Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead Officer
Information, advice and support for people with dementia and their carers	• Agencies will provide information about long-term symptoms, what will happen as dementia progresses and where to go for advice and support and this will be in a format that is easy to understand. .	• There will be enough information and advice for people with dementia and their carers to make decisions about managing, now and in the future, as their dementia progresses	• Support older people & those with long term conditions and disabilities to remain independent & in their own homes	The Dementia Strategy Multi Agency Working Group
	• All Partner agencies will take a co-ordinated approach to providing information and signposting people with dementia and their carers to the most appropriate agency to obtain information, support and guidance.	• People with dementia and their carers will know where to get the support and guidance they need and will not need to repeat their stories to different agencies	• Support older people & those with long term conditions and disabilities to remain independent & in their own homes	The Dementia Strategy Multi Agency Working Group

Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead
End of Life Services, ensuring a peaceful and pain free death in the place of choice	• The Sefton End of Life Strategy will include support for people with dementia and their carers	• People with dementia will be able 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	• Promote positive mental health and wellbeing	South Sefton Clinical Commissioning Group and Southport & Formby Clinical Commissioning Group
	• Those agencies working with People with Dementia and their carers will ensure that their wishes with regard to their palliative and end of life care are carried recorded and carried out where this is practicable.	• Improved end of life care for people with dementia	• Promote positive mental health and wellbeing	South Sefton Clinical Commissioning Group and Southport & Formby Clinical Commissioning Group
Sefton Dementia Strategy Equality Analysis	• Gather further feedback or evidence on the gaps of our understanding as identified in the Equality Analysis Report	Improved understanding of the needs of the protected groups and how relevant evidence has been used to	• All	The Dementia Strategy Multi Agency Working Group

Prepared by Business Intelligence & Performance Department
7th floor, Merton House, Stanley Road, Bootle.
Version 0.12 140515 – final draft

Appendix 1 – Action Plan

Report		understand the potential equality impacts Update Equality Analysis Report		

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

Consultation Report

G:\Policy\CSU\Public Engagement and Consultation\dementia strategy Author: June McGill
Version 0.3 – 12.05.15

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Summary Report

This report provides a summary of the findings from the consultation and engagement process undertaken on Living Well With Dementia: A Strategy for Sefton 2014-19. The consultation and engagement process took place over during the summer of 2014 and included:-

- Two Open Space and Innovation Events held in Southport (1st July 2014) and Bootle (3rd July 2014) for providers of services, voluntary community faith sector, shops, businesses and offices
- 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, 169 people engaged with the process. These are some of the common themes that people raised as part of the consultation process:-

Key findings from the Open Space and Innovation Events

Creating Dementia Friendly Communities

- Communities need to understand dementia and offer support and challenge stigma
- Education is important
- Help people to make changes to live well with dementia and as normal as possible for as long as possible.

- Support carers so that they don't lose their own identity.
- Ask people with dementia what they want
- Process for businesses becoming "dementia friendly" is too complicated and onerous and needs to be simplified
- Early diagnosis is essential
- Care homes should become community hubs and have more interaction with the public

Promoting diagnosis and supporting people to live independently

- Downes Syndrome: early screening for dementia for children/adults with Down's Syndrome as dementia statistically more prevalent in people with Down's Syndrome.
- There needs to be community based health services to maintain people in their homes for as long as possible
- There needs to be meaningful day services for people with dementia. People with dementia need activities that stimulate them.
- There needs to be a whole person approach – services need to be flexible to meet the needs of individuals.
- Need to promote the importance of getting early diagnosis. There are drug treatment and services available and early diagnosis needs to be viewed as positive.
- There needs to be easy access to Information, advice and guidance following diagnosis.
- There needs to be a structured pathway following diagnosis with other agencies involved in agreeing, developing and supporting it – information, advice, guidance, face to face, advocacy, networks and groups etc.

Information, advice, support for people with dementia

- Carers struggle on without support because they don't know what is available or they don't want people to know they aren't coping.

- Family members don't know what signs to look for when somebody is struggling.

- People need to know where to go for advice and support - Dementia agencies, pharmacists, Age UK, SAGA, etc
- More needs to be done when people are diagnosed. People are diagnosed and then just left to get on with it with no information about where to go for support.

- Need to give positive messages about dementia. It's not all over just because you have dementia – it's not all doom & gloom. Use people who are living well with dementia as champions to promote positive messages.

- Information needs to be available using language that everybody can understand. Avoid using jargon and medical terms that people can't understand.

Key findings from questionnaire for People with Dementia

- 7 people completed the questionnaire. This was facilitated by the Alzheimer's Society.

- On the whole people with dementia found it easy to get a diagnosis and that they had received enough information about their condition.

- Most people said that their GP noticed or that they noticed themselves that they were having problems.

- With regard to things that are working well for people with dementia one person felt that the time between being diagnosed and attending the memory clinic was too long, and another had found it difficult to adjust. Other respondents felt that the Alzheimer's Society was particularly helpful.

- One person had spent time in hospital and their experience was not good, with food being put out of reach, and not answering the bell during the night when they needed to use the commode.

- People that wanted to attend events and classes already do.

- Everybody that completed the questionnaire felt that everything that was important to them was covered.

Key Findings from Questionnaires for Carers of People with Dementia

- 20 people completed the questionnaire and this was facilitated by the Alzheimer's Society and the Carers Centre.

- On the whole carers noticed themselves that the person they care for were having problems with their memory. The majority felt that it was very easy to get a diagnosis for the person that they care for and that professionals listened. 80% also said that they had received enough information about dementia.

- With regard to specific information that carers would have liked to have received this included more information about the long-term symptoms; how to go about choosing residential care and the costs involved and more information about aftercare following diagnosis.

- When asked what had gone well in their role as a carer of a person with dementia, comments related to

    - ❖ problems getting reliable carers
    - ❖ having to making all decisions by themselves
    - ❖ Lack of help with transport.
    - ❖ Working through the minefield of financial support

- When asked about what was important to them as a carer of a person with dementia, carers felt that in terms of healthcare for the person they cared for it was important that they saw the same person so that they didn't have to repeat their story and over again to different people.

- With regard to the person with dementia being asked what they want, including their likes and dislikes, even if they find it difficult to answer, most felt this was important.

- All those who completed the questionnaire felt that it was important that the person with dementia should have a say in their end of life plan.

- With regard to the provider of care services, half of those who answered said that they had a choice of provider.

- Where the person with dementia had spent time in hospital comments about their experience included food just being put down and left which resulted in the person not getting anything to eat.

- Of those who indicated that they have opportunities to talk to other people in the same situation as themselves, comments included:-

    - For the person with dementia to attend a Day Centre for one day a week for him to mix with different people.

    - To be able to talk to carers in similar situations would be very useful as ideas, methods used, etc., could be swapped

    - Have had very good chats with the psychiatric nurse who gave us some good advice which stood me in good stead

- Carers were asked if there was anything else that they would like to do such as attending events and classes at local centres:-

    - If I want to go out for the day I would like him to be able to go until about 6.30 and then I could pick him up

    - I only go to events where you can both attend. I do not have time to attend classes.

- ❖ Would like to attend classes but not been possible until recently when I have managed to place my wife in day care

- The following additional comments were made by carers:-

  - ❖ Being able to come to the memory clinic to discuss any problems we may have

  - ❖ Although there are a lot of people waiting to help and a lot of information that is available, it can be a bit of hit and miss on whether you get all the support you need.

  - ❖ Perhaps when a person is first diagnosed with dementia somebody should identify who the carer is going to be and make sure they have a copy of something like the excellent "Dementia Guide" published by the Alzheimer's society.

Key findings from interviews with Carers of a person with dementia who has recently passed away

- A questionnaire was produced for use with a very small sample (3 people) to find out about end of life services for people with dementia. The interviews were undertaken by staff from the Carers Centre.

- The length of time that people had suffered from dementia prior to death ranged from 2years to 10 years. Of the three responses two people were in a care home and one was in hospital.

- End of Life Care Plans were in place for two of the three people, and in both cases the wishes of the person with dementia were carried out.

- When asked about support (including for the carer) in the final days, this was provided by care home staff, NHS staff, the Alzheimer's Society, GP, Mental Health Team, District Nurses and a Priest.

- With regard to general comments one person indicated that getting a diagnosis was very hard as letters from the GP were sent to the person they cared for so diagnosis was not made until they were in

hospital for another reason. They also found out about Alzheimer's Society far too late.

Key Findings from the General Public Questionnaire

The questionnaire was designed to test out people's thoughts and understanding about dementia and the draft Strategy, and was completed by 78 people.

The first section of the questionnaire was to get a picture of people's understanding of dementia and on the whole most people have a good knowledge of what dementia is, how it can be treated, and the standard of life that people with dementia can have.

It also asked about people's thoughts about what people with dementia should be able to do including:

- 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
- Have a single point of contact for their dementia care

Most people agreed with all of these statements. The only exception was that people with dementia should continue to live alone which had an equal split between agree, disagree and not sure.

People were then asked for their thoughts on the following statements:

- **People with dementia should be involved in activities in the community** – most people agreed with this statement

- **It is better for people with dementia and their families if they are cared for in a residential unit or a nursing home** – most people disagreed with this statement

- **There is little or no benefit to be gained from telling someone they have dementia** – the majority disagreed with the statement or were not sure about it.

- **People who have just been diagnosed with dementia are unable to make decisions about their own care** – most people disagreed with this statement

- **There is no point in trying to talk to people with dementia as they won't be able to understand** – most people disagreed with this statement

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

The final section asked about the Strategy itself. It listed the aims for people with dementia in Sefton and asked people to rank them 1-9.

The top five selections were:-

1. People with dementia should be diagnosed in a timely way
2. People with dementia are treated with dignity and respect
3. People with dementia get the treatment and support which is best for their dementia and their life
4. People with dementia will have help in planning for their future health and care needs through a co-ordinated health and social care service.
5. People with dementia's wishes with regard to end of life will be respected

Respondents were then asked to rank the Strategic Objectives in the Strategy from 1-5. These are the results:-

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

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 fulfill, 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

Information and Background

The refreshed Dementia Strategy and consultation has been developed 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.

Where we started from: Sefton Dementia Strategy 2009 – 2014

Following publication of "Living Well with Dementia: A National Dementia Strategy" which was published in 2009, a multi-agency group was formed to deliver a Sefton Dementia Strategy. This group comprised officers from NHS Sefton, Sefton Council, Mersey Care Trust, Sefton Carer's Centre, Sefton Pensioners Advocacy Centre and Sefton CVS and also included GP representation.

The National Dementia Strategy provided a strategic framework which local commissioners and service providers could use to deliver quality improvements to dementia services and address health inequalities relating to dementia; provide advice, guidance and support for health and social care commissioners and providers in the planning, development and monitoring of services; and provide a guide to the content of high quality dementia services.

It was recognised that the National Dementia Strategy would take up to 5 years to implement. The national strategy included 3 key themes, namely:-

- raising awareness
- early assessment and diagnosis and
- living well with dementia

17 objectives in support of the themes had been developed to ensure local access to services for people with dementia and their carers, and five key priorities for action in Sefton 2009-2012 were identified as follows:-.

- Improving Public and Professional Awareness
- Early intervention and diagnosis:
- Improved community support services;
- Improved quality of care for people with dementia in general hospitals:
- Living well with dementia in care homes

Work was undertaken to review services for people with dementia and develop priorities for future investment. A consultation exercise was undertaken in 2008 and a carers' survey undertaken in March 2009 formed part of the review process to assist Commissioners to determine future investment priorities and identify opportunities for service re-design.

The Strategy was monitored and reviewed by the Sefton Partnership for Older Citizens, which in turn reported to the Healthy Communities and Older People sub-group of the Sefton Borough Partnership.

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

Sefton's current strategy for Dementia runs from 2009-2014 and 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.

Dementia has been identified as a Government priority and there was an additional marketing campaign, the launch of an online training tool and a dementia promise during April 2014.

Sefton is also currently refreshing its Carers and Older People's Strategies, the consultation on which has recently taken place, and this provides an opportunity to ensure that the Dementia Strategy is linked to both of these Strategies.

The Consultation and Engagement Process

This report brings together the feedback from the communities of Sefton and sets out the key points and recommendations that have emerged through our conversations with the public and stakeholders over the recent months.

A multi-agency working group including officers from the two CCGs for Sefton, Sefton Council Business Intelligence and Performance Team, Merseycare Trust, and the Voluntary and Community Sector developed and progressed the consultation and engagement process for the Strategy. The group is chaired by the Cabinet Member for Adults and Health, Councillor Paul Cummins.

What are the aims of the engagement process?

The aim of the consultation is 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.

The outcome of the process is the development of a final version of **Living Well with Dementia: A Strategy for Sefton 2014-2019** which will inform the future planning, commissioning and delivery of services for people with dementia and their carers in Sefton.

Engaging Sefton's communities; what we did and why

The Steering group developed the proposed methodology for consultation as the representatives from the groups that work with people with dementia have experience about what approaches would work best.

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. Guidance from the Dementia Engagement and Empowerment Project (DEEP) suggests approaches including small group discussions using pictures to help people connect with the discussion topic, visual aids to help people remember questions i.e. noting them on a flipchart or post it note, and using creative approaches to reflect views such as making collective pictures.

Taking on board the need to tailor consultation to specific groups, separate questionnaires were developed:-

- A questionnaire for people with Dementia
- A questionnaire for people who care for a person with Dementia
- A questionnaire for carers who have recently lost a person with Dementia
- A general questionnaire to collect the public's perceptions and understanding of dementia

Two Open Space and Innovation Events for people, organisations, groups and providers of services were held. One in Southport on 1st July 2014 and one in Bootle on 3rd July 2014. The purpose of the events was 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.

How did we engage?

Open Space Innovation Events

In order to find out about people's experience of dementia and living well in Sefton a wide range of people, organisations, groups and Providers of services were invited to come along to two Open Space and Innovation Events. The events were held on Tuesday 1st July 2014, at The Atkinson, Southport and on Thursday 3rd July 2014 at Bootle Town Hall. People could drop in and out of the sessions any time between 9.30 a.m. and 12.00 p.m. to share their views, thoughts, ideas and experiences about how we could work together to make a difference to the lives of people living with dementia and their carers.

61 people from a wide range of organisations attended the two events.

What is an Open Space Innovation Event?

Open Space – Innovation Events enable people to drop in, join a discussion, listen to others within an 'Open' agenda and the 'Space' to share ideas and create solutions.

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There is no preset agenda other than the topic previously agreed and the time allotted for the meeting. From the start of the event until the agreed end time people meet in groups to discuss and make recommendations for action which they consider are relevant to the specific issue – in this case improving the lives of people with dementia and their carers. A facilitator was available for each topic to guide the discussion and a scribe took notes of what was discussed.

Three discussion areas were agreed. These were:-

- Promoting diagnosis and supporting people to live independently
- Information advice and support for people with dementia and their carers
- Creating dementia friendly environments and communities across Sefton

In addition a Dementia Awareness/Dementia friend's area was available to give people the opportunity to find out more about dementia

People attending the sessions were free to move between the discussion areas to ensure that they were able to put forward their views on all the topics.

What did the consultation tell us?

Open Space and Innovation Events

Discussion took place across three topics and participants were able to move to different discussions as they wished:-

Three discussion topics were:-

- Promoting diagnosis and supporting people to live independently
- Information advice and support for people with dementia and their carers
- Creating dementia friendly environments and communities across Sefton

The following comments came out of the discussions on each of the topics:-

Promoting diagnosis and supporting people to live independently

Southport Event

- **Down's Syndrome**:-
  - Early screening for dementia for children/adults with Down's Syndrome – dementia is statistically prevalent in people with Down's Syndrome and is being diagnosed more.

- Barriers to diagnosis include lack of information, lack of awareness for professionals, carers and families and general Practitioners not engaging.

- Carers are more likely to spot early signs of dementia in people with Down's Syndrome and thus the relationship between the carer and the General Practitioner needs to be stronger and based upon mutual respect and trust.

- If diagnosed early treatment can slow down the condition.

- There have been no issues to date of people with Down's Syndrome who are cared for going missing from home as far as anyone in the discussion was aware.

- **Assisting people to live independently:-**

  - A decrease in funding of packages of care may impact on people being able to live independently.

  - Important that for people with dementia who are attending hospital for treatment there is no delay for their discharge as long stays often have a negative impact on the mental wellbeing (effects them cognitively).

  - Needs to be more community based health services to maintain people in their homes for longer

  - Currently no way of giving intravenous treatment for more than twice a day – more cost effective to invest that resource in the community rather than potentially blocking hospital beds.

  - Visits to people in the community need to be for at least 30minutes and although this is currently the practice in Sefton this needs to be monitored effectively through contracts and commissioning to ensure compliance.

  - Continuity of carers going to see people in their homes – this is generally provided by commissioned agencies and there can be a high turnover of staff which does not allow for service users to build up a relationship/connection with their carers and this can add to their confusion/distress.

- Meaningful day services for people with dementia - loss of day centre provision from the Local Authority. People with dementia need activities that stimulate them. Sefton is currently looking at how it provides day care.

- Services are still a postcode lottery based upon what different agencies/trusts provide. North/South divide in terms of services available.

- Need more home care support services, particularly out of hours/night-time.

- Wider impact of those with dementia on those around them; carers, friends, family etc.

- Better use of new drugs that becomes available on the market.

- Home adaptations and accommodation design are important. Currently One Vision Housing is working on a design brief as part of their community based accommodation update/refresh that is dementia friendly. Has to be non-intrusive.

- Need to build dementia friendly considerations in to our everyday capital schemes. Taps with cut off sensors to prevent sinks/baths over flowing.

- More co-operation and integration of services.

- Better signposting for all.

- Managing risk to help people live independently.

- Greater awareness amongst professionals around roles and responsibilities – Who does what?

- Whole person approach – services need to be flexible to meet the needs of individuals.

- Understanding the General Practitioner's referral process.

- How do we support the support networks? Mutual support services/networks based upon people's experience.

- **Promoting diagnosis**

  - People's reluctance to get help in the first place due to stigma associated with mental health. Also people and families can often be in denial about the condition and try and cope as best they can.

  - General Practitioners – difficult to diagnose due to memory loss being often a symptom of other physical problems being presented at surgeries. General Practitioners tend to deal with the physical diagnosis first so often the dementia diagnosis is either lost or delayed.

  - Need to promote the importance of getting early diagnosis – drug treatment and services available. Early diagnosis needs to be publicised as positive.

  - More needs to be done on awareness raising to improve the public's perception of dementia.

  - Negative media has had an impact on people not wanting to be diagnosed in case then end up in a home that turns out to be poorly managed with poor practice habits. – Needs more positive press.

  - General Practitioner training and awareness raising – some General Practitioners are reluctant to diagnose until the patient and family reach a tipping point.

  - General Practitioner diagnosis needs to be consistent in their approach – some are overzealous and others too cautious – training to help assist.

  - The physical impact on health of people suffering with dementia needs to be recognised.

  - Being taken out of routine environment tends to highlight the issue and it is then that professional's, carers, family can help to identify and seek an assessment for diagnosis.

- A significant amount of people remain un-diagnosed.
- Professionals need to be more aware of the signs to look out for. 'Every contact counts' approach. Part of staff core knowledge.
- Professionals need to have the confidence to identify and broach issues with the individual and families (training).
- Need to investigate how local businesses can help to identify those perhaps not yet diagnosed and who do they raise this with and where does it go to?
- Need a similar campaign as Cancer in terms of the number of people dementia affects and the nature of the illness. Current campaigns around dementia have portrayed a negative image of the services received.
- Need to raise awareness that it is not just an older person problem but is wider than that. Start to teach as part of a general life course awareness raising in schools around the topic.
- Posters in prominent areas such as super markets.

The following were discussed as possible actions to take some of the above forward:-

- One Vision Housing would like a link in to Adult Social Care Services to understand the access criteria and what is available.
- Need to identify where awareness raising training currently take place in the borough?
- What level of training do Police officers have and in terms of places of safety could they be made dementia friendly?

- **Services**

  - Memory Clinic – based in the North of the Borough and linked in to the Alzheimer's Society. Could the service perform dementia assessments as an outpatient /community based service to avoid delayed discharges in hospitals? Is there evidence that this is a successful service, with appropriate waiting times and easy access?

  - When someone is diagnosed they need to have a link with Alzheimer's Society to ensure someone available to be present at the diagnosis to help answer questions and to offer support.

  - All referrals come from General Practitioners.

  - Support with early memory loss, post diagnostic work, signposting, information giving.

  - Agencies advise that they struggle to get people with severe learning difficulties assessed by Memory Clinic.

  - Pharmacists – What do local Pharmacists do in terms of identification of dementia?

  - Walk In Centres – What do local Walk in Centres do in terms of identification of dementia?

The following action is proposed with regard to the above:-

- Mersey Care Learning Disabilities to feed in to Dementia Meetings

Bootle Event

- **Assisting people to live independently:-**

  - Need to consider the impact on the family and carer(s) around the individual as they offer the most support and their health is just as important to maintaining people in their own homes longer. Also need to consider their social isolation as they often lose touch with people around them when they become the main carer (issues such as lack of sleep, increased stress levels, becoming agitated).

  - Friends and family avoid people with dementia due to a lack of understanding of dementia.

  - Cross generational work – shift in culture – young people and older people working together.

  - More work around understanding changes in behaviour as a result of dementia.

  - Immerse the family in what is happening.

  - Easy access to Information, advice and guidance.

  - Information, advice and guidance following diagnosis.

  - The assessment process needs to be more holistic and should involve other agencies who provide services as well as the person, their family and carer.

  - There needs to be a structured pathway following diagnosis with other agencies involved in agreeing, developing and supporting that pathway – information, advice, guidance, face to face, advocacy, networks and groups etc.

  - More preparation work with families/carers around planning for the future.

  - Need to consider managing end of life treatment for those with dementia, for example managing pain medication.

- At what stage do we decide when a person can come and go as they please when suffering with dementia? Managing the risk. Awaiting judgement on deprivation of liberty.
- Use of dementia friends.
- Currently services are available based upon postcode and this is not equitable.
- What is available – community equipment? Helps people to manage longer.
- Opportunities for people to meet and talk with similar people who are experiencing dementia.
- A mobile night visiting service that also offers a sitting service during the week.
- Need to consider those with dementia who have no family or carer.
- Need to revise/review the virtual ward model.
- Need to consider how we wrap the care around the individual and their carer.
- Need a 24hour 7day a week contact service for health and social care.
- Difficult to get an emergency respite night.
- Keep the individual active and improve availability of low level interventions.
- Health and Social care fragmented - confusing to both the public and professionals.
- Need a key worker for continuity when dealing with family and those with dementia.

- Doing nothing is not an option – increasing elderly population with more complex needs in Sefton matched by decreasing resources.

- Transport is an issue for people being able to access day care provision.

- Diagnosis rates for dementia are around 50% of what is believed to be the actual figure.

- **Promoting diagnosis**

  - Difficulty of accessing services as some General Practitioners diagnose only the physical health problems and overlook the potential mental health issue of dementia.

  - A general awareness raising campaign like the one rolled out for Cancer that reaches most people and training as part of a core set of skills for all professionals with regards to dementia.

  - Families and carers more likely to spot signs earlier. They need to know who they can speak to i.e. the persons General Practitioner about their concerns.

  - Need to look for the signs of people putting in place strategies and coping mechanisms to mask their illness and prevent early diagnosis.

  - Dementia needs championing positively in terms of early diagnosis. Too much bad press.

  - Still perceived as a memory issue.

  - Specialist General Practitioners with a clear understanding of dementia being available to colleagues for advice and guidance?

  - Feedback from families is that they would have appreciated advice and guidance earlier.

- Early diagnosis can lead to years of improved quality of life.
- Need to remove the fear or stigma of going in to a care home for those most needy.
- Sharing information and improving communication.
- Improving the negative image/perception of social care i.e. all they do is put you in a home.

The following action is proposed with regard to the above:-

- Post-diagnostic support available in North of Borough but not the South (Alzheimer's Society)
- **Services**
  - Health and Wellbeing Trainers – work with community, operate out of Burlington House via Sefton CVS, work around social isolation, offer training, link with some General Practitioners (those willing to engage), part of the Virtual Ward.
  - Memory Clinic – How may people do they see?
  - Community Practice Nurses – need to be trained and made aware as to what is out there.

The following action is suggested with regard to the above:-

- There needs to be a mapping exercise of befriending services in Sefton. There are currently long waiting lists – anywhere from 12weeks to 6months..

Information advice and support for people with dementia and their carers

Southport Event

- **Support for People with Dementia and their Carers**

  - People are isolated – couples live on their own and say they are coping. Are people struggling because they don't want help or don't know where to go. People just muddle along until they are in a crisis situation

  - Husbands/wives tend to think it is their role to be carer, for better or worse and don't seek support - the Label "Carer" inhibits people to get help because they are a husband or a wife. People need to be a husband or wife and understand that other "SUPPORT" is available - it is ok to have support. People need to understand they won't be a good carer if they don't get support

  - Some people are private and don't want to show they are vulnerable

  - People say Social Care hasn't worked for me after a bad experience and aren't prepared to try anything else

  - Some family members are controlling and abusive, is this conscious or does it come after years of caring and you don't realise your behaviour has changed

  - The main carer often sees other family members as interfering and pushes them away. Other family members or friends trying to get help are kept away by the carer (husband or wife)

  - It often gets to the point where the carer can't look after themselves. If a carer becomes ill and there are no family members around they can become a crisis

- People need to get over the stigma of being a carer. Maybe we should say someone is not “THE” carer but “A” carer, part of a supporting care team. People don’t like the word carer, they are a family member and we should use a whole family approach

- People sitting services are needed

- People miss out on the bigger picture; a little bit of help can make all the difference. How do you get a little bit of help? Where do you go?

- Money – Paying is an issue if you don’t get the service you are paying for

- Professional carers get people up from 11- 5pm so care isn’t tailored, people want to be up 6-10pm ish. Commissioned services are dictating delivery. Staff can’t do later because of block contracts, so people don’t want service as they can’t deliver what is needed. There is an intensive time in the morning and evening when lots of staff are required but not available

- Respite is only every 6 months, there needs to be a shift, there needs to be financial proof that giving a carer £1000 to have respite will save money in the long term by keeping them well

- 2 main barriers – hard to reach holding onto role as carers and the service options available (home care or care home) are not suitable

- Couples protect or mask each other

- Family members don’t know what signs to look for (no food in cupboard)

- Health professionals need to be harsh and tell people “you are not helping”

- GP’s play a pivotal role

- Support need to produce an “at risk profile” from demographics – over 70, no children in the areas, possibly visit GP regularly because they are lonely or don’t visit at all. These should be on a high risk register and on GP’s radar

- Organisations such as affordable warmth go into people’s houses and see risks, they should pick up on these and be able to feed them back, anyone gaining access to someone’s home should look for risks

- We should see the person not the illness, people have a range of illnesses and they shouldn’t be labeled. Medical staff often don’t worry about other ailments such as heart conditions and just deal with the dementia, dementia often masks other conditions or it might not be dementia but similar symptom

- People don’t want to admit they have a problem - If they get help first it can be better

- People need support before diagnosis as this can take a long time

- Care home staff can see deterioration over time but families can’t see it and won’t accept – a lady took her mother to Spain against advice because she thought she was ok and she was very confused which shocked her daughter who then booked a cruise

- Gentle conversations need to be had with families to build confidence about stigma

- We need to build support around the family unit

- People are angry, confused and frustrated, the main carer also has their own medical needs but no time and no one to speak to

- We need to speak to people at the right time and have tougher conversations in a supportive way and this issue is not going to go away

- We need to recognise carers as this is how we society is going to cope

- There is bad press about paid care - and paid care is open to abuse

- We need to give skills to older men re cooking / washing etc as they will never have done them before, change cultures so they can offer support

- There should be behaviour risk management

- We need wrap support round people and maintain anyone already around then add to it

- We are all carers at different levels at different times in our lives we might need to make small adjustments to our lives but it's about loving someone, duty, responsibility, it shouldn't be because we have to but because we want to. Some people don't have this view due to expectation that it is the NHS responsibility, where has love gone? There needs to be conversations that it is your responsibility, there has been a culture shift of people becoming selfish, they ring an agency and their job is done, people need to take ownership and we assist no do for.

- We recruit by behaviour now and we should be assessing the behaviour of families, we need to understand people's attitudes before they are assessed, we need to separate those who feel care should be free and believe it

- **Information and Advice**

  - Where should people go for advice? Dementia agencies, pharmacists, road shows, Age UK, SAGA (over 50's, silver surfers, have DOB to mail shot you)

  - People who get lots of information in the post don't read it and just bin it

- Organisations need to say the same thing, they need to give a consistent message and advice

- Organisations and charities should work better together and not be in competition with each other (at the Southport road show 3 different organisations were recruiting befrienders and competing against each other). Organisations should, join up, not be competition. Commission differently, work better together, pool resources, work differently, pool befrienders and sitters etc

- Information should all be put in one place and be accessible. Someone can show you how to use the information as long as it's all in one place. There should be simple stuff on the web not just diagnosis stuff

- There needs to a process in place not just a directory, a flow chart of long term condition info and advice. The Sefton directory just confuses people. We need to lay out the process families will go through

- More needs to be done at diagnosis, don't just diagnose and leave, show pathway and where to go

- Use mosaic to see how people would like to receive information

- One Vision Housing has given a pack to 1000 residents. We need to learn from this process and experience

- One Vision Housing have used the house of memories approach and this should be replicated

- There should be core information for all, if you wait till the GP tells you, you won't get it All organisations should agree basic information, at the minute information is confused and people don't do anything until it's too late

- There is a mismatch between care services language and public language, language is important (service user / client – all misunderstood) (frail elderly, Elderly & mentally infirm – degrading) People don't want to be labeled

- There should be information on early signs and symptoms and how to get help
- We shouldn't use negative labels
- A key message must be early diagnosis, if you're worried about your memory see your GP. How do we raise awareness – early diagnosis
- People are swamped with information, advice and competition between charities
- Leaflets and shops etc should use assessable information and pictures, less info & easy read (this is important for low level adult literacy, EASL too)
- People are coming to use the shops as they have more confidence, time to pack, go slow isle, people wear a badge if you need help
- Information in shops rather than GP's is good
- We need to share information, but let the individual store info and share it with who they want so no data protection issues

- **Other issues**
  - We need to support people to share their experiences with the strategy development group so we can get under the skin of issues
  - We don't shout loudly enough about carers. Sefton is a very caring borough but we do not champion this, we should have pride in carers, value them
  - Lots of carers don't recognise they are carers yet they have bought into the situation
  - This is just about us living as we will all go through it at some point with a friend / relative or ourselves

- Organisations and commissioning work in boxes so it can never be person centered

- Society has unrealistic expectations – some people can't be bothered caring for family members, we should champion great families, self care, saving money for later life care, having the human touch and listening to people. We need to reset language as we are speaking 2 different languages

- We only work at the tipping point but need to move to prevention

- We could have a Sefton version of a time bank and celebrate skills and gifts

- People with dementia have gifts and skills to share in communities and just need support. We need to get people out into the community

- We should listen to individuals but encourage them to live well in their community

- Do neighbourhoods still support each other, if it's a stable area then yes but if not no, people don't know where this support is happening or how to replicate it

- Housing providers have a responsibility to design friendly communities with low fences, walking paths etc where community champions can be based

- A block of shops has done its dementia friends training but a stumbling block is getting them to write action plans (there needs to be a light version for small businesses) – there's pop up pubs, badges, training, GP lead, memory prompts

- Faith communities – how helpful are they? Churches are big but we don't know what they are doing we need to grow and join together

- Is it dementia friends or People friendly? Family friendly, respectful, elderly friendly (MH, LD) we should be a people friendly borough running a campaign on dementia / LD etc we

should be disease or condition friendly. Champion great families, communities, Sefton a great place to live

- We need to celebrate positive stories and messages like cancer, there needs to be positive marketing and mindset. We need to show its not all over just because you have dementia – there are lots of funny stories, it's not all doom & gloom

- Because of the pattern emerging in the UK, China have passed a law 20 years before its needed making it illegal to abandon an elderly relative

- Families are not making the best decisions because of money, they are protecting their inheritance, and there have been cases of people being locked in cellars. We need to talk honestly about money – people don't like to talk about it because it's embarrassing but people wouldn't demand a paid for taxi from M&S so why do they expect it from A&E? We need to set out the costs in plain English and have discussions

- We need a "right & wrong" is this the way to treat people campaign, like moral dilemma story lines / cartoons which one are you

- There was a couple he was in his 80's and her in her 60's they used all of their savings on his care, she had no money left after he died to look after herself, is this fair?

- Some people don't want relatives back after they've been in care or hospital and they do things so they can't move back, last week a man dumped his mums furniture so she couldn't move back to her home as he'd moved in and didn't want to share

- People dump relatives before they go on holiday, we need to start involving the police if this happens

- We need to speak the same language and not pass the buck from one organisation to the next deal with it, we need to get our ducks in a row as a whole team

- If the system falls over, start again, people play the system and its a cycle

- We need to assess how efficient people are being at managing their own health, find out who is inefficient and have conversation with them, private industry would know who they are and do something about it

- We need to keep people on track on a pathway with one care plan the we all feed into

Bootle Event

- **Support for People with Dementia and their Carers**

  - It has takes a long time to get a mental health assessment for a lady being aggressive – there was lots of red tape, her family were reluctant to do anything or admit there is a problem, 1 month on and still there has been no action, time scales around assessment need addressing. Once a risk has been identified I would expect the issue to be escalated, as would be the case with a safeguarding pathway referral.

  - Issues are that people live on their own and wait until they reach crisis point – they then call the GP who rings the rapid response team, often they have an infection (such as a water infection) this can make them more confused and increase the risk of falls. People get up to 4 care visits per day bu7t nothing at night making night falls a risk, they often get up a lot at night, these people don't need to be in hospital but are not safe to be at home alone, people are placed in nursing homes for a few weeks and then have a trial at home to see if they are ok.

  - If the main carer is ill and goes into care for safety, them a double placement is needed, the CERT provide 72 hours of emergency cover but sometime this has been known to last 2 weeks.

  - People often ring and say they are not coping but this is not medical it is social; social services are very slow, why? Is the system clogged up?

- The CERT do the following – refer to Chase Hays for 2 weeks rehab (there are never enough beds which causes a back log), advocacy, befriending and help with shopping, housing support if homeless, make phone calls for people or give numbers (e.g. Carers Centre), take people to the carers centre

- The CERT is a multi disciplinary team of Nurses, GP's, Physio, OT, Memory Clinic

- We shouldn't see someone with dementia in isolation of their support network

- Anyone with dementia needs support - It financially makes sense to support

- In the past people have lived for up to 40 years in care, but thresholds are increasing so better if people live longer at home, this is better because their surroundings are familiar.

- We should support people who care to do it for longer

- We should keep people at the lower end of the spectrum as long as possible

- Families need support for long term conditions

- Dementia "Friend" – they are not a carer or an expert just a friend, this language is very good

- **Information and Advice**

  - There is lots of information available

- The CERT (Community Emergency Response Team) –People don't know who we are, we need to raise the profile with professionals as they do the referrals, we need to work hand in hand with social workers / services to pick up the slack

- Self funders do not want to pay for care (they say why should I pay) so pull out after 2 weeks (not 72 hours) then they are in crisis again and it's just a spiral.
- The CERT signpost to luncheon clubs but there are not a lot around

- The CERT do not use a PC but use hard copy directories

- One vision are holding a focus group together looking at peoples experience

- Small changes to environment can make a difference (housing & communities)

- There is lots of information around – but how do you know? You only know what you know

- Information should be not all IT based as not all on PC

- Information should be at GP's, Post office – Places where people go, also we should inform the people who work there and educate them about what groups are available locally

- We do not need to invent anything it's all there it's just about getting hold of it

- Information shouldn't just be with GP's as people are anxious at Dc's and don't read notice boards, we need to target people

- We also need to target carers – the free press is good

- People can live well and extend life so not all negative

- We need champions who are living well to promote in the media

- People don't know what to say so don't ask in case they get it wrong, saying anything is the right thing saying nothing is wrong

Creating dementia friendly environments and communities across Sefton

Southport Event

- Sefton Careline offers assistive technology to help people stay at home – alarms, monitoring, pressure pads, fall monitoring based on individual needs.
- Changes in benefits are affecting people with dementia and their carers
- Wander alerts/alarms linked to central point to advise when people go out on their own
- There is CCTV monitoring in sheltered schemes – but only in public areas for security purposes.
- CCTV monitoring of people with dementia in their homes – has privacy and human rights issues. Fine line between wanting to check person is ok and spying.
- Telehealth/Telecare is helpful – uses system like SKYPE so that professionals can contact patients to take BP readings, consultation on-line and results are sent to a central point.
- Danger that technology is replacing the personal touch which is important for people with dementia.
- We need to encourage people to do more for themselves – so they can get out of the house, build and maintain capacity and avoid social isolation.
- Early Stage Dementia – people worried about perceptions of them and it puts them off doing things for themselves – deteriorate much more quickly.
- Befriending Services are good – but over-subscribed. Do we need to identify who is providing them and encourage them to work together, identify areas where they are duplicating provision to enable them to reach more people over a wider area – need to promote volunteering.

- Use existing resources to widen help for people with dementia by training people up to become Dementia Friends – use SPOC/SPAC/VCF sector and also encourage public sector partners to become more active e.g. refuse workers being able to signpost people etc.

- Need better data sharing protocols between agencies to identify people with dementias. At the moment there are problems sharing personal data.

- Older People in general aren't accessing food banks – missed opportunity to identify those who need help.

- How do people know if shops/businesses are dementia friendly? No plaque or branding available and process to get some recognition is overly bureaucratic and needs one person to co-ordinate – off putting for small businesses

- Need to get public transport/taxi services on board – Dementia Friends Training.

- Community Leaders need to take ownership – encourage more DF areas.

- Need to change culture in neighbourhoods – build trust and encourage neighbourliness

- Safeguarding issues – where informal help is in place may be problems where people have memory issues in accusations of things happening that haven't actually happened. May put people off.

- Should we develop "informal neighbourhoods" rather than formal volunteering routes?

- How do we identify and help the "unwilling carers" who start off doing a bit but then end up as full time carers.

- Nursing Homes are seen as somewhere were "people are put" and don't come out of rather than somewhere that people might choose to

go for respite or short term care. Need to change perception and use them more as community facilities.

- Community Centres could be used as a catalyst to bring communities and resources together and work more collaboratively
- Education and awareness needs to have a more positive approach
- How can society move on to help people with dementia live well
- Dementia Friendly is of benefit to the whole community
- Needs a more positive approach to dementia – to make it less frightening using a more informal approach
- Is better planning part of the solution? Things like end of life planning, better information about changes in journey, etc.
- Need to make people with dementia "feel like people" rather than just focusing on condition.
- Approaches such as memory boxes, pop up shops, pop up pubs, music therapy, etc. are working well but heavily oversubscribed. Can we extend this further?
- How do we build up networks/communities that have been lost?
- Don't see people with dementia in isolation – need to keep the whole "unit" well in order to keep people out of hospitals and institutions if carers fall ill. Build carers into pathways.
- There are degrees of caring – people don't identify themselves as carers – just looking after mum/dad/partner/siblings, etc.
- There is a GP pilot currently running in one practice in the North and one in the South to identify carers from their lists.
- Dementia is the poor relation of mental health – it is a disease of the brain but is still often seen as taboo.
- Need to promote positive messages about living well with dementia – using positive methods and approaches.

- Need to encourage people with dementia to keep their skills – use them as positive role models.

- How do we identify those who haven't been diagnosed?

- The "face of dementia" is very negative – how do we get a more positive approach to tell people that it is possible to live well with dementia.

- Banks/Taxi operators are important to dementia friendly societies.

- Building Communities: can churches do more to bring people together.

- Hospital provides packs for people with dementia and their relatives – information sheet giving details of useful numbers plus leaflets for things such as memory cafes, etc.

- Too much time spent in hospital awaiting tests away from home – testing should be done in the community.

- Dementia Friendly communities – more information needed so that communities/stakeholders understand dementia and remove stigma/barriers, but key stakeholders need to be involved to take it forward.

- Independent Living schemes give a sense of community (Fernley Grange) but need to find ways of opening this up to the outside so that people get involved.

- Encourage volunteering as a way of avoiding social isolation.

- Top down approach doesn't work – needs to be community led.

- People on the ground need to deliver on Dementia Friendly Communities: District Nurses/Health Visitors, etc.

- Need to share good practice – how do we cascade information if we don't know what is going on? How can we join up the dots?

- Awareness raising of Dementia Friends – use all areas of organisation to identify dementia early.

- Pilot Dementia Friendly row of shops in Fylde Road, Southport – but not many people know about it – it's not advertised. There is no recognition that businesses are dementia friendly so how do people know that they are?

- There are barriers to becoming Dementia Friendly accredited that rely on one person taking responsibility for preparing an action plan for the area and reporting on every 6 months.

- Pilot in Fylde Road is good – but how do we extend this model to the rest of Sefton and other areas such as Churchtown, Maghull, Ainsdale, Netherton. All of these places are based around GP surgeries – could we use the surgery as the central point and include all the shops in the locality?

- Dementia is seen as an older person's disease – part of getting old.

- Southport Football Club hold regular Tuesday afternoon sessions for people with early onset dementia in conjunction with Merseycare – including trips out to other venues such as Everton FC.

- Need to provide more education for young carers about dementia.

- Dementia Friendly is of benefit to the whole community as it provides a positive approach, is informal and less frightening.

- There is reticence about approaching people with dementia to offer help – how far does responsibility go? This needs a common sense approach.

- Pharmacies should be used more as an interface: medicine reviews, etc.

- Lack of diagnosis is a problem: earlier diagnosis would be helpful.

- GP's are reluctant to make a diagnosis or some are "over diagnosing". GP's need better understanding of dementia and the

services available to support people and their carers – memory clinics, memory cafes, memory boxes, etc.

Bootle Event

- People make Dementia Friendly communities
- Communities need to understand dementia and offer support and challenge stigma
- Talk to people with dementia and ask what they want.
- Businesses can get an award of the national symbol for dementia friends, the Forget Me Not, but the process is quite bureaucratic. The symbol is allocated to an area and one person leads on the process to become Dementia Friendly. Can be done within existing resources and has benefits for businesses and raises standards for everyone. Nationally Tesco, Argos, M&S and Lloyds Bank Group are committed to becoming Dementia Friends.
- Some services are driven by technology – but this precludes people who are not IT aware – not just people with dementia i.e. Barclays banks taking service counters out of branches and using just machines.
- Services are moving out of communities, leading to loss of personal touch, awareness of where problems are or if somebody hasn't been seen for a while i.e. banks, post offices, etc.
- Transport needs to be improved – ring and ride service for older/vulnerable people bit like a "big taxi" service where people are collected and dropped off and then picked up again.
- Do people know what services exist?
- If people are diagnosed earlier it is easier to identify long-term support.
- Education is important – start early in schools to change "modelled behaviour". This will help children to relate to family members and others who may have dementia.

- Need more inter-generational work to raise awareness.
- Could we become “Dementia Friendly Sefton” or “Bootle” or “Southport” or “Maghull”, etc. down to smaller localities such as “Birkdale Village” or “Ainsdale Village”.
- Could GP surgeries do more to co-ordinate communities to become Dementia Friendly?
- Use “pop up shop” in empty shop fronts to raise awareness.
- Families and Friends need support too.
- The Police/Fire Service can do more – help to identify where problems arise, particularly where people are isolated.
- Need more signposting so that people know where to get help and avoid hospital admissions.
- We need to be brave – fund smaller things to keep people out of crisis and the need for more expensive services.
- We need more “age friendly shops” including the “Take a Seat” project to provide somewhere for the old and vulnerable to sit in shops and businesses.
- Wigan Project (Hindley) for Dementia whereby £15,000 funding was provided and local businesses could pitch ideas (Dragons’ Den) for help for people with dementia such as swimming sessions, etc. Services had to be provided by local businesses. Staff in Morrisons supermarket set up a dementia café where people with dementia can come and pay £1.50 for coffee and cake and sit and have a chat and this has proved extremely popular. Can we extend to other local tea and coffee shops at times when things aren’t busy?
- Local Press needs to do more to highlight activities and events for people with dementia. This needs to be included in the Action Plan.
- Who get the ball rolling and take the lead on the Strategy. Need to get local people to want to take it forward.

- The development in Southport of the Dementia Independent Living facility for couples should provide an opportunity for Churchtown to become Dementia Friendly based around the Health Centre and the local shops.

- People with dementia could give talks to local businesses to give their perspective on what it's like to live with the condition – break down barriers.

- Pubs should become Dementia Friendly so that people with dementia can have some sense of doing what they would normally do. Could be a special hour when the pub would normally be quiet.

- Need to help people to keep working as long as they can after diagnosis if they are able to.

- Later retirement age (people having to work longer) –v- increase in number of people with dementia?

- Helping people to make changes to live well with dementia and as normal as possible for as long as possible.

- Diagnosis – then what?

- Not shutting people with dementia away but encouraging them to be part of the community.

- Care homes should become community hubs – have more interaction with the local community.

- Common interests/memories – people with dementia sharing with peers at places such as day centres, etc.

- Are the services we provide dementia friendly?

- Identify places where people know that they can go to get help if they need it ("safe havens").

- Incorporate existing services into Dementia Friendly ones.

- Services/things need to join up and connected.

- Specific training needed for transport providers and taxi drivers.
- Lifestory network – developing services in Liverpool.
- Need better information – lots on physical disabilities but little for mental health issues.
- What is happening in Sefton? Need grass roots level approach.
- Need neighbourhood return scheme – volunteers helping to find people who wander.
- Lack of marketing – nobody knows what's out there.
- Need to support carers so that they don't lose their own identity.

Questionnaire for People with Dementia

A Questionnaire was developed to be completed by people with dementia, to get their thoughts and opinions on their experiences and what would help them to live well with dementia.

The Alzheimer's Society were available to act as advocates to help people complete the questionnaires if required.

7 people completed the questionnaire

Question 1 – Please tell us how you are completing this form	No of responses	%
On my own	5	70
With a family member who is not my carer	1	15
With my carer	1	15
With a health and social care professional	0	0
Other	0	0

Question 2 – How long ago were you diagnosed with dementia?	No of responses	%
Less than one year	2	29
1-3 years	2	29
3-5 years	1	13
6-10 years	2	29
10+ years	0	0

Question 3 – Who first realised that you were having problems with your memory?	No of responses	%
My GP	4	57
Other health professional – as part of another health problem	0	0
I noticed myself that I was having problems	1	15
Somebody else (family/friends) noticed something was wrong	2	28
Other (please give details)	0	0

Question 4 – How easy was it for you to get a confirmed diagnosis of your dementia?.	No of responses	%
It was very easy – professionals listened	5	83
It wasn't as easy as it should have been – I had to convince professionals that there was a problem	1	17
It was very difficult – professionals dismissed my early concerns, and did not listen	0	0

Have you received enough information about your condition	No of responses	%
Yes	7	100
No	0	0

What other information would you like? Please describe:-

Felt time between being diagnosed and appointment at memory clinic should have been substantially shorter. Constant phone calls made to chase up.

