	programmes, e.g. FNP, Health Visiting Plus and Health Visiting partnership plus	• National Child Measurement Programme (NCMP)	Health		most vulnerable families
Key objectives	**Protective factors – strengthen 'protective factors from evidence base**	**Strategies to be delivered**	**Responsible Lead**	**Timescale & Evidence**	**Measurable outcomes**
Support children to be healthier, happier and able to take advantage of opportunities that will help them reach their full potential		**HCP** via • Health Visiting plus • Health Visiting partnership plus • FNP – for teenage parents and child • Sexual health strategy • Substance misuse strategy - a series of action plans over the 5 years of the CYPP, that addresses gaps	• SMBC Public Health • SMBC Early Intervention • CCG Chief Nurse • SMBC Public Health • SMBC Public health • SMBC SEN lead • CCG Chief Nurse	Quarterly performance monitoring by commissioners	• Improved levels of reported health and well being • Reduced teenage conceptions • Increased educational attainment • Reduced smoking and substance misuse

		identified through the needs assessment. • SEN			
Reducing alcohol related admissions for children and young people	Physical and mental wellbeing, and good social relationships Delayed age at which young people start using substances School-based multi-component prevention programmes Specialist substance misuse services for young people	• Implement recommendations from the Substance Misuse Public Health Needs Assessment regarding children, young people and families.	Sefton substance misuse strategic group Director of Public Health		• Reduction in alcohol admissions for those aged under 18 years
Health children and young people achieve and maintain a healthy weight	• Breastfeeding • Whole family approach to encourage healthier	HCP via • 0-5 public health nursing • Children's centres National Child measurement	• SMBC Public Health	Quarterly performance monitoring Annual measurement at the	• Increase in initiation and continuation rates • Reduction in overweight and obesity

	lifestyle choices	Programme • YR and Y6 measurement of Ht/Wt/BMI • Monitors levels of overweight and obesity in Sefton • Provides individual feedback to families of children who are overweight/obese with signposting for support • Feedback to schools to influence local interventions to support positive dietary and physical behaviours Active Sefton, including Move it • Specialist intervention aimed at family and child to	• SMBC Public Health • SMBC Public Health	beginning of Autumn term Quarterly performance monitoring	• Reduction in BMI • Increased self-reporting on physical activity • Increased self-reporting of wellbeing

		support sustainable changes, focusing on healthy eating and increased physical activity.			

Priority 3 - 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

Key objectives	Protective factors - strengthen 'protective factors' from the evidence base	Strategies to be delivered	Responsible Lead	Measureable outcomes
The impact on children and young people of living in households experiencing neglect are reduced by the provision of a range of support and services	• Signs of safety • Early identification using health and education developmental milestones • Reduction of care givers risk factors	• LSCB Neglect Strategy • Children's workforce development strategy re improved assessment skills • Early Help strategy inc Triple P programmes and 5 to thrive • Healthy Child Programme • Family Nurse Partnership	LSCB Head of Early Intervention & Prevention CCG Director of Public Health	• More families are supported via a CAF which involves a Graded Care Profile assessment. • Reduction in referrals made to Children's Social Care due to neglect concerns. • Less children and young people are subject of a Child Protection Plan due to neglect. • Less children and young people become 'looked after' by the Local Authority due to neglect concerns.
The impact on children of living in households which experience parental substance misuse are reduced by the provision of a range of support and services	• Child focussed assessment including parenting capacity • Dynamic risk assessments (across DV & mental ill health where also present) • Corroboration of impact and usage of substances • Secure storage of substances	• Implement recommendations from the Substance Misuse Public Health Needs Assessment regarding children, young people and families. • Troubled Families	Sefton substance misuse strategic group Director of Public Health	• Increasing parenting capacity • Breaking intergenerational substance misuse • Educational outcomes gap for Children whose parents misuse substances is narrowed • Child developmental milestones met • Graded Care profiles indicates reduced risk of neglect

Key objectives	Protective factors - strengthen 'protective factors' from the evidence base	Strategies to be delivered	Responsible Lead	Measureable outcomes
The impact on children and young people living in household which experience domestic abuse are reduced by the provision of a range of support and services	• Safety and protection of children • Empowerment and safety for women • Responsibility and accountability of perpetrators of violence • Attention to strengthening the mother/child relationship which is frequently undermined by domestic abuse	• Implement recommendations from the Domestic Abuse Public Health Needs Assessment and NICE Guidelines (2014) recommendations 10 and 11 via the development of a Domestic Abuse Strategy ensuring a focus on safeguarding children and young people. • Troubled Families	Community Safety Partnership	• Less children and young people are subject of a Child Protection Plan due to domestic abuse. • Less children and young people become 'looked after' by the Local Authority due to concerns regarding domestic abuse. • Increased reporting and earlier disclosure of abuse
Young people with a range of additional needs are supported through new ways of working to minimize risk taking behaviour and maximize their life chances	• Social Pedagogy • Restorative practice • Respite • Triple P parenting programmes • Assertive Challenge approach	• Community Adolescent Service • Troubled Families	Adolescent Service Strategic Group reporting to the Corporate Parenting Board	• Support young people and families before they reach crisis to prevent young people entering the care system at 13+ • Support families to resolve problems and build resilience to prevent younger siblings entering care when they reach adolescence • Provide stability of placements for those who are already looked after with a greater potential to return home in a planned way to families who have changed • Support young people to remain in mainstream education • Looked after children making good life choices which help them meet their normal outcomes and which leads them to positive progression routes

Key objectives	Protective factors - strengthen 'protective factors' from the evidence base	Strategies to be delivered	Responsible Lead	Measureable outcomes
				• Strong and effective relationships between young people their families, peers and communities which reduces the attractiveness of gangs and criminal activity. • Co-ordinated and effective actions to reduce the number of young people victimised through child sexual exploitation and increase the potential for disruption and prosecution of offenders. Supported and empowered young people with a history of difficulties who are entering parenthood minimise the risk of their children being lost to care. • A new evidence base of what works for children and young people which diverts them from going missing from home, care and school.
To prevent and safeguard **all** children from child sexual exploitation and to prevent and safeguard individual children who are identified as at risk, or victims of child sexual exploitation.		• Child Sexual Exploitation PAN Mersey Strategy – • Sefton Implementation Plan.	LSCB	• Children and young people experiencing child sexual exploitation are identified at the earliest point of concern – increase in CSE referrals made to the Multi-Agency Safeguarding Hub (MASH). • Children and young people are safeguarded from child sexual exploitation and are offered a range of interventions and support to reduce the future risk of being sexually exploited. • Individuals sexually exploiting young people are investigated and prosecuted – number of prosecution outcomes, and, range of other Police disruption actions and outcomes are measured

Key objectives	Protective factors - strengthen 'protective factors' from the evidence base	Strategies to be delivered	Responsible Lead	Measureable outcomes
Children are enabled to live within their birth family, where this is not possible children are assisted to develop an attachment to a permanent and stable carer	• Secure and stable attachment to a primary care giver • Recruitment of sufficient high quality placements to meet the needs of adopted and looked after children • Carers including kinship carers are provided with high quality training to enhance their skills in order to meet the needs of complex children and young people. • Young people who have developed strong attachments to their foster carers are enabled to remain with them into adulthood through the 'Staying Put' initiative	• Children's Permanence Policy • Adoption Regionalisation Initiative	Corporate Parenting Board	• Children and young people live in safe, stable and appropriate homes or families with their brothers and sisters when this is in their best interests. They move only in accordance with care plans, when they are at risk of harm or are being harmed. They do not live in homes that fail to meet their needs and they do not move frequently. • There are sufficient adoptive and foster placements to meet the needs of children in care • Children and young people have appropriate, carefully assessed and supported contact with family and friends and other people who are important to them • Children and young people are helped to develop secure primary attachments with the adults caring for them. Where there are identified barriers to this children and carers are provide with therapeutic services to help strengthen and maintain these attachments. • An increasing proportion of children in foster care remain with their carers via 'Staying Put' agreements • Gap between outcomes achieved by children and young people who are looked after compared with their peers is reduced
Children and young people with Special Educational Needs and/or	• Full participation of children & young people & their parents in decisions which impact on their outcomes and lives	• Implement the Education, Health and Care (EHC) integrated Pathway	Special Education Needs Reform Steering Group Chair – Head of Learning &	• Transfer of educational statements to EHC plans • Publicised Local Offer • Increase in achievement in line with statistical

disabilities achieve their full potential	• Collaborative working across Education, health and care • Accessible local offer • High expectations • Transparent & consistent pathway from the earliest point throughout adulthood	• Aiming High • Sefton Threshold and eligibility criteria	Support Head of EIP	neighbours • Reduce fixed term exclusions in specialist provision • Safe and planned transition arrangements to adult health and social care • Active participation of children, young people and parents in the design and development of the SEND reforms
Key objectives	**Protective factors - strengthen 'protective factors' from the evidence base**	**Strategies to be delivered**	**Responsible Lead**	**Measureable outcomes**
Secure and sustain better all-round outcomes for babies and young children which narrows the gap between vulnerable children and others	• Early intervention for pre-birth to 2 to prevent neurological harm and developmental delay • Good and outstanding early years settings	• School Readiness Framework • Five to Thrive • 2 year old offer • Troubled Families	Head of EIP	• User feedback from children, parents and families alongside active engagement in service design • High levels of take up across universal early education entitlements at ages 2,3 and 4 • Affordable Childcare places and sufficiency – right number in right place • Upward trajectory in EYFS profile data for all children but especially the most vulnerable across prime and specific areas • Confident, resilient parenting and improved family relationships • Positive impact on home learning environments • Increased number of early education and care settings achieving good and outstanding Ofsted judgments • Health outcomes across Healthy Child Programme and Two Year Old Integrated Review • Highly qualified and confident workforce demonstrating increased capacity and

				capability • Targeted Early Help services available and well used locally, demonstrating impact for most vulnerable families • Effective and well-coordinated services for babies and children with additional and complex needs

Priority 4 - Ensure positive emotional health & wellbeing of children & young people

Key objectives	Protective factors - strengthen 'protective factors' from the evidence base	Strategies to be delivered	Responsible Lead	Measureable outcomes
Promote good mental health and emotional wellbeing for all children and young people, parents and care givers in Sefton.	• Participation in positive activities • Education /Training Participation • Economic Wellbeing • Positive Parenting • Whole Family / Whole Person approach • Positive social relationships • Understanding potential negative impacts of social media/E safety • Workforce and Care givers model positive emotional wellbeing behaviours • Parents foster positive attitudes and behaviours • Being well connected families and not isolated	• The Health and wellbeing strategy • The Early Help strategy • Troubled Families • Youth Offer • Public health plans around emotional health • Integration plans for joint care planning • Sefton LSCB Business Plan • Work Place wellbeing charter • MSLC (Maternity Liaison Committee) • Family Planning • The Wider determinants all age Mental Health Strategy • The Wider Determinant forum • Children's Centre & School Readiness Plans • Suicide Prevention strategy • Local Transformation Plan	• Health & Wellbeing Board • Early Intervention & Prevention Lead • Public Health • CCG and SMBC social care leads • Sefton LSCB Business Manager • Sefton CVS/Public Health • PH won't be leading this going forward – all partners will support • Wider Determinants Mental Health Task Group Lead (SMBC) • Wider Determinants Forum Chair • Early Intervention & Prevention Lead (Sefton MBC) • Public health	• Fewer children and families negatively impacted by poverty – Child poverty measures • Children and young people will have good physical and emotional health and wellbeing and will lead healthy lifestyles – obesity, school attendance, school nurse data • Fewer people taking risks with their sexual health – ISIS interventions and prescription rates • Fewer young people involved in crime – Business intelligence/Safer communities partnership DAT • Children and young people are safer in their communities and on line – anti bullying strategy action plan • Organisations with Work Place Wellbeing Charter Accreditation – CVS and Public

Key objectives	Protective factors - strengthen 'protective factors' from the evidence base	Strategies to be delivered	Responsible Lead	Measureable outcomes
				• Health Equity Audit • Access to family planning and maternity care • Early Years Foundation data (Kate Race Bray) • Parental suicide trends
Improve 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	• Families having easy access to information and support services at the right time and place • Understanding gender inequalities/stereotyping and impact on emotional health of wellbeing for males and females	• The Wider determinants all age Mental Health Strategy • Children & Young Peoples Emotional Health & Wellbeing Strategy • The Suicide Prevention Strategy • Local Transformation Plan	• SMBC Wider Determinants Mental Health Task Group Lead (Sefton MBC) • Children's Emotional Health and Wellbeing Sub Group Lead (Sefton CCG) • SMBC Mental Health Lead - Public Health – not sure PH future role in this	• Fewer unplanned hospital admissions and re-admissions relating to self-harm - CCG • Improved emotional wellbeing of children, young people and families – Commissioned services data e.g. Alderhey/CAMHS services • Improved quality of life for individuals with progressive conditions - Commissioned services data e.g. Alderhey/CAMHS services • Use/access to range of services available across the sectors • Youth voice – longitudinal studies of young people's experiences over 5 years (Young Advisors/Health Watch)

Key objectives	Protective factors - strengthen 'protective factors' from the evidence base	Strategies to be delivered	Responsible Lead	Measureable outcomes
Improve 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.	• Positive attachments in families	• The Carers Strategy • Five to thrive for all (0-5, adolescents and adults) • 5 ways to wellbeing • Children & Young Peoples Emotional Health & Wellbeing Strategy • The Wider determinants all age Mental Health Strategy • MSLC (Maternity Services Liaison Committee)	• Social Care Leads (Sefton MBC) • Early Intervention & Prevention Lead (Sefton MBC) • Children's Emotional Health and Wellbeing Sub Group Lead (Sefton CCG)	• Improved quality of life and experience for carers – PSS young carers data • Parents will have the skills, support and infrastructure to enjoy being parents – Children's centre data • More children ready for school – 2YO and 3YO offer • Early Years Foundation data • Children and young people will have a voice, will be listened to and their views will influence service design, delivery and review – example of practice where we've used this • Maternity Health Equity Audit

Glossary

Term	Explanation
Acute Services	Where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery
BME	Black and Minority Ethnic.
CAF	Common Assessment Framework which underpins Early Help support
CAMHS	Child and Adolescent Mental Health Services.
Child in Need	A child is in need if they require services from the local authority to help keep them safe and well.
Child Protection Plan	A plan for children who are at risk of neglect or abuse, which sets out what actions, will be put in place to keep them safe.
Children in care	Children who are under the care of the local authority.
Children's Trust	The local partnership which brings together the organisations working for, and with, children, young people and families.
Clinical Commissioning Groups	Groups of local doctors and other health professionals who have been responsible for planning, designing and buying – known as 'commissioning' – the majority of local health services since April 2013.
Corporate Parent	The role of the Local Authority in looking after children in care.
CYPP	Children and Young People's Plan. The overarching strategy for the Children's Trust.
Designated Teacher	The teacher within each school who is responsible for promoting the educational achievement of children and young people in care.
Duty to co-operate	The requirement for local authorities and relevant partners to co-operate to improve the well-being of children and families, as set out in the Children Act 2004. Relevant partners include health authorities, YOT, police, Job Centre Plus, schools, academies and colleges.
Early help	Targeted support to prevent poor outcomes for children, young people and families. This includes preventing difficulties from happening in the first place and mitigating the impact when things do happen to reduce the potential of repeat or relapse.

Term	Explanation
Early Life Forum	Forum of the Health and Wellbeing Board that includes the *delivery arm* of the Children's Trust at a local level.
Early Years Foundation Stage	The framework for learning and development for children aged 0-5 years old.
Families with multiple problems (also known as 'troubled families')	Families experiencing at least two of the following factors related to poor outcomes; crime and anti-social behaviour; poor school attendance; children in need; adults not in work or at risk of financial exclusion, domestic violence and abuse and parents or children with a range of health problems.
Family Nurse Partnership	A preventative programme for young first time mothers, offering intensive and structured home visiting, from early pregnancy until the child is two.
Foster carer	Someone who looks after children when they are unable to remain with their own families.
Hampshire County Youth Conference	A group of young people who influence local decision making.
Health and Wellbeing Board	A group of key leaders from the health and care system, who work together to improve the health and well-being of the local population.
Healthy Child Programme	Sets out the recommended framework for health services for children and young people aged 0-19 years old.
Healthy School	A school that promotes physical and emotional health by providing information and equipping pupils with the understanding, skills and attitudes to make informed decisions about their health.
Health and Wellbeing Strategy	The strategy of the Health and Well-being Board, setting out how health outcomes will be improved and informing decisions on how Clinical Commissioning Groups allocate resources.
Independent Reviewing Officer	Independent social workers who review children and young people's cases to make sure that plans for children in care, or those with Child Protection Plans, are being implemented.
Initial assessment	An assessment by a social worker to see if a child is at risk.
NEET	Not in education, employment or training.
Ofsted	Inspects and regulates providers of services for children and young people, including children's centres, schools and local authorities.

Term	Explanation
Referral	When someone tells the Local Authority that they are concerned about a child or young person.
Safeguarding	Protecting children and young people from abuse or neglect.
Sefton Safeguarding Children Board (SSCB)	The partnership responsible for co-ordinating and ensuring the effectiveness of local agencies in safeguarding and promoting the welfare of children.
SEN	Special Educational Needs; the term used to describe when children and young people have learning difficulties and/or disabilities that make it harder for them to learn or access education than most children of the same age.
Triple P	Positive Parenting Programme.
UNCRC	United Nations Convention on the Rights of the Child - an international human rights treaty that grants all children and young people a set of rights.
Universal services	Services that are available to all.
Virtual school	The team of people at a local authority who work with schools, social workers and carers to improve the educational achievement of children in care.
Working Tax Credit	A benefit payment for people who are working and on a low income.
YOT	Youth Offending Team; the multi-agency team co-ordinating the work of youth justice services.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2016

Agenda Item: 16/12	**Author of the Paper:** Dr Tom Davis / Angela Parkinson Primary Care Programme Lead Email: angela.parkinson@southseftonccg.nhs.uk Tel: 0151 247 7000
Report date: January 2016	

Title: Primary Care Transformation Plan 2016/17

Summary/Key Issues:

This paper summarises the work plan for Primary Care Transformation for 2016/17, the opportunities and the risks for the CCG and proposes a primary care transformation resource, led by a medical director, which is required to make this happen.

Recommendation

Receive	
Approve	x
Ratify	

The Governing Body is asked to approve the following:

1. the high level organisational development plans to achieve primary care transformation; and
2. to support the model of a medical director to lead and enable primary care transformation across South Sefton.

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.
	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	x			
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered	x			
Locality Engagement	x			
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

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
January 2016

1. Executive Summary

This paper summarises the work plan for Primary Care Transformation for 2016/17, the opportunities and the risks for the CCG and proposes a primary care transformation resource, led by a medical director, which is required to make this happen.

The Governing Body is asked to approve the following:

1. The high level organisational development plans to achieve primary care transformation;

2. To support the model of a medical director to lead and enable primary care transformation across South Sefton.

The plan is based on the following conclusions:

- General Practice is a fundamental cornerstone to developing a new model for sustainable primary care and is best placed to understand the health needs of their registered population and describe the services needed to support the population;

- General practice needs dedicated support and clinical expertise to support an innovative approach to primary care transformation;

- The CCG is committed to an innovative approach to commissioning which is based on the needs of its population at a locality level;

- The potential to exceed this return on investment is significant and has the potential to be considerably exceeded.

2. Introduction and Background

South Sefton CCG has 31 member practices and aspires to progress towards co-commissioning with NHSE. The practices are spread across four natural localities (Bootle, Crosby, Maghull and Seaforth & Litherland). The CCG population is 155,540 with a budget of £266m.

Our population is getting older with more residents aged 65 and over the national average. Fewer residents are of working age than nationally, with a falling birth rate. The area continues to have an increased ethnical diversity with c5% of the population coming from different background and cultures. One fifth of the CCG's residents live in areas that are classified as being within the most deprived 10% of communities nationally. Child poverty is also higher than national levels. The incidence of long term conditions is also higher than the national average.

General Practice is served by a variety of models of GP practices in the form of single handed, multi-partner practices and increasingly, in the interim, multiple practice partnerships. There is a high level of dependency on locums with a significant majority of the current GP workforce due to retire over the next five years.

Demand for general practice is extremely high, driven by significant need within the population, highly dependent patients and patients with multiple long term conditions, who are also often welfare-dependant.

The estate for general practice is poor, with buildings in poor condition, unable to expand or be modified to meet growing demand and changing health needs. Indeed practice estate ranges from rental properties, NHS or private, and owned (by GP Partnership). Increasingly practices are shifting away from a traditional partnership "owned building" to rental, due to the declining value of property prices and financial risk that is now associated with owning.

Ten practices have been provided by a single provider (SSP) over recent years, with 8 contracts due to be terminated by March 2016. This presents the CCG with the opportunity to work with member practices to review the structure, form and function of general practice to meet the future needs of the local population in a much more sustainable way.

There are plans for 9 Alternative Provider Medical Services (APMS) procurements in South Sefton by March 2017, co-commissioned by NHS England and the CCG. The level of co-commissioning may increase from level 1 to level 2, allowing for more involvement by the CCG. In addition the CCG is actively re-procuring community services to ensure they are designed to support general practice in optimising clinical care and management of patients in the community setting.

3. Key Issues

3.1 Organisational Development Work Plans 2016/17

In an effort to drive the thinking within each general practice, the CCG would want to support individual practice and primary care development to:

- Understand and assess existing workload, resources and demand;
- Explore and develop alternative and innovative models of General Practice, with alternative and extend roles for the wider clinical team;
- Facilitate collaboration between individual practices to optimise resource utilisation (improving patient care and clinician working experience);
- Develop a joint strategic approach to future estate provision, by locality;
- Build practice based development plans to support future service sustainability and recruitment;
- Understand clinical variation between practices and share "best practice" approaches to improving clinical care;
- Pave the way to co-commissioning and federation as practices begin to understand the opportunity to shape General Practice;
- Describe and promote the Sefton 'brand' to attract new workforce and resources.

The plans below sets out the high level approach to be taken in order to achieve some of the ambitions set out in the 'Shaping Sefton' and 'Primary Care blueprint' documents. Broadly these can be divided into the following headings, although it is recognised that they should not be tackled in isolation and the work plan (Appendix 1), which will be an evolving document, reflect this in the context of national and local work streams:

- The Locality model;
- Workforce development;
- Clinical services development;
- Premises / Estates / IT;
- Health outcomes and primary care quality improvement.

3.1.1 The Locality Model

The CCG has a clearly set out vision for Primary Care. This vision centres on the provision of more extensive Hub services in each locality delivered from purpose built facilities. These locality hubs will offer extended primary care services including diagnostics and basic surgical interventions. The locality Hubs will be underpinned by routine General Practice provided on a spoke or neighbourhood basis.

3.1.2 Workforce Development

There are opportunities to collaborate more actively with Health Education North West (HENW) and the workforce survey which would help member practices in developing a workforce plan similar to peers in other CCG regions across the North West. In addition national funding (eg practice pharmacists) has proven unobtainable due to the limited collaborative working to allow primary care to sustainably employ resources.

Locally the HCA apprenticeship will create 8 local HCAs qualifying in January 2016 and work is underway to expand this offering for the future. There is a need to ensure a workforce plan is created to accompany any new model of working.

The CCG would want to support:

- Working with HENW in mapping the local workforce;
- Formulating a workforce development plan, including the wider (clinical and non-clinical) roles that any future workforce may consist of;
- Working with HENW and other partners in creating training opportunities to support the development of the workforce;
- Ensuring that the workforce plan informs any applications to national funding and increases the opportunity of successful bidding.

3.1.3 Clinical Services Development

There has been substantial investment in this area with the development of the virtual ward, the acute visiting scheme, the urgent care team and the care home innovation programme (CHIP). The recent decommissioning of the ‘Darzi’ practice has resulted in the design of a GP-led Urgent Care Centre. The Local Quality Contract (LQC) has been successful in developing GP access and aims to improve the outcomes for the frail elderly populations and identification of End of Life patients with development of appropriate care plans in the future. Long term condition work streams continue to innovate and support primary care, including the Respiratory and CVD work streams.

For initial success to continue and further innovation prosper there is a need for the CCG to support its membership practices in embedding these services in order to gain the greatest value for money but more importantly the greatest benefit to patients. Future aspiration would be to have a sustainable process of redevelopment and reinvestment into primary care, without the need for a local quality contract.

3.1.4 Premises / Estates / IT

The CCG has recently reviewed and updated its strategic estates plan and is now focused on implementing its estates plan, to ensure primary care premises are modern, fit for purpose, fully utilised and sustainable over the long term. Locality and practice level discussions are facilitating an understanding of the requirements and opportunities for estates and infrastructure moving forward. This year the CCG will apply to the Primary Care Transformation Fund to support the delivery of a number of infrastructure projects. Estates will form a key driver to the transformation of primary care.

3.1.5 Health Outcomes and Primary Care Quality Improvement

The CCG continues to develop the primary care dashboard and is constantly looking at ways to make more appropriate use of secondary care resources. Reduction in non-elective admissions, elective procedures and outpatient activity can only be achieved with a resilient primary care platform.

Existing and future work streams that are dependent on a robust primary care platform are listed in the appendix. In addition to these there are a number of programmes outside of the primary care work streams where success is dependent primary care, these include:

- Virtual Ward;
- CHIP;
- Acute Visiting Service;
- Respiratory Projects;
- CVD;
- Urgent Care;
- Community Care.

3.2 Opportunities and Risks

The key opportunities and risks to the CCG in the pursuit of this organisational development are identified below. The organisational development plans aim to optimise the opportunities and mitigate the risks.

Opportunities

- Co-commissioning level 2
- Local Quality Contract
- APMS tenders (SSP practices, North Park)
- Community services tender
- PMS review – leading to reinvestment into primary care
- Demand management and resilience across primary care
- Sharing good practice
- Reducing commissioning spend

Risks

- Membership engagement
- Relationships with other organisations
- Workforce – retention and recruitment
- Estates
- CQC inspections
- Quality Improvement Prevention and Productivity (QIPP) challenge

3.3 Resourcing Primary Care Transformation

It has been recognised that in order to achieve sustainable transformation a dedicated resource is required. The current pressures on Primary Care in South Sefton mean that the capacity to transform in addition to maintaining the status quo is not feasible. In order for the CCG to realise the benefits of a more resilient Primary Care offering, which will ultimately support both a sustainable delivery of quality primary care and a reduction in overall spend outside of primary care, the CCG must be prepared to support the robust and sustainable development of Primary Care.

