NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

Date: Thursday, 28th January 2016, 13:00 to 15:30 hrs
Venue: Boardroom, 3rd Floor, Merton House, Bootle, L20 3DL

1300 hrs Members of the public may highlight any particular areas of concern/interest and address questions to Board members. If you wish, you may present your question in writing beforehand to the Chair.

1315 hrs Formal meeting of the Governing Body in Public commences. Members of the public may stay and observe this part of the meeting.

The Governing Body		
Dr Craig Gillespie	Chair & GP Clinical Director	CG
Graham Morris	Vice Chair & Lay Member - Governance	GM
Dr Andrew Mimnagh	Clinical Vice Chair & Governing Body Member	AM
Dr Peter Chamberlain	GP Clinical Director & Governing Body Member	PC
Roger Driver	Lay Member, Patient & Public Involvement	RD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Dwayne Johnson	Director of Social Services & Health, Sefton MBC *(co-opted member)*	DJ
Margaret Jones	Interim Director of Public Health *(co-opted member)*	MJ
Maureen Kelly	Chair, Health Watch *(co-opted Member)*	MK
Dr Dan McDowell	Secondary Care Doctor	DMcD
Martin McDowell	Chief Finance Officer	MMcD
Dr Clive Shaw	GP Clinical Director & Governing Body Member	CS
Dr Ricky Sinha	GP Clinical Director & Governing Body Member	RS
Fiona Taylor	Chief Officer	FLT
Dr Paul Thomas	GP Clinical Director & Governing Body Member	PT
Dr John Wray	GP Clinical Director & Governing Body Member	JW
In Attendance		
Jayne Byrne	PA to Chief Officer *(Minute Taker)*	JB
Lisa Gilbert	Corporate Governance Manager	LG
Tracy Jeffes	Chief Delivery & Integration Officer	TJ
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC

'Care Act' ***presentation by Dwayne Johnson, Sefton Council (15 mins)***

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
Governance					
GB16/1	Apologies for Absence	Chair	V	R	3 mins
GB16/2	Declarations of Interest	Chair	V	R	2 mins
GB16/3	Minutes of Previous Meeting	Chair	R	A	5 mins
GB16/4	Action Points from Previous Meeting	Chair	R	A	5 mins
GB16/5	Business Update	Chair	V	R	5 mins
GB16/6	Chief Officer Report	FLT	R	R	10 mins
GB16/7	GP Pressures and Supporting Practices	All	V	R	5 mins
GB16/8	Corporate Risk Register and Q3 Governing Body Assurance Framework	TJ	R	R	10 mins
GB16/9	Improving the Quality of NHS Complaints Investigations *(PHSO Summary Report)*	LG	R	R	10 mins

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
GB16/10	Liverpool City Region (LCR) NHS CCG Alliance *(formerly Merseyside CCG Network)* Terms of Reference	FLT	R	A	5 mins
Service Improvement/Strategic Delivery					
GB16/11	Children and Young People's Plan	DJ	R	R	10 mins
GB16/12	Primary Care Transformation Plan	TD / AP	R	A	10 mins
GB16/13	Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21	KMcC	R	A	10 mins
GB16/14	Shaping Sefton Update	KMcC	R	R	10 mins
Finance and Quality Performance					
GB16/15	Integrated Performance Report	KMcC/ MMcD/DF	R	R	10 mins
For Information					
GB16/16	Key Issues reports from committees of Governing Body: a) Finance & Resource Committee b) Quality Committee c) CIC: Realigned Hospital Based Care d) CIC LCR NHS CCG Alliance	CG	 R R R R	 R R R R	5 mins
GB16/17	Finance & Resource Committee Minutes		R	R	5 mins
GB16/18	Quality Committee Minutes		R	R	
GB16/19	Audit Committee Minutes		R	R	
GB16/20	Approvals Committee Minutes		-	-	
GB16/21	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting*				
GB16/22	Date of Next Meeting Thursday 31st March 2016 at 13:00 hrs in the Boardroom, 3rd Floor, Merton House.				-
Estimated meeting close					**15:30 hrs**

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

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
DRAFT Minutes

Date: Thursday, 26th November 2015 at 13:00 – 15:55 hrs
Venue: Boardroom, 3rd Floor, Merton House, Bootle, L20 3DL

Membership		
Dr Craig Gillespie	Chair & GP Clinical Director	CG
Graham Morris	Vice Chair & Lay Member – Governance	GM
Dr Andrew Mimnagh	Clinical Vice Chair & Governing Body Member	AM
Dr Pete Chamberlain	GP Clinical Director & Governing Body Member	PC
Roger Driver	Lay Member, Patient & Public Involvement	RD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Dwayne Johnson	Director of Social Services & Health, Sefton MBC *(co-opted member)*	DJ
Margaret Jones	Interim Director of Public Health *(co-opted member)*	MJ
Maureen Kelly	Chair, Health Watch *(co-opted Member)*	MK
Dr Dan McDowell	Secondary Care Doctor	DMcD
Martin McDowell	Chief Finance Officer	MMcD
Sharon McGibbon	Practice Manager & Governing Body Member	SMcG
Tanya Mulvey	Practice Manager & Governing Body Member	TM
Dr Clive Shaw	GP Clinical Director & Governing Body Member	CS
Dr Ricky Sinha	GP Clinical Director & Governing Body Member	RS
Fiona Taylor	Chief Officer	FLT
Dr Paul Thomas	GP Clinical Director & Governing Body Member	PT
Dr John Wray	GP Clinical Director & Governing Body Member	JW
In Attendance		
Lyn Cooke	Head of Communications	LC
Billie Dodd	Head of CCG Development	BD
Tom Jackson	Chief Finance Officer/Deputy Chief Officer, Liverpool CCG *(Healthy Liverpool)*	TomJ
Tracy Jeffes	Chief Delivery & Integration Officer	TJ
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Brendan Prescott	Deputy Chief Nurse/Head of Quality & Safety	BP
Katherine Sheerin	Chief Officer, Liverpool CCG *(Healthy Liverpool)*	KS
Tina Wilkins	Head of Adult Social Care, Sefton MBC *(Sefton Mental Health)*	TW
Jayne Byrne	PA to Chief Officer *(Minutes)*	JBy

Presentations

"Healthy Liverpool" by Katherine Sheerin and Tom Jackson

- Maureen Kelly of Healthwatch Sefton requested that enough time for consultation is allowed.
- MMcD to invite Local Enterprise Partnership to a future Governing Body meeting to investigate options for funding (MMcD).
- PC asked if there were any plans to review urgent care. Yes need to determine scope and what outcomes are required and work with clinicians.

"Sefton Mental Health: A Strategic Plan for Sefton 2015-2020 " by Tina Wilkins (2pm)

- DJ thanked Tina and team for producing plan.
- Tina to include finance in the action plan (TW).
- Maureen Kelly asked for young onset of dementia to be highlighted.
- JW requested that we check emergency arrangements to ensure psychiatry is available (as per Paris attack).
- CS asked when the final draft came out would there be a mechanism for commenting – let jayne.byrne@southseftonccg.nhs.uk have any comments.

No	Item	Action
GB15/196	**Apologies for Absence** were received from Canon Roger Driver, Debbie Fagan, Tanya Mulvey and Dr Ricky Sinha.	
GB15/197	**Declarations of Interest** Those members holding dual roles across both South Sefton CCG and Southport & Formby CCG declared their interest. GP and Practice Manager members declared their interest in agenda item '15/209 Co Commissioning'.	
GB15/198	**Minutes of the Previous Meeting** The minutes of the previous meeting were accepted as a true and accurate record once the sentence at the top of p7 was clarified.	
GB15/199	**Action Points from Previous Meeting** *15/51Safeguarding Strategy* – been to Quality Committee and awaiting numbers, remove from tracker. *15/124 Constitution Update – completed, remove from tracker.* *15/130 iLinks Engagement & Communication Plan* – can be removed from tracker. *15/131 Review of Case for Change* – completed, remove from tracker. *15/132 Safeguarding Service DoLs* – the Wider Membership had attended a development session with Hill Dickinson and CHC team and discussions with LMC had taken place. PC confirmed he was working with the Coroner's Office in relation to CHIP, remove from tracker. *15/162 Business Update – Media Training* – LC/TJ currently looking at suppliers and a training session will be arranged in the New Year, remove from tracker. *15/163a Chief Officer Report - Organisational Development Plan* – on agenda, remove from tracker. *15/163b Sefton Consultation & Engagement Pane*l – NHSE to be made aware of its existence, done, remove from tracker. *15/163c Committee in Common Joint Commissioning Committee (NHSE/CCG) notes to be shared* – done, remove from tracker. *15/164 GP Pressures & Supporting Practices* – workforce assessments discussed at the Practice Managers' meeting, two workforce surveys currently being undertaken, remove from tracker. *15/167 Management Allegations of Abuse Policy* - awaiting clarification on 'equality impact assessments' - TJ to ensure that's done, remove from tracker. *15/168a – Developing Personal Health Budgets* – Appendix 1 and 2 circulated to the Governing Body members, done, remove from tracker. *15/168b Developing Personal Health Budgets* – Appendix 5.5 to be updated – done – remove from tracker. *15/168c Developing Personal Health Budgets* – policy to be produced – consultation out and TF will present to the Governing Body in March 2016, remove from tracker. *15/169 Collaborative Commissioning in Specialised Services* – completed, remove from tracker. *15/170 Integrated Performance Report* - joint session to be arranged in December where further refining and augmenting of the existing IPR with take place with a view to being ready for April 2016, remove from tracker. *15/171a CCG Safeguarding Annual Report* – report to be presented to the Quality Committee on the updated Safeguarding Mandatory Training figures following data cleanse, done, remove from tracker. *15/171b CCG Safeguarding Annual Report* - Training Needs Analysis being undertaken in relation mandatory training; TJ needs to see evidence of S&M training. 1*5/176 Locality Meeting Minutes* – sharing of information across localities, SA to pick up, remove from tracker.	TJ

No	Item	Action
GB15/200	**Business Update** Dr Gillespie and Dr Mimnagh had recently met with GP leads of the Liverpool GP Federation and it was becoming clear that working at scale was a way to ensure a viable future. We could potentially be missing out on opportunities (eg pharmacy pilot) without a fit with the Department of Health plans of working at scale. We must use opportunities to move a federation forward; discussions with LMC, locality meetings, etc. CS volunteered to support the process.	
GB15/201	**Chief Officer Report** FLT highlighted items from her Chief Officer report. *Shaping Sefton* - Fiona Taylor thanked Dr Mimnagh for speaking at the recent Unplanned Care event on 12th November, particularly as it clashed with a CQC visit at his practice. *Quality* – South Sefton CCG and Southport & Formby CCG are the only 2 CCGs in the country hosting placements for pre-registered student nurses and the Quality Team is currently providing a hub placement (3 months). CS wondered if it would be possible to extend this to medical students, however Dr Chamberlain explained the CCG already had two working on projects and it was proving difficult to fit in with their training. *Balliol Lodge* – Fiona Taylor thanked all members of both the Medicines Management and Quality Teams who had been involved in the smooth transfer into the new accommodation from Balliol Lodge. **Outcome: the Governing Body received the Chief Officer report.**	
GB15/202	**GP Pressures and Supporting Practices** Dr Gillespie expressed concern at the turnover of Practice Managers having recently resigned. Dr Chamberlain believed opportunities were being missed to encourage retention. Fiona Taylor confirmed that this was currently being reviewed by Dr Tom Davis and pressures in localities should be a standing agenda item. **Outcome: The Governing Body received the update.**	
GB15/203	**Risk Management Strategy** TJ presented the Governing Body with the revised Risk Management Strategy, updated for usual changes. Two key changes: (i) The paper suggested an annual review by the Audit Committee rather than six monthly due to the number of committees already offering scrutiny; and (ii) SMT receives the Corporate Risk Register every 6, rather 4 weeks. GM and TJ have spoken about this and agreed it is acceptable. FLT assured the Governing Body that SLT meets weekly and if there are any issues they are raised immediately. **Outcome: The Governing Body received the revised Risk Management Strategy.**	
GB15/204	**Safeguarding Children & Vulnerable Adults Policy 2015: Review** The policy had been updated to ensure compliance with Section 11 of the Care Act. The paper had been presented to the Quality Committee the previous week and queried the definition in relation to 'spiritual abuse' – it had been referred back to the Safeguarding Team to check. **Outcome: Subject to changes the GB was happy to approve and ratify. Gina Halstead (Chair of QC) to confirm in writing to the GB that the Quality Committee is happy with the 'spiritual abuse definition.**	GH

No	Item	Action
GB15/205	**Communicating Health in South Sefton: Strategy** This was a second review of the original policy which had been updated to reflect corporate objectives, key messages and new legislation. It sets out the strategic approach to involving public and partners. The Engagement and Patient Experience Group (EPEG) had been asked to comment on the content. FLT thanked Lyn Cooke, Head of Communications, for a clear, concise strategy and drew the Governing Body's attention to Appendix 3, Objective 5, relating to the need to make tough decisions, which had been streamlined and strengthened to give it focus. **Outcome: The Governing Body approved the revised Communicating Health in South Sefton CCG Strategy.**	
GB15/206	**Remuneration Committee Terms of Reference** The Terms of Reference for the Remuneration Committee were due for an update and the committee had met in October and was asking the Governing Body to approve the changes highlighted in yellow. **Outcome: The Governing Body approved the revised Terms of Reference.**	
GB15/207	**Organisational Development Plan** TJ highlighted key areas of development to the Governing Body. If the Governing Body was happy with the proposal, a more detailed implementation plan would be prepared for approval by the Finance & Resource Committee. **Outcome: The Governing Body approved the Organisational Development Plan.**	TJ
GB15/208	**CCG Interim Strategic Estates Plan 2015-2020** MMcD explained that the strategy set out an approach for the development of CCG estates for the next 5 to 10 years and would form the CCG's response to the Department of Health, which had to be approved and returned in December. The CCG needed to fully rationalise its estate, maximise use of facilities and ensure value for money. It was a broad report at this stage as work at locality level, with full engagement of the membership was required to develop further. Regular updates would come back to the Governing Body for information. **Outcome:** (i) **the GB approved the Interim Strategic Estates Plan 2015-2020;** (ii) **there should be full engagement of localities and EPEG in future development of the plan.**	
GB15/209	**Co-Commissioning Update** JL gave a verbal update around primary care services. There is an opportunity to move to fully delegated status with NHS England with effect from1st April 2016. JL had discussed this with the Local Medical Council (LMC) and was asking the Governing Body whether there was any desire to do that. It may become mandated at some point in the future but is optional at the moment. CG believed the process should be started by email to see what the initial response was and if we got agreement before February 2016 then it could go to the Governing Body before the deadline. MMcD asked for the Constitution to be reviewed in relation to voting rights – JL to check. **Outcome: JL to pull timeline together before Christmas and will keep on the LMC agenda.**	JL

No	Item	Action
GB15/210	**Blueprint Summary Report** The Governing Body was keen to ensure there was a process for progressing advancement of the blueprints and this report was an update following the original report presented in March 2015 setting out components - milestones, start and finish dates - to ensure the CCG had the appropriate clinical and management leadership in place. The blueprint had been updated in synergy with the QIPP programme and the need to make the necessary cost savings and a dashboard had been created to map outcomes. Information would be included in the Integrated Performance Report. The detail would be taken to the QIPP Committee and QIPP would be reported by exception to the Governing Body. **Outcome: the GB received the report.**	
GB15/211	**Integrated Performance Report** KMcC gave highlights of the key performance areas. *A&E 4 hour wait* - continued to be challenged, however both S&O and the CCG were just below 95% threshold, which represented amongst the highest level across the Cheshire & Merseyside area, which he believed was testament to hard work. *IAPT* – there was an improvement in Q2 performance around access but still below target. Access is proving challenging nationally, as well as locally and the Cheshire and Wirral Partnership and the CCG were meeting monthly to address problems. MMcD gave highlights from the finance section of the report. He reported the CCG remains on target to deliver £2.4m in total, subject to a few risk areas. **Outcome: The GB received the report.**	
GB15/212	**Update on Cancer Access Performance following Tripartite Priority Setting** The Tripartite Group – NHSE, TDA and Monitor - had issued guidance in relation to the 62-Day wait for cancer referrals and had undertaken an assessment with providers against this guidance. Key outcomes were geared to improve performance. NICE guidance recommended direct access to diagnostics which should speed up the 62-day wait. FLT explained the update was provided to assure the Governing Body. She noted Items 6 and 7 on the action plan were highlighted as non-compliant – KMcC to check and take into Quality Committee. Dr Chamberlain believed there was a lot of work to be done on this pathway and would have a conversation with Dr Debbie Harvey to facilitate this. **Outcome: the Governing Body received the update.**	KMcC PC
GB15/213	**Key Issues reports from committees of Governing Body:** a) Finance & Resource Committee:17/9/15 b) Quality Committee: 17/9/15 c) Audit Committee – None d) Healthy Liverpool Programme Committee in Common: 7/10/15, 4/11/15 **Outcome: Key issue reports from the committees of the Governing Body were received.**	
GB15/214	**Finance & Resource Committee Minutes** Better Care Fund (BCF) – a meeting had been held with SMBC in relation to the non-achievement of the pay for performance element in relation to non-elective activity. **Outcome: The Finance & Resource Committee minutes were received by the Governing Body.**	
GB15/215	**Quality Committee Minutes** **Outcome: The Quality Committee minutes were received by the Governing Body.**	
GB15/216	**Audit Committee Minutes** No minutes presented.	

No	Item	Action
GB15/217	**Approvals Committee** No minutes presented.	
GB15/218	**Locality Meetings** a) Seaforth & Litherland Locality: 2/9/15, 7/10/15 b) Bootle Locality: 29/7/15, 30/9/15 c) Crosby Locality: 5/8/15, 2/9/15 Maghull Locality: 20/8/15, 24/9/15 **Outcome: The Locality minutes were received by the Governing Body.**	
GB15/219	**Any Other Business** FLT asked all Governing Body members to make every effort to attend the next development session despite pressures on primary care.	
GB15/220	**Date, Time and Venue of Next Meeting** Thursday 28th January 2016 at 13.00, Boardroom, 3rd Floor Merton House, Bootle **Future Meeting Dates** Thursday 31st March 2016 at 1300 hrs, Boardroom, 3rd Floor Merton House, Bootle Thursday 26th May 2016 at 1300 hrs, Boardroom, 3rd Floor Merton House, Bootle Thursday 28th July 2016 at 1300 hrs, Boardroom, 3rd Floor Merton House, Bootle Thursday 29th September 2016 at 1300 hrs, Boardroom, 3rd Floor Merton House, Bootle	

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Actions from meeting held 26th November 2015

No	Item	Action
GB15/204	**Safeguarding Children & Vulnerable Adults Policy 2015: Review** Gina Halstead (Chair of QC) to confirm in writing to the GB that the QC are happy with the 'spiritual abuse' definition.	GH
GB15/207	**Organisational Development Plan** TJ to prepare a more detailed implementation plan would be prepared for approval by the Finance & Resource Committee.	TJ
GB15/209	**Co-Commissioning Update** There is an opportunity to move to fully delegated status with NHS England with effect from 1st April 2016. JL to pull timeline together before Christmas regarding seeking views of members and will keep on the LMC agenda.	JL
GB15/212	**Update on Cancer Access Performance following Tripartite Priority Setting** (a) FLT noted Items 6 and 7 on the action plan were highlighted as non-compliant – KMcC to check and take into Quality Committee; (b) Dr Chamberlain believed there was a lot of work to be done on this pathway and would have a conversation with Dr Debbie Harvey to facilitate this.	KMcC PC

16/04 Actions

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2016

Agenda Item: 16/06	**Author of the Paper:** Fiona Taylor Chief Officer Email: fiona.taylor@southseftonccg.nhs.uk Tel: 0151 247 7061
Report date: January 2016	
Title: Chief Officer Report	
Summary/Key Issues: This paper presents the Governing Body with the Chief Officer's monthly update.	
Recommendation The Governing Body is asked to receive this report.	Receive [x] Approve [ ] Ratify [ ]

Links to Corporate Objectives *(x those that apply)*	
x	To place clinical leadership at the heart of localities to drive transformational change.
x	To develop the integration agenda across health and social care.
x	To consolidate the Estates Plan and develop one new project for March 2016.
x	To publish plans for community services and commission for March 2016.
x	To commission new care pathways for mental health.
x	To achieve Phase 1 of Primary Care transformation.
x	To achieve financial duties and commission high quality care.

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

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

Report to Governing Body
January 2016

1. Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21

The 2016/17 planning guidance was published on 22.12.15. Prepared by NHS England, NHS Improvement (Monitor and the Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE) and Public Health England (PHE) 'Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21' guidance clearly lays out the expectation for the CCG over the next few years. There is to be a Sustainability and Transformation Plan (STP) over a yet to be determined footprint. There are 4 key themes, with 9 'must dos; a need for 1 operational plan for the CCG and the STP has to cover 3 domains and covers 29 questions which each STP area will have to answer and include in the final STP for 30.6.16.The footprint has to be agreed with various partners for 28.1.16. Once finalised this will be the only mechanism for an STP area to draw down central monies from the national transformational fund.

Significantly for the composite operational plans, there has to be strong system leadership to ensure that there is an open book approach across a variety of parameters and alignment across providers and commissioners. There is sensibly a requirement to align with the NHS Mandate. Both the STP and CCG operational plans will be signed off by both NHS England and NHS Improvement. There is therefore an expectation that operational plans will be credible, reconcile financial activity, achieve financial balance, contribute to QIPP, develop risk sharing/management principles, link to the STP and clearly articulate local transformation.

https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

2. Shaping Sefton

In light of the planning guidance work is now underway to consider the role of the Shaping Sefton Transformation Board. Following the STP agreement it is likely that the Shaping Sefton Transformation Board will oversee the local operational plan-specifically the transformational programmes. A period of internal review and refresh is being undertaken in order that the CCG continues to meet its statutory duties and improve, with clear and systematic processes for project and performance management in the CCG.

Work continues with the Systems Leadership programme and the learning hubs which have been established for unplanned care and early prevention and detection. We have also secured a breakfast meeting with Roy Lilley to showcase the Shaping Sefton work as he is in Merseyside on the 11th February holding an event at Aintree University Hospitals NHS Foundation Trust.

3. Quality

3.1 Alder Hey Children's Hospital NHS Trust

A Quality Summit was held on 22nd December 2015 to present the outcome of the Chief Inspector of Hospitals / Care Quality Commission inspection. The judgements were as follows:

Overall = Good
Safe = Good

Effective = Good
Caring = Outstanding
Responsive = Good
Well Led = Good

3.2 Chief Nursing Officer (CNO) Summit 2015

The national CNO Summit 2015 was held in December 2015 and was attended by the CCG Chief Nurse and Deputy Chief Nurse. The CNO presented a session on celebrating successes within commissioning. Highlighted within this session at the national conference was the process that is in place between the SSCCG / SFCCG joint Quality Team and Aintree University Hospital NHS Foundation Trust (AUH) for undertaking proactive Quality Walk Arounds. A member of the NHSE national team has joined the CCG team and the AUH team on one such Walk Around.

3.3 Balliol Lodge Nursing Home

Post closure of the South Sefton-based nursing home, Balliol Lodge, following CQC urgent Notice to cancel the registrations, the owners have subsequently made a petition to the Court of Appeal of the action taken by CQC. South Sefton CCG have been requested by CQC to provide representation as part of the Court of Appeal process which has been scheduled to take place on 2nd and 3rd March 2016. The Programme Manager for Vulnerable People is co-ordinating the CCG's response which includes information from CCG Medicines Management and NW CSU Quality Lead. Managerial and Professional support is being provided by the Chief Nurse and Legal support is being provided by Hill Dickinson.

4. Pooled Budgets/Better Care Fund 2016/17 Arrangements

The CCG has been meeting with Sefton Council to discuss the scope of pooled budgets for 2016/17 taking account of the experience of other areas to develop a suitable governance framework to manage risks across the health and social care system. An update will be given to future Governing Body meetings.

This piece of work will also link into the arrangements for the operation of the Better Care Fund in 2016/17. The Policy Framework has been jointly issued by the Department of Health and Department for Communities and Local Government and can be found via this web-link:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf

The new policy framework highlights that the previous "pay for performance" condition, relating to reduction in Non-elective admissions within the BCF has been removed to be replaced with two new conditions which focus upon local plans aimed at reducing Delayed Transfers of Care (DToCs) and also a national condition around NHS commissioned out of hospital services.

The detailed technical guidance is awaited and the CCG is working with the local authority to develop suitable plans.

5. Primary Care Update

Work is now underway with the membership to refine the transformation programme for primary care and further updates will be brought under the Shaping Sefton item. The Local Quality Contract (LQC) for primary care appears to be working well for most areas.

6. Sefton MBC Children's Overview & Scrutiny Committee

We have received an invite from the Sefton Children's Overview & Scrutiny Committee on the 26th January 2016. This request is to assist the committees understanding of the CCG transformation work on children's service specifically related to Child and Adolescent Mental Health. The Chief Nurse and both the CCG Programme leads for Children and Mental Health will also be in attendance.

This will be very timely as the governing body will be receiving the Children and Young People's plan from the Director of Social Care & Health who has the statutory Director of Children's function.

7. Liverpool City Region (LCR) NHS CCG Alliance (formerly Merseyside CCG Network)

On the 6th January 2016 the Merseyside CCG network was formerly disestablished. This was replaced by a committee in common as agreed by the CCG Governing Body at its December 2015 meeting. The CCG constitution allows for this change.

This committee in common will be known as the Liverpool City Region (LCR) NHS CCG Alliance and will continue to meet monthly, currently hosted by Knowsley CCG.

At its first meeting it considered the new terms of reference and recommended them for each member CCG Governing Body to ratify. The majority of discussion was devoted to considering the planning guidance and the STP footprint. It was agreed to recommend the LCR as the local STP footprint, with West Lancashire, Western Cheshire and Warrington CCGs with NHS England Specialised Commissioning as Associate members. Work is now underway with local NHS providers, Local Authorities and other stakeholders to firm this up for the 28.1.16 deadline.

A work plan will now be developed.

8. Localities

The Localities have been actively focussing on key clinical priorities which is having a real impact on a number of schemes. The engagement from practices has been positive throughout the year and is reflective of the membership's commitment to drive forward change where it is needed. Localities have been able to analyse financial, clinical and activity data and generate queries that then enable the CCG to constructively challenge service providers in the context of improving patient care.

There are a number of clinically-led projects that have now been implemented and supported by our programme leads and I am confident that this great work will continue into 2016/17.

To provide ongoing assurance to the Governing Body and public and to demonstrate how the excellent work that is taking place is impacting on services, I am proposing that from now on each locality will submit four-monthly reports of the activity and progress of the groups.

9. Celebrating our Successes

NHS South Sefton Clinical Commissioning Group's (CCG's) cancer and end of life GP lead has won a national Macmillan award for cross boundary working. Dr Debbie Harvey received the inaugural David Millar award, named after the charity's first GP adviser, at the annual Macmillan Primary Care conference in Manchester. Macmillan regional GP advisers were asked to nominate leads in their areas and Dr Hong Tseung and Dr Sinead Clarke nominated Debbie. They

commended Debbie for her achievements within the primary care community and for her focus on working across boundaries.

10. Governing Body changes

The Governing Body is formally informed of the retirement of Dr Clive Shaw from the Governing body at the end of his tenure before the forthcoming elections. Clive has served as the Chair and latterly governing body member since the CCG inception in 2012. Clive has provided a great continuity from his previous role as the Chair of South Sefton Practice Based Commissioning Consortium and offered the CCG the benefit of his wide reaching experience.

Also this month we are see the resignation of both our Practice Manager members Sharon McGibbon and Tanya Mulvey, both of whom have added greatly to the work of the Governing Body.

Finally, we will also see the resignation of Canon Rev. Roger Driver who is moving from Sefton to a new parish in Bath. Roger has been the lay Member for Patient & Public participation since the inception of the CCG. The Governing Body has really benefitted from Roger's tremendous understanding and connections within the local community and beyond.