Please give details of any problems you faced or things that went well:-

- Dolypazk tablets are very successful for me
- After working until I was 72 and being a production control manager and sales manager I found it difficult to fill my time in and not a great deal to motivate me
- Joining the Alzheimers society - thankyou

Question 4 - Here are some things that people with dementia have said are important to them. Are they important to you	Yes	No
In terms of my healthcare I will be able to be seen by the same person and not have to repeat my story over and over again to different people.	4	0
I will always be asked what I want, even when I find it difficult to answer.	5	0
My carer and I will have access to information and support throughout our journey, including services that will help me to stay well, safe and independent in my own home.	4	0
I will be able to communicate my likes and dislikes where ever I am	4	0
I will have a say in my end of life plan and will be supported to die peacefully in a place of my choosing.	3	0

Question 5 – Now we would like to ask you about the services that you receive to help you with coping with your dementia

Did you have a choice of provider?	No of responses	%
Yes	3	75
No	1	25

What do you think of the services they provide?

- Being cared for at home by my husband
- Excellent - my carer is my husband
- Good
- Alzheimers Society - Very good

Question 6 – have you spent time in hospital?	No of responses	%
Yes	2	29
No	5	71

If you answered yes please tell us about your time in hospital:-

- Not with dementia, other illnesses. Staff very busy. Needed more time for one to one

- Some was bad and some was good. I found the untrained staff didn't listen - they would put my drinks and food out of reach, the ones on nights couldn't answer bells - were rude and in one case when I asked for the commode the nurse said "you've a toilet in your room use it". I told her the specialist said I wasn't to use it. She said "what does he know" and she grabbed my arm and pushed me - I had a dizzy spell and I grabbed to stop me falling and she said "you bitch".

Question 7 – Do you have opportunities to meet and talk to other people with dementia?	No of responses	%
Yes	6	100
No	0	0

Question 8 – Is there anything else that you would like to do such as attending events and classes at local centres?

- Yes if possible
- Have some in Southport
- Social events organised by Alzheimers
- We already do
- No

Question 9 – is there anything missing from these questions that is important to you (please tick all that apply)?

No responses given

Question 10 - Would you like the following people to have a better understanding of dementia?	No of responses
Family	2
Friends	2
Employers	1
Hospital Staff	2
Social Workers	1
GPs	0
Care Providers	0
People who work in shops, banks, offices and post offices	2
Police	1

Question 11 – details of any discussions you feel are imporatnt

No responses given

About You

What is the first part of your Post Code		L23 1 23% L30 1 23% L37 1 23% PR9 2 31%
Are you:		Male 5 71% Female 2 29%

What is your age?		0 0% 0 0% 0 0% 2 29% 5 71%
Disability – Do you have?		Physical Impairment 3 Visual Impairment 1 Learning Disability 0 Hearing Impairment/ deaf 2 Mental health/ Mental Distress 2 Long Term Illness 2 Other: Depression Diabetes Arthritis Autovalve replacement
Do you class yourself as disabled?		Yes 2 29% No 5 71%
Ethnicity		White British 5 84% White English 1 26%
Do you have a religion or belief		Yes 5 71% No 2 29% 5 people identified as Christian

Questionnaire for people who are for somebody with Dementia

A Questionnaire was developed to be completed by people who care for a person with dementia, to get their thoughts and opinions on their experiences about their caring role. The questions mirrored those that were put to people suffering from dementia to see if the things that were important to people with dementia were also important to those who care for them.

20 people completed the questionnaire

Question 1 – How long ago was the person you care for diagnosed with dementia?	No of responses	%
Less than one year	1	5
1-3 years	9	45
3-5 years	1	5
6-10 years	8	40
10+ years	1	5

Question 2 – Who first realised that person you care for, was having problems?	No of responses	%
My GP	3	15%
Other health professional – as part of another health problem	1	5%
I noticed myself that I was having problems	14	70%
Somebody else (family/friends) noticed something was wrong	2	10%
Other (please give details)	0	0

Question 3 – How easy was it for the person you care for to get a confirmed diagnosis of dementia?	No of responses	%
It was very easy – professionals listened	15	75
It wasn't as easy as it should have been – I had to convince professionals that there was a problem	4	20
It was very difficult – professionals dismissed my early concerns, and did not listen	1	5

Have you received enough information about dementia?	No of Responses	%
Yes	17	85
No	3	15

What other information would you like? Please describe:-

- What are the long-term symptoms. How to go about choosing residential care. What costs will be incurred in residential care.
- Need more aftercare after diagnosis
- General information
- I find the website 'Talking Point' very good
- I have received information by researching it myself. I would like to have been signposted to support organisations
- Sometimes it seems too much

Please give details of any problems you faced as a carer or things that went well:-

- I found it difficult at times when I have been ill myself
- Getting reliable carers. So many just do it as a job and do not seem to remember that the patient is also a person. It was extremely hard coping with the patient's frustration.
- Main problem was distance. I was too far away so had to rely on Social Services
- Having considerable patience
- It is a very long road having to do everything that was done by two, especially making all decisions. Lack of help with transport
- No major problems as yet
- Acting as a memory bank
- Main problem is working my way through the minefield of financial support
- The initial memory test is not conclusive and the carer has a more accurate insight in the early stages. The initial diagnosis lacked empathy, understanding and any avenue of support. We were left reeling
- Meeting at Keystones (St. Lukes Church, Crosy) excellent help
- Getting a diagnosis for a 54 year old, then getting good care and getting appropriate support
- Being part of the Alzheimers society is a godsend
- Original diagnosis was vascular dementia - no medication. 6 months later, different doctor reviewed CT scan, etc., and re-assessed as mixed dementia and dorepezil prescribed. 6 months with no treatment was wasted time/Opportunity??

Question 4 - **Here are some things that people with dementia have said are important to them. Are they important to you as a carer?**	**Yes**	**No**
In terms of healthcare I will be able to be seen by the same person and not have to repeat my story over and over again to different people.	17	0
The person I care for will always be asked what they want, even when they find it difficult to answer.	15	2
The person I care for will be able to communicate their likes and dislikes where ever they are living	14	3
The person I care for will have a say in their end of life plan and will be supported to die peacefully in a place of their choosing.	12	0

The following comments were made in response to the above questions:-

Being able to see the same person every time

- It is very helpful if the person with the dementia can be seen by the same person. They can't always speak for themselves because of their problems.
- Carer has to repeat general day to day. Particularly medical appointments and happenings.
- Yes - going to Alzheimers Groups very important
- Very important - doctors at memory clinic different every time you go. No continuity of care.

The Person I care for will be asked what they want

- Very important. You should try not to lose sight that the patient is a person
- Yes, sometimes they do understand just don't remember the decisions made
- Yes, but they need to be included.
- You always try to give them choice but most times they cannot decide for themselves
- Yes and ask me what I want.
- They must be treated as individuals for as long as possible with the carer's advice sought as back up
- Important. As disease progresses this is increasingly difficult to achieve. A lot of patience needed.

<u>The person I care for will be able to communicate their likes and dislikes</u>

- Should be able to. The system should be constant
- No one knows what the future will bring. I hope the person can stay at home for as long as possible.
- No - change upsetting
- Not always
- Less important. This is likely to be known by spouse, family

<u>The Person I care for will have a say in their End of Life Plan</u>

- Important but obviously should be discussed whilst the patient is still able to make decisions.

- Done early enough, yes.
- I hope they are able to choose, and that hospitals and care homes have the right training for staff.
- Have not considered this
- Not considered yet
- This needs to be addressed early on before it is too late due to advancement of disease

Question 5 – Now we would like to ask you about the services that you receive to help you and the person you care for cope with dementia

Did you have a choice of provider?	No of responses	%
Yes	4	22
No	14	78

What do you think of the services they provide?

- He has attended the Willows in Maghull when I had operations. They were very good with him.
- Poor standards
- We set up a care package but effectively it could never work because they were not able to be there 24/7
- Able to manage at home at this present time
- Excellent service from Sefton for Care and help in improving home environment
- Excellent

- At present none received or wanted but I know where to look for help if required
- I went to Alzheimer's society for information and support and their support staff and services are excellent

- I thought it was very poor and after research I realised I could request an out of area referral and did so. I also wrote to lots of people to highlight the inadequacies and received a social worker visit which was good

- Good

- Cared for by family at home only support by GP, memory clinic and community nurse. Needs to be better co-ordination and links between services. All very hit and miss. No one takes the lead. Responsibility not clear

Question 6 – has the person you care for spent time in hospital?	**No of responses**	**%**
Yes	4	22
No	14	78

If you answered yes please tell us about your experience of hospital

- They were ok but I noticed they just put the food down and left him to eat it. Luckily I took him homemade chicken soup every day so I knew he was eating a little.

- But not for dementia

- But not for dementia - an operation on her hand became infected and she spent 3 weeks in Whiston. Care was very good but the individual rooms were like prison cells with no view from the windows due to renovations on the exterior

Question 7 – Do you have opportunities to meet and talk to other people with dementia and/or other carers for people with dementia?	No of responses	%
Yes	13	68
No	6	32

If you answered No what opportunities would you like?

- At the moment I would like him to go to a Day Centre for one day a week for him to mix with different people.
- To be able to talk to carers in similar situations would be very useful. As ideas, methods used, etc., could be swapped
- Did have very good chats with the psychiatric nurse. Gave us some good advice which stood me in good stead.
- Have help from various groups
- One-to-one counselling. Not group social activities

Question 9 – is there anything missing from these questions that is important to you (please tick all that apply)?

- That all people can get the help they need without being financially assessed. It is very difficult on public transport to get to a care centre
- The circumstances of the initial diagnosis are very important and should be treated with understanding and compassion by professionals

Question 10 - Would you like the following people to have a better understanding of dementia?	No of responses
Family	13
Friends	10
Employers	4
Hospital Staff	10
Social Workers	4
GPs	8
Care Providers	4
People who work in shops, banks, offices and post offices	10
Police	7
Other:- • Everyone • All people with whom we have had contact with have been very supportive • Transport	

Question 11 – details of any discussions you feel are important

- Being able to come to the memory clinic to discuss any problems we may have

- Although there are a lot of people waiting to help and a lot of information that is available, it can be a bit of hit and miss on whether you get all the support you need. For example it took some time before I realised I could be registered as a carer and I didn't know until I asked, that you can purchase items for use by the person suffering from dementia VAT free. Perhaps when a person is first diagnosed with dementia somebody should identify

who the carer is going to be and make sure they have a copy of something like the excellent "Dementia Guide" published by the Alzheimer's society.

About You

What is the first part of your Post Code		L22 1 7% L23 1 7% L30 2 14% L31 2 14% L37 2 14% PR8 1 7% PR9 5 37%
Are you:		Male 7 41% Female 10 59%
What is your age?		16-24 0 0% 25-39 0 0% 40-59 1 6% 60-75 11 61% 75+ 6 33%
Disability – Do you have?		Physical Impairment 0 Visual Impairment 4 Learning Disability 0 Hearing Impairment/ deaf 3 Mental health/ Mental Distress Long Term Illness 1 Other: Diabetes Osteoporosis
Do you class yourself as disabled?		Yes 1 7% No 13 93%

Ethnicity		White British White English White Welsh Black English	14 3 1 1	74% 16% 5% 5%
Do you have a religion or belief		Yes No 11 people identified as Christian	11 6	65% 35%

Questionnaire for Carers who had recently lost a person with Dementia

A questionnaire was developed to help us to understand the experiences of people who had recently lost a person with dementia. This was also to determine whether end of life plans were in place and if so if they were followed.

The Sefton Carers Centre facilitated this small sample of returns – 3 people completed the questionnaires.

Question 1 – How long did the person you are for have dementia?

- 3-4 years – Deceased 2013
- Official diagnosis 5/12 - Deceased 7/13 - Probable length of illness 2-3 years
- Approx 10 years

Question 2 – where did the person you cared for pass away?	No of responses	%
At home	0	0

In hospital	1	33
In a care home	2	67

Question 3 – did the person you cared for have an end of life plan in place?	No of responses	%
Yes	2	67
No	1	33

Question 4 – were the wishes of the person you cared for as stated in the plan carried out?	No of responses	%
Yes	2	100
No	0	0

Question 5 – What support did the person you cared for receive in their final days and who from?

- Care Home staff made mum comfortable an clean at all times
- NHS/Alzheimer's Society support
- Support from family, care home staff, GP, mental health team, district nurses, priest

Question 6 - What support did you receive and who from?

No responses given

Question 7 - Were you and the person you cared for treated with respect and compassion and kept informed as to what was happening?

- Yes, once in the care home

Question 8 - What did you feel was helpful to you and the person you cared for during the process?

- The compassion shown by the care home

Question 9 - What did you feel was not done well and made the process difficult for both you and the person you cared for?

No responses given

Question 10 - Is there anything you would like to add?

Getting a diagnosis was very hard as letters from the GP were sent to mum. Also found out about Alzheimer's Society far too late. But that is now starting to change. Mum was not diagnosed with dementia until she was in hospital for another reason

The Public Questionnaire

The questionnaire was available on-line (via e-Consult) and also as a hard copy. Distribution of hard copies was supported by the Sefton Pensioners Advocacy Service (SPAC), the Alzheimer's Society and the Sefton Carers Centre. It was available for people to complete from 28th May 2014 – 10th August 2014. A copy of the questionnaire is attached to the report.

The purpose of the questionnaire was to ascertain people's knowledge and perceptions of dementia in general, and to test out whether the aims and objectives in the Strategy were the right ones.

A total of 78 people completed the questionnaire. 70 people have fully completed the questionnaire and 8 people have partially completed the questionnaire (i.e. they have not answered one or more questions in the consultation; this may include monitoring questions).

It is important to note that these results are not representative of the Sefton population. The results of the questionnaire will support the feedback from the other engagement methods used.

Question 1 – We would like to know about your level of understanding about dementia. Please answer true or false to each of the following statements	No of responses True	No of responses False
Dementia is a disease of the brain (**True)**	73	2
Dementia can be cured **(False)**	70	4
There are drug treatments that help with dementia **(True)**	66	5
There are many different kinds of dementia **(True)**	68	4
Dementia is part of the normal process of ageing **(False)**	9	64
People who eat healthily and exercise are less likely to get dementia **(True)**	28	43
Most people with dementia live in care **(False**)	8	66

Question 2 – If somebody has been diagnosed with dementia do you think that they should:-	Agree	Disagree	Not sure
Continue to live alone	21 (31%)	27 (38%)	27 (38%)
Be supported so that they can continue to work as long as they can	70 (93%)	3 (4%)	2 (3%)
Continue to drive as long as they are able	51 (69%)	13 (18%)	10 (13%)
Use technology to enable people to stay safe in their home	65 (88%)	1 (1%)	8 (11%)
Have a single point of contact for their dementia care	65 (89%)	0 (0%)	8 (11%)

Question 3 – These are some statements that have been made about people with dementia. Please indicate whether you agree, disagree or are not sure about each:-	Agree	Disagree	Not sure
People with dementia should be involved in activities in the community	72 (98%)	1 (1%)	1 (1%)
It is better for people with dementia and their families if they are cared for in a residential unit or a nursing home.	4 (5%)	53 (72%)	17 (23%)
There is little or no benefit to be gained from telling someone they have dementia	15 (21%)	36 (49%)	22 (30%)
People who have just been diagnosed with dementia are unable to make decisions about their own care	6 (8%)	63 (86%)	4 (6%)
There is no point in trying to talk to people with dementia as they won't be able to understand	1 (1%)	66 (92%)	5 (7%)

Do you have any comments about any of these statements?

- This will be dependent on severity and how far the dementia has progressed and how long they had dementia before they were diagnosed.

- I think that people with dementia should be involved - included in as many activities as their illness allows. I also think that you should continue talking as they can be reached by part or parts of the conversation.

- See question above about being cared for in residential unit or care home - depends on the stage of their dementia. Later stage advanced dementia is better cared for in a residential unit where specialist care is available.

- My opinion currently through the experience of looking after my mum who had Alzheimer's Dementia is that there is no point in getting a dementia diagnosis. There is very little support, you are on your own. GP's, Memory Clinics and NHS are all poor for understanding and support. They just do what they have got to do to tick the box, get the QUOF points and stuff like that.

- Though there can be confusion it is my experience that there is much understanding and less fear if they can do as many of the normal things as possible.

- I think a lot of the statements above are considerations that need to be thought about depending on each individual circumstance. The dementia consultant told my dad that there wasn't much point trying to explain to mum that she has dementia as she wouldn't remember BUT my mum does remember some things and I think it is important to try and help her understand.

- All cases are as individual as the person is. It also depends on family and support of family. No one knows what its like to live with this debilitating illness. Carers need more help in every aspect and different levels of dementia need different support. Activities, exercise and respite is very important to both carer and the person with the condition. This is not always possible because of all the obstacles and no one understanding. Training of staff of establishments to which we could attend. Carers' allowance should be looked at too - and the limitations to obtaining this should be lifted.

- It is not practicable to give a simple answer to the statements as more information about the individual involved and more clarity about the actual situation is needed (What does '... just been diagnosed ...' mean? The person could be at the early stages or the later stages when they have just been diagnosed) essentially, each individual is different and needs to be treated differently although some aspects may be common to many cases.

- Most of these answers would depend on the stage of dementia. People with early onset dementia would understand diagnosis and carry on making their own decisions.

- These statements imply that dementia is a fixed condition with "one solution fits all". It is a complex and multi-faceted disease with most patients experiencing differing levels of capacity and understanding at different points in the disease.

- I don't know anybody with dementia

- I really don't know enough about dementia to offer an opinion

- People with dementia are human beings and should be treated as such

- Need more intervention as disease progresses

- You can't give up on people with dementia. They need mental stimulation and everyone is an individual.

- People who are diagnosed with dementia and live at home should, with help from family if possible. They should be given the choice until such time as their dementia is in need of extra care.

- Apart from the first statement, all the others are very negative.

- Questions 1+2+4+5 answers would depend on the progress of the dementia in the individual. I have presumed that the person is in the early stages rather than the later stages.

- Yes - the person with dementia is me and it is at this point loss of memory As a registered person with some loss of memory I still live on my own, do absolutely everything on my own in the home and outside (even though I probably do things twice over!, lose things, forget things). Up until now I have not missed any doctor's appointments, missed a bus or train, but I do have to write everything down in several places around the house. It is pleasant when I can spend a few days here and there with members of the family - shelve some of my responsibilities. My writing has

deteriorated badly but I still write quite a lot of letters. I attend 6 or 12 months assessment of abilities, and have done so for three years.

- Depends on the severity and advancement of the dementia
- Not sure about some answers. Depends how far into dementia they are. Some I know are in early stages and understand. Short term memory that's all, remember everything years ago.
- The last four statements epitomise many people's (who do not know exactly what dementia is and how it can develop) opinions
- A lot depends on the severity of the dementia
- Very thorough and thought provoking
- I really do not know enough about dementia to give an opinion
- It all depends on the level of dementia. At first it is quite manageable but it is important to be able to identify the stage when they can no longer carry on their normal activities
- If people who have dementia are fortunate enough to have someone to love and care for them as long as it is possible, they are the lucky ones. the ones with no-one then must be placed in safe care.
- Must listen to people with dementia and their families, need to be involved in decision making they are the experts in what is happening individually to them.
- People with dementia should continue to live well in their community. Advice & support should be accessible. Early diagnosis so they can plan for the future and receive medication if suitable.
- There is a need for education and increased awareness around the condition to ensure everyone has a greater understanding of the conditions and how people can be supported.

- I think many of the above questions above don't give a true value as to how progressive Dementia is and at what stage intervention is required.

Question 4 – The Government launched the Prime Minister's Dementia Challenge in 2012. This includes creating dementia friendly communities. What do you think dementia friendly communities look like	**Agree**	**Disagree**	**Not sure**
People with dementia are supported to remain active and included members of their communities	72 (95%)	0 (0)	4 (5%)
People will have increased understanding and awareness about dementia and how to support individuals with dementia.	71 (93%)	1 (1%)	4 (5%)
To support individuals living with dementia and their carers to maintain their independence for as long as possible	73 (100%)	0	0
People with dementia being treated as valued members of society	67 (88%)	0	9 (12%)
People with dementia and their carers feel comfortable in their local environment (shops, leisure facilities, etc.)	68 (91%)	0 (0%)	7 (9%)

	Agree	**Disagree**	**Not sure**
People who work in the local community are trained to respond to the needs of people with dementia and do very simple and	70 (93%)	0 (0%)	5 (7%)

practical things that can make an enormous difference			
Implementing simple steps to help people with dementia such as slow lanes in supermarkets and banks	47 (64%)	11 (15%)	15 (21%)
Support from befriending groups to help people with dementia do the things that they want to	71 (99%)	1 (1%)	0 (0%)

Any other comments?

- Not so sure about the "SLOW" Lane in supermarkets/banks. This is secluding people with dementia. I recently became a dementia friend and found it very rewarding. Society needs to become more sympathetic and tolerant towards people with dementia.
- We just want understanding, trust, patience but to be treated normally with respect and to feel comfortable.
- Awareness of dementia is improving which is very good.
- I agree with all the above points but to achieve the above would be amazing.
- I have never attended any such groups - never been offered - but I don't think I could. Nice to sit down in the evening to watch a programme or two on TV. For me its a strain to have to answer questions when I am assessed.
- The last but one statement only applies to more advanced stages of dementia. Where possible they would not be made to feel to be a burden on society
- Slow lanes might make other users irritated and the sufferer feel loss of dignity.
- Again, some things will only be a real handicap when dementia is advanced. It seems a bit presumptuous to provide slow lanes. Perhaps these would be useful if dementia is advanced. It seems a bit patronising (is that the word I am searching for?)

- When is all this going to happen?
- Families should not have to fight constantly for support from social services
- Peer support for both carer and person with dementia. Access to advice, one on one support.
- I think day-centres may be best suited to accommodate Dementia suffers as they will be able to stimulate individual minds and monitor progress. Also provide less stress for working family members, knowing their loved one is safe.

Question 5 - The following questions relate to your thoughts about the Dementia Strategy and the Strategic Objectives for 2014 - 2019

Aims for People with Dementia

These are the aims included in the draft strategy which will help people with dementia and their carers live their lives in a positive way. Please rank them in order of importance where 1 is the most important and 9 is the least important.

These are the results of the surveys with the aim getting the most number of 1 ranked first, etc.

Rank

1. People with dementia should be diagnosed in a timely way
2. People with dementia are treated with dignity and respect
3. People with dementia get the treatment and support which is best for their dementia and their life
4. People with dementia will have help in planning for their future health and care needs through a co-ordinated health and social care service.
5. People with dementia's wishes with regard to end of life will be respected

6. People with dementia know what to do to help themselves and who else they can go to for help

7. Those looking after people with dementia are well supported.

8. People with dementia should feel included as part of society

9. People with dementia can make decisions for themselves

Strategic objectives for people with dementia in Sefton

These are the Strategic Objectives in the draft Strategy that will provide people with dementia and their carers with the support to live their lives in the way they would want to? Please rank them in order of importance where 1 is the most important and 5 is the least important :-

These are the results of the surveys with the aim getting the most number of 1s ranked first, etc.

Rank

1. Timely diagnosis, appropriate treatment and involvement in care plans

2. Support to live independently for as long as possible, and to make decisions for myself

3. Inclusive and dementia friendly communities

4. Information, advice and support for people with dementia and their carers

5. End of Life Services, ensuring a peaceful and pain free death in the place of choice.

Question 8 – Do you have any other comments about the Strategy or have we missed something?

The following responses were given:-

- I think all the above are very important and should be included in a comprehensive holistic approach.

- The strategic vision sounds good on paper but how are these objectives going to be implemented and met in practice. I feel the support for my mum who was diagnosed before Christmas has been really poor. I don't feel like we know where to go for support. The memory clinic we attend with mum says there are things like day centres my mum could go to but then we hear no more information and don't know where to go. The Social Care is supposed to be coming round to assess mum in her home - we are still waiting. It is all these things that on paper the strategic plan sounds good but not sure where the support is or how we access it.

- All these questions are for early onset. Every GP should have the ability to give all the patients on their books a well check alert after they are 60 and then every 5 years after that. This would make sure that a lot of people with early signs of dementia do not slip through the net and get the help and support they need. Financial help without means testing i.e. carers' allowance should be available to all even those on pensions as they are still carers no matter what age you are. Recognise dementia as a terminal illness.

- End of life services should not distinguish people with dementia from other people in similar situations. The implication of the above appears to be different from what is now legally available for all people.

- I would have liked the option to put many of these options as joint priorities especially for younger dementia patients which is what I am familiar with. Younger dementia patients need access to early diagnosis screening as it is so often misdiagnosed as anxiety or depression and specialist advice and support as risk management is harder for more mobile patients whose carer may still be employed and supporting children.

- I found ranking the aims difficult. I feel that the vast majority are ranked 1 because they are all interconnected. Early diagnosis is KEY. Support for independent living is vitally important. Information, advice and support are crucial keys. I am anxious when I see "End of Life" approaches. I would love 'Hospice Care' for all but am uncertain about offering medical professionals power to influence or provide 'end of life' services. 'The Liverpool Way' was a terrible thing though it meant well.

- Troubled by end of life services. How do people with severe dementia make end of life choices? The Liverpool Pathway was flawed. I asked was this used in care homes. Still waiting for reply. Finances - a trusted organisation to look after dementia sufferers' finances. Is social isolation the right way? I think not. The strategy should also include carers. How many people are caring for loved ones who are not registered because of the stigma? A strategy for dementia should have been well in place.

- End of Life should be extended to give support to carers at this difficult time.

- Too many questions are repeated?? was this intentional?

- I can't answer these because we are all different, our needs are different. I do not have a carer but on occasions my daughter may give me a hand when I get particularly anxious. Hearing As an individual I am usually ignored in conversations, chiefly because I am slow to answer and have to ask for things to be repeated, having great difficulty in understanding a lot of words. I use two hearing aids which still lack clarity. Loop system is used very little and those that have it don't understand how it works. I once asked a Post Office assistant to switch on the loop system After searching underneath the counter for ages she came up with a

very dirty looking piece of equipment but didn't manage to get it working - so we struggled on!

- They are all important. End of life services!!!?? I have sat with a friend where the family had agreed to the Pathway, where food and water is withdrawn, only they didn't sit with her and I never want to again, she was begging for a drink of water, tea, anything she said. I feel it's open to abuse. It made me ill. I couldn't get her out of my mind day or night. I'm sure the hospital didn't manage it properly. I did phone up and complain without the family knowing and said I think they had a few Dr. Shipmans working there, one nurse was horrible.

- Very difficult to rate any of these questions as they are all very important in their own way

- What does diagnosed in a timely way mean? Does it mean early? If people have dementia how do they know what to do? People with dementia should be part of society as long as they are aware yes

- I am so pleased that the strategy takes on board the knowledge that many people reaching the end of life want some control over their death. We all will die some day but why should we suffer the pain, the indignities and the fear of a horrible death. It is barbaric and in this day and age should be totally avoided. We put animals down for less than some people have to suffer. We should be given a form from our doctors as a matter of fact so that we can make a decision whilst we are of sound mind so that the doctor is aware, well ahead of end of life, that that is our dearest wish if that be so.

- I don't think ranking is helpful as it implies that items ranked lowest are not important which is not the case - all these aims are important

- Quicker response for support and care from staff specially trained and skilled at listening and communicating

- Advocacy

- It was difficult to rank the Q1 and Q2 statements as there were no least important ones
- Care staff should receive full training, experience and be to be able to cope and assist with changes to the individual as their prognosis develops. Also it is important nutritional care is given to maintain a healthy body and mind.

Equalities Monitoring

Post Code 	Completed by 53 people	**CH45**	1	**L20**	2
		L21	4	**L22**	1
		L23	3	**L30**	2
		L31	12	**L37**	2
		L38	2	**L39**	1
		L40	1	**PR8**	13
		PR9	9		
Gender 	Completed by 64 people	Male	11	(17%)	
		Female	53	(83%)	
Age 	Completed by 66 people	25 – 39	1	1%	
		40-59	18	27%	
		60-75	17	26%	
		75+	30	46%	
Disability 	People indicated that they have a disability as follows:- 37 people consider themselves disabled	8	Have a physical impairment		
		5	Have a visual impairment		
		0	Have a learning difficulty		
		10	Have hearing impairment		
		3	Have mental health / mental distress		
		13	Have a long term illness		

Ethnicity 	Completed by 65 people	White British	38	57%
		White English	26	40%

		White Welsh 1 1% Black British 1 1% Indian 1 1%
Religion 	Have a religion completed by 59 people	Have a Religion 45 76% 42 (71%) are Christian
Sexual Orientation 	Completed by 65 people	Heterosexual 54 83% Gay 2 7%
Gender  	Completed by 60 people	60 (100%) Live in the gender assigned at birth

What will happen with what you have told us?

We will take on board what people have told us and make sure that it is reflected in the draft Strategy for Sefton. The Strategy will be approved by the Cabinet Member for Older People and Health and will form part of the Sefton Health and Wellbeing Strategy.

An Action Plan will be developed for the Strategy and progress against actions will be monitored.

The Strategy is a living document and will be refreshed and updated as legislation and guidance is updated. The Strategy and action plan will be published on the Council's website.

Contributors

List of Contributors to Living Well with Dementia: A Strategy for Sefton 2014-2019

(No particular order)

This list contains the people and organisations that offered sustained and invaluable support to the process. We would like to thank everyone who was part of the process and it would be impossible to list and thank everyone as it was a huge piece of work. In particular we would like to thank:

- Councillor Paul Cummins, Cabinet Member for Older People and Health
- 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
- Southport & Ormskirk Hospital NHS Trust.
- Sefton Council Business Intelligence and Performance Team

Finally we would like to acknowledge and thank all the people of Sefton who contributed to this report.

List of Organisations who took part in the Open Space Innovation Events

Sefton Carers Centre
Southport District General Hospital
Community Emergency Response Team (Southport Hospital)
Parkhaven Trust
Living Well Centre, Southport
Sefton CVS
Care Connect
Sefton Council Public Health
The Alzheimer's Society
Sefton Council Adult Services
Community Integrated Care (Green Heys)
Lifestory Network
Merseycare
One Vision Housing
Councillor Pat Keith
Councillor Sue McGuire
Birch Abbey
ICCM
The Footcare Service
The Regenda Group
Sefton Pensioners Advocacy Service
Ainsdale Community Centre
Vitalise - Sandpipers
Brookdale Resource Centre
Brighter Living Partnership
Councillor David Barton
Sefton Community Learning Disability Team
Memory Clinic, Merseycare NHS Trust

Sefton Council

Dementia Strategy
2014 - 2019

Equality Analysis Report

June 2015

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Section One: Introduction

The Equality Act 2010

In order to meet equality legislation public bodies have to consider Section 149 of the Equality Act 2010:

A public authority must, in the exercise of its functions, have due regard to the need to –

(a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Protected Characteristics

Equality Law (Equality Act 2010) is clear that there are particular characteristic intrinsic to an individual against which it would be easy to discriminate. Section 149 (the Public Sector Equality Duty) lists the goals of the act and the characteristics, known as 'protected characteristics' against which we have to test for discrimination. These characteristics are gender, race/ ethnicity, religion and belief, sexual orientation, age, gender reassignment, pregnancy and maternity and disability.

Tackling Inequalities

The Marmot review; 'Fair Society, Healthy Lives', published in 2010, confirmed that health inequalities result from social inequalities and that action is required across all the wider determinants. The review identified the need for action to focus on reducing the gradient in health by focusing on those most in need.

In Sefton we have a strong commitment to promoting equality, tackling disadvantage and improving the life chances of our residents. We are aware that many factors combine to affect the health and wellbeing of individuals and communities. While health care services have an impact, other factors such as where people live, income, education, life experiences, behaviours and choices, along with relationships with friends and family, all have a considerable impact.

Sefton's Dementia Strategy 2014 - 2019

The Dementia Strategy must show due regard to the Equality Act 2010 and demonstrate through the process of producing, publishing and updating using both the National and Local Context how it meets the Public Sector Equality Duty. This equality analysis report is part of that process.

How we developed the Dementia Strategy for Sefton

The draft strategic objectives in the Dementia Strategy were co-produced following engagement and consultation events with service users, service providers, practitioners, VCF support organisations and carers, as well as local communities, partners, voluntary, community and faith sector and other stakeholders.

This engagement and consultation informed the setting of the overall strategic priorities outlined in the Draft Sefton Dementia Strategy.

A full report on the outcomes of the consultation and engagement will be made available at www.sefton.gov.uk

Strategic Objectives

Five Strategic Objectives for Carers in Sefton have been identified, these have been developed through both understanding the needs of the population and what carers and the people they care for including young carers, the public, community organisations and groups, commissioners and providers of services told us during the consultation and engagement process.

The strategic objectives for Dementia in Sefton are:

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.

Section Two: Identifying Impacts across Protected Characteristics

In considering the impact of the Dementia Strategy, the following analysis has been undertaken across the Strategic objectives:

The analysis has been carried out using both Office of National Statistic (ONS) Census 2011 data and responses to the Sefton Dementia Strategy; both of these data sets are created through self identification and therefore show an approximate representation.

Protected characteristic	What the Consultation and the National and Local Context told us	Linked Strategic Objective(s)	Next Steps and Action
Gender	Nationally, two thirds of people with dementia are women. Locally there is limited data regarding the demographics of people with dementia in Sefton, further data collection and analysis will improve our knowledge of need.	***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***	Feedback from the consultation and engagement process to the Dementia Subgroup, Health and Wellbeing Board, Adult Forum to be considered when developing Strategies and planning for the future. Data collection and analysis to identify local trends regarding gender and dementia

Protected characteristic	What the Consultation and the National and Local Context told us	Linked Strategic Objective(s)	Next Steps and Actions
Age	Dementia is most common in older people but younger can get it too. 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. Nationally one in three people over 65 will develop dementia and one in twenty people with dementia are under the age of 65 There is currently very little information available about the numbers of younger people (under 65) in Sefton with dementia. Further data collection and analysis will improve our knowledge of need.	***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***	Feedback from the consultation and engagement process to the Dementia Subgroup, Health and Wellbeing Board, Adult Forum to be considered when developing Strategies and planning for the future. Further data collection and analysis to identify local trends regarding Age and dementia
Protected characteristic	**What the Consultation and the National and Local Context told us**	**Linked Strategic Objective(s)**	**Next Steps and Actions**
Disability	Dementia generally affects people with learning disabilities in similar ways to people without a learning disability, but there are	***Timely diagnosis, appropriate treatment and involvement in care***	Feedback from the consultation and engagement process

	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. Nationally 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. There is currently very little information available about the numbers of people with a learning disability in Sefton with dementia.	***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***	to the Dementia Subgroup, Health and Wellbeing Board, Adult Forum to be considered when developing Strategies and planning for the future. Further data collection and analysis to identify local trends regarding Disability and dementia

	Further data collection and analysis will improve our knowledge of need.		
Protected characteristic	**What the Consultation and the National and Local Context told us**	**Linked Strategic Objective(s)**	**Next Steps and Actions**
Race/ Ethnicity	There is currently very little information available about the numbers of people from a Black and minority ethnic background in Sefton with dementia. Further data collection and analysis will improve our knowledge of need.	***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***	Further data collection and analysis to identify local trends regarding race and dementia Action will be taken to gather further information to enhance our understanding of the needs of people from BME backgrounds with regard to dementia.
Protected characteristic	**What the Consultation and the National and Local Context told us**	**Linked Strategic Objective(s)**	**Next Steps and Actions**
Religion or Belief	There is currently very little information available about people from different religious backgrounds in Sefton with dementia. Further data collection and analysis will improve our knowledge of need.	***Support to live independently for as long as possible, and to make decisions for myself***	Action will be taken to gather further information to enhance our understanding of the contribution faith

		Inclusive and dementia friendly communities ***Information, advice and support for people with dementia and their carers***	communities can make supporting people with dementia in Sefton.
Sexual Orientation	No data available	***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***	Action will be taken to gather further information to enhance our understanding of the needs of gay, lesbian and bi-sexual people and additional support will be sought through the VCF sector to help with this understanding
Protected characteristic	**What the Consultation and the National and Local Context told us**	**Linked Strategic Objective(s)**	**Next Steps and Actions**
Gender Re-assignment	No data available	***Support to live independently for as long as possible, and to make decisions for myself*** ***Inclusive and dementia friendly communities***	Action will be taken to gather further information to enhance our understanding of the needs of transgendered people and additional support will be sought

		Information, advice and support for people with dementia and their carers	through the VCF sector to help with this understanding.
Protected characteristic	**What the Consultation and the National and Local Context told us**	**Linked Strategic Objective(s)**	**Next Steps and Actions**
Pregnancy and Maternity	No data available	***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***	Further feedback will be sought to enhance our understanding of the impact dementia may have of those using pregnancy and maternity services particularly with regard to caring responsibilities and the links to the dementia strategy.

Section Three: Advancing equality of opportunity and fostering good relations between people and communities

The National and Local context document identifies key messages relating to the prevalence of need by gender, disability, age and other identified characteristics including disability. This information, combined with the feedback from the consultation and engagement process, has informed the setting of the strategic objectives within the Sefton Dementia Strategy. This information will help partners to tailor services to address the needs of carers and those cared for in communities by providing information and signposting that advance equality of opportunity and foster good relations between people and communities.

Section Four: Conclusion

The Sefton Dementia Strategy - National and Local Context Document and the consultation and engagement feedback reports contain evidence and insight relating to different groups of people within the community. They have informed the development of the Sefton Dementia Strategy and Action Plan. Partners will seek to gather further evidence relating to specific characteristics where there are current gaps in our understanding.

Section Five: Action Plan

What	When	Who
Communications Plan for Dementia Strategy	Sept2015	All Partners
Publish Final Equality Analysis Report	Sept 2015	Sefton Council
Gather further feedback or evidence on the gaps of our understanding as identified in the Equality Analysis Report and identify how relevant evidence has been used to understand the potential equality impacts and update the Equality Analysis Report.	Sept 2016	All Partners
Annual review of the Strategy and Equality Analysis Report.	Sept 2016	All Partners

South Sefton Clinical Commissioning Group

Integrated Performance Report

NHS South Sefton Clinical Commissioning Group

NWCSU A partner in our clients' future

Contents

List of Tables and Graphs

1. Executive Summary

This report provides summary information on the activity and quality performance of South Sefton Clinical Commissioning Group at Month 12 (note: time periods of data are different for each source).

CCG Key Performance Indicators

NHS Constitution Indicators	Footprint	RAG
A&E 4 Hour Waits	CCG	
Ambulance Category A Calls (Red 1)	CCG	
Cancer 2 Week GP Referral	CCG	
RTT 18 Week Incomplete Pathway	CCG	
Other Key Targets		
A&E 4 Hour Waits	AUHT	
Ambulance Category A Calls (Red 1)	NWAS	
Ambulance Category A Calls (Red 2)	CCG	
Ambulance Category A Calls (Red 2)	NWAS	
Ambulance Category 19 transportation	CCG	
Ambulance Category 19 transportation	NWAS	
Cancer 62 Day Screening	AUHT	
Diagnostic Test Waiting Time	AUHT	
Emergency Admissions Composite Indicator	CCG	
Emergency Admissions for acute conditions that should not usually require a hospital admission	CCG	
HCAI - C.Diff	CCG	
HCAI - MRSA	CCG	
HCAI - MRSA	AUHT	
IAPT - Prevalence	CCG	
IAPT - Recovery Rate	CCG	
Local Measure: Diabetes	CCG	
Patient Experience of Primary Care i) GP Services ii) Out of Hours (Combined)	CCG	
PYLL Person (Annual Update)	CCG	
Unplanned hospitalisation for chronic ambulatory care	CCG	

Key information from this report

The financial position for the ccg is £4.975m overspent (compared to £4.473m in M11) on operational budget areas before the application of reserves. The CCG has sufficient reserves in place, and has achieved the planned surplus of £2.848m. £0.548m of this surplus relates to the return of funding from the CHC Restitution risk pool which will be returned to the CCG in the new financial year (2015/16). The CCG has also met the other business rules required by NHS England. However, there are risks in the reported financial position that may materialise in the new financial year.

Ambulance Activity: The year end targets for the entire NWAS service across the Red response times have not been achieved, and a number of actions are being carried out by the provider which are detailed in this report.

A&E waits: The CCG met the 95% target for March with a performance of 98.12%, and Aintree also met the target recording 95%. Year to date CCG is flagged GREEN by achieving 97.90% with Aintree flagged RED with a performance of 90.53%. An action plan and trajectory was agreed by the Aintree with Monitor and NHS England to reach 95% by end of Q2 15/16.

Cancer Indicators: Year to date the CCG achieved all the cancer indicators. Aintree achieved all indicators apart from 62 day screening achieving 82.14% year to date against 90% target. Performance is hampered by low numbers with only one patient breach often leading to failure against the target.

Diagnostic Test waiting Times: The CCG managed to remain below the 1% target in March after failing the target for the previous 4 months. Aintree are failing the target for fourth month in a row achieving 1.03% which is a slight improvement on previous month. An extensive action plan has been received by the CCG by way of assurance.

Emergency Admissions Composite Measure: The CCG is over the monthly plan and had 547 more admissions than the same period last year. The elements of the composite contributing to over-performance are as follows: Emergency Admissions that should not usually require hospital admission- The CCG is over plan and has had 415 more admissions than the same period last year. Unplanned hospitalisation for chronic ambulatory care- The CCG is over plan with the increase in actual admissions being 184 more than the same period last year. A number of practices are analysing patient level data to understand trends and possible actions via localities and Finance and Resource Committee.

HCAI - C difficile: The CCG had 8 new cases reported in March 2015 taking the total to 64 year to date compared to a year-end plan of 60. Aintree reported 5 new cases in March bringing year to date total of 64 against a year-end plan of 81.

HCAI – MRSA: No new cases were reported for CCG in March. However, the CCG remains over the plan of 0 with 2 reported cases and will remain so for 2014/15. Both Aintree and the Walton Centre are reporting 1 case over a plan of 0.

IAPT – Prevalence and Recovery: The CCG achieved 3.62 % in quarter 4, narrowly failing the 3.75% target. Year to date the CCG are recording 13.05%.
January 2015 recording 1.32% (321 patients).
February 2015 recording 1.15% (280 patients)
March 2015 recording 1.15% (270 patients).

To have achieved the 3.75% target in Q4 the service would need to see just 31 more patients enter psychological therapies in Q4.

The CCG did not achieve the 50% recovery target in year reaching 46.7% cumulatively. The annual target for 2014/15 was therefore not achieved. A new provider will be providing services in 2015/16.

Local measure Diabetes: The current rate is below the plan of 65.9% with the CCG recording 42.2% for quarter 3, this is a decrease from quarter 2 (43.4%). The figures have been refreshed for previous quarters. There was a change of specification relating to the smoking indicator for Q3 data collection.

Patient experience of primary care: The CCG reported the proportion of negative responses at 7.89% which is above the 6% target. This is deterioration from the last survey which reported 6.92%.

2. Financial Position

2.1 Summary

This section of the report focuses on the year end financial performance for South Sefton CCG as at 31 March 2015 (Month 12). The financial position is £4.975m overspent (compared to £4.473m in M11) on operational budget areas before the application of reserves.

The CCG has sufficient reserves in place, and has achieved the planned surplus of £2.848m. £0.548m of this surplus relates to the return of funding from the CHC Restitution risk pool which will be returned to the CCG in the new financial year (2015/16).

The CCG has also met the other business rules required by NHS England, as demonstrated in Figure 1 below. However, there are risks in the reported financial position that may materialise in the new financial year

Figure 1 – Financial Dashboard

Report Section	Key Performance Indicator		This Month	Prior Month
1	Business Rule (Forecast Outturn)	1% Surplus	✓	✓
		0.5% Contingency Reserve	✓	✓
		2.5% Non-Recurrent Headroom	✓	✓
3	Surplus	Financial Surplus / (Deficit) before the application of reserves - £'000	**-4,975**	**-4,473**
4	QIPP	Unmet QIPP to be identified > 0	**0**	**0**
5	Running Costs (Forecast Outturn)	CCG running costs < National 2014/15 target of £24.78 per head	✓	✓
6	BPPC	NHS - Value YTD > 95%	**99.3%**	**99.3%**
		NHS - Volume YTD > 95%	**91.9%**	**91.3%**
		Non NHS - Value YTD > 95%	**90.4%**	**89.4%**
		Non NHS - Volume YTD > 95%	**91.7%**	**91.6%**

2.2 Resource Allocation

There were no changes to the RRL allocation in Month 12.

2.3 Position to date

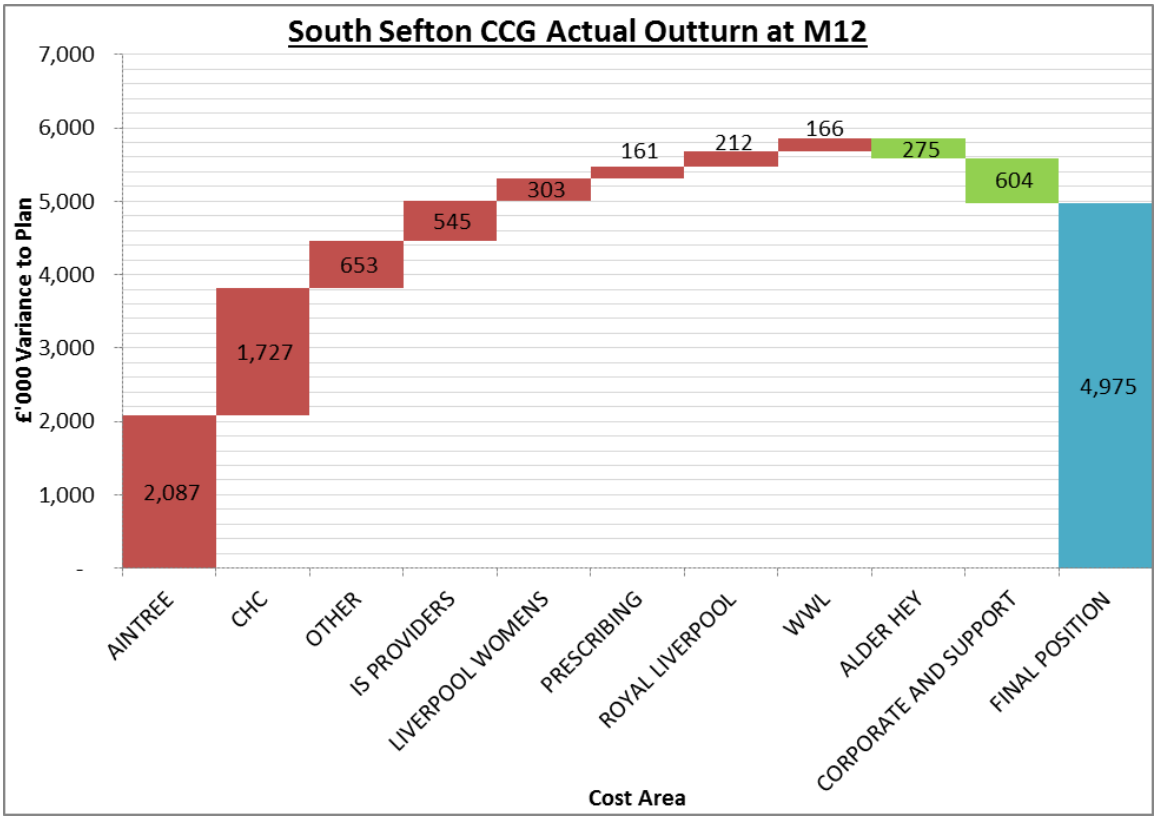
The main financial pressures within the financial position are shown below in Figure 2.

