation of the blueprints, with a real emphasis and focus on locality delivery.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives	
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.
x	Review the population health needs for all mental health services to inform enhanced

Process	Yes	No	N/A	Comments/Detail
Patient and Public Engagement	x			
Clinical Engagement	x			
Equality Impact Assessment	x			
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement	x			
Presented to other Committees	x			Presented to the Service Improvement and Redesign Committee

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

DRAFT COMMISSIONING STRATEGY, VISION AND BLUEPRINT FOR TRANSFORMATION PROGRAMMES

Southport and Formby CCG and South Sefton CCG Version 1.7 – May 2015

CONTENTS

FOREWORD

Over the last year our two Clinical Commissioning Groups, South Sefton and Southport and Formby have spoken to people across Sefton about their own health conditions, the services they access, their experiences of local health care and the kind of care and support they want to help them get back to independent living.

The case for change across the whole health and social care system is made by the need to address the demands arising from an ageing population, increasing numbers of people with multiple long-term conditions and significant reductions in public expenditure.

Developing integrated care means overcoming barriers between primary and secondary care, physical and mental health, and health and social care to provide the right care at the right time in the right place. We are therefore working in collaboration with our health and social care colleagues and partners across Sefton to define the ***'New Models of Care'*** required for Sefton residents, with a particular emphasis on ***'Integrated Care'***.

Delivery of these models requires strong leadership, effective partnership working and a commitment to deliver change. Success will be measured on the improved health and care outcomes for our Sefton residents.

As public sector organisations we are facing unprecedented challenges and we need to ensure we can support increasing demand, as well as improving the quality of care provided patients, with more limited resource.

To be signed by Fiona and each chair?

Plus pics?

Vision:

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

EXECUTIVE SUMMARY

Clinical commissioning groups are the statutory bodies responsible for commissioning local health services for local communities. The people we serve deserve to have a premium quality health service. Working together, South Sefton and Southport and Formby clinical commissioning groups have engaged with key stakeholders in the wider local health economy and with local people to identify priorities for improving health and health care.

As two CCGs we have identified three main strategic priority areas as the focus for all our work:

- Caring for our older and vulnerable residents
- Unplanned care
- Primary care

This strategy is at a point in time in terms of its development and alignment. Alongside the development of the CCG plans, we are working with partners on the delivery of our system wide Vision for 2020. In recent weeks the CCGs and its partners across health and social care have begun a process to strengthen planning and delivery of our future system and this was launched through a successful event titled 'Shaping Sefton', held in February 2015.

The event was supported by the King's Fund, who demonstrated evidence of the benefits, in particular to the experience of service users and their families, seen when organisations and services work together, make a compelling case for care to be co-ordinated around the needs of people and populations.

We will build on this event and undertake an in depth process with our partners to include more detailed agreement of the whole system programmes to be undertaken and work to establish cross-organisation governance protocols.

Therefore the CCGs key transformational programmes described later in this document are representative in terms of purpose and content, but will continue to be refined as we work with partners in the system to develop plans and mobilse resources. The intention is to harmonise effort into one single plan for the system.

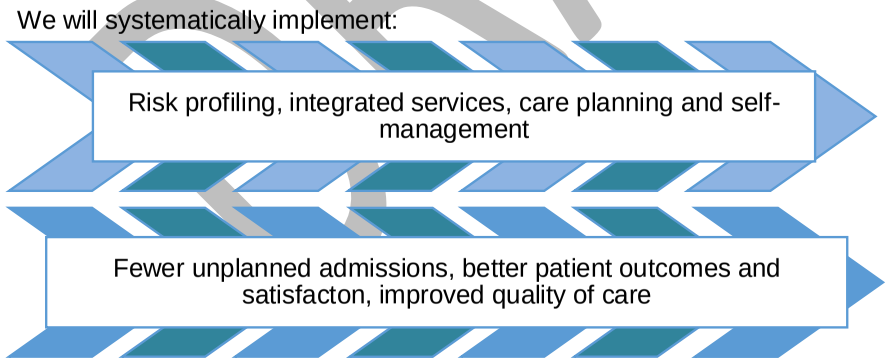
Integrated care is a key lever to commission for patient outcomes. From direct NHS health care services through to social care and voluntary services, who can provide additional on-going support for recovery and management. Every service provider will be expected to work together to improve overall outcomes of service users.

Whilst there are services available in the community to support people to manage their long term conditions and help prevent hospital admissions, these are not comprehensive and sometimes 'dis-jointed', also information sharing is limited. Services are not always straight forward to access or able to offer a rapid response and are not as well-known as emergency departments.

We will commission integrated out of hospital services, which support all patients especially those with long term conditions. In doing so, we aim to:

- Decrease the gap between expected prevalence and recorded prevalence of long term conditions
- Improve the health outcomes for people who have been diagnosed with a long term condition
- Increase the provision of healthcare in the community for people who have been diagnosed with a long term condition
- Reduce inequalities in the identification of treatment and services for people with long term conditions
- Support people with long term conditions to maintain their quality of life through being better able to manage their own care
- Provide more care closer to home

We are keen to drive forward integrated care, giving explicit consideration to ways we can increase joint working.

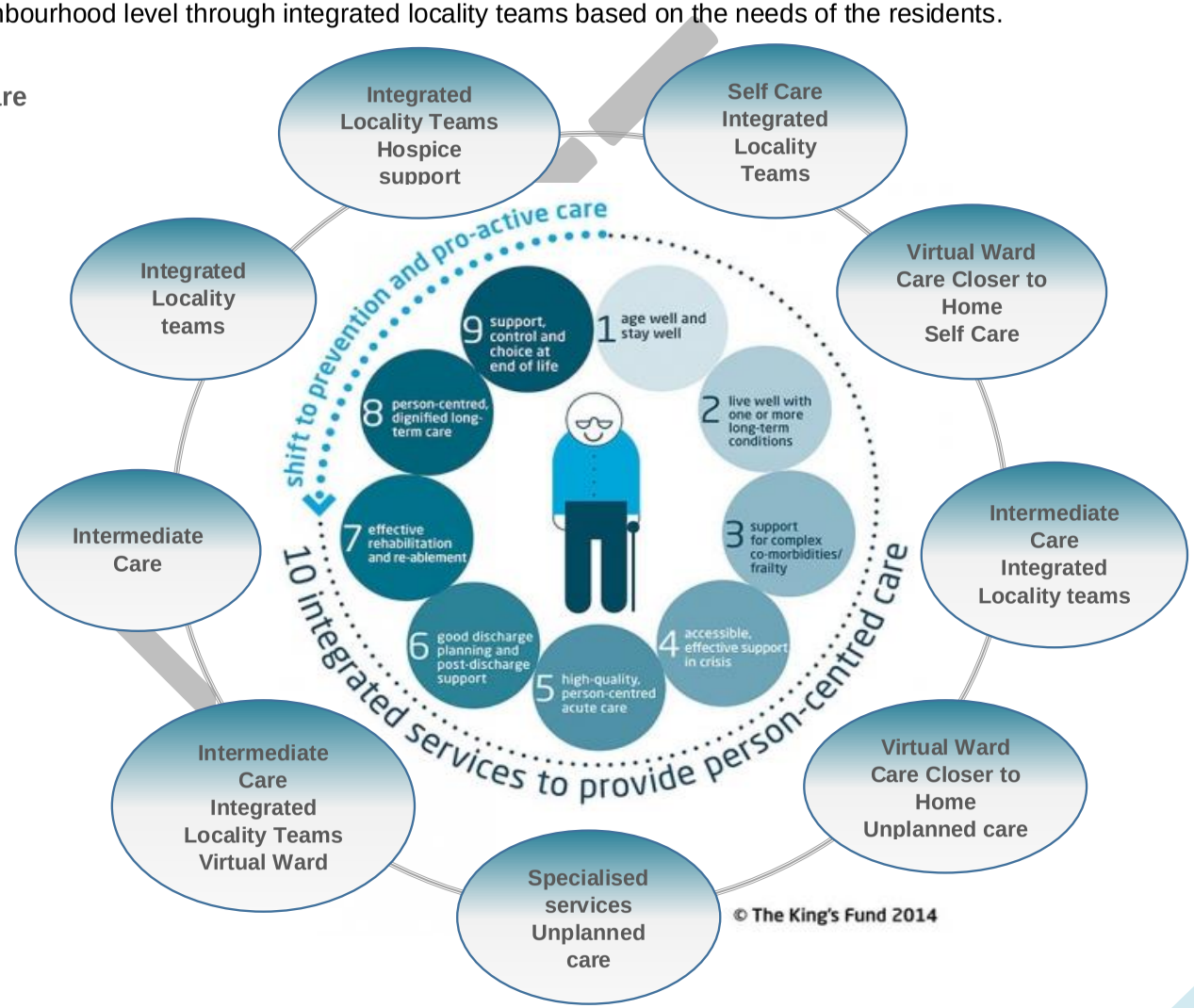


The core of the diagram below has been developed by the Kings Fund and outlines the different stages of care, it has been enhanced to show what services in Sefton available to support our residents at each of the individual stages. The vision will be to deliver care at neighbourhood level through integrated locality teams based on the needs of the residents.

Diagram one:
Components of Care

South Sefton Localities:
- Bootle
- Crosby
- Maghull
- Seaforth and Litherland

Southport and Formby Localities:
- Ainsdale & Birkdale
- Central Southport
- Formby
- North Southport

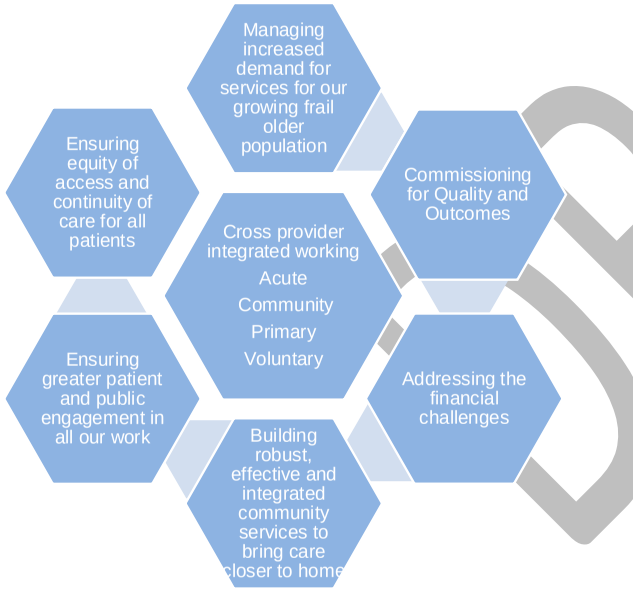


INTRODUCTION

The purpose of this document is to describe the aims and ambitions for our transformation programmes and how we are working across the health and social care system to improve quality and outcomes for our patients, as well as drive efficiencies and achieve sustainable services that meet the needs of our local population and improve outcomes. This documents articulates the changes required within the Sefton health and social care system and how the commitments made to implement our vision are being translated into programmes of work.

We describe our major transformation programmes, highlighting what we are doing and how we plan to do it amidst a national context of profound financial challenge.

We know there are specific underlying challenges in our local health economy that we must address over the next two years and into the future if we are to achieve our vision:



- The system is too complicated: it has grown organically, not strategically
- Access to many services is limited, because the system is difficult for both patients and professionals to navigate
- In particular, the system is failing to provide co-ordinated and integrated care for frail elderly and patients with complex needs
- Prevention and early treatment services are often inadequate, allowing patients to continue 'cycling' around the system until their issue become acute
- A&E is the easiest part of the system for patients to access, hence receives the largest flows
- Queues build up in A&E as a result of difficulties with flow management
- Information is not shared effectively between, and sometimes within, provider organisations

BLUEPRINT

A blueprint is used to define a programme of transformational change. It articulates the future state in more detail than a high-level vision and sets out the operational capability that will need to be put in place to enable the required outcomes and benefits. The blueprint comprises the key aspects of the business operations of not only the CCGs but also all stakeholders that must change for the system to work.

This document provides an outline of how comprehensive healthcare services for physical and mental health for all age groups and its interactions with social care could be configured in the future to maintain and improve patient experience and clinical outcomes while demand for care increases despite increasingly tight budgetary constraints.

It is a model for how services should be configured regardless of the organisations involved of its delivery. It has been designed based on input by a broad base of stakeholders that included representatives of all local providers, commissioners, patients and the general public of Sefton. We will build on this model with our partners to include more detailed agreement of the whole system programmes to be undertaken and work to establish cross-organisation governance protocols

This document is focused on the following Transformational Programmes currently underway across Southport and Formby CCG and South Sefton CCG:

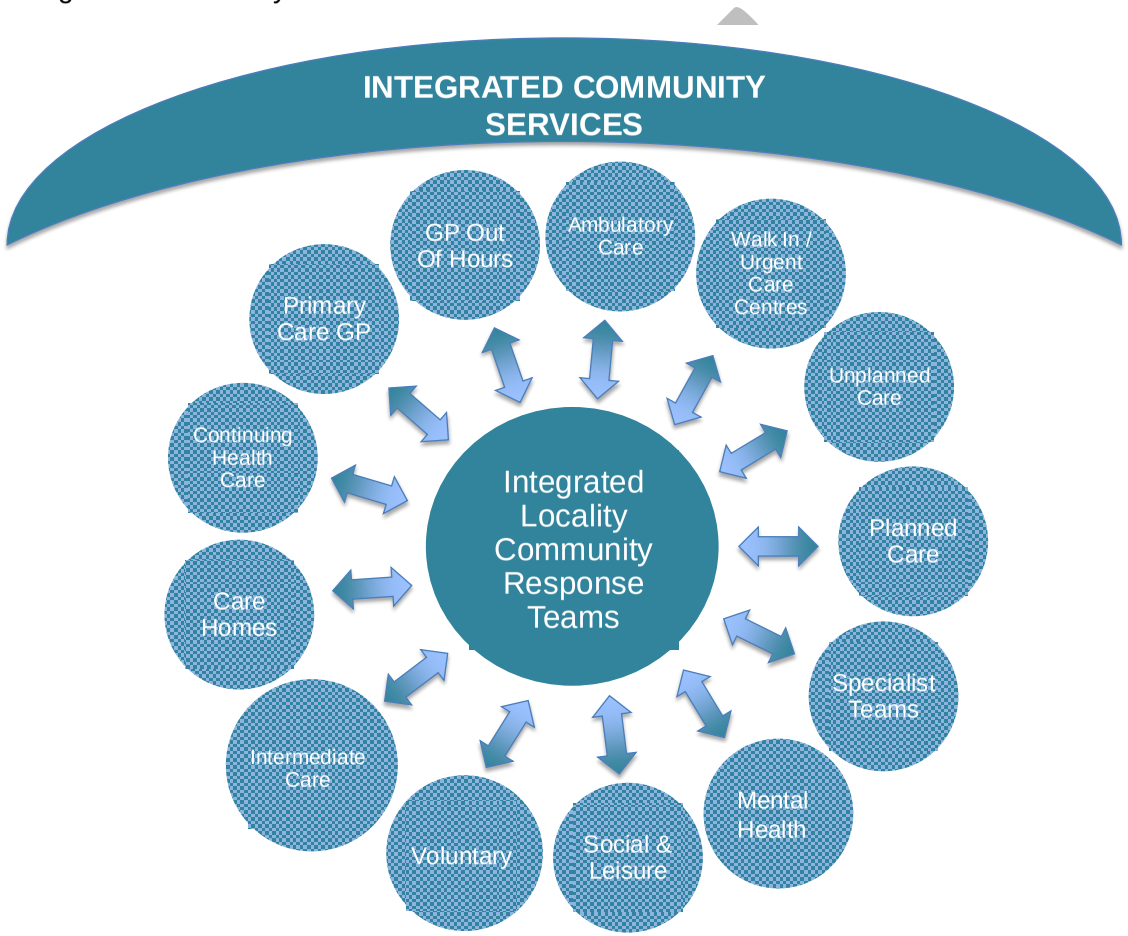
- Primary Care
- Community Care
- Intermediate Care
- Urgent Care
- Mental Health

These programmes are central to our vision for integrated, personalised services in Sefton. An additional work programme focussing on elective and planned care is currently being scoped to identify additional opportunities to provide care closer to home.

A whole system approach has been developed to focus the model of care required to deliver integrated services. The system blueprint model for integrated services is shown in Diagram two below:

Diagram Two:

System blueprint for Integrated Community Services



OUR VISION - SOUTH SEFTON AND SOUTHPORT AND FORMBY CLINICAL COMMISSIONG GROUPS

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

Our vision will be delivered in collaboration with our partners through our high impact transformation programmes. These programmes will focus on three key principles:

- Whole system transformation with collective ownership and culture change of all partners
- Patient pathways rather than organisational structures
- Clinical and patient led

OUR AIMS	• An empowered workforce with a common understanding of our vision • Breaking down of silos – building trust amongst organisations • Organisations have shared responsibility for issues in the health economy • Autonomy to act beyond organisational boundaries
KEY ENABLERS	• Access to shared medical records and care plans for all care professionals anywhere • Improved communications and relationships between all care professionals • Risk management across the system contributing to more efficient and effective care (financial risk and clinical governance) • Financial and contractual levers aligned
KEY DELIVERABLES	• Reduce hospital avoidable deaths by 13% • Improve health related quality of life for people with one or more long term conditions by 8.5% • Reduce emergency admissions by 20% • Achieve a 3.5% reduction in non-elective activity • Improve in-patient experience by 13% • Improve patient experience in GP and out of hours care by 30%

POTENTIAL CHALLENGES TO DELIVERY:

- Cultural differences between professional groups
- Different workforce terms and conditions
- Technology solutions for data/information sharing
- Differential financial pressures

NEXT STEPS

- Undertake an in depth process with our partners to include more detailed agreement of the whole system programmes enabled through the overarching Shaping Sefton programme
- Establish cross-organisation governance protocols
- Agree phased priority approach
- On-going evidence-based analysis of outcomes of new care models
- Regular review of programmes against plan
- Changes to be implemented from years 2015/16, with whole system change embedded by 2020

This document, and our vision for integrated and co-ordinated care, aligns to the vision and objectives set-out in The NHS Five Year Forward View "High quality care for all, now and for future generations"[1].

It also supports the recommendations outlined in The Dalton Review[2], which focusses on reducing variation in the quality of care across Provider organisations and developing new organisational forms. It encourages organisations to look at developing models of care that best suit local circumstances and individuals rather than existing organisational structures. This document reflects those recommendations and focusses on the patient receiving the right care at the right time and in the right place.

Integration is built upon collaborative working, shared decision making and jointly defined priorities. We have worked with our partners and patient representative groups to ensure our local priorities are appropriately aligned.

[1] Five Year Forward View NHS England October 2014 http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2] Examining new options and opportunities for providers of NHS care The Dalton Review December 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf

BETTER CARE FUND

The Better Care Fund (BCF) provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients, services users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare the Better Care Fund in 2015/16[3]. Local Better Care Fund plans must meet a number of national conditions:

- Plans must be jointly agreed and include an explanation of how local adult social care services will be protected;
- Include how 7-day services in health and social care will support patients being discharged and prevent unnecessary admissions at weekends;
- Use the NHS number to enable better data sharing between health and social care;
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional; and
- Consider the impact of changes on the acute sector.

The Health and Wellbeing Board in Sefton has worked together with local people, communities and partners to develop a Vision for the Borough. Our vision is:

Together we are Sefton – a great place to be!

We will work as one Sefton for the benefit of local people, businesses and visitors

Underpinning the Health and Wellbeing Vision is the promise that in commissioning and delivering services the different partners, stakeholders and organisations in Sefton will work together to seek to improve the health and wellbeing of everyone, with the resources available.

Our vision for integration is to deliver personalised coordinated care,

health and wellbeing services with, and around, the person

[3] http://www.england.nhs.uk/wp-content/uploads/2015/03/bcf-operationalisation-guidance-1516.pdf

By working together and aligning our resources, we aim by 2020 to:

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

We will work with parents and carers so that all children and young people have opportunities to become healthy and fulfilled adults, and create a place where older people can live, work and enjoy life as valued members of the community. We will seek to improve opportunities and support residents to make choices so that people are able to live, work and spend their time in a safe and healthy environment, and provide early support so that people can remain independent for longer.

We aim to provide cost effective support in the right place, at the right time, at the right quality, and we will seek to achieve this by focussing on the following key integration schemes:

- Promoting self care, well-being and prevention through the development of an ***Integrated Wellness and Health Improvement Service***, a Healthy Places Healthy Homes initiative (to address housing, environment, transport and employment) and a robust information and advice service. The Healthy Places scheme seeks to tackle the "causes of the causes" of ill health and reduce demand on both wellness and illness services
- Building on the existing ***Virtual Ward and Care Closer to Home programmes*** to deliver *integrated care at a locality level* - which will deliver greater coherence of processes, methods and tools used by all at a locality level, supported by integrated teams; - *delivering better patient experience and health outcomes in support of a reduction in unplanned admissions to hospital*
- Deliver *a* ***new Intermediate Care and Reablement pathway*** to support more people to receive intermediate care and reablement services based on need and pulling together a joint strategy for intermediate care focussing on delivering care closer to home; *with the aim of helping people regain their ability to carry out activities of daily living and reduce need for long term care packages*

These schemes will offer better, early intervention and prevention opportunities promoting greater self-care/self-help/self-management and a reduction on reliance of public sector services. This will be achieved by appropriate advice and information, and integrated approaches to service provision across professional and organisational boundaries through a single point of access (a seamless front door).

These schemes align to the CCGs transformation programmes and will be supported by a series of enablers, namely:

- a single point of access for all service users, supported by integrated single assessments
- transformational leadership - changing behaviours and cultures in the workforce
- enablement of appropriate sharing of person specific data, risk stratification tools and information across partner agencies
- a consistency of messages through a regular communications and engagement process
- an integrated approach across the CCG's and Council, whereby all engagement relates and contextualises integration and the Better Care Fund as part of our joint strategic approach
- development of a robust integrated commissioning process for all health and social care provision
- support for the changes, through effective finance & resource management

We are focusing on a core cohort of people – those with mental health issues, dementia, and other long term conditions and the frail elderly and people who care for others - an approach which aligns with the continued ambitions of the Health and Wellbeing Board in protecting the most vulnerable.

These deliverables are consistent with, and evidenced through, the feedback and data within our Sefton Strategic Needs Assessment, the Health and Wellbeing Strategy, the Strategic Plans for NHS Southport and Formby and South Sefton CCGs as well various forums and patient engagement events - including "Big Chat", "Mini Chat" and "Community Chats" events hosted throughout the Borough. The Health and Wellbeing Board has also utilised the National Voices approach to ensure that the public, patients and service users (including carers) have directly influenced the priorities within our Health and Wellbeing Strategy.

SEFTON PEOPLE AND THEIR NEEDS

Sefton Strategic Needs Assessment

The Sefton Strategic Needs Assessment (SSNA) [4] provides the data and intelligence on which the commissioning and delivery of health and social care services is based. We have a duty to have regard to the SSNA when developing our plans for health services for the local population. Sefton Council also use the SSNA to shape commissioning strategies for adult, children's and public health services. Together, the partners on the Health and Wellbeing Board use the SSNA to set the Sefton Health and Wellbeing Strategy 'Living Well in Sefton' and inform joint commissioning priorities.

The SSNA 2014/15 has taken a different approach to previous years and is based on the principle that understanding health and wellbeing first requires an understanding of the ***people*** who live and work in the Borough, the ***place*** and the influences on health across the ***life course*** (being born, growing up, being an adult and growing old in Sefton). The benefit of this life course approach is that it encourages thinking around the broad range of factors that impact on health and wellbeing at different stages of life and helps to promote a joined up strategic approach across the Health and Wellbeing Board and its partners.

A summary of the key issues, are included below.

[4] http://sefton.gov.uk/your-council/plans-policies/strategic-needs-assessment-(ssna).aspx

SEFTON PEOPLE AND THEIR HEALTH NEEDS

Children and Young People

- One in five children live in **low income** families
- One in five 14-17 year olds state they drink **alcohol** once a week
- 13% of 14-17 year olds claim to **smoke**
- By year 6 one in three children are **overweight or obese**
- **Low birth weight** babies

Long Term Conditions

- One in four have their day-to-day **activities limited** due to a long term condition
- **COPD** – two out of every three sufferers resides in South Sefton
- More than 11,000 Sefton residents are registered as having **chronic liver disease**
- 13,171 residents suffer from **Diabetes** which is predicted to increase by 14% by 2030
- One in 16 suffer from **Asthma**
- One in six suffer from **high blood pressure**
- Incidence rate of **Cancer** in Sefton is significantly higher than the national rate

Older People

- **Ageing population** set to increase further by 2021
- 49% predicted increase in **Dementia** sufferers between 2015 and 2030
- 57% of **Diabetes** sufferers over 65
- **Joint replacements** account for 15% of elective admissions
- Higher mortality rates for **COPD** and **Heart Attack** against the national average

Lifestyle

- 560 patients admitted annually to hospital with **drug** related conditions
- One in five adults admit to **binge drinking**
- One in five adults are **smokers**
- 14.7% of pregnant mothers are **smokers** at time of delivery
- More than half of adults in Sefton are **overweight, obese** or **very obese**
- 7.3% of Sefton residents classify themselves as in **bad** / **very bad health**, compared to 5.5% across England

Mental Health

- Around one in five females and one in eight males are thought to have some sort of **mental illness**
- South Sefton CCG amongst top 10% of CCGs for sufferers of **Depression**
- **Anti depressant** prescribing in Sefton in 13/14 totalled £1.7m
- Three in four **suicides** are male
- There has been a 47% increase in emergency hospital admissions over the last five years for people with **Schizophrenia**

Further detailed information on both the JSNA and the Health and Wellbeing Strategy can be found at:

http://sefton.gov.uk/your-council/plans-policies/strategic-needs-assessment-(ssna).aspx

http://www.sefton.gov.uk/media/450582/health-wellbeing-strategy-2014.pdf

OUR STRATEGIC PLANNING PROCESS

Throughout 2014 a series of events and meetings were held to inform and support the future model of commissioning for South Sefton CCG and Southport and Formby CCG. Partners from across the health economy including, patients, clinicians, and representatives from the community and voluntary sector were invited to these events and the outputs have informed the future model described in this document.

Both Commissioners and Providers of services to the localities have agreed that the work must focus on meeting population health needs, patients must be at the centre of this transformation.

The size of this change cannot be underestimated. It is a large scale change in terms of the level of ambition, the number of organisations involved and the emergent final state. The scale of change is a leadership challenge and will require distributed leadership to deliver the significant process, structure and cultural change.

The next steps will be for the health economy to continue working together to agree the financial and activity/contractual agreements and for operational and clinical staff to work together across organisational boundaries to deliver the vision for the Sefton population.

We will deliver our vision through the following five transformational programmes:	
Primary Care	**We will develop a population-based approach to primary care and support them to improve access to primary care and enhanced quality of service.**
Community Care	**We will commission services that better link together right across health and social care – from hospital and community and social services, to GP practices and voluntary, community and faith sector organisations – and where as much care and support as possible is delivered outside of hospital, making it easier for people to access at the times that are more convenient to them.**
Unplanned Care	**We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.**

Intermediate Care	Our aim is to have ONE point of access, ONE assessment, ONE care planning process. We will do this by commissioning co-ordinated care for patients via integrated services and be responsive to patients needs.
Mental Health	Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long term neurological condition within community based networks of care

Our transformation service models will all encompass the following six characteristics:

New approaches to ensuring the citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care	Wider primary care provided at scale, bringing services closer to home	A model of integrated care between health, social and the third sector
Access to the highest quality urgent and emergency care when appropriate	A stepped change in the productivity of elective care	Specialised services concentrated in centres of excellence

PHASED DELIVERY APPROACH:

Throughout the planning of our programmes we are adopting a four phased delivery approached, outlined below:

Phased Approach			
Phase One **Assessment**	**Phase two** **Strategic Planning**	**Phase three** **Implementation**	**Phase four** **Delivery**
Situation summary Recognise the need for change either to solve a problem or take advantage of an opportunity ➢ Review evidence that a change is required via stakeholder engagement, data analysis and reports on service provision. Test out others' views on the need for change ➢ Networking and establishing connections across health and social care to test current service provision including review of patient experience data Using appropriate diagnostic techniques, confirm the presence of hard complexity and difficulty rather than a mess ➢ Current data analysis re patient flows between services in acute and community, interaction with third sector organisations	**Generate options** Develop ideas for change into clear options for achievement of the objectives ➢ Engage provider re discussions about areas of excellence in service provision and ideas the provider and local authority may have re service improvement. Understand national examples of excellence. Consider range of options ➢ Link providers to consider alternative provision	**Develop Implementation strategies** Select preferred options and plan how to implement ➢ Finalise implementation plan with CCG, providers and Local Authority ➢ Agree implementation plan with provider	**Implement performance dashboard** Agree set of metrics to be monitored and reported on ➢ Discuss and agree with Providers as necessary

Identify objectives and constraints	**Edit options and detail selected options**	**Carry out the planned changes**	**Monitor Activity and Performance**
Set up objectives for systems of interest ➢ Review national guidance as to performance measures. ➢ Understand referral patterns and challenges to service delivery.	Fully describe chosen option ➢ Present findings to senior leadership team within the CCG and Local Authority ➢ Informal sharing with providers Decide what is in scope and how it will work ➢ Understand wider financial pressures and impact upon project. ➢ Agree financial value to provide scope for changes Open engagement with provider as to change model ➢ Link with provider organisations to discuss and shape likely vision for future delivery Consider whether higher level change is feasible ➢ Understand funding mechanism arrangements between CCG and local authority. Develop operational detail of pathway ➢ Plan stakeholder engagement event, in partnership between CCG, Local Authority, acute and community providers, to understand the challenges and	Involve all interested parties ➢ Seek approval from CCG Membership ➢ Seek ratification by CCG Board ➢ Publish Strategy Allocate responsibilities ➢ Discussions with provider ➢ Agree Commissioning Intentions ➢ Contractual levers Monitor progress ➢ Develop performance dashboard	Receive activity reports ➢ Frequency to be agreed dependent upon provider/activity ➢ To be based on outcomes Report Activity ➢ Agree reporting structure and frequency to various stakeholders Highlight issues ➢ Review activity and performance and highlight issues/concerns with relevant provider and SMT

	facilitate discussions to progress project.		
Identify performance and measures Describe how the achievement of the objectives can be measured ➢ Discuss feasibility of data collection with service providers. Benchmark service delivery – outcomes and performance - against proposed measures ➢ Request and collate evidence from providers Benchmark service delivery – patient experience - against proposed measures ➢ Request and collate evidence from providers to form benchmark against which to monitor future performance.	**Evaluate options and measures** Finalise operational details of pathway ➢ Summarise findings and circulate to all parties. ➢ Evaluate requirement for framework/memorandum of understand. Evaluate the performance of the chosen options against performance criteria identified ➢ Formally present outline strategy to CCG and local authority ➢ Outline new performance measures with providers and reinforce data collection Wider clinical engagement ➢ Engage clinicians for comments on strategy		
	Governance Strategic and operationalisation ➢ Draft Governance framework ➢ Agree Governance framework Legal framework ➢ Draft Memorandum of Understanding ➢ Execute Memorandum of Understanding		

FINANCIAL

The overriding financial strategy is to safeguard a long term sustainable financial position which ensures the CCGs overall objectives around patient care for our population can be achieved.

This can only be attained through sensible and realistic financial planning, a measured approach to risk and long term view of the local health system, which will mean difficult financial decisions will have to be taken.

Sefton health economy faces significant financial pressures - those experienced currently requiring additional support, and those anticipated into the future for which there is unlikely to be support available from external sources. This means that the basis upon which commissioners fund services will need to change radically so that it can continue to provide for the care needs of the community now and into the future.

Significant investment is going to be required to redesign and rebalance the system so that it is both effective and affordable. For us to manage pressures in a sustainable way the shape and size of existing providers will need to change dramatically, with more care being provided outside of acute settings and greater emphasis on community partners to manage and reduce overall demand entering into the care system. We will need to work collectively across the health and social care system to share resources and remove unnecessary duplication. Patient centred care provision will mean cross organisational boundaries and funding mechanisms need to change to facilitate and incentivise this.

Projected gap in 5 year if do nothing

The choice to 'Do Nothing' is not an option, outlined below is the annual profile. You will notice the pressure is primarily front-loaded in 15/16 and 16/17 this is to embed the transformational programmes outlined in the blueprint.

