NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2014

Agenda Item: 14/157	**Author of the Paper:** Paul Horwood Insight, Engagement & Research Team Leader Business Intelligence & Performance Team Email: paul.horwood@sefton.gov.uk
Report date: November 2014	

Title: Sefton Strategic Needs Assessment

Summary/Key Issues:

This paper describes a high level summary of the Sefton Strategic Needs Assessment and the approach, methodology that has been used in its development. The outcomes for the SSNA are clearly defined and aimed at assisting commissioners, including CCGs in driving strategy formulation, commissioning intentions and health and wellbeing outcomes.

Recommendation

The Governing Body is asked to receive and support the generation of feedback from members to assist in the evaluation of the SSNA.

Receive	x
Approve	
Ratify	

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

NHS
South Sefton
Clinical Commissioning Group

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				On publication, SSNA to be considered by SIR.

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
November 2014

1. Introduction

1.1 The Sefton Strategic Needs Assessment (SSNA) is a statutory document also known as the Joint Strategic Needs Assessment - JSNA) produced on behalf of the Health & wellbeing Board. The main purpose of the SSNA is to analyse the current and future health, care and well-being needs of the local population and factors that impact on those needs, to inform the commissioning of health, wellbeing and social care services. In producing this year's SSNA, the aim has been to establish a shared, evidence base to help the Health & Wellbeing Board, and its partners, to come to a consensus on the key local priorities across the borough.

1.2 A high level summary of the SSNA was approved by the Health & Wellbeing Board in September. Headlines from the SSNA and the Health and Wellbeing Strategy were then presented to the four Overview and Scrutiny Committees, which met during September.

2. Methodology

2.1 The Sefton Strategic Needs Assessment is a derivative of the statutory Joint Strategic Needs Assessment (JSNA), which can be broken down as follows:

- **Joint** – they are carried out jointly by health, local authorities, statutory partners and community and voluntary organisations to produce a picture of people's needs and to help them work together to find answers to those needs.
- **Strategic** –they identify the 'big picture' of the health and wellbeing needs and differences across Sefton. They do not try to find out the needs of individual people.
- **Needs** –they set out to find what people require to help their health and wellbeing and to identify where these requirements are not being met.
- **Assessment** - facts and figures, together with people's knowledge, experience and opinions are used to find out what people's current and future needs are. The SSNA uses a wide range of data collected from different sources including the Census, GPs, hospital admissions, social services, housing, police, leisure, education voluntary and community organisations.

2.2 The SSNA will help achieve the following outcomes:

- Define achievable improvements in health and wellbeing outcomes for the local community;
- Target services and resources where there is most need;
- Support health and local authority commissioners;
- Deliver better health and wellbeing outcomes for the local community;
- Underpin the choice of local outcomes and targets.

2.3 This information can then be used to identify the actions that local agencies will need to take to improve the physical and mental health and well-being of individuals and communities across Sefton.

3. Format

3.1 The SSNA is broken down into nine individual chapters that can be read as standalone documents. This approach has been taken to allow users to easily access data/information that is relevant to them, so as to allow for a more effective decision making process when determining priorities and commissioning intentions.

3.2 The nine chapters of the SSNA are:

- **People & Place** – An insight into the demographic, socio economic, and environment that make up the borough
- **Children & Young People** – Specifically looks at the issues impacting on young people aged 0-19 years
- **Older People** – Looks at the needs of people in the borough age 65 and over and the future potential impacts of an aging population
- **Lifestyles** – The lifestyle choices that people make that impact on health and wellbeing of individuals and communities (Alcohol, Drugs, Smoking, Sexual Health and Weight Management0
- **Health Inequalities** – Issues that adversely affect people as a result of where they live, their age, gender or other factors that are possibly out of an individual's control
- **Long Term Conditions** – The impact of health conditions on Sefton residents and what that might mean for services across the borough
- **Mental Health** – Looking at factors that impact on an individual's mental well-being and how that impacts on communities and services
- **Cancers** – looking at the screening, diagnosis, treatment and ongoing care offer
- **Environmental** – Factors around the environment, such as housing decency, green space etc that impact on the wellbeing of Sefton residents.

4. Next Steps and Engagement

4.1 All SSNA chapters are now at the final draft stage and the intention is to engage more fully on the draft chapters across a variety of DMT's, SMT's and partnership forums such as the SSCP, leading to final sign off thereof at the January Health & Wellbeing Board. The outline timetable to achieve this is as follows:

- **October –** email all Chapters to the HWBB Intelligence and Performance Group for comment, and then meet late October/Early November to identify any gaps in the Chapters.
- **October / November –** share the Chapters with all Cabinet Members, particularly those not on the Health and Wellbeing Board, so that they can 'own' the narrative presented therein. This is part of a wider engagement plan to ensure that the SSNA and the Health and Wellbeing Strategy are fully aligned with their portfolios.
- **October / November** – Presentation of the SSNA and consultation with all Council Departmental Management Team meetings, the Adults Forum, Wider Determinants Forum and 0-19 Forum; a variety of partnership forums including SSCP, LSCB, Housing Partnership; to CCGs SLT and Locality Managers, and consider presentation to the CCGs' Governing Bodies.
- **October / November** – Development of intranet/internet presence for the revised structure of the SSNA.
- **November** – Publication on intranet of final draft chapters and seeks public and partner input on-line to the content.
- **December/January** – Incorporate additional data and make amendments as a result of consultation with above
- **January** – Sign off by Health & wellbeing Board on 23rd January 2015.

4.2 The Business Intelligence & Performance Team also recognise the important role local GP's play in improving the health and wellbeing of Sefton residents and, through the CCG governing bodies and locality managers would like to canvass the views and receive feedback from G.P.'s across the Borough in relation to the content, format and usability of the SSNA.

4.3 In recognising the diversity of communities within Sefton, the SSNA is cut by Borough Electoral Ward (22 Ward Profiles), which will be refreshed to reflect the changes seen within the overarching SSNA. The Ward Profiles are the building blocks from which 'grouped' profiles are created. Given that there are a number of natural communities within Sefton, which are very distinct, an informal Health and Wellbeing Board agreed to the development of Area Profiles grouped around five areas as follows:

- Bootle
- Crosby
- Formby
- Maghull
- Southport

4.4 The rationale for these groupings is that once the ward profiles are in place, the groupings at a higher spatial level are beneficial as they more accurately reflect the differences, which are not obvious as when, for example, they are grouped as Parliamentary Constituencies

4.5 Once a web presence is developed, it is proposed that interactive geographic data tools (Instant Atlas) based on the SSNA datasets be published to allow users to self-serve data to inform decisions.

5. Recommendations

The CCG Governing Body is recommended to:

- Appraise the content and format of the Sefton Strategic Needs Assessment;
- Request that the Governing body request feedback from GP's and that details of their feedback and evaluation is fed back to the Business Intelligence Team.

Paul Horwood
November 2014

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2014

Agenda Item: 14/158	**Author of the Paper:** Sam Tunney Head of Business Intelligence and Performance Email: samantha.tunney@sefton.gov.uk Tel: 0151 247 4080
Report date: November 2014	

Title: Better Care Fund

Summary/Key Issues:

This paper provides the Governing Body with feedback from the National Consistent Assurance Review on our Better Care Fund Submission of the 19 September 2014 and subsequent actions to respond to the feedback.

Recommendation

The Governing Body is asked to note the content of the letter and action Plan and approve the making of a further submission for end of November.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Sustain reduction in non-elective admissions in 2014/15.
x	Implementation of 2014/15 phase of Care Closer to Home.
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
November 2014

1. Background

Further to previous reports to the Governing Body on the Better Care Fund Plan for Sefton, this report provides the Governing Body Members with an update on the outcomes of the National Consistent Assurance Review (NCAR) of the Better Care Fund submission for Sefton and outlines the proposed next steps for approval.

2. Outcomes from the National Consistent Assurance Review (NCAR)

2.1 The National Consistent Assurance Review (NCAR) was conducted by Deloitte on behalf of the Better Car Fund Task Force. The outcome of the assurance process was communicated in a letter dated the 29th October 2014, (attached for information). Members will note from the letter that the BCF Plan for Sefton received approval subject to the following conditions:-

- ***Condition 1b***: The plan must further demonstrate how it will meet the national condition of having an agreed impact on the acute care sector to prevent people reaching crisis point and reducing pressure on A&E
- ***Condition 3***; The plan must further demonstrate how it will deliver the planned Non-Elective admissions reduction

2.2 Given the BCF Plan received approval with conditions, a Better Care Advisor was appointed by the Better Care Fund Task Force to work with us to develop an action plan setting out the actions to be taken to discharge the conditions and secure approval. Members are asked to note that the CCG and Council cannot enter into a S75 agreement to pool budgets under the Better Care Fund until approval is secured. Furthermore commissioners, if entering into any procurement arrangements need to make it clear that until approval is confirmed commissioners should make it absolutely clear to potential providers in all procurement documentation that the award of a contract will be strictly conditional on that approval being obtained. Further details are provided in the attached letter.

2.3 A meeting has taken place with the BCF Advisor, Julie Warren, resulting in the following - outcomes - to date:-

- On Friday 14th November 2014 an action plan will be submitted, using the Deloitte template, which identifies the actions to be taken to seek to discharge the conditions;
- An official announcement is expected week commencing 10th November confirming the dates for resubmission, which we understand are the end of November (the outcome of which will be notified mid December); mid December (the outcome of which will be notified mid January 2015); and the 9th January 2015, (the outcome of which will be notified in February 2015);
- An announcement around 'Consultancy Support' to be made available to local areas is also expected this week as we understand the contract for this was awarded on Friday 7th November 2014; and
- The Advisor has confirmed that the plan will move to 'Approved', rather than 'Approved with Support', if the submission discharges the conditions.

NHS
South Sefton
Clinical Commissioning Group

3. Action Plan and Submission

3.1 At the meeting with the BCS Advisor, the attached Action Plan was developed. At the time of writing, the BCF Plan is being further refined to take account of the actions within the action plan. This is enable the Advisor to make a recommendation to the Better Care Fund Task Force on the 14th November 2014 that the actions are sufficient to progress work on the BCF Plan to a level that will support the discharging of the conditions by the date on which a further submission is made.

3.2 Members will note from the content of the plan that it is our collective view that we have already completed most of the actions recommended be taken by Deloitte during the assurance process. In seeking to discharge the conditions, we have confirmed we want 'Consultancy Support' to progress at pace, further work on cohort analysis and impact assessment of the Plan on the acute sector. This will further assist with providing robust plans which evidence the ability through the Integration Schemes of Work, to reduce non elective admissions (NEL) .

3.3 In addition, specialist support has been sought in the action plan, to undertake economic modelling to understand the impact that integration will have across the wider health, care and wellbeing system and in engaging providers across the wider system.

3.4 Notwithstanding this request for additional support, early discussions have also taken place between the Chief Officer of NHS South Sefton and NHS Southport & Formby CCGs and the Kings Fund to develop a facilitated engagement process with key stakeholders across the wider health and wellbeing system.

3.5 It has been agreed with the BCF Advisor that we will work towards making a further submission at the end of November, subject to approval of this by the CCG Governing Bodies and by the Council. This will not only provide early feedback on whether the conditions have been discharged, it will also provide additional time if further work is required for a December 2014 submission.

4. Recommendations

4.1 Governing Body members are asked to:-

- note the content of the letter and the Action Plan;
- approve the making of a further submission for the end of November.

Sam Tunney
November 2014

NHS England

Publications Gateway Ref. No. 02396

Quarry House
Quarry Hill
Leeds
LS2 7UE

E-mail: england.coo@nhs.net

To:
Sefton Health and Wellbeing Board
NHS South Sefton CCG
NHS Southport and Formby CCG

Copy to:
Sefton Metropolitan Borough Council

29th October 2014

Dear colleague,

Thank you for submitting your revised Better Care Fund (BCF) plan. I know this has been a very rigorous and demanding process, so I am extremely grateful for the considerable thought and work that has gone into your plan. It is clear that your team and partners have worked very hard over the summer, and have a clear commitment to improving people's care.

I am writing to confirm the outcome of the plan assurance process. As you will know, plans have been subject to a robust and consistent methodology to assure the quality of local plans (the Nationally Consistent Assurance Review (NCAR)). While I recognise the significant progress that has been made in such a short space of time, the review process identified a number of fundamental delivery risks and areas where the plan needs to be strengthened further. The outcome of the NCAR process has therefore placed your plan in the **'Approved Subject to Conditions'** category.

It is important to stress that we consider the conditions to be critical to the successful delivery of your plan, and at this stage it means that your plan has not yet been fully approved. The full NCAR outcome report for your plan is attached to this letter.

As set out in the NCAR methodology document published in August[1], areas whose plans fall into the 'Approved Subject to Conditions' category will need to fulfil specified conditions before their plan is fully approved. If required, you will receive additional support to assist you in meeting these conditions.

The conditions are set out below:

- Condition 1b: The plan must further demonstrate how it will meet the national condition of having an agreed impact on acute care sector to prevent people reaching crisis point and reducing the pressures on A&E
- Condition 3: The plan must further demonstrate how it will deliver the planned Non-Elective admissions reduction

Appended to this letter is your NCAR outcome report which documents the agreed actions. In order to assist you in revising your plan, we have appointed a Better Care Advisor Julie Warren who will work with you to develop an action plan to detail how and by when the agreed actions will be addressed to meet the above conditions. Once the conditions have been met your plan will be considered again for approval. More detail on this process is included further in this letter.

We recognise that you may need to start entering into spending commitments now in order to ensure continuity of service. If this is the case, and you feel that with appropriate support you will meet the conditions set out in this letter, then you should proceed with gearing up for implementation on the basis that you will meet the conditions (and thus move to an approved plan). However, we strongly recommend that:

i. Commissioners should not enter into any S.75 agreement to pool budgets and/or under which a local authority is to commission the relevant services until plan approval has been obtained;
ii. If embarking on any procurement process before approval is confirmed, commissioners should make it absolutely clear to potential providers in all procurement documentation that the award of a contract will be strictly conditional on that approval being obtained, that the commissioners have discretion to abandon, amend or vary the procurement at any point prior to contract award, and will have no liability to potential providers for wasted bid costs or otherwise should they exercise that discretion;
iii. If commissioners reach the point at which they are ready to enter into contractual arrangements with any provider for the relevant services when their plan has still not been approved, they should either (and preferably) defer doing so until approval has been obtained, or (and only if entering into the contract at that stage is entirely necessary) only do so having included in the relevant contract appropriate provisions to ensure that the contract (or the contract insofar as it relates to the relevant services) is conditional on final plan approval by NHS England and other appropriate protections as further described in the attached guidance document;
iv. Commissioners should under no circumstances make payments to providers prior to approval being obtained. In the event that payments are made and approval is not granted, commissioners will not receive funding for those payments.

Please ensure you follow the guidance issued by NHS England and include standard wording approved by NHS England in every formal document that could commit any element of your share of the national £3.46bn 15/16 BCF monies which is being routed via CCGs (i.e. contracts, procurement processes, Section 75 Agreements and such like) to ensure that it makes clear that it is subject to

final plan approval by NHS England. The guidance is attached to this letter.

NHS England may not approve the expenditure that has been committed to and this is why it is essential to follow the guidance. If the clause is not included and NHS England does not approve the expenditure, it will be for local commissioner(s) – not NHS England – to fund any shortfall.

With regards to following the guidance, I recognise that in practice CCGs will be planning to put their BCF allocation into a pooled fund under section 75 of the NHS Act 2006, and for a significant proportion of that to be spent by partner local authorities rather than the CCG. The recommendation to insert a standard clause in all contracting documents, procurement documents, and section 75 agreements relating to BCF expenditure applies to CCGs. However, given the release of the entire CCG BCF allocation will remain subject to approval of a plan, local authorities will need to work closely with relevant CCGs to consider any proposals to enter into spending commitments that are dependent on the release of CCG funds to the section 75 pool. If local authorities choose to go ahead with entering into spending commitments, they would bear the financial risk of entering into a contract which they may find in April they do not have the funding for if NHS England does not approve the plan.

For clarity the guidance only applies to the BCF funding that is routed directly through the CCG. You will be aware that a small proportion of your total BCF allocation (the Disabled Facilities Grant and Social Care Capital Grant) will be paid directly to the local authority by the Department of Health and Department of Communities and Local Government under section 31 of the Local Government Act 2003. The detailed terms and conditions under which this part of your area's BCF allocation will be paid will be confirmed later this year, but we expect this will include an equivalent requirement for this money to be spent in line with an agreed and approved BCF plan.

I want to reiterate that the policy intent is that all BCF funds will remain within the local area as per the published guidance.

Process for getting to approval

To support you to improve your plan you have been allocated a dedicated Better Care Advisor Julie Warren who will work with you to develop an action plan setting out how and when you will address the agreed actions and meet the conditions outlined above. This action plan should be submitted to bettercarefund@dh.gsi.gov.uk by 14 November 2014. This process of agreeing an action plan will also include agreeing a programme of further support.

Your Better Care Advisor will also work with you to agree the level of resubmission and further assessment that will be required, and the timetable for submission. Your updated plan will be subject to an assurance process that is proportional to the materiality of the conditions set out in your NCAR outcome report (i.e. if these are wide-ranging the plan may be subject to a full NCAR assessment, but if they are narrower in scope your Better Care Advisor will agree the level of resubmission required to secure approval).

The aim is to get your plan to a fully approved status by end of December 2014. Once the conditions set out earlier in this letter have been met, your plan may be approved subject to the following standard conditions which apply to all BCF plans. These are as follows:

- The Fund being used in accordance with your final approved plan and through a section 75 agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[2]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance.

These conditions would be imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These allow NHS England to make payment of the BCF allocation subject to conditions. If the conditions are not complied with NHS England is able to withhold or recover funding, or direct the CCG that it be spent in a particular way.

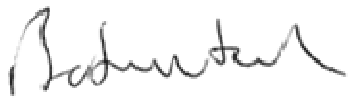
Non-elective (general and acute) admissions reductions ambition

As there is a considerable amount of time between the submission of BCF plans and their implementation from April 2015, we recognise that some areas may want to revisit their ambitions for the level of reduction of non-elective admissions, in light of their experience of actual performance over the winter, and as they become more confident of the 2014/15 outturn, and firm-up their plans to inform the 2015/16 contracting round. Any such review should include appropriate involvement from local authorities and be approved by HWBs. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans.

The Better Care Fund remains a significant enabler for delivering better, more integrated care for people locally. I hope that some further time and additional support and information will enable you to take the final steps to having a fully approved plan, and move quickly towards implementation.

Once again, thank you for the work and local leadership that you have shown in developing your plan so far.

Yours sincerely,



Dame Barbara Hakin
National Director: Commissioning Operations
NHS England

[1] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-nat-ass-methodology.pdf
[2] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