There are significant overspends in Acute Care, particularly at Aintree University Hospital and Independent Sector providers. There are also significant overspends in Continuing

Healthcare. This is offset partly by an underspend at Alder Hey NHS Trust and on Corporate and Support Services within the CCG.

Whilst the financial activity period relates to the end of March, the CCG has based its reported position on information received from Acute Trusts to the end of February 2015. Where year-end financial settlements have been agreed, the financial position has been based upon this.

Figure 2 – Forecast Outturn



Aintree Hospitals Foundation Trust

The overspend at Aintree is £2.087m, which is consistent with that reported in month 11. This was based on the full and final settlement that was agreed with the Trust.

The Trust had previously offered to block non-elective expenditure at planned levels following significant changes in the pathway. However, this offer was then withdrawn, with the Trust citing pressures in emergency care. The settlement was based on month 10 forecast activity levels, with an adjustment for CQUIN non-achievement and the application of relevant penalties and sanctions.

The main areas of overspend for the year can be seen in the following areas:

- Outpatient procedures (£0.734m), with Cardiology, Urology, ENT and Interventional Radiology being the main specialties with significant overperformance.
- Daycases (£0.427m) – the specialties with the highest overperformance are Cardiology, Gastroenterology, Ophthalmology and Trauma & Orthopaedics.
- ARMD Drugs – overspends of £0.112m.
- Excluded drugs accounts for £0.476m of the overspend at the Trust. The main area of overspend is with cytokine modulators.
- Unplanned care exceeded the budget by £1.559m. At month 6 when the pathway changes were introduced by the Trust, the overspend for the first six months was £0.363m. Further work has been conducted to understand the effect of pathway changes as part of the 2015/16 operational planning submission. This growth has been reflected in the level of activity that has been planned for 2015/16.

Activity in planned inpatient care across the year was £0.416m. A proportion of this was generated by the additional work funded by central government, estimated at £0.174m. Profiles for daycase and elective work are outlined in Figures 3 and 4.

Figure 3 – Daycase Costs

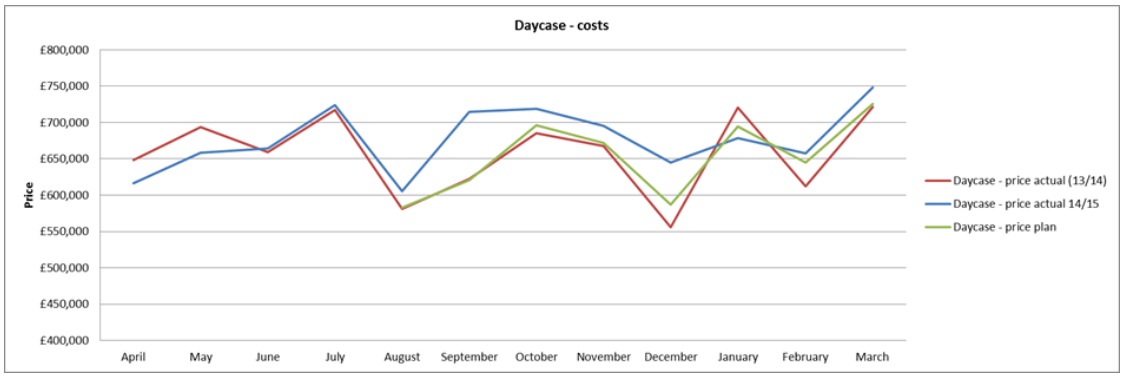
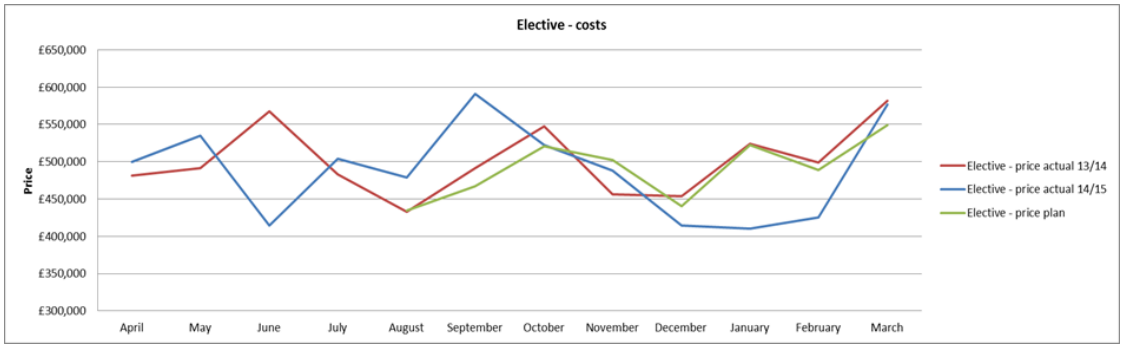


Figure 4 – Elective Costs



Continuing Health Care (Adult)

This area continues to be a major risk for the CCG, with an over spend of £1.727m for the financial year. A working group involving both the CCG and the Commissioning Support Unit meets regularly to review progress and risks.

The budget was increased by 4% from last year's expenditure levels, but the current data shows growth levels closer to 27%. Independent benchmarking has been carried out, and a comparison has been undertaken with a peer group of the 9 most similar CCGs, in relation to demographics as defined nationally. The results of this were presented to the GB in its development session in February, and have been used to influence the financial plans for 2015/16.

Independent Sector

The overspend for Independent Sector providers is £0.523m for the financial year. The majority of this is with Ramsay Healthcare (£0.96m), Spire Healthcare (£0.217m) and costs associated with the May Logan centre. Tax advice received late in the year indicated that VAT is not recoverable.

Higher than anticipated activity has been seen with these providers indicating an overall increase in planned care. This suggests that general demand for specific elective services is increasing. The overspend is in the areas of orthopaedic surgery, general surgery and ophthalmology.

Liverpool Women's Hospital

The forecast overspend at Liverpool Women's Hospital is projected to be £0.303m. This is consistent with the position reported last month. The over-spend to month 11 centres on the following areas:

- Antenatal pathway **- £0.132m** over-spend. Activity numbers are lower than plan, but there is a higher acuity in the case mix.
- Elective - **£0.032m** over-spend
- Deliveries - **£0.097m** over-spend
- Outpatients - **£0.099m** over-spend. Referrals into gynaecology outpatients have increased at the Trust. This may have resulted from national coverage of cervical screening.

Liverpool CCG act as co-ordinating commissioner and issued an Activity Query Notice specifically focusing on both the significant movement in the maternity pathway categorisation from standard to intermediate, and the increase in outpatient procedures. The draft report from external consultants Capita has been discussed with the provider and indicates a small error rate in maternity pathway coding. It appears that much of the over-performance in Gynaecology outpatient procedures is attributable to a nationally mandated coding change rather than purely increased activity. However, referrals indicate that there will be some activity driven over performance. The CCG has not agreed a year-end settlement with the provider, and once month 12 activity has been received, and any deductions for CQUIN and performance related sanctions understood, a year end balance will be agreed.

Alder Hey

A year end settlement was agreed with the Trust based on month 10 data. This assumed a continuation of the under-spends seen up to that point. The underspends were in both planned and unplanned care. Activity was expected to rise in planned care following the recruitment of both T&O and ENT medical resource. Month 11 information indicates that planned care was slightly higher than plan.

However, the emergency activity was lower than plan, with A&E being 4% lower than budget for the year to date. Non-elective admissions are 15% lower than plan up to month 11.

2.4 QIPP

South Sefton CCG has a QIPP savings target of £8.452m in 2014/15. The QIPP savings can be achieved through a reduction in either programme or running costs.

The CCG has carried out a review of the savings and costs avoided through the implementation of a number of its QIPP schemes, this indicates that the full QIPP target has now been identified.

2.5 CCG Running Costs

The CCG is currently operating within its running cost target which forms part of this budget area. The forecast for the year is an underspend on Running Costs and other Corporate and Support Services.

It is important to note that although the CCG is operating below the 14/15 national target of £24.78 per head of population, this will be reduced to £22.11 per head in 2015/16. There are plans in place to meet this target for 2015/16 and these were agreed by the Governing Body in February 2015.

2.6 Evaluation of Risks and Opportunities

The 2014/15 accounts have been closed and are now subject to external audit. There are a number of areas that are based on estimates, which could pose a risk in 2015/16 if those estimates are found to be insufficient. These are outlined below:

- Acute cost per case contracts – where the CCG does not have a full and final settlement agreed, there is a risk that activity in month 12 will be higher than estimated. The CCG will work with the host commissioner to ensure that activity is validated and CQUIN/sanctions are applied before year end balances are agreed.

- Continuing Healthcare Costs – The CCG has experienced significant pressures on the growth of CHC cases this year. The position is based on estimates up to month 11. If claims in March exceed current estimates, the excess will be borne by the CCG in the new financial year.

- Continuing Healthcare restitution claims – CCGs were notified in December of a forecast underutilisation against the national pool and resource of £0.548m was returned to the CCG in Month 10. There will be a national reconciliation exercise carried out to determine whether further returns / funding requests will be required to balance the payments nationally.

- Estates – Latest estimates have now been received from both NHS Property Services and the organisation that administers the LIFT buildings. The CCG now has estimated charges for all premises, and has sufficient reserves to meet its financial obligations. However, these are not final charges, and the values could fluctuate.

- Prescribing / Drugs costs - The prescribing data is two months in arrears. The costs for February and March may differ from the amounts accrued, with the difference being accounted for in 2015/16.

Reserve budgets are set aside as part of the budget setting exercise to reflect planned investments, known risks and an element for contingency. As part of the review of risks and mitigations during the financial year, the finance team and budget holders reviewed the expected expenditure levels for each earmarked reserve.

This is summarised in Figure 7 and shows that the CCG had sufficient reserves to manage the risks identified. The CCG met its planned surplus for the year.

Figure 5 – Reserves Analysis

	£'000
Overspend	4,975
Available reserves	(5,523)
Surplus Reserves	548

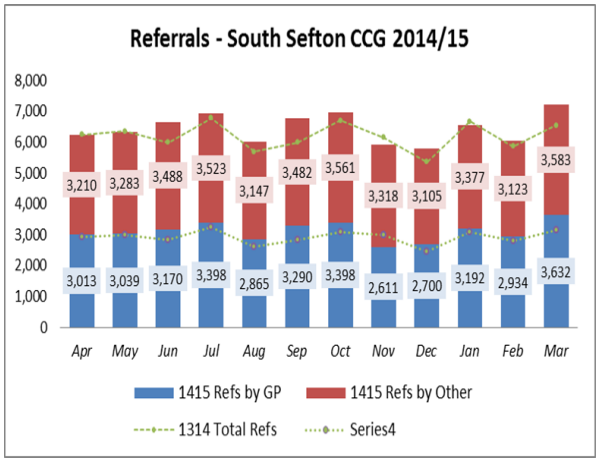
The forecast surplus increased by £0.548m in Month 10 to reflect the unutilised CHC allocation returned to the CCG.

3. Referrals

The following section provides an overview of referrals to secondary care to March 2015. Analysis also includes comparisons of 1415 referrals to the previous 2 financial years.

3.1 Referrals by source

Figure 6 - GP and 'other' referrals for the CCG across all providers for 2014/15



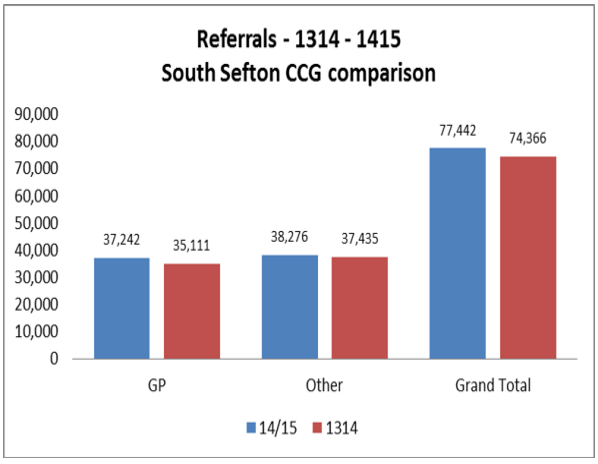


Figure 7 Monthly Average in 2014/15 compared to previous 2 years

Provider Monthly Average

Provider Name	1213 Average	1314 Average	1415 Average	% of total
Aintree Hospital	3,331	3,383	3,623	56%
Alder Hey	556	560	560	9%
Fairfield Hospital	3	2	4	0%
Isight	-	6	8	0%
Liverpool Heart and Chest	110	91	91	2%
Liverpool Womens	662	700	742	11%
Mid Cheshire	0	1	0	0%
Ramsay Healthcare	-	99	101	1%
Royal Liverpool & Broadgreen	793	787	752	13%
Southport & Ormskirk	411	475	483	7%
Spire Liverpool	-	48	59	1%
Spire Murrayfield	-	0	-	0%
St Helens & Knowsley	37	42	43	1%
Warrington & Halton	2	2	1	0%
Grand Total	5,904	6,197	6,467	

Source of Referral Monthly Average

Source of Referral	1213 Average	1314 Average	1415 Average	% of total
03	2,890	2,926	3,111	48%
01	183	173	170	9%
02	1	2	2	0%
04	302	286	258	14%
05	1,174	1,216	1,301	63%
06	259	247	268	13%
07	0	3	2	0%
10	180	229	243	11%
11	199	190	236	11%
12	6	6	6	0%
13	14	9	7	1%
14	56	68	85	4%
15	1	7	8	0%
16	0	0	-	0%
17	4	6	4	0%
92	196	195	183	10%
93	3	3	3	0%
97	435	482	421	23%
-1	1	152	160	5%
Grand Total	5,904	6,197	6,467	

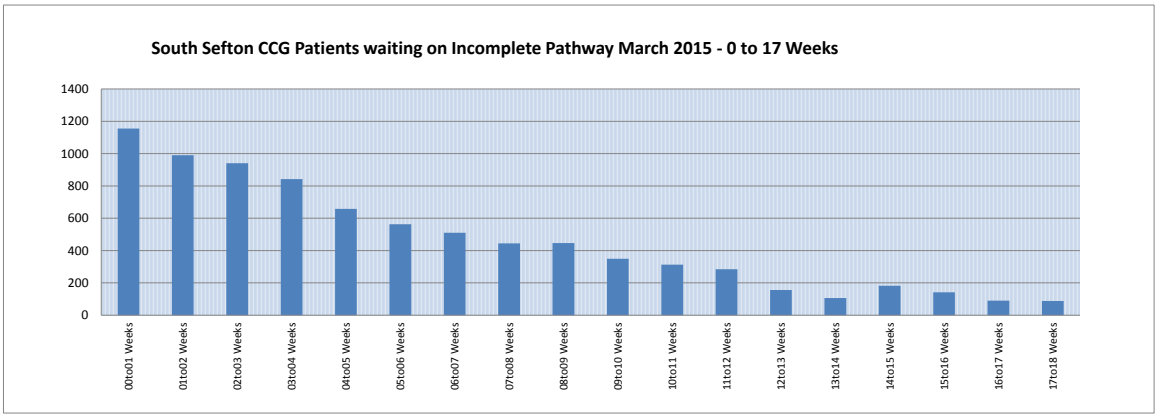
Figure 8 - GP and 'other' referrals for the CCG across all providers comparing 2013/14 and 2014/15 by month

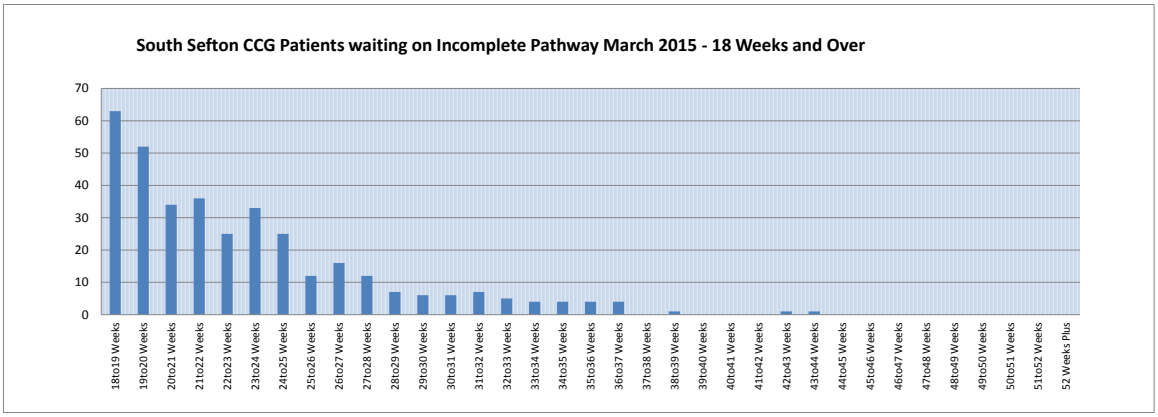
Referral Type	DD Code	Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	14/15	1314	Variance	% Variance
GP	03	GP Ref	3,013	3,039	3,170	3,398	2,865	3,290	3,398	2,611	2,700	3,192	2,934	3,632	37,242	35,111	2,131	6%
GP Total			3,013	3,039	3,170	3,398	2,865	3,290	3,398	2,611	2,700	3,192	2,934	3,632	37,242	35,111	2,131	6%
Other	01	following an emergency admission	183	178	156	199	159	176	183	163	127	157	169	185	2,035	2,073	-38	-2%
	02	following a Domiciliary Consultation			2	2	2	1	2	3	3	4	1	2	22	22	0	0%
	04	An Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)	241	308	283	273	244	263	258	244	225	257	232	276	3,104	3,426	-322	-10%
	05	A CONSULTANT, other than in an Accident and Emergency Department	1,231	1,254	1,303	1,297	1,199	1,334	1,321	1,325	1,270	1,338	1,236	1,481	15,589	14,594	995	6%
	06	self-referral	191	245	296	265	249	273	276	267	265	366	255	269	3,217	2,958	259	8%
	07	A Prosthetist		3		1	2	1		3	1	3	2	2	18	41	-23	-128%
	10	following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)	255	260	260	279	214	245	277	253	193	222	196	259	2,913	2,742	171	6%
	11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	199	209	223	251	217	320	291	225	223	221	227	221	2,827	2,284	543	19%
	12	A General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)	4	2	1	3	10	3	10	6	8	8	9	6	70	66	4	6%
	13	A Specialist NURSE (Secondary Care)	8	9	3	6	6	6	5	7	9	10	9	3	81	105	-24	-30%
	14	An Allied Health Professional	128	95	88	102	86	84	80	67	86	73	75	56	1,020	812	208	20%
	15	An OPTOMETRIST	8	3	17	5	9	11	15	5	3	3	7	9	95	80	15	16%
	16	An Orthoptist													0	1	-1	0%
	17	A National Screening Programme	3	4	1	11	2	7	4	2	1	2	2	3	42	69	-27	-64%
	92	A GENERAL DENTAL PRACTITIONER	208	184	210	174	171	193	215	169	152	145	151	194	2,166	2,342	-176	-8%
	93	A Community Dental Service	4	1	3	3	2	3	3	2	7		3	2	33	32	1	3%
	97	other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	405	393	473	481	421	395	439	434	386	400	388	429	5,044	5,788	-744	-15%
Other Total			3,068	3,148	3,319	3,352	2,993	3,315	3,379	3,175	2,959	3,209	2,962	3,397	38,276	37,435	841	2%
Unknown			142	135	169	171	154	167	182	143	146	168	161	186	1,924	1,820	104	5%
Grand Total			**6,223**	**6,322**	**6,658**	**6,921**	**6,012**	**6,772**	**6,959**	**5,929**	**5,805**	**6,569**	**6,057**	**7,215**	**77,442**	**74,366**	**3,076**	**4%**

4. Waiting Times

4.1 NHS South Sefton CCG patients waiting

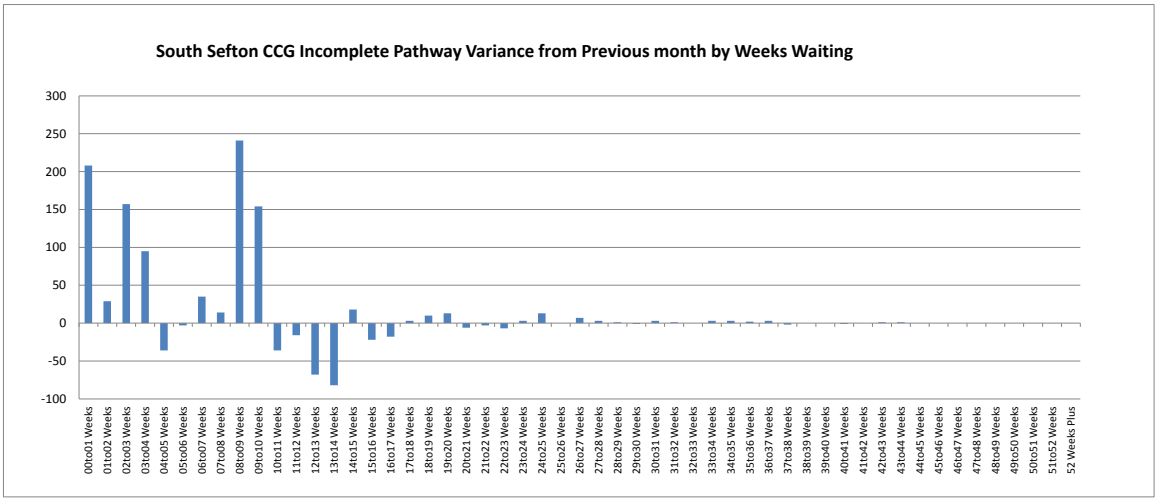
Figure 9 Patients waiting on an incomplete pathway by weeks waiting





There were 358 patients (4.2%) waiting over 18 weeks on Incomplete Pathways at the end of March 2015 an increase of 47 patients (15.1%) from Month 11.

There were no patients waiting over 52 weeks in February 2015 or March 2015.



There were 8,615 patients on the Incomplete Pathway at the end of March 2015 an increase of 720 patients (9.1%) from February 2015.

4.2 Top 5 Providers

Figure 10 Patients waiting (in bands) on incomplete pathway for the top 5 Providers

Trust	0to10 wks	10to18 wks	Total 0to17 Weeks	18to24 wks	24to30 wks	30+ wks	Total 18+ Weeks	Total Incomplete
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	4364	732	5096	92	34	15	141	5237
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	663	150	813	33	20	9	62	875
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	590	173	763	42	11	5	58	821
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	433	133	566	28	7	5	40	606
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	318	90	408	38	4	2	44	452
Other Providers	530	81	611	10	2	1	13	624
Total All Providers	6898	1359	8257	243	78	37	358	8615

4.3 Provider assurance for long waiters

In March, Aintree reported Ophthalmology non-admitted performance of 93.9%. This is unusual and does not follow the trend of Ophthalmology non-admitted performance over the past 12 months. An issue with the electronic patient list was identified in January 2015 and additional virtual clinics created. Unfortunately the majority of patients on the list had in fact already breached. Extensive report validation has taken place to ensure capacity remains manageable, a locum consultant has commenced in post to take additional clinics and capacity and demand modelling is being undertaken.Ophthalmology is expecting to achieve the target by June 2015.

Aintree also reported RTT failure for MFU in March at 94.19%. MFU have recently implemented the access and waiting list policy for patients being discharged back to their referring practitioners after one cancellation. This is being trialled on dental patents initially, to minimise risk. A large number of dental patients continue to cancel their initial appointment and are being offered several alternative dates. This has resulted in a large number of patients breaching their 18 week wait. Additional clinics have been created coupled with validation of waiting lists by clerks. Recoevery of the target is expected by June 2015.

5. Planned Care

5.1 All Providers

Figure 11 Planned Care - All Providers

Provider Name	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	143,289	143,289	148,500	5,211	3.64%	£27,897	£27,897	£28,941	£1,044	3.74%
Alder Hey Childrens NHS F/T	15,954	15,954	14,215	-1,739	-10.90%	£2,515	£2,515	£2,271	-£245	-9.72%
Countess of Chester Hospital NHS Foundation Trust	0	0	130	130	0.00%	£0	£0	£20	£20	0.00%
East Cheshire NHS Trust	0	0	2	2	0.00%	£0	£0	£0	£0	0.00%
Liverpool Heart and Chest NHS F/T	964	964	1,135	171	17.74%	£480	£480	£547	£67	13.85%
Liverpool Womens Hospital NHS F/T	13,853	13,853	13,756	-97	-0.70%	£3,130	£3,130	£3,187	£57	1.81%
Royal Liverpool & Broadgreen Hospitals	28,270	28,270	26,990	-1,280	-4.53%	£5,653	£5,653	£5,360	-£293	-5.19%
Southport & Ormskirk Hospital	12,412	12,412	13,267	855	6.89%	£2,614	£2,614	£2,766	£152	5.81%
ST Helens & Knowsley Hospitals	3,651	3,651	3,927	276	7.56%	£965	£965	£1,040	£74	7.71%
Wirral University Hospital NHS F/T	430	430	423	-7	-1.63%	£120	£120	£123	£2	1.90%
Central Manchester University Hospitals Nhs Foundation Trust	80	80	153	73	91.25%	£21	£21	£34	£14	65.58%
Fairfield Hospital	137	137	90	-47	-34.31%	£43	£43	£23	-£20	-45.90%
ISIGHT (SOUTHPORT)	361	361	325	-36	-9.97%	£92	£92	£81	-£11	-11.75%
Renacres Hospital	3,042	3,042	4,341	1,299	42.68%	£1,182	£1,182	£1,288	£106	8.97%
SPIRE LIVERPOOL HOSPITAL	2,762	2,762	3,104	342	12.37%	£770	£770	£1,011	£241	31.33%
University Hospital Of South Manchester Nhs Foundation Trust	102	102	68	-34	-33.33%	£16	£16	£12	-£4	-23.21%
Wrightington, Wigan And Leigh Nhs Foundation Trust	760	760	1,149	389	51.18%	£294	£294	£455	£161	54.89%
Grand Total	**226,068**	**226,068**	**231,575**	**5,507**	**2.44%**	**£45,792**	**£45,792**	**£47,158**	**£1,366**	**2.98%**

Total Planned care costs for contracted activity in 2014/15, at South Sefton CCG, is showing a £1.3m (3%) over performance. Activity is showing an over performance of 5k (2%).

76% of over performance is recorded at Aintree Hospital (£1m) with smaller financial over perofmrnaces seen at Spire Liverpool (£241k) and Southport & Ormskirk (£152k).

5.2 Aintree University Hospital NHS Foundation Trust

Figure 12 Month 12 Planned Care- Aintree University Hospital NHS Foundation Trust by POD

Aintree University Hospitals Planned Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	11,670	11,670	12,096	426	3.65%	£7,758	£7,758	£8,185	£427	5.50%
Elective	2,139	2,139	2,119	-20	-0.94%	£5,823	£5,823	£5,836	£13	0.22%
Elective Excess BedDays	1,138	1,138	1,001	-137	-12.04%	£257	£257	£234	-£23	-8.90%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	480	480	600	120	25.00%	£84	£84	£100	£15	17.96%
OPFANFTF - *Outpatient first attendance non face to face*	524	524	632	108	20.61%	£22	£22	£24	£3	11.84%
OPFASPCL - *Outpatient first attendance single professional consultant led*	29,030	29,030	29,152	122	0.42%	£4,416	£4,416	£4,423	£7	0.16%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	1,606	1,606	1,541	-65	-4.05%	£178	£178	£167	-£11	-6.22%
OPFUPNFTF - *Outpatient follow up non face to face*	1,416	1,416	1,302	-114	-8.05%	£32	£32	£31	-£1	-3.04%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	78,682	78,682	79,435	753	0.96%	£6,261	£6,261	£6,142	-£119	-1.90%
Outpatient Procedure	16,604	16,604	20,622	4,018	24.20%	£3,065	£3,065	£3,799	£734	23.95%
Grand Total	**143,289**	**143,289**	**148,500**	**5,211**	**3.64%**	**£27,897**	**£27,897**	**£28,941**	**£1,044**	**3.74%**

5.2.1 Aintree University Hospital NHS Foundation Trust Key Issues

Throughout 2014/15, Aintree's over performance has been focused in Daycase and Outpatient Procedures. Whilst Daycases remained a similar variance month-by-month, Outpatient Procedure cost variance continued to increase throughout 2014/15.

Continuing over performance was seen in ENT and Urology in 2014/15 and these 2 specialties have contributed the largest costs to the overspend in OPPROCs. Whilst Urology & ENT make

up 50% of the OPPROC over performance, Interventional Radiology has a zero plan for 1415 but has shown an overspend of £374k for the financial year.

The largest percentage variance against cost is in Cardiology & Breast Surgery. As reported previously, changes to Breast Services delivered at S&O have had an impact on Breast Surgery activity at Aintree. Short term and longer term proposals are being developed and therefore the overspend will continue until such proposals are agreed.

Aintree Provider report includes analysis on HRG activity within Urology and those causing the £441k overspend. One particular HRG, "LB14E – Bladder Intermediate Endoscopic Procedure 19 and over" makes up 65% of the Urology over spend and this has been a continuous theme throughout 2014/15. Other HRGs over performance appears to be decreasing on month apart from the aforementioned code.

5.3 Spire Liverpool Hospital

Figure 13 Month 12 Planned Care- Spire Liverpool Hospital by POD

Spire Liverpool Planned Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	272	272	361	89	32.72%	£391	£391	£491	£100	25.58%
Elective	57	57	52	-5	-8.77%	£189	£189	£296	£107	56.88%
OPFASPCL - *Outpatient first attendance single professional consultant led*	596	596	572	-24	-4.03%	£78	£78	£77	-£1	-1.72%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	1,641	1,641	1,813	172	10.46%	£92	£92	£109	£17	18.77%
OPFUSPNCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Non Consultant Led)*	98	98	88	-10	-10.20%	£5	£5	£4	-£1	-10.20%
Outpatient Procedure	98	98	218	120	122.45%	£15	£15	£34	£19	121.04%
Grand Total	**2,762**	**2,762**	**3,104**	**342**	**12.37%**	**£770**	**£770**	**£1,011**	**£241**	**31.33%**

5.3.1 Spire Liverpool Hospital Key Issues

South Sefton CCG financial over-performance was continuous in 2014/15. The final over performance cost is £241k (31%)

Throughout 2014/15 there is a financial over-performance but an activity under-performance. However, the level of variation has changed significantly towards the end of 14/15 which reflects the use of theatres on Sundays in March to make up for the one week closure for theatre upgrade work in February.

6. Unplanned Care

6.1 All Providers

Figure 14 Month 12 Unplanned Care – All Providers

Provider Name	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	50,407	46,126	47,957	1,831	3.97%	£28,075	£25,691	£28,616	£2,925	11.39%
Alder Hey Childrens NHS F/T	9,195	8,368	8,011	-357	-4.27%	£2,070	£1,887	£1,692	-£195	-10.33%
Countess of Chester Hospital NHS Foundation Trust	0	0	57	57	0.00%	£0	£0	£14	£14	0.00%
East Cheshire NHS Trust	0	0	12	12	0.00%	£0	£0	£2	£2	0.00%
Liverpool Heart and Chest NHS F/T	108	100	138	38	38.49%	£158	£145	£135	-£10	-6.60%
Liverpool Womens Hospital NHS F/T	3,416	3,126	3,080	-46	-1.46%	£2,786	£2,549	£2,584	£35	1.38%
Royal Liverpool & Broadgreen Hospitals	5,641	5,162	5,324	162	3.14%	£1,982	£1,814	£1,954	£141	7.76%
Southport & Ormskirk Hospital	6,705	6,101	6,634	533	8.74%	£2,634	£2,412	£2,306	-£106	-4.41%
ST Helens & Knowsley Hospitals	971	887	744	-143	-16.10%	£388	£355	£320	-£35	-9.86%
Wirral University Hospital NHS F/T	245	223	251	28	12.31%	£90	£82	£81	-£1	-0.68%
Central Manchester University Hospitals Nhs FT	67	61	72	11	17.23%	£16	£15	£13	-£2	-15.61%
University Hospital Of South Manchester Nhs FT	41	37	28	-9	-25.09%	£14	£13	£4	-£8	-65.58%
Wrightington, Wigan And Leigh Nhs Foundation Trust	42	38	61	23	58.44%	£15	£14	£21	£7	46.90%
Grand Total	**76,838**	**70,230**	**72,369**	**2,139**	**3.05%**	**£38,228**	**£34,976**	**£37,742**	**£2,767**	**7.91%**

6.2 Aintree University Hospital NHS Foundation Trust

Figure 15 Month 12 Unplanned Care – Aintree University Hospital NHS Foundation Trust by POD

Aintree University Hospitals Urgent Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
A&E - *Accident & Emergency*	30,748	28,137	28,298	161	0.57%	£3,294	£3,014	£3,106	£92	3.04%
NEL - *Non Elective*	10,592	9,692	11,252	1,560	16.09%	£22,135	£20,255	£22,729	£2,474	12.22%
NELNE - *Non Elective Non-Emergency*	40	37	46	9	25.67%	£117	£107	£127	£20	18.87%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	34	31	147	116	372.48%	£8	£7	£34	£27	383.82%
NELST - *Non Elective Short Stay*	1,270	1,162	1,780	618	53.17%	£833	£762	£1,185	£423	55.46%
NELXBD - *Non Elective Excess Bed Day*	7,723	7,067	6,434	-633	-8.96%	£1,689	£1,545	£1,434	-£111	-7.20%
Grand Total	**50,407**	**46,126**	**47,957**	**1,831**	**3.97%**	**£28,075**	**£25,691**	**£28,616**	**£2,925**	**11.39%**

6.2.1 Aintree Hospital Key Issues

The final Urgent Care over performance cost is £2.9m for 2014/15.

Urgent care over performance is attributable to the mid-year change in CDU/Non Elective admissions, resulting in a 2014/15 total Non-Elective over-performance of £2.8m

7. Mental Health

7.1 Mersey Care NHS Trust Contract

Figure 16 NHS South Sefton CCG – Shadow PbR Cluster Activity

PBR Cluster	NHS South Sefton CCG			
	2014/15 Plan	Caseload (Mar-2015)	Variance from Plan	% Variance
0 Variance	34	77	43	126%
1 Common Mental Health Problems (Low Severity)	23	39	16	70%
2 Common Mental Health Problems (Low Severity with greater need)	48	29	(19)	-40%
3 Non-Psychotic (Moderate Severity)	274	231	(43)	-16%
4 Non-Psychotic (Severe)	169	213	44	26%
5 Non-psychotic Disorders (Very Severe)	32	50	18	56%
6 Non-Psychotic Disorder of Over-Valued Ideas	43	40	(3)	-7%
7 Enduring Non-Psychotic Disorders (High Disability)	133	196	63	47%
8 Non-Psychotic Chaotic and Challenging Disorders	83	97	14	17%
10 First Episode Psychosis	93	113	20	22%
11 On-going Recurrent Psychosis (Low Symptoms)	414	438	24	6%
12 On-going or Recurrent Psychosis (High Disability)	312	315	3	1%
13 On-going or Recurrent Psychosis (High Symptom & Disability)	112	102	(10)	-9%
14 Psychotic Crisis	17	22	5	29%
15 Severe Psychotic Depression	7	2	(5)	-71%
16 Psychosis & Affective Disorder (High Substance Misuse & Engagement)	33	35	2	6%
17 Psychosis and Affective Disorder – Difficult to Engage	58	58	-	0%
18 Cognitive Impairment (Low Need)	347	210	(137)	-39%
19 Cognitive Impairment or Dementia Complicated (Moderate Need)	462	614	152	33%
20 Cognitive Impairment or Dementia Complicated (High Need)	148	262	114	77%
21 Cognitive Impairment or Dementia (High Physical or Engagement)	45	49	4	9%
Reviewed Not Clustered	36	120	84	233%
No Cluster or Review	144	197	53	37%
Total	3,067	3,509	442	14%

Figure 17 CPA – Percentage of People under followed up within 7 days of discharge

			Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
CB_B19	The % of people under adult mental illness specialities who were followed up within 7 days of discharge from psychiatric inpatient care	95%	100.00%	100.00%	100.00%	87.50%	93.75%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Figure 18 CPA Follow up 2 days (48 hours) for higher risk groups

			Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
MH_KPI.4	CPA Follow up 2 days (48 hours) for higher risk groups are defined as individuals requiring follow up within 2 days (48 hours) by CRHT, Early Intervention, Assertive Outreach or Homeless Outreach Teams.	95.0%	50.0%	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.0%	100.0%

7.2 Inclusion Matters Sefton Contract

Figure 19 PHQ13_6 Proportion of people who complete treatment who are moving to recovery

South Sefton	Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	Total
Entered (KPI4)		176	257	237	670	231	188	266	685	322	323	290	935	321	280	279	880	3170
Entered (KPI4) HSCIC		**175**	**190**	**210**	**575**	**235**	**205**	**240**	**680**									**1255**
Completed (KPI5)		163	184	140	487	208	152	219	579	224	211	153	588	215	164	220	599	2253
Completed (KPI5) HSCIC		**150**	**175**	**125**	**450**	**165**	**150**	**220**	**535**									**985**
Moved to recovery (KPI6)		59	87	51	197	95	64	92	251	89	71	54	214	83	60	95	238	900
Moved to recovery (KPI6) HSCIC		**55**	**80**	**45**	**180**	**85**	**50**	**85**	**220**									**400**
Entered Below Caseness (KPI6b)		14	8	7	29	11	9	13	33	13	19	7	39	9	10	13	32	133
Entered Below Caseness (KPI6b) HSCIC		**10**	**10**	**5**	**25**	**15**	**10**	**15**	**40**									**65**
Prevalence	15%	0.72%	1.06%	0.98%	2.76%	0.95%	0.77%	1.09%	2.82%	1.33%	1.33%	1.19%	3.85%	1.32%	1.15%	1.15%	3.62%	13.05%
Recovery	50%	39.6%	49.4%	38.3%	43.0%	48.2%	44.8%	44.7%	46.0%	42.2%	37.0%	37.0%	39.0%	40.3%	39.0%	45.9%	42.0%	42.5%
Prevalence HSCIC	15%	**0.72%**	**0.78%**	**0.86%**	**2.37%**	**0.97%**	**0.84%**	**0.99%**	**2.80%**									**5.17%**
Recovery HSCIC	50%	**39.3%**	**48.5%**	**37.5%**	**42.4%**	**56.7%**	**35.7%**	**41.5%**	**44.4%**									**43.5%**

IAPT – Prevalence: The CCG achieved 3.62 % in quarter 4, failing the 3.75% target. Year to date the CCG are recording 13.05%.
January 2015 recording 1.32% (321 patients).
February 2015 recording 1.15% (280 patients)
March 2015 recording 1.15% (270 patients).

To have achieved the 3.75% target in Q4 the service would need to see just 31 more patients enter psychological therapies in Q4.

IAPT - Recovery Rate: The CCG did not achieve the 50% target in year reaching 46.7% cumulatively. The annual target for 2014/15 was therefore not achieved.

A new provider will be providing psychological therapies in 2015/16 in place of Inclusion Matters. Some new indicaotrs on waiting times will be reported on for the first time in 2015/16.

8. Community Health

Liverpool Community Health Services (by exception)

Overall adult services demand (i.e. referrals) is currently 26.6% above plan while activity (i.e. contacts) is 0.5% below (also slightly down from previous month).The service with the majority share of the over performance is the Community Equipment service with over performance in IV therapy, Intermediate Care, Phlebotomy, Physiotherapy and Adult Speech & Language Therapy.

Community Matrons are also over performing with this increase potentially caused by the Virtual Ward which is now established and further referrals are coming through. Urgent Care has now gone live within Virtual Ward creating an increase in referrals between both services being stepped up and stepped down. Proactive care is working well at the monthly GP meetings with the community matrons and reactive work continues to come through. District Nurses are actively referring to community matrons where this is appropriate.

IV Therapy: Activity has increased in line with demand and the service is flexing across the whole service and trust to meet this.

Community Equipment: There is a sustained increase in demand which is leading to cost pressures. This is included in Financial Recovery Plan submitted to the CCG in Sept 2014. The current service review is due to be completed by the CCG and LCH in Q1 2015/16.

Adult OT: Referrals are increasing into the service as other disciplines are becoming more aware of the OT services as a result of the locality developments and Virtual ward meetings. The increase in demand from the acute sector in particular from Intensive Care units Aintree and CICT and patients waiting discharge home or to nursing home care. Activity to date is within tolerance levels.

Phlebotomy: The increase in demand and activity is due to the transfer of domiciliary phlebotomy from district nurses and this is being managed within current resources.

Podiatry: Demand and correspondingly activity is below planned levels. The trust has identified no apparent reason for the reduction in referrals with AQP in effect .It is a possibility that GPs may have been referring some patients to other non LCH AQP podiatrists. A combination of long term and sickness has impacted on the contacts seen in Sefton. The trust have brought in locum staff however they are not always available and a recruitment round is now underway.

Children's services activity and demand are below planned levels however the following service is over performing: Paediatric Continence.

Paediatric SALT: Activity to date has been affected by maternity leave however this is being managed by using agency staff. Recruitment to fixed term contracts is underway and the candidates are due to be interviewed shortly. It is expected that activity will return to planned levels along with a decrease in waiting times once the recruitment is complete.

There are a number of the services that are being measured against plans which do not reflect current and previous demand and activity levels and additional investment. These will be part of a rebasing exercise with the provider to ensure the plans have been allocated correctly and that activity associated with investment around the virtual ward is quantified and included.

Liverpool Community Health Waiting Times

The Trust is reporting significant waiting times for a small number of services (paediatric OT and Paediatric SALT). For services where the 18 week Referral to Treatment standard is not applicable, the Trust has been asked to suggest appropriate waiting time targets.

This information has been received for: Dietetics, OT, Physiotherapy, Podiatry and SALT and is currently with the CCG for review.

Waiting times are not being recorded for several services: Community Cardiac/Heart Failure, Community Matrons, District Nursing Service, IV Therapy and Palliative Care & Treatment Rooms.

Any Qualified Provider

AQP continues to perform above expected levels with a combined Podiatry block and AQP activity figure above the same period last year.

The dataset currently provided by LCH does not identify patients discharged at first assessment and this has been requested from the trust throughout the year. These cases are charged at full tariff but agreement has been reached to charge at a local tariff of £25 for these cases from April 2015.The trust has confirmed that from month one they will be using this tariff within the submitted data set.

9. Third Sector Contracts

2014/15 signed NHS Contracts are in place with all third sector providers. These contracts are on a block basis and therefore there is limited financial risk to the CCG. Contract Management meetings have taken place with all providers and actions resulting from these meetings are being progressed. CCG colleagues are currently reviewing data collected on these contracts for inclusion in future Integrated Performance Reports.

10. Quality and Performance

10.1 NHS South Sefton CCG Performance

		Current Period				
Performance Indicators	Data Period	Target	Actual	Direction of Travel	Exception Commentary	Actions
IPM						
Treating and caring for people in a safe environment and protecting them from avoidable harm						
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(CCG)**	14/15 - March	60	64	↑	8 new cases reported in March 2015. A total of 64 cases reported YTD compared to a plan of 60 cases. Of the 8 cases reported in March 6 were aligned to Aintree Hospital (5 apportioned to acute trust and 1 apportioned to community) 1 case was at The Walton Centre (apportioned to acute trust) 1 case at The Royal Liverpool Broadgreen (apportioned to community). Of the 64 cases reported YTD 57 cases have been reported by Aintree Hospital (26 apportioned to community and 31 apportioned to community), 1 case reported by St Helens and Knowsley Hospital (apportioned to acute), 2 cases reported at The Royal Liverpool Broadgreen (1 apportioned to acute trust and 1 apportioned to community), 2 cases reported by Southport and Ormskirk Hospital (apportioned to community) 1 case reported by Christie Hospital Foundation Trust (apportioned to community) and 1 case reported by The Walton Centre (apportioned to acute trust). The CCG has failed the year to date plan for 2014-15.	The majority of the cases are attributable to Aintree University Hospital, the Trust provided an update regarding their C.Dif Action Plan at the at the March CQPG meeting. The CCG continues to consider appeals at the regular appeals meetings, the last meeting was held on 12th March. (4 out of 6 appeals were supported - YTD 19 have been supported). Aintree University Hospital achieved their national C.Dif trajectory in Month 12 (March). For C.Dif cases attributed to other providers, cases are reviewed via co-commissioner arrangements. *Please Note - Data has been taken from the National HCAI Database - this is updated centrally therefore not all local appeals will be reflected in the table.*
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(Aintree)**	14/15 - March	81	64	↔	5 new cases have been reported in March bringing the year to date value to 64. Aintree remain below plan for the year and have achieved the 2014-15 plan.	
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(CCG)**	14/15 - March	0	2	↔	No new cases have been reported in March but the CCG remains red and will do for the remainder of the year due to the zero tolerance plan. The previous cases where reported against Aintree with one in May (Acute) and the other in July (Community)	Aintree Hospital reported a case in May 14, however following review by NHS England this case was found to be community aquired and attributed to South Sefton CCG. A second South Sefton case was initially reported by Aintree in July following a recent PIR (post infection review) NHS England attributed this case to Aintree Hospital. At the CQPG in October the Trust informed commissioners they had requested details of the decission making process from regional office and the reasons for assigning case to the Trust. At the March CQPG, the Trust confirmed that they are still awaiting feedback from NHS England, the CCG also confirmed thet had requested feedback on Antree's behalf. *Please Note - Data has been taken from the National HCAI Database - this is updated centrally therefore not all local appeals will be reflected in the table.*

Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(Aintree)**	14/15 - March	0	2	↔	No new cases of MRSA at Aintree in March. There is still conflicting data showing on the HCAI database, which states 1 case reported in May 2014 (not July). Unify2 data reports 0 cases in May but 1 case in July 2014. Both show the second case in December.	The CCG was informed about an MRSA case reported in December 2014 (Liverpool CCG patient) a PIR has taken place. The CCG has queried the Nationally reported figures for Aintree as the HCAI data base and Unify 2 state conflicting figures. As mentioned above the May 201 4 case has been attributed to Community / South Sefton CCG so should therefore be removed from Aintree Hospital. The Trust regularly provides an update and submits their MRSA Action Plan at the monthly CQPG meetings. *Please Note - Data has been taken from the National HCAI Database - this is updated centrally therefore not all local appeals will be reflected in the table.*
Enhancing quality of life for people with long term conditions						
Patient experience of primary care i) GP Services	Jan-Mar 14 and Jul-Sept 14		7.69%	New Measure	Percentage of respondents reporting poor patient experience of primary care in GP Services. This is an increase from the previous period which recorded 6.56%.	
Patient experience of primary care ii) GP Out of Hours services	Jan-Mar 14 and Jul-Sept 14		9.81%	New Measure	Percentage of respondents reporting poor patient experience of GP Out of Hours Services. This is an increase from the previous period which recorded 9.52%.	
Patient experience of primary care i) GP Services ii) GP Out of Hours services (Combined)	Jan-Mar 14 and Jul-Sept 14	6%	7.89%	New Measure	The CCG reported a percentage of negative responses above the 6% threshold, this being an increase from last survey which reported 6.92%.	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s(Cumulative)	14/15 - March	325.48	325.47	New Plans	This measure now has a plan which is based on the same period previous year. The number of actual admissions is the same as the same period last year.	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	14/15 - March	1035.83	1,154.36	New Plans	This measure now has a plan which is based on the same period previous year. The increase in actual admissions is 184 more than the same period last year.	
Emergency Admissions Composite Indicator(Cumulative)	14/15 - March	2444.63	2,615.32	New Plans	This measure now includes a monthly plan, this is based on the plan set within the Outcome Measure framework and has been split using last years seasonal Performance. The CCG is over the monthly plan and had 547 more admissions than the same period last year.	
IAPT - Prevalence (Quarterly)	14/15 - Qtr4	3.75%	3.62%	↓	The target for this measure changed mid-year from 15% at year end to 3.75% in Qtr4. For Q4 the CCG has achieved 3.62% which is below the 3.75% target. Previous quarters recording 2.76% for Q1, 2.82% for Q2 and Q3 recording 3.85%, Q3 being the only quarter achieving. Year to date they are recording 13.05%. January recording 1.32% (321 patients), February recording 1.15% (280 patients) and March recording1.15% (270 patients). To have achieved the 3.75% target in Q4 the service would needed to see 31 more patients enter psycholocial therapies in Q4.	Identified issue with provider not applying nationally mandated definition of KPI. Action plan in place to ensure target met by end Q4 2014/15. New provider in 2015/16.
IAPT - Prevalence (Cumulative)	14/15 - March	15.00%	13.05%	↑		
IAPT - Recovery Rate (Cumulative)	14/15 - March	50%	46.70%	↔	The CCG are not achieving the 50% target reaching 46.7% for 2014-15, the target has not been achieved during 2014/15.	