		2015/16 (£m)	2016/17 (£m)	2017/18 (£m)	2018/19 (£m)	Total (£m)
Southport and Formby CCG	Incremental QIPP Requirement	6,052	3,622	772	1,066	11,512
South Sefton CCG		3,437	4,904	1,361	1,966	11,668

Diagrams 3 and 4 below illustrate each CCG's spending on health by high level category of care

Diagram 3: South Sefton CCG total budget spend = approximately £230m

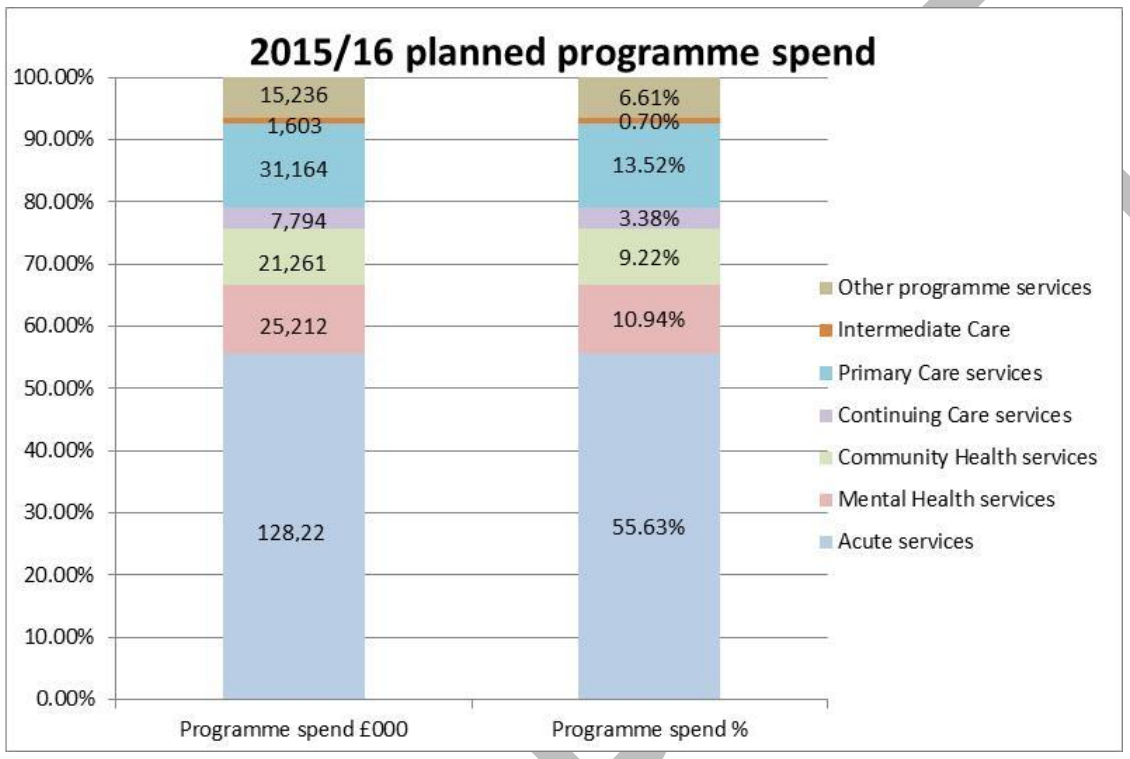


Diagram 4: Southport and Formby CCG total budget spend = approximately £170m

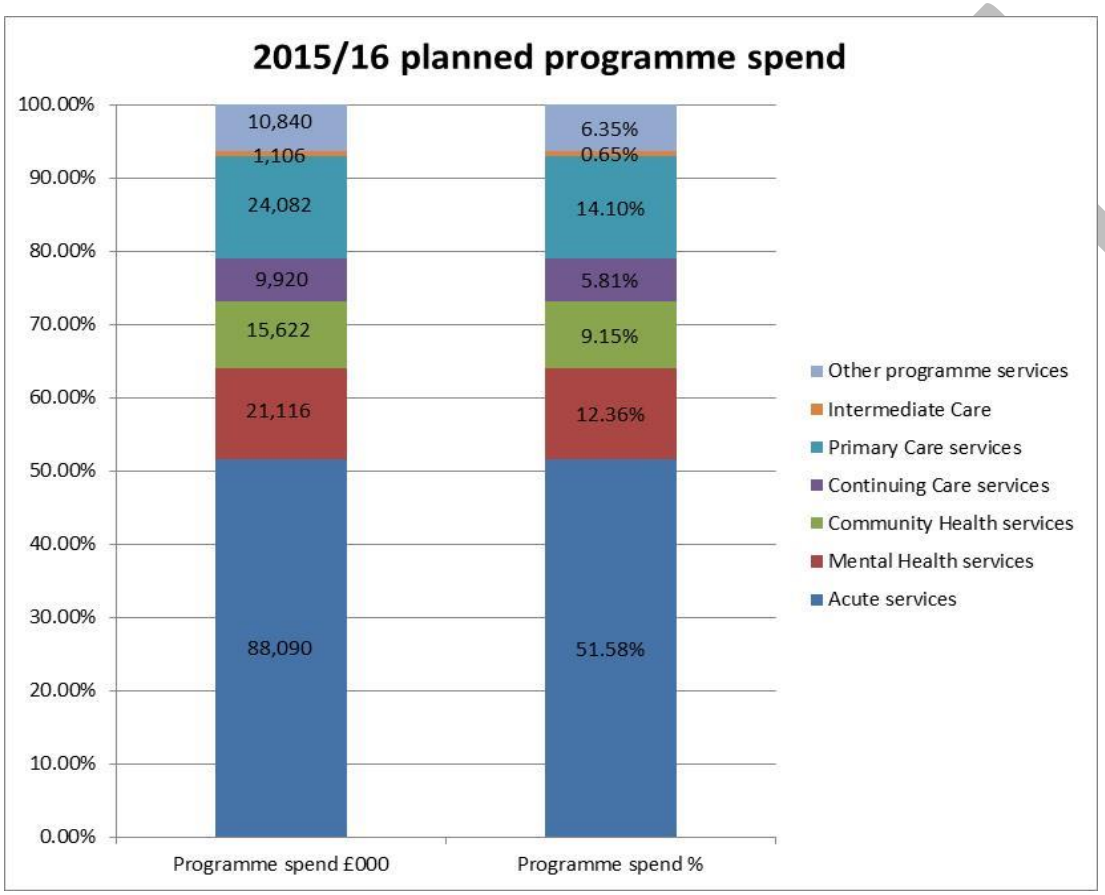


Table one below outlines the potential savings that could be generated from a 15% reduction in unplanned admissions for South Sefton CCG

Table 1: 15% reduction in unplanned admissions

South Sefton CCG	To month 10	Activity to month 10	Forecast (cost)	Forecast (activity)
Aintree University Hospitals NHS F/T	£21,796,036	11,804	£26,155,244	14,165
Alder Hey Childrens NHS F/T	£973,958	681	£1,168,749	817
Central Manchester University Hospitals Nhs Foundation Trust	£4,800	5	£5,760	6
Countess of Chester Hospital NHS Foundation Trust	£9,464	10	£11,357	12
East Cheshire NHS Trust	£1,099	2	£1,318	2
Liverpool Heart and Chest NHS F/T	£108,226	50	£129,872	60
Liverpool Womens Hospital NHS F/T	£2,157,781	1,233	£2,589,338	1,480
Royal Liverpool & Broadgreen Hospitals	£1,398,842	841	£1,678,611	1,009
Southport & Ormskirk Hospital	£1,657,495	1,484	£1,988,994	1,781
ST Helens & Knowsley Hospitals	£268,465	231	£322,158	277
University Hospital Of South Manchester Nhs Foundation Trust	£1,867	3	£2,240	4
Wirral University Hospital NHS F/T	£53,007	53	£63,609	64
Wrightington, Wigan And Leigh Nhs Foundation Trust	£13,407	8	£16,088	10
			£34,133,337	**19,686**
	Average price			£1,734
	15% reduction in activity			2952.9
	15% reduction in cost at average Non-elective tariff			**£5,120,001**

Table two below outlines the potential savings that could be generated from a 15% reduction in unplanned admissions for Southport and Formby CCG

Table 2: 15% reduction in unplanned admissions

Southport and Formby CCG	To month 10	Activity to month 10	Forecast (cost)	Forecast (activity)
Aintree University Hospitals NHS F/T	593,553	309	£712,264	371
Alder Hey Childrens NHS F/T	293,583	172	£352,300	206
Central Manchester University Hospitals Nhs Foundation Trust	13,076	16	£15,691	19
Countess of Chester Hospital NHS Foundation Trust	1,239	2	£1,486	2
East Cheshire NHS Trust	1,604	2	£1,925	2
Liverpool Heart and Chest NHS F/T	338,420	103	£406,104	124
Liverpool Womens Hospital NHS F/T	142,928	78	£171,514	94
Royal Liverpool & Broadgreen Hospitals	446,341	203	£535,609	244
Southport & Ormskirk Hospital	19,704,834	12,891	£23,645,800	15,469
ST Helens & Knowsley Hospitals	142,439	119	£170,927	143
University Hospital Of South Manchester Nhs Foundation Trust	5,373	9	£6,448	11
Wirral University Hospital NHS F/T	28,359	23	£34,031	28
Wrightington, Wigan And Leigh Nhs Foundation Trust	13,534	10	£16,241	12
			£26,070,340	**16,724**
	Average price			£1,559
	15% reduction in activity			2508.66
	15% reduction in cost at average Non-elective tariff			**£3,910,551**

Table three below outlines the potential savings that could be generated from a 20% reduction in A&E attendances for South Sefton CCG

Table 3: 20% Reduction in A&E attendances

South Sefton CCG	To month 10	Activity to month 10	Forecast (cost)	Forecast (activity)
Aintree University Hospitals NHS F/T	2,837,109	25,883	£3,404,531	31,060
Alder Hey Childrens NHS F/T	571,095	6,593	£685,313	7,912
Central Manchester University Hospitals Nhs Foundation Trust	6,569	62	£7,883	74
Countess of Chester Hospital NHS Foundation Trust	3,955	43	£4,747	52
East Cheshire NHS Trust	1,072	9	£1,287	11
Liverpool Womens Hospital NHS F/T	134,016	1,452	£160,819	1,742
Royal Liverpool & Broadgreen Hospitals	310,362	3,646	£372,435	4,375
Southport & Ormskirk Hospital	424,075	4,453	£508,890	5,344
ST Helens & Knowsley Hospitals	39,757	430	£47,709	516
University Hospital Of South Manchester Nhs Foundation Trust	2,492	25	£2,990	30
Wirral University Hospital NHS F/T	17,718	163	£21,261	196
Wrightington, Wigan And Leigh Nhs Foundation Trust	3,937	38	£4,724	46
			£5,222,589	**51,356**
	Average price			£101.69
	20% reduction in activity			10271.28
	20% reduction in cost at average A&E tariff			**£1,044,518**

Table four below outlines the potential savings that could be generated from a 20% reduction in A&E attendances for South Sefton CCG

Table 4: 20% Reduction in A&E attendances

Southport and Formby CCG	To month 10	Activity to month 10	Forecast (cost)	Forecast (activity)
Aintree University Hospitals NHS F/T	76,183	721	£91,419	865
Alder Hey Childrens NHS F/T	37,791	443	£45,349	532
Central Manchester University Hospitals Nhs Foundation Trust	7,157	76	£8,588	91
Countess of Chester Hospital NHS Foundation Trust	3,228	32	£3,873	38
East Cheshire NHS Trust	1,086	10	£1,303	12
Liverpool Womens Hospital NHS F/T	9,033	95	£10,839	114
Royal Liverpool & Broadgreen Hospitals	55,263	657	£66,315	788
Southport & Ormskirk Hospital	3,072,763	29,930	£3,687,315	35,916
ST Helens & Knowsley Hospitals	15,584	178	£18,701	214
University Hospital Of South Manchester Nhs Foundation Trust	2,279	21	£2,734	25
Wirral University Hospital NHS F/T	4,948	48	£5,938	58
Wrightington, Wigan And Leigh Nhs Foundation Trust	4,379	44	£5,254	53
			£3,947,631	**38,706**
	Average price			£101.99
	20% reduction in activity			7741.2
	20% reduction in cost at average A&E tariff			£789,526

Table five below outlines the potential savings that could be generated from the management of new to follow up rates for South Sefton CCG

Table 5: management of new to follow up rates

Areas identified as outliers compared to peers New to follow ups to:	Annual value of cost reduction	Reduction Average Follow up = £100
National Average: Aintree University Hospitals FT - Rheumatology	218,000	2180 appointments
National Average: Liverpool Womens Hospitals - Gynaecology	188,000	1880 appointments
National Average: Royal Liverpool Broadgreen University Hospitals - Ophthalmology	53,000	530 appointments
Current plan – Southport & Ormskirk Trust - Rheumatology	10,000	100 appointments
Current plan - Renacres – Trauma & Orthopaedics	47,000	470 appointments
Total	**516,000**	

Table six below outlines the potential savings that could be generated from the management of new to follow up rates for Southport and Formby CCG

Table 6: management of new to follow up rates

Areas identified as outliers compared to peers New to follow ups to:	Annual value of cost reduction	Reduction Average Follow up = £100
National Average: Aintree University Hospitals FT - Rheumatology	40,000	400 appointments
National Average: Liverpool Womens Hospitals - Gynaecology	27,000	270 appointments
National Average: Royal Liverpool Broadgreen University Hospitals - Ophthalmology	76,000	760 appointments
Current plan - Southport & Ormskirk Trust - Rheumatology	196,000	1960 appointments
Current plan - isight - Ophthalmology	16,000	160 appointments
Current plan - Renacres – Trauma & Orthopaedics	63,000	630 appointments
Total	**418,000**	

Planning assumptions

The CCGs maintain a five year financial planning model that provides a view of future financial sustainability and saving requirements. This financial model has been updated in the light of NHS England Planning Guidance for 2015/16 and revised CCG allocations, both published in late December 2014.

- Key financial planning assumptions are in line with national guidance as set out in *The forward view into action: planning for 2015/16* and supporting guidance issued by NHS England;
- Funding has been set aside from the allocation received for non-recurrent expenditure as specified in the guidance. This equates to 1.0% in 2015/16, plus a further contingency of 0.5%;
- Running costs will not exceed the allocation for this purpose;
- Clinical Commissioning Groups are required to make a surplus equivalent to 1% of allocation received.

Table seven below outlines the five year planning assumptions for both CCGs.

Table 7:

	2014 -15	2015 -16	2016 -17	2017 -18	2018 -19
	%	%	%	%	%
Allocation assumptions					
CCG Allocation Growth	2.14%	1.94%	1.30%	1.70%	1.90%
Movement to Target	0.00%	0.00%	0.00%	0.00%	0.00%
Net Growth/(reduction)	**2.14%**	**1.94%**	**1.30%**	**1.70%**	**1.90%**
Running Costs assumptions					
Running Cost Allowance		-10.00%			
Cost increase assumptions					
Tariff assumptions - provider inflation	2.80%	2.70%	4.40%	3.40%	3.40%
Tariff assumptions - provider inflation (non-acute)	2.80%	2.70%	4.40%	3.40%	3.40%
Tariff assumptions - Efficiency Savings	-4.00%	-3.50%	-4.00%	-4.00%	-4.00%
Tariff leakage - acute care	0.00%	1.50%	2.00%	2.00%	2.00%
Non-demographic growth - Prescribing	5.00%	4.00%	4.00%	4.00%	4.00%
Non-demographic growth - Acute	0.50%	0.50%	0.50%	0.50%	0.50%
Prescribing Efficiency Savings	-4.00%	-1.00%	-1.00%	-1.00%	-1.00%
Non-demographic growth - Continuing Healthcare	4.00%	5.00%	5.00%	5.00%	5.00%
Non-demographic growth - other (non acute)	0.00%	1.50%	2.00%	2.00%	2.00%
Demographic Growth	0.18%	0.15%	0.29%	0.11%	0.25%
Business Rules					
Non Recurrent requirement for CCGs	1.50%	1.00%	1.00%	1.00%	1.00%
CCG Surplus	1.00%	1.00%	1.00%	1.00%	1.00%
Contingency	0.50%	0.50%	0.50%	0.50%	0.50%
"Call to Action" Fund	1.00%				

RISK

Each organisation that are members of the Health and Wellbeing Board have their own strategic and operational risk management arrangements in place for managing risks to their business operations and the achievement of improved outcomes. Set out below articulates the approach taken by both NHS South Sefton and NHS Southport and Formby CCGs.

Since taking up its full statutory functions on 1 April 2013 the CCGs have had in place risk and assurance arrangements capable of preventing, deterring, and managing risks. The Risk Management Strategy sets out the CCG's commitment to the management of all risk using an integrated approach covering clinical, non clinical and financial risk.

The overarching broad risks to the effective implementation of the transformation programmes are as follows:

Risk Description	Mitigation Controls
The overall system's financial risk is high. Financial risks include: • Impact of CCG allocations formula • Reduction in management cost allowance • Continuing Healthcare (CHC) activity growth • Council financial position	• Working closely as a systems to achieve service transformation and avoid destabilisation • Comprehensive savings programmes (QIPP) • Plan allows for growth
Partners relationship and trust, where the challenge to each organisation is significant. There is a risk of organisations being protective and working against the best interest of the system.	• Set of principles for working together agreed • Open communications and sharing of issues • Formal and informal forums set up to discuss issues and agree delivery
Capability and capacity is a risk within organisations as the scale of the transformation stretches resources in terms of people and budgets.	• Strong programme management in place • Project support requirements identified
Joint commissioning strategies and plans do not deliver the scale of transformation required across the system.	• Continued performance management • Robust business cases • Contract levers and risk share arrangements
IT interoperability - Risk to effective delivery of integrated records, technologies and information.	• iMersey to develop IT strategy • iMersey to provide detailed implementation plan and timeline

TRANSFORMATION PROGRAMMES:

PRIMARY CARE

Primary care, and in particular care delivered by general practitioners and practice nurses, has been the cornerstone of the healthcare system since the inception of the National Health Service (NHS) in 1948. Good quality primary care is considered an essential feature of all cost-effective healthcare systems delivering improved outcomes at lower cost and with higher patient satisfaction. General practice is often quoted as providing the majority of care in the NHS whilst utilising only 9 per cent of the budget. In the NHS in England, more than 300 million consultations take place in general practice per year, which represents 90 per cent of all NHS contacts.

The two CCGs have a three year primary care quality strategy that has been developed in partnership with our member practices and has a real focus on energising the services provided in our local surgeries. The primary care system is currently running in a highly reactive way (i.e. managing patient demand simply by working longer and harder), with little time to actively find and support patients who are in potential danger of hospitalisation. General practice and wider primary care services face increasingly unsustainable pressures:

- **An ageing population**, **growing co-morbidities** and **increasing patient expectations -** resulting in large increase in consultations, especially for older patients, e.g. 95% growth in consultation rate for people aged 85-89 in ten years up to 2008/09. Number of people with multiple long term conditions set to grow from 1.9 to 2.9 million from 2008 to 2018
- **Increasing pressure on NHS financial resources** - which will intensify further from 2015/16
- **Funding streams are complicated** – fragmented and perceived as inequitable
- **Growing dissatisfaction with access to services** - Most recent GP Patient Survey shows further reductions in satisfaction with access, both for in-hours and out-of-hours services. 76% of patients rate overall experience of making an appointment as good
- **Persistent inequalities in access & quality of primary care** - including twofold variation in GPs and nurses per head of population between more and less deprived areas
- **Growing reports of workforce pressures -** including recruitment and retention problems

What is primary care for?

In 2007, a prominent primary care academic, Barbara Starfield, described primary care as:

"The provision of first contact, person-focused, ongoing care over time that meets the health related needs of people, referring only those too uncommon to maintain competence, and coordinates care when people receive services at other levels of care."[5]

Primary care provides universal and comprehensive access for all. It provides a holistic approach to an individual's care, diagnoses and manages disease, prevents illness and protects health by promoting healthy behaviours, having a whole population focus. It is the first element of the continuing healthcare process and supports patients to navigate across multiple care providers and settings.

What primary care represents

The general practice registered list establishes a primary care 'home' for patients, carers and their families and represents the potential for a close, direct relationship with a single coordinator of their care right from their birth through to the end of life.

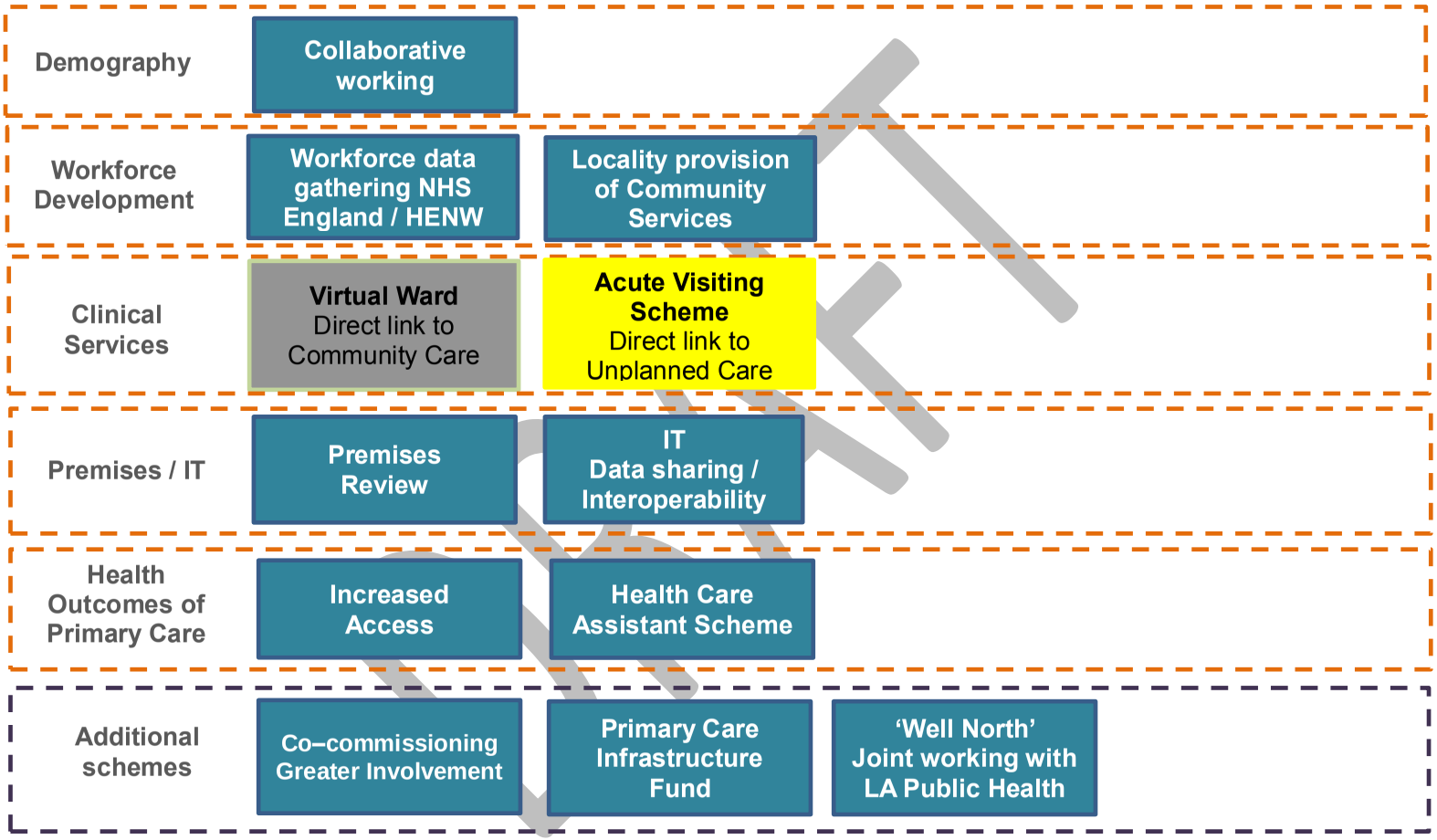
We already know from our public engagement work that people in Sefton want a service that provides timely and convenient access to care. Those with more complex physical and mental health needs want a service that provides GP-patient continuity, is seamlessly coordinated and supports them to stay well.

We are committed to supporting our member practices to look at new models of care in general practice. Our aim is to develop a population-based approach to primary care and support them to improve access to primary care and enhanced quality of service in support of a reduction of 15% in unplanned admissions.

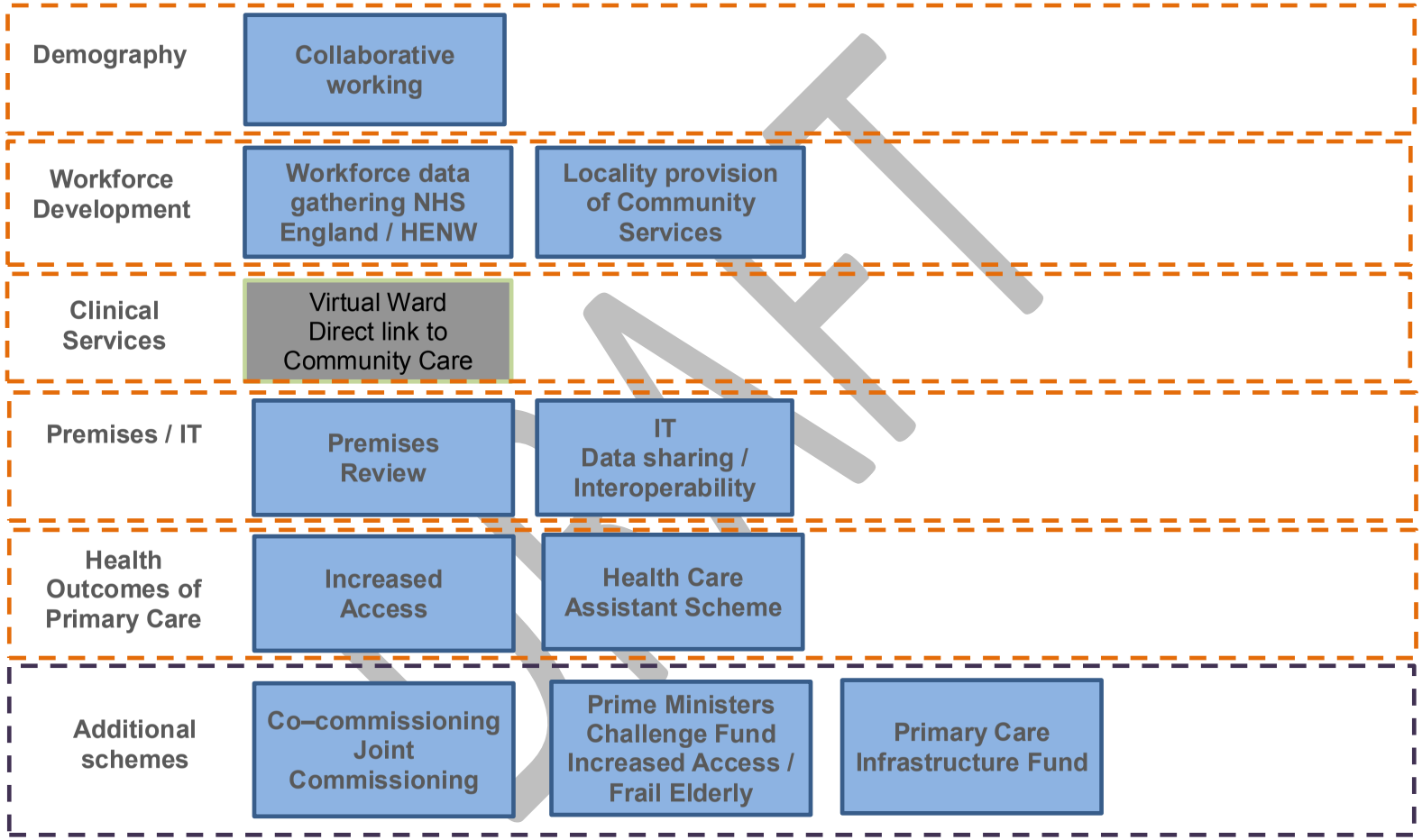
A three year Local Quality Contract was introduced in August 2014, to secure investment in General Medical Practice linked to locally driven quality markers. This has provided an opportunity for individual practice financial stability over a 3 year period in line with national drivers Improving General Practice – A Call to Action[6] as well as fulfilling our CCG strategic objectives.

[5] Barbara Starfield 2007
[6] NHS England Improving General Practice – A Call to Action (March 2014)

PRIMARY CARE PROGRAMMES SOUTH SEFTON



PRIMARY CARE PROGRAMMES SOUTHPORT AND FORMBY



COMMUNITY CARE

This is an area where we believe we can make the biggest difference to the quality and effectiveness of health and social care. Many people who receive both health and social care support have to cope with several sets of professionals coming to see them, asking similar questions and assessing them for many of the same conditions and problems. Many of these people are living with one or more long term condition and a significant number are elderly.

Working more closely together, we will empower staff in our provider and social care organisations to achieve a better understanding of how multi-professional teams can support people holistically – for example, staff will be encouraged and empowered to identify gaps in service and potential solutions for doing things better in the interests of the people they support.

Working in a more integrated way will help minimise delays, reduce duplication or fragmentation of services, reduce the number of different professionals who need to be involved, and ensure that information is shared between different professionals more effectively.

To be effective, the community care model must be the result of true partnership, not just between health and social care staff but also with people who use the services (along with their families and carers) and the local community in each locality.

We will review existing pathways, in conjunction with patients and local providers, in order to identify:

- Gaps in service provision
- Barriers to access which may result in unintended inequalities
- Potential improvements - such as provision of greater diagnostic services out of hospital

VIRTUAL WARD SOUTH SEFTON

Virtual Ward provides co-ordinated Health and Social Care for patients who are at high risk of emergency admission to hospital – such as those with long term conditions and frail or vulnerable older people.

It is called “Virtual” because you stay in your own home and “Ward” because it works like a hospital ward, where all the different members of the team meet regularly and work in a co-ordinated way to support you with your health and well-being needs.

By working together more closely through the Virtual Ward, the team can better manage each patient’s condition to keep them well and prevent them from being admitted to hospital unnecessarily.

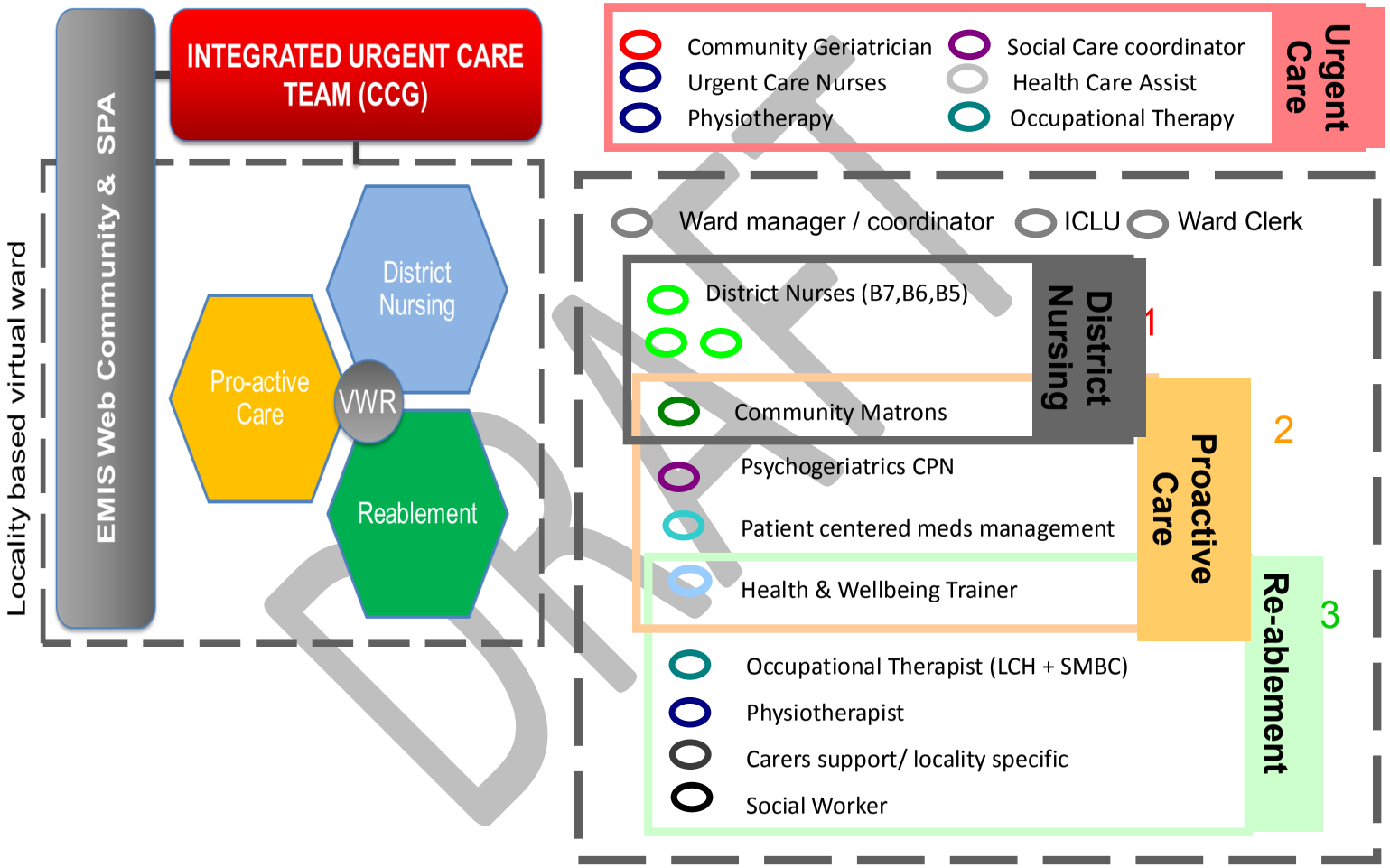
Virtual Ward teams are organised according to Community Nurse Team localities and there are four locality based groups. Each dedicated Virtual Ward team consists of a wide range of professionals from across health and social care. By working more closely together, these professionals provide more effective, joined up and collaborative care and treatment for patients:

Ward manager	Ward clerk
Community matron	District nurse lead
Health and wellbeing trainer	Pharmacist
Occupational therapists	Physiotherapists
Rehabilitation facilitator	Community geriatrician
Social worker	

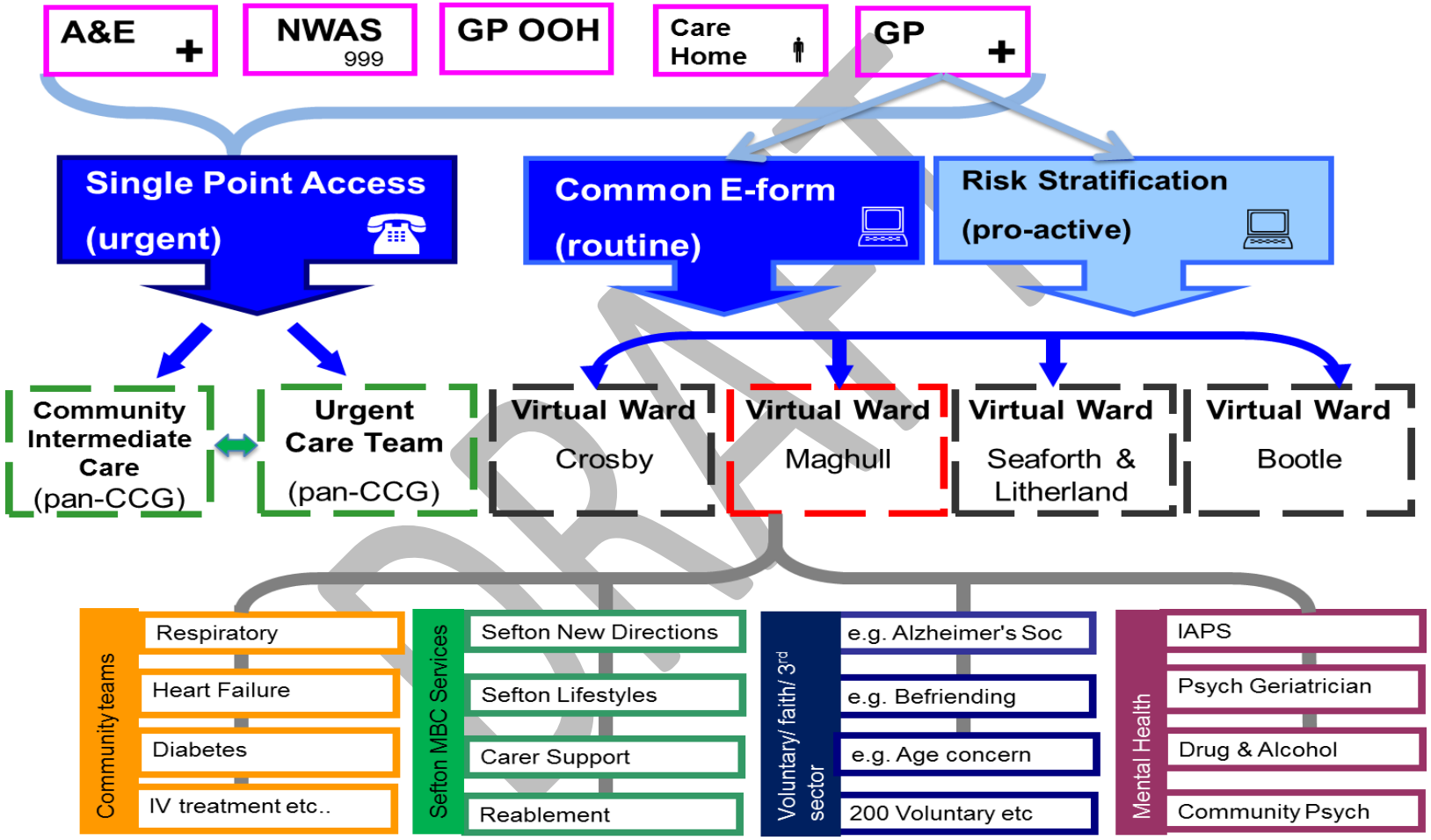
The teams hold fortnightly Virtual ‘ward rounds’, commonly known as a multi-disciplinary team (MDT) meetings. This is where all appropriate community health and social care professionals come together to review individual patients, and to decide how they can better co-ordinate their care. Decisions and information from these meetings is then communicated directly to the patient’s registered GP, updating their clinical notes.

This MDT approach reproduces the strengths of a hospital ward in the community by using a multi-disciplinary team approach in healthcare provision. It is called "virtual" because the ward does not exist physically and patients remain in their home.

The teams will look after the patients identified by the Risk Stratification tool as well as patients identified by other healthcare professionals who have been caring for them.

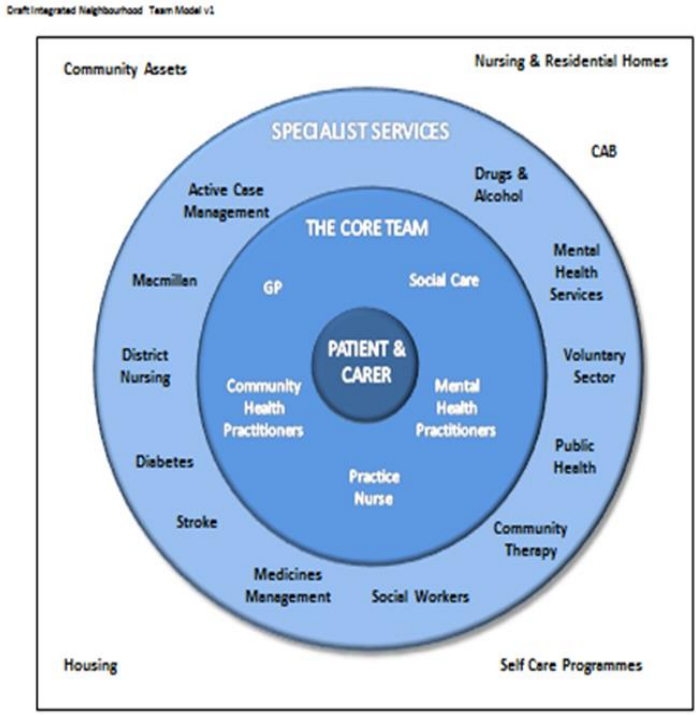

Locality based virtual ward
EMIS Web Community & SPA
INTEGRATED URGENT CARE TEAM (CCG)
District Nursing
Pro-active Care
VWR
Reablement
Community Geriatrician
Social Care coordinator
Urgent Care Nurses
Health Care Assist
Physiotherapy
Occupational Therapy
Urgent Care
Ward manager / coordinator
ICLU
Ward Clerk
District Nurses (B7,B6,B5)
District Nursing
1
Community Matrons
Psychogeriatrics CPN
Patient centered meds management
Health & Wellbeing Trainer
Proactive Care
2
Occupational Therapist (LCH + SMBC)
Physiotherapist
Carers support/ locality specific
Social Worker
Re-ablement
3

VIRTUAL WARD MODEL AND PATHWAY (SOUTH SEFTON)



CARE CLOSER TO HOME SOUTHPORT AND FORMBY

The Care Closer to Home programme is about allowing everyone to live fulfilling, independent lives, which are supported by safe, quality, patient centred, accessible and seamless services. This will be delivered by a skilled, committed, satisfied and integrated workforce, who together with the public and colleagues across the health, social care and voluntary sectors, take pride in providing quality care. We will achieve this by being innovative and having the vision and courage to do the right thing, building trust and co-ownership with care providers, partners and patients through effective two way communication and listening to experiences of care.