Local Government Association

Reviewer Body:
Deloitte

NHS England

Sefton

Please select 'preliminary' Quality of written plan (y-axis):
Medium Quality

Priority order for HWB Discussion	Review Area	Risk Category	Risk Applicable \ Line of Enquiry (please select from dropdown list)	Reviewer's Reasoning \Notes	Notes of discussion with HWB and Area Teams	Outcome Staus \ Pending HWB Action (please select staus from dropdown list in the first box)	Link to Conditions Applied (please write your conditions in bold)	How Agreed Action Will be Met You will also need to consider what additional resources and skills sets will be required within your local area to meet these actions	Target Date for Completion	Support Required (to be agreed with Better Care Advisor) Please note that although support can be provided, resource and skill sets are limited and so you will need to prioritise your requests for support with your Better Care Advisor
Example	Analytics	Showstopper	**A1-P4P: validity issue with values submitted - errors in plan values entered are causing incorrect results**	DTOCs (in 6. HWB Supporting Metrics tab, template 1) shows increase in rate quarter on quarter for two quarters, but no rationale is given in the box provided (cell R29), as required by the guidance. Increase is fairly marginal on each so may be due to local factors	HWB understood the issue during the call and agreed to look into before the final assessment day	**No longer a risk - if the following action is put in place (enter action in box below)** A rationale is added to the required box for the red ratings in 6. HWB Supporting Metrics tab, template 1, that explains the increased DTOCs in the two quarters.	The plan must further demonstrate how it will **deliver the planned Non-Elective Admissions reduction**	Further analysis will be undertaken to understand the increase in rates to provide a rationale for this trend	12/12/2014	None
1	Narrative	Showstopper	**N1-The National Conditions have not been met**	Social Care services Most of the required points have been covered. The plan does not provide the following detail outlined in the Narrative Risk Assessment Checklist: • An articulation of how this funding will be used to support improved outcomes for carers, including: What types of services are being commissioned and how will the experience be different from the perspective of a carer	HWB made it clear that they have a lot of the information requested and it was submitted in previous iterations of the template. Therefore HWB happy to provide further detail.	**No longer a risk - if the following action is put in place (enter action in box below)** Provision of further detail in the areas identified to the left.		**Amendments made to relevant sections within BCF Form. Namely:** Social Care Service - Paragraph 7a) iii) / Seven Day Services - Paragraph 7b) / NHS Number - Paragraph 7c) i) / Open APIs Open Standards - Paragraph 7c) ii) iii) / Joint Assessments & Accountable Leads - Paragraph 7d	Completed	
2	Narrative	Top Risks	**N6-The plan depends heavily on local providers but this is currently not recognised by the providers**	Southport and Ormskirk Hospital NHS Trust have agreed with the schemes and care integration in general, but believe that a) the NEL admissions reduction target does not take into account the expected demographic increase and that the calculation should be based on the baseline period, not 2014/15 projections. The Trust also point out that no additional services have been proposed within the BCF plan.	Both providers have signed up to the principles and the targets within the BCF; however, they both have concerns over the deliverability of the 3.5% target. Both trusts are financially challenged and both are seeing high levels of emergency activity, they are therefore concerned that the schemes will not deliver the 3.5% due to the pressures of continuing growth in activity for demographic reasons. Both trusts are heavily involved and engaged in the delivery of this agenda; there are strategic partnership boards in place on which both providers are represented and they are also involved in the provider forum as part of the HWB structure.	**No longer a risk - no further action required**		Not applicable	Not applicable	
3	Narrative	Top Risks	**N7-There is unsufficient detail as to how the schemes will be delivered**	Scheme 1: • Investment requirements should show detailed breakdown – what is the investment for • Impact of scheme is missing • Instead of key success factors, outputs and outcomes have been provided Scheme 2:	HWB confirmed that scheme 4 was later in the development process, which explains why there is less detail in the annex 1 scheme description. Scheme 4 is a critical scheme requiring cultural change and workforce development so it may be tricky to provide a full outline of the future model in the timeframes. However, more detail can be provided on the process.	**No longer a risk - if the following action is put in place (enter action in box below)** Provide more detailed Annex 1 scheme descriptions in the areas described to the left, ensuring that all scheme descriptions are completed to a consistent standard as far as possible within the timeframes.		**Amendments made to Scheme descriptions** Agreement reached that Scheme 4 becomes an enabler scheme	Completed and greater information included in covering letter	
4	Narrative	Further Risks	**N8-Insufficient documentation of the risks**	The submitted risk log is detailed and takes a wide range of potential risks into account. Please also consider risks related to the following areas if appropriate: • IT related risks from using the NHS no as the primary identifier, use of AIPs, implementation of IG controls • Any relating to 7 day services implementation	Not discussed as not considered a priority risk.	**No longer a risk - if the following action is put in place (enter action in box below)** Update risk log as described to the left.	The plan must further demonstrate how it will **deliver the planned Non-Elective Admissions reduction**	**Risks continue to be under consideration** Each Scheme lead will develop a risk log for each scheme and these will be reflected in the overall risk log for the BCF submission.	30/11/2014	None
5	Narrative	Further Risks	**N9-Insufficient evidence of engagement**	Please provide the following information, as outlined in the Narrative Risk Assessment Checklist: • Involvement of the local Healthwatch as a route to public engagement • Evidence of approaches taken to engage harder to reach groups	Not discussed as not considered a priority risk.	**No longer a risk - if the following action is put in place (enter action in box below)** Update engagement section as described to the left.		**Amendments made to relevant sections within BCF Form. Namely:** Engagement with Local Healthwatch - Section 8a). However, no specific mention on "Hard to Reach" Groups. Agreement at Programme and Integration Group meeting (11/11/14) to add information on work being undertaken with "Hard to Reach" Groups, notably through existing mechanisms of both service providers and Southport and Aintree Hospitals. Healthwatch to consider further the paragraph included on their engagement and strengthen as appropriate. Action to be completed by 14/11/14)	Partly completed. Completion date of 14/11/2014	
6	Analytics	Top Risks	**A4-P4P: the overall level of ambition is not consistent with the quantified impact of the schemes contributing to a reduction in non-elective admissions**	Impact in tab 4 does match P4P figure in tab 5. However, tab 4 emergency admission figure is aggregated up with no explanation in either tab 4 or in Annex 1 of how the total aggregate figure has been calculated. Annex 1 scheme templates do not seem to specifically outline the impact of BCF scheme on non-elective admissions and the 3 supporting metrics. Benefits are aggregated up in both the Benefits	HWB referred to page 23 of their submission for further detail on their P4P modelling. This provides a breakdown of the sources of the activity reductions; however, the descriptions listed do not appear to link to the titles of schemes in annex one, and there is no detail provided on how the 5-15% activity reductions have been estimated. However, a significant amount of work has clearly been done on modelling the impacts, so this risk may be about communicating and telling the story effectively rather than undertaking any further work. HWB commented that in integrated care it is very difficult to ascertain individual impacts to	**No longer a risk - if the following action is put in place (enter action in box below)** Provide in either tab 4 or Annex One detailed descriptions of the calculations and modelling undertaken for each scheme to support the figures currently stated in tab 4. these calculations should focus on identifying the patient cohort for each scheme, the associated activity, and the potential impact of the scheme based on national or local evidence or case studies. Provide appropriate cross-referencing if necessary between p23 of case for change, Annex One and tab 4.	The plan must further demonstrate **how it will meet the national condition of having an agreed impact on the acute sector** and **deliver the planned Non-Elective Admissions reduction.**	Further analysis will be undertaken to identify patient cohorts, linked to achievment of reduction in NELs and the impact on the acute care sector to prevent people reaching crisis point	30/11/2014	Support on cohort analysis and impact assessment on acute sector, therby dischraging conditions and engaging providers. Specialist support on economic modelling and engagement with the acute sector, so that we own the modelling and that it informs the schemes of work within the plan
7	Analytics	Further Risks	**A6-Supporting Metrics: validity issue with values submitted - errors in plan values entered are causing incorrect results**	Tab 6 Supporting Metrics No validity issues; however, the planned annual change in 2015/16 for re-ablement is zero - is this correct?	HWB confirmed that planned trajectory is to stay flat.	**No longer a risk - no further action required**		Not applicable	Not applicable	
8	Analytics	Further Risks	**A7-Supporting Metrics: the level of ambition for a given metric is not consistent with the quantified impact of the schemes contributing to it**	Tab 6 Supporting Metrics indicates a reduction of 5 residential admissions per year in 2014/15 and 2015/16. Tab 4 Benefits Plan is accurate for 2014/15 (reflecting a reduction of 5) but is not accurate for 2015/16 (indicating a reduction of 10). Quantified benefits of re-ablement and DTOCs not included in Tab 4 Benefits Plan. In addition, tab 6 Supporting Metrics indicates an increase rather than a decrease in annual change for DTOCs.	HWB commented that supporting metric trajectories have largely been set on the basis of remaining flat through 2015/16, therefore there are no benefits for completion in tab 4. The outcome of this risk is therefore dependent on whether the HWB consider making their trajectories more ambitious: if they do, they will need to demonstrate in tab 4 how these trajectories will be achieved, by linking back to schemes.	**No longer a risk - if the following action is put in place (enter action in box below)** If the HWB reviews and changes its trajectories for supporting metrics, complete tab 4 for all metrics. Provide calculations either in Annex 1 or in tab 4, by showing the impact of individual schemes on these metrics, and indicating that the aggregate impact links with the metric improvement in tab 6.	The plan must further demonstrate **how it will meet the national condition of having an agreed impact on the acute sector** and **deliver the planned Non-Elective Admissions reduction.**	Further analysis will be undertaken to identify patient cohorts, linked to achievment of reduction in NELs and the impact on the acute care sector to prevent people reaching crisis point	30/11/2014	Support on cohort analysis and impact assessment on acute sector, therby dischraging conditions and engaging providers. Specialist support on economic modelling and engagement with the acute sector, so that we own the modelling and that it informs the schemes of work within the plan
9	Analytics	Further Risks	**A8-Supporting Metrics: contextual information indicates that the plan(s) may be under or over ambitious**	Sefton appear to be under-ambitious on all three metrics. Residential admissions – a planned reduction of 1% or 5 admissions in both 2014/15 and 2015/16. According to contextual data, Sefton has a high rate of residential admissions compared to the national average. Re-ablement – Sefton are average compared to the national average therefore there may be room to stretch further. DTOCs - Annual change is increasing not decreasing. Statistical improvement would be a reduction of 2.4%.	HWB confirmed that planned trajectory for all three metrics is to stay flat.	**No longer a risk - if the following action is put in place (enter action in box below)** HWB should consider making these metrics more ambitious, or providing a rationale for why they are forecast to remain flat.		**Amendments made to relevant sections within BCF Form. Namely:** Rationale provided against flat rate forecast (Page 98 - Scheme 3, Annex 1)	Completed	
10	Analytics	Further Risks	**A10-Supporting Metrics: information provided on Patient Experience Metric is not valid**	Tab 6 Supporting Metrics No description is provided for patient experience metric. Baseline time period has not been entered. The patient experience metric lacks numerator and denominator data and the metric value does not indicate an improvement on the corresponding earlier period.	Not discussed as not considered a priority risk.	**No longer a risk - if the following action is put in place (enter action in box below)** Provide further information as explained on the left. Review trajectory for patient experience metric.		**Amendments made to relevant sections within BCF Form. Namely:** Local metric information supplied (Pages 99-100 - Scheme 3, Annex 1)	Completed	
11	Analytics	Further Risks	**A11-Supporting Metrics: information provided on Local Metric is not valid**	Tab 6 Supporting Metrics No description is provided for local metric. Baseline time period has not been entered. As the description for the local metric has not been included, it is not possible to assess the validity of the values inserted.	Not discussed as not considered a priority risk.	**No longer a risk - if the following action is put in place (enter action in box below)** Provide further information as explained on the left.		**Amendments made to relevant sections within BCF Form. Namely:** Local metric information supplied (Pages 99-100 - Scheme 3, Annex 1)	Completed	
12	Finance	Showstopper	**F2-The required minimum contribution to the fund as (as nationally calculated) is not met by individual HWBs**	The required minimum contribution from CCGs is not being met. Tab 1 Funding Sources indicates a required minimum of £21.232m whereas tab 3 Expenditure Plan amounts to £21.230m.	HWB explained that this was a result of the template's distinction between minimum and additional contribution being tricky to follow. Agreed to update.	**No longer a risk - if the following action is put in place (enter action in box below)** Update tab 3 so that the figures precisely match tab 1.		**Amendments made to relevant sections within BCF Form. Namely:** Anomaly sorted	Completed	
			F3-Schemes are not financially evidence-based or financially	Descriptions of financial calculations are not detailed enough. Aggregated calculations are not acceptable.	HWB referred to page 23 of their submission for further detail on their P4P modelling. This provides a breakdown of the sources of the activity reductions; however, the descriptions listed do not	**No longer a risk - if the following action is put in place (enter action in box below)**		**Amendments made to relevant sections within BCF Form. Namely:**		

13	Finance	Top Risks	**modelled adequately for full benefits realisation**	Annex 1 scheme templates do not provide descriptions as to how the financial benefits have been calculated. All columns have been completed where necessary however Column I has not been completed appropriately and aggregated calculations are not acceptable. The impact of individual schemes should be quantified. Issue: 1)Residential admissions – Column I provides some description as to	appear to link to the titles of schemes in annex one, and there is no detail provided on how the 5-15% activity reductions have been estimated. However, a significant amount of work has clearly been done on modelling the impacts, so this risk may be about communicating and telling the story effectively rather than undertaking any further work. HWB commented that in integrated care it is very difficult to ascertain individual impacts to individual schemes, as the combination of schemes will deliver an overall impact. HWB commented that supporting metric trajectories have largely been set on the basis of remaining flat through 2015/16, therefore there are no benefits for completion in tab 4. The outcome of this	Provide in either tab 4 or Annex One detailed descriptions of the calculations and modelling undertaken for each scheme to support the figures currently stated in tab 4. these calculations should focus on identifying the patient cohort for each scheme, the associated activity, and the potential impact of the scheme based on national or local evidence or case studies. Provide appropriate cross-referencing if necessary between p23 of case for change, Annex One and tab 4. Provide clarity on which schemes contribute to which reductions and on the source of the 5-15% activity reductions.		Each of 3 schemes within Annex 1 now show budget and modelling calculations	Completed	
14	Finance	Top Risks	**F4-BCF financial risks are not fully identified, inadequate contingencies, lack ownership**	Risk log appears to be missing discussions of financial risk to acute providers i.e. if non-elective activity decreases, can they release sufficient capacity in order to make savings? Risks identified elsewhere which have not been included – i.e. section 5b states "…concerns that reductions in activity may not release savings as they could be offset by increasing complexity in the providers' case mix". Risk sharing agreement is being developed. No reflection of risk	Not discussed as not considered a priority risk.	**No longer a risk - if the following action is put in place (enter action in box below)** Include further detail in risk log as described to the left.	The plan must further demonstrate how it will **deliver the planned Non-Elective Admissions reduction**	**Each Scheme lead will develop a risk log for each scheme and these will be reflected in the overall risk log for the BCF submission.**	30/11/2014	None
15	Finance	Top Risks	**F5-Full budgets are not identified to meet the additional costs resulting from the new Care Act duties**	Section 7a(iii) in Part One does not state the total amount from the BCF that has been allocated for the protection of adult social care services. With regards to how the funding will ensure the new Care Act duties are met, further detail could be included around oversight and accountability.	Not discussed as not considered a priority risk.	**No longer a risk - if the following action is put in place (enter action in box below)** Provide figure in section 7a(iii) as described to the left.		**Amendments made to relevant sections within BCF Form. Namely:** Section 7a (iii) amended to included figures	Completed	
16	Finance	Top Risks	**F6-Full budgets are not identified to meet the cost of carers**	Plan does state total value in section 7a(v). However, further detail is required – please explain what carer specific support the money is being spent on.	Not discussed as not considered a priority risk.	**No longer a risk - if the following action is put in place (enter action in box below)** Provide further detail as requested on the left.		**Amendments made to relevant sections within BCF Form. Namely:** Section 7 - V amended to show figure and types of service spend	Completed	
17	Finance	Further Risks	**F8-Insufficient funding for critical schemes**	Tab 3 Expenditure Plan and Annex 1 Templates Annex 1 templates do not provide sufficient detail with regards to expenditure of the schemes. A total expenditure cost for three of the four schemes is indicated which tallies with that detailed in tab 3 Expenditure Plan; however, the specifics of this expenditure is not provided i.e. staffing costs, equipment costs. The fourth scheme does not provide any information re expenditure.	Not discussed as not considered a priority risk.	**No longer a risk - if the following action is put in place (enter action in box below)** Provide further detail on breakdown of expenditure for each scheme where possible.		**Amendments made to relevant sections within BCF Form. Namely:** Total expenditure for each scheme listed in Annex 1 included	Completed	
18	Finance	Further Risks	**F9- Unrealistic savings**	Descriptions of financial calculations are not detailed enough. Aggregated calculations are not acceptable. Annex 1 scheme templates do not provide descriptions as to how the financial benefits have been calculated. All columns have been completed where necessary however Column I has not been completed appropriately and aggregated calculations are	HWB referred to page 23 of their submission for further detail on their P4P modelling. This provides a breakdown of the sources of the activity reductions; however, the descriptions listed do not appear to link to the titles of schemes in annex one, and there is no detail provided on how the 5-15% activity reductions have been estimated. However, a significant amount of work has clearly been done on modelling the impacts, so this risk may be about communicating and telling the story effectively rather than undertaking any further work. HWB commented that in integrated care it is very difficult to ascertain individual impacts to	**No longer a risk - if the following action is put in place (enter action in box below)** Provide in either tab 4 or Annex One detailed descriptions of the calculations and modelling undertaken for each scheme to support the figures currently stated in tab 4. these calculations should focus on identifying the patient cohort for each scheme, the associated activity, and the potential impact of the scheme based on national or local evidence or case studies. Provide appropriate cross-referencing if necessary between p23 of case for change, Annex One and tab 4.		**Amendments made to relevant sections within BCF Form. Namely:** Each scheme detail in Annex 1 has this information now included	Completed	
19	Area	Self Assessment		A description of who is delivering the care and support, who is receiving the care and support, including where and when the care and support is being delivered, and a description of which aspects of service change would not otherwise be delivered without the Better Care Fund	BCF Form Part 2	Paragraphs for inclusion in BCF 3 Plan		**Amendments made to relevant sections within BCF Form. Namely:** Part 2 (Table at Pages 8 & 9) included	Completed	
20	Area	Self Assessment		Provision of joint assessments and accountable lead professionals for high risk population to include a description of any action being taken to remove barriers to joint assessments and planning; a description of the role of accountable lead professional as it is envisaged, such that the patient knows who to contact when they need to and can get timely decisions about their care; how GPs will be supported in being accountable for co-ordinating patient centred care for older people and those with complex needs; and demonstrating consideration of	BCF Form Part 7d	Paragraphs for inclusion in BCF 3 Plan		**Amendments made to relevant sections within BCF Form. Namely:** Paragraph included at Section 7 d)	Completed	
21	Area	Self Assessment		Confirmation, in line with the Mandate requirements on achieving parity of esteem for mental health, that plans do not have a negative impact on the level and quality of mental health services	BCF Form Part 8	Paragraphs for inclusion in BCF 3 Plan		**Amendments made to relevant sections within BCF Form. Namely:** Statements made within Section 8 of the Form	Completed	

Key Issues
Quality Committee

NHS
South Sefton
Clinical Commissioning Group

Meeting Date	**23 October 2014**
Chair	**Roger Driver**

Key Issues	Risks Identified	Mitigating Actions
1. Challenges in implementing recommendations highlighted in the Safeguarding Peer Review within identified timescales	• Inability to meet timescales originally set out for achievement of specific actions due to issues that aren't directly within the CCG control	• On CCG Corporate Risk Register • CCG Steering Group established to drive necessary developments • Interaction with partners who are key to successful delivery of required actions were achievement is outside of the CCG-only control • CCG action plan presented to Quality Committee bi-monthly for purposes of scrutiny and assurance

Notifications to the Governing Body
1. **Single Item Quality Surveillance Group Meetings with the Provider Present -** The Quality Committee received an update on the outcome of the recent Single Item Quality Surveillance Groups with the Provider Present for SSP, Royal Liverpool & Broadgreen University Hospitals NHS Trust and Aintree University Hospital NHS Foundation Trust. These all took place in October 2014 and were Chaired by NHSE (Merseyside). Satisfactory levels of assurance were received.
2. **CCG Health Care Acquired Action Plan -** The Quality Committee approved the closedown of the CCG HCAI action plan for 2013/14 and approved the action plan for 2014/15. Embedding of systems and processes evident and good progress being made against 2014/15

	deliverables.
3.	**Voice of the Child and Young Person -** EPEG to lead on the CCG plans for securing the voice of the child and young person and provide regular updates to the Quality Committee by way of assurance. This is a key action within the CCG Safeguarding Peer Review.
4.	**CCG Governing Body Assurance Framework and Corporate Risk Register -** The Quality Committee reviewed the CCG Governing Body Assurance Framework for Q2 2014/15 and the Corporate Risk Register for the purposes of assurance.
5.	**CCG Risk Management Strategy** – The Quality Committee recommended that the updated Risk Management Strategy be presented to the Governing Body for approval

Key Issues
Quality Committee

NHS
South Sefton
Clinical Commissioning Group

Meeting Date	September 2014
Chair	Craig Gillespie

Key Issues	Risks Identified	Mitigating Actions
• CCG Complaints Policy.	• Requires review to ensure that the voice of the child and young person is explicit (action following safeguarding peer review).	• Appropriate component parts to be strengthened – overseen by Corporate Governance Group. To be presented back for approval.
• Cold chain incidents within General Practice.	• Potential patient safety concerns following break in cold chain.	• CCG Medicines Management Team working collaboratively with NHSE(M)/PHE. • Root cause analysis (RCA) being undertaken supported by NHSE(M)/PHE. CCG to raise with NHSE(M) / PHE concerns expressed regarding support given to a particular GP practice in order to undertake the RCA process effectively. • Quality Committee supported recommendations from Medicines Management to undertake cold chain audits, briefings to practices and liaison between team and Practice Nurse Facilitators.
• AUH Safeguarding Performance.	• Validated Trust performance feedback from Safeguarding Service resulted in the Quality Committee not having the necessary level of assurance	• Chief Nurse to facilitate a meeting between the Trust, CCCG, CSU and Safeguarding Service to go through KPIs and discuss the evidence required for validation to increase level of assurance. • Chief Nurse to arrange Safeguarding Quality Walkaround with the Trust to support the assurance process.

Notifications for the Governing Body
1. Chairs action taken to approve changes made to the CCG Safeguarding Children & Vulnerable Adults Policy. Policy presented to July 2014 Governing Body for ratification of the Quality Committee recommendation that the policy be approved subject to these amendments.

Key Issues
Service Improvement Redesign Committee

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Meeting Date **Wednesday 10th September 2014**

Chair **Dr Niall Leonard**

Key Issues	Risks Identified	Mitigating Actions
Terms of reference for SIR Committee.	Need to have separate focus on respective CCG priorities.	To run with committee in common for 6 months and review working arrangements
Strategic Programmes	Understanding an alignment of programmes across both CCGs	Programme leads to present progress to the committee on a rotational basis (Sharon F and Jenny) brief over progress paper (cathy to note)
Commissioning Intentions	Need for localities and lead clinicians to understand priority areas and opportunity areas to improve performance and quality of services	Localities to review locality packs. Locality packs to be distributed to SIR Committee membership for consideration of advanced of next meeting.
Quality Premium	Need to ensure clinical consensus of selection of local premiums for 2015/2016	Becky Williams to attend next meeting setting out choices for local QPs
Virtual Ward	Virtual ward has a narrow focus and is not sensitive to system wide transformation necessary to improve the quality of services and outcomes for patients	Develop a south sefton wide transformation approach, to be approved by the Governing Body
Care Closer to Home	Needs to refocus Care Closer to Home around CCG priorities and reduction in unplanned activity	Finalise Care Closer to Home Strategy with CCG involvement

Primary Care Quality	Lack of integrated and prioritised focus to support CCGs priorities	SIR committee and clinicians to direct areas for inclusive in primary care quality strategy for years 2 and 3

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
Southport and Formby
Clinical Commissioning Group

Key Issues Log – CCG Network

Committee: CCG NETWORK	**Meeting Date:** 3rd September 2014	**Chair:** Dr Steve Cox

Key issues:	**Risks Identified:**	**Mitigating Actions:**
1. Cheshire & Merseyside Maternity Services Review.	• Lack of alignment with output of Healthy Liverpool discussions re Maternity Services.	• Liverpool CCG Chief Nurse/Head of Quality to be on steering group for Cheshire and Mersey review.
2. Commissioning Support Arrangements.	• Failure of service delivery.	• Confirm intentions going forward. • Explore future ownership/hosting arrangements with CCGs across Cheshire and Mersey.

Recommendations to the Governing Body:
That the CCG Governing Body notes the issues, risks and mitigating actions.

NHS
Southport and Formby
Clinical Commissioning Group

Key Issues Log – CCG Network

Committee: CCG NETWORK	**Meeting Date:** 1st October 2014	**Chair:** Dr Steve Cox

Key issues:	**Risks Identified:**	**Mitigating Actions:**
1. Review of Stroke Services by Cheshire and Merseyside Clinical Strategic Network	• That local population needs are not fully recognised and direction of travel is not consistent with Healthy Liverpool Programme	• Meeting of Merseyside CCG Stroke Leads to consider how agreed standards are implemented across Merseyside.
2. Neuro Rehabilitation	• Service previously commissioned by NHS Merseyside Cluster for 18 month period – unclear whether outcome are being achieved.	• Service contract to be extended for 1 year whilst independent evaluation is undertaken

Recommendations to Governing Body:
That the CCG Governing Body notes the issues, risks and mitigating actions.