Helping people to recover from episodes of ill health or following injury						
Patient reported outcomes measures for elective procedures: Groin hernia	2012/13	Eng Ave 0.085	0.068	Refreshed data	The CCG improved on the previous years rate but failed to achieve a score higher than that of the England average.	The CCG is very close to the England Average for PROMs data, discussions are currently taking place at CCG level to establish ownership of PROMs measure and to develop an improvement plan.
Patient reported outcomes measures for elective procedures: Hip replacement	2012/13	Eng Ave 0.438	0.430	Refreshed data	The CCG improved on the previous years rate but failed to achieve a score higher than that of the England average.	
Patient reported outcomes measures for elective procedures: Knee replacement	2012/13	Eng Ave 0.318	0.343	Refreshed data	The CCG improved on both the previous years rate and achieved above the England average.	
Emergency readmissions within 30 days of discharge from hospital (Cumulative)	14/15 - March		16.24	↔		
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	14/15 - March	418.47	266.58	New Plans	This measure now has a plan which is based on the same period previous year. The decrease in actual admissions is 49 below the same period last year.	
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	14/15 - March	1142.76	1,410.08	New Plans	This measure now has a plan which is based on the same period previous year. The increase in actual admissions is 415 above the same period last year.	Patient level data is being shared with practices to analyse trends and identify inappropriate or avoidable admissions.
% who had a stroke & spend at least 90% of their time on a stroke unit **(CCG)**	14/15 - March	80%	82.35%	↑	South Sefton CCG have achieved the 80% target in March 14 patients out of 17 spending at least 90% of their time on a stroke unit. The target has been achieved in Apr, May, Aug, Sept and March in 2014-15.	
% who had a stroke & spend at least 90% of their time on a stroke unit **(Aintree)**	14/15 - March	80%	80.56%	↑	Aintree have failed to achieved the target in March, 29 patients out of 36 spending at least 90% of their time on a stroke unit. The target has been achieved in Apr, May, Sept and March in 2014-15.	
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(CCG)**	14/15 - March	60%	100%	↔		
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(Aintree)**	14/15 - March	60%	100%	↔		
Mental health						
Mental Health Measure - Care Programme Approach (CPA) - 95% (Cumulative) **(CCG)**	14/15 - Qtr3	95%	100.00%	↑		
Preventing people from dying prematurely						
Under 75 mortality rate from cancer	2013		158.70			
Under 75 mortality rate from cardiovascular disease	2013		72.60			
Under 75 mortality rate from liver disease	2013		22.60			
Under 75 mortality rate from respiratory disease	2013		38.00			
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Person)	2013	2,029.00	2,592.30	↓	South Sefton achieved above the planned figure for the latest data and is also a decreased performance from 2012 which had a rate of 2029.8. For 2013 the rate for Males was 2669.2, a drop from the previous year (2179.2). Females also had a drop in performance with a rate of 2517.7 compared with 1875.7 in 2012.	The annual variation is significant and the CCG is working with Public Health locally and regionally to understand this. Indications at present are that the PYLL is significantly susceptible to fluctuations due to changes such as young deaths, which introduces major swings, particularly at CCG level.

Cancer waits – 2 week wait						
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(CCG)**	14/15 - February	93%	94.63%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Aintree)**	14/15 - February	93%	97.05%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(CCG)**	14/15 - February	93%	95.76%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(Aintree)**	14/15 - February	93%	95.85%	↔		
Cancer waits – 31 days						
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(CCG)**	14/15 - February	96%	98.39%	↔		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Aintree)**	14/15 - February	96%	99.27%	↔		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	14/15 - February	94%	96.86%	↔		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Aintree)**	14/15 - February	94%	100%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	14/15 - February	94%	97.81%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Aintree)**	14/15 - February	94%	98.57%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	14/15 - February	98%	99%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(Aintree)**	14/15 - February	98%	99.54%	↔		

Cancer waits – 2 week wait						
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(CCG)**	14/15 - February	93%	94.63%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Aintree)**	14/15 - February	93%	97.05%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(CCG)**	14/15 - February	93%	95.76%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(Aintree)**	14/15 - February	93%	95.85%	↔		
Cancer waits – 31 days						
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(CCG)**	14/15 - February	96%	98.39%	↔		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Aintree)**	14/15 - February	96%	99.27%	↔		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	14/15 - February	94%	96.86%	↔		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Aintree)**	14/15 - February	94%	100%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	14/15 - February	94%	97.81%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Aintree)**	14/15 - February	94%	98.57%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	14/15 - February	98%	99%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(Aintree)**	14/15 - February	98%	99.54%	↔		

Referral To Treatment waiting times for non-urgent consultant-led treatment						
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted) **(CCG)**	14/15 - March	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted) **(Aintree)**	14/15 - February	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(CCG)**	14/15 - March	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(Aintree)**	14/15 - February	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(CCG)**	14/15 - March	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(Aintree)**	14/15 - February	0	0	↔		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(CCG)**	14/15 - March	90%	92.47%	↑		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(Aintree)**	14/15 - February	90%	92.75%	↓		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(CCG)**	14/15 - March	95%	97.54%	↔		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(Aintree)**	14/15 - February	95%	98.13%	↔		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(CCG)**	14/15 - March	92%	95.84%	↔		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(Aintree)**	14/15 - February	92%	96.65%	↔		
A&E waits						
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG)**	14/15 - March	95.00%	97.90%	↔		
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Aintree)**	14/15 - March	95.00%	90.53%	↔	The 95% target was not achieved in March (94.86%). Out of 11750, 604 attendances where not admitted, transferred or discharged within 4 hours. The trust has failed this target every month in 2014-15 with the year to date figure recorded as 90.53%.	Many AED clinical indicators have seen an in-month improvement in performance. The median time to see a clinician has reduced to 90 minutes (-12 minutes) in March 2015 and remains above the 60 min threshold. The left department rate decreased to 3.51% (-0.24%) despite the number of patients leaving the department increasing (+10). Rates of unplanned follow up decreased in month (-0.14%) whilst unplanned re-attendance rates increased to 8.14% (+0.53%). The 95th percentile wait time for all patients has reduced from 587 in February to 411 in March (-176 minutes). Whilst HAS compliance remains higher than many others in the region, Ambulance turnaround times remained below the expected standard (81.1%) but again above the Cheshire and Mersey average (78.4%). Ambulance attendances experienced a further increase in March (+124) which follows on from the +297 increase experienced in February 2015. The number of excess waits for ambulance turnaround in March 2015 reduced for the second consecutive month with the Trust reporting 88 delays above 30 minutes of which 13 were in excess of 60 minutes. January 2015 reported 302 turnaround times above 30 minutes of which 119 were above 60 minutes and February reported 169 delays above 30 minutes of which 42 were in excess of 60 minutes. The operational teams have continued to progress with the 4 hour action plan and the recommendations from ECIST

Diagnostic test waiting times						
% of patients waiting 6 weeks or more for a Diagnostic Test **(CCG)**	14/15 - March	1.00%	0.91%	↑		During February 1.5% of all diagnostic procedures were not performed within 6 weeks which represents a failure to deliver the national standard of 1%. This equates to 65 patients of whom 32 were awaiting endoscopic diagnostics and 28 awaiting sleep studies. Flexible sigmoidoscopy (2.3%), and gastroscopy (6.3%) remain above the 1% threshold. A comprehensive service review is underway within the sleep lab and Endoscopy are actively attempting to recruit into consultant vacancies.
% of patients waiting 6 weeks or more for a Diagnostic Test **(Aintree)**	14/15 - February	1.00%	1.03%	↑	Aintree have failed to achieved the target for February, this being the 4th month running. Aintree have put an action plan in place since breaching the target in November.	
Category A ambulance calls						
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	14/15 - March	75%	66.62%	↑	The CCG failed to achieve the 75% target year to date, or in month (March) recording 70.31%.	Overall NWAS activity at the year-end was 2.2% over plan . Merseyside activity was 0.8% over plan at year-end. South Sefton was 4.6% up. South Sefton Red activity is up 11.9% at year end against plan. Green activity remains down on plan, finishing the year at 0.4% under plan. NWAS attended a Board to Board with the Trust Development Authority on the 24th April. Subsequent to the meeting, NWAS have put in place a number of internal measures to focus staff on being able to meet performance in Quarter 1 of 2015/16. For the Trust this means working in such a way as if they were managing a major incident (suspending mandatory training and attendance at some meetings), although it should be stressed that they have not declared a major incident and remain at REAP 3. Following the meeting NWAS performance has improved significantly and the Trust provided Commissioners with assurances of meeting Q1 performance at the Strategic Partnership Board held 7th May 2015. Agreement on the contractual arrangements for 2015/16 has been reached following mediation with the Trust, avoiding the need for formal arbitration. County Lead Commissioners have agreed to invest circa £10m into NWAS for 15/16. This includes base lining funding for some of the Trusts initiatives targeted at deflecting incidents (including Paramedic Pathfinder, Complementary Resources and Frequent Callers).
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	14/15 - March	75%	66.00%	↔	The CCG failed to achieve the 75% year to date or in month (March) recording 64.31%.	
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	14/15 - March	95%	94.53%	↔	The CCG failed the to achieved the 95% target year to date, or in month (March) reaching 94.26%.	
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	14/15 - March	75%	69.13%	↔	NWAS failed to achieve the 75% year to date and also did not achieve the target in month (March) recording 68.27%.	
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	14/15 - March	75%	69.43%	↔	NWAS failed to achieve the 75% year to date and also did not achieve the target in month (March) recording 65.72%.	
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	14/15 - March	95%	93.13%	↔	NWAS failed to achieve the 95% year to date and also did not achieve the target in month (March) recording 91.16%.	
Local Measure						
Diabetes Care Processes	14/15 - Qtr3	65.9%	42.2%	New Measure	This measure makes up part of the quality premium and will be measured quarterly. Quarter 3 shows a decrease from quarter 2 (43.42%) and remains below the target.	The data search criteria is being adjusted as recording of smoking status may be too low. The effect will mean an overall increase for the indicator.

10.2 Friends and Family – Aintree University Hospital NHS Foundation Trust

Figure 20 Friends and Family – Aintree University Hospital NHS Foundation Trust

Clinical Area	Response Rate (RR) Target	RR Actual (Mar 2015)	RR - Trajectory From Previous Month (Feb 15)	Percentage Recommended (Eng. Average)	Percentage Recommended (Mar 2015)	PR - Trajectory From Previous Month (Feb 15)	Percentage Not Recommended (Eng. Average)	Percentage Not Recommended (Mar 2015)	PNR - Trajectory From Previous Month (Feb 15)
Inpatients	30%	46.5%	↓	95%	98%	↔	2%	1%	↓
A&E	20%	26.0%	↑	87%	85%	↑	6%	9%	↑

The Friends and Family Test (FFT) Indicator now comprises of three parts:

- % Response Rate
- % Recommended
- % Not Recommended

The Trust achieved their A&E response rate target achieving 26% in March against a target of 20%, there had been a significant drop in A&E response rates in February 2015 due to an IT issue within Sigma (System C). The Trust's text/IVM messaging provider Envoy was only receiving patient telephone numbers for approximately 50% of the data sent to them, however this issue has now been resolved and performance is back on track. The Trust was 2% below the national average for percentage recommended, however this was an improvement on the Fbruary figure.

The Trust achieved the Inpatient response rate target achieving 46.5% in March against a target of 30% and also exceeded the NHS England average for recommended and not recommended target.

Aintree Hospital have met their FFT 14/15 CQUIN targets for Q4, in addition have also agreed to share best practice and support other providers regarding improving response rates for FFT especially promoting the use of SMS, text, smartphone apps and telephone surveys to encourage patient participation.

10.3 Complaints

Complaints information is only reported on a Quarterly basis (in line with Quality Contract guidance), Quarter 4 data will be available in June 15 following Trust Board approval.

10.4 Serious Untoward Incidents (SUIs)

SUIs Reported at South Sefton CCG level

For South Sefton CCG there have been no serious incidents reported in March 2015, 84 reported year to date.

Number of Never Events reported in period

0 Never Events reported in March 15, 0 never events reported in 2014/15.

NHS South Sefton CCG reported Serious Untoward Incidents

84 incidents reported YTD against South Sefton CCG patients

Type of Incident	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Pressure ulcer - (Grade 3)	3	3	5	7	5	4	5	1	2	4	1		40
Pressure ulcer - (Grade 4)	3	4	4		1	3	1	1	1	3			21
Child Death			1	3				1					5
Delayed diagnosis				1			1						2
Slips/Trips/Falls					1						1		2
Other											2		2
Maternity service		1											1
Failure to act upon test results								1					1
Serious Incident by Outpatient (not in receipt)									1				1
Suicide by Outpatient (in receipt)						1							1
Sub-optimal care of the deteriorating patient										1			1
Unexpected Death of Community Patient (in receipt)						1							1
Drug Incident (general)					1								1
Unexpected Death of Outpatient (not in receipt)							1						1
Wrong site surgery								1					1
Confidential Information Leak										1			1
Admission of under 18s to adult mental health ward		1											1
Safeguarding Vulnerable Child											1		1
Grand Total	**6**	**9**	**10**	**11**	**8**	**9**	**8**	**5**	**4**	**9**	**5**	**0**	**84**

Number of South Sefton CCG Incidents reported by Provider

Please not the data comes from Datix and not StEIS, as such differences in the figures reported for Liverpool community health and Mersey Care will be notable. These known data issues are being worked though with the Providers and the differing data sets.

Provider / Type of Incident	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Aintree University Hospital NHS Foundation Trust													
Delayed diagnosis				1			1						2
Slips/Trips/Falls					1						1		2
Failure to act upon test results								1					1
Drug Incident (general)					1								1
Sub-optimal care of the deteriorating patient										1			1
Alder Hey Children's NHS Foundation Trust													
Child Death			1	1									2
Safeguarding Vulnerable Child											1		1
Liverpool Community Health NHS Trust													
Pressure ulcer - (Grade 3)	3	3	5	7	5	4	5	1	1	3	1		38
Pressure ulcer - (Grade 4)	3	4	4		1	3	1	1	1	3			21
Child Death				2				1					3
Wrong site surgery								1					1
Unexpected Death of Outpatient (not in receipt)							1						1
Serious Incident by Outpatient (not in receipt)									1				1
Other											1		1
Liverpool Women's NHS Foundation Trust													
Maternity service		1											1
Mersey Care NHS Trust													
Admission of under 18s to adult mental health ward		1											1
Unexpected Death of Community Patient (in receipt)						1							1
Suicide by Outpatient (in receipt)						1							1
Confidential Information Leak										1			1
Royal Liverpool and Broadgreen University Hospitals NHS Trust													
Pressure ulcer - (Grade 3)									1				1
Other											1		1
The Walton Centre NHS Foundation Trust													
Pressure ulcer - (Grade 3)										1			1
Grand Total	**6**	**9**	**10**	**11**	**8**	**9**	**8**	**5**	**4**	**9**	**5**	**0**	**84**

SUIs Reported at Aintree University Trust level

For Aintree University Trust there has been 2 serious incidents reported in March 2015, 20 Incidents reported in 2014/15.

- Pressure ulcer - (Grade 3)
- Slips / Trips / Falls

To note the reporting methodology has changed slightly for incidents reported within 48hrs, figures now in exclude weekends and bank holidays.

Number of Never Events reported in period

0 never events reported in March 15, 0 never events reported in year.

Number of incidents reported split by type

20 incidents reported YTD by the provider.

Incident Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Failure to act upon test results		3						1					4
Slips/Trips/Falls					1						1	1	3
Delayed diagnosis			1	1			1						3
Pressure ulcer - (Grade 3)									1			1	2
Sub-optimal care of the deteriorating patient						1				1			2
Communication issue											1		1
Pressure ulcer - (Grade 4)										1			1
Drug Incident (general)					1								1
Unexpected Death (general)		1											1
Communicable Disease and Infection Issue								1					1
MRSA Bacteraemia										1			1
Grand Total	**0**	**4**	**1**	**1**	**2**	**1**	**1**	**2**	**1**	**3**	**2**	**2**	**20**

Number of Incidents reported by CCG

CCG Name / Incident Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Knowsley CCG													
Failure to act upon test results		2											2
Unexpected Death (general)		1											1
Pressure ulcer - (Grade 3)									1				1
Liverpool CCG													
Communication issue											1		1
Slips/Trips/Falls												1	1
Pressure ulcer - (Grade 4)										1			1
Delayed diagnosis			1										1
Sub-optimal care of the deteriorating patient						1							1
Failure to act upon test results		1											1
MRSA Bacteraemia										1			1
Sefton CCG													
Delayed diagnosis				1			1						2
Slips/Trips/Falls					1						1		2
Drug Incident (general)					1								1
Failure to act upon test results								1					1
Sub-optimal care of the deteriorating patient										1			1

St Helens CCG													
Pressure ulcer - (Grade 3)												1	1
West Cheshire CCG													
Communicable Disease and Infection Issue								1					1
Grand Total	**0**	**4**	**1**	**1**	**2**	**1**	**1**	**2**	**1**	**3**	**2**	**2**	**20**

All incident investigations and action plans are discussed in details at the CCG's clinically led Monthly SUI Management Group Meetings.

11. Primary Care

11.1 Background

The primary care dashboard has been developed during the summer of 2014 with the intention of being used in localities so that colleagues from practices are able to see data compared to their peers in a timely and consistent format. From this, localities can use this data to request further analysis, raise queries with providers, determine local priorities for action, understand demand, and monitor improvement. The tool is to aid improvement, not a performance management tool.

11.2 Content

The dashboard is still evolving, but at this stage the following sections are included: Urgent care (A&E attendances and emergency admissions for children under 19, adults aged 20-74 and older people aged 75 and over separately), Demand (referrals, Choose & Book information, cancer and urgent referrals), and Prescribing indicators. Recent new additions are expected to observed disease prevalence (QOF), and forthcoming additions include financial information, and public health indicators.

11.3 Format

The data is presented for all practices, grouped to locality level and RAG rated to illustrate easily variation from the CCG average, where green is better than CCG average by 10% or more, and red is worse than CCG average. Amber is defined as better than CCG average but within 10%. Data is refreshed monthly, where possible and will have a 6 week time lag from month end for secondary care data and prescribing data, and less frequent updates for the likes of annual QOF data. The dashboards have been presented to Quality Committee and to localities, and feedback has been positive. The dashboards will be available on the new Cheshire & Merseyside Intelligence Portal (CMiP)

11.4 Summary of performance

A summary of the primary care dashboard measures at locality level for the latest available data is presented below. The criteria for the Red, Amber, Green rating is described above in section 11.3

Figure 21 Summary of Primary Care Dashboard – Urgent Care

South Sefton CCG
Urgent Care Practice Scorecard 2014/15

Indicator		A&E Attendance rate per 1000 for under 19's (12 Mths to Feb-15)			A&E Attendance rate per 1000 for 19-74 yrs (12 Mths to Feb-15)			A&E Attendance rate per 1000 for over 75's (12 Mths to Feb-15)			Emergency Admission rate per 1000 for under 19's (12 Mths to Feb-15)			Emergency Admission rate per 1000 for 19-74 yrs (12 Mths to Feb-15)			Emergency Admission rate per 1000 for over 75's (12 Mths to Feb-15)		
Code	Practice	Period	Result	Score	Period	Result	Score	Period	Result	Score	Period	Result	Score	Period	Result	Score	Period	Result	Score
N84002	AINTREE ROAD MEDICAL CENTRE	Dec-14	199.55	0	Dec-14	189.25	0	Dec-14	196.34	3	Dec-14	24.31	3	Dec-14	66.15	0	Dec-14	157.07	3
N84015	BOOTLE VILLAGE SURGERY	Dec-14	198.86	0	Dec-14	157.00	0	Dec-14	338.96	0	Dec-14	25.39	3	Dec-14	59.64	0	Dec-14	228.60	0
N84016	MOORE STREET MEDICAL CENTRE	Dec-14	224.31	0	Dec-14	175.04	0	Dec-14	395.78	0	Dec-14	30.31	0	Dec-14	72.34	0	Dec-14	290.40	0
N84019	NORTH PARK HEALTH CENTRE	Dec-14	199.41	0	Dec-14	159.36	0	Dec-14	287.82	0	Dec-14	27.65	2	Dec-14	65.06	0	Dec-14	205.88	0
N84028	THE STRAND MEDICAL CENTRE	Dec-14	211.66	0	Dec-14	172.21	0	Dec-14	357.66	0	Dec-14	31.25	0	Dec-14	64.50	0	Dec-14	267.64	0
N84034	PARK STREET SURGERY	Dec-14	206.83	0	Dec-14	173.78	0	Dec-14	357.91	0	Dec-14	26.65	2	Dec-14	63.81	0	Dec-14	237.27	0
N84038	CONCEPT HOUSE SURGERY	Dec-14	206.16	0	Dec-14	150.06	0	Dec-14	337.42	0	Dec-14	29.14	0	Dec-14	52.86	0	Dec-14	269.94	0
N84001	42 KINGSWAY	Dec-14	123.53	3	Dec-14	77.57	3	Dec-14	234.61	3	Dec-14	20.94	3	Dec-14	32.05	3	Dec-14	153.91	3
N84007	LIVERPOOL RD MEDICAL PRACTICE	Dec-14	154.96	0	Dec-14	127.28	0	Dec-14	305.34	0	Dec-14	19.62	3	Dec-14	43.53	3	Dec-14	203.24	0
N84009	AZALEA SURGERY	Dec-14	148.32	2	Dec-14	92.66	3	Dec-14	357.14	0	Dec-14	27.52	2	Dec-14	48.81	0	Dec-14	299.23	0
N84011	EASTVIEW SURGERY	Dec-14	138.97	2	Dec-14	110.60	3	Dec-14	288.60	0	Dec-14	23.22	3	Dec-14	44.26	2	Dec-14	216.91	0
N84020	BLUNDELLSANDS SURGERY	Dec-14	132.43	3	Dec-14	82.68	3	Dec-14	227.23	3	Dec-14	17.95	3	Dec-14	32.89	3	Dec-14	184.45	2
N84026	CROSBY - SSP HEALTH LIMITED	Dec-14	144.81	2	Dec-14	89.44	3	Dec-14	218.31	3	Dec-14	30.91	0	Dec-14	30.83	3	Dec-14	165.49	3
N84041	KINGSWAY SURGERY	Dec-14	130.30	3	Dec-14	98.52	3	Dec-14	315.36	0	Dec-14	27.96	2	Dec-14	38.69	3	Dec-14	184.64	2
N84621	THORNTON - SSP HEALTH LIMITED	Dec-14	137.71	2	Dec-14	117.92	2	Dec-14	412.97	0	Dec-14	40.45	0	Dec-14	52.54	0	Dec-14	265.82	0
N84626	HIGHTOWN - SSP HEALTH LIMITED	Dec-14	87.86	3	Dec-14	79.29	3	Dec-14	229.67	3	Dec-14	28.83	0	Dec-14	31.58	3	Dec-14	136.36	3
N84627	CROSSWAYS SSP HEALTH LTD	Dec-14	119.10	3	Dec-14	76.19	3	Dec-14	153.70	3	Dec-14	17.98	3	Dec-14	31.30	3	Dec-14	105.56	3
N84003	HIGH PASTURES SURGERY	Dec-14	45.77	3	Dec-14	87.85	3	Dec-14	217.42	3	Dec-14	41.24	0	Dec-14	37.81	3	Dec-14	156.45	3
N84010	MAGHULL HEALTH CENTRE (DR SAPRE)	Dec-14	65.13	3	Dec-14	102.13	3	Dec-14	269.11	2	Dec-14	29.69	0	Dec-14	34.12	3	Dec-14	186.31	2
N84025	WESTWAY MEDICAL CENTRE	Dec-14	57.26	3	Dec-14	96.91	3	Dec-14	226.32	3	Dec-14	34.36	0	Dec-14	44.92	2	Dec-14	181.17	2
N84622	MAGHULL HEALTH CENTRE (DR THOMAS)	Dec-14	61.53	3	Dec-14	104.63	3	Dec-14	259.43	2	Dec-14	35.62	0	Dec-14	51.74	0	Dec-14	185.53	2
N84624	MAGHULL HEALTH CENTRE	Dec-14	58.73	3	Dec-14	105.41	3	Dec-14	291.43	0	Dec-14	14.29	3	Dec-14	41.46	3	Dec-14	211.43	0
Y00446	PARKHAVEN SSP HEALTH LTD	Dec-14	47.08	3	Dec-14	93.07	3	Dec-14	298.77	0	Dec-14	37.21	0	Dec-14	34.33	3	Dec-14	172.84	3
N84004	GLOVERS LANE SURGERY	Dec-14	158.99	0	Dec-14	144.69	0	Dec-14	312.90	0	Dec-14	26.07	2	Dec-14	53.88	0	Dec-14	209.68	0
N84023	BRIDGE ROAD MEDICAL CENTRE	Dec-14	164.61	0	Dec-14	138.15	0	Dec-14	259.22	2	Dec-14	26.63	2	Dec-14	50.80	0	Dec-14	188.72	2
N84027	ORRELL PARK MEDICAL CENTRE	Dec-14	219.70	0	Dec-14	156.48	0	Dec-14	257.65	2	Dec-14	33.44	0	Dec-14	48.11	2	Dec-14	170.92	3
N84029	FORD MEDICAL PRACTICE	Dec-14	153.00	0	Dec-14	126.92	0	Dec-14	269.15	2	Dec-14	29.93	0	Dec-14	47.19	2	Dec-14	177.66	2
N84035	15 SEFTON ROAD	Dec-14	161.07	0	Dec-14	102.10	3	Dec-14	232.65	3	Dec-14	23.99	3	Dec-14	44.08	2	Dec-14	182.93	2
N84043	SEAFORTH SSP HEALTH LTD	Dec-14	219.36	0	Dec-14	167.04	0	Dec-14	309.86	0	Dec-14	38.98	0	Dec-14	68.30	0	Dec-14	267.61	0
N84605	LITHERLAND - SSP HEALTH LIMITED	Dec-14	186.76	0	Dec-14	144.62	0	Dec-14	307.91	0	Dec-14	38.47	0	Dec-14	58.43	0	Dec-14	231.64	0
N84615	RAWSON ROAD MEDICAL CENTRE	Dec-14	197.52	0	Dec-14	181.24	0	Dec-14	298.88	0	Dec-14	32.15	0	Dec-14	53.34	0	Dec-14	167.60	3
N84630	NETHERTON - SSP HEALTH LIMITED	Dec-14	178.01	0	Dec-14	151.11	0	Dec-14	372.00	0	Dec-14	48.41	0	Dec-14	49.72	0	Dec-14	256.00	0
Y02514	LITHERLAND PRIMARY CARE WALK-IN SERVICE	Dec-14	91.12	3	Dec-14	118.22	2	Dec-14	250.00	2	Dec-14	5.69	3	Dec-14	42.88	3	Dec-14	107.14	3
	South Sefton Average		152.55			125.04			276.16			28.75			48.40			196.83	

NHS South Sefton Clinical Commissioning Group

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Figure 22 Summary of Primary Care Dashboard – Locality level scorecard example

South Sefton CCG
Practice Local Scorecard 2014/15

Under Construction

		Frequency	Latest Update	N84002	N84015	N84016	N84019	N84028	N84034	N84038
Urgent Care	A&E Attendance rate per 1000 for under 19's	Monthly	Feb-15	199.55	198.86	224.31	199.41	211.66	206.83	206.16
	A&E Attendance rate per 1000 for 19-74 yrs	Monthly	Feb-15	189.25	157.00	175.04	159.36	172.21	173.78	150.06
	A&E Attendance rate per 1000 for over 75's	Monthly	Feb-15	196.34	338.96	395.78	287.82	357.66	357.91	337.42
	Emergency Admission rate per 1000 for under 19's	Monthly	Feb-15	24.31	25.39	30.31	27.65	31.25	26.65	29.14
	Emergency Admission rate per 1000 for 19-74 yrs	Monthly	Feb-15	66.15	59.64	72.34	65.06	64.50	63.81	52.86
	Emergency Admission rate per 1000 for over 75's	Monthly	Feb-15	157.07	228.60	290.40	205.88	267.64	237.27	269.94
Referrals	GP Referrals to Secondary Care - Dec 2014	Monthly	Feb-15	5.57	13.55	10.14	7.58	7.03	8.51	5.12
	C&B GP referrals to Secondary Care - Dec 2014	Monthly	Feb-15	1.24	2.53	1.96	1.55	0.90	0.61	0.31
	Non C&B Referrals to Secondary Care - Dec 2014	Monthly	Feb-15	3.10	0.16	1.40	0.15	2.00	0.26	3.59
	Cancer Fast Track Referrals - Dec 2014	Monthly	Feb-15	2.48	13.39	8.74	7.43	5.03	8.25	1.54
Prescribing	Lipid Modifying Drugs: Ezetimibe % items	Quarterly	Q2 14/15	2.64	5.64	4.26	3.05	7.42	3.53	2.74
	Hypnotics ADQ/STAR PU (ADQ based)	Quarterly	Q2 14/15	0.6	0.48	0.35	0.24	0.47	0.31	0.32
	Antidepressants: First choice % items	Quarterly	Q2 14/15	54.97	58.46	60.05	57.48	65.05	53.13	55.26
	Antibacterial items/STAR PU	Quarterly	Q2 14/15	0.29	0.38	0.37	0.23	0.23	0.33	0.21
	Minocycline ADQ/1000 Patients	Quarterly	Q2 14/15	0	9.23	0	8.44	23.3	9.77	0
	NSAIDs Ibuprofen & Naproxen % items	Quarterly	Q2 14/15	85.04	76.4	77.25	73.97	66.67	79	70.63
	NSAIDs ADQ/STAR PU	Quarterly	Q2 14/15	2.3	3.67	2.09	0.92	1.94	1.46	1.65
	Wound care products: NIC/item	Quarterly	Q2 14/15	87.56	17.76	18.1	33.31	26.4	21.63	27.36
	Rosuvastatin as % All Statin	Quarterly	Q2 14/15	0.50%	1.49%	0.99%	3.24%	1.18%	1.33%	2.56%
	Dosulepin as a % of All Antidepressants	Quarterly	Q2 14/15	2.27%	2.20%	1.40%	1.05%	0.92%	2.69%	0.53%
	Specials per 1000 Item based ASTRO PU	Quarterly	Q2 14/15	0.1	0.21	0.11	0.39	0.29	0.25	0.39
	Urology Products Total Actual Cost	Quarterly	Q2 14/15	69.97	0	141.36	615.97	49.75	87.72	8.79
	Potential Generics Savings	Quarterly	Q2 14/15	588.35	1398.58	1203.29	554.82	1578.17	794.23	382.99
	Enteral Sip Feeds NIC/PU	Quarterly	Q2 14/15	1.786	1.117	1.311	0.689	1.091	0.618	0.936
QOF	Estimated percentage of detected CHD prevalence	Annual	2010/11	62.16	82.95	63.52	70.84	70.09	72.43	72.94
	Estimated percentage of detected COPD prevalence	Annual	2010/11	69.97	94.80	81.73	93.49	92.51	87.05	92.82
	Estimated percentage of detected hypertension prevalence	Annual	2010/11	69.05	58.81	48.86	60.15	58.69	70.36	48.43
	Estimated percentage of detected stroke prevalence	Annual	2010/11	62.29	68.83	64.22	61.52	78.80	85.04	78.43
	Estimated percentage of detected diabetes prevalence	Annual	2008/09	109.24	97.88	94.65	101.15	93.75	108.27	109.80

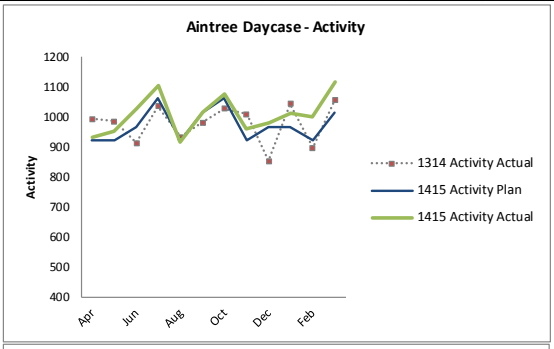
11.5 CQC Inspection Visit Update

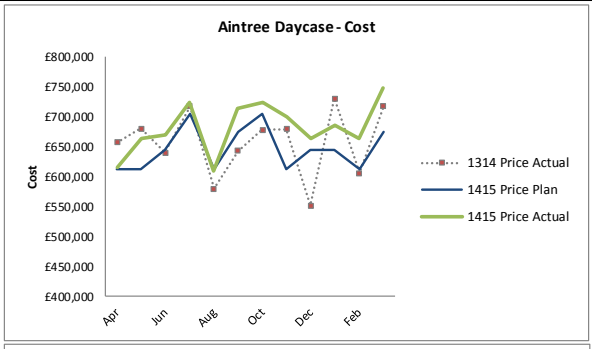
CQC Visits South Sefton								
GP Practice	Practice Code	CQC Visit Date	CQC Overall Rating	Safe	Effective	Caring	Responsive	Well - Led
Dr Bernard Thomas	N84622	04/11/2014	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD
Bootle Village Surgery	N84015	04/11/2014	GOOD	RI	GOOD	GOOD	GOOD	RI
SSP Health Hightown	N84626	06/11/2014	I	I	RI	RI	RI	I
Strand Medical Centre	N84028	11/11/2014	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD
Ford Medical Centre	N84029	11/11/2014	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD
SSP Seaforth Village	N84043	11/11/2014	I	I	RI	RI	RI	I
SSP Health Thornton	N84621	12/11/2014	GOOD	RI	GOOD	GOOD	GOOD	GOOD
Glovers Lane Surgery	N84004	12/11/2014	GOOD	RI	GOOD	GOOD	GOOD	GOOD
Dr David Goldberg Concept House	N84038	13/11/2014	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD
Dr David Goldberg Sefton Road Surgery	N84038	14/11/2014	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD
Dr Doran	N84009	18/11/2014	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD
Park Street Surgery	N84034	18/11/2014	GOOD	RI	GOOD	GOOD	GOOD	GOOD
High Pastures	N84003	18/11/2014	GOOD	RI	GOOD	GOOD	GOOD	GOOD
SSP Health Maghull	Y00446	20/11/2014	RI	RI	RI	GOOD	GOOD	RI
N/A = Not Available								
RI = Requires Improvement								
I = Inadequate								

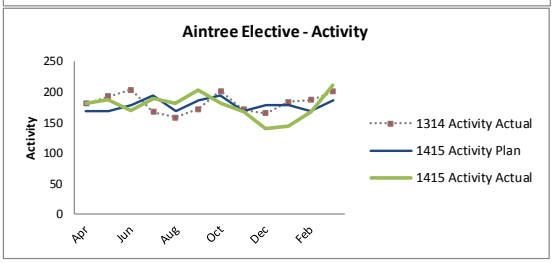
Appendix 1 Main Provider Activity & Finance Comparisons

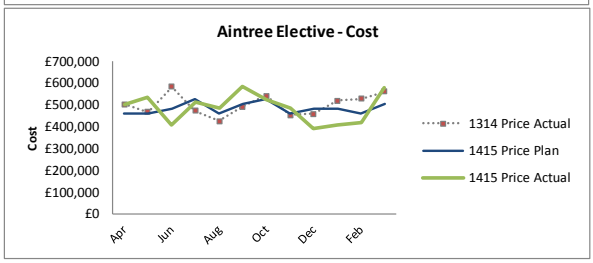
Figure 23 Month 12 Planned Care Aintree Hospital NHS Trust (13/14 and 14/15 comparison)

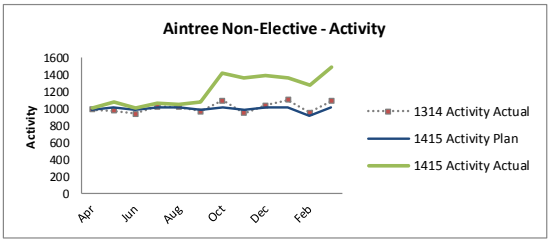
Aintree University Hospitals NHS F/T South Sefton CCG			2014/15											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Daycase	Activity	1415 Activity Plan	923	923	969	1061	923	1015	1061	923	969	969	923	1015
		1415 Activity Actual	933	951	1028	1105	916	1017	1076	961	980	1011	1001	1117
	Price	1415 Price Plan	£613,314	£613,314	£643,980	£705,312	£613,314	£674,646	£705,312	£613,314	£643,980	£643,980	£613,314	£674,646
		1415 Price Actual	£616,669	£663,922	£669,748	£724,308	£610,575	£713,917	£724,558	£699,547	£663,447	£685,620	£664,752	£747,960
Elective	Activity	1415 Activity Plan	169	169	178	194	169	186	194	169	178	178	169	186
		1415 Activity Actual	181	188	169	190	181	202	181	167	140	143	167	210
	Price	1415 Price Plan	£460,306	£460,306	£483,322	£529,352	£460,306	£506,337	£529,352	£460,306	£483,322	£483,322	£460,306	£506,337
		1415 Price Actual	£502,111	£536,883	£407,857	£512,442	£486,687	£582,022	£524,053	£483,400	£393,679	£408,282	£421,785	£576,383
Non-Elective (NEL and NELST)	Activity	1415 Activity Plan	978	1011	978	1011	1011	978	1011	978	1011	1011	913	1011
		1415 Activity Actual	1011	1071	1010	1061	1043	1082	1415	1361	1387	1363	1271	1494
	Price	1415 Price Plan	£1,897,370	£1,960,616	£1,897,370	£1,960,616	£1,960,616	£1,897,370	£1,960,616	£1,897,370	£1,960,616	£1,960,616	£1,770,879	£1,960,616
		1415 Price Actual	£1,969,411	£2,156,637	£2,005,594	£2,002,628	£2,018,160	£1,977,447	£2,348,138	£2,216,111	£2,576,528	£2,530,298	£2,252,719	£2,587,066
AandE	Activity	1415 Activity Plan	2527	2611	2527	2611	2611	2527	2611	2527	2611	2611	2359	2611
		1415 Activity Actual	2549	2651	2631	2622	2556	2528	2597	2533	2626	2579	2427	2528
	Price	1415 Price Plan	£270,763	£279,789	£270,763	£279,789	£279,789	£270,763	£279,789	£270,763	£279,789	£279,789	£252,712	£279,789
		1415 Price Actual	£275,641	£287,759	£287,833	£283,344	£279,987	£276,983	£287,385	£278,439	£290,116	£288,644	£270,464	£280,134

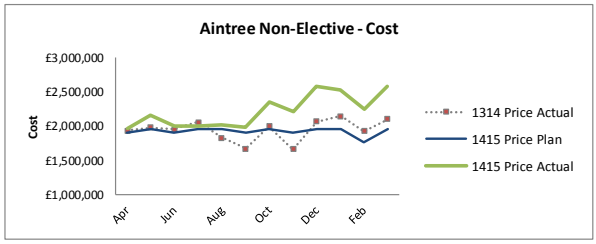


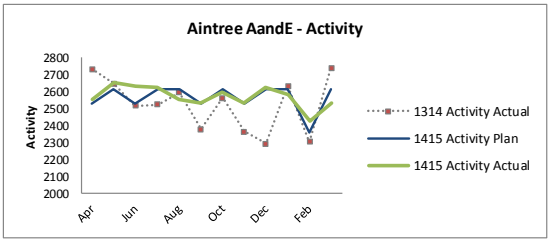












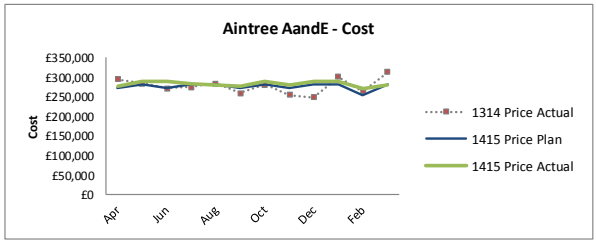
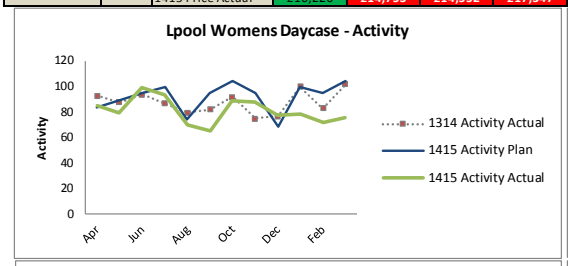
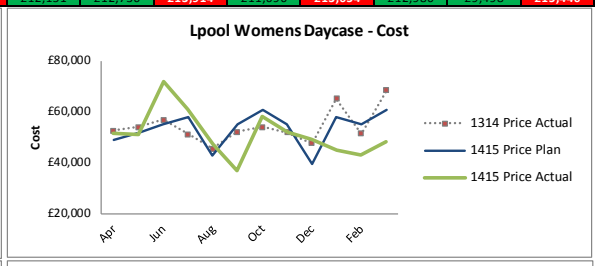
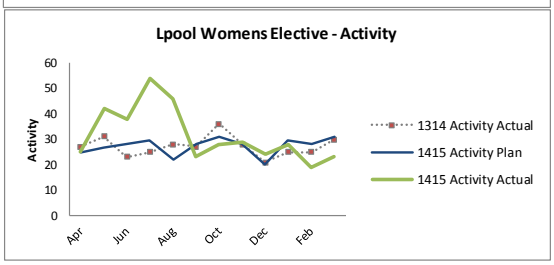


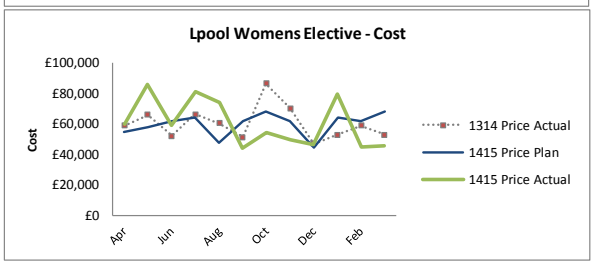
Figure 24 Month 12 Planned Care Liverpool Women's Hospital NHS Trust (13/14 and 14/15 comparison)

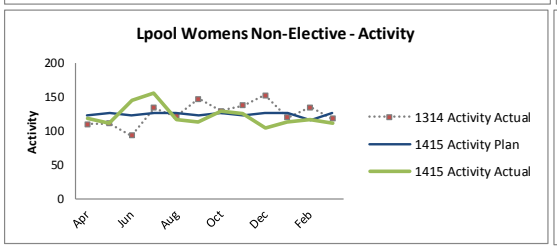
Liverpool Womens Hospital South Sefton CCG			2014/15											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Daycase	Activity	1415 Activity Plan	84	90	95	99	74	95	105	95	69	99	95	105
		1415 Activity Actual	**85**	80	**99**	94	70	65	89	88	**78**	79	72	76
	Price	1415 Price Plan	£48,833	£52,045	£55,258	£57,828	£43,050	£55,258	£61,041	£55,258	£39,837	£57,828	£55,258	£61,041
		1415 Price Actual	**£51,580**	£51,317	**£71,771**	**£60,982**	**£47,574**	£37,080	£58,075	£51,996	**£49,313**	£45,024	£42,980	£48,303
Elective	Activity	1415 Activity Plan	25	26	28	29	22	28	31	28	20	29	28	31
		1415 Activity Actual	**25**	**42**	**38**	**54**	**46**	23	28	**29**	**24**	28	19	23
	Price	1415 Price Plan	£54,488	£58,072	£61,657	£64,525	£48,035	£61,657	£68,110	£61,657	£44,451	£64,525	£61,657	£68,110
		1415 Price Actual	**£60,106**	**£85,777**	£59,466	**£81,343**	**£74,213**	£43,742	£53,981	£49,730	**£46,584**	**£79,305**	£45,016	£45,350
Non-Elective (NEL and NELST)	Activity	1415 Activity Plan	123	127	123	127	127	123	127	123	127	127	115	127
		1415 Activity Actual	118	112	**146**	**155**	116	113	**130**	**126**	104	114	**117**	111
	Price	1415 Price Plan	£208,357	£215,980	£208,357	£215,980	£215,980	£208,357	£215,980	£208,357	£215,980	£215,980	£195,653	£215,980
		1415 Price Actual	£204,996	£195,892	**£248,939**	**£265,849**	£202,205	£202,743	**£230,006**	**£225,122**	£187,712	£195,874	**£218,752**	£194,957
AandE	Activity	1415 Activity Plan	138	144	138	144	144	138	144	138	144	144	130	144
		1415 Activity Actual	112	**168**	**157**	**184**	130	**141**	**144**	129	**152**	135	104	**169**
	Price	1415 Price Plan	£12,873	£13,344	£12,873	£13,344	£13,344	£12,873	£13,344	£12,873	£13,344	£13,344	£12,088	£13,344
		1415 Price Actual	£10,226	**£14,753**	**£14,552**	**£17,347**	£12,151	£12,736	**£13,914**	£11,696	**£13,654**	£12,986	£9,498	**£15,446**