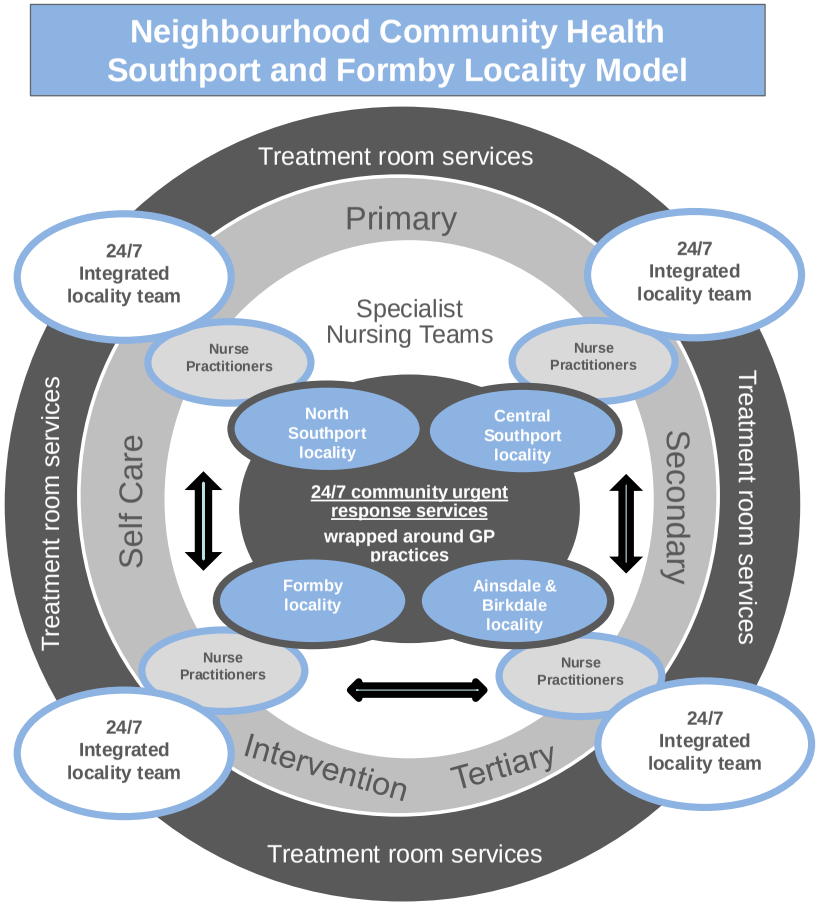
The core benefits of delivering this vision for the community and patients will include:

- Care and treatment will be accessible closer to home, or in the most appropriate setting
- Reduce need to visit A&E due to alternatives available locally
- Multi-disciplinary teams will be integrated and made up of individuals offering various clinical skills
- Care will be seamless and involve healthcare colleagues working closely together and working to a single care plan for a patient
- Everyone will learn more about self-care and how to help manage their own conditions
- Greater understanding of which health service to use and when, due to clear signposting and easier access

Our ultimate aim is to improve the outcomes and experiences of individuals and communities through the delivery of cost effective, integrated seamless care, support and treatment. To achieve this we will work together to transform our local health and care services to:

- Better co-ordinate, plan and deliver more personalised care and support to people living with long-term conditions and the frail elderly, in order to improve their quality of life and health outcomes
- Develop local community services to offer better access to care and support across the 7 day week
- Support the optimal delivery of elective care; utilising community support, where appropriate, to ensure individuals stay in hospital is minimised
- Design an urgent care system that delivers integrated services outside of hospital for people whose physical or mental health need for urgent care can be met by responsive advice, support and treatment closer to home
- Ensure that end to end integrated care pathways in and out of hospital run smoothly, ensuring evidence based care is consistently and equitably delivered to all individuals and communities in support of the best patient experience possible
- Empower communities and offer greater choice to individuals, by providing transparent information about the range and quality of health and care services available
- Effectively engage individuals, communities and our stakeholders in working with us to transform and redesign the way in which health and social services are provided to deliver better health and wellbeing for all

CARE CLOSER TO HOME MODEL (SOUTHPORT AND FORMBY)



CONTINUING HEALTH CARE

When it is assessed that an individual's primary need is a health need, the NHS offers a package of continuing health care. This is a package of ongoing care arranged and funded solely by the NHS.

If a patient requires continuing health care, South Sefton and Southport and Formby CCGs are committed to helping them to stay at home, provided that is safe for the patient and the staff looking after them to do so. We follow a number of key principles to guide this decision and if we are unable to support a package of care provided at your home we will offer you alternative care.

Eligibility is assessed through a process as defined in the Department of Health National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.

The first step in the process for most people will be a screening process using the checklist.

If an individual is referred for a full assessment for NHS continuing healthcare, the decision support tool should be completed following a multi-disciplinary assessment.

The fast track pathway tool is used in circumstances where an individual has a rapidly deteriorating condition that may be entering a terminal phase.

The CCG currently commission (160 for South Sefton and 114 for Southport &Formby) packages of continuing healthcare. The CCG also contributes funded nursing care (FNC) for (354 patients in SS and 509 patients in S&F)

Joint Funding

Adult: Informal arrangement with no panel in place. Agreement with CHC team and LA on the contribution of each organisation joint package.

Child: CHC team represent the CCG at joint panel meetings with the LA on assessment of the needs of the child, the care package to be provided and CCG contribution to the package.

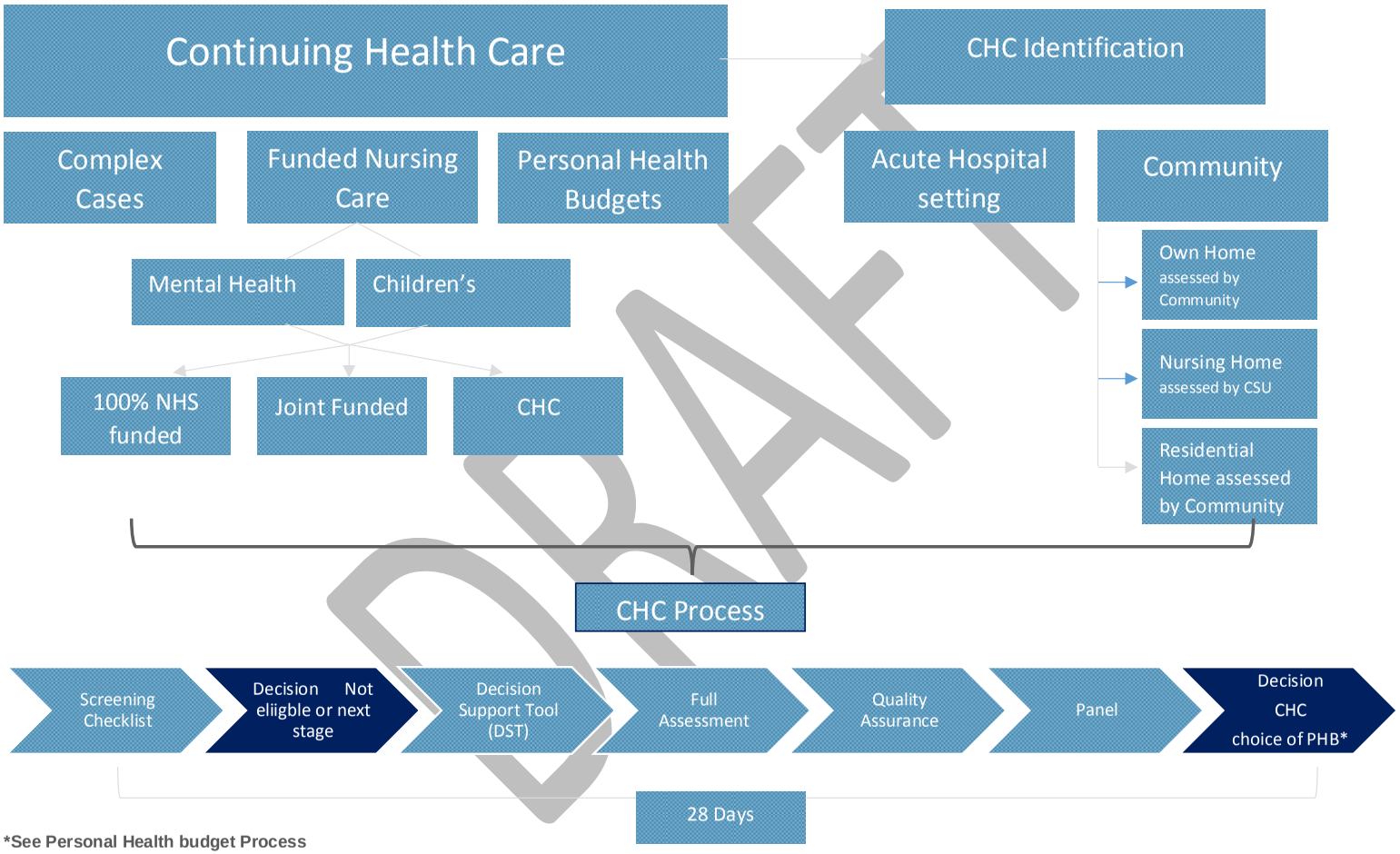
Personal Health Budget (PHB)

The CCG has a duty to ensure people eligible for NHS Continuing Healthcare and Continuing Care for Children benefit from the "right to have" personal health budget. A personal health budget is an amount of money to support the identified healthcare and wellbeing needs of an individual who is in receipt of Continuing Healthcare Funding and choose PHB as the option for provision of care. This is planned and agreed between the individual, or their representative, and the CCG. A care and support plan helps people to identify their health and wellbeing goals, together with their local NHS team, and set out how the budget will be spent to enable them to reach their goals and keep healthy and safe.

Personal Health Budgets Process:

Patient	• Existing or new CHC patient identified • Patient chooses Personal Health Budget
Process	• CHC team assess appropriateness • CHC team advise plan of care
Implementation	• Broker identified to facilitate payments • Broker provides clinical and financial assurance
Review	• Initial review after 3 months • Annual Review

CHC DRAFT PATHWAY



*See Personal Health budget Process

INTERMEDIATE CARE

Intermediate care was defined by the Department of Health (2001)[7] and "Halfway Home" (2009)[8] as a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.

Partnership working is key to successful delivery of intermediate care and work is under way in Sefton to further align services in health and social care. Through the better care fund joint working, we now have in place an agreed strategy written in partnership with the Local Authority and we will monitor delivery via the joint Implementation Group which has a robust governance framework in place.

We know we must do better at commissioning our intermediate care facilities and we will commission an improved model to reduce admissions to acute care settings and facilitate the discharge and return home of patients following admission to our acute trusts.

Those accessing Intermediate Care services should not be in need of 24-hour access to consultant-led medical care, however, they may have medium to long-term medical conditions that make them liable to relapse.

The local approach is that intermediate care delivery is provided via a single point of access or "gateway", which includes a multi-disciplinary health and social care team and works cohesively with other community and third sector services, to provide a seamless intermediate care experience for our patients.

Following entry via the gateway, Intermediate Care required is provided in three 'tiers', with patients being "stepped up" or "stepped down" the model as appropriate.

Key to delivery of this model are a Community Emergency Response Team (CERT) based in Southport and Formby and a Community Intermediate Care Team (CICT) located in South Sefton. They will act as the 'gatekeeper' or single point of access to the Intermediate Care Service across the two CCG footprints. This will facilitate the "one point of access, one assessment, one care planning process" approach.

[7] http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf
[8] Intermediate Care – Halfway Home (DH 2009)

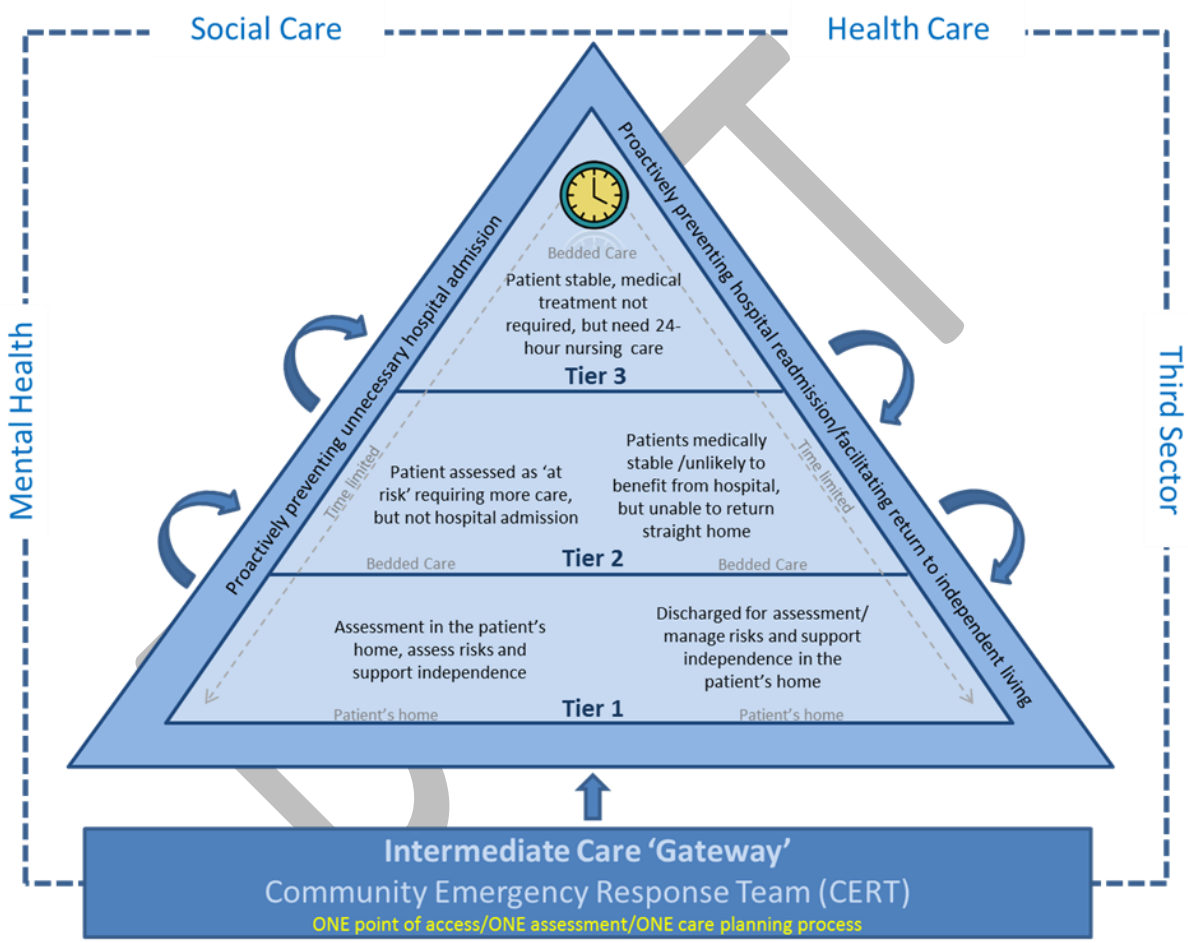
They will be an integrated, proactive, multi-agency and multi-disciplinary teams providing holistic short-term care and rehabilitation – it is not a series of standalone teams. The team will comprise:

- Nurses
- Occupational Therapists
- Physiotherapists
- a GP or Geriatrician
- Social Workers
- Mental Health Workers
- Technical Instructors
- Health Care Assistants
- Third sector representatives (ie, community, volunteer or faith services).

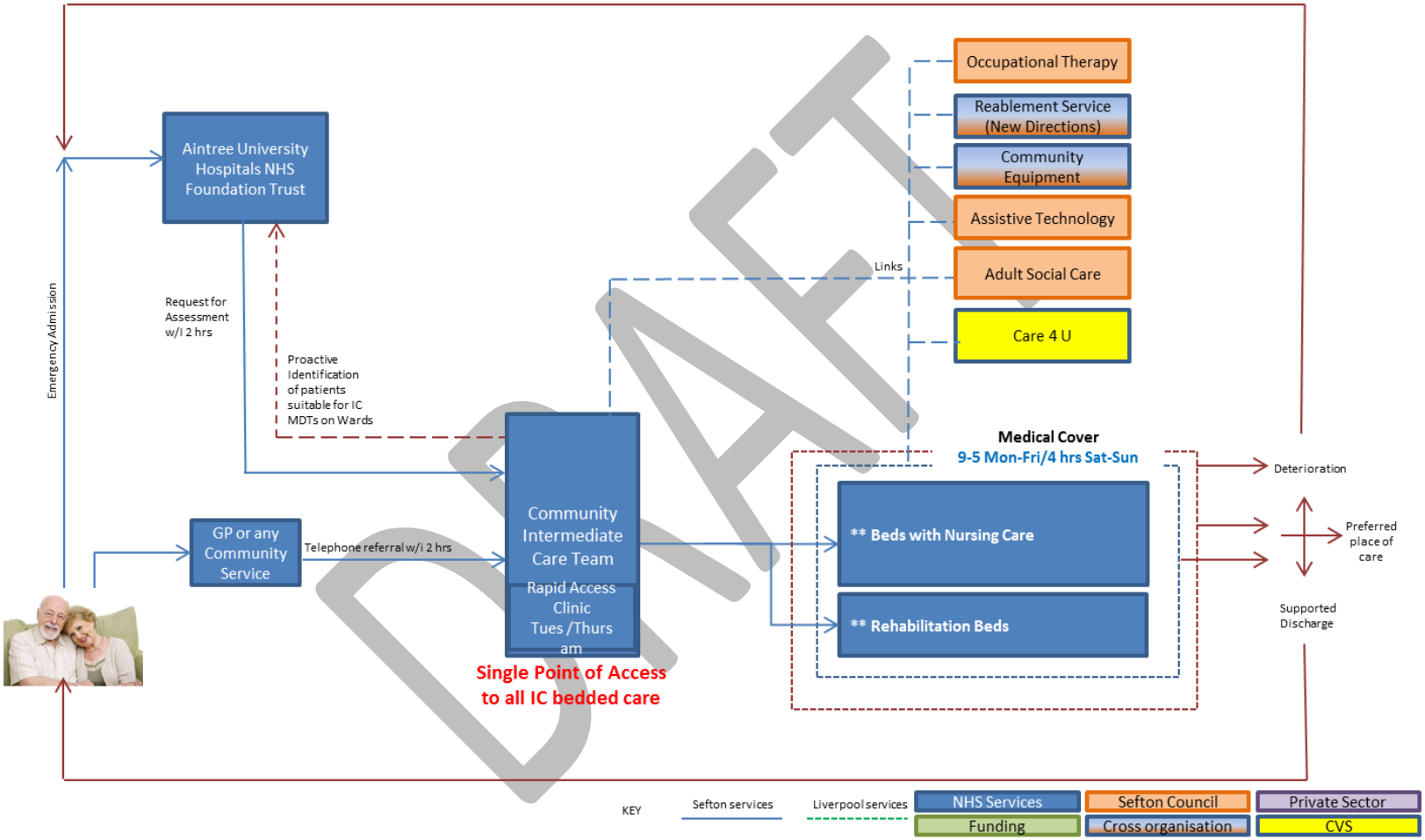
Both CERT and CICT will establish links with a variety of additional key health and social care community services to include, *inter alia*, stroke, falls, continence and respiratory services. Together with Sefton Council's Reablement and Continuing Health Care Teams they will ensure that each individual's care is person-centred and that their journey through the Intermediate Care pathway is timely and seamless.

Intermediate care will largely be provided in the person's own home (Tier 1), but for those assessed as at risk if 24-hour care is not provided or their home is unsuitable, an intermediate care bed in a residential setting (Tier 2), or with some nursing care (Tier 3) may be the only viable option to avoid hospital admission.

DRAFT INTERMEDIATE CARE MODEL



INTERMEDIATE CARE PATHWAY SOUTH SEFTON



INTERMEDIATE CARE PATHWAY SOUTHPORT AND FORMBY

Trigger to avoid deterioration/ admission assessed by professional (eg, GP, DN, Social Worker etc)

Southport & Ormskirk Hospitals NHS Trust

Patient in hospital and assessed as requiring new care service on discharge

Inreach

Referral

Other Social Services

Other NHS Services

Third Sector Services

Links

'CERT' Community Emergency Response Team

2 hr response Assessment

Assessment and care in a Community Intermediate Care bed

Person returns to self care or is supported with long term care needs

Multi-agency team

UNPLANNED CARE

There is widespread national recognition and agreement that the health and social care system is under considerable pressure to deliver better patient outcomes against a backdrop of finite resources and increasing demographic pressures, alongside changing patient expectations. Over the last few years there has been considerable focus on the need for transformational change to manage these pressures to deliver better patient experiences and outcomes as it has been recognised that incremental change will not deliver the benefits that health and care suppliers (providers), patients and the government are seeking. These changes impact all areas of the health and social care economy, and over the last few years national attention has increasingly focused on the urgent and emergency care system.

Local strategies also reflect the national position with a desire to transform the urgent and emergency care system. The 5 Year Forward View (2014-19) sets out a collective vision to create a sustainable health and care economy that supports people to be healthy, well and independent. It acknowledges the issues driving change within the urgent and emergency care system.

The real challenge in A&E is the flow of patients into, around and out of the hospital. More than two thirds of all hospital beds are occupied by people admitted in an emergency. When wards are full, and staff overstretched, people who need to be admitted to hospital end up waiting in A&E.[9]

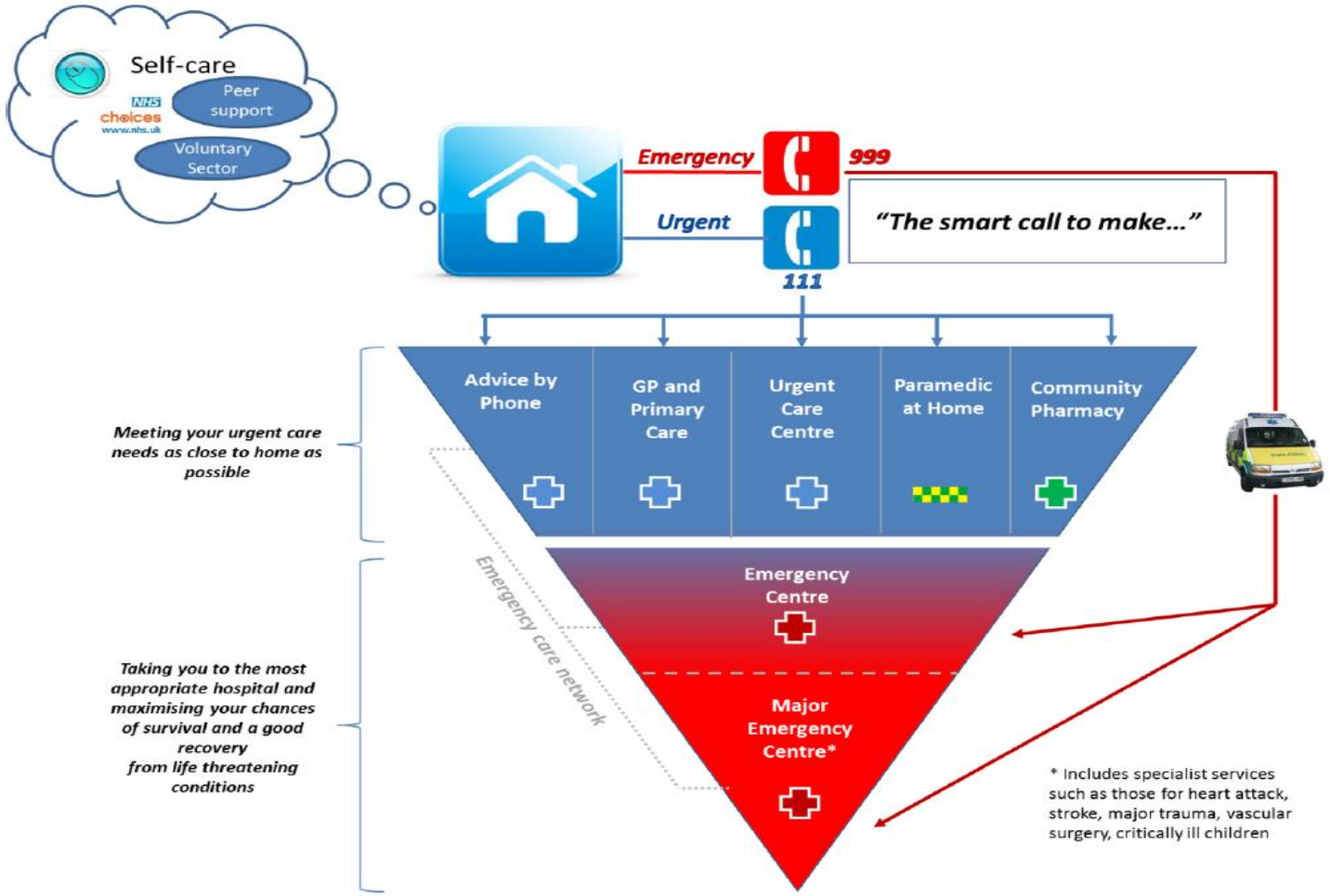
Urgent care should not be considered as a stand-alone, discrete service but embedded within patient pathways to ensure a joined up approach to care.

Evidence suggests that as attendances at A&E departments continue to rise, a significant proportion could be more appropriately dealt with by Primary and Community services. This would result in better utilisation of specialist A&E skills and enable more effective relationships being developed between the patient and primary care in managing their condition.

Professor Keith Willett who is leading on 'Transforming urgent and emergency care services in England'[10], has outlined the vision for urgent and emergency care, a visual model of this can be seen in Diagram three below:

[9] Alternative guide to the urgent and emergency care system animation transcript The Kings Fund January 2015
[10] Update on the Urgent and Emergency Care Review NHS England August 2014

Diagram three:



UNPLANNED CARE SOUTH SEFTON

South Sefton CCG will continue to improve immediate and emergency care across the system to ensure that our patients get the right care at the right time and in the right place - be that primary care, community, or acute care. The commissioning of high quality and accessible urgent care services for our residents continues to be an important priority.

In recent years there has been increasing pressure placed on urgent and emergency care systems as patients seek greater assurance regarding their condition and more rapid responses from services.

We are currently developing our model to provide urgent response within two hours for our community services led by a consultant geriatrician and supported by GPs and other clinicians to reduce the reliance on A&E departments.

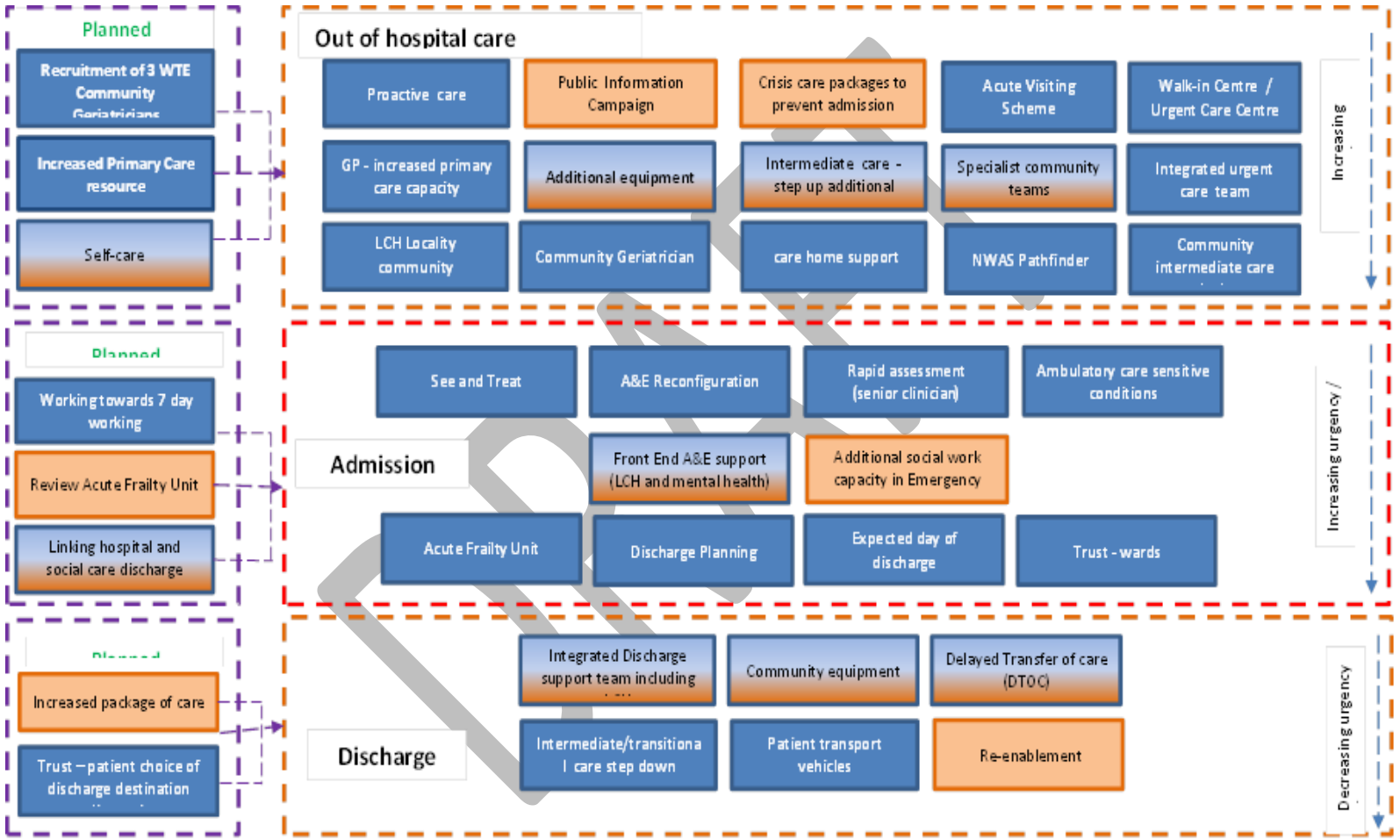
We will work collaboratively across the health sectors to ensure that patients are supported to access urgent care as needed. We will commission services across Primary Care, Community and Acute care to support patients and their clinical needs. Our integrated community mode includes social service, community services, mental health services, therapies and voluntary services, this is aimed to proactively identify and support patients at risk of future unplanned care episodes.

We will continue to develop clinically led pathways to deliver the most appropriate services to the patient need.

Our focus will be on:

- Unplanned Care teams are available to provide Urgent Care in the Home
- The Unplanned Care Team can call on support of the Unplanned Care Centre and utilise intermediate beds
- Patients can access an Unplanned Care Centre which has the support of the acute hospital
- At all times, patients with acute needs can be streamed to the acute hospital.
- Both the acute hospital and intermediate beds can step patients down to a supported discharge team
- There is whole system operational management and control

South Sefton Model for Unplanned Care



UNPLANNED CARE SOUTHPORT & FORMBY

The delivery of high quality and accessible urgent care services is an important priority for the Southport and Formby Health economy. We aim, as commissioners of care, to ensure that urgent care services in the future are delivered in a seamless integrated way to best meet the needs of our local population.

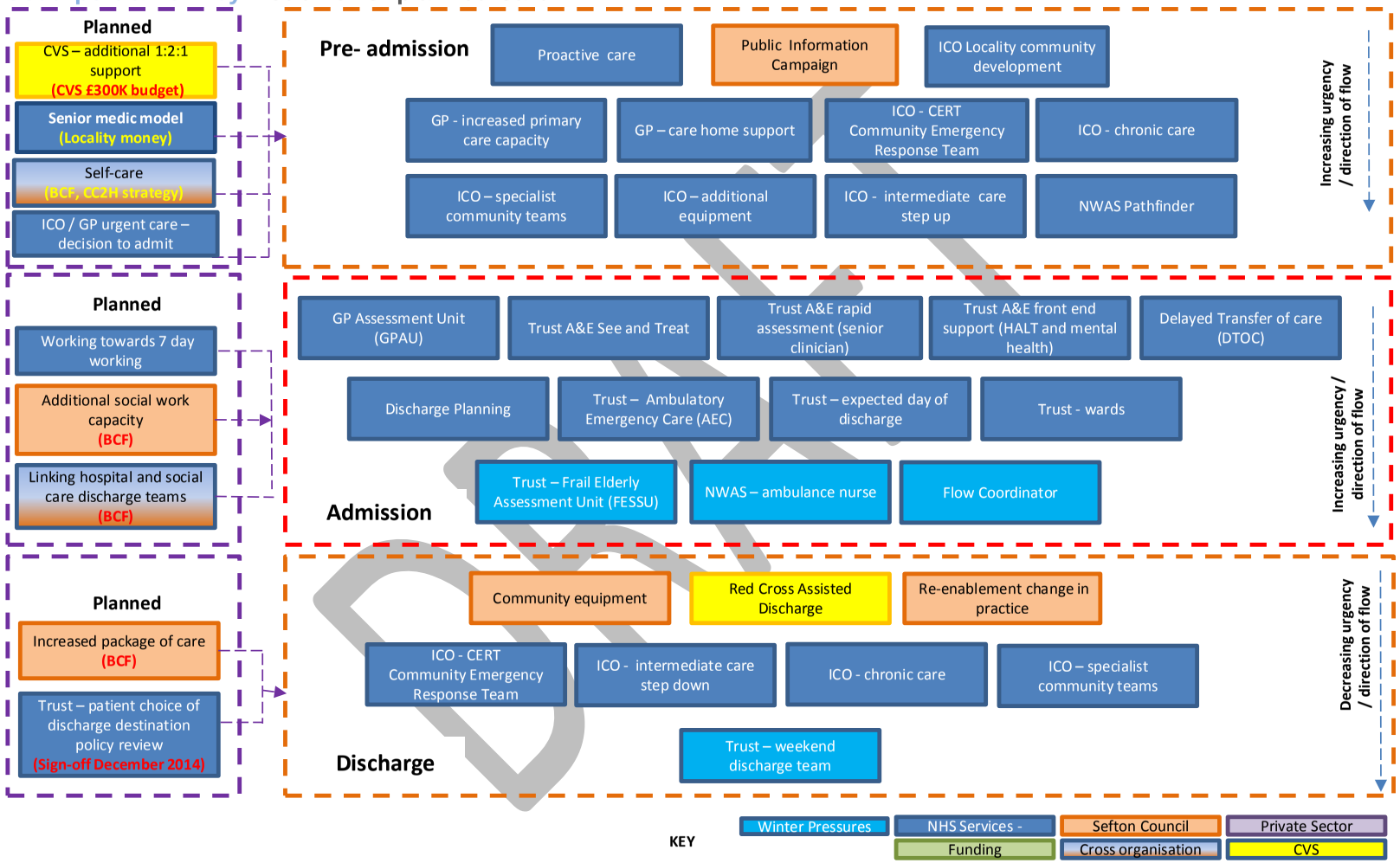
We recognise that the urgent care system is complex and the number of different entry points can be confusing to people. At times when people need things to be simple, in reality they are faced with a confusing set of options. We recognise that our role is to remove this confusion and present the public with a straightforward set of options that are obvious and easy to navigate.

Meeting the demand of unplanned care in Southport and Formby is inextricably linked to both primary and community care provision.

We will focus on delivering the following:

- The patient is supported in making informed decision
- Community Emergency Response teams are available to provide Urgent Care in the Home
- Community Emergency Response teams can utilise intermediate beds to avoid a hospital admission as well as step down from hospital care
- At all times, patients with acute needs can be streamed to the acute hospital.
- GP's proactively identify patients at risk of hospital admission and are able to enact (?) interventions through the community nursing teams
- Extra access to GP practices is being provided
- There is whole system operational management and control including escalation plans and urgent care dashboard

Southport & Formby Model for Unplanned Care



MENTAL HEALTH

Our mental health services require review and redesign to ensure they are built around the needs of Sefton residents. We will commission an all age mental health and dementia service across Sefton which is a recovery based clinical model, supportive of home care, visible, easily accessible, of high quality, safe and will deliver beneficial outcomes to the patient.

Dementia services will be enhanced so they can meet the growing demands of local people, their families and their carers.

The Government has included a specific objective for the NHS to "put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole". In line with mental health strategy and the National dementia strategy there is a fundamental shift from output focused and volume driven commissioning to outcome focused and recovery orientated service provision.

A range of services will be available to meet the patients need. There will be a reduction in stigma associated with mental health issues and confidence in local services. A focus on patient recovery and satisfaction in their experience will be tangible in local services with equal regard for mental health as physical health.

We have identified the following key priority areas to focus on:

- Primary Care
- Parity of Esteem
- Dementia
- Redesign and commission and All Age service to include Child and Adolescent Mental Health (CAHMS)
- Brain Injury
- Outcomes and Activity Information

Primary Care: We will actively facilitate work with GPs and mental health services, including 3rd Sector, to enable collaborative working to be undertaken. We will undertake a training needs analysis to ascertain the level of mental health awareness across the GP community. There will be an increased focus on locality working which will enable mental health services to be targeted at a neighbourhood level.

Parity of Esteem: We will work with our current mental health providers, Mersey Care NHS Trust and all physical health providers, to ensure that physical needs of mental health and dementia patients are met in a timely and co-ordinated manner. A future model which envisages services working in integration is to be actively encouraged.

Dementia: The current pathways are disjointed and there is an inequity across the two CCG areas as to how the dementia services are delivered. The work undertaken to-date has identified that some patients could be better managed in a primary care setting. Current estimates suggest there are almost 4,500 people aged over 65 affected by dementia, as a result of an ageing population it is forecast that by 2030 that number will have increased by 49% to over 6,600. Dementia services might best be delivered by an integrated service comprising of integrated health, social care, the third sector and nursing home provision, this would be a major shift from the current model of provision.

Child and Adolescent Mental Health (CAHMS): The national framework for Children, young people and maternity services highlighted the importance of ensuring safe and effective transition. Locally, in mental health services, transition arrangements for 16-18 year olds appear to be confusing and having two organisations involved, Mersey Care NHS Trust and Alder Hey, exacerbates this issue and carries an element of risk. Organisational barriers may affect these patients, therefore, it is paramount that we look to redesign the current CAMHS pathway to aim for a single mental health provider for young people instead of the current system of multiple providers. This new pathway could be a precursor to the development of a single and ageless service for all mental health patients who require secondary mental health services.

Brain Injury: The Brain Injury pathway is disjointed and whilst there are links between the service provided by Mersey Care through their Brain Injuries Unit and the Intensive Rehabilitation service provided by Walton Centre for Neurology moving to a new contracting arrangement whereby Walton Neurology sub contract the Mersey Care NHS Trust element of provision would enable the overall Brain Injury pathway to be more co-ordinated than at present.

Outcomes and Activity Information: The planned introduction of mental health Payment by Results (PbR) is a major organisational change for both providers and commissioners. Commissioners will need to understand in detail how the services they are purchasing meet the needs of individual people, how this directly affects the prospects for patient recovery and crucially identify any financial risks. Financial modelling and profiling of risk will need to be undertaken by the CCGs for assurance purposes.

The current mental health contracting currencies are out of date and many activity indicators are catchment and not CCG based. The Task Group believes that mental health outcomes should be predicated on more social based outcomes and it has commenced discussions with Mersey Care NHS Trust to agree an initial suite of measureable outcomes and CCG based activity measures for inclusion in 2015/16 contracts.

