NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

Date: Thursday 31st March 2016, 13:00 to 15:00 hrs
Venue: Boardroom, 3rd Floor, Merton House, Bootle, L20 3DL

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

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

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

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
Governance					
GB16/36	Apologies for Absence	Chair	V	R	3 mins
GB16/37	Declarations of Interest	Chair	V	R	2 mins
GB16/38	Minutes of Previous Meeting	Chair	R	A	3 mins
GB16/39	Action Points from Previous Meeting	Chair	R	A	5 mins
GB16/40	Business Update	Chair	V	R	5 mins
GB16/41	Chief Officer Report	FLT	R	R	10 mins
GB16/42	GP Pressures and Supporting Practices	All	V	R	5 mins
GB16/43	LCR NHS CCG Alliance – Revised Terms of Reference	FLT	✔	A	5 mins
GB16/44	Corporate Objectives	KMcC	✔	A	5 mins
GB16/45	Equality and Diversity Annual Report	AW	✔	A	5 mins

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
Quality & Safety					
GB16/46	Personal Health Budgets	TF	✔	R	10 mins
GB16/47	Safeguarding Peer Review Action Plan	DF	✔	R	10 mins
GB16/48	Looked After Children Strategy	TBC	✔	R	10 mins
Service Improvement/Strategic Delivery					
GB16/49	Dementia Friendly Communities and the CCG's Role	KT	✔	R	10 mins
GB16/50	Transforming Care for People with Learning Disabilities: Implementation of National Plan	GO'C	✔	R	10 mins
Finance and Quality Performance					
GB16/51	Integrated Performance Report	KMcC/ MMcD/DF	✔	R	10 mins
GB16/52	2016/17 Opening Financial Budgets	MMcD	✔	R	10 mins
GB16/53	Revised Financial Strategy 2016/17 to 2020/21	MMcD	✔	R	10 mins
For Information					
GB16/54	Key Issues Reports: a) Finance & Resource (F&R) Committee b) Quality Committee c) CIC: Realigned Hospital Based Care d) CIC LCR NHS CCG Alliance e) Audit Committee f) 4-Monthly Locality Reports ○ Bootle ○ Maghull – to follow ○ Seaforth & Litherland ○ Crosby	Chair	R R R R R R R R	R R R R R R R R	5 mins
GB16/55	F&R Committee Minutes - Nov 2015 - Jan 2016		R	R	5 mins
GB16/56	Quality Committee Minutes - Dec 2015 - Jan 2016		R	R	
GB16/57	Approvals Committee Minutes - no mtg since Sept 2015		-	-	
GB16/58	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting*				
GB16/59	Date of Next Meeting Thursday 26th May 2016 at 13:00 hrs in the Boardroom, 3rd Floor, Merton House.				-
Estimated meeting close					**15:00 hrs**

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

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

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

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

Presentation: 'Care Act'
Dwayne Johnson, Sefton Council

No	Item	Action
GB16/1	**Apologies for Absence** Apologies were received from Canon Roger Driver, Debbie Fagan and Margaret Jones.	
GB16/2	**Declarations of Interest** Those holding dual roles across Southport & Formby CCG and South Sefton CCG declared their interest. GP Members declared their interest in agenda item '16/12 Primary Care Transformation Plan'.	
GB16/3	**Minutes of Previous Meeting** The minutes of the previous meeting were accepted as a true and accurate record.	

No	Item	Action
GB16/4	**Action Points from Previous Meeting** 15/204 – Safeguarding Children & Vulnerable Adults – GH to confirm whether the spiritual abuse definition was acceptable. BP confirmed this was outstanding. Leave on tracker. 15/207 – Organisational Development Plan – TJ will take the detailed plan to the F&R Committee. Done remove from tracker. 15/209 – Co-Commissioning Update – going to Wider Forum on 9th Forum and an email has been issued today 28th January. 15/212 – Update on Cancer Access Performance – the CCG's position had been reviewed against that tripartite requirements, done, remove from tracker.	BP
GB16/5	**Business Update** Dr Gillespie informed the Governing Body that elections were coming up and working to constitutional timelines.	
GB16/6	**Chief Officer Report** FLT gave highlights from her report. Roy Lilley would be at a breakfast meeting on 11th February where the CCG would be showcasing some of the Shaping Sefton work. Governing Body Changes – FLT thanked Roger Driver for his commitment and support as he was standing down due to relocation. Dr McDowell commented Roger Driver will be missed as he is a great asset to the Governing Body. FLT confirmed the recruitment process was underway for both lay member for patient experience and public engagement and practice manager, as one practice manager had changed roles and another had resigned due to work pressures. Dr Clive Shaw was retiring and Dr Gillespie thanked Dr Shaw for his contribution and wished him well for the future.	
GB16/7	**GP Pressures and Supporting Practices** Local Quality Contract Funding - Dr Gillespie had received comments from a number of practices in relation to funding on the LQC and the workforce capacity to deliver that.	
GB16/8	**Corporate Risk Register and Q3 Governing Body Assurance Framework** TJ gave highlights from the report. There was a reduction in the risk in relation to the sustainability of CSU services as the mobilisation of the new CSU is on track. Corporate Risk Register – there was an additional risk in relation to intermediate care beds, raised at quality committee. Additional Community Beds – FLT confirmed this remained a key priority and would be an extreme risk although everything was being done to mitigate it. AM commented we were lucky to have experienced a mild winter and congratulated Social Services who had worked exceptionally hard over the period. **Outcome: The GB received the report**.	
GB16/9	**Improving the Quality of NHS Complaints Investigations *(PHSO Summary Report)*** FLT specifically requested that this report be included in the papers as it raised issues regarding the investigation of complaints. Lisa Gilbert was linking with colleagues to see how recommendations could be implemented locally and to ensure good practice. Primary Care was not mentioned as the systems appeared to more effectively respond. FLT had raised the matter with NHSE to make the NHS Complaints system smoother locally. Maureen Kelly was very happy to see the report contained in the meeting pack and confirmed Healthwatch wanted to work with the CCG. **Outcome: The Governing Body received the report.**	

No	Item	Action
GB16/10	**Liverpool City Region (LCR) NHS CCG Alliance *(formerly Merseyside CCG Network)* Terms of Reference** Dr Chamberlain asked if all three people from the CCG had to be in attendance at meetings to be quorate. FLT confirmed only one person needed to represent the CCG. **Outcome: The Governing Body approved the Terms of Reference.**	
GB16/11	**Children and Young People's Plan** DJ explained a plan had not been published since 2011. The Council was clear about its vision priorities and what the actions were in terms of giving children in Sefton the best start in life. DJ welcomed comments from any GPs or members of the CCG. FLT confirmed Dr Wendy Hewitt would report back formally as the CYP Clinical Lead. JL to link back with Dwayne re children's mental health. PC asked for a joint cohesive moving forward – FLT confirmed this would link into the work KMcC was doing. Maureen Kelly asked if Healthwatch could be more involved and DJ confirmed he would welcome that. **Outcome: The GB received the report.**	WH JL
GB16/12	**Primary Care Transformation Plan** JL explained the paper set out some of the issues around estate, increasing demand, provider issues and workforce, which is also a national issue. The forthcoming APMS contracts were a big massive opportunity. A proposal for a Medical Director role would be submitted through the Finance & Resource Committee; it was essential to get the right person with the right skill set to lead the transformation. AM suggested the title in Section 3.4 needed to change to include having a medical qualification. **Outcome: The Governing Body approved the paper.**	
GB16/13	**Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21** KMcC informed the Governing Body of the need to build a 5-year Strategic Transformation Plan, as well as an operational plan around activity and finance, which would be based on a larger footprint than CCG level. Much of the discussion would be around where the CCG commissioned the vast majority of services for the population and that appeared to be the Liverpool City Region. There was additional emphasis in the plan on areas such as 7-day working and in particular access to consultant and diagnostic services at weekends and extended access to GP practices at weekends and out of hours. Another requirement is that we were robust to bring urgent care services together so it is clear and more evident to the public where they should go. We had to have an aggregated plan which balanced and as part of that work we were looking at current allocations, level of income and we are describing a level of expenditure across different areas incorporating QIPP. The plan will need to set out the direction of travel for new models of care, primary care and the Organisational Development Plan will be fundamental to us to support general practice. FLT confirmed there would be a debate at the following day's meeting with NHS England to decide what footprint the STP sat in and she pointed out the CCG also needed to be cognisant that it would be the only way to draw down money. Dr Gillespie thanked KMcC and his team for a very clear paper. **Outcome: The Governing Body received the report and delegated authority to SLT to ensure the timetable was adhered to.**	SLT

No	Item	Action
GB16/14	**Shaping Sefton Update** Community Care – the Virtual Ward rollout is complete across all localities as is the community urgent care team including GPs. The next step was to enhance uptake further using opportunities and the role of medical director to try to embed that as common everyday operational practice. Care Home Improvement Programme – there was a very strong uptake with the telehealth project and although it was early days it looked as though it was having a positive impact on A&E activity. CG added he had received very positive comments from GPs in relation to the Care Home Improvement Programme. Mental Health – some significant work had been done in conjunction with Mersey Care, a joint session had been held before Xmas resulting in joint strategic principles, agreed priorities, timelines and outcomes. A discussion had also been had with Liverpool CCG with a view to adopting those principles and priorities, so now looking at a joint framework; Dr McDowell reported that people were not familiar with the acute visiting scheme when it had been raised at a locality meeting. Dr Chamberlain to follow up with the locality manager.	PC
GB16/15	**Integrated Performance Report** Performance - KMcC briefed the Governing Body on highlights from the report. Quality – a 12 hour breach in November has been through an RCA process. Quality walkarounds at Aintree are plannned. MRSA - all incidents have been investigated and there were no failures on behalf of Aintree. The involvement of a local GP has enhanced the investigation. Mixed Sex accommodation breach – BP to investigate who the breach had been accredited to. Patient Survey 2016 had been published and showed some improvements amongst the 32 practices. Finance: the summary position has broadly improved between month 8 and month 9 and MMcD was relatively confident - barring any unforeseen circumstances – the CCG would deliver its financial target. It wasimportant that between now and the end of the financial year to put in place cost reductions, Third Sector contracts – Section 9 last line “further details will follow in month 9”, should say month 10. **Outcome: The Governing Body received the report.**	BP
GB16/16	**Key Issues reports from committees of Governing Body:** **a) Finance & Resource Committee** **b) Quality Committee** **c) CIC: Realigned Hospital Based Care** **d) CIC LCR NHS CCG Alliance** Outcome: The Governing Body received the key issues logs.	
GB16/17	**Finance & Resource Committee Minutes** Outcome: The Governing Body received the minutes.	
GB16/18	**Quality Committee Minutes** Outcome: The Governing Body received the minutes.	
GB16/19	**Audit Committee Minutes** FLT noted we were getting useful feedback from both internal (MIAA) and external auditors (PWC). Therefore we are assured that governance arrangements within the organisation are working. GM and DMcD both congratulated MMcD and his team on a really robust team. Outcome: The Governing Body received the minutes.	
GB16/20	**Approvals Committee Minutes** None presented.	

No	Item	Action
GB16/21	**Any Other Business** None.	
GB16/22	**Date of Next Meeting** Thursday 31st March 2016 at 13:00 hrs in the Boardroom, 3rd Floor, Merton House.	

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

No	Item	Action
GB16/4 (GB15/204)	**Safeguarding Children & Vulnerable Adults Policy 2015: Review** Gina Halstead (Chair of QC) to confirm in writing to the GB that the QC are happy with the 'spiritual abuse' definition.	GH/BP
GB16/11	**Children and Young People's Plan** DJ welcomed comments from any GPs or members of the CCG. FLT confirmed Dr Wendy Hewitt would report back formally as the CYP Clinical Lead. JL to link back with Dwayne re children's mental health.	WH JL
GB16/13	**Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21** The Governing Body received the report and delegated authority to SLT to ensure the timetable was adhered to.	SLT
GB16/14	**Shaping Sefton Update** Dr McDowell reported that people were not familiar with the acute visiting scheme when it had been raised at a locality meeting. Dr Chamberlain to follow up with the locality manager.	PC
GB16/15	**Integrated Performance Report** Mixed Sex accommodation breach – BP to investigate who the breach had been accredited to.	BP

NHS
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MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/41	**Author of the Paper:** Fiona Taylor Chief Officer Email: fiona.taylor@southseftonccg.nhs.uk Tel: 0151 247 7061
Report date: March 2016	

Title: Chief Officer Report

Summary/Key Issues:

This paper presents the Governing Body with the Chief Officer's monthly update.

Recommendation

The Governing Body is asked to formally receive this report and approve delegated authority to the Chief Officer to sign off the BCF on its behalf.

Receive	
Approve	x
Ratify	

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

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

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

NHS
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Report to Governing Body
March 2016

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

The CCG submitted the second iteration of the one year operational plan on 18th March 2016. This date was not part of the original timetable and has been added by NHSE this month to enhance their level of assurance. The next iteration is due for submission on 11th April.

The plans have been built up by point of delivery (Elective, Out-patients, Non-electives, A&E attendances) and by provider. The baseline used at the outset was the month 6 baseline, provided by NHSE. We have up-dated the baseline for CCG planning purposes based on month 9 forecast outrun, with adjustments for seasonality. Plans have then been augmented to take account of demographic changes. Thereafter plans have incorporated adjustments based on existing QIPP and transformation schemes.

These plans will now need to be tested through Senior Leadership Team and the Governing Body Development sessions to inform the next iteration.

2. Sustainability & Transformation Plan (STP)

In terms of STP, the agreed footprint remains Cheshire and Merseyside, with the following Local Delivery Systems:

- North Mersey;
- Mid Mersey;
- Wirral & West Cheshire;
- Eastern Cheshire;
- Central & South Cheshire.

South Sefton CCG and Southport & Formby CCG remain part of the North Mersey LDS with Liverpool and Knowsley CCGs.

The CCG is now working within the LDS footprints to build up the respective plans in contribution to the STP deadline of June 2016.

3. Shaping Sefton

In February 2015 we launched the Shaping Sefton Transformation programme. Focused on the CCGs three strategic aims

- Care of frail/vulnerable person
- Transformation of the Unplanned care system
- Transformation of Primary Care

The work programmes have been built around our settings of care

- Prevention
- In Hospital
- Out of hospital

These are aligned to the three components of Triple Aim

- Better Health
- Better Care
- Better Value

We are now working within the Communications team to articulate this vision and outcomes of the programmes into our annual report and making it available for our next Big Chats. We will continue to work closely with our colleagues Liverpool CCG on shaping the 'in hospital model of care', building on the recent discussions of the governing body, engaging with the CCG membership, clinicians and public.

There is also work going on with the new Director of Public Health Matthew Ashton to build on the Health & Well Being Strategy and consolidate the CCG and Local Authority thinking across the Health & Well Being/Prevention agenda. A programme manager will be appointed on a fixed term basis to lead this work.

4. Better Care Fund Policy Framework 2016/17

The Policy Framework was published on 8 January 2016. It sets out the agreed way in which the Better Care Fund will be implemented in the 2016/17 financial year. The underlying principles are to remain in that:

- a pooled fund is required,
- Health and Wellbeing Boards are expected to agree plans,
- plans will be approved by NHS England in consultation with Department of Health and in addition the Department of Communities and Local Government.

The Framework covers:

- the legal and financial basis of the fund
- conditions of access to the fund
- national performance metrics
- the assurance and approval process

The six National Conditions remain with addition of two

- Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
- Agreement on local action plan to reduce delayed transfers of care.

These two conditions replace the performance fund element, where areas were required to commit to a reduction in non-electives and "hold funds back on the basis of making that reduction" (Payment for Performance). However, there is an option to retain this arrangement, with agreement.

The process for developing plans will be simplified and plans have been aligned to the timetable for CCG operational plans. We are currently working through our BCF plans with Sefton MBC, supported by Sharon Lomax- Integrated Health and Social Care Manager. **The governing body is asked to give delegated authority to the Chief Officer to sign off the BCF on its behalf.**

5. Quality

4.1 Nurse Revalidation

The Governing Body have previously received updates on the preparation for revalidation. Nurse revalidation comes into effect from 1st April 2016. The requirements for revalidation for each nurse registered with the Nursing & Midwifery Council are as follows:

- 450 practice hours or 900 if renewing as both a nurse and a midwife;
- 35 hours of CPD including 20 hours of participatory learning;
- Five pieces of practice-related feedback;
- Five written reflective accounts;
- Reflective discussion;
- Health and character declaration;
- Professional indemnity;
- Confirmation.

Internally Within the CCG - The Chief Nurse and Deputy Chief Nurse are aware of all registered nurses currently working within the organisation and HR has notified the Chief Nurse of all nurses working within the CCG who are due for revalidation within the next couple of months. SFCCG, SSCCG and LCCG have been working collaboratively to deliver internal awareness raising sessions and these have now developed into reflective practice opportunities for the registered nurses. Registered Nurses who are line-managed by another NMC registrant can undertake both their reflective discussion and confirmation sign-off at the same time. Registered Nurses who are not line-managed by a NMC registrant will have to seek sign-off of their reflective discussion from another NMC Registrant before confirmation can take place by their line-manager.

Practice Nurses Working Within Constituent Practices – The practice nurse facilitators have developed and delivered a reflective writing workshop session for constituent practice nurses as part of the protected learning time event in December 2015. The aim of the session was to prepare nurses on completing reflective accounts as part of the revalidation process. A revalidation page has been developed for practice nurses on the CCG web site to provide updates and links to the NMC website for revalidation guidance. Regular updates have been included in CCG bulletins over the last 9 months. The practice nurse facilitators have also contacted individual practices to offer support to both practice nurses and practice managers on revalidation.
Commissioning Assurance – CCG commissioners have jointly agreed key performance indicators to be negotiated into the 16/17 quality schedule in relevant provider contracts.

4.2 Student Nursing Times Awards 2016: Student Placement of the Year – Community Category

Southport & Formby CCG and South Sefton CCG have been shortlisted in the Student Nursing Times Awards 2016. The CCGs have made it into the final round of the 'Student Placement of the Year – Community' category. The winner of this national award will be announced at a ceremony in London on 28th April 2016.

4.3 Article for Publication – Student Placements in the CCG

The Quality Team have recently received confirmation that the article that was written regarding Student Placements within the CCG has been accepted for publication in The Nursing Times. The publication date is awaited. The article was written as a collaborative submission with input and

review from NHS Southport & Formby CCG, NHS South Sefton CCG, Edge Hill University, North West Placement Development Network and NHS England Nursing Directorate (national team).

4.4 Health Care Assistant Apprentice Graduation – Hugh Baird College

The CCG Practice Nurse Facilitators were involved in the development and delivery of the Apprentice Programme as well as providing support to both GP Practices and trainees. Evaluation of the course is currently underway and is being undertaken on behalf of the CCG by Edge Hill University. The first cohort graduated in March 2016 and an award ceremony took place – awards were presented by the CCG Deputy Chief Nurse.

4.5 NHS England Cheshire & Merseyside (C&M) Health Care Associated Infection (HCAI) Summit

In February 2016, NHS England C&M held the second HCAI Summit. The Deputy Chief Nurse delivered a joint presentation with the Infection Prevention Control Nurse Lead from Aintree University Hospitals NHS Foundation Trust on the development and implementation of the local clinically-led C.difficile appeals process. This highlighted collaboration and ownership of the process by local providers and commissioners and will form the basis for the next HCAI summit to promote reliability and consistency of the process across the wider health economy. The CCG received thanks from the NHSE C&M Director of Nursing & Quality for their involvement in the day.

4.6 Quality Walkarounds

Southport & Ormskirk Hospitals NHS Trust (Accident & Emergency Department / GP Assessment Unit) - The CCG Team, in partnership with NHS West Lancashire CCG, have recently undertaken a Quality Walkaround through the A&E Department and GP Assessment Unit at the Trust as part of the assurance process due to recent pressures. The CCGs were accompanied by the Trust Director of Nursing who also facilitated the opportunity for a discussion with staff and patients during the visit.

Southport & Ormskirk Hospitals NHS Trust (Stroke Unit) – The CCG Team, in partnership with NHS West Lancashire CCG, are awaiting a date to be finalised for a Quality Walkaround through the Stroke Unit following the confirmation of ring-fenced beds from the Trust.

Mersey Care NHS Trust – The CCG Team have recently met with the Trust Director of Nursing and the relevant provider teams to gain an understanding of the patient pathway from A&E to the specialist suite at Clock View due to some longer than expected waiting times. A member of the Quality Team has also 'shadowed' the Mersey Care Team to observe the systems and processes they have in place when undertaking internal quality assurance visits and plans are in place for a future visit to take place. The CCG Quality Team has offered a reciprocal arrangement to the Trust to see how the CCG Quality Team operates as part of a 'commissioner / provider knowledge exchange' and to further support joint working and learning opportunities across the local system.

4.7 Single Item Quality Surveillance Group –Southport & Ormskirk Hospitals NHS Trust

A follow-up Single Item Quality Surveillance Group Meeting for Southport & Ormskirk Hospitals NHS Trust was Chaired by NHS England (Cheshire & Merseyside) on 8th March 2016. The Trust evidenced progress against the key lines of enquiry which were identified at the previous meeting. A date has not been set for a future meeting as the Trust have an announced CQC visit in April 2016 and all key stakeholders will be invited to a meeting to be informed of the outcome of the planned inspection.

4.8 Care Quality Commission (CQC) Planned Inspections of Local NHS Providers

The CCG have announced that they will be undertaking planned inspections of Southport & Ormskirk Hospitals NHS Trust, Liverpool Heart & Chest Hospital NHS Foundation Trust and The Walton Centre NHS Foundation Trust in April 2016. The CQC have requested that the CCG support any promotion of the visits with the public and also inform them of any engagement events we are holding that they can utilise. As per usual practice, the CCG will be liaising with the CQC prior to the visits to share any relevant information.
Liverpool Community Health NHS Trust has had a recent inspection visit from the CQC. The Governing Body will be informed of the outcome of the CQC inspection visits once known.

4.9 Care Home Closures

At the January 2016 meeting of the Governing Body, information was relayed via the Chief Officer Report regarding Balliol Lodge Nursing Home and the action taken by the CQC to de-register the provider. The owners subsequently made a petition to the Court of Appeal of the action taken by CQC. The CCG had been requested by the CQC to provide representation as part of the Court of Appeal process which had been scheduled to take place on 2nd & 3rd March 2016. The Appellants decided not to pursue their appeal upon receiving both the evidence from the CQC and the CCG. The final order of the Tribunal approving the withdrawal of the appeal by Balliol Lodge was received on 22nd March 2016.

Since October 2015 there have been a loss of 93 nursing home beds across the borough of Sefton due to nursing home closures - 2 were as a result of CQC inspection processes and 1 home closed on a voluntary basis. There are still vacant beds available to provide care in Sefton.

4.10 Youth Offending Team Board

The Deputy Chief Nurse represents the CCG at the Youth Offending Team Board and at the March 2016 meeting presented a paper highlighting the current commissioning arrangements and health activity. Verbal feedback indicated 'reasonable assurance' and further work has been agreed to take place outside of the Board on lower level Mental Health input for those children and young people who wouldn't meet the criteria for Mental Health Services.

4.11 Individual Patient Activity (IPA) Programme Board

Midlands & Lancashire Commissioning Support Unit (MLCSU) are now delivering the commissioning support function to the CCG for individual packages of care, including Continuing Health Care (CHC), excluding non-CHC Learning Disability packages of care which are commissioned via a joint arrangement with the Local Authority. The CCG still has in place the CHC Steering Group (Chaired by a SFCCG Lay Member) but an IPA Programme Board has now been established between SFCCG, SSCCG, LCCG and M&LCSU. The purpose of the Programme Board will be to support the development and delivery of our strategic vision and provide relevant assurance. It is envisaged that the CHC Steering Group will shortly be disbanded with the work it scrutinised forming part of the remit of the IPA Board. The IPA Programme Board has now met on 2 occasions and members are keen to have Local Authority colleagues in attendance once the Board is further established.

4.12 Safeguarding

Joint Targeted Area Inspections

The Quality Committee received an update from the CCG Safeguarding Service in February 2016 regarding the new Joint Targeted Area Inspection (JTAI) which has been launched from 1st February 2016 – Inspectors will include those from Ofsted, Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC) and her Majesty's Inspectorate of Probation (HMIP). The joint inspection will examine how the Local Authority, Police, Health, Probation and the Youth Offending Service work together to identify, support and protect vulnerable children and young people. For inspections that take place between February 2016 and August 2016, the 'deep-dive' will focus on Child Sexual Exploitation (CSE) and missing from home, education and care.

The CCG Safeguarding Service have sent a briefing to the relevant commissioned provider services outlining the expectations and documents that will be required and prepared once an inspection is announced. The CCG / Safeguarding Service were in attendance at a recent meeting called by the Local Authority in order to understand and scope out the expectations of the partnership and establish communication pathways for collating and sharing requested documentation.

Section 11 Action Plan Update

The CCG is required to complete a Section 11 Audit which is returned to the Local Safeguarding Children Board (LSCB). This self-assessment undertaken by the CCG Safeguarding Service identified a high level of compliance across the majority of standards as well as some areas that could be further strengthened which include ease of availability of the CCG Safeguarding Policy to staff and the inclusion of safeguarding children signposting in induction processes . An action plan has been developed and an updated version (v2. February 2016) presented to the Quality Committee in February 2016. The revised CCG Safeguarding Policy has been uploaded onto the CCG website and includes links to the Local Safeguarding Children Board for multi-agency safeguarding children policies. With regard to the CCG induction process, the CCG Safeguarding Service are working closely with the CCG HR Team from the Commissioning Support Unit and the CCG Chief Delivery & Integration Officer is now also supporting this process.

NHS England CCG Quality Assurance Process

NHS England has written to CCGs outlining their planned assurance process for Safeguarding. The CCG are required to complete an assurance tool demonstrating the meeting of statutory requirements to safeguard children, young people and adults at risk. The completed assurance tool will be completed by the CCG Safeguarding Service and reviewed by the Chief Nurse prior to submission in April 2016. The CCG Safeguarding Service will be providing an exception report to the Quality Committee as part of the CCG internal assurance processes.

CCG Safeguarding Peer Review Action Plan

The CCG Safeguarding Peer Review Action Plan was presented to the Quality Committee in February 2016 and have supported the recommendation for closure by the Governing Body. This will be presented as a separate agenda item at the Governing Body.

Child Sexual Exploitation (CSE)

The Governing Body have previously received a CSE update from the CCG Safeguarding Service in 2015. The CCG Safeguarding Service continue their leadership role with regard to this agenda at a local and regional level. Recent CCG activity in relation to CSE includes:

- **Local Safeguarding Children Board (LSCB) CSE Summit** – this Summit for LSCB Board Members was held on 16th March 2016. The Chief Nurse, Head of Safeguarding Children / Designated Nurse and the Named GP were in attendance as members of the LSCB representing the CCG;

- **Local Authority Stakeholder Briefing** – The CCG attended a recent CSE Briefing Session facilitated by the Local Authority in February 2016;

- **Provider Contracts 16/17** - The CCG Contracts Team have worked with the CCG Safeguarding Service to ensure that expectations around CSE are included in relevant provider contracts for 2016/17. Specific reference is being made regarding the requirement for the provider to take into account and adopt the Pan Cheshire/ Merseyside Child Sexual Exploitation Multi-Agency Strategy 2015 -2017 and Pan Cheshire/ Merseyside Child Sexual Exploitation Operating Procedure 2015-17. Relevant providers were performance managed on a range of Key Performance Indicators (KPIs) in relation to CSE in 2015/16 contracts and KPIs for 16/17 are currently being determined;

- **National CSE Awareness Day** – This took place on 18th March 2016 and information was circulated within the CCG and to membership practices by the Communication & Engagement Team;

- **Joint Targeted Area Inspection (JTAI)** – The CCG Quality Team and CCG Safeguarding Service have ensured that relevant information in relation to CSE is readily available as part of the CCG preparation for the JTAI.

NHS England PREVENT Masterclasses for CCG Executive Safeguarding Leads & Directors of Nursing

This masterclass was held on 16th February 2016. This 'Senior Development Session' covered the following areas – Statutory duty and what it means in practice; Policy and Procedure; Information Governance; Data Collection; Priority areas; Role of the Regional Prevent Co-ordinators; Role of the National Prevent Sub-Group. The CCG were represented the CCG Head of Vulnerable People. The CCG's current arrangements for Prevent are in-line with the statutory requirements.

4.13 Looked After Children (LAC)

Looked After Children Health Assessments and Reviews - The issue of health assessments and health reviews for looked after children (LAC) were placed on the CCG Corporate Risk Register in 2015. On 31st March 2016, the CCG Chief Nurse is chairing a follow-up meeting to the lessons learnt event undertaken in 2015 to review progress to date. From a health perspective, work has been undertaken in the interim supported by the CCG Designated Nurse for Looked After Children, to improve local system and processes. Current provider performance in relation to health assessments for LAC has been presented and discussed at the March 2016 meeting of the Quality Committee as part of the CCG Safeguarding Service Assurance Report.

CCG Looked After Children Strategy – The CCG Looked After Children Strategy has been developed by the CCG Safeguarding Service and reflects national guidance. This has recently been presented to the Quality Committee and is a separate agenda item at today's meeting.

Governing Body Development Session – the date is currently being finalised for the delivery of Board level training by the CCG Safeguarding Service at a future Governing Body Development Session.

4.14 Local Government Association (LGA) Adults Peer Challenge Training

Peer Challenge is an important component of Sector Led Improvement in Adult Social Care. The LGA wanted to widen the number of 'Health Peers' with CCG experience and the CCG Chief Nurse, Deputy Chief Nurse and Head of Vulnerable People successfully completed training to support the LGA Adult Safeguarding Peer Challenge Programme in March 2016. The time commitment will be no more than one Peer Review per year for each of the trained individuals and this is dependent on being suitably 'matched' with the requesting area. This will develop further the experience the Quality Team has with regard to peer review and builds upon the experience of the team in supporting a mock CQC-style Chief Inspector of Hospitals inspection as previously reported to the Governing Body.

6. Mental Health Taskforce Report

In February the long awaited Mental Health Taskforce Report was published. The independent Taskforce which was established in March 2015, was chaired by Paul Farmer of Mind and aimed to pull together a long term strategic approach to improving mental health outcomes across the NHS.

The Taskforce brought together a range of experts from arm's length bodies, the voluntary sector, mental health providers, carers, experts by experience. The report set out the start of a ten year journey for that transformation a set of recommendations for the six NHS arm's length bodies to achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people. The main ambition is to have a decent place to live, a job or good quality relationships in their local communities.

There is a particular focus on tackling inequalities. Mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination. For too many, especially black, Asian and minority ethnic people, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital. To truly address this, we have to tackle inequalities at local and national level

There are 57 recommendations and while recognising that the recommendations set out in the report will be tough to implement, the report is an important challenge to the whole system, and certainly one that the CGG will take seriously. It is an opportunity to make a real difference to mental health services, address the inequalities that persist and provide the best possible care for people with mental health issues, within the available resources.

Some key messages include:

- 1 in 10 children aged 5-16 years have a diagnosable mental health problem
- Nine out of ten adults with mental health problems are supported in primary care
- £34 billion each year spent on mental health

- Just 43% of people with mental health problems are in employment
- £1 billion additional investment needed
- Right care, right time, right quality – 7 days a week

One of the recommendations specifically focuses on CCGs. It suggests that the Department of Health and NHS England should require CCGs to publish data on levels of mental health spend in their Annual Report and Accounts, by condition and per capita, including for Children and Adolescent Mental Health Services, from 2017/18 onwards. They should require CCGs to report on investment in mental health to demonstrate the commitment that commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall allocation increase. For children and young people, this should be broken down initially into spend in the community, on emergency, urgent and routine treatment, and for inpatient care.

https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

7. Review of Women's and Neonatal Services at Liverpool Women's Hospital NHS FT

On the 4th March 2016 a review to identify how health services for women and premature babies in Liverpool can continue to flourish for future generations was announced.

The review, which is part of the Healthy Liverpool programme and very much aligned to the Shaping Sefton programme, will be led by NHS Liverpool Clinical Commissioning Group (CCG) as co-ordinating commissioner, in partnership with Liverpool Women's NHS Foundation Trust.

The move comes following a piece of work undertaken by doctors, nurses and midwives at Liverpool Women's Hospital to highlight how these services could be made better for future generations of women, babies and their families. The way that services for women and babies are currently organised in the city was put in place more than 20 years ago. The health needs of the population have changed during this time, and are continuing to change, so it's important that we look at how services might be delivered differently for the benefit of patients.

First and foremost this review is about making sure local people have access to the very best care, but this process will also give us the opportunity to think about solutions which will protect services by ensuring that they are financially sustainable. This review will consider all options available to ensure that specialist women's and babies' services continue to flourish in this city for future generations.

The review results will inform a further conversation with the public early in summer 2016. This will be followed by a formal public consultation around any service changes later this year, ahead of a final decision being reached in 2017.
The governing body will continue to be updated and the CCG clinical lead for women's and children will be involved in this work as well as the work of the Vanguard.

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

As work has progressed on the Sustainability & Transformation Plan the terms of reference for the LCR NHS CCG Alliance have been reviewed and are presented for approval.

9. NHS Diabetes Prevention Programme (NHS DPP)

The Healthier You: NHS Diabetes Prevention Programme (NHS DPP) will identify those at high risk of developing type 2 diabetes. It is estimated that around 22,000 people with diabetes die early every year. Type 2 diabetes is a leading cause of preventable sight loss in people of working age and is a major contributor to kidney failure, heart attack, and stroke. As well as the human cost, Type 2 diabetes treatment currently accounts for just under nine per cent of the annual NHS budget. This is estimated at around £8.8 billion a year.

Healthier You: The NHS Diabetes Prevention Programme will start this year with a first wave of 27 areas covering 26 million people, half of the population, and making up to 20,000 places available. This will roll out to the whole country by 2020 with an expected 100,000 referrals available each year after.

Those referred will get tailored, personalised help to reduce their risk of Type 2 diabetes including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes, all of which together have been proven to reduce the risk of developing the disease.

There are currently 2.6 million people with Type 2 diabetes in England with around 200,000 new diagnoses every year. While Type 1 diabetes cannot be prevented and is not linked to lifestyle, Type 2 diabetes is largely preventable through lifestyle changes. One in six of all people in hospital have diabetes – while diabetes is often not the reason for admission, they often need a longer stay in hospital, are more likely to be re admitted and their risk of dying is higher.

Seven demonstrator sites have been testing innovative approaches to programme delivery for the last year and this learning has shaped the final programme to get the best results for patients.

Through a phased approach the 27 areas will open their doors to patients in the next few months and throughout 2016. I am pleased to report that Sefton is one of these 27 areas following on from these seven demonstrator sites. The NHS DPP is a joint commitment from NHS England, Public Health England and Diabetes UK. The programme launch coincides with PHE's new national campaign, One You, which encourages people in midlife to take control of their health and make better lifestyle choices – helping them to prevent ill health and help them live well for longer.

I want to offer my thanks to Sharon Forrester-Programme Lead and the two CCG clinical leads, Dr Doug Callow and Dr Nigel Taylor who have worked with Dr Davina Hanlon in the Councils Public Health team to submit a successful bid. The governing Body can look forward to progress updates. https://www.england.nhs.uk/ourwork/qual-clin-lead/diabetes-prevention

10. Governing Body changes

The governing body are formally informed of the results of the recent governing body elections undertaken by the Local Medical Committee (LMC). Drs Chamberlain, Gillespie, Mimnagh, Sapre, Sinha and Wray have been duly elected, subject to wider group ratification. There remains one vacancy for a GP member. A recruitment process is currently underway for the two practice manager vacancies again supported by the LMC.

As a result of an open recruitment process the position for the replacement of Roger Driver-Lay Member Engagement & Patient Experience has been offered and we are awaiting confirmation through the usual Human Resources recruitment processes.

Sefton LMC have also kindly sent out an invitation to Practice Managers for an expression of interest in our vacancies.

11. Recommendation

The Governing Body is asked to formally receive this report and approve delegated authority to the Chief Officer to sign off the BCF on its behalf.

Fiona Taylor
Chief Officer
March 2016

Liverpool City Region (LCR) NHS Clinical Commissioning Group Alliance

(Committee in Common)

Terms of Reference

1. Purpose of the Alliance

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

- Collaborate on the co-commissioning of specialised services with NHS England
- Collaborate on collaborative commissioning across other agreed areas
- Be the responsible body of NHS commissioners for discussions regarding devolution.
- Be the forum to consider alignment across STP plans and identify areas for possible collaboration across Merseyside.

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

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

2. Membership

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

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

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

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

3. Accountability and Reporting

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

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

4. Administration

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

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

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

5. Quorum

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

6. Voting arrangements

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

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

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

7. Frequency and Notice of Meetings

7.1 The Alliance will meet at least 6 times during the financial year, additional meetings may be called by the Chair of the Alliance as and when required.

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

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

8. Conduct

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

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

8.3 The Alliance will:

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

Draft V0.7

March 2016

Review date September 2016

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/43	**Author of the Paper:** Fiona Taylor Chief Officer Email: fiona.taylor@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: March 2016	

Title: LCR NHS CCG Alliance – Revised Terms of Reference

Summary/Key Issues:

As work has progressed on the Sustainability & Transformation Plan the terms of reference for the LCR NHS CCG Alliance have been reviewed and are being presented back to the Governing body for approval

Recommendation

The Governing Body is asked to approve this report.

Receive	
Approve	x
Ratify	

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

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

Links to National Outcomes Framework *(x those that apply)*	
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

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/44	**Author of the Paper:** Karl McCluskey Chief Strategy and Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk Tel: 0151 247 7251
Report date: March 2016	

Title: Corporate Objectives 2015/16

Summary/Key Issues:

The CCG has revisited its current Corporate Objectives and developed a proposal for 2016/17.

The proposed Corporate Objectives will be discussed at the CCG Senior Leadership Team and Operational Team meeting in April 2016.

Recommendation

The Governing Body is asked to approve this report.

Receive	
Approve	x
Ratify	

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

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

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

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
March 2016

1. Introduction and Background

The CCG has revisited its current Corporate Objectives and developed a proposal for 2016/17.

The proposed Corporate Objectives were discussed at the CCG Senior Leadership Team and Operational Team meetings in March / April 2016.

2. Proposed Corporate Objectives 2016/17

1 To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.

2 To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the "Forward View", underpinned by transformation through the agreed strategic blueprints and programmes.

3 To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.

4 To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complimentary primary care quality contract.

5 To advance integration of in-hospital and community services in support of the CCG locality model of care.

6 To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

3. Recommendations

The Governing Body is asked to approve the proposed Corporate Objectives for 2016/17.

Karl McCluskey
March 2016

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/45	**Author of the Paper:** Fiona Taylor Chief Officer Email: fiona.taylor@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: March 2016	

Title: Equality & Diversity Annual Report 2015/16

Summary/Key Issues:

This report introduces the South Sefton CCG Equality and Diversity (E&D) Annual Report (Appendix A) and the Governing Body are asked to pay particular attention to:

- The CCG's approach to and grading feedback in relation to, the Equality Delivery System2 (EDS2), (Appendix A section two);
- Draft CCG's refreshed 3-year Equality Objectives Plan (Appendix A, section three);
- The NHSE EDS2 Summary Report (Appendix B).

Summary/Key Issues:

The Governing Body is asked to:

a. Receive the Equality and Diversity Annual report (Appendix A);
b. Receive the CCG approach to Equality Delivery Systems 2 assessment (Appendix A section two);
c. Approve the 3 year Equality Objectives Plan in light of the EDS2 assessment (Appendix A, section three);
d. Receive the NHS England EDS summary Report (Appendix B).

Receive	x
Approve	x
Ratify	

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

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	x			Extensive engagement with national regional and local organisations who represent the views of people who share protected characteristics informed the Annual Report, Equality Objectives and Equality Delivery Systems 2 assessment
Clinical Engagement		x		
Equality Impact Assessment	x			The Annual Reports Equality Objectives Plan has been developed by the Equality Delivery Systems 2 assessment
Legal Advice Sought		x		
Resource Implications Considered		x		Presented to EPEG committee in February 2016
Locality Engagement	x			Extensive engagement with local organisations who represent the views of people who share protected characteristics informed the Annual Report, Equality Objectives and Equality Delivery Systems 2 assessment
Presented to other Committees	x			Presented to EPEG committee in February 2016

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

Report to Governing Body
March 2016

1. Executive Summary

This report introduces the NHS South Sefton CCG's Equality and Diversity (E&D) Annual Report (Appendix A) and the Governing Body are asked to pay particular attention to:

- The CCG's approach to and grading feedback in relation to, the Equality Delivery System2 (EDS2), (Appendix A section two);
- Draft CCG's refreshed 3 year Equality Objectives Plan (Appendix A, section three);
- The NHSE EDS2 Summary Report (Appendix B).

2. Introduction and Background

The CCG is required to pay due regard to the Public Sector Equality Duty (PSED) and Specific Duties to set Equality Objectives and publish equality information as set out in the Equality Act 2010. Failure to comply has legal, financial and reputational risks. Furthermore all CCGs are required to undertake the Equality Delivery Systems 2 (EDS 2) toolkit as part of the NHS England assurance process.

3. Key Issues

3.1 Annual report and legal background

The CCG has produced an annual Equality & Diversity Report which sets out how the CCG has been demonstrating 'due regard' to their Public Sector Equality Duty's three aims to eliminate discrimination, advance equality of opportunity and foster good community relations and will provide evidence for meeting the specific equality duty, which requires all public sector organisations to publish their equality information annually and set Equality Objectives.

3.2 Equality Delivery System

The CCG adopted the Equality Delivery System (EDS2) toolkit as its performance toolkit to support the NHS England Assurance process. The CCG's grades can be viewed in *Appendix A section two.* The CCG's NHS England EDS2 Summary Report can be viewed in Appendix B.