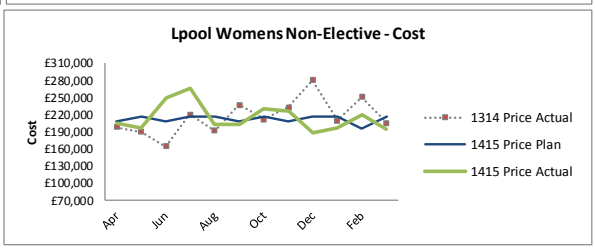


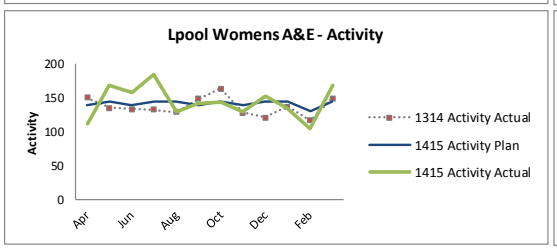












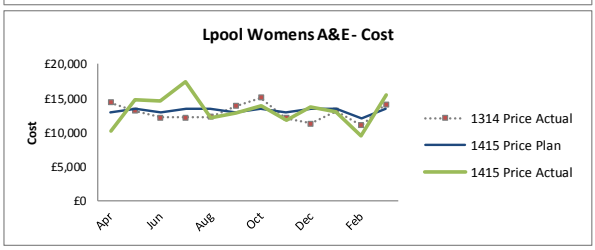
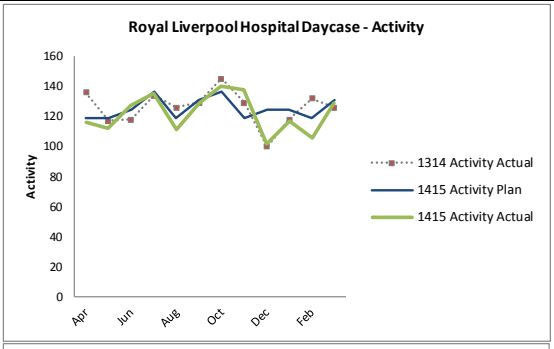
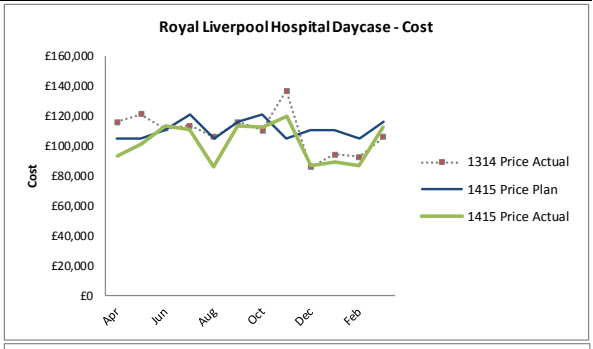
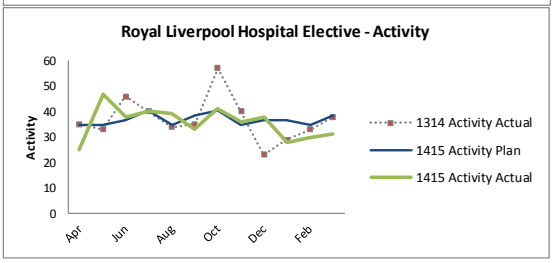


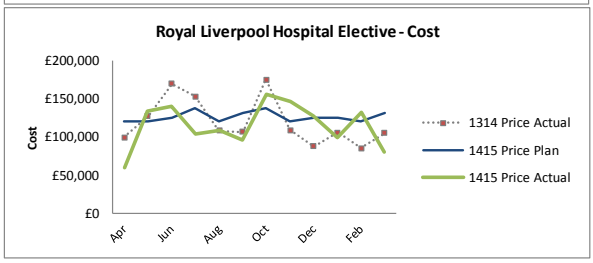
Figure 25 Month 12 Planned Care Royal Liverpool Hospital NHS F/T (13/14 and 14/15 comparison)

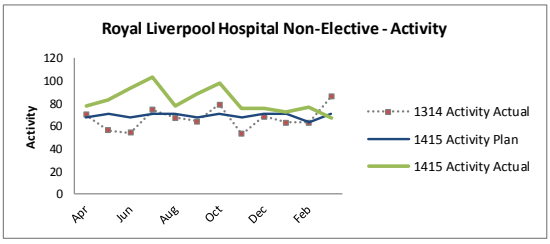
Royal Liverpool Hospital South Sefton CCG			2014/15											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Daycase	Activity	1415 Activity Plan	119	119	125	137	119	131	137	119	125	125	119	131
		1415 Activity Actual	116	112	127	135	111	129	140	138	102	117	106	129
	Price	1415 Price Plan	£105,580	£105,580	£110,859	£121,417	£105,580	£116,138	£121,417	£105,580	£110,859	£110,859	£105,580	£116,138
		1415 Price Actual	£93,425	£101,245	£113,637	£110,940	£86,338	£113,508	£112,837	£119,796	£86,794	£89,842	£87,438	£112,486
Elective	Activity	1415 Activity Plan	35	35	37	40	35	38	40	35	37	37	35	38
		1415 Activity Actual	25	47	38	40	39	33	41	36	38	28	30	31
	Price	1415 Price Plan	£119,760	£119,760	£125,748	£137,724	£119,760	£131,736	£137,724	£119,760	£125,748	£125,748	£119,760	£131,736
		1415 Price Actual	£59,269	£133,850	£139,497	£104,079	£109,147	£96,458	£155,212	£147,066	£127,637	£99,613	£132,696	£80,868
Non-Elective (NEL and NELST)	Activity	1415 Activity Plan	68	70	68	70	70	68	70	68	70	70	63	70
		1415 Activity Actual	78	83	93	103	78	88	98	75	75	72	77	67
	Price	1415 Price Plan	£126,114	£130,318	£126,114	£130,318	£130,318	£126,114	£130,318	£126,114	£130,318	£130,318	£117,706	£130,318
		1415 Price Actual	£140,993	£118,945	£135,963	£179,965	£160,353	£161,734	£120,203	£113,855	£158,966	£108,080	£137,249	£131,727
AandE	Activity	1415 Activity Plan	362	374	362	374	374	362	374	362	374	374	338	374
		1415 Activity Actual	394	365	361	385	378	366	375	334	334	354	350	376
	Price	1415 Price Plan	£30,232	£31,240	£30,232	£31,240	£31,240	£30,232	£31,240	£30,232	£31,240	£31,240	£28,217	£31,240
		1415 Price Actual	£32,676	£31,503	£30,287	£32,661	£32,747	£31,159	£32,500	£28,098	£28,489	£30,243	£29,819	£32,354

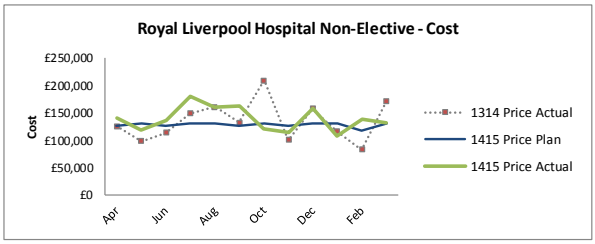


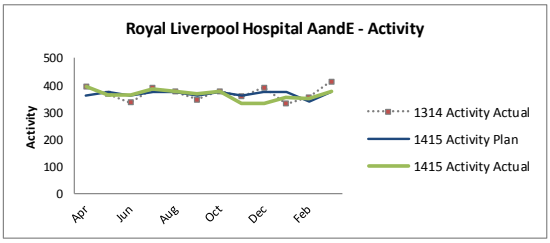


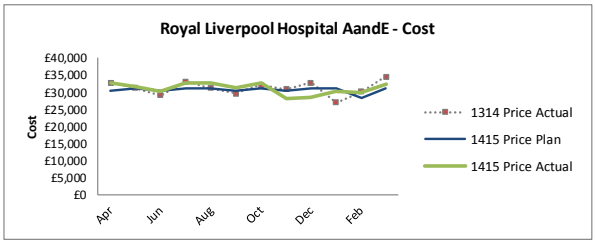












NHS South Sefton Clinical Commissioning Group

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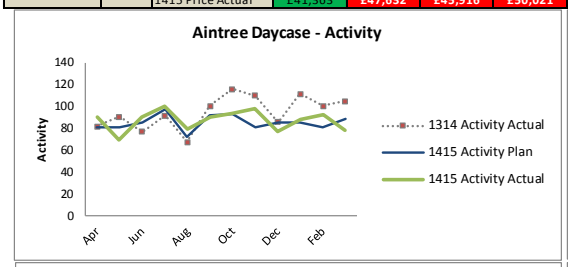
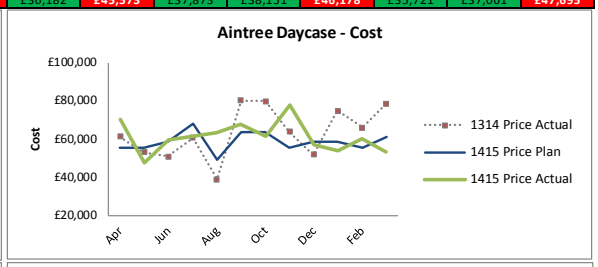
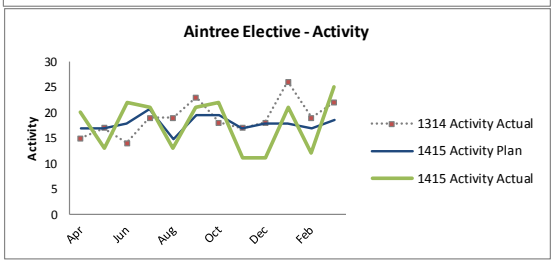
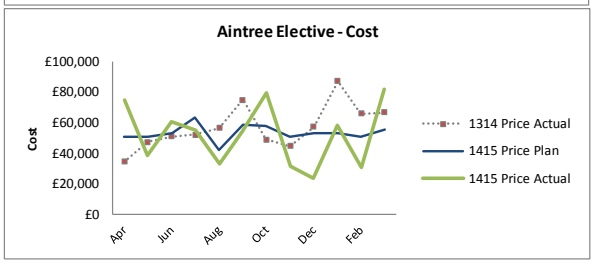
Figure 26 Month 12 Planned Care Southport & Ormskirk Hospital (13/14 and 14/15 comparison)

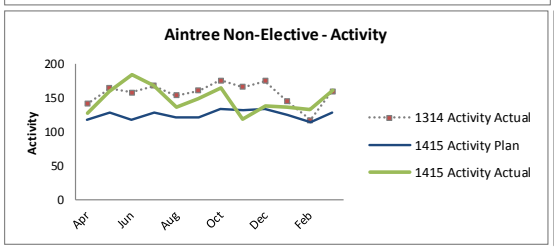
Southport & Ormskirk Hospital South Sefton CCG			2014/15											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Daycase	Activity	1415 Activity Plan	81	81	85	98	73	93	93	81	85	85	81	89
		1415 Activity Actual	**91**	70	**91**	**101**	**80**	**91**	**94**	**98**	77	**88**	**93**	78
	Price	1415 Price Plan	£55,744	£55,744	£58,531	£68,086	£49,037	£64,043	£64,105	£55,744	£58,531	£58,531	£55,744	£61,318
		1415 Price Actual	**£70,117**	£47,447	**£59,688**	£61,411	**£63,385**	**£67,723**	£61,367	**£78,270**	£57,042	£53,804	**£60,440**	£53,097
Elective	Activity	1415 Activity Plan	17	17	18	21	15	19	19	17	18	18	17	19
		1415 Activity Actual	**20**	13	**22**	**21**	13	**21**	**22**	11	11	**21**	12	**25**
	Price	1415 Price Plan	£50,620	£50,620	£53,151	£63,192	£42,323	£59,002	£58,214	£50,620	£53,151	£53,151	£50,620	£55,683
		1415 Price Actual	**£75,178**	£38,261	**£60,757**	£55,252	£33,278	£54,556	**£79,957**	£31,439	£23,321	**£58,577**	£30,668	**£82,253**
Non-Elective (NEL and NELST)	Activity	1415 Activity Plan	118	128	118	128	121	121	134	132	133	126	115	128
		1415 Activity Actual	**128**	**160**	**185**	**168**	**137**	**149**	**165**	119	**139**	**136**	**132**	**161**
	Price	1415 Price Plan	£166,707	£182,507	£170,127	£184,225	£173,776	£167,920	£189,885	£182,108	£182,444	£175,126	£157,175	£174,840
		1415 Price Actual	£149,827	£177,452	**£199,777**	**£198,132**	£167,467	£159,323	£169,402	£131,311	£141,093	£167,412	£143,073	**£176,915**
AandE	Activity	1415 Activity Plan	434	423	420	457	414	392	420	409	441	402	387	469
		1415 Activity Actual	420	**484**	**469**	**505**	368	**457**	414	**427**	**521**	384	**399**	**519**
	Price	1415 Price Plan	£42,064	£41,024	£40,683	£44,306	£40,142	£38,020	£40,726	£39,643	£42,783	£39,010	£37,479	£45,466
		1415 Price Actual	£41,363	**£47,632**	**£45,916**	**£50,021**	£36,182	**£45,573**	£37,873	£38,151	**£46,178**	£35,721	£37,061	**£47,695**

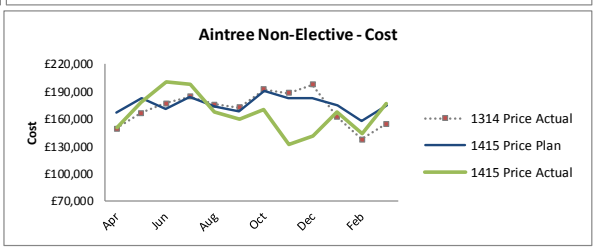


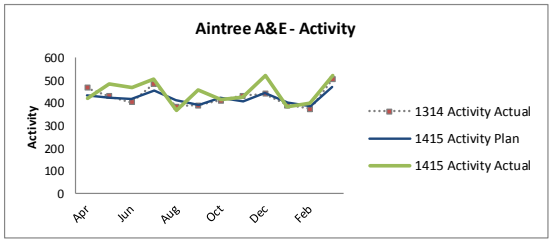


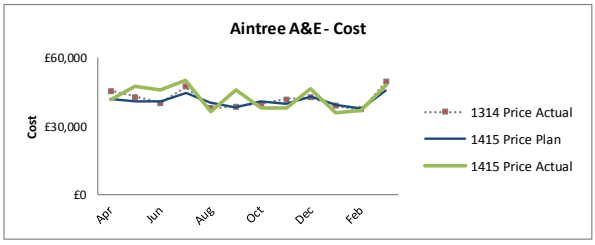












NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2015

Agenda Item: 15/98

Report Date: May 2015

Author of the Paper:
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Title: Overview, Quality and Performance – Southport & Ormskirk Hospitals NHS Trust (ICO)

Summary/Key Issues :

This paper presents the Governing Body with a brief overview of the areas of concern that the CCG has identified for Southport & Ormskirk Hospitals NHS Trust. These areas have been clearly identified through a range of assessment and assurance reviews and processes that the CCG has undertaken in its role as commissioner for this provider.

An outline of the key actions that the CCG is undertaking is set out in relation to the areas highlighted.

In addition a synopsis of the outcome of the Care Quality Commission (CQC) Chief Inspector of Hospitals Inspection Visit, undertaken in November 2014, which went into the public domain on 13 May 2015, is included.

The Governing Body are asked to note that these issues are being managed on behalf of the CCG by Southport & Formby CCG with input from the joint CCG Senior Management Team.

Recommendation

The Governing Body is asked to receive this report.

Receive	X
Approve	
Ratify	

15/100 Overview, Quality & Performance S&O

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

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

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

1. Executive Summary

1.1 This paper presents the Governing Body with an overview of the quality and performance areas of concerns emerging for the CCG with regard to Southport & Ormskirk Hospitals NHS Trust. The key actions that Southport and Formby CCG has undertaken against these areas are also set out on behalf of South Sefton CCG.

1.2 In addition, a synopsis of the outcome of the Care Quality Commission (CQC) Chief Inspector of Hospitals Inspection Visit undertaken in November 2014 which went into the public domain on 13 May 2015.

2. Identified Areas of Concern

2.1 The following services have been identified as areas of concern for the CCG:

- Breast;
- Cardiology;
- Stroke;
- Acute Medicine;
- Gastroenterology.

2.2 Further concerns have emerged as a result of:

- Serious incident reporting (SIs);
- Staffing Reports / Staff Experience Reports;
- Patient Experience;
- Mortality Performance;
- Safeguarding Performance;
- Recent Peer Reviews – Cancer and Trauma;
- Referral to Treatment (RTT) / PAS System;
- A&E performance / ambulance turnaround times;
- Orthopaedics.

3. Overview of Key CCG Actions CQC

Breast Services

3.1 Southport and Formby CCG has undertaken a public engagement exercise in conjunction with West Lancashire CCG with regard to the provision of Breast Surgery at Southport & Ormskirk Hospital NHS Trust (S&O). In addition work has been undertaken with neighbouring providers to ensure that the existing clinical pathway is maintained and that all new referrals for Breast surgery are managed according to national standards and waiting times. Provision has also been made to ensure the adequacy of both short-term and long-term follow up of patients. Southport & Formby CCG is now addressing the need for the future of sustainable provision of breast services for the residents of Southport & Formby CCG.

Cardiology

3.2 The CCG has reviewed cardiology services, including activity, compliance against NICE guidance. The CCG has assessed current and future workforce solutions and explored provider support to S&O. The CCG has developed a revised model of care and is pursuing a solution to the long term provision of cardiology services.

Stroke

3.3 The CCG has assessed stroke performance against a range of national performance and clinical indicators. A working group is in place to develop Early Supportive Discharge to support the current service. The CCG is working jointly with the clinical network in conjunction with neighbouring CCGs to review the need for Hyper acute and rehabilitation provision across Liverpool and Sefton.

Acute Medicine

3.4 The CCG has established a joint commissioner and ICO work stream on sustainability, to support the Trust. Current recruitment plans are being reviewed and assessed by Southport and Formby CCG for assurance purposes.

Gastroenterology

3.5 Southport and Formby CCG is supporting discussions between Southport &Ormskirk and Aintree University Hospitals Trust to explore a collaborative solution to the provision of services.

Further Concerns

3.6 Further concerns have emerged based on recent Cancer and Trauma peer review recommendations and contract performance and quality information which has been triangulated with soft intelligence.

4. CQC Inspection

4.1 The Care Quality Commission (CQC) undertook a Chief Inspector of Hospitals Inspection Visit in November 2014. A Quality Summit was held on 7 May 2015 at which the outcome of the inspection was presented to the Trust, NHSE, NHS Trust Development Authority Southport & Formby CCG, West Lancashire CCG, Sefton Local Authority and representation from Health Watch. The report went into the public domain on 13 May 2015.

4.2 The outcome of the inspection was as follows:

- Overall judgement = Requires Improvement

The five domains:

- 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)

4.3 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 = Good

4.2 The CQC report also included areas that require improvement in relation to Maternity Services and the Spinal Injury Unity (Spinal Injury Unit is commissioned via Specialised Commissioning / NHSE). Good practice was noted around End of Life Care.

4.3 The Trust is required to develop appropriate action plans and submit them to the CQC. Southport and Formby CCG will be working with Southport and Ormskirk NHS Trust and West Lancashire CCG with the CQC and TDA to ensure the action plans are implemented.

5. Summary of Actions Taken by the CCG

5.1 The issues detailed in this paper have been the subject of discussion at the CCG Quality Committee and escalated to the Governing Body as appropriate for purposes of assurance. The CCG has also discussed issues of concern at the Contract Review / Quality Contract Meetings as part of the formal contract management process with the Trust.

5.2 A formal Board-to-Board meeting was held with the Trust and Southport and Formby CCG as lead commissioner for Sefton CCGs on 29th April 2015 prior to the CQC Quality Summit. At the time of writing this report the CCG is awaiting the formal written response from the Trust in response to the issues raised.

5.2 The CCG has been working collaboratively with West Lancashire CCG regarding performance and quality issues at the Trust and is an active member of the Strategic Partnership Board that is in place with attendance from SFCCG, WLCCG, S&O, NHSE, SMBC and other partners and the Trust themselves.

5.3 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.

5.4 The CCG have discussed the challenges being faced at the Trust as part of the regular Checkpoint Assurance Meetings with NHSE along with the action being undertaken by the CCG.

6. Conclusion

6.1 Southport and Formby CCG on behalf of South Sefton CCG have taken the responsibility for commissioning high standards of patient quality and safety through the required Governance arrangements.

6.2 The Board of Southport and Ormskirk NHS Trust are now very aware of the CCG concerns and the CCG awaits a response and will report back to the Governing Body.

7. Recommendations

The Governing Body is asked to receive this report.

NHS
South Sefton
Clinical Commissioning Group

Debbie Fagan
Chief Nurse & Quality Officer

Brendan Prescott
Deputy Chief Nurse/ Head of Quality & Safety

May 2015

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2015

Agenda Item: 15/101	**Author of the Paper:** Martin McDowell Chief Finance Officer Email: martin.mcdowell@southseftonccg.nhs.uk Tel: 0151 247 7065
Report date: May 2015	

Title: Revised 2015/16 Financial Budgets

Summary/Key Issues:

This paper presents the Governing Body with the revised 2015/16 financial budgets for South Sefton CCG.

Recommendation

Receive	X
Approve	X
Ratify	

The Governing Body is asked to:

- Approve the revised financial budgets for the financial year 2015/16;
- Note that the unidentified QIPP is valued at £3.441m.

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

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

Links to Corporate Objectives (x those that apply)	
X	Improve 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

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
May 2015

Summary

1.1 The opening financial budgets for 2015/16 were approved at the Governing Body Meeting in March 2015. The March meeting noted that there remained uncertainties in some areas and that an update report would be presented to the Governing Body meeting in May 2015.

1.2 This paper provides details of the CCG's 2015/16 proposed revised financial budgets for consideration and approval.

1.3 The financial budgets have been prepared in conjunction with budget holders and reflect all available planning guidance and metrics requirements. A summary of the proposed revised 2015/16 Financial Budget is presented in **Table 1**.

Table 1 - Summary 2015/16 Revised Financial Budgets

Budget Area	2015/16		
	Rec	Non Rec	Total
	£m	£m	£m
Resources			
Base Allocation	222.806		222.806
Growth funding	4.322		4.322
Better Care Fund allocation	4.105		4.105
Running Cost Allowance	3.296		3.296
Enhanced Tariff option	-	0.765	0.765
Surplus b/f		2.848	2.848
Available Resources	**234.529**	**3.613**	**238.142**
Commissioning Budgets			
NHS Commissioned Services	160.313	4.521	164.834
Corporate & Support Services: admin	3.273	0.023	3.296
Corporate & Support Services: programme	2.601	0.085	2.686
Independent Sector	2.537	0.060	2.597
Medicines Management	29.952	0.180	30.132
Primary Care	2.283	0.510	2.793
Non NHS Commissioning	18.039	0.113	18.152
Sub total Operational budgets	**218.998**	**5.492**	**224.490**
Reserves			
QIPP requirement	(3.441)		(3.441)
Non Recurrent schemes		2.131	2.131
Transformation Fund		2.400	2.400
Better Care Fund investment	4.572		4.572
Other Committed Plans	4.003	0.400	4.403
Contingency	1.187		1.187
Sub total Reserves	**6.321**	**4.931**	**11.252**
Total Anticipated Spend	**225.319**	**10.423**	**235.742**
Forecast Surplus/ (Deficit)	**9.210**	**(6.810)**	**2.400**
Expressed as %			**1%**

2. Changes from Opening Budgets

2.1 Overview

There has been an increase in operational budgets of £1.800m as a result of contract negotiations and the review of opening budgets. This has been met by a corresponding reduction in Reserves budgets. In addition, a Transformation Fund reserve of £2.400m has been established, and an additional contract risk reserve of £0.199m. The impact of these changes has increased the QIPP requirement to £3.441m. **Table 2** outlines how the unidentified QIPP has changed since the report to the Governing Body in March 2015.

Table 2: Unidentified QIPP

	£m
Opening unidentified QIPP balance (March 2015)	2.131
Establish Transformation Fund	1.100
Contract risks	0.199
Other minor changes	0.011
	3.441

Following these revisions, the CCG continues to deliver a planned surplus of 1% (£2.4m). The detail by cost centre is included at **Appendix 1.**

The major movements are described under the relevant sections below.

2.2 Resource Allocations and Surplus

The Resource allocation has increased by £0.765m since the March report, to a total Allocation for 2015/16 of **£238.142m**. This increase relates to non-recurrent funding from NHS England in respect of the costs associated with the enhanced tariff.

2.3 Key Changes in Operational Budgets

NHS Commissioned Services

Overall the budget for NHS Commissioned Services has increased by £2.777m since the March report. It was noted in the March report that the CCG had not reached agreement with all providers and that this area could change significantly. These increases were largely anticipated in 'leakage' and other contract reserves.

However, there are a number of contract negotiations that are still ongoing, and the CCG has established an additional reserve to fund anticipated increases in costs. Further detail of these cost pressures is provided in **Table 3** below, and these have been included in the revised budgets.

Table 3 – Cost Pressures - NHS Commissioned Services

Budget	**£**
Alder Hey - Realignment of community block	£75,250
Liverpool Community Health - Community equipment	£123,750
Total	**£199,000**

Non NHS Commissioning
There has been an increase of £0.125m to the budgets for Continuing Health Care and Funded Nursing Care. The budgets have been revised to reflect the year end results, with actual costs higher than those anticipated when the budget was originally calculated.

Corporate & Support Services
Within the Running Costs budget, there have been a small number of amendments to transfer resource between cost centres but no change to the overall budget presented to the Governing Body in March.

The Programme Costs budget has increased by £0.03m due to an allocation of resource for CCG management posts previously recorded under the Running Costs budget for which the costs meet the definition of Programme Costs.

Medicines Management
The Prescribing Budget has been increased by £0.248m to reflect the revised forecast. The year-end costs for prescribing are higher than those anticipated when the budget was calculated.

There has been a reduction of £0.166m to the budget for High Cost Drugs. Anticipated costs associated with recommendations from the Area Prescribing Committee have been moved to reserves.

2.4 **Reserves**
There has been a reduction in the 2015/16 Reserves budget of £2.187m since the opening budgets were presented. This reflects the increase in operational budgets described above.

2.5 **Transformation Fund**
Within the Reserves budget, the CCG has allocated £2.400m resource for the Transformation Fund. Utilisation of this fund will be approved by the QIPP group and Service and Improvement Redesign Committee.

2.6 **QIPP**
The unidentified QIPP target for the CCG is £3.441m. The QIPP budget is set as a negative budget in reserves, and when schemes are identified, their associated resource is transferred to reserves to achieve the requirement.

3 Key Financial Risks and Pressures

3.1 Outstanding contracts – Most contacts have been agreed, but a number are still to be settled. Where risks are known, the CCG has set aside reserves to mitigate the risks (see **Table 3**). However, a number of smaller contracts are yet to be agreed by other host commissioners, and changes to assumptions within those contracts where negotiation is ongoing will result in future adjustments to budgets.

3.2 The CCG plans have been prepared using 2014/15 financial year out-turn position so any growth in demand will need to be funded using CCG contingency reserves.

3.3 The commissioning of individual packages of care within Mental Health and Continuing Health Care (CHC) was identified as a major risk area for the CCG through 2014/15. The 2015/16 budgets have been set on the basis of 2014/15 outturn plus growth of 5%. There are still some unresolved issues regarding the quality of the underlying data from CSU which means that

there remains some risk around the accuracy of the budget. In addition, the pricing framework expires in-year, and providers may seek for an increase to current prices.

3.4 Prescribing - It should be noted that aspects of prescribing remain volatile and this area could present risks to budgets in 2015/16. Continued support from community pharmacist teams and practices will be required to deliver a balanced position.

3.5 Continuing Healthcare (CHC) restitution payments – The CCG has included provision for CHC restitution payments of £0.575m in Reserves. The value of this reserve is based on the most recent guidance from NHS England which indicates that, in 2015/16, CCGs will be required to contribute to a national risk pool.

4. Conclusions & Recommendations

4.1 The Governing Body is asked to:-

- Approve the revised financial budgets for the financial year 2015/16; and
- Note that the unidentified QIPP is valued at £3.441m.

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

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

5. Appendices

Appendix 1: Analysis by cost centre – revised 2015/16 Budget compared to Opening 2015/16 Budget.

NHS
South Sefton
Clinical Commissioning Group

Appendix 1

Comparison of 2015/16 Opening Budget to Revised Budgets

Cost centre Number	Cost Centre Description	Budget Holder	Original Budget (March 15)	Revised Budget 2015/16	Increase (Decrease)
			£000	£000	£000
COMMISSIONING - NON NHS					
598501	Mental Health Contracts	Jan Leonard	1,053	1,053	0
598506	Child And Adolescent Mental Health	Jan Leonard	238	238	0
598511	Dementia	Jan Leonard	118	118	0
598521	Learning Difficulties	Debbie Fagan	516	516	0
598541	Mental Health Services - Collaborative Commissioning	Debbie Fagan	0	0	0
598596	Collaborative Commissioning	Jan Leonard	521	521	0
598661	Out Of Hours	Jan Leonard	1,232	1,232	0
598682	Chc Adult Fully Funded	Debbie Fagan	6,528	6,611	83
598684	Chc Adult Joint Funded	Debbie Fagan	1,428	1,460	32
598685	Chc Adult Joint Funded Personal Health Budget	Debbie Fagan	67	36	(31)
598687	Chc Children	Debbie Fagan	581	589	7
598691	Funded Nursing Care	Debbie Fagan	2,298	2,332	34
598711	Community Services	Jan Leonard	447	447	0
598721	Hospices	Jan Leonard	1,536	1,536	0
598726	Intermediate Care	Jan Leonard	217	217	0
598796	Reablement	Jan Leonard	1,245	1,245	0
Sub-Total			**18,026**	**18,152**	**126**
CORPORATE & SUPPORT SERVICES					
600251	Administration & Business Support	Fiona Clark	155	155	0
600271	CEO/ Board Office	Fiona Clark	632	531	(101)
600276	Chair and Non Execs	Fiona Clark	148	251	103
600286	Clinical Governance	Fiona Clark	0	0	0
600296	Commissioning	Fiona Clark	1,295	1,265	(30)
600316	Corporate Costs & Services	Fiona Clark	250	275	25
600346	Estates and Facilities	Martin McDowell	334	334	0
600351	Finance	Martin McDowell	339	336	(3)
600391	Medicines Management	Jan Leonard	23	23	0
600266	Business Informatics	Karl McKluskey	75	80	5
600426	Quality Assurance	Debbie Fagan	45	45	0
	Sub-Total Running Costs		**3,296**	**3,296**	**0**
598646	Commissioning Schemes (Programme Cost)	Fiona Clark	1,091	1,121	30
598656	Medicines Management (Clinical)	Jan Leonard	737	737	0
598776	Non Recurrent Programmes (NPfIT)	Martin McDowell	423	423	0
598676	Primary Care IT	Martin McDowell	250	250	0
598810	Nursing and Quality Programme	Debbie Fagan	155	155	0
	Sub-Total Programme Costs		**2,656**	**2,686**	**30**
Sub-Total			**5,952**	**5,982**	**30**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS					
598571	Acute Commissioning	Jan Leonard	112,002	113,287	1,285
598576	Acute Childrens Services	Jan Leonard	8,625	8,428	(197)
598586	Ambulance Services	Jan Leonard	5,351	5,741	389
598616	NCAs/OATs	Jan Leonard	1,446	1,446	0
598631	Winter Pressures	Jan Leonard	0	0	0
598756	Commissioning - Non Acute	Jan Leonard	34,623	35,923	1,300
598786	Patient Transport	Jan Leonard	9	9	0
Sub-Total			**162,057**	**164,835**	**2,777**
INDEPENDENT SECTOR					
598591	Clinical Assessment and Treatment Centres	Jan Leonard	2,541	2,597	56
Sub-Total			**2,541**	**2,597**	**56**
PRIMARY CARE					
598651	Local Enhanced Services and GP Framework	Jan Leonard	2,283	2,283	0
598791	Programme Projects	Jan Leonard	510	510	0
Sub-Total			**2,793**	**2,793**	**-**
PRESCRIBING					
598606	High Cost Drugs	Jan Leonard	761	595	(166)
598666	Oxygen	Jan Leonard	434	434	0
598671	Prescribing	Jan Leonard	28,974	29,103	129
Sub-Total			**30,169**	**30,132**	**(37)**
Sub-Total Operating Budgets pre Reserves			**221,538**	**224,490**	**2,952**
RESERVES					
598761	Commissioning Reserves	Martin McDowell	13,439	11,252	(2,187)
Sub-Total			**13,439**	**11,252**	**(2,187)**
Grand Total I & E			**234,977**	**235,742**	**765**

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Thursday, 19th February 2015	Chair: Roger Driver

Key Issue	Risk Identified	Mitigating Actions
• Estates Utilisation	• Likely under-use of buildings leading to "void costs"	• Establish Estates Implementation Working Group

Information Points for South Sefton CCG Governing Body (for noting)

- CCG remains on target to deliver its financial duties, but still risks between now and year-end, notably the December prescribing report following pressures on general practice.
- CCG has adopted NICE recommendations in respect of prescribing Nalmefene for reducing alcohol consumption in people with alcohol dependence.
- A number of benchmarking reports were discussed and the Governing Body is asked to support further clinical engagement to help understand trends etc, and develop a narrative to be shared with localities and the wider group.
- The Committee supported plans for "improvement of respiratory care management" in Primary Care, through a development and audit programme estimated to cost in the region of £150k.

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Thursday, 19th March 2015	Chair: Graham Morris

Key Issue	Risk Identified	Mitigating Actions

Information Points for South Sefton CCG Governing Body (for noting)

- CCG remains on course to deliver its financial target.
- QIPP group to be established in April.
- Prescribing report requires adjustments to budgets to reflect changes in population, CATM not included in original budget.
- CVS investment approved.
- 2015/16 Prescribing Quality Scheme approved.
- Agreed Pharmacy Rebate Scheme.

Key Issues
Quality Committee

NHS
South Sefton
Clinical Commissioning Group

Meeting Date	**February 2015**
Chair	**Roger Driver**

Key Issues	Risks Identified	Mitigating Actions
• PALS and Complaints Report – timelines and local standard for response times	• Reputational risk for the CCG regarding timelines for completion • Quality assurance of responses to complainants	• Internal quality assurance process that has been implemented in the CCG to ensure improvements in quality of service from CSU • Service that CCG has stated an intent to 'in-house' in 2015/16 • Quality Committee has requested an audit of provider response times

Notifications to the Governing Body
1. **Continuing Health Care** – Quality Team received an update from the Chief Nurse regarding progress to date of the Joint CCG CHC Steering Group that meets weekly
2. **CCG Safeguarding Strategy** – The Quality Committee recommended submission to the Governing Body for approval

Key Issues
Service Improvement and Redesign Committee

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Meeting Date	**Wednesday 4th March 2015**
Chair	**Dr Paul Thomas**

Key Issues	Risks Identified	Mitigating Actions
Community navigator model	Lack of alignment and consistency with existing models in place	Tracy to work with Anna Nygaard from Public Health to ensure consistency and alignment going forward
Primary Care Dashboard	Potential lack of clinical application and use at a practice level	Revised primary care dashboard with practice comparators to be available from April 2015 for use through localities

Recommendations to the Governing Body
1. **The Governing Body is asked to receive the contents of this Key Issues log by way of assurance**

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Minutes

Thursday 19th February 2015, 1.00pm to 3.00pm
3rd Floor Board Room, Merton House

Membership		
Roger Driver	Lay Member (Chair)	RD
Steve Astles	Head of CCG Development	SA
Sharon McGibbon	Practice Manager	SMcG
Debbie Fagan	Chief Nurse & Quality Officer	DF
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Martin McDowell	Chief Finance Officer	MMcD
Andy Mimnagh	GP Governing Body Member	AM
Graham Morris	Lay Member	GM
Paul Thomas	GP Governing Body Member	PT
John Wray	GP Governing Body Member	JW
Ex-officio Member		
Fiona Clark	Chief Officer	FLC
In Attendance		
James Bradley	Head of Strategic Finance Planning	JB
Malcolm Cunningham	Head of Primary Care & Contracting	MC
Janet Faye	Senior Practice Pharmacist	JF
David Smith	Deputy Chief Finance Officer	DS
Suzie Forde	Senior Healthcare Planner, GB Partnerships	SF
Peter Musselwhite	Healthcare Planner, GB Partnerships	PM
Mike Webb	General Manager, LSHP	MW
Apologies		
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Susanne Lynch	CCG Lead for Medicines Management	SL
Paul Thomas	GP Governing Body Member	PT
Becky Williams	Chief Analyst	BW
Minutes		
Ruth Moynihan	PA to Chief Finance Officer	RM

Attendance Tracker ✓ = Present A = Apologies N = Non-attendance

Name	Membership	Nov 14	Jan 15	Feb 15	Mar 15	May 15	June 15	July 15	Sept 15	Oct 15	Nov 15	Jan 16
Roger Driver	Lay Member (Chair)	✓	✓	✓								
Steve Astles	Head of CCG Development	A	A	✓								
Sharon McGibbon	Practice Manager	N	✓	✓								
Debbie Fagan	Chief Nurse & Quality Officer	√	✓	✓								
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A	✓	A								
Martin McDowell	Chief Finance Officer	✓	✓	✓								
Andy Mimnagh	GP Governing Body Member	✓	A	✓								
Graham Morris	Lay Member	A	A	✓								
Paul Thomas	GP Governing Body Member	✓	✓	A								
John Wray	GP Governing Body Member	N	A	N								
Fiona Clark	Chief Officer	A	✓	A								
James Bradley	Head of Strategic Finance Planning	✓	✓	✓								
Karl McCluskey	Chief Strategy & Outcomes Officer	A	A	A								
Malcolm Cunningham	Head of Primary Care & Contracting	✓	A	A								
Jan Leonard	Chief Redesign & Commissioning Officer	✓	✓	A								
Susanne Lynch	CCG Lead for Medicines Management	✓	✓	A								
David Smith	Deputy Chief Finance Officer	✓	✓	✓								

No	Item	Action
FR15/19	**Apologies for absence** Apologies for absence were received from Fiona Clark, Paul Thomas, Jan Leonard, Tracy Jeffes, Susanne Lynch, Karl McCluskey, Malcolm Cunningham and Becky Williams.	
FR15/20	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both Southport and Formby and South Sefton CCGs declared their potential conflicts of interest. It was noted that there was a potential conflict of interest by Members employed in, or having interests in, general practice with regard to item FR15/23. SMcG and AM also declared their interest in item FR15/32.	
FR15/21	**Minutes of the previous meeting** The minutes of the previous meeting were approved as a true and accurate record and signed off by the Chair.	
FR15/22	**Action points from the previous meeting** **FR14/66 - Case for change** JB confirmed that Business Intelligence is conducting work on this and an update will be brought to the meeting in March. **FR15/15 - Work Plan 2015/16** The work plan has been updated following feedback from January's meeting.	JB
FR15/23	**Estates Utilisation** A series of utilisation and occupancy studies were undertaken by Suzie Forde, Senior Healthcare Planner, GB Partnerships. The reports detailed reviews of clinical services and administration accommodation provided in the following buildings: • Litherland Town Hall, Utilisation Review • Maghull Health Centre, Utilisation Review MMcD stated the purpose of the estates utilisation programme was to identify void spaces, increase better utilisation of spaces and potentially, but not necessarily, bring savings to the CCG. MMcD outlined that this could start the discussion to transform the estate across the CCG. He identified that we should be thinking about how we want the estate to look like in 10 to 15 years' time. SF stated that this was a "snapshot" in time looking at an 8 hour day, Monday-Friday, between the hours of 9.00am and 4.00pm. As such, use of space outside of these hours was not analysed.	

No	Item	Action
FR15/23	**Estates Utilisation *(continued)*** SF summarised the reviews and her key observations, stating that the reports will enable the CCG to make informed decisions based upon the findings therein. The results highlighted the possibility of reconfiguring the use of the buildings and, in order to do this, an estates implementation working group needed to be formed to take this to the next stage. SF stated that Prince Street, from a functionality point, was in poor condition. RD queried if refurbishment costs would be higher than relocation costs. MW said the best option would be to build a new centre for Waterloo/Crosby, to include some services for other providers and potentially phlebotomy. PM said it was important not to underestimate the disruption if a property was to be upgraded. RD said the reviews sharpened the CCG's focus and said we should seek to build collaborations as part of our plans. MMcD put forward a recommendation for an estates working group consisting of 2 CCGs plus local partners, eg local council, and voluntary sectors who may be operating from smaller premises and would benefit from co-location. MMcD said the local authority is keen to explore opportunities to get best use of it's estate. RD asked who would form members of this group. MMcD said he would look to take volunteers from the Finance and Resource Committee, the local authority and other public sector bodies. RD noted there could be potential conflicts of interest and MMcD suggested, as an example, a short survey be sent to GPs asking what their view of their practice's future is. MMcD said going forward his view is for South Sefton to have 8 to 10 community resource centres in the next 10 to 15 years. RD said it was important to make a distinction between the larger bodies eg Nugent Care, in terms of the potential to collaborate with the CCG. MMcD said the CCG should look to establish meeting on a quarterly basis with the first meeting to take place in April. Once established, the group will report back in 12 months' time, at which point some clinical options might have emerged. MMcD is to lead on this.	MMcD
	Action taken by the Committee	
	The Committee received the report by way of assurance.	

No	Item	Action
FR15/24	**Month 10 Finance Report** This paper presented the Finance and Resource Committee with an overview of the financial position for NHS South Sefton Clinical Commissioning Group as at month 10 and outlined the key financial risks facing the CCG. MMcD drew the Committee's attention to Table B within the report which showed the CCG near the bottom end of the group, and this needed to be borne in mind as part of the discussions going forward. MMcD said another risk is the cost of care homes which has been held relatively static over the last few years. The care homes have said they are unable to cope going forward. DF said care homes are increasing in price and the CCG is looking to move forward with the local authority, involving a lot of scrutiny and hard work by the CCG, to review quality in terms of provision. Concluding, MMcD said the CCG is on target and there are risks, and he expected December's prescribing figures to be high but needed to be taken into account with the January figures. MMcD said he expected the CCG to overspend in relation to this, but everything else is on target, and felt the CCG's Finance Team had been prudent in their forecasting. Action taken by the Committee The Committee received the report and noted that the CCG remains on target to deliver its financial duties for 2014/15, noting that risks remained in the system. The Committee approved the recommendations within the report.	
FR15/25	**Prescribing Performance Update** This paper presented the Committee with an update on prescribing spend for November 2014 (month 8). JF gave an overview of the report and said the Committee should be aware of the Category M drugs; all GP practices have been made aware of this. JF said certain practices have been looked at in great detail; the feeling is it is quality driven and the GPs are prescribing more appropriately to give the best. JF said there is a need to look at prescribing in more detail to better understand and to work closely with the CCG's Finance Team. JF confirmed the figures are shown to localities so they are made aware of them.	

No	Item	Action
FR15/25	**Prescribing Performance Update *(continued)*** MMcD said the CCG needs to start picking up some of these key indicators and putting into a scorecard, eg what is the optimum level of prescribing; also need to look at sector by sector and see how to get the balance for each area. JB said the primary care dashboard is still being tweaked, and MMcD suggested this is something to be shared with clinicians to help develop the narrative, in terms of devising plans to ensure that the CCG is receiving value for money. DF asked if this is something the Quality Team could be involved with, and JF is to liaise with BP on this point.	JF/SL
	Action taken by the Committee	
	The Committee noted the update.	
FR15/26	**APC Recommendations** The Pan Mersey Area Prescribing Committee has recommended the commissioning of the following medicine at the January 2015 meeting: • Nalmefene for reducing alcohol consumption in people with alcohol dependence JF briefed the Committee on the drug and, as this had been recommended by NICE, the CCG were required to support this. MMcD recognised the cost per population but expected it to be slow in terms of uptake, meaning that the CCG should not experience a significant increase. RD asked what would be the implication if the CCG declined this recommendation. AM stated this is an optional recommendation and not an enforcement. JF stated that if the evidence changed then NICE will change their recommendation.	
	Action taken by the Committee	
	The Committee approved the recommendation.	
FR15/27	**Capital Plans and Updates** MMcD referred the group to previous discussion on estates and suggested that this item be replaced by Estates Working Group in the work plan. MMcD stated that the estates utilisation programme is to be deferred until the plan for this is put into place.	RM
	Action taken by the Committee	
	The Committee noted the update.	

No	Item	Action
FR15/28	**External Updates/Benchmarking and VFM Report** This report set out the financial position of the CCG in the key areas of spend against similar CCGs nationally, and also against Cheshire and Merseyside. DS advised the CCG is now a member of a benchmarking club and will bring an update to each meeting. Regarding better care value a "how to" guide is being produced on how to look at your own data. DS said need to look at the whole pathway before having conversations with the Trust. MMcD said need to be more targeted and although information is indicative and useful, need to test the ability of the activity and see how it is taken to the wider group. DS said with regard to programme budgeting the figures show the CCG is a consistently high spender, and that it is important that programme leads are aware of their position to help understand whether good outcomes are being achieved.	
	Action taken by the Committee	
	The Committee received the report by way of assurance.	
FR15/29	**QIPP Update** MMcD and KMcC are to give a joint presentation to the Governing Body on Thursday, 26th February.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/30	**Better Care Fund Update and Draft Section 75 Agreement** DS advised that the Section 75 Agreement is due soon, and the template was being tweaked to meet the needs of the CCG. The Agreement will be presented to the Finance and Resource Committee in March 2015 for sign-off.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/31	**Review of Annual Work Plan** The work plan has been updated following feedback from the meeting in January.	
	Action taken by the Committee	
	The Committee noted the updated work plan.	