We would like to wish Clive, Roger, Sharon and Tanya well and all the best for the future.

Tracy Jeffes, Chief Delivery & Integration Officer, is now working with the Local Medical Committee to prepare for the forthcoming CCG elections as per the constitutional requirements.

11. Recommendation

The Governing Body is asked to formally receive this report.

Fiona Taylor
Chief Officer
January 2016

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2016

Agenda Item: 16/8	**Author of the Paper:** Tracy Jeffes Chief Delivery and Integration Officer Email: tracy.jeffes@soutseftonccg.nhs.uk Tel: 0151 247 7244
Report date: January 2016	

Title: Corporate Risk Register and Governing Body Assurance Framework Update

Summary/Key Issues:

The Governing Body is presented with the updated Corporate Risk Register (CRR) as at December 2015 and the Quarter 3 (end December) Governing Body Assurance Framework (GBAF.) Due to unforeseeable circumstances, these updates were not previously presented to the Quality Committee for prior scrutiny as usually occurs, but were however reviewed by the Corporate Governance Group and the Senior Management Team prior to submission to the Governing Body. The Governing Body is therefore asked to fully review, scrutinise and if satisfied, accept the updates.

Recommendation

The Governing Body is asked to receive the report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives	
x	To place clinical leadership at the heart of localities to drive transformational change.
x	To develop the integration agenda across health and social care.
x	To consolidate the Estates Plan and develop one new project for March 2016.
x	To publish plans for community services and commission for March 2016.
x	To commission new care pathways for mental health.
x	To achieve Phase 1 of Primary Care transformation.
x	To achieve financial duties and commission high quality care.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement				
Clinical Engagement				
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement				
Presented to other Committees	x			Presented to January Corporate Governance Group. Reviewed by Senior Management Team.

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

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
January 2016

1. Executive Summary

This paper provides the Governing Body with an updated Governing Body Assurance Framework and Corporate Risk Register.

Position Statements Q3 2015/16

Governing Body Assurance Framework
There are a total of 15 risks against the 7 objectives for South Sefton CCG:

Risk Positions
Of the 15 risks there are:
- 1 'Extreme': 7.3
- 13 high
- 1 moderate: 4.1
- 0 low

Risk Rating:
Following review of Q2 by the Governing Body and amendment to the risk rating for 7.2 from 3x4 to 2x4, all risks have remained static.

Assurance Rating
Of the 15 risks presented:
- 12 Limited
- 2 Reasonable: 5.1 and 7.4
- 1 Significant: 7.2

One risk (7.2) has changed in assurance rating since Q2.

Highlights
Please see the following which highlights the risks that have either (a) changed in rating or (b) extreme risks:

GBAF Highlights	Q3 Update
7.2 **Risk Rating**: 2x4 (reduced from 3x4) **Assurance**: Significant (Increase from Limited) **Risk:** Lack of sustainability of CSU services during transition and the effective procurement of CSU services via LPF	Closedown of NWCSU proceeding as planned. Mobilisation Board meeting regularly to review plans & are on track
7.3 **Risk Rating:** 4x4 (Extreme) **Assurance:** Limited (static) **Risk:** Non-delivery of 2015/16 QIPP Plan which supports transformational change	QIPP Plan presented to November 2015 Governing Body, Governing Body Sub-committee structure revised. QIPP & SIR merged

Corporate Risk Register

There are 33 operational risks recorded on the South Sefton CCG Corporate Risk Register (CRR) for quarter 3 (December) 2015/16:

- 30 risks continue from November 2014/15
  - 23 have stayed the same
  - 6 have reduced in risk rating: FIN003, QUA028, QUA030, QUA031, REP004, REP036
  - 1 has increased in rating: REP035
- 3 new risks: BUO020, FIN009, QUA041
- 2 risks removed following review of Q2 at SMT and Governing Body: placed on Removed Risk Log.

Of the 33 operational risks recorded:
- 6 extreme: BUO020, FIN009, QUA011, QUA022, REP035, STA038
- 20 high
- 3 moderate
- 4 low

Highlights
Please see the following which highlights the risks that have either (a) changed in rating or (b) extreme risks:

CRR Highlights	Q3 Update
BUO020 ***NEW RISK*** No additional community beds available during Winter 2015	**Risk Rating: 5x3 (New Risk – extreme risk)** Alternative scheme developed and agreed to commence in January 2016. Will not deliver the same level of care as a bedded unit, but will support another cohort of patients to remain in their usual place of residence/be discharged from hospital promptly.
FIN003 Changes in patient flow causes financial issues, due to increases in activity overall and the financial implications on the 15/16 Financial performance of the CCG. Increased activity has resulted in a QIPP saving required of 3.4 million to be delivered for 15/16. Predominant risk areas are: CHC and Urgent Care which have both seen significant growth in demand. Significant QIPP scheme to be delivered during year totalling 3.4 million.	**Risk Rating: 2x3 (reduced from 3x3)** £1.474m now identified at M9 with £1.967m still to identify in 2015/16 to ensure long term sustainability. Non recurrent measures in place for 2015/16 to achieve financial duties. Underlying position has worsened in M8.

CRR Highlights	Q3 Update
FIN009 ***NEW RISK*** Financial duties in 2016/17 will not be met due to significant unidentified QIPP in 2015/16 and 2016/17	**Risk Rating: 4x4 (New Risk – extreme risk)** £1.967m still to identify in 2015/16, 2016/17 QIPP target to be identified is £4.060m
QUA011 Risk that patients could be harmed or receive inadequate care due to failure to deliver against National Key Performance Indicator for IAPT (Improving Access to Psychological Therapies)	**Risk Rating: 4x4 (static - extreme risk)** Remedial action plan in place Continued monitoring against plan underway
QUA022 LCH risk to delivery of commissioned community service would result in reduced quality of clinical care.	**Risk Rating: 4x4 (static – extreme risk)** formal arrangements in place with TDA managing transition of services to interim NHS providers
QUA028 Unable to deliver Personal Health Budgets (PHB) to patients as a result of CCG not having a governance system nor process in place to develop the provision of personal health budget's (PHB) to eligible patients choosing the PHB option.	**Risk Rating: 2x3 (reduced from 3x3)** Draft policy for approval presented to Quality Committee December 2015 to reflect expanded PHB agenda and for GB ratification after consultation in March 2016. Likelihood reduced to 2 from 3 and new risk score of 6 down from 9
QUA030 Impact on local practices to absorb patients into list who have been affected by lapse of local contract.	**Risk Rating: 1x3 (reduced from 3x3)** TO BE CLOSED: All patients dispersed and no adverse impact on practices
QUA031 Risk to quality of patient care as a result of non-achievement of deficits highlighted through CQC inspection	**Risk Rating: 1x3 (reduced from 3x3)** TO BE CLOSED: CQC re-inspected and classified satisfactory
REP035 Non delivery of BCF target reductions in non-	**Risk Rating: 5x3 (increased from 4x3 – extreme risk)** Performance element of the BCF has not been

CRR Highlights	Q3 Update
elective activity will lead to fewer resources available for BCF and impact on partnership working with the Local Authority.	achieved. LA concern over implications of the non-payment of the performance fund. BCF review group meeting but new HWBB structures not yet established.
REP036 Non-delivery against national trajectory for CHC restitution cases (PUPoC - packages of care for Previously Unassessed Periods of Care)	**Risk Rating: 3x3 (reduced from 4x3)** 'PUPoC continues to be at or exceed trajectory for September, October and November with completion by NHS E deadline planned. Reduce likelihood to from 4 to 3 with overall risk score down from 12 to 9
STA038 Risk that patients could be harmed or receive inadequate care due to lack of commissioner assurance in current processes for Looked After Children Health Assessments and Reviews across the local system	**Risk Rating: 5x4 (static - extreme risk)** Paper presented to Corporate Parenting Board in October on issues with assessment for LAC. Collaboration between LA and provider still being monitored

Tracy Jeffes
Chief Delivery and Integration Officer
January 2016

SOUTH SEFTON CCG

Corporate Risk Register

Q3 December 2015

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

By User: Danielle Love

ID	Date Added	2014/15 Reference	Principal Risk	2015/16 Corporate Objective	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	Update on Progress	0+2 May	Q1	Q2	L	C	Current Risk Rating - Q3	Change Since Last Update
Business Objective																						
BUO001	Prior Q3 2013/'14	BUO001	18 week & cancer pathways may not be met due to non delivery of target by provider	1	Business Objective and Statutory Duty	Chief Strategy & Outcomes Officer (Karl McCluskey) and Chief Redesign & Commissioning Officer (Jan Leonard)	1. Monthly contract meetings 2. Clinical Quality and performance meetings 3. Clinical lead for contracts and quality 4. Additional funding for RTT, worked closely with providers on cancer pathway. 5. Clinical meetings with Cancer Leads and Manager. 6. Managerial lead for cancer has action plan in place. 7. Weekly and monthly monitoring through SMT and contractual performance. 8. RCA for any 62 day breaches 9. RTT plans with Aintree and Southport & Ormskirk agreed and weekly review of performance is in place. 10. Reporting system developed that provides earlier notification of waiting time concerns. Is reviewed on a weekly basis and reported to SMT (Senior Management Team and SLT (Senior Leadership Team). 11. Integrated Performance Report developed and presented to Governing Body. 12. Action plans in place for failed areas: progress being monitored via SMT, contractual performance and continued reviews. Completed for Maxillofacial, Ophthalmology and Waiting Times.	3	3	9				Cancer 2 week: Systems in place and fit for purpose. All indicators achieved other than 62 day screening. Cancer 62 day screening: Not achieved. Affected by low patient numbers and breeches across multiple organisations and pathways, usually specialised services. Repeatedly raised with NHS England. 18 Week Referral to Treatment times: RTT: Met. Action Plans targets for Maxillofacial and Ophthalmology met and complete. Integrated Performance Reporting System: in place and ongoing. Diagnostic Waiting Time Target achieved in March and revised action plan in place with provider. Action Plan timelines reviewed monthly. Targets were previously split for *'admitted and 'non-admitted'*, now combined. Specific Cancer Performance Report being presented to the Governing Body in November. Will include 2 week and 62 day. Aim being to tease out any possible issues; differing issues month to month so no obvious trend is ever highlighted.	Continuing to monitor progress and action accordingly.	3x4	3x4	3x4	3	4	12	▶
BUO017	**Apr-15**	N/A	CCG Locality working does not lead to greater clinical engagement with CCG plans and objectives.	1		Chief Delivery and Integration Officer (Tracy Jeffes)	1. Roles of Locality Managers and Team Development reviewed ~~2. Managed by Chief Delivery and Integration Officer and supported by Leadership Team.~~ 3. Progress reported to Governing Body 4. Wrap around support team identified to support localities 5. Key priority in Organisational Development Plan	4	4	12	Regular Locality review meetings to be set-up. Will include Governing Body members. Will focus on further developing the communications bulletin. Locality Plans to be developed.	Jun-15	Jul-15	Development meetings: being held. - Testing plans with localities - membership being reviewed - implementation from June Progress is dependant on Primary Care Transformation, and investment and improvements in community services.	Localities have identified key priorities and plans. Planning sessions held in most localities. Locality links for BI, Finance and LT established. Improved access to financial and activity data but still a significant areas for development and as such remains risk. Discussions with new CSU provider re prioritising work re new portal.	3x4	3x4	3x4	3	4	12	▶
BUO018	**Apr-15**	N/A	Risk to service delivery as a result of an LCH restructure that impacts on LCH staff supporting Sefton.			Head of South Sefton CCG Development (Stephen Astles)	1. Weekly meetings: reported to SMT and SLT 2. Clinical Leadership 3. Clinical Forum 4. Contract Meetings 5. Collaborative monthly meetings 6. Senior LCH management team now in place	3	4	12	- Senior Management Model identified: funding approved for post - waiting position to be advertised: closed.			Position out to advert the end of June. Senior LCH management team now in place however, new team will take time to become established. Delivery to be monitored.	Transaction Board established overseeing transaction process LCH Transition team monitoring stabilisation of services	3x4	3x4	3x4	3	4	12	▶
BUO019	**Apr-15**	N/A	Increase in delayed discharge as a result of LCH and Aintree Discharge teams failing to work collaboratively.			Head of South Sefton CCG Development (Steven Astles)	1. Monthly meetings with LCH and Aintree: reported to CCF (Collaborative Commissioning Forum) 2. Collaborative work with Liverpool and Knowsley CCG's	3	3	9	- Letter to be written to implementation plan - Awaiting LCH/Aintree mobilisation plan.			Meeting held with Aintree on 6th May: LCH and Aintree aware of plans. Awaiting formal confirmation of letter requesting implementation plan. Still requiring implementation plan. Potential issue being debated with LCH and CCG's. Awaiting mobilisation plan to set dates with a view to South Sefton IICB procurement model. Meeting due to be held on 8th October.	Mobilisation plan unsatisfactory Meeting with Trust scheduled in Feb In light of the system pressures, daily review of discharge pressures implemented.	3x3	3x3	3x3	3	3	9	▶
BUO020 - NEW RISK	**Dec-15**	N/A	No additional community beds available during Winter 2015	7		Locality Development Manager (Mel Wright)	1. Investigation of alternative suppliers for bed base 2. Longer term procurement process commenced 3. Alternative scheme developed, commencing Jan 2016	5	3	15	Development of feasible alternatives for winter period and longer term.			Alternative scheme developed and agreed to commence in January 2016. Will not deliver the same level of care as a bedded unit, but will support another cohort of patients to remain in their usual place of residence/be discharged from hospital promptly.					5	3	15	***NEW***
FIN003	Revised Q1 2015/'16	FIN003	Changes in patient flow causes financial issues, due to increases in activity overall and the financial implications on the 15/16 Financial performance of the CCG. Increased activity has resulted in a QIPP saving required of 3.4 million to be delivered for 15/16. Predominant risk areas are: CHC and Urgent Care which have both seen significant growth in demand. Significant QIPP scheme to be delivered during year totaling 3.4 million.	7	Finance	Chief Financial Officer (Martin McDonell)	1. Monthly contracting meetings with main acute providers 2. Information shared with GP leads 3. Practice level reporting of financial information 4. Monthly monitoring of financial position 5. QIPP Working Group established and meet monthly. 6. CHC Working Group established	4	3	12	QIPP working Group to identify savings totalling 3.4 million			Monthly QIPP Working Group have robust interrogation from acute provider to identify any inaccuracies in coding. CHC Working Group with robust management of CHC finance team to ensure finances are actioned. Processes in place to eliminate financial waste. £0.0378m has been identified in QIPP schemes to date, Non recurrent mitigating actions are in place to ensure financial target will be met in 15/16. Remaining QIPP target of £3.063m still to be identified for long term sustainability.	£1.474m now identified at M9 with £1.967m still to identify in 2015/16 to ensure long term sustainability. Non recurrent measures in place for 2015/16 to achieve financial duties. Underlying position has worsened in M8.	4x3	4x3	3x3	2	3	6	▼
FIN008	Q3 Dec 2014	FIN008	Reductions in local authority expenditure may impact on NHS services and delivery of BCF schemes	7	Financial	Chief Financial Officer (Martin McDonell)	1. Monitoring progress of BCF schemes 2. Continued work with local authority	4	3	12	Need to understand the impact of the proposed budget reductions. Explore areas for effective joint commissioning to maximise use of the Sefton £1: ongoing.	Sept 2015 Sept 2015	Sept 2015 Sept 2015	Further cuts identified in public health on top of previous plans. Joint working has commenced to understand scale of cuts across Sefton. P4P target is not being met at present (6% behind baseline as at July 2015)	As at M9 P4P target unlikely to be achieved for 2015/16. Executive meeting has taken place between CCGs and Council to determine way forward for 15/16.	4x3	4x3	4x3	4	3	12	▶

16/08 CRR and GBAF

SOUTH SEFTON CCG

Corporate Risk Register

Q3 December 2015

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

By User: Danielle Love

ID	Date Added	2014/15 Reference	Principal Risk	2015/16 Corporate Objective	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	Update on Progress	0+2 May	Q1	Q2	L	C	Current Risk Rating - Q3	Change Since Last Update
FIN009 - NEW RISK	Revised Q3 2015/16	NEW RISK	Financial duties in 2016/17 will not be met due to significant unidentified QIPP in 2015/16 and 2016/17	7	Finance	Chief Financial Officer (Martin McDowell)	1. Monthly contracting meetings with main acute providers 2. Information shared with GP leads 3. Practice level reporting of financial information 4. Monthly monitoring of financial position 5. QIPP Working Group established and meet monthly.	4	4	16				Monthly QIPP committee to identify plans to meet the QIPP shortfall.	£1.967m still to identify in 2015/16, 2016/17 QIPP target to be identified is £4.060m				4	4	16	*NEW*
			Quality																			
QUA002	Prior Q3 2013/14	QUA002	Need for clarity of roles and responsibilities between Safeguarding Hosted Service, CSU CHC team and LCH Provider Safeguarding Team to enable CCG to discharge their safeguarding function. Need for further clarity between health and social care commissioning / safeguarding for vulnerable adults.	1	Quality	Chief Nurse (Debbie Fagan)	1. Regular 1:1 meetings between safeguarding adults lead in hosted service and CHC locality lead. 2. Identified a single point of contact system for Safeguarding Adults between the Safeguarding Service and hosted service. 3. Standard Operating Procedure developed, includes recommendations as per review.	4	5	20	Awaiting feedback from Quality Committee on draft SOP Review required on the needs of the Sefton patch in order to determine commissioning responsibilities and necessary specification. To obtain the recommendations from Liverpool Community Health's internal Safeguarding review that explored the role of the Safeguarding Adults team. Part 1 received: Awaiting part II which looks at progress against ongoing recommendations.	April 2015 TBC March 2015	May 2015 TBC March 2015	SOP in place. Meeting held with Safeguarding Service and CCG's Chief Nurse/Deputy Chief Nurse. Difference in response from provider services across Sefton patch regarding needs. Review now required in order to determine commissioning responsibility and necessary specification. LCH internal review requested by Chief Nurse. Discussed at Contract meeting. Part 1 previously received., still awaiting part 2. Chief Nurse has contacted the Deputy Director of Nursing - meeting was to be held with new Nursing Director when in post (expected January 2015). Contacted on 2/2/15 for confirmation of meeting and again 10/02/15 to confirm date with interim Nursing Director but no date set as yet. Plan for SOP review as part of meeting with LCH's review. Still waiting information from LCH in order to finalise SOP. CCG Network Steering Group updated at a meeting on 23rd February. Mitigating actions put in place. Still no meeting held or part 2 received despite efforts made by Chief Nurse. Chief Nurse to further raise. Role clarity exists between CCG safeguarding services and CHC/CSU team. Meeting held 10/6/15 to look at inequity of provider response into care homes identified. Need clarity on expectations of Local Authority and then CCG/LA commissioning responsibility. LCH Safeguarding Review to be utilised to inform discussion as appropriate. CCG has successfully appointed to role of Programme Manager of vulnerable people who will support this work going forward. Awaiting commencement into post. Chief Nurse has e-mailed the Local Authority regarding scoping out the extent of any possible issues. Programme Manager Vulnerable People commenced in post on 01.09.15. Meeting took place with LA to discuss possible inequity of response. Programme Manager Vulnerable People leading on this piece of work including possible future commissioning model / re-specification of what is required locally.	Programme Manager has completed the specification which as been sent to the CCG Head of Development.	2x4	2x4	2x4	2	4	8	▶
QUA006	Q3 2013/14	QUA006	Providers RAG rating in relation to robust Safeguarding systems and processes presents lack of assurance for CCG based upon validation of information presented by the Trust.	1	Quality and Financial	Chief Nurse (Debbie Fagan)	1. Assurance process paper presented to LSCB on processes in place. 2. RAG rating monitored via Quality Contract meetings. Reported to Quality Committee and escalated to Governing Body as required. Chief Nurse informed NHS England (M) and safeguarding will be included in the quality review process with the Trust. 3. Monitored through quality contract meetings with CSU 4. Agenda item for discussion at provider Quality Contract meetings. 5. Safeguarding performance discussed at Quality Committee. 6. Process developed between CSU and Safeguarding service to further develop information flow across the two services. 7. Quality 'Walk Around' carried out with feedback and outcomes reported to Executive Nurse, contract meetings, Quality Committee. 8. Contract reviewed to ensure in line with KPI's 9. Quality Surveillance agenda item for February 2015.	4	4	16	Awaiting formal Q1 feedback from Safeguarding Service.	TBC	TBC	- Formal processes now in place and reportedly working well between provider, CSU and Safeguarding Services. Systems in place between CSU and Safeguarding Services which is working well. Quality and performance function in-housed from 1st June which will enable tighter controls. - Increased level of assurance reported from CCG Safeguarding Service for the main commissioned providers. One contract query was issued in March 2015 and remains open. Although action plan has already been put in place in response to the contract query. Contract query remains in place with Southport & Ormskirk hospital due to limited assurance still being reported by CCG and Safeguarding Services. Is being closely monitored. Contract Query remains in place with S&O. Discussion of other provider performance where CCG is not the co-ordinating commissioner discussed at QC in September 2015 . Chief Nurse in contact with co-ordinating CCG to discuss concerns raised at the QC and for the purposes of assurance that all providers are being performance managed using a consistent approach. Awaiting formal Q1 feedback from Safeguarding Service.	Contract query notice served by LCCG with SSCCG sign up to RLCH with specific assurance on safeguarding training sought and recovery plan in place. Update on plan is a per trajectory.	2x3	1x3	1x3	1	3	3	▶
QUA008	Q1 2014/15	QUA008	Lab results not being communicated to GP practices (from the Lab provider) due to IT system/technical issues that may have an impact on patient safety.		Quality	Chief Nurse (Debbie Fagan) and Deputy Head of Quality and Safety and Medicines Management Lead. (Brendan Prescott)	1. Raised as an issue at the Quality Committee and Contract meetings. Director of Public Health notified. CCG comms notified. 2. GP clinical lead identified within CCG 3. Steering group set-up with reps from lab provider, local CCGs, I-Merseyside, Aintree Hospitals, NHS England and St Helens and Knowsley Informatics. Remains agenda item for discussion at Aintree CQPG and Aintree Collaborative forum. 4. Task and Finish Group established and receive progress and lessons learnt are discussed.	4	5	20	Four issues previously identified. Technical aspect closed however clinical issues still remain: 1. Macroprolactin 2. Clinisys (NT-proBNP & other analyses) 3. EPOC/EMIS 4. Clinisys Corrupt Characters/EMIS Web Decision to commission external review in relation to lessons learnt agreed. Scope of review to be finalised.	July 15	July 15	Meeting to be held on 20th May to agree Terms of Reference for external review. Terms of Reference not agreed due to commissioning difference of opinion. Subsequent meeting with Liverpool and South Sefton CCG's. Agreed to commission a joint review with the possibility of Knowsley CCG commissioning a further review if required. Issues around the need for the review and the scope of the review discussed and agreed with provider on 13th May 2015; meeting on 20th May to finalise. Further meeting held 15/6. Now need to agree scope of review. Action log reviewed with further actions closed down at meeting. Another meeting planned for 14/7. External agency contacted. Further incident occurred that tested the system installed by LCL. System was proved 'fit for purpose': doesn't mitigate for human error but highlights when an error has occurred. Decision-made at Collaborative Forum to commission an end-to-end commissioning review. External body commissioned. Scope of the review finalised.	Initial feedback on recommendations to be completed by end of January 2016 in terms of end to end testing as well as the collaboration of stakeholders where accountability rests with more than one organisation	1x5	1x5	1x5	1	5	5	▶

SOUTH SEFTON CCG

Corporate Risk Register

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

Q3 December 2015

By User: Danielle Love

ID	Date Added	2014/15 Reference	Principal Risk	2015/16 Corporate Objective	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	Update on Progress	0+2 May	Q1	Q2	L	C	Current Risk Rating - Q3	Change Since Last Update
QUA010	Split from original risk Q3 Dec 2014, reworded April 2015	QUA010 (newly numbered - split from QUO009)	Risk that patients could receive inadequate care due to failure of implement local delivery of strategic blueprints and programmes (CVD and Respiratory)	1	Quality, Finance and Performance	Chief Strategy & Outcomes Officer (Karl McCluskey)	1. Strategic blueprints 2. Strategic programmes 3. Primary Care Dashboard 4. Integrated performance report 5. Updates to SMT 6. Clinical and managerial leads identified for all blueprints and programmes.	3	5	15	PMO blueprint report to be presented to November 2015 Governing Body. To include plans, milestones, risk and progress. Activity Impact Plans to be affirmed for each blueprint and programme area.	Nov 2015		New PMO established. To support implementation and delivery, including process for localities. Indicated plan for disinvestment on current PMO function served by Informatics Merseyside. Development session held with wider membership strategy blue prints and priority programmes. QIPP Lead (Maria Dorpman) appointed; will focus on the Impact Plans..	Monthly blueprint leads meetings being established QIPP lead meetings being convened and further development of QIPP dashboard	3x3	2x3	2x3	2	3	6	▶
QUA011	Q3+1 January 2015	QUA011	Risk that patients could be harmed or receive inadequate care due to failure to deliver against National Key Performance Indicator for IAPT (Improving Access to Psychological Therapies)	1	Quality	Chief Strategy & Outcomes Officer (Karl McCluskey) and Chief Redesign & Commissioning Officer (Jan Leonard)	1. Investigation completed: established that provider had made a local interpretation of target resulted in an over inflation of position. Situation has been notified to NHS England 2. Remedial action plan in place 3. Performance and contractual meetings and reporting process in place 4. paper presented to Governing Body November 2014 5. Contract awarded to another provider effective April 2015. 6. Fortnightly review meetings	4	3	12	Detailed session to be held with the Governing Body in October 2015. - need to clarify waiting list position on new IT system	'Oct 2015		Transferred to new provider. Historic issues relate to data transfer and performance. Detailed Mental Health Performance Report presented to Governing Body in September 2015. Detailed session to be held with Governing Body in October. Validation of waiting list and backlog completed. Backlog reduced from 1200 to 800. Acton plan in place. Tackled, addressed and reduced to under 400. Full HR programme in place to address and tackle all identified HR issues with ongoing action plan. Now addressed and resolved. Posts gone through management of change. New system in place. Monthly reporting from July as part of internal performance report and weekly to SLT and SMT. Continues. **NOTE:** **16/10** following presentation to the SMT was agreed that this risk be reduced from 4x4 to 3x4. Meeting recovery rates target, backlog is addressed, but not meeting referral rates, so has improved. **21/10** The Quality Committee reviewed the risk and considered it should remain red due to the wait getting worse (v5)	remedial action plan in place continued monitoring against plan underway	4x3	4x4	4x4	4	4	16	▶
QUA016	Q3+2 February 2015	QUA016	High volume of over 60 minute AMB turnaround times result in patients not receiving appropriate care	1	Quality	Head of Primary Care & Contracting (Malcolm Cunningham)	1. Regular feedback to monthly contract meetings 2. Regular communication with Blackpool CCG (lead commissioner)	3	3	9	Contract sanctions to be applied (as mandated April 2015)			Review carried out to help identify where improvements could be made to turnaround times. systems and processes looked at. Review indicated issues were related to capacity.	Contract query raised with Aintree and continued monitoring of Southport and Ormskirk Hospital	3x3	3x3	3x3	3	3	9	▶
QUA020	Q3 Dec 2014	REP005	The closure of Breast Surgery Service (for new patients) at Southport & Ormskirk poses a risk to the CCG and concerns for local residents.	1	Quality	Chief Redesign & Commissioning Officer (Jan Leonard)	1. pro-active engagement exercise with effective public and key stakeholders completed and report presented to Governing Body in March 2015. 2. Safe services have been put in place via Aintree Hospital Trust - Patient Safety maintained throughout 3. Equality Impact Assessment 4. External review commissioned with and action plan pulled together based on the outcome and recommendations.	4	4	16	Draft pathway redesign, incorporating the findings of the engagement, to be presented to the Governing Body Patients Engagement exercise to be carried out	Sept 2015 Oct 2015	Sept 2015 Oct 2015	Future planning and re-aligning pathways almost completed. Multi provider meeting held. Action plan expected by the end of May 2015, with a further meeting to be held June 2015. Meeting to be held with West Lancashire CCG to discuss new pathway (30/6). Multi provider meeting being held mid July 15, outcome to be presented to September 15 Governing Body. Discussions to include implications of pathway. Waiting comments from providers on new proposed pathway - plan to engage with patients to gain their feedback: October 2015. Trust has commissioned external review and has formulated an action plan based on the recommendations. Note: is a lower risk to South Sefton patients.	Still in discussions with West Lancashire CCG who are discussing new pathways with Lancashire and Manchester Providers	4x3	4x3	4x3	4	3	12	▶
QUA021	Apr-15	N/A	Impact on ability to deliver as a result of not being able to maintain Commissioning Support Services, neither via sustainability of existing services from NWCSU nor suitability of locally responsive Commissioning Support Services through the LPF	7	Quality	Chief Delivery and Integration Officer (Tracy Jeffes)	1. Working collaboratively with Merseyside and Cheshire CCG's as part of Transformation Board to identify and look at any concerns regarding sustainability. 2. Collaborative working with neighbouring CCGs to secure best value for money from the LPF	4	3	12	To commence work with NHS England to look at the LPF process and will include workshops on the specification and procurement process.	Jul-15	Aug-15	Meeting held with neighbouring CCG's. Agreement reached on approach across all stakeholders. - Specifications developed. Bids received and moving to evaluation phase. - Ongoing performance management of NWCSU and support from stability partner. - In-housing of agreed support functions.	South Sefton CCG are still in discussions with West Lancashire CSU who are discussing with Lancashire and Manchester providers.	4x3	4x3	4x3	4	3	12	▶
QUA022	Apr-15	N/A	LCH risk to delivery of commissioned community service would result in reduced quality of clinical care.	4, 2	Quality, Business Objective, Statutory Duty, Reputation.	Chief Strategy & Outcomes Officer (Karl McCluskey)	1. Joint Sustainability Review being led by TDA (Trust Development Authority) with South Sefton CCG and Liverpool CCG. Meetings currently being held every two weeks. 2. Regular review on a week basis with LCH (operational level).	4	4	16				~~LCH now managing directly and working with Staff Side representatives~~ ~~Regular operational meetings held to review programme and mitigate clinical and service risks~~ ~~Series of 3 workshops held: LCH, TDA, NHS England and CCG. Looking at future provider options for delivery. Sessions held June, July and August. Outcome was an agreement on services and timetable for dissolution. Procurement process commenced.~~	formal arrangements in place with TDA managing transition of services to interim NHS providers	4x4	3x4	4x4	4	4	16	▶