3.3 Equality Objective Plan

All Public authorities are required to meet their specific duties under the Equality Act 2010 to set Equality objectives every 4 years. As a result of the EDS 2 process an Equality Objective Plan has been developed to improve access and outcomes across protected characteristics over the next three years.

4. Conclusions

4.1 By receiving the Annual Report and ratifying the Equality Objective plan the CCG will continue to pay due regard to the exacting Public Sector Equality Duty and strive to continue to address barriers people with protected characteristics face.

4.2 The CCGs' are now required to complete and maintain an NHS England EDS2 Summary Report (Appendix B), which will be available on our websites and the link shared with NHS England for the national EDS2 dashboard.

4.3 The CCGs Annual report and Equality objectives plan will be published on the CCG website where it can be accessed by external stakeholders, patients and communities.

4.4 The Governing Body will continue to receive an annual update report and other key reports will be presented to other relevant CCG committees.

5. Recommendations

5.1 The Governing Body are asked to:

a) Receive the Equality and Diversity Annual report (Appendix A);
b) Receive the CCG approach to Equality Delivery Systems 2 assessment (Appendix A section two);
c) Approve the 3 year Equality Objectives Plan in light of the EDS2 assessment (Appendix A, section three);
d) Receive the NHS England EDS summary Report (Appendix B).

Appendices

Appendix A - Equality & Diversity Annual Report
Appendix B - NHSE EDS2 Summary Report

Fiona Taylor
March 2016

NHS
South Sefton
Clinical Commissioning Group

APPENDIX A

EQUALITY & DIVERSITY ANNUAL REPORT

Contents

Foreword

There is clear evidence that people's health, their access to health services and experiences of health services are affected by their age, gender, race, sex, sexual orientation, religion/belief, transgender, marital/civil partnership status and pregnancy/maternity status. NHS South Sefton Clinical Commissioning Group (CCG) strive to commission services that meet the needs of our communities; improving access and outcomes for residents and communities in the area.

South Sefton CCG believes that equality & diversity should be embedded into all our commissioning activity as well as addressing health inequalities.

1.0 Introduction

This document is the CCG's annual Equality & Diversity Report which sets out how the CCG has been paying 'due regard' to the Equality Act 2010's, Public Sector Equality Duty's (PSED) three objectives to:-

1. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Protected characteristics include the age Race, sex, gender reassignment status, disability, religion or belief, sexual orientation, marriage and civil partnership status

This document outlines the CCG's approach to embedding Equality & Diversity within the organisations via the EDS 2 toolkit, setting Equality objectives, monitoring the equality performance of our key NHS providers, ensuring our workforce are supported and engaged and we have robust processes in place to consider our Public Sector Equality Duty (PSED) when we are making commissioning decisions. The report also outlines our strategy and plans to ensure we have strong engagement with people who share protected characteristics.

1.1 What is 'due regard'?

"Due regard" means that the CCGs have given *advanced* consideration to issues of equality and discrimination before making any commissioning decision or policy that may affect or impact on people who share protected characteristics. It is vitally important Equality is an integral part of what we as a CCG do.

The CCG has considered their PSED by undertaking Equality Assessments on Policy and Service changes, by undertaking their Equality Delivery Systems 2 toolkit over 2015 and by ensuring communities who share protected characteristics have a voice in how services are delivered. The CCG prides itself of our involvement of local organisations within the Community and Voluntary Sector who have expertise or who represent the issues of communities and people who share protected characteristics.

1.2 What is discrimination?

Discrimination can be direct or indirect.

Direct discrimination is when one person receives less favourable treatment than another person because of a protected characteristic. For example, if a clinic refuses to offer fertility services to a lesbian couple because they are not heterosexual, this constitutes direct discrimination on grounds of sexual orientation.

Indirect discrimination is when there is a condition, rule, policy or practice that applies to everyone, but which particularly disadvantages people who share a protected characteristic. For example, a social care provider that runs a day centre decides to apply a 'no hats or other headgear' rule to its service users. If this rule is applied to every service user, then Sikhs, Jews, Muslims and Rastafarians, who may cover their heads as part of their religion, will not be allowed to use the drop-in centre. Unless the social care provider can objectively justify using the rule, this is indirect discrimination.

The Equality and Human Rights Commission has developed guidance for users of health and social care

For more information please visit http://www.nhs.uk/NHSEngland/thenhs/equality-and-diversity/Pages/equality-and-diversity-in-the-NHS.aspx

1.3 What the Equality Act 2010 means for you

The Equality Act 2010 gives the NHS opportunities to work towards eliminating discrimination and reducing inequalities in care. The NHS already has clear values and principles about equality and fairness, as set out in the NHS Constitution, and the laws under the Equality Act 2010 reinforce many of these.

Most of us need to visit a doctor or may need hospital treatment on occasion. Others may rely on the NHS and social care services for help with long-term health conditions or disabilities. Whenever you need healthcare, medical treatment or social care, you have the right to be treated fairly and not to be discriminated against, regardless of your 'protected characteristics' (you can see a list of protected characteristics below). Laws under the Equality Act set out that every patient should be treated as an individual and with respect and dignity.
The laws mean that all NHS organisations will be required to make sure health and social care services are fair and meet the needs of everyone, whatever their background or circumstances

1.4 Protected characteristics

The Equality Act 2010 offers protection to nine characteristics. These are:

- age
- race
- sex
- gender reassignment status
- disability
- religion or belief
- sexual orientation
- marriage and civil partnership status
- pregnancy and maternity

For the first time the law also protects people who are at risk of discrimination by association or perception. This could include, for example, a carer who looks after a disabled person.

This Equality and Diversity report sets out our ambitions for equality and diversity between 2015 and 2018, both in relation to staff and in delivering services to the public.

2.0 Equality Delivery Systems (EDS2)

We have adopted the Equality Delivery System (EDS2) as our performance toolkit to support us in demonstrating our compliance with the Public Sector Equality Duty. The Equality Delivery System (EDS) is a tool-kit that can the CCG improve the services we provide for our local communities, consider health inequalities in our locality and provide better working environments, free of discrimination, for those who work with us in the NHS.

The EDS 2 has four goals key goals (with 18 specific outcomes) achieving **better outcomes**, **improving patient access and experience, developing a representative and supported workforce and finally, demonstration of inclusive leadership**. Each of these goals can be assessed and a grading applied to illustrate progress in achieving the outcomes and the involvement of the communities and organisations who represent the views of people with protected characteristics is important. The grading's applied as follows:

> ***Undeveloped*** if there is no evidence one way or another for any protected group of how people fare or Undeveloped if evidence shows that the majority of people in only two or less protected groups fare well
>
> ***Developing*** if evidence shows that the majority of people in three to five protected groups fare well
>
> ***Achieving*** if evidence shows that the majority of people in six to eight protected groups fare well

Excelling if evidence shows that the majority of people in all nine protected groups fare well

2.1 The local approach to EDS 2

During 2015/16, the CCG's adopted an innovative approach to delivering the EDS 2 Toolkit; engaging with national, regional and local organisations who represent the views of people and communities who share protected characteristics. We undertook one-to-one meetings, workshops, interviews, briefings and research with partner organisations and stakeholders including to name but a few: Healthwatch, The Race Equality Foundation, Deaf Health Champions (Sick of It Report), In Trust Merseyside, Alzheimer's Society, Age Concern, Sefton Equalities Partnership and other key networks across Sefton CVS. The aim of the engagement was to ensure the CCG's understand the 'barriers' communities across protected characteristics face to enable the CCG to improve access and outcomes.

The CCG recognises that patients and staff who share certain protected characteristics are less likely to complain, complete NHS surveys or access community networks to provide their feedback and this level of engagement with stakeholders will ensure that entrenched barriers communities face in relation to accessing healthcare services are understood and mitigated as part of the CCG strategic and operational programmes. Meeting and understanding the needs of people is essential to remove disadvantage and advance equality of opportunity, so we will continue to endeavour to address these issues through mainstream plans, changing service specifications, the way we monitor our NHS providers, business plans and strategies, procurement activity, contract monitoring and discussions with key partners including NHS England, the Local Authority and community, voluntary and faith sectors.

The EDS2 findings identified a range of actions for CCGs' Equality Objective Plan and fair EDS 2 grading. This process also informed the preparation of the CCG's *EDS2 Summary Submission* to NHS England for 2015/16, which explains some of our processes.

Currently Grading for the vast majority of patient and public related services (Goals 1, 2& 4) for the CCG is assessed as **Developing**. Once these key issues are being addressed and or mitigated via mainstream business plans then the CCG can progress form ***developing*** status to ***achieving*** status across the relevant outcomes and goals.

The EDS2 assessment for the CCGs can be viewed in **Appendix 1** below and each goal is presented alongside the national EDS 2 grading achieved by the CCGs.

3.0 NHS South Sefton CCG Equality Objective Plan 2015/18 (Appendix Two)

As a direct result of EDS 2 the CCG has developed a specific long term Equality Objectives Action Plan, which will enable the CCG to address barriers through mainstream plans including- changes to specifications, business plans and strategies, improving procurement activity and processes, changing quality contract monitoring and enabling improved

information and intelligence exchange with key partners including NHS England, the Local Authority and Community Voluntary and Faith Sector.

Some of the key issue are

- Translation and interpretation across health services remains varied and standards need to be raised via work through the Quality Contract Schedule for Secondary Care Providers and establishing a base line of standards and usage in Primary Care
- the duty carry out reasonable adjustments (Equality Act 2010) to support better access and outcomes for disabled people and frail elderly is often misunderstood, and needs to addressed via contract monitoring and collaborative work between providers
- Understanding Transgender issues across health services is a key priority and needs to be progressed further within the CCG, the services they commission and Primary Care.

The CCG's current equality objectives are:-

- To make fair and transparent commissioning decisions;
- To improve access and outcomes for patients and communities who experience disadvantage
- To improve the equality performance of our providers through robust procurement and monitoring practice
- To empower and engage our workforce

The Objective plan has mapped the Objectives, EDS 2 outcomes and Public Sector Equality Duties to each action area.

4.0 Monitoring the Equality& Diversity performance of our key NHS providers

During the year we collaborated with neighbouring CCGs to ensure that contracts with key local NHS providers include requirements to achieve and improve equality and diversity standards, including through the Equality Delivery System.

Providers over 2015/16 were expected to:

- Agree a Smart Equality Objectives Plan;
- Complete an EDS assessments
- Provide evidence of compliance with Equality Act 2010 specific duties (including the Workforce Race Equality Standard)
- Only take decisions about service redesign after an equality analysis or equality impact assessment has been carried out to demonstrate due regard of the PSED
- Provide data on the use of translation and interpretation services.

5.0 Equality & Diversity and the Workforce

The CCG is committed to developing a representative and supported workforce and we specifically consider equality and diversity for our staff. We are aim to ensure that we have fair and equitable employment and recruitment practices as well as holding up to date information about the CCGs' workforce. It should be noted that as the CCGs have a small workforce and as such we are not required under the Specific Equality Duty to publish our workforce data. Over the next year our Workforce Equality plan in **Appendix 4** below will ensure we are cognisant of Equality Duties and our Workforce Race Equality Standard and that our relevant committees scrutinise the data available to them and ensure we value diversity and advance equality of opportunity for our staff.

5.1 Workforce and EDS 2

A key part of our EDS 2 (Goal 3) assessment focusses on our workforce and for the majority of our outcomes we are graded as achieving and developing status. These grades can be viewed in **Appendix 1**. By rolling out our Equality Workforce Plan over the next year we intend to progress to ***achieving*** across all our EDS 2 workforce outcomes.

5.2 Staff Training

Staff working within the CCGs undertakes annual equality and diversity training. The training is designed not only as an introduction to diversity and cultural awareness, but also as a practical guide to making our organisational culture an inclusive one. It combines a focus on personal and organisational beliefs, values and behaviours and the impact they have in our interactions at workplace, internally and externally. Furthermore programme leads within the CCG who are responsible for transforming health services have received training and one to one coaching on undertaking Equality Assessment reports.

6.0 Governance and accountability

The corporate team manged by the Chief Corporate Delivery and Integration Officer will be directly responsible to the Senior Management Team and Governing Body of the clinical commissioning group for providing the necessary information on progress and compliance to the PSED as part of their update on equality and diversity, which is planned into the Governing Body reporting and meeting cycle.

Over the last two years update reports on our compliance and issues associated with meeting our statutory duties have taken place in our EPEG Committee, Sefton Corporate Governance Group and Human Resources committee.

7.0 Conclusion

The CCG will continue to strive to ensure that the services the CCG commission are accessible to all. During the last twelve months we have made good progress around equality & diversity developing new and building on existing relationships with groups and individuals who share and represent the interests of protected characteristics. This year's EDS exercise has allowed us to fully improve our understanding of what barriers certain communities face and tackle them through mainstream processes and plans. We have developed a refreshed and long term Equality Objective Plan 2015-18 that focuses' on the internal processes we need to improve and the actions we need to undertake to tackle barriers and disadvantages certain communities face. The CCG has developed Workforce Equality & diversity Plan which aims to build on the solid foundations that are already in place. The CCG will continue to engage with the population and staff as a whole and continue to develop strong links with members of the population and groups who represent the interests of people who share protected characteristics and ensure that their views are built into the services we commission or the policies we develop.

NHS South Sefton CCG is committed to reducing health inequalities, promoting equality and valuing diversity as an important part of everything we do. This document clearly describes the headline activity that has taken place and more importantly it sets out the work and approaches that need to be undertaken to advance equality of opportunity.

We will continue to monitor our progress against the action plan and report annually and openly on the development of this work.

APPENDIX 1 SOUTH SEFTON CCG EDS 2 GRADES AND OUTCOMES

NHS South Sefton CCG EDS2: The Goals and Outcomes			Grade Status
Goal	**Number**	**Description of outcome**	
Better health outcomes	**1.1**	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Developing
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Developing
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	Developing
	1.4	When people use NHS services their safety is prioritised, and they are free from mistakes, mistreatment and abuse	Developing

	1.5	Local health campaigns reach communities	Developing
Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Developing
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	Developing
	2.3	People report positive experiences of the NHS	Developing
	2.4	People's complaints about services are handled respectfully and efficiently	Developing
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Developing
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Achieving
	3.3	Training and development opportunities are taken up and positively evaluated by all staff	Developing
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Developing
	3.6	Staff report positive experiences of their membership of the workforce	Developing
Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Developing
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Developing

NHS
South Sefton
Clinical Commissioning Group

APPENDIX 2 NHS South Sefton CCG Equality Objective Plan 2015-18

The CCGs current equality objectives are:-

1. To make fair and transparent commissioning decisions;
2. To improve access and outcomes for patients and communities who experience disadvantage
3. To improve the equality performance of our providers through robust procurement and monitoring practice
4. To empower and engage our workforce

The Objective plan has mapped the Objectives, EDS 2 outcomes and Public Sector equality Duties to each action area

Protected Characteristic	Key Issue and Barrier Identified	Action and responsible Officer	EDS Outcome PSED CCG Equality Objective
Race	Language and cultural barriers	Consider implementation of the new NHSE Translation and interpretation Framework for primary care when they are launched in 2015. Chief Corporate Delivery and Integration Officer awaiting launch address issues of Equality Impact to the CCGs' Primary Care Teams.- March 2018 The CCGs to address this issue in line with plans on delegated commissioning responsibility in primary care (on going) Develop base line usage of T&I services in Primary Care-CCG E&D lead – July 2016 (in progress) Ensure Key secondary care providers continue to report on T&I usage via the Quality Contract Schedule -2016/17 on going – Chief Nurse (in progress) Explore CCG support of sustain and continue to develop a Bilingual Volunteer project– March 2017	1.1, 1.2,1.3, 1.4, 1.5, 2.1, 2.2, 2.3, 2.4, Eliminate Discrimination Advance Equality Of Opportunity Equality Objectives 1,2,3

Race	Lack of understand on which services to access and inappropriate A&E attendance	Work collaboratively with relevant Community groups and health services to develop local communications to support appropriate access including registration with GPs- CCGE& lead and primary care Locality lead – March 2017 Ensure Specification for CCG BME related project reflects actions within Equality objective Plan- Chief Corporate Delivery and Integration Officer (October 2016)	2.1, 1.1 Advance Equality of Opportunity Equality Objective-1,2
Race	Lack of Cultural understanding within commissioning and primary and secondary care services	Promote BME organisations offer and promote Cultural competency training across CCGs, primary and secondary care (CCG E&D Lead &head of communications)- December 2016	1.1, 1.5, 2.1Advance Equality Of Opportunity and Foster Good Community relations Equality Objective-1, 2,3
Disability / age older citizens and young people)	Lack of understanding of mental health resulting in negative attitudes	Address issues of attitudes to people with mental ill health to lead mental health commissioner and Chief Nurse – CCG E&D December 2016 monitor progress of changes made to mental health services on issues associated with extensive EDS engagement- Mental Health lead Commissioners - March 2016 – on going	2.1,1.2, 1.3, 1.4 Eliminate Discrimination, Advance Equality Of Opportunity Equality Objective-1,2,3
Disability / age / frail elderly	Lack of understanding of reasonable adjustments by health professionals across Health services Implement Accessible information Standard Duty to make Reasonable	Implement Accessible information Standard is embedded across the CCG –Head of Communications & CCG E&D lead July 2016 – on going (In progress) Develop local CCG Translation and Interpretation policy — CCG E&D lead March 2016 (In progress) Develop comprehensive reasonable adjustment Guidance to support improvement in standards – CCG E&D lead – April 2016 – on (In progress) Ensure Accessible Information Standard and the need to make Reasonable	1.1,1.2,1.3,2.1 Advance equality of opportunity Equality Objective-1,2,3

	Adjustments	Adjustments is monitored with the providers via the Quality Contract Schedule – CCG E&D lead & Chief Nurse - March 2016 and on-going (In progress) Develop communication brief on the standard to primary care Develop and Distribute Reasonable Adjustment Guidance – E&D lead & head of Communications January 2016 (completed) Produce brief Consider Reasonable Adjustments CQUIN proposal and address in Quality schedule March 2016 (completed)	
Age- young people and working age older citizens	Further explore potential for vulnerable Young people to face disadvantages	Issue will be addressed in Quality Surveillance thematic work stream for mental health and Crisis care - Chief Nurse December 2015 - ongoing (In progress) Ensure CaMHs service contract is monitored and patient experience is captured across all protected characteristics –Lead CAMH Commissioner & Quality Team March 2017	1.1, 1.2, 1.4, 1.3 Advance equality of Opportunity Equality Objective- 2,3
Age- older citizens	Waiting times and timescales of referrals and appointments for frail elderly and Older citizens living alone	Address concerns raised by age organisations of flexibility and times around appointments to providers and relevant forums –Chief Corporate Delivery and Integration Officer March 2017 (In progress) Implements and monitors Accessible information Standard into provider contracts –E&D Lead & Head of Communications July 2016 (In progress) Address concerns raised in EDS 2 engagement on older people and mental health Chief Corporate Delivery and Integration Officer March 2017 (In progress)	1.1,1/2,1.3, 1.4, 2.1, 2.3, Advance Equality Of Opportunity Equality Objective- 2,3

Age	access to primary care for vulnerable young people lack of understanding Re children and young people	work underway via review of children's Mental Health Services - Lead CAMH Commissioner & Quality Team -July 2016 on going ensure all work re reasonable Adjustments is implemented – Chief Corporate Delivery and Integration Officer as above (In progress) ensure serious incidents policy and activity consider PSED and needs associated with protected characteristics –Chief Nurse & Quality Team March 2017 Forward concerns on lack of understanding of legal highs to Local Authority — Chief Corporate Delivery and Integration Officer December 2016	2.1, 1.4 Advance Equality Of Opportunity and Foster Good Community relations Equality Objective- 1,2,3
Transgender	Lack of understanding of trans issues, variation in service standards	explore options to improve knowledge and understanding of Transgender across health Services (issues raised are stored in EDS Engagement Excel spreadsheet) –Chief Nurse and Quality Team E&D lead-March 2017 options to include:- • add to portfolio of Clinical Support Officer to determine needs • work on cheshire wide footprint on Transgender support officer • raise issue at Quality Surveillance Group	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 2.3 Eliminate discrimination, advance equality of opportunity Equality Objective- 1,2,3,4
Sexual Orientation	Poorer patient experience and lack of understanding of needs across health services	Ensure clear communications are available across health services, specifically to support LGBT friendly services – March 2017 Head of Communications Ensure LGB information is acknowledged in specification and Commissioning –E&D lead and Chief Strategy and Outcomes Officer 7 Chief Redesign and Commissioning Officer March 2016 – on going	1.1, 1.2, 1.4 Eliminate Discrimination Advance equality of opportunity and Foster good Community relations Equality Objective- 1,2,3,4

Pregnancy & Maternity	Barriers will identified via the maternity services review Pre and post Equality assessment process	Barriers will identified via the maternity services review Pre and Post Equality assessment process –in line with Improving Me timescales – Coordinating CCG lead (Halton CCG) Chief Corporate Delivery and Integration Officer	1.1,2.1,1.21.3, Eliminate Discrimination Advance equality of opportunity and Foster good Community relations Equality Objective- 1,2,3,4
All		Ensure actions identified in EDS 2 feedback form are addressed including system and process changes to complaints resolution – March 2017 Chief Corporate Delivery and Integration Officer	All EDS 2 PSED Equality Objective- 1,2,3,4
All	Human resources and workforce	CSU Ensure HR Business Partner implement equality plan into HR committee HR –March 2017- Chief Corporate Delivery and Integration Officer	3.1,3.2,3.3,3.4,3.5,3.6 Eliminate Discrimination Advance equality of opportunity and Foster good Community relations Equality Objective 4
All Protected Groups (specifically for language and reasonable adjustments)	Access needs of Patients and public need to be addressed consistently in contract specifications	To ensure all specifications instruct all CCG commissioned providers to apportion accessibility funding to meet the needs of communities and patients. - Chief Corporate Delivery and Integration Officer & Chief Redesign and Commissioning Officer (March 2016)	1.1, 1.5, 2.1, 1.4, 2.2, 2.3, Advance equality of opportunity Equality Objectives 1,2,3
All		Ensure EDS 2 approach and plans are embedded in to the refreshed Communications and Engagement Strategy – E&D lead and head of Communications - October 2016 Ensure EDS engagement concerns for all protected Groups are communicated and addressed via relevant commissioners and approaches - Chief Redesign and Commissioning Officer -March 2018 Ensure that Governing Body and	Equality Objectives 1,2,3,4, All PSED 4.2 Equality Objectives 1,2,3,4

		programme leads receive the appropriate level of E&D training - March 2017 Develop guidance to support the CCG to pay due regard to difficult commissioning decisions- Chief Corporate Delivery and Integration Officer June 2016 CCG E&D lead (In Progress) Continue to monitor and improve equality performance of providers- Chief Nurse – on going (In progress) Ensure Governance and decision making committee templates are reviewed to meet Equality Act 2010 requirements Chief Corporate Delivery and Integration Officer October 2016 (In Progress)	

APPENDIX 3 Key NHS Provider EDS 2 grades

Goal	Number	Liverpool Womens	Aintree	Liverpool Community Health	Alder Hey	Mersey Care	Liverpool Heart & Chest
Better health outcomes	1.1	Achieving	Developing	Achieving	Developing	Achieving	Developing
	1.2	Achieving	Developing	Achieving	Developing	Achieving	Developing
	1.3	Developing	Developing	Achieving	Developing	Achieving	Developing
	1.4	Achieving	Developing	Achieving	Developing	Achieving	Developing
	1.5	Achieving	Developing	Achieving	Developing	Achieving	Developing
Improved patient access and experience	2.1	Achieving	Developing	Achieving	Developing	Achieving	Developing
	2.2	Achieving	Developing	Excelling	Developing	Achieving	Developing
	2.3	Achieving	Developing	Achieving	Developing	Achieving	Achieving
	2.4	Achieving	Developing	Achieving	Developing	Achieving	Achieving
A representative and supported workforce	3.1	Achieving	Developing	Achieving	Developing	Achieving	Developing
	3.2	Achieving	Developing	Achieving	Developing	Achieving	Achieving
	3.3	Developing	Developing	Achieving	Developing	Achieving	Developing
	3.4	Developing	Developing	Achieving	Developing	Achieving	Developing
	3.5	Achieving	Developing	Developing	Developing	Achieving	Developing
	3.6	Achieving	Developing	Developing	Developing	Achieving	Developing
Inclusive leadershi	4.1	Developing	Developing	Achieving	Developing	Achieving	Developing

p	4.2	Developing	Developing	Achieving	Developing	Achieving	Developing
	4.3	Developing	Developing	Developing	Developing	Achieving	Developing

APPENDIX 4 Workforce E&D plan

Task	Activity	Outcome	EDS comparator
Policy Proofing	1. Prioritise policies 2. Identify policy against essential list[1] 3. Identify guidance with policy[2] and test for indirect discrimination & advancing opportunity	1. Proportional input. 2. Cover fundamental elements of Equality Act 2010 3. Impact assess process against PSED – identifying any remedial actions	3.1 3.2 3.4
Monitoring	Identify policies and performances for monitoring – check against key tasks: • Recruitment	1. Establish monitoring system 2. Identify indirect discrimination 3. Consider positive action or	3.1 3.2 3.3 3.4

[1] See annex 2 and worksheet 1

[2] policy may be a statement of intention but the process of enacting the policy, i.e. guidance notes , also needs to be proofed

	• Selection • Review & performance • Disciplinary	corrective action	4.3
Training	Identify current training programmes linked to E&D	Proof suitability and identify gaps in provision. Check profile of attendees against worker profile	3.3 4.3
Annual review **Publish equality Objectives**	Establish best measure for review programme Develop and review action plan in HR committee	Performance of polices monitored against PSED	3.3 3.4 3.5 4.3
Staff profile and surveys	Establish staff profile and include questions on E&D	Understanding staff relationship with organisational culture to eliminate any institutional discrimination	3.4 3.6 4.3
Positive Action	1. Monitor performance against policies to establish base line. 2. Identify trends 3. Establish conditions for positive action	Understanding travel of workers by protected characteristic through organisation's functions. Challenge barriers if data/evidence identifies them Advance equality of opportunity.	3.2 3.5 3.1 3.3 3.5 4.1 4.3
WRES	Complete the WRES template and ensure it is in the public domain	Advance Equality of opportunity and Foster good Community Relations Satisfy NHS England assurance processes	3.1 to 3.6

APPENDIX B

Equality Delivery System 2 for the NHS

EDS 2 Summary Report NHS South Sefton CCG

Additional Summary Report

NHS Organisation name: NHS South Sefton Clinical Commissioning Group

Organisation's Board lead for EDS 2: Tracy Jeffes

Organisation's EDS 2 Lead: tracy.jeffes@southseftonccg.nhs.uk

Level of Stakeholder Involvement in EDS 2 Assessments and Grading and Subsequent Actions

NHS South Sefton Clinical Commissioning Group is committed to carrying out meaningful engagement and communications with the local population, giving people: our patients, public and stakeholders, the opportunity to be involved in and to influence healthcare in their local area, ensuring that their voices are heard and that their thoughts and experiences are taken into consideration, specifically for our commissioning priorities and blueprints which are intended to transform health services to meet the needs and demands of our diverse population.

To support this process, the CCG has undertaken an innovative and sustainable approach to EDS 2 and has worked closely with a number of stakeholders who represent the interests of people who share protected characteristics at a national, regional and local level. This aims to ensure that the CCG can identify barriers that impact on access and unequal outcomes. Examples of key stakeholders have included the Race Equality Foundation, Deaf Health Champions, In Trust Merseyside, Age Concern, Sefton CVS including Sefton Equalities Partnership and Healthwatch Sefton, to name but a few. Stakeholders have been engaged via a variety of different methods, including workshops, one to one meetings, attendance at voluntary group meetings, and via desktop research on a variety of reports. The CCG recognises that patients and staff who share protected characteristics are less likely to complain, to complete NHS surveys or access community networks to provide their feedback. This level of engagement with stakeholders will ensure that entrenched barriers faced by communities with regard to accessing healthcare services are understood and mitigated as part of the CCGs strategic and operational programmes. These include mainstream plans, changes to service specifications, business plans and strategies, procurement activity, contract monitoring and discussions with key partners, including NHS England, the Local Authority and community, voluntary and faith sectors.

The CCG has also, in the summary report below, reflected the good work it is undertaking with regard to commissioning services that meet needs across all communities.

The CCG will amend its Equality Objective Plan to reflect the EDS 2 for 2015/16, and has clear plans to move from '*developing*' to '*achieving*' status for a number of outcomes over the next year.

We will continue to strengthen relationships with a range of national, regional and local partners and work with them in various ways.

We will communicate and engage with local people, including patients and their carers, to involve them in our plans and decisions and listen to their views and suggestions.

We will be open and transparent. Our Governing Body meetings and our Annual General Meeting are held in public, and meeting papers are available on our website.

Organisation's Equality & Diversity Objectives (2013-17)

1. To make fair and transparent commissioning decisions;

2. To improve access and outcomes for patients and communities that experience disadvantage;

3. To improve the equality performance of our providers through robust procurement and monitoring practice;

4. To empower and engage our workforce.

Headline good practice examples of EDS 2 outcomes

The CCG has undertaken an innovative and sustainable approach to community engagement, and has improved its understanding of the health needs which particular groups face with regard to accessing services and experiencing unequal outcomes. The engagement and research took place over a ten month period across a number of national, regional and local organisations that represent the views of communities sharing protected characteristics. This enabled the CCG to:

- Understand entrenched 'barriers' that exist on a national and local footprint;
- Address these barriers through mainstream plans, including:
    - changes to specifications, business plans and strategies;

  - improving procurement activity and processes;
  - changing quality contract monitoring;
  - enabling improved information and intelligence exchange with key partners, including NHS England, the Local Authority and the Community Voluntary and Faith Sector.

- Involve local stakeholders in a continuous model of engagement and drive up improvements in access and outcomes;
- Ensure that local and regional stakeholders are informed of the actions that the CCG will undertake to improve access and outcomes and provided with the evidence that people with protected characteristics fare as well as people overall;
- Enables the CCG to understand and improve access and outcomes across all protected groups.

Furthermore, the EDS 2 recommendations have clearly identified some key gaps and issues that need to be addressed across all protected characteristics areas. This work has been captured on a master Excel template and a subsequent action plan. Some of the broad issues have been highlighted below:

- Translation and interpretation across health services remains varied and standards need to be raised.

- The duty carry out reasonable adjustments (Equality Act 2010) to support better access and outcomes for disabled people and the frail elderly is often misunderstood, and needs to addressed via contract monitoring and collaborative work between providers.

- Understanding Transgender issues across health services is a key priority and needs to be progressed further at the Merseyside Quality Surveillance Group.

Currently, grading for patient and public related services (Goals 1, 2 and 4) for the CCG is assessed as Developing. Once these key issues are being addressed and/or mitigated via mainstream business plans, the CCG can progress from *developing* status to *achieving* status across the relevant outcomes and goals.

Better Health Outcomes

Outcome 1.1: Services are commissioned, procured, designed and delivered to meet the health needs of local communities – Developing

We are a membership organisation, made up of 32 general practices within the south Sefton area , led by a Governing Body. This is a mixture of GP's, a hospital doctor, nurses and non-medical people who represent the local community. The

Governing Body and its committees makes strategic decisions and oversees the smooth running of the CCG, and its compliance with its duties and NHS Policy.

We listen to local people, and use clinical knowledge and close working relationships with various partners to improve services and ensure that they benefit our population as much as possible. To support us in setting priorities and to work closely with our partners and improve the way we meet the diverse needs, we use a range of strategy documents tools and processes including:

- Joint strategic needs assessment (JSNA);
- Continuous engagement with our population and patients, including those with protected characteristics and those who face stigma and or disadvantages;
- Sefton Blueprints and Vision;
- Monitoring the performance of our providers with regard to quality which includes patient experience data and equality related performance and KPI's;
- Setting incentives and targets for our secondary care and primary providers in order to meet needs and address the challenges that our population faces;
- Ensure that our work is underpinned through the process, using tools including equality impact assessments and engagement assessments;
- Implementation of our EDS 2 2015/16 Assessment, ensuring that we mainstream the recommendations;
- Considering our duty to address Health inequalities;
- Setting and updating our Equality Objectives.

We want to transform services outlined in our Blueprints to better meet the physical, mental and emotional health needs of our population. The services we commission should be designed around patients and the potential benefits to them. GP clinical leads on our governing body take responsibility for specific commissioning priorities, as set in our Programmes and Priorities.

South Sefton CCG has certain legal duties under the NHS Act 2006 (as amended by the Health and Social Care Act 2012) including:

1. **Duty to improve the quality of services**

   The CCG buys services from providers of hospital, mental health and community services, voluntary groups and charities. We may do this on our own or in partnership with other organisations, including neighbouring CCGs. We monitor how well these services are run and whether or not patients are happy with them. We also design new services that are better for people, and are better value for money.

We now also manage GP practice contracts and can design incentive schemes and/or services to encourage improved performance. We are able to establish new practices and approve mergers between existing ones.

We hope that delegated commissioning will help pull together local health and care systems. It should help improve general practice, so that patients benefit more from the treatment received and have a better, safer experience.

These new powers will help us to tackle health inequalities to make it easier for everyone to get the care they need. We particularly want to improve care outside of hospital for people with mental health problems and learning disabilities, or those who live in the more deprived areas of South Sefton

There are various ways that the CCG monitors quality. The CCG is a member of clinical quality and performance groups (CQPGs) for all local providers, where current performance, issues and risks are discussed.

Internally, the CCG has a Quality Committee to assess our performance. This looks at all the ways in which we measure quality, including current key performance indicators, and our performance on safeguarding adults and children and infection control, amongst other areas.

The role of the Quality Committee is to lead the continuous improvement of service quality. During the year, all members have all been involved as members of the Clinical Quality Performance Groups of the providers from which we commission services, and our own primary care quality network, which includes GP's, public health experts and CCG staff.

The CCG is also an active member of the local Quality Surveillance Group, which is led by NHS England and involves Healthwatch, the Care Quality Commission, the regulatory body Monitor, the NHS Trust Development Authority and other CCGs.

The CCG has a number of communities of practice/clinical reference groups, where clinical staff from hospitals, public health and community care, with a specific shared interest, such as cancer or mental health, can explore ways to improve related services.

2. Duty to ensure public involvement and consultation

We want local people to feel heard, listened to and cared for. South Sefton GP's - the members of the CCG - are particularly well placed to understand local needs and priorities.

The CCG's vision, values and strategy were developed in consultation with patients and the public, and we aim to continually engage with and involve them in our work, so that the local population can help to shape the commissioning agenda and the services that we commission.

During the year, we continued to engage with the public regarding our transformation programme via stakeholder events including Big and Little Chats

Underpinning our programme and operational commitments, we ensure that we have the right processes in place, such as our Engagement and Equality Planning Process and risk assessment tools, to ensure that services are transformed in conjunction with people who share protected characteristics, thereby meeting our statutory requirements.

We work closely with our main providers and ensure that equality and inclusion performance is monitored and improved. This involves EDS 2 compliance, compliance with specific duties and ensuring that Public Sector Equality Duty is considered when providers make changes to services that will impact on patients

As we share our geographical boundaries with Sefton Council, we frequently work in partnership. For example, the CCG and the Council developed a plan for the Better Care Fund (BCF). This will provide support for integrating health and social care services locally, so they are more joined up.

Most CCG member practices have their own Patient Participation Groups, and representatives have attended Patient Participation and other CCG forums to help inform the development of the CCG's plans.

The CCG is an active member of the Sefton Health and Wellbeing Board, which meets regularly to decide on shared priorities and actions to promote the health and wellbeing of people who live, work or are registered with GP's.

The Board has developed a joint Health and Wellbeing Strategy that shows how it intends to make improvements for local people. This is based on a Joint Strategic Needs Assessment that identified the biggest issues facing our population. Furthermore our joint work includes an innovative programme entitled Shape Sefton aimed at developing models of care that meet needs of our population and this work is being conducted jointly with our Health and Wellbeing Board and with the Kings Fund.

Our commissioning priorities has incorporated the implications of the national NHS Five Year Forward View, published in October 2014, which sets out the changes needed to close widening gaps in the health of the population, quality of care and funding of services.

It calls for:

- A radical upgrade in prevention and public health;
- Far greater patient control;

- Steps to break down barriers in how care is provided.

Our Transformation Programme is about making a fundamental shift in the way in which we approach things.

Our Transformation Model is based on the characteristics of a sustainable health and social care system, which include citizens being at the heart of what we do. We also need to acknowledge that we will have difficult commissioning decisions to make with financial pressures against a backdrop of increasing demands on our current services and we will endeavour to ensure that our public is involved and consulted when necessary and that these processes are equality assessed.

The CCG also utilise their EPEG committee to work with our partners in the Council and across the Voluntary sector to support our models of Inclusive engagement.

Throughout the EDS 2 Engagement Process, the stakeholder identified a range of issues and barriers that need to be addressed in order to improve access and outcomes linked to this goal. These issues have formulated into an action plan, which will form part of our long term Equality Objectives. Once these issues are addressed in mainstream plans, the grading status will progress from *developing* status to *achieving* status.

Outcome 1.2: Individual people's health needs are assessed and met in appropriate and effective ways – Developing

We are committed to overcoming any disadvantages people experience on the basis of any of the protected characteristics covered by the Equality Act 2010.

The CCG has worked towards reducing inequalities through the commissioning of safe, high quality services, in partnership with the local population and its stakeholders. As part of the recognition and commitment of the CCG to provide sustainable and high quality services for the future, we have been engaging extensively with patients, the public, provider organisations, the Health and Wellbeing Board and ensuring that Sefton Blueprint for Services is fit for purpose and delivered to the population of South Sefton

We commission and work closely with the Black and Minority Ethnic (BME) Community Development Service, which aims to tackle discrimination and improve access to mental health and wellbeing services for BME communities.

As part of this service, community development workers raise awareness and understanding among local health providers about the needs of BME communities, including how mental illness is perceived in different cultures.

Our Equality Objectives Plan for 2013-17 is in line with the CCG's statutory requirements and commissioning priorities. These set out clearly how we will meet our Public Sector Equality Duty to eliminate discrimination, advance equality of opportunity and foster good community relations. These objectives will help us to make fair and transparent commissioning decisions and improve the equality

performance of our providers, and will be significantly refreshed as a result of the EDS process which we undertook.

Key additions to the revised objectives plan include implementing:

- The new NHS England Accessible Information Standard to ensure that people receive information about services in an appropriate format, which involves finding out if a patient has additional communication needs because of a disability or sensory loss;
- The new NHS Workforce Race Equality Standard, which requires NHS organisations to take positive action to ensure that employees from BME backgrounds have equal access to career opportunities, and receive fair treatment in the workplace.

Following our EDS 2 assessment, the equality Objective Plan has been significantly refreshed.

During the year, we collaborated with neighbouring CCG's to ensure that contracts with key local providers include requirements to achieve and improve equality and diversity standards, including through the Equality Delivery System.

Providers will be expected to:

- Agree an equality objectives plan;
- Complete an EDS self-assessment with plans to achieve at least five outcomes;
- Provide evidence of compliance with Equality Act 2010 specific duties;
- Only take decisions about service redesign after an equality analysis or equality impact assessment has been carried out;
- Provide data on the use of translation and interpretation services;
- Ensure that providers are effectively equipped to carry out Reasonable Adjustments.

We have other examples of how services have been commissioned to reflect the specific needs of those with protected characteristics, including the Pan Merseyside Maternity Review of Services, which will be subject to targeted consultation and equality assessments. The CCG has also embarked on a CVF sector grant programme to enable the community and voluntary sector to support groups which share protected characteristics in accessing health services, thereby improving the patient experience and improve health outcomes.

Throughout the EDS 2 engagement process, the stakeholder identified a range of issues and barriers that need to be addressed in order to improve access and outcomes linked to this goal. These issues have formulated into an action plan which will form part of our long term equality objectives. Once these issues are addressed in mainstream plans, the grading status will progress from *developing* status to *achieving* status

Outcome 1.3: Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed – Developing

We have also developed a robust Quality and Improvement team to ensure that sustained efforts take place to raise standards and support all residents to live well in a homely environment.

Our wider ambition, as set out in Commissioning Priorities, is to support patients to transfer safely between types of care, working as single health service and team, with patients' needs at the heart of the service

The CCG has signed up to the Merseyside Crisis Care Concordat. The Concordat commits NHS bodies, local councils, the police and others to support people in a mental health crisis to find the help that they need - whatever the circumstances and whichever service they turn to first.

We are collaborating with our main mental health service providers, including Merseycare , to monitor the Concordat's progress, and will work together to prevent crises happening whenever possible, by intervening at an early stage.

The CCG developed also local action plans across a range of areas to ensure that transition across services is smooth, and we monitor this through contract performance processes.

As part of the Transformation Programme, the CCG has embarked on a programme to ensure that patients, their families and carers, plus health and social care practitioners, are empowered and enabled to make the right choice and access the most appropriate service to meet their needs.

Throughout the EDS 2 engagement process, the stakeholder identified a range of issues and barriers that need to be addressed in order to improve access and outcomes linked to this goal. These issues have formulated into an action plan which will form part of our long term Equality Objectives. Once these issues are addressed in mainstream plans, the grading status will progress from *developing* status to *achieving* status

Outcome 1.4: When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse – Developing

South Sefton CCG has in place robust contract management and governance processes, to effectively monitor quality and safety standards and to put action plans in place where required. These processes include collaborative contract management arrangements with other CCGs. This work is overseen and scrutinised through the organisation's Governance Committee structure. The Senior Management Team has embedded a culture of high performance through effective programme management, and a proactive approach to governance and risk management.