Exploring successful transformation programmes across healthcare would suggest that the key drivers to success include:

- Clinical leadership;
- Collaboration;
- Culture (willingness to change);
- Time.

The challenge for the CCG leadership is that primary care transformation cannot be delivered without the collaboration of the CCG membership. Dedicated clinical leadership cannot come from the incumbent clinical leadership in the CCG as they do not have the time and there will always be a perceived conflict of interest.

The primary care transformation team currently supports the operational and developmental work streams for primary care but in order to fast track the necessary organisational development to support primary care transformation a dedicated resource is required to work with the membership and support Primary Care transformation in South Sefton. This proposed resource is a dedicated medical director role.

The key objectives of the medical director will be to lead and enable the primary care transformation team in achieving the objectives listed under the organisational development plans on page 2. This can be achieved through capitalising on opportunities for organisational development by having time to think and plan outside of the operational needs of the team. This team will be integrated into primary care, working in partnership with existing resources in:

- Locality representation, including GPs, practice managers, nurses;
- Practice managers;
- Nursing and other primary care health professionals;
- Senior local clinicians.

The team will have key relationships within the CCG, including;

- The locality leads;
- The medicines management lead;
- The finance team;

And build key relationships outside the CCG with:

- The LMC;
- NHS England;
- HENW;
- Patient representatives;
- Health Watch;

- CVS / Voluntary Sector;
- Sefton Council;
- Public Health team;
- Community and Acute Provider organisations.

3.4 The Medical Director Role - Proposal

The medical director must be an enthusiastic clinician who will provide clinical leadership in the development and delivery of primary care transformation in South Sefton. They will be able to communicate and interact effectively with colleagues and multi-professional teams, including the member practices, commissioners, clients, other providers and patient representatives.

To allow the role to achieve the greatest possible outcomes the CCG should be prepared to be flexible for the best candidate. However, based on the current needs of the system and the experience gained from reviewing other areas the proposal is based on the following recommendations that the CCG should:

- Encourage clinicians from a range of backgrounds to apply for this role, including partner and salaried GPs, locums, and nurses as well as more experienced clinicians;
- Be prepared to fund up to a full time role for 1 year initially;
- Advertise nationally to attract the best candidates;
- Be flexible (in number of sessions, allowance for clinical work, provision of backfill, etc) to secure the right candidate.

4. Conclusions

This paper has outlined the high level aspirations for the CCG to support organisational development in order to facilitate primary care transformation.

5. Recommendations

The Governing Body is asked to approve:

1. The high level organisational development plans to achieve primary care transformation;

2. To support the model of a medical director to lead and enable primary care transformation across South Sefton.

Appendices

Appendix 1 South Sefton CCG Organisational Development Work Plan

Dr Tom Davis / Angela Parkinson
January 2016

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South Sefton
Clinical Commissioning Group

Organisational Development Work Plan

	Workstreams	Practice Demographics/ Locality Model	Workforce Development	Clinical Services Development	Premises/ Estates/IT	Health Outcomes and Primary Care Quality Improvement
National	Co- Commissioning Agenda	•	•	•	•	•
	QOF	•	•	•	•	•
	Core Contracts	•	•	•	•	•
	Direct Enhanced Services	•	•	•	•	•
	Primary Care Infrastructure Fund			•	•	
	111					•
	GP Plus	•	•	•	•	•
	Friends and Family Test					•
	Support for Vulnerable Practices: Pilot Programme	•	•	•	•	•
	CQC	•	•	•	•	•
	Health Education England	•	•	•		•
	Primary Care Commissioning (PCC)	•	•	•	•	•
Local CCG	Transformation Funds	•	•	•	•	•
	Medical Director Role	•	•	•	•	•
	Federation	•	•	•	•	•
	Collaborative Working / New Models of Working	•	•	•	•	•
	Diagnostics			•	•	•
	Community Services	•	•	•	•	•
	Virtual Ward	•	•	•	•	•
	Choose and Book (community Services)			•	•	•
	Respiratory	•	•	•	•	•
	CVD	•	•	•	•	•
	Maghull Estates	•			•	•
	Crosby Estates	•			•	•
	Out of Hospital Workforce		•	•		•
	Care Certificates		•			
	Revalidation- GP		•	•		•
	Revalidation- Nurse		•	•		•
	HCA Apprenticeship		•	•		•
	PN Training		•	•		•
	Non Clinical Staff Training		•			•
	Urgent Care /GTD/AVS		•	•	•	•
	Emis Mobile Project (GP/PN/HCA's)			•	•	•
	iLinks Transformation Strategy				•	
	Data Sharing				•	
	CHIP/Telehealth			•	•	•
	Imerseyside Information Facilitators	•	•	•	•	•
	Local Quality Contract / Access/ Frailty/EOL	•	•	•	•	•
	APMS Procurements	•	•	•	•	•
	Procurement engagment	•	•	•	•	•
	Primary Care Dashboard					•
	Healthwatch					•
	CVS	•		•		•
	QUIPP			•		•
Boroughs	Care Homes	•	•	•	•	•
	Social Services	•	•	•	•	•
	Local Authority Public Health Initiatives	•	•	•	•	•
Practice	Childhood Imms Activity					•
	DES activity					•
	Seasonal Flu Activity					•
	Primary Care Budgets (commissioning)					•
	LQC Activity		•			•
	Prescribing Information/Meds Management					•
	HENW	•	•	•		•
	Clinical/Non Clinical Staff Training		•	•		•
	A+E /OP/ Unplanned Admissions Activity					•

Timelines

	2015/16			2016/17												2017
	Q4			Q1			Q2			Q3			Q4			Q1
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April
Every Contact Counts Training	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
HCA Programme ends	●															
Pharmacy Contracts	●															
LQC Contract Variations	●															
Vullnerable Practices Pilot	●															
Frail Elderly Event planning	●															
North Park Legacy Letters Project	●	●	●	●	●	●	●	●	●							
New Practice Manager Support- Glovers Lane	●															
Data Collection - Change of use part 2 access Christmas and New Year	●															
LQC Y1 Outcomes Report	●															
Communication to Interim Providers re CCG	●															
Co-Commissioning/Primary Care Training Day	●															
OD/Medical Director Bid	●															
SAFE assessment Training	●															
North Park Bidder Event	●															
GP Survey Results - EPEG		●														
Interim Providers start- 8 x SS		●														
Frail Elderly Event		●														
NHSE Easter Opening Returns		●														
Pre-Procurement Stage ends for North Park		●														
Procurement Stage starts - North Park		●														
Protected Learning Time (venued)			●													
Outcomes Quality Premium investment			●													
Data Collection- HENW			●													
Data Collection- Phase 2 LQC			●													
Procurement- 9 x APMS contracts			●													
Out of Hospital Workforce			●													
High Pastures APMS			●													
Commissioning Gateway- SS				●												
QOF				●												
Direct Enhanced Services				●												
Review Core Contract funding/list sizes				●												
Prep- Phase 3 LQC				●												
Project Group- APMS procurements				●												
PMS Reviews				●												
Procurement stage ends- North Park					●											
Post procurement stage begins- North Park					●											
LQC Steering Group (clinical)/Frailty Pathways					●											
Protected Learning Time (venued)						●										
Finalise Specs/finances/evaluation questions/criteria APMS						●										
Weightings- populate contract documents APMS						●										
Successful bidder informed - North Park						●										
Contract Awarded- North Park						●										
Mobilisation- North Park						●	●	●	●							
Prepare advert (MyTender/Contract Finder)- APMS							●									
Sign-off documentation- APMS							●									
Procurement stage starts- APMS								●								
Data Collection- Phase 2 LQC									●							
Sign off Specs and Finances- LQC Phase 3									●							
Protected Learning Time (venued)										●						
North Park new Provider starts- 01.10.2016										●						
NHSE Return Christmas Opening										●						
Frailty Pathways										●	●	●	●	●	●	
LQC- Phase 3 Event											●					
Procurement stage ends- APMS											●					
Post Procurement stage begins- APMS											●					
Successful bidders informed- APMS												●				
Contracts Awarded- APMS												●				
Mobilisation- APMS												●	●	●	●	
LQC Meeting Queries														●	●	●
Final Data Collection- LQC															●	
20% of the population to have enhanced access to primary care															●	
New Providers start- APMS- 01.04.2017																●
Phase 3 Begins- LQC																●
Primary Care Quality Strategy Ends																●
LCH/ICO- Community Providers																●

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MEETING OF THE GOVERNING BODY
January 2016

Agenda Item: 16/13	**Author of the Paper:** Karl McCluskey Chief Strategy & Outcomes Officer Email:karl.mccluskey@southseftonccg.nhs.uk Tel: 0151 247 7006
Report date: January 2016	

Title: Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21

Summary/Key Issues:

Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21 was published on 22nd December 2015. This sets out a requirement for CCG's to develop;

A five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and A one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

The guidance places a real emphasis on speed of transformation in priority areas in an effort to build the necessary momentum on prevention and re-designed care.

Recommendation

Receive	x
Approve	x
Ratify	

The Governing Body is asked to:

(i) receive this summary for information;

(ii) approve the approach and delegate authority to the relevant SLT members, to enable the required submission timetable to be met.

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
Patient and Public Engagement	x			
Clinical Engagement	x			
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement	x			
Presented to other Committees				

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

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South Sefton
Clinical Commissioning Group

Report to Governing Body
January 2016

1. Introduction

1.1 This paper provides a summary derived from the latest planning guidance, "Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21", which was published on 22nd December 2015. This sets out a requirement for CCGs to develop:

- A five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
- A one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

1.2 The guidance places a real emphasis on speed of transformation in priority areas in an effort to build the necessary momentum on prevention and re-designed care.

2. Place-based Planning

2.1 The guidance describes the need for CCG's to focus plans on meaningful footprints that are sensible for our population that overcomes more traditional geography based on organisational structures. This place-based approach should be underpinned and driven through system leadership to:

- Enable local leaders to come together as a team;
- Build a shared vision with the local community and local government;
- Programme specific work and activity to make change happen;
- Delivery against plans;
- Learning and adaptation from successes and failures.

2.2 As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including:

(i) **Specialised services:** where the planning will be led from the 10 collaborative commissioning hubs; and
(ii) **Primary medical care**: from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

3. Proposed Place-based Planning Footprints

3.1 From the perspective of South Sefton CCG and Southport & Formby CCG the proposed footprints are set out in the table overleaf:

Tier	Footprint	Construct
1	Cheshire & Merseyside	Specialised Services (Cancer, Neurology, Maternity)
2	Liverpool City region	Southport & Formby CCG South Sefton CCG Liverpool CCG Knowsley CCG Halton CCG
3	West Lancashire Southport & Formby South Sefton Liverpool	Urgent Care Planned Care
4	Sefton	Sefton Metropolitan Borough Council
5	Southport & Formby South Sefton	Acute Provider: Aintree university Hospitals Foundation Trust Southport & Ormskirk Hospital Trust

3.2 The guidance provides a clear indication that STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

3.3 The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative and be based upon:

(i) **Quality of plans:** particularly the scale of ambition and track record of progress already made. The best plans will have a clear and powerful vision. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically borrow good practice from other geographies, and adopt national frameworks;

(ii) **The reach and quality of the local process:** including community, voluntary sector and local authority engagement;

(iii) **The strength and unity of local system leadership and partnerships**, with clear governance structures to deliver them;

(iv) **Confidence:** that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

What CCG's need to do!

7 Day Services

3.4 CCG Plans are expected to address the need for seven day services such that;

- by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week;

- 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:

  (i) Reducing excess deaths by ***increasing the level of consultant cover and diagnostic services available in hospitals at weekends***;
  (ii) Improving access to out of hours care by achieving ***better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services*** to enhance the patient offer and flows into hospital; and
  (iii) Improving ***access to primary care at weekends and evenings*** where patients need it by increasing the capacity and resilience of primary care over the next few years.

3.5 CCG's will need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services as part of their STPs.

3.6 **The nine 'must dos' for 2016/17 for every local system:**

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through **implementing the Right Care programme in every locality**.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

3.7 ***New care models*** will feature prominently within STPs. In addition to existing approaches, in 2016/17 there will be the opportunity to trial two new specific approaches:

- Secondary mental health providers managing care budgets for tertiary mental health services; and
- The reinvention of the acute medical model in small district general hospitals;
- The CCG's will need to consider if it wants to express an interest in working with NHSE on these by 29th January 2016.

4. Operational Plan for 2016/17

4.1 All plans will need to demonstrate:

- How they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
- Planned contribution to the efficiency savings;
- Plans to deliver the key must-dos;
- How quality and safety will be maintained and improved for patients;
- How risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
- How they link with and support with local emerging STPs.

4.2 The 2016/17 Operational Plan should be regarded as year one of the five year STP, and we expect significant progress on transformation through the 2016/17 Operational Plan.

5. Allocations

5.1 In line with strategic priorities, overall primary medical care spend will rise by 4-5 percent each year.

5.2 Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

5.3 To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, no CCG will be more than 5 percent below its target funding level.

6. Returning to Financial Balance

6.1 During 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England.

6.2 Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation.

7. Measuring Progress

7.1 CCG progress will be assessed through a new CCG Assessment Framework. NHS England will consult on this in January 2016, and it will be aligned with this planning guidance. The framework is referred in the Mandate as a CCG scorecard.

8. Timetable

8.1 The timetable for building the 2016/17 plans is set out below.

Table 1.0

Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers	By 29 January 2016

for mental health and small DGHs trials	
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

9. Enhancing the CCG Plans to meet the STP Requirements

9.1 While the CCG has a clearly described strategic plan, with priorities, the planning requirement for 2016/17 require a further iteration of the CCG plans to be undertaken. Some of this will simply need the CCG to describe its plans under headings and categories set out in the planning guidance.

9.2 Some of the transformational work that the CCG is undertaking cuts across many of the "identified elements" set out in the guidance. This will require the CCG to consolidate existing work such that a more comprehensive plan can be described which satisfies the national planning headings and requirements.

9.3 The planning guidance has also identified new and additional priority areas, where the CCG has been less focused on. The CCG will need to consider how to build coherent plans in these areas, which complement existing work and do not create or require additional structures to support delivery.

9.4 In an effort to support the CCG in building on existing plans and meet the additional planning requirements, a stock-take of existing transformation work needs to be undertaken. The table below is derived from the planning guidance and will assist in enabling a quick assessment of existing work and gaps. This can then be used to enhance relevant strategic blueprints and programmes, without the requirement to create additional structures.

Table 2.0 Assessing the CCG Plans and Alignment with Planning Guidance

Planning Requirement	Identified Elements	CCG Lead	Current CCG Status	Additional work required to Enhance CCG Plans
Placed Based	Prevention			
	Self-care	Tracy Jeffes		
	Patient empowerment	Tracy Jeffes		
	Workforce			
	Digital	Martin McDowell		
	Finance	Martin McDowell		
New Care Models	Urgent Care?			
	Locality?			
	Primary Care?			
	New organisational?			

10. Conclusions

10.1 The CCGs are well placed to augment the existing Strategic Plan such that it will be in line with the latest planning guidance.

10.2 Some areas of the current strategic plan will need to be enhanced with additional focus to meet the criteria and must do's set out in the guidance.

10.3 The CCGs are already reviewing existing plans against the guidance to clearly understand alignment and identify any gaps.

10.4 The likely footprint for the CCGs will be based upon the Liverpool City Region.

11. Recommendations

11.1 The CCG is requested to receive and note the detail contained in the planning guidance and it relevance to the existing strategic plan.

11.2 Support the current work that is focused on a stock-take of existing plans to identify alignment and any gap areas that need to be addressed.

11.3 Requested to provide delegated authority to the relevant individuals, within the Senior Leadership Team, to meet the deadlines set out in this paper.

11.4 Be assured that Governing Body members and the Senior Leadership Team will be involved and briefed on planning requirements, changes and iterations as progress is made through the prescribed timetable. All relevant forums will be utilised for this purpose.

Planning Requirement	Identified Elements	CCG Lead	Current CCG Status	Additional work required to Enhance CCG Plans
Engagement	Community Involvement	Tracy Jeffes		
	Voluntary Sector Involvement	Tracy Jeffes		
	Local Authority Engagement	Tracy Jeffes		
Supporting Governance Structures	HWBB SMO Blueprints	Tracy Jeffes Karl McCluskey		
Actions, milestones, timetable	SMO Framework	Fiona Doherty		
7 day working	Consultant Reviews			
	Diagnostic Access			
	Urgent Care Model (OOH, WiC, 111)	Steve Astles Billie Dodd		
	Primary Care at Evenings and Weekends	Jan Leonard		
Financial Recovery	5 Year Plan Linked to activity RightCare Based	James Bradley Becky Williams Fiona Doherty		
Primary Care	Quality	Jan Leonard		
	Sustainability	Jan Leonard		
A&E	4 hour wait performance	Steve Astles Billie Dodd		
	Ambulance turnaround times	Malcolm Cunningham		
Diabetes	National Prevention Programme	Sharon Forrester		
Obesity	Children	Peter Wong		
	Adults			
NHS Constitution Standards	62 day Cancer Waits	Sarah McGrath		
	Diagnostic Capacity			
	2 Week Waits			
	31 day Waits			
	1 yr survival rate			
Mental Health	>50% of Pts with first diagnosis of psychosis commence a NICE approved package of care within 2 weeks	Gordon Jones		
	75% target for IAPT			
	IAPT 6 week target			
	IAPT 95% treatment within 18 weeks			
	Dementia Diagnosis Rate			
	Learning Disabilities			

Karl McCluskey
Chief Strategy and Outcomes Officer
January 2016

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2016

Agenda Item: 16/14	**Author of the Paper:**
Report date: January 2016	Karl McCluskey Chief Strategy & Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk Tel: 0151 247 7006

Title: Shaping Sefton Update

Summary/Key Issues:

This paper provides a briefing and overview in relation to the key strategic blueprints as part of the strategic plan.

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
Patient and Public Engagement	x			
Clinical Engagement	x			
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement	x			
Presented to other Committees				

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

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
January 2016

1.0 Introduction

1.1 This paper provides the Governing Body with a short briefing up-date on the Shaping Sefton Transformation plan, as part of the overall CCG Strategic Plan.

2.0 Primary Care Blueprint

2.1 South Sefton

Current progress on primary care within South Sefton largely relates to new models of care. Several factors are providing imminent opportunities to consider new models of care to improve outcomes, and redesign services across Sefton:

- Partnership working to develop ideas on primary care transformation via Shaping Sefton events;
- 9 APMS contracts are due for procurement by March 2017;
- Local Quality Contract – the frail elderly scheme encourages practices to consider the workforce needed to deliver care to an elderly population, and skill mix required within the practice, and recognises frailty as a long term condition for proactive case finding and management;
- Community services are being procured by March 2017, to ensure they support general practice in optimising clinical care and management of patients in the community setting;
- Investment in telehealth/clinical triage;
- Redesign of Litherland Walk-in Centre to provide GP led urgent care services;
- The opportunity to increase the level of co-commissioning from level 1 to level 2, allowing for more involvement by the CCG;
- Greater investment available through Primary Care Infrastructure and Transformation Funds;
- Consideration of a Medical Director role to support ongoing developments. The business case for this is scheduled for consideration at the next QIPP meeting.

2.2 Southport and Formby

- Partnership working to develop ideas on primary care transformation via Shaping Sefton events;
- 2 APMS contracts are due for procurement by March 2017;
- Local Quality Contract – the frail elderly scheme encourages practices to consider the workforce needed to deliver care to an elderly population, and skill mix required within the practice, and recognises frailty as a long term condition for proactive case finding and management;
- Community services are being procured by March 2017, to ensure they support general practice in optimising clinical care and management of patients in the community setting;
- Investment in telehealth/clinical triage;
- Programme of work to develop collaborative working;

- Roving GP and community GPSIs to enable frail elderly patients to remain in their usual place of residence where appropriate;
- The opportunity to increase the level of co-commissioning, allowing for more involvement by the CCG;
- Greater investment available through Primary Care Infrastructure and Transformation Funds;
- Recent formation of a federation;
- Appointment of Band 7 to support primary care commissioning and support exploration of new care model;
- Pending recruitment to Medical Director Role in support of re-design.

3.0 Unplanned Care and Community Care Blueprints

South Sefton Update

3.1 The Virtual Ward has been rolled out across all localities in South Sefton. Community Urgent Care is now in place and responding to GP referrals, and has capacity to receive further referrals, avoiding unnecessary attendance and admissions. The CCG is supporting the provider in promoting services across the localities. Community services are all fully staffed and there are currently no local vacancies.

3.2 The Care Home Improvement Programme (CHIP) telehealth project has been rolled out to all care homes apart from one home. Care home matrons have been recruited for each locality and are proving effective in supporting Primary Care. The CCG is currently reviewing data to understand the schemes impact on hospital attendances, but early indications are very encouraging. The CCG are still in discussions with Aintree Hospital regarding a review of their Frailty Pathway with the proposed focus being on direct admissions.

3.3 The Trust Development Authority (TDA) has confirmed that the transaction process that will conclude with the acquisition of Liverpool Community Health by a new provider, will be an "NHS only" procurement led by the TDA. A Transaction Board has now been established comprising relevant stakeholders to oversee the programme of work that will be completed by April 2017. This Board is supported by a number of key work streams, including a clinical forum that will lead on the development of specifications.

3.4 The first meeting of the Board took place on 11th November 2015.

Southport and Formby Update

3.5 The Trust has identified new Acting Director of Operations for Community services and is now in post. The CCG is discussion with the Trust how to ensure we receive assurance on progress against community services. The Trust is reviewing their governance structures to reflect plans for facing the future together to provide assurance to the CCG. Trust recruitment is targeting local, European and international recruitment to address vacancies. To date 25 nurses have been recruited, with further 82 nurses currently on pre-employment phase of the appointment process.

3.6 Joint work on capacity and demand has progressed with the CCG and the ICO, which is contributing to the direct work of the SRG for Southport & Formby.

3.7 The Community Services Procurement Steering Group, that will oversee the procurement in Southport and Formby has now been established and is supported by a number of work streams including a specification development group. This group was established so that there is a clinically led forum for the development of outcome based transformational specifications. Critically, the CCG has secured evidence support services as part of that process, so that clinicians and other leads can explore examples of good practice and examine supporting literature which will help ensure the development of transformational specifications.

3.8 The bidder day for Southport and Formby bidder day took place on the 18th November 2015.

4.0 Intermediate Care Blueprint

South Sefton

4.1 The Governing Body will recall that in September 2015, authority was given to pursue a procurement exercise for the provision of intermediate care beds. The bidding process closed in December and unfortunately, the exercise failed to deliver any viable bidders.

4.2 The delivery of the fully integrated team across health and social care, including third sector colleagues, was planned for July 2016. Unfortunately, due to the TDA acquisition process, it has been necessary to postpone the decommissioning of Ward 35 until 2017, which impacts upon our ability to effect the desired integration before that time. Consideration is now being given to the impact of these events on our longer term plans for intermediate care and whether our strategy may now require some redesign.

Southport and Formby

4.3 The Leadership Team, with delegated authority from the Governing Body, approved the purchase of additional intermediate care beds for a 12-month period to progress the Admission Avoidance and Transition from Hospital Scheme. However, upon analysis of the incumbent costs associated with developing the CERT team to support this service, in the absence of a pooled budget for health and social care in Sefton and given the CCG's challenging financial position, the decision was made that progressing with the scheme at this time presents too significant financial risk to the CCG. This position remains under constant review.

5.0 Mental Health Blueprint

5.1 The CCG's have developed and agreed a set of joint strategic working principles with Merseycare, following a combined workshop held in December. These are derived and based upon a common language and understanding which is complementary to both the CCG's and Merseycare's strategic plans. Following the workshop a common set of priorities have been developed and agreed in an effort to focus joint working. These priorities have agreed delivery timetables and outcomes against which we will be progressing our transformation work together.

5.2 In addition, discussions have taken place with Liverpool CCG, with a view to establishing a joint commissioning framework with South Sefton and Southport & Formby CCG in relation to Merseycare. Liverpool CCG are very supportive and work is on-going now to move to operating against this new framework in support of aligned and co-ordinated commissioning.

5.3 South Sefton, Southport & Formby CCG's in conjunction with Liverpool CCG has also reviewed their collective mental health priorities and transformation programmes. Agreement has been reached to develop a single transformation structure to advance the identified priorities and transformation work.

5.4 in addition to the above a selection of specific service lines have been identified for joint work with Mersey Care in terms of cost of current service contract, specification, activity and demand and future service requirements.

6.0 Conclusion

6.1 The Governing Body is requested to note the progress under the respective strategic blueprints, noting that more detailed performance is contained within the Integrated Performance Report.

Karl McCluskey
Chief Strategy and Outcomes Officer
January 2016

REPORT TO THE GOVERNING BODY
JANUARY 2016

Agenda Item: 16/15	**Author of the Paper:** Karl McCluskey Chief Strategy & Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk
Report date: January 2016	

Title: South Sefton Clinical Commissioning Group Integrated Performance Report

Summary/Key Issues: This report provides summary information on the financial, activity and quality performance of South Sefton Clinical Commissioning Group (note time periods of data are different for each source)

Recommendation

The Governing Body is asked to receive this report by way of assurance.

	x
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.
	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.

NHS South Sefton Clinical Commissioning Group

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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

South Sefton Clinical Commissioning Group

Integrated Performance Report

NHS
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Clinical Commissioning Group

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1. Executive Summary

This report provides summary information on the activity and quality performance of South Sefton Clinical Commissioning Group at Month 8 (note: time periods of data are different for each source).