SOUTH SEFTON CCG

Corporate Risk Register

Q3 December 2015

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

By User: Danielle Love

ID	Date Added	2014/15 Reference	Principal Risk	2015/16 Corporate Objective	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	Update on Progress	0+2 May	Q1	Q2	L	C	Current Risk Rating - Q3	Change Since Last Update
QUA023	Apr-15	N/A	The supplementary 800k investment in Mersey Care for 2015/16 does not deliver required transformation resulting in diminished quality of care and lack of contribution to strategic Mental Health priorities	5, 1, 7	All	Chief Strategy & Outcomes Officer (Karl McCluskey)	1. Clinical transformation Board established. 2. Work plan developed.	4	3	12				- Members notionally identified. To be discussed at a further meeting being held in May. Meeting held. Reviewed list of services and identified long list of provider options. Monthly meetings and draft TOR to be discussed and agreed at the next meeting to be held 14/7. Completed. Work plan developed. Clinical Schemes have been listed however further review and clinical discussion is needed before being detailed and finalised. Clinical schemes identified. To further discuss and agree at next meeting on 19/6. Schemes agreed subject to assessment for affordability. All business cases for initiatives against £800K developed or in process of. Due to be considered at November Mental health Transformation Steering Group.	Setup transformational board and managing performance against agreed plan	4x3	4x3	4x3	4	3	12	▶
QUA024	Apr-15	N/A	Risk of poor quality patient care as a result of not delivering against A&E target	2,7	Quality, Business Objective, Statutory Duty.	Chief Strategy & Outcomes Officer (Karl McCluskey)	1. Strategic Resilience Group (SRG) in place. Meetings held on a monthly basis and feed into Governing Body. 2. Operational Service level meetings held: currently weekly. 3. Monthly contractual performance meetings 4. Monthly Integrated Performance Report: reported to Governing Body. 5. Monthly Quality meeting: reported to Governing Body	3	3	9				~~Aintree achieved target 95.04% (week ending 26.4.15). Recovery plan in place to achieve and sustain by end of quarter 2. All achieved. Culminated in a single item QSC (beginning – October). NHS England have de-escalated concerns.~~ ~~Lead has considered the removal of the risk following assurance that the risk has been managed. However has decided that the risk should remain to ensure close monitoring.~~	ongoing work with SRG in place specific actions to tackle 12 hour wait for patients in A&E progressed with Aintree & Merseycare	3x3	3x3	1x3	1	3	3	▶
QUA025	Apr-15	N/A	Failure to progress an integrated approach across providers as a result of not delivering against the CCG's strategic blueprint for Shaping Sefton.	1,2,4,5,6,7	Quality, Business, Finance	Chief Strategy & Outcomes Officer (Karl McCluskey)	1. Blueprints established and agreed 2. Kings Fund supporting progress and development	3	3	9	-Governance and reporting arrangements received. Awaiting to be enacted.	~~Dec 2015~~ Mar 16		New National planning guidance received in December 15 requesting CCGs to develop a Sustainability and Transformational Plan (STP) across a larger footprint. Working ongoing with other CCGs and notionally agreed STP footprint as Liverpool City Region. A full day sessions will be held on 29 Jan 16 with CCGs and providers to confirm arrangements		3x3	3x3	3x3	3	3	9	▶
QUA027	Apr-15	N/A	Lack of affective pathways of care for specialist CAMHS (Child and Adolescent Mental Health Services - all age model and task force) as a result of ineffective joint commissioning.	7, 5	Quality	Debbie Fagan and Geraldine O'Carroll (Team Manager)	1. Joint funded post employed within the Sefton Council infrastructure	3	3	9	Joint post possibly being looked at as part of review. Local CAMHS to be transformational plan implemented			Looking at 'all age' mental health service. Currently have sufficient resources and capacity to take forward. Joint post might be looked at as part of LA review and cost savings.	Continuing to monitor progress and action accordingly.	3x3	3x3	3x3	3	3	9	▶
QUA028	Apr-15	N/A	Unable to deliver Personal Health Budgets (PHB) to patients as a result of CCG not having a governance system nor process in place to develop the provision of personal health budget's (PHB) to eligible patients choosing the PHB option.		Quality, Reputation, Finance	Deputy Chief Nurse/Head of Quality and Safety (Brendan Prescott)	1. CCG/CHC Steering Group: issue raised with CHC team leads and strategic leads 2. Specification developed for PHB support 3. Fixed term 1 year role Programme Manager Role agreed 4. Regular Local Authority meetings held	3	3	9	- Education for Deputy Chief Nurse on developing PHB process at regional level - need to agree with LA on shared use of direct pay - Programme Manager role to be appointed to; would be responsible for developing PHB.	June 15 June 15 July 15	Jan-16	Meeting to be held with Department of Health appointed facilitator and attendance at regular events. Meeting held. Linked into Learning Network on PHB's. Out to provider for response on costings and timings. Further meeting with LA to be arranged for July in order to discuss potential shared use of Direct Payment system. Position appointed to. Awaiting start date. Discussions regarding integrated back room functions with the LA continue as part of the integration work plan. Additional Programme Management support procured from CSU Stability Partner and work commenced in August 2015. Paper on CCG process for PHB approved at September 2015 Governing Body. Programme Manager Vulnerable People now in post from 1st September 2015 who will take a lead on this area of work reporting to the CCG Deputy Chief Nurse. Risk Rating to remain the same until process is operational.	Draft policy for approval presented to Quality Committee December 2015 to reflect expanded PHB agenda and for GB ratification after consultation in March 2016. Likelihood reduced to 2 from 3 and new risk score of 6 down from 9	3x3	3x3	3x3	2	3	6	▼
QUA029	Apr-15	N/A	Lack of resource to re-procure and ensure robust, open and transparent procurement process and quality service (SSP)	6	Quality, Reputation	Chief Redesign & Commissioning Officer (Jan Leonard)	1. Regular meetings with NHS England: reported to Governing Body	3	4	12	- NHS England to write to provider - Procurement Plan - Public Consultation	July 2015 Aug 2015 Oct 2015	Jan-16	- NHS England Evaluation matrix devised: looks at the risks for each practice. Went to part 2 Governing Body in May 2015. CCG requested NHS England review 1 aspect of matrix. NHS England now ready to write to provider. Interim providers identified for all practices and NHSE agreeing contracts. Procurement Planning meetings ongoing with NHS England. Further discussion at Governing Body Development meeting on the configuration of practices in relation to contracts. Working with NHS England and provider to develop action plan. NHSE awaiting responses for potential interim providers, due in by 9/10/15. We await a copy of NHSE risk assessment on the procurement and handover of practices. Mobilisation meetings planned by NHSE and CCG will be represented.		3x4	3x4	3x4	3	4	12	▶
~~QUA030~~	~~Apr-15~~	~~N/A~~	~~Impact on local practices to absorb patients into list who have been affected by lapse of local contract.~~	~~6~~	~~Quality, Reputation, Statutory Duty~~	~~Chief Redesign & Commissioning Officer (Jan Leonard)~~	~~1. Regular meetings with NHS England: reported back to SLT 2. Regular Seaforth & Litherland Locality meetings: reported to Governing Body. 3. LMC meeting~~	~~3~~	~~3~~	~~9~~				~~- NHS extended current contract in order to enable more time to pull together plans to redesign existing service to accommodate gaps. - Press release prepared and ready. - Commissioning plan ready. - MPs and GPs briefing on findings. NHSE have moved to managed dispersal of those patients who have not registered with a new practice. We continue to work with NHSE to conclude this process.~~	TO BE CLOSED: All patients dispersed and no adverse impact on practices	3x3	3x3	3x3	1	3	3	▼
~~QUA031~~	~~Apr-15~~	~~N/A~~	~~Risk to quality of patient care as a result of non achievement of deficits highlighted through CQC inspection~~	~~6~~	~~Quality, Reputation, Statutory Duty~~	~~Chief Redesign & Commissioning Officer (Jan Leonard)~~	~~1. Regular meetings with NHS England to look at action plan.~~	~~4~~	~~3~~	~~12~~	~~- Practices to devise action plan to cover the deficits identified. - Re inspection by CQC TBC~~	~~TBC TBC~~		-	TO BE CLOSED: CQC re-inspected and classified satisfactory	4x3	4x3	4x3	1	3	3	▼

SOUTH SEFTON CCG

Corporate Risk Register

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

Q3 December 2015

By User: Danielle Love

ID	Date Added	2014/15 Reference	Principal Risk	2015/16 Corporate Objective	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	Update on Progress	0+2 May	Q1	Q3	L	C	Current Risk Rating - Q3	Change Since Last Update
QUA032	Apr-15	N/A	Delay's in specialist review of referrals which may result in a potential risk to patients (Choose and Book)		Quality	Terry Hill	1. Escalation through a letter via CCF to the chief executive (Catherine Beardshaw). 2. Clinical risk of patient referral (ASI) not being triaged in a timely manner, added to Trust risk register. 3. Project plan developed to tackle key issues resulting in the large number of appointment slot issues (ASI's), including high risk arear's. 4. Interim process established with high risk services to ensure timely review of referrals (Dummy clinics) 5. Trust monitoring of Clinical business units via reporting mechanism 6. Interim targets set to ensure timely review of referrals (Max. 2ww = 2 days, urgent = 1 weeks; Routine = 6 weeks) 7. Standard Operating Procedures in place with specialities that ensure the reviewed of 'daily ASI reports' to ensure patients are appointed in a timely manner a specialist review of referral. Based on agreed flags, referrals escalated to service for a decision on appointing (seek agreement for overbooking or additional clinics). 8. Monthly meetings with the trust with clinical representation from CCG 9. Bi-monthly RTT meeting with the trust – C&B standing agenda item 10. Identification of high risk areas and process of monitoring/reporting	4	3	12	- Review of other trusts to learn best practice. - Reset targets in order to meet national guidance (2ww = 1 day, urgent/routine = 5days). - Reporting mechanism to assure the CCG that patients are appointed and referrals reviewed within set timescales.	Aug 2015 Aug 2015		An outline plan has been articulated however no timescales provided. A capacity review with local improvement plans developed for each directorate/specialty in order ensure a reduction in the number of ASI's which will result in a timely review of referrals and reduced risk to patients. The plan includes: - Trust and commissioner added Risk to organisational risk register (trust completed) - Identification of high risk areas and process of monitoring/reporting (Completed) - Interim 'dummy clinics' implemented to allow timely review of referrals in high risk areas until a full capacity review has been implemented (Completed) - Standard operating procedure by division introduced in order that ASI are managed affectively. (Completed) - Service level demand and capacity modelling linked to capacity available on CAB (incomplete) - Trust visit to practice (incomplete) - Work towards introduction of new NHS E-referrals (incomplete) CCG in the process of: - looking at how to work to national guidance - LTT - assurance reports to speciality* *Problems with implementation of the new E-referrals system nationally has impacted on the trusts ability to report on numbers of C&B issues. No national reports have been available since May 2015. HSCIC are hoping to resolve this shortly.		**4x3**	**4x3**	**4x3**	4	3	**12**	▶
QUA040	Oct-15	N/A	12 hour waiting time in A&E in relation to Mental Health patients not being delivered will result in compromised quality of care.	7	Quality	Chief Strategy & Outcomes Officer (Karl McCluskey)	1. Confirmed process's for escalation and alert to the CCG and NHS England 2. Joint operational arrangements between Aintree and Mersey Care; day to day/hour to hour/as arise so as to ensure adequate provision. 3. Recovery Action Plan in place to address capacity issues within Mersey Care wards 4. RCA process; review of patient should they experience excessive waiting or admission.	4	3	12	Mersey Care Recovery Plan; enacting ongoing.	Oct-15	Nov-15	Mersey Care enacting plan to ensure patient transfer more timely.	remedial action plan in place no 12 hour waits since Sept 12	**N/A**	**N/A**	**3x3**	3	3	**9**	▶
QUA041 - NEW RISK	Jan-16	NEW RISK	Risk of patients receiving care in Primary Care which may not meet quality standards	7	Quality	Debbie Fagan	1. Support systems in place via quality team and Primary Care Support 2. Monitor issues through Quality Committee 3. Collaborate with NHSE regarding identified concerns 4. Support individual practices when quality issues arise	3	4	12	Meet with NHSE on progress of plans to mitigate as required	Mar-16	Mar-16	Support delivered to 1 practice with NHSE collaboration Development and regular review of practices Negotiation with NHSE on resource support Inspection of practice and provision of delivery of care		**N/A**	**N/A**	**N/A**	3	3	**9**	**NEW**
			Reputation/Adverse Publicity																			
REP004	Oct 2014: originally split from REP001	**REP004**	Unable to effectively manage local demands due to inadequate local CHC processes.		Quality, Reputation Link risk to TJ LPF risk	Chief Nurse (Debbie Fagan)	1. CCG/CSU CHC Steering Group. Currently meet fortnightly. 2. Improvement plan in place monitored at Steering Group 3. CHC backlog monitored on a monthly basis now that residual backlog has decreased 4. Regular meetings with CCG Chief Nurse/Deputy Chief Nurse with local CHC leadership. 5. MD of stability partner has met with Chief Officer 6. Regular monthly meetings with Locality Lead: now in place from stability partner.	4	3	12	Progress of stability partner to be reviewed after 3 months To go to LPF for new service provider.	Sept 15 July 2015	Oct 15	- No strategic support for CHC team based at Merton House. NWCSU requested for a stability partner. Stability partner identified for leadership of team for initially 3 months. Locality Lead now in place (commenced June 2015) - Discussions being had with Local Authority regarding a possible future integration model: ongoing. - high level plans presented to Leadership Team and SLT on 23/6 -Preparatory work plans in place and progressing on track. To go to LPF for new service provider (July 2015). Plans progressing via the LPF to procure new provider for CHC service. New provider expected to be in place for the beginning of March 2016. Monthly Steering Group remains in place where improvement plan is monitored. Risk rating to remain the same until outcome of LPF process known.	New Provider now mobilising to start contract in February 2016. Initial scoping via workshop now complete. Likelihood down from 4 to 3 with new risk score down from 12 to 9	**4x3**	**4x3**	**4x3**	3	3	**9**	▼
REP035 (re-numbered from 032 as duplicate number)	Apr-15	N/A	Non delivery of BCF target reductions in non-elective activity will lead to fewer resources available for BCF and impact on partnership working with the Local Authority.			Chief Delivery and Integration Officer (Tracy Jeffes)	1. Clear reporting on BCF to Health and Wellbeing Board and Programme Integration Group (PIG). 2. Joint Leadership Team and Sefton Council Senior Leadership team meetings established 3. Terms of Reference for Programme Integration Group (PIG). 4. Terms of Reference for Health & Wellbeing Board 5. Ongoing implementation of three BCF schemes aimed at reducing non-elective activity.	4	3	12	- Review of all Health & Well Being governance arrangements - New governance arrangements to be implemented.	Sept 2015		One meeting held and a series of dates for further meetings booked. BCF Review Group meeting regularly. New governance arrangements agreed.	Performance element of the BCF has not been achieved. LA concern over implications of the non-payment of the performance fund. BCF review group meeting but new HWBB structures not yet established.	**4x3**	**4x3**	**4x3**	5	3	**15**	▲
REP036	**Oct 2014: originally split from REP001**	N/A	Non-delivery against national trajectory for CHC restitution cases (PUPoC - packages of care for Previously Unassessed Periods of Care)		Reputation, Quality	Chief Nurse (Debbie Fagan)	1. CCG/CSU Steering Group 2. Trajectory monitored on a monthly basis by steering group and via monthly reporting from CSU 3. Agenda item for discussion at CCG SLA meetings with CSU 4. CCG reports on performance to NHS England at Checkpoint meetings	4	3	12				- CCG attended Footprint meeting with CSU (June 2015) - CCG discussed issue with NHS England and asked for support as issue not just specific to CCG - 1:1 outcomes including: - CSU to work on plans to reduce backlog - Lessons Learnt to be identified from how another CSU operates CCG have now met monthly PUPoC target for June 2015, July 2015 and August 2015 - September data being awaited. Performance continues to be monitored at the CCG/CSU CHC Steering Group. NHSE are Chairing a SIQSG for PUPoC on 28.09.15 due to the risk across the system - the CCG have submitted information to inform the meeting and will be represented by the Deputy Chief Nurse. Risk rating to remain the same until further positive performance is seen.	PUPoC continues to be at or exceed trajectory for September, October and November with completion by NHS E deadline planned. Reduce likelihood to from 4 to 3 with overall risk score down from 12 to 9	**N/A**	**4x3**	**4x3**	3	3	**9**	▼
			Statutory Duty																			
STA037	**Jun-15**	N/A	Risk that patients could be harmed or receive inadequate care as a result of commissioned provider unable to deliver within statutory timeframes the health outcome information to be inserted into Education & Health Care Plans (EHCP) for children and young people with Special Educational Needs & Disability (SEND)		Statutory Duty	Chief Nurse (Debbie Fagan)	1. CCG systems and processes in place 2. CCG members of SEND Steering Group 3. Children's Commissioning Manager in regular contact with LA and provider to support system and flow 4. Regular reporting of position to Leadership Team	5	4	20	- meeting needed with LA to discuss issues - Awaiting provider remedial action plan - Formal meeting needed with LCH: awaiting date	Jul 15 July 15 July 15		- CCG Children's Commissioning Manager has met with LCH to discuss LCH systems and processes and those of LA - Discussed at CCG Leadership Team - meet with LA planned for 2/7 to discuss issues - Liaise with Director of Nursing and Operational Manager at LCH - Chief Nurse has requested as a regular agenda item at the contract meetings with the provider New system sat LA Teething problems expected however these masked actual issues. Regular contact maintained between health commissioned provider and the LA. Provider improvement plan appears to be having desired effect as statutory timelines are now being met, risk rating ahs been reduced as a result of the initial impact.	Continuing to be monitored via CCG commissioner to ensure timelines continue to be met. Awaiting trend of improvement before reducing risk	**N/A**	**5x3**	**4x3**	4	3	**12**	▶

SOUTH SEFTON CCG

Corporate Risk Register

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Q3 December 2015

By User: Danielle Love

ID	Date Added	2014/15 Reference	Principal Risk	2015/16 Corporate Objective	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	Update on Progress	0+2 May	Q1	Q3	L	C	Current Risk Rating - Q3	Change Since Last Update
STA038	**Jun-15**	N/A	Risk that patients could be harmed or receive inadequate care due to lack of commissioner assurance in current processes for Looked After Children Health Assessments and Reviews across the local system		Statutory Duty, Quality	Chief Nurse (Debbie Fagan)	1. Reporting position to Leadership Team 2. Monitor through Quality Committee 3. Agenda item for contract meeting 4. KPI's in contract for Looked After Children 5. Statutory 903 return will be presented to Corporate Parenting Board by LA: CPB chaired by an elective member	**5**	**4**	**20**	Data quality exercise to be carried out. Areas of assessment is on data to 31st March 2015 and will include: - whether or not assessed - if assessed, at what stage - whether assessments have been carried out but information not forwarded. Lessons Learnt event to be held	Jul 15 Jul 15		- Chief Nurse in conversations with Executive team of LCH and Head of Service in LA: discussions 25 and 26/6. - Remedial actions between LCH and LA with support from designated nurse for Looked After Children for CCG. Actions include data quality exercise on data to the end of March 2015 to determine whether or not assessed and at what stage of assessment. - Chief Nurse has sent an e-mail on 26/6 regarding a Lessons Learnt event to be held the beginning of July 15, with a Pathway meeting to be held within 2 weeks of event. - Designated Nurse for Looked After Children has requested provider do risk assessment for the children in order to prioritise any health assessment or review that might need to be undertaken. CCG Safeguarding Service provided a status update at August 2015 Quality Committee. Performance data on remedial actions received by CCG Designated Nurse for Looked After Children. Operational Group meetings set up and remedial work continues via this forum. Joint briefing to be prepared by the LA and CCG for presentation to the Corporate Parenting Board. Risk rating to remain the same until further progress is seen.	Paper presented to Corporate Parenting Board in October on issues with assessment for LAC. Collaboration between LA and provider still being monitored	**N/A**	**5x4**	**5x4**	**5**	**4**	**20**	▶

South Sefton CCG Assurance Framework – Quarter 3 2015-16: October – December

NHS South Sefton Clinical Commissioning Group

Corporate Objective 1: To place clinical leadership at the heart of localities to drive transformational change				**Governing Body Reports**			
Lead Officer/Risk Owner: Jan Leonard							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
1.1 Lack of capacity amongst clinical colleagues to deliver transformation ***(Carried forward from Q4 14/15: previously 5.1 - updated – new objective 1)***	**3 x 3**	Development of Local Quality Contract Primary Care Clinical Lead identified in new GB Documented and robust PDR process for Governing Body members and locality lead roles Locality and practice lead roles clarified Service Improvement and Redesign (SIR) Committee, established. Consultation complete. Contract finalised, all practices signed up.	Monitoring of uptake and performance of LQC, reported to SIR Committee and Governing Body. Regular updates to Senior Leadership Team on LQC Minutes of Locality Meetings received by Governing Body Governing Body oversight of PDR process for members/clinical and locality leads via exception reporting Primary Care Programme Lead appointed. Will have responsibility for focus on primary care development and transformation.	**Significant** **Reasonable** **Limited** Primary Care Programme Lead appointed: awaiting commencement.	(GIC) Review needed on 2014/15 delivery and outcomes. (GIC) Monitoring of 2015/16 uptake, delivery and performance needed.	To be undertaken by Programme Lead. To be undertaken by Programme Lead. Panel met to review 14/15 contract performance in early September. A report is being compiled and will be shared with SLT in October 2015.	Sept 2015 Ongoing through year. Oct 2015
Progress Reports	**Q1**	**Primary Care Programme Lead appointed: awaiting commencement. Will have responsibility for focus on primary care development and transformation.**				**Assurance Rating**	**Limited**
	Q2	**Panel met to review 14/15 contract performance in early September. A report is being compiled and will be shared with SLT in October 2015.**					**Limited**
	Q3	**Report shared with SMT in October**					**Limited**
	Q4						

Corporate Objective 1: To place clinical leadership at the heart of localities to drive transformational change				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
1.2 Lack of clinical engagement in Primary Care and other providers limit level of clinical engagement in locality to drive transformational change	**4 x 3**	Organisational Development Plan in place. Local Development Plans	Support from Governing Body for the local development plans Reported to leadership team Regular Governing Body Development Sessions to help drive agenda.	**Significant** **Reasonable** **Limited** Roles and responsibilities of leads, locality support and reporting mechanisms being reviewed.	(GIC) Review to be undertaken on Organisation Development Plan. (GIC) Review to be undertaken on Local Development Plans (GIC) Clearer performance to deliver CCG Strategy (GIC) Capacity of clinicians to be release and engaged in CCG activity	Being developed further including the roles and responsibilities of leads, locality support and reporting mechanisms. PMO involvement to support locality plans. Clinical leadership succession plan and commissioning training and development for emergent Clinical Commissioners. Work with LCH Leadership to support on-going input into localities	Sept 2015 July 2015 Dec 2015 March 2016
Progress Reports	**Q1**	**Roles and responsibilities of leads, locality support and reporting mechanisms being reviewed.**				**Assurance Rating**	**Limited**
	Q2	**Multidisciplinary support team in place for each locality.**					**Limited**
	Q3	**Localities developed priorities for action.**					**Limited**
	Q4						

Corporate Objective 1: To place clinical leadership at the heart of localities to drive transformational change				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
1.3 Inability to maintain active involvement of all constituents and stakeholders ***(Carried forward from Q4 14/15: previously 5.2 - updated – new objective 1)***	**3 x 4**	Increased development of Locality model & resourcing Effective running of Engagement and Patient Experience Group in place to ensure on-going active involvement of key partners e.g. Sefton Health Watch, voluntary sector and LA & coordination of local patient and public activities CCG public-facing internet site now live Lead locality GP, Practice Nurse & Practice Manager meetings on monthly basis for each locality Remunerations Committee has agreed financial resourcing for backfill/Clinical involvement	Documented evidence of involvement Quarterly Wider Constituent meetings with GP attendance recorded/minuted Governing Body receive minutes of Locality meetings. 360 review.	**Significant** **Reasonable** **Limited** Reviewing arrangements of Wider Constituent meetings	(GIA) Wider Constituent meetings to be reviewed. (GIA) Need to improve attendance at Locality meetings (GIA) Need to identify Governing Body member to attend Locality meeting (GIA) Need to change perception of 'lack of clinical leadership' *(outcome of 360 review)* A review of	Timings, dates and meetings to be reviewed in order to improve attendance. Attendance to be reviewed: need to ensure locally led and clinical involvement. Governing body member now attends meetings. Governing Body member now attends. Clear lead roles identified for Board members and shared with Wider Constituent Group	July 2015 July 2015
Progress Reports	**Q1**	**Reviewing arrangements of Wider Constituent meetings to co-inside with protected learning time. Governing Body member now attends Locality meetings. Clear lead roles identified for Governing Body members and shared with Wider Constituent group.**				**Assurance Rating**	**Limited**
	Q2	**No consensus view on changing meeting dates, need discussion at Novembers Wider Group**					**Limited**
	Q3	**Locality meetings well attended next year's wider group dates circulated.**					**Limited**
	Q4						