The stakeholder relationships which influence the performance of the CCG include:

a) Patients, public, community groups and representative organisations such as Healthwatch, whose engagement and involvement are key to informing effective commissioning, monitoring, evaluating and improvement of services via our EPEG committee

b) Commissioned healthcare providers, including acute, mental health and community trusts, from which the majority of healthcare services are commissioned, together with the third sector, which offers a new way of delivering health and social care in the future;

c) Strategic partnership arrangements with Sefton Council, which address the wider determinants of health through effective membership of the Health and Wellbeing Board, and joint working, to deliver service transformation.

The Clinical Leads have been involved in the provider organisation quality boards, the CCG's Primary Care Quality Network and ensuring nursing home quality, and have challenged, supported, and clinically led the continuous improvement of the quality of services commissioned by the CCG.

The CCG is an active member of the local Quality Surveillance Group: some of the recommendations of the EDS 2 assessments include tackling issues through the remit of this group. For example, on the issues around outcomes associated with our transgender population

As the CCG commissions from several major providers, it has been actively involved in a number of quality improvements and quality reviews, resulting in increased surveillance. The Governing Body has oversight of the action plans and discusses quality at each meeting. The Quality Committee provides a close level of scrutiny of the quality of commissioned services, including inviting providers to the committee when a more in-depth analysis and discussion is warranted. E&D currently feeds into to the decision making structure via the EPEG Committee and Governance Group

The CCG has a dedicated Quality and Safeguarding Team with focused roles and responsibilities, eg care and nursing homes, mental health and across all secondary care providers. Dedicated Safeguarding Quality Reports feed into the Governing

Body Meeting, and are addressed at a specific 'Quality' Committee and EPEG committee .

The Quality Contract Schedule is rigorous and tackles issues concerns, incidents and serious incidents via the Clinical Quality and Performance Group Meetings (for all local providers) where current performance, issues and risks are discussed together with coordinating commissioners.

Throughout the EDS 2 engagement process, the stakeholder identified a range of issues and barriers that need to be addressed in order to improve access and outcomes linked to this goal. These include the need to make reasonable adjustments. These issues have formulated into an action plan which will form part of our long term Equality Objectives. Once these issues are addressed in mainstream plans, the grading status will progress from *developing* status to *achieving* status.

Outcome 1.5 -CCG communications and health campaigns reach and benefit all – Developing

As part of the programme and on-going operational work, the CCG has conducted extensive communications and engagement across all parts of the Borough, and has been targeted to include different demographics and socio-economic backgrounds. This work has supported the development of commissioning priorities, and has demonstrated the vast networks across all protected characteristics.

The EPEG committee sense checks engagement and communications to its population. The committee is represented by a range of CCG partners including Healthwatch, local Authority and a range of representatives across the community & voluntary sector including Sefton Equalities Partnership, which manages a number of networks across protected characteristics including BME (Equal Voice), Disability (ABILITY and Sefton Access Forum) and LGB (Embrace) . Furthermore the lay member is key member of the faith networks in Sefton.

Throughout the EDS 2 engagement process, the stakeholder identified a range of issues and barriers that need to be addressed in order to improve access and outcomes linked to this goal, such as improved communications to our BME communities and learning disabled people. These issues have formulated into an action plan, which will form part of our long term Equality Objectives.

Outcome 2.1: People, carers and communities can readily access hospital, community health or primary care services, and should not be denied access on unreasonable grounds – Developing

A great deal of work has been carried out to determine the quality of services provided to patients, eg. mental health services, as this has been identified by the

membership and the population as a key area for improvement. The CCG has worked effectively with the provider to improve access and outcomes for patients who require access to psychological therapies.

The CCG will continue to refine and improve its approach to improving quality through its Transformation Programme and will further development of productive relationships with all partners.

Provider delivery against the Contract Quality Schedule has been reviewed throughout the year, and reported to Clinical Quality and Performance Groups (CQPG). This is enabling greater monitoring and leadership of all quality aspects, quality schedules and Commissioning for Quality and Innovation (CQUIN) schemes across the CCG providers, including improving access to services.

During the year, the CCG has also established a Primary Care Support function to support both primary care and NHS England, as part of its duty to improve the quality of Primary Care.

The CCG has been developing systems to better understand the needs of communities, and improve access and outcomes. Key activity over the year has included:

1. Equality delivery system process and provide the CCG with key qualitative intelligence about barriers patients with protected characteristics face;

2. The work of the Black Minority and Ethnic Community Development Service

3. The role of EPEG to improve inclusive engagement with communities

4. The Community Services review which was underpinned and steered through a robust Equality Assessment process

Under Section 106 of the Equality Act 2010, CCG's are vicariously liable for the equality performance of their providers. Key activity over the year has included:

a. The CCG's quality contract schedule being reviewed and updated to include robust equality and quality measures designed to drive up equality performance across providers;
b. New contract requirements being implemented for our key NHS providers;
c. Improvements to equality performance being made with regard to ensuring that the internal redesign of Trust services is subject to equality analysis.

The CCG has continued to invest in initiatives to support an anticipated increase in demand throughout the winter by improving hospital discharges and avoiding unnecessary hospital admissions. These have included further additional GP appointments, GP home visits and the introduction of a number of schemes focussing on mental health issues, including assessment of interim measures on elective admissions.

Specific plans are underway to ensure that changes within primary care are properly impact assessed and also consider and mitigate the needs of patients with protected characteristics. An example would be the joint working involved with NHS England on the Litherland darzi practise.

Access to healthcare is available to all of our population but, should issues with access happen, we have a system in place whereby the CCG's work closely with Healthwatch and other partners and providers to share experiences of NHS services. Regular meetings of the Quality Committee and clinical quality and performance groups (CQPG's) take place with provider organisations in order that various patient experience information can be triangulated to identify trends and be acted upon. This will include issues identified via the EDS 2 Engagement Plan.

In addition to this, the CCG's ambitious Transformational Plan includes models that will ensure that care takes place closer to home, that there is extended access to Primary Care and improved access channels to other services, including social care, community and the voluntary sector. A comprehensive directory of services will support this.

The CCG is well aware that discrimination is often very difficult to 'detect', as many communities which share protected characteristics do not complain, complete Office for National Statistics and Friends and Family surveys, and do not access engagement events. Hence, the approach used this year has been to identify barriers specific to people who share protected characteristics, and address them through CCG mainstream functions, including strategy development, specification reviews, procurement activity, contract monitoring and key discussions with partners.

EDS 2 exercise has identified issues related to transgender, children and young people, race and the frail elderly, including specific issues on carrying out reasonable adjustments, and standards across translation and interpretation.

Outcome 2.2: People are informed and supported to be as involved as they wish to be in decisions about their care – Developing

The CCG is dedicated to ensuring that local populations and vulnerable groups, as well as those from protected characteristics, have been engaged with.

All of the patient experience tools and intelligence discussed above monitor the effectiveness of our systems, and we are aware that EDS 2 engagement identified a range of issues that need to be addressed to ensure we are doing all we can on this. These issues include variation in standards across translation and interpretation services and being able to carry out reasonable adjustment effectively. Furthermore, the CCG has ensured that the Accessible Information Standard is implemented across secondary care providers, and that communications have been distributed to primary care providers

Outcome 2.3: People report positive experiences of the NHS – Developing

The CCG works closely with Healthwatch and other partners and providers to share experiences of NHS services. Regular meetings take place of the Quality Committee and Clinical Quality Performance Group with providers and Quality Surveillance Groups. This ensures the sharing and triangulation of patient experience information in order that trends can be identified and acted upon: eg complaints. Healthwatch are represented on some of these groups.

The CCG has made a concerted effort through the EDS 2 engagement exercise to capture the views of communities and patients which share protected characteristics; so that barriers and experiences can be mainstreamed within commissioning plans and functions.

The CCG recognises that patients and staff who share protected characteristics are less likely to complain, complete NHS surveys or access community networks to provide their feedback. Therefore, this level of engagement with stakeholders will ensure that the entrenched barriers that communities face with regard to accessing healthcare services are understood and mitigated as part of the CCG strategic and operational programmes. These will include mainstream plans, changes to service specifications, business plans and strategies, procurement activity, contract monitoring and discussions with key partners including NHS England, the Local Authority and community, voluntary and faith sectors.

Outcome 2.4: People's complaints about services are handled respectfully and efficiently – Developing

The CCG has a Complaints Policy covering complaints about the CCG and complaints about providers.

Provider complaint reports are considered by Clinical Quality Provider Groups (CQPG's), which include CCG and provider representatives. These reports feed into the CCG's Quality Committee.

Contracts with providers include complaints responses and management key performance indicators.

The EDS 2 assessment has identified the need to expand complaints monitoring to identify the barriers preventing people with a protected characteristic from complaining.

Outcome 3.1

Fair NHS recruitment and selection processes lead to a more representative workforce at all levels – Achieving

The CCG is committed to ensure, wherever possible, that its workforce is representative of the community that it serves.

There is an overarching Recruitment and Selection Policy which has been agreed with staff side representatives, and is reviewed every three years.

Jobs are advertised via the NHS Jobs website and, at the short-listing stage, all references to personal details are removed, which aims to ensure that candidates are selected for the next stage on the merits of their application. Positive steps have also been built into the process, such as the Interview Guarantee Scheme, for candidates who have a disability and meet the minimum essential criteria for a post.

Work is underway within the CCG with regard to the NHS Workforce Race Equality Standard.

Outcome 3.2

The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations – Achieving

The Agenda for Change Agreement has been equality impact assessed to ensure that it is not discriminatory across all protected characteristics, and the grading of posts and the rates of pay applicable to them is determined through job evaluation.

Local procedures in place include annual leave, special leave and travel expenses.

The CCG has not received any equal pay claims since its inception.

Outcome 3.3

Training and development opportunities are taken up and positively evaluated by all staff – Developing

The CCG has been operating its appraisal system since 2013.

The HR Committee is developing a robust Personal Development Review reporting system to ensure that appraisals which are carried out are monitored, and that recovery plans are put in place where the numbers of appraisals undertaken are low.

The CCG has many examples of where equality and diversity runs through, or is a key and essential part of, many learning and development activities, including

mandatory training and core training and management development (delivered on an ad hoc basis and based on need).

Outcome 3.4

When at work, staff are free from abuse, harassment, bullying and violence from any source – Developing

Harassment and bullying on the grounds of any of the protected characteristics will not be tolerated.

Various forms of support are in place for employees: these include the provision of counselling via the Occupational Health Service.

This work is underpinned by a robust Harassment and Bullying Policy that was approved by the Staff Side Partnership and ratified locally by the CCG. This Policy includes an escalation process to ensure that staff have recourse to advice, guidance and support within the CCG and across other agencies, including from HR and staff side. Over the course of the years, the CCG develop and implement a Workforce Equality Plan to support transition from *developing* to *achieving.*

Outcome 3.5

Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives – Developing

There is a Family Leave Policy and Flexible Working and Special Leave Policy which meets legislative requirements for parents and carers around flexible working, but also extends to all employees and offers several different types of flexible working.

Both policies reference the Equality and Diversity (Workforce) Policy. The Family Leave Policy is being reviewed due to legislative changes – additional paternity leave entitlement is being replaced by shared parental leave. Over the course of the years, the CCG has developed and implemented a Workforce Equality Plan to support transition from *developing* to *achieving.*

Outcome 3.6

Staff report positive experiences of their membership of the workforce – Developing

The CCG has a number of policies, both existing and in development, to support the health and well-being of its workforce. Staff views are sought through a number of

means within the CCG. The CCG also provides support via Occupational Health Services, which include counselling and physiotherapy services. Over the course of the years, the CCG has developed and implemented a Workforce Equality Plan to support transition from *developing* to *achieving.*

Outcome 4.1: Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations – Developing/Achieving

The CCG's constitutional, governance and decision-making arrangements aim to involve patients and the public through the Lay Member for Patient and Public Involvement, who Chairs EPEG committee. They include Healthwatch Sefton and patient representation at all levels of the organisation's governance arrangements.

The CCG has worked with the public to make the Governing Body Meetings accessible and understandable, and to ensure that they feel that they and their contributions are valued. Governing Body Meetings are preceded by a public briefing session and have an open forum for questions at the end of each meeting. The Accountable Officer and other Governing Body Members have also been available to meet with members of the public. This has elicited positive feedback from the public, and ensured that meetings are well attended;

Furthermore the CCGs lay member is a key member in the faith network within Sefton and is plays a key role in Sefton Partnership work to combat poverty in the area.

The Council's Overview and Scrutiny Committee provides opportunities to widen involvement in the work of the CCG, and this is being built upon through members' seminars to increase the knowledge and understanding of health issues among elected members.

The CCG will continue to support the delivery of the Joint Health and Wellbeing Strategy, which is closely aligned to the Transformation Programme and the Better Care Fund as part of that programme.

The CCG is committed to improving access and outcomes for protected groups across the Borough which experience disadvantage in health and wellbeing services. The Governing Body receives annual updates against progress in line with CCG statutory requirements and commissioning priorities. Key additions to the revised plan include:

- Implementing the new NHS England 'Accessible Information Standard' - which is about ensuring that NHS service providers give people information in the best format for their needs. This requires all organisations to discover if a patient has extra communication needs because of a disability or sensory loss, and to take steps to meet those needs;

- The new Department of Health, Workforce Race Standard – NHS organisations are required to take 'Positive Action' to ensure that employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities, and receive fair treatment in the workplace;

- Comprehensive equality analysis against key commissioning priorities, and embedding this process into the CCG's programme management processes and project initiation and approval documentation.

The CCG has also worked with its key providers, in collaboration with neighbouring CCGs, to include equality requirements in the Contract Quality Schedule, as mentioned earlier.

The CCG continues to work in partnership with Sefton Council (through a Section 75 Agreement), as an active member of the Sefton Health and Wellbeing Board, and as a member of the wider Sefton Strategic Partnership, including representation on the Partnership Board, the Executive Team and the Area Partnership Boards to develop a Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy.

Outcome 4.2: Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed – Developing

The CCG has appointed Clinical Leads as members of the Governing Body who lead on the Sefton priorities, as outlined above.

The Clinical Leads have been involved in the provider organisation quality boards, the CCG's Primary Care Quality Network and nursing home quality and have challenged, supported, and clinically led the continuous improvement of the quality of services commissioned by the CCG.

The CCG is keen to ensure that it has the right skills, processes and governance arrangements in place to meet the Public Sector Equality Duty, as commissioning decisions are made. Key activity has included:

a. PSED training for the Governing Body;

b. Comprehensive equality and engagement guidance for key programmes and other key operational work streams;

c. High level and detailed Equality Impact Assessment processes have been developed, including the decommissioning and guidance on cessation to ensure that, during these challenging financial times, PSED will be considered and, wherever possible, mitigated.

A sample of 10 Governing Body Reports during 2015 identified that only some papers identified equality related risks. Undertaking Equality Assessments and

outlining equality risks and implications and solutions for mitigation is essential for future reporting and CCG decision-making.

Outcome 4.3: Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination – Developing

Face-to-face Equality and Diversity training (Public Sector Equality Duty) has been provided to all CCG staff, and this is monitored to ensure compliance.

One to one support is available to support programme leads to undertake equality assessments

A number of briefs on current case law and guidance documents have been developed to support the capacity, skills and understanding.

Dedicated CCG specific equality and diversity training over the last eighteen months has included commissioner and decision-maker and decommissioning guidance (Governing Body) sessions.

NHS employee policies and procedures adhere to all the requirements of the Equality Act.

One key recommendation of the EDS 2 process is to ensure that commissioners have better access to culturally competent training, which is to be delivered by experts and specialist providers.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/46	**Author of the Paper:** Tracey Forshaw Head of Vulnerable People Email: tracey.forshaw@southseftonccg.nhs.uk Tel: 0151 247 7247
Report date: March 2016	

Title: Personal Health Budgets for NHS Funded Packages of Care for Adults and Children Policy & Practice Guidance

Summary/Key Issues:

This paper is in support of the policy for personal health budgets for all NHS Funded Packages of Care for Adults and Children in line with current government policy and national guidance. The Governing Body are requested to review and approve the draft policy and practice document from which the CCG can base it's 'local offer' for PHB's, which is required to be published on the CCG website from April 2016.

Government policy requires Clinical Commissioning Groups (CCGs) to ensure that people in receipt of a health funded package of care, either by Continuing Health Care (CHC) for adults and or Complex Care (CC) for children, have a 'right to have' a Personal Health Budget (PHB) form October 2014. Alongside this the Government has confirmed a commitment in the NHS mandate 2014-2015 that anyone with a long term condition, who can benefit from a PHB, should have the right to ask for one by April 2015.

Recommendation

The Governing Body is asked to approve this policy and practice guidance.

Receive	
Approve	x
Ratify	

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

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	x			Sefton Carers Centre, Sefton CVS are supporting the public consultation and engagement processes
Clinical Engagement	x			NHS Liverpool Community Health NHS Trust, Mersey Care NHS Trust, Commissioning Support Unit, CCG Clinical and Locality Leads have been included as part of the consultation process
Equality Impact Assessment	x			Completed and approved by the Equality & Inclusion Panel on 4th November 2015
Legal Advice Sought	x			Via CCG Solicitors Hill Dickinson
Resource Implications Considered	x			Presented and discussed at Senior Management Team
Locality Engagement				
Presented to other Committees	x			Corporate Governance and Support Group NHS South Sefton CCG Quality Committee Engagement and Patient Experience Group CCG / CSU CHC Steering Group

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

Report to Governing Body
March 2016

1. Executive Summary

1.1 NHS Southport and Formby CCG are required to have in place a policy outlining the CCG's plan to implement the Government's requirements to ensure that people in receipt of a health funded package of care, either by Continuing Health Care (CHC) for adults and or Complex Care (CC) for children, have a 'right to have' a Personal Health Budget (PHB) from October 2014. Running alongside, a directive from Government which has confirmed a commitment in the NHS mandate 2014 - 2015 that anyone with a long term condition, who can also benefit from a PHB, should have the right to ask for one from April 2015.

1.2 NHS Southport and Formby Governing Body are requested to ratify the CCG PHB policy from which the CCG can base its 'local offer' for PHB's, as a national requirement which can be published on the CCG website by April 2016.

2. Introduction and Background

2.1 Following a successful pilot programme by the Department of Health, which ended in October 2012, the Government announced that from April 2014, Eligible Persons will have the "right to ask" for a Personal Health Budget (PHB), including by way of a direct payment. From October 2014, this right to ask was converted to a "right to have" a PHB. The Government has also confirmed a commitment in the NHS mandate 2014 - 2015 that anyone with a long term condition, who can benefit from a PHB, should also have the right to ask for a PHB by April 2015.

2.2 A PHB is an allocation of NHS funding which patients, after an assessment and planning with their clinical team, are able to personally control and use for the services they choose to support their health needs. This enables them to manage identified risks and to live their lives in ways which best suit them. Enabling people to exercise choice and control over their lives is central to achieving better outcomes for individuals. For Eligible Persons there is a duty on CCGs to:

- Consider any request for a PHB;
- Inform them of their right to ask for a PHB (April 2014);
- Inform them of their right to have a PHB (October 2014);
- Provide information, advice and support in relation to PHBs.

There are five essential characteristics of a PHB. The person with the PHB (or their representative) must:

1. be able to choose the health outcomes they want to achieve;
2. know how much money they have for their healthcare and support;
3. be enabled to create their own care plan, with support if they want it;
4. be able to choose how their budget is held and managed;
5. be able to spend the money in ways and at times that make sense to them, as agreed in their plan.

Deciding to have a PHB is a voluntary arrangement, with no requirement on individuals to take up this option. There are three mechanisms by which people can be supported to utilise a PHB: Notional Budget, 3rd Party Budget and or a Direct Payment. For all PHB's where a 3rd party and or Direct Payment has been the chosen option, the CCG utilises the services of non NHS independent brokerages to support the individuals to develop the support plans and manage the monies aligned to the PHB.

2.3 Following a period of Stakeholder consultation and engagement, and taking into account existing integrated budget arrangements that exist for joint funding arrangements for adults and children, the CCG has determined PHB's will be available for NHS Southport and Formby CCG residents in the following cases:

- Adults who are CHC eligible and or in receipt of 100% health funding, will be eligible and be offered a PHB;

- Adults who have learning disabilities and mental health with complex health needs or challenging behaviour, who are in receipt of a joint funding arrangement with South Sefton CCG and Sefton MBC, have the right to explore whether their needs can be met by utilising a personal budget. The integrated personal budgets under joint funding arrangements for Southport and Formby CCG will be managed by Sefton MBC, this includes access to a direct payment. Adults with a learning disability and or mental health difficulty, who are in receipt of a joint funded package of care, and receiving a direct payment, will by nature already be in receipt of an integrated PHB;

- Children Complex Care - In the case of children where continuing care is being received, the child and or family will have an, education, health and social care plan in place (EHC) or will be in the process of transferring over to an EHC. For children, personal health budgets can contribute to some or all of the social, health and educational elements of this plan. Within Southport and Formby CCG this will be provided by the SEND 'local offer', the joint funding arrangements will be managed via by Sefton Metropolitan Council (MBC) as a direct payment. Children across Southport and Formby CCG who are already in receipt of a direct payment, will by nature already be in receipt of an integrated PHB;

- Individuals who have a long term condition who may benefit from personal health budget who are not in receipt of NHS funded packages of care.

2.4 The CSU and CCGs are using a 'ready reckoner' approach to set the level of the PHB. This approach uses an existing care plan / package of support to calculate an indicative budget. Where there is no existing care plan or package of support already in place, the budget will be based on a standard hourly rate. Whilst the 'ready reckoner' approach is based on existing services, it can be simpler to use, more transparent and easier to understand. In principle, the allocation of monies that would have been spent on NHS Services as part of an individual's CHC, CC and or long term conditions could be available to use as a PHB. As much of this budget as possible should be included in a PHB.

In the case of individuals with long term conditions, who are not in receipt of a health funded package of care. The CCG will need to work out the indicative budget in terms of the overall cost of NHS Services used, and determine which elements cannot be utilised e.g. regular routine hospital consultant appointments and which elements could form the basis of the indicative budget as part of the PHB, with the emphasis of reducing overall NHS expenditure.

3. Key Issues

3.1 The CCG is required to have a policy in place to support the implementation of PHB's for eligible groups of people e.g. CHC / CC under the 'Right to Have' from October 2014 and the governments mandate 2014-2015 that anyone with a long term condition, who can also benefit from a PHB, should have the right to ask for one by April 2015.

3.2 The CCG is required to publish the 'local offer' for PHB's on CCG websites from April 2016

4. Conclusions

Southport and Formby CCG are required to have a policy in place outlining the CCG's plan to implement the Government's requirements to ensure that people in receipt of a health funded package of care, either by Continuing Health Care (CHC) for adults and or Complex Care (CC) for children, have a 'right to have' a Personal Health Budget (PHB) from October 2014. Running alongside this directive, the Government has confirmed a commitment in the NHS mandate 2014-2015 that anyone with a long term condition, who can also benefit from a PHB, should have the right to ask for one by April 2015.

The policy submitted which has been subject to wide engagement and consultation sets out the CCG plans to whom and how PHBs will be implemented for the residents of the borough of Sefton.

5. Recommendations

NHS Southport and Formby CCG Governing Body are requested to receive and approve the policy.

Appendices

Appendix 1: Southport & Formby CCG Personal Health Budgets for NHS Funded Packages of Care for Adults and Children Policy & Practice Guidance

Tracey Forshaw
March 2016

Appendix 1

NHS Southport and Formby Clinical Commissioning Group

Personal Health Budgets for NHS Funded Packages of Care for Adults and Children

Policy & Practice Guidance

Title:	NHS Southport and Formby Clinical Commissioning Group Personal Health Budgets for NHS Funded Packages of Care for Adults and Children Policy & Practice Guidance
Version:	Draft 0.5 under consultation
Ratified by:	NHS Southport and Formby CCG Governing Body
Date ratified:	
Name of originator/author:	Katy Murray, Interim PHB Project Manager. Midlands and Lancashire Commissioning Support Unit Tracey Forshaw Head of Vulnerable People
Name of Lead:	Chief Nurse
Date issued:	
Review date:	
Target audience:	CCG, CSU, NHS Community Providers, NHS Mental Health Providers

In the event of any changes to relevant legislation or statutory procedures this policy will be automatically updated to ensure compliancy without consultation. Such changes will be communicated.

Version Number	Type of Change	Date	Description of change

Table of Contents

1.0 Purpose & Introduction

This document sets out the policy and practice guidance developed to ensure the consistent and transparent delivery of Personal Health Budgets ("PHBs") for Eligible Persons (see section 3.1 for definition). This policy took effect from April 2014. The policy has been revised for the "right to have a PHB" for Eligible Persons from October 2014, and the wider expansion of PHBs at the CCGs discretion from April 2015 onwards. National policy in this area is still developing and the CCGs will review this paper when new guidance, regulations or national policy is published.

NHS Southport and Formby CCG (CCG) will ensure that PHBs are value for money for patients and the CCG. This will be done though the way in which PHBs are set up, through robust support planning and through effective monitoring of direct payments.

NHS Southport and Formby CCG would like to acknowledge Midlands and Lancashire Commissioning Support Unit, for the development of this policy, practice guidance and supporting documentation.

1.1 Consultation

This policy was developed in consultation with:

- NHS South Sefton CCG: Lead Commissioner – Learning Diversity, Children and Mental Health, Head of Finance, Head of Communications, Senior Governance Manager (Equality and Diversity).
- NHS Southport and Formby CCG meetings: Corporate Governance Support, Clinical Quality Committee, Evaluation of Patient Experience Group, NHS South Sefton Governing Body, CCG / CSU CHC Steering Group.
- CCG Legal representation – Hill Dickinson
- Sefton Metropolitan County Council: Dwayne Johnson, Tina Wilkins, Nick Roberts, Margaret Milne, Carol Cater, Mark Waterhouse, Lauren Sadler, Lesley McCann, Mike McSorely.
- Commissioning Support Unit (CSU) – Continuing Health Care / Complex Care and Quality Team: Lorraine Norfolk, Jo Ryder, Margie Learie, Lead for Children, Mental Health and Learning Disability
- Service user / Patient consultation: Commissioned and delivered by Sefton Carers Centre,
- Personal Health Budget Brokerage: Salvere, Your Life Your Way, SOLO Support Services, Sefton MBC Consultation and Engagement Panel
- Third sector Organisations: Sefton Carers Centre, Sefton Council for Voluntary Services, HealthWatch Sefton
- NHS Community Provider: Director of Nursing: Southport and Formby NHS Trust, Liverpool Community Health NHS Trust and Merseycare NHS Trust.

1.2 Ratification

This policy and practice guidance will be ratified by NHS Southport and Formby CCG Governing Body.

1.3 Scope

This policy applies to all employees of NHS Southport and Formby / South Sefton CCG, Commissioning Support Unit, NHS Providers commissioned to deliver services by Southport and Formby CCG.

1.4 Other Relevant Legislation

- Human Rights Act 1998, including the Article 8 Right to respect for private and family life, and Article 14 Prohibition of discrimination

- The Data Protection Act 1998

- The Carers (Equal Opportunities) Act 2004 provides carers with the right to receive assessment for support and a duty on various public authorities to give due consideration to a request to provide services to carers.

- The Mental Capacity Act 2005 ("MCA"). The Mental Capacity Act provides a framework for decision making applicable where people lack capacity to make a decision for themselves. The overriding principles of the Mental Capacity Act are set out in section 1 and include a requirement to ensure that all practicable steps are taken to seek to enable a person to make a decision for himself. Where a person is unable to make a decision, any decision made on their behalf must be made in accordance with his/her best interests and must be the least restrictive of the person's rights and freedom of action. A person is not to be treated as unable to make a decision simply because he makes an unwise decision.

- The Equality Act 2010. The Equality Act brought together the various earlier discrimination laws under one statute. It is unlawful to act in a discriminatory manner against any "protected characteristics", including race, sex and disability.

- The Children and Families Act 2014. This Act intends to improve services for key groups of vulnerable children (e.g. those in adoption and those with special educational needs and disabilities).

- The National Health Service (Direct Payments) Regulations 2013 (SI 2013 No.1617)

- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013. These Regulations set out the duties of CCG's relating to NHS Continuing Healthcare rights and personal health budgets.

- NHS England – The Forward View into action: Planning for 2015 / 2016

- Department of Heath The Government's Mandate to NHS England 2016 / 2017

2.0 Overview

2.1 History

Following a successful pilot programme by the Department of Health, which ended in October 2012, the Government announced that from April 2014, Eligible Persons will have the "right to ask" for a PHB, including by way of a direct payment. From October 2014, this right to ask was converted to a "right to have" a PHB, specifically for Continuing Health Care (CHC) and Continuing Care (CC) for children with complex care needs.

This development mirrors other changes within the NHS, including the drive generally for greater patient choice, shared decision-making and innovation in managing funds. The Government has confirmed a commitment in the Mandate to NHS England 2016-2017 that PHB's including direct payments, should be an option extended to anyone who could benefit from a PHB from April 2015. The Mandate requires the consideration of more personalised care, including variant forms of PHBs even when a person is not suitable to receive a direct payment, with the emphasis on identifying any way in which the person's care could be personalised.

2.2 What is a PHB?

PHBs are the allocation of NHS funding which patients, after an assessment and planning with their NHS clinical team, are able to personally control and use the services they choose to support their health needs. This enables them to manage identified risks and to live their lives in ways which best suit them. Enabling people to exercise choice and control over their lives is central to achieving better outcomes for individuals.

For Eligible Persons there is a duty on CCGs to:

- Consider any request for a PHB;
- Inform them of their right to ask for a PHB (April 2014);
- Inform them of their right to have a PHB (October 2014)
- Provide information, advice and support in relation to PHBs.

There are five essential characteristics of a PHB.

The person with the PHB (or their representative) must:

1. be able to choose the health outcomes they want to achieve
2. know how much money they have for their healthcare and support
3. be enabled to create their own care plan, with support if they want it
4. be able to choose how their budget is held and managed
5. be able to spend the money in ways and at times that make sense to them, as agreed in their plan.

The CCG is committed to promoting service user choice, where available, while supporting them to manage risk positively, proportionately and realistically. As part of good practice, health care professionals should support and encourage service users' choices as much as possible, and keep them informed, in a positive way, of issues associated with those choices and how to take reasonable steps to manage them.

2.3 Principles

There are six key principles for PHBs and personalisation in health:

1. *Upholding NHS principles and values* - The personalised approach must support the principles and values of the NHS as a comprehensive service which is free at the point of use, as set out in the NHS Constitution. It should remain consistent with existing NHS policy, including the following principles:

- Service users and their carers should be fully involved in discussions and decisions about their care using easily accessible, reliable and relevant information in a format that can be clearly understood;
- There should be clear accountability for the choices made;
- No one will ever be denied treatment as a result of having a PHB;
- Having a PHB does not entitle someone to additional or more expensive services, or to preferential access to NHS services;
- There should be efficient and appropriate use of current NHS resources.

2. *Quality* – safety, effectiveness and experience should be central. The wellbeing of the individual is paramount. Access to a PHB will be dependent on professionals and the individual agreeing a care plan that is safe and will meet agreed health and wellbeing outcomes. There should be transparent arrangements for continued clinical oversight, proportionate to the needs of the individual and the risks associated with the care package.

3. *Tackling inequalities and protecting equality* – PHBs and the overall movement to personalise services could be a powerful tool to address inequalities in the health service. A PHB must not exacerbate inequalities or endanger equality. The decision to set up a PHB for an individual must be based on their needs, irrespective of race, age, gender, disability, sexual orientation, marital or civil partnership status, transgender, religion, beliefs or their lack of the requisite mental capacity to make decisions regarding their care.

4. *PHBs are purely voluntary* - No one will ever be forced to take more control than they want.

5. *Making decisions as close to the individual as possible* - Appropriate support should be available to help all those who might benefit from a more personalised approach, particularly those who may feel least well served by existing services / access, and who might benefit from managing their budget.

6. *Partnership* - Personalisation of healthcare embodies co-production. This means individuals working in partnership with their family, carers and professionals to plan, develop and procure the services and support that are appropriate for them. It also means CCGs, local authorities and healthcare providers working together to utilise PHBs so that health and social care work together as effectively as possible.

2.4 Standards for self-directed health support

The following standards for self-directed support are followed nationally and articulated as seven outcomes, which will be delivered through the implementation of this policy. These seven outcomes are:

Outcome 1 - Improved health and emotional well-being: To stay healthy and recover quickly from illness.

Outcome 2 - Improved quality of life: To have the best possible quality of life, including life with other family members supported in a caring role.

Outcome 3 - Making a positive contribution: To participate as an active citizen, increasing independence where possible.

Outcome 4 - Choice and control: To have maximum choice and control.

Outcome 5 - Freedom from discrimination, harassment and victimisation: To live free from discrimination, harassment and victimisation.

Outcome 6 - Economic well-being: To achieve economic well-being and have access to work and / or benefits as appropriate.

Outcome 7 - Personal dignity: To keep your personal dignity and be respected by others.

3.0 PHB eligibility

3.1 Who can have a PHB?

From 1 October 2014, all Eligible Persons acquired a 'right to have' a PHB including by way of a direct payment. Whilst the offer was initially only for CHC and CC, CCG's can at their discretion now offer this to a wider group of people who may benefit from a PHB. This is related to the NHS commitment and mandate to support individuals with long term conditions. This provision has been extended as part of the NHS England 'Moving Forward with Personal Health Budgets' development programme.

For South Sefton CCG this includes:

- People who are eligible for fully funded NHS continuing healthcare (adults), including people with a learning disability, mental health difficulties who have complex health needs and or challenging behaviour, and long term conditions (refer to 3.1.1)
- Families of children eligible for Continuing Care (refer to 3.1.2)
- Individuals who have a long term condition who may benefit from personal health budget who are not in receipt of NHS funded packages of care.

3.1.1 Adults who have learning disabilities and mental health with complex health needs or challenging behaviour, who are in receipt of a joint funding arrangement with Southport and Formby CCG and Sefton MBC, have the right to explore whether their needs can be met by utilising a personal budget. The personal budgets under joint funding arrangements for Southport and Formby CCG will be managed by Sefton MBC, this includes access to a direct payment. Adults with a learning disability and or mental health difficulty, who are in receipt of a joint funded package of care, and receiving a direct payment, will by nature already be in receipt of an integrated PHB.

3.1.2 Children Complex Care - In the case of children where continuing care is being received, the child and or family will have an, education, health and social care plan in place

(EHC) or will be in the process of transferring over to an EHC. For children, personal health budgets can contribute to some or all of the social, health and educational elements of this plan. Within Southport and Formby CCG this will be provided by the SEND 'local offer', the joint funding arrangements will be managed via by Sefton Metropolitan Council (MBC) as a direct payment. Children across Southport and Formby CCG who are already in receipt of a direct payment, will by nature already be in receipt of an integrated PHB.

Individuals and their representatives already in receipt of CHC or CC may take up their right for a personal health budget at any time and CCGs must give due consideration to any request made. Individuals and families assessed as eligible for CHC or CC from October 2014 should be informed of their "right to have" their NHS care delivered in this way (see section 5.1 below).

In accordance with the overall drive towards greater patient choice and control, PHBs for patients other than those listed above, can still be considered and offered the benefit of a personalised care plans. In line with the NHS England 'Moving Forward with Personal Health Budget' development programme agenda this will form the basis of the CCG Local Offer which will be published on the CCG website from April 2016.

3.2 Exclusions for PHBs

If an individual comes within the scope of the "right to have" a PHB, then the expectation is that one will be provided. However, the NHS England guidance states:

"There may be some exceptional circumstances when a CCG considers a personal health budget to be an impracticable or inappropriate way of securing NHS care for an individual. This could be due to the specialised clinical care required or because a personal health budget would not represent value for money as any additional benefits to the individual would not outweigh the extra cost to the NHS."

Where a PHB by way of a direct payment is being considered, please also see exclusions listed at section 6.4.

3.3 PHBs for people in nursing or residential care home settings

The Government's intention is for all Eligible Persons to have the "right to have" a PHB where they would benefit from personalised care. Therefore, such Eligible Persons living in nursing or residential care who may benefit from receiving care via a PHB, ought to be offered this option. However, CCGs need to be satisfied that the use of a PHB in such settings is cost effective and is a sensible way to provide care to meet or improve the individual's agreed outcomes. PHBs should not generally be used to pay for care and support services being commissioned by the NHS that a person will continue to access in the same way whether they have a PHB or not. See section 6.10 for further detail relating to direct payments for those in nursing / residential care home settings.

4.0 Options for managing PHBs

The most appropriate way to manage a PHB should be discussed and agreed with the person, their representative or nominee as part of the care planning process. PHBs can now be received and managed in the following ways, or a combination of them:

a) Notional budget – where an individual is informed of the amount of funding available to them and decides how the budget is used (by input into the care plan) but the CCG continues to commission services, manage contracts and make purchases etc. Notional budgets could be an option for individuals who want more choice and control over their healthcare but who do not feel able or willing to manage a budget.

b) Third party budget – A non NHS support service organisation, legally independent of both the individual and the NHS, holds the money for the individual and arranges and pays for all of the services on behalf of the individual in accordance with the care plan.

c) Direct payments - Can differ whether a person lacks or retains capacity:

i. Direct payments for people *with capacity* – where the individual receives the funding that is available to them and they purchase the services and support they want in accordance with the agreed care plan (with or without assistance). The individual can elect to receive and manage the payment themselves or decide for it to be received and managed by a person of their choosing (a nominee). If the individual chooses a nominee, that nominee becomes responsible for managing the funds and services and accounting for expenditure. Support from CCG recommended support services are available for all direct payment recipients.

ii. Direct payments for people who lack capacity – where the individual lacks capacity, an 'authorised representative' (agreed by the CCG – see 5.4 for further detail) receives the funding that is available to the individual as a direct payment. The authorised representative is responsible for managing the funds and services and accounting for expenditure. The 'authorised representative' must involve the individual as much as possible and all decision making must be in line with the individual's best interests, in accordance with s.4 Mental Capacity Act 2005. Support from a CCG recommended support services (a direct payment support service) are available for all direct payment recipients. In the case of children, direct payments can be received by their parents or those with parental responsibility for that child.

Further detail on Direct Payments is set out in Section 6 of this Policy.

5.0 How do PHBs work?

5.1 Informing people about PHBs

All policies relating to NHS Continuing Healthcare and Continuing Care continue to apply alongside the new law and guidance on PHBs. From April 2014, the named health professional will inform Eligible Persons of their right to request a PHB (including by way of direct payments) at the initial assessment, the 12 week review or annual review. From October 2014 the named health professional will inform Eligible Persons of their right to have a PHB (including by way of direct payments) at the initial assessment, the 12 week review and or annual review. See exclusions in Section 3.2 and 6.4. The Personal Health Budget pathway is outlined in Appendix 1.

Health professionals will also seek to identify other patients who do not fall within the scope of the "right to have" but who may benefit from the provision of a PHB. PHBs are not restricted to Eligible Persons and CCGs will seek to offer PHBs on a voluntary basis to those patients with long term conditions for whom it would be appropriate. Where such patients are identified, the health professionals involved in their care will provide them with information about PHBs.

PHBs are entirely voluntary and there is no obligation for a patient to accept the offer. Patients and their families will need to be provided with the CCG PHB standard leaflet or where appropriate Easy Read leaflet.

The CCGs have made arrangements for non NHS support services for example: Salvere (a direct payment support service), SOLO Support Services and Your Life Your Way (third party budget support services) to provide information, advice and guidance to prospective and existing PHB recipients, and their families.

The list of non NHS support services above will be subject to change and extension subject CSU / CCG 3rd Party Assurance Process.

The services provided by these organisations will include:

- Information on how a PHB can be used and managed
- Guidance on producing a personalised care / support plan
- Advice and support to manage a PHB, including a direct payment
- Guidance on record keeping requirements
- Information about direct payments, including the responsibilities around financial monitoring that will need to be taken on by the recipient of the direct payments.

Patients and families who wish to consider and explore PHBs further will be offered a referral to a non NHS support service by the named health professional. This will require the named health professional to complete a PHB enquiry form, as well as a PHB care plan (a copy of which is at Appendix 2) which includes recording the clinical needs of the individual. This will begin the process of identifying risks so the care / support planning process can commence. Enquiries should be made to CMCSU.Care@nhs.net. The lead health professional (see section 5.5) will be supported by the Commissioning Support Officers within the CCG and CSU to progress the request.

5.2 Budget Setting

Under the traditional model of CHC / CC, an assessment would be followed by the named health professional producing a care plan, i.e. a schedule prescribing episodes of care and defining specific tasks for the care worker. Under PHBs, after an assessment, a 12 week review and or an annual review an 'indicative budget' is set. The indicative budget gives a financial envelope within which the PHB Care Plan is completed.

The CSU and CCGs are using a 'ready reckoner' approach to set the level of the PHB. This approach uses an existing care plan / package of support to calculate an *indicative budget.* Where there is no existing care plan or package of support already in place, the budget will be based on a standard hourly rate (see below). Whilst the 'ready reckoner' approach is based on existing services, it can be simpler to use, more transparent and easier to understand.

The PHB amount is therefore based on:

- 90% of the money that would otherwise be spent on meeting the fully funded NHS continuing healthcare needs or continuing care needs for Eligible Persons.
- If no package of care is in place an hourly rate of £13.50 will be used to set as a baseline amount of PHB for each hour of care the patient is assessed as needing.
- In the case of individuals with long term conditions, who are not in receipt of a health funded package of care. The CCG will need to work out the indicative budget in terms of the overall cost of NHS Services used, and determine which elements cannot be utilised e.g. regular routine hospital consultant appointments and which elements could form the basis of the indicative budget as part of the PHB, with the emphasis of reducing overall NHS expenditure.