CCG Key Performance Indicators

NHS Constitution Indicators	CCG	Main Provider
A&E 4 Hour Waits		Aintree
Ambulance Category A Calls (Red 1)		NWAS
Cancer 2 Week GP Referral		Aintree
RTT 18 Week Incomplete Pathway		Aintree
Other Key Targets	**CCG**	**Main Provider**
A&E 4 Hour Waits (Type 1)		Aintree
Ambulance Category A Calls (Red 2)		NWAS
Ambulance Category 19 transportation		NWAS
Cancer 14 Day Breast Symptom		Aintree
Cancer 31 Day First Treatment		Aintree
Cancer 31 Day Subsequent - Drug		Aintree
Cancer 31 Day Subsequent - Surgery		Aintree
Cancer 31 Day Subsequent - Radiotherapy		Aintree
Cancer 62 Day Standard		Aintree
Cancer 62 Day Screening		Aintree
Cancer 62 Day Consultant Upgrade		Aintree
Diagnostic Test Waiting Time		Aintree
Emergency Admissions Composite Indicator		
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)		
Emergency Admissions for acute conditions that should not usually require a hospital admission		
HCAI - C.Diff		Aintree
HCAI - MRSA		Aintree
IAPT Access - Roll Out		
IAPT - Recovery Rate		
Mixed Sex Accommodation		Aintree
Patient Experience of Primary Care i) GP Services ii) Out of Hours (Combined)		
PROM: Elective procedures: Groin Hernia		Aintree
PROM: Elective procedures: Hip Replacement		Aintree
PROM: Elective procedures: Knee Replacement		Aintree
PYLL Person (Annual Update)		
RTT 18 Week Admitted Pathway		Aintree
RTT 18 Week Non Admitted Pathway		Aintree
RTT 18 Week Incomplete Pathway		Aintree
RTT 52+ week waiters		Aintree
Stoke 90% time on stroke unit		Aintree
Stoke who experience TIA		Aintree
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s		
Unplanned hospitalisation for chronic ambulatory care		
Local Measure: Access to services BME		

Key information from this report

Financial Performance - The financial position is £0.948m overspent at Month 9 on operational budget areas before the application of reserves or contingency. The forecast position has improved by £0.211m during the month. It should be noted that achievement of the planned surplus is reliant on a number of non-recurrent benefits which will not be available beyond Q1 of next year. It is imperative that the CCG develops plans to reduce expenditure between now and then, otherwise it will threaten ongoing delivery of its financial targets.

Referrals – GP Referrals have been increasing since March 2015. Analysis by specialty and provider reveals that ENT at Aintree receives the most GP Referrals and has seen an increase since the middle of 2014/15. Gastroenterology referrals also continue to increase. General Medicine is showing a dramatic increase for 15/16. These are the GP Hotline referrals which we have notified Aintree that the CCG will not be funding.

A&E waits (All Types) – The CCG met the 95% target for November with a performance of 96.17% year to date (in month achieving 91.09%). Aintree failed the target in November recording 87.96%, and are also failing year to date reaching 93.16%. In November 1491 out of 12384 attendances where not admitted, transferred or discharged within 4 hours. Provider comment - The Trust continues to report high numbers of medically optimised patients remaining in an inpatient bed. This peaked at 94 patients in early October and is currently at 81 patients. A point prevalence study was undertaken in November 2015 for all medical inpatients. This showed that 161 patients were optimised for discharge, 45% of the total medical inpatients. The main delays noted were waits for placement and intermediate care. The number of medically optimised patients needs to be consistently below 50 to maintain flow. To ensure sustained improvement, the implementation of outstanding actions remains a priority.

A&E Waits (Type 1) – The CCG have failed the 95% target in November reaching 78.85%, and year to date reaching 86.09%. In November 812 attendances out of 3840 were not admitted, transferred or discharged within 4 hours. Aintree have failed the target in November reaching 77.13%, and year to date reaching 87.09%. In November 1491 attendances out of 6520 were not admitted, transferred or discharged within 4 hours.

Ambulance Activity - The CCG are failing one ambulance indicator, Cat A (Red2) indicator achieving 73.6% year to date and in month (November) recording 70.0%. NWAS are failing 2 of the ambulance indicators Category A (Red 2) achieving 74.5% and in month 68.5% and Category 19 transportation time, achieving 94.4% year to date, in month achieving 92.0%. Demand in terms of Red activity in South Sefton was particularly high in November, and average handover times at Aintree Hospital were on average the longest in the North West in November. A Contract Performance Notice relating to Ambulance Handover was discussed at Aintree SRG Wednesday 16th December 2015, and the North Mersey SRG will also discuss the reinvestment of fines that have been applied to providers across the SRG footprint.

Cancer Indicators – The CCG achieved all the cancer indicators year to date as at October 2015 apart from 62 day screening achieving 86.67% year to date against a 90% target, in month achieving 80.0%. In October 1 patient out of 5 breached the 90% target (80%). This was a Lower Gastro patient and the delay was 83 days due to complex pathway and patient choice issues. Treatment Provider was Aintree. Aintree achieved all their cancer indicators year to date as at October 2015.

Emergency Admissions Composite Measure – For November the CCG is over the monthly plan and had 147 more admissions than the same period last year. The monthly plans for 2015-16 been split using last year's seasonal performance. Pathway changes at Aintree resulting in

higher activity levels, may not have been reflected in the planned targets due to when the changes were implemented compared to when the targets were set.

HCAI – MRSA - One new case has been reported in November of MRSA for South Sefton CCG reporting Trust being Aintree. Year to date they has now been 2 cases attributed to the CCG against a zero tolerance target.

IAPT Access – Roll Out – The CCG are under plan for Q2 for IAPT Roll Out and reached 2.48% which shows an improvement on Q1 (2.07%) plan 3.75%. This equates to 602 patients having entered into treatment out of a population of 24298 (Psychiatric Morbidity Survey). November data shows the CCG are under plan with 252 patients having entered into treatment (1.04%). This is an increase from last month when 0.76% was reported.

IAPT - Recovery Rate – The CCG are under the 50% plan for recovery rate in Q2 reaching 48.5%. This equated to 180 patients who moved to recovery out of 371 who completed treatment. November data shows the CCG are under plan for recovery rate reaching 47.10%. This equates to 56 patients who have moved to recovery out of 119 who have completed treatment. This is a decrease from last month when 53.6% was reported.

Patient experience of primary care - The CCG reported the proportion of negative responses at 6.91% which is above the 6% target. This is a slight improvement from the last survey which reported 7.63%. Detailed data has been shared with primary care, quality and communications colleagues for discussion and actions at the appropriate committees.

Patient Safety Incidents Reported – Aintree reported 2 new Serious Untoward Incidents in November, year to date are reporting 26 in total, 1 unexpected death and 1 pressure ulcer grade 3.

RTT – 52 week waiters - The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has 1 patient waiting for 52+ weeks for treatment in T&O. This patient is currently undated – did have TCI of 22/10/2015 but patient cancelled. Capacity issues with Spinal patients – patient had TCI in October but cancelled as daughter due to give birth around then and requested a date in the New Year. The Robert Jones and Agnes Hunt reported 28 breaches in November (only one attributed to South Sefton CCG), these will start to reduce from December, a recovery plan is now in development and will be finalised at the end of February.

Friends and Family Test - Aintree University Hospital NHS Foundation Trust achieved the response rate target in both inpatients and A&E in November, but are failing the targets for A&E recommended and not recommended.

2. Financial Position

2.1 Summary

This report focuses on the financial performance for South Sefton CCG as at 31st December 2015 (Month 9). The financial position is £0.948m overspent at Month 9 on operational budget areas before the application of reserves or contingency. The forecast position has improved by £0.211m during the month.

The overall forecast for the CCG is a surplus of £2.400m against a planned surplus of £2.400m after the application of reserves.

It should be noted that achievement of the planned surplus is reliant on a number of non-recurrent benefits which will not be available beyond Q1 of next year. It is imperative that the CCG develops plans to reduce expenditure between now and then, otherwise it will threaten ongoing delivery of its financial targets.

To date, the CCG has identified £1.474m QIPP savings against the target of £3.441m, leaving £1.967m required to deliver the plan in full. Unless plans to achieve the QIPP are identified in full, the CCG will not deliver a surplus in the new financial year.

Figure 1 – Financial Dashboard

Key Performance Indicator		This Month	Prior Month
Business Rule (Forecast Outturn)	1% Surplus	✓	✓
	0.5% Contingency Reserve	✓	✓
	1% Non-Recurrent Headroom	✓	✓
Surplus	Financial Surplus / (Deficit) *	£2.400m	£2.400m
QIPP	Unmet QIPP to be identified > 0	£1.967m	£2.285m
Running Costs (Forecast Outturn)	CCG running costs < National 2015/16 target of £22.07 per head	✓	✓

Note this now reflects the overall surplus net of any reserves adjustments

2.2 Resource Allocation

Additional allocations have been received in Month 9 as follows:

- Liaison Psychiatry - £0.041m
- CAMHS Transformation - £0.179m
- IAPT Waiting list - £0.016m

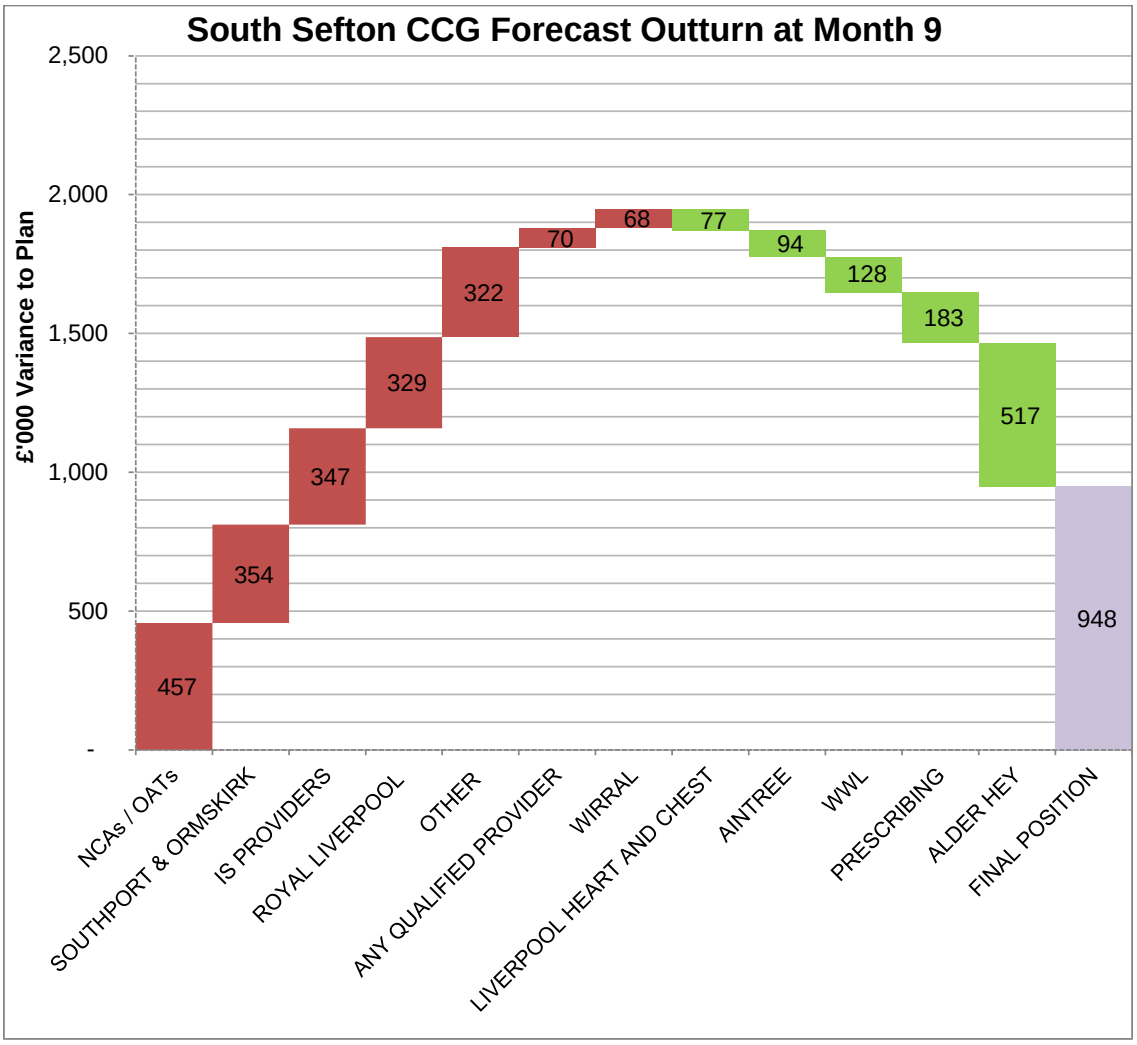
These allocations are all non-recurrent and are expected to be utilised within this financial year.

2.3 Position to date

There are forecast overspends on the non-contract / out of area activity (NCAs/OATs) budgets and within acute care across a range of providers, particularly Southport & Ormskirk Hospital, Royal Liverpool Hospital, Ramsay Healthcare for orthopaedics and Spa Medica for ophthalmology. The overspend is partly supported by underspends with other acute providers, particularly Alder Hey and Aintree Hospitals due to underperformance against contract.

Whilst the financial activity period relates to the end of December, the CCG has based its reported position on information received from Acute Trusts to the end of November 2015.

Figure 2 – Forecast Outturn



NCAs/OATs

The budget for non-contract activity (NCA) and Out of Area Treatments (OATs) is overspent in Month 9 by £0.457m. The overspend relates to a number of high value invoices with various

providers for out of area patients (St Georges University, Guys & St Thomas, and York FT) and overseas patients. (Aintree Hospital, and the Walton Centre).

Independent Sector

The forecast overspend for independent sector providers is £0.347m for the financial year and has reduced slightly during the month. The majority of this expenditure relates to orthopaedic activity with Ramsay Healthcare. A detailed review of the current Trauma and Orthopaedic pathway is being undertaken across the CCG, results of which will be reported to the CCG in January 2016.

There are also additional costs at Spa Medica for ophthalmology treatment where the forecast overspend is £0.182m. A review is being undertaken to understand the referrals and activity in respect of this expenditure.

Under the current arrangements patients accessing independent hospitals are likely to complete their treatment well in advance of the 18 week target set out in the NHS Constitution. Whilst this is positive from both a patient experience and performance perspective, it is becoming increasing difficult for the CCG to sustain this position in terms of affordability. Changes in referral patterns are required in both the short and long-term to address the financial affordability issue.

Acute commissioning

Royal Liverpool Hospital Foundation Trust

The forecast overspend for Royal Liverpool Hospital is £0.329m. Overspending areas include non-elective vascular surgery, planned care, trauma and orthopaedics, anti-TNF drugs and ARMD.

Southport and Ormskirk NHS Trust

The forecast overspend for Southport and Ormskirk has increased during the month to £0.354m and relates to over performance within a range of areas:

- Maternity pathway payments and deliveries (£0.195m variance at month 8)
- Outpatient attendances (£0.013m variance at month 8)
- Outpatient procedures (£0.109m variance at month 8)
- Planned inpatient care (£0.065m at month 8)
- A&E (£0.064m at month 8)

These overspends are partially offset by underspends in non-elective care of £0.075m at month 8.

Aintree University Hospital Foundation Trust

The year to date underspend reported for Aintree is £0.018m and the year-end forecast is £0.094m underspent. This position is reported after a budget reduction of £0.208m due to QIPP, transferred from the contract in relation to the respiratory scheme. Efficiencies achieved have

been evidenced by reduced activity in Non Elective admissions from respiratory conditions; primarily Pneumonia and COPD.

The current position and forecast is based on the Month 8 performance information received from the Trust. The activity in November was greater than plan, with overspends in daycases, excluded drugs and outpatient attendances. This was offset by continued underspends in emergency admissions.

The main underspends relate to unplanned admissions, which are £1.255m (6.8%) lower than plan at the end of November (adjusted for £0.208m QIPP reduction). This is offset in part by an increase in outpatient activity (£0.662m above plan at the end of November or 6.1%), high cost drugs (£0.312m above plan at the end of November or 17.8%), and elective care (0.251m above plan at end of November or 2.6%).

The other significant reason for the reduction in NEL activity is the impact of a new Ambulatory Emergency Care (AEC) pathway that the Trust implemented in July 2015. The result of this is that fewer patients are being admitted, and costs therefore have reduced. All activity as a result is paid in line with national tariff which is consistent with other providers in the region.

The graphs below show the activity trends for inpatient care at the Trust. The CCG continues to review activity data from the Trust and query inappropriate charges when identified.

Figure 3 – Daycase Activity

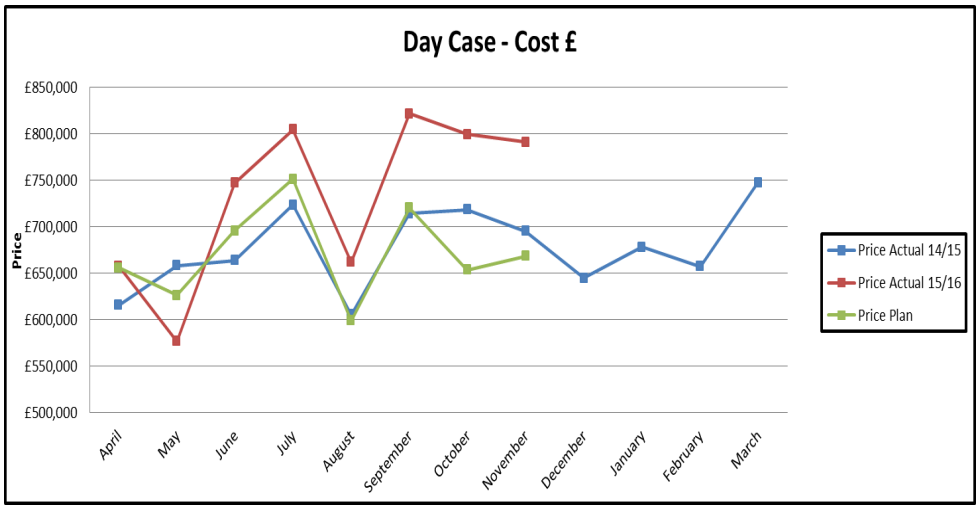


Figure 4 – Non Elective Activity

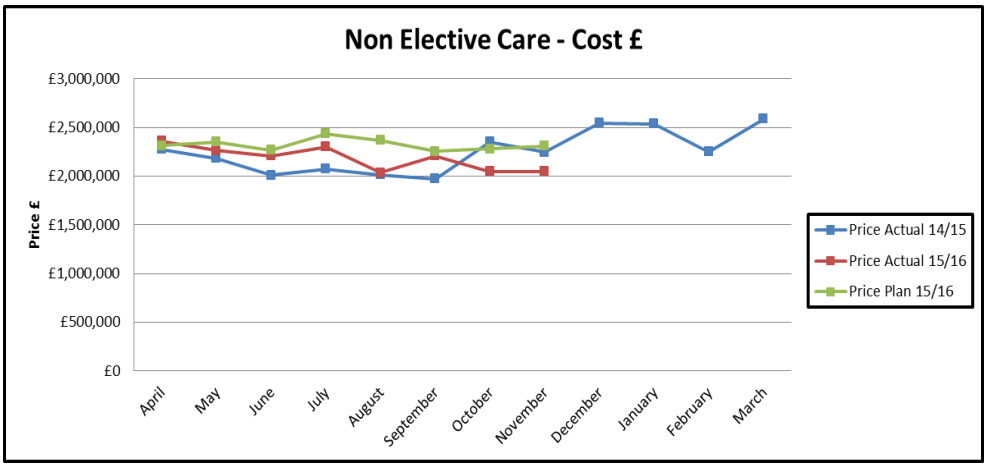
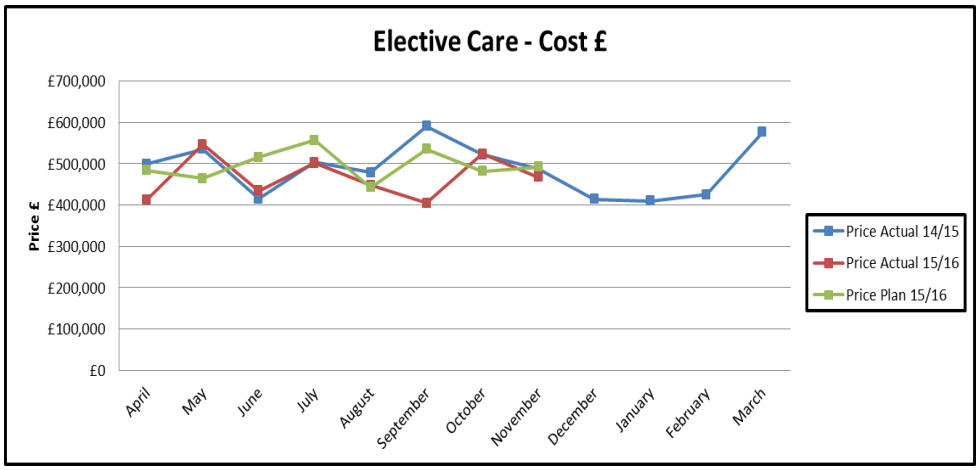


Figure 5 – Elective Activity



Alder Hey NHS Children's Foundation Trust

The year to date performance data received from Alder Hey shows an underperformance against plan across a number of specialties: paediatric ophthalmology, audiological medicine, trauma and orthopaedics and rheumatology. The activity plan was profiled to take into account the planned move to the new hospital with lower activity planned in September and higher activity in October. The actual move took place one month later than planned, and the impact of this has been reflected in the forecast and year to date position.

The current forecast for Alder Hey is an underspend of £0.517m.This underspend has been a consistent trend throughout the year.

Prescribing

The prescribing financial position improved during the month due to efficiencies on category M drugs, the forecast overspend of £0.191m at month 8 has been revised to an underspend of

£0.183m in month 9. The reduction in the forecast overspend relates to a reduction in the cost of category M drugs from Q4, and also a rebate from GlaxoSmithKline for the drug 'Seretide'.

The latest forecast received from the PPA still indicates an overspend on the prescribing budget although this overspend is offset by the efficiencies described above.

Costs remain volatile, partly due to the introduction of a new electronic payment mechanism in place at community pharmacies.

Continuing Health Care and Funded Nursing Care

The current forecast for this budget is an underspend of £0.039m. The forecast reflects the current number of patients, average package costs and an estimate for growth until the end of the financial year. There has been a sustained effort from the CCG and the CSU to contain CHC and FNC costs at 14/15 levels through robust case management and reviews.

As a result of this work, a recurrent efficiency of £0.460m has been achieved and transferred to support the QIPP savings target. The forecasted underspend is taken following this budget reduction.

2.4 QIPP

The QIPP savings target for South Sefton CCG is £3.441m for 2015/16. This has reduced to £1.967m following delivery of schemes totalling £1.474m.

	£'m
QIPP schemes reported at Month 8	**1.156**
QIPP schemes identified in current Month:	
Adjustment of CM rehab	(0.050)
FNC Review	0.160
Aintree Respiratory	0.208
QIPP schemes reported as at Month 9	**1.474**

The CCG established a 1% Transformation Fund in the budgets. This was set up to fund transformational initiatives that would result in more efficient delivery of healthcare and improvements to quality.

The fund is expected to underspend in 2015/16 by £1.436m due to the time taken to devise, review and implement schemes. However, the total fund on a full year basis is over-subscribed, and one of the roles of the QIPP Committee is to prioritise these schemes, with a view to understanding benefits achieved and to recommend whether they should be continued in 2016/17.

In addition to the transformational initiatives, a number of other cost reduction schemes are also being implemented.

2.5 CCG Running Costs

The CCG is currently operating within its running cost target of £3.296m, with a small underspend of £0.053m. This is mainly due to vacant posts within the medicines management team.

2.6 Evaluation of Risks and Opportunities

The CCG's primary risk is non-achievement of the QIPP requirement. £1.967m of recurrent savings must be realised in 2015/16 in order to achieve financial stability at the start of the next financial year. In addition, there are a number of other risks that require monitoring and managing:

- Acute cost per case contracts – The CCG has experienced significant growth in acute care in previous years. Previously this has been particularly evident in Urgent Care whereas the significant growth currently being seen is in planned care in both the independent sector and in the NHS.

- Estates – The methodology for charging estates costs has changed in 2015/16. Previously, the costs had been based on historic charges. In 2015/16, the organisation that administers the LIFT buildings (Community Health Partnerships – CHP) will be charging based on actual usage. The implementation of this change has been delayed to quarter 3. The CCG has set aside reserves to cover estates costs, and proposed charges have now been received from CHP. These are currently under review with CHP and local providers, particularly where proposed charges have risen unexpectedly. The data shows an increase in costs for the CCG and these have been queried with CHP. The charges are yet to be finalised as work with CHP is ongoing.

- Prescribing / Drugs costs - This is a volatile area of spend, and this risk has increased following implementation of a new electronic prescribing system leading to a change to the process for pharmacies to submit their prescribing scripts. As a result, it is unclear whether all prescriptions relating to the period have been submitted. This is leading to inconsistent reporting through PPA forecasts and is affecting CCG estimates.

Reserve budgets are set aside as part of the Budget Setting exercise to reflect planned investments, known risks and an element for contingency. Each month, the reserves and risks are analysed against the forecast financial performance and QIPP delivery.

Whilst the forecast position indicates that the CCG is on target to deliver its financial plans for 2015/16, the recurrent forecast surplus before risks/mitigations is £0.670m, primarily due to the failure to deliver QIPP schemes and is directly linked to the unmet QIPP figure of £1.967m. This presents a financial risk to the CCG in preparing for 2016/17.

This risk will be reflected accordingly in the CCG's risk reporting framework and must be considered as the CCG's top priority for both the remainder of this financial year and also 2016/17, alongside the commissioning of safe services.

It is critical for Governing Body Members to reflect this position in discussions with wider members. An intensive review of current expenditure is required at all levels of the CCG which will need considerable support from member practices, supported by Governing Body GP leads. The focus must be on reducing access to clinical services that provide low or little clinical benefit for patients.

The CCG's commissioning team must support Member practices in reviewing their commissioning arrangements to identify areas where clinical variation exists, and address accordingly. High levels of engagement and support is required from Member practices to enable the CCG to reduce levels of low value healthcare and improve value for money.