Future Dementia Pathway

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

Secondary Care Presentation

Memory Service (MCT) for Assessment Monitoring and Review including medication

Alzheimers Society provide post diagnostic support

Community Care Navigators

Social Services

VCF Community

Care Closer to Home/Virtual Ward

Care Homes

Care Home Liaison

Patient presents to Dementia Friendly Surgery with health concerns

Shared care

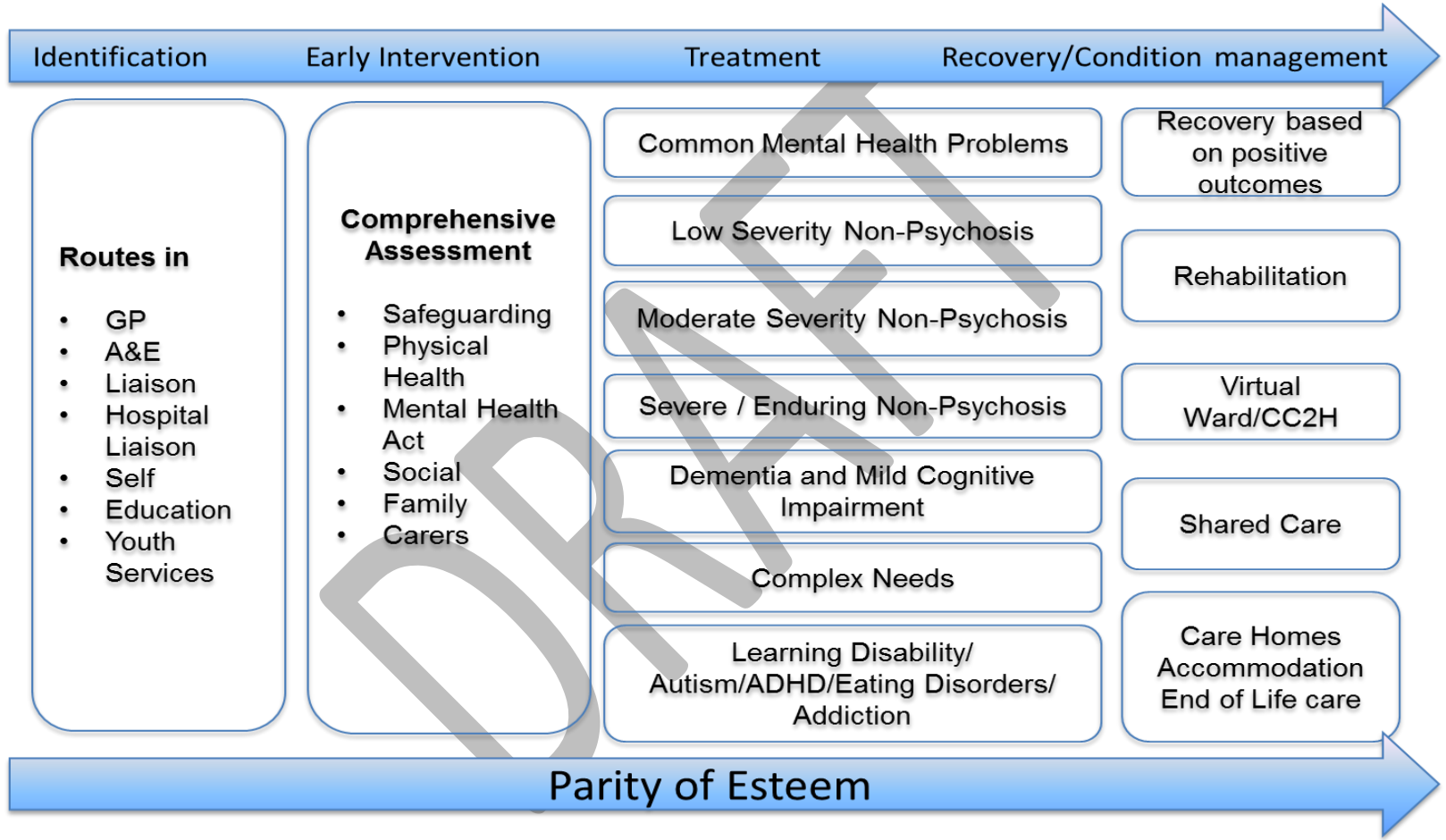
GP does initial assessment and may refer to Memory Clinic and also make referral to VCF Sector

Carer Support Education Signposting

Staying **local & together**

together with you

MENTAL HEALTH MODEL OF CARE



ACTION, DELIVERY AND GOVERNANCE

We will focus on delivery of our transformation programmes through the agreed governance structures outlined in Appendix one, whilst these transformational programmes are the main focus, they are not the only mechanism for delivering improvements and driving quality, safety and standards in health and care.

The ongoing improvement and enabling activity aimed at raising standards of care across the system are set out for each CCG below. The anticipated impact of these activities is being assessed and modelled to enable us to continue to improve health service within a sustainable local health and social care system. High level action plans, alongside benefits and measures are attached in Appendix two.

ACTIONS, DELIVERY AND TIMELINES SOUTH SEFTON CCG

PRIMARY CARE

Scope and Rationale

The aim of the Primary Care transformation programme is to develop a population-based approach to primary care and support them to improve access to primary care and enhance quality of service.

Priority Projects/Activities

- Increased access
- Enhanced management of patients over 75
- Workforce
  - Succession Planning
- Early detection:
  - CVD – increased uptake of Health Checks
  - Hypertension – recording, management and treatment
  - Atrial Fibrillation (AF) Management – improve case finding and management
- Planned Care
  - Increase use of Choose and Book utilisation

Outcomes

- Better patient experience
- Reduce A&E attendances
- Reduction in referrals
- Reduction in admissions
- Increased prevalence rates
- Reduction in re-admissions
- Reduced length of stay
- Reduced number of admissions from care homes
- Increased quality and provision of primary care diagnostics and monitoring

Contribution to Strategic Priorities

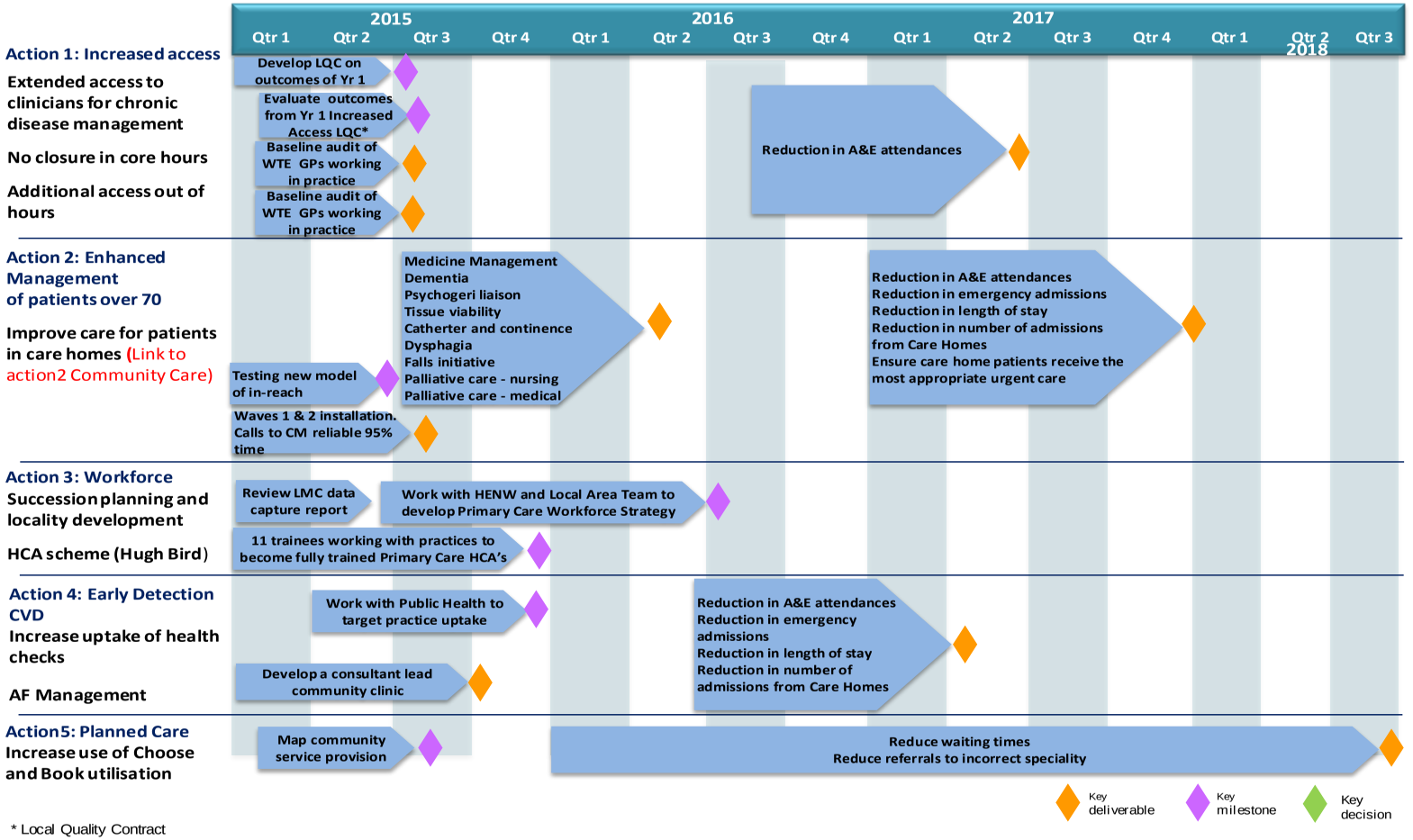
- Primary Care transformation
- Frail Elderly
- Unplanned Care

Workstream name: *Primary Care*	**Date:** *09 Feb. 15*
Senior Manager Lead: *Angela Parkinson*	**Updated**:

Programme Aim
We will develop a population-based approach to primary care and support them to improve access to primary care and enhanced quality of service.

ID Number	Action	Responsible Lead	Date due for Completion	Actual completion date	RAG
SSPC01	**Increased access** Extended access to clinicians for chronic disease management. No closure in core hours, additional access outside of core hours. Link to Local Quality Contract (LQC)	Angela Parkinson	Aug 15		
SSPC02	**Enhanced management of patients over 75** Improved care for patients in care homes by offering more intensive health treatment Link to Local Quality Contract (LQC)	Moira McGuiness	Sept 15		
SSPC03	**Workforce** Succession planning and locality development HEE data capture LMC report Link with HCA scheme in collaboration with Hugh Bird College	Angela Parkinson	Mar 17		
SSPC04	**Early detection** CVD Increased uptake of Health Checks. Hypertension – recording, management and treatment Atrial Fibrillation (AF) Management – improve case finding and management	Sharon Forrester	Mar 16		
SSPC05	**Planned Care** Increase use of Choose and Book utilisation for both acute and community services	Terry Hill	Sept 15		

South Sefton Primary Care - Timeline



* Local Quality Contract

COMMUNITY CARE

Scope and Rationale

We will commission services that better link together right across health and social care – from hospital and community and social services, to GP practices and voluntary, community and faith sector organisations – and where as much care and support as possible is delivered outside of hospital, making it easier for people to access at the times that are more convenient to them.

Outcomes

- Improved support for frail elderly
- Reduction in unplanned/emergency admissions
- Reduction in re-admissions
- Reduced length of stay
- Better health outcomes
- Reduced mortality rates
- Reduce A&E attendances
- Better patient experience
- Care closer to home
- Reduce referrals into secondary care
- Increase number of people dying in usual place of residence
- Admission avoidance
- Self Care

Priority Projects/Activities

- Locality and virtual wards
- Care Homes
- Community urgent care team
- Review Integrated care pathways for long term conditions – focus on urgent care:
  - Diabetes
  - Heart Failure
  - COPD
  - Palliative Care
  - Dementia and Frailty
- Review of Community Tier 2 services and activity

Contribution to Strategic Priorities

- Frail Elderly
- Unplanned Care

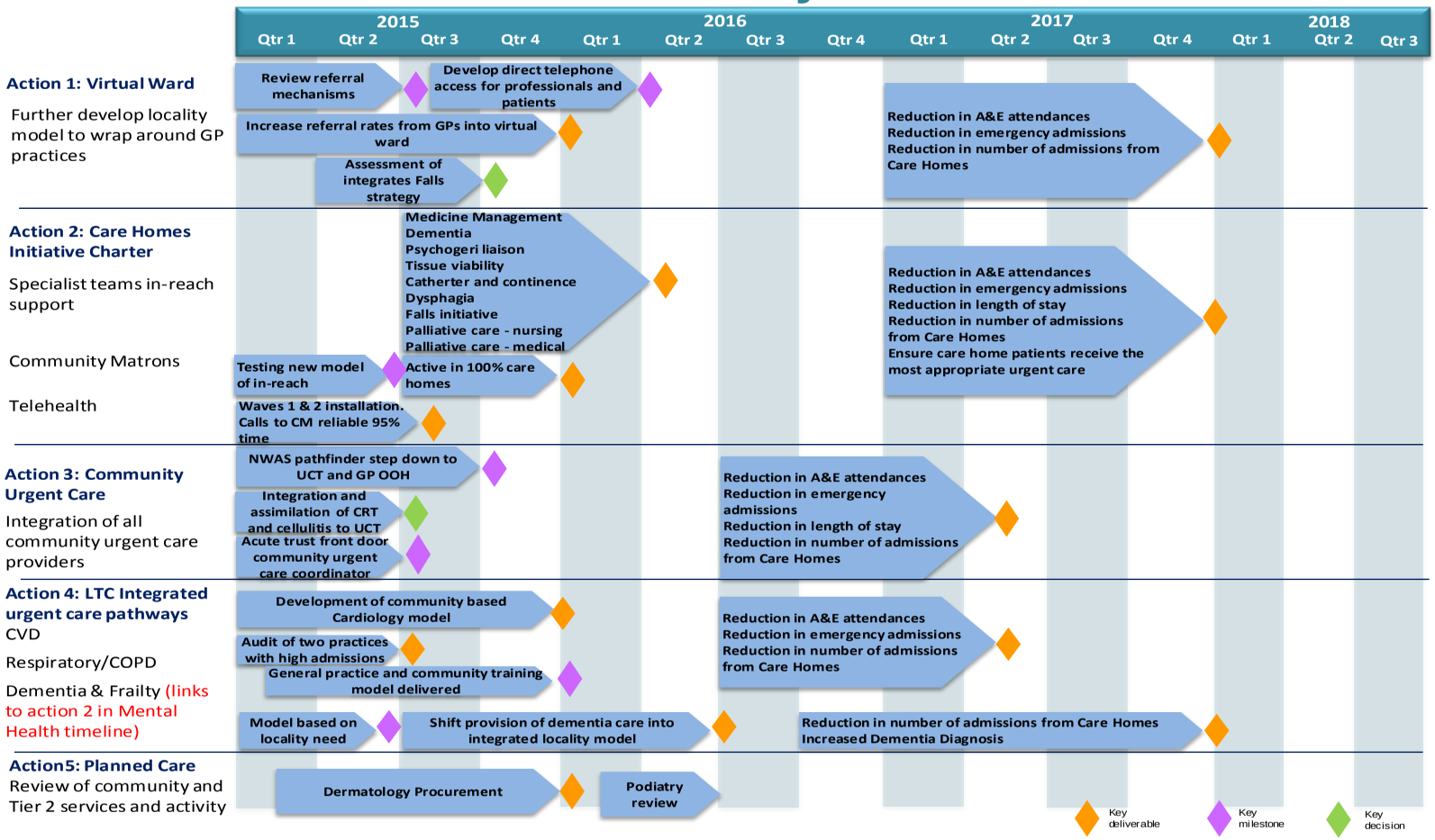
Workstream name: *Community Care*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Steve Astles*	***Updated****:*

Programme Aim

We will commission services that better link together right across health and social care – from hospital and community and social services, to GP practices and voluntary, community and faith sector organisations – and where as much care and support as possible is delivered outside of hospital, making it easier for people to access at the times that are more convenient to them.

ID Number	Action	Responsible Lead	Date due for Completion	Actual completion date	RAG
CC01	**Locality and Virtual Wards** Further development of locality modelling to ensure community services are wrapped around GP practices	Steve Astles Peter Chamberlain	Ongoing		
CC02	**Care Homes** • Community geriatrician in-reach to care homes • Community Matrons • Telehealth	Steve Astles	 Mar 15 Apr 15 Apr 15		
CC03	**Community Urgent Care** Integration of all community urgent care providers including: • NWAS pathfinder step down to UCT and GP OOH • Integration and assimilation of CRT and cellulitis to UCT • Acute trust front door community urgent care coordinator	Steve Astles Andy Mimnagh	Jun 15		
CC04	**Review and redesign Integrated Care Pathways for Long term conditions. Phase 1 focus on urgent care element** • CVD • COPD • Dementia & Frailty	Steve Astles Sharon Jenny Kevin Thorne			
CC05	**Review of Community/Tier 2 services and activity** • De-commission and procurement	TBC			

South Sefton Community Care - Timeline



INTERMEDIATE CARE

Scope and Rationale

The Intermediate Care aim is to have ONE point of access, ONE assessment, ONE care planning process. This will be enabled by commissioning co-ordinated care for patients via integrated services and being responsive to patient's needs.

Outcomes

- More integrated, efficient and effective intermediate care
- Reduce hospital admissions
- Reduce re-admissions
- Reduce length of stay
- Ensure decisions about long term care are not made in an acute setting

Priority Projects/Activities

- Better Care Fund priority
  - Integrated approach with local authority
- Single entry coordination for all intermediate care
- Integrated care at locality level
- Increase use of appropriate use of step up / step down beds
- Stroke:
  - Development of Intermediate care beds in nursing homes

Contribution to Strategic Priorities

- Frail Elderly
- Primary Care transformation

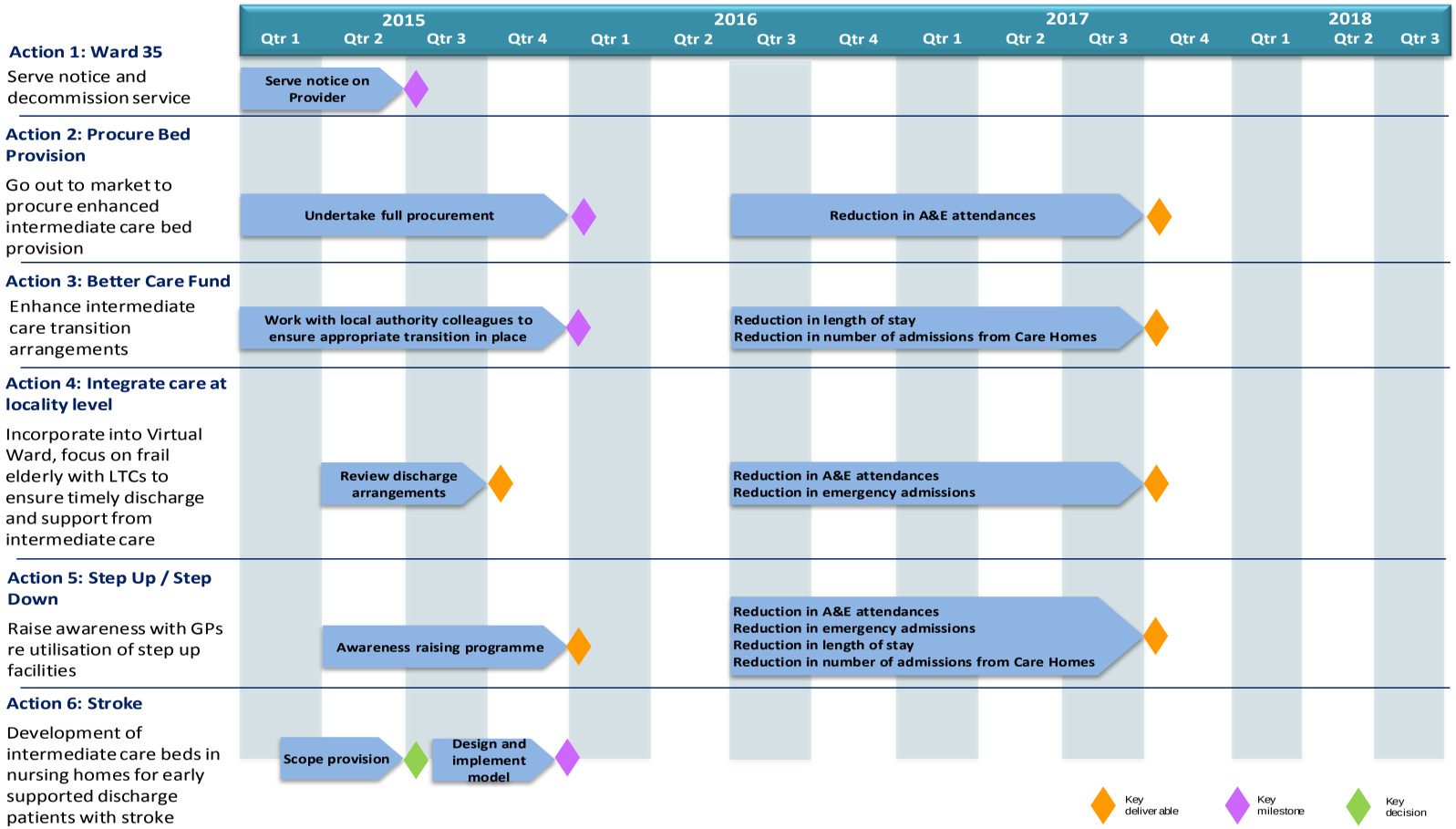
Workstream name: *Intermediate Care*	**Date:** *09 Feb. 15*
Senior Manager Lead: *Melanie Wright*	**Updated**:

Programme Aim

Our aim is to have ONE point of access, ONE assessment, ONE care planning process. We will do this by commissioning co-ordinated care for patients via integrated services and be responsive to patients needs.

ID Number	Action	Responsible Lead	Date due for completion	Actual completion date	RAG
IC01	**Ward 35** Serve notice to decommission current service	Mel Wright	01/04/15		
IC02	**Procurement** Go out to market to reprocure enhanced intermediate care bed provision	Mel Wright	*01/04/16*		*Not yet started*
IC03	**Better Care Fund** Work with local authority to enhance intermediate care transition arrangements Better Care Fund initiative	Mel Wright	Ongoing		
IC04	**Integrated care at locality level** Incorporate into virtual ward model with particular focus on frail and elderly with long term conditions, ensure timely discharge and support from intermediate care Better Care Fund initiative	Mel Wright	*01/04/16*		
IC05	**Step up/down** patient flow - appropriate increase in use of step up beds particularly requested by GPs - Awareness raising exercise with GPs	Mel Wright	*31/03/16*		*Not yet started*
IC06	**Stroke** Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Sharon Forrester	*31/03/16*		

South Sefton Intermediate Care - Timeline



UNPLANNED CARE

Scope and Rationale

We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.

Outcomes

- Reduced emergency admissions
- Reduced readmissions
- Reduced A&E attendances
- Reduced non-elective admissions
- Admission avoidance
- Reduction in admissions
- Increased availability of ambulances
- Increased discharges to home
- Reduced time from discharge to home
- Reduced patients in long term care
- Reduced average length of stay
- Increase number of adults making healthy lifestyle choices
- Increase people's feeling of involvement and confidence to be involved

Priority Projects/Activities

- Review of walk in centre and development of Urgent Care Centre
- Transportation review to support walk in centre model
- Acute visiting scheme
- NWAS pathfinder
- Development of bids from Community Voluntary Sector to support urgent care admissions

Contribution to Strategic Priorities

- Primary Care transformation
- Frail Elderly
- Unplanned Care

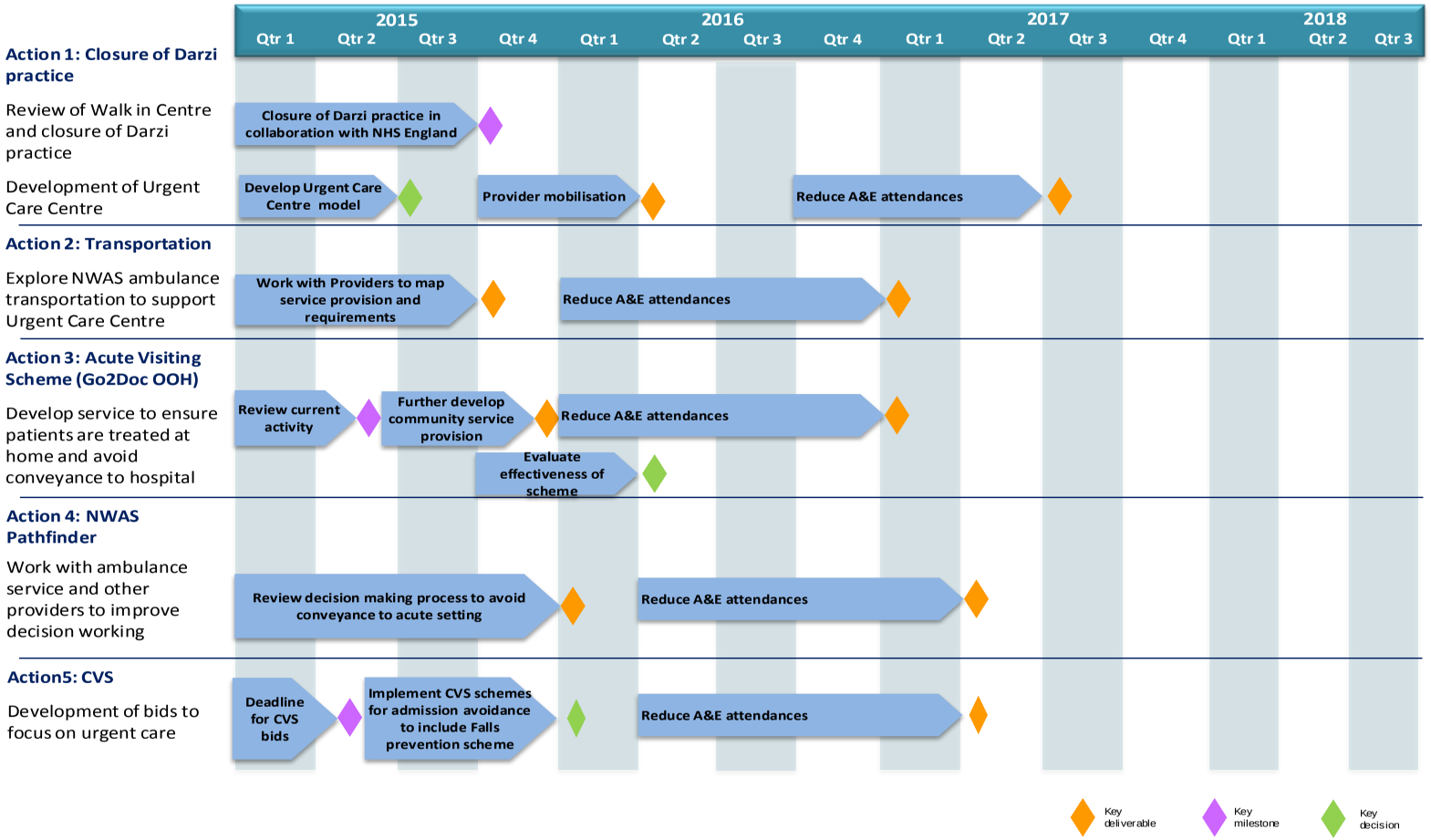
Workstream name: *Unplanned Care*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Steve Astles*	***Updated****:*

Programme Aim

We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.

ID Number	Action	Responsible Lead	Date due for completion	Actual completion date	RAG
UC01	**Closure of Darzi practice** Review of Walk in Centre and impact of closure of Darzi practice, development of an Urgent Care Centre	*Steve Astles* *Andy Mimnagh*	*Sept 15*		
UC02	**Transportation** Explore ambulance transportation requirements to support Walk in Centre as part of new model of care as an alternative to A&E	*Steve Astles* *Terry Hill*	*June 15*		
UC03	**Acute Visiting scheme** Develop service to ensure patients are treated at home and avoid conveyance to hospital	*Steve Astles*	*Mar 16*		
UC04	**NWAS pathfinder** Work with ambulance service and other providers to improve decision-making before making transfer to urgent care settings.	*Steve Astles*	*Mar 16*		
UC05	**Community Voluntary Sector (CVS) and Public Health** Development of the bids from CVS to focus on urgent care to support patients to avoid admission	*Steve Astles* *Geraldine O'Carroll*	*May 15*		

South Sefton Unplanned Care - Timeline



MENTAL HEALTH

Scope and Rationale

Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long neurological condition within community based networks of care

Outcomes

- Dementia diagnosis
  - 75% of identified population by 2015/16
  - 90% of identified population by 2018/19
- More people independently managing dementia
- Reduce Tier 4 placements
- Improve response times
- Reduce waiting times
- Early Identification
- Improve patient experience

Priority Projects/Activities

- Outcomes and Activity
  - Develop suite of measurable outcomes with Provider
- Dementia
  - development of integrated locality model
- Commission All Age Mental Health Service
  - To incorporate Child and Adolescent mental health services (CAMHS)
- Brain Injury
  - Move to new contracting arrangements following review by Cheshire and Mersey Clinical Network
- Primary and Community Care Development
  - Training analysis

Contribution to Strategic Priorities

- Frail Elderly
- Primary Care Transformation

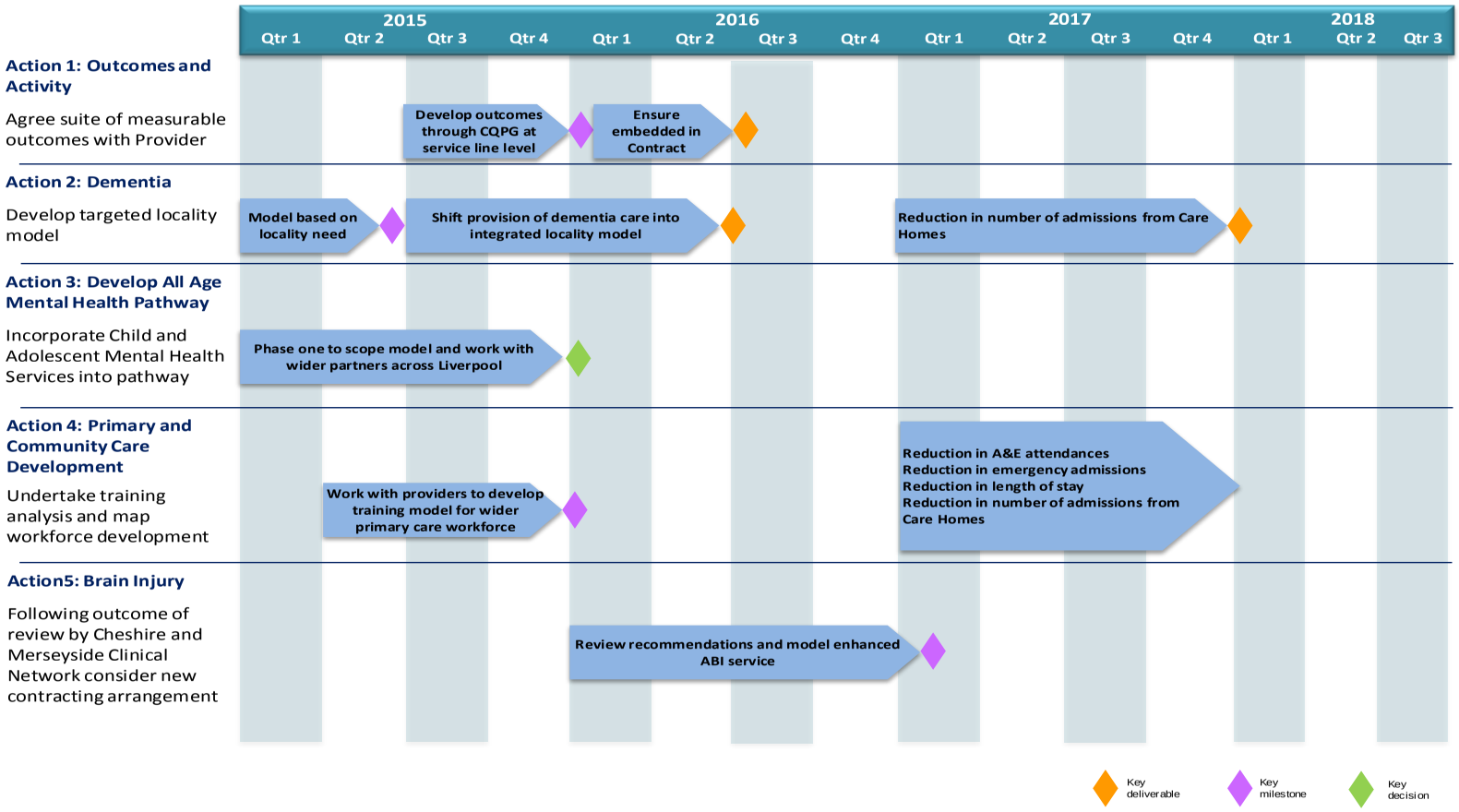
Workstream name: Mental Health	*Date: 09 Feb. 15*
Senior Manager Lead: *Geraldine O'Carroll*	***Updated****:*

Programme Aim

Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long neurological condition within community based networks of care

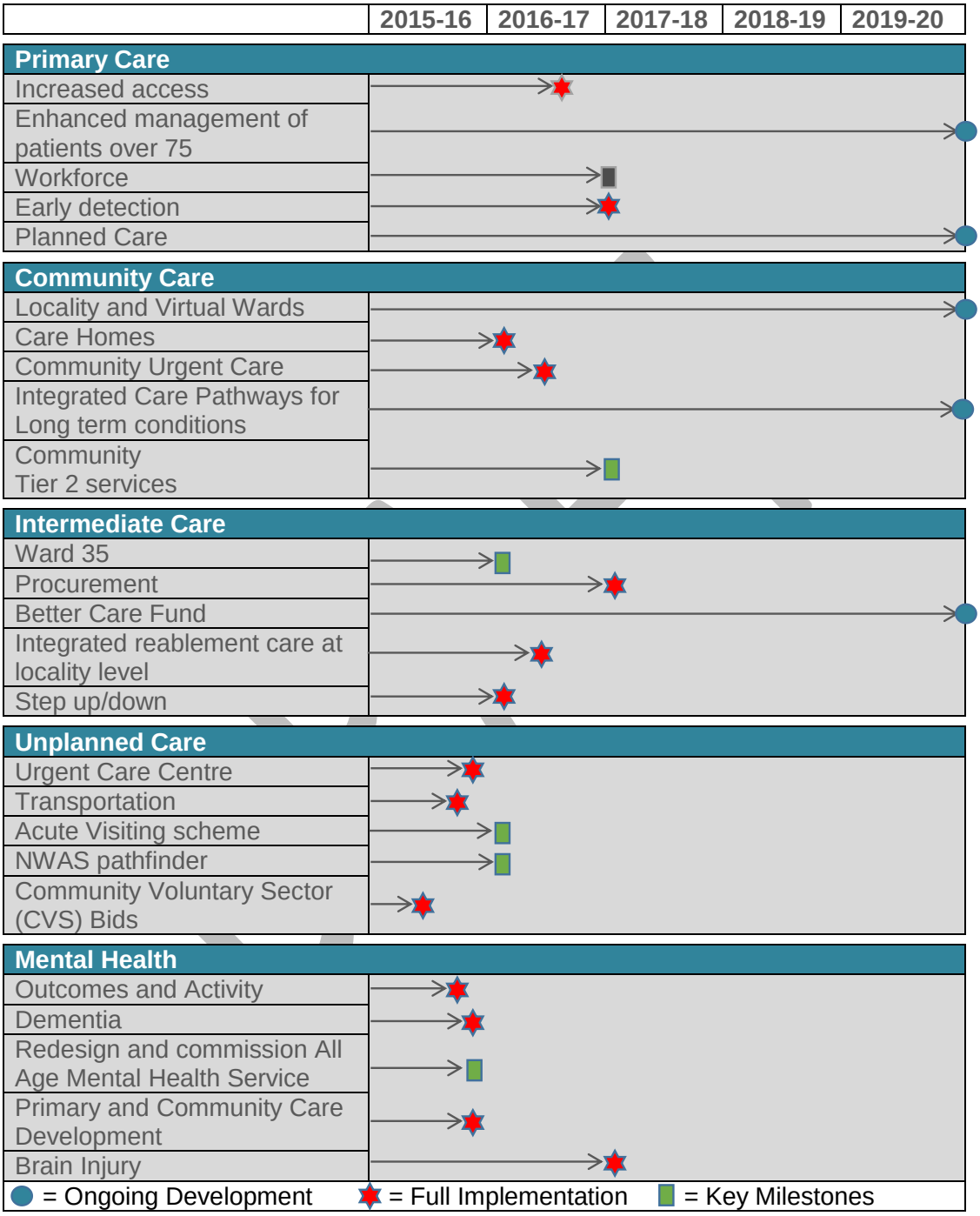
ID Number	Action	Responsible Lead	Date due for completion	Actual completion date	RAG
MH01	**Outcomes and Activity** Agree a suite of measureable outcomes with Mersey Care	*Malcolm Cunningham*	*Dec 15*		
MH02	**Dementia** Shift provision of dementia care from current provider to integrated locality model	*Kevin Thorne*	*Mar 16*		
MH03	**Redesign and commission All Age Mental Health Service** To incorporate Child and Adolescent mental health services (CAMHS)	*Gillian Bruce*	*Phase one Mar 16*		
MH04	**Primary and Community Care Development** Undertake training analysis and map workforce development	*Geraldine O'Carroll*	*Mar 16*		
MH05	**Brain Injury** Move to new contracting arrangement following review by Cheshire and Merseyside Clinical Network	*Geraldine O'Carroll Martin McDowell*	*Mar 17*		

South Sefton Mental Health - Timeline



TIMELINE

Key workstream delivery schedule for South Sefton CCG:



ACTION, DELIVERY & TIMELINES SOUTHPORT AND FORMBY CCG

PRIMARY CARE

Scope and Rationale

The aim of the Primary Care work stream is to develop a population-based approach to primary care and support them to improve access to primary care and enhance quality of service.