Following a person being assessed / reviewed and identified or re-confirmed as an individual entitled to receive a PHB, the indicative budget will be agreed by CSU / CCG. See section 6 for additional information.

In principle, the amount of money that would have been spent on NHS Services as part of an individual's CHC, CC and or long term conditions could be available to use as a PHB. As much of this budget as possible should be included in a PHB. Where it is not possible to do so (for example, where money currently being used to commission services cannot be released immediately for use under a PHB), CCGs will work with the patient to tailor services as best as possible until this service can be provided under the PHB arrangement (where appropriate).

5.3 PHB care planning

Everyone who has a PHB will go through a care planning process, which leads to a person-centred Care Plan. Care planning for PHBs is fundamentally different from traditional care planning carried out for CHC / CC for children patients. Whereas a traditional care plan starts with the existing services, the starting point for a PHB Care Plan is the agreement of an indicative budget.

A PHB Care Plan is developed jointly by the individual, their family (if appropriate), a non NHS support services planner, and the individual's lead health professional. The process should be driven by the individual's choices and the Care Plan should clearly show how a PHB will be used to achieve the individual's identified health and care outcomes. This includes:

- the health needs of the individual and the desired outcomes;
- the amount of money available under the PHB;
- what the PHB will be used to purchase;
- how the PHB will be managed;
- who will be managing the budget;
- who will be providing each element of support;
- how the plan will meet the agreed outcomes and clinical needs;
- who is responsible for monitoring the health condition of the individual;
- who the individual should contact to discuss any changes in their needs;
- the anticipated date of the first review;
- how the individual has been involved in the production of the plan;
- how any training needs will be met;
- identifying any risks, consequences and mitigating actions;
- contingency planning.

Good care planning involves looking holistically at the individual's life to improve their health, safety, independence and wellbeing. The individual should be supported throughout the care planning process.

The NHS (Direct Payments) Regulations 2013 ("the regulations") and associated guidance set out what direct payments (using NHS money) can and cannot be used for, and how they should be administered. The CSU / CCGs will apply the regulations to all forms of PHB as far as possible, whether it is received/managed by way of direct payments or otherwise (as detailed at section 4). How a PHB will be used (however it is received / managed) must be set out in the PHB Care Plan. Please see section 6 of this Policy which is to be applied, as far as possible, to all PHBs.

Delay in arranging PHBs should be avoided. Where delay is unavoidable (for example, where circumstances make it difficult to plan for a person's ongoing care), the reasons for it must be made clear to the individual. Regular review should take place so that a person's PHB can be put in place as soon as practicably possible.

The CSU and CCGs will make sure that this delay does not cause a delay in hospital discharges or in ensuring an appropriate package of care is in place pending finalisation of the PHB arrangements. An interim care package may be offered to avoid such delay.

5.4 Representatives for children and people who lack capacity

A PHB arrangement for a person who lacks capacity will require the appointment of a 'representative' by the appropriate CCG. A representative is someone who agrees to act on behalf of someone who is otherwise eligible to receive a PHB but cannot do so because they do not have capacity to consent to receiving one (see Appendix 4) or because they are a child.

An appointed 'representative' could be anyone deemed suitable by the CCG, and who would accept the role. The representative can be:

- a friend, carer or family member;
- a deputy appointed by the Court of Protection;
- an attorney with health and welfare or finance decision-making powers created by a lasting power of attorney;
- someone appointed by the CCG.

In the case of adults who lack capacity, when choosing the 'representative' the CCG must adopt a decision making process in line with the requirements of the MCA and within the context of the individual's best interests as per the checklist at s.4 of the Act. This includes seeking the views of the individual, where possible, about who they would want to manage their PHB.

The decision making process for the appointment of the 'representative' must be documented and discussed as part of care planning process, and agreed by the CSU / CCG.

The representative will take on the responsibilities associated with the PHB. Where it is believed to be appropriate to provide a PHB by way of direct payments, the representative must be fully informed about, and consent to accepting, the responsibilities relating to the receipt and management of the direct payment on the individual's behalf (see section [6.8] below).

The involvement of the representative should be reviewed if the individual regains capacity and/or reaches the age of 16.

5.5 Lead Health Professional

A lead health professional will be named in an individual's Care Plan. This should be someone who has regular contact with the individual and their representative or nominee if they have one. It is likely that the lead health professional will be the most appropriate person to undertake this role. The Care Coordinator is responsible for:

- Managing the assessment of the health needs of the individual as part of the care plan;
- Ensuring that the individual, representative and CSU / CCG clinician have agreed the care plan;
- Undertaking or arranging for the monitoring and review of the care plan and health of the person;
- Liaising between the individual (or their representative or nominee) and the CCG as the primary point of contact.

5.6 Approval of Care Plan

PHB Care Plans are agreed in principle by the named health professional. However, all PHB Care Plans will also need to be signed off by the appropriate CSU & CCG panel (which will include a relevant CCG representative). This process includes reviewing, agreeing and signing off the Care Plan which includes a risk identification and management plan. A PHB checklist has been developed to ensure consistency and adherence to the law and guidance. A copy of this checklist is at Appendix 5 of this Policy.

The CSU / CCG clinician will not agree to any services named in the Care Plan if they believe that the potential health outcomes are outweighed by significant risks to the individual's health. However, the CCGs will not impose blanket prohibitions and will remain open to considering different approaches to achieving outcomes other than those traditionally used, considering the particular circumstances of the individual and balancing the risks and benefits accordingly.

If a service named in the Care Plan is not agreed, the CSU / CCG clinician will provide the individual, representative or nominee the reasons why this decision has been reached. The individual, their representative or nominee may ask the CSU / CCG clinician to reconsider their decision and provide additional evidence or information to inform that decision. The CSU / CCG clinician must reconsider their decision in a timely manner upon such a request being made. The CSU / CCG clinician will notify and explain the outcome in writing to the individual. See sections 6.7 & 6.8 for further detail on the process to be followed.

If a part of the Care Plan is refused, the CCG should make every effort to work in partnership with the individual, their representative or nominee to ensure their preferences are considered and taken into account.

5.7 PHB Agreement

When taking up a PHB, the patient, their representative and / or their nominee must sign a 'PHB agreement', which explains the responsibilities associated with the PHB and sets out the agreement that the PHB will be spent as set out in the Care Plan.

If the patient is receiving the PHB as a direct payment, the PHB agreement will confirm that the PHB will be spent in accordance with the NHS (Direct Payments) Regulations 2013. A copy of this Agreement is at Appendix 5 for an adult and Appendix 6 for children in this Policy.

5.8 Assistance to manage PHBs

The CCGs have arranged for non NHS support services e.g. Salvere, Your Life Your Way and SOLO Support Services to provide support to individuals in receipt of PHBs. It is envisaged that over time a wider range of organisations will become available to offer support and that this will be reflected in the choices available to PHB recipients, this will be subject to CSU / CCG 3rd Party Assurance Process. Salvere offers support services for those in receipt of direct payments. It can also support individuals in activities such as recruiting, employing staff and payroll. Further detail on these services can be found at section 6.12.

SOLO Support Services and Your Life Your Way offer services for those with third party budgets, including options where they become the employer and manage the PHB on an individual's behalf.

The costs associated with utilising a non NHS support service will be met from the PHB allocation. This requires the PHB to be paid directly to these organisations so that their charges can be deducted.

5.9 Monitoring and Review

Regular review is required in order to ensure that an individual's Care Plan continues to meet their needs.

In respect of continuing healthcare for adults, this review is carried out in line with the continuing healthcare national service framework, i.e. three months after patients become eligible for continuing healthcare and annually thereafter. Reviews will also confirm whether or not the patient remains eligible and in need continuing healthcare.

In respect of continuing care for children, the care package should be reviewed after three months and then at least every six months to ensure it continues to meet the child or young person's needs. Reviews will also confirm whether or not the child or young person still has continuing care needs.

Reviews may need to take place sooner or more frequently if the CCG or CSU become aware that:

- the health needs of the individual have changed significantly;
- the care plan is not being followed or expected health outcomes are not being met; or
- the individual, their representative or their nominee requests it.

It should be made clear under the Care Plan who the PHB holder should contact to discuss changes to their PHB should their needs change. In most cases, the Care Coordinator will be best placed to undertake this role.

5.10 Stopping or reclaiming PHBs

Arrangements under PHBs can be stopped and, where applicable, money can be reclaimed. The details of this are set out at section 6.16 and 6.17 but, to the extent possible, this applies to all types of PHB.

6.0 Direct Payments

The National Health Service (Direct Payments) Regulations 2013 set out how direct payments should be administered and on what they can be spent. The regulations are similar to the regulations and guidance for social care direct payments. PHB Guidance on the new direct payments for healthcare regulations was published in March 2014. Although the NHS (Direct Payments) Regulations 2013 apply to direct payment PHBs, as noted above the CCG has agreed to apply these regulations, as far as possible, to all forms of PHB to ensure transparency, fairness and best practice. References in this section to "direct payments" should therefore be treated as referring to all forms of PHB.

6.1 Who can receive a direct payment PHB?

A direct payment PHB can be made to any Eligible Person, where they are:

- In receipt of any benefit that may or must be provided or arranged by a health body under the NHS Act 2006 or under any other enactment and;
- A person aged 16 or over, who has the capacity to consent to receiving a PHB by way of a direct payment and consents to receive one (please see Appendix 4 in relation to capacity);
- A child under 16 where they have a suitable representative who consents to a PHB by way of a direct payment;
- A person aged 16 or over who does not have the capacity to consent to receiving a PHB by way of a direct payment but has a suitable representative who consents to it.
- A direct payment PHB is appropriate for that individual with regard to any particular condition they may have and the impact of that condition on their life;
- A direct payment PHB represents value for money and, where applicable, any additional cost is outweighed by the benefits to the individual;
- The person is not subject to certain criminal justice orders for alcohol or drug misuse (see Section 6.4). However, such a person may be able to use another form of PHB to personalise their care.

The CCG will only provide direct payments if it is satisfied that the person receiving the direct payments (which may be the patient, a nominee or representative) understands what is involved, and has given consent.

People aged 16 or over who have capacity, representatives of people aged 16 or over who lack capacity, and representatives of children can request that the direct payment is received and managed by a nominee (see Section 6).

Decisions about providing direct payments for healthcare should be based around need rather than being based around a particular medical condition or severity of condition.

Health professionals will also seek to identify other patients who do not fall within the scope of the “right to have” but who may benefit from the provision of a PHB. PHBs are not restricted to Eligible Persons and CCGs will seek to offer PHBs on a voluntary basis to those patients with long term conditions for whom it would be appropriate. Where such patients are identified, the health professionals involved in their care will provide them with information about PHBs.

6.2 Considerations when deciding whether to make a direct payment

The CCG will adhere to the requirements as detailed at Regulation 7 of the NHS (Direct Payments) Regulations 2013 when deciding whether to make a direct payment. In doing so the CCG will contact a range of people for information to help make the decision whether a direct payment may be suitable. From this range will be any health or social care professional involved in the provision of care/treatment to the individual e.g. a personal assistant, occupational therapist, community mental health nurse or social care team. The CCG will also consult:

- Anyone identified by the individual as a person to be consulted for this purpose.
- If the individual is a person aged 16 or over but under the age of 18, a person with parental responsibility for the individual.
- The person primarily involved in the care for the individual.
- Any other person who provides care for the patient.

- Any Independent Mental Capacity Advocate (IMCA) or Independent Mental Health Advocate (IMHA) appointed for the individual.

The CCG will consider whether the individual will be able to manage the direct payment (see section 6.3 below).

If the person is aged between 16 and 18, a parent or guardian with parental responsibility will be assessed, to look at whether they could manage a direct payment.

If the individual has a deputy appointed by the Court of Protection in relation to matters about which direct payments may be made, this will be considered and the CCG may consult the appointed person to help decide whether or not the person would want to receive direct payments.

In considering whether to provide direct payments, the CCG may ask the individual or their representative for information about:

- Their overall health;
- The details of their condition in respect of which they would receive direct payments;
- Any bank, building society, Post Office or other account into which direct payments would be paid; and
- Anything else which appears relevant.

6.3 Ability to manage direct payments

The CCG will consider whether an individual (whether the patient or their representative) is able to manage direct payments by:

- Considering whether they would be able to make choices about, and manage the services they wish to purchase;
- Whether they have been unable to manage either a heath care or social care direct payment in the past, and whether their circumstances have changed;
- Whether they are able to take reasonable steps to prevent fraudulent use of the direct payment or identify a safeguarding risk and if they understand what to do and how to report it if necessary; and
- Considering any other factor which the CCG may consider is relevant.

If the CCG is concerned that an individual is not able to manage a direct payment they must consider:

- The individual's understanding of direct payments, including the actions and responsibilities on their part.
- Whether the person understands the implications of receiving or not receiving direct payments.
- What kind of support the individual may need to manage a direct payment.
- What help is available to the individual.

Any decision that an individual is unable to manage a direct payment must be made on a case by case basis, taking into account the views of the individual, and the help they have available to them. The CCG will not make blanket assumptions that groups of people will or will not be capable of managing direct payments.

The CCG will inform the individual in writing if the decision has been made that they are not suitable for direct payments and whether an alternative method of receiving the PHB is considered to be suitable instead. See section 6.5 for further information.

6.4 Who cannot receive a direct payment?

There are some people to whom the duty to make direct payments does not apply . This includes those:

a) subject to a drug rehabilitation requirement, as defined by section 209 of the Criminal Justice Act 2003 (drug rehabilitation requirement), imposed by a community order within the meaning of section 177 (community orders) of that Act, or by a suspended sentence of imprisonment within the meaning of section 189 of that Act (suspended sentences of imprisonment);
b) subject to an alcohol treatment requirement as defined by section 212 of the Criminal Justice Act 2003 (alcohol treatment requirement), imposed by a community order, within the meaning of section 177 of that Act, or by a suspended sentence of imprisonment, within the meaning of section 189 of that Act;
c) released on licence under Part 2 of the Criminal Justice Act 1991 (early release of prisoners), Chapter 6 of Part 12 of the Criminal Justice Act 2003 (release on licence) or Chapter 2 of the Crime (Sentences) Act 1997 (life sentences) subject to a non-standard licence condition requiring the offender to undertake offending behaviour work to address drug or alcohol related behaviour;
d) required to submit to treatment for their drug or alcohol dependency by virtue of a community rehabilitation order within the meaning of section 41 of the Powers of Criminal Courts (Sentencing) Act 2000 (community rehabilitation orders) or a community punishment and rehabilitation order within the meaning of section 51 of that Act (community punishment and rehabilitation orders);
e) subject to a drug treatment and testing order imposed under section 52 of the Powers of Criminal Courts (Sentencing) Act 2000 (drug treatment and testing orders);
f) subject to a youth rehabilitation order imposed in accordance with paragraph 22 (drug treatment requirement) of Schedule 1 to the Criminal Justice and Immigration Act 2008 (“the 2008 Act”) which requires the person to submit to treatment pursuant to a drug treatment requirement;
g) subject to a youth rehabilitation order imposed in accordance with paragraph 23 of Schedule 1 to the 2008 Act (drug testing requirement) which includes a drug testing requirement;
h) subject to a youth rehabilitation order imposed in accordance with paragraph 24 of Schedule 1 to the 2008 Act (intoxicating substance treatment requirement) which requires the person to submit to treatment pursuant to an intoxicating substance treatment requirement;

i) required to submit to treatment for their drug or alcohol dependency by virtue of a requirement of a probation order within the meaning of sections 228 to 230 of the Criminal Procedure (Scotland) Act 1995 (probation orders) or subject to a drug treatment and testing order within the meaning of section 234B of that Act (drug treatment and testing order);

j) released on licence under section 22 (release on licence of persons serving determinate sentences) or section 26 of the Prisons (Scotland) Act 1989 release on licence of persons sentenced to imprisonment for life, etc.) 34 or under section 1 (release of short-term, long term and life prisoners) or section 1AA of the Prisoners and Criminal Proceedings (Scotland) Act 1993 (release of certain sexual offenders) and subject to a condition that they submit to treatment for their drug or alcohol dependency;

k) If the individual is subject to certain criminal justice orders for alcohol or drug misuse, then they will not receive a direct payment. However, they might be able to use another form of PHB to personalise their care and alternatives should be considered.

6.5 Deciding not to offer a direct payment.

In addition to section 6.4 above, a CCG may decide to refuse to make a direct payment if it believes it would be inappropriate to do so, for example:

- if there is significant doubt around an individual's or their representative's ability to manage a direct payment;
- if there is a high likelihood of a direct payment being abused;
- if the benefit to the particular individual of having a direct payment does not represent good value for money;
- if it considers that providing services in this way will not provide the same or improved outcomes.

Such a view may be formed from information gained from anyone known to be involved with the individual, including health professionals, social care professionals, the individual's family and close friends, and carers for the individual.

In all cases where a direct payment is refused, the Eligible Person and any nominee or representative will be informed in writing of the refusal and the grounds by which the request is declined. The individual or their representative may request a review of this decision, in which case, the process set out at section 6.7 will be followed.

If a direct payment is refused, other options to personalise the package of care for the individual will be explored and facilitated as much as is possible, and other forms of PHB, such as a notional budget or third party budget, should be considered.

6.6 Decision Making

Where there is a recommendation to accept or reject a request for a direct payment, the CCG will use a Panel to consider this recommendation. This Panel will consist of:

- Senior Nurse CCG (Chair)
- Senior Nurse CSU (Chair) under delegated responsibilities
- CSU Representatives individual commissioning nurse (CHC, CC, Mental Health, LD) – appropriate to individuals needs
- CCG GP representative
- Lead Health Professional
- Co-opted Members as appropriate this may include; medicines management, Sefton MBC representative (this list is not exhaustive)

The Panel will consult the appropriate Terms of Reference when making its decisions.

6.7 Request for review of a decision

Where the CSU / CCG decide that a direct payment would be inappropriate, the patient, their representative or nominee may require the CSU / CCG to reconsider the decision, submitting additional information to support the deliberation. The CSU / CCG must reconsider its decision in a timely manner upon such a request being made but is not required to undertake more than one re-consideration in any six month period following the initial decision.

The CCGs will use an Appeals Panel to make a decision regarding a request for reconsideration of a refusal to provide a direct payment. The membership and terms of reference of the Appeals Panel should be in accordance with the requirements of the relevant CCG. However, with regards to timeframe for the Appeals process, the Panel should seek to follow the recommended timescales set out under national guidance. Details of these timescales are set out at Appendix 9.

No member will have had previous involvement in the case.

The patient, representative or nominee must be informed in writing of the outcome of the review and the reasons for the decision. If the refusal is upheld, other options to personalise the package of care for the individual will be explored and facilitated as much as is possible, and other forms of PHB, such as a notional budget or third party budget, should be considered.

6.8 Representatives and direct payments

Information surrounding the appointment of Representatives is set out earlier in this Policy. When the use of direct payments is being considered, the CCG must be satisfied that a person agreeing to act as a representative understands what is involved, and has provided their informed consent, before going ahead and providing direct payments. They should be informed of the restrictions surrounding employment of a family member or person living in the same household to provide care (see section 7.1).

Full advice, support and information should be provided so that people contemplating taking on the role of representative know what to expect. In addition, the CCG must provide its consent to the representative acting in this role, having duly considered whether the person is competent and able to manage direct payments, either on their own or with whatever assistance is available to them.

A representative may identify a nominee to receive and manage direct payments on their behalf, subject to the nominee's agreement and the approval of the CCG (see section 6.9 below).

A representative must (unless they have appointed a nominee to do so):

- act on behalf of the person, e.g. to help develop a PHB Care Plan and to hold the direct payment
- act in the best interests of the individual when securing the provision of services
- be the principal person for all contracts and agreements, e.g. as an employer;
- use the PHB and direct payment in line with the agreed Care / Support Plan
- comply with any other requirement that would normally be undertaken by the individual (e.g. participating in a review, providing information)

When considering whether to make direct payments to representatives, the CCG will consider:

- Whether the person receiving care had, when they had capacity, expressed a wish to receive direct payments;
- Whether the person's beliefs or values would have influenced them to have consented or not consented to receiving a direct payment;
- Any other factors that the person would be likely to take into account in deciding whether to consent or not to receiving direct payments;
- As far as possible, the person's past and current wishes and feelings.

6.9 Nominees

If a person aged 16 or over has capacity, but does not wish (for whatever reason) to receive direct payments themselves, they may nominate someone else (a nominee) to receive them on their behalf.

A representative (for a person aged 16 or over who does not have capacity or for a child) may also choose to nominate someone (a nominee) to hold and manage the direct payment on their behalf.

Where a nominee is appointed, they become responsible for managing the PHB and direct payment on behalf of the individual or the appointed representative (for individuals without capacity). They must:

- act on behalf of the person, e.g. to help develop a PHB Care / Support plan(s) and to hold the direct payment;
- act in the best interests of the individual when securing the provision of services;
- be the principal person for all contracts and agreements, e.g. as an employer;
- use the PHB and direct payment in line with the agreed Care / Support Plan;
- comply with any other requirement that would normally be undertaken by the individual (e.g. review, providing information).

It is important to note that the role of nominee for direct payments for healthcare is different from the role of nominee for direct payments for social care. For social care direct payments, a nominee does not have to take on all the responsibilities of someone receiving direct payments, but can simply carry out certain functions such as receiving or managing direct payments on behalf of the person receiving them. In direct payments for healthcare, however, the nominee is responsible for fulfilling all the responsibilities of someone receiving direct payments, as outlined above. Those receiving direct payments for healthcare and their nominees must be made fully aware of these responsibilities.

The CCG must be satisfied that a person agreeing to act as a nominee understands what is involved, and has provided their informed consent, before going ahead and providing direct payments. Full advice, support and information should be provided so that people contemplating taking on the role of nominee know what to expect. In addition, the CCG must provide its consent to the nominee acting in this role, having duly considered whether the person is competent and able to manage direct payments, either on their own or with whatever assistance is available to them.

Before the nominee receives the direct payment, the CCG must consent to the nomination. In reaching its decision, the CCG may:

- Consult with relevant people;
- Require information from the person for whom the direct payments will be made on the state of health or any health condition they have which is included in the services for which direct payments are being considered;
- Require the nominee to provide information relation to the account into which direct payments will be made.

If the proposed nominee is not a close family member of the person (see Appendix 8), living in the same household as the person, or a friend involved in the person's care, then the CSU / CCG will require the nominee to apply for an enhanced Disclosure and Barring Service (DBS) certificate (formerly a CRB check) with a check of the 'adults barred' list and consider the information before giving their consent. If a proposed nominee in respect of a patient aged 18 or over is barred, the CCG must not give their consent. This is because the Safeguarding Vulnerable Groups Act 2006 prohibits a barred person from engaging in the activities of managing the person's cash or paying the person's bills.

If the proposed nominee is a close family member of the person, living in the same household as the person, or a friend involved in the person's care, the CCG cannot ask them to apply for a DBS certificate and has no legal power to request these checks.

The CCG must notify any person identified as a nominee where it has decided not to make a direct payment to them. The notification must be made in writing and state the reasons for the decision.

6.10 What can and cannot be bought with direct payments

The NHS direct payments regulations and associated guidance set out what direct payments (using NHS money) can and cannot be used for, and how they should be administered.

A direct payment can be spent on a range of services and equipment that will lead to health outcomes, but only if they have been agreed in the Care Plan (see Appendix 3). The person receiving the direct payment (whether it is the individual requiring support, their nominee or a representative) is responsible for ensuring that it is only used as specified in the care plan. If it is not, the direct payment may have to be stopped and the law allows for certain payments which have been mis-spent to be reclaimed. Please see section 6.17 below.

There are some restrictions on how PHBs can be used. These are not intended to reduce choice and control for individuals, but to ensure that PHBs are used for maximum benefit and to ensure they are administered consistently and fairly for everyone.

Direct payments cannot be used to pay for the following:

- alcohol
- tobacco
- gambling
- debt repayment (other than for a service specified in the support plan)
- core GP services
- planned surgical interventions
- pharmaceutical charges
- services provided through vaccination or immunisation programmes
- any service provided under the NHS health check or National Child Measurement Programme
- Urgent or emergency treatment services

For the avoidance of doubt, as Southport and Formby CCG will apply the regulations to any form of PHB insofar as it is possible, the above restrictions will equally be applied to all forms of PHB insofar as it is possible.

In addition, pending the outcome of a further pilot scheme, caution should be had when considering the use of direct payments for those in nursing/residential care home settings.

Where a request for a direct payment for healthcare is made for a person living in a residential setting the CCG must be certain that providing care in this way adds value to the person's overall care. Generally, direct payments should not be used to pay for care and support services being commissioned by the NHS that a person will continue to access in the same way whether they have a PHB or not. In such instances, where no additional choice or flexibility has been achieved by giving someone a PHB, then allocating a direct payment only adds an additional financial step and layer of bureaucracy into the commissioning of the care. CCGs need to be clear that the use of a direct payment in such settings is cost effective and is a sensible way to provide care to meet or improve the individual's agreed outcomes.

Other types of PHB, for example notional budgets, can be used where direct payments are not a practical route and many people may find great benefit in planning their care using the personalised care planning process associated with developing a PHB.

6.11 Imposing conditions in connection with the making of direct payments

The following conditions may be imposed on the individual, their representative or nominee in connection with the making of direct payments:

- the recipient must not secure a service from a particular person; and/or
- the individual, their representative or their nominee must provide information that the CSU / CCG considers necessary (other than information already covered by other regulations in the NHS (Direct Payment) Regulations 2013.

Conditions should only be imposed in exceptional circumstances. The reasons for the imposed conditions should be documented clearly.

6.12 Assistance to manage a direct payment – Supported Managed Accounts

As outlined at section 5.1 above, the CCGs have arranged for non NHS support services to provide support to individuals in receipt of PHBs.

Where an individual chooses a direct payment there are extra responsibilities on the individual (or their appointed representative and / or nominee) to manage their care package. These are set out within the PHB Agreement – see Appendix 6.

It is essential that either the individual or their representative has the ability to consent to and manage both their direct payment and the dedicated bank account. In certain circumstances, the option of a Supported Managed Account can be considered. These circumstances include:

- Where the individual or representative feels assistance is required;
- Where mental capacity indicates; or

For those in receipt of direct payments, the non NHS support services offer Supported Managed Accounts and can support individuals in activities such as recruiting, employing staff and payroll. This option for support is open to people with PHBs and direct payments. However, in circumstances where Supported Managed Accounts are being considered, it may be more appropriate to consider the use of a notional budget. The respective benefits of each option should be discussed with the individual, their representative or nominee.

The costs of the non NHS support service are met from the PHB allocation. This requires the PHB to be paid directly to the non NHS support service so that its charges can be deducted. In certain circumstances the non NHS support service may make direct health care payments to patients, their representative or their nominee. This can only be carried out with the agreement of the CSU / CCG.

Individuals, representatives and appointed nominees employing staff are strongly recommended to utilise the information, advice, guidance and payroll and HR facilities of the non NHS support services e.g. Salvere, Your Life Your Way or SOLO (or, as the range of organisations offering such services widens, an alternative agreed support service) to ensure the legal responsibilities of being an employer are satisfied. Should the individual, representative or nominee not wish to accept this recommendation the request for a direct payment may be refused because requirements of employment law will fall to the individual, their representative or their nominee as the employer. In such circumstances, the CCG would have to be satisfied that the individual, their representative or nominee are able to manage such responsibilities by other means.

6.13 Receiving a direct payment

Direct payments will be paid in advance on the 15th day of the month, and where this day falls on the weekend, it will be paid on the Friday before. Under no circumstances should individuals have to pay for care and be reimbursed.

With the exception of one-off direct payments (see below), direct payments must be paid into a separate bank account used specifically for the direct payment. The bank account must be in the name of the person receiving the care, or their nominee or representative.

When receiving direct payments, the account holder should keep a record of both the money received and where it is spent. They are responsible for keeping hold of statements and receipts for auditing.

6.14 One-off payments

A one-off payment is used to buy a single item or service, or a single payment for no more than five items or services, where the individual is not expected to receive another direct payment in the same financial year.

When someone is receiving a one-off direct payment, it can be paid into the individual's ordinary bank account (or that of a nominee or representative). Individuals will need to provide evidence that the direct payment was used as agreed in the Care Plan, for example, by producing receipts of items/services purchased.

6.15 Monitoring and review of direct payments

As a minimum, a clinical review of an individual's direct payments should be performed within three months of the first direct payment and then annually. Financial monitoring will take place quarterly. Financial reviews will be completed by the non NHS support service.

There must be a review if the CCG or CSU become aware that direct payments have not been sufficient to secure the services specified in the care plan. If someone wishes to purchase additional care privately, they may do so, as long as it is additional to their assessed needs and it is a separate episode of care, with clearly separate lines of accountability and governance. They may not top up the direct payment with their own money to purchase more expensive care than that agreed in the Care Plan.

Where concerns are raised regarding how the PHB is being spent, the non NHS support service will inform the CCG to alert them to any concerns, and the CHC / CC lead at the Commissioning Support Unit.

These considerations are in addition to those set out at section [5.9] above, which requires review of an individual's Care Plan to ensure it remains appropriate to meeting the individual's needs.

6.16 Stopping or reducing direct payments

There is an ongoing duty to ensure that direct payments are reviewed. The amount provided under direct payments may be increased or decreased at any time, provided the new amount is sufficient to cover the full cost of the individual's care plan. PHBs and direct payments are not a welfare benefit and do not represent an entitlement to a fixed amount of money. A surplus may indicate that the individual is not receiving the care they need or too much money has been allocated. It should be noted that a surplus is different to a contingency – it is permissible to include an amount for contingency in a PHB, for example, to cover employment costs such as redundancy. As part of the review process, the CSU / CCG should establish why the surplus has built up. Under these circumstances, a reduction in direct payment in any given period cannot be more than the amount that would have been paid to them in the same period.

Before making a decision to stop or reduce a direct payment, wherever possible and appropriate, the CSU / CCG should consult with the person receiving it to enable any inadvertent errors or misunderstandings to be addressed, and enable any alternatives to be made.

Where direct payments have been reduced, the individual, their representative or nominee may request that this decision be reconsidered, and may provide evidence or relevant information to be considered as part of that deliberation. Where this happens, the individual, representative or nominee must be informed in writing of the outcome of the reconsideration and the reasons for this decision. The CSU / CCGs are not required to undertake more than one reconsideration of any such decision. If the individual remains unhappy about the reduction, they should be referred to the local NHS complaints procedure.

The CSU will stop making direct payments on behalf of the CCGs where:

- A person with capacity to consent, withdraws their consent to receiving direct payments;
- A person who has recovered the capacity to consent, does not consent to the direct payments continuing; or
- A representative withdraws their consent to receive direct payments, and no other representative has been appointed.

The CSU may stop direct payments if it is satisfied that it is appropriate to do so. For example where:

- the money is being spent inappropriately (e.g. to buy something which is not specified in the support plan);
- direct payments are no longer a suitable way of providing the person with care;
- a nominee withdraws their consent, and the person receiving care or their representative does not wish to receive the direct payment themselves;
- the CSU / CCG has reason to believe that a representative or nominee is no longer suitable to receive direct payments, and no other person has been appointed;
- where there has been theft, fraud or abuse of the direct payment; or
- if the patient's assessed needs are not being met or the person no longer requires care.

Where PHBs and direct payments are stopped, the CSU / CCG will give reasonable notice to the patient, their representative or nominee in writing, explaining the reasons behind the decision. There is no definition as to what constitutes "reasonable notice". It should be noted that, after a direct payment is stopped, all rights and liabilities acquired or incurred as a result of the service purchased by direct payments will be transferred to the CCG. This should therefore be considered. However, in some cases, it may be necessary to stop the direct payment immediately, for example, if fraud or theft has occurred.

6.17 Reclaiming a direct payment

The CSU can claim back PHBs and direct payments on behalf of the CCGs where:

- they have been used to purchase a service that was not agreed in the care plan;
- there has been theft or fraud; or
- the money has not been used (e.g. as a result of a change in the care plan or the individual's circumstances have changed) and has accumulated.

If a decision to reclaim payments is made, reasonable notice must be given to the individual, their representative or nominee, in writing, stating:

- the reasons for the decision;
- the amount to be repaid;
- the time in which the money must be repaid; and
- the name of the person responsible for making the repayment.

The individual, their representative or nominee may request that this decision be reconsidered and provide additional information to the CSU / CCG for reconsideration. Notification of the outcome of this reconsideration must be provided in writing and an explanation provided. The CSU / CCGs are not required to undertake more than one reconsideration of any such decision. If the individual remains unhappy about the reduction, they should be referred to the local NHS complaints procedure.

7.0 Using a direct payment to employ staff or buy services

7.1 Using a direct payment to employ staff

People may wish to use their direct payment to employ staff to provide them with care and support. In so doing, they will acquire responsibility as an employer and need to be aware of the legal responsibilities associated with this. This should not discourage people who would otherwise be willing and able to manage a direct payment. In order to ensure that people are appropriately informed and supported in meeting their duties as an employer, the CCGs have arranged for non NHS support services e.g. Salvere to provide information, advice and support. This includes support in relation to payroll, Human Resources and other employment related services. People should be made aware of the availability of this service, along with any others which may become available. Individuals, representatives and appointed nominees employing staff are strongly recommended to utilise the information, advice, guidance and payroll and HR facilities of non NHS support services (or an alternative agreed support service as a wider range or organisations become available) to ensure the legal responsibilities of being an employer are satisfied.

The costs associated with utilising a non NHS support service are met from the PHB allocation. This requires the PHB to be paid directly to these organisations so that their charges can be deducted. This cost should be factored in when setting the budget.

7.2 Employing a family member or person living in the same household

A direct payment can only be used to pay an individual living in the same household, a close family member (as defined in Appendix 8) or a friend if the CCG is satisfied that to secure a service from that person is necessary in order to satisfactorily meet the individual's need; or to promote the welfare of a child for who direct payments are being made. It is anticipated that this will be permitted in very limited circumstances. The CCGs must make judgements on a case by case basis.

Any arrangement of this nature must be formally agreed by the CSU / CCG, and recorded in writing in both the care plan and the PHB agreement.

The suitability will be reviewed at least every three months, (following the existing pathways for complex, children's and adults). This process includes reviewing, agreeing and signing off the risk identification and mitigation tool.

This restriction is not intended to prevent individuals from using direct payments to employ a live-in personal assistant. The restriction applies where the relationship between the two people is primarily person rather than contractual (for example, if the people concerned would be living together in any case).

7.3 Safeguarding and employment

People may wish to use their direct payment to employ staff to provide them with care and support. When deciding whether or not to employ someone, patients and their families should follow best practice in relation to safeguarding, vetting and barring including satisfying themselves of a person's identity, their qualifications and professional registration if appropriate and taking up references.

The CSU and CCGs have made arrangements with non NHS support services to provide advice and accessible services in relation to the provision of DBS checks for individual employers.

Individuals cannot request DBS checks on other individuals. However, an individual or their nominee or representative may wish to ask the CCG or another Umbrella Organisation e.g. a non NHS support service, if it is possible to arrange for the prospective employee or contractor to apply for an enhanced DBS check with a check of the adult's (or children's if appropriate) barred lists when employing or contracting with people who are not close family members or people living in the individual's household providing care to the individual but who are:

- regulated health care professionals – for example, nurses or physiotherapists
- people providing healthcare under the direction or supervision of a health care professional
- people providing personal care

Alternatively, if the individual can satisfy the DBS that they have a legitimate interest in knowing if that person is barred, the DBS may supply this information.

If the potential employee is barred they must not be used to supply services as they pose an ongoing risk to adults or children.

If the individual is contracting with a close family member or a person who is living in the individual's household or a friend it is not possible to undertake any DBS checks.

The DBS has recently launched the Update Service. This is a service that allows people to reuse their certificate for multiple roles. If a potential employee or contractor has subscribed to the Update Service and has a check of the appropriate level, the individual should ensure they see the person's original certificate and use the free online portal to check for up to date information on that certificate. If the certificate is not up to date the individual should ask the potential employee or contractor to apply for a new certificate.

7.4 Indemnity

Direct payments can be used to pay for a personal assistant (PA) to carry out certain personal care and health tasks that might otherwise be carried out by qualified healthcare professionals such as nurses, physiotherapists or occupational therapists. In such cases the healthcare professional and CSU / CCG will need to be satisfied that the task is suitable for delegation, specify this in the Care Plan and ensure that the PA is provided with the appropriate training and development, assessment of competence and have sufficient indemnity and insurance cover. More information on this can be found in the 'Personal assistants - delegation, training and accountability' document in the toolkit.

Indemnity is a complex area for individual employers, and one where sufficient support will need to be in place from the start to enable people to understand and be supported to meet any obligations they have.

Providers of some services may need to conform with prospective legislation which will implement the Finlay Scott Recommendations (June 2010) on indemnity cover and Article 4(2) (d) of Directive 2011/24/EC. NHS England will provide further guidance on what this covers in due course.

PAs employed via a direct payment do not need to comply with the legislation that will require them to have indemnity cover if practising unless they are a member of a regulated health profession (see Appendix 9), even if carrying out activities which might otherwise be performed by health professionals. Care co-ordinators, the CSU & CCGs will need to consider and discuss with the person, their nominee or representative, the potential risks associated with the clinical tasks being carried by the PAs on a case by case basis. This needs to form part of the risk assessment and care planning process and outcome recorded in the Care Plan.

The person buying services needs to be aware of whether the provider needs to comply with prospective legislation discussed above. If the provider does not need to comply people may, if they wish, buy services from providers who have limited or no indemnity or insurance cover. So long as the person buying the service is aware of the potential risks and implications, limited or no indemnity should not automatically be a bar to purchasing from a provider. This should be included in the discussion around risks when developing the Care Plan.

In the first instance, it will be the responsibility of the person buying the service to check the indemnity cover of the provider from which they are buying services. They must make enquiries to ascertain whether the provider has indemnity or insurance, and if so, whether it is proportionate to the risks involved, and otherwise appropriate.

If the person buying the service asks the CCG to undertake these checks on their behalf, the CCG must do so. Care co-ordinators and care planners should also ensure that people are aware that this is an option, and may wish to offer this as part of the risk assessment and care planning process.

Regardless of who carries out the initial check, the CCG will review this as part of the first review, to ensure the checks have been made and are appropriate.

7.5 Registration and regulated activities

If someone wishes to buy a service which is a regulated activity under the Health and Social Care Act 2008, they will need to inquire as to whether their preferred provider is registered with the Care Quality Commission (CQC). A direct payment cannot be used to purchase a regulated activity from a non-registered service provider.

If a person or related third party employs a care worker directly, without the involvement of an agency or employer, the employee does not need to register with CQC. A related third party means:

(a) an individual with parental responsibility for a child to whom personal care services are to be provided

(b) an individual with power of attorney or other lawful authority to make arrangements on behalf of the person to whom personal care services are to be provided

(c) a group or individuals mentioned in a) and b) making arrangements on behalf of one or more persons to whom personal care services are to be provided

(d) a trust established for the purpose of providing services to meet the health or social care needs of a named individual

This means that individual user trusts, set up to make arrangements for nursing care or personal care on behalf of someone, are exempt from the requirement to register with the CQC.

Also exempt are organisations that only help people find nurses or carers, such as employment agencies (sometimes known as introductory agencies), but who do not have any role in managing or directing the nursing or personal care that a nurse or carer provides.

If someone wishes to use a direct payment to purchase a service which is not a regulated activity, they may do so.

In some circumstances, the provider may also need to be a registered member of a professional body affiliated with the Council for Healthcare Regulatory Excellence. If the Care Plan specifies that a task or tasks require a registered professional to undertake it, only a professional who is thus registered may be employed to perform that task or tasks. See Appendix 8.

In the first instance it will be the responsibility of the person buying the service to check whether the provider they are purchasing from is appropriately registered. They can request the CCG investigate this, and if they ask, the CCG must do so. As with indemnity cover, the CCG must also review this as part of their assessment as to whether the direct payment is being effectively managed.

While some service providers, for example aroma therapists, are not statutorily required to be registered, there are professional associations with voluntary registers that practitioners can choose to join. Typically, such practitioners can only join these associations or registers if they meet the standards of education, training, conduct and performance required by the professional body. However, there is no legal requirement to join these registers, and practitioners can still offer unregulated services without being a member of any organisation. If a provider is not registered with an appropriate body this should not automatically be a bar to purchasing from that provider but this should be included in the discussion around risks when developing the Care Plan.

8.0 Service User Evaluation

It is vital that CCG's have systems and processes in place to review the effectiveness of PHB's to provide assurance that the individual support plans are; clinically safe, effective and meeting individual needs and outcomes. To facilitate evaluation the CCG are utilising the Patient Experience Outcome Tool (POET), which was developed by Lancaster University. POET is designed specifically for PHB budget holders and family carers to provide insight into the experiences of personal health budget holders and their families. POET also aims to shows the impact having control over the budget has on their lives.

All PHB budget holders will be provided with an opportunity and or supported to complete the POET on an annual basis as part of their annual review. The results will be collated and reported to the CCG on an annual basis, as part of ongoing cycle of evaluation. The process of POET will be carried out by the CCG Commissioning Support Unit on behalf of the CCG.

9.0 Equal Opportunities / Equalities Impact Assessment

An Equality Impact Assessment has been completed and approved by the Equality & Inclusion Panel on 4th November 2015 for this policy and procedure and it does not marginalise or discriminate minority groups.

10.0 Review Date

This policy and procedure will be reviewed in April 2016 and will be reviewed and updated at the request of Southport & Formby CCG or earlier in light of any changes to legislation or National Guidance.