No	Item	Action
FR15/32	**Any Other Business** **Improving Respiratory Care In Primary Care** This aim of this report was to inform and receive approval from the Finance and Resource Committee of a proposed project, intended to improve respiratory care and reduce unnecessary A&E and inpatient admissions in South Sefton CCG constituent practices. SA it was important to target patients before they reach a critical point and need to go to A&E. Education is biggest expenditure and 90% of users aren't using inhalers correctly. SA confirmed this was a one off training programme, and MMcD suggested an 18 month follow-up type arrangement could be put in place for SL to catch up with localities. SA said he would put this in place. SA is to link in with Medicines Management on how patients are to be managed going forward. Action taken by the Committee The Committee approved the recommendation with the **exception** of funding the equipment identified in the proposal.	
FR15/33	**Date of next meeting** Thursday 19th March 2015, 1.00pm to 3.00pm 3rd Floor Board Room, Merton House	

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Minutes

Thursday 19th March 2015, 1.00pm to 3.00pm
3rd Floor Board Room, Merton House

Membership

Graham Morris	Lay Member (Chair)	GM
Steve Astles	Head of CCG Development	SA
Sharon McGibbon	Practice Manager	SMcG
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Martin McDowell	Chief Finance Officer	MMcD
Andy Mimnagh	GP Governing Body Member	AM
Paul Thomas	GP Governing Body Member	PT

Ex-officio Member

Fiona Clark	Chief Officer	FLC

In Attendance

David Smith	Deputy Chief Finance Officer	DS
Malcolm Cunningham	Head of Primary Care & Contracting	MC
Susanne Lynch	CCG Lead for Medicines Management	SL

Apologies

Roger Driver	Lay Member	RD
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Debbie Fagan	Chief Nurse & Quality Officer	DF
James Bradley	Head of Strategic Finance Planning	JB

Minutes

Ruth Moynihan	PA to Chief Finance Officer	RM

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Roger Driver	Lay Member (Chair)	✓	✓	✓	A							
Steve Astles	Head of CCG Development	A	A	✓	✓							
Sharon McGibbon	Practice Manager	N	✓	✓	✓							
Debbie Fagan	Chief Nurse & Quality Officer	√	✓	✓	A							
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A	✓	A	✓							
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓							
Andy Mimnagh	GP Governing Body Member	✓	A	✓	✓							
Graham Morris	Lay Member	A	A	✓	✓							
Paul Thomas	GP Governing Body Member	✓	✓	A	✓							
John Wray	GP Governing Body Member	N	A	N	N							
Fiona Clark	Chief Officer	A	✓	A	A							
James Bradley	Head of Strategic Finance Planning	✓	✓	✓	A							
Karl McCluskey	Chief Strategy & Outcomes Officer	A	A	A	A							
Malcolm Cunningham	Head of Primary Care & Contracting	✓	A	A	✓							
Jan Leonard	Chief Redesign & Commissioning Officer	✓	✓	A	A							
Susanne Lynch	CCG Lead for Medicines Management	✓	✓	A	✓							
David Smith	Deputy Chief Finance Officer	✓	✓	✓	✓							

No	Item	Action
FR15/34	**Apologies for absence** Apologies for absence were received from Fiona Clark, Roger Driver, Debbie Fagan, Karl McCluskey, Jan Leonard and James Bradley.	
FR15/35	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both Southport and Formby and South Sefton CCGs declared their potential conflicts of interest. Also declared was a potential conflict of interest by Members employed in, or having interests in, general practice with regard to agenda item FR15/48 AOB (2) Proposed Prescribing Quality Scheme for the year 2015/16.	
FR15/36	**Minutes of the previous meeting** The minutes of the previous meeting were approved as a true and accurate record and signed-off by the Chair.	
FR15/37	**Action points from the previous meeting** **FR15/22 (FR14/66) - Case for change** DS stated that following the approval of the Case for Change in May 2014, this had been monitored by Finance, including reviewing outpatient data with the CSU, and the overall assumption was that savings had not materialised. This action is now closed. **FR15/25 – Prescribing Performance Update** SL confirmed she had liaised with Brendan Prescott and confirmed that if a practice had a non-medical provider eg a nurse, then the expectation is for a member of the Quality Team to attend the meeting. This action is now closed. **FR15/27 - Work Plan 2015/16** - the work plan has been updated accordingly.	
FR15/38	**Month 11 Finance Report** This paper presented the Finance and Resource Committee with an overview of the financial position for NHS South Sefton Clinical Commissioning Group as at Month 11 and outlined the key financial risks facing the CCG. GM asked if the work of the CHC sub-committee had led to better understanding of the system and DS said it had meant that the CSU had to look at their processes. MMcD said with regard to the desktop review of high cost cases he would expect savings to be delivered, and he is looking for assurance in 2015/16 that the responsibility lies with the decision maker of the CHC. He believed the steering group had done part of this already and the next step is to have a discussion with the decision makers. Action taken by the Committee The Committee received the report and noted that the CCG remains on target to deliver its financial duties for 2014/15, noting that risks remained in the system.	

No	Item	Action
FR15/39	**Financial Strategy Update** MMcD presented to the Governing Body in February and received feedback on some assumptions eg leakage. MMcD said the Governing Body meeting next week will focus on budgets and at that time he will be requesting sign-off as well as QIPP target. MMcD also said the CCG were looking at a transformation scheme to look at changing how care is delivered, eg GP hotline, pathfinder scheme, and these will be grouped under Transformation Fund. GM said it was important to identify and prioritise these potential savings. MMcD also noted the importance of taking on some of these schemes in the coming year eg how mental health can link into other aspects of care, as there appeared to be potential to deliver cost efficiencies in this area. Action taken by the Committee The Committee noted the update.	
FR15/40	**Prescribing Performance Update** **Quarter 3 Report** This paper presented the Committee with a report on prescribing performance for the third quarter of 2014/15 across South Sefton CCG practices, and compared activity against the third quarter 2013/14. SL said she is meeting with the Chief Pharmacist of Mersey Care next week to discuss the switch from MR quetiapine to IR quetiapine as per the Pan Mersey Area Prescribing guidance. This piece of work could produce significant cost savings for the CCG but will be led by Mersey Care clinicians during patient reviews. Pregabalin was discussed with regard to the recent NHS England guidance recommending brand prescribing for neuropathic pain. Potential savings forecast from the patent expiry for the next financial year may not be gained. Medicines Management pushing the Pan Mersey neuropathic pain guideline. SA noted that the increase in opioid analgesics may be due to patients being treated at home and not hospital. SL confirmed work will be done with the CD Accountable Officer at NHSE regarding this as an increase in prescribing of opioids has occurred across Merseyside. **Month 9 Report** This paper presented the Committee with an update on prescribing spend for December 2014 (month 9). The South Sefton CCG position for month 9 is a forecast overspend of £246k on a budget of £26.6m. SL said Category M continues to affect the CCG to c£190k, and this will continue to be monitored to the end of the year. SL will then make the necessary adjustments using risk pool money. MMcD asked that an updated presentation of the locality scorecards be received in May. Action taken by the Committee The Committee noted the update.	DS/BW/FD

No	Item	Action
FR15/41	**Primary Care Rebate Scheme** MMcD presented a paper detailing this Scheme and the Committee agreed to support it. SL said the industry has identified a market in primary care, and drug companies approach the CCGs with contracts and offers of rebate schemes, effectively reducing the cost of drugs. SL said the CCG will only participate in drugs approved by Pan Mersey and confirmed that no exclusivity was in place, stating the rebate is based purely on quantity of drugs used. GM said the Committee would approve this Scheme on the proviso that the CCG could opt out if conditions became onerous. SL confirmed this is the case and MMcD stated it will be reviewable on an annual basis. Action taken by the Committee The Committee approved the use of this Scheme subject to annual review.	Committee (review March 2016)
FR15/42	**External Updates/Benchmarking and VFM Report** This report set out the financial position of the CCG in the key areas of spend against similar CCGs nationally, and also against Cheshire and Merseyside. The report continued to build upon the benchmarking information previously presented to the Committee, with a key focus on urgent care. DS presented the report and said there was a potential saving of £2m if the CCG could manage non elective activity in line with the national average. The Committee noted that coding issues remained in the system which skewed some of the figures shown in the table, and KMcC's team is working closely on this. Action taken by the Committee The Committee received the report by way of assurance.	
FR15/43	**CCG Assurance** MMcD gave a verbal update and noted that the CCG had been reviewing performance issues; between now and the Q3 Assurance meeting in April MMcD said themes will be identified and taken to SLT. SA gave an update re North Mersey and said a letter had been received asking to continue schemes until the end of April. SA said resources were available to do this as required, but SRG focus would remain on identifying which schemes had proved effective. MMcD said with regard to local schemes these will all be in place. Action taken by the Committee The Committee noted the update.	
FR15/44	**QIPP Update** MMcD said the development of a new QIPP sub-group is to be discussed in next week's Governing Body meeting. Action taken by the Committee The Committee noted the update.	

No	Item	Action
FR15/45	**Better Care Fund Update** MMcD said the CCG is working alongside the Local Authority with regard to the Section 75 Agreement and this has been approved by their solicitor. MMcD said the big issue is Council demography change for social care will have a rise of £3m, and he wanted to work with partners to see a 3 year trend to understand risks. MMcD noted a budgetary cut has been trialled with the Council, and the CCG has a broad agreement with the Council re expenditure on social care. MMcD said there is to be a closer vigilance on collective spend across Sefton, with a view to releasing savings through effective use of resources. Action taken by the Committee The Committee noted the update.	
FR15/46	**CVS Expenditure** This paper presented the Finance and Resource Committee with details of the proposed investment in continued support for Sefton Council for Voluntary Services (CVS) for 2014/15. It provided information regarding the investment criteria, process and performance management of the investments, as well as a summary of investments provided to date. DS said a lot of these schemes will go into the BCF and asked for continuation of funding as results were positive. MMcD pointed out that some of the smaller schemes could potentially have bigger impacts, eg on A&E. Work is to continue in the next 3-6 months to identify what is being gained by this investment. MMcD said the CVS are holding this money and the CCG are able to direct where the money is to go. GM said the Committee would approve this as a non-recurrent spend but it is not to be considered as an expectation going forward. Action taken by the Committee The Committee noted the update and approved this non-recurrent spend.	
FR15/47	**Review of Annual Work Plan** The work plan has been updated following feedback from the meeting in March. Action taken by the Committee The Committee noted the updated work plan.	
FR15/48	**Any Other Business** **(1) Committee Self Assessment Checklist** As part of the completion of the Annual Governance Statement of the CCG and the Annual Report, it is necessary that the Governing Body Sub Committees review their effectiveness. As such the Committee was made aware of this checklist, and noted that the Chair and MMcD are to complete this and bring a draft response for discussion to the next meeting in May. Any feedback from Committee Members is to be received by Friday, 27th March.	ALL

No	Item	Action
FR15/48	**Any Other Business (continued)** **(2) Proposed Prescribing Quality Scheme for the year 2015/16** SL presented a paper on the above Scheme on which the Medicines Management Team (MMT) is briefed and ready to proceed. The aim of the Scheme is to provide an incentive to GP practices to deliver medicines optimisation. SL said that this would be taken out of a budget target and replaced with practices showing engagement with the MMT. SL advised that she had produced a new document for the MMT to use consistently at quarterly meetings, where levels of compliance will be recorded; the Scheme is quality based, with subtle changes aimed at involving the practices more without taking up significant clinician time. MMcD proposed that the Committee receive the Scheme on the understanding that it has been fully assessed, and delegate it for approval by MMcD and GM/RD.	
	Action taken by the Committee	
	The Committee received the Scheme and delegated authority for approval to MMcD and GM/RD. The Committee noted that GP Members of the Committee had a potential interest in this Scheme.	
FR15/49	**Date of next meeting** Thursday 21st May 2015, 1.00pm to 3.00pm 3rd Floor Board Room, Merton House	

NHS
South Sefton
Clinical Commissioning Group

Quality Committee Minutes

Date: Thursday 19th February 2015, 3.00pm to 5.00pm
Venue: 3rd Floor Boardroom, Merton House, Stanley Road, Bootle

Membership

Dr Craig Gillespie	GP Governing Body Member (Chair)	CG
Stephen Astles	Head of CCG Development	SA
Malcolm Cunningham	Head of Primary Care & Contracting	MC
Roger Driver	Lay Member	RD
Debbie Fagan	Chief Nurse	DF
Dr Gina Halstead	(Acting Chair) GP Quality Lead	GH
Martin McDowell	Chief Finance Officer	MMcD
Sharon McGibbon	Practice Manager / Governing Body Member	SMcG
Dr Andy Mimnagh	GP Governing Body Member	AM

Ex-Officio Members

Fiona Clark	Chief Officer	FLC

Also in attendance

Ann Dunne	Designated Nurse for Safeguarding Children	AD
Tracey Forshaw	Deputy Head Adult Safeguarding	TF
Brendan Prescott	Deputy Chief Nurse / Deputy Head of Quality & Safety	BP

Minute Taker

Jacqueline Jones	Interim PA to the Chief Nurse	JJ

Membership Attendance Tracker

Name	Title	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr Craig Gillespie	Chair and Governing Body Member	√	√	√	A	√	√	A	√	√	A	A	
Steve Astles	Head of CCG Development	A	A	A	A	√	A	A	√	√	A	√	
Lin Bennett	Practice Manager Governing Body Member	√	A	√	√	√	√	√	A	A	√		
Malcolm Cunningham	Head of Contract and Procurement	√	A	√	√	√	√	√	√	√	A	√	
Roger Driver	Lay Member	√	√	√	√	A	√	√	√	√	√	√	
Debbie Fagan	Chief Nurse & Quality Officer	√	√	√	√	√	√	√	√	A	√	√	
Dr Gina Halstead	Clinical Lead for Quality	√	√	A	√	A	A	√	√	√	√	√	
Martin McDowell	Chief Finance Officer	√	√	√	√	√	A	√	A	√	√	A	
Sharon McGibbon	Practice Manager / Governing Body Member											√	
Dr Andrew Mimnagh	Clinical Governing Body Member	A	√	√	A	A	√	√	√	√	√	√	

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/017	**Apologies for Absence** Apologies for absence were received from FLC, AD, TF, CG, JH, DMcD, MMcD and BP. DS was in attendance on behalf of MMcD.	
15/018	**Declarations of interest regarding Agenda items** None declared. However, it was noted that agenda item 15/25 involved General Practice.	
15/019	**Minutes of the previous meeting and Key Issues Log** Minutes of the previous meeting were agreed as an accurate reflection of the meeting.	

No	Item	Action
15/020	**Matters Arising / Action Tracker** **14/131(i) Complaints Policy (Voice of the Child & Young Person)** – This is being managed via the Corporate Governance Support Group (CGSG). The CGSG will review amended wording that CSU will have suggested at their next meeting and then the policy will be re-presented to the Quality Committee for approval purposes. The decision was made to close this action as the revised policy will automatically be presented to the Committee as per CCG governance arrangements. **Outcome: Action closed – to be removed from the tracker.** **14/131(3) Missed Fracture Incident / X-Ray Reporting Process** – GH provided a detailed update. Adequate assurances have been received to date and there have been no knowledge of any Serious Incidents (SI) being reported in relation to this by the Provider. The CCG has SI management processes in place that would enable the identification should such incidents occur in the future. **Outcome: Action closed – to be removed from the tracker**. **14/133 NWAS 111 Call Report (Activity Data) –** AM stated that the Committee could receive the full Activity Data Pack but it was lengthy. DF stated that exception reporting from the data received could be included in the Provider Quality Reports that are presented at the external Quality Committee Meetings going forward. The committee supported this way forward. **Outcome: Action closed – to be removed from the tracker.** **14/147 Quality Committee Workplan** – Updated workplan is an agenda item for discussion at this meeting. **Outcome: Action closed – to be removed from the tracker.** **14/153 CCG Primary Care Dashboard** – The dashboard is now to be presented at the CCG SIR Group instead of the Quality Committee. **Outcome: Action closed – to be removed from the tracker.** **14/178 Safeguarding Peer Review / Action Plan** – DF stated that this was an agenda under 'Any Other Business' but asked if this item could be deferred until the next meeting to enable updates from the CCG Network Safeguarding Steering Group that is scheduled to take place on 23rd February 2015 to be reflected in the action plan – the committee supported this request. AM asked a question regarding the process for Managing Allegations of Abuse regarding health professionals and the Multi-Agency Safeguarding Hub (MASH) process – DF stated that this is usually managed through the LADO but will ask the Safeguarding Service to contact AM to discuss further. **Outcome:** **1) Action: The Quality Committee agreed to defer this initial action until the next meeting** **2) Action: DF to ask the CCG Safeguarding Service to contact AM to discuss the LADO / MASH process in relation to managing allegations of abuse against a health professional.** **141/181 and 14/182 PALS and Complaints Overview Report** – DF provided information from JH regarding the main reasons for delays and the constraints currently within the system eg. timelines in providers returning information; agreeing extensions with complainants due to the type of investigation required. DF stated that she frequently has cause to return complaints to the CSU due to quality assurance purposes so that can prolong response times. DF stated that this is one of the functions that the CCG has signalled the intention to bring back 'in-house' from April 2015 onwards. **Outcome: Action closed – to be removed from the tracker**.	

No	Item	Action
	15/005(1) - Catheter Project / Quality Team to further explore the idea of a specific catheter service being commissioned DF stated that JH is liaising with the CCG Programme Office to explore the feasibility of generating the requested business case. SA asked if JH could liaise with PC as there may be some overlap with the Community Matron service that has been developed. DF stated that she would ensure JH spoke with PC. **Outcome: Action closed – to be removed from the tracker.** **15/005(2) – Catheter Project / Quality Team to look at development of KPIs in relevant contracts** DF reported that a Catheter Passport KPI is being inserted into the relevant Provider Quality Schedules as appropriate. **Outcome: Action closed – to be removed from the tracker** **15/006 CAS Alerts** – Agenda item not yet due **Outcome: Agenda item due March 2015** **15/011 Rotavirus Study** – Agenda item not yet due **Outcome : Agenda item due March 2015**	
15/021	**Chief Nurse Report** DF presented the Chief Nurse Report. The Committee were asked to take particular note of the updates in relation to the following: • Continuing Health Care – progress from the weekly CCG/CSU Steering Group • Contract Query for Southport & Ormskirk Hospital NHS Trust regarding Safeguarding performance – the CCG Safeguarding Service are working with the CCG Contracts Team to draft the appropriate query • Shadowing of the Health Visiting Service – reflections from the visit, including record keeping challenges (hard copy records and EMIS), were relayed GH stated that shortly parents would be able to access their child's E-record and asked if the challenges could be raised with I-Merseyside. **Action: DF to email P Shilcock regarding parental access to children's records**	DF
15/022	**Safeguarding Strategy** DF presented the Safeguarding Strategy and requested that the Quality Committee recommend approval by the Governing Body. DF explained that the CCG Safeguarding Service had made further amendments to the one that was originally deferred in January 2015 in order to ensure it took into account some additional guidance from the Care Act. The Quality Committee acknowledged that this was a Merseyside wide Strategy but queried the apparent lack of local focus not only within Sefton but within the CCG area. DF explained that this had been discussed with the Safeguarding Service and the localism would be reflected in the local implementation / action plan which would be monitored via the Quality Committee as many of the LSCB priorities were common across Merseyside eg. Child Sexual Exploitation. DF also stated that the CCG Safeguarding Service had stated that they would ensure that future reiterations of the strategy would demonstrate more localism. **Action: The Quality Committee recommended presentation of the Safeguarding Strategy to the Governing Body for approval.**	

No	Item	Action
15/023	**PALS and Complaints – 12 Month Overview Report** DF presented the report on behalf of JH. The Committee were also referred to the earlier conversation in relation to agenda item 14/181 from the action tracker which was discussed under 15/020. DF explained the processes that were in place within the CCG and the weekly contact that has been introduced which informs a weekly tracker that is reviewed by TJ and herself from a SMT perspective. RD stated that many contacts that could result in a complaint could be more effectively managed if they are dealt with immediately at the source by an acknowledgement of what has happened and an apology rather than the need to go through a complaints procedure that can be quite bureaucratic. DF stated that both herself and the CCG Chief Officer often meet with complainants and their families to ensure the human element of the process is not lost. GH suggested that a snapshot audit be undertaken of response times from providers so the CCG can gain a better understanding of provider status. The Quality Committee also asked if there were different response times for MP letters and queries to those received from members of the General Public. DF responded that dependent upon the nature of the contact eg. Parliamentary question etc then timelines would be different. DF stated that she would provide feedback re: timelines for MP complaints at the next meeting. **Action:** **1. DF to ask CSU to undertake an audit of Provider response times for complaints** **2. DF to provide feedback regarding response times for the different MP requests regarding complaints and queries.**	
15/024	**Quality Committee Workplan** DF presented the updated workplan on behalf of JH. DF explained that some items have not got any defined months for presentation against them as these will come on an ad hoc basis. Content has been amended to demonstrate how certain areas of responsibility detailed in the ToR have been delegated to sub-groups eg. EPEG **Action: The Quality Committee approved the workplan.**	
15/025	**CQC Intelligent Monitoring – GP Practices** DF presented the report to the Committee and discussed the key points including the table that indicated the Bandings of the practices within the SSCCG area. AM and SMcG gave their experiences of the process that is undertaken from a General Practice perspective. DF explained that the Quality Team were hoping to meet with the CQC to discuss Intelligent Monitoring further and explained the process which would include matrix working between the Quality and Primary Care Teams within the CCG in order to use this information as part of a suite of intelligence to aid the CCG in their Primary Care Quality role. **Action: The Quality Committee received the report.**	

No	Item	Action
15/026	**General Practice Incident** DF informed the Committee that the CCG had been notified by NHSE of an incident reporting allegations of a bogus health professional working within General Practice in the CCG area. The Committee were asked to note that this has been identified as a possible national issue and is not restricted to the CCG area. NHSE are leading on the investigation and will liaise with the CCG as appropriate – this will include any possible patient safety issues to ensure no patients resulted in harm. DF reported that BP is attending a Single Item Quality Surveillance Group Meeting called by NHSE at which this incident will be discussed further. The Quality Committee were informed of the confidential nature of this inquiry and further information will be given accordingly. **Action: The Quality Committee received this information.**	
15/027	**Minutes & key Issues to be Formally Received** **a) Joint Medicines Operational Group (JMOG)** AM asked regarding Agenda 14/069 Grey List Removal / Coagucheck Testing Strips how this information was being communicated to General Practice. **Action: DF to contact SL to discuss communication to practices with AM** **b) Medicines Management Operational Group (MMOG)** The Quality Committee queried whether these minutes were meant for presentation to the SSCCG Quality Committee as they made reference to SFCCG. **Action: DF to contact SL to query the relevance of these minutes for the Quality Committee** **c) South Sefton Medicines Optimisation Operational Group (SSMOOG)** The minutes were received.	
15/028	**Key Issues Log** The following key issues were raised from this meeting for escalation to the Governing Body: 1. Update from the CHC Steering Group 2. Safeguarding Strategy for approval 3. Revised PALS and Complaints Report – timelines and local standard for response times	
15/029	**Any Other Business** **Safeguarding Peer Review Action Plan** - Refer to agenda item 14/178 discussed in 15/020. The action plan will be submitted at the next meeting **Corporate Governance Group Report** – This will be contained in the papers for the next Quality Committee as it was not available for inclusion this month. **Practice Manager / Governing Body Member** The Quality Committee formally noted the contribution that LB had made to Quality Committee Meetings prior to her resignation and welcomed SMcG to the membership in the interim until a new Practice Manager is appointed to the Governing Body.	
15/030	**Date of Next Meeting** Thursday 19th March 2015, 1500hrs – 1700hrs, Boardroom, 3rd Floor, Merton House, Bootle.	

Chair : _____ _____

PRINT NAME SIGNATURE

Date : _____

NHS
South Sefton
Clinical Commissioning Group

Quality Committee
Minutes

Date: Thursday 19th March 2015, 3.00pm to 5.00pm
Venue: 3rd Floor Boardroom, Merton House, Stanley Road, Bootle

Membership

Dr Craig Gillespie (Chair)	GP Governing Body Member (Chair)	CG
Stephen Astles	Head of CCG Development	SA
Malcolm Cunningham	Head of Primary Care & Contracting	MC
Roger Driver	Lay Member	RD
Debbie Fagan	Chief Nurse	DF
Dr Gina Halstead	(Acting Chair) GP Quality Lead	GH
Martin McDowell	Chief Finance Officer	MMcD
Sharon McGibbon	Practice Manager / Governing Body Member	SMcG
Dr Andy Mimnagh	GP Governing Body Member	AM

Ex-Officio Members

Fiona Clark	Chief Officer	FLC

Also in Attendance

Ann Dunne	Designated Nurse for Safeguarding Children	AD
Tracey Forshaw	Deputy Head Adult Safeguarding	TF
Brendan Prescott	Deputy Chief Nurse / Deputy Head of Quality & Safety	BP

Minute Taker

Jacqueline Jones	Interim PA to the Chief Nurse	JJ

Membership Attendance Tracker

Name	Title	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr Craig Gillespie	Chair and Governing Body Member	√	√	√	A	√	√	A	√	√	A	A	√
Steve Astles	Head of CCG Development	A	A	A	A	√	A	A	√	√	A	√	√
Lin Bennett	Practice Manager Governing Body Member	√	A	√	√	√	√	√	A	A	√		
Malcolm Cunningham	Head of Contract and Procurement	√	A	√	√	√	√	√	√	√	A	√	A
Roger Driver	Lay Member	√	√	√	√	A	√	√	√	√	√	√	A
Debbie Fagan	Chief Nurse & Quality Officer	√	√	√	√	√	√	√	√	A	√	√	A
Dr Gina Halstead	Clinical Lead for Quality	√	√	A	√	A	A	√	√	√	√	√	A
Martin McDowell	Chief Finance Officer	√	√	√	√	√	A	√	A	√	√	A	√
Sharon McGibbon	Practice Manager / Governing Body Member											√	√
Dr Andrew Mimnagh	Clinical Governing Body Member	A	√	√	A	A	√	√	√	√	√	√	√

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/031	**Apologies for Absence** Apologies for absence were received from RD, DF, GH, FC, AD.	
15/032	**Declarations of interest regarding Agenda items** None declared.	
15/033	**Minutes of the previous meeting and Key Issues Log** **PALS & Complaints Report** A response time for Complaints has been requested.	

No	Item	Action
15/034	**Matters Arising / Action Tracker** **15/178 Safeguarding Peer Review / Action Plan** Item 4.3 Deputy Chief Nurse has discussed further with Chief Nurse and the rating of amber was clarified and is due to named GP Safeguarding providing formal functions on behalf of South Sefton as opposed to not having a named GP in place. The supervision plan has been signed off and once a new safeguarding GP has been appointed needs can be identified in terms of GP development and the risk rating should change to Green. **15/006 CAS Alerts** JS to review CAS alert that states breakdown in communication for accuracy. JS was not present at the March Quality Committee to provide an update on the CAS Alert. **15/011 Rotavirus Study** BP to liaise with the LMC regarding the Rotavirus Study and if in agreement to present back to the Quality Committee for approval. BP has contacted the LMC and is awaiting a response. It was agreed if LMC agree with data sharing plans BP will feed back to the study investigator and can go ahead this item can be Closed and removed from the Action Tracker. **15/021 Electronic Patient Record** DF to email P Shilcock regarding parental access to children's records BP emailed P Shilcock on behalf of DF. An update will be provided when there are some significant changes to report. Meeting agreed Electronic Patient Records Item covers a large project expected to be ongoing for 12 months and should remain on the Action Tracker. **15/023 (1) (2) Complaints** This Item was deferred for discussion at April's meeting. **15/027 (1) JMOG** BP to confirm if SL is aware for changes Grey List as a result of NICE guidance changes. Item to remain on the Action Tracker. **15/027 (2) MMOG** BP wasn't aware if DF had met with SL and will confirm at the next meeting. Item to remain on the Action Tracker.	

No	Item	Action
15/035	**Provider Quality Reports** JH presented an update in the absence of JS. **University Hospital Aintree** Against Cancer Measures the trust failed the target of 90%, achieving 50%. JH suggested slow responses from patients could have contributed to the failed target. **Action :** BP to investigate the perspective of the Trust of "capacity constraints and patient choices" so as the Committee are clear. A Mortality Group has been set up at Aintree University Hospital and Dr G Halstead has been undertaking reviews on deaths within 30 days of discharge as an input of work to the Group. Regarding the Stroke Measure more information is needed. The Committee agreed Stroke indicators should be addressed in more depth at Aintree CQPG and particularly the scenario of discharge of stroke patients in a relatively short space of time. In relation to Accident and Emergency, SA provided an account of current activity and outputs of the SRG to affect AED performance. Rapid Access Chest Pain Clinics (RACPC). The Trust failed to achieve the Target of 98% but has shown an improvement from the previous Quarter. The Committee discussed referrals being made from AED or AMAU which are diagnosed as cardiac cases. The committee proposed an audit of referral activity to the service to ensure appropriate referral to the RACPC. Aintree will be contacted to understand how many patients are referred to the RACPC and who are discharged at first appointment. There was a discussion on the potential of being too cautious in referring to RACPC and possible factors for this. Some referrals did not go on to attend their scheduled appointments. **Action :** CG to discuss this issue with Dr Gina Halstead Dementia. The Trust failed their 90% Target in December 2014 although a slight improvement in performance was noted in comparison to November. The Trust are investigating what actions can be taken to reach the target. Although the Trust failed to achieve their 100% MRSA Patient Screening Target in January 2015, a slight improvement has been noted from December 2014. A whiteboard is now in operation to flag up MRSA screening required. The Division of Medicine has an Action Plan in place to increase uptake which is being monitored via the Divisional Assurance meetings. There were no issues to report in relation to the Mersey Care Provider Trust for South Sefton CCG. LCH reported an issue concerning Phlebotomy and the high level of demand on the Phlebotomy Clinics. Some clinics have reported a high level of activity which affects the capacity of the clinic but is an issue in some clinics and not all. The LCH Lorenzo Patient Record System has recorded a high amount of "open" episodes on the Lorenzo system from 2005 to date (7,000 for Sefton). LCH cannot be sure that the tests requested have been completed and are in the process of investigating why episodes have not been closed and what the outcomes for patients are.	BP CG

No	Item	Action
15/035	A review of Phlebotomy Clinics will be organised. SSCCG require more details before any service change. **Action :** LCH to bring Phlebotomy issues to the next CQPG Meeting.	LCH
15/036	**Serious Incident Report** An update on the current status of serious incidents relating to Aintree University Hospital Trust and South Sefton CCG patients was provided by JH. • An MRSA incident from January was brought to the attention of SS CCG. • 91 Serious Incidents are currently Open, 66 belong to Liverpool Community Health. Most Incidents relate to Pressure Ulcers. A Pressure Ulcer Steering Group has now been set up to investigate and tackle the Pressure Ulcer issues. • A sexual assault incident has been brought to the attention of EPEG. • The timescales for all SUI Reports being added to the SUI database needs to be investigated. **Action :** JH to investigate issues relating to X-Rays.	JH
15/037	**Draft Quality Strategy** JH provided an overview and context of the draft CCG Quality Strategy. The strategy aligns with the CCG Strategic Plan and 5 year Forward View. JH confirmed the CCG Quality Strategy has recently been circulated for comments prior to the Committee meeting to expedite ratification at Governing Body. JH explained the Quality Strategy contained within the Quality Committee pack for March is currently a draft version which will be presented to the SS Governing Body Meeting w/c 23rd March 2015. Once all comments have been received and added to the Quality Strategy the correct formatting will be added before final approval. SS Quality Committee agreed to approve the CCG Quality Strategy with amendment to only the SS Quality Schemes being included in the strategy.	
15/038	**Safeguarding Service Update Report** The Action Plan has been agreed. Initially Trusts responded and questioned the requirement to attend regular business meetings. More inclusive information is now being received from Providers with strong assurance received from Mersey Care. Alder Hey have provided limited Safeguarding assurances but have demonstrated improvement from the previous quarter. TF confirmed there was overall improvement from Trust's performance compared to the same period 12 months ago. There have been some robust discussions with providers on planned indicators for 15 -16 but TF confirmed good Stakeholder involvement.	

No	Item	Action
15/038	KPIs are ready. An Information Governance breach at Southport & Ormskirk Hospital has been reported as an internal issue, although could have wider implications. Due to the serious incident concern has been raised regarding email distribution lists, which is being reviewed. JH agreed the need for this and used the SUI / MARAC (Domestic Violence incident) as a strong example. A highly sensitive email sent in error by a member of the hospital clinical team to 60 recipients was not password protected with one email address being unsecured (Hotmail). The incident was reported to the CCG who have begun to investigate and understand the processes that are currently being followed when sending out sensitive information by email. There is an urgent need to investigate the problem further and on a wider scale. The SUI process will be reviewing the problems. A 12 month Awareness Project on Child Sexual Exploitation (CSE) was launched on 18 March 2015 and the CCG have supported Sefton LSCB financially in the development of awareness raising materials to be made available for the partnership including GPs, hospitals, clinics and community health services. BP raised the point in GPs being clear on the allowance to share information to protect a vulnerable child. A ministerial letter was tabled advising on information sharing for child protection. AM enquired on the governance process in place for requesting information. It was agreed this needs to be clarified in terms of information sharing / consent to share, statutory disclosure, obligations and timelines. Also an understanding regarding what information is being stored by multi-agencies needs to be clarified. **Action :** Safeguarding Service to contact Chair of LSCB, David Sanders, to obtain clarity regarding Governance and Statutory Authority to request medical information on behalf of MASH activity.	DS
15/039	**Safeguarding Peer Review Action Plan** This paper presented the Quality Committee with the updated version of the CCG Safeguarding Peer Review Action Plan (v5). The Action Plan demonstrated positive progress against the recommendations. BP confirmed good progress has been made against the action listed on the "Recommendations & Action Plan" table, although a number of Actions still remain in Amber status. Further updates will come back to the Quality Committee to monitor further progress.	

No	Item	Action
15/040	**Continuing Health Care / Complex Care Services Quality & Safeguarding Report for South Sefton** This Item was deferred to April's Quality Committee Meeting as there was nobody present at the March Quality Committee Meeting to provide an update. **Action :** BP to invite a colleague from the CSU CHC Team to attend Quality Committee meeting in April to provide an update on this Item.	BP
15/041	**Dementia Diagnosis Rate Letter** Targets are not being reached, Action Plans are being drawn up by Geraldine O'Carroll to enable South Sefton to address the problem. Southport & Formby have already created their Action Plan and begun work on resolving the issue. **Action :** GO'C to draw up plans to address the issue of targets not being reached.	GO'C
15/042	**GP Quality Lead Update** Dr Gina Halstead was not present to provide an update on this Item. BP discussed the proposal to commission an Independent Review by Commissioners in relation to the review of incidents concerning laboratory test requesting and conveyance of results back to practice. The scale of incidents had been discussed at Aintree CQPG as numbers were less than previously thought. There was discussion amongst members about the benefits of an independent review taking place and the decision was going to the Collaborative Commissioning Forum before being fed back to the provider. An update will be provided to Quality Committee in April. **Action :** BP to update the committee on the decision to commission a review.	BP
15/043	**Locality Update** BP – no feedback to report. CG – Gina Halstead has raised a question relating to Ophthalmology / GPs calling District Nurses. Any issues raised will be discussed at the next CQPG meeting w/c 23rd March 2015. The results of discussions will be fed back.	
15/044	**Mersey Internal Audit Agency Continuing Healthcare Review Final Report 2014/15** The MIAA Report summarises there is significant assurance for CHC processes in terms of roles and responsibilities; guidance; CHC assessments; payments and management of information for NHS South Sefton CCG. BP confirmed significant operational work with the CHC Team is currently ongoing and monitored through the CHC Steering Group.	

No	Item	Action
15/045	**Key Issues Log** CG confirmed none of the items discussed at this Quality Committee Meeting needed to be included on the Agenda for the March Governing Body Meeting.	
15/046	**Any Other Business** JH reminded ALL of the Joint Quality Team Away Day being held at Formby Hall on Thursday 18th June 2015.	
15/047	**Date of Next Meeting** BP & JH reminded ALL the date for the **April Quality Committee Meeting** has been moved to :- **Thursday 23rd April** **3.00 – 5.00 pm** **Boardroom, Merton House**	

Chair : _____ _____

PRINT NAME **SIGNATURE**

Date : _____

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Service Improvement and Redesign Committee Minutes

Wednesday 4 March 2015, 9:30 a.m. – 11:30 a.m.
Venue: Classroom 4, Crosby Lakeside Adventure Centre, Crosby Coastal Park, Off Cambridge Road, Waterloo, L22 1RR

Attendees

Dr Niall Leonard	Vice Chair, Southport and Formby CCG	NL
Dr Dan McDowell	Secondary Care Doctor, South Sefton CCG	DMcD
Dr Kati Scholtz	Governing Body Member, Southport and Formby CCG	KS
Dr Jeff Simmonds	Secondary Care Doctor, Southport and Formby CCG	JS
Dr Paul Thomas	Governing Body Member, South Sefton CCG	PT
Steve Astles	Head of CCG Development, South Sefton CCG	SA
Billie Dodd	Head of CCG Development, Southport and Formby CCG	BD
Jan Leonard	Chief Redesign and Commissioning Officer, South Sefton CCG & Southport and Formby CCG	JL
Karl McCluskey	Chief Strategy & Outcomes Officer, South Sefton CCG and Southport and Formby CCG	KMcC
Sarah McGrath	Locality Manager, Southport and Formby CCG	SMcG
Angela Parkinson	Locality Manager, South Sefton CCG	AP
Brendan Prescott	Deputy Chief Nurse, South Sefton CCG & Southport and Formby CCG	BP
Colette Riley	Practice Manager, Governing Body Member, Southport and Formby CCG	CR
David Smith	Deputy Chief Finance Officer, South Sefton CCG & Southport and Formby CCG	DS
Becky Williams	Chief Information Analyst, South Sefton CCG & Southport and Formby CCG	BW

Attendance Tracker ✓ = Present A = Apologies N = Non-attendance

Name	Membership	Sept 14	Nov 14	Jan 15	Mar 15	May 15	July 15	Sept 15	Nov 15
Dr Niall Leonard	Vice Chair, Southport and Formby CCG	√	A	√	√				
Dr Dan McDowell	Secondary Care Doctor, South Sefton CCG	√	√	√	√				
Dr Kati Schotz	Governing Body Member, S&F CCG	√	√	√	√				
Dr Jeff Simmonds	Secondary Care Doctor, S&F CCG	A	√	√	√				
Dr Paul Thomas	Governing Body Member, South Sefton CCG	√	√	A	√				
Colette Riley	Governing Body Member, S&F CCG	√	A	√	√				
Karl McCluskey	Chief Strategy & Outcomes Officer, South Sefton CCG and S&F CCG	√	√	A	√				
Jan Leonard	Chief Redesign and Commissioning Officer, South Sefton CCG & Southport and Formby	√	√	√	√				
Steve Astles	Head of CCG Development, South Sefton CCG	√	√	√	√				
David Smith	Deputy Chief Finance Officer, South Sefton CCG & S&F CCG	√	√	√	√				
Billie Dodd	Head of CCG Development, S&F CCG	√	√	√	√				

No	Item	Action
15/010	**Apologies** Apologies were received from Colette Page, Pippa Rose, Dr Debbie Harvey, Dr Pete Chamberlain, Moira McGuinness and Susanne Lynch.	

15/011	**Minutes of Last Meeting** The minutes of the last meeting were agreed.	
15/012	**Matters Arising** Item 14.3 Jan Leonard has spoken to Debbie Fairclough re voting rights as it is not clear where the balance of power lies with it being a committee in common especially if there was an issue with one CCG. Debbie Fairclough will clarify this in the revised terms of reference which will be circulated once amended. Item 14.18 This work is ongoing. Dr Leonard informed the group that Dr Emily Ball from Trinity Practice is interested in undertaking a piece of research work around the frail and elderly in Southport. Dr Leonard also confirmed that once this piece of work has been undertaken he is happy for it to be shared with South Sefton CCG. Item 15.05 Tracy Jeffes and Dr Leonard has met with Anna Nygaard re the Community Navigation Model. Dr Leonard thinks it is more of a public health model and not an operational model which is what the CCGs would want. The committee would be anxious about giving resources to a model which has not been defined as meeting the needs of the clinicians. Tracy Jeffes is meeting with Anna Nygaard on Thursday to discuss further. The model will be brought back to the SIR committee once it is consistent. Dr Bal Duper was invited to the SIR committee but unfortunately couldn't attend. There needs to be a more understanding of the case mix and the model which will be delivered. Jan Leonard informed the committee that there is a QIPP challenge for both CCGs and this needs to be considered with other schemes. Dr Leonard has been having discussions with Dr Mike Briggs, Ophthalmology Consultant at Aintree Hospital who is complementary about the scheme and says it could become effective about reducing the number of people they don't need to see at the Hospital. It is triage and assessments that has put the costs up of the scheme. **Action** The committee is not in a position to consider the business case in its current form but will relook at the model and consider triage and assessment altered in some way with a view to making it more reasonable costs with a lower target in reduction in secondary care. Sarah McGrath will also contact Dr Mike Briggs to discuss further. It was confirmed that the End of Life business case was approved by the Finance and Resource Committees.	TJ SMcG
15/013	**Strategic Programmes – Performance Dashboard Update** A discussion took place regarding the Progamme Milestones Dashboard which Fiona Doherty tabled (copy attached for information). This dashboard included the RAG status so that members of the committee could see how the programmes were progressing. A discussion took place regarding the programmes for 15/16 and Karl McCluskey sought the committee's permission to work up reduced programme areas with a better locality focus. **Action**	

	Karl McCluskey to relook at list of programmes and develop or consolidate high level priorities and how we manage going forward, or whether we take it down to a locality level, this list will be brought back to the committee in May 2015. The clinicians agreed that the data needs to be comparative data and relevant to the GPs and also needs to be in a simplified format.	KMcC
15/014	**Strategic Planning Update and Progress** Karl McCluskey informed the committee that he had attended both recent Governing Body sessions and has shared the planning challenges for 15/16 and beyond. NHSE have altered the dataset that was used for planning purposes in 2014. Last year used monthly activity returns (MAR) which related to general and acute activity only. This year NHSE has asked CCGs to use SUS data, which is more comprehensive and covers all specialties and is based on spells. This has meant considerable inconsistency in relating the plans that were developed in 2014 as part of the two year and five year operational and strategic plans and the 2015/2016 planning submission. The planning team have been working with the respective Governing Body's during January 2015 and February 2015 to develop the submitted plans. Final plans will be signed off by the respective Governing Body's at the end of March 2015.	
15/015	**Primary Care Dashboard** Becky Williams tabled the Primary Care Dashboard (copy attached for information). A discussion took place about the best use of the dashboard and how the content could be improved and made more relevant to clinicians at both a locality and practice level. The purpose of this is to assist practices in understanding their performance against a range of indicators and to assist them in improving their services and commissioned services going forward. It was suggested that the dashboard should be used to share best practice and localities could focus on a different area of the dashboard each month. The committee explored and agreed a range of modifications and improvements to the dashboard which should be reflected in the version going forward from April 2015. This item needs to become a standard item on the agenda which needs to be led by the clinicians. **Action** Becky Williams happy to lead on sessions with locality chairs and locality managers so they're confident about the dashboard. Need to focus on one area each month and not the whole dashboard. Localities have to see the data in advance so it gives them time to digest the information. Agreement that once a topic has been reviewed then the topic is put to bed. Becky Williams to lead on additional items felt useful for the dashboard e.g. walk in centre attendances, GP satisfaction etc.	BW BW BW
15/016	**Any Other Business** There was no other business.	
15/017	**Date of Next Meeting** • 13 May 2015 at 9:30 a.m. venue CLAC	

NHS
South Sefton
Clinical Commissioning Group

Seaforth & Litherland Locality Meeting Minutes

Wednesday, 4th February 2015, 1.00pm – 3:00pm
Crosby Lakeside Adventure Centre

Attendees		
Dr Martin Vickers	GP, Bridge Road Surgery	MV
Lin Bennett	PM, Ford Medical Practice	LB
Lynne Creevy	PM, Bridge Road Surgery	LC
Dr Ramon Ogunlana	GP, Orrell Park Medical Centre	RO
Ian Hindley	PM, Seaforth and Litherland SSP Health	IH
Dr Martina Cornwell	GP, Glovers Lane Surgery	MC
Dr Colette McElroy	GP, 15 Sefton Road	CE
Dr T Thompson	GP, 15 Sefton Road	TT
Alison Harkin	PM, 15 Sefton Road	AH
Louise Armstrong	PN, Ford Medical Practice	JI
Dr Noreen Williams	GP, Ford Medical Practice	NW
Mark Halton	PN, Ford Medical Practice	MH
Angela Dunne	PM, Rawson Road Medical Centre	AD
Pam Maher	PM, Litherland Darzi Practice	PM
Dr Mark Goulden	GP Registrar, Ford Medical Practice	MG
In attendance		
Angela Parkinson	Locality Manager, SSCCG	AP
Lynne Cooke	Head of Communications SSCCG	LCo
Helen Roberts	Senior Pharmacist, SSCCG	HR
Tracy Jeffes	Chief Corporate Delivery and Integration Officer	TJ
Diane Blair	Healthwatch Sefton	DB
Tony Leo	Director of Commissioning NHS England	TL
David Scannell	Contracts Manager NHS England	DS
Jan Hughes	Project Manager NHS England	JH
Apologies		
Louise Taylor	PM, Glovers Lane Surgery	LT
Dr Joanna Wallace	GP, Litherland Darzi Practice	JW
Dr Naresh Choudhary	GP, Netherton SSP Health	NC
Lorraine Bohannon	PM, Netherton SSP Health	LBo
Dr Fred Cook	GP, Rawson Road Medical Centre	FC
Dr Jane Irvine	GP,15 Sefton Road	JI
Paula Bennetts	Public Health	PB

Attendance Tracker

✓ Present
A Apologies
L Late or left early

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr T Thompson	GP – 15 Sefton Road Surgery		✓	✓		✓		✓		✓	✓	✓	
Dr C McElroy	GP – 15 Sefton Road Surgery	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	
Dr J Irvine	GP – 15 Sefton Road Surgery						✓	✓	✓		✓	A	
Alison Harkin	PM – 15 Sefton Road Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Paula Lazenby	PN – 15 Sefton Road Surgery												
Dr A Slade	GP – Glovers Lane Surgery												
Dr P Goldstein	GP – Glovers Lane Surgery	✓	✓	✓			✓	✓	✓				
Dr M Cornwell	GP – Glovers Lane Surgery									✓	✓	✓	
Louise Taylor	PM – Glovers Lane Surgery	A	✓	✓	✓	✓	A	✓	✓	✓		A	
Dr M Vickers	GP – Bridge Road Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Dr E Carter	GP – Bridge Road Surgery			✓									
Lynne Creevy	PM – Bridge Road Surgery	✓	A	A		✓	✓	✓	✓			✓	
Dr N Choudhary	GP – Netherton Practice	✓	A	✓	✓	✓	✓	A	A	A	A	A	
Lorraine Bohannon	PM – Netherton Practice	✓	✓	✓	✓	✓	✓	A	A	A	✓	A	
Dr N Williams	GP – Ford Medical Practice	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Dr B Fraser	GP – Ford Medical Practice				✓								
Dr A Ng	GP – Ford Medical Practice					✓							
Dr M Goulden	GP – Ford Medical Practice											✓	
Lin Bennett	PM – Ford Medical Practice	A	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	
Louise Armstrong	PN – Ford Medical Practice	✓	✓	✓	✓		✓	A	✓	✓	A	✓	
Mark Halton	PN – Ford Medical Practice	✓	✓	✓	✓		✓	A	✓	A	A	✓	
Dr R Ogunlana	GP – Orrell Park Medical Centre	A	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	
Jane McGimpsey	PM – Orrell Park Medical Centre	✓	✓	✓	✓	A	✓	✓	✓	A			
Dr A Hameed	GP – Litherland Darzi	✓		✓									
Dr B Schoenberger	GP – Litherland Darzi			✓									
Dr Jo Wallace	GP – Litherland Darzi						✓	A	✓	✓		A	
Pam Maher	PM – Litherland Darzi/ Town Hall				✓		✓	A	✓	✓	A	✓	
Dr A Patrick	GP – Litherland Town Hall	A	✓	✓	✓	A	✓				A		
Dr F Cook	GP – Rawson Road/Orrell Park	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	A	
Angela Dunne	PM – Rawson Road/Orrell Park	✓	✓	A	✓	✓	✓	✓	A	✓		✓	
Ruth Powell	PN – Rawson Road												
Samantha Standley	PN – Rawson Road						✓	✓	✓	✓	✓		
Ian Hindley	PM – Seaforth Practice/Litherland Town Hall	✓	A		✓	✓	✓	A	✓			✓	

No	Item	Action
15/11	**Apologies for absence** Apologies were noted. Action to be taken by the Locality	
15/12	**Declarations of interest** Dr N Williams LMC Action to be taken by the Locality	
15/13	**Minutes of previous minutes** The minutes of the previous meeting were discussed, and with suggested amendments were agreed. **Matters Arising** A point was raised regarding the nursing home pilot as a formal letter from the locality had been discussed. There had been clarity required which Dr Debbie Harvey provided in an email circulated to the locality. Paul Shilcock has asked his training team to undertake some assessment of the slow connection/ password problems when trying to gain remote access to GP records during home visits using iPads, in an attempt to improve the service. The reporting for the A+E indicator for year 1 Local Quality Contract (LQC) was discussed in terms of the readcode 13Zz, and the updated template provided in November for practices to complete. It was recognised that practices felt the data being used was outdated, that there was some crossover with previous audits undertaken for Quality and Outcome Framework (QOF), and the additional readcodes in the second template did not form part of the original specification. These points will be considered when reviewing year 2 of the LQC. Action to be taken by the Locality	
15/14	**Litherland Darzi** Representatives from NHS England attended the locality, Tony Leo Director of Commissioning, David Scannell Contracts Manager, and Jan Hughes Project Manager. Litherland Darzi is a legacy contract procured for 5 years, with a 1 year extension. • 680 patients registered, by year 5 this should have been in the region of 1350 patients • In 13/14 there were 6,800 appointments compared to a similar resource of 21,000 contacts • 335 patients with Seaforth and Litherland postcodes, other patients in other wards, 2 patients in Fazackerly • Practice open 7 days a week 8am – 8pm no obvious spikes in activity. Between 3 and 4pm there are more children attending, but it is unclear whether this is walk in activity as services cross over • Cost is 3 times the rate of other practices • Located next to a nurse led walk in service, there has been historical crossover of services	

No	Item	Action
	• Service specification has not been fulfilled Practices had been concerned that a message about the public consultation was in the CCG bulletin but that there had been no communication with local practices. NHS England had been doing work with the CCG, but acknowledged that there was learning to take from this. There will also be representation at South Sefton Wider Group meeting next week to talk to the wider membership. The Overview and Scrutiny Committee have been consulted and councillors felt that the crossover of services at Litherland is very confusing for patients. A patient survey to understand why patients choose to use Darzi is being undertaken to inform the patient consultation and is due to finish on the 8th February. Stakeholder engagement is ongoing. The timescale for an outcome is the first week in March. Liverpool Community Health staff had received communication to say that commissioning decisions are being taken. The practice list has been closed since December 2014 in which time 65 patients have been turned away. Practices raised concerns regarding capacity if the consultation resulted in closure of Darzi, and the timescale to manage. Another concern is the expectations of patients who have experienced a 7 day 8 – 8 service, as this will also need to be managed. There will be discussions with the CCG regarding how patients might be dispersed and a demobilistation plan agreed. There are primary care pressures across the system, with an acknowledgement of large variation between contracts locally, the intention is to retain the financial resource within South Sefton. NW commented that the resource needs to be in the form of additional clinicians. Action to be taken by the Locality	
15/15	**Healthwatch Sefton** Diane Blair attended the meeting and explained that Healthwatch is operational across England and has been set up by the Department of Health as the voice of local people, patients, carers etc. This is a company limited by guarantee. Responsibility has been delegated down by a steering group across key networks with a broad representation across groups. Healthwatch Sefton would like to work with GP practices within Seaforth and Litherland to listen to patients and carers and gather views of experiences of access. A patient survey has recently been piloted at Hightown SSP Health, and feedback has been provided to the practice, there were positive comments. Volunteers who have been DBS checked have undergone training including safeguarding to capture patient views, this is not an inspection or monitoring process. Two volunteers were used in the morning, and two in the afternoon. The aim is to roll this out across all the localities in South Sefton. Practices would be asked to promote the survey, and allow volunteers in the reception area to speak to patients. Specific themes would include access to appointments, continuity, and access to information. Feedback would be provided to individual practices and collated across the CCG. The group were supportive of this process. Diane agreed to schedule dates, and provide information and posters to practices. Volunteers would have ID, and a letter from Healthwatch as authorisation.	DB

No	Item	Action
	It is intended that this will start in March.	
	Action to be taken by the Locality	
	Schedule dates and provide information to practices	DB
15/16	**Medicines Management** Month 8 budget data presented for information. Locality and CCG prescribing costs have both decreased compared to month 7. Still relatively early in terms of prescribing data, this means forecasts are likely to improve in accuracy over the coming months. Discussed draft format for presenting budget information at the locality meetings, to add in Sefton average where available – HRo to request monthly report in this format for the locality meeting. Discussed possibility of using STAR-PU as a weighting in place of COM weighting for setting budget – HRo to ask advice from SL and TR HRo to circulate link to up to date grey list and prescribing data http://nww.southseftonccg.nhs.uk/patient-care/Medicines/The_Grey_List.aspx Technical issues raised with scriptswitch at Ford and no engineers have been out to resolve – HRo to raise with scriptswitch lead	HR HR HR HR
	Action taken by the Locality	
	Request monthly report, discuss STAR-PU as a waiting, circulate link and raise technical scriptswitch issues.	HR
15/17	**Locality £50K** **Housebound Reviews** Practices were reminded that SBS invoices should have been submitted to claim the 60% upfront payment for this scheme. AP to produce a form to work out outstanding payment due if 60% of visits have been exceeded. **Stoma** Patient numbers have been provided from each practice, there are a total of 105 patients across the locality. Roll out to begin mid March, details to follow. **Inhaler Technique** Pharmacist to review all at risk patients, roll out plan to be shared with localities in March. **Public Health Schemes – Falls Pilot** Sheltered accommodation within the locality is being looked at. A community programme at Litherland Sports Park or the Feelgood Factory could be an alternative. Paula to feed back at the next meeting.	AP
	Action to be taken by the Locality	
	Produce a final invoice form and circulate to practices	AP
15/18	**Quality Premium(QP) – Diabetes Local Indicator** The January QP report showing progress against 2014/15 indicators was circulated prior to the meeting and discussed**.** The group were informed about a diabetes dashboard which is independent from QOF which is in development. Dr Taylor will be able to demonstrate at a future locality meeting, and come out to practices if required.	