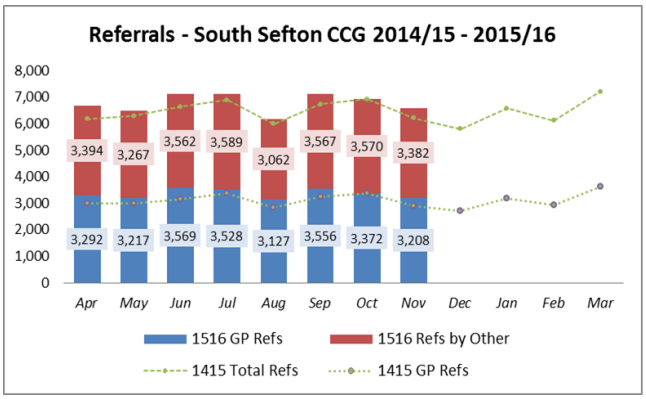
Figure 6 – Reserves Analysis

	Recurrent £000	Non-Recurrent £000	Total £000
Target surplus	2.400		2.400
Unidentified QIPP	(3.441)		(3.441)
Revised surplus / (deficit)	(1.041)		(1.041)
Forecast (against operational budgets)	(0.848)	(0.100)	(0.948)
Contingency reserves	1.044		1.044
Transformation Fund slippage		1.436	1.436
Reserves	0.041	0.394	0.435
QIPP:			
CM Rehab	0.150		0.150
Jospice	0.064		0.064
Contract Adjustments	0.050		0.050
Budget adjustments	0.064		0.064
Acute Growth restraint	0.478		0.478
CHC	0.300		0.300
FNC	0.160		0.160
Respiratory (Aintree)	0.208		0.208
QIPP Achieved	1.474	0.000	1.474
Forecast surplus / (deficit)	0.670	1.730	2.400
Risks	(1.750)		(1.750)
Mitigations	1.750		1.750
Risk adjusted forecast surplus / (deficit)	0.670	1.730	2.400

3. Referrals

3.1 Referrals by source

Figure 7 - GP and 'other' referrals for the CCG across all providers for 2015/16



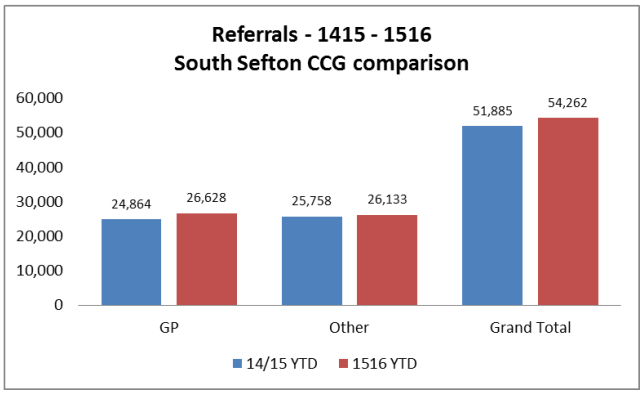


Figure 8 GP and 'other' referrals for the CCG across all providers comparing 2013/14, 2014/15 and 2015/16 by quarter

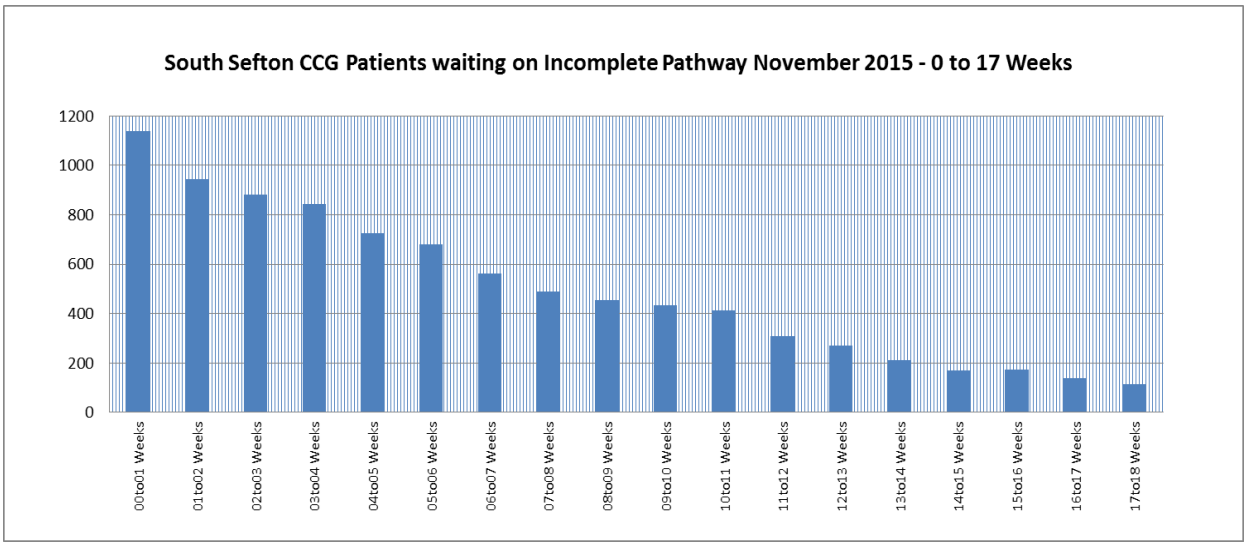
Referral Type	DD Code	Description	1314 Q1	1314 Q2	1314 Q3	1314 Q4	1415 Q1	1415 Q2	1415 Q3	1415 Q4	1516 Q1	1516 Q2	1516 Q3 FOT	1314 YTD	1415 YTD	1516 YTD	% Variance 1415 - 1516	1314-1516 Trendline
GP	03	GP Ref	8,766	8,709	8,563	9,073	9,130	9,480	8,953	9,773	10,078	10,211	9,870	26,038	27,563	30,159	9%	
GP Total			8,766	8,709	8,563	9,073	9,130	9,480	8,953	9,773	10,078	10,211	9,870	**26,038**	**27,563**	**30,159**	**9%**	
Other	01	following an emergency admission	553	513	538	469	517	534	473	511	527	509	509	1,604	1,524	1,545	1%	
	02	following a Domiciliary Consultation	7	6	8	1	2	5	8	7	5	2	5	21	15	12	0%	
	04	An Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)	1,024	875	721	806	832	780	727	762	1,385	1,208	1,242	2,620	2,339	3,835	64%	
	05	A CONSULTANT, other than in an Accident and Emergency Department	3,689	3,556	3,668	3,681	3,788	3,829	3,919	4,077	3,934	3,856	3,942	10,913	11,536	11,732	2%	
	06	self-referral	827	672	703	756	731	786	811	889	861	900	923	2,202	2,328	2,684	15%	
	07	A Prosthetist	1	16	10	14	3	4	4	7	6	2	0	27	11	8	-27%	
	10	following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)	561	659	711	811	775	738	723	676	291	268	300	1,931	2,236	859	-62%	
	11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	571	551	568	594	631	788	738	674	593	720	818	1,690	2,157	2,131	-1%	
	12	A General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)	22	8	11	25	7	16	24	23	17	20	23	41	47	60	27%	
	13	A Specialist NURSE (Secondary Care)	35	21	19	30	21	18	21	22	18	30	33	75	60	81	35%	
	14	An Allied Health Professional	224	214	195	179	311	272	233	204	280	352	333	633	816	965	18%	
	15	An OPTOMETRIST	20	22	19	19	28	25	23	19	26	28	45	61	76	99	30%	
	16	An Orthoptist	0	0	1	0	0	0	0	0	2	0	0	1	0	2	0%	
	17	A National Screening Programme	3	39	20	7	8	21	7	6	6	17	23	62	36	46	26%	
	92	A GENERAL DENTAL PRACTITIONER	589	568	568	617	602	538	536	524	539	502	525	1,725	1,676	1,566	-7%	
	93	A Community Dental Service	6	9	12	5	8	8	12	5	5	0	6	27	28	11	-61%	
	97	other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	1,382	1,535	1,371	1,500	1,271	1,299	1,263	1,219	1,270	1,313	1,238	4,288	3,833	3,821	0%	
Other Total			9,514	9,264	9,143	9,514	9,535	9,661	9,522	9,625	9,765	9,727	9,962	**27,921**	**28,718**	**29,454**	**3%**	
Unknow n			315	485	511	509	446	492	471	515	458	491	467	1,311	1,409	1,416	0%	
Grand Total			**18,595**	**18,458**	**18,217**	**19,096**	**19,111**	**19,633**	**18,946**	**19,913**	**20,301**	**20,429**	**20,298**	**55,270**	**57,690**	**61,028**	**6%**	

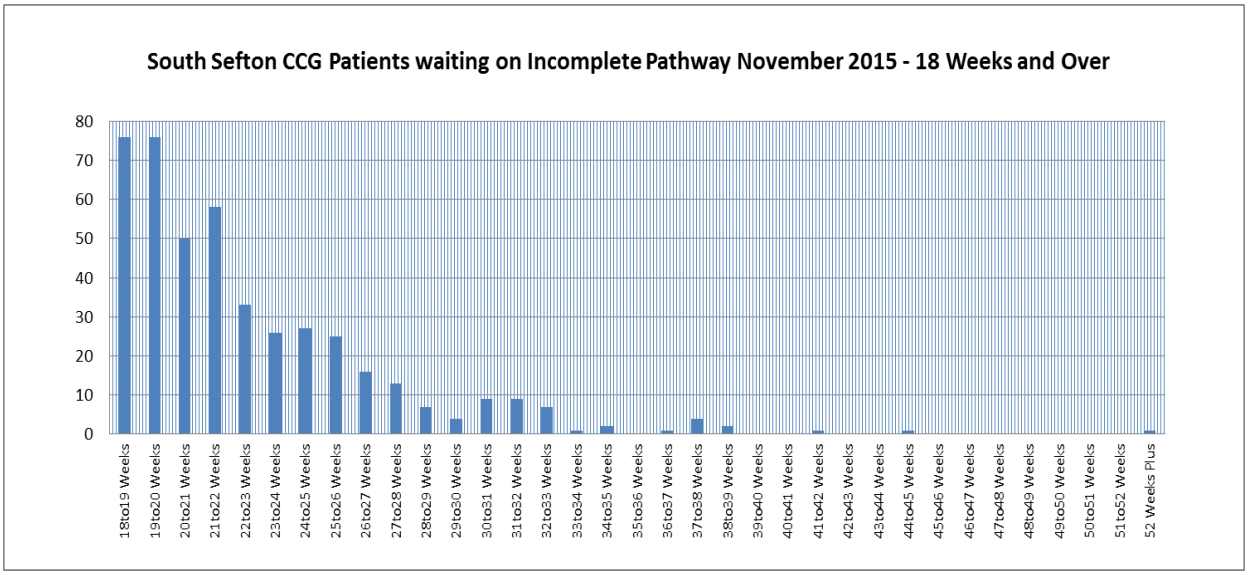
GP Referrals have been increasing since March 2015. Analysis by specialty and provider reveals that ENT at Aintree receives the most GP Referrals and has seen an increase since the middle of 2014/15. Gastroenterology referrals also continue to increase. General Medicine is showing a dramatic increase for 15/16. These are the GP Hotline referrals which we have notified Aintree that the CCG will not be funding.

4. Waiting Times

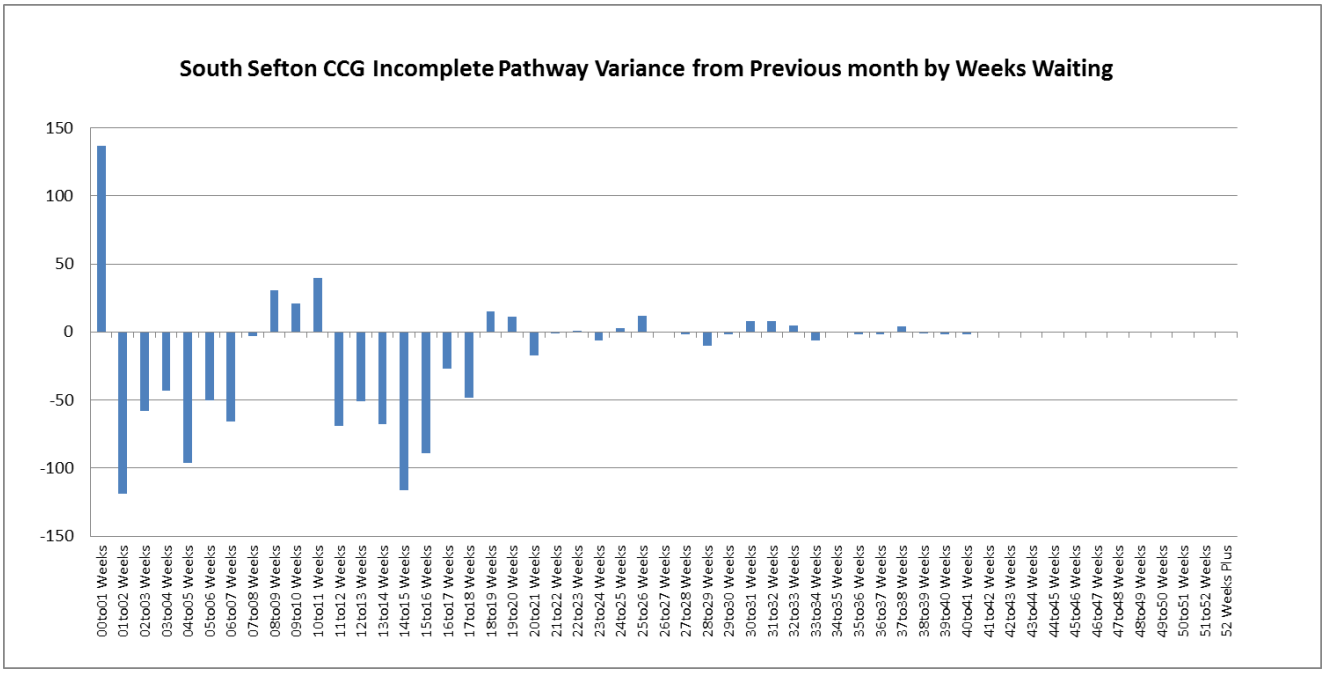
4.1 NHS South Sefton CCG patients waiting

Figure 9 Patients waiting on an incomplete pathway by weeks waiting.





There were 449 patients (4.8%) waiting over 18 weeks on Incomplete Pathways at the end of November 2015, an increase of 14 patients (3.2%) from Month 7 (15/16).
There was one patient waiting over 52 weeks at the end of November 2015. Further narrative for this is included in section 9 of this report.



There were 9,401 patients on the Incomplete Pathway at the end of November 2015, a decrease of 660 patients (6.6%) from October 2015.

4.2 Top 5 Providers

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

Trust	0to10 wks	10to18 wks	Total 0to17 Weeks	18to24 wks	24to30 wks	30+ wks	Total 18+ Weeks	Total Incomplete
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	4797	1004	5801	171	45	10	226	6027
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	677	296	973	65	22	9	96	1069
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	488	79	567	19	7	3	29	596
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	383	176	559	19	9	4	32	591
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	228	139	367	27	6	7	40	407
Other Providers	580	105	685	18	3	5	26	711
Total All Providers	7153	1799	8952	319	92	38	449	9401

4.3 Provider assurance for long waiters

Trust	Speciality	No of weeks waited	Reason for the delay
Royal Liverpool & Broadgreen Hospitals	General Surgery	41-42	Awaiting reasons from Provider
St. Helens & Knowsley Hospitals	Plastic Surgery	44-45	Awaiting reasons from Provider
The Robert Jones And Agnes Hunt Orthopaedic Hospital	Trauma & Orthopaedics	52+	Awaiting reasons from Provider

5. Planned Care

5.1 All Providers

Performance at Month 8 2015/16, against planned care elements of the contracts held by NHS South Sefton CCG shows an over-performance of circa £694k.This over-performance is driven by increases at Aintree Hospital (£867k), Southport & Ormskirk Hospital (£185k) and Renacres (£187k). Overspends are offset at Royal Liverpool (-£195k) and Alder Hey (-£228k).
ARMD is a growing area. Benchmarking has revealed a variance in the prices charged by providers under local tariff arrangements. A review is being undertaken across the region to standardise treatment pathways and prices. This will be completed in Spring 2016 with an in year impact expected in 2016/17. Paitents seen in ARMD clinics are followed up for life meaning outpatient activity will continue to increase over time.

Figure 11 Planned Care - All Providers

Provider Name	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	170,685	115,330	119,440	4,110	4%	£31,071	£20,998	£21,866	£867	4%
Alder Hey Childrens NHS F/T	14,711	9,765	7,988	-1,777	-18%	£2,326	£1,545	£1,317	-£228	-15%
Countess of Chester Hospital NHS FT	0	0	105	105	0%	£0	£0	£11	£11	0%
Liverpool Heart and Chest NHS F/T	1,273	871	719	-152	-17%	£578	£396	£256	-£140	-35%
Liverpool Womens Hospital NHS F/T	15,539	10,543	10,678	135	1%	£3,282	£2,220	£2,219	-£1	0%
Royal Liverpool & Broadgreen Hospitals	29,929	20,479	19,345	-1,134	-6%	£5,827	£3,987	£3,792	-£195	-5%
Southport & Ormskirk Hospital	13,390	9,158	9,725	567	6%	£2,753	£1,878	£2,063	£185	10%
ST Helens & Knowsley Hospitals	4,070	2,715	2,824	109	4%	£1,014	£679	£728	£49	7%
Wirral University Hospital NHS F/T	462	308	252	-56	-18%	£123	£82	£61	-£21	-26%
Central Manchester University Hosp Nhs FT	86	57	94	37	64%	£22	£14	£20	£6	39%
Fairfield Hospital	95	63	85	22	35%	£20	£13	£16	£3	21%
ISIGHT (SOUTHPORT)	262	175	242	67	39%	£65	£44	£57	£14	32%
Renacres Hospital	3,913	2,636	3,647	1,011	38%	£1,265	£858	£1,044	£187	22%
SPIRE LIVERPOOL HOSPITAL	3,334	2,236	1,902	-334	-15%	£999	£670	£590	-£80	-12%
University Hosp South Manchester Nhs FT	108	73	71	-2	-3%	£16	£11	£12	£1	14%
Wrightington, Wigan And Leigh Nhs FT	846	564	694	130	23%	£305	£203	£240	£37	18%
Grand Total	**258,704**	**174,972**	**177,811**	**2,839**	**2%**	**£49,666**	**£33,598**	**£34,292**	**£694**	**2%**

5.2 Aintree University Hospital NHS Foundation Trust

Figure 12 Month 7 Planned Care- Aintree University Hospital NHS Foundation Trust by POD

Aintree University Hospitals Planned Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	12,615	8,502	9,018	516	6%	£7,916	£5,335	£5,910	£575	11%
Elective	2,171	1,475	1,363	-112	-8%	£5,849	£3,975	£3,740	-£235	-6%
Elective Excess BedDays	1,134	771	535	-236	-31%	£252	£171	£117	-£54	-32%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	633	428	305	-123	-29%	£113	£77	£54	-£22	-29%
OPFANFTF - *Outpatient first attendance non face to face*	716	484	441	-43	-9%	£28	£19	£18	-£1	-6%
OPFASPCL - *Outpatient first attendance single professional consultant led*	31,994	21,650	22,697	1,047	5%	£4,593	£3,108	£3,388	£280	9%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	1,577	1,067	1,022	-45	-4%	£172	£117	£111	-£6	-5%
OPFUPNFTF - *Outpatient follow up non face to face*	1,251	847	2,212	1,365	161%	£30	£20	£53	£33	163%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	83,804	56,710	56,739	29	0%	£6,558	£4,438	£4,487	£50	1%
Outpatient Procedure	20,122	13,616	14,766	1,150	8%	£3,254	£2,202	£2,390	£188	9%
Unbundled Diagnostics	13,104	8,736	9,352	616	7%	£1,147	£765	£849	£84	11%
Wet AMD	1,566	1,044	990	-54	-5%	£1,157	£771	£747	-£24	-3%
Grand Total	**170,685**	**115,330**	**119,440**	**4,110**	**4%**	**£31,042**	**£20,979**	**£21,848**	**£868**	**4%**

5.2.1 Aintree University Hospital NHS Foundation Trust Key Issues

Analysis in the table above excludes GP Hotline activity recorded under OPFANFTF. The Collaborative Commissioning Forum has confirmed to Aintree Hospital in a letter that this activity will not be paid for by CCGs

Daycase over performance continues to rise to £575k/11% (£468k/10% in M7). This is primarily driven by Gastroenterology's over performance of £303k. 30% of Gastro over performance is attributable to one particular HRG "*FZ61Z - Diagnostic Endoscopic Procedures on the Upper GI Tract with biopsy 19 years and over*"

Combined Daycase/Elective Cardiology activity has seen a marked increase since month 8. This is as a result of three heart failure HRGs applicable to the new ambulatory heart failure service. This activity is being coded as Daycase & Electives rather than Outpatient procedures. There has been no agreement with the Trust relating to the cost of the tariff and the commissioners will expect an outpatient procedure cost for this service.

Over performance for Outpatient First attendances is in single professional consultant led. £280k over performance for month 8 is driven by Clinical Haematology which is showing a £143k/126% over performance. This area was raised at the Contract Review Meeting and the Trust has been asked for further info regarding the increase in Clinical Haematology.

Outpatient Procedure over performance is attributable mainly to two Specialties – Cardiology £90k/58% and Interventional Radiology £53k/63%. The Interventional Radiology over performance is linked to HRG 'Unilateral Breast Procedures'. Further analysis of activity carried out under this HRG show that procedures involve fine needles and imaging-guided biopsy's, therefore attributable to Interventional Radiology, but also increased due to the transfer of Breast Surgery activity into Aintree and the Breast Surgery over performance in outpatient first attendances. Cardiology over performance is solely attributable to Echocardiograms and is currently £90k/59% over performing against plan.

5.3 Southport & Ormskirk Hospital

Figure 13 Month 7 Planned Care- Southport & Ormskirk Hospital by POD

Southport & Ormskirk Hospital Planned Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	1,030	702	636	-66	-9%	£702	£479	£508	£29	6%
Elective	194	131	152	21	16%	£583	£394	£433	£38	10%
Elective Excess BedDays	13	9	1	-8	-89%	£3	£2	£0	-£2	-90%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	113	77	187	110	143%	£18	£12	£28	£15	123%
OPFASPCL - *Outpatient first attendance single professional consultant led*	2,611	1,787	1,514	-273	-15%	£366	£251	£223	-£28	-11%
OPFUPMPCL - *OP follow up Multi-Professional Outpatient First. Attendance (Consultant Led)*	210	144	380	236	164%	£21	£15	£37	£22	154%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	5,260	3,599	3,559	-40	-1%	£456	£312	£315	£3	1%
Outpatient Procedure	3,070	2,100	2,713	613	29%	£537	£368	£476	£109	30%
Unbundled Diagnostics	889	609	583	-26	-4%	£66	£45	£44	-£1	-3%
Grand Total	**13,390**	**9,158**	**9,725**	**567**	**6%**	**£2,753**	**£1,878**	**£2,063**	**£185**	**10%**

5.3.1 Southport & Ormskirk Hospital Key Issues

Outpatients Procedures is seeing increased activity in Trauma & Orthopaedics and Dermatology. HRG “HB56C Minor Hand or Foot Procedures” has shown an increase in activity since 1415. Procedures associated with the HRG are Joint injections for arthritis and “examination” of joint. “Investigative Procedures” in Dermatology has also shown a marked increase. Procedures associated with this HRG are generally Diagnostic dermatoscopy of skin. These two specialties make up almost all of Outpatient Procedure variance and this has been the theme throughout 2015/16.

5.4 Renacres Hospital

Figure 14 Month 6 Planned Care- Renacres Hospital by POD

Renacres Hospital Planned Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	500	340	377	37	11%	£622	£423	£417	-£6	-1%
Elective	72	49	70	21	44%	£308	£209	£328	£119	57%
OPFASPCL - *Outpatient first attendance single professional consultant led*	1,021	686	787	101	15%	£136	£92	£106	£15	16%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	1,264	850	1,900	1,050	124%	£100	£67	£111	£44	65%
Outpatient Procedure	662	445	224	-221	-50%	£63	£42	£53	£11	25%
Unbundled Diagnostics	394	266	289	23	9%	£37	£25	£30	£5	18%
Grand Total	**3,913**	**2,636**	**3,647**	**1,011**	**38%**	**£1,265**	**£858**	**£1,044**	**£187**	**22%**

5.4.1 Renacres Hospital Key Issues

Trauma & Orthopaedics is driving the Elective overspend with a M8 variance of £102k/53%. Activity within T&O is showing a marked increase in Major Hip & Knee Procedures. Activity in both of these areas is over performing by 53%, with the combined cost variance of £108k.

Outpatient Follow Ups are over performing by £44k/65%, and excluding the highest specialty of T&O, we have activity and finance recorded under three specialties with no plan – Spinal Surgery Services, Nursing Episodes and Allied Health Professional Episode. Further investigations will be conducted as TFC codes for Nursing Episodes and Allied Health Professional Episodes are no longer in use.

6. Unplanned Care

6.1 All Providers

Unplanned Care at Month 8 of financial year 2015/16, shows an under-performance of circa -£1.2m for contracts held by NHS South Sefton CCG.

This underspend is clearly driven by the -£1.4m under spend at Aintree Hospital and -£168k at Alder Hey. If we exclude Aintree, we would be reporting a month 8 over spend of £219k/1%. The two main Trusts over spending are Liverpool Women's £110k and Royal Liverpool £142k.