11.0 Further Information

The NHS England website has a section dedicated to PHBs. This has information about national policy, the implementation toolkit, stories and other resources.

www.personalhealthbudgets.england.nhs.uk

The Peer Network, a user-led organisation for PHBs, has its own website: www.peoplehub.org.uk

12.0 Appendices

Appendix 1 - Personal Health Budgets Pathway

Appendix 2 - PHB Care Plan

Appendix 3 – Capacity and Consent

Appendix 4 – PHB Checklist

Appendix 5 – Personal Health Budget Agreement (Adult)

Appendix 6 – Personal Health Budget Agreement (Child)

Appendix 7 – Close Family Members

Appendix 8 – Regulatory Bodies

Appendix 9 – Timescales for Appealing Personal Health Budgets Decisions

Appendix 1

Personal Health Budgets Pathway

1.0 Introduction

1.1 This procedure details the steps required from the agreement of a Personal Health Budget (PHB) to promptly expediting the first payment to the relevant organisation/individual.

1.2 Non-compliance with this procedure could cause delays to the commencement date of the PHB funded package of care resulting in dissatisfaction from families and direct payment support services and non NHS support services e.g. Salvere, Your Life Your Way and Solo (or an alternative agreed support service as a wider range or organisations become available).

2.0 Process

2.1 The CCG appropriate panel will approve a PHB for an individual. This will include the financial value of the PHB, specified as an annualised amount.

2.2 From the date of the Panel and the agreement for a PHB, the relevant direct payment support services and third party budget agencies are required to invoice the relevant CCG via SBS. On receipt of an invoice it can take up to 30 calendar days for the invoice to be paid. The invoice must state the correct Broadcare reference number. The value of the invoice should equate to 3 months (i.e. one quarter) of the annualised budget.

2.3 To facilitate this process the CSU are to complete a 'Financial Commitment Form' for all PHBs. The form will include the following details as agreed by the Panel:

- Broadcare reference number
- Type of PHB (notional payment, direct payment or third party budget)
- Type of package (adult, children's, complex mental health etc.)
- Organisation/Individual to whom PHB invoices are to be paid.
- PHB start date (this must be at least 30 days, after the panel date)
- End Date (if applicable)
- Review Date (this must be within 12 weeks if it is a direct payment)
- Annualised value
- Forecast charge in current financial year
- Percentage of PHB to be funded by Local Authority (if applicable)
- Details (including telephone number) of a named CSU contact / DN (named health professional) and locality team contact number
- Space for the form to be signed by a CCG authorised signatory. It is acknowledged that each CCG will have its own Scheme of Delegation and authorisation limits.

2.4 Upon completion the form is to be:

- Retained by the CSU to hold on the individual's file and for entry into Broadcare;
- Sent to the relevant direct payment support service / third party budget agency in order for them to promptly raise an invoice to the CCG;
- Sent to the relevant CCG so they can anticipate and approve the invoice from the third party agency, as well as incorporate the information into financial forecasts. If the invoice is consistent with the amount as specified in paragraph 2.2 then the CCG must not delay approving the payment on SBS. If there is a discrepancy the CCG is to contact the CSU to understand the reasons for this. If the issue is still unresolved then the CSU should query the invoice with the third party agency.

2.5 If the non NHS support service has not received payment by the agreed date then it should escalate the issue to the named contact on the Financial Commitment Form.

Appendix 2

Personal Health Budget Care & Support Plan for Southport and Formby CCG

Tables 1, 2 & 3 to be completed by NHS staff before submitting to the PHB Support Service, Table 3 must be signed by the patient or their representative. The Support Service and Patient complete the remainder of the Tables

Table 1 - To be completed by the NHS Named Health Professional (NHS)

Patients Name	Title	D.O.B (DD/MM/YYYY)
Address		Postcode
Home Telephone	Mobile	E-mail
Named Health Professional Name: Tel: E-mail	Request submitted to the following Support Service:	Indicative Budget amount: Annual £ Weekly £ Number of hours per week:

Table 2 - To be completed by the NHS Named Health Professional (NHS)

Patients Health Needs	Activities / Provisions	How the activities / provisions will meet my health and wellbeing needs
To be completed by the NHS Named Health Professional (NHS)	To be completed by the Support Service & Family	To be completed by the Support Service & Family
Add / delete rows as required		

Table 3 - To be completed by the NHS Named Health Professional (NHS) and patient

Declaration	
Please sign this document to show you give your consent (on the date of signing) that the details within this plan can be shared with the Support Service of your choice	
Signature of Patient	Date
Please provide the name of the chosen Support Service who will support you to develop a plan and a financial budget showing how you intend to meet your health and wellbeing needs	Name of chosen Support Service
If patient/ client is unable to sign, an appropriate adult representative with decision making responsibility OR consent from the patient / client should complete the fields below. This signature confirms that you give your consent to this document being shared with your chosen Support Service	
Name:	Relationship to patient:
Signature	Date

Table 4 - To be completed by the Support Service & Family

Significant People in your life In this section please include family and friends, health professionals, care agencies, carers, colleagues, neighbours and any others who play an important part of your life, even if they are not directly involved in your health care			
Name	Are they registered with CQC (Yes / No or N/A)	Contact Details	Do they help you make decisions?

Table 5 - To be completed by the Support Service & Family

Risk Assessment In this section please include any required risk assessments			
Type of risk assessment	Completed Yes / No / N/A	Proposed Risk Mitigation	Action taken / Agreed by Patient
Equipment (e.g. medical devices, consumables, therapy equipment etc.)			
Moving & Handling			
Environment			
Drug Management including covert medication policy if applicable			
Fire			
Managing Behaviour (Personal Intervention Plan)			
Nutritional (e.g. Malnutrition Universal Screening Tool)			
Pressure Area			
Others (add rows if applicable)			

Table 6 - To be completed by the Support Service & Family

Risks PAs do not need to comply with the legislation that will require them to have indemnity cover, unless they are a member of a regulated health profession, even if carrying out activities which might otherwise be performed by health professionals. The Support Service will need to consider and discuss with the person, their nominee or representative, the potential risks associated with the clinical tasks being carried out by the PAs on a case by case basis. This needs to form part of the risk assessment and care planning process and the outcome recorded in the care plan			
Identified Clinical Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient
Identified Financial Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient
Other Identified Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient

Table 7 - To be completed by the Support Service & Family

Support to Manage Personal Health Budget	How will this be managed and by who
Support for sourcing package of care for either agency or PA's	
Recruitment support - Tax, NI, Pension, Employment Rights / Law, Min Wage etc.	
DBS Checks (formerly CRB) and barred lists have been checked for all staff including nominees, representatives and family members (if applicable)	
Appropriate training and accountability measures including assessment of competencies are in place	
Insurance cover in place (employers and public liability etc.)	
Contracted Health professional(s) are registered with the appropriate body and have appropriate indemnity cover	
Identity, qualifications and professional registration checks for employees and the taking up of references has been explored and an approach to manage this agreed and recorded	
Management of the personal health budget	
Payment to staff i.e. Payroll (dependent on type of budget taken)	
Preparation and submission of financial monitoring information	
If any regulated activities are provided by agencies they must be registered with CQC	

Table 8 - To be completed by the Support Service & Family

Finally, your support plan must demonstrate how you have thought about and addressed any unforeseen or difficult times. To be completed by the Support Service & Family
What happens if something unforeseen happens? Please detail below
Add / delete rows as required

Table 9 - To be completed by the Support Service with the patient

Budget – How the Personal Health Budget will be spent		
Area:	Weekly Cost £	Yearly Total £
Staff: including NI, Pension, holiday pay, holiday cover		
Staff hours for shadow training		
DBS checks		
Redundancy		
Agency Fees		
Respite Costs		
Recruitment & Advertising		
Equipment		
Consumables – PPE; Printing		
Training: including clinical competencies / supervisions		
Transport		
Insurance		
Contingency costs; additional training for the new staff; emergency agency fees		
Support Service Charge		
List others costs as applicable		
Total		

Table 10 - To be completed by the Support Service with the patient

Declaration	
Please sign this document to show you agree (on the date of signing) that the details within this plan meet your Health and Wellbeing needs and that in your opinion you have been sufficiently involved in the putting together of your support plan. That you give your consent for the support planner to share this completed plan with appropriate persons involved in the PHB provision.	
Signature of Patient	**Date**
Name of Organisation Support Planning	
If patient / client is unable to sign, an appropriate adult representative with decision making responsibility OR consent from the patient /client should complete the fields below. That you give your consent for the support planner to share this completed plan with appropriate persons involved in the PHB provision.	
Name	**Relationship to patient**
Signature	**Date**

Appendix 3 **Capacity & Consent**

PHB arrangements can only be made where appropriate consent has been given by:

- a person aged 16 or over who has the capacity to consent to the making of direct payments to them;
- the suitable representative of a person aged 16 or over who lacks capacity to consent themselves to receipt of a PHB by way of a direct payment;
- the suitable representative of a child under 16.

Capacity

Under the MCA, there is a presumption that everyone over the age of 16 has capacity to make decision for themselves, unless they are assessed as lacking capacity.

When assessing a person's capacity to make a decision, the assessor should follow the two stage test set out under the MCA which asks:

1. Does the person have an impairment of the mind or brain, or is there some disturbance in the functioning of their mind or brain?
2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? Are they able to:
    a. A Understand the issues relevant to the decision
    b. Retain the information relevant to the decision
    c. Weight up to the pros and cons of the decision
    d. Communicate their decision having done so

Capacity is time and issue specific. For example, a person may be able to make a decision about who they would like to support them, but not about how to manage a PHB. PHBs should remain an option for all eligible patients regardless of whether they are deemed to have capacity or not.

There are a number of important decision-making points in setting up and managing PHBs. Where a person lacks the capacity to make a particular decision, their views must still be sought to the extent possible.

Wherever possible a person should be supported to be as involved as possible in all aspects of their PHB including the support planning process. To enable a person to understand their options and to help them feel at ease, those supporting them in their decision making need to think about:

- using the person's preferred methods of communication
- a suitable location
- the persons' privacy and dignity
- letting the person make the decision at their own pace

The Best Interests Principle

Under the MCA, anyone making decisions or acting on behalf of someone who lacks capacity has a duty to act in that person's best interests. Therefore, people who lack the capacity to consent to and manage PHBs can still receive one, including by way of a direct payment, if this is believed to be in their best interests (in accordance with the MCA).

Section 4 of the Mental Capacity Act sets out a checklist of factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in any particular situation. This checklist includes a duty to:

- encourage the person to participate or improve their ability to take part in making the decision
- identify all the relevant circumstances
- consider the person's views (past and present)
- avoid discrimination - not simply make assumptions about someone's 'best interests' on the basis of their age, appearance, condition or behaviour
- assess whether the person might regain capacity and whether the decision can wait until that time
- if the decision concerns life-sustaining treatment the decision maker should not be motivated in any way by a desire to bring about the person's death
- consult those close to the patient for their views about the person's 'best interests'
- avoid restricting the person's rights by seeing if there are other options that may be less restrictive of the person's rights
- weigh up all of the above factors in order to determine best interests

This is not an exhaustive list of factors and the decision maker is under a duty to take into account "all relevant circumstances".

Decisions about the treatment and care of a patient who lacks capacity should follow the same best interests framework as outlined above.

Fluctuating Capacity

Where a person who has agreed to a care plan and consented to the making of direct payments to them subsequently loses their capacity to consent, the CCG may, where it is satisfied that the loss of capacity is temporary, allow a representative to be appointed to receive direct payments on their behalf, or an existing nominee to continue to receive them, until they regain capacity. In these circumstances, the role will be similar to that of a representative for someone who has been assessed to lack capacity on an ongoing basis.
Where someone's capacity to consent fluctuates, for example where a person's mental illness is such that it impairs their capacity to make decisions at certain times but not others, it is important that there should be continuity of care, and any disruption should be as minimal as possible. It may be helpful to work with people with fluctuating conditions to draw up advance decisions under the MCA and contingency plans to ensure that their care in a

crisis, better meets their wishes, including the identification of a nominee or representative who may take control of the direct payment at such times.

When a person with fluctuating capacity gains or regains their capacity to consent, their consent is needed to continue the direct payments. If they consent, the representative or nominee must agree to continue their role in respect of the direct payment until a review is held. This is because it is the representative, not the person who has gained or regained capacity who, consented to the arrangements. This allows direct payments to continue until the CCG can arrange a review, which it must do as soon as is reasonably possible. At this review, the CCG and the person receiving care will review and if necessary develop a new care plan. However, if the person who has gained or regained capacity, does not consent to the representative or their nominee continuing in that role until a review is held, or if the representative or nominee does not wish to continue in that role, then direct payments must stop. As in all circumstances when direct payments stop, alternative provision should be made to ensure continuity of care until the required review takes place and new arrangements, which may include direct payments, are put in place.

Appendix 4

PHB Care Plan Sign Off Sheet – Right to Have

To Be Completed by the Direct Payment / Third Party Support Service

Patient Details

About Whom?	Surname: …… First Name(s): …… Broadcare Number: …….. Responsible CCG: ……

Care Plan Checklist

Named Care Coordinator	Named care coordinator is recorded in the care plan	**Yes / No**	**N/A Please add explanatory text**
Review	Anticipated date of the first review (at least within three months of the person receiving a direct healthcare payment)	**DD/MM/YYYY**	
Risk Assessments Completed	Risk assessments included within the care plan and agreed as appropriate	**Yes / No**	**N/A**
Clinical risks recorded	Clinical risks recorded in the care plan including risk mitigation	**Yes / No**	**N/A**
Regulated activities must be carried out by CQC registered providers	Are or will any 'regulated activities' be commissioned from a provider?	**Yes / No**	**N/A**
Care Agencies	Is the provider CQC registered?	**Yes / No**	**N/A**
Meeting Health Needs	Does the Care Plan set out the health needs that the direct healthcare payment is to address?	**Yes / No**	**N/A**
	Is it clear to both CSU/CCG and the people involved what the direct healthcare payments are meant to achieve?	**Yes / No**	**N/A**
	Does the plan specify the services to be secured by the direct healthcare payment in order to achieve the health (and wellbeing) needs?	**Yes / No**	**N/A**
	Is the budget sufficient to meet all of the above?	**Yes / No**	**N/A**
	Are the identified clinical tasks suitable for delegation, specified in	**Yes / No**	**N/A**

	the care plan, with appropriate training, development and assessment of competence in place and sufficient indemnity and insurance cover?		
	Safeguarding has been considered by CSU/CCG?	**Yes / No**	**N/A**
	Is the liberty of the patient being promoted by the care plan? This is especially important where the patient lacks capacity, and or when there are safeguarding issues and /or the patient is in a vulnerable situation.	**Yes / No**	**N/A**
Provision of Information / Advice & Guidance	Has the person, their representative or nominee received information, advice and support from YLYW, SOLO Support Services or Salvere?	**Yes / No**	**N/A**
Are you satisfied that sufficient support has and will be provided to ensure:	The development and agreement from CSU / CCG of an appropriate care plan?	**Yes / No**	**N/A**
	Payroll, Tax and NI are managed effectively	**Yes / No**	**N/A**
	The direct healthcare payment will be managed appropriately?	**Yes / No**	**N/A**
	Monitoring, audit responsibilities and accountabilities are understood and can be adhered to?	**Yes / No**	**N/A**
	The employment of PAs & understanding of employer responsibilities is fully understood and will be adhered to?	**Yes / No**	**N/A**
	Regulated activities, will and are only commissioned from CQC registered providers?	**Yes / No**	**N/A**
	Appropriate insurances are, and remain, in place for the employer?	**Yes / No**	**N/A**
	Appropriate registration is in place?	**Yes / No**	**N/A**
	Appropriate training & development, assessment of competence, sufficient indemnity and insurance cover is, and remains, in place for employed PAs and providers?	**Yes / No**	**N/A**
	The costs for this and ongoing support from YLYW / SOLO Support Services / Salvere are set	**Yes / No**	**N/A**

	out within the care plan?		
	There are sufficient funds to meet the support service costs and meet all of the health needs safely?	**Yes / No**	**N/A**
	Family members, close relatives and people living in the same home as the patient or their partners will not be employed unless agreed by the CSU / CCG? **(If the CCG is considering such a request please complete appendix 1)**	**Yes / No**	**N/A**
Consent & Capacity	Does the patient or Person with Parental responsibility for a child 16 or under - have capacity to consent to a PHB / direct payment	**Yes / No**	**N/A**
	Has the patient / Person with Parental responsibility for a child 16 or under - consented to a PHB / direct payment **(if no Representatives and Nominees section below must be completed - see below)**	**Yes / No**	**N/A**
Representatives and Nominees	Any representative and / or nominee must be agreed by the CCG / CSU. Does the CCG approve the named representative and / or nominee **(When considering such a request please complete appendix 2)**	**Yes / No**	**N/A**
PHB Start Date	The intended commencement date of the PHB:	**DD/MM/YYYY**	

Appendix 1
Employing family members, close relatives and/or people living in the same household as the patient or their partners
If family members, close relatives and/or people living in the same household as the patient or their partners will be employed using a direct healthcare payment the CCG / CSU must record this here. The CCG / CSU will need to confirm that this is necessary in order to satisfactorily meet the person receiving care's need for that service; or to promote the welfare of a child for whom direct healthcare payments are being made. **Name / Relationship** **…….** Has the CCG / CSU agreed to any family members, close relatives, people living in the same household or their partners being employed? **Yes / No / N/A** Please include details below, the name of the person(s), relationship, what has been agreed and the reason for this, including the time period and review timeframe for this decision.

Appendix 2	
Capacity Does the patient have capacity?	**Yes / No**
Consent Has the patient (16+) consented to a PHB and / or direct healthcare payment or Have the child's (under 16) parent(s) / those with parental responsibility consented to a PHB and / or direct health care payment	**Yes / No** **Yes / No**
Has the Patient consented to receiving a PHB / direct healthcare payment and fulfilling all of the responsibilities of someone receiving a PHB / direct healthcare payment?	**Yes / No**

Representatives	**If No is used Representative do not complete**
For patients (16+) unable to consent to a PHB / direct healthcare payment a Representative can be appointed. For children (under 16) a parent or those with parental responsibility for the child must be appointed as a Representative.	
The CCG / CSU must ensure that the Representative has consented to receiving a direct healthcare payment and fulfilling all of the responsibilities of someone receiving direct healthcare payments.	
Name of agreed Representative:	
Has the Representative consented to receiving a direct healthcare payment and fulfilling all of the responsibilities of someone receiving a direct healthcare payment?	**Yes / No**
The CCG / CSU must give consent and consider whether the person is competent and able to manage direct healthcare payments.	
Does the CCG / CSU consent to the Representative? Does the CCG / CSU consider the representative is competent and able to manage direct healthcare payments?	**Yes / No** **Yes / No**
Has the Representative applied for an Enhanced DBS check? Parents or those with Parental responsibility for a child (under 16) do not ordinarily need to apply, neither do family members living in the same household	**Yes / No / N/A**
Has the Representative been checked against the Adults' / Children's Barred List? Parents or those with Parental responsibility for a child (under 16) do not ordinarily need to apply, neither do family members living in the same household	**Yes / No / N/A**
Are the results of both of these checks satisfactory?	**Yes / No / N/A**

Employing Relatives	
Will the Representative be paid or employed in any capacity using the direct healthcare payments?	**Yes / No**

Will / is the Representative paid or employed in any capacity by the PHB support service e.g. YLYW / SOLO Support Services or Salvere?	**Yes / No**
Will any partner, relative, friend or person living in the same household as the patient / their Representative be paid or employed in any capacity using the direct healthcare payment?	**Yes / No**

If the CCG / CSU cannot approve the proposed Representative or wishes to attach conditions to the PHB the reason / conditions must be recorded here:

Nominees	
Is a nominee being requested?	**Yes / No**
If yes please complete the remainder of this section	
A Representative or a person with capacity (16+) can choose a Nominee.	
Has the Nominee consented to receiving a PHB / direct healthcare payment and fulfilling all of the responsibilities of someone receiving a PHB / direct healthcare payment?	
Has the Nominee applied for an Enhanced DBS check?	**Yes / No**
Has the Nominee been checked against the adults'/children's barred list?	**Yes / No**
Are the results both of these checks satisfactory?	**Yes/No /N/A**
Will the Nominee be paid or employed in any capacity using the direct healthcare payments?	**Yes / No**
Will / is the Nominee paid or employed in any capacity by the PHB support service e.g. SOLO Support Services or Salvere?	**Yes / No**
Will any partner, relative, friend or person living in the same household as the patient / their nominee be paid or employed in any capacity using the direct healthcare payment?	**Yes / No**
Does the CCG / CSU consent to the Nominee?	**Yes / No**
Name of agreed Nominee	

If the CCG / CSU cannot approve the proposed Nominee or wishes to attach conditions to the PHB the reason / conditions must be recorded here:

Appendix 5

PERSONAL HEALTH BUDGET AGREEMENT (ADULT)

This document tells you about having a Personal Health Budget

1. Information about You and Community Services
2. Basis of the agreement
3. Responsibilities of your Nominated Representative (if you have one)
4. Responsibilities of your Nominee (if you have one)
5. About your Personal Health Budget
6. General Rules on How to Use the Money
7. Record Keeping and Audit
8. Review, Changed Needs, Contingent and Emergency Arrangements
9. Comments, Complaints and Compliments
10. Ending the Agreement
11. Data Protection and Use of Data
12. Signatures
13. Annex A

1. Information about You and Community Services

This agreement is between:

[Enter name of relevant CCG here] Clinical Commissioning Group

_____

(Referred to in this agreement as 'we' or 'us')

and

Name and address of person receiving the Personal Health Budget

PLEASE PRINT:

First Name(s) _____

Surname _____

Address _____

_____

Post Code _____

(Referred to in this agreement as 'you')

In certain circumstances, including where you are under 16 or are unable to consent to your direct healthcare payment, someone else may legally consent to and manage your direct healthcare payments on your behalf. That person is called a 'representative'. Your representative will sign and agree to the terms of this agreement, and any other obligations on them under the regulations.

Your representative, if applicable and agreed by us is:

Name and address of Representative* or chosen decision maker

PLEASE PRINT:

First Name(s) ___ _____

Surname _____ _____

Relationship to 'you' _____

Address _____

_____

Post Code _____

*Referred to in this agreement as 'Representative' who has been appointed to arrange the services and manage the direct healthcare payment on behalf of the Patient who lacks capacity, and who has been agreed by 'Us'.

And, if applicable you or your representative is entitled to appoint a nominee to take on the contractual responsibilities including arranging the services and support detailed in your support plan, the nominee will also become responsible for how the money is spent. Where we agree to it your nominee will sign and agree to comply with the terms of this agreement and any other obligations on them under the regulations.

Name and address of Nominee

PLEASE PRINT:

First Name _____

Surname _____

Address _____

_____

_____

Post Code _____

(Referred to in this agreement as 'Nominee')

2. Basis of the Agreement

This agreement is made on the basis that:

- An assessment of your health needs has been completed with a health professional and it has been identified that you are eligible to receive health care funding.
- Your care plan will identify the care and / or support that you need to meet your assessed health care outcomes in order to maintain your independence.
- You are willing and able to secure the care / support detailed in your care plan yourself or with support**,** (from a Representative or Nominee) and we agree to make your Personal Health Budget available to you to purchase the support and / or care that you need.

Any payment made under this agreement will be subject to regular audit and monitoring by Salvere, Your Life Your Way or SOLO Support Services and us which may be reviewed by the Personal Health Budget Programme Board.

Further information about Your Life Your Way, SOLO Support Services and Salvere can be found at Appendix A.

3. Responsibilities of Your Nominated Representative (If you have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Representative, that person must be prepared to accept the following responsibilities:

- To involve you in decisions about your support
- To represent your best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Even if you need a Representative you still have the right to be involved whenever possible. There is a duty placed on the Representative to involve you in all relevant decisions where possible.

If the Representative repeatedly fails to make decisions that reflect these key responsibilities, then their role as a Representative would need to be reconsidered.

Representatives are appointed only with the CCGs approval. Representatives can be appointed for individuals who do not have the capacity to consent to a direct healthcare payment or for a child under 16 when Representatives can include the parents of the child or those with parental responsibility for that child.

If you gain or regain capacity your consent is required to continue your direct healthcare payment.

Where an individual in receipt of a direct healthcare payment subsequently loses their capacity to consent, and the CCG is satisfied this is temporary, the CCG may allow a Representative to be appointed to manage the direct healthcare payments or allow a Nominee to continue to manage them until a review can be arranged.

4. Responsibilities of Your Nominee (If you or your Nominated Representative have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Nominee, that person must be prepared to accept the following responsibilities:

- To involve you in decisions about your support
- To represent your best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Nominees must agree to act in the capacity of your Nominee and provide informed consent; the CCG must also consent to that Nominee acting in this capacity, and consider whether the Nominee is competent and able to manage direct healthcare payments with or without assistance.

You or your Representative may choose to elect a Nominee where you / your Representative wish to delegate all of the responsibilities of managing and receiving a direct healthcare payment.

5. About your Personal Health Budget

The amount of money you will receive

Start Date: _____
(Proposed) Breakdown of Payments:
Weekly (if applicable) £_____
One Off Value (if applicable) £ _____

The frequency of your payments will be discussed with you. However, payments are usually made to Solo Support Services / Salvere in advance on a three monthly basis and will be reviewed within the first 12 weeks and then annually, unless your health care needs change.

How you will receive your money

There are three main ways that you can receive your personal health budget:

1. A direct payment with support from Salvere
2. A cash budget held and managed by Your Life Your Way or SOLO Support Services
3. A 'Notional' budget

You will have all the options explained to you before you decide which is the best option for you. When you have decided which way you would like to receive your budget please mark your choice with an 'X' in the box.

A Direct Healthcare Payment

√

A direct healthcare payment is where we pay money to you. The money will be paid into a bank account set up for this purpose by Salvere.

- Your Personal Health Budget will be paid into a bank account, which will be opened by Salvere in your name / your Representative's name / your Nominee's name and managed by you or your nominated representative or nominee.
- You will need to sign this agreement
- You will need to sign an agreement with Salvere, this sets out the services they will provide to you, your Representative / Nominee and the charges they will deduct from your direct healthcare payment for these services. Salvere will advise you about this.
- You, your Representative or Nominee must take advice on becoming an employer from Salvere, as any employment, insurance and tax issues will be the responsibility of the employer. You will be required to adhere to all aspects of employment law.
- You will be required to provide evidence of how you have spent the money for audit purposes. You will need to keep a record of your income and expenditure including receipts, invoices, timesheets, payslips and bank statements. Salvere can help you to manage this

- The bank account will be audited by Salvere and us and therefore it is important that you / Salvere submit all receipts and invoices for related expenditure.

- Salvere may make direct healthcare payments directly to you / your Representative or Nominee however the CCG will need to approve this.

- See Section 6. Employing your own Staff

A √ **'cash budget' (third party arrangement) held and managed by SOLO / Your Life Your Way**

A cash budget is where the Clinical Commissioning Group pays your allocated budget to an organisation called either Your Life Your Way or SOLO Support Services, who hold the money for you and help you decide what you need. After you have agreed this with us, Your Life Your Way or SOLO Support Services will then buy and pay for the care and support you have chosen. Please note – Your Life Your Way or SOLO Support Services will employ your Personal Assistants if you choose to have a cash budget.

- The account is held and managed by Your Life Your Way or SOLO Support Services on your behalf

- Your Life Your Way or SOLO Support Services will buy the care and support you have chosen and take on the employment responsibilities

- You / your Representative / Nominee will need to sign an agreement with Your Life Your Way or SOLO Support Services; this sets out the services they will provide to you and the charges they will deduct from your Personal Health Budget for these services. Your Life Your Way or SOLO Support Services will advise you about this.

- You can request the balance of your bank account during working hours, Monday-Friday

- The bank account will be audited by Your Life Your Way or SOLO Support Services and us and therefore it is important that you / Your Life Your Way or SOLO Support Services submit all receipts and invoices for related expenditure.

√ **A Notional budget**

A Notional Budget enables you to be involved in planning your own care. The Clinical Commissioning Group will pay your service provider directly for any services that you have been assessed as needing. Please note - you cannot employ your own Personal Assistants if you choose to have a notional budget.

- The Clinical Commissioning Group will purchase and arrange the care and support from the provider(s) you have chosen

- The Clinical Commissioning Group will fund the care and support directly

- You will be involved in planning your care and support including developing your care plan

6. General Rules about How to Use the Money

Your Personal Health Budget enables you to buy the care, support or service that is detailed and agreed in your care plan.

The money cannot be spent on illegal services or activities, alcohol, tobacco, gambling or debt repayment.

You cannot use your Personal Health Budget to pay for primary or general medical services, for example GP services, vaccinations, dental charges, or optical appliances and hospital care.

If funds are used in this way the CCG may cease your Personal Health Budget and recover the inappropriately spent monies from you, your Representative / Nominee as appropriate.

Using a Care Agency

If you wish to use a care agency to provide a regulated activity you must purchase care from a provider who is registered with the Care Quality Commission, who regulate the standards of care agencies nationally. There is a list of registered providers available, please see www.cqc.org.uk for more information. Salvere / Your Life Your Way / SOLO Support Services or your named health professional can also advise you about choosing a care agency.

If you choose to purchase a service through a care agency then please be advised that the contract and agreed price is a private arrangement between you, your Representative or Nominee and the care agency. Should the care agency increase its prices in the future above the agreed personal health budget amount, or require you to give a period of notice, we recommend that you request a review of your care plan and budget by contacting your named health professional. It may be more cost effective for the CCG to commission the service directly from your preferred care agency and the CCG will provide you with the option of a notional budget to ensure value for money.

Employing your own staff

You may also use your Personal Health Budget to purchase a service from any willing trained provider. This may include employing a Personal Assistant. If a provider you choose requires training to enable them to carry out their role effectively, training must be undertaken to ensure that you receive a high quality service. Salvere can support you to access training as an employer and for your Personal Assistant(s).

We strongly recommend that a DBS check (Disclosure and Barring Service) is completed as part of the employment process. If you choose to employ your own staff you will have some legal responsibilities as an employer. These include but are not limited to providing:

- A statement of employment particulars including: providing a written contract; highlighting the location of the work; remuneration; period of notice etc. It is a legal requirement to have a written contract of employment between you and your member of staff

- Deducting Tax and National Insurance Contributions

- Adhering to Minimum Wage, Statutory Sick Pay and Maternity Entitlements and Responsibilities, Paternity leave and pay, Annual leave and pay, Adoption, Redundancy, Equal Opportunities, Unions and Health and Safety policies.

- You are legally required to take out Employers and Public Liability Insurance.

You will be responsible for all the employer responsibilities. Guidance can be obtained online at: www.direct.gov.uk: '*Employing a professional carer or personal assistant'* or www.hmrc.gov.uk

We recommend that you consult Salvere, who support people using direct healthcare payments for information and advice about becoming an employer. You cannot ordinarily employ family members or anyone who lives with you or the spouse / partner of a relative / anyone living in the same house as you*.

This will only be agreed if, the CCG is satisfied that to secure a service from that person is necessary to meet your needs or promote the welfare of a child.
This will be detailed here if agreed by us.

The CCG has agreed that the following family members (detailed above*) are employed by you, your Representative / Nominee: N/A Full Name N/A _____ Relationship _____ Reason _____

Representatives and Nominees and their relatives and partners cannot be employed to avoid any conflict of interest.

7. Record Keeping and Audit

You are required to keep basic records.

Your bank account will be audited through Salvere, Your Life Your Life or SOLO Support Services. Salvere, Your Life Your Way and SOLO Support Services are only able to make payments that are agreed in your care plan. The records will be subject to audit arrangements and Salvere, Your Life Your Way and SOLO Support Services will be audited annually (as a minimum).

The balance of the bank account will be reviewed regularly and any money that has not been allocated to your care or support excluding your contingency funds will be returned to the Clinical Commissioning Group (unless a prior agreement has been made with your named health professional).

8. Review, Changed Needs, Contingency and Emergency Arrangements

The arrangements agreed within your care plan will be reviewed within the first 12 weeks and then at least annually. The review will determine if your health needs and your personal outcomes have been met or have changed, and to establish what has worked well or not worked well for you.

The Clinical Commissioning Group will arrange a review earlier or if we become aware that your health needs have changed and/or if your Personal Health Budget is insufficient to secure the services. You or your Representative can also ask for a review.

If your needs have changed during this period of time you may request an earlier review of your needs by contacting your named health professional.

You are required to make contingency arrangements within your care plan, which may include having a contingency fund. In crisis situations the Clinical Commissioning Group may, in the absence of alternative support, step in and help on an interim basis.

Primary care services, including access to your GP and emergency services, such as Accident and Emergency, will always be available to you regardless of having a Personal Health Budget. These services are not included in your budget.

If your needs change or something is not working, you or your Representative or Nominee, must contact your named health professional.

If you go into hospital, you or your Representative must inform us

9. Comments, Complaints and Compliments

You have a right to comment, complain or compliment through the Clinical Commissioning Group's complaints procedure about any action, decision or apparent failing of the Clinical Commissioning Group.

Contact the Customer Care Team:
by telephone: 0151 247 700
by email: Southportandformbyccg.complaints@nhs.net
by post: NHS Southport and Formby CCG
3rd Floor Merton House,
Stanley Road,
Bootle
L20 3DL

10. Ending the Agreement

Either you, your Representative or we may end this agreement by giving one months' notice in writing to the other party.

We may end this agreement with immediate effect if, after investigation, it is found:

- You are using the money illegally
- You are not using it in your own best interests
- Your Nominated Representative is found to be acting in a way that is not in your best interests

Wherever possible, we will work with you and your Representative to find a resolution to the issues before ending the agreement.

At the point of ending the agreement, any funds paid to you by the Clinical Commissioning Group which covers the period after the termination date, must be paid back in full.

Following a review if we decide to reduce the amount of or stop making your direct healthcare payment you, your Representative or Nominee may ask us to reconsider this decision, and can provide evidence or relevant information to inform the reconsideration. We will inform you, your Representative or Nominee in writing of the decision following the reconsideration and state the reasons for the decision.

If this agreement ends for any reason and you continue to have health needs, the funding for your health needs will be provided by the CCG as part of the NHS in the usual way.

11. Data Protection and Use of Data

We may share information that we hold or become aware of with other statutory agencies for the prevention of fraud and abuse.

12. Signatures

This is where all parties are signing up to this agreement. This means that we will all work to what has been agreed in this document.

1st Party:

Us – Signature on behalf of the Clinical Commissioning Group:

Signature: _____
Date: _____

2nd Party:

You – The person receiving the Personal Health Budget

Signature: _____
Date: _____

3rd Party:

Representative – the person receiving and managing the Personal Health Budget on behalf of the above named person
Signature: _____
Date: _____

4th Party:

Nominee – the person receiving and managing the Personal Health Budget on behalf of the above named Representative or person

Signature: _____
Date: _____

13. Annex A
SOLO Support Services and Your Life Your Way

SOLO Support Services and Your Life Your Way are the CCGs approved providers for a personal health budget deployed as a 'cash budget' (third party arrangement). SOLO Support Services and Your Life Your Way are both Care Quality Commission (CQC) registered care agencies.

SOLO Support Services and Your Life Your Way work with families to build care plans and hold your personal health budget for you. SOLO and Your Life Your Way buy and pay for the care and support you have chosen. Please note – SOLO and Your Life Your Way will employ your Personal Assistants if you choose to have a 'cash budget' (third party arrangement). SOLO and Your Life Your Way will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Your Life your Way / SOLO Support Services as part of your care plan.

Salvere

Salvere are the CCGs approved provider for making direct healthcare payments for personal health budgets. Salvere are a Community Interest Company who support and assist families to organise, buy and manage their care, including building your own care plan using a direct healthcare payment.

Salvere will help you to manage all of your responsibilities as an employer and help you to employ personal assistants, arrange payroll, pay HMRC, provide staff handbooks, contracts of employment, risk assessment, help you make decisions about disclosure barring service checks, and ensure appropriate training and competency checks are in place and ensure clinical tasks are delegated safely.

Salvere will hold your Personal Health Budget in a bank account, which will be opened in your name / your Representative's name / your Nominee's name and managed by you or your nominated representative or nominee. Salvere will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Salvere as part of your care plan.

Appendix 6

PERSONAL HEALTH BUDGET AGREEMENT (Children)

This document tells you about having a Personal Health Budget

2. Information about You and Community Services

This agreement is between:

(Enter name of relevant CCG here) Clinical Commissioning Group (Referred to in this agreement as 'we' or 'us')

and

Name and address of the child for who the Personal Health Budget is being made PLEASE PRINT: **First Name(s)** : **Surname:** **Address**   **Post Code** (Referred to in this agreement as 'the child')

In certain circumstances, including for people who are under 16 or people who are unable to consent to a direct healthcare payment, someone else may legally consent to and manage the direct healthcare payments on their behalf. That person is called a 'representative'. The representative will sign and agree to the terms of this agreement, and any other obligations on them under the regulations.

Once the child reaches 16 they will be able to consent to and receive the direct healthcare payment in their own right. The CCG will discuss the options with the child and may discuss the options with a person with parental responsibility at this time.

Your representative, if applicable and agreed by us is:

Name and address of Representative* or chosen decision maker

PLEASE PRINT:

First Name(s) :

Surname:

Relationship to 'the child' : Parent or person with parental responsibility

Address

Post Code

*Referred to in this agreement as 'you' or 'Representative' who has been appointed to arrange the services and manage the direct healthcare payment on behalf of a child for whom they have parental responsibility, and who has been agreed by 'Us'.

A representative is entitled to appoint a nominee to take on the contractual responsibilities including arranging the services and support detailed in the child's support plan, the nominee will also become responsible for how the money is spent. Where we agree to it your nominee will sign and agree to comply with the terms of this agreement and any other obligations on them under the regulations.

Name and address of Nominee

PLEASE PRINT:

First Name Not Applicable

Surname _____

Address _____

_____

_____

Post Code _____

(Referred to in this agreement as 'Nominee')

2. Basis of the Agreement

This agreement is made on the basis that:

- An assessment of your child's health needs has been completed with a health professional and it has been identified that your child is eligible to receive health care funding.

- Your child's care plan will identify the care and / or support that your child needs to meet their assessed health care outcomes in order to maintain your child's' independence.

- You - The parent / person with parental responsibility (Representative) is willing and able to secure the care / support detailed in your child's care plan yourself or with support**,** (from a Nominee) and we agree to make your child's Personal Health Budget available to you as the Representative to purchase the support and / or care that your child needs.

Any payment made under this agreement will be subject to regular audit and monitoring by Salvere or Your Life Your Way / SOLO Support Services and us which may be reviewed by the Personal Health Budget Programme Board.

Further information about Your Life Your Way, SOLO Support Services and Salvere can be found at Appendix A.

3. Responsibilities of the Nominated Representative

As part of the Clinical Commissioning Group agreeing to someone acting as a Representative, that person must be prepared to accept the following responsibilities:

- To involve the child in decisions about their support

- To represent the child's best interests

- To consent to receiving and managing the direct healthcare payment, and

- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Even with a Representative a child still has the right to be involved whenever possible. There is a duty placed on the Representative to involve the child in all relevant decisions where possible.

If the Representative repeatedly fails to make decisions that reflect these key responsibilities, then their role as a Representative would need to be reconsidered.

Representatives are appointed only with the CCGs approval. Representatives can be appointed for individuals who do not have the capacity to consent to a direct healthcare payment or for a child under 16 when Representatives can include the parents of the child or those with parental responsibility for that child.

4. Responsibilities of Your Nominee (If you have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Nominee, that person must be prepared to accept the following responsibilities:

- To involve you and the child in decisions about the child's support
- To represent the child's best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Nominees must agree to act in the capacity of your Nominee and provide informed consent; the CCG must also consent to that Nominee acting in this capacity, and consider whether the Nominee is competent and able to manage direct healthcare payments with or without assistance.

A Representative for the child may choose to elect a Nominee where the Representative wishes to delegate all of the responsibilities of managing and receiving a direct healthcare payment.

5. About your child's Personal Health Budget

The amount of money you will receive

Start Date: xx/xx/xx **(Proposed) Breakdown of Payments:** **Weekly (if applicable) £** **One Off Value (if applicable) £** **NOT APPLICABLE**

The frequency of the payments will be discussed with you. However, payments are usually made to Your Life Your Way / Solo Support Services / Salvere in advance on a three monthly basis and will be reviewed within the first 12 weeks and then annually, unless your health care needs change.

How you will receive the money

There are three main ways that you can receive the personal health budget:

4. A direct payment with support from Salvere
5. A cash budget held and managed by Your Life Your Way / SOLO Support Services
6. A 'Notional' budget

You will have all the options explained to you before you decide which is the best option for you. When you have decided which way you would like to receive the budget please mark your choice with an 'X' in the box.

A √ **Direct Healthcare Payment**

A direct healthcare payment is where we pay money to you. The money will be paid into a bank account set up for this purpose by Salvere.

- The Personal Health Budget will be paid into a bank account, which will be opened by Salvere in your name or the Nominee's name and managed by you or the Nominee.
- You will need to sign this agreement
- You will need to sign an agreement with Salvere, this sets out the services they will provide to you or your Nominee and the charges they will deduct from the direct healthcare payment for these services. Salvere will advise you about this.
- You or your Nominee must take advice on becoming an employer from Salvere, as any employment, insurance and tax issues will be the responsibility of the employer. You or your Nominee will be required to adhere to all aspects of employment law.
- You will be required to provide evidence of how you have spent the money for audit purposes. You will need to keep a record of all income and expenditure including receipts, invoices, timesheets, payslips and bank statements. Salvere can help you to manage this
- The bank account will be audited by Salvere and us and therefore it is important that you / Salvere submit all receipts and invoices for related expenditure.
- Salvere may make direct healthcare payments directly to you or your Nominee however the CCG will need to approve this.
- See Section 6. Employing your own Staff

A √ **'cash budget' (third party arrangement) held and managed by SOLO or Your Life Your Way**

A cash budget is where the Clinical Commissioning Group pays the allocated budget to an organisation called Your Life Your Way, SOLO Support Services, who hold the money for you and help you decide what you and your child need. After you have agreed this with us, Your Life Your Way, SOLO Support Services will then buy and pay for the care and support you have chosen. Please note – Your Life Your Way, SOLO Support Services will employ your Personal Assistants if you choose to have a cash budget.