Corporate Objective 2: To develop the integration agenda across health and social care.				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
2.1 Inability to carry out system wide change due to resource and structural re-organisation constraints ***(Carried forward from Q4 14/15: previously 6.1 - reworded and updated – new objective 2)***	**4x3**	Regular joint meetings with Sefton Council to develop Integration Plans. Key officers assigned from Sefton Council and CCG to develop intermediate care strategy Section 75 in place: BCF Cross sector "Shaping Sefton" to stimulate whole system working: 2 held to date.	Documented Evidence of reports and minutes from meetings Regular joint reporting on BCF to NHS England	**Significant** **Reasonable** **Limited** ~~Review of HWBB structure to ensure streamlined and effective however, awaiting completion of Local Authority restructure.~~ New governance structure for transformation agreed following review. Awaiting implementation	(GIC) ~~Review of HWBB structure to ensure a streamlined and effective approach to commissioning.~~ (GIC) Awaiting implementation of new governance structure for transformation. (GIA) Next "Shaping Sefton" event due to be held.	Awaiting completion of Local Authority restructure. LA changes completed. New governance structure for transformation agreed. Yet to be implemented. Integration post out to advert to provide additional capacity. Third Shaping Sefton event planned. Commencement of systems leadership with support by Kings Fund	August 2015 October 2015 October 2015 Dec 15
Progress Reports	**Q1**	**Review of HWBB structure to ensure streamlined and effective however, awaiting completion of Local Authority restructure.**				**Assurance Rating**	**Limited**
	Q2	**Shaping Sefton Governance Arrangements agreed. Funding agreed for post to support integrated commissioning.**					**Limited**
	Q3	**Post recruited. Bids submitted to support BCF delivery. Still awaiting implementation of new HWBB structure.**					**Limited**
	Q4						

Corporate Objective 3: To consolidate the Estates Plan and develop one new project for March 2016.				Governing Body Reports			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
3.1 Securing adequate resources and expertise to deliver NHS Estates Strategy	**3x3**	CCG's requirement to deliver the Estates Strategy	Locality meetings Sefton Property Partnership established. Estates support secured 1 day per week	**Significant** **Reasonable** **Limited** ~~Draft strategy being worked on. First draft due November 2015.~~ Final strategy in development	(GIC) Late notification from on responsiveness (GIA) Shared view at locality level regarding the outcome of the strategy	Draft strategy being worked on. First draft to November Governing Body. Expected to be finalised December 2015.	November 2015 December 2015
Progress Reports	**Q1**	**Draft strategy being worked on. First draft due November 2015.**				**Assurance Rating**	**Limited**
	Q2	**First draft of strategy due November 2015.**					**Limited**
	Q3	**Draft strategy reviewed by Governing Board in December 15, final strategy being developed**					**Limited**
	Q4						

Corporate Objective 3: To consolidate the Estates Plan and develop one new project for March 2016.				Governing Body Reports			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
3.2 Failure to develop a coherent view in order to deliver an agreed project across part /full locality	**3x3**	Delivery of Estates Strategy by end of 2015	Locality meetings Sefton Property Partnership established. Estates support secured 1 day per week Ongoing dialogue with NHS England for capital project funding and finance	**Significant** **Reasonable** **Limited** Estates support secured. Ongoing dialogue with interested parties. . ~~Draft Strategy still being developed.~~ Final strategy in development	(GIC) Lack of clarity around finance and availability. National guidance expected. (GIA) Need a clear response from GPs on Locality Estates Strategy		Q3 (Oct – Dec 2015) Sept 2015
Progress Reports	**Q1**	**Estates support secured. Ongoing dialogue with interested parties.**				**Assurance Rating**	**Limited**
	Q2	**Ongoing dialogue with interested parties. Draft Strategy still being developed.**					**Limited**
	Q3	**Draft strategy reviewed by Governing Board in December 15, final strategy being developed**					**Limited**
	Q4						

Corporate Objective 4: To publish plans for community services and commission for March 2016.				Governing Body Reports			
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
4.1 Delay in implementing new pathways due to non-achievement of reductions in admissions needs to draw out requirement to deliver savings. ***(Carried forward from Q4 14/15: previously 3.1 - updated – new objective 4)***	**2 x 3**	Virtual Ward development identified as a priority area Action plan in place with Aintree UHT KPIs for all non-elective admissions monitored under contract process via CSU information portals fed into contract meeting Monitoring of A&E attendance conversion rates (non-elective admissions) via CSU information portals in contract meeting Monthly steering groups to evaluate progress Monthly agenda item on contract review meetings with Liverpool Community Health Services Monthly performance review meetings.	Aintree achieved year 95% A&E target. Discussion at CCF relating to closing of contract query – carried forward to Q1 2014/15. Q1 not achieved Contract query process reviewed in monthly contract meetings. Minutes received by Governing Body Progress of action plan reviewed by Unplanned Care Network – exception reports produced Minutes of CCG Urgent Care Collaborative meetings Action plan continues to support on-going Trust achievement (including monthly meetings). Assurance & exception reporting continues via Quality Committee Quarterly reports/minutes of meetings received by Governing Body for oversight of delivery progress via performance data. Urgent Care referral processes in place and being monitored. Monthly meeting with system resilience partners.	**Significant** **Reasonable** **Limited** Continues to be monitored. Aintree A&E patient pathway discussed at monthly SRG meetings.	(GIC) Change in Aintree A&E patient pathway, may lead to increased admission coding.	Discussed at monthly SRG Aintree meeting. Contract meetings now include other partners.	
Progress Reports	**Q1**	**Continues to be monitored. Discussed at monthly SRG meetings.**				**Assurance Rating**	**Limited**
	Q2	**Clinical lead attending all locality meetings to encourage utilisation of community services**					**Limited**
	Q3	**Clinical lead has attended all locality meetings and utilisation being monitored.**					**Limited**
	Q4						

Corporate Objective 4: To publish plans for community services and commission for March 2016.			Governing Body Reports				
Lead Officer/Risk Owner: Stephen Astles							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
4.2 Current provider unable to deliver community service as specified by the CCG. ***(Carried forward from Q4 14/15: previously 4.1- updated – new objective 4)***	**3x3**	Contract meetings monthly Clinical performance and quality meetings monthly Clinical liaison meeting s monthly Interim senior management team attending all locality meetings Meetings with lead GPs to review core delivery	Minutes, clinical and managerial lead feedback to practices and localities. Locality Implementation Group established with recovery plan of work in place: meet on a six monthly basis. Mobilisation reviewed at each meeting. Action tracker in place to record agreements. Service agreed and locality based where appropriate. Fortnightly meetings held with Senior CCG team and Executives from LCH responsible for Sefton.	**Significant** **Reasonable** **Limited** Awaiting recruitment of Senior Manager with responsibility for Sefton delivery: gap created following MARS scheme.	(GIC) Senior Manager role to be recruited to: person would be responsible for Sefton delivery.	Position going to advert: now appointed to. ~~Following~~ Work initially ~~currently being~~ covered on a temporary basis by a Senior Executive and management team. Senior management team now recruited for LCH, direction of procurement decided. New team will need time to become established. Delivery to be monitored.	July 2015
Progress Reports	**Q1**	Awaiting recruitment of Senior Manager with responsibility for Sefton delivery: gap created following MARS scheme.				**Assurance Rating**	**Limited**
	Q2	**Senior management team recruited for LCH, direction of procurement decided.**					**Limited**
	Q3	**Regular meeting with LCH SMT instigated.**					**Limited**
	Q4						

Corporate Objective 5: To commission new care pathways for mental health.				Governing Body Reports			
Lead Officer/Risk Owner: Karl McCluskey							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
5.1 Failure to progress recommendations and priorities from Mental Health review ***(Is a continuation/ progression from Q4 14/15: re 7.1 – reworded and updated – new objective 5)***	**3 x 3**	Clinical lead appointed Blueprint agreed and signed off by Governing Body (June 2015). Clinical Group established. Project Group agreed and in place.	Regular progress reporting to Governing Body Progress management and assessment undertaken. Minutes of meetings PMO monitoring process in place.	**Significant** **Reasonable** Commissioning Lead for Mental Health appointed and position commenced. Role will include reconstructing the commissioning framework. Areas worked on. Blueprint report being presented to the Governing Body in November **Limited** Enhanced resource position going out to advert. Detailed project plan being progressed.	(GIC) ~~Enhanced resource required.~~ (GIC) ~~Detailed project plan required.~~ (GIA) ~~Project plan to be presented to the Service Improvement & Redesign Committee~~ (GIA) To review priority areas, service lines and activity plans.	~~Position to go out to advert.~~ Commissioning Lead for Mental Health appointed and position commenced. Role will include reconstructing the commissioning framework. ~~Currently being worked on. Will include:~~ - Primary Care Mental Health - Dementia - CAMHS - Brain Injuries Areas worked on. Blueprint report being presented to the Governing Body in November. ~~Plan scheduled for review by SIR committee.~~ QIPP & SIR merged. Meetings held. Has resulted in affirmed priority areas, service lines and activity plans.	~~July 2015~~ ~~July 2015~~ ~~July 2015~~ Nov 2015
Progress	**Q1**	**Enhanced resource position going out to advert. Detailed project plan being progressed.**				**Assurance**	**Limited**

Corporate Objective 5: To commission new care pathways for mental health.				Governing Body Reports			
Lead Officer/Risk Owner: Karl McCluskey							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
Reports	**Q2**	**Enhanced resource position appointed and commenced. Detailed project plan progressed. Report to be presented to the November Governing Body.**				**Rating**	**Reasonable**
	Q3	**Series of monthly Blueprint leads meetings arranged for Feb 16**					**Reasonable**
	Q4						

Corporate Objective 6: To achieve Phase 1 of Primary Care transformation.				Governing Body Reports			
Lead Officer/Risk Owner: Jan Leonard							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
6.1 Inability to deliver transformational change as a result of inappropriate estates	**4x3**	Leads for transformation agenda to be identified.		**Significant** **Reasonable** **Limited** Estates Group to be established and confirm position of estates review.	(GIC) Estates Group to be established. (GIC) Position of estates review to be confirmed by Estates Group.	Membership to include Finance, Clinicians, NHS England, Local Authority and Estates. Discussions are on-going with NHSE around particular localities. The CCG led Estates Group is leading discussions with stakeholders. Business case for GP transformation lead being developed by Dr T Davis. Plans to discuss wider transformation in place for Jan 16 Locality Meetings.	July 2015 Aug 2015
Progress Reports	**Q1**	**Estates Group to be established and confirm position of estates review.**				**Assurance Rating**	**Limited**
	Q2	**Discussions are on-going with NHSE around particular localities. The CCG led Estates Group is leading discussions with stakeholders**					**Limited**
	Q3	**Event Planned for Jan 16 – update to be given Q4**					**Limited**
	Q4						

Corporate Objective 7: To achieve financial duties and commission high quality care.				Governing Body Reports			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
7.1 Non Delivery of financial targets due to failure to control CCG expenditure budgets or failure to deliver required QIPP scheme ***(Carried forward from Q4 14/15: 1.1 reworded, merged and updated with 1.2 – new objective 7)***	**3x4**	Internal and External Audit Plan in place to review systems of internal control Robust financial management and control processes in place to ensure reserves and contingency are utilised in an appropriate manner Internal budgetary management process in place to support and challenge budget holder to deliver within agreed limit. Provider contracts agreed and signed with specified activity levels and associated costs	Financial Plan for 2015/16 signed off by Governing Body (May 2015). Agreed provider contracts signed for 2015/16. Robust contract management arrangements in place to review performance, activity and quality, including associated costs within agreed limits (including CQUIN) Monthly Finance performance reports presented to Finance & Resource Committee with reporting to Governing Body by exception report. Monthly reporting to NHS England as part of the collective NHS Financial position. Internal budgetary management process in place to support and challenge budget holder to delivery within agreed limit. Budget holder training held: ongoing rolling programme. Working Group established to identify required QIPP scheme	**Significant** **Reasonable** **Limited**	(GIC) Required QIPP schemes to be identified (GIA) Better information needed at practice level.	QIPP working group established. Group to identify required schemes Currently working through. CCG formally entered Financial Turnaround process with NHSE and FRP and is being developed. Draft plan has been submitted and awaiting formal feedback. QIPP scheme still to be fully identified. Practice level information is being rolled out and discussed at locality meetings and incorporated into practice level packs. Somewhat dependent on new Data Management provider for full drilldown capability by practice so interim solutions being put in place to target high spending practices.	August 2015 August 2015

Corporate Objective 7: To achieve financial duties and commission high quality care.			Governing Body Reports				
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
				Better information being provided at practice level however further improvements to be developed. Joint QIPP & SIR working group established.			
Progress Reports	**Q1**	**QIPP working group established. Group to identify required schemes. Further improvements to be developed for practice level information.**				**Assurance Rating**	**Limited**
	Q2	**CCG has entered Financial recovery process with NHSE and FRP and is being developed. Draft plan has been submitted and awaiting formal feedback.**					**Limited**
	Q3	**Plans submitted to NHSE. Further CCG Membership discussions and ongoing implementation of QIPP plans**					**Limited**
	Q4						

Corporate Objective 7: To achieve financial duties and commission high quality care.				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
7.2 Lack of sustainability of CSU services during transition and the effective procurement of CSU services via LPF ***(Carried forward from Q4 14/15: 1.5 updated – new objective 7)***	2 x 4	New SLA in place with CSU Contract/Performance Monitoring Group in place and meeting on monthly basis. Exception reporting on performance and delivery at SMT Pan Cheshire and Merseyside Collaborative approach to commissioning future services via LPF.	Monthly meeting of Performance Monitoring Group. Performance now reported by exception. Reports to Finance & Resource Committee on six monthly basis Plan in place CHC. Project management support from NHS England. Additional capacity and support via secondment position across Merseyside. Weekly meeting of Merseyside CCG's: work on procurement through LPF. Reported to Transition Board Stability partner identified.	**Significant** All CCGs in Merseyside collaborating on Mobilisation Board and plan on track **Reasonable** **Limited** In-housing of some services continues. Stability partner identified. Robust specifications in development for the LPF.	(GIA) To complete in-housing of identified services (GIA)	Some additional services being brought in-house in order to secure local responsiveness and sustainability Specifications developed. LPF process proceeded to evaluation stage. In-housing of planned services Contracting staff now in-housed. Signed contract with new CSU provider mobilisation plan on track and closedown of NWCSU underway.	November 2015 Nov 2015 – March 2016 Jan 16
Progress Reports	**Q1**	**In-housing of some services continues. Stability partner identified. Robust specifications in development for the LPF.**				**Assurance Rating**	**Limited**
	Q2	**Procurement proceeding to evaluation stage. Stability partner supporting gaps in provision where possible. Majority of services are stable.**					**Limited**
	Q3	**Closedown of NWCSU proceeding as planned. Mobilisation Board meeting regularly to review plans & are on track**					**Significant**
	Q4						

Corporate Objective 7: To achieve financial duties and commission high quality care.				Governing Body Reports			
Lead Officer/Risk Owner: Karl McCluskey							
Principal Risks *Risk Owner*	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
7.3 Non-delivery of 2015/16 QIPP Plan which supports transformational change ***(Carried forward from Q4 14/15: 1.6 updated – new objective 7)***	4 x 4	Development Plan commenced. Initial focus will include Dermatology, Gynaecology and Development Plan commenced. Initial focus will include Dermatology, Gynaecology and Development Plan commenced. Initial focus will include Dermatology, Gynaecology and	QIPP financial savings targets and plans signed off by the Governing Body (April 2015) Monthly financial performance reports (including QIPP targets and associated savings) presented to Finance and Resource Committee and reviewed by the Governing Body. Revised Strategic Plan develop Joint QIPP & SIR Group established (Governing Body and Clinical Leadership)	**Significant** **Reasonable** **Limited** Clinical QIPP Group established to explore referral guidelines, evidenced based practice, NICE guidance to support targeted QIPP areas. Commissioning intentions issued to providers, informed by identified QIPP schemes. Additional target areas agreed including Gastroenterology.	(GIC) ~~Development plan required. Needs to include areas for financial cost reduction.~~	~~Being developed. Initial focus will include:~~ 1. Dermatology 2. Gynaecology 3. Gastroenterology QIPP Plan in place. Report being presented to November 2015 Governing Body. Governing Body Sub-committee structure revised. QIPP & SIR merged. Meet more regularly. QIPP Lead appointed.	July 2015 Nov 15
Progress Reports	**Q1**	**Development Plan commenced. Initial focus will include Dermatology, Gynaecology and Gastroenterology.**				**Assurance Rating**	**Limited**
	Q2	**QIPP Plan in place.**					**Limited**
	Q3	**QIPP Plan presented to November 2015 Governing Body, Governing Body Sub-committee structure revised. QIPP & SIR merged**					**Limited**
	Q4						

Corporate Objective 7: To achieve financial duties and commission high quality care.			Governing Body Reports				
Lead Officer/Risk Owner: Karl McCluskey							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
7.4 Potential for any reduction in non-elective admissions may be offset by increased demand ***(Carried forward from Q4 14/15: 2.1 updated – new objective 7)***	**4x3**	Weekly and monthly non-elective performance reviewed by PMO / SMT Bi-monthly performance reports to Governing Body	Exception reporting to Governing Body bi-monthly Exception issues raised and alerted through SMT to be addressed via Head of CCG Development. Integrated Performance Report produced monthly for Governing Body. Minutes of meetings Revised 2015/16 activity plan developed with detailed rationale. Reviewed by Governing Body February 2015 with agreement and sign-off April 2015. 2016/17 Plans being developed based on National Planning Guidance	**Significant** **Reasonable** Performance being closely monitored with appropriate systems and procedures in place. Contract query issued to Southport & Ormskirk as a result of a performance issue being identified. Detailed action plan compiled; ongoing. **Limited**	(GIA) Awaiting response on contract query issued to Southport & Ormskirk	Fully reviewing activity performance, and plans as part of 2016/17 planning round.	July 2015
Progress Reports	**Q1**	**Performance being closely monitored with appropriate systems and procedures in place. Contract query issued to Southport & Ormskirk as a result of a performance issue being identified.**				**Assurance Rating**	**Reasonable**
	Q2	**Detailed action plan compiled and ongoing. Involvement in Trusts Prioritised Target List meetings.**					**Reasonable**
	Q3	**2016/17 Plans being developed based on National Planning Guidance**					**Reasonable**
	Q4						

Corporate Objective 7: To achieve financial duties and commission high quality care.				Governing Body Reports			
Lead Officer/Risk Owner: Debbie Fagan							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
7.5 Failure of provider to deliver high quality services for the delivery of CHC/Individual packages of care would result in patients not receiving appropriate level of care to meet their needs.	**4x3**	Steering Group established. Improvement Plan in place with NWCSU Weekly meetings between CCG Chief Nurse/Deputy Chief Nurse and operational leads within CSU	MIAA review of CCG internal processes: significant assurance. Closely monitor and review backlog for improvement in performance on a bi-monthly basis via Steering Group. Action plan in place. Regular reporting to Leadership Team and SLT. Regular reporting to F&R Committee. Regular review of Corporate Risk at Quality Committee. Continue to support CSU in local delivery of SOP and governance processes.	**Significant** **Reasonable** **Limited** Assurance level decrease following review of CSU information regarding Mental Health reviews. Assurance levels remain limited until formal report received and CSU demonstrate any required improvement in processes.	(GIC) Discussion needed on the outcome of the CCG's review on NWCSU CHC systems, processes and evidence.	CCG requested information from NWCSU on the systems and processes in place for CHC, specifically Mental Health reviews and including: - Supervision policy - Templates used - Evidence of audit plan and outcome - 2 anonymised cases for independent review Evidence collated and reviewed. CCG consider 'Limited' assurance. Letter to be sent to MD of NWCSU. Letter sent to MD of CSU outlining the CCG concerns. Externally commissioned review of Mental Health packages of care now completed. Informal feedback received but awaiting formal report – discussions taking place	July 2015

Corporate Objective 7: To achieve financial duties and commission high quality care.				Governing Body Reports			
Lead Officer/Risk Owner: Debbie Fagan							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
						between CSU and CCG regarding required actions following the verbal feedback.	
Progress Reports	**Q1**	**Assurance level decrease following review of CSU information regarding Mental Health reviews.**				**Assurance Rating**	**Limited**
	Q2	**Assurance level remains the same until formal report received from external reviewer and CSU demonstrate and required improvement in processes**					**Limited**
	Q3						
	Q4						

GUIDANCE

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

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

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

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

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

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

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

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

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

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

Assurance Rating

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

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

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

Examples of what constitutes differing levels of assurance:

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

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

Risk Grading Matrix

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

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

Significant risk

Significant Risk

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

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2016

Agenda Item: 16/09	**Author of the Paper:** Lisa Gilbert Corporate Governance Manager Email: lisa.gilbert@southseftonccg.nhs.uk Tel: 0151 247 7238
Report date: January 2016	

Title: Improving the Quality of NHS Complaints Investigations

Summary/Key Issues:

This paper provides a summary of the Parliamentary and Health Service Ombudsman (PHSO) report published on 8th December 2015 into the quality of NHS complaints investigations where serious or avoidable harm has been alleged; it findings, highlights the issues identified, and sets out the action the PHSO believe needs to be taken to improve the quality of NHS investigations.

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
	To place clinical leadership at the heart of localities to drive transformational change.
	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	To publish plans for community services and commission for March 2016.
	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
x	To achieve financial duties and commission high quality care.

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

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

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
January 2016

1. Executive Summary

This paper provides a summary of the Parliamentary and Health Service Ombudsman (PHSO) report published on 8th December 2015 into the quality of NHS complaints investigations where serious or avoidable harm has been alleged; it findings, highlights the issues identified, and sets out the action the PHSO believe needs to be taken to improve the quality of NHS investigations.

2. Introduction and Background

When things go wrong with NHS care, it can have devastating consequences for patients and their families. People want answers, to understand what happened and why, and to know that action is being taken to prevent the same thing happening again to others.

In January 2015 the PHSO reviewed 150 NHS complaints investigations where avoidable harm or death was alleged. The PHSO was interested to learn about the quality of complaints investigations; did these NHS investigations get to the root cause? Were the findings evidence based? They also spoke to six different trusts; they wanted to know what the challenges were to conducting these types of investigation and where there might be opportunities to improve the system. Finally, they surveyed over 170 NHS complaints managers to provide additional insight into the issues and brought together an advisory group to test their findings.

As part of the PHSO review of the quality of NHS investigations, they asked: how successful are NHS organisations, particularly acute trusts, at determining what went wrong and why? Are lessons being learnt and applied, not just across departments but across organisations and localities? Is appropriate action being taken and if not, why not? What can be done to improve how local investigations are conducted and delivered so that more people are not subjected to the same errors time and time again?

3. Key Issues

What the PHSO review found:

The process of investigating as it stands is not consistent, reliable, or good enough

- 40% of investigations were not adequate to find out what had happened.
- 19% of investigations had relevant evidence (medical records, statements and interviews) missing when they were conducted.
- Trusts did not find failings in 73% of cases in which we found them.
- Trusts did not find out why things went wrong in 36% of cases where they found failings.

Serious incidents are not being reliably identified by trusts, and there exists wide variation between trusts, and within trusts, in terms of how patient safety incidents are investigated

- Out of the 150 cases we reviewed, 28 were judged by us to be serious enough to lead to serious incidents, but only 8 were reported as such. We found that identification often relied on either clinicians to spot an incident or on a central risk team flagging incidents.

There is a lack of shared investigatory principles - how a case is investigated depends on the individual investigator

- There is no national guidance on patient safety incident investigations that sets out who should investigate and how independent they should be, level of training required, requirements for evidence needed, quality assurance, and general outcomes for good investigations.

Poor quality investigations only increase the distress to the person who is complaining and their families

- In almost a fifth of investigations medical records, statements and interviews were missing, making it difficult for trusts to arrive at what went wrong and why.
- In 41% of cases inadequate explanations were given to complainants for what went wrong and why.

Staff do not feel adequately supported in their investigatory role

- There is no national, accredited training programme to support investigators and/or complaints staff in their role.
- During our visits to trusts, staff cited a lack of respect, not being provided with protected time to investigate, and the lack of an open and honest culture as barriers to getting to the heart of why something has happened.
- There is inequity in terms of who can lead different types of investigations. We found serious incident investigations would often be led by a named investigator with training; all other investigations not meeting serious incident criteria could be led by an 'appropriate person'.

There are missed opportunities to learn

- 25% of complaints managers were unsure that sufficient processes existed to prevent a recurrence of an incident.
- A further 10% of complaints managers believed sufficient processes were not in place.

4. Conclusions

What needs to change?

In April 2016, a new Independent Patient Safety Investigation Service (IPSIS) will be established. Through a combination of exemplary practice and structured support to others, IPSIS has the opportunity to make a decisive difference to how the NHS improves the way it investigates in the future.

The PHSO call upon IPSIS and the NHS more broadly, to consider how the following recommendations can be implemented:

- IPSIS and NHS England should consider how the role of NHS complaints managers and investigators can be better recognised, valued and supported. This includes working with others to develop a national accredited training programme.
- To support all investigations to be carried out to a consistent and high quality, IPSIS should develop and champion broad principles of a good investigation. The emphasis should be on building capability and capacity at a local level whilst also allowing for flexibility and proportionality.
- IPSIS should work with others to lead, inspire and share learning from its own investigations in order to improve the capability of the local NHS. This includes demonstrating to organisations how they can take what they have learned from one investigation and apply it not just across divisions within a hospital, but across organisations too.

- Trusts should demonstrate to their boards that they have clear objectives both for their organisations and their staff to be open and honest, learn from investigations, and resolve complaints. Boards should be using My Expectations to assess to what extent local complaints services are meeting the needs of people who use the service.
- The Department of Health and NHS England should work with IPSIS to make clear who has accountability for conducting quality NHS investigations at a national and local level. The different roles of organisations that provide care, commissioners, regulators including NHS Improvement, should be clearly outlined.

The PHSO believe that taken together, these changes will result in tangible improvements to the quality of local investigations.

5. Recommendations

NHS South Sefton CCG Governing Body is asked to note the findings of this report.

An update report will be brought back to Governing Body following the establishment of the Independent Patient Safety Investigation Service (IPSIS).