No	Item	Action
	The local indicator is the diabetes care processes, which are currently red on the QP dashboard. There was a known issue with the extraction of recording of smoking status data which was rectified in January. Retinal screening has also been flagged as an issue. Retinopathy is not in QOF, so there could be a simple coding issue. There is time to fix this issue if all practices are aware of this. A gap in services has been identified in terms of housebound patients requiring ambulance transport for retinopathy screening.	
	Action to be taken by the Locality	
	AP to feedback local indicator retinopathy issue / gap in service for housebound patients to Dr Nigel Taylor for action across all localities.	AP
15/19	**Any Other Business** Healthwatch public transport experience posters were circulated to practices.	
	Action to be taken by the Locality	
15/20	**Date and Time of Next Meeting** **March 4th 2015, 1 – 3pm Crosby Lakeside Adventure Centre**	

South Sefton
Clinical Commissioning Group

Seaforth & Litherland Locality Meeting Minutes

Wednesday, 4th March 2015, 1.00pm – 3:00pm
Crosby Lakeside Adventure Centre

Attendees

Dr Martin Vickers	GP, Bridge Road Surgery	MV
Louise Taylor	PM, Glovers Lane Surgery	LT
Dr Martina Cornwell	GP, Glovers Lane Surgery	MC
Dr Naresh Choudhary	GP, Netherton Health Centre	NC
Dr Ramon Ogunlana	GP, Orrell Park Medical Centre	RO
Samantha Standley	PN, Rawson Road / Netherton HC	SS
Angela Dunne	PM, Rawson Road / Orrell Park	AD
Louise Armstrong	PN, Ford Medical Centre	LA
Noreen Williams	GP, Ford Medical Centre	NW
Pam Maher	PM, Litherland Darzi	PM
Dr Jo Wallace	GP, Litherland Darzi	JW
Lynne Creevy	PM, Bridge Road Surgery	LC
Alison Harkin	PM, 15 Sefton Road	AH
Colette McElroy	GP, 15 Sefton Road	CMc

In attendance

Angela Parkinson	Locality Manager, SSCCG	AP

Minutes

Apologies

Lin Bennett	PM, Ford Medical Practice	LB
Paula Bennetts	Public Health	PB
Helen Roberts	Medicines Management	HR

Attendance Tracker

✓ Present
A Apologies
L Late or left early

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr T Thompson	GP – 15 Sefton Road Surgery		✓	✓		✓		✓		✓	✓	✓	
Dr C McElroy	GP – 15 Sefton Road Surgery	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓
Dr J Irvine	GP – 15 Sefton Road Surgery						✓	✓	✓		✓	A	
Alison Harkin	PM – 15 Sefton Road Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Paula Lazenby	PN – 15 Sefton Road Surgery												
Dr A Slade	GP – Glovers Lane Surgery												
Dr P Goldstein	GP – Glovers Lane Surgery	✓	✓	✓			✓	✓	✓				
Dr M Cornwell	GP – Glovers Lane Surgery									✓	✓	✓	✓
Louise Taylor	PM – Glovers Lane Surgery	A	✓	✓	✓	✓	A	✓	✓	✓		A	✓
Dr M Vickers	GP – Bridge Road Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr E Carter	GP – Bridge Road Surgery			✓									
Lynne Creevy	PM – Bridge Road Surgery	✓	A	A		✓	✓	✓	✓			✓	✓
Dr N Choudhary	GP – Netherton Practice	✓	A	✓	✓	✓	✓	A	A	A	A	A	✓
Lorraine Bohannon	PM – Netherton Practice	✓	✓	✓	✓	✓	✓	A	A	A	✓	A	
Dr N Williams	GP – Ford Medical Practice	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Dr B Fraser	GP – Ford Medical Practice				✓								
Dr A Ng	GP – Ford Medical Practice					✓							
Dr M Goulden	GP – Ford Medical Practice											✓	
Lin Bennett	PM – Ford Medical Practice	A	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	A
Louise Armstrong	PN – Ford Medical Practice	✓	✓	✓	✓		✓	A	✓	✓	A	✓	
Mark Halton	PN – Ford Medical Practice	✓	✓	✓	✓		✓	A	✓	A	A	✓	✓
Dr R Ogunlana	GP – Orrell Park Medical Centre	A	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓
Jane McGimpsey	PM – Orrell Park Medical Centre	✓	✓	✓	✓	A	✓	✓	✓	A			
Dr A Hameed	GP – Litherland Darzi	✓		✓									
Dr B Schoenberger	GP – Litherland Darzi			✓									
Dr Jo Wallace	GP – Litherland Darzi						✓	A	✓	✓		A	✓
Pam Maher	PM – Litherland Darzi/ Town Hall				✓		✓	A	✓	✓	A	✓	✓
Dr A Patrick	GP – Litherland Town Hall	A	✓	✓	✓	A	✓				A		
Dr F Cook	GP – Rawson Road/Orrell Park	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	A	
Angela Dunne	PM – Rawson Road/Orrell Park	✓	✓	A	✓	✓	✓	✓	A	✓		✓	✓
Ruth Powell	PN – Rawson Road												
Samantha Standley	PN – Rawson Road						✓	✓	✓	✓	✓		✓
Ian Hindley	PM – Seaforth Practice/Litherland Town Hall	✓	A		✓	✓	✓	A	✓			✓	

No	Item	Action
15/23	**Apologies for absence** Apologies were noted. Action to be taken by the Locality	
15/24	**Declarations of interest** NW – Local Medical Committee Action to be taken by the Locality	
15/25	**Minutes of previous minutes** The minutes of the last meeting were approved **Matters Arising** **Medicines Management** **scriptswitch** -following the various problems experienced Scriptswitch have agreed to provide a free month however the contract will not be renewed at the end of March. SL met with Optimise who have done a pilot in Liverpool. Their software fits well with EMIS and is very safety conscious and more functional than Scriptswitch. They are offering a free 4 week pilot and are keen to localise. This was presented at the JMOG who felt that the Optimise software should be trialled in a small number of local practices. **Use of STAR-PU weighting for budget comparison** - we have looked in to a variety of different weightings and that due to the unusual fluctuations in patients over the last couple of years the current model gives the best fit we can looking at the whole CCG. The intention is to move the focus on to specific areas of cost savings to demonstrate engagement with financial management to address this problem. **Quality Premium (QP)– Diabetes Local Indicator** The diabetes lead confirmed that the eight care processes for QP excludes retinopathy. The achievement of 'the eight care processes' indicator is currently under scrutiny. This is partially due to poor performance relating to recording of smoking status. The reporting tool has since been validated and it has been identified that there was an error in the report relating to those patients who were either ex-smokers or never smoked. QOF states that if a patient is over the age of 25 and has never smoked or an ex-smoker for more than 3 years, then it is unlikely they would start. Therefore this does not need to be coded yearly. The report did not factor this in. Facilitators have been requested to re-run the searches and this information is being collated and will be disseminated in the near future.	

No	Item	Action
	Action to be taken by the Locality	
15/26	Current Respiratory Referral Process and How Moving Forward – Mike Hammond Specialist Nurse The community respiratory team are more aligned with the urgent care team, this is in the early stages. There is a single point of contact via the urgent care team, which is a telephone call and summary of the patient details. The criteria is expanding from COPD to include pneumonia. An issue was raised regarding patients who are discharged from CRT, who are then told to contact them again if needed, but CRT cannot accept the patient again without the patient first going through the GP. The GP is required to do BP and sats to refer back in. Patients are discharged from 'Hospital at Home' when stable, however those that need ongoing support can be referred to Sandra Bonner. Patients will have a management plan. It is difficult to accept self referrals, and patients are made aware of this. A member of the team can be contacted if a clinical discussion is needed.	
15/27	**Litherland Darzi** A meeting was held regarding the impact on surrounding practices should the result of the ongoing consultation regarding Litherland Darzi recommend closure. An urgent care model for the WIC was discussed. This included a GP being part of the WIC team where episodes of care could be completed. NHS England were represented for the second part of the meeting and a possible extension to the LCH contract was discussed, to enable a phased dispersal of patients. Practices were emailed to find out what monthly capacity would be available, and to identify any additional resources needed. Action to be taken by the Locality Practices who have not already provided monthly capacity information to forward to angela.parkinson@southseftonccg.nhs.uk by 5th March 2015	All
15/28	**Proposed LCH Locality Structure** A proposed structure was discussed which has each locality set up with 4 key people, GP Locality Lead, CCG Locality Manager, LCH Clinical Lead and LCH Manager. This team would work with the locality to identify the needs for locality specific community services. It is acknowledged that some services would need to retained CCG wide. Each practice has different requirements agreed in terms of frequency/methods of contact for the community nursing team. Practices are reporting sporadic attendances.	

No	Item	Action
	A message book has been left at each practice, although an electronic solution was felt to be a better means of communication. There are still issues with faxes and chasing up whether information had been received, an email to get a message to the team would be a better alternative. Practices queried whether the nursing team had access to tasks? Palliative care numbers were requested.	
	Action to be taken by the Locality	
	Meet with Karen Sandison prior to the next meeting	AP
15/29	**Medicines Management** This item was not discussed.	
	Action taken by the Locality	
	Carry items forward to next agenda	AP
15/30	**Locality £50K** **Housebound Reviews** A final invoice form had been circulated for practices to claim an outstanding payment due if 60% of visits had been exceeded. All practices need to complete the audit information required. Visits booked in until the end of March can be included for payment. Invoices are required by 13th March 2015. **Falls Pilot** PB had given her apologies for the meeting, an update will be planned for the next meeting	
	Action to be taken by the Locality	
	AP to recirculate housebound payment/audit form	AP
15/31	**Any Other Business** There has been a central request from NHS England to gauge interest from practices who may wish to provide cover over the Easter period. An email to that affect will be circulated	
	Action to be taken by the Locality	
		AP

No	Item	Action
	Easter - An email re Easter opening will be circulated to GP practices to gauge interest in additional opening. **Thematic review of Crisis care in Sefton** – there is a group involving Dr Hilal Mulla who are looking at pathways for crisis care in Sefton, and at mental health issues at the primary/secondary interface. They are trying to achieve effective management of crises which includes minimizing the delay for GPs to get emergency assessment of patients, including a single point of access for mental health acute problems. There was a discussion about getting patients to Fazackerly and Walton site for the crisis team to see them in A&E, and patients now being seen at Clock Tower, an updated list from Merseycare was discussed.	
15/32	**Locality Chair** Dr Vickers will continue to be Locality Chair until April 2015. Dr McElroy will take up the role from 1st May 2015 for a 12 month period, followed by Dr Cornwell from May 2016 for a 12 month period Action to be taken by the Locality	
15/33	**Date and Time of Next Meeting** **April 1st 2015** **1 – 3pm Crosby Lakeside Adventure Centre**	

NHS
South Sefton
Clinical Commissioning Group

Bootle Locality Meeting
Minutes

Date: Tuesday 24th March 2015: 1pm-2.30pm

Venue: Park Street Surgery

Attendees		
Dr Gina Halstead	Concept House Surgery/Sefton Road Surgery	GH
Dr Anna Ferguson	The Strand Medical Centre/North Park	AF
Dr Kong Chung	Park Street Surgery	KC
Dr Helen Mercer	Moore Street Surgery	HM
Helen Shillcock	Moore Street Surgery	HS
Tanya Mulvey	The Strand Medical Centre	TM
Pauline Sweeney	Park Street Surgery	JE
S. S. Sapre	GP Aintree Road	SS
Lynne Smith	IMerseyside	LS
Jane Elliott	North Park Health Centre	JE
In attendance		
Paul Halsall	South Sefton Clinical Commissioning Group	PH
Angela Curran	South Sefton Clinical Commissioning Group	AC
Rebecca McCullough	South Sefton Clinical Commissioning Group	RMc
Jenny Khristianson	South Sefton Clinical Commissioning Group	JK
Minutes		
Anne Graham	South Sefton Clinical Commissioning Group	
Apologies		
Rob Sivori	Bootle Village Surgery	
Paula Byrne	Clinical Lead, LCH	

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr S Sapre	GP – Aintree Road Surgery	✓	✓	✓	✓	✓	✓	✓		A	✓	✓
Sanju Sapre	PM – Aintree Road Surgery	A	✓	A	A	A	A	A		A		
Dr S Stephenson	GP – Bootle Village Surgery	A	A	A	A	A	A	A		A		
Dr C McGuinness	GP – Bootle Village Surgery	A	A	A	A	A	A	A		A		
Dr R Sivori	GP – Bootle Village Surgery	A	A	A	✓	✓	✓	✓		✓	✓	A
Gill Riley	PN – Concept House	A	✓	A	A	A	A	A		A		
Dr D Goldberg	GP – Concept House	✓	A	✓	A	A	A	✓		A		
Dr G Halstead	GP – Concept House	A	✓	A	✓	✓	✓	✓		✓	✓	✓
Dr H Mercer	GP – Moore St Surgery	✓	A	A	A	A	A	✓		✓	✓	✓
Dr A Roberts	GP – Moore St Surgery	A	A	A	A	A	A	A		A		
Dawn Rigby	PM – Moore St Surgery	A	A	A	A	A	A	A		A		
Helen Shillcock	PM – Moore St Surgery	✓	A	✓	✓	✓	✓	✓		✓	✓	✓
Dr R Sinha	GP – North Park Health	A	A	A	A	A						
Pam Sinha	PM – North Park Health	A	A	A	A	A						
Jane Elliott	PM – North Park Health				A					✓	A	✓
Dr K Chung	GP – Park St Surgery	✓	✓	✓	✓	✓	✓	A		✓	✓	✓
Pauline Sweeney	PM – Park St Surgery	✓	✓	✓	A	✓	A	✓		A	✓	✓
Dr A Ferguson	GP – Strand Medical Centre	✓	✓	✓	✓	✓	✓	A		✓	✓	✓
Tanya Mulvey	PM – Strand Medical Centre				A					✓	✓	✓
Gerry Devine	PM – Strand Medical Centre	✓	✓	A	A	A						
Dr M Gozzelino	GP – Strand Medical Centre	A	A	A	A	A	A	A		A		
Dr S Morris	GP - Strand Medical Centre	A	A	A	A	A	A	✓		A		
M Hinchliff	PM – Strand Medical Centre	A	A	A	A	A	A	A		A		

✓ Present
A Apologies
L Late or left early

No	Item	Action

No	Item	Action
15/22	**Apologies for absence** Apologies were noted.	
15/23	**Declarations of interest** None declared.	
15/24	**Minutes from the last meeting** The minutes following the meeting held on 17th February were agreed as a true record following a number of amendments, which included: • Page 3, 2nd para under Matters arising should read *"practices still need to telephone **to request blood test results**.* • Page 5, 15/17 3rd para should read *"The information received is also inadequate as the practice has to contact patients directly if they need **a result to get them an anticoagulant**, which is adding a risk to the patient.* • Dr Sapre to be included in the Minutes and Paul Halsall removed. **Matters arising/action tracker** **15/14** GH to meet with Becky Williams on Thursday 26th March to look at referral rates for cancer and nephrology in relation to the locality profile and will report back to the Committee. **15/14** PB was unavailable to give feedback to members on ongoing issues with the phlebotomy service and sent his apologies. The item to go on next month's agenda. **15/14** JK made contact with Tracy Jeffes (TJ) in relation to the elderly living in social isolation, which was an action from the Locality away day session in November. TJ is now working in conjunction with Public Health to develop a proposal for new Health Trainer roles as part of the Better Care Fund. One meeting has been held to agree principles and draft service specifications are in development. TJ would welcome any input from members of the locality if they are interested in shaping the specification. The CCG Service Improvement Committee has, in principle, supported the approach although the funding is yet to be confirmed. **15/14** JK reported back on the CVS Direct web-based referral system. It is now being piloted Bludellsands practice and the subject will be taken to the practice manager's meeting to help shape it further.	GH JK JK/All JK

No	Item	Action
	15/15 Lifeline have sent information about SMASH. JK to organise a presentation from all alcohol services to the meeting in the near future. **15/15** Leisure Centre's have offered chargeable rooms and we will need to decide how we can use them. This could be considered for alcohol clinics in the future. **15/16** PH reported back to members re Warfarin prescribing software (see 15/26 below) **15/17** JK confirmed she had forwarded an invoice template to practices for the housebound project.	JK
15/25	**Presentation - The importance of sharing patient information across VW disciplines** **15/25.1** <u>Overview of Managed Referrals</u> Lynne Smith from iMerseyside gave an overview on managed referrals and confirmed that Data sharing facilitators have been going out to Sefton practices getting them to switch on. Bootle now had 75% of practices data sharing. LS and her colleague then ran through the process of managed referrals. Hand-outs showing the procedure were provided to members. Members of the committee discussed the benefits of the system and asked for clarification on some of the wording. LS was asked what the lead time was? She replied that it would be reviewed at a meeting arranged for Thursday 26th March, but she would send the information to all parties before being signed off. The current paperwork was discussed and members were advised to initially carry on with what they were doing, as the new form still had to be agreed as fit for purpose. LS said that they would make a return visit to the locality meeting sometime in the future and confirmed that a firm plan would be in place towards the beginning of April.	

No	Item	Action
	15/25.2 <u>Data Sharing Process</u> The presentation considered the following: • Concept House has 100% switch on • Urgent care has not been switched on for all practices, but Paul Shillcock has given a timescale of 2 weeks; • Managers asked to make sure that District Nurses use the system; • There is a meeting this week on how we roll-out Tier 1 Members considered the presentation and there was a discussion regarding the problems of the data sharing process. • GP's were concerned about the quality of the information recorded by the DN team. LS said that going forward things would get better; • The Urgent Care Team need to be confident on the information they are receiving; • Whether in the future A&E could utilise the service • Locality meetings should encourage practitioners to use the system more; • Concern was raised about sensitive information being available, but members were assured that admin staff would only be seeing codes.	
15/26	**Quality & Patient Safety – Warfarin monitoring** PH reported back to members in relation to the Warfarin prescribing software and said that he had contacted Ian Fleming (Community Anticoagulant Service Manager) this morning who explained that while DAWN is a stand-alone system, the idea of allowing compatibility with Emis web has been discussed recently. He says that there has not been much progress on this because "compatibility" was not part of the tender specification which Aintree created to win the monitoring contract He says they are looking at moving DAWN to the Aintree Hospital patient administration system. Talks with "Sigma" about this are active and this could result in opening a window of opportunity to send INR results to practices via ICE. He says there is no time-scale over which this might happen. The Medicines Management Team have a review meeting with the CCG which is due mid- April.	

No	Item	Action
	Members of the Committee discussed the problems about DAWN which included: • The print is too small • It is not an ideal situation • INR's were discussed and the frailty of what we are doing at the moment • Negotiation of the contract was done without clinical input • Southport provides data but Aintree does not. It was agreed that an e-mail be sent to Jayne raising the concerns of the Bootle Locality.	
15/27	**Locality Business** **15.27.1 Housebound Project - Update** JK encouraged those practices that have not submitted invoices to do so ASAP. **15.27.2 Health and Wellbeing Shop for Bootle** JK reported to members that the shop was going forward and would like a representative from this group to sit on the Planning group. **15.27.3 MECC Update** AC informed the group about the progress of the purchasing of the signing in machines and training schedule for reception staff. **15.27.4 Respiratory Training Programme** JK reported that nurses were not up to date with respiratory training. Tracey Kirk, who is a practice nurse, has been approached to put a project together. She has been accredited by GP's and will be doing this nationally. An e-learning course has been suggested. Funding has been secured for a medicines review. **15.27.5 Acute Visiting Team** The locality was asked if they had used the AVT and if they found it useful. The Chair mentioned that they do visits throughout the day. However, she reported that on one occasion the Doctor had not read the referral form properly and failed to notice an allergy. She said the service was good and appropriate most of the time, but frustrating if it went wrong, as surgeries did not receive the paperwork until the	

No	Item	Action
	following day. **15.27.6 Dates for future meetings** Committee Members discussed dates for future meetings but were unable to reach a consensus. It was agreed that members e-mail JK to put forward possible days of the week for future meetings.	All

15/28	**Performance & Finance Update**
	
	RMc gave the Month 11 (February 2015) Finance Update
	
	• Report is up to the end of February 2015
	• CCG Allocates budgets for the year based on expected expenditure, agreed price uplifts, inflation, cost savings etc.
	• Budgets held in reserves for: Contingency, Over-performance, Investment
	• Overall CCG is on target to achieve the required 1% surplus of £2.3m
	• Excluding budgets held in reserves, CCG position is as follows:
	• Financial Position is £3.1m overspent (this financial year to date)
	• Forecast for year end is £4.3m overspent
	• Main pressures are in Acute Care, Independent Sector providers, Continuing Health Care and Prescribing
	• Main Forecast overspends as follows:
	  ○ Aintree Hospital - £2.1m
	  ○ Continuing Healthcare - £1.6m
	  ○ Independent Sector - £612k
	  ○ Prescribing - £438k
	• The pressures in Acute Care are at Aintree (Outpatients (mainly Cardiology and Urology) and excluded drugs) and at Liverpool Women's Hospital (Antenatal pathway, Outpatients and Deliveries)
	• Continuing Health Care costs have increased 23% more than anticipated during the year, costs may increase further following expiry of the current price framework in February.
	• Expenditure with Independent Sector providers has increased during the year
	• Prescribing costs are forecast to overspend, the main factors being volume of prescribing has increased and the value of Category M drugs increased in October.
	• Reserve budgets set aside during Budget Setting will be used to support this overspend and the CCG will achieve a 1% surplus overall.
	• Contract negotiations are ongoing, weekly meetings being held	

No	Item	Action
	with providers. • Final Settlements for this financial year being agreed • Budgets for 2015/16 currently being set. In conclusion RMc requested that any outstanding invoices be copied to herself or JK.	All
15/29	**Medicines Management Update** **Bootle Locality March 2015 Meds Management Update** **1. Prescribing data** for fentanyl patches highlighted. • An SPU on fentanyl patches has recently been circulated. • Prescribing comparison data for South Sefton was highlighted encourage high prescribers to review their prescribing • Also a Care Quality Commission document: Preventing harms from fentanyl and buprenorphine transdermal patches, was highlighted. **2. Budget Data:** Month 10 (Jan 2014) Prescribing Budget data spreadsheet was handed out to highlight most recent data and Forecast Out-Turn. **3. The Bootle Locality generics report** Q3 2014/15 was highlighted **4. Medicines Management Update from February JMOG was highlighted:** Pan-Mersey Prescribing guidelines for specialist infant formula feeds in lactose intolerance and cow's milk protein allergy Guideline approved at JMOG Pan-Mersey guidelines for the non-specialist management of dry eye symptoms Guideline approved at JMOG Pan-Mersey COPD inhaled drug therapy guidelines Guideline approved at JMOG **5. Medicines Management Update from March 2015 JMOG was**	

No	Item	Action

highlighted:

Fluticasone furoate with vilanterol inhaler (Relvar Ellipta ®▼) statement	The Pan Mersey Area Prescribing Committee recommends that Relvar Ellipta could be considered in patients who require medium/high-dose ICS in combination with a LABA, **and where other formulary ICS /LABA combinations are unsuitable**. http://www.panmerseyapc.nhs.uk/recommendments/PS89.pdf
Phosphodiesterase type-5 inhibitors statement	http://www.panmerseyapc.nhs.uk/recommendments/PS116.pdf
Oxycodone + naloxone modified release (Targinact®) statement Classified as AMBER	Updated policy statement, restricting Targinact® to 3rd line opioid use in patients with constipation not relieved by regular combination laxatives. http://www.panmerseyapc.nhs.uk/recommendments/PS117.pdf
Avoidance of clostridium difficile infection guideline	http://www.panmerseyapc.nhs.uk/guidelines/G19.pdf Guidance on optimal prescribing of antibiotics and proton pump inhibitors to minimise clostridium difficile infection.

6. PH requested that the Bootle Locality carry out an antimicrobial peer review at next meeting regarding the care home antibiotic prescribing audit for third and fourth quarters of 2014/2015. Prescribers should discuss results with their practice pharmacist before the next Locality meeting.

There was a brief discussion in relation to the information provided and KC raised the issue of 2,000 patients who were on the waiting list for gender re-assignment. He said that he had been informed NHS England where looking to do a shared care agreement. Only one hospital was doing operations and with no specialists involved who do you share the care with? KC said that he had a couple of these patients and they were being prescribed un-licenced medication, it was starting to become a big problem. KC said we need a local specialist. He was very concerned that patients were not getting treated. JK said she had been looking into it and had contacted a specialist on the

No	Item	Action
	Wirral. She was trying to find alternatives in the interim until a more permanent solution can be found. JK responded that Suzanne lynch was looking into this issue and will send the Committee an update when she begins talking with NHS England.	
15/30	**Any other business** **CAMHS Referrals** AF raised the issue of young patients not meeting the threshold for a CAMHS referral and asked if anyone had any ideas regarding current services. JK agreed to find out what is available and get back to AF directly. **Financial Report** It was suggested that in the future could financial reports be displayed on the screen to avoid waste of resources.	JK
	Date of next meeting Tuesday, 28th April 2015, 1:00pm – 2:30pm Park Street Surgery	

NHS
South Sefton
Clinical Commissioning Group

Bootle Locality Meeting Minutes

Date: Tuesday 17th February 2015: 1pm-2.30pm

Venue: Park Street Surgery

Attendees		
Dr Gina Halstead	Concept House Surgery/Sefton Road Surgery	GH
Dr Rob Sivori	Bootle Village Surgery	RS
Dr Anna Ferguson	The Strand Medical Centre/North Park	AF
Dr Kong Chung	Park Street Surgery	KC
Dr Helen Mercer	Moore Street Surgery	HM
Helen Shillcock	Moore Street Surgery	HS
Tanya Mulvey	The Strand Medical Centre	TM
Pauline Sweeney	Park Street Surgery	JE
Doreen Porter	Public Health LCH	DP
Emily Meels	Student, Concept House Surgery	EM
Dr F Sulan	GP Reg, Bootle Village Surgery	FS
Paula Byrne	Clinical Lead, LCH	PB
In attendance		
Jenny Kristiansen	South Sefton Clinical Commissioning Group	JK
Paul Halsall	South Sefton Clinical Commissioning Group	PH
James Bradley	South Sefton Clinical Commissioning Group	JB
Minutes		
Angela Curran	South Sefton Clinical Commissioning Group	AC
Apologies		
Jane Elliott	North Park Health Centre	

NHS
South Sefton
Clinical Commissioning Group

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr S Sapre	GP – Aintree Road Surgery	✓	✓	✓	✓	✓	✓	✓		A	✓	
Sanju Sapre	PM – Aintree Road Surgery	A	✓	A	A	A	A	A		A		
Dr S Stephenson	GP – Bootle Village Surgery	A	A	A	A	A	A	A		A		
Dr C McGuinness	GP – Bootle Village Surgery	A	A	A	A	A	A	A		A		
Dr R Sivori	GP – Bootle Village Surgery	A	A	A	✓	✓	✓	✓		✓	✓	
Gill Riley	PN – Concept House Surgery	A	✓	A	A	A	A	A		A		
Dr D Goldberg	GP – Concept House Surgery	✓	A	✓	A	A	A	✓		A		
Dr G Halstead	GP – Concept House Surgery	A	✓	A	✓	✓	✓	✓		✓	✓	
Dr H Mercer	GP – Moore St Surgery	✓	A	A	A	A	A	✓		✓	✓	
Dr A Roberts	GP – Moore St Surgery	A	A	A	A	A	A	A		A		
Dawn Rigby	PM – Moore St Surgery	A	A	A	A	A	A	A		A		
Helen Shillcock	PM – Moore St Surgery	✓	A	✓	✓	✓	✓	✓		✓	✓	
Dr R Sinha	GP – North Park Health Centre	A	A	A	A	A						
Pam Sinha	PM – North Park Health Centre	A	A	A	A	A						
Jane Elliott	PM – North Park Health Centre				A					✓	A	
Dr K Chung	GP – Park St Surgery	✓	✓	✓	✓	✓	✓	A		✓	✓	
Pauline Sweeney	PM – Park St Surgery	✓	✓	✓	A	✓	A	✓		A	✓	
Dr A Ferguson	GP – Strand Medical Centre	✓	✓	✓	✓	✓	✓	A		✓	✓	
Tanya Mulvey	PM – Strand Medical Centre				A					✓	✓	
Gerry Devine	PM – Strand Medical Centre	✓	✓	A	A	A						
Dr M Gozzelino	GP – Strand Medical Centre	A	A	A	A	A	A	A		A		
Dr S Morris	GP - Strand Medical Centre	A	A	A	A	A	A	✓		A		
M Hinchliff	PM – Strand Medical Centre	A	A	A	A	A	A	A		A		

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/12	**Apologies for absence** Apologies were noted.	
15/13	**Declarations of interest** None declared.	
15/14	**Minutes from the last meeting** The minutes following the meeting held on 27th January were agreed as a true record. **Matters arising/action tracker** GH to meet with Becky Williams to look at referral rates for cancer and nephrology in relation to the locality profile. It was reported that there are currently ongoing problems with the phlebotomy service, practices still need to telephone for results. PB agreed to feedback on this issue at the next meeting. JK agreed to speak to Tracy Jeffes in relation to the elderly living in social isolation action from the Locality away day session in November. JK to liaise with Angie Parkinson regarding possible development of a local scheme via QOF and feedback at next meeting. JK reported that the business case in relation to providing practices with signing-in machines to free up staff to implement the training for healthy chats – 'Making Every Contact Count' has been agreed in principle. JK to update at the next meeting following ratification of the business case through the CCG SMT. HM agreed to distribute information on how to respond to an acute medical incident and reported that dates are being set for teaching. JK agreed to incorporate this into the report for the health shop. Radiology referrals - GH asked HM and RS to provide some examples of problems they are experiencing with referrals to this service and GH will write to David White seeking clarification and report back at the next meeting.	
15/15	**Presentation – Alcohol Services** Margaret Jones (MJ), Public Health, Sefton MBC provided members with an update of the alcohol service. The local authority commission's alcohol services. MJ also informed members that they also commission SMASH which is a younger persons services. A detox service is available through Mersey Care. Members were unfamiliar with the younger person's service and MJ agreed to forward details of all the alcohol services currently commissioned by the Local Authority. Work is currently in progress to join up the different elements of the service, with Lifeline having the most client base. Lifeline has been in place for 18 months and MJ explained to members that in 2013 there were a number of different services supporting people with substance misuse with different contracts and providers. The	

No	Item	Action
	Local Authority is planning to commission one package for all alcohol services and going forward will be named Addictions. MJ added that the Lifeline contract is up for review and discussions are taking place whether to extend for a further 2 years or to out to tender. Discussions entail looking back at the service to ascertain what has gone well and where improvements can be made. Evidence has shown that the outcome of patients is not altered due to a delay in accessing the service but this will prolong their treatment. It was noted that the national standard for waiting times is 3 weeks. There was a brief debate around waiting times and members were concerned that 3 weeks is too long for most patients needing to access the service. It was appreciated by members that DNAs are a problem with this client group and MJ added that Canal Street is not an appropriate venue and there service are now trying to establish satellite sites. MJ added that it has been difficult to access rooms for the sites and JK offered assistance and agreed to look at rooms in Bootle Health Centre. There was a discussion around the Lifeline service and GH added that it may be useful for them to attend a locality meeting to explain the referral process. Concerns were expressed in relation to delays with the detox service at Mersey Care; MJ was not aware of any problems but agreed to look into this. Mersey Care is currently under activity and there is capacity at Windsor Clinic.	
15/16	**Presentation – Current Respiratory Referral Process and plans going forwards Jane O'Connor Community Respiratory Lead & Paul Walker Respiratory Consultant** Dr Paul Walker (PW) and Jane O'Connor (JO'C) from the Community Respiratory Team attended the meeting to provide the locality with an update on the 2 hour response team service. Dr Paul Walker is new to the team and has been looking at the number of referrals and although there has been a major increase in December/January in Liverpool CCG, the same has not been seen in South Sefton where capacity is available. Dr Walker encouraged South Sefton GPs to increase their utilisation of the service as there is capacity to take more South Sefton patients. The referral process is through ICS, available Monday – Friday from 6am – 8pm, but can cover 7 days working if necessary. Once the referral is received, the patient is seen within 2 hours where a full assessment is carried out in the same way as supporting a hospital discharged patient. JO'C added that GPs can refer directly, any patients experiencing an exacerbation or following triage a potential exacerbation to avoid a hospital admission. If a patient doesn't fit the criteria the GP will be given the option to speak to a more appropriate team, the patient will not be rejected.	

No	Item	Action
	JK added that work is being done with Pete Chamberlain to link together the Urgent Care Team with the Hospital at Home Team to create a more resilient team with one point of access. It is planned to have this operational by June 2015.	
15/17	**Quality & Patient Safety – Warfarin monitoring** AF has been looking at how warfarin is monitored in her practice. It was highlighted that the anticoagulation service sends across reams of paper for practice admin staff to input in the computers and queried whether this could be done via EMIS. The information received is also inadequate as the practice has to contact patients directly if they need an anticoagulant which is adding a risk to the patient. AF explained further that software used for prescribing warfarin is not compatible with EMIS; this was therefore accepted as a risk to patients. Medicines Management were unable to attend the meeting but it was agreed that JK would contact Paul Halsall, Locality Pharmacist to query whether a solution can be sort and brought back to the next meeting.	
15/18	**Locality Business** <u>Housebound</u> JK reminded members to ensure that they invoice for the 60% upfront payment and agreed to forward the template to practices. <u>Health Shop</u> JK informed members that the business case was due to be considered/ratified at the CCG SMT and JK would report the outcome at the next meeting. JK added that there will be a weekly changeover on health issues/solutions in the shop to keep the public engaged. A template will be used to capture the outcomes of patients attending and record signposting to appropriate services. <u>Locality Model</u> Steve Astles had requested that the proposed LCH/locality structure be shared with members to ascertain their views. JK provided this information and explained how the model would look going forward.	
15/19	**Performance & Finance Update** GH reported that she had received an inappropriate referral from the CSU in relation to CHC. Debbie Fagan is looking into this. GH added that if any members were having similar problems could they please email Debbie Fagan. RS discussed poor discharge of patients from the Royal Liverpool University Hospital in that no discharge information was made available to the GP regarding their patients. GH asked RS to contact Debbie Fagan.	
15/20	**Medicines Management Update** PH sent apologies. Update deferred to next meeting.	