Outcomes

- Better patient experience
- Reduce A&E attendances
- Reduction in referrals
- Reduction in admissions
- Increased prevalence rates
- Reduction in re-admissions
- Reduced length of stay
- Reduced number of admissions from care homes
- Increased quality and provision of primary care diagnostics and monitoring

Priority Projects/Activities

- Increased access
- Enhanced management of patients over 75
- Workforce
  - Succession Planning
- Early detection:
  - CVD – increased uptake of Health Checks
  - Hypertension – recording, management and treatment
  - Atrial Fibrillation (AF) Management – improve case finding and management
- Planned Care
  - Increase use of Choose and Book utilisation

Contribution to Strategic Priorities

- Unplanned Care
- Long term conditions

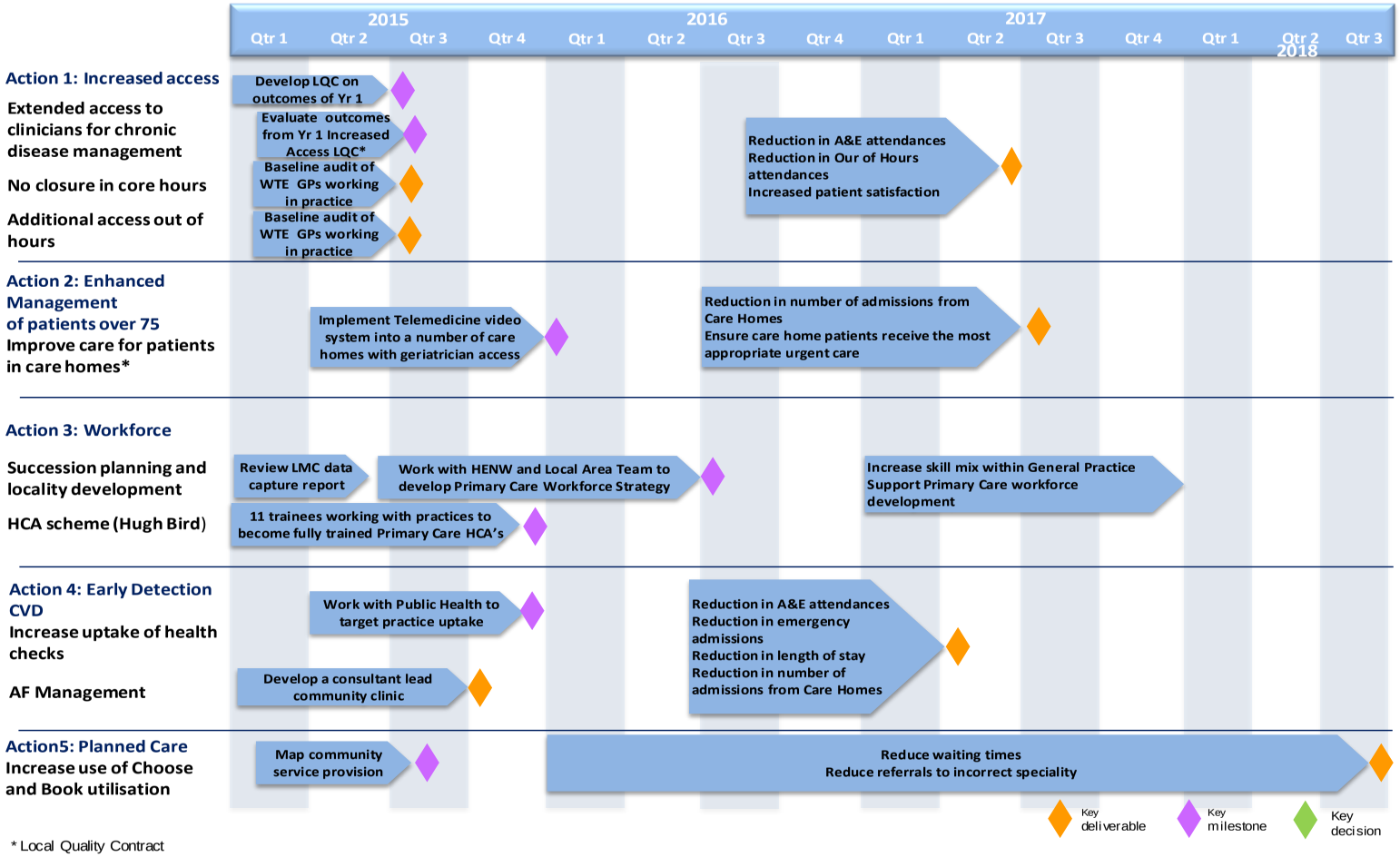
Workstream name: Primary Care	***Date:*** *09 Feb 15*
Senior Manager Lead: *Angela Parkinson*	***Updated****:*

Programme Aim

We will develop a population-based approach to primary care and support them to improve access to primary care and enhanced quality of service.

ID Number	Action	Responsible Lead	Date due for Completion	Actual completion date	RAG
PC01	**Increased access** Extended access to clinicians for chronic disease management. No closure in core hours, additional access outside of core hours. Link to quality scheme	Angela Parkinson	Aug 15		
PC02	**Enhanced management of patients over 75** Improved care for patients in care homes by offering more intensive health treatment Link to quality scheme	Moira McGuiness	Sept 15		
PC03	**Workforce** Succession planning and locality development HEE data capture LMC report	Angela Parkinson	Mar 17		
PC04	**Early detection** CVD Increased uptake of Health Checks. Hypertension – recording, management and treatment Atrial Fibrillation (AF) Management – improve case finding and management	Sharon Forrester	Mar 16		
PC05	**Planned Care** Increase use of Choose and Book utilisation for both acute and community services	Terry Hill	Sept 15		

Southport and Formby Primary Care - Timeline



* Local Quality Contract

COMMUNITY CARE

Scope and Rationale

We will commission services that better link together right across health and social care – from hospital and community and social services, to GP practices and voluntary, community and faith sector organisations – and where as much care and support as possible is delivered outside of hospital, making it easier for people to access at the times that are more convenient to them.

Outcomes

- Improved support for frail elderly
- Reduce A&E attendances
- Reduction in admissions
- Improve health outcomes
- Reduce inequalities
- Admission avoidance
- Long Term Condition support
- Discharge Support
- Increase the number people dying in their preferred place of care by 1%
- Increased use of clinical pathways

Priority Projects/Activities

- Further develop Integrated Community Services
  - Enhance skills of CERT
  - Review treatment rooms
  - Develop SPA
  - Develop Geriatrician model
- Implement developed care pathways
  - Diabetes
  - Cardiology
  - Respiratory
  - Dementia
  - End of Life
  - Frail elderly
- Review of community tier 2 services
- Reduce unplanned admissions for children with:
  - Asthma
  - Epilepsy
  - Diabetes
  - CF

Contribution to Strategic Priorities

- Unplanned Care
- Frail Elderly

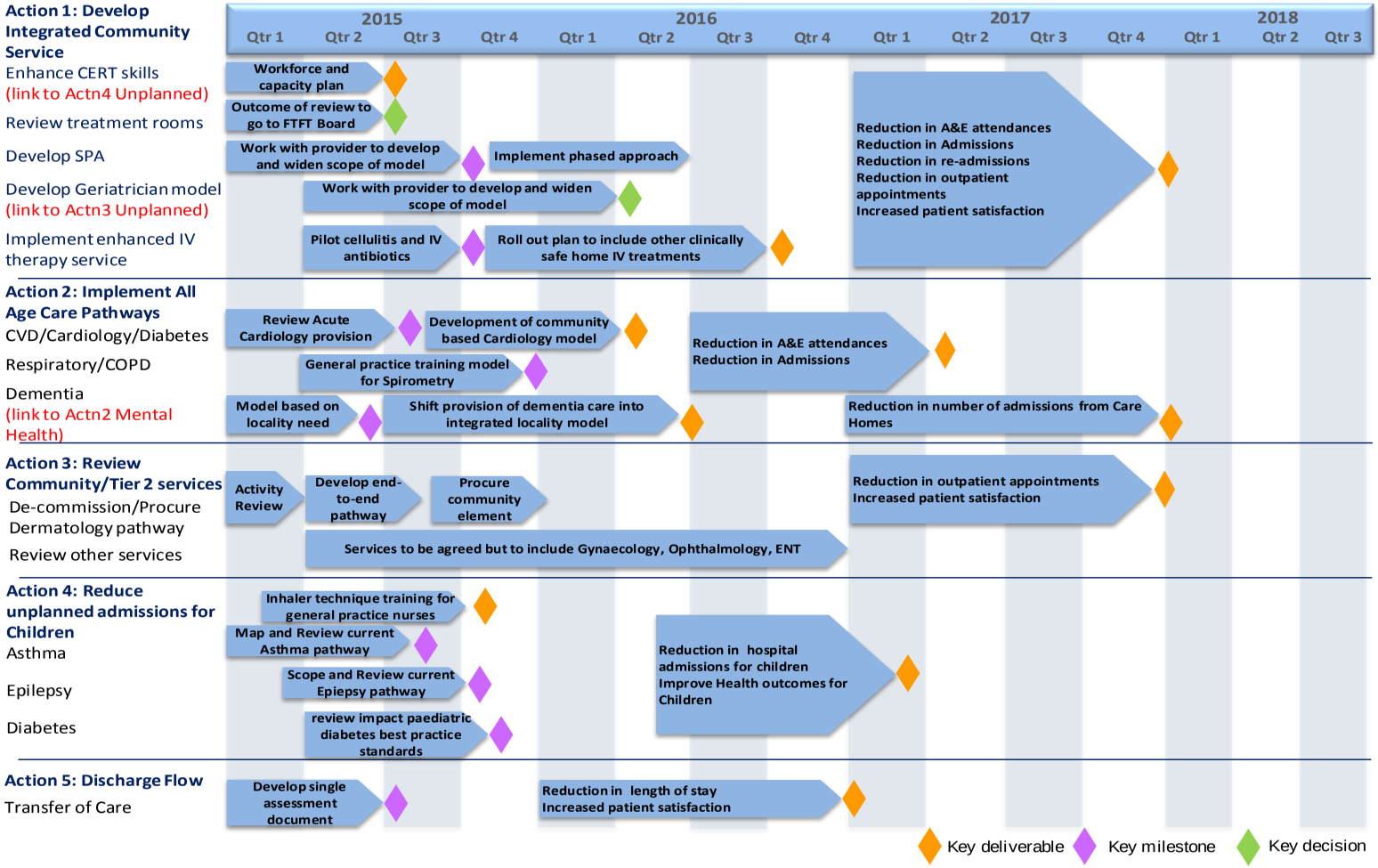
Workstream name: *Community Care*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Billie Dodd*	***Updated****:*

Programme Aim

We will commission services that better link together right across health and social care – from hospital and community and social services, to GP practices and voluntary, community and faith sector organisations – and where as much care and support as possible is delivered outside of hospital, making it easier for people to access at the times that are more convenient to them.

ID Number	Action	Responsible Lead	Date due for Completion	Actual completion date	RAG
CC01	**Develop Integrated Community Services** • Enhance skills of Community Emergency Response Team (CERT) • Review treatment rooms • Develop Single Point of Access (SPA) • Develop Geriatrician model • Implement enhanced IV therapy service	Billie Dodd	Phase one - June 15 Phase two – Apr 16		
CC02	**Implement Developed All Age Care Pathways** • CVD /Cardiology / Diabetes • Respiratory • Dementia and Frail elderly	Sharron Forrester Terry Hill Jenny Kristensen Kevin Thorne	Jan 16		
CC03	**Review of Community/Tier 2 services and activity** • De-commission • Procurement	Billie Dodd	Phase one Dermatology Apr 16		
CC04	**Children** Reduce unplanned admissions for children with: • Asthma / Epilepsy / Diabetes	Jane Uglow	Apr 16		
CC05	**Discharge flow** Transfer management of discharge from acute into community	Mel Wright	Sept 15		

Southport and Formby Community Care - Timeline



INTERMEDIATE CARE

Scope and Rationale

The Intermediate Care aim is to have ONE point of access, ONE assessment, ONE care planning process. This will be enabled by commissioning co-ordinated care for patients via integrated services and being responsive to patient's needs.

Priority Projects/Activities

- Tender Intermediate Care bed provision
- Better Care Fund
  - Integrated approach with local authority for care transition
- Integrated care at locality level to ensure timely discharge
- Increase use of appropriate use of step up / step down beds
- Stroke:
  - Development of Intermediate care beds in nursing homes

Outcomes

- More integrated, efficient and effective intermediate care
- Reduce hospital admissions
- Reduce re-admissions
- Reduce length of stay
- Ensure decisions about long term care are not made in an acute setting

Contribution to Strategic Priorities

- Frail Elderly
- Primary Care Transformation

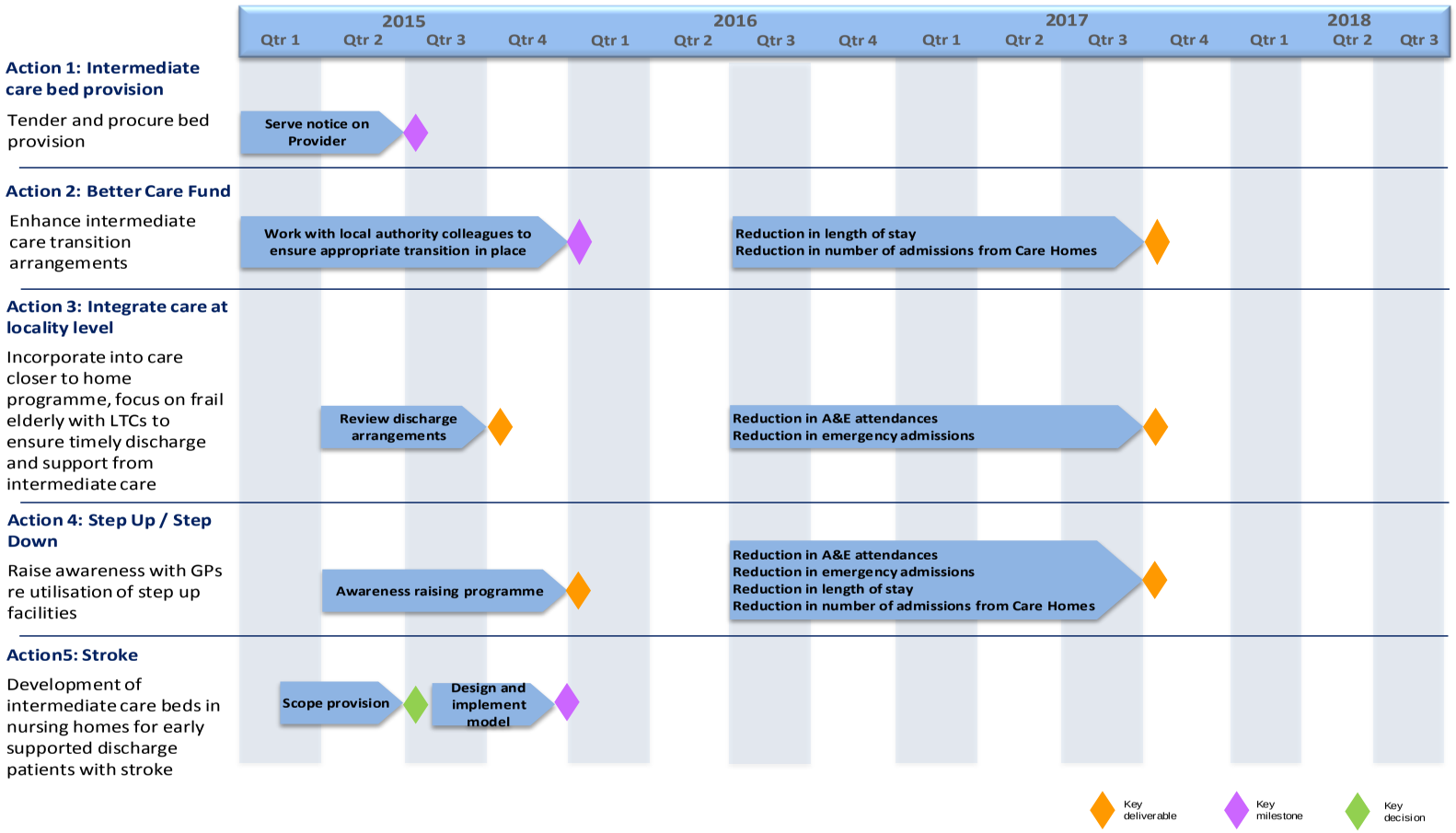
Workstream name: *Intermediate Care*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Melanie Wright*	***Updated****:*

Programme Aim

Our aim is to have ONE point of access, ONE assessment, ONE care planning process. We will do this by commissioning co-ordinated care for patients via integrated services and be responsive to patients needs.

ID Number	Action	Responsible Lead	Date due for completion	Actual completion date	RAG
IC01	**Intermediate Care Bed Provision** Tender above service	Mel Wright	01/04/16		*Not yet started*
IC02	**Better Care Fund** Work with local authority to enhance intermediate care transition arrangements Better Care Fund initiative	Mel Wright	Ongoing		
IC03	**Integrated care at locality level** Incorporate into care closer to home model with particular focus on frail and elderly with long term conditions, ensure timely discharge and support from intermediate care Better Care Fund initiative	Mel Wright	*01/04/16*		
IC04	**Step up/down** patient flow - appropriate increase in use of step up beds particularly requested by GPs - Awareness raising exercise with GPs	Mel Wright	*TBC*		*Not yet started*
IC05	**Stroke** Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Sharon Forrester	*31/03/16*		

Southport and Formby Intermediate Care - Timeline



UNPLANNED CARE

Scope and Rationale

We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.

Priority Projects/Activities

- Primary Care Engagement
- Development Ambulatory Care Sensitive Conditions pathways:
  - CVD – Heart Failure reconfiguration
  - Diabetes – In reach diabetes nurse
- Implement Rapid Access Geriatrician Service
- Review role and function of Chronic Care Co-ordinators
- Development of bids from Community Voluntary Sector

Outcomes

- Reduced emergency admissions
- Reduced readmissions
- Reduced A&E attendances
- Reduced non-elective admissions
- Increased availability of ambulances
- Increase number of adults making healthy lifestyle choices
- Increase people's feeling of involvement and confidence to be involved
- Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking)
- Reduce hospital admissions

Contribution to Strategic Priorities

- Primary Care Transformation
- Frail Elderly
- Unplanned Care

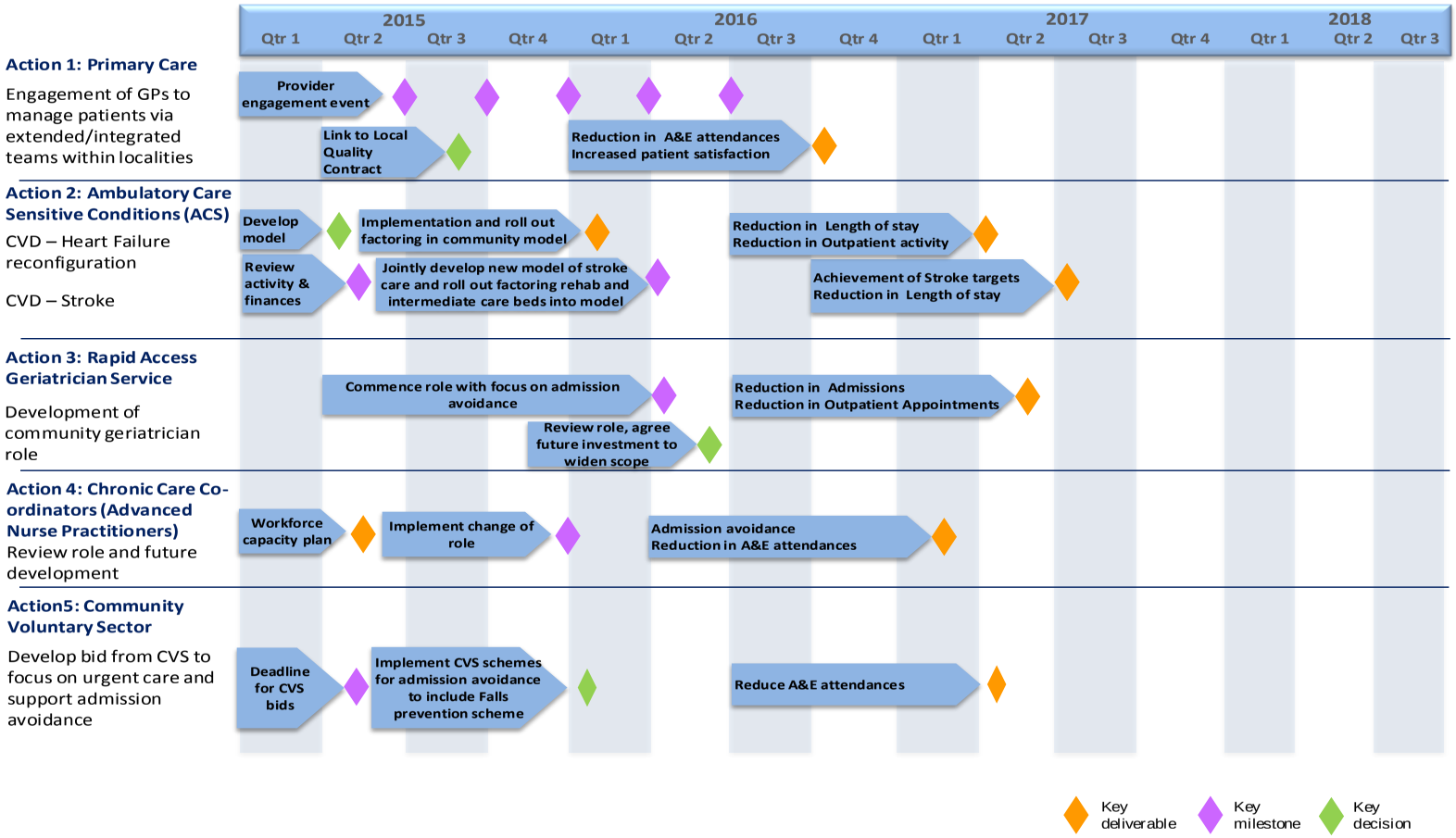
Workstream name: *Unplanned Care*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Billie Dodd*	***Updated****:*

Programme Aim

We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.

ID Number	Action	Responsible Lead	Date due for completion	Actual completion date	RAG
UC01	**Primary Care** Engagement of GPs within Primary Care to support practices to manage patients via extended/integrated primary care teams within localities	Billie Dodd Angela Parkinson	Aug 15		
UC02	**Ambulatory Care Sensitive Conditions (ACS)** CVD • Heart Failure - reconfiguration • Stroke – link with network Diabetes • In reach diabetes nurse	Sharon Forrester Terry Hill	*Jun 16*		
UC03	**Raid Access Geriatrician Service** Further development of geriatrician role to support community teams	Billie Dodd	Operational Jun 15		
UC03	**Chronic Care Co-ordinators** Review of role and future development	Billie Dodd	*Apr 16*		
UC05	**Community Voluntary Sector (CVS)** Development of the bids from CVS to focus on urgent care to support patients to avoid admission	Geraldine O'Carroll	Jun 15		

Southport and Formby Unplanned Care - Timeline



MENTAL HEALTH

Scope and Rationale

Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long neurological condition within community based networks of care.

Outcomes

- Dementia diagnosis
  - 75% of identified population by 2015/16
  - 90% of identified population by 2018/19
- More people independently managing dementia
- Reduce Tier 4 placements
- Improve response times
- Reduce waiting times
- Early Identification
- Improve patient experience

Priority Projects/Activities

- Outcomes and Activity
  - Develop suite of measurable outcomes with Provider
- Dementia
  - development of integrated locality model
- Commission All Age Mental Health Service
  - To incorporate Child and Adolescent mental health services (CAMHS)
- Brain Injury
  - Move to new contracting arrangements following review by Cheshire and Mersey Clinical Network
- Primary and Community Care Development
  - Training analysis

Contribution to Strategic Priorities

- Frail Elderly
- Primary Care Transformation

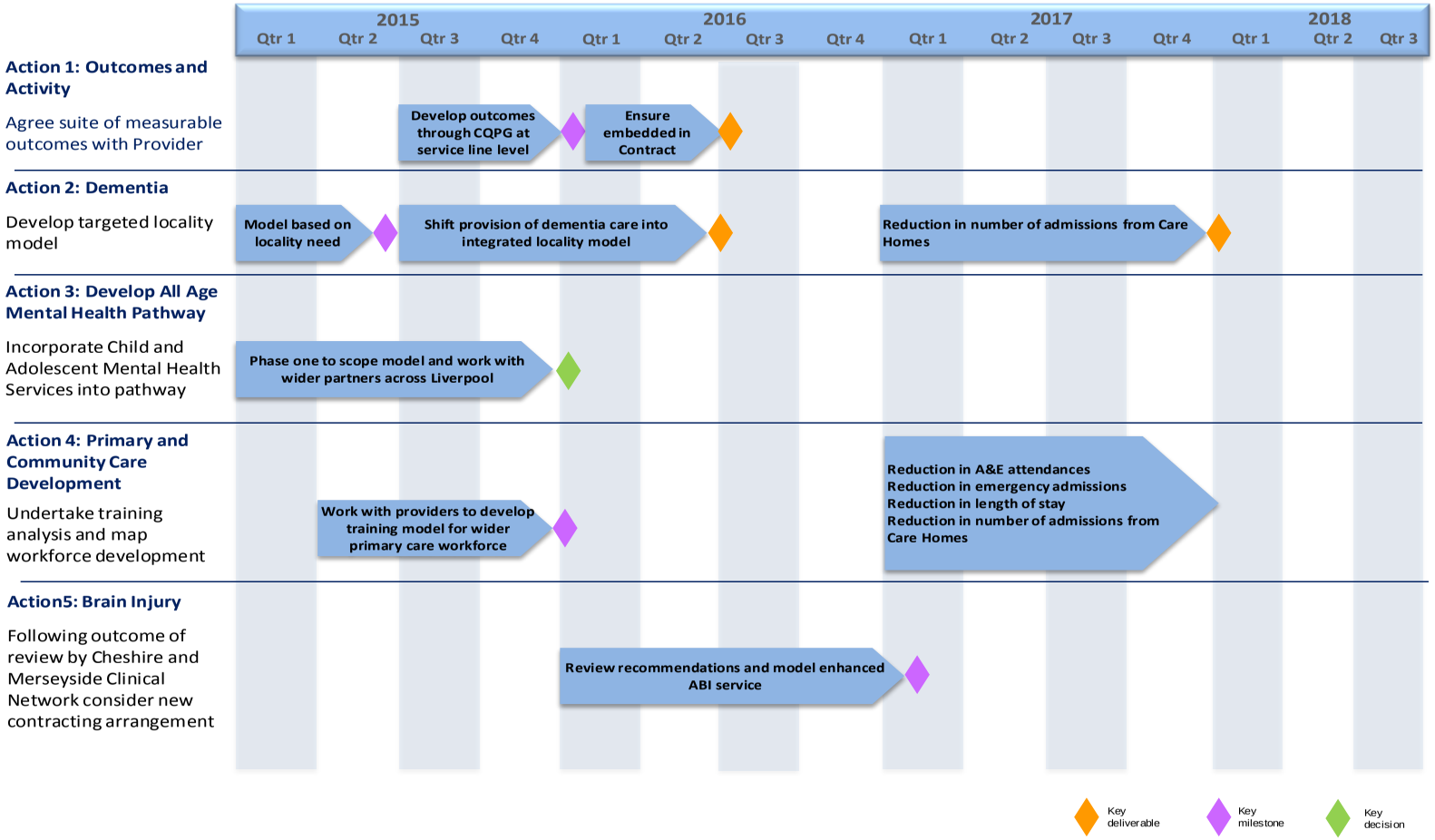
Workstream name: *Mental Health*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Geraldine O'Carroll*	***Updated****:*

Programme Aim

Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long neurological condition within community based networks of care.

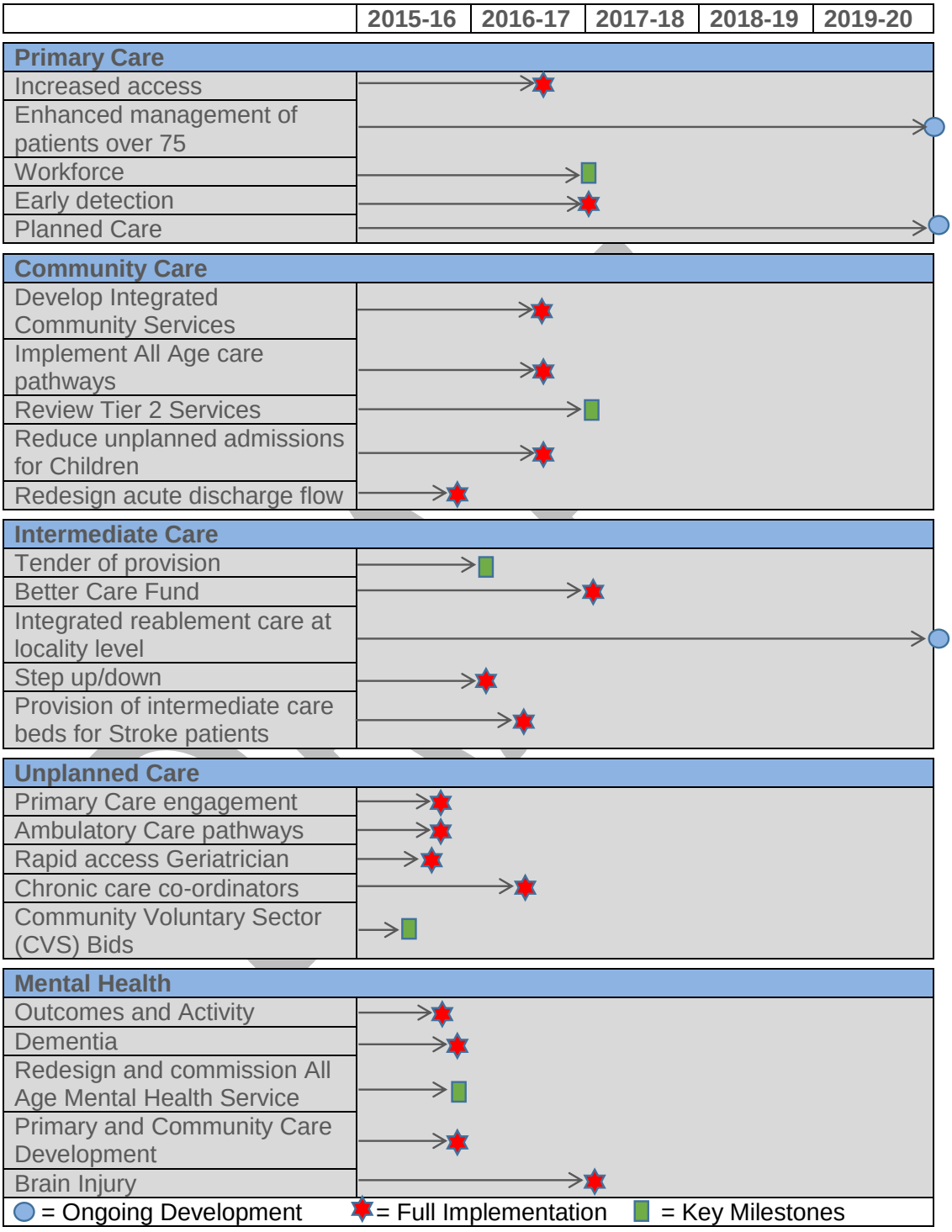
ID Number	Action	Responsible Lead	Date due for completion	Actual completion date	RAG
MH01	**Outcomes and Activity** Agree a suite of measureable outcomes with Mersey Care	*Malcolm Cunningham*	*Dec 15*		
MH02	**Dementia** Shift provision of dementia care from current provider to integrated locality model	*Kevin Thorne*	*Mar 16*		
MH03	**Redesign and commission All Age Mental Health Service** To incorporate Child and Adolescent mental health services (CAMHS)	*Gillian Bruce*	*Phase one Mar 16*		
MH04	**Primary and Community Care Development** Undertake training analysis and map workforce development	*Geraldine O'Carroll*	*Mar 16*		
MH05	**Brain Injury** Move to new contracting arrangement following review by Cheshire and Merseyside Clinical Network	*Geraldine O'Carroll Martin McDowell*	*Mar 17*		

Southport and Formby Mental Health - Timeline



TIMESCALES

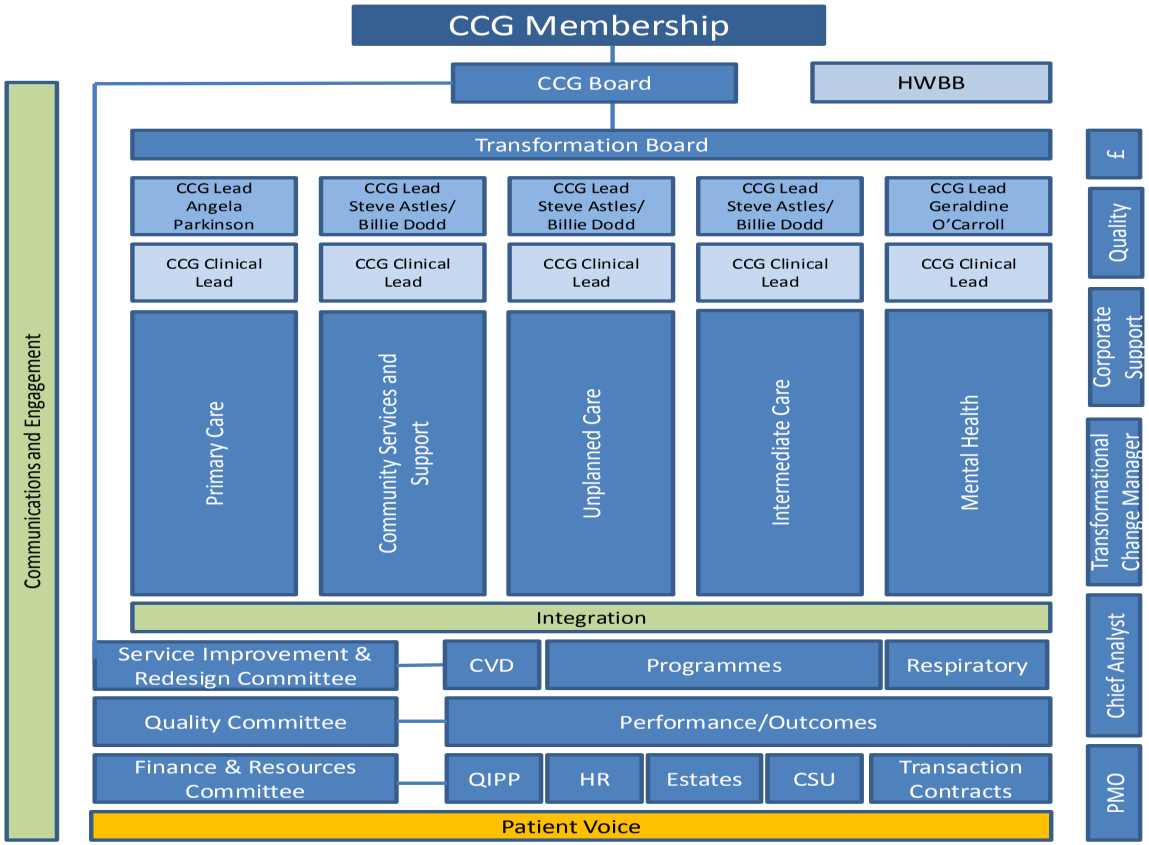
Key workstream delivery schedule for Southport and Formby CCG:

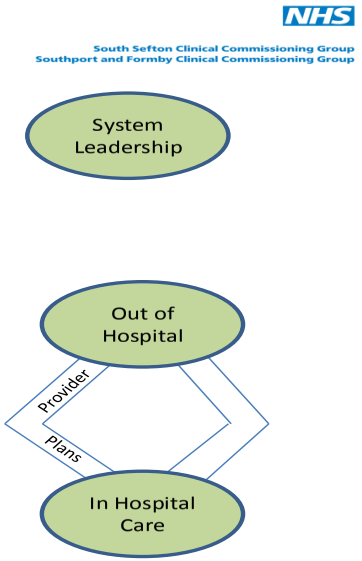


APPENDIX ONE
PROPOSED GOVERNANCE STRUCTURE

DRAFT GOVERNANCE STRUCTURE FOR DELIVERY

These transformation programmes will be managed, progressed and implemented through the individual multi agency gateway groups which will report formally into the Transformation Board.