Figure 15 Month 7 Unplanned Care – All Providers

Provider Name	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	97,701	65,180	61,904	-3,276	-5%	£34,338	£22,898	£21,437	-£1,461	-6%
Alder Hey Childrens NHS F/T	8,868	5,797	5,865	68	1%	£1,905	£1,281	£1,113	-£168	-13%
Countess of Chester Hospital NHS FT	0	0	81	81	0%	£0	£0	£35	£35	0%
Liverpool Heart and Chest NHS F/T	171	114	155	41	36%	£144	£96	£185	£89	92%
Liverpool Womens Hospital NHS F/T	3,458	2,334	2,574	240	10%	£3,009	£2,038	£2,148	£110	5%
Royal Liverpool & Broadgreen Hospitals	5,851	3,900	4,319	419	11%	£2,145	£1,429	£1,572	£142	10%
Southport & Ormskirk Hospital	6,978	4,698	5,372	674	14%	£2,492	£1,679	£1,687	£9	1%
ST Helens & Knowsley Hospitals	850	567	595	28	5%	£361	£241	£228	-£13	-5%
Wirral University Hospital NHS F/T	245	163	258	95	58%	£90	£59	£73	£14	24%
Central Manchester University Hospitals Nhs FT	67	45	53	8	19%	£16	£11	£12	£1	9%
University Hospital Of South Manchester Nhs FT	41	27	24	-3	-13%	£14	£9	£7	-£2	-20%
Wrightington, Wigan And Leigh Nhs FT	42	28	34	6	21%	£15	£10	£12	£2	19%
Grand Total	**124,270**	**82,852**	**81,234**	**-1,618**	**-2%**	**£44,529**	**£29,751**	**£28,509**	**-£1,242**	**-4%**

6.2 Aintree University Hospital NHS Foundation Trust

Figure 16 Month 7 Unplanned Care – Aintree University Hospital NHS Foundation Trust by POD

Aintree University Hospitals Urgent Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
A&E WiC Litherland	41,953	27,994	26,988	-1,006	-4%	£953	£636	£635	-£1	0%
A&E - *Accident & Emergency*	30,956	20,655	20,041	-614	-3%	£3,646	£2,433	£2,416	-£16	-1%
NEL - *Non Elective*	13,932	9,289	8,316	-973	-10%	£25,986	£17,327	£16,292	-£1,035	-6%
NELNE - *Non Elective Non-Emergency*	44	29	26	-3	-11%	£122	£81	£64	-£17	-21%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	40	27	86	59	222%	£10	£6	£17	£11	174%
NELST - *Non Elective Short Stay*	2,732	1,822	1,438	-384	-21%	£1,764	£1,176	£965	-£211	-18%
NELXBD - *Non Elective Excess Bed Day*	8,044	5,364	5,009	-355	-7%	£1,858	£1,239	£1,046	-£192	-16%
Grand Total	**97,701**	**65,180**	**61,904**	**-3,276**	**-5%**	**£34,338**	**£22,898**	**£21,437**	**-£1,461**	**-6%**

6.2.1 Aintree Hospital Key Issues

Discussions regarding activity and finance are on-going both internally and with the Trust with a view to informing contract negations for 2016/17. The North West Utilisation Management team have been conducting a review at Aintree into urgent care, and a formal report has been shared with the CCG and Aintree.

6.3 Alder Hey Hospital

Figure 17 Month 7 Unplanned Care – Alder Hey Hospital by POD

Alder Hey Childrens Hospital Urgent Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
A&E - *Accident & Emergency*	7,899	4,472	4,524	52	1.15%	£688	£390	£387	-£3	-0.78%
NEL - *Non Elective*	854	493	455	-38	-7.68%	£1,174	£713	£581	-£131	-18.41%
NELNE - *Non Elective Non-Emergency*	1	1	0	-1	-100.00%	£1	£1	£0	-£1	-100.00%
NELXBD - *Non Elective Excess Bed Day*	113	69	10	-59	-85.60%	£42	£26	£3	-£22	-86.53%
Grand Total	**8,868**	**5,036**	**4,991**	**-45**	**-0.88%**	**£1,905**	**£1,129**	**£973**	**-£156**	**-13.82%**

6.3.1 Alder Hey Hospital Key Issues

The underperformance against contract plan has also been mirrored by Liverpool CCG, although other local CCGs have seen over performance against plan at this provider. The current financial position as a Trust for Urgent Care is 4% below plan. The Trust has been asked to provide further information into the variances, highlighting key specialties and possible reasons.

6.4 Royal Liverpool & Broadgreen Hospitals

Figure 18 Month 6 Unplanned Care – Royal Liverpool & Broadgreen Hospitals by POD

The Royal Liverpool Hospital Urgent Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
A&E - *Accident & Emergency*	4,422	2,948	3,235	287	10%	£397	£265	£295	£30	11%
AMAU - *Acute Medical unit*	63	42	44	2	5%	£6	£4	£4	£0	4%
NEL - *Non Elective*	692	461	453	-8	-2%	£1,355	£903	£997	£94	10%
NELNE - *Non Elective Non-Emergency*	24	16	13	-3	-19%	£179	£119	£99	-£21	-18%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	149	99	0	-99	-100%	£33	£22	£0	-£22	-100%
NELST - *Non Elective Short Stay*	268	179	188	9	5%	£137	£92	£103	£12	13%
NELXBD - *Non Elective Excess Bed Day*	234	156	386	230	148%	£50	£33	£83	£50	148%
readmissions	0	0	0	0	0%	-£13	-£9	-£9	£0	-3%
Grand Total	**5,851**	**3,900**	**4,319**	**419**	**11%**	**£2,145**	**£1,429**	**£1,572**	**£142**	**10%**

6.4.1 Royal Liverpool & Broadgreen Hospitals Key Issues

Non Electives & Non Elective Excess Bed days make up £143k of the total £142k unplanned over spend. Vascular Surgery is the main cause of NEL and NELXBD overspend, more specifically, 2 particular HRGs relating to Amputations and Lower Limb Arterial Surgery make up £85k of the total NEL overspend. This activity took place earlier in the financial, with the later months seeing activity more in line with the 2015/16 plan.

6.5 Delayed Transfers of Care

Delayed transfers of care are discussed weekly between the CCG, Hospital Providers and the Local Authority and figures are agreed each week. Note that these figures may not always match nationally reported figures from NHS England as they are often revised and agreed locally after the data submission deadlines of HS England. In South Sefton CCG, numbers of patients "Ready for Discharge" are reported alongside Delayed Transfers of Care.

Week Commencing 04/01/2016:

Monday: 34 – no DTOC
Tuesday: 33 – 2 DTOC
Wednesday: 32 – 1 DTOC
Thursday: 30 – 1 DTOC
Friday: 29 – No DTOC

7. Mental Health

7.1 Mersey Care NHS Trust Contract

Figure 19 NHS South Sefton CCG – Shadow PbR Cluster Activity

	NHS South Sefton CCG			
PBR Cluster	Plan	Caseload	Variance from Plan	% Variance
0 Variance	34	98	64	188%
1 Common Mental Health Problems (Low Severity)	23	48	25	109%
2 Common Mental Health Problems (Low Severity with greater need)	48	28	(20)	-42%
3 Non-Psychotic (Moderate Severity)	274	219	(55)	-20%
4 Non-Psychotic (Severe)	169	226	57	34%
5 Non-psychotic Disorders (Very Severe)	32	65	33	103%
6 Non-Psychotic Disorder of Over-Valued Ideas	43	38	(5)	-12%
7 Enduring Non-Psychotic Disorders (High Disability)	133	196	63	47%
8 Non-Psychotic Chaotic and Challenging Disorders	83	103	20	24%
10 First Episode Psychosis	93	137	44	47%
11 On-going Recurrent Psychosis (Low Symptoms)	414	434	20	5%
12 On-going or Recurrent Psychosis (High Disability)	312	315	3	1%
13 On-going or Recurrent Psychosis (High Symptom & Disability)	112	108	(4)	-4%
14 Psychotic Crisis	17	25	8	47%
15 Severe Psychotic Depression	7	4	(3)	-43%
16 Psychosis & Affective Disorder (High Substance Misuse & Engagement)	33	33	-	0%
17 Psychosis and Affective Disorder – Difficult to Engage	58	59	1	2%
18 Cognitive Impairment (Low Need)	347	227	(120)	-35%
19 Cognitive Impairment or Dementia Complicated (Moderate Need)	462	509	47	10%
20 Cognitive Impairment or Dementia Complicated (High Need)	148	336	188	127%
21 Cognitive Impairment or Dementia (High Physical or Engagement)	45	74	29	64%
Reviewed Not Clustered	36	225	189	525%
No Cluster or Review	144	190	46	32%
Total	3,067	3,697	630	21%

Figure 20 CPA – Percentage of People under CPA followed up within 7 days of discharge

			Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
E.B.S.3	The % of people under adult mental illness specialities who were followed up within 7 days of discharge from psychiatric inpatient care	Target 95%	100 %	100%	100%	93%	100%	100%	100%	100%

Figure 21 CPA Follow up 2 days (48 hours) for higher risk groups

			Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
KPI_32	CPA Follow up 2 days (48 hours) for higher risk groups are defined as individuals requiring follow up within 2 days (48 hours) by CRHT, Early Intervention, Assertive Outreach or Homeless Outreach Teams.	Target 95%	100%	100%	100%	100%	No patients requiring follow up in August	100%	No patients requiring follow up in October	100%

Quality Overview

At Month 8, Merseycare are compliant with quality schedule reporting requirements. The Trust is working with the CCG Quality team to develop the safer staffing report , a presentation was provided at the December CQPG meeting. In addition work is ongoing with Liverpool CCG and Mental Health Quality Leads to develop a new Serious Incident report .

Specific concerns remain regarding DNA's at Clock View site, GP referral pathways, AED assessment and access to psychotherapy. The CCG are monitoring these areas through the CQPG and SRG meetings.

A Contract Performance Notice has been issued to Merseycare regarding the recent A&E waits, a remedial Action Plan is now in place as a result. Four meetings have already been held with the Trust, South Sefton CCG, Liverpool CCG and Knowsley CCG, the next meeting is due to be held in January. An Escalation Plan has been developed between Merseycare and Aintree, to date there have not been any further long waits. As of 9th November the Prenton assessment suite at Clock View has been fully operational 24/7.It has been noted that communications have significantly improved between Merseycare and Aintree.

7.2 Cheshire Wirral Partnership - Improving Access to Psychological Therapies Contract

The prevalence rate at month 8 (6.34%) is below the target but has improved on last month. Current activity levels would indicate that the trust will fall below the annual 15% target at March 2016. To achieve the prevalence target of 15%, 2,160 people would need to enter treatment between December and March.

The Recovery rate in month 8 is 47.1% against the target of 50% and this is a fall compared to the October position of 53.6%.

Performance against waiting time targets continues to exceed the required minimum targets.

The number of patients self-referring is up on last month and this may be the result of awareness initiatives. The percentage of patients entering treatment in 28 days or less has also improved on last month.

Cancellations by patients at month 8 are up on last month's position. Appointments cancelled by the provider remain at levels that have been questioned by commissioners. The provider has offered no current explanation to the reasons for this and have previously attributed to staff sickness.

Previously Step 2 staff have reported that they were experiencing a high DNA rate and are confirming appointments with clients over the phone who then subsequently do not attend the appointment. The wait to therapy post screening is still part of the timeline and as such the service have reported that that the client may sometimes feel they need to accept the appointment as they have waited a significant time, but then do not feel the need to attend, as essentially the need has passed. At month 8 it would appear that what this process may be giving some results as the DNAs are less than last month for step 2.

The percentage of GP referrals appear to be on a downward trend with a corresponding increase in the proportion of self-referrals. The increase in self- referrals may be impacting on the "watchful wait" that is usually managed by the GP as this step is missed, and clients referring are assessed promptly. Following the assessment the natural process of managing some level of emotional distress occurs and when appointments are offered the desire to engage in therapy has diminished.

A text reminder service would assist in the reduction of DNAs. This would give the prompt to clients 24 hours before an appointment for those clients most likely to have forgotten.

Bespoke analysis from the provider has shown the opt in rates by practice and referral source which has been shared with practices.

A meeting was held with the provider on 10/12/2015 to discuss the Contract Performance Notice issued by the CCG relating to underperformance. The provider presented an action plan for review. A discrepancy was raised between the local data submitted to the CCG by the provider and the data the provider has submitted to the Health & Social Care Information Centre for the national data requirements. In a meeting on 07/01/2016 agreement was reached for the national Intensive Support Team to assist the provider in resolving this. Other actions agreed include:

- A focus of efforts to attract numbers in to IAPT treatment via engagement with GPs

- The inherited waiting list for the service has reduced from 1,100 to 64. Ongoing communication with GPs is planned to raise the profile of the service and dispel any myths around waiting times
- Embedded IAPT staff in targeted practices will also generate quicker access to services by undertaking assessments in GP practice setting.
- The service is initiating weekly SMS texting to reduce DNAs
- Referral criteria for Older People/Health Visiting team has been revised and this should generate more referrals.

Figure 22 Monthly Provider Summary including (National KPI s Recovery and Prevalence)

Performance Indicator			Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	TOTALS
Population (Paychiatric Morbidty Survey)			24298	24298	24298	24298	24298	24298	24298	24298	24298
National defininiton of those who have entered into treatment			143	158	201	204	166	232	184	252	1540
Prevelance Trajectory (%)			1.25%	1.25%	1.25% (q1=3.75%)	1.25%	1.25%	1.25% (q2=3.75%)	1.25%	1.25%	**15.00%**
Prevelance Trajectory ACTUAL			0.59%	0.65%	0.83%	0.84%	0.68%	0.95%	0.76%	1.04%	6.34%
National definition of those who have completed treatment (KPI5)			134	117	120	136	119	143	117	132	
National definition of those who have entered Below Caseness (KPI6b)			9	4	11	9	10	8	5	13	
National definition of those who have moved to recovery (KPI6)			75	51	61	66	49	65	60	56	
Recovery - National Target			50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	
Recovery ACTUAL			60.0%	45.1%	56.0%	52.0%	45.0%	48.1%	53.6%	47.1%	
Referrals Received			435	395	355	405	331	335	400	429	
Gp Referrals			289	215	152	161	115	114	107	108	
%GP Referrals			66%	54%	43%	40%	35%	34%	27%	25%	
Self referrals			114	149	175	205	184	207	235	271	
%Self referrals			26%	38%	49%	51%	56%	62%	59%	63%	
Other referrals	Other Referrals are 34 - Assessment and Immediate Care, 6 - Other, 1-WaltonNeuro, 2- Acute Care Team, 3 - Secondary Care, 1-Community(Adult), 2-Health Visitor, 1-Practice Nurse		32	31	28	39	32	14	58	50	
%Other referrals			7%	8%	8%	10%	10%	4%	15%	12%	
Referral not suitable or returned to GP			0	0	0	0	0	0	0	0	
Referrals opting in			415	355	285	299	259	249	288	284	
Opt-in rate %			95%	90%	80%	74%	78%	74%	72%	66%	
Patients starting treatment by step (Local Definition)		Step 2	94	119	142	157	125	178	137	240	
		Step 3	49	39	59	47	41	54	47	12	
		Step 4									
		Total	143	158	201	204	166	232	184	252	
Percentage of patients entering in 28 days or less			53.0%	37.0%	59.0%	60.0%	46.0%	29.0%	18.0%	31.8%	
Completed Treatment Episodes by Step (Local Definition)		Step 2	138	175	128	203	127	240	172	201	
		Step 3	341	329	363	383	287	462	377	245	
		Step 4									
		Total	479	504	491	586	414	702	549	446	
Activity	Attendances	Step 2	369	456	536	788	618	645	621	662	
		Step 3	389	422	547	460	466	507	412	499	
		Step 4		1	2	3	6	17	13	12	
	DNA's	Step 2	80	92	146	179	129	175	149	90	
		Step 3	52	49	75	56	55	60	45	45	
		Step 4		1					2		
	Cancels	Step 2	40	82	159	225	137	176	180	198	
		Step 3	62	89	107	95	81	99	116	119	
		Step 4						6	4	1	
	Attendances	Total	758	879	1085	1251	1090	1169	1046	1173	
	DNAs	Total	132	142	231	235	184	235	196	135	
	Cancelled	Total	102	171	266	320	218	281	300	318	
	Number Cancelled by patient	Total	45	109	194	253	181	239	205	243	
	Number Cancelled by provider	Total	57	62	72	67	37	42	95	75	

Figure 23 IAPT Waiting Time KPIs

	Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Year To Date
EH.1_A1	The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treament in the reporting period	75% To be achieved by April 2016									
	Numerator		120	114	128	140	124	174	137	124	1061
	Denominator		124	121	136	145	130	179	146	131	1112
	%		97%	94%	94%	97%	95%	97%	94%	95%	95%
EH.2_A2	The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	95% to be achieved by April 2016									
	Numerator		123	120	136	145	130	179	145	131	1109
	Denominator		124	121	136	145	130	179	146	131	1112
	%		99%	99%	100%	100%	100%	100%	99%	100%	100%

8. Community Health

Liverpool Community Health Services (by exception)

Community Equipment: The increase in demand is attributed to a number of factors: Sefton MBC budget issues, a new financial ordering system introduced by Sefton MBC, staffing resources in the warehouse, availability of delivery slots, and operational issues within the CES. Additional funding has been agreed by the commissioners to be split proportionally across both CCGs and this is documented in the FIG work plan. NHS South Sefton CCG has agreed to fund £165,000 non-recurrently in 2015/16 for the provision of the Community Equipment Store.
A number of actions have also been identified for this service
• Trust to provide a detailed overview of current waiting list.
• Trust to consider providing training on prescribing equipment and budget allocation.

Community Cardiac/Heart Failure: The reduction in referrals is due to the change in the cardiac rehab element of the service, which previously accounted for 25% of referrals. The reduction in out -patient activity, is a direct consequence of the change in the cardiac rehab contract arrangements.

Diabetes specialist nurse: This service has experienced issues with staffing since January 2015 including sickness and two appointed staff members subsequently resigned shortly after starting employment. Both vacancies were re advertised as part of the recruitment process and to date one band 6 has now been recruited and started in October. The service is focusing on providing clinic based delivery to maximise efficiency and domiciliary activity is reduced due to long term vacancy and long term sickness.

Palliative Care: The service performance has been affected by the staff training District Nurses, participating in joint visits and caseload reviews. The Palliative care programme is now part of the STEP (Supporting Transition & Education through Preceptorship) for all new staff, some of which at first do not understand the role of the service. The new locality working has resulted in fewer referrals as staff are talking to each other and are able to provide appropriate advice at that point in time. The service has also been affected by long term sickness in the team, however it is anticipated that staffing levels will be back to full capacity by December 2015.

Treatment Rooms: Demand and activity are up for this service and additional capacity has been created through the introduction of specific ear syringing clinics. A trajectory for improvement is under development. This will be reported on from next month. The change in delivery model has resulted in the increase in referrals from District Nurses. The trust will be monitoring this going

forward. The service continues to ensure that the majority of (95%) patients receive an appointment within 2 weeks of referral in Sefton. There are patients who opt to have an appointment appropriate to them and that falls outside of the 2 weeks. This is also attributed by the service to patients who request to wait for an appointment at a particular clinic location. Additional capacity has been created through the GP practices in Sefton conducting ear syringing sessions and this reduces the number of patients accessing the treatment rooms. There is an action from the contracts and clinical quality performance group for the trust to provide analysis around the ratio of contacts to referrals. An update on this work is awaited.

Intravenous Therapy (IV)- The current over performance is due to an increase in long term antibiotic referrals along with cellulitis referrals from GPs. The trust is utilising staff from other localities along with staff working extra hours to deal with the demand. IV patients are seen within 72 hours with cellulitis patients seen the same day as long as the referral is received before 3pm.The team continues to hand over non –complex patients to district nurses when capacity allows.
Previously there was an issue with staff not inputting activity to EMIS which made its look like demand is much higher than activity. The service has worked towards correcting this and continues to ensure that staff recognises the importance of capturing all activity.

Speech and Language Therapy (SALT) Adult and Children-The team is not able to meet the increased numbers of referrals and demand for SALT assessments and the trust is in the process of reviewing the core offer. There are planned discussions with the education authority with regards to the service provided to special educational settings and resourced units. The service states that additional funding needs to be sought outside of the block contract to enable the current staff to manage the high numbers of children waiting for support and assessment. A business case has been provided and this is to be discussed by Clinical Leads and processed by the CCG funding approval process. Waiting times for this service have not been provided for month 7. The trust submitted a business case for waiting list initiative funding and this has not been approved. The commissioner has asked for this to be reviewed to clearly demonstrate cost savings for the CCG.

Walk in Centre-The trust is working towards achieving the stretch target of all patients seen within 2 hours. See and Treat model is to be implemented in February 2016. Recruitment of GPs is behind schedule and projected for March 2016.

Virtual Ward-The trust have agreed to uplift service plans accordingly for services that deliver the virtual ward model. It was agreed that a financial breakdown would be provided by the end of quarter 1 to assist with this at the July finance and information group. The uplifted plans will then be reflected in the monthly reports going forward. The FIG work plan documents that the trust are awaiting guidance from the CCG. Update on progress is still awaited. The development of the activity plan has been be picked up as part of contract re-negotiation for 2016/17.

Wheelchairs: The waiting times are reported as above the commissioner set target of 4 weeks at 36 weeks. The service is now staffed to full establishment. Improvement trajectory has been developed to ensure the commissioner set target of 4 weeks is achieved by May 2016. Waiting list validation was due to be completed in December 2015. The application of the Access Policy/DNA policy has also been implemented. An improved trajectory is being agreed in December 2015.

Liverpool Community Health Waiting Times

Paediatric Speech and Language Therapy: The current waiting time for Paediatric Speech and Language Therapy is reported is in excess of 18 weeks at 22.1 weeks for NHS South Sefton CCG.

It was reported at the LCH December Board that a full service review is currently being completed including waiting list validation. The Board was also informed that a decision was made to close the waiting list. It was reported that 260 patients are waiting for an appointment across LCH catchment. It was confirmed that a locum has been commissioned in order to offer an appointment to patients on the waiting list.

The waiting times remain significantly above target in Sefton due to demand and capacity being significantly out of balance. Full validation of the waiting list is due to be completed in Sefton by January 2016.

The Capacity and demand model was expected by 18th December 2015 to inform the resources required to ensure waiting times are achieved. Additional therapists have been recruited and locums are due to start in January 2016. The waiting list remains closed and weekly meetings with commissioners will continue to monitor the impact. For this financial year 2015-16, CSU has asked (via email Tue 19/05/2015) LCH to give an indication of which waiting times will be reported during the current month, a month behind and not at all. LCH has not responded.

Wheelchairs: Waiting times are reported to be 36 Weeks at Month 8, previously reported as 33 weeks at Month 7. The Trust has reported that the service is now staffed to full establishment and a trajectory of improvement has been developed to ensure the commissioner set target of 4 weeks is achieved by June 2016.

Waiting times are not being recorded for several services: Community Cardiac/Heart Failure, Community Matrons, District Nursing Service, Diabetes Specialist Nurses, IV Therapy, Intermediate care community, Respiratory, Palliative Care & Treatment Rooms. Requests continue to be made for this to be included with the monthly reports but to date has not been forthcoming.

The development of waiting time thresholds is part of the work plan for the FIG as currently the default of 18 weeks is being used. A document was provided by the trust for discussion at the last finance and information group and it was agreed this would be circulated to clinicians for discussion and for the trust to consider the implications of adopting aspirational targets identified in the document. This document is due to go to the trust board in November.

Any Qualified Provider
The trust is using the agreed £25 local assessment tariff.

Patient Identifiable Data at Liverpool Community Health Trust

The Trusts Caldicott guardian had requested that no patient identifiable data sets are to be released from Liverpool Community Health. This includes all national submissions such as those made to the secondary user's service e.g. Inpatient, outpatient and WIC CDS. This was escalated last year and the update to this is that the approach now being implemented is a reversal of this approach and the trust are raising patient awareness around the use of patient identifiable data and have introduced an op out process. This means that patients can opt out from having identifiable electronic information flowed related to them. It was agreed that the trust

would forward a copy of the letter prepared by the Caldicott guardian about what the trust plans to do at the last LCH finance and information group meeting**.**

Southport and Ormskirk Trust

Community Gynaecology-The trust are submitting the monthly dataset as required however the data set provided does not includes the capture of onward referrals. The service is due to migrate to EMIS in 2016 when this issue will be rectified. This is all part of the on-going discussions around this service with the commissioner.

Quality Overview

Liverpool Community Health Trust is subject to enhanced surveillance. Work streams have been identified by the Collaborative Forum (CF) including Culture, Governance, Safety and Workforce, each area has an identified clinical and managerial lead from the CCG and the Trust, each work stream reports directly into the joint CQPG and CF.

Looked After Children (LAC)
Currently issues regarding the timely return of LAC Health Information from Liverpool Community Health to the Local Authority and the undertaking of health assessments, the CCG is holding them to account regarding any challenges they may have from across the system. The CCG Designated Nurse for Looked After Children has reported positive remedial action from the Trust with the back log of outstanding reviews now reduced significantly, however progress needs to be monitored and maintained.

Serious Incidents
Key areas of risk identified for Liverpool Community Health continue to be pressure ulcers, where the collaborative workshop has taken place alongside the trust and Liverpool CCG. The workshop has developed a composite action plan to address the 8 identified themes. The trust alongside both Liverpool and South Sefton CCG have confirmed their attendance at the NHSE Pressure Ulcer action plan development session, where the composite action plan will be share.

SALT Waiting Times
South Sefton CCG patients continue to experience longs waits for both paediatric and adult SALT services delivered by Liverpool Community Health, this has been raised at CQPG and Contract meetings, the Trust has submitted a business case regarding Adult SALT which is currently being reviewed with the clinical leads. The Trust has been asked to submit an updated progress report / recovery plan for CCG assurance.

9. Third Sector Contracts

Reports outlining service outcomes during 2015-16 are underway; Information Schedules detailing Q3 activity and case studies have now been received by most providers, those who have not yet submit information are currently being chased.

All providers are working towards v13 of the IG Toolkit and expect to be compliant before 31st March 2016. Information Schedules for the new contracting year are currently under review and are to be re-written to ensure the quality of the information provided demonstrates the service

outcomes and the contributions made to the wider health economy of South Sefton, Southport & Formby.

Support groups provided by Sefton Carers Centre and Swan Women's Centre have been attended by CCG Contracts to gain a greater understanding of the services provided and the work they do within the community, further visits have been arranged with Alzheimer's Society, SWACA, Sefton Cancer Support, Age Concern & SPAC.

Further consultation with iMersey around NHS Number collection for service users accessing Third Sector provider services is underway. IMersey are looking into possibilities of nhs.net email account set up for each provider to enable secure transfer of data to GP Practices for input and analysis. The aim is to analyse this data against GP appointments and hospital admissions within an electoral ward to see if the intervention is having an overall impact to the wider health economy of South Sefton, Southport & Formby.

An NHS Grant Agreement is currently being pulled together for services provided by AHDH Foundation for 2015-16. This grant is non-recurrent and is for the value of £30,000. Further details are to follow in month 9.