Appendices

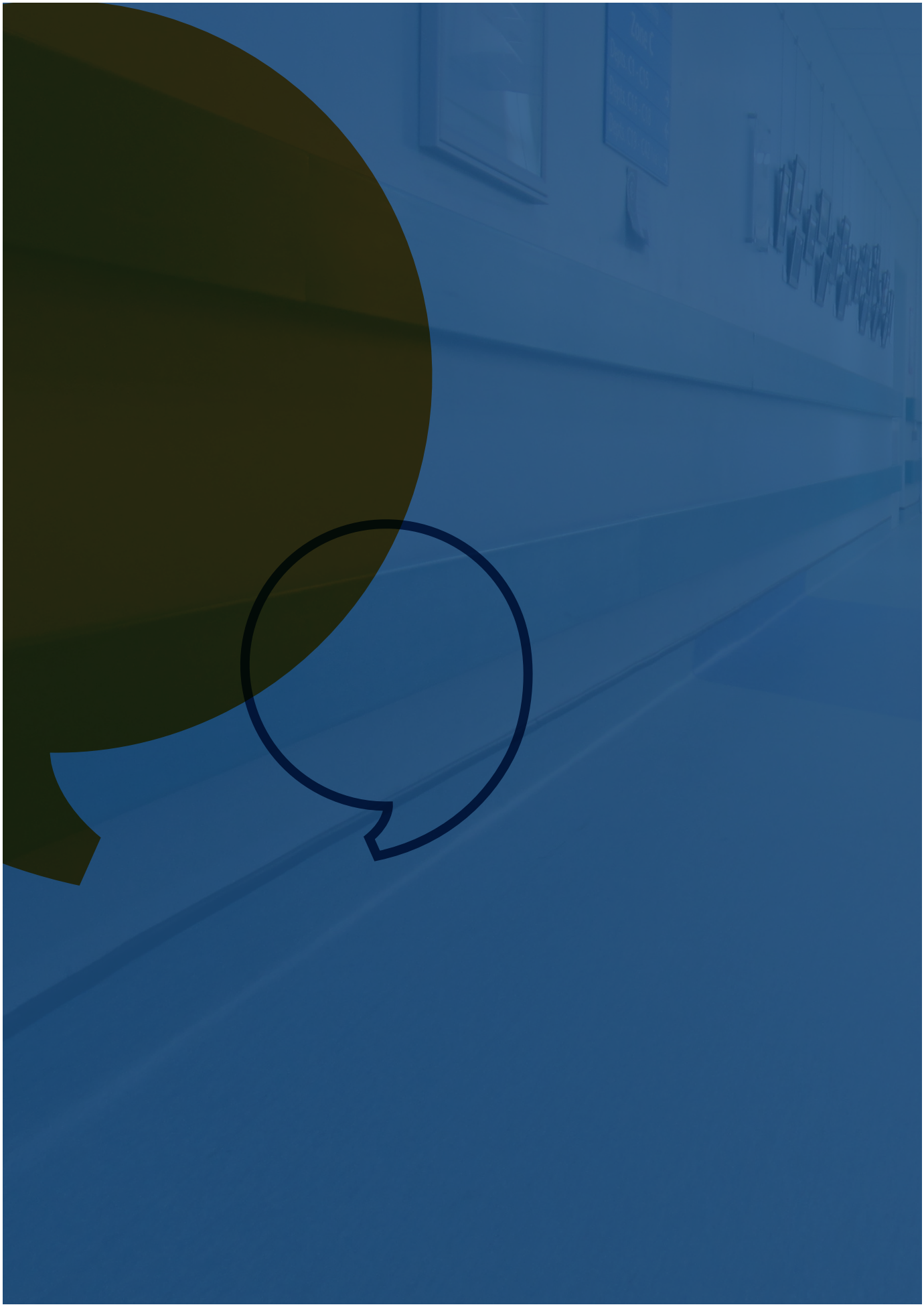
Appendix 1 – PHSO Summary Report

Lisa Gilbert
Corporate Governance Manager
January 2016

Parliamentary and Health Service Ombudsman

A review into the quality of NHS complaints investigations

where serious or avoidable harm has been alleged



Contents

The images used in this report are not representative of any person or particular individual and are used for illustrative purposes only.

Introduction

When things go wrong with NHS care, it can have devastating consequences for patients and their families. People want answers, to understand what happened and why, and to know that action is being taken to prevent the same thing happening again to others.

But our research has cast a question mark over the current ability of NHS organisations to conduct effective investigations where it is alleged that someone may have been harmed, or died, avoidably. We have found that NHS trusts are not always identifying patient safety incidents and are sometimes failing to recognise serious incidents. When investigations do happen, the quality is inconsistent, often failing to get to the heart of what has gone wrong and to ensure lessons are learnt.

As part of our review of the quality of NHS investigations, we asked: how successful are NHS organisations, particularly acute trusts, at determining what went wrong and why? Are lessons being learnt and applied, not just across departments but across organisations and localities? Is appropriate action being taken and if not, why not? What can be done to improve how local investigations are conducted and delivered so that more people are not subjected to the same errors time and time again?

This report explains the findings of our research, highlights the issues we have identified, and sets out the action we believe needs to be taken to improve the quality of NHS investigations.

About complaints investigations, serious incidents and patient safety incidents

More than 80% of the complaints we receive are about NHS care and treatment, many involving avoidable harm.

Avoidable harm spans everything from minor to moderate harm, to unexpected or avoidable death and incidents that may cause widespread public concern resulting in a loss of confidence in healthcare services. Where the consequences of these failures to patients, families and carers, staff or organisations are so significant or the potential for learning is great, cases should be investigated as serious incidents[1].

Generally, the complaints we see are about incidents of avoidable harm. These could be classed as patient safety incidents; cases where minor or moderate harm has occurred. Four out of five of the cases we reviewed were investigated as patient safety incidents as opposed to serious incidents.

As an Ombudsman's service, we believe that whether or not the event was significant enough to warrant being labelled a serious incident or a patient safety incident, people have a right to know that their complaint has been taken seriously and investigated thoroughly. Indeed, we expect trusts to be measuring and improving people's experience of complaining by using *My Expectations*[2] when assessing the performance of their complaints service and to what extent this is meeting the needs of the public.

How we approached this

We reviewed 150 NHS complaints investigations where avoidable harm or death was alleged. We were interested to learn about the quality of complaints investigations; did these NHS investigations get to the root cause? Were the findings evidence based? We also spoke to six different trusts; we wanted to know what the challenges were to conducting these types of investigation and where there might be opportunities to improve the system. Finally, we surveyed over 170 NHS complaints managers to provide additional insight into the issues and brought together an advisory group to test our findings.

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1 Serious incidents are defined as "*unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.*" NHS England (March 2015) *Serious Incident Framework*. Available at https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

2 PHSO (Nov 2014) *My Expectations: a user-led vision for raising concerns and complaints*. Available at: http://www.ombudsman.org.uk/__data/assets/pdf_file/0008/28817/My-expectations-for-raising-concerns-and-complaints-summary-leaflet.pdf

What we found

1. The process of investigating is not consistent, reliable or good enough.

We found that 40% of investigations were not adequate to find out what happened. Not only are trusts not identifying failings, they are also not finding out why the failings happened in the first place. For example, trusts did not find failings in 73% of cases in which we found them, and in over a third of cases where failings were found, trusts did not find out why something went wrong. This is in marked contrast to the perception of 91% of NHS complaints managers who were confident an investigation could find out what had gone wrong.

Serious incidents are not being reliably identified by trusts; we judged 28 of the cases we looked at to be serious enough to lead to a serious incident investigation, but only 8 had been treated as such by the NHS. Identification often relied on either clinicians to spot an incident or on a central risk team flagging incidents. It was clear from our visits to trusts that not all had reliable processes in place, contrary to the perception of complaints managers; 96% stated there was both a process and trigger to help identify a serious incident at their trusts.

We found wide variation between and within trusts in terms of how patient safety incidents are investigated. Perhaps more worrying, is a distinct absence of shared investigatory principles. How a case is investigated is subject to the individual investigator.

We are concerned that there is no national guidance for patient safety incident investigations which make clear:

- who should investigate and how independent of events they should be;
- the level of training an investigator should have for any particular type of investigation;
- broad requirements for the specific evidence needed. For example, statements, interviews or independent clinical reviews;
- how investigations should be independently quality assured;
- what general outcomes any good investigation should aim to achieve.

Worryingly, medical records, statements and interviews were missing from almost a fifth of investigations making it even harder for trusts to arrive at what went wrong and why. Organisations that provide care should not lose sight that it is patients, carers and families who are often at the heart of these investigations. They need to be involved in a meaningful way if investigations are to answer their questions. All of this has a huge impact on patients and families at the centre of any investigation. Our results show that in 41% of cases, complainants were given inadequate explanations for what went wrong and why. The two cases opposite highlight the tragic impact poor quality investigations can have on families and those raising complaints, and why it's important that lessons are learned.

Case study

A one-day-old baby received a blood transfusion to treat severe jaundice. Tragically, serious errors were made in delivering the transfusion resulting in Baby F's collapse, which led to permanent brain damage. Although a serious incident investigation was carried out, it was done so by a close colleague of the paediatrician in charge that day.

We considered that Baby F's collapse was avoidable and requested the trust carry out a review to find out why things went so seriously wrong. The trust acknowledged the investigation was a review of notes only, and clinical staff were not interviewed or asked to provide written statements.

It took three years for Baby F's parents to get a proper explanation for what happened to their baby, adding to their distress.

Case study

Mr M, a 36-year-old father, was taken to accident and emergency with sudden, severe chest pain. Medical staff suspected a heart attack however further tests revealed Mr M may have suffered a tear to the wall of his heart.

After being admitted to a medical ward, Mr M was later discharged with a possible blockage in the bowel with further investigation of his abdomen planned. The following day, Mr M collapsed and lost consciousness. Attempts at resuscitation failed and Mr M died.

Our investigation concluded had a CT scan taken place, Mr M would have been transferred for surgery giving him an 80% chance of survival. No serious incident investigation was conducted and two complaints meetings failed to give the family the answers they needed, despite a list of questions being submitted by the family in advance.

The hospital refused to provide an 'expert view' on whether the doctors' actions were appropriate, adding to the injustice and distress felt by the family.

2. Staff do not feel adequately supported in their investigatory role

There is no national, accredited training programme to support investigators and/or complaints staff in their role. Cultural issues can often be a barrier to getting to the heart of why something has happened.

Common reasons cited during our visits to trusts included a lack of respect; not being provided with protected time to investigate, and the lack of an open and honest culture despite the introduction of the duty of candour in November 2014.

Our visits suggest inequity in terms of who can lead different types of investigations. Our visits revealed that serious incident investigations would often be led by a named investigator with training; all other investigations which fell short of the serious incident criteria could be led by an 'appropriate person'.

Ultimately, staff need to be equipped and empowered to carry out investigations otherwise trusts risk adding to the distress felt by individuals and missing opportunities to make essential service improvements as the following case illustrates.

Case study

Ms G was concerned about changes to her breast and was referred by her GP to a breast clinic. An ultrasound scan led to a diagnosis of mastitis. At a follow-up appointment, a different breast specialist made the same diagnosis. When Ms G missed a follow-up appointment three months later, she was discharged from the breast clinic.

Fourteen months later, Ms G was diagnosed with incurable, advanced breast cancer that had spread to her bones, liver and brain. We found that the secondary cancers were allowed to develop because she had been misdiagnosed and that the two letters she had received confirming mastitis gave her false reassurance. We also found that the trust failed to fully investigate, and did not acknowledge the extent of the failings or the impact on Ms G.

The trust later acknowledged that it should have instigated a serious incident investigation when Ms G was diagnosed with cancer and had it done this, it could have considered learning and service improvements much sooner.

The trust identified a skills gap for staff responsible for investigating complaints, and developed and commissioned a complaint handling course with a local university; complaints management would now become part of their individual appraisals. The trust also established a quality approval process for complaints.

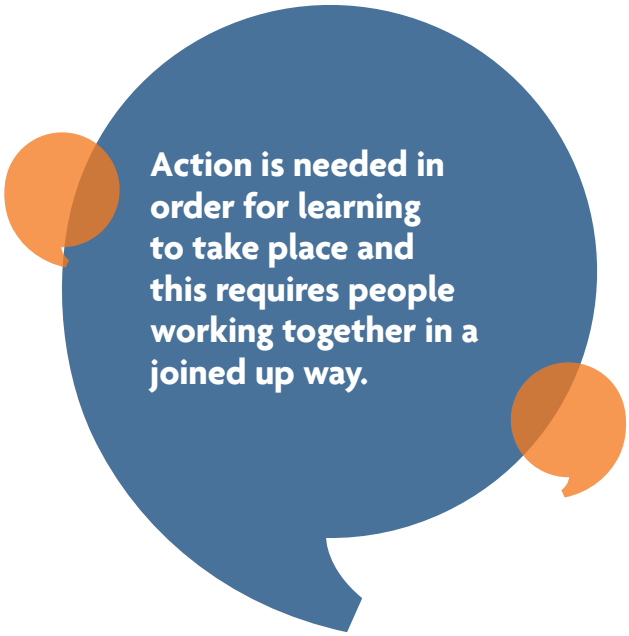
3. There are missed opportunities for learning.

Many complain because they do not wish the same thing to happen to somebody else. Therefore it was worrying to find that 25% of complaints managers were unsure that sufficient processes existed to prevent a recurrence of an incident, and a further 10% believed sufficient processes were not in place.

The impact of poor quality investigations that do not trigger a serious incident is felt most significantly by individuals and their families. However, it also results in missed opportunities to learn and make the relevant service improvements as the case opposite illustrates.

Action is needed in order for learning to take place and this requires people working together in a joined up way. NHS complaints managers, who are responsible for providing explanations to families and ensuring learning takes place, need to be joined up with clinical staff who are often tasked with leading patient safety incident investigations.

Our findings demonstrate that divisions within hospitals often work in isolation to each other; learning from investigations appears to be trapped in high level meetings; and learning across organisations often relies on goodwill and personalities rather than any established processes or mechanisms. Our advisory group reported that cross organisational learning tends to be led by the willing few rather than something that is a widespread practice across the NHS.



Case study

Mr D, a 77-year-old man, was admitted to A&E and seen by a junior doctor who suspected the cause of his symptoms was sepsis, a severe infection. He was not seen by a doctor for two-and-a-half hours, and antibiotics were then not given until two hours after they were prescribed.

Despite stepping up his treatment, Mr D died two days later. Concerns were raised by close family about the timeliness of Mr D's treatment and whether his death could have been avoided. In response to the complaint raised, the trust outlined chronological events using clinical records only.

Had a complaints investigation been done thoroughly, the trust would have found that clinical staff failed to recognise the severity of Mr D's illness, that he was not seen by a doctor for more than two hours, observations were not taken regularly and that a serious incident should have been triggered.

Our investigation concluded that the hospital missed an opportunity to give him the best chance of recovery by failing to give him more timely treatment.

What needs to change?

In April 2016, a new Independent Patient Safety Investigation Service (IPSIS) will be established. Through a combination of exemplary practice and structured support to others, IPSIS has the opportunity to make a decisive difference to how the NHS improves the way it investigates in the future.

We therefore call upon IPSIS and the NHS more broadly, to consider how the following recommendations can be implemented:

1. IPSIS and NHS England should consider how the role of NHS complaints managers and investigators can be better recognised, valued and supported. This includes working with others to develop a national accredited training programme.

2. To support all investigations to be carried out to a consistent and high quality, IPSIS should develop and champion broad principles of a good investigation. The emphasis should be on building capability and capacity at a local level whilst also allowing for flexibility and proportionality.

3. IPSIS should work with others to lead, inspire and share learning from its own investigations in order to improve the capability of the local NHS. This includes demonstrating to organisations how they can take what they have learned from one investigation and apply it not just across divisions within a hospital, but across organisations too.

4. Trusts should demonstrate to their boards that they have clear objectives both for their organisations and their staff to be open and honest, learn from investigations, and resolve complaints. Boards should be using *My Expectations* to assess to what extent local complaints services are meeting the needs of people who use the service.

5. The Department of Health and NHS England should work with IPSIS to make clear who has accountability for conducting quality NHS investigations at a national and local level. The different roles of organisations that provide care, commissioners, regulators including NHS Improvement, should be clearly outlined.

We believe that taken together, these changes will result in tangible improvements to the quality of local investigations. Although our report is a snapshot in time, it raises doubts over the ability of trusts to reliably identify when something has gone seriously wrong and why. Without this capability, trusts will continue to miss opportunities to learn and make service improvements.

As the stories in our report highlight, this is leading to tragic consequences for the people and families who are directly affected, and raises questions about whether the same preventable mistakes will not be repeated. There is some way to go before the NHS can be confident in the quality of local NHS investigations.

We look forward to playing our part in supporting improvements. As a first step, we will commit to disseminating our findings and will be sending copies of this report to the boards of each NHS trust across England.

Headline figures and insight

The evidence that we collated is attached to this report in annexes B to E. This shows variation in the quality of investigations of patient safety incidents, and provides comprehensive evidence about what is going wrong in the system. This evidence is summarised here.

Insight	Evidence	Our recommendation
The process of investigating as it stands is not consistent, reliable, or good enough.	40% of investigations were not adequate to find out what had happened. 19% of investigations had relevant evidence (medical records, statements and interviews) missing when they were conducted. Trusts did not find failings in 73% of cases in which we found them. Trusts did not find out why things went wrong in 36% of cases where they found failings.	To support all investigations to be carried out to a consistent and high quality, IPSIS should develop and champion broad principles of a good investigation. The emphasis should be on building capability and capacity at a local level whilst also allowing for flexibility and proportionality.
Serious incidents are not being reliably identified by trusts, and there exists wide variation between trusts, and within trusts, in terms of how patient safety incidents are investigated.	Out of the 150 cases we reviewed, 28 were judged by us to be serious enough to lead to serious incidents, but only 8 were reported as such. We found that identification often relied on either clinicians to spot an incident or on a central risk team flagging incidents.	

Insight	Evidence	Our recommendation
There is a lack of shared investigatory principles - how a case is investigated depends on the individual investigator.	There is no national guidance on patient safety incident investigations that sets out who should investigate and how independent they should be, level of training required, requirements for evidence needed, quality assurance, and general outcomes for good investigations.	To support all investigations to be carried out to a consistent and high quality, IPSIS should develop and champion broad principles of a good investigation. The emphasis should be on building capability and capacity at a local level whilst also allowing for flexibility and proportionality.
Poor quality investigations only increase the distress to the person who is complaining and their families.	In almost a fifth of investigations medical records, statements and interviews were missing, making it difficult for trusts to arrive at what went wrong and why. In 41% of cases inadequate explanations were given to complainants for what went wrong and why.	
Staff do not feel adequately supported in their investigatory role.	There is no national, accredited training programme to support investigators and/or complaints staff in their role. During our visits to trusts, staff cited a lack of respect, not being provided with protected time to investigate, and the lack of an open and honest culture as barriers to getting to the heart of why something has happened. There is inequity in terms of who can lead different types of investigations. We found serious incident investigations would often be led by a named investigator with training; all other investigations not meeting serious incident criteria could be led by an 'appropriate	IPSIS and NHS England should consider how the role of NHS complaints managers and investigators can be better recognised, valued and supported. This includes developing a national accredited training programme. Trusts should demonstrate to their boards they have clear objectives, both for their organisations and their staff, to be open and honest, learn from investigations, and resolve complaints. Boards should be using My Expectations to assess to what extent local complaints services are meeting the needs of people who use the service.

Insight	Evidence	Our recommendation
There are missed opportunities to learn.	25% of complaints managers were unsure that sufficient processes existed to prevent a recurrence of an incident. A further 10% of complaints managers believed sufficient processes were not in place.	IPSIS should work with others to lead, inspire and share learning from its own investigations in order to improve the capability of the local NHS. This includes demonstrating to organisations how they can take what they have learned from one investigation and apply it not just across divisions within a hospital, but across organisations too. The Department of Health and NHS England should work with IPSIS to make clear who has accountability for conducting quality NHS investigations at a national and local level. The different roles of providers, commissioners, regulators including NHS improvement, should be clearly outlined.

Annexes

Annex A: Our approach and the evidence we gathered

We gathered evidence about the quality of NHS investigations through four strands of work: a review, a survey, visits to trusts, and an advisory panel.

The review

In January 2015 we completed an initial review of 150 of our cases that involved a complaint about avoidable harm or death. The aim was to establish whether trusts' own handling and investigation of these types of cases are adequate to identify and deal with failings in care or a serious incident. Our investigators answered a series of questions about the quality of the NHS' original complaint investigations, and the evidence that the trusts had relied upon in coming to their decisions.

The survey

In March 2015, we sent a survey about the investigation processes in relation to complaints about patient safety incident to 171 complaints managers in all acute trusts in England. The purpose of the survey was to understand their processes, and gain insight into best practices and areas for improvement. We asked closed questions and gave staff the opportunity to provide qualitative comments. The survey was anonymous. There were 104 responses after a three-week period. This equates to a response rate of 61%.

The visits

We visited acute trusts across the country, including small trusts, large trusts, trusts that had been performing well, and also those that had recently been in special measures. We asked the trusts questions about how they investigate allegations of a patient safety incident and how their complaints process is set up to investigate and learn from complaints. We spoke to a wide variety of staff including directors of nursing, complaints managers, complaints staff, divisional leads, and governance leads. We used the information from these visits to validate and add depth and context to the information that we obtained from the survey and the review. We also looked to find examples of good practice.

Advisory group

Once we had gathered evidence from the review, the survey and the visits, we convened an advisory group. The advisory group was made up of organisations and individuals with a special interest in patient safety incident investigations. We discussed our findings with the advisory group, whether what we found fits with their experience and how our work fits into the wider landscape. All members of the advisory group said that our evidence resonated with their experience.

You can read a summary of the evidence we gathered in Annexes B to E of this report.

After we had collated all the evidence, we analysed it against the existing applicable standards: the *Ombudsman's Principles of Good Administration* and *Good Complaint Handling*, *My Expectations*, the *Duty of Candour*, and the *Complaints Regulations*. We considered whether what we had found suggested that the NHS was falling short of those standards when conducting a patient safety investigation following a complaint. We looked at whether the culture, systems and processes that were in place were robust enough to allow those standards to be met.

Annex B: The review - summary

Introduction

We undertook this review because our casework tells us that there is a wide variation in the quality of NHS investigations into complaints that patients have suffered serious avoidable harm. We completed this in January 2015 and the aim was to establish whether the NHS complaints process is acting adequately as a safety net to identify and deal with failings in care and patient safety incidents. We also looked for features of good practice.

Methodology

We identified and considered 288 cases about the NHS in England that we investigated in 2014. In each of the 288 cases a patient, or relative, alleged that they had suffered avoidable harm because of NHS treatment. Out of those cases, we identified 150 that raised issues of serious avoidable harm or death at acute trusts. The focus of our review was to look at the features and quality of the NHS investigation into the allegation, rather than the result of our subsequent investigation. We therefore did not discriminate between cases that we had upheld or not upheld.

Our investigators reviewed the case file for each of the 150 cases. They answered a series of questions[3] about the quality of the trust's original investigation into the complaint and the evidence that the trusts had relied on in coming to their decisions.

The questions were:

- Was the allegation of avoidable harm or avoidable death?
- What was the nature of the alleged avoidable harm?
- What was the main alleged clinical failing leading to avoidable harm or avoidable death?
- Which specialism was complained about?
- Was a serious incident investigation carried out?
- Do you consider that it should have been?
- Did the organisation understand and investigate the complaint put to it?
- Was the complaints investigation carried out by appropriate staff?
- Did the organisation communicate adequately with the complainant?
- Did the organisation have access to the relevant clinical records?
- Was there a review of the care and treatment by appropriate clinical staff?
- If yes, was the review done by a clinician not involved in the patient's care?
- Were key staff interviewed?
- Were key staff asked to provide a written statement?

[3] The criteria for the questions were informed by, but not confined to, the requirements of the *Serious Incident Framework*.

- Was any relevant evidence missing or not considered?
- Were the investigation findings reasonable and based on evidence?
- Did the organisation give the complainant an adequate explanation of what happened and why?
- Did the organisation find failings relating to avoidable harm or death?
- If yes, did the organisation find out why things went wrong?
- If failings were found, did the organisation take action to ensure patient safety?
- How long did the investigation take?
- Was the investigation adequate or inadequate?
- Was the complaint upheld or not upheld by us?

What we found

Our initial review bore out our premise that the NHS complaints process does not adequately address complaints about avoidable harm. Out of the cases we reviewed, over one third of investigations into allegations by patients, or their relatives, were not good enough to identify if something had gone seriously wrong.

We found that one third of investigations did not have reasonable conclusions that were based on evidence, and did not reliably identify when something had gone wrong.

Equally we found that, even when investigations did identify failings, the trusts did not always try to find out why something had gone wrong, or take remedial action.

In our review, 14 investigations (9%) found failings relating to avoidable harm; however, our subsequent investigations identified failings relating to avoidable harm in 52 cases (35%). Furthermore, in only 9 of the 14 cases did the trust try to find out why something had gone wrong, and in only 10 of the cases did the trust take action to try to make sure patients were safe in the future.

In the majority of cases the trusts had access to the relevant clinical records, and in 56% of investigations written statements were obtained and 38% involved interviewing key staff. In 90% of cases a review of the clinical care was carried out, but only 52% of cases involved an independent clinical review. In almost a fifth of cases we found that relevant evidence was missing from the trust's investigation. Some of the reasons that our investigators gave for this included that evidence had been given orally, and not documented; interviews or written statements, although considered necessary, were not obtained, and some clinical records could not be obtained.

We looked at the features of the investigations that we considered adequate, and those we considered inadequate. There was no significant difference in the adequate or inadequate groups in how frequently the trusts obtained written statements, interviewed staff, or obtained independent clinical reviews.

However, 71% of complaints that should have triggered a serious incident investigation were not identified as such. The 20 cases that should have been classified as a serious incident included: complaints about missed opportunities to survive; delays in providing medication and fluids that could have contributed to death; problems administering blood transfusions, leading to adverse consequences, including brain damage; and unexpected deaths. We found that for these 20 cases:

- 9 did not obtain written statements;
- 9 did not interview key staff;
- 7 did not either obtain written statements or interview key staff;
- 4 had evidence missing;
- 4 did not obtain a clinical review; and
- 6 of the 16 clinical reviews carried out were not independent.

Given the seriousness of these complaints, we considered that, even if the trusts did not recognise that these cases should have been classified as a serious incident, they should have followed a more thorough investigation process.

In addition to how trusts investigated the complaints, we also looked at how they communicated with complainants. Having reviewed the complaints files, we considered that in 27% of cases the trusts did not communicate adequately with the complainants. The reasons they gave for this include: delays in the complaints process; infrequent contact with complainants; and not keeping complainants updated about the progress of the investigation. We also found that in 41% of cases the trusts did not provide complainants with an adequate explanation of what happened and why.

Annex C: The survey – summary

Introduction

In March 2015, we sent a survey about the way complaints about patient safety incidents are investigated to complaints managers in all acute trusts in England, 171 in total. The purpose of the survey was to understand the trusts' processes, and gain insight into best practices and areas for improvement.

What we found

The survey asked closed questions and gave staff the opportunity to provide qualitative comments. Feedback was anonymous.
We received 104 responses after a three-week period, which is a response rate of 61%.

Below is a breakdown of the key results by question.

1. *Does your trust's complaint team follow different investigation processes for complaints of avoidable harm, in comparison to other complaints?*
    - Just under a tenth of respondents did not know whether they have different processes in place for avoidable harm complaints.
    - Out of the remaining respondents, approximately half follow a different investigation process for complaints about avoidable harm.
2. *In your opinion, do you think that improvements are required in the complaints process to adequately investigate allegations of avoidable harm?*
    - No respondents selected that 'a lot of improvements' were required to their complaints process.
    - However, over half (53%) stated that 'some' improvements were required.
    - 47% felt 'no improvements' were needed.
3. *If a complaints investigation identifies that something has gone wrong with the care provided, do you feel that there is an adequate process at your trust to find out why things went wrong?*
    - The majority (91%) felt that there is an adequate process at their trust to find out why things went wrong.
4. *If a complaints investigation identifies that something went wrong with the care provided, do you feel that your trust has a sufficient process to prevent the same mistakes happening again?*
    - In contrast to the previous question, only 6 in 10 respondents felt that their trust has sufficient processes in place to prevent mistakes happening again.
    - Over a quarter of respondents were 'unsure', with over a tenth stating their trust did not have sufficient processes in place.

5. *Is there a process at your trust to identify a serious incident?*

- The majority of respondents (96%) said that there is a process to identify a serious incident at their trust.

6. *Is there a process for your complaints team to trigger a serious incident once the complaint has been identified as requiring one?*

    - As in the previous question, the majority of respondents (96%) said that there is a process to trigger a serious incident.

7. *In your opinion do you consider that the complaints process at your trust can identify and trigger a serious incident when necessary?*

    - The majority of respondents (92%) felt their trust's processes can identify and trigger a serious incident when needed.

8. *Has your trust signed up to NHS England's safety campaign?*

    - Just over half of respondents said their trust has signed up to this campaign.
    - However, 45% of respondents said their trust had not.

Qualitative statements

Respondents were asked to offer ideas for improvements to complaint-handling processes. These centred on the following themes:

- Better training (for complaints teams, as well as others in trusts);
- Being more open, and creating a culture of openness;
- Better engagement between divisions and cross-department collaboration when investigating a complaint, so that people can learn from complaints;
- National guidelines and nationwide consistency (as it was felt that current complaints regulations are outdated);
- Greater ownership of the complaint and taking responsibility for actions relating to it, and for sharing any learning from it;
- Better resources; more time, money, and appropriate manpower;
- Involving more independent opinions in the complaints process;
- Greater focus on quality and consistency of the trust's responses; and
- Auditing the effectiveness of the actions taken.