NHS
South Sefton
Clinical Commissioning Group

Quality Committee Minutes

Date: Thursday 21 August 2014
Venue: 3rd Floor Boardroom, Merton House, Stanley Road, Bootle

Membership		
Craig Gillespie	Chair, GP Governing Body Member	CG
Lin Bennett	Practice Manager Governing Body Member	LB
Dan McDowell	Secondary Care Doctor	DMcD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Martin McDowell	Chief Finance Officer	MMcD
Malcolm Cunningham	Head of Primary Care & Contracting	MC
Also in attendance		
James Hester	Programme Manager – Quality	JH
Apologies		
Dr Debbie Harvey	Clinical Lead for Integrated Care	DH
Fiona Clark	Chief Officer	FLC
Dr Debbie Harvey	Lead Clinician for Strategy and Innovation	DH
Dr Gina Halstead	GP Quality Lead	GH
Jo Simpson		
Brendan Prescott	Deputy Head of Quality	BP
Tracey Forshaw		
Ann Dunn		

Membership Attendance Tracker

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

✓ Present
A Apologies
L Late or left early

No	Item	Action
General business		
14/114	**Apologies for absence** were noted as above.	
14/115	**Declarations of interest regarding agenda items** Members holding dual roles across CCGs declared their interest. CG and LB declared their interest in General Practice in relation to Agenda Item 14/119	
14/116	**Minutes of the previous meeting** were accepted as a true record.	
14/117	Matters arising/action tracker *14/31 C-Diff cases reported* - CMCSU to provide full year to date information required based on provider not patient. ***JS tabled two sheets of provider data in relation to this item.*** ***Aintree UHNHS FT have set an internal target of 37 cases. This data will be brought to the external meetings going forward.*** *14/33 Reporting of SIs* – meeting arranged with Mersey Care/ our GP clinical leads/CCG to discuss SUI reporting within the Trust ***These issues have been resolved. DF will review the current reporting arrangements.*** *14/105 SI update* - JH to follow-up the missed fracture incident at LB's practice, as it had not yet appeared on system. ***JH has shared this information with LB. Further investigation will take place and be reported via the Internal SUI Group.*** 14/106 Liverpool Clinical Laboratories – GH/DF to report back to Quality Committee with more information. ***DF reported that further task and finish group has been held. DF will ensure that LCL write to practices in November 2014 to ascertain if patients have suffered harm. Agreed that level of assurance is currently deficient. This issue will go to external review. LCL will send list of all patients by practice that they have contacted. It has been identified that the contract is with Aintree UHNHSFT. There are a number of governance arrangements to be resolved. FLC has requested that each issue be individually risk rated and describe the mitigations in place.*** ***CG requested clarification that all affected patients have been contacted and can the CCG be assured that this will not happen again?*** ***DF confirmed that updated software is in place in addition the daily checks. The CCG is assured as it can be.***	JS DF JH DF
Service improvement/strategic delivery		
14/118	**Approval of the Travel Vaccination Patient Group Directions** SR presented this report requesting the approval of the Travel Vaccination Patient Group Directive. The Quality Committee noted that: Although certain travel vaccinations are not part of the National Immunisation Programme they can be given to patients as part of NHS provision though GMS Additional Services. Patient Group Directions for these vaccines have been developed and produced by the Cheshire and Merseyside Childhood Immunisation PGD subgroup, they have been	

No	Item	Action
14/118	signed by a lead doctor and a lead pharmacist, however the CCG needs to authorise their use and subsequently a senior GP within a practice needs to authorise their use within individual GP surgeries SR noted that a question had arisen in relation to particular brands being named in the PGD. If practices want to use a different brand but would need to issue an individual patient prescription. Clarification will be sought from Helen Stubbs SA requested clarification of funding in relation to these prescriptions. It was identified that this PGD will expire in 2015. Action taken by the Quality Committee **The Quality Committee approved the Travel Vaccination Patient Group Direction.**	SL
14/119	**Asthma Management Plan** SR presented this report and noted that this plan is being brought back to the committee as asthma treatment should be reviewed every 6 months. The committee requested that the evidence for this is examined as currently in primary care the QoF requirement is to review asthmatic patients every 12 months. The clinical guidance has been examined and: • QoF states: the percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions; • The British Thoracic Society guidelines state: in primary care, people with asthma should be reviewed regularly by a nurse or doctor with appropriate training in asthma management. The review should incorporate a written action plan. Action taken by the Quality Committee **The Quality Committee approved the use of this asthma management plan within South Sefton CCG practices.**	

No	**Item**	Action
14/120	**Management of allegations policy** DF presented this policy and noted the aim is to ensure that there is a single, consistent approach in the management of an allegation made against a professional or CCG employee about a child/young person/ vulnerable adult that is consistent with national and local guidance. It was noted that the table of contents needs to be approved prior to submitting to the Governing Body. Action taken by the Quality Committee **The Quality Committee recommended the approval of the Management of Allegations policy to the Governing Body.**	DF

14/121	**Virtual Ward Governance** PC presented this report and noted that the Virtual Ward is an integrated clinical care system encompassing different providers. The three papers have been developed with the support of CSU to provide the committee with assurances regarding all areas relating to governance in the Virtual Ward: • Virtual Ward Governance arrangements document; • PIA; • ISA. CG requested clarification in relation to the PIA and how the GP would confirm with whom the information had been shared. PC confirmed that the data would only be shared via the Virtual Ward Group with approved providers. LB requested clarification in relation to data sharing as this could result in the practice having to re-contact the patient when there is a requirement to forward information to other service providers as the patient may not have given specific consent to share all aspects of the patients care history. PC noted that if the patient does not want share their entire health history then they may need to be advised of the potential impact this could have on their treatment. Action taken by the Quality Committee **The Quality Committee noted the content and approved the content of the Virtual Ward Governance papers**. **Approval was given by Martin McDowell as SIRO and Debbie Fagan as Caldicott Guardian.**	
Quality and Safety		
14/122	**Chief Nurse Report** DF presented the Chief Nurse report to update the committee regarding key issues that have occurred since the last report which was presented in June 2014 Particular attention was drawn to: • Merseyside Quality Surveillance Process • Continuing Healthcare Workshop - CCG and Sefton Council • Promoting the voice of children and young people in the CCG • Corporate Parenting Board • Local Safeguarding Boards – both Adults and Children • CCG Partnership working to support the role of student Quality Ambassador/Caremaker Role input within commissioning. LB noted concerns in relation to district nurse recruitment issues. CG assured the meeting that plans are in place for improvements; however, the CCG is aware of the risks and appreciates that the improvement programme may take up to two years. Action taken by the Quality Committee **The Quality Committee noted the contents of the Chief Nurse report.**	
14/123	**Safeguarding Peer Review Action plan** DF presented the Safeguarding Peer Review action plan which had been updated with progress to date. The next report will be brought in October 2014. Action taken by the Quality Committee **The Quality Committee noted the contents of the Safeguarding Peer Review Action plan.**	DF

Information		
14/124	**Meeting minutes of the Primary Care Quality Board were received.** LB noted that a number of practices are reported to have "unofficially" closed lists. SA will attend the next meeting and take this action forward.	
14/125	**EPEG Key Issues Log June 2014 received.**	
Closing business		
14/126	**Any Other Business** **DF reported that there had been two reported never events at S & O Hospital.** **DF reported that in relation to the Safeguarding documentation there has been an improvement.**	
14/127	**Date of next meeting** **Thursday 18th September 2014** **3.00pm – 5.00pm** **Boardroom, 3rd Floor, Merton House**	

NHS
South Sefton
Clinical Commissioning Group

Quality Committee
DRAFT Minutes

Date: Thursday 18th September, 3.00pm to 5.00pm
Venue: 3rd Floor Boardroom, Merton House, Stanley Road, Bootle

Membership		
Dr Craig Gillespie	Governing Body Member (Chair)	CG
Stephen Astles	Head of CCG Development	SA
Lin Bennett	Practice Manager Governing Body Member	LB
Malcolm Cunningham	CCG Head of Primary Care & Corporate Performance	MC
Roger Driver	Governing Body Lay Member	RD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Dr Gina Halstead	Clinical Lead for Quality	GH
Martin McDowell	Chief Finance Officer	MMcD
Dr Andy Mimnagh	Clinical Governing Body Member	AM
Ex-Officio Members		
Fiona Clark	Chief Officer	FLC
In attendance		
James Hester	Programme Manager – Quality & Safety	JH
Susanne Lynch	Head of Medicines Management	SL
Dr Dan McDowell	Secondary Care Doctor	DMcD
Brendan Prescott	Deputy Chief Nurse / Head of Quality & Safety	BP

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	√	√						
Steve Astles	Head of CCG Development	A	A	A	A	√	A						
Lin Bennett	Practice Manager Governing Body Member	√	A	√	√	√	√						
Malcolm Cunningham	Head of Primary Care & Corporate Performance	√	A	√	√	√	√						
Roger Driver	Lay Member	√	√	√	√	A	√						
Debbie Fagan	Chief Nurse & Quality Officer	√	√	√	√	√	√						
Dr Gina Halstead	Clinical Lead for Quality	√	√	A	√	A	A						
Martin McDowell	Chief Finance Officer	√	√	√	√	√	A						
Dr Andrew Mimnagh	Clinical Governing Body Member	A	√	√	A	A	√						

✓ Present
A Apologies
L Late or left early

No	Item	Action
14/128	**Apologies for absence** Apologies were received from SA, GH, WH, TJ, MMcD.	
14/129	**Declarations of interest regarding agenda items** Members holding dual roles across CCGs declared their interest. CG, AM and LB declared an interest in agenda item 14/132 due to their links with general practice. AM declared an interest in agenda item 14/133 due to their role as NHS111 GP Clinical Lead within the CCG.	
14/130	**Minutes of the previous meeting** These were accepted as a true record.	
14/131	**Matters arising/action tracker** CG informed the Committee that a Chair's action had been taken regarding the suggested amendments to the Safeguarding Policy that had previously been presented to the Committee, ie strengthening of safeguarding adults' flowchart and removal of the primary care audit tool and relevant wording within the body of the policy. **14/64 Data Analysis / PROMS** – BP informed the Committee that this information is available on a 6 monthly basis on the HSCIC portal. PROMs information is included in agenda item 14/135 in today's meeting and BP and JS stated that the numbers are low and that it may be more beneficial for the Committee to have a further discussion at the year end. AM stated that it would remain an area of interest due to provider performance. CG noted that Aintree University Hospital (AUH) appears to be at the lower end of the acceptable confidence interval. The Committee supported the suggestion to review the PROMs data at year end. **Outcome: Action completed.** **14/93 Feedback from the NHS England National Audit of the Child Health Surveillance System** – Not due for feedback until November 2014. **14/95 Complaints Policy (Specifically relating to the voice of children and young people)** – JH reported that the advice from the CSU to the CCG was that although amendments could be made to the policy it was not usually good practice to do so with the policy only recently having been approved. DMcD asked when the next review date would be for the policy and that the Committee would need assurances that if we waited for the scheduled review date that the policy would be amended to strengthen the contents in relation to the voice of children and young people. DF stated that the CCG mechanism for securing the voice of the child had been discussed at EPEG following on from the recommendations from the CCG peer safeguarding review and suggested that if the policy was not to be amended until the review period then the Quality Committee would need assurances that EPEG would oversee the work plan and report back. RD and JH confirmed this had been a discussion at EPEG and gave details of the work that was being undertaken. AM asked if we would be adequately assured by this and CG stated that the action was part of a recommendation from the peer review. LB stated that in General Practice they would make an addendum to the policy if the policy was not ready for review. The Committee decided that a dual approach would need to be taken – firstly, the necessary amendments should be made as appropriate at this time rather than at a future date; secondly, EPEG should continue to oversee the work plan for the voice of the child and report back to the Quality Committee by way of assurance. **Outcome 1: Action completed.** **Outcome 2: Further actions required:** **14/131(1) – JH to liaise with Debbie Fairclough and Tracy Jeffes to make the necessary amendments to the Complaints Policy. To be represented to the Quality Committee for approval once considered at the CCG Corporate Governance Group.** **14/131(2) – JH / RD to inform EPEG of the decision for the group to oversee the work plan for the voice of the child. Update report back to the Committee in December 2014.**	JH JH/RD

No	Item	Action
14/131	**14/102 Safeguarding Service Update** – DF reported that this work has been commenced via the Steering Group established and Chaired by the CCG Chief Officer. **Outcome: Action completed.** **14/105 Clinical Incident Update (issue identified from General Practice – missed fracture)** – JH provided the Committee with a response from the provider Trust (tabled response as only recently been received). CG stated that he didn't feel that the response fully answered the query that had been raised by the Quality Committee. LB stated that the response didn't feel that the response clearly set out the process for assurance purposes. AM asked if there was a clear service specification for AED attendances. MC reflected that there wouldn't usually be a specification that went into that detail. **Outcome 1: Action completed.** **Outcome 2: Further action required:** **14/131(3) - GH and Dr John Wray to pick up a conversation with the Trust regarding issue.** **14/131(4) JH/JS to look at what processes are in place in other Trusts re: x-ray reporting for A&E – to liaise with clinical colleagues.** **14/106 Liverpool Clinical Laboratories: Report to Governing Body and meeting to be arranged by NHSE(M)** – DF stated that an update had gone to the Governing Body contained within the Chief Officer Report and that NHSE(M) had arranged a date at the end of September 2014 to discuss lessons learnt. **Outcome: Action completed.** **14/117 Liverpool Clinical Laboratories: LCL to write to practices in November 2014 to close the loop in relation to any potential patient harm. Each risk to be individually risk rated** – DF reported that plans are in place for LCL to write to practices and that the rating of each individual risk has commenced and will be discussed at the Aintree Collaborative Forum. DF stated that the overall risk associated with this has previous been entered onto the CCG Risk Register. Regular updates will be received by the Quality Committee by GH and DF. **Outcome: Action completed.** **14/111 Commissioning review policy (including infertility and varicose veins)** – Update to Quality Committee when Jan Leonard receives the necessary clarity re: varicose veins element as work still on-going. **Outcome: Action deferred to November 2014** **14/117 C.Diff data for providers to be brought to external Quality Committee Meetings as benchmarking data** – JS tabled the data. To be included in Performance and Quality Report going forward. **Outcome: Action completed.** **14/117 Reporting of SUIs (refers to previous action 14/33) to review reporting practice in relation to Mersey Care** – DF stated that the Quality Committee had previously been informed that the meeting between the CCG and the provider has taken place. DF suggested to the Committee that the review of the reporting practice should take place at the CCG internal SI meeting and any issues in future addressed through the CQPG. This was supported by the Committee. **Outcome: Action completed.**	GH/JW JH/JS JL

No	Item	Action
14/131	**14/118 Travel Vaccinations: Clarification to be sought from the Meds Management Team with Helen Stubbs from CSU regarding practices using a different brand than that stated within the PGD (feasibility of doing so / does another brand exist / will an individual prescription be required** – awaiting response. Susanne Lynch to follow-up with the team. **Outcome: Action deferred until October 2014** **14/120 Management of Allegations of Abuse Policy: contents page to be amended before going to Governing Body** – this action has been completed and evidenced to Chair of the Quality Committee. **Outcome: Action completed.** **14/122 Safeguarding Peer Review Action Plan** – not due until October 2014 **14/124 Closed Practice Lists** – AM stated that there should be no such thing as an unofficially closed practice list. BP stated that the action for himself and SA to discuss this issue at the Primary Care Quality Board will be evidenced in that board's minutes and escalated back to the Quality Committee if necessary. **Outcome: Action completed.**	SL
14/132	**Vaccine Incidents in General Practice** Suzanne Lynch (SL) presented the paper to the Committee that gave details regarding four recent cold chain incidents that had occurred within south Sefton CCG practices. The committee was asked to receive and approve a plan of action to reduce risks to patients. The proposed plan consists of cold chain audits; briefings for practice staff; individual advice to practices regarding cold chain management from the Medicines Management Team; circulation of the CCG cold chain policy to practices following appropriate approval mechanisms (including the September 2014 meeting of the Joint Medicines Operational Group); liaison between Medicines Management and practice nurse facilitators to brief practice nurses at a development session. CG raised that a practice involved in one of the incidents brought the issue to a locality meeting as part of peer review and the committee acknowledged this as good practice. The committee discussed the support that the CCG had given to the Root Cause Analysis (RCA) Investigation process that was being led by NHSE/PHE and how the lessons learnt should feed into the work plan presented within the paper. SL raised the concern that the Practice Manager for one of the practices had been asked to lead on this process and further support from a leadership perspective may be required from NHSE/PHE to the practice as this was new to them in order to ensure accurate identification of the root cause in order to inform lessons learnt and recommendations. Action taken by the Quality Committee 1. The Quality Committee approved the recommendations in the paper 2. DF to contact NHSE(M) Director of Nursing to confirm leadership arrangements around the RCA for the cold chain incidents	DF
14/133	**NWAS 111 Call Report for June 2014 Activity** BP and AM presented the report to the Committee and stated that this was the first time such a report had been on the agenda. The Committee were asked to consider if going forward this high level data across Merseyside was of use to the Committee. AM expressed the opinion that the Quality Committee may be interested in selected reporting of patient incidents. MC stated that it would be necessary to examine what was in the current contract in order to inform discussions regarding the level of data that would be available. Action taken by the Quality Committee 1. The committee received the report. 2. BP, MC, AM and Terry Hill (TH) to meet to discuss format of data and intelligence to be received at the Quality Committee and feedback to NWAS.	BP/MC/ AM/TH

No	Item	Action
14/134	**Safeguarding Assurance Report** AD and TF presented the Safeguarding Assurance Report to the Committee and stated that only information regarding the CCG main providers was included as due to timelines for submission of papers it had not been possible to quality assure all of the provider submissions. The Safeguarding Service stated that they were able to give the Committee reasonable assurance with regard to the information submitted for Q1 for Liverpool Community Health NHS Trust. AD and TF reported on-going issues with Aintree University Hospital NHS Foundation Trust (AUH) regarding the information flow out of the Trust in order to give reasonable assurance for this provider. AM stated that this report from the Safeguarding Service made it difficult for the Quality Committee to have the necessary level of assurance. DF asked the Safeguarding Services about the previous improvements that had been reported and reminded the Committee that meetings had taken place between the CCG and the Trust in order to gain the necessary clarity regarding the information that was required by way of assurance. DF stated that Safeguarding was on the Corporate Risk Register and was regularly reviewed and updated. RD asked if this was becoming a common theme within the Trust due to a similar debate that had been undertaken at another Committee within the CCG. DF suggested to the committee that with regard to AUH it would be a positive way forward to arrange to meet with the Trust and propose a safeguarding themed quality walkaround in order to audit practice at a ward and department level whilst the required discussions took place regarding information submission for the KPIs. This suggestion was supported by the committee.	
	Action taken by the Quality Committee	
	1. The committee received the report. 2. DF to contact the Trust to arrange the proposed safeguarding themed quality walkaround	DF
14/135	**Provider Quality KPI Report** JS provided the report to the Committee by exception and noted the accompanying narrative that was provided detailing action taken for each of the exceptions which are discussed at each Quality Contract Meeting. **Aintree University Hospital NHS Foundation Trust (AUH)** – AM and DF in the absence of SA informed the Committee of the key areas of work that were being undertaken to support the Trust and gain assurance regarding A&E performance. DF also reported to the Quality Committee that the CCG had agreed to the NHSE (Merseyside) suggestion made at the CCG Checkpoint Meeting in September 2014 to plan to hold a Single Item Quality Surveillance Group with the provider present for the Trust due to the challenges being faced in relation to A&E performance. BP gave feedback to the Committee regarding the outcome of the recent C.Difficile appeals process that had been undertaken from which the Trust had 11 cases supported. DF stated that the recent case of MRSA at the Trust that both the CCG and the Trust had referred to NHSE for consideration as a third party attribution as no lapses in care could be identified during the PIR had been finally attributed to the Trust by NHSE. The CCG and the Trust will be requesting feedback from NHSE to support the lessons learnt process. DF informed the Committee that GH was meeting with the Medical Director from the Trust today for a discussion regarding Infection, Prevention and Control / Health Care Acquired Infections hence the reason she had sent her apologies/ **Liverpool Community Health NHS Trust (LCH)** – CG as Chair of the Contract Performance Review / Clinical Performance & Quality Group meeting stated that the issues contained within the exception report where all known, discussed within the contract process and contained within the improvement work that is currently being undertaken with the Trust. DF informed the Committee that she had previously reported that the enforcement actions against the Trust had been lifted by the CQC but that compliance actions were still in place and that the LCH Collaborative Forum had been reconvened and a meeting had taken place in September 2014.	

No	Item	Action
14/135	**Mersey Care NHS Trust** – The Committee noted the lack of accompanying narrative from the provider to accompany the provider dashboard. JS stated that the provider did not appear to have submitted the required commentary for the KPIs but an update had been received the morning of the Quality Committee. The Committee expressed their concern regarding this lack of submission and queried what next steps would be in terms of contract levers in order to receive the necessary information by way of assurance. JS described what action is being taken through colleagues who attend the Quality Contract meetings and MC stated that he would also raise this issue at the next Contract Meeting. **Alder Hey Children's NHS Foundation Trust (AHCH)** – The committee noted the content of the exception report in relation to the provider. BP reported back the positive outcome of the recent CQC inspection visit and reported that a Collaborative Forum was being set up by Liverpool CCG as lead commissioner for AHCH. The initial meeting is due to be held later in September 2014. BP and WH are intending to attend to represent the CCG. **Royal Liverpool & Broadgreen University Hospitals NHS Trust (RLBUHT)** – The committee noted the content of the exception report. DF informed the committee that the Single Item Quality Surveillance Group (SIQSG) with the provider present has been scheduled for October 2014. Either JH and / or BP will be in attendance at the meeting to represent the CCG and feedback will be given at the next meeting of the Quality Committee. **Liverpool Women's Hospital NHS Foundation Trust (LWH)** – The committee noted the content of the exception report. The CCG continue to work closely with LCCG as the Co-ordinating Commissioner. Action taken by the Quality Committee 1. The committee received the report. 2. MC to raise the lack of narrative to accompany KPIs at the next Mersey Care contract meeting 3. JH / BP to feedback outcome of the SIQSG at the October 2014 meeting of the Quality Committee.	MC JH/BP
14/136	**Serious Incidents & Never Events Update** The committee received the report from JH. AM queried the accuracy of the data demonstrating the reporting of incidents from providers within 48 hours. JH gave details of discussions that had taken place regarding the inability of providers to report an incident within 48 hours of it occurring if they had only become aware of the incident some time later. The committee discussed if there was any relationship between the incidents within this report for the community provider and the Virtual Ward development. Action taken by the Quality Committee 1. The Quality Committee received the report. 2. JH to explore linkages between the content in this report and the virtual ward with Dr Pete Chamberlain and Dr Debbie Harvey.	JH

No	Item	Action
14/137	**AUH Complaints Report** The Committee received the report from JS. RD asked if it was known if there were any connection between car parking complaints and patients not attending for their hospital appointments. AM queried regarding the categorisation of complaints and when patient information concerns were considered to be a standard of clinical practice complaint or concern. JS reported that this links into a piece of work that is being considered by EPEG regarding triangulation of information. MC stated it would be beneficial to know if the number of complaints is comparable with other providers and if any benchmarking data was available. RD agreed that this would be of benefit and added that the intelligence gained from the complaints was important in addition to the numbers. Action taken by the Quality Committee 1. The Quality Committee received the report 2. JS to explore what benchmarking information may be available regarding complaints pertaining to providers so that benchmark data could be considered.	JS
14/138	**GP Quality Lead Update** There were no specific updates to be received by the Quality Committee.	
14/139	**Locality Update** CG made reference to the discussion detailed in 14/132 regarding the vaccine / cold chain incident that had been discussed at a locality meeting. AM re-affirmed that this was an example of good practice in relation to peer review. No further updates were received by the Quality Committee.	
14/140	**Food First Leaflets** This item was asked to be deferred by the CCG Medicines Management Team who will advise if this is to be re-submitted for consideration by the Quality Committee at a later date. Action taken by the Quality Committee 1. The Quality Committee agreed to defer this agenda item until further notice by the CCG Medicines Management Team.	
14/141	**Any Other Business** LB brought to the attention of the Quality Committee apparent staffing issues within AUH in relation to a possible lack of clinical / consultant cover for Cardiology and Ophthalmology. AM stated that he recalled reviewing a Serious Incident Root Cause Analysis Investigation Report relating to Ophthalmology previously. Action taken by the Quality Committee 1. SA to liaise with AUH to explore any apparent clinical / consultant staffing issues within the Trust in relation to a possible lack of clinical cover for Cardiology and Ophthalmology.	SA
14/142	**Date of next meeting** Thursday 23rd October 2014 3.00pm – 5.00pm Boardroom, 3rd Floor, Merton House	

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Agenda

Date: Thursday 24 July 2014 1.00pm – 3.00pm
Venue: Boardroom 3rd floor Merton House, Stanley Road, Bootle.