- The account is held and managed by Your Life Your Life or SOLO Support Services on your behalf
- Your Life Your Way or SOLO Support Services will buy the care and support you have chosen and take on the employment responsibilities
- You or your Nominee will need to sign an agreement with Your Life Your Way / SOLO Support Services; this sets out the services they will provide to you and the charges they will deduct from your Personal Health Budget for these services. Your Life Your Way / SOLO Support Services will advise you about this.

- You can request the balance of your bank account during working hours, Monday-Friday

- The bank account will be audited by Your Life Your Way / SOLO Support Services and us and therefore it is important that you / SOLO Support Services / Your Life Your Way submit all receipts and invoices for related expenditure.

√	**A Notional budget**

A Notional Budget enables you to be involved in planning your child's care. The Clinical Commissioning Group will pay your service provider directly for any services that your child has been assessed as needing. Please note - you cannot employ your own Personal Assistants if you choose to have a notional budget.

- The Clinical Commissioning Group will purchase and arrange the care and support from the provider(s) you have chosen

- The Clinical Commissioning Group will fund the care and support directly

- You will be involved in planning your child's care and support including developing your child's care plan.

6. General Rules about How to Use the Money

The Personal Health Budget enables you to buy the care, support or service that is detailed and agreed in your child's care plan.

The money cannot be spent on illegal services or activities, alcohol, tobacco, gambling or debt repayment.

You cannot use your Personal Health Budget to pay for primary or general medical services, for example GP services, vaccinations, dental charges, or optical appliances and hospital care.

If funds are used in this way the CCG may cease your Personal Health Budget and recover the inappropriately spent monies from you or your Nominee as appropriate.

Using a Care Agency

If you wish to use a care agency to provide a regulated activity you must purchase care from a provider who is registered with the Care Quality Commission, who regulate the standards of care agencies nationally. There is a list of registered providers available, please see www.cqc.org.uk for more information. Salvere / SOLO Support Services / Your Life Your Way or your child's named health professional can also advise you about choosing a care agency.

If you choose to purchase a service through a care agency then please be advised that the contract and agreed price is a private arrangement between you or your Nominee and the care agency. Should the care agency increase its prices in the future above the agreed personal health budget amount, or require you to give a period of notice, we recommend that you request a review of your child's care plan and budget by contacting your child's named health professional. It may be more cost effective for the CCG to commission the service

directly from your preferred care agency and the CCG will provide you with the option of a notional budget to ensure value for money.

Employing your own staff

You may also use your Personal Health Budget to purchase a service from any willing trained provider. This may include employing a Personal Assistant. If a provider you choose requires training to enable them to carry out their role effectively, training must be undertaken to ensure that your child receives a high quality service. Salvere can support you to access training as an employer and for your child's Personal Assistant(s).

We strongly recommend that a DBS check (Disclosure and Barring Service) is completed as part of the employment process. If you choose to employ your own staff you will have some legal responsibilities as an employer. These include but are not limited to providing:

- A statement of employment particulars including: providing a written contract; highlighting the location of the work; remuneration; period of notice etc. It is a legal requirement to have a written contract of employment between you and your member of staff

- Deducting Tax and National Insurance Contributions

- Adhering to Minimum Wage, Statutory Sick Pay and Maternity Entitlements and Responsibilities, Paternity leave and pay, Annual leave and pay, Adoption, Redundancy, Equal Opportunities, Unions and Health and Safety policies.

- You are legally required to take out Employers and Public Liability Insurance.

You will be responsible for all the employer responsibilities. Guidance can be obtained online at: www.direct.gov.uk: '*Employing a professional carer or personal assistant'* or www.hmrc.gov.uk

We recommend that you consult Salvere, who support people using direct healthcare payments for information and advice about becoming an employer. You cannot ordinarily employ family members or anyone who lives with you or the spouse / partner of a relative / anyone living in the same house as you*.

This will only be agreed if, the CCG is satisfied that to secure a service from that person is necessary to meet the child's needs or promote the welfare of the child.
This will be detailed here if agreed by us.

The CCG has agreed that the following family members (detailed above*) are employed by you or your Nominee: Full Name: _____Not Applicable_____ Relationship _____ Reason _____

Representatives and Nominees and their relatives and partners cannot be employed to avoid any conflict of interest.

7. Record Keeping and Audit

You are required to keep basic records.

Your bank account will be audited through Salvere, Your Life Your Way or SOLO Support Services. Salvere, Your Life Your Way and SOLO Support Services are only able to make payments that are agreed in your child's care plan. The records will be subject to audit arrangements and Salvere, Your Life Your Way and SOLO Support Services will be audited annually (as a minimum).

The balance of the bank account will be reviewed regularly and any money that has not been allocated to your child's care or support excluding your contingency funds will be returned to the Clinical Commissioning Group (unless a prior agreement has been made with your named health professional).

8. Review, Changed Needs, Contingency and Emergency Arrangements

The arrangements agreed within your child's care plan will be reviewed within the first 12 weeks and then at least annually. The review will determine if your child's health needs and personal outcomes have been met or have changed, and to establish what has worked well or not worked well for you and your child.

The Clinical Commissioning Group will arrange a review earlier if we become aware that your child's health needs have changed and/or if the Personal Health Budget is insufficient to secure the services. You can also ask for a review if your child's needs have changed during this period of time - you may request an earlier review of your child's needs by contacting your child's named health professional.

You are required to make contingency arrangements within your child's care plan, which may include having a contingency fund. In crisis situations the Clinical Commissioning Group may, in the absence of alternative support, step in and help on an interim basis.

Primary care services, including access to your child's GP and emergency services, such as Accident and Emergency, will always be available to your child regardless of having a Personal Health Budget. These services are not included in your budget.

If your child's needs change or something is not working, you or your Nominee, must contact your child's named health professional. If your child goes into hospital, you must inform us so that we can consider whether an adjustment to the personal health budget is needed for services which are not provided while your child is in hospital.

9. Comments, Complaints and Compliments

You have a right to comment, complain or compliment through the Clinical Commissioning Group's complaints procedure about any action, decision or apparent failing of the Clinical Commissioning Group.

Contact the Customer Care Team:
by telephone: 0151 247 700
by email: southport and formbyccg.complaints@nhs.net
by post: NHS Southport and Formby CCG, 3rd Floor Merton House, Stanley Road, Bootle, L20 3DL

10. Ending the Agreement

Either you or we may end this agreement by giving one months' notice in writing to the other party.

We may end this agreement with immediate effect if, after investigation, it is found:

- You are using the money illegally or for any purpose which is not permitted in this Agreement or in the child's care plan
- You are not using the money in your child's best interests or as agreed with us
- You are found to be acting in a way that is not in the child's best interests

Wherever possible, we will work with you to find a resolution to the issues before ending the agreement.

At the point of ending the agreement, any funds paid to you by the Clinical Commissioning Group which covers the period after the termination date, must be paid back in full.

Following a review if we decide to reduce the amount of or stop making the direct healthcare payment you or your Nominee may ask us to reconsider this decision, and you may provide evidence or relevant information to inform the reconsideration. We will inform you or your Nominee in writing of the decision following the reconsideration and state the reasons for the decision.

If this agreement ends for any reason and your child continues to have health needs, the funding for your health needs will be provided by the CCG as part of the NHS in the usual way.

11. Data Protection and Use of Data

We may share information that we hold or become aware of with other statutory agencies for the prevention of fraud and abuse.

12. Signatures

This is where all parties are signing up to this agreement. This means that we will all work to what has been agreed in this document.

1st Party:

Us – Signature on behalf of the Clinical Commissioning Group:

Signature: _____
Date: _____

2nd Party:

You / The Representative– The person receiving the Personal Health Budget on behalf of a child for who you have parental responsibility

Signature: _____
Date: _____

3rd Party:

Nominee – the person receiving and managing the Personal Health Budget on behalf of the above named Representative

Signature: _Not Applicable_____
Date: _____

13. Annex A
SOLO Support Services & Your Life Your Way

SOLO Support Services & Your Life Your Way are the CCGs approved provider for a personal health budget deployed as a 'cash budget' (third party arrangement). SOLO Support Services & Your Life Your Way are Care Quality Commission (CQC) registered care agencies.

SOLO Support Services & Your Life Your Way work with families to build care plans and hold your personal health budget for you. SOLO & Your Life Your Way buy and pay for the care and support you have chosen. Please note – SOLO & Your Life Your Way will employ your Personal Assistants if you choose to have a 'cash budget' (third party arrangement). SOLO & Your Life Your Way will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and SOLO Support Services & Your Life Your Way as part of your care plan.

Salvere

Salvere are the CCGs approved provider for making direct healthcare payments for personal health budgets. Salvere are a Community Interest Company who support and assist families to organise, buy and manage their care, including building your child's own care plan using a direct healthcare payment.

Salvere will help you to manage all of your responsibilities as an employer and help you to employ personal assistants, arrange payroll, pay HMRC, provide staff handbooks, contracts of employment, risk assessment, help you make decisions about disclosure barring service checks, and ensure appropriate training and competency checks are in place and ensure clinical tasks are delegated safely.

Salvere will hold your Personal Health Budget in a bank account, which will be opened in your name / your child's name / your Nominee's name and managed by you or your nominee. Salvere will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Salvere as part of your child's care plan.

Appendix 7

Close Family Members

Who is a close family member?

A person's close family members are described in the regulations as:

a. the spouse or civil partner of the person receiving care
b. someone who lives with the person as if their spouse or civil partner
c. their parent or parent-in-law
d. their son or daughter
e. son- in- law or daughter- in- law
f. stepson or stepdaughter
g. brother or sister
h. aunt or uncle
i. grandparent, or
j. the spouse or civil partners of (c)- (i), or someone who lives with them as if their spouse or civil partner.

Appendix 8

Regulatory Bodies

Which are the statutory regulatory bodies?

- The General Chiropractic Council (GCC) regulates chiropractors.
- The General Dental Council (GDC) regulates dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists.
- The General Medical Council (GMC) regulates doctors.
- The General Optical Council (GOC) regulates optometrists, dispensing opticians, student opticians and dispensing opticians, specialist practitioners and optical businesses.
- The General Osteopathic Council (GOsC) regulates osteopaths.
- The Health and Care Professions Council (HCPC) regulates the members of 15 health professions: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, speech and language therapists, and social workers in England.
- The Nursing and Midwifery Council (NMC) regulates nurses and midwives.
- The Royal Pharmaceutical Society of Great Britain (RPSGB) regulates pharmacists, pharmacy technicians and pharmacy premises in Great Britain in England, Wales and Scotland.

Appendix 9

Timescales for Appealing Personal Health Budgets Decisions

1.0 Timescales:

1.1 The appeal must be made within 4 weeks of receiving the CCG's response to the PHB request. Appeals can be made by email, letter, by phone, either direct to the CCG, or via the CSU.

1.2 On receipt of an appeal, the CCG will respond within 10 working days confirming that a meeting will be convened.

1.3 The meeting should take place within 25 working days of the appeal being received.

1.4 The response of the panel will be confirmed to the service user in a letter within 28 working days of acknowledgement the original request meeting. The reasons for the decision will be set out in the decision letter, (together with an information leaflet on the NHS Complaints Procedure if the patient or their representative is not satisfied with the decision).

1.5 In the event of any timescales being exceeded, it is the responsibility of the CCG to keep the patient or their representative informed of reasons and progress.

1.6 Once the review is complete the CCG will inform the patient or their representative of its decision in writing, setting out the reasons for its decision within 28 working days of acknowledgement of the original request. If a patient or their representative is not satisfied that can pursue the matter via the local NHS complaints process.

1.7 If the internal process cannot resolve the concerns of the individual and/or their representative then the appellant can use the NHS Complaints Procedure.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/46	**Author of the Paper:** Debbie Fagan Chief Nurse Email: debbie.fagan@southportandformbyccg.nhs.uk Tel: 0151 247 7252
Report date: March 2016	

Title: CCG Safeguarding Peer Review Action Plan (v9i)

Summary/Key Issues:

This paper presents the Governing Body with the updated CCG Safeguarding Peer Review Action Plan (v9i). Positive progress has been made against the recommendations. The action plan was last reviewed by the Quality Committee in February 2016 who recommended presentation to the Governing Body for closure due to the CCG Scheme of Delegation and Reservation.

Recommendation
The Governing Body are asked to receive the report / action plan and to support the recommendation from the Quality Committee to approve formal closure of the action plan.

Receive	
Approve	X
Ratify	

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

16/47

Process	Yes	No	N/A	Comments/Detail *(X those that apply)*
Patient and Public Engagement			X	
Clinical Engagement	X			Via the CCG Safeguarding Service, Named GP for Safeguarding Children and Quality Committee
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)*	
	Preventing people from dying prematurely.
	Enhancing quality of life for people with long-term conditions.
	Helping people to recover from episodes of ill health or following injury.
	Ensuring that people have a positive experience of care.
X	Treating and caring for people in a safe environment and protecting them from avoidable harm.

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
March 2016

1. Executive Summary

This paper presents the Governing Body with the updated CCG Safeguarding Peer Review Action Plan (v9i). Positive progress has been made against the recommendations. The action plan was last reviewed by the Quality Committee in February 2016 who recommended presentation to the Governing Body for closure due to the CCG Scheme of Delegation and Reservation.

2. Progress

2.1 The CCG commissioned a Safeguarding Peer Review the outcome of which has previously been presented to the Governing Body and then to the Local Safeguarding Children Board and the Safeguarding Adult Board.

2.2 The resulting action plan has subsequently been presented to the Quality Committee who have been reviewing progress. In January 2016, Halton CCG confirmed arrangements for supervision for the CCG safeguarding service (hosted service arrangements for the Merseyside CCGs).

2.3 The completed action plan was presented to the Quality Committee in February 2016. The Quality Committee recommendation presentation to the Governing Body for formal closure due to the assurance mechanisms being in place as outlined in section 3. Formal closure sits with the Governing Body due to the CCG Scheme of Delegation and Reservation.

3. Future Assurance

The following is in place regarding future assurance:

- CCG Safeguarding Network Steering Group – via MoU and KPIs for the service;
- MIAA – safeguarding review as part of workplan;
- LSCB – Section 11 audit;
- NHSE – CCG Safeguarding Assurance Tool.

4. Recommendations

The Governing Body are asked to receive the report / action plan and to support the recommendation from the Quality Committee to approve formal closure of the action plan.

Appendices

Appendix 1 – CCG Safeguarding Peer Review Action Plan v.9i

Debbie Fagan
March 2016

16/47

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

Peer Reviews of Safeguarding Adults, Safeguarding Children and Looked After Children

Recommendations & Action Plan

Ref	Review Theme	Recommendation	Lead	Initial Timing /	Initial Comments	Initial RAG	Progress update	Updated RAG
1								
1	**The voice of the child young person and vulnerable adult**	Securing the voice of the child young person and vulnerable adult to inform safeguarding arrangements within Sefton CCGs needs accelerated progress and must be managed as a priority area for the CCGs. Further work is required to ensure that outcome measures and quality of experience are included within the safeguarding adults performance reporting.	Hosted Service	~~Plan required by Sept 14~~ Plan required by Oct 14 **High priority**	Recommendation from both child and adult reviews	**A**	30.07.14 Update from Safeguarding Service: KPI within provider contract but further work required to strengthen this element of work further. 13.08.14 Update from Chief Nurse: Paper presented to EPEG meeting on 13.08.14. Outcome to be reported to the Quality Committee. 13.08.14 Update from Chief Nurse: Chief Nurse requested Programme Manager Quality & Safety to co-ordinate action plan /	~~A~~ ↑ ~~A~~ ↑ ~~A~~ ↑ ~~A~~ ↑ **B**

							collate evidence of the methods by which the CCG secures the voice of the child, young person and vulnerable adult. 03.10.14 Update from Chief Nurse. Capturing the voice of C&YP has been an agenda item for discussion within provider Quality Contract Meetings. 03.10.14 Update from Chief Nurse. Outcome of agenda item for discussion at EPEG reported to September 2014 Quality Committee. Quality Committee have charged EPEG with having oversight of workplan / action plan. 03.10.14 Update from Chief Nurse. Raised C&YP voice at Corporate Parenting Board. Meeting arranged between CCG and LA on 14	

							October 2014 to discuss how this can be strengthened for Looked After Children. 09.12.14 Chief Nurse Update: Meeting undertaken between Corporate Parent Board Lead, Safeguarding Service and Programme Manager Quality & Safety to discuss strengthening links. Programme Manager working with CSU to further develop this area of work. Raised at appropriate provider Contract Meeting. 05.03.15 Chief Nurse Update: Meeting scheduled w/c 17.03.15 for CCG, CSU and Safeguarding Service to meet to complete gap analysis work. Amendments to the Complaints policy to ensure C&YP easily understand how they can complain are	

							being completed and will come to the Quality Committee for the purposes of approval once reviewed by the Corporate Governance Support Group 08.08.15 Chief Nurse Update: Confirmation from EPEG received of developments in this area and that this will be on-going work. Updates to be received by the Quality Committee as part of the work plan. **ACTION COMPLETE as this work is to be mainstreamed into the work of EPEG as requested by the Quality Committee.**	
2								
2.1	**Vision, strategy, leadership & capacity to improve**	A Safeguarding Strategy (2014-16) must be developed. The strategy would be endorsed by SS&SF CCGs Governing Bodies and monitored via the	Hosted Service	~~1st Draft strategy required by Sept 14~~ 1st Draft strategy	Recommendation from both child and adult reviews	**R**	30.07.14 Update from Safeguarding Service: Initial draft developed by the team for the Merseyside footprint and circulated within Safeguarding Service.	~~A~~ ↑ **A** → ~~A~~ ↑ ~~A~~ ↑

		governance structure. It is recommended that the strategy as described above is developed in collaboration with all Merseyside CCGs.		required by Nov 14 **High priority**			To be shared with CCGs once the whole team has had opportunity to input. 11.08.14 Update from Safeguarding Steering Group: Line manager for Safeguarding Service confirmed status as per 30.07.14. 03.10.14 Update from Chief Nurse. E-mail sent to Halton CCG Chief Nurse on 30.09.14 requesting update on Safeguarding Strategy. Discussion with Safeguarding Service on 01.10.14 - draft Safeguarding Strategy not yet been shared with CCGs as undergoing further work within the team. 09.12.14 Chief Nurse Update: Safeguarding Strategy produced by Safeguarding Service. To be presented to December 2014 meeting of CCGs'	**G**

							Quality Committee for approval to the Governing Bodies in January 2015 05.03.15 Chief Nurse Update: Safeguarding Strategy furthered updated by the Safeguarding Service to incorporate the Care Act. Presented to both CCG Quality Committees in February 2015 – recommended for approval by the Governing Bodies at the March 2015 meeting. Once approved this action will be completed. 03.08.15 Chief Nurse Update: Safeguarding Strategy approved by the Governing Body. CCG Business Manager addressing approval and version control information following MIAA review. **ACTION COMPLETE**	

Ref	Review Theme	Recommendation	Lead	Timing / Priority	Comments	Initial RAG	Progress update	Updated RAG
2.2	**Vision, strategy, leadership and capacity to improve**	The Hosted Service Specification and integral Service Standards/Measurements/Quality Assurance framework to be reviewed in 2014 to ensure that the specification encapsulates the aims and objectives within the newly developed safeguarding strategy.	CCG Chief Nurses	~~Reviewed and revised document required by Oct 14~~ Reviewed and revised document required by Nov 14 **High priority**	Recommendation from both child and adult reviews	**R**	11.08.14 Update from Safeguarding Steering Group: Cross reference to 2.1. Safeguarding assurance framework document discussed that had previously been developed. NHSE(M) supporting the development of KPIs for the Safeguarding Service as part of how the CCGs hold the service to account in terms of performance. To be reviewed on a Quarterly basis at the Steering Group. 03.10.14 Update from Chief Nurse. Awaiting draft Safeguarding Strategy to support progression. E-mail sent to Halton CCG on 10.09.14 and 30.09.14 to request confirmation of	~~A~~↑ **A→** ~~A~~↑ **G**

							meeting date for the Chief Nurses to progress work before next meeting of the Steering Group – awaiting confirmation. 09.12.14 Chief Nurse Update: Safeguarding Service Specification drafted by Halton CCG. Comments fed back by Chief Nurse to Halton CCG Chief Nurse by November 2014 deadline. Assurance framework / Service Standards being amended accordingly by Halton CCG. Ready for sign-off in December 2014 with update to the CCG Network. 05.03.15 Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Final version of the service specification and MoU reviewed and agreed. **ACTION COMPLETE**	
2.3	**Vision, strategy,**	Strengthen the connections	Chief Nurse	~~Describe~~	Recommendation from	**R**	30.07.14 Update from	~~A~~↑

	leadership and capacity to improve	between adult safeguarding and domestic abuse by identifying some of the organisational developments which can support best practice in this area. Ensure that the strategic approach for safeguarding commissioning reflects the recently revised definition of domestic abuse to include so called 'honour based violence, female genital mutilation and forced marriage.	and Hosted Service	~~strategic direction for this within safeguarding strategy and business plan by Sept 14~~ Describe strategic direction for this within safeguarding strategy and business plan by Nov 14 **High priority**	adults review		Safeguarding Service: Elements of this work is addressed in the draft Safeguarding Strategy that is awaiting circulation to the CCG (cross reference to 2.1). Recently revised definition of domestic violence has been incorporated in the revised Safeguarding Policy which was presented to the Quality Committee in July 2014 with recommendations for approval to the Governing Body. Approved at Governing Body in July 2014. 13.08.14 Chief Nurse Update: Need to share Safeguarding Strategy with CCG Chef Strategy and Outcomes Officer once strategy has been shared with CCG to ensure alignment with CCG Strategic Plan and	**A→** **~~A↑~~** **~~G~~**

							priorities. 03.10.14 Chief Nurse Update No further progress to report. 09.12.14 Chief Nurse Update: Safeguarding Strategy produced by Safeguarding Service. To be presented to December 2014 meeting of CCGs' Quality Committee for approval to the Governing Bodies in January 2015. Meeting held between CCG Chief Nurse, Chief Strategy and Outcomes Officer and CCG Safeguarding Service to ensure explicit links between LSCB/SAB/YOT/Safe guarding Strategy are evident in CCG priorities and commissioning intentions. 06.03.15 Chief Nurse Update: Safeguarding Service have met with CCG Chief Planning &	

							Outcomes Officer to ensure safeguarding priorities are aligned within the CCG plans. Safeguarding Strategy developed, presented to the Quality Committees who have recommended approval by the Governing Bodies in March 2015. Relevant KPIs are included in provider contracts. **ACTION COMPLETE**	
2.4	**Vision, strategy, leadership and capacity to improve**	In conjunction with NHS England Area Team and the Hosted Service, SS&SF CCGs must make accelerated progress to ensure that MCA / BIA and DoLs principles are embedded within the Health Provider organisations including General Practice.	NHSEM & Chief Nurse	~~Plan required by Sept 14~~ Plan required by Nov 14	Recommendation from adults review	**R**	11.08.14 Update from Safeguarding Steering Group: Discussed at meeting. NHSE(M) discussed central funding that was received in 2013/14 which was distributed to Local Authorities. Reduced funding available for 2014/15 – awaiting confirmation centrally. 13.08.14 Update from Chief Nurse: MCA paper presented to CCG Quality	~~A↑~~ **A↑** **A↑** ~~A→~~ **B**

							Committee by the Safeguarding Service in June 2014. Quality Committee recommendation that MCA/BIA/DoLS be considered as part of CCG PLT and Governing Body Development session – Chief Nurse has liaised with CCG Chief Corporate Delivery & Integration Officer to make plans for PLT and Governing Body session. 03.10.14 Chief Nurse Update. MCA/DoLS training confirmed for joint CCG Governing Body development session in November 2014. Request for MCA/DoLS update as part of PLT forwarded to Practice Nurse Facilitators for action at the PLT Meeting Group. MCA/DoLS KPI in provider contract in 2014/15 09.12.14 Chief Nurse	

							Update: Governing Body Development session undertaken in November 2014 re: DoLs/MCA/ Court of Protection. PLT event in planning stage. Safeguarding Service to confirm relevant KPIs in provider contracts for 2015/16 – plans in place for development with support of CSU. 05.03.15 Chief Nurse Update: Relevant KPIs within provider contracts. MCA / DoLs / BIA being discussed as part of PLT planning – for further discussion once Named GP is in post. 08.09.15 Chief Nurse Update: Coroner's circular disseminated to General Practice informing GPs of legal requirements around MCA & Care Homes. Dedicated post in Safeguarding Service to support MCA &	

							DoLS – this postholder will be of support to the Named GP. CCG PLT leads to liaise with Safeguarding Service re: MCA & DoLs training and consider best practice training from across the Merseyside footprint in order to ensure it meets needs. **ACTION COMPLETE as this work is to be mainstreamed into the work of PLT. NHSE as contract holders to lead on any contractual requirements that may be required within primary care and General Practice.**	

Ref	Review Theme	Recommendation	Lead	Timing / Priority	Comments	Initial RAG	Progress update	Updated RAG
2.5	**Vision, strategy, leadership and capacity to improve**	SS&SF CCGs and NHS England should develop a programme to deliver the work that will be required under Care and Support Act;	Chief Nurse and NHSEM Leads	Plan required by Nov 14	Recommendation from adults review	**R**	13.08.14 Update from Chief Nurse: Action plan shared with NHSE(M). Implications of the	~~**R**~~↑ **R**→ ~~**A**~~↑

		identify a lead person responsible for coordinating and driving delivery of this and model the likely costs and other impacts of the Act.					Care and Support Act and impact this will have discussed at the Safeguarding Steering Group meeting held on 11.08.14. Plan still requires development. 03.10.14 Chief Nurse Update. No further progress to report. Requires further liaison with NHSE(M) 09.12.14 Chief Nurse Update: Halton CCG developing costings to be presented to CCGs to enhance hosted service to provide necessary support regarding Care Act. Awaiting receipt. 05.03.15 Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. HR consultation commenced on the adult element of the structure to ensure the service can support the requirements of the	**A↑** **G**

							CCGs in relation to the Care Act 03.08.15 Chief Nurse Update: CCG Safeguarding Service review completed. Re-design completed of Adult element of the team with HR input – posts. Shared CCG post recruited to for a Programme Manager Vulnerable People (12 month fixed term) which will also support the CCGs in service development taking account the requirements of the Care Act. **ACTION COMPLETE**	
3								
3.1	**Governance, accountability and risk management**	Ensure that annual reports are in development for this reporting year (2013-2014) having agreed the data set and safeguarding activity 'Dashboard' so that safeguarding activity across Sefton CCGs can be easily demonstrated.	Hosted Service	Data set agreed. ~~Draft report required by July 14~~ Draft report required by November 14	Recommendation from both child and adult reviews	**A**	30.07.14 Update from Safeguarding Service: 2013/14 annual report in draft and in process of being circulated to area leads by end of July 2014 for further population. On CCG Quality Committee workplan to be	~~**A**~~↑ **A**→ **G**

				Medium priority			presented in September 2014/October2014 meeting according to internal/external meeting schedule. Dashboard to be developed. 03.10.14 Chief Nurse Update. Annual Report scheduled to be presented to Quality Committee in October 2014. Safeguarding Service report this is in draft and requested this be deferred until November 2014. Request granted and deferred until November 2014 Quality Committee 09.12.14 Chief Nurse Update: Annual Report approved by the CCGs' Governing Body in November 2014. **ACTION COMPLETE**	
3.2	**Governance, accountability and risk**	Mersey CCG Chief / Lead Nurses to work collaboratively to agree 1	CCG Chief Nurses	Complete by July 14 Complete by	Recommendation from both child and adult reviews. Safeguarding	**A**	13.08.14 Update from Chief Nurse: Progress to be informed by the	~~A~~→ **A**→

	management	reporting framework for safeguarding. This reporting template will be informed by the safeguarding strategy.		Nov 14 **Medium priority**	Governance Group has been formed		Safeguarding Strategy (cross reference to 2.1). To continue with current reporting template until Strategy is completed 03.10.14 Chief Nurse Update. No further progress to report. 09.12.14 Chief Nurse Update: Safeguarding Service Specification drafted by Halton CCG. Comments fed back by Chief Nurse to Halton CCG Chief Nurse by November 2014 deadline. Assurance framework / Service Standards being amended accordingly by Halton CCG. Ready for sign-off in December 2014 with update to the CCG Network. 05.03.15 Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Final version of the service specification and MoU	~~A~~† **G**

							reviewed and agreed. **ACTION COMPLETE**	
3.3	**Governance, accountability and risk management**	Further develop the competency level of primary care practitioners in safeguarding adults area & with a detailed focus on embedding the principles of the MCA / BIA and Deprivation of Liberties Safeguards: link with 2.4	NHSEM & Chief Nurse	~~Plan required by Sept 14~~ Plan required by Nov 14	Recommendation from adults review	**A**	13.08.14 Update from Chief Nurse: Cross reference to 2.4. CCGs discussing a possible model that reflects GP Clinical Lead / Named GP for Safeguarding Children but for Vulnerable Adults. 03.10.14 Chief Nurse Update. Cross reference to 2.4 09.12.14 Chief Nurse Update. Cross reference to 2.4 05.03.15 Chief Nurse Update: Relevant KPIs within provider contracts. MCA / DoLs / BIA being discussed as part of PLT planning – for further discussion once Named GP is in post. 08.09.15 Chief Nurse Update: Coroner's circular disseminated to General Practice	~~A~~↑ ~~A~~↑ ~~A~~↑ ~~A~~→ **B**

							informing GPs of legal requirements around MCA & Care Homes. Dedicated post in Safeguarding Service to support MCA & DoLS – this postholder will be of support to the Named GP. CCG PLT leads to liaise with Safeguarding Service re: MCA & DoLS training and consider best practice training from across the Merseyside footprint in order to ensure it meets needs. **ACTION COMPLETE as this work is to be mainstreamed into the work of PLT. NHSE as contract holders to lead on any contractual requirements that may be required within primary care and General Practice.**	

APPENDIX 1

Ref	Review Theme	Recommendation	Lead	Timing / Priority	Comments	Initial RAG	Progress update	Updated RAG
4								
4.1	**Quality improvement, learning/ workforce development**	Further develop the role of safeguarding GP leads in Sefton. This would include the development of Common Assessment Framework within primary care.	NHSE (Mersey) Safeguarding Leads	Progress report required in Sept 14 Progress report required in Nov 14 **High priority**	Plan is in place. Recommendation from SLAC review	**A**	13.08.14 Update from Chief Nurse: Progress report to be received from current Named GP Safeguarding Children in time for September 2014 03.10.14 Chief Nurse Update. Update awaited from Named GP 09.12.14 Training has been undertaken by the Named GP and a presentation regarding the Early Help offer by LA colleagues. To be further progressed when CCG GP Clinical Lead for Safeguarding comes into post 05.03.15 Chief Nurse Update: To be further progressed once Named GP Safeguarding appointed.	~~A→~~ **A→** **A↑** ~~A→~~ ~~A↑~~ **G**

							05.08.15 Chief Nurse Update: Discussion with new Named GP Safeguarding Children – will discuss with previous postholder in order to inform next steps and continue work already commenced. Named GP Safeguarding Children has list of all GP Safeguarding Leads in each practice and will be making contact as part of on-going workplan **ACTION COMPLETE**	
4.2	**Quality improvement, learning/ workforce development**	A model of safeguarding supervision to be developed and secured for Designated Nurses and Deputy Designated Nurses within the Hosted Safeguarding Service.	Chief Nurse Halton	~~Implementation to be set for Sept 14~~ Implementation to be set for Nov 14 **High priority**	Recommendation from both child and adult reviews	**R**	13.08.14 Update from Halton CCG Chief Nurse (line manager of the Safeguarding Service): NHS Halton CCG is currently reviewing a number of options for provision of supervision for the service. A decision on the supervision model and implementation of the model is expected to commence in November 2014 as	~~**A**~~↑ **A**→ ~~**A**~~↑ ~~**G**~~ ~~**A**~~ **G**

							provider capacity to implement needs to be measured and be assured before agreement. 03.10.14 Chief Nurse Update. No further progress to report until November 2014 09.12.14 Chief Nurse Update: Informed by Safeguarding Service that procurement completed and awaiting contract sign-off. Will be notified when complete. 05.03.15 Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Supervision has been commissioned for the Safeguarding Service from 5 Borough Partnership. ~~**ACTION COMPLETE**~~ 08.08.15 Chief Nurse Update: Discussion with CCG Safeguarding Service.	

							Commissioned model of supervision has stalled. Further work being undertaken by the Safeguarding Service with the support from Halton CCG (host CCG) to secure commissioned model until national model becomes apparent. 09.02.16 Chief Nurse Update: Confirmation received from host CCG that supervision has been commissioned for the service. **ACTION COMPLETE**	
4.3	**Quality improvement, learning/ workforce development**	A model of safeguarding supervision to be developed and secured for the Sefton / Liverpool Named GP.	Chief Nurse / Designated Doctors	~~Implementation to be set for Sept 14~~ Implementation to be set for Nov 14 **High priority**	Recommendation from SLAC review	**R**	30.07.14 Update from Safeguarding Service: Initial meeting took place on 24.06.14 – agreed development of supervision strategy to include Named GP arrangements. 03.10.14 Chief Nurse Update. No further progress to report.	~~**A**~~↑ **A**→ **A**→ ~~**A**~~→ **G**

							09.12.14 Chief Nurse Update: To be progressed once CCGs' GP Clinical Lead Safeguarding in post – to liaise with other CCGs regarding arrangements they have in place. 05.03.15 Chief Nurse Update: Safeguarding supervision / peer supervision is in place for existing Named GPs. Once the Named GP for safeguarding is in place for Sefton – individual supervision requirements will be discussed in order to ensure it meets the needs of the new appointee. 03.08.15 Chief Nurse Update: 1:1 with Named GP on 08.07.15 – Supervision discussed. Confirmed C&M Peer Group is in place and good support is available at present. Would prefer	

							to review supervision requirements once in post for longer. Regular 1:1s scheduled between Named GP and Chief Nurse. **ACTION COMPLETE**	
4.4	**Quality improvement, learning/ workforce development**	Audit of supervision to be factored into the safeguarding audit plan of the hosted service for 2014-15 (this relates to an audit of safeguarding supervision commissioned / provided for the safeguarding service to gain assurance re: effectiveness)	Hosted Service	~~Implementation to be set for Sept 14 as part of supervision model~~ Implementation to be set for Nov 14 as part of supervision model	Recommendation from both child and adult reviews	**R**	13.08.14 Update from Chief Nurse: Cross reference to 4.2 due to interdependency 03.10.14 Chief Nurse Update. No further progress to report until November 2014 09.12.14 Chief Nurse Update: Cross reference to 4.2. Will show pace in achievement once supervision is in place. 05.03.15 Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Supervision has been commissioned for the Safeguarding Service from 5 Borough	~~**R**~~→ **R**→ **R**→ **G**

							Partnership – audit is built into this process. **ACTION COMPLETE**	
5								
5.1	**Efficient/effective use of safeguarding resources**	Agree the employment status and support mechanisms for the Named GP with strong links to Designated Doctors and CCG GP Chairs for clinical support.	Chief Nurse	~~Agreement to be reached by July 14~~ Agreement to be reached by Oct 14 **High priority**	Discussions with NHSEM and Liverpool CCG in place. Recommendation from SLAC review	**A**	13.08.14 Update from Chief Nurse: Meeting taken place in July 2014 with LCH Medical Director, Named GP and Chief Nurses for LCCG and SS/SFCCG to discuss future model. SSCCG/SFCCG in the process of serving notice to Liverpool Community Health in order for this function to sit within the CCG. CCGs will need to recruit to this post but interim arrangements discussed with LCCG should these be required (services would be secured from LCCG where the current Named GP will transfer into) 03.10.14 Chief Nurse Update. Liverpool Community Health have served notice to	~~A~~↑ ~~A~~↑ ~~A~~↑ ~~A~~↑ **G**

							CCGs. Meeting taken place between CCGs' C&YP GP Clinical Leads to discuss post. Draft JD developed. For sign-off at SMT in October 2014 re: model and JD. Arrangements in place with LCCG re: SLA for Named GP cover in Liverpool to provide the function in Sefton should the CCG face challenges in recruiting. 09.12.14 Chief Nurse Update: Job description agreed. Awaiting financial envelope from within provider contract and then recruitment to commence 05.03.15 Chief Nurse Update: Named GP role advertised with closing date of 03.03.15. Interview date set for 24.03.15 03.08.15 Chief Nurse Update: Recruitment complete and Named	

							GP now in post. Links established with Designated Doctor for Safeguarding Children. Arrangements established with GP Chairs for any clinical support that may be required. **ACTION COMPLETE**	

Ref	Review Theme	Recommendation	Lead	Timing / Priority	Comments	Initial RAG	Progress update	Updated RAG
5.2	**Efficient/effective use of safeguarding resources**	Service Level Agreement for the Named GP function to be brought up to date in line with the decision making process described above.	Chief Nurse	July 14 **Medium priority**	As above Recommendation from SLAC review	A	13.08.14 Update from Chief Nurse: Cross reference to 5.1 03.10.14 Chief Nurse Update. CCG have served notice on this function by Liverpool Community Health. Agreement reached that this function will now be undertaken within the CCG. **ACTION COMPLETE**	~~A~~↑ ~~G~~
5.3	**Efficient/effective use of safeguarding resources**	Provide the assurance that the Designated Nurse LAC role and function is being delivered and must agree the source of the function. Provide assurance that the monitoring and performance management systems are in place for this and that activity data is being captured.	CCG Chief Nurses	~~July 14~~ Nov 14 **High priority**	Recommendation from SLAC review	R	11.08.14 Update from Safeguarding Steering Group: Cross reference to 5.4. Activity data re: Looked After Children is currently captured via the service that is commissioned via Liverpool Community Health / information made available to the Local Authority 13.08.14 Update from	~~R~~↑ ~~R~~→ ~~A~~↑ ~~A~~↑ G

							Chief Nurse: CCG Chief Nurse and Deputy Designated Nurse Safeguarding Children are now in attendance at the Sefton Corporate Parenting Board 03.10.14 Chief Nurse Update. No further progress to report. Update following next Steering Group meeting and production of Safeguarding Strategy. 09.12.14 Chief Nurse Update: Safeguarding Service Specification drafted by Halton CCG includes Looked After Children. Comments fed back by Chief Nurse to Halton CCG Chief Nurse by November 2014 deadline. Assurance framework / Service Standards being amended accordingly by Halton CCG. Ready for sign-off in December 2014	

							with update to the CCG Network. 05.03.15 Chief Nurse Update: Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Halton CCG have started the recruitment process for the post of Designated Nurse Looked After Children. 03.08.15 Chief Nurse Update: Designated Nurse Looked After Children now in post within the CCG Safeguarding Hosted Service. Post holder establishing links with local providers. Revised Looked After Children KPIs have been developed and feature in relevant provider contracts for 2015/16. **ACTION COMPLETE**	
5.4	**Efficient/effective use of safeguarding**	Consider a detailed re-view of the hosted safeguarding team roles, responsibilities,	CCG Accountable Officers &	To commence when	Recommendation from both child and adult	**R**	11.08.14 Update from Safeguarding Steering Group: Chief Nurses	~~A~~

	resources	skill mix options. Agree and align lead areas to the portfolio of the Hosted Service members. This would include allocation of the role and function of Designated Nurse LAC. *Deputy* Designated Nurse title should be re-considered in light of the fact that *Designated* is a *statutory* title and role.	Chief Nurses	safeguarding strategy and associated business plan has been agreed	reviews		to meet to discuss and report back to SSCCG/SFCCG Chief Officer in September 2014 as current Chair of the Steering Group 03.10.14 Chief Nurse Update. E-mail sent to Halton CCG on 10.09.14 and 30.09.14 to request confirmation of meeting date for the Chief Nurses to progress work before next meeting of the Steering Group – awaiting confirmation. Safeguarding Service informed Chief Nurse on 01.10.14 that the team were in formal consultation phase with Halton CCG re: re-design of the service 09.12.14 Chief Nurse Update: Review undertaken and consultation commenced on new structure. Recruitment has been undertaken to the	**A↑** **~~A↕~~** **~~A↕~~** **G**

							Safeguarding children element of the service. Safeguarding adults element not yet completed. 05.03.15 Chief Nurse Update: Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Review completed for Children's element of the service and re-structure completed following HR consultation. Now Head of Service role at 8c and Designated Nurse role at 8b – role of Deputy Designated Nurse no longer exists within the structure. HR consultation commenced on the adult element of the structure. Once HR process for adults has ended this action will be complete. 03.08.15 Chief Nurse Update: CCG Safeguarding Hosted Service review now	

							completed for both adult and child elements of the service. Recruitment process completed by Halton CCG. Designated Nurse Looked After Children also in post within Hosted Service. **ACTION COMPLETE**	

Ref	Review Theme	Recommendation	Lead	Timing / Priority	Comments	Initial RAG	Progress update	Updated RAG
5.5	**Efficient/effective use of safeguarding resources**	The Hosted Service Specification and integral Service Standards / Measurements/Quality Assurance framework to be reviewed early in 2014 to accurately reflect the statutory Looked After Children Designated Nurse arrangements	Chief Nurses	~~To be complete in July 14~~ To be complete in Nov 14	Recommendation from both child and adult reviews	**R**	13.08.14 Update from Chief Nurse: Cross reference to 2.2; 5.3; 5.4 03.10.14 Chief Nurse Update. Cross reference to 2.2; 5.3; 5.4 09.12.14 Chief Nurse Update. Cross reference to 2.2; 5.3; 5.4 05.03.15 Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Final version of the service specification and MoU reviewed and agreed. **ACTION COMPLETE**	~~**A↑**~~ **A→** ~~**A↑**~~ ~~**G**~~
5.6	**Efficient/effective use of safeguarding resources**	Sefton and Liverpool CCGs Chief Nurses to have a discussion with LCH Executive Nurse (acting) regarding any **relevant** outcome of the LCH safeguarding service review to support a collaborative	Chief Nurses	~~To be complete by June 14~~ To be complete by Dec 14	Recommendation from adults review	**R**	13.08.14 Update from Chief Nurse: Chief Nurse has requested site of LCH internal review at Contract Meeting and followed up by e-mail to LCH Interim DoN and	~~**A↑**~~ **A↑** ~~**A→**~~ ~~**A→**~~ **G**

		approach to the future of effective and efficient use of adult safeguarding resource.					Deputy DoN 03.10.14 Chief Nurse Update. LCH Safeguarding Review (1) recommendations have been shared with the CCGs. Interim Executive Team have commissioned a follow-up review to assess progress made regarding recommendations which they will share with the CCGs once completed. 09.12.14 Chief Nurse Update: Chief Nurse contacted LCH to see if recommendations from their second review is available for sharing. 05.03.15 Chief Nurse Update: Still being awaited – update requested by Chief Nurse 05.03.15 03.08.15 Chief Nurse Update: Action now superseded. CCG have served notice on	

							LCH. Discussion taken place with Local Authority regarding local commissioning arrangements for safeguarding adults. Community Service Specifications in the process of being developed – these will include any safeguarding adult service response that may be required from a locally commissioned provider. **ACTION COMPLETE**	

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/48	**Author of the Paper:** Carmel Farmer Designated Nurse Looked After Children Tel: 0151 495 5469
Report date: March 2016	
Title: CCG Looked After Children Strategy	

Summary/Key Issues:

This paper presents the Governing Body with the recommended strategy that the CCG needs to adopt and approve with regard to Looked After Children. It has been developed in accordance with the current legislation and guidance published 2015. Once approved the CCG Safeguarding Service will develop a workplan / action plan to support delivery which will be monitored via the Quality Committee.