Joint\management\transformation governance structure v5 060515.ppt

APPENDIX TWO
INITIATIVES, BENEFITS AND MEASURES
SOUTH SEFTON CCG

PRIMARY CARE

INITIATIVE	QUALITY BENEFIT	MEASURE
Increased access and patient choice	Extended access to clinicians. No closure in core hours, additional access outside of core hours.	Reduce A&E attendances
Collaboration across practices	Better patient access Care closer to home	Better patient experience
Co-commissioning – greater involvement	Co-ordination of service provision	Better patient experience
Workforce Planning and Development • Work with HEE to develop a Primary Care workforce strategy Heath Care Assistant scheme in collaboration with Hugh Bird College	Informed and empowered Workforce Succession Planning	Better patient experience Reduction in referrals Reduction in A&E attendances
Primary Care Infrastructure Fund	Potential to provide a wider range of services closer to home	Better patient experience Reduction in referrals
IT Data sharing / Interoperability	Holistic approach to patient care	Better patient experience
Early detection CVD • Increased uptake of Health Checks. • Hypertension – recording, management and treatment • Atrial Fibrillation (AF) Management – improve case finding and management	Prevention of multiple long term conditions Better patient outcomes Better management of patients with long term conditions	Reduce A&E attendances Reduction in admissions Increased prevalence rates Better patient experience
Early detection	Joint commissioning of rehabilitation facilities with Public Health and third sector Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Reduce A&E attendances Reduction in admissions Reduction in re-admissions Reduced length of stay Reduced number of admissions from care homes
Enhanced management of patients in care homes	Improved care for patients in care homes by offering more intensive health treatment	Reduced number of admissions from care homes

	Reduction in hospital acquired complications Maintain function level of patients Improve End of Life care	Reduced length of stay Reduction in Hospital acquired infections Increase the number people dying in their preferred place of care by 1%
Children • **obesity – supporting primary care and public health** • **Reducing variability within primary care by optimising medicines use**	Better Quality of Life Reduced morbidity Eradicating prescribing errors between secondary and primary care Support patients to get the best from their medicines	Reduction in referrals Reduction in admissions
Diabetes • **Prevention – Impaired Glucose Regulation (IGR)** • **Prevention – Increased awareness** • **Identify pilot areas to further develop pathways for IGR screening** • **Dashboard due to be rolled out to all practices to support practices to case find, identify and understand variation at practice level** • **Education – for both health professionals and patients**	Early intervention can prevent, delay or reverse the onset of diabetes Evidence of clinical and cost effectiveness for lifestyle interventions Offer of support every step of the way, take small steps, Provide assistance with willpower, coping strategies and practical support.	Reduction in referrals Reduction in admissions Better patient experience
Respiratory • **Primary care education programme covering Asthma and COPD all ages** • **Roll out inhaler technique across all localities** • **Review all at risk patients across all four localities**	Understand the impact the disease process regarding the quality of life of these patients and the importance of self management. Identifying the early detection of COPD. Increased self management	Reduce A&E attendances Avoid hospital admissions Better patient experience

Cancer • Cancer Research UK – two posts in Merseyside and Cheshire undertaking practice visits • Programme of screening uptake • Embedding best practice via Macmillan GPs	Increased awareness Earlier diagnosis Increased screening uptake Management of late effects of cancer and cancer treatments	Reduce A&E attendances Avoid hospital admissions Better patient experience
Planned Care • Choose and Book utilisation • Choose and Book addition of community services	Increased patient choice Reduce DNAs Increased	Reduce waiting times Reduce referrals to incorrect speciality Reduce referrals to secondary care Reduction in unplanned admissions
End of Life • Access to Community geriatrician team to support Primary Care Team in complex cases • Collaborative working with Public Health to raise awareness of 'Dying Matters' • Raise public awareness around care planning • Develop bereavement frameworks to effectively and efficiently provide bereavement support and signposting to avoid future psychological distress and morbidity • TRANSFORM Education programme	Extended access to clinicians. Care closer to home Co-ordination of service provision Holistic approach to patient care Promote public awareness of dying, death and bereavement improve the quality of end of life care	Increase the number people dying in their preferred place of care by 1% Reduction in unplanned admissions

COMMUNITY CARE SOUTH SEFTON

INITIATIVE	QUALITY BENEFIT	MEASURE
Locality and Virtual Wards • Enable direct telephone access for professionals and patients • Improve internal coordination including permanent role of dedicated virtual ward manager • Develop the community matron model • Facilitate improved integration across all disciplines through electronic and face-to-face mechanism including effective virtual ward round • Improve pro-active care program impact • Shared care planning for top 2% at risk including palliative and care home patients using standardised template • Access to all respective virtual ward staff to the common care record • Mobile working for all virtual ward staff • Electronic managed referrals into the virtual ward • Continuity and relational coordination of staff aligned to specific GP practices • Align health visitors and district nurses to practices • Streamline treatment room workflow and task shift to enable efficiency • Community Navigators (Health Trainers) in partnership with Public Health– focus on prevention and healthy living	Identification and case management of 'at risk' patients within the community Outcomes for the frail elderly and those with long-term conditions will be improved Co-ordination of care Integration of care Proactive nursing Re-ablement Common patient record and IT system	Reduction in unplanned/emergency admissions Reduction in re-admissions Reduced length of stay Better health outcomes

Care Homes • **Community matron for each locality to support care homes along with primary care** • **Promotion and support of NWAS/SSCCG care plan along with advanced care planning facilitated via care home facilitator (6 steps programme) and advanced care plan lead (new post)** • **Standardisation of care home protocols** • **Community geriatrician in-reach to care homes** • **Tele-medicine video support for care homes to community matrons, UCT, on-call geriatrician and remote nursing support** • **Quality dashboard working in conjunction with the LA** • **Ongoing support by meds management** • **Care home improvement collaborative**	Extended access to clinicians. Co-ordination of service provision Potential to provide a wider range of services closer to home Holistic approach to patient care Better patient outcomes Better management of patients with long term conditions Improved care for patients in care homes by offering more intensive health treatment Reduction in hospital acquired complications	Reduced number of admissions from care homes Reduced length of stay for care home admissions Reduction in Hospital acquired infections Increase the number people dying in their preferred place of care by 1% Reduction in A&E attendances Avoid hospital admissions Better patient experience

Community Urgent Care
• **Acute GP home visiting scheme**
• **Integration of all community urgent care providers including the following**
  ○ **NWAS pathfinder step down to UCT and GP OOH**
  ○ **Integration and assimilation of CRT and cellulitis to UCT**
  ○ **Acute trust front door community urgent care coordinator**
• **Urgent care team input into care homes directly**
• **Increase number of community based**
	Improved access to primary care
	Care closer to home
	Reduced exposure to hospital acquired infections
	Co-ordinated response to urgent care
	Patients able to live more independently
	Patients stay at home longer
	Emotional, physical and social care needs assessed together
	Common patient record and IT system
		Reduced number of admissions from care homes
		Reduced length of stay for care home admissions
		Reduction in Hospital acquired infections
		Reduction in A&E attendances
		Avoid hospital admissions
		Better patient experience

intermediate care beds • Single entry and coordination for intermediate care • Rotation of therapists through acute trust, CICT, ward 35 • Patient alert system to community matrons, specialist teams, acute trust front end coordinator • Ratified pathway development for 14 ambulatory care conditions • Mobile access to EMIS for all staff • Consolidation of SPC including scoping health and social integration		

Integrated Care Pathways for LTCs
• For the following conditions
  ○ Diabetes
  ○ Heart Failure
  ○ COPD
  ○ Palliative care
  ○ Dementia & Frailty
• Consultant community hot clinics
• Consultant oversight for specialist nursing teams
• Develop role and opportunity of GPSI
• Seamless step-up step down
	Improved access to clinician
	Care closer to home
	Reduced exposure to hospital acquired infections
	Patients able to live more independently
	Patients stay at home longer
	Holistic approach to patient care
	Better patient outcomes
	Better management of patients with long term conditions
		Reduction in admissions
		Reduction in re-admissions
		Reduced length of stay
		Improve health outcomes
		Reduce Inequalities

Diagnostic Services • Urgent bloods wait time to 24h for domiciliary, treatment room and UCT	Develop more community specialty services to streamline intervention Ensure only appropriate conditions are referred to secondary care	Reduce A&E attendances Better patient experience Care closer to home Reduce referrals
End of Life • develop a locality based structure for all staff	Extended access to clinicians.	Increase number of people

delivering palliative care • ensure that those who wish to die in the community in their PPC have the support they require • improve access to EOL beds in the community for those where it is not possible to support their needs in their own home • commission additional bed capacity for EoL patients • support and improve integration of all EOL services to ensure that patients are able to die in their PPC • support an integrated programme of education for all of those delivering EOL care in the community • ensure that all EOL care in the community is of high quality and supported by the necessary expertise regardless of where this take place ie, private home, care home	Care closer to home Co-ordination of service provision Holistic approach to patient care Improve the quality of end of life care Appropriate increase in use of step up beds Promote awareness of dying, death and bereavement	dying in usual place of residence Reduced LoS Admission avoidance Reduction in unplanned admissions Increase in reablement
Cancer • to develop the virtual ward Macmillan coordinator role (vacant) • to scope the information and support needs of patients in South Sefton and recognise existing services to develop a directory/programme for survivorship • to improve the cancer knowledge of existing staff including primary care so that patients can/may receive their long term cancer follow up in the community (see primary care)	Increase awareness of Macmillan's services Communicate campaign messages Involve local people Improve the lives of people affected by cancer across the Sefton	Admission avoidance Reduction in unplanned admissions

Respiratory • **Develop patient led self-care pilot programme** • **Review current respiratory pulmonary rehab programme and develop new programme with Public Health and SCVS** • **Commission enhanced Home Oxygen Therapy Service** • **Set- up MUR programme to train local pharmacies correct inhaler technique**	Early detection Increased self management Care closer to home	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances
CVD • **Telehealth – consultant hotline pilot** • **Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.**	Increased access to clinician Increased self management Care closer to home	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances
Diabetes • **Review of community diabetes care** • **Work with current Acute Provider to explore benefits of joint clinics for patients with diabetes and kidney injury** • **Implementation of a primary care pathway for diabetes footcare, scope and potential cost and provider implications** • **Gestational diabetes – clinical pathway out to consultation outlining support before and during pregnancy**	Early detection Increased access to clinician Increased self management Care closer to home Holistic approach Reduce morbidity	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances
Children • **Review children's community nursing team with a view to commissioning an integrated children's nursing model in 16/17** • **Reduce unplanned admissions for children with LTC: asthma, epilepsy, diabetes, CF**	Increased access to clinician Care closer to home	Admission avoidance LTC support Discharge Support Reduce A&E attendances

• Review community paediatric services • Review children's therapies • Replicate inhaler technique pilot for children • Palliative care review • End of Life review • Review complex children's nursing care		
Development of community/Tier 2 services • Ophthalmology community assessment service (OCAS) • ENT • Dermatology	Care closer to home	Reduce outpatient activity

INTERMEDIATE CARE

INITIATIVE	QUALITY BENEFIT	MEASURE
Enhanced intermediate care and reablement (BCF initiative)	Patients able to live more independently Patients stay at home longer Emotional, physical and social care needs assessed together	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting
Step up/down – patient flow (CC2H)	Appropriate increase in use of step up beds particularly requested by GPs	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting
Integrated care at locality level building on virtual ward and care closer to home (BCF initiative)	Focus on Frail and elderly with LTCs	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting

UNPLANNED CARE SOUTH SEFTON

INITIATIVE	QUALITY BENEFIT	MEASURE
Acute Visiting Scheme	Support for care home patients More patients being treated at home rather than being conveyed to hospital	Reduction in unnecessary attendances to hospital
Ambulatory Care Sensitive (ACS) Conditions • **CVD Heart failure – reconfiguration of acute heart failure team to work alongside consultant in AED** • **Respiratory – in reach of Community team**	Development of zero-stay ambulatory care condition pathways This would offer appropriate fast track diagnosis and treatment in an assessment area and discharge to the community to prevent admission Consultant reviews Initiation of treatment	Admission avoidance Reduction in admissions Admission avoidance Reduction in admissions
NWAS pathfinder acute visiting scheme	Ambulance service and other providers working together to improve decision-making before making transfers to urgent care settings More patients being treated at home/in the community rather than being conveyed to hospital	Increased availability of ambulances Reduce A&E attendances Reduce emergency admissions
Explore ambulance transportation requirements to support Walk in Centre as part of new model of care as an alternative to A&E	Reducing conveyance to A&E Referring to Primary Care/OOH if required	Reduction in non-elective activity
Integrated Discharge Team	Better patient and carer experience Reduction in hospital acquired complications Prompt and pro-active identification of end of life care	Increased discharges to home Reduced time from discharge to home Reduced patients in long term care Reduced length of stay
111 programme implementation	Provide advice for patients and appropriate use of services	Reduce A&E attendances

Review of Walk in Centre and impact of closure of Darzi practice – development of Urgent Care Centre	More patients being treated in the community rather A&E	Reduce A&E attendances
Self care/management • **easily accessible support for the self management of conditions delivered as part of the virtual ward and health and wellbeing board via the better care fund** • **Patient education**	Disease prevention Minor illness Improved signposting Targeted education Tailored self-care plan Assistive Technologies	Increase number of adults making healthy lifestyle choices Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Development of the Community Voluntary Sector (CVS) - Bids from CVS to focus on urgent care to support patients to avoid admission	Ensure services are used appropriately and community Engagement and commissioning	
Proactive case management	To support self-care and early disease management	Increase number of adults making healthy lifestyle choices Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Proactive case finding	To support self-care and early disease management	Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of

		unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Additional Community Geriatricians	To support the Community teams	Reduction in unplanned admissions Reduced Length of Stay
Cancer **Develop acute oncology to include outpatient clinic access for cancer of unknown primary 2/52 clinic, side effects of treatment**	Better patient and carer experience To support early diagnosis	Reduction in unplanned admissions Reduced Length of Stay

MENTAL HEALTH

INITIATIVE	QUALITY BENEFIT	MEASURE
Primary Care development and education	Raise awareness and understanding	Patient satisfaction Survey
Dementia	Holistic care for patient Improved screening Services wrapped around patient Access to voluntary services Develop service to meet patient need Extend memory services Enhance Alzheimer's Society Support Review use of anti psychotic drugs for Dementia	75% of identified population by 2015/16 90% of identified population by 2018/19
Child and Adolescent Mental Health Services (CAMHS)	Improve access and understanding of CAMHS services Ensure seamless transiton Increased patient experience	Reduce Tier 4 placements Improve response times
Brain Injury	Co-ordinated care for patient	Better patient experience
Outcomes and Activity Information	Introduction of Payment by Results (PbR) is a major organisational change for both providers and commissioners Financial modelling and profiling of risk to be undertaken	To be agreed with Mersey Care NHS Trust
Children • Review ADHD and ASD pathways • Develop Children's IAPT service	Improve access to services Increased patient experience	Reduce waiting times Early Identification Better patient experience
Cancer • Psychological support via Aintree cancer pathway		Better patient experience

APPENDIX TWO
INITIATIVES, BENEFITS AND MEASURES
SOUTHPORT CCG

PRIMARY CARE		
INITIATIVE	**QUALITY BENEFIT**	**MEASURE**
Collaboration across practices	Better patient access Care closer to home	Better patient experience
Co-commissioning – greater involvement	Co-ordination of service provision	Better patient experience
Workforce Planning and Development **Heath Care Assistant scheme in collaboration with Hugh Bird College**	In collaboration with NHS England/HENW Succession Planning	
Primary Care Infrastructure Fund	Potential to provide a wider range of services closer to home	Better patient experience Reduction in referrals
IT Data sharing / Interoperability	Holistic approach to patient care	Better patient experience
Increased access and patient choice	Extended access to clinicians. No closure in core hours, additional access outside of core hours.	Reduce A&E attendances
Early detection CVD • **Increased uptake of Health Checks.** • **Hypertension – recording, management and treatment** • **Atrial Fibrillation (AF) Management – improve case finding and management** • **Community cardiology services – review acute cardiology provision**	Prevention of multiple long term conditions Better patient outcomes Better management of patients with long term conditions Rapid access to diagnostics	Reduce A&E attendances Reduction in admissions Increased prevalence rates Better patient experience Reduced LoS
Early detection	Joint commissioning of rehabilitation facilities with Public Health and third sector Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Reduce A&E attendances Reduction in admissions Reduction in re-admissions Reduced length of stay Reduced number of admissions from care homes
Enhanced management of patients in care homes	Improved care for patients in care homes by offering more intensive health treatment	Reduced number of admissions from care homes

	Reduction in hospital acquired complications Maintain function level of patients Improve End of Life care	Reduced length of stay for care home admissions Reduction in Hospital acquired infections Increase the number people dying in their preferred place of care by 1%
End of Life • **Access to Community geriatrician team to support Primary Care Team in complex cases** • **Collaborative working with Public Health to raise awareness of 'Dying Matters'** • **Raise public awareness around care planning** • **Develop bereavement frameworks to effectively and efficiently provide bereavement support and signposting to avoid future psychological distress and morbidity** • **TRANSFORM Education programme**	Extended access to clinicians. Care closer to home Co-ordination of service provision Holistic approach to patient care Promote public awareness of dying, death and bereavement improve the quality of end of life care	Increase the number people dying in their preferred place of care by 1% Reduction in unplanned admissions
Children • **obesity – supporting primary care and public health**	Better Quality of Life Reduced morbidity	Reduction in referrals Reduction in admissions
Diabetes • **Prevention – Impaired Glucose Regulation (IGR)** • **Prevention – Increased awareness** • **Identify pilot areas to further develop pathways for IGR screening**	Early intervention can prevent, delay or reverse the onset of diabetes Evidence of clinical and cost effectiveness for lifestyle interventions Provide assistance with willpower, coping strategies and practical support.	Reduction in referrals Reduction in admissions Better patient experience

Cancer • Cancer Research UK – two posts in Merseyside and Cheshire undertaking practice visits • Programme of screening uptake • Embedding best practice via Macmillan GPs	Increased awareness Earlier diagnosis Increased screening uptake Management of late effects of cancer and cancer treatments	Reduce A&E attendances Avoid hospital admissions Better patient experience
Respiratory • Primary care education programme covering Asthma and COPD all ages • Roll out inhaler technique across all localities	Understand the impact the disease process regarding the quality of life of these patients and the importance of self management. Identifying the early detection of COPD. Increased self management	Reduce A&E attendances Avoid hospital admissions Better patient experience
Planned Care • Choose and Book utilisation • Choose and Book addition of community services • Choice	Increased patient choice Reduce DNAs Increased	Reduce waiting times Reduce referrals to incorrect speciality Reduce referrals to secondary care Reduction in unplanned admissions

COMMUNITY CARE		
New pathways of care introduced (CC2H)	For diabetes, cardiology, respiratory, dementia, End of Life, Frail Elderly fully in place by April 2015	Reduce A&E attendances Reduction in admissions Improve health outcomes Reduce inequalities
End of Life • Commission TRANSFORM hospice based community team • Equitable and speedy access to EoL beds • Ensure that services are developed which provide holistic care regardless of the need. (eg dementia, LTC, cancer, frail elderly) • Access to a full compliment of staff within the community to prevent hospital admission • Seamless 24/7 access to care • Full integration of provider services • Audit of quality of Gold Standards Framework (GSF) registers • All care homes to complete Six Steps to Success programme or GSF care homes • All people identified as being EoL will be registered on GSF register, regardless of diagnosis or capacity • Mobile working for all community and SPCS staff • OOH – integration and improved handover processes of DN night service to OOH services and day DN services • Sharing of relevant information, including	Extended access to clinicians. Care closer to home Co-ordination of service provision Holistic approach to patient care Improve the quality of end of life care Appropriate increase in use of step up beds Promote awareness of dying, death and bereavement	Increase number of people dying in usual place of residence Reduced LoS Admission avoidance Reduction in unplanned admissions Increase in reablement

care plans • Evaluate care home provision with a view to supporting equitable and sustainable EoL care across care homes		
Community Emergency Response Team	Improved access to primary care Care closer to home Reduced exposure to hospital acquired infections Co-ordinated response to urgent care Patients able to live more independently Patients stay at home longer Emotional, physical and social care needs assessed together Common patient record and IT system	Reduced number of admissions from care homes Reduced length of stay for care home admissions Reduction in Hospital acquired infections Reduction in A&E attendances Avoid hospital admissions Better patient experience
Children • Evaluate children's community nursing team • Reduce unplanned admissions for children with LTC: asthma, epilepsy, diabetes, CF • Review community paediatric services • Review children's therapies • Replicate inhaler technique pilot for children • Palliative care review • End of Life review • Review complex children's nursing care • Develop community audiology service	Increased access to clinician Care closer to home	Admission avoidance LTC support Discharge Support Reduce A&E attendances
Diabetes • Review of community diabetes care • Implement generic agreed pathways in collaboration with West Lancashire CCG • Implementation of a primary care pathway for diabetes footcare, scope and potential cost	Early detection Increased access to clinician Increased self management Care closer to home Holistic approach	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances

and provider implications • Gestational diabetes – clinical pathway out to consultation outlining support before and during pregnancy	Reduce morbidity	
CVD • Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Increased access to clinician Increased self management Care closer to home	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances
Cancer • Support community based Macmillan centre providing: ○ info and support ○ Survivorship ○ In-reach into Southport & Ormskirk Hospital ○ Wellness and Activity co-ordinator • Potential for new community recovery and support pathways for breast patients following service changes at Southport and Ormskirk Acute Trust	Increase awareness of Macmillan's services Communicate campaign messages Involve local people Improve the lives of people affected by cancer across the Sefton	Admission avoidance Reduction in unplanned admissions
Respiratory • Develop patient led self-care pilot programme • Review current respiratory pulmonary rehab programme and develop new programme with Public Health and SCVS • Commission enhanced Home Oxygen Therapy Service	Early detection Increased self management Care closer to home	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances

INTERMEDIATE CARE		
Enhanced intermediate care and reablement (BCF initiative)	Patients able to live more independently Patients stay at home longer Emotional, physical and social care needs assessed together	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting
Step up/down – patient flow (CC2H)	Appropriate increase in use of step up beds particularly requested by GPs	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting
Integrated care at locality level building on virtual ward and care closer to home (BCF initiative)	Focus on Frail and elderly with LTCs	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting

UNPLANNED CARE		
End of Life • Speedy diagnostic and access to treatment to negate the need for transfer to a secondary care setting • Acute hospital to attain GSF accreditation and undertake national TRANSFORM programme • Appropriate and timely discharge	Care closer to home Improve the quality of end of life care Promote awareness of dying, death and bereavement	Reduce A&E attendances Reduce LoS Admission avoidance
Ambulatory Care Sensitive (ACS) Conditions **CVD** • Heart failure – possible reconfiguration of acute heart failure team to work alongside consultant in AED based on Aintree model • Stroke – link with Cheshire and Merseyside networks to explore the possibility of 3 hyper Acute Stroke Units across Cheshire and Merseyside to address and improve inconsistences of the quality of care **Diabetes** • In-reach diabetes nurse to identify and appropriately discharge in-patients with diabetes who no longer need to be in a hospital setting	This would offer appropriate fast track diagnosis and treatment in an assessment area and discharge to the community to prevent admission Access to Consultant reviews Timely initiation of treatment	Reduction in admissions Admission avoidance Reduce LoS Better patient experience
Cancer Develop acute oncology to include outpatient clinic access for cancer of unknown primary 2/52 clinic, side effects of treatment	Better patient and carer experience To support early diagnosis	Reduction in unplanned admissions Reduced LoS

NWAS CERT pathfinder	Ambulance service and other providers working together to improve decision-making before making transfers to urgent care settings More patients being treated at home/in the community rather than being conveyed to hospital	Increased availability of ambulances Reduce A&E attendances Reduce emergency admissions
Self care/management • **easily accessible support for the self management of conditions delivered as part of the virtual ward and health and wellbeing board via the better care fund** • **Patient education**	Patients will: • have knowledge of the condition and/or its management • adopt a self-management care plan agreed and negotiated in partnership with health professionals, significant others and/or carers and other supporters • actively share in decision-making with health professionals, significant others and/or carers and other supporters • monitor and manage signs and symptoms of the condition • manage the impact of the condition on physical, emotional, occupational and social functioning • adopt lifestyles that address risk factors and promote health by focusing on prevention and early intervention • have access to, and confidence in the ability to use support services	Increase number of adults making healthy lifestyle choices Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Development of the Community Voluntary Sector (CVS) - Bids from CVS to focus on urgent care to support patients to avoid admission	Ensure services are used appropriately and community Engagement and commissioning	Reduce A&E attendances Better patient experience

111 Programme implementation	Provide advice for patients and appropriate use of services	Reduced attendance in A&E
Proactive case management	To support self-care and early disease management	Increase number of adults making healthy lifestyle choices Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Proactive case finding	To support self-care and early disease management	Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Community Geriatrician	To support the Community teams	Reduction in unplanned admissions Reduced LoS

MENTAL HEALTH		
Primary Care development and education	Raise awareness and understanding	Patient satisfaction Survey
Dementia	Holistic care for patient Improved screening Services wrapped around patient Access to voluntary services Develop service to meet patient need Extend memory services Enhance Alzheimer's Society Support Review use of anti psychotic drugs for Dementia	75% of identified population by 2015/16 90% of identified population by 2018/19
Child and Adolescent Mental Health Services (CAMHS)	Improve access and understanding of CAMHS services Ensure seamless transiton Increased patient experience	Reduce Tier 4 placements Improve response times
Brain Injury	Co-ordinated care for patient	Better patient experience
Outcomes and Activity Information	Introduction of Payment by Results (PbR) is a major organisational change for both providers and commissioners Financial modelling and profiling of risk to be undertaken	To be agreed with Mersey Care NHS Trust
Children • **Review ADHD and ASD pathways** • **Develop Children's IAPT service**	Improve access to services Increased patient experience	Reduce waiting times Early Identification Better patient experience
Cancer • **Psychological support via Aintree cancer pathway**		Better patient experience

APPENDIX THREE
LOCALITY PLANS

South Sefton CCG
Transformation Programmes
Governance and Reporting Structure

Management and External Scrutiny

The programme structure addresses The three priorities to:

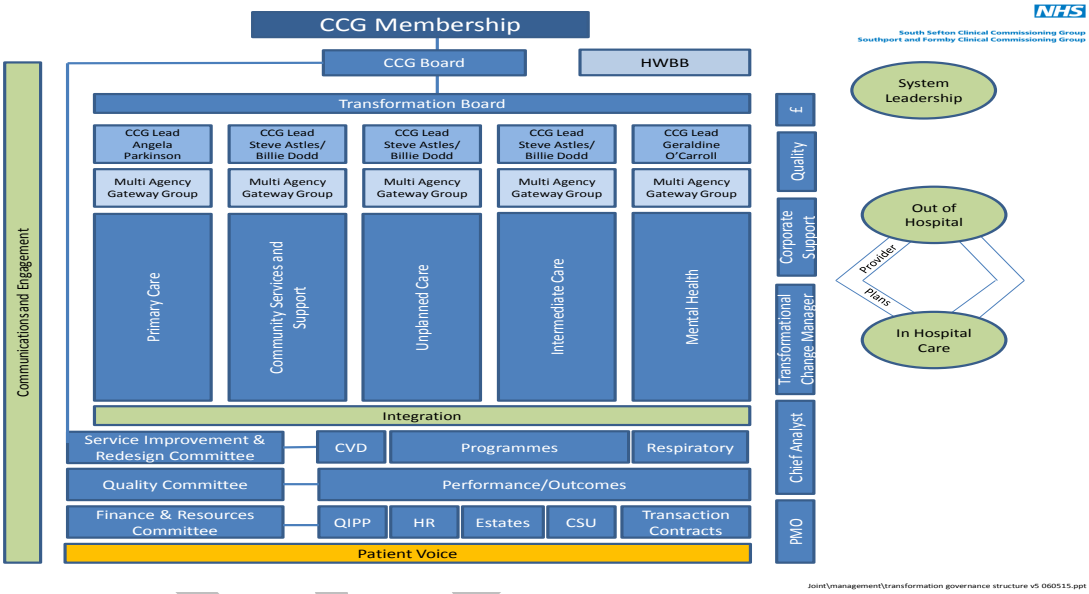
- Care for our older and Vulnerable residents
- Unplanned Care
- Develop and support Primary Care

Executive Management Team
Meets monthly and receives an overview report of activity, including any activity that requires authorisation

→ **Health and Wellbeing Board**

→ **Governing Body**

Governance



Blue-print Area

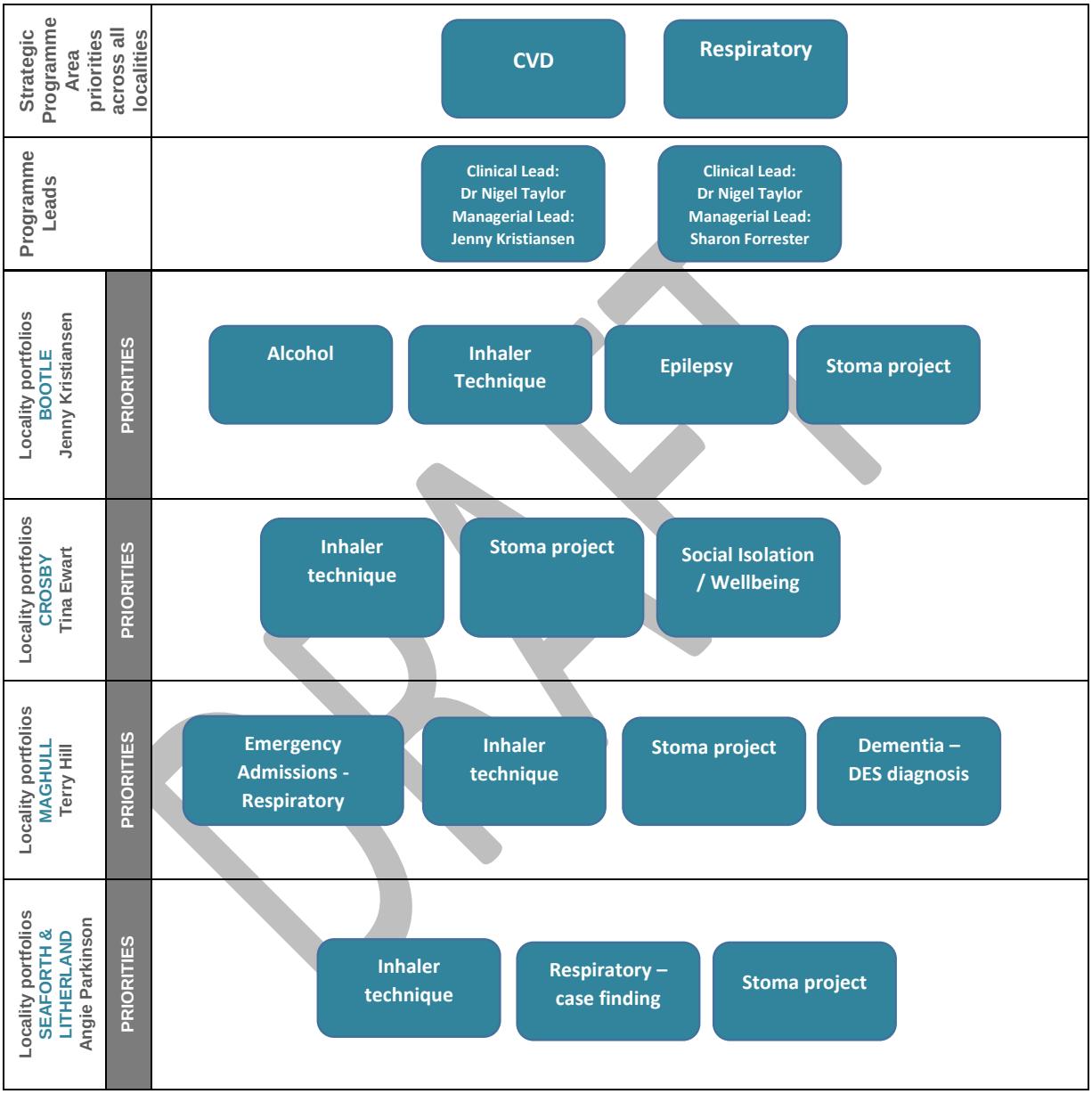
Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health

Blueprint Leads

Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health
Clinical Lead: Dr Craig Gillespie Managerial Lead: Angela Parkinson	Clinical Leads: Dr Ricky Sinha (Transactional) Dr Paul Thomas (Transformational) Managerial Lead:	Clinical Lead: Dr Daniel McDowell Managerial Lead: Melanie Wright	Clinical Lead: Dr Andy Mimnagh Managerial Lead: Steve Astles	Clinical Lead: Dr Sue Gough Managerial Lead: Geraldine O'Carrol

Blueprint top 5 priorities across all localities

Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health
Increased Access	Locality and virtual wards	Better Care Fund	Develop Urgent Care Centre	Dementia locality model
Enhanced Mngt of ptns over 75	Care Homes	Single entry co-ordination	Transportation review for WIC	Ageless service to include CAMHS
Workforce Succession Planning	Community urgent care team	Integrated care at locality level	Acute visiting Scheme	Primary and community training
Early detection	Integrated care pathways LTCs	Increased use of Step Up/Step down	NWAS pathfinder	Develop outcomes & activity dataset
Choose and Book utilisation	Review community tier 2 services	Stroke beds development	CVS bids	Brain Injury pathway


Strategic Programme Area priorities across all localities
CVD
Respiratory
Programme Leads
Clinical Lead: Dr Nigel Taylor Managerial Lead: Jenny Kristiansen
Clinical Lead: Dr Nigel Taylor Managerial Lead: Sharon Forrester
Locality portfolios BOOTLE Jenny Kristiansen
PRIORITIES
Alcohol
Inhaler Technique
Epilepsy
Stoma project
Locality portfolios CROSBY Tina Ewart
PRIORITIES
Inhaler technique
Stoma project
Social Isolation / Wellbeing
Locality portfolios MAGHULL Terry Hill
PRIORITIES
Emergency Admissions - Respiratory
Inhaler technique
Stoma project
Dementia – DES diagnosis
Locality portfolios SEAFORTH & LITHERLAND Angie Parkinson
PRIORITIES
Inhaler technique
Respiratory – case finding
Stoma project

Southport and Formby CCG
Transformation Programmes
Governance and Reporting Structure

Management and External Scrutiny

The programme structure addresses the three priorities to:

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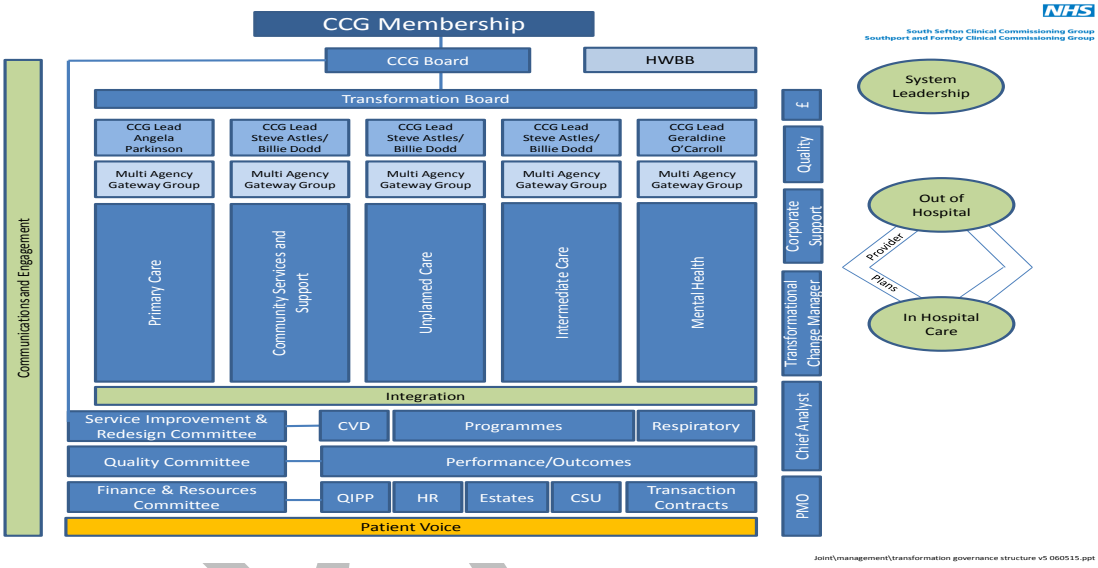
Governance



Blue-print Area

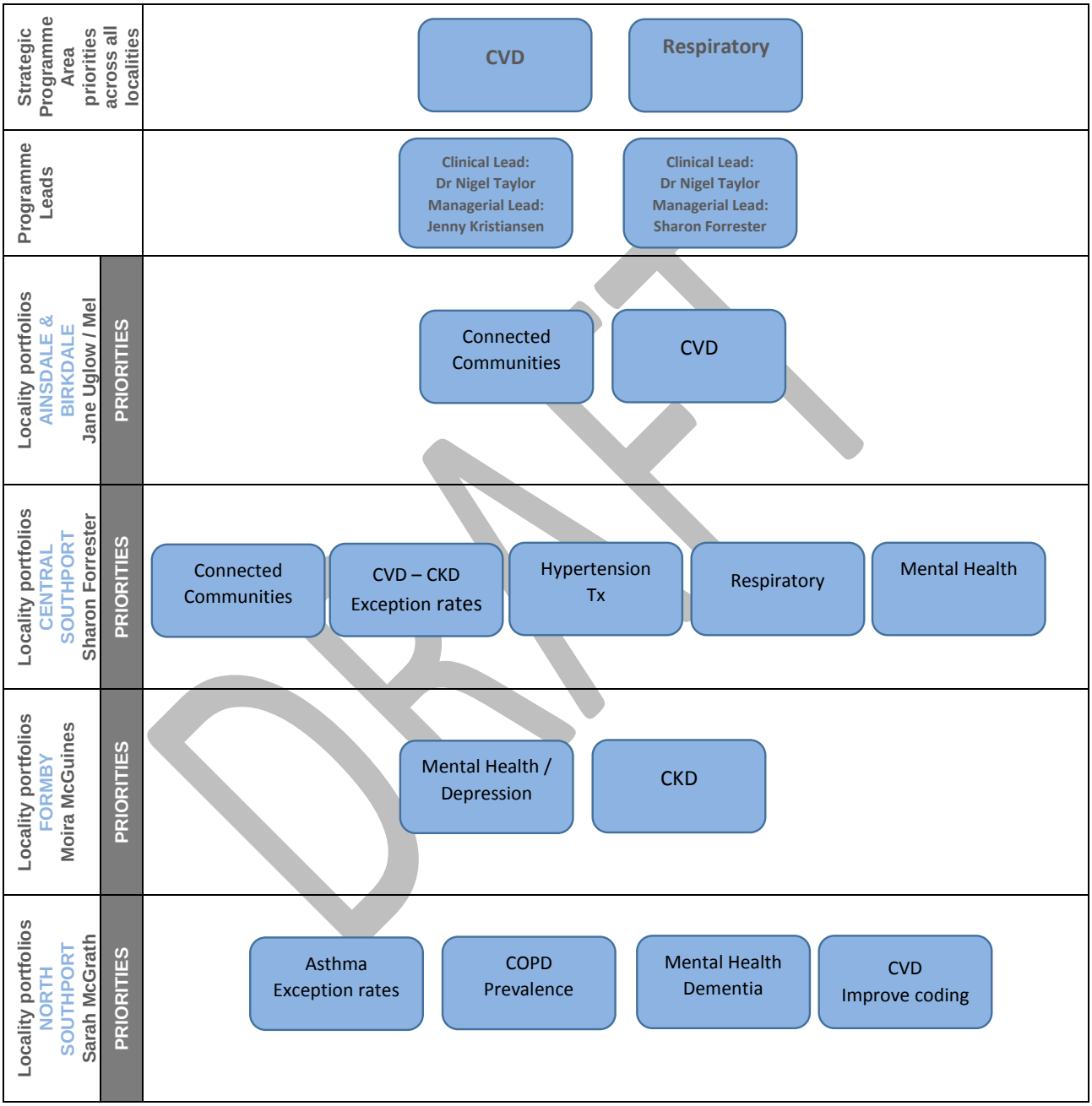
Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health

Blueprint Leads

Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health
Clinical Lead: Dr Niall Leonard Managerial Lead: Angela Parkinson	Clinical Lead: Dr Rob Caudwell Managerial Lead: Billie Dodd	Clinical Lead: TBC Managerial Lead: Melanie Wright	Clinical Lead: Dr Martin Evans Managerial Lead: Billie Dodd	Clinical Lead: Dr Hilal Mulla Managerial Lead: Geraldine O'Carrol

Blueprint top 5 priorities across all localities

Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health
Increased Access	Integrated Community Services	Better Care Fund	Primary Care Engagement	Dementia locality model
Enhanced Mngt of ptns over 75	Care Homes	Tender of Intermediate care	Transportation review for WIC	Ageless service to include CAMHS
Workforce Succession Planning	Community urgent care team	Integrated care at locality level	Acute visiting Scheme	Primary and community training
Early detection	Integrated care pathways LTCs	Increased use of Step Up/Step down	NWAS pathfinder	Develop outcomes & activity dataset
Choose and Book utilisation	Review community tier 2 services	Stroke beds development	CVS bids	Brain Injury pathway


Strategic Programme Area priorities across all localities
CVD
Respiratory
Programme Leads
Clinical Lead: Dr Nigel Taylor Managerial Lead: Jenny Kristiansen
Clinical Lead: Dr Nigel Taylor Managerial Lead: Sharon Forrester
Locality portfolios AINSDALE & BIRKDALE Jane Uglow / Mel
PRIORITIES
Connected Communities
CVD
Locality portfolios CENTRAL SOUTHPORT Sharon Forrester
PRIORITIES
Connected Communities
CVD – CKD Exception rates
Hypertension Tx
Respiratory
Mental Health
Locality portfolios FORMBY Moira McGuines
PRIORITIES
Mental Health / Depression
CKD
Locality portfolios NORTH SOUTHPORT Sarah McGrath
PRIORITIES
Asthma Exception rates
COPD Prevalence
Mental Health Dementia
CVD Improve coding

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2015

Agenda Item: 15/97	**Author of the Paper:** Fiona Clark Chief Officer Email: fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: May 2015	

Title: Shaping Sefton Update

Summary/Key Issues:

This paper presents the Governing Body with an update on Shaping Sefton.