Membership		
Roger Driver	Lay Member (Chair)	RD
Graham Morris	Lay Member	GM
John Wray	GP Governing Body Member	JW
Andy Mimnagh	GP Governing Body Member	AM
Sharon McGibbon	Practice Manager	SMG
Fiona Clark	Chief Officer	FLC
Martin McDowell	Chief Finance Officer	MMD
Debbie Fagan	Chief Nurse	DF
Steve Astles	Head of CCG Development	SA
Tracy Jeffes	Head of Delivery and Integration	TJ
In attendance		
Gustavo Berni	GP Lead Crosby Locality	GB
Brendan Prescott	CCG Lead for Medicines Management	BP
James Bradley	Head of Strategic Financial Management	JB
David Bacon	Interim Deputy Chief Finance Officer	DB
Ken Jones	Chief Accountant	KJ
Fiona Doherty	Transformational Change Manager	FD
Becky Williams	Chief Analyst	BW

No	Item	
FR14/82	**Apologies for absence** Fiona Clark, Dr Andy Mimnagh, Sharon McGibbon, Debbie Fagan, Fiona Doherty. The committee noted that it was not quorate and therefore whilst recommendations could be made approval would not be granted at this committee. RD further noted that no GP Governing Body Members were present at the meeting and that there attendance was essential to remain informed of financial issues and risks and to communicate these back to GP colleagues. The absence of clinical input for decision making was also noted.	
FR14/83	**Declarations of interest regarding agenda items** CCG officers who hold dual roles declared the potential declarations of interest.	
FR14/84	**Minutes of the previous meeting** The minutes of the previous meeting were approved as an accurate record.	
FR14/85	**Action points from the previous meeting** Action points were closed as appropriate.	

No	Item	
FR14/86	**Finance Reports** **a) Month 3 Finance Report** MMcD and JB presented this report which gave the committee and overview of the financial position for NHS South Sefton CCG at month 3 and outlines the key financial risks facing the CCG. The committee noted that the CCG is on target to achieve the planned £2.3m surplus by the end of the year. The year to date financial position before the application of reserves is an overspend of £0.565m (£0.205m underspend at Month 2). The full year outturn forecast is £2.485m overspent (Month 2 £2.013m overspent) on operational budgets, before the application of available reserves. A number of risks have been identified including: • Continuing healthcare • Overspends on Acute cost per case contracts • Continuing healthcare restitution claims • Estates • Prescribing/drugs costs **The Finance and Resource Committee noted the content of the Month 3 Finance Report.** **b) Financial Strategy Update** MMcD presented a verbal update noted that the updated strategy will be brought back to committee in September. The CCG will reflect on the new better care fund guidance within any revisions **The Finance and Resource Committee noted the content of the financial strategy update report**.	MMCD
FR14/87	**IFR Update Report** **The Finance and Resource committee noted the content of the IFR Update**	
FR14/88	**Better Care Fund** MMcD presented a verbal update on the Better Care Fund and noted that the CCG is anticipating the technical guidance in relation to the funding and is attempting to make appropriate provision. **The Finance and Resource committee noted the content of the verbal update on the Better Care Fund.**	
FR14/89	**Quality Premium Dashboard** BW presented this report and noted that going forward a best case; likely and worst case scenario will be presented. For the next quarter the committee requested that focus is directed towards the performance dashboard as opposed to the potential financial gain. SA noted that the available funding is likely to be in the region of £500k and that localities should start to work up proposals on this basis. **The Finance and Resource committee noted the content of the Quality Premium Dashboard.**	

No	Item	
FR14/90	**South Sefton PMO programme update and exception report** BW presented is update on behalf of Fiona Doherty. From September 2014 this report will be presented to the Service Improvement and Redesign Committee. **The Finance and Resource Committee noted the content of the PMO programme exception report.**	
FR14/91	**Procurement Strategy** MC presented this verbal update on the procurement strategy. New guidance has been issued from the EU in relation to procurement activities. The UK Government has given an undertaking to embrace these changes. The strategy will be updated when the new guidance comes into place. MMcD asked for a schedule of current and proposed procurement for the next meeting. **The Finance and Resource Committee noted the content of the verbal update on the Procurement Strategy**.	MC
FR14/92	**MCSU Performance Report** TJ presented this report. The committee's attention was drawn to the delay in reviewing the SLA which is due to the CSU not providing clear guidance for proposed services. The current SLA is being extended pending a review of the proposed SLA. The committee noted that there is potential to bring some services in house. **The Finance and Resource Committee noted the content of the MCSU Performance Report.**	
FR14/93	**HR Performance Report** TJ presented the high level HR performance report. This report is being developed and refined; however, there are no significant concerns to be noted. **The Finance and Resource Committee noted the content of the HR Performance Report**.	
FR14/94	**Evaluation of Case for Change Health Watch Sefton Community Champion** TJ presented this verbal update and noted that Healthwatch are aware that the funding is non-recurrent and finishes in October. The current evaluation report will be summarised for the next meeting and a detailed report of performance against target will be brought to the next meeting. **The Finance and Resource Committee noted the content of the verbal update.**	TJ
FR14/95	**Prescribing Report Q4** BP presented this report and noted the prescribing performance of South Sefton CCG. **The Finance and Resource Committee noted the contents of the Q4 Prescribing Report.**	

No	Item	
FR14/96	**APC Recommendations** SL presented this report and noted the following recommendations: • Sodium Oxybate Oral Solution (Xyrem) as a treatment option for narcolepsy with cataplexy • Sequential use of biologic agents for Psoriatic arthritis (PsA) • Biological agents for Non-radiographic axial spondyloarthritis (NRAxSpA) Certolizumab for Ankylosing spondylitis (AS), PsA and NRAxSpA MMcD noted that these costs were derived from the NICE model and that actual as opposed to proposed costs would be reviewed at the end of Year 1. **Martin McDowell Chief Finance officer approved the APC recommendations as per the report, as allowable within the scheme of delegation.**	JB
FR14/97	**Commissioning Policy Review** TJ presented this report for JL and noted that the Committee is being asked to recommend the policy to the Governing Body in terms of affordability. The report will also be submitted the Quality Committee to review quality and clinical aspects. TJ drew attention to varicose veins & fertility treatment as two areas particularly impacted by NICE guidance. In relation to varicose veins, it was agreed that further investigation is required before the local policy is changed. The cost impact of the fertility treatment changes is forecast to be £142k per annum at its highest. MMcD confirmed that funding had been set aside in the Strategic Plan. **The Finance and Resource Committee agreed to recommend the revised Commissioning Policy & the revised Fertility Policy for adoption by Governing Body.**	
FR14/98	**Home Oxygen Service - Procurement Proposal** BP joined the meeting to present this paper which describes the options for procurement for Home Oxygen service. BP advised that the preferred option was Option 2, to commission jointly with NHS Southport and Formby CCG. The financial impact for SS CCG will be £40k per annum above current funded cost of £130k. **Martin McDowell, Chief Finance Officer approved this proposal as per the report, as this is within his remit in the Scheme of Delegation.**	

No	Item	
FR14/99	**Informatics Update** Paul Shilcock (PS), from iMerseyside presented this report which provided a general update on informatics & information regarding the Transformation Programme. The two main areas of focus were output reporting & refresh of strategy. PS noted that the team are still at the stage of identifying work streams & governance arrangements. This report did not request approval for any costs – these will be brought back as separate business cases. MMCD proposed that Pete Chamberlain & Lyn Cooke should link in with this work. **The Finance and Resource Committee noted the content of the Informatics update and approved the direction of travel**.	PC/LC
FR14/100	**GP Roles and ad hoc payments** Deferred to next meeting.	
FR14/101	**Any other business** **MMcD noted two items of other Business.** **Additional funding has been allocated for supporting the 18 week target.** **Resilience plans will be submitted by the CCG by 30th July 2014**	
FR14/102	**Date, time and venue of next meeting** Thursday 18 September 2014 1.00pm – 3.00pm 3rd Floor Boardroom Merton House.	

Meeting Held Wednesday, 2 July 2014, Daresbury Park Hotel, Warrington

SESSION 1 – CHESHIRE AND MERSEYSIDE CCG MEETING

Minutes

Present	
Dr S Cox	Clinical Accountable Officer, St Helens CCG (Co-Chair)
S Whitehouse	Chief Executive, NHS Vale Royal CCG (Co-Chair)
S Johnson	Deputy AO, Head of Commissioning, St Helens CCG
Dr C Shaw	Chair, SSCCG
F Clark	Chief Operating Officer, S&F SCCG
Dr N Fazlani	Chair, Liverpool CCG
K Sheerin	Chief Officer, Liverpool CCG
M McDowell	CFO, S&F SS CCG
T Jackson	CFO Liverpool CCG
D Johnson	Chief Officer Knowsley CCG
P Thomas,	Director of Commissioning, Knowsley CCG
Dr J Caine	Chair, West Lancashire CCG
J Owen	Deputy Chief Nurse, Halton CCG
N Evans	Eastern Cheshire CCG
A Lee	Chief Officer, WC CCG
J Wicks	Interim Chief Officer, WCCG
In attendance	
J Wood	Director, NHS CC
Dr A Doyle	Co-Chair NHSCC/ Chief Officer NHS Blackpool CCG, Co-Chair NHS Clinical Commissioning

Minute taker: Julie Burke

APOLOGIES

Dr A Pryce	Chair, KCCG
P Brickwood	CFO, KCCG
S Banks	Chief Officer, HCCG
I Davies	LCCG
R Cauldwell	Chair S&F CCG
N Leonard	Chair, S&F CCG
A Davies	Chair, WCCG
L Bennett	Head of Commissioning WCCG
J Hawker	Chief Officer, EC CCG
P Bowen	Chair, EC CCG
A Wilson	Chair, SC CCG
M Maguire	Chief Officer, WLCCG

C Hodgkinson	CMCSU

No	Item	Action
140702	Welcome & Introductions were made. Introductions were made and Steve Cox and Simon Whitehouse welcomed colleagues to the meeting. SC explained that the Joint meeting of C&M and CW&W CCG colleagues had been arranged following discussions with SC and SW to explore if there was a collective view regarding current arrangements with key developments affecting all CCGs such as CSU, NHSE Area Team configuration, specialised commissioning and co-commissioning. The meeting would explore how we could work collaboratively to ensure future functionality of the system best fits the requirements of CCGs.	
140703	**NHSE Area Teams recent developments and configuration** Colleagues were invited to comment SW echoed comments by SC regarding working collaboratively on common areas, eg LETB), and asked collectively what this group could do regarding NHSE's national review of function and geographical configuration. Currently in CW&W a number of key Directors/Senior Managers have been seconded to other posts and/or leaving by August which will have significant impact on capacity on the level of expected service that can be delivered. The AT will be running on interim posts in several key areas, which the CCGs shared concern over. SC added that in Merseyside two key posts are subject to secondment to other organisations with interim posts in place, (Director of Ops Director of Nursing). C Duggan had met with S Stevens and reconfiguration decisions are expected by the end of July. The Area Team's are thought to become autonomous with delegated authority from central NHSE but may be fewer in number. VSM posts will reduce by at least 10% and staffing within the Area Team will be significantly reduced with the possibility of significant changes to NHSE Area Team structures. This may be a three year reduction process. **Nadim**; Need to influence function of future team configuration rather than structure. **JW** commented that he would not like to see the return to a bigger footprint, ie 10 SHA areas. Strategically a C&M footprint is better to ensure local and strategic direction which this group need to influence. **KS** commented the importance of ensuring the functions are correct to link with co- commissioning and the assurance process. Functions need to be clear and how they are discharged. If regions are staying, fixed functions need to be flexible across different geographical areas. **AD** added that C&M could be used for some services but not others, ie splitting of specialist commissioning. It is these type of views / comments that NHSE want CCGs views to inform future direction and provide solutions where possible. **AL:** Echoed previous comments of the importance of ensuring functionality is correct and look what services can be offered on a bigger footprint. **JW:** Ways of Working survey is being repeated in September and asked all CCGs to respond as this may inform future configuration.	

No	Item	Action
	SJ:. Functionality and scope of ATs needs to be clear. **MMcD**; Practitioner performance – an over-arching board (LETB) across the northwest, outside NHSE could provide a better system and more finances as part of a specialist body. **SW:** limited capacity in CWW Are Team due to acting up interim roles. **TJ:** moving to a function based landscape could cover assurance, but all CCGs have different views on primary care commissioning and specialist commissioning. If this is population based, need to commission services to improve the health of the population. There will always be a work-around due to geographical/functions,ie estates etc. **SC/NF**: NHSE ATs have limited decision making powers. They are not statutory bodies and do not have a board. CCGs need to use this as an opportunity to reinforce population based commissioning to see what CCGs can do for themselves. SC gave examples of where services need to be matched geographically, ie clinical networks, LETB, Science Networks. **SW:** for function-based structure to be successful, good relationships with all partners. Outcomes of discussions today need to be articulated to NHSE, where value has been added, to look at propose solutions to geographical/boundary issues. JW will feed comments made today through NHSCC to NHSE North via Richard Barker. **ACTION: Collective letter from C&M and CWW CCGs articulating comments made today relating to C&M CSU and both Area Teams to be sent to NHSE North before the end of July.** **Telephone calls, or if possible, meetings to take place with each respective Area Team, week commencing 7 July 2014 providing a copy of the letter informing them of the content of the letter following the outcome of discussions today.**	
140704	**Primary Care Commissioning** SC commented that following the PMS, review funding for general practice will be significantly reduced and smaller practices will be challenged financially. CCGs need to influence the future of primary care commissioning. Colleagues were asked if there was a collective view on the vision for primary care commissioning in 5-7 years time. **JW** added that a large number of expressions of interest were received with local variation on how primary care services are commissioned. Primary care needs to be a robust service, detailing what would be classified as enhanced services. **SC** noted that local variations would be built on a standard GMS type NHSE contract. AW provided an update on progress to date as Chair of the Commissioning Assembly Primary Care Group. They are looking at governance, assurance process and roles and how primary care co-commissioning can be taken forward. CCG leaders and NHSE are both involved in this process. A significant number of CCGs are seeking full delegated authority including premises responsibility but there has been no confirmation of what indicative allocations would be for CCG areas. There is a sub-group looking at finances within primary care	

No	Item	Action
	These would operate in shadow form from October 2014 with full delegated authority in May 2015. AW asked the CCGs to think about local GMS contracts, the impact if these are not negotiated and how CCGs can influence the shape of the new contract. More core primary care commissioning is required to enable CCGs to deliver other services. **57 out of 68 CCGs applied** 183 out of 211 across the country AW added that the comments made regarding ATs not having the authority to make primary care decisions as not a statutory body and many decisions were deferred centrally. **TJ** added that schemes could be put into new contracts as primary and secondary care commissioning are similar, depending on definition of commissioning. A significant change will be needed in the commissioning cycle to ensure needs of the population are met. KS added the need for distinguishing between commissioning primary care and how CCGs support practices in this area to avoid confusion over governance of commissioning and primary care development. **NF** reiterated that there are national contracts negotiations with the BMA's GPC which may include with local variations. Due to the shortfall in the number of general practitioners across the country delivery of robust primary care commissioning. **AW** added that NHSE are undertaking PMS reviews which could lead to further disinvestment for general practice. **ACTION: The CCGs present agreed that a C&M Co-commissioning group to be established to explore where common standards across services could be implemented and what CCGs would aspire to.**	**SC**
140705	**NHS Clinical Commissioning** JW, Director of NHSCC summarised the role of NHSCC, their role in supporting CCGs to ensure their views, comments and aspirations are fed through to NHSE. JW introduced Amanda Doyle, Co-Chair of NHSCC. JW and AD are the CCG's link through to NHSE and asked for any ideas, comments or views to be sent to be sent to them at any time. The NW is represented on the NHSCC Board with recently elected K Sheerin (LCCG), Gora Badly (NHS Chorley and South Ribble). The Nurses Forum representative is Judi Thorley, (NHS South Cheshire CCG and NHS Vale Royal CCG). The new Board of NHSCC will meet on 24 July. **Congratulations were conveyed to KS on her successful election to the NHSC Board.** **Presentation to be circulated to members.** **NF** asked what the mechanism is for NHSCC / CCGs to contact the membership at a local level. AW replied that all local information needs to be fed through to the National NHSCC Board via the local representative. **KS** will ensure clear messages are communicated via NHSCC relating to urgent care, TDA/Monitor, resilience issues. A general discussion was held.	
140706	**CSU integrating with GMCSU and ongoing concerns on delivery and costings** Discussion took place regarding adequacy of the current service being provided by C&M CSU and if a collective view could be reached today regarding level of	

No	Item	Action
	service expected and the CSUs emergent views on alleged stranded costs. Many services were provide on day rates and so stranded costs were inappropriate. A number of CCGs had reviewed specific service lines and where the level of service had not been acceptable, notice had been given services had been brought back in-house. MMcD added that a discussion document relating to stranded costs with CCGs costs had been tabled at a recent Merseyside Finance Directors meeting and bore little justification for the costs tabled. Comments were raised at the time for feedback and concerns had been expressed regarding the functionality within CSU. Other colleagues expressed concerns regarding an apparent leadership vacuum in the CSU with overhead costs at 20-25%. **KS** added that CSU cannot be looked at in isolation as they are NHSE staff and any future configuration should be used as an opportunity to look at future functions and what is required from NHSE. CCGs expressed varying levels of satisfaction with different service lines although only two CCGs raised any positive comments. **JW** expressed concerns regarding business intelligence and communications, adding that CCGs should not bear the cost of any service they are not satisfied with. CCGs also need to be mindful of any potential reputational issues that the public may perceive regarding further possible reconfigurations and the financial costs which could be incurred. **TJ** added concerns from LCCG regarding support of business intelligence. CCGs need to review each of their service lines, options and risks. **SW** expressed concerns regarding business intelligence and CHC. AL added that a 'Pioneer' CHC service was being delivered collectively with West Cheshire and Wirral, as a shared service from September 2014 with 1 of the 4 CCGs hosting the service with a collective board. Halton CCG are undertaking a review of CSU service under their SLA with the potential of taking some services in-house. **All present agreed that there were significant concerns over stranded costs issues.** **ACTION: TF to facilitate a review across C&M and CWW on all service lines to identify what services could be taken back in-house.** **MMcD to lead on CWW and C&M collective paper on stranded costs with DoF colleagues. AL to advise Wirral CCG colleagues.**	**TJ** **MMcD**
140707	**Specialised Commissioning – co-commissioning a way forward** SC commented that discussions are still on-going on how specialised commissioning will be configured nationally by NHSE. Some CCGs have different perspectives on how they can influence this. Proposal submitted for LCCG to take the lead on the 'hub' and for example, StHCC and others would support a 'spoke' service commissioning services. SC acknowledged the geographical issues raised earlier by JW and SW. in that parts of Cheshire look to Manchester and North Staffordshire for services. **KS** had received recent communication from A Tonge at NW Specialised Commissioning Oversight Group stating that discussions on co-commissioning were progressing and that a sub-group had been set up to develop further and work up governance in terms of national work. South and East Cheshire attended but a CCG representative from Merseyside is needed.	

No	Item	Action
	TJ added that some services are core business for CCGs, eg dialysis. Decision required on what can be commissioned nationally to improve health outcomes for patients. LCCG had looked at this via the Healthy Liverpool Programme. A central NHS specialised commissioning review had made to S Stevens and the outcome would work in shadow from 1 October 2014. There may be some economies of scale and some services nationally declassified from specialist commissioning. Data needs to be analysed to identify where finances/activity are spent. Geographically networks need to be linked to pathway / flows. Geography is not as straight forward as it seems with end to end pathways and population commissioner important. Where there a number of specialist providers it would be sensible that local commissioners are involved in certain aspects via appropriate networks. **AD** added that there are some specialist services which could be moved from regional bases back to CCGs but need to ensure the correct allocations and resources are in place. **ACTION: CCGs sin agreement that co-commissioning is important and that pathways must reflect flows particularly around border areas. Feedback to be included in the NHSE document.**	**SC**
140708	**Future Meeting plans** It was agreed it was beneficial for colleagues from CW&W and C&M to meet in a forum to discuss common issues. It was agreed this would be on a quarterly basis, with the next meeting **Wednesday 1 October, venue tbc**	**SC/JB**
	PART 2	

Apologies for Absence were received from

Dr A Pryce	Chair, KCCG
P Brickwood	CFO, KCCG
S Banks	Chief Officer, HCCG
I Davies	LCCG
R Cauldwell	Chair S&F CCG
N Leonard	Chair, S&F CCG
A Davies	Chair, WCCG
L Bennett	Head of Commissioning WCCG
M Maguire	Chief Officer, WLCCG
C Hodgkinson	CMCSU

140709	**Minutes from the previous meeting** Minutes of the meeting held 7 May 2014 were agreed as an accurate record. **EPRR** – DJ to meet with R Booth and I Davies. Key issues relating to EPRR to be presented to the CCG Network bi-monthly, commencing 3 September 2014	**DJ**
140710	**ToR** **SC** The ToR circulated were not the current version. Current version to be circulated and discussed at next meeting but comments were invited today in relation to the Group's current form and function. **SC** opened up discussions and invited comments and asked if this Forum was functioning how it was first perceived and if any changes were required. This debate would be moved to the August meeting.	**JB**

140711	**Decision making function** **SC** asked as this Group is not a decision making body, should the group consider a pilot area to work on in shadow form with delegated decision making. This was with an aim to look at things on a common ground which could be agreed collectively to make the patient journey easier, ie standard contracts on a larger footprint as we had done with EPRR. **FC** commented that this Group was established to take decisions back to each of the CCG Governing Body as the statutory body and what would be the added value to establish it as a decision making body. **DJ** referred to the NHS Constitution and that any changes in the powers of this Group would need be reflected in the CCGs constitution, taking into account the perception of the Membership, ie reverting back to 'PCTs'. **SC** gave an example of co-commissioning of specialist services which could work in shadow format with NHSE on C&M footprint. **NF** raised concerns and asked if this is the correct footprint depending on future hospital configurations and if collaborative commissioner forums could work. **KS** agreed that developing common standards across C&M CCGs would be beneficial in primary care and the CCGs do not need delegated authority to do this. Positive examples of working together evidence in EPRR on call. **ACTION September meeting to discuss possible areas for joint working, eg primary care standards with Cheshire CCGs. SJ offered to co-ordinate a collation of views on this matter to be presented to August meeting. Template to be circulated for completion.**	**SJ**
140712	**Commissioner requested services** Papers had previously been circulated for the June meeting which had been cancelled. MMcD provided an update. C Hodgkinson had been asked to conduct a scoping exercise on behalf of C&M CCGs to identify what commissioner requested services will look like in the future. By 6 April 2016 all CCGs need to have developed a service specification and determined if current services would be carried out a certain hospitals. Liverpool, Sefton and Southport and Formby CCGs had agreed to funding of £1k each to support this scoping exercise. This is not part of any of the CCGs core offer within their SLAs. Both St Helens and Knowsley CCGs were asked to confirm their support. FC added it was important that CCGs understood and were clear what services would be included or not in Commissioner Requested Services. A risk for the CCGs could be being less able to direct some of the market place. **ACTION: Knowsley and St Helens CCG agreed to contribute £1k each.**	
140714	**Merseyside Collaborative Future meetings** Following discussion it was agreed: (a) The August Health Collaborative meeting will be a collaborative meeting, C Duggan to invite K Wheeler to attend to discuss service models. (b) September Health Collaborative Meeting will be for CCGs and NHSE only to discuss provision of healthcare and service models including hospitals, GP Out of Hours, community integration, palliative care models etc. (c) The October Health Collaborative meeting will be for NHS, CCG, LA's and Providers to discuss commissioner arrangements and interaction with NHSE.	