10. Quality and Performance

10.1 NHS South Sefton CCG Performance

		Current Period				
Performance Indicators	**Data Period**	**Target**	**Actual**	**Direction of Travel**	**Exception Commentary**	**Actions**
IPM						
Treating and caring for people in a safe environment and protecting them from avoidable harm						
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(CCG)**	15/16 - November	36	31	↑	There were 4 new cases reported in November 2015, year to date there have been 31 cases against a plan of 36. Of the 31 cases reported in year to date 29 have been aligned to Aintree Hospital and 2 to the Royal Liverpool Broadgreen Hospital (15 apportioned to acute trust and 16 apportioned to community).	
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(Aintree)**	15/16 - November	30	30 (15 following appeal)	↑	There were 2 new cases have been reported in November. Year to date there have been 30 cases against a plan of 30, the year to date plan is 46.	
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(CCG)**	15/16 - November	0	2	↑	There was 1 new case has been reported in November of MRSA for South Sefton CCG. Year to date they has now been 2 cases attributed to the CCG against a zero tolerance target.	The first MRSA case was reported in September, the PIR was chaired by the South Sefton CCG Chief Nurse, the RCA was reviewed and chronology discussed, a decision was made to attribute the case to the CCG instead of Aintree as it was felt the CCG was the best placed to ensure lessons are learned . The second case relates to a community aquired case, a PIR has taken place, further details will be provided in the next report.
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(Aintree)**	15/16 - November	0	0	↔	No new cases reported in November. Initially there has been one case reported at Aintree in August, however following local Post Infection Review (PIR) the case originally attributed to Aintree has now been attributed to the CCG , taking Aintree back below zero tolerance	The CCG was informed on 16/12/15 that a possible MRSA had been reported by Aintree Hospital, a PIR was held on 04/01/16 and the case was attributed to Aintree Hospital. An update regarding the outcomes and lessons learned from the PIR will be included in the next report.
Mixed Sex Accommodation Breaches						
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(CCG)**	15/16 - November	0.00	0.20	↓	In November the CCG had 1 mixed sex accommodation breach (2 year to date) which is above the target and as such are reporting red for this indicator for the first time in 2015-16.	The breach occurred at Liverpool Heart and Chest, the CCG is working with the co-ordinating commissioner to review the RCA.
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(Aintree)**	15/16 - November	0.00	0.00	↔		

Enhancing quality of life for people with long term conditions						
Patient experience of primary care i) GP Services	Jan-Mar 15 and Jul-Sept 15		6.64%	↓	Percentage of respondents reporting poor patient experience of primary care in GP Services. Thiswas a decrease from the previous period which recorded 7.64%.	
Patient experience of primary care ii) GP Out of Hours services	Jul-Sept 15		10.05%		Percentage of respondents reporting confidence and trust in person/people seen or spoken to at the GP Out of Hours Service. Due to slight alteration to the question on out of hours, the results are based on Jul-Sept 15 only.	
Patient experience of primary care i) GP Services ii) GP Out of Hours services (Combined)	Jan-Mar 15 and Jul-Sept 15	6%	6.91%	↓	The CCG reported a percentage of negative responses above the 6% threshold, this being a decrease from last survey which reported 7.63%.	Detailed practice level data has been shared with primary care, quality and communications colleagues for discussion and actions at the appropriate committees.
Emergency Admissions Composite Indicator(Cumulative)	15/16 - November	1470.90	1,676.78	↑	This measure now includes a monthly plan, this is based on the plan set within the Outcome Measure framework and has been split using last years seasonal Performance. The CCG is over the monthly plan and had 147 more admissions than the same period last year.	Unplanned care leads continue to monitor these indicators closely. Pathway changes at Aintree have not have been reflected in the planned targets as the targets were set in 2013 when the 5 year strategic plans were set. Aintree implemented pathway changes in October 2014 which has led to a higher number of admissions than originally planned for.
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s(Cumulative)	15/16 - November	204.59	158.09	↓	This measure now has a plan which is based on the same period previous year. The CCG is under the monthly plan and the decrease in actual admissions is 15 less than the same period last year.	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	15/16 - November	707.95	754.96	↑	This measure now has a plan which is based on the same period previous year. The CCG is over the monthly plan and the increase in actual admissions is 73 more than the same period last year.	
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	15/16 - November	83.69	114.69	↑	This measure now has a plan which is based on the same period previous year. The CCG is over the monthly plan and the increase in actual admissions is 10 more that same period last year.	
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	15/16 - November	858.04	900.55	↑	This measure now has a plan which is based on the same period previous year. The CCG is over plan, actual admissions is 66 above the same period last year.	
Emergency readmissions within 30 days of discharge from hospital (Cumulative)	15/16 - November	No Plan	15.38	↓	The emergency readmission rate for the CCG is lower than previous month (16.94) and also lower than the same period last year (15.89).	

Helping people to recover from episodes of ill health or following injury						
Patient reported outcomes measures for elective procedures: Groin hernia	Apr 14 - Mar 15 (Prov data)	0.0697	0.080	Provisonal data	Provisonal data shows the CCG improved on the previous years rate of 0.680 in 2013/14 but achieved a score lower than that of the England average 0.085.	PROMS have been selected as the Local Quality Premium measure for 2015/16. Discussions with clinicians have centred around a proposal to use Shared Decision Aids with patients for a number of surgical areas. This is awaiting approval and is thought to aid improvement in PROMS by ensuring the most appropriate patients are treated with surgery and are fully involved in the decision making process.
Patient reported outcomes measures for elective procedures: Hip replacement	Apr 14 - Mar 15 (Prov data)	0.430	0.403	Provisional data	Provisional data shows the CCG has declined on the previous years rate of 0.420 in 2013/14 and are also achieving a score lower than the England average 0.440.	
Patient reported outcomes measures for elective procedures: Knee replacement	Apr 14 - Mar 15 (Prov data)	0.341	0.323	Provisional data	Provisonal data shows the CCG's rate has declined from previous year 2013/14 - 3.33 but is over the England average 0.316.	
% who had a stroke & spend at least 90% of their time on a stroke unit **(CCG)**	15/16 - November	80%	91.00%	↑		
% who had a stroke & spend at least 90% of their time on a stroke unit **(Aintree)**	15/16 - November	80%	80.00%	↑		
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(CCG)**	15/16 - November	60%	100%	↔		
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(Aintree)**	15/16 - November	60%	100%	↔		
Mental health						
Mental Health Measure - Care Programme Approach (CPA) - 95% (Cumulative) **(CCG)**	15/16 - Qtr2	95%	98.30%	↑		
IAPT Access - Roll Out	15/16 - Qtr2	3.75%	2.48%	↑	The CCG are under plan for Q2 for IAPT Roll Out, this equates to 602 patients having entered into treatment out of a population of 24298 (Psychiatric Morbidty Survey).	See section 7 of main report for commentary.
IAPT Access - Roll Out	15/16 - November	1.25%	1.04%	↑	The CCG are under plan in November for IAPT Roll Out, out of a population of 24298, 252 patients have entered into treatment. There has been a increase from last month when 0.76% was reported.	See section 7 of main report for commentary.
IAPT - Recovery Rate	15/16 - Qtr2	50%	48.52%	↑	The CCG are under plan for recovery rate reaching 48.5% in Q2. This equates to 180 patients who have moved to recovery out of 371 who have completed treatment.	See section 7 of main report for commentary.
IAPT - Recovery Rate	15/16 - November	50%	47.10%	↓	The CCG are under plan for recovery rate reaching 47.10% in November. This equates to 56 patients who have moved to recovery out of 119 who have completed treatment. This is a decrease from last month when 53.6% was reported.	See section 7 of main report for commentary.

The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	15/16 - Qtr2	75%	98.00%	↑	November data shows 94.7%.	
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	15/16 - Qtr2	95%	100.00%	↔	November data shows 100%.	
Preventing people from dying prematurely						
Under 75 mortality rate from cancer	2014		152.20	↓	Under75 mortality rate from Cancer has dropped from 158.7 in 2013 to 152.20 in 2014.	
Under 75 mortality rate from cardiovascular disease	2014		72.90	↑	Under 75 mortality rate from cardiovascular disease increased slightly from 72.60 in 2013 to 2.90 in 2014.	
Under 75 mortality rate from liver disease	2014		29.10	↑	Under 75 mortality rate from liver disease has increased from 22.6 in 2013 to 29.1 in 2014.	
Under 75 mortality rate from respiratory disease	2014		40.50	↑	Under 75 mortality rate from respiratory disease increased from 38.0 in 2013 to 40.50 in 2014.	
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Person)	2014	2,022.6	2,660.6	↓	South Sefton achieved a rate of 2660.6 in 2014 which has failed against the plan of 2022.6. For 2014 the rate for Males was 2981.1, a increase from the previous year (2669.2). Females had a decrease with a rate of 2349.2 compared with 2517.7 in 2013.	The annual variation is significant and the CCG is working with Public Health locally and regionally to understand this. Indications at present are that the PYLL is significantly susceptible to fluctuations due to changes such as young deaths, which introduces major swings, particularly at CCG level.
Cancer waits – 2 week wait						
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(CCG)**	15/16 - October	93%	96.61%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Aintree)**	15/16 - October	93%	96.25%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(CCG)**	15/16 - October	93%	94.10%	↑		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(Aintree)**	15/16 - October	93%	94.90%	↔		

Cancer waits – 31 days						
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(CCG)**	15/16 - October	96%	98.81%	↔		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Aintree)**	15/16 - October	96%	99.63%	↔		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	15/16 - October	94%	96.53%	↓		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Aintree)**	15/16 - October	94%	100.00%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	15/16 - October	94%	95.16%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Aintree)**	15/16 - October	94%	98.91%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	15/16 - October	98%	99.08%	↑		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(Aintree)**	15/16 - October	98%	100.00%	↔		
Cancer waits – 62 days						
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set (Cumulative) **(CCG)**	15/16 - October	85% local target	90.91%	↑		
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set (Cumulative) **(Aintree)**	15/16 - October	85% local target	90.96%	↑		

Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(CCG)**	15/16 - October	90%	86.67%	↓	The CCG has failed the target year to date for 62 day screening. In October 1 patient out of 5 breached the 90% target (80%). This was a Lower Gastro patient and the delay was 83 days due to complex pathway and patient choice issues. Treatment Provider was Aintree.	8 Key prioirities for managing 62 day performance have been put in place.Improvement is expected by end of December 2015.
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(Aintree)**	15/16 - October	90%	97.73%	↔		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(CCG)**	15/16 - October	85%	86.10%	↔		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(Aintree)**	15/16 - October	85%	85.82%	↔		
Referral To Treatment waiting times for non-urgent consultant-led treatment						
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted) **(CCG)**	15/16 - November	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted) **(Aintree)**	15/16 - October	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(CCG)**	15/16 - November	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(Aintree)**	15/16 - October	0	0	↔		

The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(CCG)**	15/16 - November	0	1	↑	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust had 1 patient waiting for 52+ weeks for treatment in T&O.	Capacity issues with Spinal patients – patient had TCI in October but cancelled and requested a date in the New Year. The Robert Jones and Agnes Hunt reported 28 breaches in November (only one attributed to South Sefton CCG), these will start to reduce from December, a recovery plan is now in development and will be finalised at the end of February.
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(Aintree)**	15/16 - October	0	0	↔		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(CCG)**	15/16 - November	90%	90.53%	↓		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(Aintree)**	15/16 - October	90%	90.91%	↓		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(CCG)**	15/16 - November	95%	96.16%	↔		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(Aintree)**	15/16 - October	95%	96.97%	↔		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(CCG)**	15/16 - November	92%	95.22%	↔		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(Aintree)**	15/16 - October	92%	95.74%	↔		

A&E waits						
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG) All Types**	15/16 - November	95.00%	96.17%	↔		The Trust continues to report high numbers of medically optimised patients remaining in an inpatient bed. This peaked at 94 patients in early October and is currently at 81 patients. A point prevalence study was undertaken in November 2015 for all medical inpatients. This showed that 161 patients were optimised for discharge, 45% of the total medical inpatients. The main delays noted were waits for placement and intermediate care. The number of medically optimised patients needs to be consistently below 50 to maintain flow. To ensure sustained improvement, the implementation of outstanding actions remains a priority. These include: • Full utilisation of the step down facility, Aintree 2 Home, which opened in December 2015. • Implement the mobilisation plan for the transfer of the Discharge Planning Team to be community based. • Explore alternative models to support reducing delays for medically optimised patients, including the provision of a second step down facility within the Trust. The senior leadership team are continuing with the 'fortnightly focus' improvement methodology, whereby key actions are identified for AED.
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG) Type 1**	15/16 - November	95.00%	86.09%	↓	The CCG have failed the target in November reaching 78.85%, and year to date reaching 86.09%. In November 812 attendances out of 3840 were not admitted, transferred or discharged within 4 hours	
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Aintree) All Types**	15/16 - November	95.00%	93.16%	↓	Aintree have failed the target in November reaching 87.96%, and year to date reaching 93.16%. In November 1491 attendances out of 12384 were not admitted, transferred or discharged within 4 hours. This is the fifth month the trust have not achieved the target in 2015/16	
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Aintree) Type 1**	15/16 - November	95.00%	87.09%	↓	Aintree have failed the target in November reaching 77.13%, and year to date reaching 87.09%. In November 1491 Attendances out of 6520 were not admitted, transferred or dishcharged within 4 hours.	
Diagnostic test waiting times						
% of patients waiting 6 weeks or more for a Diagnostic Test **(CCG)**	15/16 - November	1.00%	0.68%	↑		
% of patients waiting 6 weeks or more for a Diagnostic Test **(Aintree)**	15/16 - October	1.00%	0.84%	↓		

Category A ambulance calls						
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	15/16 - November	75%	79.40%	↑		A Contract Performance Notice relating to Ambulance Handover was discussed at Aintree SRG Wednesday 16th December 2015. The onset of winter has seen the whole of the urgent care system coming under pressure due to high levels of demand. Whilst overall demand in November, for NWAS was 4.3% higher than planned for and 4.2% for South Sefton CCG; that for the most time critical response times (Red) was 12.5% higher than plan for NWAS as a whole, but 25.8% higher than plan for South Sefton, the highest in Merseyside. Together with the continuing lengthening of turnaround times, these levels of demand severely impacted upon NWAS's performance against the response time targets, during the month. Average turnaround times at Aintree Hospital were teh longest of any CHeshire & Merseyside Hospital in November at over 34 mins on average. Turnaround times will be discussed at the next contract meeting with Aintree, and the North Mersey SRG will also discuss the reinvestment of fines that have been applied to providers across teh SRG footprint.
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	15/16 - November	75%	73.60%	↓	The CCG failed to achieve the 75% year to date or in month (Nov) recording 70.0%.	
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	15/16 - November	95%	96.60%	↔		
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	15/16 - November	75%	77.10%	↔		
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	15/16 - November	75%	74.50%	↓	NWAS failed to achieve the 75% year to date or in month (Nov) recording 68.5%.	
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	15/16 - November	95%	94.40%	↔	NWAS failed to achieve the 95% year to date or in month (Nov) recording 92.0%.	
Local Indicator						
Access to community mental health services by people from Black and Minority Ethnic (BME) groups (Rate per 100,000 population)	2014/15	2400	2451.5	↑	The latest data shows access to community mental health services by people from BME groups is over the CCG plan. This is also improvement on the previous year when the CCG rate was 2309.0.	CCG and CSU colleagues are working to obtain an updated position from local data.

10.2 Friends and Family – Aintree University Hospital NHS Foundation Trust

Figure 24 Friends and Family – Aintree University Hospital NHS Foundation Trust

Clinical Area	Response Rate (RR) Target	RR Actual (Nov 2015)	RR - Trajectory From Previous Month (Oct 15)	Percentage Recommended (Eng. Average)	Percentage Recommended (November 2015)	PR - Trajectory From Previous Month (Oct 2015)	Percentage Not Recommended (Eng. Average)	Percentage Not Recommended (Nov 2015)	PNR - Trajectory From Previous Month (Oct 15)
Inpatients	25%	50.2%	↑	96.0%	96.0%	↔	1.0%	2.0%	↑
A&E	15%	20.5%	↓	87.0%	86.0%	↑	7%	9.0%	↔

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

- % Response Rate
- % Recommended
- % Not Recommended

Aintree University Hospital NHS Foundation Trust routinely achieves the response rate target in both inpatients and A&E as outlined above.

For Inpatient services, the percentage of people who would recommend that service is on par with the England average and has remained static compared to the previous month (Oct 2015). The percentage of people who would not recommend the inpatient service has declined marginally on the previous month and is now above the England average.

The percentage of people that would recommend A&E has improved since October, but remains marginally below the England average. The percentage of people who would not recommend the A&E service has remained static compared to the previous month but remains below the England average.

The trust consistently returns response rates and recommendation percentages significantly higher than the regional and national averages.

The patient experience lead within the trust presented the ongoing work the organisation is doing with the Friends and Family data to EPEG in October 2015. They demonstrated how feedback obtained is informing the trust how they can improve services for its patients. The presentation was well received by EPEG and gave assurances that patient engagement and experience is viewed as important as clinical effectiveness and safety in making up quality services.

10.3 Serious Untoward Incidents (SUIs)

10.3.1 CCG level Serious Untoward Incidents

These are serious incidents involving South Sefton CCG patients irrespective of their location of care. Inclusive of month 9, there have been 78 Serious Incidents involving South Sefton CCG patients.

Figure 25 SUIs Reported at South Sefton CCG level

Type of Incident	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Abscond		2								2
Delayed diagnosis			1							1
Failure to act upon test results				1						1
Homicide by Outpatient (in receipt)	1									1
Maternity service						1				1
Maternity services - unexpected neonatal death.					1					1
Medical Devices/Equipment			1							1
Other								1		1
Pressure Sore - (Grade 3 or 4)			1	2						3
Pressure ulcer - (Grade 3)	6	6	3	3	3	16	1		2	40
Pressure ulcer - (Grade 4)	1	1	2	2						6
Results									1	1
Serious Incident by Outpatient (in receipt)									1	1
Serious Self Inflicted Injury Outpatient	1			1		1				3
Slips/Trips/Falls				2						2
Sub-optimal care of the deteriorating patient			1							1
Surgical Error		1						1		2
Treatment						1				1
Unexpected Death		2							4	6
Unexpected Death (general)						2				2
Wrong site surgery			1							1
Grand Total	**9**	**12**	**10**	**11**	**4**	**21**	**1**	**2**	**8**	**78**

Number of Never Events reported in period for South Sefton CCG patients

One never event reported in June 15, 1 reported year to date. (South Sefton CCG patient in Alder Hey- wrong site surgery)

Figure 26 SUIs by Provider

Provider / Type of Incident	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Aintree University Hospital NHS Foundation Trust										
Delayed diagnosis			1							1
Failure to act upon test results				1						1
Pressure ulcer - (Grade 3)									1	1
Sub-optimal care of the deteriorating patient			1							1
Treatment						1				1
Unexpected Death									1	1
Unexpected Death (general)						1				1
Alder Hey Children's NHS Foundation Trust										
Unexpected Death									1	1
Wrong site surgery			1							1

Liverpool Community Health NHS Trust										
Medical Devices/Equipment			1							1
Pressure Sore - (Grade 3 or 4)			1	2						3
Pressure ulcer - (Grade 3)	5	5	3	3	3	16	1		1	37
Pressure ulcer - (Grade 4)		1	2	2						5
Slips/Trips/Falls				1						1
Surgical Error								1		1
Unexpected Death		1							1	2
Unexpected Death (general)						1				1
Liverpool Women's NHS Foundation Trust										
Maternity service						1				1
Surgical Error		1								1
Unexpected Death		1								1
Mersey Care NHS Trust										
Abscond		2								2
Homicide by Outpatient (in receipt)	1									1
Other								1		1
Serious Incident by Outpatient (in receipt)									1	1
Serious Self Inflicted Injury Outpatient	1			1		1				3
Slips/Trips/Falls				1						1
Unexpected Death									1	1
Southport and Ormskirk Hospital NHS Trust										
Maternity services - unexpected neonatal death.					1					1
Pressure ulcer - (Grade 3)	1	1								2
Pressure ulcer - (Grade 4)	1									1
St Helens and Knowsley Hospitals NHS Trust										
Results									1	1
Grand Total	**9**	**12**	**10**	**11**	**4**	**21**	**1**	**2**	**8**	**78**

Number of Never Events reported in period

1 never events reported in June 15, 1 reported year to date. (South Sefton CCG patient in Alder Hey- wrong site surgery)

10.3.1 Aintree Hospital level Serious Untoward Incidents

SUIs Reported at Aintree University Trust level

Aintree University Hospital Foundation Trust reported 2 serious incidents in December 2015 with 26 incidents reported YTD by the provider.

Number of incidents reported split by type

The Trust has had four incidents repeated in 2015/16.

- 6 x delayed diagnosis
- 5 x Sub-optimal care of the deteriorating patient
- 5 x Pressure Ulcer (grade 3)
- 3 x Treatment delay
- 3 x Unexpected death

Number of Never Events reported in period

Aintree University Hospital NHS Foundation Trust reported zero Never Events year to date.

Figure 27 Number of Incidents at Aintree reported by type

Incident Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Accident Whilst in Hospital							1			1
Critical Care Transfer								1		1
Delayed diagnosis			2							2
Failure to act upon test results			1	1						2
Pressure ulcer - (Grade 3)					1		2	1	1	5
Results					1					1
Slips/Trips/Falls							1			1
Sub-optimal care of the deteriorating patient	2		1							3
Treatment						2				2
Unexpected Death						1	1		1	3
Unexpected Death (general)	1				1	2				4
Unexpected Death of Inpatient (in receipt)							1			1
Grand Total	**3**	**0**	**4**	**1**	**3**	**5**	**6**	**2**	**2**	**26**

Figure 28 Number of Incidents reported at Aintree by CCG

CCG Name / Incident Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Knowsley CCG										
Delayed diagnosis			1							1
Sub-optimal care of the deteriorating patient	1									1
Liverpool CCG										
Accident Whilst in Hospital							1			1
Critical Care Transfer								1		1
Pressure ulcer - (Grade 3)								1		1
Delayed diagnosis					1					1
Slips/Trips/Falls							1			1
Sub-optimal care of the deteriorating patient	1					1				2

Surgical/Invasive Procedure					1					1
South Sefton CCG										
Delayed diagnosis			1							1
Treatment				1						1
Pressure ulcer - (Grade 3)									1	1
Sub-optimal care of the deteriorating patient			1							1
Treatment						1				1
Unexpected Death									1	1
Sub-optimal care of the deteriorating patient						1				1
Southport & Formby CCG										
Treatment						1				1
Sub-optimal care of the deteriorating patient	1									1
St Helens CCG										
Unexpected Death (general)						1				1
West Cheshire CCG										
Pressure ulcer - (Grade 3)							2			2
Unexpected Death							1			1
Unexpected Death of Inpatient (in receipt)							1			1
West Lancashire CCG										
Delayed diagnosis			1							1
Pressure ulcer - (Grade 3)					1					1
Grand Total	**3**	**0**	**4**	**1**	**3**	**5**	**6**	**2**	**2**	**26**

11. Primary Care

11.1 Background

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

11.2 Content

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

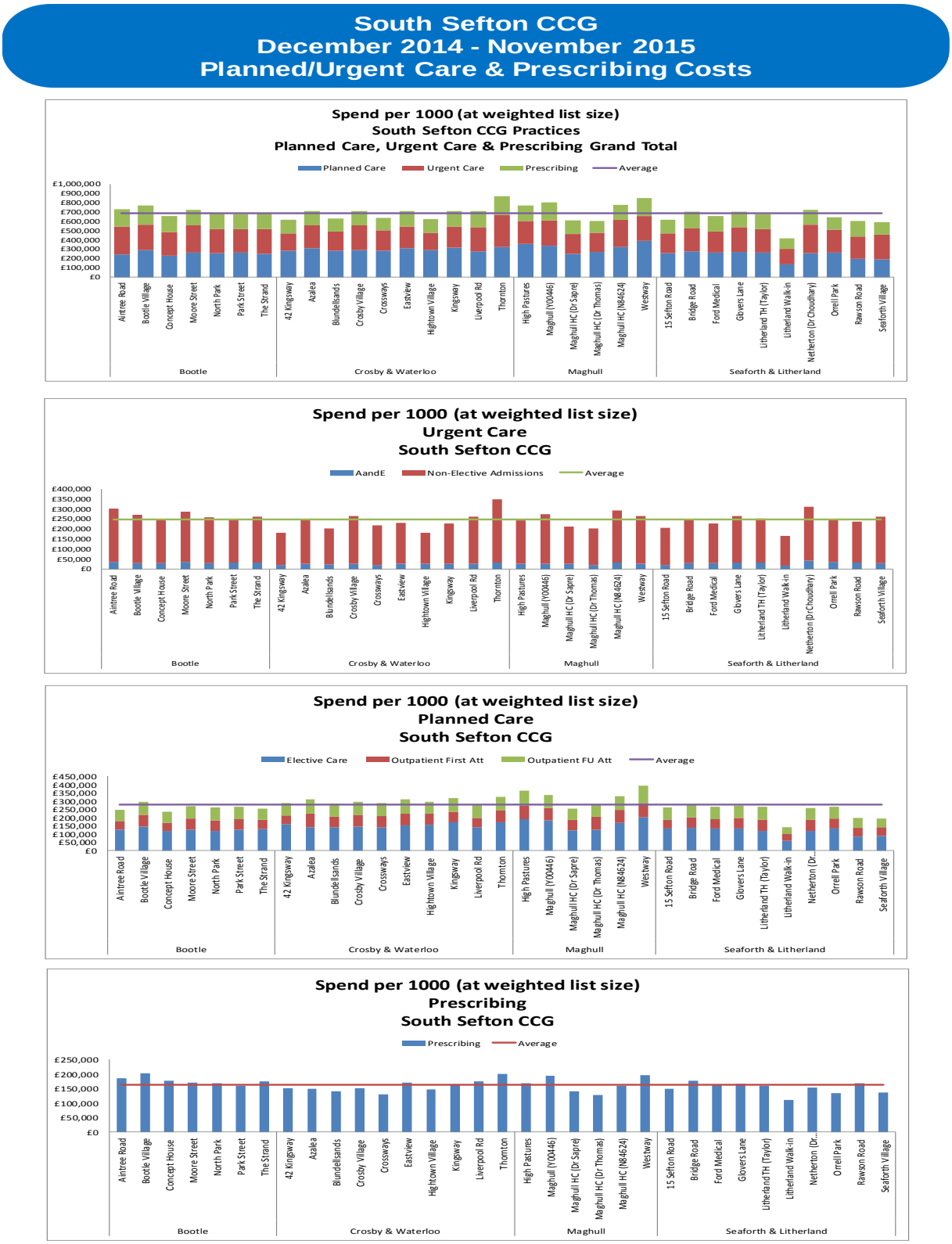
11.3 Format

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

11.4 Summary of performance

Colleagues from Finance and Business Intelligence teams within the CCG have been working closely with clinical leads to develop financial information. Colleagues have developed a chart to show weighted spend per head of weighted practice population which takes into account age, sex, deprivation, rurality, case mix, care and nursing home residents amongst others to standardise the data. The chart below is in draft format and is currently being shared with localities for feedback.