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
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.
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

Shaping Sefton - Start Well, Stay Well & Age Well
May 2015

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

1. Introduction

The need for better integrated joined-up working across health and social care is now seen as unequivocal.

The mechanisms for achieving this have focussed on the provision and latterly, on the commissioning of the care as the means to successful delivery.

Since their inception in April 2013, both NHS Southport and Formby CCG and NHS South Sefton CCG have been working to define their strategies and plans to implement this ambition successfully.

Working closely with the Health and Wellbeing Board, the CCGs' strategy has been closely aligned. The CCGs' identify three key aims in transforming care and the local system:

(i) Frail/Elderly Care;
(ii) Primary Care; and
(iii) the Unplanned Care System.

The CCGs have now developed blueprints for each of these areas. Crucially, the programmes of work have been mapped through in order to maximise delivery of the CCGs' strategic aims. The identified programmes include:

(i) Respiratory;
(ii) Cardiovascular Disease;
(iii) Cancer;
(iv) Diabetes;
(v) Mental Health;
(vi) End of Life;
(vii) Dementia;
(viii) Children's Health.

Much activity has been undertaken to understand local needs, care and support, together with future care requirements.

Transforming Health and Social Care and support in Sefton will be challenging, given the financial backdrop of both the CCG and the Local Authority.

Arguably a 45% reduction or £170m less spending power by the local authority alongside the minimal allocation of 1.94% for the CCGs has somewhat challenged the local health and social care economy, thus the need to find creative solutions to enable transformational change is vital. This change has to be led across the local system, by the leaders of the local system in order to find the right solutions for Sefton to meet the economic, financial, demographic, workforce and infrastructure challenges it faces.

> "Be the change that you wish to see in the world."
>
> - Mahatma Gandhi

2. The Health and Wellbeing Board (HWBB)

Health and wellbeing boards are an important feature of the reforms introduced by the Health and Social Care Act 2012. All upper-tier local authorities set up shadow boards in April 2012, which became fully operational on 1 April 2013.

The boards are intended to bring together bodies from the NHS, public health and local government, including Healthwatch, as the patient's voice, jointly to plan how best to meet local health and care needs and to commission services accordingly (Humphries & Galea, 2013).

The Sefton HWBB believes everyone in Sefton should have a healthy and fulfilling life. Since becoming a formal committee of Sefton Council in April 2013, Sefton's Health and Wellbeing Board has brought together those who buy services across the NHS, public health, social care and children's services, plus Elected Councillors and service user representatives, to jointly consider local needs and plan the right services for the population of Sefton.

The main statutory functions of the Health and Wellbeing Board are:

- to assess the needs of the local population through the Joint Strategic Needs Assessment process;
- to produce a local Health and Wellbeing Strategy as the overarching framework within which commissioning plans are developed for health services, social care, public health and broader wellbeing services;
- to promote integration and partnership, including joint commissioning, integrated provision and pooled budgets, where appropriate.

In addition to the above statutory functions, the Board's role is to provide system leadership for change across care, health and wellbeing. This role requires the involvement of a wide range of leaders from not only the Council and the two Clinical Commissioning Groups' Governing Bodies, but other public sector organisations, such as hospitals and community based health care providers, Merseyside Police, Merseyside Fire and Rescue, Merseyside Probation Service, Schools and Colleges, Merseytravel and housing providers and, of course, our voluntary community and faith sector groups and organisations. These are just some of the organisations that the Board works alongside and there are a whole range of other organisations which have a stake in Sefton, too many to list, but which are just as important within the wider system. The Board has created a sub-structure to engage as wide range of partners, stakeholders and organisations as possible to ensure Sefton has the delivery infrastructure to achieve the best care, health and wellbeing outcomes for people in Sefton, through integrated, collaborative working.

The Adult, Early Life and Wider Determinants Forums provide opportunities for wider stakeholders, partners and representatives to come together to look at how by listening to local people, the right services can be commissioned and delivered to achieve the outcomes outlined within this Strategy. Importantly, as resources within the public sector decrease, the role of the Forums becomes even more important, as through this sub-structure the Board engages with people in communities, to build independence, resilience and tackle loneliness and isolation together. The shift from 'dependence' to 'independence' is crucial to the work of the Board if it is to rise to the challenges presented by our demography, levels of inequality and a reducing public sector resource base. Representatives from a wide range of organisations influence the debate at the Forums and bring their expertise, knowledge and specialism to better inform decision making – for example, understanding the positive impact being in employment can have on a person's health or how a home impacts on mental wellbeing. This way of working (a leadership collaborative) takes the Board beyond its statutory function, to that which is needed to achieve change - collective systems leadership.

The overall aim of the Board in providing system leadership for change is to ensure that the broadest range of partners, stakeholders and organisations are joining together to help shape Sefton, through the care, health and wellbeing of its people - our aspiration for Sefton by 2020.

By working together and aligning our resources, by 2020 we aim to improve the care, health and wellbeing of all Sefton residents and narrow the gap between those communities with the best and worst health and wellbeing outcomes. We will promote independence and help build personal and community resilience. We will work with parents and carers so that all children and young people have opportunities to become healthy and fulfilled adults and create a place where older people can live, work and enjoy life as valued members of the community. We will seek to improve opportunities and support residents to make choices so that people are able to live, work and spend their time in a safe and healthy environment and provide early support so that people can remain independent for longer (Sefton Health & Wellbeing Board, 2014).

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

3. Local Provider Landscape

The provider landscape is complex in Sefton. There are currently two acute providers, one integrated care organisation, one mental health provider, one community provider, and five specialist providers of children's, women's, cardiac, cancer and neurological care. Some of these providers have gained Foundation Trust status and are regulated by Monitor, some are in the Foundation Trust pipeline with the Trust Development Authority (TDA) and others are exploring the future options. Whilst co-terminus with the Local Authority, the two CCGs have a very differing demography.

Both the Dalton Review started in February 2014 and the Five year Forward view published in November 2014 describe the need for change and potential future models. Sir David Dalton's review of the role of chains of hospitals and services explores one particular approach with a focus on how high-performing NHS organisations might lend their support to providers in difficulty.

The NHS has dramatically improved over the past fifteen years. Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. Even during the global recession and hardship, progress has continued thanks to protected funding and the commitment of NHS staff. However, the quality of care that people receive can be changeable, preventable illness is widespread and health inequalities are deep-rooted. Our patients' needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients the service pressures are building (NHS England, 2014).

Fortunately, there is now agreement on what a better future should be. The Five Year Forward View sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself; other actions need new partnerships with local communities, local authorities and employers. Some important decisions – for example about money, on various public health measures and on local service changes – will need firm support from the next government.

The Five Year Forward view argues that public health and prevention should be at the heart of any future system. Fundamentally, there is not a 'one size fits all' approach and new creative solutions to enable new models of care need to be promulgated. This change should involve a process of discovery and not design. There should be a commitment to real-time evaluation and learning throughout the process (NHS England, 2014).

Work also needs to be undertaken at a national level to implement new forms of commissioning and contracting. It would help if NHS England and Monitor accelerate the development of new payment systems such as capitated budgets, pooled budgets and integrated personal commissioning. In Sefton we will look to influencing this element of change (Ham & Murray, 2015).

4. Sefton Strategic Needs Assessment (SSNA)

The Sefton Strategic Needs Assessment (SSNA) clearly outlines the suggested themes below, which have been derived from analysis of the evidence of data and information within the SSNA The themes reflect the key areas of need across the Borough, however the suggestion of priority themes is a guide to assist the Health & Wellbeing Board in deciding on the priorities for the Borough going forward are not meant to be an exhaustive or definitive priority list.

- **Lifestyles** – recognise the major impact of common lifestyle behaviours, which often start in childhood and continue throughout life.
- **Obesity** (childhood and adult) - child poverty, alcohol misuse and smoking, promoting physical activity, plus mental wellbeing which can have an impact on long term conditions.
- **Alcohol Related Conditions** – respond to high levels of alcohol consumption, alcohol specific hospital admissions, chronic liver disease, alcohol specific mortality
- **Child Health & Young People** – focus on ensuring a positive start to life for children, given the growing evidence of the impact this will have throughout their lives. Promoting breastfeeding initiatives, childhood obesity, underage under 18 alcohol related hospital admissions, emergency hospital admissions (asthma & injury) .
- **Older People** – plan now for the significant forecast growth in the number of older people in Sefton over the next 20 years by prioritising needs and requirements of an aging population. Tackling health issues for elderly, including dementia and reconfigure services to support older people to live in a community setting as long as possible.
- **Supporting Carers** - there are believed to be in excess of 30,000 carers across Sefton, who reduce the burden on both health & local authority services, however impact on the local economy through having to give up work to provide care.
- **Mental Health Issues** – to promote individual and community resilience and mental health including community engagement. Dementia is prevalent amongst the older population and depression amongst those in more deprived areas.
- **Long Term Conditions** – this also links to lifestyle as determinant lifestyle choices can have a direct impact on coronary heart disease (CHD) / heart failure, hypertension, cancers etc. Promoting early intervention and prevention through improved screening uptake and health checks.
- **Health & Social Inequalities** – current social and health inequalities and trends in Sefton have a significant impact on local people's health and wellbeing. Reducing the health inequality gaps between the most deprived and most affluent families/ communities, reducing deprivation and worklessness and improving skills.
- **Vulnerable Groups** - within Sefton there a number of vulnerable groups whose health status typically reveals inequalities and difficulties in accessing health and other public services. Interventions to reduce inequalities for these groups in particular need to focus long term and require a joined-up approach if they are to be tackled appropriately.

The health of people in Sefton is mixed compared with the England average. Deprivation is higher than average and about 10,000 children live in poverty. Life expectancy for both men and women is lower than the England average. Life expectancy is 11.9 years lower for men and 9.4 years lower for women in the most deprived areas of Sefton than in the least deprived areas. Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen but the former is worse than the England average.

About 20.7% of Year 6 children are classified as obese, higher than the average for England. Levels of alcohol-specific hospital stays among those under 18, breast feeding initiation and smoking in pregnancy are worse than the England average. The level of teenage pregnancy is better than the England average. An estimated 19.6% of adults smoke and 23.9% are obese. Rates of smoking related deaths and hospital stays for alcohol related harm are worse than the England average. Rates of sexually transmitted infections and road injuries and deaths are better than the England average (Sefton MBC, 2014).

5. Delivering Change

In order to deliver the required change at pace, the CCGs and Local Authority must work even more closely across the strategic landscape in Sefton working with the providers. The financial pressures must be used as a force for change to help to shape new models of care in Sefton.

Chris Ham described at the Shaping Sefton event on the 12th February 2015, 'the soft stuff is the hard stuff'.

- System leadership
- Trusting relationships
- Collaborative behaviours
- A willingness to cede sovereignty for the greater good
- Leaders who collaborate as well as compete.

Pace now needs to be injected into the delivery of Shaping Sefton - Start Well, Stay Well, Age Well. There will also be opportunities for learning as we discover new and creative solutions and we will use our membership contact with such bodies as the Advancing Quality Alliance (AQuA), the Kings Fund, NHS Leadership Academy, Academic Health Science network, Health Education England, Local Government Association, local colleges and Universities and NHS Clinical Commissioners to share the Sefton experiences.

The changes as identified and developed will be formally project managed and reported through the Transformation Board and ultimately held to account through the various Boards. We will continue to work really closely with our CCG colleagues in West Lancashire CCG, Knowsley CCG and Liverpool CCG and also learning across the wider Cheshire & Merseyside footprint.

6. Systems Leadership

Ham (2014) suggests that strengthening leadership within the NHS holds the key to providing patients with access to high-quality care wherever they live. He argues that leadership needs to be collective and distributed, as important in the frontline teams delivering care as in the boards responsible for running NHS organisations. It needs to be developed across organisations and areas where networks and chains are involved. And there needs to be much greater continuity of leadership in place of the constant chopping and changing that has bedevilled the NHS in recent times.

The task now is to identify the skills, knowledge and behaviours that this new breed of system leaders will need if they are to be successful and to consider how such an approach to developing leadership – which is likely to be different to that found inside many of our institutions – can best be fostered.

System leadership is equally important at a local level, where organisational changes following from the Health and Social Care Act 2012 have left a vacuum that commissioners and providers are seeking to fill through partnership arrangements of various forms. At a time of growing pressures within the NHS, the absence of a designated system leader places the onus on commissioners and providers to agree how this vacuum should be filled. Much then hinges on the quality of relationships between organisations and their leaders and their willingness to seek common cause to deal with the challenges facing the health and care system (Ham & Murray, 2015).
They go on to say that new kinds of leadership will be needed to make a reality of new models of care. Specifically, leaders of different organisations will need to work together to provide leadership across local systems of care, however these are defined. The challenge this presents is that most NHS leaders are first and foremost organisational leaders rather than system leaders, and they will have to learn new skills to operate effectively in the NHS of the future.

Leaders must learn to operate without the might of the hierarchy behind them and use their individual skills rather than their formal position to achieve results. They must be able to compete in a way that enhances rather than undercuts the competition and to do this these leaders must become successful collaborators. Leaders who conduct their business to the highest ethical standards; trust is crucial to successful alliance-building, develop a process focus – concentrating not only on what is to be achieved but how it is done (Fillingham & Weir, 2014).

Within Sefton a place based approach to leadership is underway, with sponsorship of the system leadership challenge by the consortium led by Chris Lawrence-Petronie. Over the next 12 months, the local leadership will be challenged and supported to create a social movement of change to deliver the emergent models of care, identified through the work of the Transformation Board.

7. Governance to Underpin Delivery

The governance must be clear and structured for delivery. The proposed governance structure can be found at Appendix 1. The Board itself will comprise of senior local system leaders. Each of the five work streams will be clinically led by the CCGs and provider clinicians, supported by various leaders in the variety of organisations across Sefton, both statutory and the community, voluntary and faith sector.

The desire is that this work will be underpinned by the work of Healthwatch and the development of a citizen's voice linking in with the work of the Engagement Patient Experience Group (EPEG). The Transformation Board and supporting work streams will be established during May 2015. It will report to both CCGs' Governing Bodies and work is underway with the Chief Executive of Sefton Council to clarify the relationship with the HWBB.

8. Future sessions

Two further sessions are planned to cover Unplanned Care and Primary Care, to compliment the work of Dr David Oliver on Elderly Care. The sessions will be developed in conjunction with the work stream clinicians and may include the following:

8.1. Unplanned care
- To cover work to assess the role of the SRGs in delivering successfully in past 12 months and explore future possibilities
- To explore the opportunities to develop an alternative model of care for unplanned networks
- To take best practice and benchmarking and develop future commissioning intentions to deliver across the urgent care/unplanned pathway.

8.2. Primary Care
- To build on emergent models of primary care
- To tie into the Local Quality Framework for affordability and delivery
- To take best practice from Prime Ministers Challenge Fund areas.

8.3. Elderly Care
- To cover work to assess the success of currently commissioned pathways
- To explore further options for managing the elderly wellness and health/social care agenda
- To take best practice and benchmarking and develop future commissioning intentions to deliver across the elderly care pathway.

9. Next Steps

9.1. Three further dates identified with the Kings Fund - 16 June 2015, July 2015 and one further date to be confirmed.

9.2. Define governance structures, develop terms of reference and invite strategic leaders to the Transformation Board and work streams.

9.3. Ensure clinical leadership is shaping and driving the future models within the five work streams supporting the Transformation Board.

9.4. Create the programme of system leadership to support place based delivery.

9.5. Identify project lead to support transformation/integration project agenda.

10. Recommendations

10.1. The Governing Body is asked to receive this report and support the direction of travel for Shaping Sefton transformation.

References

Department of Health (2014)
Filingham, D. & Wier, B. (2014) System leadership Lessons and learning from AQuA's Integrated Care Discovery Communities.
Ham, C. (2014) Future organisational models for the NHS Perspectives for the Dalton review.
Ham, C. & Murray, R. (2015) Implementing the NHS five year forward view: aligning policies with the plan
Humphries, R. & Galea, A. (2013) Health and wellbeing boards One year on. Kings Fund, London.
NHS England (2014) Five Year Forward View.
Sefton Health & Wellbeing Board (2014) Living Well in Sefton-Health & Wellbeing Strategy 2014-2020.
Sefton Metropolitan Borough (2014) Sefton Strategic Needs Assessment 2012-13.

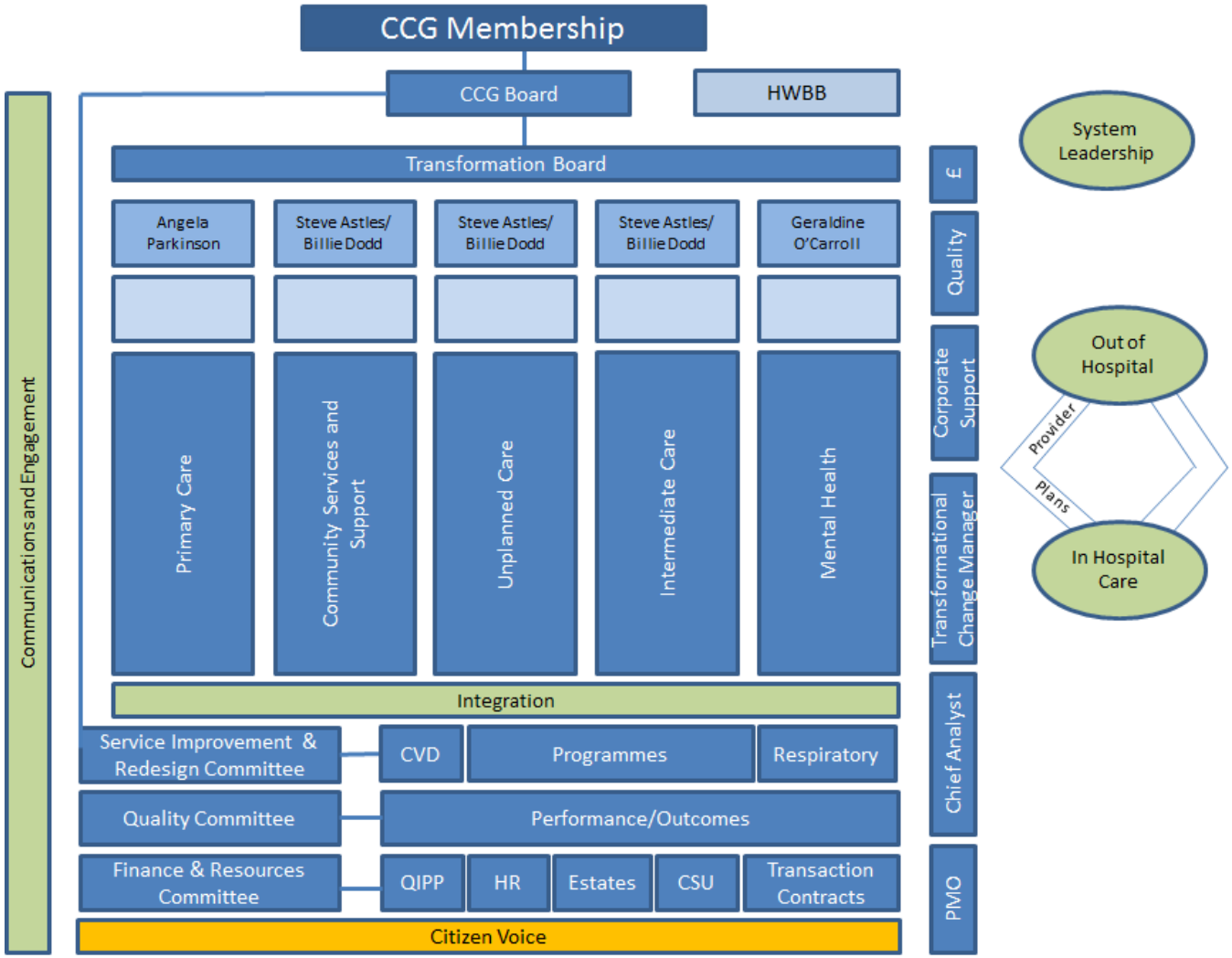
Appendices

Appendix 1 - Draft Shaping Sefton - Transformational Governance Framework

Fiona Clark
Chief Officer
May 2015

Appendix 1
Shaping Sefton – Transformational Governance Framework

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group



NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2015

Agenda Item: 15/98	**Author of the Paper:** Dwayne Johnson Director Older People, Sefton MBC Email: dwayne.johnson@sefton.gov.uk Tel: 0151 934 4900
Report date: May 2015	

Title: Refresh of the Dementia Strategy for Sefton

Summary/Key Issues:

Sefton's current strategy for Dementia, written following the publication of "Living Well with Dementia: A National Dementia Strategy" which was published in 2009, ran from 2009-2014. There is therefore a need to refresh this in order to reflect changes in national policy and guidelines and the changes in structure to health services in Sefton.

The Strategy has been refreshed and includes a draft collaborative action plan and is seeking the Governing Body's views and agreement to the draft Dementia Strategy for Sefton.

Recommendation

The Governing Body is asked to receive the draft strategy.

Receive	
Approve	x
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			Full consultation report attached as annex
Clinical Engagement	X			Clinicians have been involved in developing the draft strategy as detailed in the Strategy document and the Consultation Report
Equality Impact Assessment	X			Draft EIA attached as annex
Legal Advice Sought				
Resource Implications Considered	X			The Draft Strategy provides a framework to guide the Council and its partners in seeking to support people with dementia and their carers in the context of the current financial climate. Where actions will result in additional resources being required then this will be costed and referred to Elected Members and other partners to consider.
Locality Engagement				
Presented to other Committees	X			HWBB Programme and Integration Group 11th May 2015

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

Report to the Governing Body
May 2015

1. Executive Summary

Sefton's current strategy for Dementia, written following the publication of "Living Well with Dementia: A National Dementia Strategy" which was published in 2009, ran from 2009-2014. There is therefore a need to refresh this in order to reflect changes in national policy and guidelines and the changes in structure to health services in Sefton

2. Introduction and Background

The draft 2014 – 2019 Dementia Strategy, attached at Appendix 1 to this report, provides an overarching framework within which the council and partners can provide positive, proactive approaches to service development providing individualised support to ensure that older citizens experiencing dementia can access appropriate, joined-up services that are provided safely and effectively to maximise independence, choice and quality of life.

The refreshed Dementia Strategy and consultation has been developed during the past 12 months by a multi-agency working group including officers from Sefton Council Business Intelligence and Performance Team, NHS South Sefton CCG, NHS Southport and Formby CCG, Sefton CVS, Mersey Care NHS Trust, Alzheimer's Society, Sefton Pensioners Advocacy Centre, Age Concern, Sefton Partnership for Older Citizens, One Vision Housing, Care Homes Association, Liverpool Community Health NHS Trust and Southport & Ormskirk Hospital NHS Trust. The group is chaired by the Cabinet Member for Adults and Health, Councillor Paul Cummins.

Through various consultation responses the communities of Sefton have identified the following thematic priorities:

- Most Vulnerable;
- Community Resilience;
- Economy;
- Environment;
- Health and Wellbeing.

The draft Strategy has been co-produced with people who have dementia, their carers and service providers. The draft Strategy has been developed within the context of the above thematic priorities and provides the Council and its partners with a refreshed approach to improving quality outcomes for people with dementia and their carers and families as they progress through the dementia care pathway. It has also been developed in the context of the current financial climate that the Council finds itself in.

Co-production of the Dementia Strategy

The multi-agency working group designed the consultation to be able to gather the views of people with dementia and their carers on the realities of living with dementia, to understand how their needs are being met, what gaps they have encountered and their views on improving services across Sefton. A range of methods were used to engage with people with dementia, their families and carers and providers. Care was taken in identifying the methods to be used to consult with people who have dementia and their carers. There is no "one size fits all" approach as each person is different, will interact differently and traditional approaches may not be suitable.

The process for developing the draft Strategy included a consultation and engagement process that included Open Space and Innovation Events to enable the sharing of views, thoughts, ideas and experiences about how together we can make a difference to the lives of people living with Dementia and their carers, meetings with Voluntary, Community and Faith Networks and hard to reach groups and taking on board the need to tailor consultation to specific groups, separate questionnaires were developed:

- A questionnaire specifically for people with dementia;
- A questionnaire for carers of people with dementia;
- A questionnaire for people who have recently lost somebody with dementia;
- A general questionnaire for members of the public;
- An easy read version of the general questionnaire which was used to engage with people with learning disabilities.

In total, in excess of 160 people engaged with the process. Regardless of whether people where old, young, disabled, living in the north or south of the Borough, there were some common themes that repeatedly emerged which resulted in the development of the five theme areas outlined within the Strategy as follows:

- Timely diagnosis, appropriate treatment and involvement in care plans;
- Support to live independently for as long as possible, and to make decisions for myself;
- Inclusive and dementia friendly communities;
- Information, advice and support for people with dementia and their carers;
- End of Life Services, ensuring a peaceful and pain free death in the place of choice.

Summary Feedback from the Consultation and Engagement Process

Attached to this report, at Appendix 2, is the full feedback report from the consultation and engagement process. The feedback from the consultation and engagement process found the following:

- Education is important. There is a need to increase awareness and understanding of dementia and to challenge stigma;

- Carers should be supported in their role as a carer but also as an individual, as to not lose their own identity;

- Early diagnosis is important and then once diagnosed, access to services quicker;

- People with dementia should be asked for their opinion, including their End of Life Plan;
- Services should be flexible and have a whole person approach. Activities available either in the day centre or in the community should be stimulating;
- There should be good quality, consistent information, advice and guidance for the person who has been diagnosed and for the carer.

With regard to the Prime Minister's Dementia Challenge to create dementia friendly communities, which was launched in 2012, people felt that dementia friendly communities will be places where:

- People with dementia are supported to remain active and included members of their communities;
- People will have increased understanding and awareness about dementia and how to support individuals with dementia;
- To support individuals living with dementia and their carers to maintain their independence for as long as possible;
- People with dementia being treated as valued members of society;
- People with dementia and their carers feel comfortable in their local environment (shops, leisure facilities, etc);
- People who work in the local community are trained to respond to the needs of people with dementia and do very simple and practical things that can make an enormous difference;
- Implementing simple steps to help people with dementia such as slow lanes in supermarkets and banks;
- Support from befriending groups to help people with dementia do the things that they want to.

Equality Analysis Report

In developing the draft Strategy, the Council has shown due regard to the Equality Act 2010, and attached at Appendix 3 is a draft copy of the Equality Analysis Report for views and agreement.

3. Key Issues

The draft Strategy is centred on improving quality outcomes for people with dementia and their carers and families as they progress through the dementia care pathway. The Partners to the Dementia Strategy will need to work together towards actions that promote early intervention and prevention in order to help to delay the onset of dementia and encourage healthy lifestyles, both physically and mentally, to help improve the wellbeing of Sefton's residents. A draft Action Plan is within the Strategy that will require resource allocation and the Governing Body is asked to consider the draft Action Plan, in particular the actions where the Clinical Commissioning Group is identified as the Lead.

4. Conclusions

Sefton has also recently consulted and refreshed its Carers and Older People's Strategies and this provides an opportunity to ensure that the Dementia Strategy is linked to both of these Strategies.

The Strategy provides a framework from which an overarching action plan will be developed for the delivery of the strategy in the context of the Strategic Objectives in the Sefton Health and Wellbeing Strategy and the priorities within the Sefton Carers Strategy 2014 – 2019 and Sefton Strategy for Older Citizens 2014 – 2019. These will be monitored through the Health and Wellbeing Board Adults Forum and reported from this forum to the Programme and Integration Group and the Health and Wellbeing Board.

The draft Strategy and associated documents will also be considered by the Sefton Council Strategic Leadership Team, before being considered at the Health and Wellbeing Board meeting in June, the Cabinet in July and by Full Council in September.

5. Recommendations

- That the content of the report and the feedback from the consultation and engagement process be noted, as described in the report;

- The Draft Equality Analysis Report and the actions therein are approved.

Appendices

Appendix 1: Draft Dementia Strategy – Living Well with Dementia 2014 – 2019
Author: Sefton Council Business Intelligence & Performance Team, May 2015

Appendix 2: Draft Dementia Strategy – Full Consultation Report
Author: Sefton Council Business Intelligence & Performance Team, May 2015

Appendix 3: Draft Equality Impact Assessment Dementia Strategy – Living Well with Dementia 2014 – 2019
Author: Sefton Council Business Intelligence & Performance Team, May 2015

Living Well with Dementia: A Strategy for Sefton 2014-2019

DRAFT

Prepared by Business Intelligence & Performance Department
7th floor, Merton House, Stanley Road, Bootle.
Version 12 12.05.15

Table of Contents

Prepared by Business Intelligence & Performance Department
7th floor, Merton House, Stanley Road, Bootle.
Version 12 12.05.15

Foreword:

Councillor Paul Cummins, Cabinet Member for Older People and Health

Like most of the country, Sefton is experiencing a continuing rapid increase in the proportion of older people in its population. Older people in Sefton generally enjoy good physical and mental health, and they are a great asset to their communities through their many contributions to local organisations, neighbourhoods and their own families. Nevertheless, this increasing proportion of older people in the population will make increasing demands on health and social care services, including those with dementia.

Dementia can affect adults of any age, but is most common in older people. One person in 20 over 65 has a form of dementia, rising to 1 in five in those over 80. Dementia in people aged under 65 is relatively rare – less than 3% of all those with dementia.

Positive, proactive approaches to service development providing individualised support can help ensure that physical and mental health are sustained as long as possible, that people live at home for as long as possible and that crises and unnecessary use of intensive costly services are minimised. It remains our intention to ensure that older citizens experiencing dementia can access appropriate, joined-up services that are provided safely and effectively to maximise independence, choice and quality of life.

This draft strategy has been produced by a number of partners, together with input from people with dementia and their carers:-

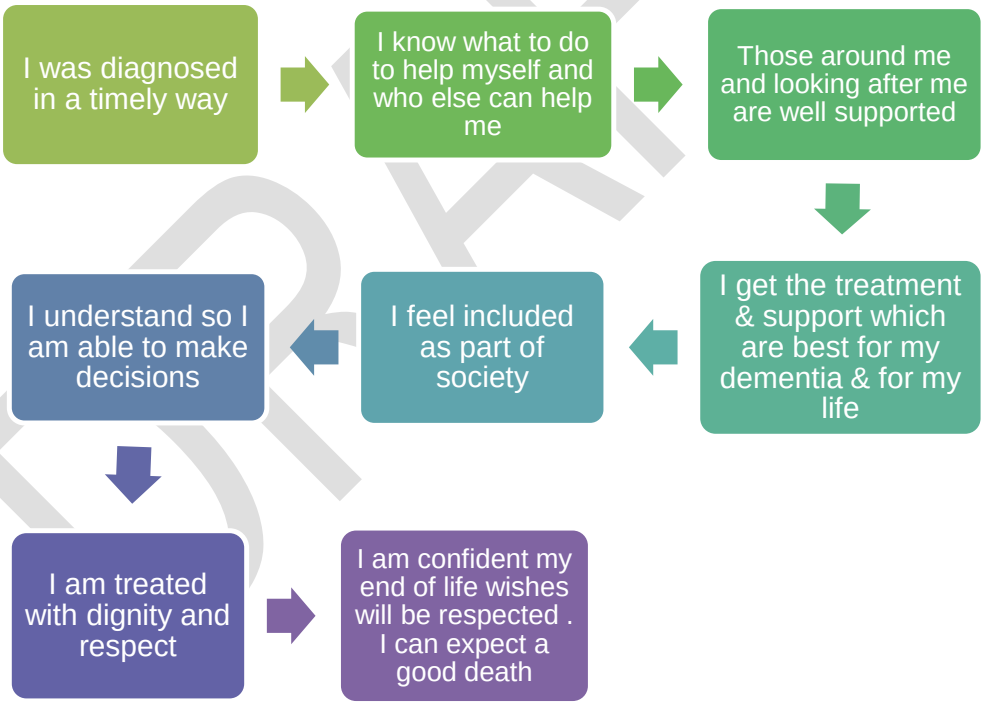
- Sefton Council
- South Sefton CCG
- Sefton CVS
- One Vision Housing
- University Hospital Aintree NHS Foundation Trust
- NHS Liverpool Community Health Trust
- Sefton Partnership for Older Citizens
- Southport & Formby CCG
- Sefton Carers Centre
- Alzheimer's Society
- Sefton & Liverpool Age Concern
- Mersey Care NHS Trust
- Southport & Ormskirk NHS Trust
- Sefton Pensioners' Advocacy Service

Vision for People with Dementia in Sefton

We want to ensure that people with dementia and their carers receive high quality, compassionate care whether they are at home, in hospital or in a care home. We want the person with dementia, and their family and carer, their wellbeing and quality of life to be first and foremost in the minds of those commissioning and providing services for them.

Aim for People with Dementia in Sefton

The following strategic priorities have been identified that will help people with dementia, and their carers, to live their lives in a positive way. They are based on what people with dementia and their carers have said nationally are important to them:-



Developing Sefton's Dementia Strategy

Living Well with Dementia has been developed in partnership with people with dementia and the people who care for them. We asked people with dementia and their carers what was important to them in order to make sure that this was reflected in the Strategy.

Conversations took place with providers of services, shops, businesses and offices around the themes of creating dementia friendly communities, promoting diagnosis and supporting people to live independently and information, advice, support for people with dementia.

Consultation also took place with the general public to test out people's thoughts and understanding about dementia, what they felt that people with dementia should be able to do (such as continue to live alone/being able to continue to work for as long as they are able/continue to drive for as long as they can/use technology to enable people to stay safe in their home) and their thoughts on the draft strategy and the priorities in it.

A full consultation and engagement report on has been prepared and is a separate document to this Strategy. In total 169 people engaged with the consultation and engagement process.

People with dementia and their carers told us that:-

- On the whole they found it easy to get a diagnosis, although some felt that the length of time from diagnosis to accessing the memory service was too long.

- Information and advice is available, although carers would like more information about long-term symptoms, how to choose residential homes and information about the costs involved. The work of the Alzheimer's Society and the support they offer was felt to be invaluable.

- In terms of healthcare it is important to see the same person each time so that they didn't have to repeat their story and over again to different people.

- People with dementia should be asked what they want, including their likes and dislikes, even if they find it difficult to answer

- It is important that the person with dementia should have a say in their end of life plan and this should be done at an early stage

- Where people with dementia have to stay in hospital, their experiences have been poor and that there needs to be more training and awareness raising for staff.

What is Dementia?

The term dementia describes a set of symptoms, including memory loss, mood changes and problems with communication and reasoning. Dementia is not a natural part of growing old. It is caused by diseases of the brain, the most common being Alzheimer's.