	ACTION: Work plan for the Health Collaborative meetings to be circulated.	**SJ/JB**
140715	**Any Other Business**	
(a)	*Liverpool Womens Hospital*. KS and NF led a discussion on Liverpool Womens Hospital, relating to the impact of the recent CQC published report which highlighted inadequate staffing levels and safety issues. LCCG are working with Liverpool Womens Hospital to see if there could be a local adjustment in the maternity tariff and asked for the support of this forum to progress discussions. Outcome needs to be based on clinical safety for patients. Agreement needed by Monitor and the DoH regarding inadequacy of the maternity tariff and it is a stand along maternity and gynaecology unit. Discussions to include possible co-location with adult services, senior clinicians and management are part of these discussions to agree what the organisational form needs to be. **ACTION: CCGs present supported LCCG approach to this matter.** SC added that a similar level of deliveries in total occur between StH&KHT and WHHFT hospitals. Discussions have apparently started between WHHFT and StH&KHT regarding future configuration of maternity services.	
(b)	**RTT -** MMcD introduced the item, noting that Trust's estimates of costs to deliver RTT were significantly higher than the notional allocation for Merseyside and he raised concerns. The group noted that information had been sent out from the TDA and NHS England did not appear consistent and individual CCG's would seek clarity in their discussions with NHS England. SC noted that each Trust had different issues with RTT and advised that all CCGs be kept in the loop. **Workforce event** FC is attending a half day workforce event on 9 July and asked for any comments to be forwarded to her. KS advised that resilience plans are to be submitted by 30 July 2014.	
140716	**Date of Next Merseyside CCG Network Meeting** Wednesday, 6 August 2014, 1pm lunch, meeting to commence at 1.30pm Conference Rooms A&B St Helens Chamber, 1st Floor, Salisbury Street, off Chalon Way, St Helens WA10 1FY	

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Minutes

Thursday 18th September 2014 1.00pm – 3.00pm
Boardroom, 3rd Floor, Merton House, Stanley Road, Bootle.

Present		
Roger Driver	Lay Member (Chair)	RD
Debbie Fagan	Chief Nurse	DF
Martin McDowell	Chief Finance Officer	MMD
Sharon McGibbon	Practice Manager	SMG
In attendance		
James Bradley	Head of Strategic Financial Management	JB
Fiona Doherty	Transformational Change Manager	FD
Craig Gillespie	GP Lead	GG
Ken Jones	Chief Accountant	KJ
Susanne Lynch	CCG Lead for Medicines Management	SL
David Smith	Deputy Chief Finance Officer	DS
Becky Williams	Chief Analyst	BW

No	Item	Action
FR14/103	**Apologies for absence** Apologies for absence were received from Graham Morris, Fiona Clark, Becky Williams, Fiona Doherty, Gustavo Berni, Steve Astles, Tracy Jeffes and Brendan Prescott. The committee noted that they were not quorate.	
FR14/104	**Declarations of interest regarding agenda items** The CCG Officers who hold dual roles at both NHS Southport and Formby CCG and NHS South Sefton CCG declared their potential conflicts of interest. Practice Manager Sharon McGibbon declared her interest in agenda item 14/112.	
FR14/105	**Minutes of the previous meeting** The minutes of the previous meeting were approved as a true and accurate record.	
FR14/106	**Action points from the previous meeting** The action points from the previous meeting were closed as appropriate.	
FR14/107	**Finance Reports** a) Month 5 Finance Report b) Detailed Contract Performance Report c) Financial strategy JB and MMcD presented this report and noted that the CCG is on target to achieve the planned £2.300m surplus by the end of the year. It also meets the other business rules required by NHS England.	

No	Item	Action
FR14/107	There have been two changes to the RRL allocation this month: • RTT funding – The CCG received £0.359m for payment relating to additional activity associated with the national initiative to address patients who have waited over 18 weeks for treatment; • GP IT transitional funding – The CCG received £0.161m for primary care IT transitional funding, which is the full value of the CCGs application to NHS England. It should be noted that this level of funding is unlikely to be made available in 2015/16 and the CCG's IT partners are assessing options within an affordable financial envelope. A number of risks have been identified including: • Overspends on Acute cost per case contracts • Continuing healthcare • Estates • Prescribing drug costs • CSU Service Level Agreement **The Finance and Resource Committee noted the finance update, particularly that the CCG will require a management action plan in order to deliver its financial targets for 2014/15**.	
FR14/108	**IFR Update Report** MMcD and JL presented a verbal update on this item and noted that going forward the summary document previously presented would continue to be submitted on a monthly basis. JL will continue to liaise with the CSU in relation to IFR approvals. **The Finance and Resource Committee noted the verbal update in relation to IFR Reporting.**	
FR14/109	**Better Care Fund** MMcD presented the committee with a verbal update and noted that the deadline for submission is 19/09/2014. Consultancy support has been access and metrics reviewed by CCG Chair from a clinical perspective. **The Finance and Resource Committee noted the verbal update in relations to the Better Care Fund**.	
FR14/110	**Quality Premium Dashboard** FD presented this report and asked the committee to noted that The final 2013/14 data is yet to be validated and published by NHS England, and we do not expect to receive confirmation until Q3 of the 2014/15 financial year. Indicative local data for 2013/14 reveals that South Sefton CCG should receive a payment of £460,519 against a total possible payment (if all indicators were within tolerance) of £736,830. This is due to underperformance in a number of areas which were described in the April report to this committee. However, data is still awaited for a further indicator, which may increase the total amount payable to £552,623 should it be at or below target.	

No	Item	Action
FR14/110	Based on local data performance for the indicators for 2014/15 (April 2014 – May 2014), South Sefton CCG are on target to receive a payment in 2014/15 of £232,820 against a total possible payment (if all indicators were within tolerance) of £776,065. This is due to underperformance on the ambulance measure, which would result in a 25% reduction to the overall possible payment, plus indicators for which performance is currently unknown due to annual reporting frequencies, and data validations. However, taking a likely case scenario approach, apportioning a 50% notional amount may be applied to the indicators where performance is currently unknown, except for the medication error reporting indicator where performance is split between three providers, therefore a notional amount is calculated based on 1/3 of each provider's performance against the measure. The total amount payable under the likely case scenario is £494,741 against a total possible payment (if all indicators were within tolerance) of £776,065. **The Finance and Resource Committee noted the contents of the Quality Premium Dashboard.**	
FR14/111	**Evaluation of Case for Change Health Watch Sefton Community Champion** MMcD presented the Evaluation of the case for Change Health Watch Sefton Community Champion and asked the committee to note that a detailed report had been received in relation to process. The committee noted that this post was funded non-recurrently and that going forward the CCG may choose to commission bespoke pieces of work as required. **The Finance and Resource Committee noted the contents of the report.**	
FR14/112	**Prescribing budget allocations** SL presented the Prescribing Budget Allocations report and requested that the committee approve the process for the practice level allocations. **The Finance and Resource Committee noted the content of the report and approved the process of for the allocation of practice level prescribing budgets.**	
FR14/113	**APC Recommendations** SL presented the APC recommendation and requested that the committee approve the Pan Mersey APC recommendations form the July 2014 meeting where cost impact is greater than £5000 per CCG population**.** **The Finance and Resource Committee approved the recommendation by the Medicines Management Operational Group for Canagliflozin as a treatment option for treating type 2 diabetes mellitus as per NICE TA 315 has an annual cost implication of**	
FR14/114	**GP Roles and ad hoc payments** MMcD presented this paper in conjunction with JL. The committee noted the requirement to compensate GP colleagues for additional work. The committee discussed the parity of payment for other colleagues who also undertake additional work. **The Finance and Resource Committee approved the GP Roles on the proviso that this is amended to read Practice Roles and approved the ad hoc payments**.	
FR14/115	**Any other business** There were no items of other business.	
FR14/115	**Date and time of next meeting** Wednesday 23 October 2014, 1.00pm-3.00pm Boardroom, Merton House	

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

Service Improvement and Redesign Committee Minutes

Date: Wednesday 10 September 2014, 9.30 hrs – 11.00 hrs
Venue: Classroom 4, Crosby Lakeside Adventure Centre, Waterloo, L22 1RR

Attendees		
Dr Niall Leonard	Chair and Vice Chair of Southport and Formby CCG	NL
Steve Astles	Head of CCG Development, South Sefton CCG	SA
Dave Comber	Service Improvement Manager, Informatics Merseyside	DC
Fiona Doherty	Transformational Change Manager, South Sefton and Southport and Formby CCGs	FD
Dr Susan Gough	Clinical Lead, South Sefton CCG	SG
Jenny Kristiansen	Locality Manager, South Sefton CCG	JK
Jan Leonard	Chief Redesign and Commissioning Officer, South Sefton and Southport and Formby CCGs	JL
Karl McCluskey	Chief Strategy and Outcomes Officer, South Sefton and Southport and Formby CCGs	KMcC
Dr Dan McDowell	Secondary Care Doctor, South Sefton CCG	DMcD
Sarah McGrath	Locality Manager, Southport and Formby CCG	SMcG
Angela Parkinson	Locality Manager, South Sefton CCG	AP
Brendan Prescott	Deputy Chief Nurse, South Sefton and Southport and Formby CCG	BP
Colette Riley	Practice Manager and Governing Body Member, Southport and Formby CCG	CR
Dr Kati Scholtz	Governing Body Member, Southport and Formby CCG	KS
David Smith	Deputy Chief Finance Officer, South Sefton and Southport and Formby CCG	DS
Dr Paul Thomas	Governing Body Member, South Sefton CCG	PT
Minutes		
Cathy Loughlin		

No	Item	Action
14/1	**Apologies** Apologies were received from Tracy Jeffes, Dr Debbie Harvey, Dr Martin Vickers, Dr Jeff Simmonds, Dr Graeme Allan, Lin Bennett and Dr Kebsi Naidoo.	
14/2	**Introduction** Karl McCluskey welcomed the group to the first meeting of the new committee and indicated that it was proposed to operate the committee as a committee in common. Introductions were given.	

No	Item	Action
14/3	**Draft Terms of Reference** The draft terms of reference were circulated with the agenda and considered at the meeting. Karl McCluskey confirmed that the revised subcommittee for both South Sefton CCG and Southport and Formby CCG had been adapted to include the Service Improvement and Redesign Committee as a formal subcommittee of the respective Governing Bodies. The committee considered the committee in common proposal and working arrangements. A number of views were expressed the need to have a separate committee for each CCG given their respective agendas, priorities and direction of travel. The committee also recognized that there was considerable benefit in sharing ideas, examples of good practice and developments across both CCGs which could be mutually beneficial. It was also recognized that the major value and contribution of this committee will be for the presence and contribution from clinical members. It was noted that this committee, in its first meeting, has managed to bring together the largest group of clinical leadership across both CCGs. The enormous benefit of the clinical contribution was supported and the committee agreed to operate as a committee in common in the first instance with a view to reviewing this position within three – six months. In addition there was recognition that the localities and boundaries of the respective CCGs overlap, an example being Maghull where patients are both served by Aintree Hospital and S&O Hospital. The obvious benefit in both CCGs working together was recognized in this context. The committee recognized the purpose (to energise and prioritise service improvement) and ensure major transformation programs such as primary care quality, care closer to home and the virtual ward are managed within the context of both CCGs strategic plan, priorities and purpose. This committee has a key role in ensuring that these programs are progressed in a coherent and joined up manner to optimize effect and improve service and clinical outcomes. As part of the committees portfolio both primary care quality, care closer to home, virtual ward and mental health review programs will be required to report on progress with regularity. The Service Improvement and Redesign Committee will need to ensure it can assist with testing performance and delivery, address any issues for escalation and assure the respective governing bodies on progress. Dr Leonard confirmed that together with Dr Scholtz an expect clinicians group was being established for S&F CCG. The intention being that this group could provide expertise, views and strategic direction in relation to key clinical areas and services. This would then enable this committee to consider any clinical recommendations for service, redesign, development and transformation as well as supporting any case for change.	

No	Item	Action
	Steve Astles highlighted the need for this committee to challenge business and redesign cases. This can be only done with adequate clinical scrutiny and review. The current clinical presence at F&R committees is limited and thus the clinical consideration of cases can be sub-optimal. This committee would enable a much greater level of clinical review and scrutiny of cases and developments, as well as commissioning discrete pieces of work related to redesign and transformation. Dr Paul Thomas referenced future potential changes in services at Aintree, Royal and S&O. This committee is central to assessing, understanding issues related to services at this providers and establishing a co-horent clinical direction to support services going forward and secure local service provision for our patients. The committee agreed the initial schedule for future meetings should take place on a two monthly basis. The group considered the proposals set out in the Terms of Reference. The consensus was that membership could be enhanced from representation from a practice manager and practice nurse from each CCG. Billie and Steve to look at this. The importance of medicine management as part of service redesign was agreed. Suzanne Lynch to attend future committee meetings as appropriate and relevant to the agenda. **Action - Terms of reference to be updated to reflect the above.** A specific issue with regard to the committee in common function was raised, in that there was uncertainty about what arrangements should be in place to enable this committee to decide on the progression of cases or schemes specific to one CCG. **Action - Jan Leonard to speak to Debbie Fairclough to confirm decision making and voting arrangements**	CL JL
14/4	**Strategic Plan, Priorities and Programmes** Karl McCluskey confirmed there is one strategic plan for the two CCGs. The three priority areas are jointly combined and will focus on primary care, frail and elderly and unplanned care. In support of these priorities both CCGs have confirmed workstreams with managerial and clinical leadership in place. It is important that this committee is sighted on the various workstreams, their thrust and progress. **Action - Programme Leads to be scheduled to provide progress update at future meetings.**	KMcC/ CL

No	Item	Action
14/5	**Commissioning Intentions** Jan Leonard confirmed that this is the time of year that the CCGs will start to think about pulling the commissioning intentions together. Fiona Doherty confirmed that value packs and locality packs had been produced and will be circulated to the committee. **Action – Fiona Doherty to circulate value packs.** These packs should be helpful in enabling a clinical discussion about the priorities and needs to be addressed going forward. It is important that these are given careful consideration in developing and driving commissioning intentions. The value packs have been built using the Right Care approach and indeed detail on this was shared with both respective Governing Bodies at their development sessions last year, to assist in developing the strategic plan and priorities. **Action - The clinicians to consider information contained within the packs and proposed specific areas for focus at the next meeting.** **It was agreed that the next meeting of the committee would focus on commissioning intentions and priorities.**	FD Clinicians JL/ KMcC
14/6	**Quality Premium** The quality premium is intended to reward clinical commissioning groups for improvements in the quality of the services they commission and for associated improvements in health outcomes and reducing inequalities. **South Sefton** Based on local data performance for the indicators for 2014/15 (April 2014 – May 2014), South Sefton CCG should receive a payment in 2014/15 of £87,307 against a total possible payment (if all indicators were within tolerance) of £776,065. This is due to underperformance in a number of area, plus indicators for which performance is currently unknown due to annual reporting, and data validations. **Southport and Formby** Based on local data performance for the indicators for 2014/15 (April 2014 – May 2014), Southport & Formby CCG should receive a payment in 2014/15 of £68,954 against a total possible payment (if all indicators were within tolerance) of £612,925. This is due to underperformance in a number of area, plus indicators for which performance is currently unknown due to annual reporting, and data validations. Discussions need to start taking place for 2015/2016 about which quality premiums need to be chosen.	

No	Item	Action
	The challenge with quality premium remains in that the CCGs operate a year in arrears on quality premium performance e.g. CCGs are due to learn of their performance and allocated funding in September and this relates to the performance period for last year. **Action - Committee to consider quality premiums for 2015/2016 at the next meeting.** **Becky Williams to outline QP areas and choices for consideration to assist the committee.** Consideration needs to be given on the financial approach that the CCGs adopt for the quality premium, in particular levels and opportunity for reinvestment in primary care.	All BW
14/7	**Case for Change** Fiona Doherty shared the case for change approach to be adopted. This provides a simple template for the consideration and development of all cases against a set of criteria. The criteria ensure that any case is relevant to both the NHS Operational Framework and CCG priorities. The proposal is also intended to support the generation, development and progression of cases in an easier fashion, particular in relation cases for values under £50,000 (these can be considered and approved the Senior Management team on a weekly basis). Whilst the case for change approach and documentation is intended for all cases, specific reference to supporting locality cases has been considered. Feedback from localities has clearly indicated that the locality allocated monies are proving difficult for localities to spend. Indeed rather than stimulating and incentivizing cases at locality level, the reality has been that idea generation has been hindered by the short time frame by case development and the non-recurring nature of funds. The committee expressed a view that the CCGs should move away from providing discrete non recurring funding for locality investment to a more considered approach, where by localities should be supported to develop service improvement and redesign schemes which can improve service delivery and outcomes and avoid unnecessary admission to hospital . There was also recognition that some localities have developed and progressed schemes to good effect. **Action - An example of some progressed locality schemes to be shared at next meeting.**	FD

No	Item	Action
14/8	**Virtual Ward KPIs Dashboard and Performance** Dave Comber outlined the governance and reporting structure that is proposed to be adopted to support the South Sefton transformation programme. The committee noted that Steve Astles, Dr Pete Chamberlain and Karl McCluskey are reviewing the scope of virtual ward and its relationship with the wider health system in South Sefton. In addition to this South Sefton have also described the purpose and function of localities, in recognition of the need and importance that localities have in progressing and driving the transformation agenda. Some detailed work on locality services is taking place with LCH and led by Dr Pete Chamberlain. The committee recognized the enhanced functionality of the PMO, including standardized programme documentation, independent assessment on progress and rag rating. Existing virtual ward steering and operational groups to be augmented and have a wider system focus with appropriate provider representation at the necessary level of responsibility to progress programmes.	
14/9	**CC2H Briefing Paper** Janice Horrocks gave an update regarding her briefing which was circulated with the agenda. Janice Horrocks confirmed that the CC2H strategy will be finalized in draft format by Monday and once it has been signed off by the Care Closer to Home Group, it will be sent out for consultation. A timetable re the above consultation was tabled and is attached for information.	JH
14/10	**Primary Care Quality Schemes – Progress Report** As from 1st April 2013 CCGs have not been allowed to use Local Enhanced Services (LESs) to commission General Practice. Clinicians were engaged in December 2013 to look at pre-existing schemes commissioned through the PCT to assess current clinical value. A Local Quality Contract (LQC) for each CCG has been developed to incorporate those services still required, and some new services that go beyond those that practices are expected to provide under GP contract. This has been commissioned from 1st August 2014, using an NHS Standard Contract for a three year period, with all schemes being reviewed on an annual basis. Investment for LQC has been secured from funding from pre-existing LES's, together with Primary Care Quality monies, and Everyone Counts funding. Total resource in Sefton has increased from £1.7m for pre-existing LES's to £3.7m for LQC. National changes to GP contracts for 2014/5 have been implemented from 1st April 2014. These include an increase of GMS/PMS and APMS baselines (at differing amounts dependent upon contract type), due to a reduction in QOF and enhanced services, Minimum Practice Income Guidance (MPIG) erosion (GMS), and inflationary uplift. There is a planned review of PMS contracts by NHS England.	

No	Item	Action
	An event for each CCG to discuss the content of the LQC took place in May 2014, with further versions produced following feedback. It was noted that three specific practices had not signed their contracts. LMC are asking practices not to sign and there are discussions taking place about this with Joe Chattin. The August LES payment has been made to practices. Plans remain to progress to new quality contract from 1st October 2014. A discussion took place with regard to the contribution this committee could make to the direction of travel for years 2 and 3 of the primary care quality contract. The committee felt it was important to ensure consistency of approach as well as building on key clinical opportunities in order to maximum the impact and benefit of the primary care quality contract. **Action - Dr Niall Leonard to discuss primary care schemes with localities and will feedback to the committee at the next meeting.**	NL
14/11	**Any Other Business** There was no other business.	
14/12	**Dates of Future Meetings** 5 November 2014 14 January 2015 4 March 2015 13 May 2015 1 July 2015 9 September 2015 4 November 2015 All meetings will be held at 9.30 hrs – 11.30 hrs and will take place at Crosby Lakeside Adventure Centre, Waterloo, L22 1RR.	