We also asked respondents to share experiences about serious incident processes at their trust. They raised issues about decisions and processes being out of the complaint team's hands, meaning that staff in the complaints team had less influence in decisions. However, it was noted that things that worked well include:

- Sharing complaints and what is learned from them with other teams;
- Deciding the importance and urgency of complaints;
- Close working with other teams, for example, weekly meetings;
- Clear and consistent processes to deal with the complaint; and
- Having personnel involved who have experience of investigating and handling complaints.

Annex D: The visits – summary

Introduction

In April and May 2015, we visited six acute trusts[4] across the country. These included smaller acute trusts, large trusts, trusts that had recently been in special measures, as well as trusts that had been performing well. We asked the trusts questions about how they investigate allegations of avoidable harm and how their complaints process is set up to investigate and learn from complaints. We spoke to a wide variety of staff, including directors of nursing, complaints managers, complaints staff, divisional leads, and governance leads.

We used the information from these visits to validate or highlight gaps in the information that we obtained from the survey and the review. We also looked to find examples of good practice.

Below is an overview of the feedback we received from these six trust visits.

What we found

We were made to feel welcome, and generally, trust staff spoke to us openly about the complaints process and their approach to investigating allegations of avoidable harm. The staff we spoke to were keen to improve the system.

We have not quantified how many trusts provided certain responses. This is because we only spoke to six trusts and this, therefore, cannot be representative of all trusts. However, themes did emerge. Equally, the information we gathered helped validate the information we had already collected.

The themes we looked at:

- **How the complaints teams and process is structured:**

  Often the complaints teams do not, structurally, sit with the governance teams, but within the nursing directorate. This means the governance and complaints systems run in parallel. The complaints teams tend to liaise with complainants and deal with minor complaints, but do not investigate patient safety incidents. Generally we found that the complaints teams sent complaints about patient safety incidents to the division where the complaint arose to be investigated by clinical staff within that division.

  However, one of the trusts we talked to was in the process of changing its approach, and its complaints team (who are lay people) will be investigating patient safety incidents. This is unless the complaint has already been reported on the relevant patient and risk management software (Datix) and investigated within the division.

  We did not find any consistency about who would be investigating the complaint, and the level of training of investigators. Some trusts had a list of trained investigators within the divisions. Other trusts did not necessarily use trained investigators, but said that incidents were investigated by 'the appropriate person'.

[4] The trusts provided information anonymously.

Another variation we found was that in some trusts a trained investigator would investigate a serious incident, but anyone could investigate a patient safety incident that did not meet the criteria of a serious incident. Trusts also told us that investigators did not necessarily have time in their working week to do the investigations, but had to do this in addition to their clinical or managerial workloads.

The complaints staff we spoke to were all keen to resolve complaints and were persistent in following them through to the end. In some trusts, it appeared to be personalities and persistence that was improving the complaints and investigations process, rather than the investigations process itself. The majority of trusts were open in telling us that they did not feel they had a culture of openness.

- **Investigation process (patient safety incidents)**

  In general, we found that complaints staff speak to the complainants and agree the scope of the investigation, and then pass the investigation over to the division where the patient safety incident occurred. However, one trust was starting to use complaints staff to investigate patient safety incident that did not meet the criteria for serious incident. Complaints teams generally told us that when they received a complaint about a patient safety incident they would cross reference it on the trust's logging system - most commonly Datix - and if the incident was not already reported they would report it. Different trusts said there were different levels of reporting of patient safety incidents by clinical staff on Datix before the complaint was raised.

  The larger trusts told us that it can be difficult to obtain clinical records, whereas the smaller trusts found this less of a barrier. Trusts that had an electronic records system said they were better able to get access to clinical records.

  Some trusts relied on statements and did not interview staff because they said interviews were too difficult to arrange. Trusts also reported poor quality written statements and having to keep going back to the clinicians to get the information they needed.

  Some trusts said that clinicians were unwilling to review their colleagues' work, which made getting an independent clinical review difficult. However, the majority of trusts could get clinical reviews from within the division where the incident occurred for patient safety incidents, and some sought reviews from different divisions for serious incidents, but there was no consistent approach to this. Trusts' complaints staff reported difficulties in challenging clinical opinions. Generally, external clinical reviews were only sought for serious incidents and larger trusts found it easier to get an independent clinical review. Trusts reported difficulty in obtaining independent clinical reviews where the speciality was rare and the number of clinicians working in that field at that trust was limited.

It was generally reported that doctors were more unwilling or slower to provide opinions and statements than nurses. Trusts considered that where the complaint response was quality assured by staff not involved in the care, this introduced an element of independence.

We found variation in whether trusts dealt with serious incidents, and patient safety incidents that did not meet the serious incident criteria, in the same way, or whether they approached them differently.

Equally, we did not find consistency in how the investigations were approached. Some trusts had a root cause analysis (RCA)[5] template that the investigators followed, and others simply said that the investigator would choose how to approach the investigation on a case-by-case basis. The process and approach also differed between divisions within the same trust. Trusts generally expected the investigator to analyse the information and uncover why things went wrong.

We found that complaints teams tended to have a weekly meeting with the divisions where the complaint arose to discuss progress of outstanding investigations, and this helped the complaints team manage the process.

- **Governance**

  We found, in general, that divisional leads quality assured the investigation reports, which were then quality assured by various senior managers and the chief executive. We were told that when a lot of people were in the quality assurance chain the process was longer and harder. This is because staff would tailor the write-up of the investigation and/or response to suit an individual's style, and it would then go to a different individual who would have a different personal preference about writing style. Trusts considered that the quality assurance chain introduced an element of independence. The complaints teams also quality assure responses before they are sent out and will query the complaint response if it does not answer the question, or is not written in plain English.

  Trusts told us that complaints and patient safety incident/serious incident investigations were discussed at regular governance and senior management/ board meetings. Trusts reported a move towards better identification of trends of where things are going wrong. Trusts reported that senior management gave complaints priority. Trusts also told us that governance and/or auditing of any changes that were implemented is an area that needs improvement.

[5] A methodology in which steps are taken to identify, and tackle, the root causes of any errors or failings identified as the result of an investigation, in seeking to prevent them from recurring.

- **Communication**

  Trusts reported that since the *Duty of Candour* requirements came out in November 2014 they inform patients more reliably about patient safety incidents. Trusts all reported that they have improved how they respond to complaints, and are aiming to give complainants clearer explanations of what happened and why. Trusts also reported that they explained, in their responses, what improvements had been put in place as a consequence of the complaint. Some trusts reported that local resolution meetings with complainants helped communication, and others said that written responses worked well.

- **Implementation and learning**

  The majority of trusts said that the investigator was responsible for drawing up action plans for learning from a complaint. Usually the heads of division will sign off an action plan once the investigator has drawn it up. Trusts told us that not all investigations (even upheld ones) resulted in an action plan.

  Trusts also told us that an area they needed to work on was sharing with staff what had been learned from complaints and investigations. They said that patient safety incidents and investigations were discussed at high level governance meetings, and that learning was cascaded down through matrons to ward staff. However, there was inconsistency in how this translated into changes in delivering clinical care.

  Trusts also said that monitoring and auditing any changes was an area that needed improving, and there did not appear to be any robust processes in place to make sure this happened. Trusts said that the culture around learning from complaints and patient safety incidents needs to improve. Trusts also told us that it is difficult to achieve cross-divisional or trust-wide learning, as currently divisions appear to work as isolated units.

- **Serious incidents**

  Trusts did not have a consistent process to identify a serious incident. They told us that, often, these had not been reported before a complaint was raised. They also told us that clinicians in some trusts use their experience to 'spot' serious incidents, whereas other trusts had a central risk team that flagged serious incidents.

  It is more likely that serious incidents are investigated by a trained RCA investigator who will use an RCA investigation template, but this is not guaranteed. Again there is no set process to investigate these complaints. Some trusts follow the same approach for patient safety incidents and serious incidents, and others do not.

- **Barriers**

  Trusts told us that the barriers they face are:

  - Difficulty getting access to clinical records;
  - Problems contacting staff who have moved;
  - The use of temporary staff, which makes it harder to identify and track people;
  - The challenging pace and scale of work;
  - Poor interpretation of the available evidence;
  - Lack of a system for learning from complaints;
  - Lack of a culture of openness; and
  - A culture where doctors who do not accept it when complaints staff and investigators challenge them about their statements or reviews.

- **Areas for improvement**

  Trust staff suggested these areas for improvement:

  - Create a check list for complaints team to help them identify if a complaint should be reported as a serious incident..
  - Train complaints staff in investigation skills.
  - Standardise processes for investigating patient safety incidents that do not meet the serious incident criteria, and use of an RCA template, irrespective of whether the issue was raised by a health professional or as a complaint.
  - Better collaboration across the divisions when investigating and learning from patient safety incidents and complaints.
  - Better ownership and dissemination of learning and action.
  - More resources, including appropriately trained staff.
  - Better consistency and quality of investigation reports.
  - Better and more consistent monitoring of the effectiveness of action plans/change.
  - More thorough, but not unnecessarily cumbersome, quality assurance processes.
  - Senior acceptance of changing culture in respect of openness.
  - Buddying system with different trusts for clinical reviews.
  - Cross trust learning methods such as the National Patient Safety Agency (NPSA) or Medicines and Healthcare Products Regulatory Agency (MHRA)[6] alerts could help share learning across the country.
  - Creation of a pool of national clinical advisers to review cases.
  - More consistent national guidelines (we were told that the new serious incident guidelines are cumbersome).

[6] The MHRA regulates medicines, medical devices and bloods for transfusions in the UK.

Annex E: Advisory group - summary

Introduction

In June 2015 we held a meeting with an advisory group to discuss our findings, how what we had found resonates with their experience, and how our work fits into the wider landscape. The advisory group was made up of organisations and individuals with a special interest in complaints investigations, patient safety incidents and serious incidents. The advisory group comprised Peter Walsh (Action Against Medical Accidents), Chloe Peacock (Healthwatch), Brian Toft (Coventry University), Denis Wilkins (CORESS), Donna Forsyth (NHS England), Nikki Pitt (Department of Health), Maria Dineen (Consequence UK), Carol Brennan (Queen Margaret University), Paula Mansell (Care Quality Commission) and Umesh Prabhu (Wrightington, Wigan and Leigh NHS Foundation Trust). Paula Mansell and Umesh Prabhu were unable to attend the advisory group meeting and therefore we met with them separately to capture their views. All members of the advisory group said that our evidence resonated with their experience.

Key areas

At the advisory group discussions, we identified key areas for improvement: those most in need of change; and those areas which, if changed, would have most impact on improving investigations. We also identified that culture and leadership are crucial to improving the following areas:

- **Staff**

  The advisory group considered that it would be useful for investigators to have a skills and competency framework.

  Skills that were seen as important to such a framework include:

  - Facilitation;
  - Analytical;
  - Project and multi-project management;
  - Time management;
  - Interviewing;
  - Research, including content mapping[7] and affinity mapping[8];
  - Active oral and written communication, which is empathetic and non-judgemental.

  The advisory group also considered that investigators should have enough seniority to carry things through, and have a sound knowledge of a range of investigation and human factors[9] methodologies.

  The group felt that training for investigators should be accredited, and those that provided the training should be able to show evidence of competency and compliance with national requirements in their training packages.

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[7] A tool used to map content to the needs of service users or the organisational goals.

[8] A tool used to group information and ideas together according to them having a shared relationship.

[9] The process of understanding what factors will affect how people think, behave and act.

In addition, they felt that a senior level champion (a named person) in each trust, for example, a head of profession, at board level could oversee the training of staff conducting investigations.

The advisory group suggested that a buddying, leadership and mentorship pool within and across clinical care group communities could be developed to aid training and share experience.

- **Consistent process**

  The advisory group felt that the patient and family that had made the complaint should be involved at every stage to manage expectations and to provide information for the investigation. They also felt that the patient and/or family should be able to have access to a source of independent advice and support.

  They said that consideration should be given to standardising the investigation process across the NHS. This may include alignment of complaints investigations into patient safety incidents and serious incidents investigations, so that all investigations are subject to the same process, albeit the size, complexity and terms of reference of the investigation could change. For this to happen, the advisory group said that the complaints team and governance may need to sit and work together.

  The advisory group noted that the NPSA had developed an investigation template, but this is not used routinely. It was hoped that the new clinical incident investigation unit (IPSIS) would consider how to make sure that a template is used consistently. This may include considering how any template would match the skills and/or competencies of investigators, so that staff have the knowledge to use the template.

  The advisory group also considered that commissioners could be involved in ensuring independence in the investigations process. Clinical commissioning groups, or a group of trusts, could develop a pool of investigators who can share resources and reciprocate help by giving independent views. Equally a group of people who would challenge the investigation process could be set up.

- **Learning and monitoring**

  The advisory group agreed that the term 'learning' needed to be clearly defined.

  The theory of the use of legislation versus education to spread what is learned from complaints across the NHS was discussed. That is, do trusts need someone external to the system to motivate and make changes happen (for example, legislation and/or policy changes backed up by penalties for non-compliance), or whether training, empowering staff, and making changes to the culture would result in change.

The group felt that the possible blocks to improving learning from complaints (both across and within trusts) were:

- 160+ trusts all approach this differently and they do not always talk to each other;
- Limitations on resources, although it was felt that a potential solution to this would be to involve the third (charitable) sector;
- They felt that there have been opportunities to build a more collaborative culture and it may not have happened because:
  - People are not always willing to share (in order to prevent bad press or the need to be the best independently);
  - There was a risk to organisations' reputations;
  - People do not want to relinquish control;
  - People work in isolated groups;
  - There tends to be a coalition of the willing - those who would naturally engage with this do, and the remainder do not.

The advisory group considered leadership to be the key to a supportive learning environment by:

- Using a public forum to discuss patient safety incidents where staff can make public pledges;
- Involving staff in finding solutions;
- Working together;
- Listening to staff at all levels; and
- Encouraging staff at all levels to speak up, and bring down the hierarchy.

Many of the advisory group members thought that the solution, therefore, was to use the benefits of both legislation and encouraging collaboration and partnership. Together these methods may result in:

- Empowerment of clinical teams;
- Legislation and accountability as the backstop if individuals or organisations are unwilling to learn; and
- Harnessing good practice and inviting people to tell and/or share their stories.

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MEETING OF THE GOVERNING BODY
January 2016

Agenda Item: 16/10	**Author of the Paper:** Fiona Taylor Chief Officer Email: fiona.taylor@southseftonccg.nhs.uk Tel: 0151 247 7061
Report date: January 2016	

Title: Liverpool City Region (LCR) NHS CCG Alliance Terms of Reference

Summary/Key Issues:

This report provides the Governing Body with the Terms of Reference for the newly formed Committee in Common, LCR NHS CCG Alliance, formerly the Merseyside CCG Network.

Recommendation

The Governing Body is asked to approve the terms of reference.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	To place clinical leadership at the heart of localities to drive transformational change.
x	To develop the integration agenda across health and social care.
x	To consolidate the Estates Plan and develop one new project for March 2016.
x	To publish plans for community services and commission for March 2016.
x	To commission new care pathways for mental health.
x	To achieve Phase 1 of Primary Care transformation.
x	To achieve financial duties and commission high quality care.

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

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

Liverpool City Region (LCR) NHS Clinical Commissioning Group Alliance (Committee in Common)

Terms of Reference

1. Purpose of the Alliance

1.1 The Committee in Common, referred to from here as the Alliance will be the formal vehicle for the LCR NHS CCGs to:

- Oversee co-commissioning of specialised services with NHS England;
- Oversee collaborative commissioning across other agreed areas;
- Be the responsible body of NHS commissioners for discussions regarding devolution;
- Oversee the production of a sustainability and transformation plan (STP) for health services across the Liverpool City Region (LCR) footprint;
- Oversee plans for re-configuration of hospital services (including mental health services) across LCR.

1.2 The purpose of the Alliance detailed above will be set out in an indicative annual work plan which will be signed off by each full member CCG's Governing Body.

1.3 The Alliance will make decisions on areas of work agreed in the workplan and other areas as required from time to time in line with the individual CCG's schemes of delegation.

2. Membership

- NHS Halton Clinical Commissioning Group
- NHS Knowsley Clinical Commissioning Group
- NHS Liverpool Clinical Commissioning Group
- NHS Southport and Formby Clinical Commissioning Group
- NHS South Sefton Clinical Commissioning Group
- NHS St Helens Clinical Commissioning Group
- NHS Wirral Clinical Commissioning Group

2.1 Attendees from each CCG will be the Chief Officer, Chair and Chief Finance Officer.

2.2 A nominated deputy in line with the relevant CCG's scheme of delegation is permitted, however, this person should be named in advance of the meeting.

2.3 Associate members:

- NHS West Lancashire CCG
- NHS Warrington CCG
- NHS West Cheshire CCG

2.4 Representatives from other organisations will be co-opted/invited to attend in line with agenda items, eg NHS England Specialised Commissioning representative.

3. Accountability and Reporting

3.1 The Alliance is a committee of each full member CCG and reports to each Governing Body.

3.2 Ratified minutes from the Alliance meetings will be submitted to each Governing Body for receipt.

4. Administration

4.1 Responsibility for chairing the Alliance will rotate between the 7 full CCG members on a six monthly basis.

4.2 Dedicated administrative support will be identified to support the work of the Alliance.

4.3 Managerial leadership and support will be identified for key areas of the work programme.

5. Quorum

5.1 The Alliance will be quorate if all full member CCGs are represented.

6. Voting arrangements

6.1 Each CCG forming part of the full membership will have one vote.

6.2 A minimum of 5 CCGs in agreement is required for a decision to be carried.

6.3 Associate CCG's or colleagues in attendance do not have a vote.

7. Frequency and Notice of Meetings

7.1 The Alliance will meet at least 10 times during the financial year, additional meetings may be called by the Chair of the Alliance as and when required.

7.2 Members shall be notified at least 10 days in advance that a meeting is due to take place. Exceptionally the Chair may call an urgent meeting with notice of 2 working days.

7.3 Agendas and reports shall be distributed to members 5 working days in advance of the meeting date, except in the case of urgent meetings above where supporting papers will be provided when it is called.

8. Conduct

8.1 All members are required to make open and honest declarations of interest at the commencement of each meeting or to notify the Committee Chair of any actual, potential or perceived conflict in advance of the meeting.

8.2 All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

8.3 The Alliance will:

a) Comply with the principles of good governance;
b) Operate in accordance with each CCG's scheme of reservation and delegation;
c) Comply with each CCG's standing orders;
d) Operate in accordance with these terms of reference;
e) Comply with all relevant statutory and regulatory requirements.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2016

Agenda Item: 16/11	**Author of the Paper:** Dwayne Johnson Director Social Care and Health Email: dwayne.johnson@sefton.gov.uk Tel: 0151 934 3333
Report date: January 2016	

Title: Children & Young People's Plan (CYPP)

Summary/Key Issues:

To seek views and agreement to the content and layout of the draft Children & Young People's Plan for Sefton.

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
	To place clinical leadership at the heart of localities to drive transformational change.
x	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
x	To publish plans for community services and commission for March 2016.
x	To commission new care pathways for mental health.
x	To achieve Phase 1 of Primary Care transformation.
	To achieve financial duties and commission high quality care.

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

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

Report to Governing Body
January 2016

1. Executive Summary

Members and officers of the South Sefton Clinical Commissioning Group are asked to receive and comment on the draft Children & Young People's Plan for Sefton. This plan has been written in partnership and can be used to support service commissioning and delivery.

2. Introduction and Background

2.1 Under the Children's Act 2004 the statutory responsibility for the production of a Children & Young People's Plan for the borough was transferred from the Council's Children's Services to the Children's Trust Board. In November 2013 the Early Life Forum of the Health & Wellbeing Board was delegated powers to discharge the Children's Trust arrangements and facilitated the production of the draft Children and Young People's Plan. This is attached for consideration by members of Overview and Scrutiny for Children's Services and Safeguarding.

2.2 A small Task and Finish Group, led by the Director of Children's Services reporting to the Early Life Forum, developed the draft Plan. This Task and Finish group was made up of members from various organisations and service areas including Schools and Families, Children's Social Care, Early Years, Sefton CVS (Every Child Matters Forum), Strategic Support, Public Health and Sefton's two CCG's. Young People attended the early Life Forum to give feedback and input into the draft Plan and a group of Young People youth proofed the plan as well as producing a series of poster and animation to represent the plan.

2.3 In agreeing to the development of the Plan, the Early Life Forum were keen that it should be an overarching five year plan to be used by officers and wider partners in designing and delivering services for children and young people to ensure they had the best possible start in life. The plan outlines the ambitions for children, young people and families in the borough, setting it in both within a strategic and demographic context. The Forum agreed that the Plan should be available in both Youth friendly and accessible versions which will be published when the plan is finalised.

2.4 The Plan defines the following four key priority areas which underpin the achievement of the priority, "Ensure all children have a positive start in life" in the Health & Wellbeing Strategy:

- Ensure all children and young people have a positive educational experience;
- Ensure all children are supported to have a healthy start in life and healthy adulthood;
- Improving the quality of lives of children and young people with additional needs and vulnerabilities, to ensure they are safe and fulfil their individual potential;
- Ensure positive emotional health and wellbeing of children and young people is achieved.

2.5 Production of the Children and Young People Plan - A multi-agency working group designed a consultation to gather the views of people caring for or working with children and young people in Sefton as well as young people themselves. This was done via a World Café style event in Formby PDC, which was attended by Young Advisors, parent carer reps, teacher's, social workers and other practitioners from a range of statutory and voluntary organisations. The aim of the event was to better understand how their needs were being met, what gaps they have encountered and their views on improving services across Sefton.

2.6 The Sefton Young Advisors were commissioned to produce as series of age appropriate posters and an animated video clip for children and young people that could be used to promote the content of the plan and what it means for children and young people in Sefton.

2.7 Next Steps

Officers are asked to

- Consider the draft and make recommendations for modifications to content and or layout;
- Recommend Cabinet and Council approval of the draft plan with required modifications;
- Endorse the launch of the Children & Young People's age-appropriate posters and animation to promote the content of the plan through schools, youth centres and other locations across the borough that deliver services to young people;
- Receive annual updates from key officers with responsibility for the delivery of the action plan;
- Endorse the creation of a Young Peoples reference group to work with the Cabinet member for Children, Schools and Safeguarding and the Director Social Care and Health to help monitor and evaluate the delivery of the plan.

3. Key Issues

Views are sought from members of Governing Body on the following:

- Does the plan look and feel about right?
- Are the priorities the right things?
- Do members feel that a short pictorial summary should be produced?
- How do members want to be involved in the delivery plan?

4. Conclusions

The draft Children and Young Peoples Plan is centred on improving outcomes for children and young people and families across the borough. The partners of the plan will work towards actions that promote early intervention and prevention to improve the health and life chances of all children regardless of their background.

5. Recommendations

5.1. Note the content of the report and make recommendations for modifications;
5.2. Receive further updates on the work to implement the Children & Young People Plan in Sefton.

Appendices

Appendix 1 – Draft Children and Young People's Plan

Nicola Beattie
January 2016

Sefton Children & Young People's Plan 2015 – 2020

Sefton Council

Table of Contents

Foreword

Welcome to the 2015-2017 Children and Young People's Plan for Sefton.

The children and Young People's Plan (CYPP) is the single strategic 5 year plan for all services and organisations which work with children and families in Sefton.

At a time of significant reduction in public spend it is important to ensure that resources are targeted to where they will have the greatest positive impact on the lives of our children and young people. The priorities outlined in this Plan sit within the wider determinants of health and wellbeing, as outlined in its 2014-2020 Strategy, and are informed by Sefton's Strategic Needs Assessment.

The Plan is broken into four major themes, reflecting the priorities of the Health and Wellbeing Early Life (0-25) Forum. They are:

- Ensure all children and young people have a positive educational experience
- Ensure all children are supported to have a healthy start in life and a healthy adulthood
- Improving the quality of lives of children and young people with additional needs and vulnerabilities, to ensure they are safe and fulfil their individual potential.
- Ensure positive emotional health and wellbeing of children and young people is achieved

These will work towards the overall aim to "Ensure all children have a positive start in life and are safe"

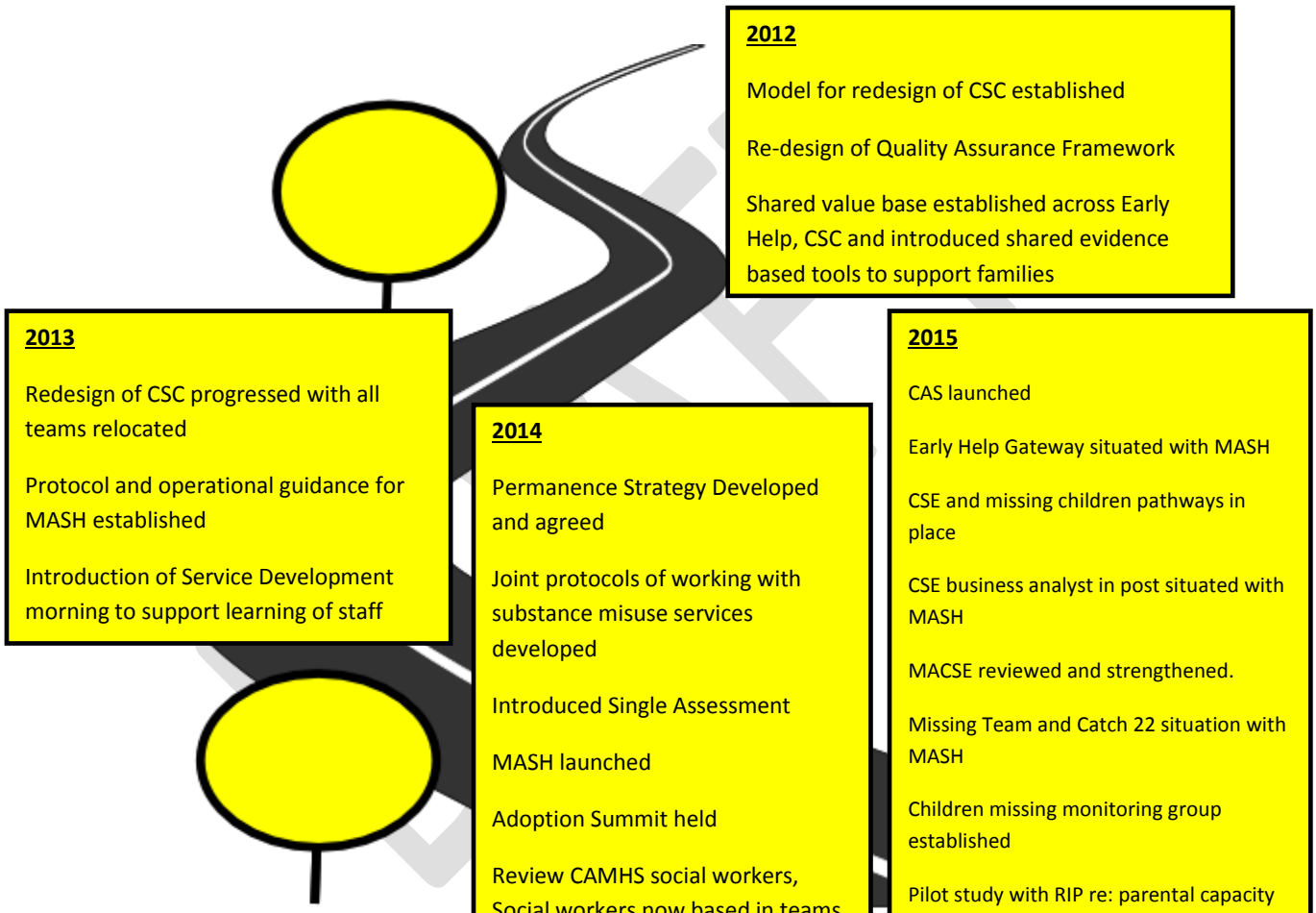
Councillor John J. Kelly
Cabinet Member - Children, Schools & Safeguarding

Director of Social Care & Health

Nigel Bellamy
Deputy Chief Executive, Sefton CVS & Chair of 0-25 Forum

The Journey so Far

In Sefton we are proud of the achievements we have made in recent times for our Children & Young People, some of these successes include.