Although regarded and classified as a mental disorder, dementia is predominantly a physical, progressive condition; the symptoms becoming more severe over time and impacts on a person's functional ability and most noticeably their daily routines. Symptoms include:-

Impairment of memory

- Increasing difficulty in remembering recently acquired information
- Difficulty recognising friends and family
- Forgetting names of friends and common objects

Impairment of reasoning

- Difficulty in working things out
- Not being able to use a new design of kitchen appliance
- New-found difficulty handling money

Impairment of learning

- Inability to learn or remember names of people or objects
- Repetitive questioning due to inability to remember the answer
- Problems learning how to learn to use new objects

Increased stress levels

- Becoming distressed if you are in an unfamiliar environment
- Anxiety from not recognising people
- Inability to recognise, understand or adapt to what's going on around

Reduced capacity to deal with age-related changes

- Forgetting to use recently acquired prosthetics, e.g., glasses or hearing aids
- Neglecting to keep the house warm
- Forgetting to eat or drink enough fluids

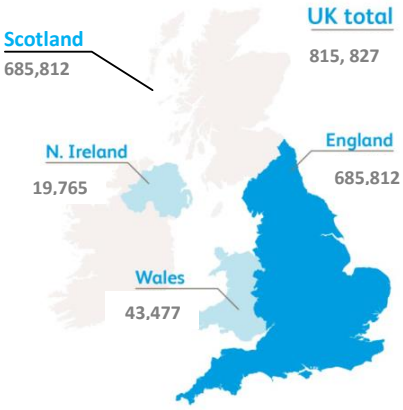
Dementia often becomes more common with ageing, but can also be present in people of working age. People with dementia can present family, friends and carers with complex issues (especially in the later stages of the disease) which can include restlessness and wandering, mobility difficulties leading to falls and fractures, eating difficulties, recognition difficulties, memory and recollection difficulties, incontinence and, sometimes, a range of behaviours that can be challenging to carers, family and care home staff.

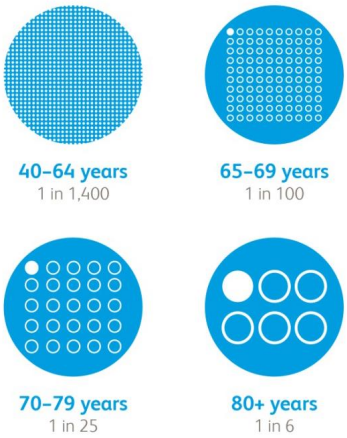
Dementia presents a huge challenge to society, both now and increasingly in the future. It is a common condition, which has a large impact on carers and society with an increasing cost attached to caring for people within the community.

Dementia: the National Context

In 2013 there were 815,827 people were suffering with dementia in the UK.

Dementia is most common in older people but younger in the can get it too



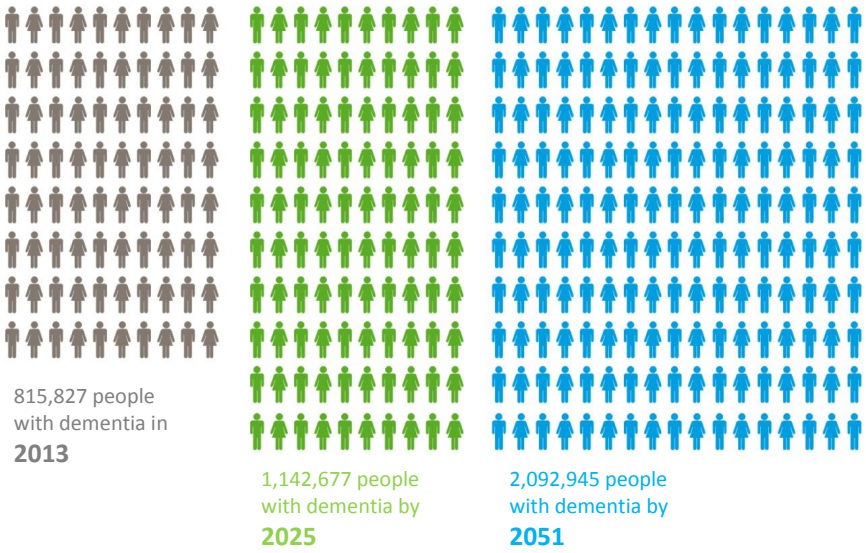


Two thirds of people with dementia are women

One in three people over 65 will develop dementia

One in twenty people with dementia are under the age of 65

If trends continue, the number of people with dementia will double in the next 40 years.

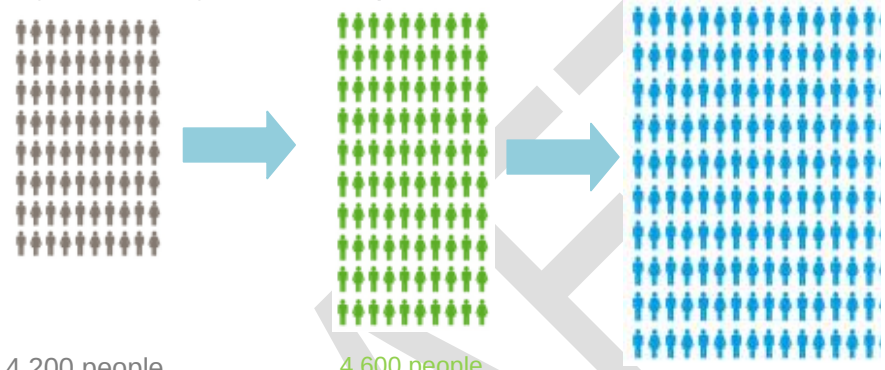


Dementia: the Sefton Context

Sefton has one of the highest percentages of adults with dementia in the UK.

According to figures recently released by the Alzheimer's Society, **Southport** has the highest number of people with a diagnosis of dementia in the North West and one of the highest rates in the UK – 1,765.

The number of people in Sefton over 65 with dementia is steadily increasing and this growth is expected to continue



Of these numbers between 50% and 65% will **not** have a confirmed diagnosis

There will also be an increase in the number of people **under the age of 65** diagnosed with dementia

The numbers of people with dementia in Sefton is spread evenly across North and South of the Borough (based on statistics quoted in Dementia UK 2nd Edition). However there are differences in that the number of younger people (aged 40-64) with dementia is slightly higher in the South of the Borough, and the number of older people (aged 95 – 95+) with dementia is slightly higher in the North of the Borough.

The Economic Impact of Dementia

The overall economic impact of dementia in the UK is £26.3 billion, which works out at an annual cost of £32,250 per person (this excludes the costs of early onset dementia). Two-thirds (£17.4 billion) of the cost of dementia is paid by people with dementia and their families, either in unpaid care (£11.6 billion) or in paying for private social care. This is in contrast to other conditions, such as heart disease and cancer, where the NHS provides care that is free at the point of use. This is because, although dementia is a physical disease of the brain, most of the essential care required supports daily activities, such as washing and dressing, which is classified as 'social' rather than 'health' care.

£4.3 billion is spent on healthcare costs of which around £85 million is spent on diagnosis

£10.3 billion is spent on social care for people with dementia in the UK.

Social care is either publicly funded (£4.5 billion – 17.2% of the overall total cost of dementia) or privately funded (£5.8 billion – 22.9% of the total)

The cost of unpaid care for people with dementia in the UK is £11.6 million , working out as 44% of the total cost of dementia. The total number of unpaid hours of care provided to people with dementia in the UK is 1.34 billion

£111 million is spent on other dementia costs

Reducing the Risk of Dementia

While the causes of dementia remain unclear, it is known that a good diet, regular physical exercise and avoiding smoking and excessive alcohol consumption can reduce the risk of developing dementia. Interventions focusing on encouraging a healthier diet, regular exercise, reducing smoking and avoiding excessive alcohol consumption would therefore likely reduce future incidence of dementia.

While a lifelong approach to good cardiovascular health is recommended for some conditions (for example high blood pressure, blood cholesterol or BMI), a healthy lifestyle from midlife onwards is likely to be particularly effective at combating dementia. In addition to these vascular approaches, psychosocial factors such as educational attainment, complex work, and mental and social stimulation throughout life also reduce the risk of developing dementia. They are thought to do so by building up a cognitive reserve. Growing evidence also suggests that midlife depression is a probable risk factor for later dementia and its treatment should be encouraged.

There is no certain way to prevent all types of dementia. However, a healthy lifestyle can help lower the risk of developing dementia as people become older. It can also prevent cardiovascular diseases, such as strokes and heart attacks.

To reduce the risk of developing dementia and other serious health conditions, the following are recommended:

- Eating a healthy diet
- Maintaining a healthy weight
- exercising regularly
- Not drinking too much alcohol
- stopping smoking (if you smoke)
- keeping blood pressure at a healthy level

Helping People with Dementia and their Carers to Live Well

Housing and support for people with dementia

Two thirds of people with dementia live in the community and people with dementia and their carers place great importance on their homes. However, research undertaken nationally by the Alzheimer's Society shows that:-

- More needs to be done to link housing with health and social care services
- Many people with dementia and carers want to be supported in their current homes, but others prefer the option of housing with care where care is available on site.
- There are mixed experiences of accessing information and advice on housing and housing options, including access to funding and support to make adaptations to the home
- More needs to be done to ensure homes are designed and built with the needs of people with dementia in mind and older people in general
- The use of assistive technology to support people with dementia and their carers to be supported to stay in their own homes where possible. This includes things such as telecare, personal alarm systems, movement sensors, tracking devices and door opening detectors.

Current national and local planning policies do not require developers of elderly friendly homes to carry out an assessment of how dementia friendly their new developments are. However the National Planning Policy Framework (Paragraph 171) states that Planning and Health need to work together to consider health status and needs of local population both now and in the future. In Sefton's case this includes an increase in the older population and a need for environments that are supportive of those living with dementia.

The Town and Countryside Planning Association is working with Public Health England to identify ways in which Planning and Public Health can work together and contribute to outcomes for older people and those who are living with dementia. The Association has held two workshops in Sefton with the Council and other partners.

At a meeting of the full Council on 25th September 2014, Sefton Councillors considered the issue of dementia and housing and indicated that developers of homes should consider the issues associated with an ageing population, including how dementia-friendly their developments are at all stages of those developments.

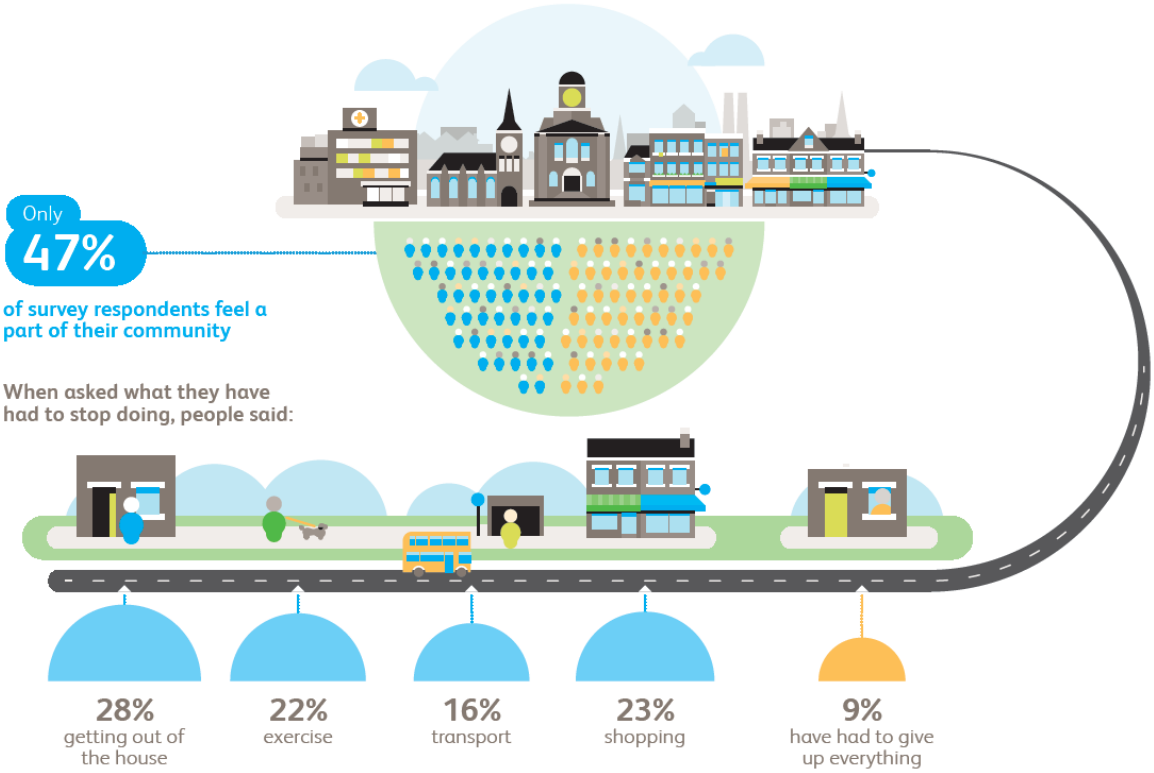
It passed a resolution that the Council will promote increased awareness of the needs of older people amongst those wishing to develop housing in the Borough, including the design and development of a dementia–friendly environment. The Council also resolved to consider, through the emerging Local Plan process, the making of a policy requiring developers to identify how best to address the housing needs of the ageing population.

With regard to **Social Housing** for people with dementia, the Council supports the provision of 'extra care housing schemes'. Extra Care Housing offers accommodation for older applicants who may need additional care and support services and there are specific assessment criteria to ensure an appropriate balance of residents with high/medium/low care needs.

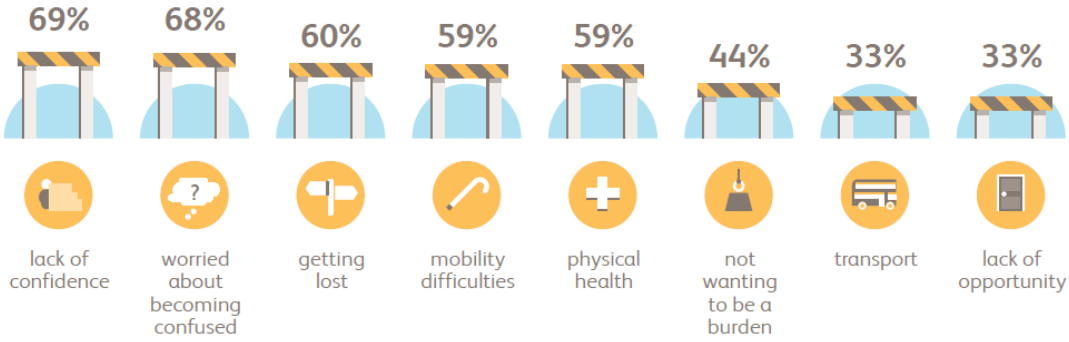
Creating Dementia Friendly Communities in Sefton

People with dementia and their carers can face many challenges going about their daily lives when shopping, using public transport, socialising and getting involved in their community. Having dementia does not mean someone has to stop carrying out everyday tasks or enjoying activities.

The Alzheimer's Society asked people with dementia for their views about living with dementia in their community:-



People with dementia feel their biggest barriers to participating in their local area are:



Whilst the main priorities for the Sefton dementia strategy are around prevention (e.g. tackling isolation, promoting wellbeing and healthy eating) and better treatment, by making Sefton more dementia friendly, it will make for a better quality of life for those who are already suffering from it.

At a meeting of the full Council held on 25th September 2014, Sefton Councillors resolved that the Sefton Dementia Action Alliance will seek dementia-friendly community status for the whole of the Borough.

In order for Sefton to become Dementia Friendly it will require strong commitment from everybody. This will be achieved by the Public Sector, the Private Sector, the Voluntary Sector, Church groups and individuals working together to enable people with dementia to live well. This might be making the bus into town or the library more accessible, or thinking about the support needed to go shopping. A little understanding about dementia and its effects is the only way to create dementia-friendly communities.

A dementia-friendly community is one in which people with dementia are empowered to have aspirations and feel confident, knowing they can contribute and participate in activities that are meaningful to them. Many villages, towns and cities are already taking steps towards becoming dementia-friendly, or have an ambition to do so

A group of shops on Fylde Road, Southport have recently received recognition from the Alzheimer's Society for being dementia friendly. The staff in the shops received Dementia Friends training and changed practices within their business to help people with dementia to use their services. Dementia-Friendly communities benefit everybody not just people with dementia.

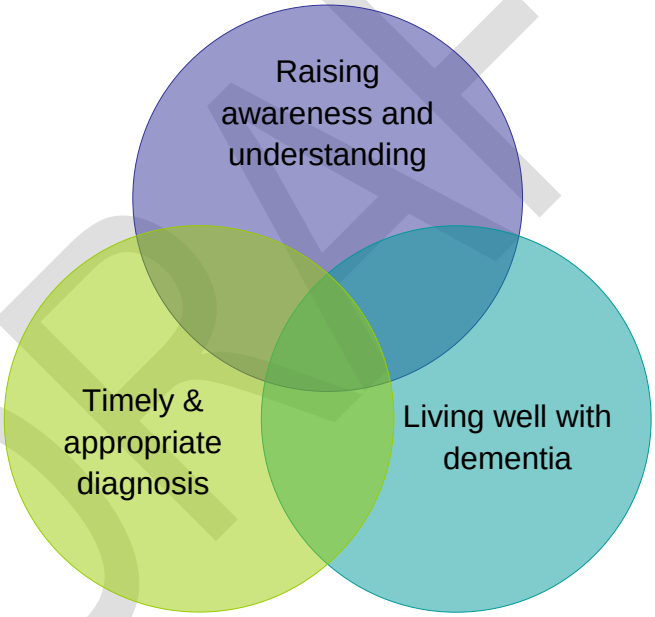
Links to National Strategies and Policies

This draft strategy is aligned with, a number of National Strategies and Policies:-

National Dementia Strategy 2009

In 2009 the Department of Health launched the first ever National Dementia Strategy for England. The Strategy is the Government's plan which explains what needs to happen to radically transform the quality of life for people with dementia and their carers.

The Dementia Strategy sets out 17 recommendations that the Government wants the NHS, local authorities and others to adopt to improve dementia care services. The recommendations are focused on three key themes of:



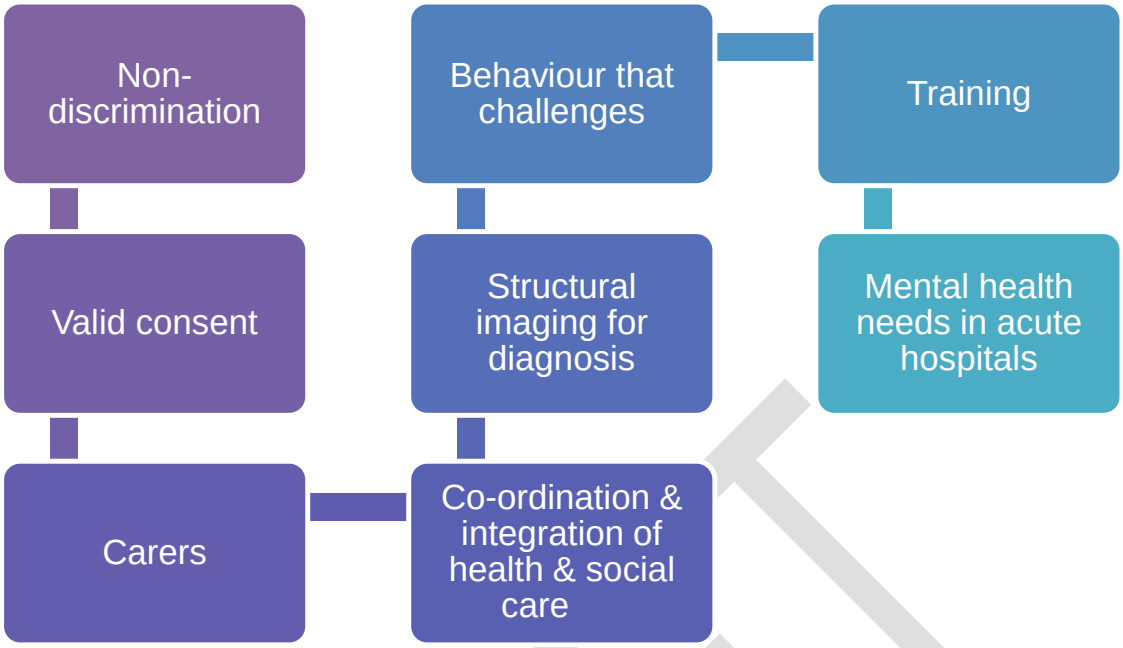
Following on from the publication of the Strategy, in 2010 the Government produced the document **Quality outcomes for people with dementia: building on the work of the National Dementia Strategy**. The document lists four priority areas for the Department of Health's policy development work to support local delivery of the Strategy. These areas provide a real focus on activities that are likely to have the greatest impact on improving quality outcomes for people with dementia and their carers:-

More generally the improvement of community personal support services is integral to and underpins each of the four priorities as it supports early intervention; prevents premature admission to care homes and impacts on inappropriate admission to hospital and length of stay.

National Institute for Health and Care Excellence /Social Care Institute for Excellence Guidance 42 2006 (updated March 2013)- Supporting People with Dementia and their Carers:

This guidance makes recommendations for the identification, treatment and care of people with dementia and the support of carers. Settings relevant to these processes include primary and secondary healthcare, and social care. It states that wherever possible and appropriate, agencies should work in an integrated way to maximise the benefit for people with dementia and their carers

The following recommendations have been identified as priorities for implementation:-



Prime Minister's Dementia Challenge 2012:

The dementia challenge was launched in March 2012 by Prime Minister David Cameron The Dementia Challenge is an ambitious programme of work designed to make a real difference to the lives of people with dementia and their families and carers, building on progress made through the National Dementia Strategy.

There are 3 dementia challenge champion groups, each focusing on 1 of the main areas for action:

National Dementia Declaration for England – Dementia Action Alliance

The Dementia Action Alliance is made up of over 900 organisations committed to transforming the quality of life of people living with dementia in the UK and the millions of people who care for them.

Members of Dementia Action Alliance have signed up to a National Dementia Declaration. Created in partnership with people with dementia and their carers, the Declaration explains the huge challenges presented to society by dementia and some of the outcomes it is seeking to achieve for people with dementia and their carers. Outcomes range from ensuring people with dementia have choice and control over decisions about their lives, to feeling a valued part of family, community and civic life.

These are the seven outcomes that people with dementia and their family carers said they would like to see in their lives.

Dementia and People with Learning Disabilities Charter, 2013:

Advances in medical and social care have led to a significant increase in the life expectancy of people with learning disabilities. Understanding the effects of ageing among this group − including the increased risk of developing dementia - has therefore become increasingly important. People with learning disabilities in general and people with Down's syndrome specifically, have a higher risk of developing dementia and at a younger age than people in the general population and:-

- often show different symptoms in the early stages of dementia
- are less likely to receive a correct or early diagnosis of dementia and may not be able to understand the diagnosis
- may experience a more rapid progression of dementia
- may already be in a supported living environment, where they are given help to allow them to live independently
- may have already learned different ways to communicate (e.g. more non-verbal communication if their disability affects speech)
- will require specific support to understand the changes they are experiencing, and to access appropriate services after diagnosis and as their dementia progresses

The Charter outlines 14 important outcomes for the individual person that organisations need to be aware of, and that are aimed at improving the persons experience of support, underpinned by comprehensive person centred planning based on their own wishes, their capacity (maximising their decision making, wherever possible), and their needs and history.

Links to Local Strategies

There are a number of local strategies that link to this draft strategy, but do not duplicate it. These include:

The Sefton Health & Wellbeing Strategy 2013 – 2018 which this draft strategy seeks to support in the delivery of the six strategic objectives for Health and Wellbeing:

The Sefton Carers Strategy 2014-2019

This Strategy has been co-produced with partners, providers and the carers themselves (including young carers) and identifies a set of draft strategic objectives for Carers in Sefton, together with the creation of a model for working with Carers, and a whole life course approach to defining carers. A draft model of working with carers in Sefton has

been created which shows that carers and those they care for are at the heart of the process and that those closest to them “their world” are also very important.

The model shows that all organisations should talk to each other and where ever possible share appropriate data in a secure way to ensure that services provided best meet the need.

Sefton Strategy for Older Citizens 2014 – 2019

Sefton Partnership for Older Citizens (SPOC), continues to work with partners to create a better place where older people can live, work and enjoy life as valued members of the community. The five year strategy for older citizens sets clear direction for our communities and strives to ensure that the needs of people are met. It also provides a framework of common outcomes that link directly to the ambition and vision within other strategies (Carers, Mental Health and End of Life) currently being developed and in this way helps to bring a shared focus and collaborative approach to service development in Sefton.

Sefton Mental Health and Wellbeing Strategic Plan

Work is also underway to develop a draft Sefton Mental Health and Wellbeing Strategic Plan based on feedback from service users as part of the consultation on the Health and Wellbeing Strategy.

End of Life / Palliative Care

A Sefton commissioning strategy is being developed that will enable patients, carers and families to access appropriate high quality care when facing the issues associated with life threatening illness. The strategy aims to ensure that all services involved in end of life care act in a compassionate way, that treats, comforts and supports people who are living with progressive, chronic or life threatening conditions. All care services need to acknowledge and have a plan for the cultural, personal and spiritual beliefs, values and practices that need to be considered as part of their role in giving support up to and including the period of bereavement

These draft strategies and plans will be further consulted upon to ensure that this strategy and other strategies and plans are aligned, but do not duplicate activities and deliver value for money.

Gaps identified from the Consultation & Engagement Process

Early Onset Dementia

There is currently very little information available about the numbers of younger people (under 65) in Sefton with dementia.

Getting an accurate diagnosis of dementia can take a very long time for people under 65, often due to lack of awareness that dementia can happen in this age group. Medical professionals often misdiagnose them as being depressed, experiencing relationship difficulties, suffering from the effects of stress or, for women, it may be put down to the onset of the menopause.

Younger people with dementia will face different issues, especially if they are still working when they receive a diagnosis. They may face discrimination at work and have to give up work earlier than they would like. As the population ages and the retirement age increases, it is more likely that more people will be diagnosed with dementia while they are still in work.

Dementia care services are usually designed for older people. Some dementia services have a minimum age criterion of 65 and even if services accept younger users the type of care they provide may not be appropriate. This means that younger people with dementia may have to travel considerable distances to access appropriate services or they may be left without the support they need.

It is essential that younger people with dementia have access to a range of specialised services that address their particular needs and enable them to live well with dementia. This should include not only health and social care services, but also wider services that promote their wellbeing such as financial advice and support to remain in work should they choose to do so. Many will have significant financial commitments such as a mortgage. They often have children to care for and dependent parents too.

Their lives tend to be more active and they have hopes, dreams and ambitions to fulfil, up to and beyond their retirement.

The contribution of family members and carers is often very important in helping to reach a correct diagnosis in this age group. Many people say the first sign that something was wrong was that the person 'didn't seem quite themselves' or they started to make mistakes at work that didn't fit with their usual performance

Dementia and Learning Disability

This was raised at the Open Space and Innovation events during discussions around the topic “Promoting Diagnosis”.

Dementia generally affects people with learning disabilities in similar ways to people without a learning disability, but there are some important differences. People with a learning disability are at greater risk of developing dementia at a younger age – particularly those with Down’s syndrome where one in three develop dementia in their 50s. People with learning disabilities:-

- often show different symptoms in the early stages of dementia
- are less likely to receive a correct or early diagnosis of dementia and may not be able to understand the diagnosis
- may experience a more rapid progression of dementia
- may already be in a supported living environment, where they are given help to allow them to live independently
- may have already learned different ways to communicate (e.g. more non-verbal communication if their disability affects speech)
- will require specific support to understand the changes they are experiencing, and to access appropriate services after diagnosis and as dementia progresses.

There is no evidence that dementia affects people with learning disabilities differently to how it affects other people. However, the early stages are more likely to be missed or misinterpreted - particularly if several professionals are involved in the person's care. The person may find it hard to express how they feel their abilities have deteriorated, and problems with communication may make it more difficult for others to assess change.

It is vital that people who understand the person's usual methods of communication are involved when a diagnosis is being explored

Studies have shown that the numbers of people with Down's syndrome who have Alzheimer's disease are approximately:

- 1 in 50 of those aged 30 to 39 years
- 1 in 10 of those aged 40 to 49 years
- 1 in 3 of those aged 50 to 59 years
- more than half of those who live to 60 or over.

With regard to those people with learning disabilities other than Down's syndrome studies suggest that approximately:-

- 1 in 10 of those aged 50 to 65
- 1 in 7 of those aged 65 to 75
- 1 in 4 of those aged 75 to 85
- nearly three-quarters of those aged 85 or over.

These numbers indicate a risk about three to four times higher than in the general population. At present we do not know why this is the case and further research is needed

Strategic Objectives

The following strategic objectives have been identified for the Sefton Dementia Strategy.

Timely diagnosis, appropriate treatment and involvement in care plans – people receive a timely diagnosis of their dementia, have their concerns listened to by healthcare professionals, and, together with their cares, are involved in developing care plans.

Support to live independently for as long as possible, and to make decisions for myself – people with dementia and their carers can live in their own homes for as long as they choose to do so, and can make decisions about choices that affect their lives.

Inclusive and dementia friendly communities – people with dementia and their carers will have support from local communities, will not suffer any stigma as a result of their condition and will be able to live as normal a life as possible for as long as they can.

Information, advice and support for people with dementia and their carers – people with dementia and their carers will have easy access to the information and advice they need to manage their condition, to stay as well and active as possible, and know where to go to find out what they need to know.

End of Life Services, ensuring a peaceful and pain free death in the place of choice – people with dementia and their carers will be helped to plan for their end of life, enabling them to die free from pain, fear and with dignity, cared for by people who are trained and supported in high quality palliative care, in the place of their choosing.

This table also shows how these local priorities relate to the national objectives in the National Dementia Strategy and the Dementia Declaration.

Sefton's Draft Strategic Objectives	Timely diagnosis, appropriate treatment and involvement in care plans	Support to live independently for as long as possible, and to make decisions for myself	Inclusive and dementia friendly communities	Information, advice and support for people with dementia and their carers	End of Life Services, ensuring a peaceful and pain free death in the place of choice
					
Objectives from National Dementia Strategy	• Good-quality early diagnosis and intervention for all • Easy access to care, support and advice following diagnosis	• Development of structured peer support and learning networks • housing support, housing-related services and telecare to support people with dementia and their carers	• Improved community personal support services • Living well with dementia in care homes	• Good-quality information for those with diagnosed dementia and their carers • An informed and effective workforce for people with dementia • Improving public and professional awareness and understanding of dementia	• Improved end of life care for people with dementia
Statements from Dementia Declaration	• I have received an early diagnosis • I can make decisions now about the care I want in my later life • If I work, I have an employer that understand my condition which means I can still work and stay connected to people in my life	• There are a range of services that support me with my daily living that enable me to stay at home and in my community, enjoying the best quality of life for as long as possible • It is easy for me to continue to live in my own home and I and my carer will both have the support needed for me to do this	• I live in an enabling and supportive environment where I feel valued and understood • I have a sense of belonging and of being a valued part of family, community and civic life • I feel safe and supported in my home and in my community, which includes shops and pubs, sporting and cultural opportunities	• I have the knowledge and know-how to get what I need • I have enough information and advice to make decisions about managing, now and in the future, as my dementia progresses • I have information and support and I can have fun with a network of others, including people in a similar position to me.	• I will die free from pain, fear and with dignity, cared for by people who are trained and supported in high quality palliative care

Next Steps

Dementia remains a national challenge in terms of its scale and impact. Research shows that in 2014 there are 835,000 people in the UK who have dementia. Over 40,000 younger people (65 years of age or below) live with the condition.

With an ageing population the numbers of people with dementia in the UK are increasing and as Sefton has an ageing population this will be an issue that will need to be dealt with.

The Partners to the Dementia Strategy will work towards actions that promote early intervention and prevention in order to help to delay the onset of dementia and encourage healthy lifestyles, both physically and mentally, to help improve the wellbeing of Sefton's residents.

Everybody will need to work together to make Sefton a Dementia-Friendly Borough and a place where people with Dementia and their carers can find the support they need to live well with dementia.

The Action Plan, attached as Appendix 1, gives a list of actions against each of the Objectives and partners will use this plan to achieve positive outcomes for people with dementia and their carers in Sefton.

Financial Implications

Delivery of the attached action plan will be contained within existing budgets.

However, where actions will result in additional resources being required then this will be costed and referred to Elected Members and other partners to consider.

For further information on the Dementia Strategy please contact Nicola Beattie on 934 4664

Copies of this document are available in large print and other formats on request. To request this service please call 0151 934 4664

Produced in collaboration with

Sefton Council
NHS South Sefton Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
Sefton CVS
OneVision HOUSING
Leading the fight against dementia Alzheimer's Society
Sefton Partnership For Older Citizens
SPAC Sefton Pensioners Advocacy Centre
Sefton Carers Centre
The Princess Royal Trust for Carers Network Member
Liverpool Community Health NHS
LCH Delivering quality health services in your community
AGE concern Liverpool & Sefton
NHS Mersey Care NHS Trust

Prepared by Sefton Council Business Intelligence and Performance Division, Bootle Town Hall, Oriel Road, L21 7AE, Tel. 0151 934 4664

Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead
Timely diagnosis, appropriate treatment and involvement in care plans	• People will receive a timely diagnosis of their dementia, have their concerns listened to by healthcare professionals, and, together with their cares, are involved in developing care plans.	• People with dementia and their carers will receive the support and care that they want and need, tailored to their individual needs	• Support people early to prevent & treat avoidable illnesses & reduce inequalities in health	South Sefton Clinical Commissioning Group and Southport & Formby Clinical Commissioning Group
	• Agencies will work together to improve the rate of diagnosis for people with early onset dementia and provide access at an early stage to a range of specialised services that address their particular needs and enable them to live well with dementia. To include not only health and social care services, but also wider services that promote their wellbeing such as financial advice and support to remain in work should they choose to do so	• Improved identification of those with early onset dementia and involvement in care plans helping them to live active lives and fulfilling their hopes, dreams and ambitions up to and beyond their retirement	• Support people early to prevent & treat avoidable illnesses & reduce inequalities in health	The Dementia Strategy Multi Agency Working Group

Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead
	• Agencies will work together to improve the rate of diagnosis of dementia in people with Downs Syndrome and learning disabilities ensuring that the people who understand the person's usual methods of communication are involved when a diagnosis is being explored and care plans are being put in place.	• Those with Downs Syndrome and learning disabilities and dementia will be identified earlier and the special challenges that they face will be recognised and the support they need put in place	• Support people early to prevent & treat avoidable illnesses & reduce inequalities in health	The Dementia Strategy Multi Agency Working Group
	• Partners to the Dementia Strategy will promote the early intervention and prevention of dementia including healthy lifestyles, healthy eating and keeping active	• The onset of dementia will be delayed and healthy lifestyles, both physically and mentally, will be developed in Sefton's communities.	• Support people early to prevent & treat avoidable illnesses & reduce inequalities in health	The Dementia Strategy Multi Agency Working Group
Support to live independently for as long as possible, and to make decisions for myself	• The Council will promote increased awareness of the needs of older people amongst those wishing to develop housing in the Borough, including the design and development of a dementia–friendly environment.	• There will be housing provision available that will support the needs of older people and people with dementia to live in their own homes for longer without the need for adaptations to be made.	• Support older people & those with long term conditions and disabilities to remain independent & in their own homes	Sefton Council – Head of Service Regeneration and Housing

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Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead
	• The Council will consider, through the emerging Local Plan process, the making of a policy requiring developers to identify how best to address the housing needs of the ageing population.	• The future housing needs of Sefton's older population will be met, enabling them to stay in their own homes for longer, and living independent lives.	• Support older people & those with long term conditions and disabilities to remain independent & in their own homes	Sefton Council – Head of Regeneration and Housing

	• Partners will provide support and advice to people with dementia and their carers to enable them to keep as healthy and active for as long as possible and prevent further ill health including:-
	  • eating a healthy diet
	  • maintaining a healthy weight
	  • exercising regularly
	  • Not drinking too much alcohol
	  • Stopping smoking
	  • Keeping blood pressure at a healthy level
		• People with dementia and their carers will have improved health and wellbeing and be able to manage their condition themselves, with support, for as long as possible.	• Support people early to prevent & treat avoidable illnesses & reduce inequalities in health	The Dementia Strategy Multi Agency Working Group

Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead
	• All Agencies will develop Dementia Friendly Workplaces	• People with early onset dementia will be supported to remain in employment for as long as possible	• Promote positive mental health and wellbeing	The Dementia Strategy Multi Agency Working Group
Inclusive and dementia friendly communities	• Sefton Dementia Action Alliance will seek dementia-friendly community status for the whole of the Borough.	• People with dementia and their carers will have support from local communities, will not suffer any stigma as a result of their condition and will be able to live as normal a life as possible for as long as they can.	• Build capacity & resilience to empower & strengthen communities	Dementia Action Alliance
	• The Dementia Strategy Multi Agency Working Group will co-ordinate the development of an area based approach to "Dementia Friendly Sefton" by the creation of more dementia friendly areas across the whole of the Borough.	• People with dementia will feel safe and supported in their home and community, which includes shops and pubs, sporting and cultural opportunities.	• Build capacity & resilience to empower & strengthen communities	The Dementia Strategy Multi Agency Working Group

Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead
	• All partner agencies will sign up to the "Dementia Friends" programme by requiring staff to undertake dementia friends training resulting in more Dementia Friendly services, businesses, services and shops.	• There will be increased understanding of the needs and behaviours of people with dementia which means that they will be able to be as independent as possible for as long as possible	• Build capacity & resilience to empower & strengthen communities	The Dementia Strategy Multi Agency Working Group
	• Sefton Library Service will develop the "Sefton Lost Voices Project". The project will record the memories of people who are in the early stages of memory loss.	• People with dementia and their families will have an 'aide-memoire', as the person's memory begins to fade and as a keepsake once the person is lost to the family	• Promote positive mental health and wellbeing	Sefton Council – Head of Service Communities
	• Sefton Libraries will make available a series of memory boxes and reminiscence packs to all areas of Sefton. These will contain old photographs, newspaper cuttings and maps, oral histories, etc.	• The boxes will evoke memories and start conversations with People with dementia and their carers, maintaining relationships and memories.	• Promote positive mental health and wellbeing	Sefton Council – Head of Service Communities