No	Item	Action
15/21	**Any other business** There was a brief discussion in relation to issues around Mersey Care referrals and GH agreed to write to Gordon Jones at the CCG. Concern was raised around the lack of service for non-English speaking ECG patients who attend Litherland Walk-in Centre. It was noted that this is an Aintree service but GH agreed to look at an interpreting service.	
	Date of next meeting Tuesday, 24th March 2015, 1:00pm – 2:30pm Park Street Surgery	

Crosby Locality Meeting Minutes

Wednesday, 4th February 2015
1:00pm – 2:30pm
CLAC

Attendees

Dr Craig Gillespie	GP Blundellsands Surgery	CG
Carolyne Miller	PM Blundellsands Surgery	CM
Sue Hancock	PN Blundellsands Surgery	SH
Dr Damian Navaratnam	GP 20 Kingsway	DA
Sharon McGibbon	PM Eastview Surgery	SMc
Dr C McDonagh	GP 30 Kingsway	CMc
Shelley Keating	PM 30 Kingsway	SK
Dr G Misra	GP 133 Liverpool Road	GM
Maureen Guy	PM 133 Liverpool Road	MG
Dr R Ibreck	GP Thornton Practice	RH
Dr S Roy	GP Crosby Village	SR
Pippa Rose	PN Crosby Village	PR
Pauline Woolfall	Pm Crosby Village	PW

In Attendance

Tina Ewart	South Sefton Clinical Commissioning Group	TE
Becky Williams	South Sefton Clinical Commissioning Group	BW
Janet Faye	South Sefton Clinical Commissioning Group	JF
Sue Edmondson	Community Matron LCH	SE
Gill Rice	Deputy Area Manager LCH	GR
Pat Lloyd	Housebound Project Nurse	PL

Minutes

Angela Curran	South Sefton Clinical Commissioning Group	AC

Apologies

James Bradley
Stella Moy
Dr Prema Sharma

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Pippa Rose	PN – Crosby Village Surgery	✓	✓	✓	A	A	✓	A	A	A	A	✓	
Dr M Taylor	GP – Crosby Village Surgery	A	A	A	A	A	✓	✓	A	A	A	A	
Dr S Roy	GP – Crosby Village Surgery	✓	✓	✓	A	✓	✓	✓	✓	✓	A	✓	
Bruce Duncan	PM – Crosby Village Surgery	✓	✓	✓	✓	✓	✓	A	✓	✓	left	left	left
Sharon McGibbon	PM – Eastview Surgery	✓	A	✓	✓	✓	✓	✓	A	✓	✓	✓	
Dr A Mimnagh	GP – Eastview Surgery	✓	A	✓	A	A	A	✓	A	✓	✓	A	
Dr M Hughes	GP – Eastview Surgery	A	A	A	A	A	✓	✓	A	A	A	A	
Dr R Ratnayoke	GP – Eastview Surgery	✓	A	A	A	A	✓	✓	A	A	A	A	
Dr P Sharma	GP – Crossways Surgery	✓	✓	✓	A	✓	✓	✓	A		A	A	
Bruce Duncan	PM – Crossways Surgery	A	A	✓	A	✓	✓	✓	✓	✓	left	left	left
Jenny Kimm	PM – Thornton Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	
Stella Moy	PN – Thornton Surgery	A	A	A	A	A	✓	A	A	✓	A	A	
Dr R Huggins	GP – Thornton Surgery	A	✓	A	A	✓	✓	✓	A	A	✓	A	
Dr R Ibreck	GP – Thornton Surgery	A	✓	A	✓	A	✓	✓	✓	A	A	✓	
Maureen Guy	PM – 133 Liverpool Road	✓	✓	A	A	A	✓	✓	✓	✓	A	✓	
Dr G Misra	GP – 133 Liverpool Road	✓	✓	✓	A	A	A	✓	A	A	A	✓	
Sandra Holder	PN – 133 Liverpool Road	A	A	A	A	A	✓	✓	A	A	A	A	
Dr N Tong	GP – Blundellsands Surgery	✓	A	✓	A	✓	✓	✓	✓	A	A	A	
Dr C Gillespie	GP – Blundellsands Surgery	A	✓	A	✓	A	✓	✓	✓	✓	✓	✓	
Sue Hancock	PN – Blundellsands Surgery	✓	✓	✓	A	✓	✓	A	✓	✓	A	✓	
Colin Smith	PM – Blundellsands Surgery	A	✓	✓	A	A	A	A				left	left
Carolyne Miller	PM – Blundellsands Surgery								A	✓	A	✓	
Shelley Keating	PM – 30 Kingsway	✓	✓	A	A	✓	✓	✓	A	A	✓	✓	
Dr C Shaw	GP – 30 Kingsway	A	A	A	A	✓	✓	✓	A	A	A	A	
Dr C McDonagh	GP – 30 Kingsway	✓	✓	A	✓	A	A	✓	✓	A	✓	✓	
Dr E Pierce	GP – Hightown Village Practice	A	A	A	A	A	✓	✓	A		A	A	
Pauline Woolfall	PM – Hightown Village Practice	✓	✓	✓	A	✓	A	✓	A	A	A	✓	
Lisa Roberts	PM – Hightown Village Practice									✓	A	A	
Dr Barouni	GP – Hightown Village Practice	A	A	A	A	✓	✓	✓	A	A	A	A	
Dr Marzu	GP – Hightown Village Practice									✓	A	A	
Dr C Allison	GP – Hightown Village Practice	A	A	A	A	A	A	A	A	A	A	A	
Dr Ghalib	GP – Hightown Village Practice	A	A	A	A	A	A	A	A	A	A	A	
Dr S Bussolo	GP – Hightown Village Practice	A	✓	✓	A	✓	✓	✓	A	A	A	A	
Dr D Navaratnam	GP – Azalea Surgery	✓	✓	✓	✓	✓	A	A	✓	A	✓	✓	
Dr C Doran	GP – Azalea Surgery	A	A	A	A	A	A	A	A	✓	A	A	
Dr G Berni	GP – 42 Kingsway	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	A	
Alan Finn	PM – 42 Kingsway	✓	✓	✓	A	✓	✓	✓	✓	✓	A	A	
Dr U Pfeiffer	GP – 42 Kingsway	A	A	A	A	A	A	A	A	A	A	A	
Dr F Vitty	GP – 42 Kingsway	A	A	A	A	A	A	A	A	A	A	A	

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/13	**Apologies for absence** Apologies were noted. Action to be taken by the Committee	
15/14	**Declarations of interest** None declared. Action to be taken by the Committee	
15/15	**Minutes of the last meeting** The minutes were agreed as a true record. Action to be taken by the Committee	
15/16	**Matters arising** CG suggested we have a separate 'action tracker sheet' for future minutes SA had contacted Ian Senior in relation to unused flu vaccinations. It was reported that this has now been passed over to Dr Daniel Seddon, Chair of the Area Team. To be followed up and brought to next locality meeting. It was reported that Dr Gina Halstead and Steve Astles had taken forward the patient safety issues that were raised at the last meeting. Action to be taken by the Committee	TESA

No	Item	Action
15/17	**Respiratory Team Visit** Dr Paul Walker (PW) and Jane O'Connor (JO'C) from the Community Respiratory Team attended the meeting to provide the locality with an update on the 2hour response team service. Dr Paul Walker is new to the team and has been looking at the number of referrals and although there has been a major increase in December/January in Liverpool CCG, the same has not been seen in South Sefton where capacity is available. **Dr Walker encouraged South Sefton GPs to increase their utilisation of the service as there is capacity to take more South Sefton patients.** **The referral process is through ICS, available Monday – Friday from 6am – 8pm, but can cover 7 days working if necessary.** **Once the referral is received, the patient is seen within 2hours where a full assessment is carried out in the same way as supporting a hospital discharged patient.** The locality was assured that senior respiratory staff members are within the team and it is also planned to integrate with the IV teams. JK added that work is being done with Pete Chamberlain to link together the Urgent Care Team with the Hospital at Home Team to create a more resilient team with one point of access. It is planned to have this operational by June 2015. There was discussion around the team needing access to spirometry results and they are working towards obtaining full access to EMIS, this will also give assurances to safely prescribe medicines. JO'C gave an overview of the Hospital at Home service provided by the team to support early discharge of patients which is now integrated into community respiratory team. This is the second winter the service has been available and GPs can refer directly, any patients experiencing an exacerbation or following triage a potential exacerbation to avoid a hospital admission. **If a patient doesn't fit the criteria the GP will be given the option to speak to a more appropriate team, the patient will not be rejected.** CG added that within Blundellsands, many patients are ambulatory and asked whether clinics were available. Currently the team are only providing home visits; there are no clinics in place. Action to be taken by the Committee	
15/18	**Locality Business** TE introduced the newly appointed Housebound Project nurse, Pat Lloyd (PL) to the locality who will be commencing the role shortly. It is planned to pilot the project in Blundellsands Surgery then rollout across the locality	

No	Item	Action
	according to volume of patients. We have also agreed to provide reviews of two practices within the Bootle locality within the project. TE agreed to send out to members the documentation that will be used by the nurse to record visits. Pippa is working on a template to capture the action for each patient that will be installed on your practice system to record the reviews.	TE
	TE reported that the **CCG 'Blueprints'** for the CCG commissioning strategy had been discussed at the Operational Team meeting yesterday.	
	This is basically who we are and what we are going to deliver, identifying savings that will be delivered via QUIPP programmes. All programmes will link directly in to the Blueprints focussing on;	TE
	• Early detection of CVD • Enhanced management of patients in their own homes • End Of Life	
	To oversee the implementation of the Blueprint Strategy, a **Primary Care Board** has been set up – Ange Parkinson's area of work.	
	TE asked the locality to think about ideas that will address the Locality Needs for delivering the Blueprint and investing in any initiative funding.	
	The '**Well North'** initiative will focus on Alcohol, Respiratory and Epilepsy.	
	Primary Care Initiatives via the LQC will focus on Access, A&E frequent attenders, Exception coding, Community Health and Practice Improvement goals. **In year 2** : Frail Elderly, PMS reviews where practices will either retain funding of be given the option to revert to GMS contract	
	TE shared the **NHS improvement data tool** with the locality showing performance data of practices as well as the CCG as a whole and offered to visit practices to look at future schemes on how to hit performance targets. **http://www.productivity.nhs.uk**	
	Crosby's Profile shows high AKI /Cancer and Liver related admissions and readmissions. If you want to view in more detail use the dropboxes to drill down and view your practice, CCG, Trust data.	
	Dave Smith has agreed to attend a future locality meeting to explain and identify opportunities per quarter to improve performance areas in line with National averages.	
	TE informed the group that she has requested Business Intelligence to provide a breakdown of our Outpatient attendances and charges for the locality to see if we can reduce unnecessary visits and costs. These will be shared at the March locality meeting.	
	Also tabled and previously emailed out was the Public Health 'Locality Profile' document. Please be advised that Public Health need to correct the make up of localities – a Maghull practice had been included under Crosby profile in error.	
	It has been suggested that the next locality meeting would be a good opportunity for all practices who have signed up to the Admissions Avoidance DES to share and feedback outcomes of A&E frequent attenders audit, feedback re OOH providers and any themes arising. Please bring your information to discuss at the next meeting.	ALL
	TE asked on behalf of LCH that **each practice to provide a bypass number for the Urgent Care team,** to ensure communication re patient	ALL

No	Item	Action
	care is not delayed. Please share numbers with Asan's team thanks. Action to be taken by the Committee **Each practice to provide a bypass number for the Urgent Care team** All to think about ideas that will address the Locality Needs for delivering the Blueprint and investing future initiative funding All practices who have signed up to the Admissions Avoidance DES to bring your findings for discussion at the next meeting.	
15/19	**Medicines Management** JF informed the locality that a new referral form is now available for GPs to refer patients prescribed vitamin K antagonist oral anticoagulants, to the anticoagulation service for an INR check, if a medication is started/stopped that may affect a patients INR value. TE has already forwarded this referral form electronically to the locality. Recent advice to GP practices from the LMC about treating gender dysphoria patients and interim guidance from NHS England, was discussed. Action to be taken by the Committee	
15/20	**Quality, Patient Safety and Issues Log** An issue was noted around junior doctors sending discharge letters out late. Another practice stated they have had duplicated Discharge notices from UHA, which has already been reported via CQUIN/Gina Halstead. One of the locality practices also raised the late receipt of ECG reports from Aintree Cardiac Service. One report had been sent to the patients' home address rather than to the practice. TE requested the practice to contact the CCG Quality Committee with details to raise the concern. TE confirmed that Aintree have a dedicated GP mailbox if you are dissatisfied or need to complain: gp@aintree.nhs.uk If you are not satisfied with their response then the CCG quality team should be notified and they will raise it directly with the Risk Team at Aintree The CCG secure email address is seftonccgs.qualityandsafety@nhs.net This account can receive patient identifiable information securely A social services issue was raised by a practice and following discussion, it was suggested that the patient could have been referred to the Virtual Ward specifically requesting Social Services input or alternatively Health and Wellbeing Trainer input who can signpost to a 3rd sector or Voluntary service Action to be taken by the Committee	ALL for note
15/21	**Strategic/Finance Performance Update**	

No	Item	Action
	Strategic Performance BW provided the locality with copies of the latest Quality Premium and explained that there are certain indicators that the locality will be unable to influence but provided assurance that the CCG is continuing to work on this and reported that Blackpool CCG is the lead commissioner for the Quality Premium, and Sefton does have input into this. The locality does have influence on Diabetes which it is anticipated will be back on track by the end of March. Emergency admissions are a concern at present and it was appreciated that that not may CCGs will be on target for this. BW informed the locality that they can obtain data from the NHS Productivity website, 'Better Care, Better Value for the NHS' and agreed to look at this to ensure that all practices have been included in the statistical provision. There was a brief discussion around the recording of medical errors and BW advised the locality that medication errors for Mersey Care will be removed from the reports. Susanne Lynch is planning to meet with Aintree to ensure that these errors are recorded appropriately. BW explained that the dashboard will be populated with information to give projections and financial value for the CCG to invest in health inequalities schemes. At present, the actual is £0 target but work on Diabetes should bring this up along with the removal of the medication errors. We are potentially looking at a 10% claw back. CMIP; Cheshire and Merseyside Information Portal This has been launched through the CSU and practice training on the system will be followed up now that Sue Skidmore has returned from maternity leave. The CSU will be establishing a portal user group to capture feedback from practices to help improve the information and how to use it. Sue Skidmore has also offered to carry out one-to-one training with practices that require more support. It was agreed that there is merit is using CMIP but also appreciated that it is difficult to allocate viewing time within practice workloads. The locality discussed using the iMersey data facilitators to access data on behalf of practices: Possibly putting some support in place by 1st April. Primary Care Dashboard BW reported that work is taking place to refresh the dashboard data to provide a more rounded view of the quality aspects and financial information. BW will bring this to the locality upon completion of update. OOH Contract It was agreed that there is locality obligation to monitor this contract and to report any problems, and positive feedback to the CCG by submitting evidence. It was agreed to peer review this feedback and submit recommendations.	
15/22	**Feedback to report from CCG Board** It was reported that the Litherland Darzi is currently under consultation by NHS England for de-commissioning. This does not affect the SSP practice or the Walk-in Centre.	

No	Item	Action
	IAPT – Inclusion Matters will no longer deliver this service from 1st April 2015. The contract has been awarded to the Wirral Partnership but the referral process will remain the same. The Clatterbridge Cancer Centre will be developed on the Royal Liverpool site and the Aintree site will continue to operate. NHS England Mersey has now become NHS England Cheshire & Merseyside. Clare Duggan will continue as Director and Kieran Murphy has been appointed as the Medical Director. The CCG have overspent by £1.76m. Poor performance areas based on Trust information: NEL admissions, Out Patients Attendances for all population, and Out Patient attendances for the over 65 year olds. It is appreciated that the CCG and practices need to think about community services going forward. Aintree A&E 4hour target is 84% therefore not meeting target of 95% and the CCG is continuing to monitor this. It was reported, however, that the CCG is hitting their target for A&E but Aintree is currently failing. LCH are no longer pursuing a Foundation Trust pathway but looking at good providers for healthcare and also looking into core community services through localities. The out-of-hours pharmacy at Litherland Town Hall is closing, the service has been deemed not cost-effective for what it delivers and will therefore be de-commissioned. No patient safety issues have been raised. Healthwatch are planning to visit practices on an individual basis to talk to patients around access. They are starting with Seaforth & Litherland and have asked if they can attend a locality meeting to introduce themselves and explain the project. It was reported that Lin Bennett has stepped down from the Board creating a vacancy for a Practice Manager.	
15/23	**Any Other Business** No further business was discussed.	
15/24	**Date of next meeting** **date rescheduled to** **Wednesday, 11th March 2015, 12:30 – 2:30pm, CLAC**	

Crosby Locality Meeting
Minutes

Wednesday, 11th March 2015
1:00pm – 2:30pm
Crosby Lakeside Adventure Centre (CLAC)

Attendees

Dr Craig Gillespie	GP Blundellsands Surgery	CG
Carolyne Miller	PM Blundellsands Surgery	CM
Sue Hancock	PN Blundellsands Surgery	SH
Dr Damian Navaratnam	GP Azalea Surgery	DN
Dr C McDonagh	GP 30 Kingsway	CMc
Jenny Kimm	PM Thornton Practice	JK
Dr R Huggins	GP Thornton Practice	RH
Stella Moy	PN Thornton Practice	SM
Pauline Woolfall	PM Crosby Village & Hightown practices	PW
Dr M Taylor	GP Hightown Village Practice	MT
Dr P Sharma	GP Crossways Surgery	PS
Maureen Guy	PM 133 Liverpool Road	MG
Sharron McGibbon	PM Eastview Surgery	SMc
Dr A Mimnagh	GP Eastview Surgery	AM
Dr G Berni	GP 42 Kingsway	GB

In Attendance

D Barton	IM	DB
L Smith	IM	LS
Pippa Rose	Lead Nurse	PR
Janet Fay	SSCCG MM	JF
Sue Edmondson	LCH	SE
Ian Senior	LCH	IS
Pat Lloyd	LCH	PL
Tina Ewart	SSCCG	TE
Liam Jones	SSCCG	LJ

Minutes

Anne Graham	SSCCE	AG

Apologies

Paul Shillcock	Informatics Merseyside	PS
Alan Finn	PM 42 Kingsway	AF
Shelley Keating		SK

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Pippa Rose	PN – Crosby Village Surgery	✓	✓	✓	A	A	✓	A	A	A	A	✓	✓
Dr M Taylor	GP – Crosby Village Surgery	A	A	A	A	A	✓	✓	A	A	A	A	✓
Dr S Roy	GP – Crosby Village Surgery	✓	✓	✓	A	✓	✓	✓	✓	✓	A	✓	
Bruce Duncan	PM – Crosby Village Surgery	✓	✓	✓	✓	✓	✓	A	✓	✓	left	left	left
Sharon McGibbon	PM – Eastview Surgery	✓	A	✓	✓	✓	✓	✓	A	✓	✓	✓	✓
Dr A Mimnagh	GP – Eastview Surgery	✓	A	✓	A	A	A	✓	A	✓	✓	A	✓
Dr M Hughes	GP – Eastview Surgery	A	A	A	A	A	✓	✓	A	A	A	A	
Dr R Ratnayoke	GP – Eastview Surgery	✓	A	A	A	A	✓	✓	A	A	A	A	
Dr P Sharma	GP – Crossways Surgery	✓	✓	✓	A	✓	✓	✓	A		A	A	✓
Bruce Duncan	PM – Crossways Surgery	A	A	✓	A	✓	✓	✓	✓	✓	left	left	left
Jenny Kimm	PM – Thornton Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓
Stella Moy	PN – Thornton Surgery	A	A	A	A	A	✓	A	A	✓	A	A	✓
Dr R Huggins	GP – Thornton Surgery	A	✓	A	A	✓	✓	✓	A	A	✓	A	✓
Dr R Ibreck	GP – Thornton Surgery	A	✓	A	✓	A	✓	✓	✓	A	A	✓	
Maureen Guy	PM – 133 Liverpool Road	✓	✓	A	A	A	✓	✓	✓	✓	A	✓	✓
Dr G Misra	GP – 133 Liverpool Road	✓	✓	✓	A	A	A	✓	A	A	A	✓	
Sandra Holder	PN – 133 Liverpool Road	A	A	A	A	A	✓	✓	A	A	A	A	
Dr N Tong	GP – Blundellsands Surgery	✓	A	✓	A	✓	✓	✓	✓	A	A	A	
Dr C Gillespie	GP – Blundellsands Surgery	A	✓	A	✓	A	✓	✓	✓	✓	✓	✓	✓
Sue Hancock	PN – Blundellsands Surgery	✓	✓	✓	A	✓	✓	A	✓	✓	A	✓	✓
Colin Smith	PM – Blundellsands Surgery	A	✓	✓	A	A	A	A				left	left
Carolyne Miller	PM – Blundellsands Surgery								A	✓	A	✓	✓
Shelley Keating	PM – 30 Kingsway	✓	✓	A	A	✓	✓	✓	A	A	✓	✓	
Dr C Shaw	GP – 30 Kingsway	A	A	A	A	✓	✓	✓	A	A	A	A	
Dr C McDonagh	GP – 30 Kingsway	✓	✓	A	✓	A	A	✓	✓	A	✓	✓	✓
Dr E Pierce	GP – Hightown Village Practice	A	A	A	A	A	✓	✓	A		A	A	
Pauline Woolfall	PM – Hightown Village Practice	✓	✓	✓	A	✓	A	✓	A	A	A	✓	✓
Lisa Roberts	PM – Hightown Village Practice									✓	A	A	
Dr Barouni	GP – Hightown Village Practice	A	A	A	A	✓	✓	✓	A	A	A	A	
Dr Marzu	GP – Hightown Village Practice									✓	A	A	
Dr C Allison	GP – Hightown Village Practice	A	A	A	A	A	A	A	A	A	A	A	
Dr Ghalib	GP – Hightown Village Practice	A	A	A	A	A	A	A	A	A	A	A	
Dr S Bussolo	GP – Hightown Village Practice	A	✓	✓	A	✓	✓	✓	A	A	A	A	
Dr D Navaratnam	GP – Azalea Surgery	✓	✓	✓	✓	✓	A	A	✓	A	✓	✓	✓
Dr C Doran	GP – Azalea Surgery	A	A	A	A	A	A	A	A	✓	A	A	
Dr G Berni	GP – 42 Kingsway	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	A	✓
Alan Finn	PM – 42 Kingsway	✓	✓	✓	A	✓	✓	✓	✓	✓	A	A	

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr U Pfeiffer	GP – 42 Kingsway	A	A	A	A	A	A	A	A	A	A	A	
Dr F Vitty	GP – 42 Kingsway	A	A	A	A	A	A	A	A	A	A	A	

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/25	**Apologies for absence** Apologies were noted	
	Action to be taken by the Committee	
15/26	**Declarations of interest** None declared	
	Action to be taken by the Committee	
15/27	**Minutes of previous minutes** The minutes were agreed as a true record.	
	Action to be taken by the Committee	
15/28	**Matters arising** **Practice Reimbursement of lost Flu Vaccinations** The Chair (CG) confirmed that from his discussions with Dr Daniel Seddon, NHS England do not intend reimbursing Practices for lost flu vaccinations. CG had requested an official response be mailed out but this response is still outstanding. After discussion it was agreed that CG would copy committee members into the e-mail to Dr Daniel Seddon, Chair of the Area Team with NHS England. AM pointed out that currently, the onus is on patients to attend surgery to receive the flu vaccination.	CG
	Update on this issue is to be brought to the next locality meeting. The Chair reported that in future, Practices may be asked to vaccinate housebound patients in their own home and he is more than willing to challenge this if this is the case. TE reminded members that all Practices should provide bypass numbers for the Urgent Care Team as a matter of urgency. A template will be sent to all Practices who are asked to complete this as early as possible.	TE
	Action to be taken by the Committee	
	CG to circulate copy of email to Dr Seddon to locality members **TE to send template out for PMs to provide a bypass number for the VW Urgent Care Team.**	

No	Item	Action
15/29	**Locality Business** The locality shared their outcomes relating to A&E frequent attenders, OOH providers and themes from Admissions Avoidance DES: **Positive issues** included: • OOH provider reports timely and received within 1 working day • Majority of Hospital Discharge letters received within the appropriate time scale • Most practices reported most GP initiated attendances had been appropriate • Alcohol attendances appear to have dropped • Dr Asan Akpan Urgent Care service is excellent and has prevented 10 – 15 admissions for Azalea Practice alone **Negative issues** included: • Nursing Homes are high users of 999 to hospital • WIC sent patient to A&E with a boil, A&E referred to GP OoH • Catheterisations in hospital were noted as high • Identified the potential for the DVT pathway • Many children end up in A&E due to no children's service in community • Admissions continue despite Care Plans in place • Families still panic with DNAR patients and call ambulance for hospital admission • 111 service overcautious and transport patients to hospital • Duplication of Discharge paperwork – letters being faxed *and* mailed – time consuming (noted for Gina CQUIN radar) • Follow up test requests with Community Phlebotomy taking too long, inappropriate timescale • One Pt Discharge letter received yet patient was actually still in hospital on to a ward Discussion identified areas for development within the Community: **Catheterisations**, **Blood transfusions**, **Pneumonia**, **Fractures and DVT** investigations were most frequent reasons for attenders. The Group asked Ian Senior to investigate urgent blood test delays within Phlebotomy pathway. IS responded that they were mobilising more Phlebotomists and will report back on this to the Committee. *See note below under Quality & Patient Safety section*	IS
	Action to be taken by the Committee	
	Ian Senior to respond to locality re Issues on sending Referrals to	

No	Item	Action
	Phlebotomy	
15/30	**Medicines Management** JF reported to the Committee that current data shows an overspend of £246,000 which is 0.92% of the overall budget. When January figures are released may give a more favourable picture. The predicted overspend in prescribing may be attributed to the increase in appropriate prescribing for patients with chronic diseases Updated COPD guidelines from PAN Mersey were distributed. JF advised that if patients are well controlled on their current inhalers then we were not recommending switching inhalers. Updated guidelines and recommended inhaler choice should be considered for new patients. Guidelines on 'Dry Eye' and infant formula have been updated and are available on the PAN Mersey APC website. JF considered issues with (Pregabalin) for neuropathic pain and advised the locality that the recent court case was a patent issue not a clinical one. Practices should have received advice from NHS England. JF said that it was an individual Practice decision on how to manage it and that Practice Pharmacists will support. Action to be taken by the Committee 	
15/31	**Guest Presentation - iMerseyside Overview on Managed Referrals from Lynne Smith** Officers from Informatics Merseyside gave a short presentation on electronically managed referrals and how it will eliminate the need for faxing paper referrals. Referral information is completed on a template which is then attached and sent - similar to sending emails with attachment. The Emanaged referral will be delivered directly to the provider's mail inbox and the information passes seamlessly and efficiently between the variety of care team and disciplines. Screen presentations showed the documentation processes and what to expect to see when sending Referral letters, editing, accessing the workflow manager system and acceptance notifications on the referral. Questions raised following the presentation included the following: • Phlebotomy service is not yet included which is a concern • Who is responsible if a referral is rejected? One of the Practice Managers reported that this happened and there did not appear to be a process in place to inform the Practice. • There is no provision if the patient has more than one health	

No	Item	Action
	issue, thus two referrals e.g. Gynae and OT? As it is known that there is currently an issue with Ereferrals to Therapies which urgently need to be resolved The Chair agreed that testing of the system with Crosby has revealed problems and felt that that there needed to be some adjustments made to the referral form. LS agreed to speak to Paul Shillcock. Other problems are currently being investigated and upgrades should be coming through this week. In conclusion, the Chair said that he was concerned with patient safety when a referral is not being picked up. He will monitor the process of referrals and update the Committee at a future date. **Data Sharing Process** LS discussed the Data Sharing Process and raised the following issues: - • Facilitators will be available to visit and support Practices with enabling data sharing switch on process • IM to find establish any issues arising with this • A Timescale plan is in the process of being written and will be shared with Group Practices	LS TE LS Imersey/ TE
	Action to be taken by the Committee	
	LS and TE to progress via iMersey project team and PS	
15/32	**Quality, Patient Safety and Issues Log** A number of Practices were concerned over the time they were spending sending fax requests to Phlebotomy, which were reported as not being received. One Practice reported it taking over 2 hours, despite being requested to fax to two different Faxes and also by e-mail. IS responded that he accepted there was a problem and he would sort this immediately having a response by the following day. SMcG gave example of a post-operative request from Aintree Hospital Opthalmology requesting the District Nurses attend to administer eye drops This was noted by the Chair to raise via Dr Gina Halstead CQUINN Dr Sharma reported Lablinks poor response regarding an incident with a Histology report; She had to ring hospital for follow up and they 'weren't sure' 'nothing on system yet'. PS questioned whose responsibility it is to follow up, what is the expectation? Chair agreed	IS CG CG

No	Item	Action
	to take issue to the Quality Committee via Gina. Action to be taken by the Committee CG to contact Gina Halstead re Opthalmology and Lablinks issues	
15/33	**Feedback to report from CCG Board** The Chair reported that no formal meeting had taken place but noted that Peter Chamberlain is now a Governing Board Member. Clive steps down at the end of the month and interested parties have put themselves forward for the position of Chair. The Governing Body will make a recommendation. AM reported back to the Committee on a recent event at Aintree race-course, which was well attended and useful.	
15/34	**Any Other Business** TE reported that Finance Committee have decided that the QP reports will be produced Quarterly and therefore be on locality agendas quarterly. In terms of 2015/16 still no word nationally on whether QP will continue. TE reported that the Housebound Reviews were going really well and had identified many patients requiring D/Nurse follow up for Pressure Ulcers. She has informed Gill Rice the manager of the Nursing team of this to ensure they were aware and resourced to manage. For note, Pat is inputting her actions to EMIS herself. TE is in pursuit of a handheld device to assist her. Terry Hill requested feedback on the Acute Visiting Service; responses were very positive and more commissioning of this service was requested. Stoma and Respiratory projects: Please assign a named admin person for each project to ensure smooth running. Amit Patel will shortly be contacting practice managers re the Respiratory project. The practice pharmacist will be co- coordinating the Stoma project – please can you identify a named admin person to liaise with pharmacist re your cohort. You will be paid £2 per patient per project. Housebound project:	All practice mgrs

No	Item	Action
	Pat has identified many cases of Pressure Ulcers which have been reported to the D/N team for attention. A GP and practice nurse raised the issue of some practices in the locality running without a regular practice manager, practice nurse or enough GP sessions. There was a consensus view that this could impact on patient safety and the chair offered to take this forward to NHSE for action.	CG
15/35	**Date of next meeting** 1st April 2015, 13:00 – 2:20pm, CLAC	

NHS
South Sefton
Clinical Commissioning Group

Maghull Locality Meeting Minutes

Thursday, 19th February 2015
1:00pm – 2:30pm
Westway

Attendees		
Dr Sue Gough	Westway Medical Centre	SG
Gillian Stuart	Westway Medical Centre	GS
Carol Howard	Westway Medical Centre	CH
Dr R Killough	Westway Medical Centre	RK
Dr Jon Clarkson	High Pastures Surgery	JC
Carole Morgan	High Pastures Surgery	CM
Gill Kennedy	High Pastures Surgery	GK
Dr Bernard Thomas	Broadwood Surgery	BT
Dr Sapre	Maghull Health Centre	SS
Dr J Krecichwost	Maghull Family surgery	JK
Karen Sandison	Liverpool Community Health	KR
Donna Hampson	SSP Practice	DH
Terry Hill	Locality Manager, SSCCG	TH
Tracy Greenwood	Liverpool Community Health	TG
Paul Walker	Liverpool Community Health	PW
Mike Hammond	Liverpool Community Health	MH
Apologies		
Ian Senior	Liverpool Community Health	IS
Dr J Wray	GP – West way MC	JW
Jennifer Johnston	Medicines Management Pharmacist	JJ
Gill Rice	Liverpool Community Health	GR
Dr M A Khan	SSP Practice	MK
Minutes		
Angela Curran	Locality Development Support, SSCCG	AC

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr S Sapre	GP – Maghull Family Health Centre	✓	✓	✓	✓		✓	✓	A			✓	✓
Dr J Krecichwost	GP – Maghull Family Health Centre				✓	✓		✓	✓			✓	✓
Gillian Stuart	PM – Westway Medical Centre	✓	✓	✓			✓	✓	✓		✓	✓	✓
Carol Howard	PM – Westway Medical Centre	✓			✓		✓	✓	✓		✓	✓	✓
Dr S Chandra	GP – Westway Medical Centre						✓						
Dr R Killough	GP – Westway Medical Centre	✓		✓			✓					✓	
Dr J Wray	GP – Westway Medical Centre	A	A	A	A	A	A	A	A	A	A	A	
Dr S Gough	GP – Westway Medical Centre	A	✓	A	✓	✓	✓	✓	✓		✓	✓	✓
Jennie Proctor	PN – Westway Medical Centre												
Gill Kennedy	PM – High Pastures Surgery	✓	A	✓	✓	✓	✓	✓	✓				✓
Dr P Thomas	GP – High Pastures Surgery												
Dr C Thompson	GP – High Pastures Surgery					✓							
Dr J Clarkson	GP – High Pastures Surgery	✓	✓	✓	A	✓	✓	✓	✓		✓	✓	A
Dr P Weston	GP – High Pastures Surgery												
Dr N Ahmed	GP – High Pastures Surgery												
Dr W Coulter	GP – Maghull SSP Practice		✓	✓									
Lesley Bailey	PN – Maghull SSP Practice												
Donna Hampson	PM – Maghull SSP Practice	A	✓	✓	✓		✓	✓			A	✓	✓
Dr A Banerjee	GP – Maghull SSP Practice	✓	✓	✓									
Dr M A Khan	GP – Maghull SSP Practice										✓	A	
Dr J Thomas	GP – Broadwood Surgery	✓	✓	✓									
Dr B Thomas	GP – Boardwood Surgery	✓	✓	✓	A			✓	✓		✓	✓	
Dr Surinder Goyal	Clinical Lead, LCH								✓		✓	A	✓
Ian Senior	Mobilisation Manager								✓		A	A	
Jenny Johnston	Meds Management								✓		✓	A	✓
Karen Riddick/Gill Rice	LCH Area Manager								✓		✓	A	A

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/11	**Apologies for Absence** Apologies were noted.	
15/12	**Declarations of Interest** None declared.	
15/13	**Minutes of Previous Meeting** Subject to minor amendments the minutes from the meeting held on 22nd January were agreed as a true record. It was noted that there are ongoing difficulties with minute takers and the locality agreed to write to the CCG's Chief Officer to raise this concern. **Action Points** ABPI – TH reported that one practice in Maghull was delivering this service and stated that a full list of signed-up practices available. TH did raise this with Angie Parkinson, Primary Care Programme Lead, who clarified that for those practices that are currently providing this service or would like to, they will need to forward a certificate to Angie. Following this action the list will be uploaded to the CCG intranet. TH agreed to provide a full list to members and it was also appreciated that the full service will need further clarity in the near future. Business continuity plans – this action was deferred to the next meeting in order for members to discuss with their respective practices and report back at the next locality meeting.	
15/14	**Quality and Patient Safety** No issues were reported.	
15/15	**Performance and Finance update** TH reported that there were no changes in terms of the Quality Premium from the previous month; currently at zero. TH added that facilitators have been requested to provide diabetes information as there was an issue with this indicator re: smoking status of patients which was incorrectly reported on. Following this correction it is anticipated that this will bring the numbers back up, however it is unknown as yet whether this indicator will be achieved. It was reported that at month 10, there is currently a £3.2m overspend with the main pressures being on acute care, continuing care and prescribing. CHC costs have increased more than was previously anticipated. It is, however, predicted that the reserve budget will give a 1% surplus at the end of the financial year and adjustments for next year are currently being set. Contingency prescribing budgets are in place, especially for dementia drugs which have not been previously prescribed. TH added that the Quality Premium document will be circulated with the minutes. TH reported that discussions had taken place at the Wider Group meeting held on 10th February in relation to a proposal to practices who are currently at £90 per patient or below, to bid for the QP funds and Jan Leonard would be writing to these practices including a template for completion. There is a deadline of 6th March and practices will be asked to send the template accompanied by an invoice back to Angie Parkinson. The bids will be ratified by the CCG SMT and signed-off for payment. It was also stipulated that funding will be allocated in this financial year for spend in next year.	

No	Item	Action
15/16	**Service Improvement/Redesign** Respiratory project Funding has been confirmed to employ a pharmacist, Amit Patel, to rollout the inhaler technique project across the locality. TH asked members to provide a point of contact for their practice for Amit. The BI team will carry out a patient search and Amit will go into practices to arrange clinics. Dr P Walker (PW) from the respiratory team attended the meeting to provide an update to members regarding the community respiratory team. There is currently capacity within the team to take patients which has increased over the last 6 months. PW asked if the locality had encountered any problems with referrals and members reported that they found the service was working well. The CCG are looking to change the referral system to go through the urgent care pathway to integrate services and work is currently being done to link together the Urgent Care Team with the Hospital at Home Team to create a more resilient team with one point of access. It is planned to have this operational by June 2015. There was discussion around the team needing access to spirometry results and there is now a database in place for all patients who have been seen where their most recent results are recorded. PW reported that they are currently trialling the community management of pneumonia patients with plans to manage them through the Hospital at Home service. PW again reiterated that there is capacity to take more patients and asked member to continue to refer into the team. Stoma TH gave an update on the stoma project stating that the search has been completed and the number of patients who need to be reviewed is due to go live in mid-March. TH asked members if they could identify and email him with the relevant admin staff from their practices for the stoma team to contact. Housebound project TH confirmed that the housebound project is going well.	
15/17	**Locality business** BMA The BMA document 'Quality First: Managing Workload to Delivery Safe Patient Care' was discussed with members. The document reflects on the pressures that GPs are under at present and discusses ways in how to reduce the workload currently deflected by secondary care unnecessarily. SG pointed out that there are some useful templates to help GPs move things on rather than deal with themselves. Members discussed issues with regards to hospital cancellations and follow-up appointments. It was agreed that the locality should put mechanisms in place to feedback issues in order to hold the trusts accountable. SS reported that his practice is having problems accessing dermatology appointments through Choose & Book, TH agreed to look into this and added that there is a plan of action in place for Choose & Book with the trust. SS asked if the document had been approved by the CCG or the LMC but it was agreed that this is a national document therefore does not require approval. Members discussed patient safety in relation to prescribing. Primary Care Infrastructure TH informed members that this is an NHS England venture which is a 4 year strategy. If co-commissioning is accepted, the CCG will then be	

No	Item	Action
	involved but at present this will be co-ordinated by NHS England. SS updated members regarding the infrastructure funds, and stated that NHS England will only be funding 67% of any projects and practices will need to find the remaining 33%. Local Priority Area's Update Following the locality development session, it was agreed that Maghull would look further into dementia. TH agreed to send members a copy of the dementia strategy asking for member input as there may be gaps or recommendations in the strategy that the locality would like to look at. It was agreed to include the dementia strategy on the next agenda and to invite Kevin Thorne to report on this. Urgent care – the AVS scheme has been running for 5 weeks and is going well looking at 20 – 25 care home visits per week. It was appreciated that the service was currently being under-utilised however demand is increasing. Currently plans are being proposed to extend this service into the next financial year. TH reported that 49 patients have been diverted away from A&E so far with 23 potential avoiding admissions which has potentially saved 146 bed days at an estimated cost of £60,000. CMIP Update Deferred to next meeting.	
15/18	**Medicines Management Update** JJ sent apologies to the meeting. No update available therefore deferred to next meeting.	
15/19	**Any Other Business** TG had attended the meeting to update members on treatment rooms. It was reported that a number of patients were attending treatment rooms for ear syringing. LCH have now set up designated clinics for this cohort of patients which should free up appointments. Ambulatory patients are being moved over and TG reported the establishment of late clinics for more complex patients. This will increase to a 7-day service which will commence in Maghull next week. TG added that there are no waiting times for treatment rooms but some members complained that they are currently experiencing a 3 week delay on appointment. TG agreed to look into this and report back. TG informed members that x-ray facility at Litherland Walk-in Centre will be closed for 8 weeks due to the installation of a new x-ray kit. During this period, patients can access the x-ray facility at the St Chad's Walk-in Centre in Kirkby. **Action** TG to investigate appointment delays in treatment rooms.	TG
15/20	**Date and Time of Next Meetings** Thursday 19th March 2015 1.00 pm – 2.30pm High Pastures Surgery	

No	Item	Action
	Future meetings Thursday 23rd April 2015 – Westway Medical Centre Thursday 21st May 2015 - High Pastures Surgery Thursday 18th June 2015 - Westway Medical Centre Thursday 23rd July 2015 – High Pastures Surgery Thursday 20th August 2015 - Westway Medical Centre Thursday 17th September 2015 – High Pastures Surgery Thursday 22nd October 2015 - Westway Medical Centre Thursday 19th November 2015 - High Pastures Surgery Thursday 17th December 2015 - Westway Medical Centre	

NHS
South Sefton
Clinical Commissioning Group

Maghull Locality Meeting
Minutes

Thursday, 19th March 2015
1:00pm – 2:30pm
High Pastures Surgery

Attendees

Dr Sue Gough	Westway Medical Centre	SG
Gillian Stuart	Westway Medical Centre	GS
Carol Howard	Westway Medical Centre	CH
Dr S. Sapre	Maghull Health Centre	SS
Dr James Edmeads	SSP Practice	JE
Donna Hampson	SSP Practice	DH
Gill Kennedy	High Pastures Surgery	GK
Surinder Goyle	Liverpool Community Health	SG
Dr J Krecichwost	Maghull Family Surgery	JK
Jennifer Johnston	Medicines Management Pharmacist	JJ
Terry Hill	Locality Manager, SSCCG	TH

Minutes

Anne Graham	Locality Development Support, SSCCG	AG

Apologies

Dr John Clarkson	High Pastures Surgery	JC
Rebecca McCullough	South Sefton CCG	RM
Gill Rice	Liverpool Community Health	GR

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr S Sapre	GP – Maghull Family Health	✓	✓	✓	✓		✓	✓	A			✓	✓
Dr J Krecichwost	GP – Maghull Family Health				✓	✓		✓	✓			✓	✓
Gillian Stuart	PM – Westway Medical Centre	✓	✓	✓			✓	✓	✓		✓	✓	✓
Carol Howard	PM – Westway Medical Centre	✓			✓		✓	✓	✓		✓	✓	✓
Dr S Chandra	GP – Westway Medical Centre						✓						
Dr R Killough	GP – Westway Medical Centre	✓		✓			✓					✓	
Dr J Wray	GP – Westway Medical Centre	A	A	A	A	A	A	A	A	A	A	A	
Dr S Gough	GP – Westway Medical Centre	A	✓	A	✓	✓	✓	✓	✓		✓	✓	✓
Gill Kennedy	PM – High Pastures Surgery	✓	A	✓	✓	✓	✓	✓	✓				✓
Dr C Thompson	GP – High Pastures Surgery					✓							
Dr J Clarkson	GP – High Pastures Surgery	✓	✓	✓	A	✓	✓	✓	✓		✓	✓	A
Dr W Coulter	GP – Maghull SSP Practice		✓	✓									
Lesley Bailey	PN – Maghull SSP Practice												
Donna Hampson	PM – Maghull SSP Practice	A	✓	✓	✓		✓	✓			A	✓	✓
Dr A Banerjee	GP – Maghull SSP Practice	✓	✓	✓									
Dr M A Khan	GP – Maghull SSP Practice										✓	A	
Dr J Thomas	GP – Broadwood Surgery	✓	✓	✓									
Dr B Thomas	GP – Boardwood Surgery	✓	✓	✓	A			✓	✓		✓	✓	
Dr Surinder	Clinical Lead, LCH								✓		✓	A	✓
Ian Senior	Mobilisation Manager								✓		A	A	
Jenny Johnston	Meds Management								✓		✓	A	✓
Karen	LCH Area Manager								✓		✓	A	A

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/21	**Apologies for absence** Apologies were noted Action to be taken by the Committee 	
15/22	**Declarations of interest** None declared.	
15/23	**Minutes of previous meeting** The minutes were declared a true record.	
15/24	**Action Points from previous meeting** • TH reported that he was still awaiting responses from practices for inclusion on the ABPI list and once this was complete the list would be uploaded onto the CCG intranet. • The Chair said she would write the letter this week regarding CCG support for the locality. • SG reported that there should not be any further appointment delays in treatment rooms.	TH SG
15/25	**Quality and patient safety** No issues raised	
15/26	**Performance and Finance Update** As Rebecca McCullough was unavailable to deliver the performance and finance update for Month 11 (February 2015), TH summarised the main points, which included: • CCG Allocates budgets for the year based on expected expenditure, agreed price uplifts, inflation, cost savings etc., • Budgets held in reserves for: Contingency, over performance, investment; • Overall CCG is on target to achieve the required 1% surplus of £2.3m; • Excluding budgets held in reserves, CCG position is as follows:- • Financial Position is £3.1m overspent (this financial year to date);	

No	Item	Action

	• Forecast for year end is £4.3m overspent;
	• Main pressures are in Acute Care, Independent Sector providers, Continuing Health Care and Prescribing;
	• Main Forecast overspends as follows:-
	  ○ Aintree Hospital - £2.1m
	  ○ Continuing Healthcare - £1.6m
	  ○ Independent Sector - £612k
	  ○ Prescribing - £438k
	• The pressures in Acute Care are at Aintree (Outpatients (mainly Cardiology and Urology) and excluded drugs) and at Liverpool Women's Hospital (Antenatal pathway, Outpatients and Deliveries);
	• Continuing Health Care costs have increased 23% more than anticipated during the year, costs may increase further following expiry of the current price framework in February;
	• Expenditure with Independent Sector providers has increased during the year;
	• Prescribing costs are forecast to overspend, the main factors being volume of prescribing has increased and the value of Category M drugs increased in October;
	• Reserve budgets set aside during Budget Setting will be used to support this overspend and the CCG will achieve a 1% surplus overall;
	• Contract negotiations are ongoing, weekly meetings being held with providers;
	• Final Settlements for this financial year being agreed;
	• Budgets for 2015/16 currently being set.
	
	Locality Members discussed the over spend and alternative ways to develop services. Issues raised included the following:
	• The advantages and disadvantages of a block contract for the hospital centre;
	• The costs of physiotherapy and podiatry treatments provided in the private sector;
	• Waiting times for treatments
	• Value for money
	
	In conclusion TH said that he would obtain financial data on our commission providers for a future meeting.
		TH

15/27	**Service Improvement / redesign** 15/28.1 <u>Locality development opportunities</u> No issues were reported. 15/28.2 <u>Stoma, Respiratory and Housebound Health Check projects Update</u>	

No	Item	Action
	• TH said that the **Stoma** project had not yet started; • TH said that the **Respiratory** project had now been going for 3 weeks. Practitioners noted that they were seeing more COPD cases than asthma. • TH reported that all invoices for the **Housebound** project had been sent in.	
15/28	**Locality business** 15/28.1 Locality priority area's update None discussed 15/28.2 Dementia Discussion and Data Review Gordon Jones from the Mental Health Task Group addressed the Committee on the subject of Dementia and said he was glad this issue was now a priority. He said that Dementia was a long-term condition which required much more focus within localities. Historically, patients are treated under the canopy of Mental Health. However, dementia is predominantly a physical, progressive condition with the symptoms becoming more severe over time. This starts to impact on a person's functional ability and most noticeably their daily routines. The Mental Health task group advocate treating the condition more holistically with post-diagnostic support, ongoing through the patient's journey. They suggest care navigators, who working with families and patients, support patients and direct them to the right treatments. Members of the locality discussed the presentation and raised the following which included - • That there is under-diagnosis of Dementia within the community; • Possible future discussions with consultants at Locality meetings; • The need to improve the confidence of GP's as to resources; • Sending dementia patients with shared care to GP's • Merseycare has to change and its services have to be more accessible; TH pointed out that Dr Harvey is leading on care planning.	

No	Item	Action
	In conclusion Gordon Jones said that a paper from the Mental Health Task Group will be going before the Board next week and that Localities will be sent more details in the near future. The Chair thanked Gordon Jones for an interesting presentation and members for an informative discussion. 15/28.3 Urgent Care TH gave an update on the schemes, which included: – **Pathfinder** • In and out of hours and the first 8 weeks of the pilot, 63 ambulance conveyances were avoided. This equates to potentially 38 admissions and 263 bed days avoided. Based on the Liverpool CCG tool, this equates to a potential gross saving of 82k; • At current performance, we are forecasting a net saving of approximately £80k over a 22 week period. • Work is currently underway with NWAS, LCH and GTD to increase utilisation via production of case studies, GTD GP conversations with NWAS crews and development of pathways to other community services i.e. LCH Urgent Care Team. **Acute Visiting Scheme** • 158 care home visits have been conducted by GTD in the first 8 weeks. This is an under-utilisation of capacity (planned for 50 visits per week), however practices are providing positive feedback regarding the service and utilisation is increasing; • The cost effectiveness of this element of the scheme is harder to quantify. It can be inferred that a good proportion of the requested visits may have elicited visit by a GP and therefore has provided GP practices with additional capacity. 15/28.4 Business continuity and estates • TH will e-mail update on the availability of rooms and costs, with further ongoing discussions by practices with Sefton Council re: room suitability. • Martin McDowell has produced a draft estates report looking at a 10 years strategy. Once it has gone past the draft stage he will be invited to discuss the report; • We have a new community champion in Maghull; • It has been decided to undertake a review and look at all of the services that exist in Maghull. There is a potential use for clinical rooms. TH to report back to this committee.	TH TH

No	Item	Action
15/29	**Medicines Management Update** At Month 10 Maghull locality are forecast a 5.46% overspend. All practices are overspent on their medicines management budget with the exception of Parkhaven SSP. JJ reiterated that adjustments would be made at the end of the year to take into account high cost drugs and movement between practices. Peer review of antimicrobial prescribing in care homes quarter 4 data:	

Practice	Number of prescriptions for antimicrobials	Number within guidelines
High Pastures	0	n/a
Westway	1	1
Dr Thomas	0	n/a
Dr Sapre (1)	0	n/a
Dr Sapre (2)	0	n/a
Parkhaven SSP	3	1

JJ reiterated the importance of documenting that a drug had been prescribed on the medication screen not just in the consultation as this was how the system was interrogated and was recommended in GMC guidance. All GP's agreed that they did that. JJ noted that when the audit was completed at Parkhaven it was hard to ascertain whether the drug was prescribed within guidelines because there was no documentation in the patient's notes.

Update from the Joint Medicines Operation Group (JMOG):

- Fluticasone furoate with vilanterol inhaler (Relvar Ellipta ®▼) : The Pan Mersey Area Prescribing Committee recommends that Relvar Ellipta could be considered in patients who require medium/high-dose ICS in combination with a LABA, **and where other formulary ICS/LABA combinations are unsuitable**
- Phosphodiesterase type-5 inhibitors: NHS prescribing of generic sildenafil no longer restricted. Generic sildenafil is first choice, avanafil and vardenafil are second choice and tadalafil is 3rd choice in specified groups of patients.
- Oxycodone + naloxone modified release (Targinact®): Updated policy statement, restricting Targinact® to 3rd line opioid use in patients with constipation not relieved by regular combination laxatives.

- Avoidance of clostridium difficile infection guideline: Can be found at: http://www.panmerseyapc.nhs.uk/guidelines/documents/G19.pdf
  Guidance on optimal prescribing of antibiotics and proton

No	Item	Action
	pump inhibitors to minimise clostridium difficile infection. At the conclusion of the medicine management update a number of issues were discussed by members of the committee which included: • the considerable expenditure for dementia drugs • cost savings • the Joint Medicines Operation Group • Branded medicines	
15/30	**Any Other Business** **Secondary Care Prescribing** The Committee discussed the following issues: - • Care packages and when they should be given, before a patient is discharged or afterwards; • Patients not being given enough medication when they are discharged from hospital; JJ will take this up with the relevant department as she thinks they should be receiving a 28 day prescription; • The problems of electronic discharges. Issue to be put on the next agenda; **Request for By Pass Numbers from Practices** • TH requested that all Practices provide a direct line back office number for emergency services and the Urgent Care Team. At the conclusion of the meeting, SS said she had met with Karl McCluskey (KMc). He wants to discuss transferring resources from Primary to Secondary Care. There are problems with patients attending multiple outpatient appointments, significantly above the national average in specialties such as: dermatology, gastroenterology, geriatric medicine and ENT. KMc has requested that the locality have a discussion regarding elective activity and how potentially some services could be delivered in the community or closer to home. **The meeting finished at 2:40pm**	JJ
15/31	**Date and Time of Next Meeting** Thursday 23rd April 2015 1.00 pm – 2.30pm Westway Medical centre	