Recommendation
The Quality committee are asked to approve the CCG Looked After Children Strategy.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(X those that apply)*	
	To place clinical leadership at the heart of localities to drive transformational change.
x	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	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.

16/48

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

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

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
March 2016

1. Executive Summary

1.1 This report provides the committee with the Looked After Children Strategy. This will support the CCG to demonstrate safe discharge / duty of care to this vulnerable client group.

1.2 The strategy has been developed in accordance with current legislation and guidance published in 2015.

1.3 Once approved the Work Plan will be further developed and updates provided in accordance with current CCG Governance arrangements.

1.4 The Governing Body is asked to approve this strategy.

2. Introduction and Background

2.1 Looked After Children Strategy

The Looked After Children Strategy (Appendix 1) has been developed, the purpose of which is to understand and plan for the current and future needs of our Looked After Children and Care Leavers to help them achieve positive outcomes.

The strategy development has utilised the commissioning principles and processes in the Joint Commissioning Strategy and Framework for South Sefton Children and Young People 2014-2017, Sefton Local Children in Care Pledge and national priorities and included a scoping exercise to develop a Children Looked After baseline assessment for Sefton.

The Strategy has been developed in accordance with the current guidance and conforms with:

- Working Together to Safeguard Children (2015)
- Children Acts (1989, 2004)
- Human Rights Act (1998)
- Promoting the health and well-being of looked-after children (2015)
- Halton Joint Strategic Needs Assessment (2014)
- Looked-after children and young people. Public health guidance 28. NICE (2013)
- Quality standard for the health and wellbeing of looked-after children and young people. Quality standards QS31 NICE (2013)
- Outcomes Framework 2014/15: Domain 4: Ensuring people have a positive experience of care, Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. NHS England (2014)
- Public Health Outcomes Framework 2013/16: Domain 1 Improving the wider determinants of health, Domain 2 health improvements. Public Health England (2013)

2.2 Following submission to the Quality Committee, the CCG Chief Nurse met with the Director of Children's Services and the opportunity was extended to provide any comments on the Strategy before being submitted to the Governing Body.

2.3 The CCG Chief Nurse and CCG Chief Strategy and Outcomes Officer have plans in place to ensure that the CCG can plan for the deliverables outlined in the strategy as appropriate.

3. Key Issues

3.1 This report provides the Governing Body with the Looked After Children Strategy. This will support the CCG to demonstrate safe discharge / duty of care to this vulnerable client group.

3.2 The purpose of this commissioning strategy is to understand and plan for the current and future needs of our Looked After Children and Care Leavers to help them achieve positive outcomes.

3.3 As statutory bodies, CCGs have a responsibility for improvements in the quality of primary medical services, safeguarding and looked after children's services across the local economy.

3.4 As statutory bodies CCGs need to be assured that all children and young people in care have access to appropriate health care services, which will promote health and enable them to make positive life choices.

4. Conclusions

4.1 The strategy will be delivered through development and implementation of a work-plan / action plan and working alongside existing partnerships for both children and adult safeguarding. This will be monitored and reviewed through the CCG Quality Committee.

4.2 A timescale will be agreed against each priority, and a responsible lead identified through the safeguarding work-plan. The work plan will develop and emerge over time to include additional activity as required through any review processes or changes to either local or national guidance or requirements.

5. Recommendations

The Governing Body are asked to:

- Approve the CCG Looked After Children Strategy;
- Delegate responsibility for overseeing the delivery of the workplan / action plan to the Quality Committee with any concerns against delivery being escalated to the Governing Body.

Appendices

Appendix 1 - Looked After Children Strategy

Carmel Farmer
Designated Nurse Looked After Children
March 2016

NHS South Sefton Clinical Commissioning Group

LOOKED AFTER CHILDREN STRATEGY

2015- 2017

South Sefton Clinical Commissioning Group

Looked After Children Strategy

Carmel Farmer, Designated Nurse Looked After Children, January 2016

Index

South Sefton Clinical Commissioning Group

Looked After Children Strategy

1. Introduction

1.1 The term Looked After Children has a specific legal meaning based on the Children Act (1989). A child is looked after by a local authority if he or she has been provided with accommodation for a continuous period of more than 24 hours, in the circumstances set out in sections 20 and 21 of the Children Act 1989, or is placed in the care of a local authority by virtue of an order made under part IV of the Act.

1.2 The majority of children who are looked after by the local authority are placed with foster carers, as it has been demonstrated, that for most children, it is best to live within a family environment. For some children where this is not the case, residential care may be more appropriate.

1.3 Local authorities have a duty under the Children Act to safeguard and promote the welfare of children of the children they look after. The NHS has a major role in ensuring that health services are delivered in a timely and effective manner to all looked after children to support local authorities with their duty.

1.4 Most children become looked after as a result of abuse or neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half of the children in care have diagnosable mental health disorder and two-thirds have special educational needs. Delays in identifying and meeting their emotional well-being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy, healthy lives as adults.

1.5 The purpose of this commissioning strategy is to understand and plan for the current and future needs of our Looked After Children and Care Leavers to help them achieve positive outcomes.

1.6 The strategy development has utilised the commissioning principles and processes in the Joint Commissioning Strategy and Framework for South Sefton Children and Young People 2014-2017, Sefton Local Children in Care Pledge and national priorities.

1.7 NHS South Sefton CCG will ensure:

- Effective partnership working is central to service planning, commissioning and delivery to enhance the child's health and well-being. They will work with the Corporate Parenting Board (CPB) and Sefton Safeguarding Children's Board (LSCB), statutory agencies and its provider organisations to ensure effective multi-agency arrangements are embedded into practice;
- Services are commission based on the needs of looked after children in Sefton that exhibits quality of care of effective, efficient care;
- Individuals are empowered to choose services on the basis of quality and outcomes. This involves providing clear information to the public about the quality of services which are commissioned on their behalf, including information about poor quality, unexplained variation and differential health outcomes;
- Continuous improvement and compliance in quality and safety outcomes for commissioned services is evident and will be demonstrated through the use of specific contractual arrangements and metrics with provider organisations. This will include having in place:
  - Key Performance Indicators (KPI);
  - Commissioning for Quality and Innovation (CQUIN) targets;
  - Quality schedules;

- Systems to embed learning from incidents and complaints;
- Comprehensive single and multiagency Safeguarding and Looked After Children's policies and procedures and Looked After Children training strategy and framework, which is in line with Intercollegiate document (2015).

1.8 In addition the CCG will support specific Francis recommendations relating to improving safety for vulnerable groups to develop an on-going culture of quality across the health economy including assurance in relation to the legal requirements for Duty of Candour.

1.9 This strategy should be read in conjunction with the CCG Safeguarding Policy, Safeguarding / Looked After Children Training Strategy and other relevant policies.

2. Background

2.1 Although, it is defined that local authorities have a duty to safeguard and promote the welfare of children, and of the children they look after (Children Act 1989), the NHS has a major role in supporting local authorities to fulfil this duty.

2.2 The Mandate to NHS England, Statutory Guidance on Joint Strategy Needs Assessments, Joint Health and Wellbeing Strategies and NHS Constitution for England defines NHS responsibilities. In fulfilling these responsibilities the NHS contributes to meeting the health needs for looked after children in three ways:

- commissioning effective services;
- delivering through provider organisations;
- individual practitioners providing coordinated care for each child.

2.3 For children and young people, the key pieces of legislation are the Children Act (1989 and 2004). Section 10 of the 2004 Act creates a statutory framework for local co-operation between local authorities, partner agencies and other bodies including the voluntary and community sector in order to improve the wellbeing of children in a local area.

2.4 Statutory guidance such as 'Making arrangements to promote the welfare of children under section 11 of the Children Act 2004' (2007) reinforces and describes the duties of health services. Working Together to Safeguard Children (2015) and Promoting the health and wellbeing of looked after children (2015) recognise the changing commissioning arrangements within the health service and clarifies the role of the CCGs.

3. Responsibilities

3.1 The overall accountability for Looked After Children within South Sefton CCG rests with the Accountable Officer (AO). The Chief Nurse (CN) is responsible for senior clinical leadership and advocates for vulnerable groups across the CCG health economy.

3.2 The AO and CN are responsible for ensuring that robust constitution and governance arrangements are in place and maintained. This includes succession planning, to ensure the delivery of all safeguarding duties and objectives.

3.3 As statutory bodies, CCGs have a responsibility for improvements in the quality of primary medical services, safeguarding and looked after children's services across the local economy.

3.4 NHS England and the CCG will work closely with the local authorities, Corporate Parenting Board, Children in Care Scrutiny Panel and Sefton Safeguarding Children Boards to ensure there are effective NHS arrangements for looked after children across the health communities. At the same time, ensuring absolute clarity about the underlining statutory responsibilities that each commissioner has for the services that they commission, together with a clear leadership role for NHS England.

3.5 Role of designated professionals

The designated doctor and nurse role is to:

- Provide advice to the service planning and commissioning organisation and to the local authority, on questions of planning, strategy, commissioning and the audit of quality standards including ensuring appropriate performance indicators are in place in relation to health services for looked after children;
- Work with all healthcare organisations to monitor performance of local health services for looked after children and young people;
- Ensure expert health advice on looked after children is available to children's social care, healthcare organisations, residential children's homes, foster carers, school nurses, clinicians undertaking health assessments and other health staff;
- Advise colleagues in health and children's social care on issues of medical confidentiality, consent and information sharing;
- Work with health service planners and commissioners to ensure there are robust arrangements to meet the health needs of looked after children placed outside the local area and ensure there are robust arrangements to meet the health needs of looked after children placed outside the local area and ensure close working relationships with Local Authorities to achieve placement decisions which match the needs of children;
- Work with local service planners and commissioners to advocate on behalf of and ensure looked after children benefit as appropriate from the implementation of wider health policies such as in England - any qualified provider, personal health budgets;
- Work with commissioners and providers to gain the best outcome for the child/ young person within available resources, including involvement in fostering and adoption panels according to local arrangements.

4. Strategy

4.1 South Sefton CCG's Vision:
"To create a sustainable healthy community based on health needs, with partners; focused on delivering high quality and integrated care services to all, to improve the health and wellbeing of our population."

4.2 The CCG will need to commission services that promote and protect individual human rights, independence and well-being and secure assurance that the child or adult thought to be at risk, stays safe. They will also need to ensure that children and young people are effectively safeguarded against abuse, neglect, discrimination, are treated with dignity and respect, and enjoy a high quality of life.

4.3 Principles:

- Strive for excellence;
- Embed a focus on early intervention and prevention into the routine delivery of all services to children, young people and families to;
- Safeguard and protect vulnerable children within a framework of universal services to improve the well-being of every child;
- Narrow the gap in outcomes between the most vulnerable children and their peers;
- Consult, listen to and hear the voices of children, young people and families and provide them with opportunities to participate in decision making;
- Use evidence on outcomes for children as the basis for improving standards and targeting resources;
- Commission the right services in the right place at the right time for all children, young people and families;
- Promote interaction between children and families from different backgrounds; and deliver excellent, integrated working across services through investing in a skilled, well trained and valued children's workforce.

4.4 We know we will have achieved our vision when:

- All children and young people in care have access to appropriate health care services, which will promote health and enable them to make positive life choices;
- Communication between Local Authority and NHS organisations is outstanding;
- Children new into care will receive a comprehensive Initial Health Assessment in a timely manner to inform the first multi-agency meeting;
- The number of children and young people attending annual health and dental checks will increase;
- Screening and referral for emotional health services is integral to the routine health assessments;
- The quality of health assessments will be outstanding;
- Referral for specialist services, once identified, are actioned promptly;
- Health outcomes for looked after children will improve, as health needs are identified and addressed;
- Young people leaving care will feel prepared and supported. They will have access to their health history and be in receipt of information how to access universal (and specialist, as appropriate) health services;
- Looked after children have their voices heard and we maximise their rights to choice and control.

4.5. Strategic objectives:

The key strategic objectives are to:

- Provide senior and board-level leadership;
- Senior leadership responsibility and lines of accountability for the CCG safeguarding/looked after children arrangements are clearly outlined to employees and members of the CCG as well as to external partners;
- Contribute to the work of the Corporate Parenting Board and LSCB to ensure that the boards meet their statutory responsibilities. This would include engagement with specific work streams, such as, Child Sexual Exploitation (CSE) and Emotional Health;
- Support designated individuals to contribute to the work of the corporate parenting board and LSCB subgroups and other national and local safeguarding implementation networks;
- The CCG will ensure that its designated clinical experts are integral to decision making within the CCG and have the authority to work across local health economies, to influence and shape the culture and practice within provider services;
- The designated professionals will work with neighbouring and national CCGs to ensure that looked after children receive seamless care regardless of their geographical placement.

Ensure looked after children's arrangements are in place:

- Integrate looked after children within other CCG functions, such as quality and safety, patient experience, healthcare acquired infections, management of serious incidents;
- Secure the expertise of designated professionals. This includes the expertise of a designated doctor for looked after children;
- Ensure key priorities such as Child Sexual Exploitation and emotional health needs are delivered effectively locally;
- The CCG, through its designated professionals, will ensure that local and national learning for looked after children is disseminated and actioned;
- Notification systems between local authority and the CCG are developed to enable coordination of care for children placed out of area;

- To support children and young people with special educational needs or disabilities.

Commission safe services:

- Ensure that all safeguarding elements and needs for looked after children are incorporated in all existing provider contracts and Service Level Agreements;
- Service developments take into account the need of all looked after children, and are informed, where appropriate, by the views of this group of children and by a Quality Impact Assessment;
- Strengthen contractual arrangements for looked after children in 'out of area' provision;
- Local mechanisms are in place to establish the responsible commissioner to resolve any funding issues;
- Ensure that there are effective arrangements for sharing information with partners for the protection of children;
- Monitoring systems for looked after children's training for all NHS providers are undertaken by the designated professionals;
- Seek assurance that commissioned providers are meeting their statutory safeguarding responsibilities, and in particular that staff are following approved local, national and NICE guidance;
- Ensure that robust systems are in place to facilitate transition from children's to adult services.

5. Deliver the strategy

5.1 The strategy will be delivered through development and implementation of a work-plan and working alongside existing partnerships for both children and adult safeguarding. This will be monitored and reviewed through the CCG Quality Committee.

5.2 A timescale will be agreed against each priority, and a responsible lead identified through the safeguarding work-plan. The work plan will develop and emerge over time to include additional activity as required through any review processes or changes to either local or national guidance or requirements.

6. Monitor Assurance

6.1. Service specifications and contract quality schedules will include clear service standards and KPIs (key performance indicators) for safeguarding Children and promoting their welfare, consistent with the LSCB procedures and regular reporting on KPI compliance will be made to the CCG. The KPIs will be agreed with the provider as part of contractual negotiations and will include training level requirements, safer recruitment, supervision of staff, voice of the child, early recognition, Looked After Children and CSE action plans.

6.2 Service specifications and service level agreements will be reviewed annually via completion of the safeguarding audit tool to ensure safeguarding and quality elements of care are monitored effectively and consistently within provider contracts.

6.3 Where appropriate quality assurance visits to commissioned services and independent providers will be undertaken and the collation of quality and patient safety data and 'soft' intelligence will facilitate the identification, monitoring and analysis of safeguarding concerns in relation to vulnerable groups.

6.4 An annual Looked After Children's Report will be provided to CCG Governing Body, Corporate Parenting Board and the Local Safeguarding Children Board.

6.5 In line with national guidance for monitoring Quality and recognition of early warnings of service failure NHS South Sefton CCG will ensure the provision of safeguarding assurance for its providers through the NHS England local Quality Surveillance Group.

6.6 NHS South Sefton CCG will take an active role through the CN and Designated professionals in the local safeguarding assurance process with NHS England.

6.7 In addition to promoting on-going quality improvement, as commissioners, we need to be assured that existing services meet acceptable standards. Whilst regulators play a key role here, commissioners must still actively monitor the quality of services delivered by our providers. Where we are not assured about the quality of any of the services we commission, detect early warnings of a potential decline in quality or suspect a breach of unacceptable standards we have a responsibility to intervene.

6.8 NHS South Sefton Clinical Commissioning Group (CCG) and Sefton Children's Trust strongly believes that commissioning services effectively is a vital step in achieving the best outcomes for children, young people and their families.

6.9 By working together, the partnership can achieve the right level of integration to secure better outcomes, high quality sustainable services and a resulting reduction in the gap in health inequalities, educational attainment, skills and well-being.

References

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NICE (2013) Quality standard for the health and wellbeing of looked-after children and young people. NICE quality standards [QS31]. April 2013: https://www.nice.org.uk/guidance/qs31

NHS England (2014) Outcomes Framework 2014/15: Domain 4: Ensuring people have a positive experience of care, Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

Public Health England (2013) Public Health Outcomes Framework 2013/16: Domain 1 Improving the wider determinants of health, Domain 2 health improvements: http://www.phoutcomes.info/

NHS
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MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/49	**Author of the Paper:** Name: Kevin Thorne Job Title: Integrated Commissioning Manager Email: kevin.thorne@southseftonccg.nhs.uk Tel: 0151 247 7278
Report date: March 2016	

Title: Developing Dementia-Friendly Communities and the Sefton Dementia Action Alliance

Summary/Key Issues:

Sefton has one of the highest percentages of adults with dementia in the UK and figures produced by Oxford Brookes University predict there are considerably more people affected by dementia than are registered with GPs. Current estimates suggest there are 4,446 people aged over 65 affected by dementia, more than double the number registered with GPs. As well as the 4,446 dementia sufferers over the age of 65 in Sefton in 2015 it is estimated that there are 77 people who are affected by Early Onset Dementia.

People with dementia and their carers face many challenges going about their daily lives including whilst shopping, using public transport, socialising and remaining involved in their community. The development of dementia friendly communities will mean that people with dementia and their carers will have support from local communities, will not suffer any stigma as a result of their condition and will be able to live as normal a life as possible for as long as they can.

NHS South Sefton CCG can contribute to this growing social movement by signing up to the Sefton Dementia Action Alliance and making a commitment to becoming a dementia friendly organisation. In doing so NHS South Sefton must commit to an action plan detailing what it will do as an organisation to contribute to this growing social movement to support people with dementia and their carers.

Recommendation

The Governing Body is asked to approve this report.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
	To place clinical leadership at the heart of localities to drive transformational change.
X	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	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.
	To achieve financial duties and commission high quality care.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	X			
Clinical Engagement	X			
Equality Impact Assessment			X	
Legal Advice Sought			X	
Resource Implications Considered	X			Staff time
Locality Engagement	X			
Presented to other Committees	X			Local authority is supporting dementia friendly initiatives.

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

Report to Governing Body
March 2016

1. Executive Summary

Sefton has one of the highest percentages of adults with dementia in the UK and figures produced by Oxford Brookes University predict there are considerably more people affected by dementia than are registered with GPs. Current estimates suggest there are 4,446 people aged over 65 affected by dementia, more than double the number registered with GPs. As well as the 4,446 dementia sufferers over the age of 65 in Sefton in 2015 it is estimated that there are 77 people who are affected by Early Onset Dementia.

People with dementia and their carers face many challenges going about their daily lives including whilst shopping, using public transport, socialising and remaining involved in their community. The development of dementia friendly communities will mean that people with dementia and their carers will have support from local communities, will not suffer any stigma as a result of their condition and will be able to live as normal a life as possible for as long as they can.

NHS South Sefton CCG can contribute to this growing social movement by signing up to the Sefton Dementia Action Alliance and making a commitment to becoming a dementia friendly organisation. In doing so NHS South Sefton must commit to an action plan detailing what it will do as an organisation to contribute to this growing social movement to support people with dementia and their carers.

2. Introduction and Background

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

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

It is estimated that there are around 4,500 in Sefton living with some form of dementia. Positive, proactive approaches to service development providing individualised support can help ensure that physical and mental health are sustained as long as possible, that people live at home for as long as possible and that crises and unnecessary use of intensive costly services are minimised.

The recently published Sefton Dementia Strategy is an extremely important step in facing the challenges of a rising population of people who will have some form of dementia.
Dementia presents a huge challenge to society, both now and increasingly in the future. It is a common condition, which has a significant impact both on carers and society with an increasing cost attached to caring for people within the community.

Providing access to high quality services is appropriate to enable people to remain at home, for as long as possible, however for people trying to live well with dementia requires more than access to statutory services.

3. Key Issues

People with dementia and their carers face many challenges going about their daily lives. This can include difficulty using technology, getting appropriate service in shops, banks and post offices and in using transport, going on holiday, maintaining social contact and hobbies. Although help from health and care services is vitally important, making it possible for people affected by dementia to live well will require help from people and organisations across society and local communities.

Sefton already has pockets of good practice where shops, businesses and organisations came together to form local alliances that committed resources, raised awareness, trained staff and made some simple changes to improve the experiences of people with dementia and their carers using their services.

The Sefton Dementia Action Alliance was formally established at a recent meeting on the 20th January 2016 which brought together interested stakeholders from across Sefton to begin to identify the key changes required to make Sefton a friendlier place.

4. Conclusions

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

One of the key ways in which this can be done is through supporting the development of local dementia action alliances across England.

NHS South Sefton CCG has a leadership role across North Sefton and is in a prime position to demonstrate its support for Sefton Dementia Action Alliance by formally joining the initiative and complete an Action Plan setting out what it can do to make a difference to people living with dementia.

5. Recommendations

1. That NHS South Sefton CCG staff and member practices become dementia-friendly by undertaking appropriate awareness training and cascading awareness sessions throughout the organisation.

2. That NHS South Sefton CCG joins the Sefton Dementia Action Alliance. Attendance at bi-monthly meetings would be required.

3. That NHS South Sefton CCG encourage its member practices to become dementia-friendly and also sign up to the Sefton Dementia Action Alliance.

4. That NHS South Sefton CCG actively promotes dementia friends training and awareness with commissioned services via its contracting processes and provider specifications.

5. That NHS South Sefton CCG monitors the delivery of actions in the Dementia Strategy "Living Well with Dementia: A Strategy for Sefton 2014-2019". This can be done by continuing to support the strategy group chaired by Cllr. Paul Cummins of Sefton MBC. Kevin Thorne - Dementia Lead could take on this role.

Kevin Thorne
March 2016

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/50	**Author of the Paper:** Geraldine O'Carroll Senior Integrated Commissioning Manager Email: geraldine.o'carroll@southseftonccg.nhs.uk Tel: 0151 247 7112
Report date: March 2016	

Title: Transforming Care: Implementation of National Plans across Cheshire and Merseyside

Summary/Key Issues:

As a result of the Winterbourne View Review: Concordat: Programme of Action (2012) NHS England is committed to improving the health and outcomes of people with learning disabilities and autism, and transforming services to improve the quality of care throughout people's lives.

In line with the priorities of the Transforming Care programme, it is intended that this will involve a significant shift in commissioning towards high quality community-based services over the next 3 years, allowing the closure of inpatient beds and facilities.

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

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

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

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

Report to Governing Body
March 2016

1. Introduction and Background

Purpose of Report

1.1 The purpose of this report is to update Clinical Commissioning Group (CCG) Governing Bodies with regard to the national, regional and local programme of work with regard to Transforming Care for children, young people and adults with learning disabilities. The Care and Treatment Review: Policy and Guidance October 2015 relates to people of all ages with learning disabilities who are at risk of admission or currently in receipt of specialist learning disability or mental health inpatient services and are the commissioning responsibility of NHS England or the Clinical Commissioning Groups.

Background

1.2 As a result of the Winterbourne View Review: Concordat: Programme of Action (2012) NHS England is committed to improving the health and outcomes of people with learning disabilities and autism, and transforming services to improve the quality of care throughout peoples' lives.

1.3 Transforming Care for People with Learning Disabilities - Next Steps, (July 2015) outlined an ambitious programme of system wide change to improve care for people with learning disabilities and/or autism, and behaviour that challenges (learning disabilities).

1.4 Next Steps (July 2015) set out clear expectations that six organisations - NHS England, Department of Health (DH), Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Care Quality Commission (CQQ) and Health Education England (HEE) - would work together more effectively, to drive forward change.

1.5 There is now a single shared Transforming Care programme that recognises the scale of the change required, and ensures that we address the underlying causes of why so many people remain in, and are continuing to be placed in, hospital settings.

1.6 The five areas in the Transforming Care programme are:

- **Empowering individuals** – giving people with learning disabilities and/or autism, and their families*, more choice* and say in their care;
- **Right care in the right place** – ensuring that we deliver the best care now, including a new approach to *care and treatment reviews*, whilst re-designing services for the future, starting with five fast-track sites to accelerate service re-design and share learning;
- **Regulation and inspection** – tightening regulation and the inspection of providers to *drive up the quality of care*;
- **Workforce** – developing the *skills and capability* of the workforce to ensure we provide high quality care;
- **Data and information** – making sure the *right information is available* at the right time for the people that need it, and continuing to track and report progress.

1.7 Next Steps (July 2015) set out a clear ambition for a radical re-design of services for people with learning disabilities. A draft service model has been recently published, which sets out nine overarching principles which define what 'good' services for people with learning disabilities and/or autism whose behaviour challenges should look like.

1.8 In line with the priorities of the Transforming Care programme, it is intended that this will involve a significant shift in commissioning towards high quality community-based services over the next 3years, allowing the closure of inpatient beds and facilities.

1.9 Friday 30 October 2015 saw a key milestone in the Transforming Care programme with the publication by NHS England, the Local Government Association (LGA), and the Association of Directors of Adult Social Services (ADASS) of; 'Building the right support: A national implementation plan to develop community services and close inpatient facilities and a 'New Service Model' (2015).

1.10 The establishment of six Fast-Track areas, announced by Simon Stevens at the NHS Confederation conference will 'test; the draft Service model during the summer of 2015.

Cheshire & Merseyside Transforming Care Board

1.11 In response to the national programme (Building the right support, 2015) a Cheshire & Merseyside Transforming Care Board has been established.

1.12 The Board are undertaking 2 pieces of work in the first instance. The first is to establish the population need to enable commissioning of high quality services moving forward. We have commissioned a Joint Strategic Needs Assessment across Cheshire & Merseyside to inform current work programmes in partnership with Public Health England and Liverpool John Moore's University.

1.13 The second is a look back exercise to evaluate were we have come from in terms of bed usage and models of care and where we need to get to as a health and social care economy.

1.14 It is recognised that Cheshire & Merseyside have already undertaken a significant amount of service improvement in this area and recognising the journey so far is significant when reviewing in-patient provision. To this end the Board will:

- Undertake a retrospective review of LD service provision and activity from 2010-2015 focussing on Assessment and Treatment beds, Locked Rehabilitation beds and Neuro Psychiatry beds, both in and out of area. Within this work there will be a look at:
  - The trend analysis and identify complementary activity within local NHS in patient provision in assessment and treatment units;
  - Identify elements of key community services that contribute to care and prevent admission, and accelerate discharge;
  - Performance as measured in the LD Self-Assessment Framework over this period;

- Developing a model of care for the coming 3 years, 2016-2019, for LD services for Cheshire and Merseyside that builds on the strengths identified in the retrospective study that draws on Government Policy and the NHS 5 Year Forward View (NHS England 2015).

1.15 It is expected that the TCPs will now follow the same programme of work as the six national fast track sites. Therefore the programme plan of transformation will include:

- Development of local plans that support the development of new models of care and long term bed closures, underpinned by a robust learning disability joint strategic health needs assessment. The North Mersey Hub is Liverpool and Sefton (as shown in the diagram below);

- Rapid expansion and improvement in community provision, encompassing a range of supported living options and housing with accompanying care and support, to enable the transfer of people from inpatient facilities;

- Any use of in-patient services must be based on robust assessment of an individual's needs. People that do require in-patient care due to the severity of their condition should have the highest quality of care and an agreed plan to return to their community placement as quickly as possible;

- Repatriation of out of area placements.

1.16 There will be one Transforming Care Partnership or unit of planning across the Cheshire & Merseyside footprint to ensure commissioning at scale, with three geographical collaborative commissioning delivery hubs as outlined below.

Cheshire and Merseyside Unit of Planning			
Hub	**CCGs**	**Local Authority**	**Total Population**
Hub 1 Cheshire	Wirral West Cheshire, East Cheshire, South Cheshire Vale Royal	Wirral West Cheshire & Chester East Cheshire	1,078,886 Population
Hub 2 Mid Mersey	Halton St Helens Warrington Knowsley	Halton St Helens Warrington Knowsley	701,952 Population
Hub 3 North Mersey	South Sefton Southport & Formby Liverpool	Sefton Liverpool	786,383 population

1.17 This approach builds on:

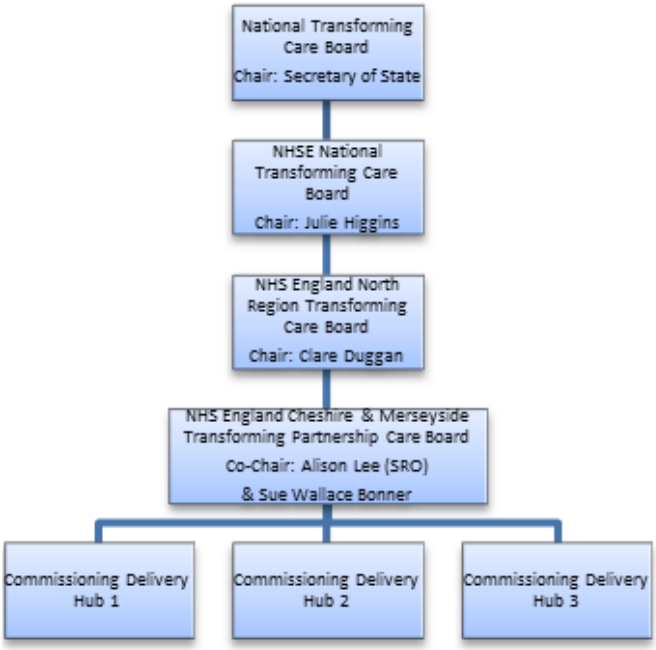
- existing CCG/LA collaborative commissioning arrangements;
- current clinical pathway service delivery;
- joint purchasing arrangements between some CCGs;
- joint CCG/LA arrangements, including governance for joint decision-making;
- excellent CCG/Provider working relationships;
- provider financial viability and clinical sustainability.

Governance Arrangements to Support Delivery

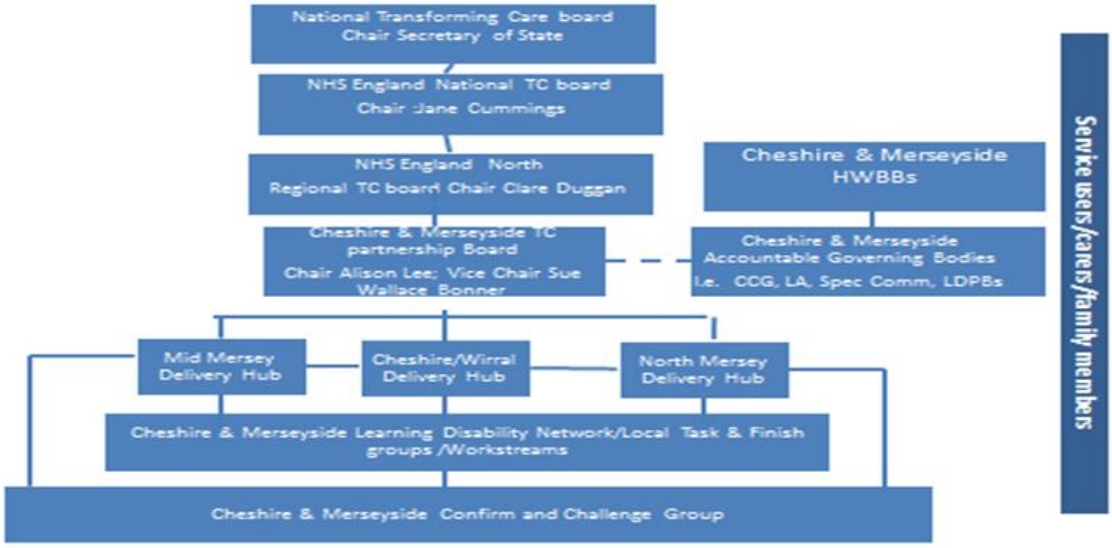
1.18 There is a well-established Cheshire & Merseyside learning disabilities network with CCG, LA, Provider and service user representation. This group will now undertake task and finish work on behalf of the board. One of the current strategic work themes is, 'Safe and Responsive services' for which a full work plan has been developed. However it is envisaged that this work plan will be captured and continue as part of the Cheshire and Merseyside Transforming Care Board which will hold partners to account for delivery of the National Implementation programme (2015).

1.19 There will be financial support via a national budget to progress some of this work; the amount and process for access to funding is still yet to be agreed nationally, but there is local agreement that a project management office function be established to facilitate the work programme locally.

1.20 The **national governance structure** to support delivery of the national plan is outlined below:



1.21 As NHS England is not a Governing body the suggested local governance structure to support delivery of the national plan is outlined below:



Care and Treatment Reviews

1.22 CTRs have been developed as part of NHS England's commitment to improving the care of people with learning disabilities with the aim of reducing admissions and unnecessarily lengthy stays in hospitals and reducing health inequalities.

1.23 CTRs were initiated with a target of supporting the discharge of 50% of the people who were inpatients on the 1st April 2014 by the end of March 2015. The process introduced a level of external scrutiny to existing processes, in effect offering those people in hospital a degree of 'second opinion'.

1.24 Care and Treatment reviews (CTR) are offered to all patients who are or have been an inpatient for 6 months or longer and patients have a right to request these at any time, it is expected that patients should be offered a CTR prior to admission or alternatively within two weeks following admission and then 6 monthly thereafter. It is expected that each Care and Treatment Review will take about a day.

1.25 The review panel will be made up of the responsible commissioner and two independent expert advisers; one expert by experience and one clinical expert. If the commissioner is unable to attend then they must ensure that they send a representative who carries delegated authority. From APRIL 1ST Clinical Lead, will now have to be independent of local services and this will incur a cost to the local CCGs.

1.26 The commissioner responsible for the person's care following discharge, which should include local authority colleagues or joint commissioners, should be involved in the review process. This is vital for planning for the future and understanding and resolving any barriers.

Benefits

- Proactive planning including discharge planning or plans to move to step down accommodation where appropriate. The reviews had a constant focus on repatriating individuals into their local communities or a place closer to home where appropriate. An emphasis on planning for the future including setting target dates for discharge was also inherent to the process, even if a person needed to remain in their current placement in the short-medium term.
- The planned discharge dates for all patients are detailed in the fortnightly and monthly returns.
- Where a date for transfer or discharge has not yet been finalised, the date of the next review has been stated and a reason for this has been given, for example a clinical decision has been made that it is not safe for the person to be in an alternative placement and they require an on-going intervention that can only be delivered within the current environment.

1.27 Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition-Transforming Care Service Model for Commissioners of Health and Social Care Services.

2. Service Model

2.1 This service model is about those people with a learning disability and/or autism who display behaviour that challenges, including behaviour which is attributable to a mental health condition.

2.2 The principles which underpin this service model build on what have been described before, including in Valuing People and Valuing People Now, all of which focus on rights, independence, choice and inclusion for people with a learning disability and/or autism.
Good practice guidance around the commissioning of services for people with a learning disability and/or autism who display behaviour that challenges, including the 1993 and 2007 Mansell reports, describe the need to develop high quality local services that understand and support people, and reduce the reliance on out-of-area placements. They focus on ensuring the best outcomes for people by working in partnership with individuals and families/carers and through adopting person-centred approaches – vital to delivering independence and control for people and ensuring that the person's wishes and aspirations for their own life are at the centre of their care and support. This service model is for all health and social care commissioners – not just learning disability commissioners; in particular, this includes mental health commissioners, Continuing Health Care (CHC) commissioners, public health and children's commissioners. It covers the full range of commissioning – strategic, operational and individual/micro commissioning.

2.3 Commissioners should ensure that plans impacting on people of all ages with a learning disability and/or autism align with related initiatives, and identify opportunities for joint working. This should include commissioners seeking to align these plans with the development of their Local Transformation Plans for Children and Young People's Health and Wellbeing, local action plans under the Mental Health Crisis Concordat and the 'local offer' for personal health budgets.

2.4 This service model is intended for a particular juncture in the transformation of services for people with a learning disability and/or autism. It builds on existing NICE guidance (such as that on challenging behaviour and learning disabilities and that on autism and will be

superseded as good practice develops and in particular once NICE service model guidance is published in 2017.

3. Financial Underpinnings

3.1 A new financial framework will underpin and enable transformation.

3.2 Local transforming care partnerships (CCGs, local authorities and NHS England specialised commissioning) will be asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care in a different way to achieve better results. This includes shifting money from some services (such as inpatient care) into others (such as community health services or packages of support). The costs of the future model of care will therefore be met from the total current envelope of spend on health and social care services for people with a learning disability and/or autism. NHS estimate that the closure of inpatient services Will release hundreds of millions of pounds for investment in better support in the community.

3.3 To enable that to happen, NHS England's specialised commissioning budget for secure learning disability and autism services will be aligned with the new transforming care partnerships, and CCGs will be encouraged to pool their budgets with local authorities whilst recognising their continued responsibility for NHS Continuing Healthcare.

3.4 Dowries will be paid by the NHS to local authorities They should apply to those patients discharged on or after 1 April 2016, and only to those patients who have been in inpatient care for five years or more on 1 April 2016 (not any patient who reaches five years in hospital subsequent to that date) discharge. We expect that NHS England will pay for dowries when the inpatient is being discharged from NHS England-commissioned care, and that CCGs will pay for dowries when the individual is being discharged from CCG commissioned care. Dowries will be recurrent, will be linked to individual patients, and will cease on the death of the individual. In addition to paying for these dowries, the NHS will continue to fund continuing healthcare (CHC) and relevant Section 117 aftercare.

3.5 In addition, from November 2015 *Who Pays* guidance – determining responsibility for payment to providers - will be revised to facilitate swifter discharge from hospital of patients originating from one CCG but being discharged into a different local area. This will ensure continuity of care with responsibility remaining with one CCG rather than being passed from commissioner to commissioner.

3.6 Transformation of this scale will entail significant transition costs, including the temporary double running of services as inpatient facilities continue to be funded whilst new community services are established. To support local areas with these transitional costs, building on the approach tested with fast track areas, NHS England will make available up to £30 million of transformation funding over three years, with national funding conditional on match-funding from local commissioners.

3.7 In addition to this, £15 million capital funding over three years will be made available, and NHS England will explore making further capital funding available following the Spending Review.

3.8 As set out in the national service model, alongside these new financial underpinnings to enable transformation, we expect to see a significant growth in personalised funding approaches (personal budgets, personal health In some parts of the country, local transformation plans will also need to align with Integrated Personal Commissioning (IPC) pilots.

4. Sefton's Local Provision

4.1 At the time of writing this report Sefton is in a strong position as it does not commission out of area placements. Sefton currently commissions 5 inpatient beds at the STAR unit (Mersey Care NHS Trusts learning disability in patient unit as Mossley Hill Hospital; a 9 bedded in patient facility for people with learning disabilities and associated mental health and behavioural problems, which accepts individuals from Sefton and Liverpool either on an informal basis or detained under the Mental Health Act). Sefton's current use of local assessment and treatment beds is around 2 beds per year, which is part of the current block contract arrangement with NHS Mersey Care Trust.

4.2 Formal links with Specialised Commissioning are in place to ensure that information re: reviews undertaken and individuals identified for discharge is communicated to CCG's and community services. There is representation by the CCGs and CLDT at both discharge and CPA 117 reviews at local inpatient services and within Specialised Commissioning placements.