NHS
South Sefton
Clinical Commissioning Group

Seaforth and Litherland Locality Meeting Minutes

Date: Wednesday 3rd September 2014 at 13.00 – 15.00

Venue: Crosby Lakeside Adventure Centre

Attendees		
Dr A Patrick	Litherland Town Hall	AP
Ian Hindley	Litherland Town Hall	IH
Dr C McElroy	15 Sefton Road	CM
Dr J Irvine	15 Sefton Road	JI
Dr P Goldstein	Glovers Lane	PG
Dr F Cook	Rawson Road	FC
Samantha Standley	Rawson Road	SS
Angela Dunne	Rawson Road	AD
Dr A Patrick	Seaforth Practice	AP
Dr N Williams	Ford Medical Practice	NW
Mark Halton	Ford Medical Practice	MH
Louise Armstrong	Ford Medical Practice	LA
Dr M Vickers	Bridge Road Surgery	MV
Lynne Creevy	Bridge Road Surgery	LC
Dr N Choudhary	Netherton Practice	NC
Lorraine Bohannon	Netherton Practice	LB
Dr R Ogunlana	Orrell Park	RO
Jane McGimpsey	Orrell Park	JM
Dr J Wallace	Litherland Darzi	JW
Pam Maher	Litherland Darzi	PM
Angela Parkinson	South Sefton Clinical Commissioning Group	AP
Helen Roberts	Medicines Management	HR
Tracy Jeffes	South Sefton Clinical Commissioning Group	TJ
Karl McCluskey	South Sefton Clinical Commissioning Group	KM
Val Metcalf	Alzheimer's Society	VM
Minutes		
Angela Curran	South Sefton Clinical Commissioning Group	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 T Thompson	GP – 15 Sefton Road	A	✓	✓	A	✓	A						
Dr C McElroy	GP – 15 Sefton Road	✓	✓	✓	✓	A	✓						
Alison Harkin	PM – 15 Sefton Road	✓	✓	✓	✓	✓	✓						
Paula Lazenby	PN – 15 Sefton Road	A	A	A	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 A Slade	GP – Glovers Lane Surgery	A	A	A	A	A	A						
Louise Taylor	PM – Glovers Lane Surgery	A	✓	✓	✓	✓	A						
Dr P Goldstein	GP – Glovers Lane Surgery	✓	✓	✓	A	A	✓						
Dr M Cornwell	GP – Glovers Lane Surgery	A	A	A	A	A	A						
Dr M Vickers	GP – Bridge Road Surgery	✓	✓	✓	✓	✓	✓						
Lynne Creevy	PM – Bridge Road Surgery	✓	A	A	A	✓	✓						
Dr E Carter	GP – Bridge Road Surgery	A	A	✓	A	A	A						
Dr N Choudhary	GP – Netherton Practice	✓	A	✓	✓	✓	✓						
Lisa Roberts	PM – Netherton Practice	A	A	A	A	A	A						
Lorraine Bohannon	PM – Netherton Practice	✓	✓	✓	✓	✓	✓						
Dr N Williams	GP – Ford Medical Practice	✓	✓	✓	A	✓	✓						
Lin Bennett	PM – Ford Medical Practice	A	✓	✓	✓	✓	A						
Eils McCormick	PN – Ford Medical Practice	✓	✓	✓	✓	A	A						
Louise Armstrong	PN – Ford Medical Practice	✓	✓	✓	✓	A	✓						
Dr B Fraser	GP – Ford Medical Practice	A	A	A	✓	A	A						
Dr A Ng	GP – Ford Medical Practice	A	A	A	A	✓	A						
Jane McGimpsey	PM – Orrell Park Medical	✓	✓	✓	✓	A	✓						
Dr R Ogunlana	GP – Orrell Park Medical	A	✓	✓	✓	A	✓						
Dr A Hameed	GP – Litherland Darzi	✓	A	✓	A	A	A						
Dr B Schoenberger	GP – Litherland Darzi	A	A	✓	A	A	A						
Julie Price	PN – Litherland Darzi	A	A	A	A	A	A						
Pam Maher	PM – Litherland Darzi /	A	A	A	✓	A	✓						
Dr A Patrick	GP – Litherland Town Hall	A	✓	✓	✓	A	✓						
Dr F Cook	GP – Rawson Road / Orrell	✓	✓	✓	✓	✓	✓						
Angela Dunne	PM – Rawson Road / Orrell	✓	✓	A	✓	✓	✓						
Ruth Powell	PN – Rawson Road	A	A	A	A	A	A						
Ian Hindley	PM – Seaforth Practice/	✓	A	A	✓	✓	✓						
Dr S Fraser	GP – Seaforth Practice	A	A	A	A	A	A						

✓ Present
A Apologies
L Late or left early

No	Item	Action
14/77	**Apologies** All apologies were noted for Lin Bennett and Louise Taylor.	
14/78	**Declarations of Interest** Dr Noreen Williams - LMC	
14/79	**Minutes of the Last Meeting / Matters Arising**	

No	Item	Action
	NW informed the group that Eils McCormick had now left Ford Medical Centre and has been replaced by Mark Halton and asked if Dr Steve Fraser could be removed from the list as he is no longer part of S&L Locality. 14/70 – AP informed the group that Jeanette Hogan from LCH had been invited to attend the meeting at 1:30pm. The locality would need to decide on the frequency of attendance at locality meetings for the LCH representative. AP informed the group that the matter raised by Lin Bennett at the last meeting around individual funding requests will be discussed at the next Wider Group meeting to be held on 11th September, to establish clarity.	
14/80	**Jeanette Hogan Nurse Manager Specialist – Liverpool Community Health** Jeanette Hogan from LCH did not attend – deferred to next meeting.	
14/81	**Val Metcalfe Alzheimer's Society** Val Metcalfe provided the group with details of the Alzheimer's Society. The Society is currently based in Southport and was established 30 years ago by two carers. The Society offers support from initial diagnosis to assist clients with living well in the community. They attend memory clinics in Southport and also have a presence at diagnosis meetings to provide support to the patient and the carer. VM left the group a fact sheet and leaflets and informed them that Justine Shenton is the Support Manager who GPs can refer patients directly to on a daily basis. Justine can be contacted on justine.shenton@alzheimerssociety.org.uk . The aim of the Society is prevent social isolation and offers coping strategies to patients. They are able to provide 1-2-1 visits to patients and their carers and there are also monthly groups available across both North and South Sefton. VM added that the Society was having problems accessing the Waterloo Memory Clinic. It was agreed that Tracy Jeffes would seek the reasons why the Waterloo Memory Clinic were blocking access and report back to the locality for them to write out and request access for the Alzheimer's Society. It was agreed to ask Lyn Cooke, CCG Communications Manager, to add the Alzheimer's Society's details to the intranet.	
14/82	**Locality Budget** **Stoma Care Project** The stoma care project was not agreed at the last meeting. AP provided an overview of the project that has been piloted in Bootle and asked the locality if they would be willing to give £5k from the budget to adopt this for S&L. Dr Williams suggested that this should probably sit within Medicines Management in order to hit a wider audience. For this to continue through localities, funding will be needed. The locality provisionally approved but would like to explore the possibility of future funding before adopting this concept. AP to investigate and report back to the next meeting. **Suggestions for Locality Spend** There was a discussion on the MCAS service and current waits. SA had asked for feedback from the locality in relation to any problems currently being experienced by practices. It was reported that there is a 6-week wait	

No	Item	Action
	on referrals to Aintree with longer waits in Litherland. Referrals can be made to Aintree via Choose & Book. There are instances where the patient has been able to see a surgeon before getting a MCAS referral. The group complained that MCAS needs to have more appropriate triage as problems have arisen when sending patients to MCAS and added that they didn't feel locality monies should be used to fix a service that is already commissioned. AP agreed to discuss these issues with Steve Astles. Following the last meeting, the locality had fed back suggestions for the locality spend. CQC registration was discussed and TJ advised the group that if monies were used for CQC registration they would need to demonstrate that this would improve patient care. The group debated that this is a practice requirement but no funding was attached to it. It was reported that many CCGs do pay for this one being Yorkshire CCG. It was agreed that it would not be an acceptable use of monies to fund CQC registration as this could potentially be seen as a conflict of interest. CCG commission a variety of providers who are required to pay a CQC registration. AP asked the group if they could think of any gaps in services that the locality could commission to meet a need that is currently not being met. TJ asked the group if the £50k was being a bit of a distraction. The CCG intention for these monies was to get localities thinking but if this isn't working maybe there should be a rethink on a bigger scale as to what can be commissioned to improve patient care and not just a focus on how to allocate £50K. KMc added that a locality pack is now available, which has been produced in conjunction with public health, but the group had not had sight of this and it was agreed to get this out to localities. KMc added that there is a need to take some investment out of secondary care and think about schemes that will avoid admissions to A&E. The group were encouraged to look at the needs and what would make a difference within S&L and to think about how to improve care over 2 or 3 years not just 12 months. AP advised the group that an idea for a visiting scheme for care/ nursing homes had been suggested . It was acknowledged that work in this area is currently taking place with future additional community matron input. This together with the work that Asan is implementing may be seen as duplication. There was a debate around the problems with nursing homes and AP added that there is currently a nursing home project underway in Formby. TJ informed the group that the Maghull locality have planned a locality development session to look at data and discuss what they think their priorities are to establish a direction of travel for the locality. The group agreed to look at the locality pack and agreed to discuss this at the next meeting. **Housebound Reviews** AP provided figures to the group based on the original submissions from practice searches to identify housebound patients. The project is now in a position to start. There is a 60% upfront payment to practices which should be claimed on an SBS template that AP will circulate. Practices are asked not to use this template for anything other than the housebound reviews as	

No	Item	Action
	there is a code in the template that tracks the payment to this project. It was agreed that the locality should start to submit invoices and begin the reviews. Future invoicing should be on a quarterly basis (November and February) which will reflect actual number of reviews that have taken place, plus mileage costs. AP has also spoken with the Virtual Ward admin team who have stipulated that patients referred will need to be identified on the Virtual Ward form that they are part of the S&L housebound pilot – to keep track of any onward referral. **Case for Change Document** AP reported that comments were fed back to the CCG. KMc added that there was no expectation that clinicians will be completing this form and KMc will be working with Locality Managers on this. Low level schemes will be taken through the CCG SMT to be endorsed more quickly.	
14/83	**Medicines Management** HR reported that practices have been sent notification of their budgets. The audit results will be sent out to all practices for peer review at the next locality meeting. HR updated the locality on current drugs and agreed to forward the information which has also been added to the bulletin. If anyone has any queries they can contact Helen.	
	Action: HR to send drugs information out to practices.	HR
14/84	**Job Profiles Locality and GP Practice Lead** NW reported that rates of pay etc will be classed by the revenue as employment. This will mean rights of employment such as sick leave etc It was suggested that this needs to be looked at again with job titles, hours of work and rate of pay etc removed. This needs to reflect that this is a reimbursement of time to the practice and not a job role within the CCG. This will need to be non-person specific. H M Revenue advice was advised. TJ agreed to take back to CCG and seek advice to feedback to next the meeting.	
	Action: TJ to look at job roles and seek advice for next meeting.	TJ
14/85	**Any other Business** AP asked the group whether Dr Pandit was still needed to attend a locality meeting to discuss the erectile distress clinic. The locality would like AP to pursue this. No further business was discussed.	
14/86	**Date and Time of Next Meeting** 1st October 2014, 1 – 3pm Crosby Lakeside Adventure Centre	

NHS
South Sefton
Clinical Commissioning Group

Seaforth & Litherland Locality Meeting Minutes

Wednesday, 1st October 2014, 1.00pm – 3:00pm
Crosby Lakeside Adventure Centre

Attendees		
Dr Martin Vickers	GP, Bridge Road Surgery	MV
Samantha Standley	PN, Rawson Road & Netherton	SS
Angela Dunne	PM, Rawson Road	AD
Dr Ramon Ogunlana	GP, Orrell Park Medical Centre	RO
Jane McGimpsey	PM, Orrell Park Medical Centre	JMc
Lynne Creevy	PM, Bridge Road Surgery	LC
Dr Peter Goldstein	GP, Glovers Lane Sugery	PG
Louise Taylor	PM, Glovers Lane Surgery	LT
Dr Colette McElroy	GP, 15 Sefton Road	CE
Dr T Thompson	GP, 15 Sefton Road	TT
Dr Jane Irvine	GP, 15 Sefton Road	JI
Alison Harkin	PM, 15 Sefton Road	AH
Dr Noreen Williams	GP, Ford Medical Practice	NW
Lin Bennett	PM, Ford Medical Practice	LB
Dr Choudhary		
In attendance		
Angela Parkinson	Locality Manager, SSCCG	AP
Ian Senior	Operational Manager, LCH	IS
Karen Tong	LCH	KT
Karen Sandison	Community Matron LCH	KS
Helen Roberts	Senior Pharmacist, SSCCG	HR
Tracy Jeffes	Chief Corporate Delivery and Integration Officer	TJ
Minutes		
Angela Curran	Locality Development Support, SSCCG	AC
Apologies		
Louise Armstrong	PN, Ford Medical Practice	LA
Mark Halton	PN, Ford Medical Practice	MH
Dr Fred Cook	GP, Rawson Road	FC
Dr Naresh Choudhary	GP, Netherton SSP	NC
Pam Maher	PM, Litherland Darzi	PM
Ian Hindley	PM, Seaforth SSP/ Litherland SSP	IH
Lorraine Bohannon	PM, Netherton SSP	LB
Dr Jo Wallace	GP, Litherland Darzi	JW

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						✓	✓					
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	✓					
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					
Lorraine Bohannon	PM – Netherton Practice	✓	✓	✓	✓	✓	✓	A					
Dr N Williams	GP – Ford Medical Practice	✓	✓	✓		✓	✓	✓					
Dr B Fraser	GP – Ford Medical Practice				✓								
Dr A Ng	GP – Ford Medical Practice					✓							
Lin Bennett	PM – Ford Medical Practice	A	✓	✓	✓	✓	A	✓					
Louise Armstrong	PN – Ford Medical Practice	✓	✓	✓	✓		✓	A					
Mark Halton	PN – Ford Medical Practice	✓	✓	✓	✓		✓	A					
Dr R Ogunlana	GP – Orrell Park Medical Centre	A	✓	✓	✓	A	✓	✓					
Jane McGimpsey	PM – Orrell Park Medical Centre	✓	✓	✓	✓	A	✓	✓					
Dr A Hameed	GP – Litherland Darzi	✓		✓									
Dr B Schoenberger	GP – Litherland Darzi			✓									
Dr Jo Wallace	GP – Litherland Darzi						✓	A					
Pam Maher	PM – Litherland Darzi/ Town Hall				✓		✓	A					
Dr A Patrick	GP – Litherland Town Hall	A	✓	✓	✓	A	✓						
Dr F Cook	GP – Rawson Road/Orrell Park	✓	✓	✓	✓	✓	✓	A					
Angela Dunne	PM – Rawson Road/Orrell Park	✓	✓	A	✓	✓	✓	✓					
Ruth Powell	PN – Rawson Road												
Samantha Standley	PN – Rawson Road						✓	✓					
Ian Hindley	PM – Seaforth Practice/Litherland Town Hall	✓	A		✓	✓	✓	A					

No	Item	Action
14/86	**Apologies for absence** Apologies were noted. Action to be taken by the Locality	
14/87	**Declarations of interest** Dr N Williams, LMC and Lin Bennett, SSCCG Board member. Action to be taken by the Locality	
14/88	**Minutes of previous minutes** The minutes from the last meeting were agreed as a true record. Action to be taken by the Locality	
14/89	**Matters arising/action tracker** AP sought agreement from the locality in relation to the stoma project and reported that all other localities in South Sefton have agreed to the scheme at a cost of £5k. It was also reported that discussions will take place in Senior Management Team (SMT) around future funding of this work and whether this will be from the localities or medicines management. Feedback was given regarding MCAS – Steve Astles is looking into the issues that were reported back from the last meeting. NW reported that MCAS are now hitting a two week turnaround; previous issues have now been resolved. Locality packs have been disseminated but AP drew attention to the traffic light colours, some of which are incorrect. This has been noted by Becky Williams who is looking at this. Housebound review scheme – AP has provided the locality with the template for payment and asked members to ensure that they only use this particular template in relation to housebound payments. Helen Roberts from Medicines Management circulated the information following the last meeting, as requested. TJ reported that the job profiles will be re-draft following suggestions and discussion from the last meeting. Action to be taken by the Locality	
14/90	**Liverpool Community Health** Jeanette Hogan is the LCH representative for S&L, but due to annual leave, Ian Senior and Karen Tong attended the meeting. Karen Sandison also attended as Clinical Lead for the locality.	

No	Item	Action
	The purpose of LCHs attendance was to provide an update and open discussions regarding any current issues and to agree a way forward. IS provided an update on the current status of LCH. Those areas that have been classed as critical have action plans in place which are moving forward into localities to address all critical areas. All DN posts have been recruited to and GP liaison meetings have taken place which DNs have attended. Pathway reviews have begun and the Virtual Ward pro-active workstream is currently being evaluated, Paula Byrne will be supporting this and any issues that emerge will be dealt with immediately. Clinical leads have been appointed to each locality to support development work and will attend locality meetings to provide a link with LCH and report any issues. Senior Operational Managers have also been allocated to localities and it was agreed that they should be invited to attend on a quarterly basis, with Pete Chamberlain attending at the same time to feedback on any issues that have been raised. It was also suggested that complaints identified by practices could be flagged to Pete, for Pete to liaise with LCH and provide a response back to practices. Dr McElroy agreed to contact Dr Chamberlain The first locality implementation session took place on 24th September and further sessions are planned. Following this first session contact details for all DNs and health visitors will be sent to practices. Karen Sandisons mobile number will be distributed to the group. The locality reported that they are having a lot of problems getting appointments for treatment rooms. A number of patients are currently being referred from secondary care, not all patients are from primary care. Specific patient issues are being resolved when raised, but the group seek assurance that the system change is implemented so that all patients benefit where an issue has been flagged. There is a need to triage phone calls to treatment rooms to find out the patients who are being deflected as this is what is causing problems for GPs. IS fed back that LCH are working with teams to ascertain where the issues lie and how to rectify this. IS informed the locality that LCH are currently reviewing treatment rooms and information has been sent to the CCG from LCH around treatment rooms which was to be passed to GPs. It was agreed to chase this and clarify if the CCG had disseminated this information. ***Please note for clarity, following this meeting it can be verified that the treatment room information from LCH was sent out via the CCG bulletin on 10th September 2014.*** Lin Bennett has asked other managers at a Managers Meeting to offer their services on this issue to map out the provision and process for capacity and demand. This will be shared with GPs. IS added that DN issues are being addressed and IS agreed to look into DN inconsistencies in palliative care. It was agreed that SPC also needs addressing and the locality debated the issues around faxing referrals and the need for reassurance that faxes have been received and actioned. It was suggested that a similar process is followed to the 2 week rule with a confirmed receipt, or an email option with acknowledgement of receipt via a standard message. LB added that the locality needs to think about the future model of community services for delivery to patients and what they want LCH to provide. After debate, it was agreed to develop a template to label those	CMc AP

No	Item	Action
	community services that are needed, to send to LCH. Louise Taylor agreed to devise the template and send out to practices for completion. It was agreed that 3 monthly attendance by the LCH team accompanied by Dr Chamberlain, with a request to attend in between if needed. Dr Chamberlain will be invited to attend the November meeting	LT AP
	Action to be taken by the Locality	
	LCH operational managers to attend locality meeting on a quarterly basis. CMc to contact Pete Chamberlain re overview of complaints LT to create a template and disseminate to practices. AP to invite Pete Chamberlain to November locality meeting	
14/91	**Medicines Management – Peer Review Care Home Audit** Q1 – there was an outbreak of C.diff in care homes and public health has investigated this. Will be looking at antibiotics every quarter around this. No acute issues in May. NW commented that there had been a discussion as to what constitutes a six month review and added that this is in the guidelines. Q2 – HR will send the RCGP link to members in relation to the standard approach for antibiotics re-prescribing to patients, the patient must be re-assessed. Comments – in August there were a number of issues around prescribing COPD drugs for 7 days, 5 is not acceptable. The length of course is within guidelines. There have been problems with PPIs in residential care as patients are at risk of chronic infection simply because of who they are and where they are. All nursing home patients have had a medicines management review. PPIs are been looked at. Discussions took place around nursing homes and OOH doctors prescribing antibiotics. A letter will be sent out in November to raise awareness. HR reported that peer review can be done within the practice.	
	Action taken by the Locality	
	HR to send RCGP link to the group.	

No	Item	Action
14/92	**Locality Packs/Locality Budget** Locality pack – Members highlighted that there were a number of under 18s within their locality and S&L are the second most deprived area in South Sefton, behind Bootle but very close in disease prevalence. Members went through the pack and asked for clarity on the digestive data for unplanned admissions. AP reported that Jenny Kristiansen, Bootle Locality Manager was currently undertaking a piece of work with Gill Blane from Sefton CVS around alcohol. S&L would also like to do a piece of work with Bootle on this issue as the current service, which is currently with social services, is causing problems. The locality are also interesting in doing some work around targeting under 18's to encourage healthy lifestyle and education. AP agreed to link with Paula Bennett from Public Health to ascertain what services are available in the locality. There was a discussion around the number of patients in care homes and people living alone and suggested doing a mapping exercise as to what is available within the locality. Action to be taken by the Locality AP to clarity digestive data issues and feedback at next meeting. AP to link with Paula Bennett from Public Health and possibly invite Paula to the next meeting. TJ to feedback on demographics of disease prevalence at next meeting.	
14/93	**Any other business** AP to send out quality premium information Winter pressures – NHS England/ additional capacity in practice. AP to find out what is happening.	AP AP
14/94	**Date of next meeting** Wednesday, 5th November 2014, 1.00pm – 3.00pm Crosby Lakeside Adventure Centre	

NHS
South Sefton
Clinical Commissioning Group

Bootle Locality Meeting Minutes

Date: Tuesday 29th July 2014 at 13.00 – 14.30

Venue: Park Street Surgery

Attendees

Dr G Halstead	(Chair) Concept House	GH
Dr K Chung	Park Street Surgery	KC
Helen Devling	Moore Street Surgery	HD
Dr A Ferguson	Strand Medical Centre & North Park Medical Centre	AF
Dr S Sapre	Aintree Road Surgery	SS
Pauline Sweeney	Park Street Surgery	PS
Dr R Sivori	Bootle Village Surgery	RS
Jenny Kristiansen	South Sefton Clinical Commissioning Group	JK
Angela Curran	South Sefton Clinical Commissioning Group	AC
Paul Halsall	Medicines Management	PH

Minutes

Gary Killen	South Sefton Clinical Commissioning Group	GK

Apologies

Gerry Devine	Strand Medical Centre	GD
Dr S Stephenson	Bootle Village Surgery	SS

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 – Aintree Road Surgery	✓	✓	✓	✓								
Sanju Sapre	PM – Aintree Road Surgery	A	✓	A	A								
Dr S Stephenson	GP – Bootle Village Surgery	A	A	A	A								
Dr C McGuinness	GP – Bootle Village Surgery	A	A	A	A								
Dr R Sivori	GP – Bootle Village Surgery	A	A	A	✓								
Gill Riley	PN – Concept House Surgery	A	✓	A	A								
Dr D Goldberg	GP – Concept House Surgery	✓	A	✓	A								
Dr G Halstead	GP – Concept House Surgery	A	✓	A	✓								
Dr H Mercer	GP – Moore St Surgery	✓	A	A	A								
Dr A Roberts	GP – Moore St Surgery	A	A	A	A								
Dawn Rigby	PM – Moore St Surgery	A	A	A	A								
Helen Devling	PM – Moore St Surgery	✓	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 R Sinha	GP – North Park Health Centre	A	A	A	A								
Pam Sinha	PM – North Park Health Centre	A	A	A	A								
Dr K Chung	GP – Park St Surgery	✓	✓	✓	✓								
Pauline Sweeney	PM – Park St Surgery	✓	✓	✓	✓								
Dr A Ferguson	GP – Strand Medical Centre	✓	✓	✓	✓								
Gerry Devine	PM – Strand Medical Centre	✓	✓	A	A								
Dr M Gozzelino	GP – Strand Medical Centre	A	A	A	A								
Dr S Morris	GP - Strand Medical Centre	A	A	A	A								
M Hinchliff	PM – Strand Medical Centre	A	A	A	A								

✓ Present
A Apologies
L Late or left early

No	Item	Action
14/45	**Apologies** All apologies were noted	
14/46	**Minutes of last meeting & matters arising** Minutes of the last meeting were agreed as an accurate record. **14/38** JK to investigate the monthly statements from NHS England. Park street reported a £5 difference between NHS England's figure and the CCG figure. This lead to discussions around the table for the need of clarification JK to take up KC concerns to both NHS England and the CCG. **Action: JK to email Bal Duper for clarity.**	JK
14/47	**Quality and patient safety** AF spoke of some potential patient safety issues at North Park, this included the scanning letters and medical notes are behind. Helen Devling has been appointed as an independent auditor. Things are now getting better; Staff at North Park is working with Brenden Prescott and his safety team to sort out with ongoing problems. Medicines management are helping out with medicines queries. **Action: GH to contact safety and quality team.**	GH
14/48	**Performance and Finance update** **14/48.1 Medicines Management update** The PQS for this year requires a peer review of the data from the antimicrobial care home quarterly audit twice in the year at localities. So at the end of quarter 2 peer reviews Q1 and Q2 is required and at the end of Q4 we will peer review Q3 and Q4. PQS results letters will be sent to all practices soon. The adjusted results,	