2012

Model for redesign of CSC established

Re-design of Quality Assurance Framework

Shared value base established across Early Help, CSC and introduced shared evidence based tools to support families

2013

Redesign of CSC progressed with all teams relocated

Protocol and operational guidance for MASH established

Introduction of Service Development morning to support learning of staff

2014

Permanence Strategy Developed and agreed

Joint protocols of working with substance misuse services developed

Introduced Single Assessment

MASH launched

Adoption Summit held

Review CAMHS social workers, Social workers now based in teams

Legal Gateway reviewed and PLO process strengthened

Advanced Practitioners for each service in post

Referrals regarding vulnerable pregnant women taken at earlier stage in pregnancy to prevent risk of escalation of concerns.

2015

CAS launched

Early Help Gateway situated with MASH

CSE and missing children pathways in place

CSE business analyst in post situated with MASH

MACSE reviewed and strengthened.

Missing Team and Catch 22 situation with MASH

Children missing monitoring group established

Pilot study with RIP re: parental capacity to change implemented

High Risk pre-birth assessment introduced.

Changes to ICS implemented to support workers recording and performance management

EHM launched

Care leavers centre operational

Plans to robustly challenge care orders at home put in place

9 additional social work posts established

Positive messages

What it's like to live in Sefton

Sefton is an area that stretches from Southport in the North to Bootle in the South. To the east lies the town of Maghull and the west is bordered by an award winning coastline covering Crosby through to Formby and Ainsdale. There are a lot of things that make life good for people but it is not so good for others. The health and wellbeing of everyone is important to Sefton's Health and Wellbeing Board.

People enjoy living in Sefton with **80%** of Sefton residents saying that they are either **very or fairly satisfied** with their local area as a place to live

Our young people **achieve well** in school

Crime rates are either **equal to or lower than** the average for our neighbouring authorities in the Liverpool City Region

There is a **good quality coast line and green spaces** which residents and visitors enjoy.

Sefton's Population

Sefton's **overall population** has **reduced** between 2001 and 2011

Sefton's Strategic Needs Assessment includes official government population projections (Office of National Statistics), which indicates that Sefton's population will **increase by 1%** by **2021**, with the most **significant increase** occurring amongst the **over 65 population**. However, ONS guidance states that projections are uncertain and become increasingly so the further they are carried forward

There are **less people in employment** and a **significant increase in youth unemployment;**

There are areas of the borough where people and families are **in poverty and this leads to poorer health and wellbeing**

The Council currently spends over **£90 million on acute services for older people**, and the NHS spends **£15.2 million a year on routine and emergency surgery for older citizens** in the borough.

The Council spends a further **£33 million on children's social care.**

These present significant challenges to commissioners.

What life is like for Children and Young People living in Sefton?

The number of **children and young people** living in Sefton (0-25 year olds) is **62,100** a **fall of 14%** (9,990) since 2001. Sefton is a **good place for** children and young people to **live and grow up**. Most receive their **immunisations**, with rates being close to - or above - the national average;

On the whole our children and **young people achieve in school**. However, there are still **some that do not reach their full potential** which impacts on their ability to go into further education, training and to get a job.

The **health** of children and young people is **generally improving** and they have access to a **wide range of physical activity opportunities.**

Almost 20% of our children are obese when they leave primary school at **11 years**.

The number of **hospital admissions related to alcohol use in under 18's is also higher (though declining) than the England average** and **childhood smoking rates are average**

There are **fewer teenage mothers** in the borough than in previous years

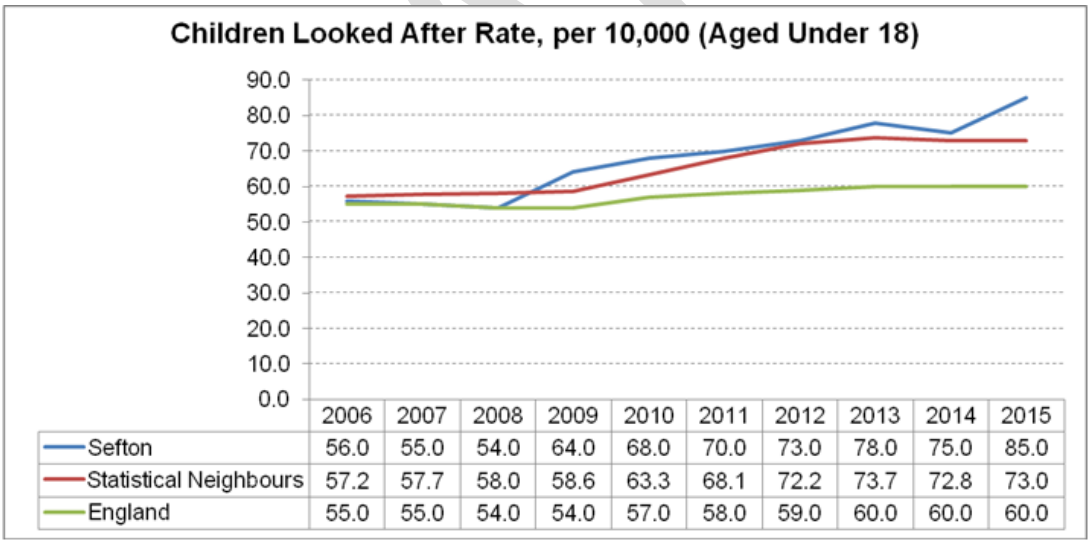
Whilst the **total number of births** in Sefton **is not rising**, there has been an increase in the **number of babies born to non British born women.** These mothers may need additional support to access maternity and other health services

Sefton mothers are **more likely** to **smoke during pregnancy** and **less likely to breastfeed their baby at 6 weeks**

Some of our children and young people **cannot live with their parents or families**; they live with **Foster Carers**, in **children's homes** or are **adopted**. These children and young people are **more likely to experience poor life chances**

As of November 2015 there are 454 looked after children (LCS)

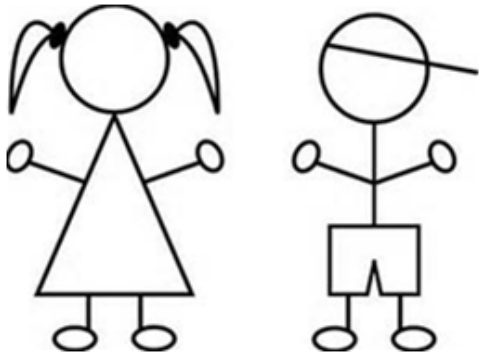
Most recently available Comparison data shows that At March 2015 there were 85 looked after children per 10,000 population in Sefton, compared with 73 for our statistical neighbours and 60 for all England (https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2014-to-2015)



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Sefton	56.0	55.0	54.0	64.0	68.0	70.0	73.0	78.0	75.0	85.0
Statistical Neighbours	57.2	57.7	58.0	58.6	63.3	68.1	72.2	73.7	72.8	73.0
England	55.0	55.0	54.0	54.0	57.0	58.0	59.0	60.0	60.0	60.0

If Sefton had 100 Children (0-18years inc), as they grow up……..

19 will live in poverty
6 will be low birth weight babies (below 2500g)
66 will be achieving good development in Early Years Foundation Stage One
76 will achieved Yr1 Phonics
93 will make expected progress in Primary school in Reading
94 will make expected progress Primary school in Writing
93 will make expected progress Primary school in Maths
58 will achieve A*-C GCSE's including English & Maths
25 will be overweight / obese in reception
35 will be overweight / obese by Year 6
16 will be eligible for free school meals
5 will be persistently absent from secondary school
13 will live in lone parent families



If Sefton's Constituencies had 100 Children (0-18inc), as they grow up.....

Southport Constituency

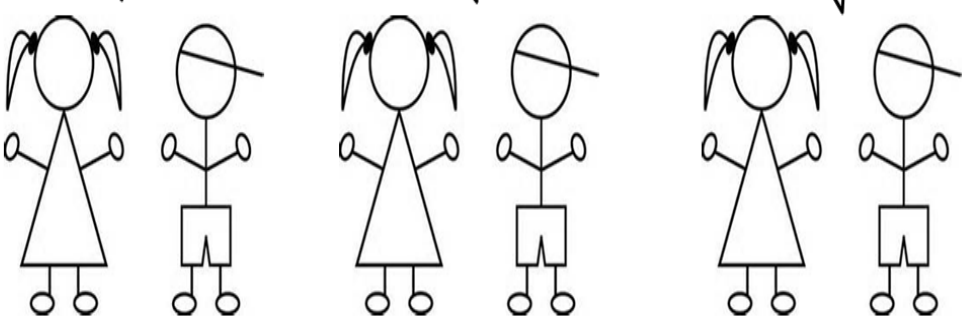
15 will live in poverty
7 will be low birth weight babies (below 2500g)
93 will make expected progress at Primary school
58 will achieve A*-C GCSE's including English & Maths
22 will be overweight / obese in reception
36 will be overweight / obese by Year 6
13 will be eligible for free school meals
8 will be persistently absent from secondary school
19 will live in lone parent families

Central Constituency

9 will live in poverty
6 will be low birth weight babies (below 2500g)
96 will make expected progress in Primary school
58 will achieve A*-C GCSE's including English & Maths
23 will be overweight / obese in reception
31 will be overweight / obese by Year 6
13 will be eligible for free school meals
7 will be persistently absent from secondary school
15 will live in lone parent families

Bootle Constituency

29 will live in poverty
8 will be low birth weight babies (below 2500g)
92 will make expected progress in Primary school
52 will achieve A*-C GCSE's including English & Maths
28 will be overweight / obese in reception
39 will be overweight / obese by Year 6
28 will be eligible for free school meals
9 will be persistently absent from secondary school
31 will live in lone parent families



Sefton Health & Wellbeing Board

The Health and Wellbeing Board in Sefton was formally established as a Committee of the Council in April 2013, having operated in Shadow form for 12 months.

Membership of the Board

The membership of the Board comes from the range of organisations that have the biggest impact on the health and wellbeing of local people, and those required by Health and Social Care legislation, including Sefton Council, NHS South Sefton Clinical Commissioning Group (CCG), NHS Southport and Formby CCG, Healthwatch and NHS England.

The aim of the Health and Wellbeing Board is to make a real difference to the health and wellbeing of the people of Sefton.

The legislation that established the Board also gave it some specific functions:-

- To prepare a Sefton Strategic Needs Assessment (SSNA) of the health needs of the people of Sefton
- A responsibility and duty to encourage integrated working between organisations that plan and deliver health and social care services for local people
- A power to encourage close working relationships between all partners that plan and provide services that can improve the health and wellbeing of local people.

The Board's role is to

- Encourage integrated working between commissioners of health services, to public health and social care services.
- Encourage those who provide services related to wider affects of health, such as housing, to work closely with the Health and Wellbeing Board.
- Lead on the Sefton Strategic Needs Assessment (SSNA) and Joint Health and Wellbeing Strategy (JHWS) involving users and the public in their development.
- To provide system leadership for change across care, health and wellbeing across a wide range of leaders from not only the Council and the two Clinical Commissioning Groups Governing Bodies, but other public sector organisations such as hospitals and community based health care providers, Merseyside Police, Merseyside Fire and Rescue, Merseyside Probation Service, Schools and Colleges, Merseytravel and housing providers and of course our voluntary community and faith sector groups and organisations.

Health and Wellbeing Board Vision

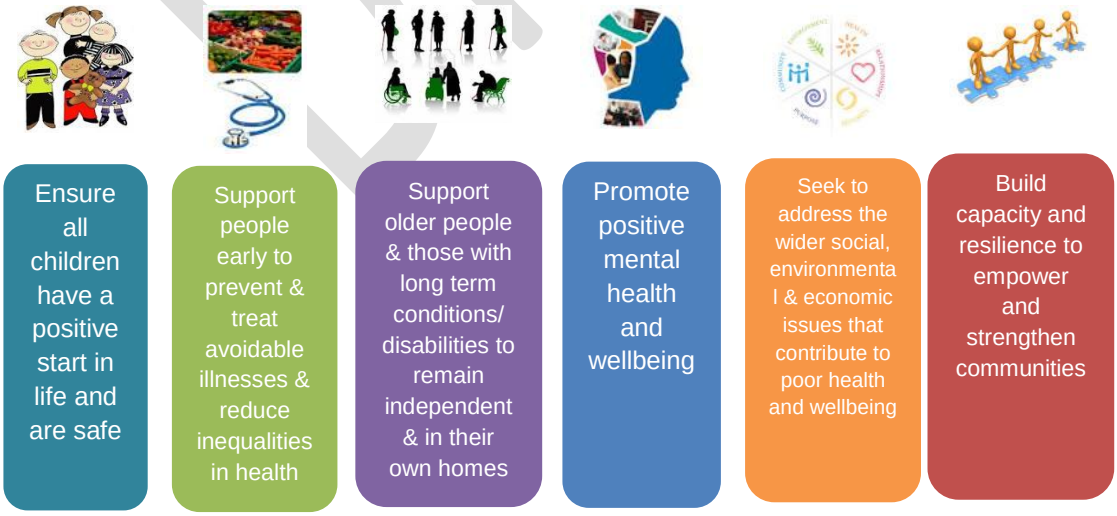
The Vision which the Health and Wellbeing Board has adopted is:

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

Health and Wellbeing Strategic Priorities

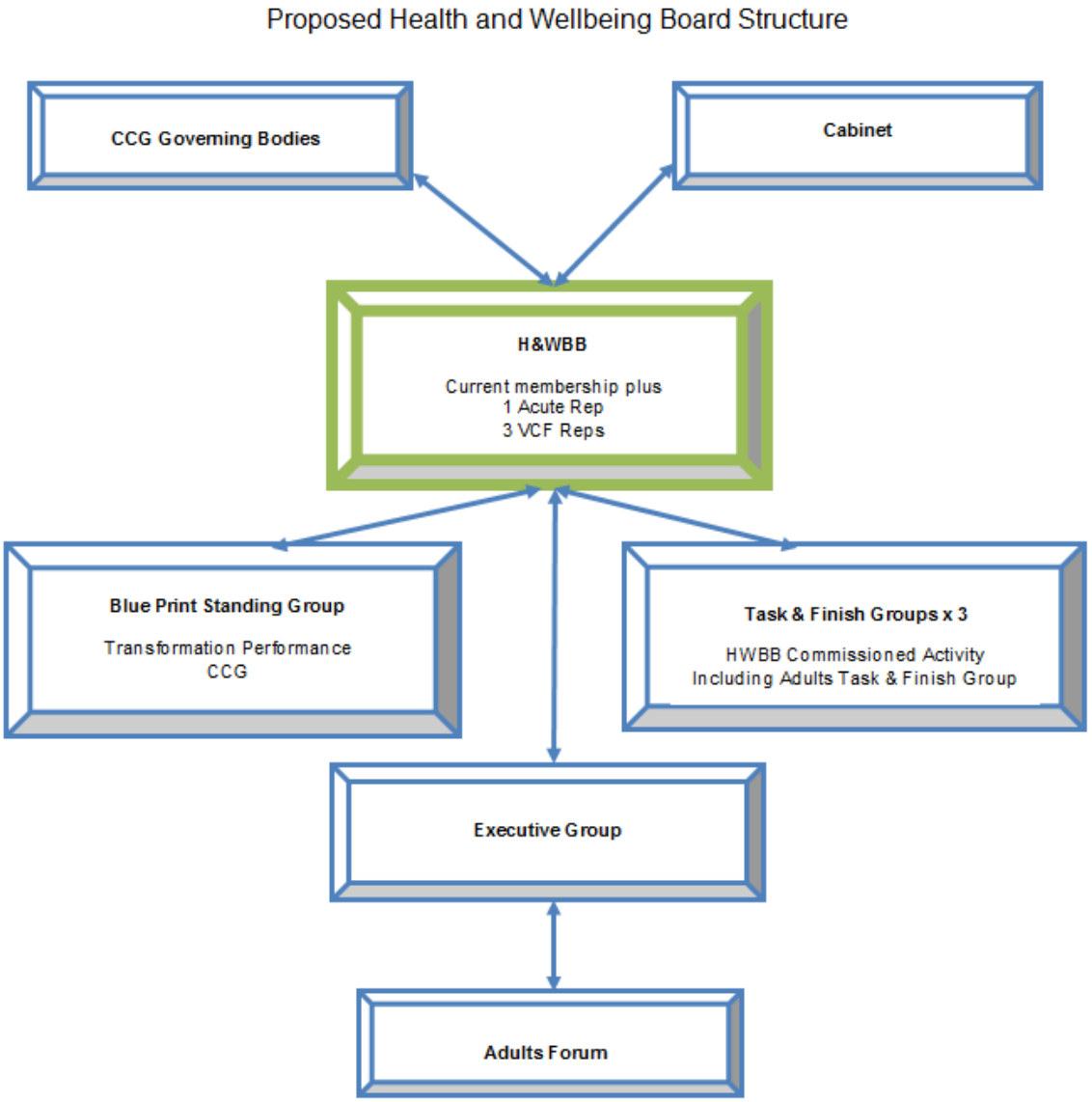
The strategic priorities of the Board have been developed through both understanding the analysis of need and the feedback from our communities, through extensive consultation and engagement. These priorities are for the borough of Sefton, and through partnership working seek to deliver:-

These priorities will be delivered through the following strategic objectives for health and wellbeing in Sefton:-



The Structure of the Health and Wellbeing Board

The Health and Wellbeing Board has a proposed new structure to ensure Sefton has the delivery infrastructure to achieve the best care, health and wellbeing outcomes for people in Sefton, through integrated, collaborative working.



The Health and Wellbeing Board is also proposing that the Children's Trust Arrangements are discharged through the Health and Wellbeing Board as outlined in the attached Memorandum of Understanding to be agreed by Cabinet and Council.

Developing the Children & Young People's Plan

To identify and agree the priorities within this Plan we:

Reviewed our previous Children & Young People's Plan

Collected information from a wide range of partners and analysed the characteristics and needs of children and young people within Sefton, compared to national data and the needs of children and young people from each area of Sefton to identify gaps

Considered national and local priorities and how these affect services for children and young people in Sefton

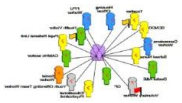
Discussed the information and emerging priorities arising from the Sefton Strategic Needs Analysis 2014.

The Plan has been written in the context of significant pressures on public sector budgets which will continue to impact up to 2017 and beyond. This will require organisations to work in very different ways, focusing on the most vulnerable in an innovative and creative way to promote community resilience and by maximising the use of new technology.

In developing and implementing this Plan, we have focussed on:

Narrowing the gap between children's outcomes via supporting children with additional needs and the most vulnerable;

Helping communities and individuals to help themselves – where we find ways to support people, allowing them to be as independent as possible;



Locality working – where locality approaches are used when they are the best way to make improvements

Priorities for Children and Young People in Sefton

This has resulted in a set of Priorities which will underpin the Vision for the 0-25 Forum as follows:-

Ensure all children and young people have a positive educational experience

Ensure all children are supported to have a healthy start in life and a healthy adulthood

Improving the quality of lives of children and young people with additional needs and vulnerabilities, to ensure they are safe and fulfil their individual potential.

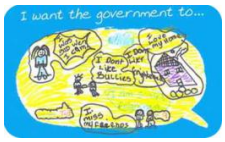
Ensure positive emotional health and wellbeing of children and young people is achieved

These priorities are underpinned by the United Nations Convention of the Rights of a Child (UNCRC) and by a shared commitment to remove barriers to access, participation and achievement, and not tolerating discrimination or abuse.

Principles for delivering the Priorities for Children and Young People in Sefton

In developing this Plan the Forum has agreed a set of principles that will shape the way we work towards delivering the priorities:-

Having a Family approach - utilising Early Intervention and Prevention services help build resilience and strengthen protective factors in the lives of children and young people and their families



Listening to children and young people - giving children and young people opportunities to be engaged in decision-making processes and give them as much influence as possible. This will be crucial to us in improving their future outcomes

Promoting partnership working, joint commissioning and investing in children and young people's futures - Joint commissioning and service delivery will enable partners to provide services which deliver improved children and young people's outcomes

Smoothing the transition between childhood and adulthood

Ensuring services are delivered cost effectively

Priority 1

Ensure all children and young people have a positive educational experience

National context

Through a range of central government reforms, schools now have greater freedom to innovate and raise standards for their children and young people. The most significant reform has been the creation of academies and free schools, which are outside the direct control of local authorities and are formally accountable to the Secretary of State for Education.

A national priority for the new system to address is the fact that in two thirds of local authorities, pupils have a higher chance of attending a good or outstanding primary school than a secondary school.

Regional context

The North West has a rich variety of education provision and expertise, including system leaders in the region who are making an excellent contribution to school improvement in the most disadvantaged areas. Good collaborative networks exist to promote school-to-school support, and local authorities support and challenge each other on their performance and new roles going forward.

In terms of overall school performance and inspection outcomes, children in the region have a greater chance of attending a good or outstanding primary school than their peers nationally. However, this performance is not matched at secondary level, where Ofsted have found too much variation in the quality of secondary school teaching and leadership, and an increase in the number of failing schools.

The proportion of early year's providers who received an outstanding Ofsted judgement is significantly above both local and national averages. A similar pattern emerges when considering early year's providers who are good or outstanding. This reflects the ongoing support and training offered to the sector.

Sefton context

Over the past decade, our children and young people have had access to a wide variety of educational provision. Significant investment and additional funding was sought to create and upgrade schools and other settings across early years providers, children's centres, further education, special educational needs provision, and alternative curriculum provision. The local authority has positively encouraged school autonomy and has delegated higher levels of school funding than that found regionally. The ultimate aim has been to ensure that all Sefton children and young people have a positive educational experience.

With reference to the national and regional context, Sefton schools and settings have built upon their autonomy and have embraced the academisation programme, teaching schools, National

Leaders of Education, and Local Leaders of Education. However, schools are keen to balance school autonomy and school-to-school support with the local authority maintaining a secure enough oversight of school performance and provision – the full expression of this will be set out in a new Education and Skills Strategy.

Education remains a key priority for the local authority, particularly given the fact that inequalities still exist in provision across the borough - at secondary level there is considerable variation in KS4 performance and Ofsted inspection outcomes. The local authority recognises that there are specific parts of the borough where pupils do not have access to a "good" secondary school as judged by Ofsted.

Improvement has been made at KS1 and KS2, which has brought Sefton broadly in line with national averages, but there is obviously further room for improvement.

Sefton Performance

In terms of performance, standards of **Early Years provision** are above national and regional averages

94% of children taking up the **two year old offer** and **90%** of funded **three and four year olds** are in provision rated **good** or **better** by Ofsted

The proportion of children achieving a '**good level of development'** are broadly in line with national averages although a significant gender issue exists, with the proportion of girls achieving a 'good level of development' some 20 points above the boys

Children's Centres offer a wide range of universal and targeted services for under 5 year olds. Currently **80%** of those inspected are **good or better**

Ofsted have found that children are well supported in their early years. 84% of 0-5s attend a good or outstanding setting.

At Key Stage 1, Sefton has made improvement and is now broadly in line with national averages for reading, writing and mathematics at all Levels.

At Key Stage 2, Sefton has made improvement and is now broadly in line with national averages for reading, writing and mathematics at all Level 4 and 5.

The percentage of A*-C (including mathematics and English) is 56% is in line with the national average.

Overall school performance at secondary at secondary level has improved from 55% to 65% but Sefton is still below the national average

Sefton's **post-16 average point score** (APS) per candidate is **below the national average** and above for the APS per entry against figures for statistical and Merseyside neighbours.

Percentage of children attending good or outstanding schools

	North	Central	South
Primary Schools	27%	42%	27%
Secondary Schools	21%	74%	4%
Special Schools	28%	40%	27%

- There are two general FE Colleges, one sixth form college and one LA governed sixth form centre
- Both general FE colleges and the six form centre were graded good at their last inspections
- The sixth form college in Southport is in special measures. This is obviously a cause for concern as residents in the Southport area are seeking good or better A level provision elsewhere, particularly high achieving sixth form colleges in Lancashire. Actions are being taken by the college, supported by the SFA and LA to address the issues but given freedom of choice for young people and parents, this is not an easy task.
- There are 9 schools with sixth forms, mainly serving the middle and north of the borough where there is more affluence and generally higher achievement at KS4. The outcomes are comparable with regional averages in terms of average point's scores at A level, but there is much variance between schools.
- There is a very good range of vocational provision in the borough: two general FE colleges which offer courses at all levels, now including degree courses
- There is a full range of work based learning provision, providing training for Apprenticeships, Traineeships, study programmes and re- engagement programmes
- There is a strong Post 16 participation group which addresses such issues as strengthening provision, gaps in provision, NEET 9 by areas within the borough and performance
- NEET is currently at its lowest level since records began (5.4%) and the "not known" rate is also very low (3.5%) but these figures to some extent mask the regional variances between highest and lowest performing wards (highest NEET is 15%, lowest is 1.6%)
- NEET is disproportionately high amongst vulnerable

groups, particularly Care Leavers and YOT. The connexions service is commissioned to work on behalf of the authority to address these issues in conjunction with LA and non- LA support services.

- There is a strong relationship between the LA and schools/colleges in collecting data, particularly September Guarantee and Activity survey data.

In those schools judged to require i**mprovement** or **failing** at inspection, the local authority has been swift in tackling the issues of underperformance by working closely with the school's leadership and governance, and, in some instances has removed the governing body to create Interim Executive Boards (IEBs) to oversee improvement

33% of young people in north and central Sefton go to university but if the young people live further south in the borough they don't tend to travel far or go to red brick universities.

A new Education and Skills Partnership will be established, which will work closely with the Health and Wellbeing Board to ensure all school improvement priorities are successfully achieved. The Partnership will also oversee the work required to tackle surplus places in the secondary sector and the sufficient number of places required in the primary sector, as well as ensuring the success of our strategies to implement SEN reforms, reduce persistent and overall absence, virtual school, NEET and post-16 progression, and the development of a commercial traded services model for all schools.

Key Priorities

We want to ensure that all Sefton children and young people are equipped with the knowledge, skills, and desire needed to fulfil their true potential. We aim to do this by giving children the very best start in life through good early years provision and support, and then ensure that they progress and achieve high standards at good and outstanding primary schools, secondary schools, and further education provision.

We will do this by:-

1. Ensuring good leadership and governance across all educational settings in Sefton
2. Ensuring that barriers to participation and progress are addressed
3. Ensuring children are ready for school and to move onto the next stage of their lives
4. Ensuring all pupils make at least 'good' progress in every year of their education
5. Ensuring young people leave education with the skills and opportunities to achieve.

Priority 2

Ensure all children are supported to have a healthy start in life and a healthy adulthood

National Context

The Healthy Child Programme (HCP) is the early intervention and prevention public health programme that lies at the heart of universal services for children and families. It is delivered by a range of health, education, early years and social care agencies working in partnership.

The **HCP for 0-5 year olds** aims to:

- Help parents develop a strong bond with children
- Encourage care that keeps children healthy and safe
- Protect children from serious diseases, through screening and immunisation
- Reduce childhood obesity by promoting healthy eating and physical activity
- Encourage mothers to breastfeed
- Identify problems in children's health and development so that they can get help with their problems as early as possible.
- Make sure children are prepared for school

The **HCP for 5-19 year olds** demonstrates how health, education and other partners working together across a range of settings can significantly enhance a child or young person's life chances by supporting children to be healthier, happier and able to take advantage of opportunities that will help them reach their full potential.

From 1st October 2015, the Government intends that Local Authorities take over responsibility for **commissioning public health services for children aged 0-5**. This includes health visiting and Family Nurse Partnership (FNP). In addition, certain elements of the HCP will become mandatory including; Antenatal health promoting visits, new baby review, 6-8 week assessment, 1 year assessment and 2-2 ½ year assessment.