Figure 29 Summary of Primary Care Dashboard – Finance



11.5 CQC Inspections

A number of practices in South Sefton CCG have recently been visited by the Care Quality Commission. CQC publish all inspection reports on their website.

Eastview Surgery **Requires improvement** (11.4 miles away)

81 Crosby Road North, Waterloo, Liverpool, L22 4QD
(0151) 928 8849
Provided by: Eastview Surgery

CQC inspection area ratings
(Latest report published on 7 January 2016)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

CQC Inspections and ratings of specific services
(Latest report published on 7 January 2016)

Older people	Requires improvement
People with long term conditions	Requires improvement
Families, children and young people	Requires improvement
Working age people (including those recently retired and students)	Requires improvement
People whose circumstances may make them vulnerable	Requires improvement
People experiencing poor mental health (including people with dementia)	Requires improvement

Doctors/GPs

Specialisms/services

- Diagnostic and screening procedures
- Maternity and midwifery services
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

Bootle Village Surgery Good (0.6 miles away)

204 Stanley Road, Bootle, Liverpool, L20 3EW
Provided by: Bootle Village Surgery

CQC inspection area ratings
(Latest report published on 14 January 2016)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

CQC Inspections and ratings of specific services
(Latest report published on 14 January 2016)

Older people	Good
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Doctors/GPs and Clinics

Specialisms/services

- Diagnostic and screening procedures
- Family planning services
- Maternity and midwifery services
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

Moore Street Medical Centre Good (1 mile away)

77 Moore Street, Bootle, L20 4SE
(0151) 944 1066
Provided by: Moore Street Medical Centre

CQC inspection area ratings
(Latest report published on 26 November 2015)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

CQC Inspections and ratings of specific services
(Latest report published on 26 November 2015)

Older people	Good
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Outstanding ☆
People experiencing poor mental health (including people with dementia)	Good

Doctors/GPs and Clinics

Specialisms/services

- Diagnostic and screening procedures
- Family planning services
- Maternity and midwifery services
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

Litherland Practice Good (1.9 miles away)

This service was previously managed by a different provider - see old profile

Litherland Town Hall Health Centre, Hatton Hill Road,
Litherland, Liverpool, L21 9JN
Provided by: SSP Health Ltd

Doctors/GPs

Specialisms/services

- Diagnostic and screening procedures
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

CQC inspection area ratings
(Latest report published on 26 November 2015)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

CQC Inspections and ratings of specific services
(Latest report published on 26 November 2015)

Older people	Good
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Seaforth Village Surgery **Good** (1.3 miles away)

20 Seaforth Road, Litherland, Liverpool, L21 4LF
Provided by: SSP Health Ltd

CQC inspection area ratings
(Latest report published on 29 October 2015)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

CQC Inspections and ratings of specific services
(Latest report published on 29 October 2015)

Older people	Good
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Doctors/GPs

Specialisms/services

- Diagnostic and screening procedures
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

Crosby Village Surgery **Requires improvement** (3.5 miles away)

This service was previously managed by a different provider - see old profile

The provider of this service has requested a review of one or more of the ratings.

3 Little Crosby Road, Crosby, Liverpool, L23 2TE
Provided by: SSP Health Ltd

Doctors/GPs

Specialisms/services

- Diagnostic and screening procedures
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

CQC inspection area ratings
(Latest report published on 29 October 2015)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

CQC Inspections and ratings of specific services
(Latest report published on 29 October 2015)

Older people	Requires improvement
People with long term conditions	Requires improvement
Families, children and young people	Requires improvement
Working age people (including those recently retired and students)	Requires improvement
People whose circumstances may make them vulnerable	Requires improvement
People experiencing poor mental health (including people with dementia)	Requires improvement

Netherton Practice Good (3.2 miles away)

This service was previously managed by a different provider - see old profile

Netherton Health Centre, Magdalen Square, Netherton, Bootle, L30 5SP
Provided by: SSP Health Ltd

Doctors/GPs

Specialisms/services

- Diagnostic and screening procedures
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

CQC inspection area ratings
(Latest report published on 24 September 2015)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

CQC Inspections and ratings of specific services
(Latest report published on 24 September 2015)

Older people	Good
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Full Details › Share your experience Email alert sign-up

16/15 Integrated Performance Report

Rawson Road Surgery Good (SSP Health Ltd) (1.9 miles away)

136-138 Rawson Road, Seaforth, Liverpool, L21 1HP
(0151) 928 7576
Provided by: SSP Health Ltd

CQC inspection area ratings
(Latest report published on 10 September 2015)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

CQC Inspections and ratings of specific services
(Latest report published on 10 September 2015)

Older people	Good
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Doctors/GPs

Specialisms/services

- Diagnostic and screening procedures
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

Orrell Park Medical Centre Good (SSP Health Ltd) (1.8 miles away)

Trinity Church, Orrell Lane/Rice Lane, Liverpool, L9 8BU
(0151) 525 3051
Provided by: SSP Health Ltd

CQC inspection area ratings
(Latest report published on 20 August 2015)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

CQC Inspections and ratings of specific services
(Latest report published on 20 August 2015)

Older people	Good
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Doctors/GPs

Specialisms/services

- Diagnostic and screening procedures
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

Crossways Practice Good (3 miles away)

This service was previously managed by a different provider - see old profile

168 Liverpool Road, Crosby, Liverpool, L23 0QW
(0151) 293 0800
Provided by: SSP Health Ltd

CQC inspection area ratings
(Latest report published on 6 August 2015)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

CQC Inspections and ratings of specific services
(Latest report published on 6 August 2015)

Older people	Good
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Doctors/GPs

Specialisms/services

- Diagnostic and screening procedures
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

Hightown Surgery **Inadequate** (6.3 miles away)

This service was previously managed by a different provider - see old profile

The provider of this service has requested a review of one or more of the ratings.

1 St George's Road, Hightown, Merseyside, L38 3RY
(0151) 929 3603
Provided by: SSP Health Ltd

Doctors/GPs

Specialisms/services

- Diagnostic and screening procedures
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

CQC inspection area ratings
(Latest report published on 23 April 2015)

Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Inadequate

CQC Inspections and ratings of specific services
(Latest report published on 23 April 2015)

Older people	Inadequate
People with long term conditions	Inadequate
Families, children and young people	Inadequate
Working age people (including those recently retired and students)	Inadequate
People whose circumstances may make them vulnerable	Inadequate
People experiencing poor mental health (including people with dementia)	Inadequate

Concept House Surgery Good (0.5 miles away)

17 Merton Road, Bootle, L20 3BG
(0151) 476 7962
Provided by: Dr David Goldberg

CQC inspection area ratings
(Latest report published on 23 April 2015)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

CQC Inspections and ratings of specific services
(Latest report published on 23 April 2015)

Older people	Good
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Doctors/GPs and Clinics

Specialisms/services

- Diagnostic and screening procedures
- Family planning services
- Maternity and midwifery services
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

Dr Doran and Dr Navaratnam Good (2.7 miles away)

20 Kingsway, Waterloo, Liverpool, L22 4RQ
(0151) 920 9000
Provided by: Azalea Surgery

CQC inspection area ratings
(Latest report published on 16 April 2015)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

CQC Inspections and ratings of specific services
(Latest report published on 16 April 2015)

Older people	Good
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Doctors/GPs and Clinics

Specialisms/services

- Diagnostic and screening procedures
- Family planning services
- Maternity and midwifery services
- Services for everyone
- Treatment of disease, disorder or injury

12. Better Care Fund update

Quarterly data collection templates are been issued by the Better Care Support Team for completion. It requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The payment for performance element of BCF requires a target reduction to be reached in the number of non elective admissions to hospital. Performance for Q1 and Q2 was above the required level of reduction, therefore no payment for performance was available. Quarter 2 performance improved on Q1 with a reduction in two of the three months of the quarter, which has continued in October at 3.8% below plan, and November at 0.6% below plan, but 2.9% over plan overall for the year to date (Jan-Nov). Performance is summarised below:

BCF NEL Admissions (MAR)	Jan	Feb	Mar	Q4	Apr	May	Jun	*Q1*	Jul	Aug	Sep	*Q2*	Oct	Nov	*Year to Date*
Plan	3003	3003	3003	9009	2941	2941	2941	*8822*	2935	2935	2935	*8806*	2921	2921	*32480*
Actual	3176	2976	3516	9667	3257	3245	2958	*9461*	2957	2849	2766	*8573*	2811	2902	*33415*
Var	173	-27	513	658	317	304	18	*639*	22	-86	-169	*-233*	-110	-19	*935*
%age Var	5.8%	-0.9%	17.1%	7.3%	10.8%	10.3%	0.6%	*7.2%*	0.7%	-2.9%	-5.8%	*-7.9%*	-3.8%	-0.6%	*2.9%*

13. NHS England Activity Monitoring

Figure 30 NHS England Activity Monitoring

Source	Referrals (G&A)	*Month 8 YTD PLAN*	*Month 8 YTD ACTUAL*	*Month 8 YTD Variance*	ACTIONS being Taken to Address Cumulative Variances GREATER than +/-3%
	Referrals (G&A)				
MAR	GP	24365	26870	10.3%	Please see previous months report detailing issues with GP hotline at Aintree. Excluding activity levels of the GP hotline, year to date up to November the increase is much lower compared to last year's activity at 3.4%.
MAR	Other	14476	16393	13.2%	Please see previous months report detailing problems with identifying increase in MAR data as local referral data for the CCG suggests a much lower increase of less than 1% when comparing the same period last year.
MAR	Total	38841	43263	11.4%	As above.
	Outpatient attendances (G&A)				
SUS	All 1st OP	41114	41260	0.4%	
SUS	Follow-up	103221	108158	4.8%	Please see previous report detailing the problems with the plans (based on MAR) against the actuals (based on SUS). Actual activity for the same period last year compared to this year has increased but within the 3% threshold, currently at 2.1%.
SUS	Total OP attends	144335	149418	3.5%	As above.
SUS	Outpatient procedures (G&A) (included in attends)				
	Admitted Patient Care (G&A)				
SUS	Elective Day case spells	14815	13193	-10.9%	As with previous months comments the actual increase compared with the same period last year is approx. 7%.

SUS	Elective Ordinary spells	2528	2347	-7.2%	As noted in previous returns, plan v actual remains in line with the year to date comparison of last year to this year's activity levels.
SUS	Total Elective spells	17343	15540	-10.4%	When comparing actual activity from April to November 2014/15 to the same period this year the overall increase is below 5%, at 4.7%.
SUS	Non-elective spells complete	13775	13086	-5.0%	Actual activity from April to November 15/16 compared with the same period last year shows an increase of 7% in NEL admissions, a slight decrease from the figure reported last month. This is due to the impact of CDU closure and the figures being added to NEL admissions from October 2014 onwards. As the year progresses we will be able to see more accurately the comparison of NEL admissions from last year to this year.
SUS	Total completed spells	31118	28626	-8.0%	As above.
	Attendances at A&E				
SUS	Type 1				
SUS	All types	33164	36383	9.7%	As per the comments from M7, the variance of actual activity from April to November 2014/15 compared with the same period this year shows a slight decrease of -0.7%.

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Thursday 22nd October 2015	Chair: Graham Morris

Key Issue	Risk Identified	Mitigating Actions
• The CCG remains on target to deliver break-even position.	• Delivery of recurrent financial balance required.	• Ongoing requirement to deliver additional QIPP schemes. Greater clinical engagement required. Further discussions at Wider Group meeting and with individual practices.

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

- The Finance and Resource Committee received the updated financial strategy paper and noted the requirement to deliver c£6.4m worth of savings before April 2017.
- The CCG noted that NHSE's assessment of its performance in 2014/15 was "assured with support".
- SL noted that discussions had taken place with public forums to highlight the issues around unused and wasted prescriptions.
- The CCG noted progress in respect of the quality premium although it was concerned that funding would not be available if the financial plan was not met.
- The Committee approved the following HR Policies:
  - Incremental Pay Progression Policy
  - Agenda for Change Rebanding Policy
  - Annual Leave Policy
  - Attendance Management Policy
  - Management of Organisational Change Policy
  - IVF Guidance for Managers

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

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

Key Issue	Risk Identified	Mitigating Actions
• The CCG remains on target to deliver planned surplus but is reliant upon non-recurrent measures	• Delivery of recurrent financial balance required.	• Ongoing requirement to deliver additional QIPP schemes. Greater clinical engagement required. Further discussions at Wider Group meeting and with individual practices.
• £6.4m QIPP savings required to deliver recurrent surplus by the end of March 2017	• High risk of under-delivery on QIPP	• Further review of CCG expenditure required by programme and clinical leads to identify areas of low value / poor outcome expenditure.

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

- The Committee recommended that further review of prescribing for Pain Relief took place to better understand variation across member practices. It also supported the recommendation to include the issue within PLT.
- The Committee recommended that the CCG should pursue a mentoring scheme to support more inexperienced doctors following concerns raised by Dr Paul Thomas. It was suggested that recently retired GP's could be approached to undertake this role.
- The "Pay for Performance" part of the Better Care Fund continues to miss its target. Discussions are ongoing between the CCG and the Council regarding the next steps.
- The Committee approved the CCG's Recruitment and Selection Policy.

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Quality Committee Meeting held on 19th November 2015	Chair: Dr Gina Halstead

Key Issue	Risk Identified	Mitigating Actions
Closure of Balliol Lodge Nursing Home with loss of 22 nursing home beds at short notice	Risk on transfer of patients to new homes in terms of medicines reconciliation, CHC offering of choice of home. Notifying OOH service on change of address.	Medicines management to complete medicines review of all patients to ensure 7 day supply of medicines on transfer. CHC notify families and care homes to arrange transfer to home of choice. Stakeholders to be notified. Closure of home debrief to be held to reflect on actions to mitigate risk.
Provider performance with reference to LCH SALT and Therapy waiting times for both adults and paediatric services.	Patient access to services may affect plan of care as well as activities of living.	Review business plan for adult service and challenge current systems of working. Request progress of recovery plan for paediatric service from provider. Report at LCH CQPG.

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

Provider Safeguarding Contract Query Update - S&O Contract Query remains open; AHCH Contract Query issued in October 2015; LWH and RLBUHT position to be discussed with LCCG as co-ordinating commissioner following outcome of next performance information analysed by the CCG safeguarding service.

CCG Safeguarding Policy – The Quality Committee reviewed the policy and recommended presentation to the Governing Body for approval. The Governing Body are asked to note that a discussion took place regarding section 6.4.1 which relates to GP practices.

Acute Visiting Scheme and relationship with CHIP Matrons. CCG to develop more integration with care home team.

South Sefton Respiratory Programme – a formal report to be produced for submission to QC in January 2016

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Quality Committee Meeting held on 17th December 2015	Chair: Dr Gina Halstead

Key Issue	Risk Identified	Mitigating Actions
CHC Care Home Safeguarding Officer leaving role	Updat4 to Quality Committee may be affected	Continue CHC Ensure representatives for action on reporting to Quality Committee
Monitoring of Quality Indicators to hold domiciliary providers to account	Not being able to identify quality concerns	1. Meeting to discuss indicators on current contract in January 2. Explore adoption of framework for domiciliary providers
CHC Safeguarding Care Home Officer leaving role	1. Reports/update to Quality Committee will no longer be submitted 2. No liaison with care home issues	Ensure appropriate updates at Quality Committee and identified officer for care home issues
CQC notification on submission of Letters of Intent to providers	Unable to provide adequate alternative provider cover	Meet with CQC to notify of concerns and request standard notice of 5 working days (subject to confidentiality)

HEALTHY LIVERPOOL PROGRAMME
RE-ALIGNING HOSPITAL BASED CARE

COMMITTEE(S) IN COMMON (CIC)
KNOWSLEY, LIVERPOOL AND SOUTH SEFTON CCGS

WEDNESDAY 6th JANUARY 2016
Boardroom, Nutgrove Villa
Westmorland Road, Huyton, L36 6GA
Time 4:00pm – 5:30pm

1.	Welcome, Introductions and apologies	All
2.	Declarations of Interest	All
3.	Notes / Actions from the previous meeting held on 4 November 2015 **(to follow)**	All
4.	Links with Liverpool City Region Committee in Common and Feedback	KS
5.	Interdependencies across Sefton, Knowsley and Liverpool • Shaping Sefton • Knowsley Joint Health & Wellbeing Strategy	F Taylor D Johnson
6.	Feedback from clinical discussions	F Lemmens
7.	Liverpool Women's Hospital Update	KS
8.	Planning Guidance (attached)	All
9.	Strategic Estates Programme (attached)	TJ
10.	Strategic Options Appraisal – report from RLUBHT & AUHFT (copies will be provided on the day)	KS
11.	Public Engagement / Consultation (attached)	KS
12.	Any other business	All
13.	Date of Next Meeting – **Wednesday 3 February 2016 4:00pm - 5:30pm (venue same as the CIC (formerly CCG Network) – Nutgrove Villa)**	

Key Issues Log

Title of Meeting	CIC: Realigned Hospital Based Care
Chair	Dr Nadim Fazlani
Date of Meeting	5th January 2016

NHS
South Sefton
Clinical Commissioning Group

Issue	Risk Identified	Mitigating Action
1. Relationship between this Committee and the LCR NHS CCG Alliance.	• Confusion/lack of clarity leading to slower implementation of required changes.	• The CIC: Realigned Hospital Based Care to continue to meet, focusing on engagement of partners and recommending courses of action regarding services delivered from the Liverpool footprint. • Governance and reporting arrangements to be reviewed.

Recommendations to NHS South Sefton CCG Governing Body:
1. To note the above issues, risks and mitigating actions.

	CCG's COMMITTEE IN COMMON **Wednesday 6th January 2016** **Chief Officers Pre-Meet - 12.00 pm to 12.45 pm** **Lunch 12.45 pm** **Meeting: 1.00 pm Boardroom, Nutgrove Villa** **Westmorland Road, Huyton, L36 6GA**

TIME		
1pm	**Welcome and Introductions**	*Chair*
	Apologies for Absence	*Chair*
	Declarations of Interest	*Chair*
1:05pm	**Minutes and Action Log from the CCG Network meeting held on Wednesday 2nd December 2015**	*All*
1:15pm	**Dissolution of the CCG Network (5mins)**	*All*
1	**Terms of Reference of the Committee in Common (*to be reviewed throughout the meeting and finalised at the end*)**	*All*
2	**Delivering the 5 Year Forward View – footprint discussion**	*All*
3	**Repository update/developing our work programme**	*JD/All*
4	**CCG Alliance Slide Deck**	*JD*
5	**Provider Alliance**	*KS*
6	**Strategic Approach** **Marketing ourselves and our successes**	*All*
3:45pm	**Any Other Business**	*All*

DATE AND TIME OF NEXT MEETING:
Wednesday 3rd February 2016
1pm in the Boardroom, Nutgrove Villa Westmorland Road, Huyton, L36 6GA

Key Issues Log

Title of Meeting	LCR NHS CCG Alliance (Merseyside CCG Network)
Chair	Dianne Johnson
Date of Meeting	5th January 2016

NHS
South Sefton
Clinical Commissioning Group

Issue	Risk Identified	Mitigating Action
1. Need for more formal collaborative commissioning and strategic planning across Liverpool City Region (LCR).	• Opportunities for hospital service reconfiguration are not realised, resulting in poor services and outcomes for patients. • CCG statutory duties are not delivered.	• Establishment of LCR NHS CCG Alliance as a Committee in Common across all 7 LCR CCGs. • Draft Terms of Reference amended and agreed - to be approved by each CCG Governing Body in January/February 2016. • Work Programme to be confirmed including production of Sustainability Transformation Plan as set out in Planning Guidance 2016/17–2020/21.

Recommendations to NHS South Sefton CCG Governing Body:
1. To note the Merseyside CCG Network has been formally disbanded.

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Minutes

Thursday 22nd October 2015
1.00pm to 3.00pm
3rd Floor Board Room, Merton House

Attendees		
Roger Driver (joined meeting at 1.45pm)	Lay Member (Chair)	RD
Graham Morris	Lay Member	GM
Andy Mimnagh (joined meeting at 1.30pm)	GP Governing Body Member	AM
Paul Thomas	GP Governing Body Member	PT
Tanya Mulvey	Practice Manager	TM
Martin McDowell	Chief Finance Officer	MMcD
David Smith	Deputy Chief Finance Officer	DS
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Debbie Fagan	Chief Nurse & Quality Officer	DF
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Malcolm Cunningham	Head of Primary Care & Contracting	MC
Susanne Lynch	CCG Lead for Medicines Management	SL
James Bradley	Head of Strategic Finance Planning	JB
Adam Burgess	HR Business Partner	AB
Donna Webster	Shadowing Debbie Fagan	DW
Ex-officio Member*		
Fiona Taylor	Chief Officer	FLT
Apologies		
John Wray	GP Governing Body Member	JW
Minutes		
Ruth Moynihan	PA to Chief Finance Officer	RM

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

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

No	Item	Action
FR15/113	**Apologies for absence** Apologies for absence were received from Fiona Taylor and John Wray. GM chaired the meeting in RD's initial absence.	
FR15/114	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both Southport and Formby and South Sefton CCGs declared their potential conflicts of interest.	
FR15/115	**Minutes of the previous meeting** The minutes of the previous meeting were approved as a true and accurate record and signed-off by the Chair.	
FR15/116	**Action points from the previous meeting** ***FR15/103 Month 5 Finance Report*** *– SL and JB to work together re use of Blutech software by the Trust* – JB advised that this has been outlined in contracts as part of the CCG's commissioning intentions, and SL does not envisage any issues with pharmacists. **FR15/104 *Prescribing Performance*** *– SL to discuss budget reports within the localities* – SL advised that these are now going to localities. *All other actions were completed and closed accordingly.*	
FR15/117	**Month 6 Finance Report** JB presented this report which focused on the financial performance for South Sefton CCG as at 30 September 2015 (Month 6). The Committee noted that on 2nd November, DS is to attend a collaborative working/sharing session with Wirral, St Helens and West Cheshire CCGs, and he will report back to the QIPP Committee on this.	
	Action taken by the Committee	
	The Committee noted the content of this report and the recommendations therein.	
FR15/118	**Financial Strategy Update** JB presented this report which set out an update to the long term financial strategy and the assumptions which underpin it. It had been updated to reflect the 2015/16 budget and contracts, and also to reflect changes to assumptions regarding future QIPP delivery and expenditure commitments. MMcD stated the importance of making the Governing Body aware of the requirement for £6.4m savings before the end of March 2017. This will be discussed further at the upcoming Governing Body development session.	
	Action taken by the Committee	
	The Committee noted the content of this report and the recommendations therein.	

No	Item	Action
FR15/119	**Prescribing Performance Report** **(a) Month 4 Report** SL presented this report which updated the Committee on prescribing spend for July 2015. She advised that the waste campaign is going well, and said the issue may well have been underestimated. She advised that it had been written into contracts that if medicines were prescribed which were inappropriate/not required, then the pharmacist will have committed a breach of contract; pharmacists have been advised of this, as well as being advised that the CCG will be carrying out audits. Concern was voiced regarding distribution of pharmaceutical items and there was a desire to find out the scale of the problem. SL is to meet with Mersey Care and LMC next week and will provide feedback at the next meeting. A typing error was noted on p37 of 160, Section 4 which reads "forecasting an under spend" instead of "forecasting an over spend". **(b) APC Recommendations** Pan Mersey had recommended the commissioning of the following medicine at the September 2015 meeting: • EDOXABAN tablets (Lixiana®▼) for the treatment and prevention of Deep Vein Thrombosis and Pulmonary Embolism • VEDOLIZUMAB (Entivyo®▼) for the treatment of Crohn's Disease The Committee noted that figures shown in Section 3 were incorrect, and the correct figures are shown in Section 4. **Action taken by the Committee** The Committee noted the content of these reports and approved the APC recommendations therein.	SL
FR15/120	**HR Policies** AB presented the following policies to the Committee which supersede all previous policies; these have all been ratified by the Corporate Governance Support Group: • Incremental Pay Progression Policy • Agenda for Change Rebanding Policy • Annual Leave Policy • Attendance Management Policy • Management of Organisational Change Policy • IVF Guidance for Managers DF referred to Section 9 of the Annual Leave Policy and queried the 20 day statutory entitlement mentioned therein; AB clarified that this is in line with EU law and extra days awarded through Agenda for Change conditions are local agreements. **Action taken by the Committee** The Committee approved all of the above HR Policies.	

No	Item	Action
FR15/121	**External Updates/Benchmarking and VFM Reports** DS presented this benchmarking paper which provided an update from the recently published Q4 figures. DF advised that CSU colleagues were reviewing FNCs, and the LA are to be formally informed if any patients are not eligible for FNC; this work is commissioned to run to 1st March 2016. MMcD referred to the consistency in outpatient referrals and follow ups, noting that the CCG has been ranked high in terms of number of attendances during the last two years, and said this is something the CCG needs to look into. DF is to raise the Committee's concerns with Gina Halstead at the collaborative forum.	DF
	Action taken by the Committee	
	The Committee noted this benchmarking update.	
FR15/122	**CCG Assurance** The Committee formally received this annual assurance letter from NHSE, noting the headline assessment for Quarter 4 as being assured with support. DF referred to an inaccuracy regarding the date reported to "in-house the CHC processes" on p148 of 160, and this has been referred back to NHSE.	
	Action taken by the Committee	
	The Committee noted this update.	
FR15/123	**QIPP Update** The Committee noted that the CCG has surplus QIPP plans in place which need to be operationalised in order to deliver these plans. MMcD said a PMO type report is to be introduced focussing on progress, including finance and community support. There is to be a dashboard for each scheme, with the aim of targeting the first 5-6 schemes that the CCG wish to have up and running; this will then feed into the QIPP Committee.	
	Action taken by the Committee	
	The Committee noted this update.	
FR15/124	**Better Care Fund Update** DS advised the Committee that the next submission is due at the end of November, but said the payment for performance element will not be achieved.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/125	**Quality Premium Dashboard** JL presented this report which updated the Committee on progress against the 2015/16 Quality Premium indicators.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/126	**Any Other Business** None.	