No	Item	Action
	with the budget accounting for practice population/anti dementia /personally administered medications etc. have been agreed by the Senior Management Team of the CCG. **Action: PQS 14/15 to be added to September agenda.** Budget figures for the new financial year have now also been agreed and practices will be informed by letter. The budget for practices is based on a 1% uplift on the out-turn from last year. However, this year the budgets for practices will not remain constant. There will be flexible adjustment. Prescribing of "high cost drugs" will be accounted for together with patient population number fluctuation quarter on quarter. Medicine Management have been made aware of Flutiform inhaler representatives highlighting cost savings to practices through the prescribing Flutiform inhaler for asthma. PAN Mersey has issued a statement regarding Flutiform with the guidance as **NOT to switch stable** patients. **14/48.2 Finance update** The QP report was handed to the group. There is a total of £460,000 being handed out for bigger improvements within the South Sefton. JK requested that the group went away to look at ideas how to use these funds. KC raised concerns about the ambulance figures already for 14/15. The consensus was the locality was not happy that providers are not penalised for failing on objectives outside the localities control.	
14/49	**Service improvement/redesign** **14/49.1 Stoma Assessment & Review Project** JK passed around a summary of cost savings for the stoma project. JK is requesting 5K from each locality to employ Pauline 2 days a week, this will eventually cover the whole of South Sefton. The plan is also to train Pauline as a prescribing nurse. Medicines management are to help with guidance in giving Pauline authorisation for all needs from the incontinence service, this would free up more GP time. It was agreed that Bootle put in 5K from the locality fund to go forward. **14/49.2 Housebound reviews discussion** GH asked if the practices will get paid if they use their own nursing staff. The reviews would require different skill sets. JK is to contact a locum company that provides nurses and HCA's. JK asked what do the practices need, can most be done by HCA's to get wider benefits. KC suggested that HCA could cover nurses, when they go out. Different practices have different models. The share of funding is to be based on patient numbers. JK to collate the information (models, agency facilitators) and liaise with staff. JK asked the LCH representative to take the business cases back to	

No	Item	Action
	LCH for costing everything apart from nursing homes. **14.49.3 LCH Presence at future meetings** Not discussed. **14/49.4 LCH Session feedback – 15.7.14** The feedback from the Bootle locality at LCH meeting included LCH are looking to take an on additional nurses by October, Problems with referrals `forms creating lot of barriers, loss of communication. LCH informed everyone that a case load holder will be at every practice by at the beginning of September. They are also looking at getting a locality model together, and getting LCH representatives to discuss after the October locality meeting .LCH Band 6 staff will be making contact with the practices.	
14/50	**Locality Business** Not discussed.	
14/51	**Issues log**	
14/52	**Any other business** • A discussion was raised over dietians going into nursing homes and putting patients on SIP Feeds, it was brought up that SIP feeds need to stopped at a specific upper weight then Discontinued at this weight. GP's requested guidance from Medicines Management with reducing costs especially choice of feeds. • The locality agreed to focus the next meeting on the housebound business case and the meeting in October to focus on the locality model facilitated by LCH.	
14/53	**Date and time of next meeting** Tuesday 30th September 2014 (No meeting in August) 1pm – 2.30pm Park Street Surgery	

NHS
South Sefton
Clinical Commissioning Group

Bootle Locality Meeting Minutes

Date: Tuesday 30th September 2014 at 13.00 – 14.30

Venue: Bootle Health Centre

Attendees

Dr Sunil Sapre	Maghull Family Surgery	SS
Dr R Sivori	Bootle Village Surgery	RS
Dr A Ferguson	Strand Medical Centre & North Park Medical Centre	AF
Helen Devling	Moore Street Surgery	HD
Dr K Chung	Park Street Surgery	KC
Dr G Halstead	Concept House	GH
Pauline Sweeney	Park Street Surgery	PS
Jenny Kristiansen	South Sefton Clinical Commissioning Group	JK
Paul Halsall	Medicines Management	PH
Nancy White	Health and Wellbeing Trainer	NW
Tracey Lee	Health and Wellbeing Trainer	TL
Sam Poon	Student	SP
Ian Senior	Liverpool Community Health NHS Trust	IS

Minutes

Trish Cresswell	South Sefton Clinical Commissioning Group	GK

Apologies

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 – Aintree Road Surgery	✓	✓	✓	✓		✓						
Sanju Sapre	PM – Aintree Road Surgery	A	✓	A	A		A						
Dr S Stephenson	GP – Bootle Village Surgery	A	A	A	A		A						
Dr C McGuinness	GP – Bootle Village Surgery	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						
Dr D Goldberg	GP – Concept House Surgery	✓	A	✓	A		A						
Dr G Halstead	GP – Concept House Surgery	A	✓	A	✓		✓						
Dr H Mercer	GP – Moore St Surgery	✓	A	A	A		A						
Dr A Roberts	GP – Moore St Surgery	A	A	A	A		A						
Dawn Rigby	PM – Moore St Surgery	A	A	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
Helen Devling	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						
Dr K Chung	GP – Park St Surgery	✓	✓	✓	✓		✓						
Pauline Sweeney	PM – Park St Surgery	✓	✓	✓	✓		✓						
Dr A Ferguson	GP – Strand Medical Centre	✓	✓	✓	✓		✓						
Gerry Devine	PM – Strand Medical Centre	✓	✓	A	A		A						
Dr M Gozzelino	GP – Strand Medical Centre	A	A	A	A		A						
Dr S Morris	GP - Strand Medical Centre	A	A	A	A		A						
M Hinchliff	PM – Strand Medical Centre	A	A	A	A		A						

✓ Present
A Apologies
L Late or left early

No	Item	Action
14/54	**Apologies** There were no apologies.	
14/55	**Minutes of last meeting & matters arising** Minutes of the last meeting were agreed as an accurate record.	
14/56	**Quality and Patient Safety** 14/56.1 **Flu Campaign** JK distributed copies of the latest public health information. This led the group into a discussion around the process and how unhelpful it has been. A discussion ensued regarding the cold chain requirements and cost of calibration etc. GH asked JK to cost this up across the locality and see if this can funding can be used for this via Locality Development funds.	
	Action: JK to cost up and feed back at the next meeting.	JK
	14/56.2 **Friends and Family update** GH informed the group that Angela Curran from the CCG has organised for a member of staff from NHS England to attend the next Practice Managers Meeting practice to discuss how the training will be rolled out.	
14/57	**Performance and Finance Update** 14.57.1 **Medicines Management Update & PQS – Antimicrobial Care**	

No	Item	Action
	home quarterly audit – Paul Halsall The PQS for this year requires a peer review of the data from the antimicrobial care home quarterly audit twice during the year at localities. The data from the first two quarters for the Bootle Locality for this financial year was considered. Each patient and practice anonymised case was Peer reviewed by the GPs present and results were agreed. <u>Out of 10 prescription antibiotic courses it was agreed that only one followed the Local Antimicrobial Guidelines</u> <u>Actions agreed:</u> • All prescribers need access to printed version of the Local Antimicrobial Guidelines. • Each GP present to highlight within their practices. • The decision for prescribing the antimicrobial should be clearly documented in patient's notes. • A Local Patient Safety Alert regarding the Cold Chain was highlighted and together with the a reminder that an audit of the systems in place at each practice will be requested from each practice. Details have already been forwarded to the Locality. • The July 2014 prescribing budget data (First four months prescribing data) for the Bootle Locality was highlighted • PH highlighted the change to prescribing restrictions for Generic Sildenafil - It is now allowed on NHS prescription for all EDD. • South Sefton Locality Antimicrobial Audit report 2014 for High Risk Antimicrobial prescribing was highlighted and the results for the Bootle Locality were briefly discussed. 4.57.2 **Finance Update** The Finance and Resource papers were distributed. JK explained that there was no one available from the Finance Department. JK asked if the group has any comments or queries to feed them back to her and she will co-ordinate. 14.57.3 **Quality Premium Update** The Quality Premium Update was circulated. JK asked if the group has any comments or queries to feed them back to her and she will co-ordinate	
14/58	**Locality Business** 14.59.1 **Health & Wellbeing Trainers** TL introduced herself and NW and gave an overview of their service and the referral process. Tracie explained that at the moment all referrals came via the Virtual Ward. Tracie went through a couple of case studies to explain how the process works. **Action: TL to send JK service information for circulation.**	

No	Item	Action
	14/59.2 **Housebound Business Case** JK gave an update on the planning of the housebound reviews. It was identified that all practices could provide additional nurse time from their own practices apart from North Park and Moore Street Practices. JK will update the group with further details. 14/59.3 **Locality Packs** JK handed out the Locality Packs that provide information on key factors such as wider determinants of health, disease prevalence, high level data and reasons for admission. JK will circulate with the minutes of this meeting.	
	Action: JK to circulate locality packs with the minutes.	
	14.59.4 **Locality Lead GP Job Roles** JK circulated the Lead GP Job Roles that describes the key responsibilities and financial reimbursements. JK will circulate with the minutes of this meeting.	
14/59	**Any other business** **LCH Treatment Centre** PS raised the issue around lack of appointments and the number of rejections received. GH said seeing the pattern of referrals and reasons for rejection would be interesting. IS offered to get this information for JK to share with the locality.	
	Action: IS to send information to JK.	JK
14/60	**Date and time of next meeting** 28th October 2014 1pm-2.30pm at Park Street Practice Away session - 25th November 2014 at 1pm to 4pm at the Crosby Lakeside	

NHS
South Sefton
Clinical Commissioning Group

Crosby Locality Meeting Minutes

Date: Wednesday 3rd September 2014 at 12.45 – 14.30

Venue: Crosby Lakeside Adventure Centre

Attendees		
Dr G Berni	(Chair) 42 Kingsway	GB
Alan Finn	42 Kingsway	AF
Dr C Shaw	30 Kingsway	CS
Shelley Keating	30 Kingsway	SK
Maureen Guy	133 Liverpool Road	MG
Dr C Gillespie	Blundellsands Surgery	CG
Sue Hancock	Blundellsands Surgery	SH
Dr S Roy	Broadwood Surgery	SR
Pippa Rose	Crosby Village	PR
Dr P Sharma	Crossways	PS
Bruce Duncan	Crossways Surgery	BD
Dr R Huggins	Thornton Surgery	RH
Jennifer Kimm	Thornton Surgery	JK
Dr H Manzur	Hightown Village Practice	HM
Sean Reck	Medicines Management	SR
Tina Ewart	South Sefton Clinical Commissioning Group	TE
In attendance		
Lisa Hammond	Liverpool Community Health	LH
Alan McGee	Sefton MBC	AM
Tracie Lee	Sefton CVS	TL
Fiona Clarke	Sefton CVS	FC
Minutes		
Gary Killen	South Sefton Clinical Commissioning Group	GK
Apologies		
Dr G Misra	133 Liverpool Road	GM
Dr C McDonagh	30 Kingsway	CM
Pauline Woolfall	Hightown Village Practice	PW
Colin Smith	Blundellsands Surgery	CS
Andy Minmagh	Eastview Surgery	AM

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	✓						

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 M Taylor	GP – Crosby Village Surgery	A	A	A	A	A	A						
Dr S Roy	GP – Crosby Village Surgery	✓	✓	✓	A	✓	✓						
Sharon McGibbon	PM – Eastview Surgery	✓	A	✓	✓	✓	A						
Dr A Mimnagh	GP – Eastview Surgery	✓	A	✓	A	A	A						
Dr M Hughes	GP – Eastview Surgery	A	A	A	A	A	A						
Dr R Ratnayoke	GP – Eastview Surgery	✓	A	A	A	A	A						
Dr P Sharma	GP – Crossways Surgery	✓	✓	✓	A	✓	✓						
Bruce Duncan	PM – Crossways Surgery	A	A	✓	A	✓	✓						
Jenny Kimm	PM – Thornton Surgery	✓	✓	✓	✓	✓	✓						
Stella Moy	PN – Thornton Surgery	A	A	A	A	A	A						
Dr R Huggins	GP – Thornton Surgery	A	✓	A	A	✓	✓						
Dr I Break	GP – Thornton Surgery	A	✓	A	✓	A	A						
Maureen Guy	PM – 133 Liverpool Road	✓	✓	A	A	A	✓						
Dr G Misra	GP – 133 Liverpool Road	✓	✓	✓	A	A	A						
Sandra Holder	PN – 133 Liverpool Road	A	A	A	A	A	A						
Dr N Tong	GP – Blundellsands Surgery	✓	A	✓	A	✓	A						
Dr C Gillespie	GP – Blundellsands Surgery	A	✓	A	✓	A	✓						
Sue Hancock	PN – Blundellsands Surgery	✓	✓	✓	A	✓	✓						
Colin Smith	PM – Blundellsands Surgery	A	✓	✓	A	A	A						
Shelley Keating	PM – 30 Kingsway	✓	✓	A	A	✓	✓						
Dr C Shaw	GP – 30 Kingsway	A	A	A	A	✓	✓						
Dr C McDonagh	GP – 30 Kingsway	✓	✓	A	✓	A	A						
Dr E Pierce	GP – Hightown Village Practice	A	A	A	A	A	A						
Pauline Woolfall	PM – Hightown Village Practice	✓	✓	✓	A	✓	A						
Dr Barouni	GP – Hightown Village Practice	A	A	A	A	✓	A						
Dr C Allison	GP – Hightown Village Practice	A	A	A	A	A	A						
Dr Ghalib	GP – Hightown Village Practice	A	A	A	A	A	A						
Dr S Bussolo	GP – Hightown Village Practice	A	✓	✓	A	✓	A						
Dr D Navaratnam	GP – Azalea Surgery	✓	✓	✓	✓	✓	A						
Dr C Doran	GP – Azalea Surgery	A	A	A	A	A	A						
Dr G Berni	GP – 42 Kingsway	✓	✓	✓	✓	✓	A						
Alan Finn	PM – 42 Kingsway	✓	✓	✓	A	✓	✓						
Dr F Vitty	GP – 42 Kingsway	A	A	A	A	A	A						

✓ Present
A Apologies
L Late or left early

No	Item	Action
14/86	**Welcome and apologies** were noted	

No	Item	Action
14/87	**Declarations of interest** None declared	
14/88	**Minutes of last meeting- 6th August 2014** The minutes of the last meeting were agreed as a true record of discussions.	
14/89	**Matters Arising** None	
4/90	**Medicines Management Update** Sean Reck gave an update on the local patient safety alert issued by Public Health England, in regard to 'cold chain' training and practices. This led to a general discussion and Sean recommended if they have any problems to inform their practice pharmacist.	
14/91	**Finance Update** No one from Finance was present but the monthly report will be circulated as soon as received.	
14/92	**Health & Wellbeing Trainers** The Manager of the Team – Tracie Lee from CVS addressed the meeting to inform the locality of the services provided by the Health & Wellbeing trainers. They work mainly with patients who feel socially isolated or need support and coaching to regain confidence to achieve a personal lifestyle goal. Referrals are accepted via the Virtual Ward on the multidisciplinary referral form. Working closely with the community matrons and district nurses, the aim is for the patients to reconnect with the community by linking them to supportive care groups and agencies. Fiona gave an example of how they have helped patients to achieve healthier lifestyles by quitting smoking or alcohol, joining exercise classes, self-help groups, benefit checks, access to Keep-Warm initiative grants or simply arranging dog walking for patients who are recovering from recent illness. Service capacity at the moment it is running at about 10 to 12 referrals per month with a full capacity of 25 cases on the locality list at any one time. The service tries not to have a waitlist, and if this happens, they will keep in contact with the patient and progress letters will be sent to GPs involved. Referrals should be made using the Virtual Ward multidisciplinary Referral Form by ticking the Health & Wellbeing Trainer discipline box.	
14/93	**Health watch Patient Representative** Postponed to a later date	

No	Item	Action
14/94	**Quality, Patient Safety and Issues Log** GB and TE outlined a proposal to invest some of the locality money on upskilling clinical staff to perform targeted Respiratory reviews using the In Check device method to ensure correct inhaler technique is understood by patients with COPD. TE had previously shared proposal to provide clinical training sessions for staff to deliver reviews and patient education, followed by two sessions per practice with specialist pharmacist assisting and observing nurses one to one. Nurses would then continue to review either 20% or 100% of registered COPD & Asthma patients in the locality depending on how the locality wishes to invest. Dr Gillespie asked how the reviews would count as being over and above QOF; TE explained that by purchasing the Incheck devices and training the teams to deliver using In check methodology; this would provide an enhanced service specifically targeting patients using new device and methods. Sean qualified the evidence of using In-Check methodology referencing other areas use of this. He and the CCG pharmacy team have already undertaken training sessions with Jon Bell, Director of a commercial organisation that investigates inhaler devices and they use (Canday Medical Ltd). Jon Bell is a respiratory physiologist. Reference Link to the Isle of White project for evidence reference if you need: http://www.nice.org.uk/proxy/?sourceurl=http://www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/eximpresults.jsp?o=461 Nearly all pharmacists were surprised and impressed to discover that the training they had received at University was in fact now out of date. This training highlighted training needs amongst the pharmacy team. See link to other areas evidence: https://wessexhiecpartnership.org.uk/wires/files/2013/07/120904-CIREM_ITIP_HIEC_Evaluation.pdf Findings lifted from document for reference: “The main cause of poor inhaler technique is too high an inspiration rate leading to most of the inhaled medication being swallowed instead of inhaled. The medicine is largely wasted, thus reducing the efficacy of the medication. Low efficacy leads to poorer disease control and higher rates of exacerbation. The In-Check Dial is a device which helps to identify whether a patient is using their inhaler correctly. The In- Check dial has the added advantage in that it can be set to simulate inhalation through different types of inhalers. It measures the speed at which air is inhaled when the patient blows through the mouthpiece. By comparing the patient's results with the optimum results, patients can be trained to use their inhaler correctly. The device comes with an optimum inspiratory flow card, which informs users of the optimum inspiratory flow rates for different types of inhalers. The pharmacists who undertook the training supported this assertion, as is evidenced from their on-line survey responses. Ninety three per cent agreed or strongly agreed that the training had enabled them to implement the service confidently” Discussion ensued re annual COPD review times which were agreed to be 20 minutes. New ‘Targeted review’ time is 30 mins. If practice nurses were	

No	Item	Action
	to deliver targeted reviews, payment for work would be based on extra 10 mins per patient against Nurse salary. It was suggested that we should include nursing home staff to training sessions. TE and Nurse Suzanne from Blundellsands (SH) agreed to work together in working up the project. Dr Clive Shaw suggested that we simply pay for Pharmacist to perform 20% register reviews on behalf of the practice, plus training to be undertaken by clinical staff to then continue the COPD reviews in the future to include the In check targeted reviews. Dr Gillespie reiterated that the housebound reviews were also a very good idea to bring to the locality	
	Action: TE to cost up Respiratory and Housebound projects and bring to the next meeting	TE & SH
14/95	**Handover of Locality Chair** GB announced that from October CG will take over as Chair of the locality. GB thanked everyone for their support, and the group thanked GB for the work he has done over the last 12 months. Clive thanked Gus for his hard work and commitment to bring the locality through its first year as a CCG.	
14/96	**Any other business** None discussed.	
14/97	**Date and time of next meeting** Wednesday 1st October 2014 12.30 lunch 12.45 – 14.30 Crosby Lakeside Adventure Centre (CLAC)	

NHS
South Sefton
Clinical Commissioning Group

Crosby Locality Meeting Minutes

Date: Wednesday 1st October 2014: 12.45pm-2.30pm

Venue: Crosby Lakeside

Attendees		
Dr Craig Gillespie	GP Blundellsands Surgery	CG
Dr Andy Minmagh	GP Eastview Surgery	AR
Dr Damian Navaratnam	GP 20 Kingsway	DA
Collette O'Loughlin	Urgent Care Manager LCH	CO'L
Sue Edmondson	Community Matron LCH	SE
Dr Clive Shaw	GP 30 Kingsway	CS
Dr Gokul Misra	GP 133 Liverpool Road	GM
Janet Faye	SSCCG Pharmacist	JF
Maureen Guy	Practice Manager, 133 Liverpool Road	MG
Dr Prema Sharma	GP 168 Liverpool Road – Crossways	P
Dr Ramona	GP Thornton Practice	R
Jenny Kimm	Practice Manager, Thornton	JK
Asan Akpan	Consultant Community Geriatrician	AA
Dr Gus Berni	GP 42 Kingsway Practice	
Ian Senior	Transformational Manager LCH	IS
Alan Finn	Practice Manager 42 Kingsway	AF
In Attendance		
Tina Ewart	South Sefton Clinical Commissioning Group	TE
Steve Astles	South Sefton Clinical Commissioning Group	SA
Minutes		
Trish Cresswell	South Sefton Clinical Commissioning Group Temp	TC

Apologies
James Bradley, Finance
Colin Smith, Practice Manager Blundellsands
Pippa Rose, Crosby Village Nurse
Suzanne Hancock, Blundellsands Nurse
Stella Moy, Thornton Nurse
Bruce Duncan, Practice Manager Crossways
Ian Knowles, CSU analyst

Belated apologies for Dr Andy Minmagh noted for previous meeting in September

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 Craig Gillespie	Blundellsands Surgery							✓					
Dr Andy Minmagh	Eastview Surgery							✓					
Dr Damian Navaratnam	20 Kingsway							✓					
Dr Clive Shaw	30 Kingsway							✓					
Dr G Misra	133 Liverpool Road							✓					
Janet Faye	Meds Mmgt							✓					
Maureen Guy	P.Mgr 133 Liverpool Road							✓					
Dr Prema Sharma	168 Liverpool Road Crossways							✓					
Dr Ramona	Thornton Practice							✓					
Jenny Kimm	Practice Manager, Thornton							✓					
Asan Akpan	Community Geriatrician							✓					

✓ Present
A Apologies
L Late or left early

No	Item	Action
14/96	**Apologies** James Bradley, Colin Smith, Pippa Rose, Suzanne Hancock, Stella Moy, Bruce Duncan, Ian Knowles	
14/97	**Minutes of last meeting & matters arising** CG asked for future minutes to be page numbered Sean Reck had sent a correction for the previous minutes via TE and JF that the Inhaler technique training was delivered by Jon Bell, Director of Canday Medical Ltd a commercial organisation that investigates inhaler devices, and not Amit as had been minuted. Jon Bell is a respiratory physiologist. Also attached is the link to the Isle of White project for reference as promised. http://www.nice.org.uk/proxy/?sourceurl=http://www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/eximpresults.jsp?o=461 With this amendment, the minutes of the last meeting were agreed as an accurate record.	
14/98	**Declarations of Interest** LCH staff present	
14/99	**Matters Arising** TE was requested to cost up Respiratory and Housebound projects which are on this agenda.	