FNP is a dedicated programme offered to first time mothers aged 19 or under. Unlike the regular health visiting service, it begins in early pregnancy; with the Family Nurse offering weekly and fortnightly visits right up until the child is two years old. The aim is to work with young parents, helping them to understand about their pregnancy and how to care for themselves and their baby. FNP will be available in Sefton from early 2015.

The council will be responsible for commissioning core health, education and children's services and will have the opportunity to commission a fully integrated 0-19 HCP.

Regional context

Commissioners in Sefton work closely with neighbouring commissioners and healthcare providers to ensure children and young people receive high quality services and continuity of care regardless of where a child lives or attends school.

- Sefton Council, NHS South Sefton CCG and NHS Southport and Formby CCG are members of the Merseyside Health Visiting Strategic Assurance Board.
- Partners in Sefton are supporting NHS England manage the Sefton FNP Advisory Board that will monitor and oversee the implementation and continued delivery of FNP programme in Sefton.
- Sefton revised the school health service specification in collaboration with Liverpool, Knowsley, St Helens and Halton. The re-commissioned Sefton service went live in October 2014.

Sefton context

The National Public Health Outcome Framework includes a number of indicators that help Local Authorities and their partners gauge whether they are providing a HCP which supports children and young people achieve good health and wellbeing. There are a number of areas where Sefton is performing significantly better than the England average. These include:

2 year vaccinations.

Family homelessness

Child Mortality

However, Sefton falls below the national average on a number of key health outcomes.

Breastfeeding - One in two mothers initiate breastfeeding in Sefton (compared to one in three across the North West and three in every four across England) and rates differ across the Borough (e.g. Harrington 63.8% , Netherton and Orrell, Derby and Linacre at 20% or lower)

The rate of mothers who are partially or fully breastfeeding at 6-8 weeks is around 26-29%, much lower than the national rate of 47%

In Sefton the percentage of **mothers smoking at time of delivery** is 15.6%, which is the lowest of all the Mersey authorities, but still higher than the England figure of 12.0%. The rate is significantly higher for mothers living in South Sefton than North Sefton. (17.1% compared to 12.2%)

Childhood obesity in Sefton is **higher than the national and regional averages** for children in reception year and year 6. Approximately one in ten children entering primary school is obese and by the time they leave primary school one in five are obese.

Sefton's reception obesity rates are **lower than Liverpool** and the year six rate is **lower than all other Merseyside** areas except Wirral.

The reception and year 6 obesity rates are higher than all demographically similar areas.

What are we doing to improve things?

Breastfeeding - The key to successful breastfeeding is the protection, promotion and support of breastfeeding in health and community settings and Midwives, health visitors, breastfeeding peer supporters, healthy living centres and children's centres all have a role to play. The award of UNICEF Baby Friendly Initiative recognised the high standard of breastfeeding knowledge and skilled practice that exists amongst staff and volunteers working with parents in Sefton. We will continue to explore ways of promoting and encouraging breastfeeding

Mothers smoking at time of delivery - Sefton has a specialist service for pregnant and new mothers provided by Sefton's local NHS stop smoking service. 138 Sefton mothers were helped to stop smoking by our specialist services during 2013/14. Everyone who works with parents should encourage smoking cessation including signposting and helping pregnant women access smoking cessation services

Childhood obesity – There are a range of interventions to help families and children chose healthier food and be more active through a whole family approach to support young people to achieve and maintain a healthy weight.

During 2013/14 programmes took place in Sefton schools and leisure centres, with 521 children and 51 parents completing courses (78 % adherence rate) with 100% of participants experiencing positive health gains. We need to explore ways of sustaining such programmes for the most vulnerable families needing support

Key Priorities

We want to ensure that all children and young people in Sefton are healthier and happier and able to take advantage of opportunities that will help them reach their full potential.

We will do this by:-

1. Encouraging care that keeps children healthy and safe.
2. Identifying problems in children's health and development so they can get help with their problems as early as possible
3. Supporting children to be healthier, happier and able to take advantage of opportunities that will help them reach their full potential.

Priority 3

Improving the quality of lives of children and young people with additional needs &vulnerabilities, to ensure they are safe and fulfil their individual potential

National Context

Domestic Abuse

Domestic violence and abuse between parents is the most frequently reported form of trauma for children. In the UK, 24.8% of those aged 18 to 24 reported that they experienced domestic violence and abuse during their childhood and around 3% of those aged under 17 reported exposure to it in the past 12 months. It has an impact on their mental, emotional and psychological health and their social and educational development. It was a feature of family life in 63% of the serious case reviews carried out between 2009 and 2011

Parental Substance Misuse

A recent NSPCC study showed that 198,000 babies in the UK are at high risk because they were born into homes where life was disrupted by domestic abuse, drug and drink addictions and mental distress with 144,000 babies under one living with a parent who has mental health problems.

More than 93,000 babies live with a parent who is a problem drinker and more than 50,000 live with a parent who has used an illegal drug in the past year.

For children raised in such circumstances, the risk of child maltreatment and neglect is substantially higher than in ordinary homes.

Neglect

Nationally neglect is the most common factor for children to be subject to a child protection plan.

In the most recent NPSCC prevalence study 9.8% of the 2,275 11 – 17 year olds surveyed had experienced severe emotional neglect or lack of physical care or supervision

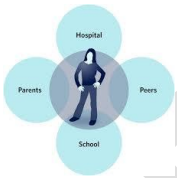
Disability

Disabled children are at risk of being disproportionately disadvantaged by systems that do not integrate care well at the point of delivery in particular how support is organised and eligibility. There are at least six distinct systems that impact on the lives of disabled children and their families:

- healthcare,
- benefits,
- tax and tax credits,
- education and schooling,
- children's social care,
- Adult's social care.

The new Special Educational Needs and Disability Code of Practice will play a vital role in underpinning the major reform programme for children and young people. Their special educational needs and disabilities will be picked up at the earliest point with support routinely put in place, and their parents will know what services they can reasonably expect to be provided. Children and young people and their parents or carers will be fully involved in decisions about their support and what they want to achieve. Importantly, the aspirations for children and young people will be raised through an increased focus on life outcomes, including employment and greater independence.

Vulnerable Adolescents



Adolescents in and on the edge of care have complex needs and face a wide range of risk factors including alienation from families, exiting mainstream education and not achieving their academic potential, homelessness, drug and alcohol misuse, domestic abuse in the home, child sexual exploitation ,gun and gang crime involvement and entry into the criminal justice system.

They are often in need of support from and in contact with a wide range of different agencies but the demarcation of services and responsibilities across public service providers currently prevents a shared and consistent approach to doing the right thing at the right time. Young people find themselves referred from service to service, subject to multiple plans, and having to tell their story to a queue of changing professionals and maintaining effective and meaningful relationship s with professionals is difficult.

Child Sexual Exploitation

In addition to the focus on partnership working within *Call to End Violence against Women and Girls*, a number of other strategic documents reflect the importance of multi-agency working and information sharing. For example, an action plan developed by the Sexual Violence Against Children and Vulnerable People (SVACV) National Group acknowledges the need for multi-agency responses from partners who are addressing issues which are closely linked to the sexual exploitation of children such as missing children, gangs and human trafficking. It also highlights the importance of partnering with local safeguarding children boards in delivering this joined up agenda

Pre-birth to 5

Numerous indicators highlight the substantial differences in early childhood experiences across children that affect their initial development. Such factors include, for example, the nature of early relationships with parents and other caregivers, the extent of cognitive stimulation, and access to adequate nutrition, health care, and other resources such as a safe home and neighbourhood environment.

Poverty affects a sizable share of young children in the UK; the number living in low income households in the UK reached 3.9 million in 2008/09. Such neighbourhoods offer limited opportunities in terms of resources important for early child development, including health facilities, parks and playgrounds. Preventative health care does not reach all parents and young children, which disadvantages those children who miss out on opportunities for health and developmental screenings, through which parental behaviours are also encouraged, to promote healthy child development

Regional Context

Domestic Abuse

Regional approaches will have increasing relevance for the delivery of domestic abuse and violence against women services, as Merseyside's Police and Crime Commissioner is set to have increased responsibility for commissioning victim services. This will include making the criminal justice service more responsive and easier to navigate for victims and witnesses. The Criminal Justice Board's *Reducing Domestic Violence and Abuse: Merseyside Partnership Strategy (2013)* is a pan-Merseyside approach to tackling domestic abuse.

Sefton Context

Keeping children safe

Keeping children safe in Sefton is a key priority for the 0-25 Forum. To avoid duplication we will work with a range of partnerships to ensure children living within families experiencing a range of needs are also supported. Working closely with Sefton Local Safeguarding Children Board (LSCB) we will ensure that children, young people and their families are provided with support as early as possible to reduce abuse, neglect and exploitation. The Forum will also support the LSCB in implementing the LSCB Neglect Strategy and Sefton's Child Sexual Exploitation PAN Mersey Strategy Implementation Plan.

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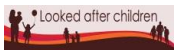
Domestic Abuse

Sefton's Domestic and sexual violence framework 2014 seeks to coordinate and enable key partnerships in relation to domestic abuse. A Domestic Abuse Public Health Needs Assessment has been carried out in 2014 and is forming the basis of a Domestic Abuse Strategy. The Forum will develop strong links with the Safer Stronger Communities Partnership to ensure the Domestic Abuse Strategy has a focus on safeguarding children living within households experiencing domestic abuse.

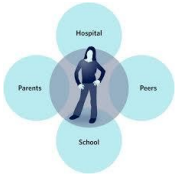


Looked After Children

With regard to children in care and leaving care we will work with the Corporate Parenting Board to ensure the Childs Permanence Policy is effectively implemented. The focus of permanency planning is to ensure children are assisted to achieve attachment to a permanent and stable care giver. Sefton Council is working with partners in the region to strengthen the recruitment of both foster carers and adopters This will ensure that there are increasing numbers of high quality permanent placements for our children. Sefton is also part of an initiative to improve the quality of accommodation for our care leavers through an updated regional framework.

Disability

Locally partners across education, Early Intervention & Prevention, health, social care (adults and children) have worked with parents to prepare for the new arrangements, to jointly plan and commission services for children and young people who have special educational needs or are disabled. Those with more complex needs will have an integrated assessment and where appropriate a single education, health and care plan for their support.



Vulnerable Adolescents

Sefton Council, in partnership with CCGs in Sefton, Merseyside Probation and Merseyside Police has secured a Department for Education Innovation grant to pilot a range of interventions and ways of working with young people and the adults who make teenagers more vulnerable.

Missing Children

There are approximately 100 individual children reported missing each quarter in Sefton and about 250-300 missing episodes, between 33% and 50% of those reported would be children who go missing from care.

Pre-birth to 5

Sefton has developed a school readiness framework with its partners in schools and health. The school readiness framework focussing on three broad strands of - Child Ready, Family Ready and School Ready with five high priority areas for consideration – understanding the language of school readiness, sustainability of leadership, progress and accountability**,** variability within and between settings and quality of teaching and learning

PREVENT and CHANNEL

The PREVENT Duty Guidance (under the Counter-Terrorism and Security Act 2015) came into force on 1st July 2015. The Guidance places a duty on schools, and child care providers, to "have due regard to the need to prevent people from being drawn into terrorism".

Work with schools, governing bodies, colleges and child care providers has been the priority area of focus over the last quarter. Merseyside Police Special Branch have delivered workshops raising awareness in relation to PREVENT. The target audience has included; head teachers, senior leaders, safeguarding leads, Chairs of Governors and early year and child care providers.

The PREVENT Duty to address radicalisation is included in the content of centrally delivered safeguarding training for Designated Leads and Designated Governors.

CHANNEL is about early intervention, to protect and divert people away from the risk they face and to safeguard children and adults from being drawn into committing terrorist-related activity before illegality occurs. This also includes extremist's views that present risk in the community. It will assess the nature and extent of that risk and develop the most appropriate support plan for the individuals concerned. All schools and further education institutions in Sefton understand the referral route for vulnerable individuals to receive support through the CHANNEL process.

Sefton Council and the LSCB have set up a website featuring resources for schools, colleges and child care providers.

Female Genital Mutilation

has been carried out for centuries and directly causes serious short and long term medical and psychological complications. Consequently it is considered to be a physically abusive act against female children and also adult females who come under the Care Act 2014 definition of an Adult at Risk.

To prevent FGM in the future, agencies need to work closer with communities that practice FGM and foster stronger links so together we are able to break the taboo and silence surrounding the harmful practise of FGM.

The Serious Crime Act 2015 introduced a new duty on teachers, social workers and healthcare professionals to report to the police known cases of female genital mutilation involving victims aged under 18. This duty came into force on 31 October 2015. 'Mandatory reporting of female genital mutilation: procedural information'.

An e-learning course for all frontline staff, promoted by Sefton LSCB, is available via the following link

http://www.safeguardingchildrenea.co.uk/resources/female-genital-mutilation-recognising-preventing-fgm-free-online-training/ and a pan-Merseyside LSCB Protocol to illustrate how agencies and individuals should respond to concerns about FGM, is currently being developed.

Key Priorities

We want to improve the quality of lives of children and young people with additional needs and vulnerabilities, to ensure they are safe and fulfil their individual potential

We will do this by:-

1. Reducing the impact on children and young people of living in households experiencing neglect by the provision of a range of support and services.

2. Reducing the impact on children of living in households which experience parental substance misuse by the provision of a range of support and services.

3. Reducing the impact on children and young people living in household which experience domestic abuse by the provision of a range of support and services.

4. Supporting young people with a range of additional needs through new ways of working to minimize risk taking behavior and maximize their life chances.

5. Enabling children to live within their birth family, where this is not possible children are assisted to develop an attachment to a permanent and stable carer.

6. Children and young people with Special Educational Needs and/or disabilities achieve their full potential

7. Securing and sustaining better all-round outcomes for babies and young children which narrows the gap between vulnerable children and others

Priority 4

Ensure positive emotional health and wellbeing of children and young people is achieved

National Context

- 1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every class.
- Between one in every 12 and one in 15 children and young people deliberately self-harm and there has been a big increase in the number of young people being admitted to hospital because of self-harm. Over the last ten years this figure has increased by 68%.
- More than half of all adults with mental health problems were diagnosed in childhood. Less than half were treated appropriately at the time.

The national strategy No Health Without Mental Health 2011 (NHWMH), the public health white paper Healthy Lives Healthy People 2010 has mental health as a cross-cutting theme and the 2014 government call to action in 'Closing the Gap' includes a 25 point action plan for change in mental health.

Mental health is central to our quality of life, our economic success and interdependence, with our success in improving education, training and employment outcomes and tackling some of the persistent problems that scar our society, from homelessness, violence and abuse, to drug use and crime'.

The Government requires individuals, communities and the organisations within them to take responsibility for improving their own mental health and wellbeing and/or taking care of that of other people. Challenging "the blight of stigma and discrimination" is also prioritised as both an individual and collective responsibility.

In March 2015 the Department of Health and NHS England produced a taskforce report called *Future in mind - Promoting, protecting and improving our children and young people's mental health and wellbeing*. Over the next 5 years, a significant amount of *additional* money is available to flow via CCG's to support transformation programmes based on the aspirations of this report. Accessing this funding is dependent on demonstrating "strong local leadership and ownership at a local level through robust action planning and the development of publically

available 5 year Local Transformation Plans for Children and Young People's Mental Health and Wellbeing." These plans will be based on the taskforce report 'Future in Mind'. What is included should be decided at a local level in collaboration with children, young people and their families as well as commissioning partners and providers.

Key objectives of the investment are:

1. Build capacity and capability across the system
2. Roll-out the Children and Young People's Improving Access to Psychological Therapies programmes (CYP IAPT)
3. Develop evidence based community Eating Disorder services for children and young people
4. Improve perinatal care.

Regional Context

Public Health England in 2014 launched a national finger tips health database to support in presenting data on a national, regional and local level. However data relating to Children and young people's mental health is currently limited due to the pending implementation of the CAMHS (Child and Adolescent Mental Health Service) minimum data sets. NHS England's Strategic Clinical Network for Merseyside and Cheshire in 2014 also formed a mental health specialist interest group who are assisting in developing a greater regional understanding, key themes of which will be communicated in the near future.

Sefton Context

The following are findings from CHIMAT (Child and Maternal Health Observatory) 2014 and the 2014 Sefton Strategic Needs Assessment. Current data available is recognised as limited and the implementation of the 2015 Sefton Children's Emotional Health and Wellbeing strategy will seek to address as part of its aims and action plan for 2014-2017.

The rate of young people under 18 who are **admitted to hospital because of alcohol specific conditions**, such as alcohol overdose, has declined in the period 2010-13 when compared with the period 2006-09. However, overall rates of admission in the period 2010-13 are significantly higher than the England average.

The rate of young people under 18 who are **admitted to hospital as a result of self-harm** increased in 2011/12 when compared with figures from 2009/10. Overall rates of admission in 2011/12 are significantly higher than the England average. In this period, the rate of self-harm hospital admissions was 171.2 per 100,000 young people aged 0-17. Nationally, levels of self-harm are higher among young women than young men. This is the same in Sefton

The rate of Sefton Children and Young People **admitted to hospital as a result of a mental health problem** in 2012/13 was 98.5 per 100,000 young people aged 0-17. This is similar to the England average

The level of **child poverty** in Sefton in 2011 was 20.9%, which was 0.3% higher than the England average. The difference is not significant. Approximately 9,300 children in Sefton live in poverty.

Sefton is ranked 92 out of 326 authorities in the 2010 Index of Deprivation (1 is most deprived). Approximately 18% of Sefton's residents live within the most deprived 10% of areas within England and Wales

What are we doing to improve things?

The establishment of a Sefton children and young people's emotional health and wellbeing steering group, as well as provider partnerships are enabling services to work together to better understand emotional health and wellbeing locally and improve access to services

Sefton has been successfully appointed by NHS England as a CYP IAPT (Children and Young People's Improving Access to Psychological Therapies) site, bringing enhanced resource, workforce development opportunities and an increased focus on youth involvement in the delivery and design of emotional wellbeing services

A joint NHS CQUIN (Commissioning for Quality and Innovation) programme, involving Alder Hey and Merseycare Trusts is shaping improved transitions between children and adult services for 0-25's and new service model.

CHILD & ADOLESCENT MENTAL HEALTH SERVICES

Sefton were successful in 2014/15 in receiving national funding from NHS England to enhance how Clinical Commissioning Groups (CCGs), Education and the Local Authority work together to fund Child and Adolescent Health Services (CAMHS), with a particular focus on utilising the local voluntary sector to provide early and accessible support in the community

Sefton has developed a Local Transformation Plan in response to Future in Mind (DH & NHSE, 2015) that is focussed on improving and increasing local mental health services for children and young people

CHILD & ADOLESCENT MENTAL HEALTH SERVICES

"CAMHS staff link with schools for children who are receiving an intervention and where contact or joint working with the school is indicated or requested. In addition, there is a duty line accessible to all professionals including school staff Monday – Friday 9-5.

Training that has been offered by CAMHS in the past has been offered out to schools. CAMHS are current liaising with third sector partners about offering further training around mental health including self-harm specifically tailored to school staff that should run early 2016 as part of the co-commissioning pilot. Specific training has been offered to some schools.

CAMHS offer supervision to the Specialist School Nurse for Emotional Health and Wellbeing who in turn offers supervision and consultation to generic school nurses around emotional health and wellbeing. CAMHS also offer consultation to the Well Young Person's Project who work with children, commissioned by schools."

Key Priorities

We want good mental and emotional well-being for children and young people in Sefton where the psychological development and emotional welfare of the child is paramount.

We will do this by:-

1. Promoting good mental health and emotional wellbeing for all children and young people, parents and care givers in Sefton.

2. Improving access for all children and young people who have mental health problems and disorders to timely, integrated, high quality, multi-disciplinary mental health services that ensure effective assessment, treatment and support for them and for their families, and to work together to tackle the stigma of mental ill-health

3 Improving knowledge of brain development and attachment theory with parents and services so we can build on this to reduce the numbers of children and young people presenting with mental health issues.

How we will measure success

Each priority has its own plan for delivery which includes outcome success measures. The outcome success measures have clear indicators and targets which are monitored by the 0-25 Forum, to access progress being made and the impact upon children and young people's outcomes.

The 0-25 Forum of the Health and Wellbeing Board has overall responsibility for the production, evaluation and monitoring of this plan. The plan is subject to annual review to ensure it continues to reflect local need and priorities, whilst taking into account changing national policy, financial and local service issues.

Key partners as members of the 0-25 Forum will monitor the delivery of this plan, evaluate its impact and inform future planning.

Sefton children and young people's emotional health and wellbeing steering group will oversee and guide the implementation of the Local Transformation Plan

The following section sets out the four priorities in the context of the national, regional and Sefton picture. What we know has worked well to date is referenced. Details as to how the priority will be implemented and the success outcomes which are expected to be achieved is also presented.

Making it happen

The Early Life forum of Sefton's Health & Wellbeing Board is committed to delivering the priorities outlined in this plan and improving the life outcomes for all Children and Young People in the Borough. The successful delivery of Sefton's CYPP depends on the success of the following elements

- Integrated working of the Early Life Forum, Local Children's Partnerships and Partners
- A diverse and experienced workforce
- Information sharing
- Engaging children and young people
- Working with parents/carers
- Strong safeguarding arrangements
- Building new relationships with those working with children and young people
- Promoting diversity in the provision of services
- Exploring new funding models

Vision	**Ensure all children have a positive start in life and are safe**			
Aims	• **Having a Family approach** • **Listening to children and young people** • **Promoting partnership working, joint commissioning and investing in children and young people's futures** • **Smoothing the transition between childhood and adulthood** • **Ensuring services are delivered cost effectively**			
Priorities	 **Ensure all children and young people have a positive educational experience**	 **Ensure all children are supported to have a healthy start in life and a healthy adulthood**	 **Improving the quality of lives of children and young people with additional needs &vulnerabilities, to ensure they are safe and fulfil their individual potential**	 **Ensure positive emotional health and wellbeing of children and young people is achieved**
	Children are ready for school with good social and emotional development.	Encouraging care that keeps children healthy and safe.	Reducing the impact on children and young people of living in households experiencing neglect by the provision of a range of support and services.	Promoting good mental health and emotional wellbeing for all children and young people, parents and care givers in Sefton.
	Ensuring that barriers to participation and progress are addressed.	Identifying problems in children's health and development so they can get help with their problems as early as possible.	Reducing the impact on children of living in households which experience parental substance misuse by the provision of a range of support and services.	Improving access for all children and young people who have mental health problems and disorders to timely, integrated, high quality, multi-disciplinary mental health services that ensure effective assessment, treatment and support for them and for their families, and to work together to tackle the stigma of mental ill-health.
	Ensuring all pupils make at least 'good' progress in every year of their education.	Supporting children to be healthier, happier and able to take advantage of opportunities that will help them reach their full potential.	Reducing the impact on children and young people living in household which experience domestic abuse by the provision of a range of support and services.	Improving knowledge of brain development and attachment theory with parents and services so we can build on this to reduce the numbers of children and young people presenting with mental health issues.
	Ensure young people leave formal education with the skills and opportunities to achieve.		Supporting young people with a range of additional needs through new ways of working to minimize risk taking behaviour and maximize their life chances.	
	Ensure good leadership and governance across all educational settings in Sefton.		Enabling children to live within their birth family, where this is not possible children are assisted to develop an attachment to a permanent and stable carer.	Providing access to a range of evidence based therapeutic support for looked after children and their carers. Commissioning timely and appropriate support to adopted children and their families to strengthen attachment and prevent placement breakdown
			Children and young people with Special Educational Needs and/or disabilities achieve their full potential	

			Securing and sustaining better all-round outcomes for babies and young children which narrows the gap between vulnerable children and others	

Priority 1 - Ensure all children and young people have a positive educational experience

Key objectives	Protective factors – strengthen 'protective factors from evidence base	Strategies to be delivered	Responsible Lead	Timescale & Evidence	Measurable outcomes
Children are ready for school with good social and emotional development	• Pre-school assessments • Positive parenting • Health review on school entry • Positive attachments in families.	• Education & Skills Strategy • Early years strategy • Nurseries/Early years setting & Children centres, • Early Help Strategy • Five to thrive.	Head of Learning & Support (Education Services Manager, School Readiness Service Manager)	September 2017	• Children exceed the expected level against each of the early learning goals. • Disadvantaged children attain in line with all other children.
Ensure that barriers to participation and progress are addressed	• School & colleges collaborative	• Education &Skills Strategy • SEND strategy/Sefton Local Offer • Attendance & Welfare, Sefton Turnaround Programme • 14-19 Education & Skills Strategy • Youth Offer.	Head of Learning and Support (Vulnerable Services Manager, Attendance Services Manager, 14-19 Services Manager)	September 2017	• Reduce authorised & persistent absence in primary and secondary schools • Reduce unauthorised, persistent & overall absence for those children supported by a child in need plan • Reduce unauthorised, persistent & overall absence of children looked after .Pupils have appropriate pathways to achieve good progression and attainment. • Disadvantaged pupils and pupils with additional needs

					are able to make good progress throughout school.

Key objectives	Protective factors – strengthen 'protective factors from evidence base	Strategies to be delivered	Responsible Lead	Timescale & Evidence	Measurable outcomes
Ensure all pupils make at least 'good' progress in every year of their education	• Pupil / school data analysis	• Education and Skills Strategy • Schools Causing Concern Protocol.	Head of Learning and Support (Education Services Manager, School Readiness Service Manager, School Improvement Advisers)	September 2018	• Pupils develop strong phonics, reading and writing skills in early primary years. • Pupils make good levels of progress by the end of schools. • All pupils attend a school which is good or outstanding (as defined by Ofsted).
Ensure young people leave formal education with the skills and opportunities to achieve.	• Participation and engagement activities and feedback	• Education and Skills Strategy • 14-19 Strategy • Local Plan.	Head of Learning and Support (Education Services Manager, 14-19 Services Manager)	September 2018	• Young people leave school with the skills and qualifications to access training, apprenticeships and employment. • Young people achieve the highest grades in further education to access additional learning opportunities. • Young people have flexible skills to access jobs in future growth areas.
Ensure good leadership and governance across	• Inspection report analysis • Governor skills	• Education and Skills Strategy, • Schools Causing	Head of Learning and Support	September 2018	• All pupils attend a school which is good or outstanding (as defined by Ofsted).

all educational settings in Sefton.	audits • Schools Causing Concern intelligence.	Concern Protocol.			• Leadership and governance inspection judgements are good or outstanding (as defined by Ofsted).

Priority 2 - Ensure all children are supported to have a healthy start in life and a healthy adulthood

Key objectives	Protective factors – strengthen 'protective factors from evidence base	Strategies to be delivered	Responsible Lead	Timescale & Evidence	Measurable outcomes
Encourage care that keeps children healthy and safe	• Breastfeeding • Safe sleeping • Immunisation • Tobacco free homes • Parenting skills • Early engagement with antenatal care	**HCP** via • Health visiting implementation plan (HV strategic Board & Sefton 0-5 Transition Group) • Family Nurse Partnership Implementation plan (FNP Advisory Board) • Midwifery • Children's Centres.	SMBC Public Health NHS England SMBC Public Health NHS England CCG Chief Nurse SMBC Early Intervention	Sefton council commission HV/ FNP Oct 15 First FNP families supported from March 15 Oct 15	• Higher rates of breastfeeding • Safe sleeping practice • Increased immunisation • Reduced prevalence of smoking amongst parents • Reduction in outpatient and hospital admissions following accidents • Greater levels of attachment).
Identify problems in children's health and development so they can get help with their problems as early as possible	• Screening, e.g. hearing, new born blood spots • Developmental checks • Health review on school entry • Intensive	**HCP** via • As above • Commissioned screening programmes • Commissioned School Health programme	• As above • Public Health England • SMBC Public	Quarterly performance monitoring NCMP – yearly measurement, reception, year 6	• Coverage, accuracy & successful interventions of screening programmes, NCMP • Impact of developmental checks • Appropriate uptake of intensive programmes & subsequent impact, e.g. FNP: should see increase in breastfeeding, reduced smoking at time of delivery, higher rates of return to education/training & employment, greater financial independence in