No	Item	Action
FR15/127	**Key Issues Review** MMcD summarised the key issues of this meeting, and these will be presented to the Governing Body.	
	Date of next meeting Thursday 19th November 2015 1.00pm to 3.00pm 3rd Floor Board Room, Merton House	

Quality Committee
Minutes

Date: **Thursday 19th November 2015, 3.00pm to 5.00pm**
Venue: **3rd Floor Board Room, Merton House, Stanley Road, Bootle.**

Membership		
Dr Gina Halstead	GP Lead for Quality (Chair)	GH
Stephen Astles	Head of CCG Development	SA
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	PC
Malcolm Cunningham	Head of Primary Care & Contracting	NC
Roger Driver	Lay Member	RD
Debbie Fagan	Chief Nurse	DF
Dr Dan McDowell	Secondary Care Doctor	DMcD
Martin McDowell	Chief Finance Officer	MMcD
Sharon McGibbon	Practice Manager/Governing Body Member	SMcG
Dr Andy Mimnagh	GP Governing Body Member	AM
Ex Officio Members		
Fiona Taylor	Chief Officer	FLT
In Attendance		
Julie Cummins	Clinical Quality & Performance Co-ordinator	JC
James Hester	Programme Manager Quality & Safety	JH
Terry Hill	Locality Manager	TH
Kate Mahon	Student Nurse	KM
Brendan Prescott	Deputy Chief Nurse / Head of Quality and Safety	BP
Helen Roberts	Senior Pharmacist	HR
Jo Simpson	Quality & Performance Manager	JS
Minute Taker		
Vicky Taylor	Quality Team Business Support Officer	VT

Membership Attendance Tracker

Name	Title	April 15	May 15	June 15	July 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Dr Gina Halstead	Chair (w.e.f. May) and Clinical Lead for Quality	√	√			√	√	√	√				
Steve Astles	Head of CCG Development	A	√			√	A	A	√				
Dr Peter Chamberlain	Clinical lead Strategy & Innovation					√	√	√	√				
Malcolm Cunningham	Head of Contract and Procurement	√	√			A	A	A	A				
Roger Driver	Lay Member	A	√			A	L	√	√				
Debbie Fagan	Chief Nurse & Quality Officer	√	√			√	√	√	√				
Dr Dan McDowell	Secondary Care Doctor	A	A			A	L	√	√				
Martin McDowell	Chief Finance Officer	√	√			A	A	√	√				
Sharon McGibbon	Practice Manager / Governing Body Member	A	A			√	A	A	A				
Dr Andrew Mimnagh	Clinical Governing Body Member	√	√			√	√	√	A				
Dr Craig Gillespie	Chair and Governing Body Member to April	√											

✓ - Present A – Apologies L - Late or left early

No.	Item	Action by
15/126	**Apologies for Absence** Apologies for absence were received from: AM, JH and MC.	
15/127	**Declarations of interest regarding Agenda items** CCG officers holding dual roles in both South Sefton and Southport & Formby CCGs declared their potential conflicts of interest.	
15/128	**Minutes of the previous meeting and Key Issues Log** The minutes of 22nd October 2015 were approved.	
15/129	**Matters Arising / Action Tracker** **15/038 Safeguarding Service Update report** DF has spoken to the Chair of the Local Safeguarding Children's Board (LSCB) and is awaiting a response. The matter is to be escalated via the Governing Body if this remains unresolved. **Further update to Committee January.** **15/074 Acute Visiting Scheme** The Committee are to receive a presentation on the Acute Visiting Scheme which is on today's agenda. **Action closed.** **15/081.1 Provider quality Performance Reports (Performance Framework)** JS confirmed that a new style of report is in the course of development and will be introduced to the CCGs next year (16/17). Accessing the provider's raw data and using run charts will be discussed at the planning meeting with the BI Team to be held on 2nd December, reviewing all reports presented to the CCG Committees and Governing Bodies. **Further update to Committee in January.** **15/081.2 Provider quality Performance Reports (Sickness Absence)** A verbal update is to come back to the Committee in January, following the CQPG meeting in December. The LCH CQPG meeting in November was cancelled due to a clash of commitments. LCH are trialling a new Board report which will address issues raised. **Action Closed.** **15/082.2 Serious Incident Report (SUI)** The Chair noted that the definition of a SUI had not been included within this month's report and requested that this be included in the next report to the Committee in January. **Action to be completed for delivery of January's Committee pack.** **15/084.3 Safeguarding Service Update Report** The Committee agreed that the presentation on the outcome of Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework due this month, could be brought to January's meeting. **Action to be completed for delivery of January's Committee pack.** **15/101 CCG Safeguarding Peer Review Action Plan (v8)** The Committee agreed that the amended version of the action plan due to be presented this month could be brought to January's meeting. **Action to be completed for delivery of January's Committee pack.** **15/102 Provider Quality Performance Reports**	

	Aintree University Hospital Foundation Trust *Preventing People from Dying Prematurely* 1. Completed and **closed**. 2. Completed and **closed**. 3. Completed and **closed**. *A&E Measures* 3. RCAs completed following the A&E Waits at Aintree (involving Mersey Care) and have been shared with NHSE who are organising Lessons Learnt events. Completed and **closed**. 4. GH will update the Committee later in the meeting. Completed and **closed**. **Mersey Care** 5. Completed and **closed**. **LCH** *Intermediate Bed Base* 6. The issue relating to intermediate care beds has been added to the CCGs Risk Register following discussion with Steve Astles, Mel Wright and Jan Leonard. SA advised that the pressures in the Acute Trusts were unlikely to change however; he had identified some funding to support patient discharge from hospital. Completed and **closed**. *Home Equipment* 7. Feedback awaited from MC on CAMHs Contract queries. **Further update to Committee in January.** **15/103.1 Serious Incident Report Aintree University Hospital Foundation Trust** This action related to the sudden death of a surgical patient. The Committee discussed the steps taken and the action is considered completed for the purposes of the Committee. **Action Closed.** **15/113 Governing Body Assurance Framework (GBAF) & Corporate risk Register (CRR)** VT confirmed that the correct version of the CRR has been circulated to all Committee members. **Action Closed.** **15/116 Chief Nurse Report** DF confirmed that the narrative recorded against 4.2 of the Southport & Ormskirk Hospitals NHS Trust RCOG review had been removed as requested by the committee. **Action Closed.**	
15/130	**CCG Safeguarding Service Quarterly Report** For the purpose of future reports, the Chair requested that Clinical Engagement is referenced on the 'Process' table. The Committee received the quarterly update which included a table referencing the progress made through quarter 3 and noted that all Trusts were providing reasonable assurance with the exception of Alder Hey Children's Hospital Foundation Trust (AHCHFT). • Alder Hey Children's Hospital Foundation Trust (AHCHFT) - Issues in relation to safeguarding risks for adults and transition to adult services at Alder Hey were discussed and the Committee were advised that a Business Plan had been requested but not received. These issues are being progressed as part of a contract performance notice issued on 27th October 2015. • Royal Liverpool and Broadgreen University Hospital Trust (RLBUHT) - An external safeguarding review has been undertaken at the Trust. A full Action Plan has been put in place to address issues of concern included staff training	

	and policies. • Liverpool Women's Hospital (LWH) - Although the Trust continues to deliver 'limited assurance', early indications of a review of Quarter 2 data and evidence submitted suggests that improvements are beginning to show as new systems are put in place to capture data. The Committee noted that a significant number of staff changes and changes in leadership around safeguarding were having an impact. The issues experienced at both RLBUHT and LWH are under discussion with Jane Lunt, Head of Quality/Chief Nurse at Liverpool CCG to determine whether they should be raised as a contract query. The Chair was concerned to note the performance on safeguarding reported against Alder Hey Children's Hospital FT and Liverpool Women's Hospital. HS confirmed that Section 11 compliance outcomes would be brought to the December meeting of the Quality Committee and reported through to the Governing Body. The Committee noted the updates with regard to Domestic Homicide Reviews, Goddard Inquiry, LSCB Section 11 audit (update regarding CCG position and action plan expected at December 2015 Quality Committee), PREVENT and Child Sexual Exploitation. DF stated that the relevant update letters as detailed in the appendices to this document had been circulated as appropriate via the CCG Communications Bulletin. HS updated the Committee on the current position of the commissioning of supervision support for the CCG Safeguarding Service that is an outstanding action on the CCG Peer Review Safeguarding Action Plan. This is now expected to be finalised for January 2016 by Halton CCG as the host organisation for the service.	
	The Committee received the report	
15/131	**Safeguarding Children & Vulnerable Adults Policy 2015 (Incorporating Safeguarding and Mental Capacity Act Standards for Commissioned Services** HS presented the updated policy to the Quality Committee. DF asked for clarification in Section 6.4.1 and clarifies the current position of the CCG with regard to co-commissioning with NHSE. The committee received the policy and recommended presentation to the Governing Body for approval. **Action: DF to ensure that the updated CCG Safeguarding Children & Vulnerable Adults Policy 2015 (incorporating Safeguarding & Mental Capacity Act Standards for Commissioned Services) is presented to the Governing Body for approval at the November 2015 meeting.** **Action: DF to check with Wendy Hewitt to ascertain whether the most up to date version of the escalation of concern regarding a child/adult are the same as currently used in practices.** RD questioned whether spiritual abuse should come under psychological or be recorded as an individual form of abuse. HS agreed consideration should be given to including spiritual abuse within the policy as an individual form of abuse. **Action: RD to request Archdiocese Safeguarding Officer to forward definition of spiritual abuse to HS for consideration as to whether it should be included as an individual form of abuse in the CCGs' Safeguarding policy.** **Action: The Governing Body are to be made aware of the issue raised by RD**	DF DF RD

	on spiritual abuse and will be recommended to approve the policy, subject to receipt of a satisfactory response to the outstanding question.	RD
	The Committee received and supported the approval of the Safeguarding Children & Vulnerable Adults Policy 2015 by the Governing Body with the Governing Body to be made aware of the issue relating to spiritual abuse	
15/132	**CSU Q2 2015/16 Quality Report** JC presented the report which highlighted performance and quality monitoring information for Nursing Homes in SSCCG. The Committee noted the recent closure of Balliol Lodge Care Home. An unannounced CQC inspection at the home in September found the Home to be inadequate and requiring improvement in a number of areas. The CQC invoked their powers under statute with the home owners served notice of closure as the action plan for improvement had not been followed by the home. As a result the residents of the home were transferred to alternative homes in the interests of quality and safety and within a 24 hour timeframe. Both the Health Team and Medicines Management Team provided support during the mobilisation of the patients alongside support from Sefton Local Authority. JS confirmed that a debrief session on lessons learned will take place internally and with local partners. PC asked whether Joint Quality Assurance Framework information could be made available for all care homes to enable triangulation of information. **Action: JC to provide PC with care home information included in her report for all care homes.** The Committee noted that this report would be presented on a quarterly basis. DF advised that Tracey Forshaw, Programme Manager Vulnerable People would liaise with the CSU regarding the future format for reports. The Chair formally thanked JC on behalf of the Committee for her support whilst working in this area and wished her well in her new role.	JC
	The Committee received the report	
15/133	**Alternative to Transfer (ATT) and Acute Visiting scheme (AVS)** The Committee received a presentation on Alternative to Transfer (ATT) and Acute Visiting Scheme (AVS) from Terry Hill, Locality Manager noting the delivery against outcomes to date.	
	The Committee received the presentation	
15/134	**Provider Quality Reports (inc NHS111)** JS presented the report which was discussed by the Committee. *Aintree University Hospital FT* Feedback on the following areas contained within the report was noted: • Rapid Access Chest Pain Clinic – Assurances had been given from the Trust that priority is given to GP referrals to the Clinic following a recent enquiry from the CCG on internal referrals • Patient Reported Outcome Measures (PROMs) – Discussions have taken place with the Trust to ensure meaningful narrative is submitted with the data to provide quality information on outcomes for patients • 12 hour trolley wait in October – Assurance has been received from the Director of Nursing (DoN) and the Clinical Performance Quality Group (CQPG) that the patient involved was comfortable throughout their wait • Clostridium Difficile (C.diff) – Four cases out of six were upheld by the November Appeals Panel with Estates issues sited as partially responsible for	

	the two which were not upheld. Whilst there were other issues in terms of opportunity to test patients, the Panel recognised the decision had to be based on the estate at present and could not take into account any planned changes which the Trust have committed to. BP is due to attend an NHSE Healthcare Acquired Infection Summit in February 2016 which is to focus on C.diff and where it is expected wider guidance will be provided. *Mersey Care Provider Trust* • Keeping Nourished and Falls – The Trust are to provide updated narrative for the December Report, this will be included in the January meeting packs *LCH* • Treatment Rooms – The reporting of Treatment room performance is to be reviewed • Speech and Language Therapy (SALT) – JS confirmed that the performance in this service had been picked up by the LCH Board. BP referred to discussions which had taken place at CQPG regarding Adult's SALT waiting list times. JS confirmed that the Trust have been asked to provide a briefing report regarding the Paediatric SALT waiting times The Committee noted that the performance information relating to Therapies and SALT was not included within this month's report. JS will liaise with the Business Intelligence (BI) team in relation to the missing information. *Alder Hey Hospital Foundation Trust (AHHFT)* • A&E Referrals - GH commented on the unsatisfactory quality of correspondence provided with A&E referrals to other Trusts. **Action: GH is to provide examples to JS of A&E correspondence when patients are transferred in order that this issue can be resolved** *KPI16g Total Number of patients presenting at A&E who had previously contacted their GP prior to attending A&E* **Action: JS to clarify why this information is being reported as GH did not consider it to be a KPI** The contents of the reports submitted by Liverpool Heart & Chest Hospital, Liverpool Women's Hospital and the Royal Liverpool and Broadgreen University Hospital Trust together with NHS111 were noted. **Action: JS to ensure that a full description of all acronyms used within future reports is provided.**	GH JS JS
	The Committee received the report	
15/135	**Serious Incident Report** The Chair noted that the definition of a Serious Untoward Incident (SUI) had not been included within this month's report and requested that this is provided in future. Action 15/082(ii) under Matters Arising/Action Tracker has been updated to reflect this comment. *Aintree University Hospital FT* The Committee discussed the number of open SUIs and the current system used to report and record them. In order to try and address, GH asked whether this report could be taken to the SUI Group to be closed off. DF was conscious that the 60 day time frame for RCAs could have attributed to the reporting figures. **ACTION: Outstanding SUIs within current report to be taken to the SUI Group to be closed off.** **Action: A review of in-house administration of SUIs is to be carried out to**	JH JH

	ensure there are no issues with management procedures.	
	The Committee received the report	
15/136	**EPEG issues Update** RD provided the following update of issues reportable to the Committee: • Discharge Arrangements – older patients often left outside at the hospital entrance as opposed to the discharge suite – Healthwatch reviewing • Care Homes - Healthwatch have a planned programme of enter and view inspections of care homes • Trends in calls to Healthwatch – increased number of calls received in relation to CHC packages of care and the length of time taken to deliver outcomes – clarification required to determine what delays are attributable to, i.e. legacy issues for previously unassessed periods of care or new cases. • Patient Choice Policy – This policy has been revised as a result of EPEG input • Deaf & Hard of Hearing - Aintree University Hospital Trust have introduced a hand held buzzer system as a result of a Healthwatch inspection report for use in waiting areas. RD suggested this aid could be used more widely • Podiatry – Healthwatch concerned LCH may re-introduce Single Point of Access **Action: SA will contact LCH for clarification** • NHS111 – EPEG recommended both CCGs support this year's marketing plan to ensure materials are in circulation as soon as possible to promote this service. MMcD said NHS111 has been a soft launch hence the lack of wider publicity. MMcD asked that Urgent Care leads review. **Action: SA to feedback to Tracey Jeffes re expectation that the evaluation of the service will address EPEG's recommendation re CCGs supporting this year's NHS111 marketing plan**	SA SA
	The Committee received the verbal update	
15/137	**GP Quality Lead Update/LCL update** • BP provided the Committee with an update following the recent presentation given to the Laboratory Meeting by reviewers of the process	
	The Committee received the verbal update	
15/138	**Locality Update** • Respiratory Programme: SA updated the Committee on Tracey Kirk's (TK) work on high users of secondary care in three local practices with variation of care highlighted. TK is continuing investigations and is to compile a report on actions taken in terms of support. It is anticipated that the report will provide improvements for patients. • PC advised the Committee of Breathlessness trials taking place • MMcD asked whether any work was being done in Acute Trusts in relation to the frequency of patients presenting for care. SA said a plan was in place with GPs to identify patients and the reasons for presenting to A&E. • MMcD asked about the likelihood of transformational funding being made available. PC said the CCG had to check what was already being done to direct what action the CCG might take. **Action: SA to ensure the Respiratory Programme Report is brought to the Committee in January with individuals' needs highlighted**	SA
	The Committee received the verbal report	
15/139	**Key Issues** • Provider safeguarding performance • Balliol Lodge closure • AVS and ATT presentation and relationship with CHIP Matrons. Need to develop more integration across care home team	

	• Provider performance – reference to LCH SALT and Therapy waiting times. Discussed at CQPG and LCH submitted business case to contract meeting. • SI paper – SI report to go to internal SUI meeting and review internal processing in-house to ensure scrutiny • Commissioning respiratory programme formal report to be produced for submission to QC in January 2016	
15/140	**Any Other Business** **Action: BP is to distribute a copy of a note received from Andy Mimnagh to all Committee members** • Edge Hill - The Committee were requested to approve the commissioning of research work at Edge Hill in relation to the evaluation of the apprentice Healthcare Assistants programme running at Hugh Baird College. The Committee confirmed they were happy for the work to be undertaken. **Action: Terms of Reference – Having reviewed the Terms of Reference (TOR) of the Committee, DF confirmed that a change in the TOR will be taken to the Governing Body for approval to note that the Committee Chair is a GP Clinical Lead and not a Governing Body Member**	BP DF
15/141	**Date of Next Meeting** Thursday 17th December 2015 – 11.30 am -12.30 pm 3rd Floor Board Room - Merton House, Stanley Road, Bootle.	

NHS
South Sefton
Clinical Commissioning Group

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Audit Committee Minutes

Thursday 15th October 2015, 12.30pm to 2.00pm
3rd Floor Board Room, Merton House

Attendees		
Graham Morris	Lay Member (Chair)	GM
Dr Dan McDowell	Secondary Care Doctor	DMcD
Martin McDowell	Chief Finance Officer	MMcD
Debbie Fagan	Chief Nurse & Quality Officer	DFa
Tracy Jeffes	Head of Corporate Delivery and Integration	TJ
Adrian Poll	Senior Audit Manager, MIAA	AP
Michelle Moss	Local Counter Fraud Specialist, MIAA	MM
Ken Jones	Deputy CFO, Trafford CCG (ex SSCCG Chief Accountant)	KJ
Jillian Burrows	Audit Senior Manager, KPMG	JB
Apologies		
Roger Driver	Lay Member	RD
David Smith	Deputy Chief Finance Officer	DS
Tanya Mulvey	Practice Manager	TM
Minutes		
Ruth Moynihan	PA to Chief Finance Officer	RM

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

Name	Membership	Oct 14	Jan 15	April 15	May 15	July 15	Oct 15	Jan 16
Graham Morris	Lay Member (Chair)	✓	A	✓	✓	✓	✓	
Roger Driver	Lay Member	✓	A	A	✓	A	A	
Dan McDowell	Secondary Care Doctor	A	✓	✓	✓	✓	✓	
Sharon McGibbon	Practice Manager	N	N	A	A	N		
Lin Bennett	Practice Manager	✓	✓					
Tanya Mulvey	Practice Manager						A	
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓	✓	
Debbie Fagan	Chief Nurse & Quality Officer	✓	✓	✓	A	A	✓	
David Smith	Deputy Chief Finance Officer	✓	✓	✓	✓	A	A	
Tracy Jeffes	Head of Corporate Delivery and Integration	✓	N	A	N	N	✓	
Ken Jones	Chief Accountant	✓	N	✓	✓	A	✓	
Debbie Fairclough	Head of Client Relations, CMCSU	A	N	A	N	N	N	
Roger Causer	Senior Local Counter Fraud Specialist, MIAA	✓	N	N	N	✓	N	
Wendy Currums	Local Counter Fraud Specialist, MIAA	✓	✓	✓	N	N		
Michelle Moss	Local Counter Fraud Specialist, MIAA			✓	N	✓	✓	
Adrian Poll	Audit Manager, MIAA	✓	✓	✓	N	✓	✓	
Elizabeth Tay	Audit Manager, PricewaterhouseCoopers	✓	✓	N	✓	N		
Mark Jones	Audit Director, PricewaterhouseCoopers	A	A	A	✓	✓		
Ian Roberts	Senior Manager, PricewaterhouseCoopers		✓	✓	N	N		
Rachael McIlraith	Audit Director, PricewaterhouseCoopers	✓						
Jillian Burrows	Audit Senior Manager					✓	✓	

No	Item	Action
A15/66	**Apologies for absence** Apologies for absence were received from Roger Driver, David Smith and Tanya Mulvey.	
A15/67	**Declarations of interest** Declarations of interest were received from CCG officers who hold dual posts in both South Sefton CCG and Southport and Formby CCG. The Committee noted that Ken Jones, now Deputy CFO at Trafford CCG, was in attendance to present agenda items A15/73, 74, 75 and 78.	
A15/68	**Advance notice of items of other business** The Chair had not been advised of any items of other business.	
A15/69	**Minutes of the previous meeting** The minutes of the previous meeting were approved as a true and accurate record and signed-off by the Chair.	
A15/70	**Action points from previous meeting** **A15/59 *Bribery Act Compliance Review*** – *MMcD to speak with Lisa Gilbert re e-learning on this subject* – MM advised that MIAA had developed a package, but it was not an e-learning version. All other actions were closed as appropriate.	
A15/71	**Internal Audit Progress Report** AP presented this report which provided an update to the Audit Committee in respect of the assurances, key issues and progress against the Internal Audit Plan for 2015/16. Regarding CHC counter fraud, DFa advised that she had previously been interviewed regarding this and asked for an update. MM to check and advise DFa accordingly. **Action by the Committee** The Committee received this report by way of assurance.	MM
A15/72	**Internal Audit Counter Fraud Progress Report** MM presented this report which updated the Committee on progress against the agreed Anti-Fraud Strategy for 2015/16. The Committee noted that since the writing of this report one of the active formal investigations had been closed. Only one formal investigation now remains (LCFS 0987), and MM is to liaise with MMcD, providing updates as soon as there are any developments. **Action by the Committee** The Committee received this report by way of assurance.	

No	Item	Action
A15/73	**Review of Losses and Special Payments** KJ presented this report and advised that there had been no losses or special payments made in the period since the last Audit Committee. The Committee noted that since the writing of this report Sefton MBC had made payment against their outstanding debt of £21k. **Action by the Committee** The Committee received this report by way of assurance.	
A15/74	**HMRC PAYE Review** KJ advised the Committee that all Governing Body members were now on the payroll, and gave assurance that the CCG is compliant with HMRC. **Action by the Committee** The Committee noted the update.	
A15/75	**Review of NFI Matches** KJ advised the Committee that the CCG had started a review of duplicate payments with MM. Although some duplicate payments were genuine, ie duplicate recurrent contract payments, a few had been duplicated erroneously. KJ said although the amounts were small the CCG would seek refund of the monies. **Action by the Committee** The Committee noted the update, and that the deadline for completion of this review is 31st December 2015.	
A15/76	**Review of Risk Registers** TJ presented the Committee with the papers from the July 2015 Governing Body meeting, in order for the Committee to review the approach taken, and provide assurance to the Governing Body that the CRR and GBAF processes are fit for purpose, forming a fundamental part of the CCG's internal controls. The Committee noted that the CRR and GBAF are reviewed on a regular basis by SMT and the Corporate Governance Group, as well as being formally presented to the Quality Committee. MMcD advised that SMT look to moderate the risks to ensure that they represent the key risks faced by the organisation. These risks are also subject to review by MIAA. **Action by the Committee** The Committee received these reports by way of assurance.	
A15/77	**Financial Control Assurance Self Assessment** This paper updated the Committee on the CCG's self-assessment of financial governance and controls of key areas, in line with NHSE's initiative to test financial resilience and sustainability. This assessment was completed with the help of the finance team, and subsequently reviewed and approved by the Chair of this Committee. **Action by the Committee** The Committee approved this draft self-assessment.	

No	Item	Action
A15/78	**Audit Follow-up Actions Review (Recommendations Tracker)** KJ presented this recommendations tracker, which had been compiled from a review of recommendations made to the Committee over the past 12 months, using various reports and internal audit reviews. The recommendations had been RAG rated, and the Chair of the Committee suggested that further colours needed to be incorporated into the tracker eg for items having passed the deadline but still in progress, and for red items to have accompanying narrative. This report should also identify origin of the recommendation. DFa advised the Committee that Safeguarding Policy and Strategy shown as red is now complete (p107 of p118), and the tracker is to be updated accordingly. **Action by the Committee** The Committee noted the tracker and acknowledged it as a useful tool to be used on an ongoing basis.	DS
A15/79	**Whistle Blowing Policy Review** The Committee were advised that this policy had been updated with the counter fraud contact details, and subsequently approved. An extract from the policy showing this update is to be presented at January's meeting. **Action by the Committee** The Committee noted the update.	DFa
A15/80	**Macpherson Review** MMcD informed the Committee that this review relates to the CCG's control systems, in which the CCG is required to review techniques where estimation is required, and highlighted CHC and prescribing as key issues. DS will review the CCG's approach in this area and bring a short paper back to the Audit Committee. This will then be evidenced in the CCG's Annual Governance Statement in April 2016. **Action by the Committee** The Committee noted this update.	
A15/81	**Key Issues of other Committees** The following Key Issues reports were received by the Committee: • Finance and Resource - June 2015 - July 2015 • Quality Committee - May 2015 - August 2015 **Action by the Committee** The Committee noted the key issues in these reports.	

No	Item	Action
A15/82	**Any other business** • **Ken Jones** Both the Chair and Committee expressed their formal thanks to Ken Jones for all of his work and much valued contribution as Chief Accountant, during his time at the CCG. • **New Appointment: Chief Accountant** MMcD informed the Committee that Leah Smith has been appointed as Chief Accountant and is expected to join the CCG at the beginning of January 2016.	
	Date and time of next meeting Thursday 14th January 2016 1.00pm to 2.30pm 3rd Floor Board Room, Merton House	