No	Item	Action
14/100	**Urgent Care within Virtual Ward – Asan Akpan and Colette O'Loughlin** AA reported that as of October practices can start referring to the Urgent Care team. The times of availability are 8am to 7pm, and open to aged 18yrs and over. The service is available to anyone. They have seen 19 patients since starting in June and only 8 have been referred on to hospital. All patients to date have been seen within one hour. The official agreement is to see them within 2 hours. The Urgent Care team cover everything; Falls, Dehydration, confusion, ongoing illnesses, we can arrange short term carers, physios, therapists IV therapies etc. We have also commissioned a number of beds outside of hospitals to care for patients in the best setting. If your patient *does* need to go to hospital – we will arrange admission on GP's behalf. If you are not sure – ring Asan on his mobile. *Asan urged the group to contact him at any time on his mobile if you are in any doubt or want to discuss a case*. **Asan's mobile number is 07964462754** **<u>Questions from the group to Asan</u>**: **Q**. If I have a patient aged 80years with a respiratory condition, should I call the specialist community respiratory team or you? **A**. Contact the respiratory team, they will already know the patient however, if there are any issues, do not hesitate to call Asan and the Urgent Care team. **Q**. Where are the community beds? **A**. Cambridge Court. SA commented these beds have been funded by Resilience Care monies AA commented that they also have a number of hospital beds. **Q**. Patients living on their own having had a fall – can these be referred to the Urgent Care team? **A**. Yes. CO'L added that falls usually come with other issues, e.g. chest infections, mobility, Cellulitis – these often go on to A&E but please refer them to the Urgent Care team. SA re iterated that this service is a proper single point of contact. This is aimed towards ringing one central number. AA added that if the patient doesn't meet the criteria – contact our team. We will go to see the patient. AM commented that AA and the team have not disappointed! **Q.** Do patients have any method of access back in to the service? **A**. KA – Yes, patients get back in touch. Absolutely, patients can ring us if they still have concerns. **Q**. Do you accept referrals from Nursing Homes etc.? **A**. We will see all referrals. We have two Rapid Access clinics in Litherland. CG asked how the referral process works. AA – Ring Katie Molloy on 0151 475 0147 (this number is on the Intranet).	

No	Item	Action
	CO'L - We have two dedicated call handlers using a landline – they go straight to an Urgent Care Nurse. AA confirmed that the specification is 2 hours response although; all have been seen within one hour so far. I can go to home visits if patients can't get to the clinic. Feedback relating to the Urgent Care / VWard service is crucial , please continue to keep us informed of experiences and suggestions – Contact details will be re circulated with named individuals to wards etc.	
14/101	**Quality, Patient Safety and Issues Log** CG – ask for feedback from the group and TE suggested an example that she has been made aware via SUIs that there high numbers of reported problems relating to pressure ulcers in the community. TE asked if locality members have any issues to report that may indicate a theme emerging or something that could have caused harm. SA asked if there is anything from Acute services; <u>Responses:</u> ENT appointments are being cancelled at Aintree. AM stated there is an 18 week wait at Aintree and Walton Centre. If there are any problems, GPs need to know. SA said there have been problems with clinicians. Trying Community Clinics for lower end ENT patients.	
	Action: SA to come back to next meeting with answers after speaking to Aintree.	SA
	It was raised that at Alder Hey there is a 40 minutes wait for prescriptions and noted by SA. AM said a record needs to be kept of referrals. GP referrals are the majority. SA asked who controls referrals. Can Consultants refer to other Consultants without speaking to GPs? AM said the dubious referrals are the ones in the middle and GPs should perhaps audit referrals. SA – Monitor referrals closely. PS Alder Hey issue raised re Appointment cancelled 5 times and now been given appointment in the new year with no explanation.	
	Action: SA to supply details to TE and investigate.	SA/TE
14/102	**Strategic Performance Update** Apols from Ian Knowles, he is required to attend a Finance meeting today, and TE reported a new SSCCG Dashboard that has been launched, RAG rated – red/amber/green offering a more strategic view of our performance. There are direct links to Disease areas and the locality will find it useful. CG commented that he had in fact looked at this and it appears user friendly. There are also two other links to organisational profiles of performance to assist us identify areas we may **wish** to celebrate, review or improve.	

No	Item	Action
	These links are referenced below: **Profiles for ALL to view:** **Public Health link** http://fingertips.phe.org.uk/profile/general-practice This Public Health link is for all GP Practices to view and compare profiles. These profiles are designed to support GPs, clinical commissioning groups (CCGs) and local authorities to ensure that they are providing and commissioning effective and appropriate healthcare services for their local population. In addition to viewing individual practice profiles, you can view summary profiles for CCGs. Each practice can be compared with the CCG and England, and also with the practice deprivation decile and 'peer group' Also **Public Health Gateway link** http://datagateway.phe.org.uk/ which will help provide some additional data and back round to support exploration of programme issues at both locality and practice level. **SSCCG Dashboard** : Apols to most of the locality but this specific link is only available to GP's/leads who can access the SSCCG 'W' drive when visiting Merton House. Please find attached a link to our M4 Programme Dashboards showing performance against our main KPIs, down to locality level for each CCG W:\Performance\PMO\Dashboard\2014_15 Dashboards\Month 4.	
14/103	**Medicines Management** JF reported that early indications show a forecast for both CCGs being underspent however she is cautious given that the official figures have not yet been received. Generic Sildenafil is now available on the NHS for all appropriate patients with Erectile Dysfunction. There are now no limits on prescribing. Department of Health have removed the SLS prescribing restrictions. Patients should be reviewed and changed from private to NHS prescriptions. Dr CG questioned quantity recommended. JF informed the group that there are no recommended restrictions on quantity now Janet reminded everyone that her team will be available to help and assist you meet the 'Cold chain' recommendations if required. Janet informed the group of 'low outcomes' following recent audit results of antibiotic prescribing in care homes which opened up discussion highlighting likely reasons that might skew these findings; Quite a lot of colleagues who have handwritten a script on a home visit then only "free text" the product and dosage onto the electronic patient record on their return to surgery. If this practice is widespread, electronic searches will not pick up the information. Handwritten records are not acceptable and should be recorded on the EMIS / practice system. It was agreed that we need to "share this learning" in a non-confrontational	

No	Item	Action
	manner to plug a foreseeable and thus avoidable clinical risk, whilst the long term solution is clearly the roll out of remote access solutions to GP records for GP's and Electronic Transfer of Prescription projects. JF AM requested all to look at practice records, discuss with your Practice Managers, collate information audit and report back to the locality. JF will send out information on what to do.	
14/104	**Locality Business** **Investment Projects: Inhaler Technique Improvement and Housebound Assessments** TE reported that both Inhaler Improvement Technique and Housebound projects were agreed and passed at SMT with authorisation to go ahead. She has not yet written the Business case for the Inhaler Technique project because the Pharmacist is not able to commence this work until the new year. She has written a Business case for the Housebound project and the next stage will be to decide how practices want to deliver it - Either; by using *their own practice Nurse* or *employing a nurse to perform the checks on their behalf.* TE has been given the name of at least one Nurse who would be willing to do these checks on behalf of practices and is known to you all. Suzanne Hancock also knows of another one should we need to enrol two to do the job. SA – Emphasised that CCG can't employ this nurse. Either they want to do this as locality, or themselves. CG suggested TE will send out details of project and request 2 weeks from now response and feedback. **Resilience Planning** SA – explained that Resilience Planning was formerly known as Winter Planning. All CCGs have been allocated money from government. Sefton have been given £1.2m plus bids for additional money. The North Mersey pot has been given to Acute trusts, Merseycare, Alder Hey and Social Services. Potential resources are available for Primary Care; can we make system work better? any innovative ideas are welcomed. Discussion included; staggering home visits, re-hash visits/appointments, and extra resource.	
14/105	**Any Other Business** TE - Reminder request for a rep from each practice to sign sheet receipt of the SSCCG constitution. SA said Invoices need countersignature. Guest speakers to next meeting; Merseycare – TE reminded all that Merseycare have launched 'curry nights' to meet, appraise network and shape services. See CCG bulletins for details. Agreed that they can attend Crosby Nov/Dec meeting. Bal will be attending next Locality meeting.	
14/106	**Date and Time of next meeting**	

No	Item	Action
	5 November 2014, 12.30pm @ CrosbyLakesideAdeventureCentre (CLAC)	

NHS
South Sefton
Clinical Commissioning Group

Maghull Locality Meeting Minutes

Date: Thursday 21st August 2014 at 13.00 – 14.30

Venue: High Pastures Surgery

Attendees		
Dr S Gough	(Chair) Westway Medical Centre	SG
Gill Kennedy	High Pastures Surgery	GK
Dr J Clarkson	High Pastures Surgery	JC
Dr C Thompson	High Pastures Surgery	CT
Carol Roberts	Westway Medical Centre	CR
Dr B Thomas	Broadwood Surgery	BT
Karen Riddick	Liverpool Community Health	KR
Dr J Krecichwost	Maghull Health Centre	JK
Jenny Kristiansen	South Sefton Clinical Commissioning Group	JKr
Angela Parkinson	South Sefton Clinical Commissioning Group	AP
Laura Doolan	South Sefton Clinical Commissioning Group	LD
Minutes		
Angela Parkinson	South Sefton Clinical Commissioning Group	AP
Apologies		
Terry Hill	South Sefton Clinical Commissioning Group	TH
Gill Stuart	South Sefton Clinical Commissioning Group	GS
Dr J Wray	Westway Medical Centre	JW

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 Surgery	✓	✓	✓	✓	A							
Gillian Stuart	PM – Westway Medical	✓	✓	✓	A	A							
Carole Howard	PM – Westway Medical	✓	A	A	✓	A							
Dr S Chandra	GP – Westway Medical	A	A	A	A	A							
Dr R Killough	GP – Westway Medical	✓	A	✓	A	A							
Dr J Wray	GP – Westway Medical	A	A	A	A	A							
Dr S Gough	GP – Westway Medical	A	✓	A	✓	A							
Jennie Procter	PN – Westway Medical	A	A	A	A	A							
Gill Kennedy	PM – High Pastures Surgery	✓	A	✓	✓	✓							
Dr P Thomas	GP – High Pastures Surgery	A	A	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 J Clarkson	GP – High Pastures Surgery	✓	✓	✓	A	✓							
Dr P Weston	GP – High Pastures Surgery	A	A	A	A	A							
Dr N Ahmed	GP – High Pastures Surgery	A	A	A	A	A							
Carole Morgan	PM - High Pastures Surgery	A	✓	✓	A	A							
Lesley Bailey	PN – Maghull SSP Practice	A	A	A	A	A							
Donna Hampson	PM – Maghull SSP Practice	A	✓	✓	✓	A							
Dr A Banerjee	GP – Maghull SSP Practice	✓	✓	✓	A	A							
Dr J Thomas	GP – Broadwood Surgery	✓	✓	✓	A	A							
Dr B Thomas	GP – Broadwood Surgery	A	A	A	A	✓							
Judith Abbott	PN – Broadwood Surgery	A	A	A	A	A							
Dr J Krecichwost	GP – Maghull Health Centre	A	A	✓	✓	✓							

✓ Present
A Apologies
L Late or left early

No	Item	Action
14/61	**Apologies** All apologies were noted	
14/62	**Declarations of interest** None put forward	
14/63	**Action Points** High Pastures have been experiencing problems with payments via SBS, and have been directed to a call centre in India. The finance team are aware of communication problem between SBS and practices, whereby practices have not been informed of issues with invoices, which has led to non-payment. Linda Pye is currently helping practices with these issues. A review of previous payment queries will take place by finance in conjunction will relevant colleagues to understand the blockers. A letter has recently been circulated regarding practices vaccinating housebound patients against flu. This has been identified as a practice responsibility via the DES. This will be picked up when discussing the housebound visiting scheme under section 14/66. Karen Riddick gave her apologies for the last locality meeting, but this did not appear on the minutes, Ian Senior attended in her absence.	
14/64	**Quality and Patient Safety – N/A**	
14/65	**Performance and Finance Update – Laura Doolan** **Quality Premium** There is currently an approximate £500K Quality Premium payment due for 2013/14, the final 13/14 data is yet to be validated and published by NHS	

No	Item	Action
	England, confirmation is expected by Quarter 3 of the 2014/15 financial year, use of this income needs to be considered. **Finance Update** As at month 4 (July 2014) the CCG is reporting £0.904m overspent position on Operational budgets before the application of reserves. The CCG is on target to achieve the planned surplus of £2.300m by the end of March 2015. The main pressures emerging are within acute care particularly Aintree Hospital and Liverpool Women's Hospital. Also overspends within Continuing Healthcare. Aintree forecast overspend has reduced however the overspent areas are being investigated by the Business Intelligence team. An increase of 4% was applied to the Continuing Healthcare budget in April. However, this continues to be a major risk area with a continued forecast overspent position. There have been improvements in the quality of data received from CSU which enables the CCG to place better reliance on the financial information received. The CCG has identified £7.959m of its planned £8.452m QIPP savings leaving a shortfall of £0.493 still to be identified.	
14/66	**Service Improvement Redesign – Locality Development Opportunities** **Stoma and Respiratory Projects – Jenny Kristiansen** Jenny Kristiansen presented the Stoma Care Project that Bootle locality undertook last year. Between October 2013 and February 2014, 35 patients were referred, 31 were reviewed, with the outcome of a reduction in stoma items of 11.81%, and a cost reduction of 5.27% (£10,125) from the previous year. Other localities have seen a cost increase for the same period. There is an opportunity for Maghull to participate in the project at a cost of £5K funded from the locality budget. **Housebound Healthcheck Scheme – Angela Parkinson** A business case has been developed by Ford Medical Practice for Seaforth and Litherland Locality where housebound patients with a long term condition receive an annual review. A cohort of approximately 444 patients were identified which included those patients who are in their own home, care and nursing homes. Originally it was planned that a HCA would undertake the review, however due to the small numbers of HCAs available in the locality and issues with indemnity insurance, this has now been altered to the practice employed nurses carrying out the reviews at a set fee per review. Templates have been devised for data collection, the business case had been circulated to the group prior to the meeting. The business case has been approved to start in September. Bootle locality are also adopting the scheme, however the practice nurses are being backfilled at the practice by locum HCAs.	

No	Item	Action
	Maghull locality were asked to consider whether this scheme would be useful and how it could be adapted to suit the needs of the locality. **Case for Change Business Case – Angela Parkinson** These documents were circulated prior to the meeting and consist of a proposal checklist and templates to complete once a proposal has been agreed for the £50k locality money. The process would be that the checklist would be agreed with the Locality and submitted to Senior Management Team to review for agreement. The Locality would then proceed to complete the Case for Change template. The level 1 Case for Change template (0-£50K) would be applicable for the locality budget, this consists of 2 sides of A4 to complete.	
14/67	**Locality Business (including Chair's update (Governing Body, WCG,GP Locality Leads meetings)** There was no business to discuss under this agenda item. **Medicines Management Update – Jennifer Johnson** This item was not discussed. **Review of draft job roles – Angela Parkinson** Draft job roles were circulated prior to the meeting, regarding the roles of Locality Chair and Practice GP Leads, no comments were received. **Resilience plans (winter pressures) – Angela Parkinson** Communications are now taking place with NHS England regarding additional capacity in primary care over the winter period, further ideas are welcomed from practices to reduce pressures. The visiting scheme introduced by the PCT some years ago was discussed where visits from 4pm onwards could be forwarded to the Out of Hours service. Although this wasn't a perfect service the group felt that this could be adapted to work well in Maghull. That particular scheme when introduced was not utilised very well. Ideas for resilience planning is going to be an agenda item at the Wider Group meeting in September. A shortage of locums to increase capacity in the winter periods was noted. **Locality Development Session** Dr Gough reminded the group that Septembers locality meeting would be used for a development session.	
14/68	**Any other business** Karen Riddick informed the group that LCH are currently recruiting 4 extra community matrons for care homes.	
14/69	**Date and Time of next meeting:** Thursday 25th September – Westway Thursday 23rd October, 1 - 2.30pm – High Pastures surgery	

No	Item	Action
	Thursday 20th November, 1 - 2.30pm – Westway MC Thursday 18th December, 1 - 2.30pm – High Pastures surgery Thursday 22nd January, 1 - 2.30pm – Westway MC Thursday 19th February, 1 – 2.30pm – High Pastures surgery Thursday 19th March, 1 – 2.30pm – Westway MC Thursday 23rd April, 1 – 2.30pm – High Pastures surgery	

NHS
South Sefton
Clinical Commissioning Group

Maghull Locality Meeting Minutes

Date: Thursday 25th September 2014 at 13.00 – 14.30

Venue: Westway Surgery

Attendees		
Dr S Sapre	Maghull Family Surgery	SS
Dr S Gough	Westway Medical Centre	SG
Gillian Stuart	Westway Medical Centre	GS
Dr R Killough	Westway Medical Centre	RK
Dr S Chandra	Westway Medical Centre	SC
Dr Jan Clarkson	High Pastures Surgery	JC
Donna Hampson	SSP Parkhaven	DH
Dr Bernard Thomas	Broadwood Surgery, Westway	BT
Jenny Johnston	Meds Management	JJ
Gill Kennedy	High Pastures Surgery	GK
Tracy Jeffes	South Sefton CCG	TJ
Terry Hill	South Sefton CCG	TH
Ian Senior	Liverpool Community Health	IS
Minutes		
Trish Cresswell	South Sefton Clinical Commissioning Group	TC
Apologies		
Dr J Krecichwost	Maghull Health Centre	JK
Dr John Wray	Westway Medical Centre	JW

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 Surgery	✓	✓	✓	✓	A	✓						
Gillian Stuart	PM – Westway Medical	✓	✓	✓	A	A	✓						
Carole Howard	PM – Westway Medical	✓	A	A	✓	A	✓						
Dr S Chandra	GP – Westway Medical	A	A	A	A	A	✓						
Dr R Killough	GP – Westway Medical	✓	A	✓	A	A	✓						
Dr J Wray	GP – Westway Medical	A	A	A	A	A	A						
Dr S Gough	GP – Westway Medical	A	✓	A	✓	A	✓						
Jennie Procter	PN – Westway Medical	A	A	A	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
Gill Kennedy	PM – High Pastures Surgery	✓	A	✓	✓	✓	✓						
Dr P Thomas	GP – High Pastures Surgery	A	A	A	A	A	A						
Dr J Clarkson	GP – High Pastures Surgery	✓	✓	✓	A	✓	✓						
Dr P Weston	GP – High Pastures Surgery	A	A	A	A	A	A						
Dr N Ahmed	GP – High Pastures Surgery	A	A	A	A	A	A						
Carole Morgan	PM - High Pastures Surgery	A	✓	✓	A	A	A						
Lesley Bailey	PN – Maghull SSP Practice	A	A	A	A	A	A						
Donna Hampson	PM – Maghull SSP Practice	A	✓	✓	✓	A	✓						
Dr A Banerjee	GP – Maghull SSP Practice	✓	✓	✓	A	A	A						
Dr J Thomas	GP – Broadwood Surgery	✓	✓	✓	A	A	A						
Dr B Thomas	GP – Broadwood Surgery	A	A	A	A	✓	✓						
Judith Abbott	PN – Broadwood Surgery	A	A	A	A	A	A						
Dr J Krecichwost	GP – Maghull Health Centre	A	A	✓	✓	✓	A						

✓ Present
A Apologies
L Late or left early

No	Item		Action
14/70	**Apologies** As above.		
14/71	The purpose of the session was to enable the locality to: • Give everyone a change to reflect on how to move forward as a group • Consider how to best meet the needs of local people • Develop a plan to help focus efforts The group began with a SWOT analysis which enabled a discussion around the locality's current strengths, weaknesses, opportunities and threats. The key points from the discussion were captured on a flip chart which is reproduced below.		
14/72	**SWOT Analysis**		
	Strengths • Meeting up enables good clinical/ peer group feedback. • Support – able to share issues, openness. • Familiarity/ good connections between practices • Experience as a group • Good links with Board (The locality is well represented by Governing Body members) • Compact geographically	**Weaknesses** • Time – we have support from Terry but difficult to make time for CCG work on top of practice work • Geography – we can feel "out on a limb". Seen as an affluent area but are hidden needs • Funding gaps compared to profile of the population? • Age profile of current GP	

No	Item		Action
	• Same demography, same issues • Good engagement • Good attendance at meetings • Good patient engagement e.g. Patient reference groups	workforce means many will retire at same time – recruitment issues re new GPs • Do we do we know our practice populations are similar? We need to test this out. • Different practice size/different approaches within locality • We can focus on short term not longer term issues • Gap in commissioning skills. Clarity re role as commissioner/provider and time to develop • Mixed loyalties – locality, CCG, practice • Premises – need development • Transport issues to services Communications with Governing Body	
	Opportunities • Common themes from patients • Move to a more strategic approach – tackle bigger issues • Shape community provision – what our patients need in our locality • Development of locality schemes, e.g. Stoma, pinch ideas from elsewhere! • Use of Information Portal to compare data • Development of premises • Challenge each other more? • Data /analysis to get better a understanding of local needs and current provision • To reshape services within the locality	**Threats** • NHS England Commissioning of primary care • Recruitment/workforce for future • Conflicts of interest • Political landscape - changes to NHS - privatisation (General practice) • Threats to local care from short term contracts • Estates – affordability of new developments • GP Pay • Shift from secondary care without properly resourcing community/primary care.	
14/73	**What is the role of the locality?** • Input into / influence changes in local health system • Ensure high standard of equitable health care – both in terms of		

No	Item	Action
	commissioning and local provision • Make at least one small change – make a difference. • Understanding needs of locality to inform commissioning. - identify gaps - shift provision to meet needs • Ensure sufficient resources • Develop longer term goals • Share good practice within the group • Try to make sure whole team is involved e.g. Practice Nurses, salaried GPs • Use opportunities to feedback to colleagues who don't attend locality meetings and bring ideas/ issues back from practices	
14/74	**Action Plan** 1. Locality GP leadership succession plan: To be discussed at the next locality meeting on **23rd October 2014**. 2. Data to be shared (down to practice level where possible) with the locality. Ideas include:- • QOF data • Long Term Conditions prevalence – (plus opportunities to link with programme leads in future) • Admission and A&E attendances • Referrals • Dementia rates • Frail/elderly –Demography of patients by practice • Residential homes by practice • A&E data (in and out of hours) • Contact number/Activity by practice for community services/treatment rooms. (LCH to provide) • Meds management data **October meeting**, the locality will have seen the emerging locality information packs and will review to see what further information is needed against the above list and suggest areas for action **November meeting** – additional data needed to be provided and priorities for action agreed – plan to be drafted for end of November **December** meeting– Maghull locality plan approved 3. Share good practice: Practices to share good practice to help the locality to achieve its goals. Terry to share ideas from other localities and to provide evidence of effective GP / locality commissioning initiatives from elsewhere in the country in order to stimulate ideas and discussion (in addition to local data.) October / November meeting 4. Ensure that estates / premises is part of the longer term locality plan 5. Develop plans re workforce issues such as longer term workforce planning and training and development opportunities for commissioning skills (possible use of a future Protected Learning Time venued session)	

No	Item	Action
	6. Agenda management at locality meetings:– • Ensure there is time devoted to developing and monitoring implementation of the plan • Don't invite so many external • Ensure data/ information is circulated well in advance to enable discussions at practices ahead of locality meetings. 7. Information Portal - Ensure proper role out of the portal –use it "live" at locality meetings to inform the discussion, peer review of data, agree actions etc.	
14/75	**Next Steps** These actions will begin reviewed at the meeting and leads and timescales agreed.	
14/76	**Date and Time of next meetings** Thursday 23rd October, 1 - 2.30pm – High Pastures surgery Thursday 20th November, 1 - 2.30pm – Westway MC Thursday 18th December, 1 - 2.30pm – High Pastures surgery Thursday 22nd January, 1 - 2.30pm – Westway MC Thursday 19th February, 1 – 2.30pm – High Pastures surgery Thursday 19th March, 1 – 2.30pm – Westway MC Thursday 23rd April, 1 – 2.30pm – High Pastures surgery	