4.3 The table below shows the number of People with Learning Disabilities secure placements that has been commissioned by NHS England at the time of writing this report.

CCG	South Sefton	Southport and Formby
Number under the Mental Health Act	4	2
Number in placement longer than 5 years	2	1

4. 4 All of these placements have been made via Court one however is a recall for a Care Treatment order in South Sefton.

4.5 The joint funding process between Southport and Formby and South Sefton CCGs and Sefton Social Services has been in operation since 1997. The joint funding process is a means of commissioning an integrated package of care, for those individuals with learning disabilities and complex challenging behaviour. Its aim is to enable those individuals to remain living within their local community as opposed to having to access out of area specialist care. There is also a joint funded post to co-ordinate and monitor individual's packages of care.

4.6 Providers that have a track record in supporting individuals with managing individuals with challenging behaviour housing provision that in the main can accommodate learning disabilities.

Response to Winterbourne View - Transforming Care - (Monitoring of patient placements) Fortnightly Winterbourne Patient Tracker

4.7 Individuals are monitored by NHS Area Teams on a fortnightly basis via a return from each CCG. A rota has been established amongst CCG Commissioners to ensure that several members of staff are able to complete this return.

4.8 The governance process is as follows:

- Each fortnight (alternate Tuesdays) each CCG submits the updated return;
- The tracker is then submitted to North Regional office for Merseyside.

Monthly HSCIC Winterbourne Returns

4.9 All CCGs/LAs are required to submit a monthly Winterbourne return which has patient identifiable data on it. This is submitted electronically directly from CCGs to HSCIC.

4.10 Sefton is fully compliant with this return.

4.11 For Sefton there are separate assurances submitted by Merseyside Specialised Commissioning (who report on services users in secure settings) and by the Commissioning Team (who report on services users in non-secure settings) this ensures that all patients are identified and are managed in a co –ordinated way.

Bed Reduction Programme

4.12 Based on national planning assumptions, it is expected that no area should need more inpatient capacity than is necessary at any time to care for:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million populations;
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million populations.

4.13 NHS South Sefton and Southport and Formby CCGs will work closely with Sefton MBC and Mersey Care NHS Trust to reduce bed occupancy by 10% by March 2016 which is in line with National targets and equates to approximately 182 bed days in total. This will form part of the National target to reduce occupancy by 30%. Sefton's Assessment and Treatment bed activity from 2010/11 to 2015/16 shows a 47% reduction in bed usage.

4.14 Throughout this process and as part of partnership working, South Sefton and Southport and Formby CCGs will work closely with Sefton MBC, NHS England and partners to agree a process for managing local resources.

Understanding the Local Population

4.15 A Health needs assessment was commissioned by NHS England from Liverpool Public Health Observatory across Cheshire and Merseyside; (see Appendix 5) Learning disabilities and autism: A health needs assessment for children and adults in Cheshire and Merseyside- January 2016.

4.16 The aforementioned report has provided commissioners with the understanding of different types of need to ensure the availability of the right sorts of support and services in Sefton.

5. Conclusions

5.1 A significant amount of work has been undertaken collaboratively in Sefton in relation to transforming service provision for people with Learning Disabilities and or Autism and/or autism, and behaviour that challenges (learning disabilities).In terms of the Cheshire and Merseyside Transforming Care Plan, Sefton is in a strong position as it does not commission out of area placements and has achieved a 47% reduction in bed usage in assessment and treatment provision over the last 5 years. Our challenge locally is how do we sustain our local position given the financial restraints across the systems.

6. Recommendations

6.1 The Board is asked to note the content of this report

Appendices

Appendix 1 – Transforming Care: Implementation of National Plans across Cheshire and Merseyside

Geraldine O'Carroll
March 2016

Transforming Care: Implementation of National Plans across Cheshire and Merseyside

January 2016

16/50

Transforming Care: Implementation of National Plans across Cheshire and Merseyside

Version number: 1

First published: December 2015

Prepared by:
Michelle Creed, Deputy Director of Nursing,
Jackie Rooney, Patient Safety & Experience Manager
Chief Nurses and Directors of Quality Cheshire & Merseyside CCGs.

Classification: OFFICIAL

1. **Purpose of report**

The purpose of this report is to update Clinical Commissioning Group (CCG) Governing Bodies with regard to the national, regional and local programme of work with regard to Transforming Care for people with Learning Disabilities.

2. **Background**

As a result of the Winterbourne View Review: Concordat: Programme of Action (2012) NHS England is committed to improving the health and outcomes of people with learning disabilities and autism, and transforming services to improve the quality of care throughout people's lives.

Transforming Care for People with Learning Disabilities - Next Steps, (July 2015) outlined an ambitious programme of system wide change to improve care for people with learning disabilities and/or autism, and behaviour that challenges (learning disabilities).

Next Steps (July 2015) set out clear expectations that six organisations - NHS England, Department of Health (DH), Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Care Quality Commission (CQQ) and Health Education England (HEE) - would work together more effectively, to drive forward change.

There is now a single shared Transforming Care programme that recognises the scale of the change required, and ensures that we address the underlying causes of why so many people remain in, and are continuing to be placed in, hospital settings.

The five areas in the Transforming Care programme are:

- **Empowering individuals** – giving people with learning disabilities and/or autism, and their families*, more choice* and say in their care.

- **Right care in the right place** – ensuring that we deliver the best care now, including a new approach to *care and treatment reviews*, whilst re-designing services for the future, starting with five fast-track sites to accelerate service re-design and share learning.

- **Regulation and inspection** – tightening regulation and the inspection of providers to *drive up the quality of care*.

- **Workforce** – developing the *skills and capability* of the workforce to ensure we provide high quality care.

- **Data and information** – making sure the *right information is available* at the right time for the people that need it, and continuing to track and report progress (Appendix 1).

3. **National Transforming Care Programme 2015 - 2019**

Next Steps (July 2015) set out a clear ambition for a radical re-design of services for people with learning disabilities. A draft service model has been recently published,

which sets out nine overarching principles which define what 'good' services for people with learning disabilities and/or autism whose behaviour challenges should look like.

These principles will underpin how local services are redesigned over the coming months and years – allowing for local innovation and differing local needs and circumstances, while ensuring consistency in terms of what patients and their families should be able to expect from local decision-makers.

The establishment of six Fast-Track areas, announced by Simon Stevens at the NHS Confederation conference will 'test; the draft Service model during the summer of 2015.

NHS England have continued to seek the views of clinicians, commissioners, providers, people with learning disabilities and/or autism who have a mental health condition or display behaviour that challenges (including offending behaviours) and their families, ahead of the publication of a final version published in autumn 2015. This will help to support commissioning intentions and financial planning 2016/17.

In line with the priorities of the Transforming Care programme, it is intended that this will involve a significant shift in commissioning towards high quality community-based services over the next 18 months, allowing the closure of inpatient beds and facilities.

Friday 30 October 2015 saw a key milestone in the Transforming Care programme with the publication by NHS England, the Local Government Association (LGA), and the Association of Directors of Adult Social Services (ADASS) of; 'Building the right support: A national implementation plan to develop community services and close inpatient facilities and a 'New Service Model' (2015).

Taken together, these documents have asked Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England specialised commissioners to come together to form Transforming Care Partnerships (TCPs) to build up community services and close unnecessary inpatient provisions over the next 3 years and by March 2019.

Based on national planning assumptions, it is expected that no area should need more inpatient capacity than is necessary at any time to care for:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population;
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population.

While local areas will be able to design bespoke services with those who use them, the national plan (2015) also sets out the need for:

- Local councils and NHS bodies to join together to deliver better and more coordinated services;

- local housing that meets the specific needs of this group of people, such as schemes where people have their own home but ready access to on-site support staff;
- a rapid and ambitious expansion of the use of personal budgets, enabling people and their families to plan their own care, beyond those who already have a legal right to them;
- people to have access to a local care and support navigator or key worker, and investment in advocacy services run by local charities and voluntary organisations so that people and their families can access independent support and advice;
- pooled budgets between the NHS and local councils to ensure the right care is provided in the right place;
- Using the nine principles set out in the 'New Service Model' (2015) TCPs should have the flexibility to design and commission services that meet the needs of people in their area.

There is also an expectation as part of the national Transforming Care programme of work for:

- A 10% reduction in in-patient admissions using the pre 31.3.15 cohort of patients as the baseline, by 31 March 2016; and
- Care and Treatment reviews (CTRs) for all people in an inpatient bed to become 'business as usual'.

4. Transforming Care Partnerships (TCPs)

Cheshire & Merseyside have had an historic Learning Disability Network that has undertaken much work from the Winterbourne View Recommendations over the past 3 years. Discussions through this network resulted in an agreed consensus to progress developments via one Transforming Care Partnership or unit of planning across the Cheshire & Merseyside footprint to ensure commissioning at scale, with three geographical collaborative commissioning delivery hubs as outline below.

Cheshire and Merseyside Unit of Planning			
Hub	**CCGs**	**Local Authority**	**Total Population**
Hub 1 Cheshire	Wirral West Cheshire, East Cheshire, South Cheshire Vale Royal	Wirral West Cheshire & Chester East Cheshire	1,078,886 Population
Hub 2 Mid Mersey	Halton St Helens Warrington Knowsley	Halton St Helens Warrington Knowsley	701,952 Population
Hub 3 North Mersey	South Sefton Southport & Formby Liverpool	Sefton Liverpool	786,383 population

This approach builds on:

- existing CCG/LA collaborative commissioning arrangements;
- current clinical pathway service delivery;
- joint purchasing arrangements between some CCGs;
- joint CCG/LA arrangements, including governance for joint decision-making;
- excellent CCG/Provider working relationships;
- provider financial viability and clinical sustainability.

NHS England has proactively facilitated the bringing together of local delivery hubs and local discussions have already commenced

4.1 Cheshire & Merseyside Transforming Care Board

In response to the national programme (Building the right support, 2015) a Cheshire & Merseyside Transforming Care Board has been established; with Alison Lee, Accountable Officer, West Cheshire CCG as Senior Responsible Officer for this programme of work and Sue Wallace-Bonner, Director of Adult Social Care Halton Council as Deputy Chair. There are current discussions underway with service user groups to establish a co-chair position.

The Board are undertaking 2 pieces of work in the first instance. The first is to establish the population need to enable commissioning of high quality services moving forward. We have commissioned a Joint Strategic Needs Assessment across Cheshire & Merseyside to inform current work programmes in partnership with Public Health England and Liverpool John Moore's University.

The second is a look back exercise to evaluate were we have come from in terms of bed usage and models of care and where we need to get to as a health and social care economy.

It is recognised that Cheshire & Merseyside have already undertaken a significant amount of service improvement in this area and recognising the journey so far is significant when reviewing in-patient provision. To this end the Board will:

- Undertake a retrospective review of LD service provision and activity from 2010-2015 focussing on Assessment and Treatment beds, Locked Rehabilitation beds and Neuro Psychiatry beds, both in and out of area. Within this work there will be a look at:

    - The trend analysis and identify complementary activity within local NHS in patient provision in assessment and treatment units;

    - Identify elements of key community services that contribute to care and prevent admission, and accelerate discharge;

    - Performance as measured in the LD Self-Assessment Framework over this period.

- Developing a model of care for the coming 3 years, 2016-2019, for LD services for Cheshire and Merseyside that builds on the strengths identified in the retrospective study that draws on Government Policy and the NHS 5 Year Forward View (NHS England 2015).

The target completion date for this work is January 2016.

It is expected that the TCPs will now follow the same programme of work as the six national fast track sites. Therefore the programme plan of transformation will include:

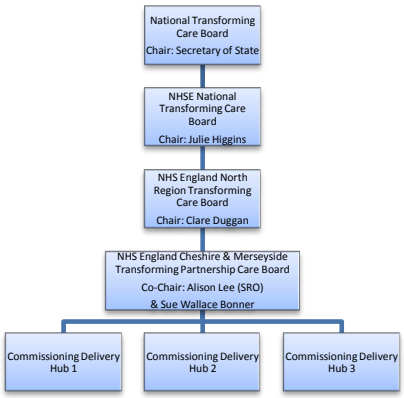
- Development of local plans that support the development of new models of care and long term bed closures, underpinned by a robust learning disability joint strategic health needs assessment;
- Rapid expansion and improvement in community provision, encompassing a range of supported living options and housing with accompanying care and support, to enable the transfer of people from inpatient facilities;
- Any use of in-patient services must be based on robust assessment of an individual's needs. People that do require in-patient care due to the severity of their condition should have the highest quality of care and an agreed plan to return to their community placement as quickly as possible.
- Repatriation of out of area placements.

4.2 Governance arrangements to support delivery

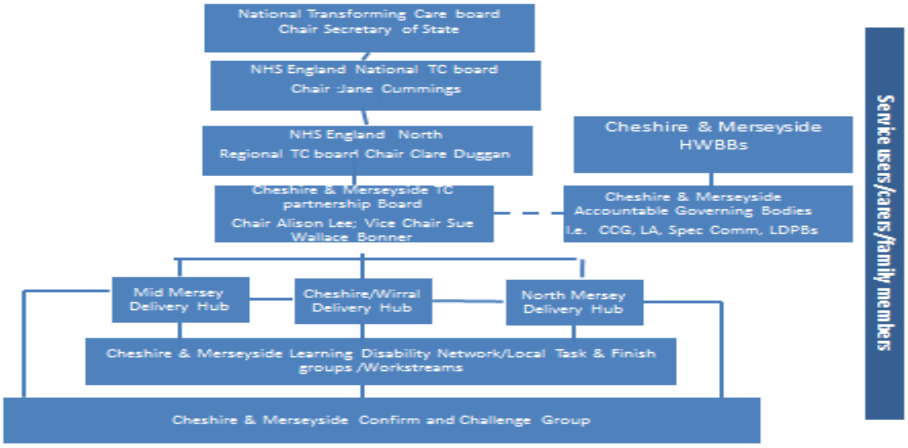
There is a well-established Cheshire & Merseyside learning disabilities network with CCG, LA, Provider and service user representation. This group will now undertake task and finish work on behalf of the board. One of the current strategic work themes is, 'Safe and Responsive services' for which a full work plan has been developed. However it is envisaged that this work plan will be captured and continue as part of the Cheshire and Merseyside Transforming Care Board which will hold partners to account for delivery of the National Implementation programme (2015).

There will be financial support via a national budget to progress some of this work; the amount and process for access to funding is still yet to be agreed nationally, but there is local agreement that a project management office function be established to facilitate the work programme locally.

The **national governance structure** to support delivery of the national plan is outlined below:



As NHS England is not a Governing body the suggested **local governance structure** to support delivery of the national plan is outlined below:



4.3 National and Local Focus 2016 – 2019

The expectation is that the non-fast track areas (Cheshire & Merseyside being one of them), will start to mobilise using the learning from the fast track areas and begin collaborative working to enable the system to realise the start date of April 2016 for:

- A reduction in in-patient admissions using the pre 31.3.15 cohort of patients of 10% by 31 March 2016
- Long term learning disability bed closures in
    - Assessment and Treatment beds
    - Locked Rehabilitation beds
    - Neuro Psychiatry beds

  (Forensic beds, low, Medium and High secure are being led by Specialised Commissioning)
- Development of new models of care.

4.3.1 Care and Treatment reviews

Care and Treatment reviews (CTR) are offered to all patients who are or have been an inpatient for 6 months or longer and patients have a right to request these at any time. More recently the expectation is that patients should be offered a CTR prior to admission or alternatively within two weeks following admission and then 6 monthly thereafter.

Cheshire and Merseyside CCGs and 3 main LD NHS Providers (Merseycare, 5 Borough Partnership and Cheshire Wirral Partnerships NHS Mental Health Trusts) are fully engaged in the CTR process and have pooled clinical resource to enable delivery in a consistent manner. Pathways Associates/North West Training and

Development Team provide Experts by Experience (service users, families and carers). There has been local proactive development of local operational models to ensure CTRs are 'business as usual' from September 2015. The patient stories of individuals who have had Delayed discharges have been collated which is useful in detailing some of the challenges in the system and will be considered in the new service models.

As of December 2015:

- 135 CTRs have been undertaken across CCGs for CCG commissioned services.
- There are 5 patients who have a delayed discharge; the main reasons being accessing an appropriate community provider, no local care package availability and requirement for housing adaptations to be undertaken.
- The use of the pre admission / blue light CTR protocol has avoided 4 hospital admissions during the period October-December 2015

Specialised commissioning

CTRs are also undertaken for patients in forensic/secure commissioned services. The aim being to progress the patient along the secure/forensic pathway into CCG commissioned services or community settings.

To aid progress NW Specialised Commissioning team have established quarterly meetings with local commissioners to ensure the number of Cheshire and Merseyside patients moving along the secure/forensic pathways of care into CCG commissioned placements is planned and funded for.

As of December 2015 the number of Cheshire and Merseyside patients in Specialised Commissioned services is outlined below:

CCG	Stepdown	LSU	MSU
East Cheshire		1	0
West Cheshire		3	0
Halton		0	4
South Cheshire		2	0
Vale Royal		0	0
Warrington		2	1
Wirral		1	2
Knowsley		1	1
South Sefton	1	4	3
Southport		0	0
St Helens		3	2
Liverpool	1	5	4
Totals	2	23	17

(Data source NHS England Specialist Commissioning Tracker Dec 2015)

4.3.2 In patient reduction & bed closure programme

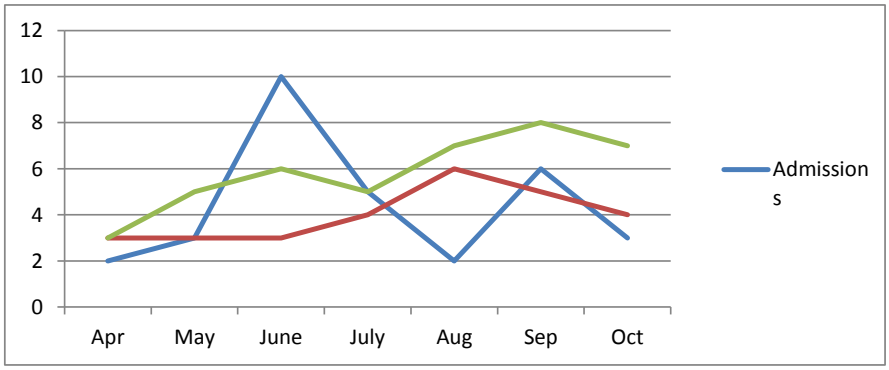
In patient reduction

One of the main responses to the Winterbourne View Concordat (2012) was the requirement to discharge patients from in patient settings if clinical safe to do so. The National Transforming Care board set a national discharge trajectory of between 10% - 13% for patients currently in an inpatient setting as of 31.3.15 to be achieved by 31. 3.16

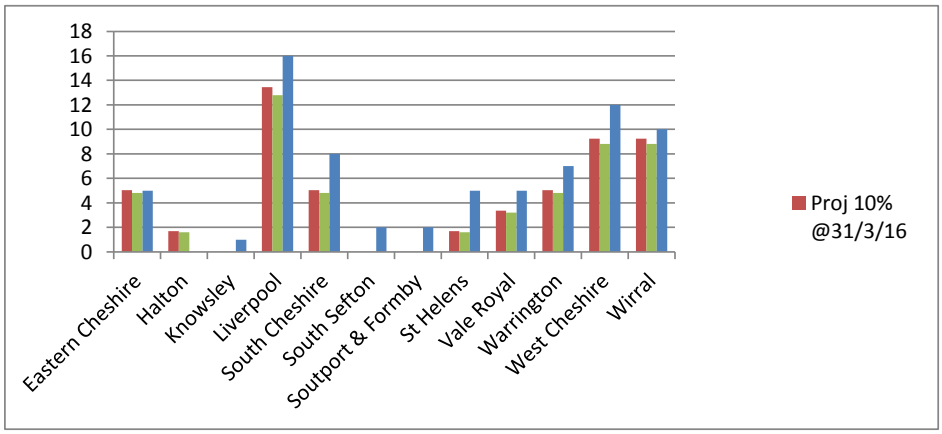
Progress to date for Cheshire and Merseyside's discharge trajectory is outlined below:

Team / CCG	Baseline@31/3/15	April	May	June	July	Aug	Sep	Oct	Nov	Proj 10% @31/3/16	Proj 13% @31/3/16	Diff to P1	Diff to P2
North of England	994	928	950	969	970	979	954	959	947	893	861	-66	-98
Cheshire & Merseyside	64	56	61	66	73	69	71	68	73	54	51	-19	-22
Eastern Cheshire	6	5	5	5	5	6	6	5	5	5	5	0	-0
Halton	2	2	1	0	0	0	0	0	0	2	2	2	2
Knowsley	0	0	0	1	1	1	1	1	1	0	0	-1	-1
Liverpool	16	15	16	15	17	17	17	16	16	13	13	-3	-3
South Cheshire	6	7	7	8	8	6	7	6	8	5	5	-3	-3
South Sefton	0	0	0	1	2	1	1	1	2	0	0	-2	-2
Soutport & Formby	0	0	0	0	1	1	1	1	2	0	0	-2	-2
St Helens	2	1	2	2	4	4	4	5	5	2	2	-3	-3
Vale Royal	4	4	5	5	5	5	5	5	5	3	3	-2	-2
Warrington	6	4	6	6	6	6	7	7	7	5	5	-2	-2
West Cheshire	11	9	9	12	11	10	11	12	12	9	9	-3	-3
Wirral	11	9	10	11	13	12	11	9	10	9	9	-1	-1

Data source: HSCIC Assuring Transformation dataset & NHS England TC Tracker Dec 15



Data source: NHS England TC Tracker Dec 15



Data source: NHS England TC Tracker Dec 15

4.3.3 Bed closure programme

Based on national planning assumptions, it is expected that no area should need more inpatient capacity than is necessary at any time to care for:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million populations
    - Cheshire & Merseyside target = 25 – 37 (CCG beds)
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million populations
    - Cheshire & Merseyside target = 50 – 62 (specialised beds)

The Cheshire and Merseyside Transforming Care board are currently undertaking the following baseline exercise which will help inform commissioners of bed activity as the new models are care are developed:

- A retrospective review of LD service provision and activity from 2010-2015 focussing on Assessment and Treatment beds, Locked Rehabilitation beds and Neuro Psychiatry beds, both in and out of area. Within this work look at:

    - The trend analysis and identify complementary activity within local NHS in patient provision with assessment units.

    - Identify elements of key community services that contribute to care and prevent admission, and accelerate discharge.

The detail from the baseline report will be available January 2016.

4. Potential risks that may prevent delivery

Risk	Risk Level	Mitigating Actions
Lack of robust baseline data	Medium	• Commissioned LD JSNA to understand robust population based needs • Timescales for completion of LD JSNA not in line with timescales for service development • Commissioned look back exercise of bed state
Requirement for Efficiency savings	High	• Work with CCG/LAs to ensure funds are ring fenced for LD service development & delivery • Bids for capital funds available for adaptions etc. via NHS England
Viability of Providers	High/medium	• Providers to develop models of care that ensure trust viability • Providers to commence discussions with legal teams regarding consultation • Commission at scale to ensure viability of providers
Delayed discharges / transfers	High	• Work with LAs to ensure robust process in place to move patient to suitably commissioned supported living placements • Map current provision of commissioned services and benchmark against LD profile

Risk	Risk Level	Mitigating Actions
		• Commissioners to hold providers to account in ensuring planned discharge date for individual on admission
Lack of sustainable community LD teams /services	High	• Commissioners to collaborate to develop strategic provider / preferred provider frameworks with commissioning collaborations need to be as local as possible • Work with commissioner to understand what community services are current commissioned – mapping & identifying 'what goods look like' to support shaping of future local service models • Development of bids to 'double run' services
Disruption to natural patient pathway/flows	Medium	• Clinical Leadership • Clear communication
Limited personalised social care	Medium	• Mapping of housing providers and social care providers • Establish market place

5. Service Change Assurance

The scale of change being envisaged (introduction of new care models and removal of beds may be considered a significant change, with associated risk of Judicial Review or referral to the Secretary of State.

To mitigate these risks NHS England with key partners (LGA, ADASS, Service users etc.) has a role in assuring the service change proposal before progress to the next stage. The assurance would need to be tailored to the specific circumstances and scale of the proposal. Details of assurance process to follow from National TC programme leads.

6. Next steps

Following local discussions at the Regional Transforming Care engagement workshop (9 November 2015) the following areas were identified as essential to support delivery of the national implementation plan:

- Clear governance structures
- As the national plan is reflective of all age ranges, further mapping of stakeholders to ensure all relevant stakeholders engaged in local development work i.e. Children's commissioners, CAMHS etc.
- Review of current community learning disability team (CLDT) specifications
- Review of out of area patients and development of repatriation programme
- Mapping of current social care/housing providers with CCG & LA commissioners with the potential to develop a social care framework
- Hold social care provider forum to establish current and potential services on offer
- Consideration of interim residential placements for current in-patients cohort with delayed discharge
- Development of 'Step up Step Down beds' to support crisis management building on what models that are nationally/regionally evidenced to support local developments

- Establish a provider forum
- Strength the 'at risk register' development's with all stakeholders: including development and agreement of data sharing agreements
- Strength local authority involvement in work programme via ADASS leads
- Pooled budgets
- Hold a local stakeholder dialogue event

7. Cheshire & Merseyside Stakeholder event

A local stakeholder event was held on 16 Dec 2016 at Daresbury Park Warrington to understand the local 'ask' of the National Transforming Care programme across the Cheshire & Merseyside footprint.

Over 85 delegates attended the event, with representation from health, local authority, social care, NHS providers, Healthwatch, advocacy, housing, and experts by experience and family members.

Members of the National Transforming Care Programme (NHS England and LGA) outlined the national 'ask' and timescales for mobilisation and delivery. As Senior Responsible Officer for this programme of work, Alison Lee, Accountable Officer, West Cheshire CCG endorsed the progress and work to date in this field across Cheshire & Merseyside, but also acknowledged the challenge ahead.

Moving into their relevant delivery commission hubs, the stakeholders started to work together to:

- Describe the vision for services for people with a Learning disability/autism or behaviours that challenge living in Cheshire & Merseyside?
- Established the strengths and weakness of current LD service provision in their locality
- Identify any key stakeholder that are missing and need to be involved
- Describe what does success look like
- Identify some local quick wins, and
- Begin to prioritise services developments for Years 1, 2 and 3
- Give thought to how the delivery hubs will progress locally

Details from the event have been collated and shared with stakeholders present (Appendix 2). NHS England will now utilise the detail from the event together with the findings of the retrospective reviews to develop a strategic plan for Cheshire & Merseyside which will be shared with the 3 delivery hubs and relevant governing bodies.

8. Conclusion

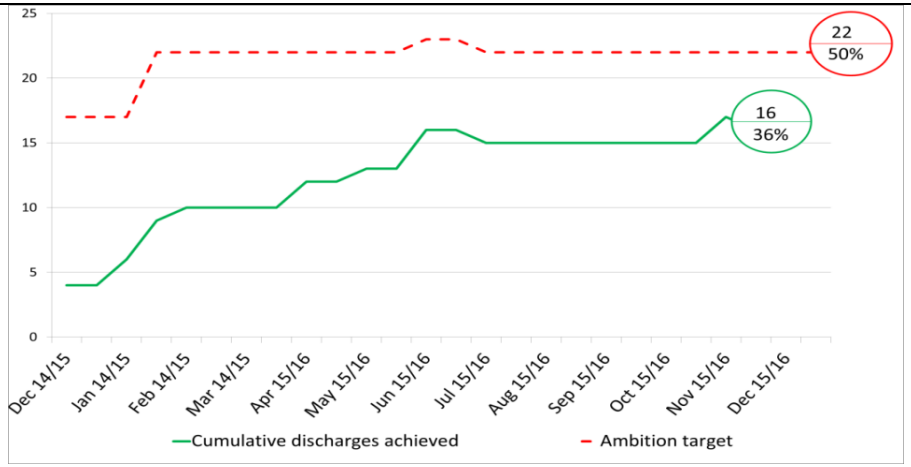
It is recognised that Cheshire & Merseyside have already undertaken a significant amount of work with regard to service provision for people with learning disabilities and/or autism, and/or behaviours that challenge.

Telling the story of the journey so far is significant when reviewing in-patient provision to ensure we have adequate support for people who require it in times of deteriorating health or crisis. Alongside this the development of high quality services closer to home will enable people to live independent lives closer to their friends, family and carers.

The Cheshire & Merseyside Transforming Care Partnership Board will strive to delivery that national priorities locally, ensuring this is done in a co-productive manner with the patient's voice at the centre of the service model. Governing Bodies are asked to note the content of this report and support its implementation as a high priority area of work.

ENDS

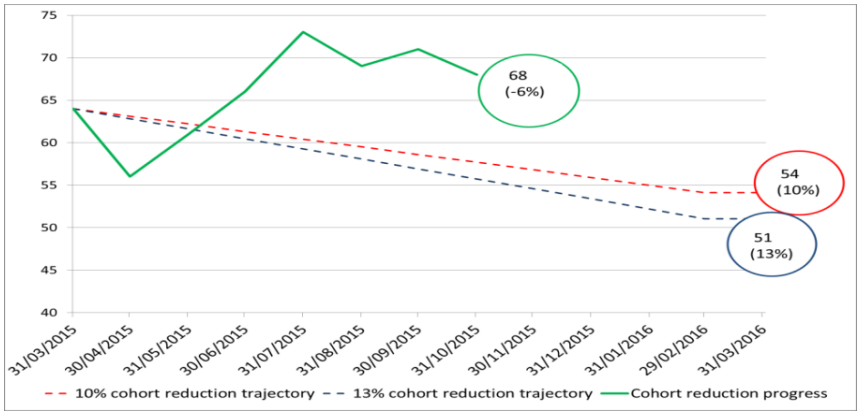
Empowering Individuals	Empowering people with learning disabilities and their families to have greater rights and say in their care, underpins the Transforming Care programme. We have been working with partners across the health, local authority and voluntary sectors to strengthen the collective voice of individuals with learning disabilities and their families, to ensure greater personalisation, increased choice about care, and greater influence over service design and delivery. An important milestone this year was the public consultation issued by the Government, 'No voice unheard, no right ignored', to strengthen the rights of people with mental health issues, learning disabilities and autism, so they can live independently, be included in their community, and make choices about their own lives. Locally we continue to work closely with Pathways Associates in: • Developing an expert hub of clinical reviewers and experts by experience to undertake Care and treatment reviews • ensuring we are asking whether people are getting support from advocacy through the revised approach to Care and Treatment • Reviewing Assuring Transformation data to gather information that tells us what sort of advocacy a person is receiving. • Developed a Co-production workstream to ensure the voice of the service user/Family carers is heard locally, regionally and nationally As a result of the work undertaken local we have successfully presented our methodology and how we have utilised the LDSAF validation process to improve and drive forward quality for people with LD locally at 2 national workshops run by IHAL. The workshops were held in June 2015 in Manchester and Bristol. Wirral CCG presented how this work at been used strategically at a local level to drive forward a joint action plan. As part of this they have streamlined processes, integrated stakeholders and worked towards joint ownership. **Governance: Co-production Sub Group of the Cheshire & Merseyside Transforming Care Board.**
Right Care, Right Place, Right Time	The national ambition is to discharge 50% of patients from an inpatient facility at 1 April 2014 to the community by 31 March 2015; and to carry out care and treatment reviews for any patients in that cohort who have not got a discharge date and are in a low secure setting. Cheshire & Merseyside position at November 2015:



50% discharge ambition: Currently on trajectory to achieve discharge ambition of 65% by Q4 leaving 15 inpatients from the 31 March 2014 cohort with discharge dates during 2016/17

There is a renewed focus on reducing hospital admissions from the 2013/14 baseline by 10% during 2015/16, reducing length of stay and tackling delayed discharges. This will require a focus on developing community based provision locally. Improving the patient experience and outcomes is a key factor to drive this initiative.

Cheshire & Merseyside position at November 2015:



10% discharge ambition: despite an increase in admission numbers over summer months (due to CCG's has found patients who were out of area) now on a downward trend and confident that the 10% ambition will be achieved by end of Q4. Current focus on 3 CCGs with highest admission rate: West Cheshire, Wirral and Liverpool CCGs.

Governance: Commissioning Hubs of the Cheshire & Merseyside Transforming Care Board.

Regulation & Inspection	NHS England has established an Enhanced Quality Assurance Programme (EQAP) with the specific role of making sure people are safe and monitoring the quality of care reviews. EQAP will seek the firmest assurances that patients have clear care plans and are receiving the support they need and deserve. CQC is working to ensure that its assessment methods are fully adapted to ensure robust inspections of hospital and community learning disability services. The CQC is further developing the work on registration, to ensure that: • Applications by any service provider to vary their 'service type', that describes the services that they offer, are only agreed when the new 'service type' accurately reflects a changed model of care. This will also ensure that any inappropriate models of care for people with learning disabilities do not continue after the 'variation' has been agreed; and • new applications are only agreed when the application reflects the agreed model of care for people with learning disabilities, which is currently being defined by the Transforming Care programme and outlined in the new Service Model for commissioners **Governance: Safe and Responsive Services Sub Group of the Cheshire & Merseyside Transforming Care Board.**
Workforce	Since the publication of Next Steps (July 2015), Health Education England (HEE) has been working with its Transforming Care partners, including Skills for Health and Skills for Care, to ensure that workforce development and planning supports the wider service re-design across health and social care. Work to date will includes the development and testing a new Learning Disability Skills and Competency Framework that outlines the competencies that staff needs to have, to fulfil certain roles, to ensure that we have the right skills in the right place. This Framework will be rolled-out in January 2016. **Governance: Safe and Responsive Services Sub Group of the Cheshire & Merseyside Transforming Care Board.**
Data and Information	Health and Social Care Information Centre (HSCIC) is the national electronic information data analysis system for the Assuring Transformation Clinical Platform. All local CCGs are registered with HSCIC and actively submitting data. Local CCG/LA leads are also required to submit fortnightly data to NHS England via the local Transforming Care tracker. This enables the local monitoring of CTRs, admissions, in patient length of stay and progress being made towards individual, anticipated and planned discharge dates. Work is currently ongoing between NHS England Transforming Care analytical team and HSCIC to enable all clinical data fields to be submitted via one clinical portal on HSCIC system. It is

	envisaged that the NHS England TC tracker will cease in December 2015. **Governance: Safe and Responsive Services Sub Group of the Cheshire & Merseyside Transforming Care Board.**
Learning Disabilities Mortality Review (LeDeR) Programme	The new Learning Disabilities Mortality Review (LeDeR) Programme has been commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and will run from 2015 – 2018. The Programme has been established as a result of the key recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD). The aim of the Programme is to make improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities, through national and local reviews of deaths. There will be a phased roll-out of the programme across the 12 NHS Clinical Senate geographical areas of England from January 2016, following a piloting phase in autumn 2015. Once known, dates for C&M will be disseminated locally. **Governance: Health Inequalities Sub Group of the Cheshire & Merseyside Transforming Care Board.**

Appendix 2

Transforming Care Stakeholders event 16 December 2015 Daresbury Park Hotel Warrington

Cheshire Delivery Hub

Who's missing?
• Family Carer's • Carer's • CCG's • Eastern Cheshire CCG's • Educational Sector • Employment Services
Overall Vision for People with Learning Disabilities
• Care in the community / Closer to home • Safety • Proportionate risk taking • Right care, Right Treatment, Right time. • Own front door (Housing) • Working together (CCG, LA's, Independent Sector) • Forums - Culture change - Workforce development - Market shaping • 'Nothing about us without us'. • Honest • Self-Advocacy • Community Development • Leading 'own' support (Self/peer advocacy) • 'Good Lives' – People leading • Sharing Data • Working with service users. • Reducing Barriers. • Stream less Services / Transitions. • Sharing Resources - Useful tools - More co-production • Gaps in service (Autism) • Good Communication - Person centred. • Culture Change • Right People? - Employers - Children's Services
Shared Vision
• Meeting needs at times of crisis - Appropriate planning - Step up/step down beds - Person led • Individuals taking control of care planning • Safe happy and well • Supporting services to meet peoples neds • Individuals More in control of own budgets
What could be improved?
• Patient voice being heard.

- 24/7 support for service users in the community
- Transparency
- Patient-led care
  - Managing own budget
- Contingency planning
  - Crisis support
- Employment Service Users
  - Autism/LD
  - Opportunities
  - Improving quality of life, achieving goals.
- Involvement of employment and children's service and stakeholder groups.
- Care within home – Not sending out of area / secure units etc.

What does success look like?

- Working alongside service users - Closer collaboration.
  - Getting the best out of the services.
- Transparency
  - Between Services
  - Available Services
  - E.g. Development of land
- Shared Vision
- Meeting needs
  - Times of crisis
  - Appropriate planning step up / step down
  - Person-Led
- Individuals taking control of care planning.
- 'Safe, Happy and Well'
- Supporting services to meet person's needs.
- More In control of own budget (Service users)

What's Working Well?

- Local area coordinator's scoping available services – Individualised.
- Person – centred planning
- Improved communication – Hospitals / GP's
- Lots of work with Hospitals
  - Reasonable adjustments
  - GP Training
  - Health Champions (Training)
- Caring (CQC)
- Effectiveness (CQC)
  - Communication / Staff and carers
- Service users key role in recruitment.
- Service users assessing services
- Fewer people LD in assessment

What keeps you awake at night?

- Safeguarding issues – Problematic providers.
- Quality of service provision – Leadership
- Sending service users out of area
- Isolation
  - No support company

How are you going to progress locally?

- Out of area
  - Jan 16 meeting CCG's service users
- Single plan
  - Commissioner led
  - Strategic group set up
  - Joining commissioners / joined-up commissioners.
- Strategic Visions
  - Work streams working to same vision.
  -

Mid Mersey delivery Hub

Overall Vision for People with Learning Disabilities
• Gaps in provision need to be addressed such as post diagnostic services – for people with Autism / Asperger's. • Clarity of responsibilities of health provider 5BP • Better planning around transition and people coming through the service. • Involvement of voluntary sector to meet needs – potentially? • Housing / Builders being on board with transitional planning (Affordable housing) • Smarter intelligence and how we collate information of people coming through the transitional system. • Greater involvement of people of all ages including younger people. • Greater support for parents to understand the transitional process. • Positive communication with people from birth.
What could be Improved
• Autism Post Diagnostics (decisions making) what will be decided when • Transitional Process • Reasonable adjustments process, explaining to people (Staff as well as service users) • Embedding reasonable adjustments in general practice. • Educating the wider population around learning disability awareness – Autism and Asperger's Syndrome. • Community Cohesion / resilience?
Gaps within the Process
• No Children's Service representation. • Ensuring the right cohort of people are involved (E.g. LD Social Work) • We need to ensure all professionals are communicated with. (E.g. GP's/CCG's) • Strategic Planning and building positive relationships with housing providers. • Ensuring people receive the right care in the right setting – -Improving transitional processes -Partnerships is second -Care particularly elder carers
What Does Success Look Like?
• Seamless Services • Establishing what is important to the individual • Co-ordinated support through the journey (navigation role)
What is Working Well?
• Cohesive approach and relationships. • Good advocacy • Integration • Co-production (Partnership boards) • Voluntary sector involvement to develop groups • Learning Disability Pathway • Skill up the workforce (Educate workforce) • Positive behaviour support working well in some areas. • PBS not a short term solution for crisis – Community teams generally pick VWs up.
What keeps you awake at night?
• Impact on family carers, particularly older family carers / significant others. • Needs to be more communication between professionals.

North Mersey Delivery Hub

Who's missing?
• Sefton Local Authority • Liverpool City Council • Autism Initiatives • Options • Natural Breaks • People First • Sefton and Liverpool Partnership • Education
Overall Vision for People with Learning Disabilities
• Right Care, Right Time, Right Place, Right Professionals • Individual/Personalised Care Packages • Care primarily provided in the community not hospital. • Communities that welcome support. • Care pathway relating to OATS • Efficient funding • History of wrap around care – third sector. • Good third sector providers.
What could be improved?
• Information and support to families early on. • Inclusive education systems. • Avoiding the cliff of transition. • Insufficient capacity in the autistic spectrum.
Gaps within the Process
• Post diagnostic support – Autism • Autism (Big Gap) • Crisis management capacity is not robust. • Refresh Green Light Tool Kit • No short term care in the home. • Crisis House – Crash Pads • Lack of agreed definition. • Pool budgets, Joint funding – Something needs sorting out. • Horizontal and vertical care integrated.
Quick wins.
• Develop a pathway – OATS repatriation. • Utilise Merseyside Partners and the Joint Training Partnership – To be invested in. • Review of the past five admissions. • Audit Green Light Tool Kit • Test PBS • Agree Service Specifications – CLT • Repatriate OATS • Revisit SAF • HWB Report • TC-The Local vision for CCGs

REPORT TO THE GOVERNING BODY
MARCH 2016

Agenda Item: 16/51	**Author of the Paper:** Karl McCluskey Chief Strategy & Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk
Report date: March 2016	

Title: South Sefton Clinical Commissioning Group Integrated Performance Report

Summary/Key Issues: This report provides summary information on the 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.

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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

16/51

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List of Tables and Graphs

1. Executive Summary

This report provides summary information on the activity and quality performance of South Sefton Clinical Commissioning Group at Month 10 (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 (All Types)		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		
Mental Health Measure - CPA		
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
Stroke 90% time on stroke unit		Aintree
Stroke 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 £2.836m overspent at Month 11 on operational budget areas before the application of reserves or contingency. 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.

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 January with a performance of 95.0% year to date (in month achieving 89.49%). Aintree failed the target in January recording 84.8%, and are also failing year to date reaching 91.30%. In January 2062 out of 13562 attendances where not admitted, transferred or discharged within 4 hours. Provider comment - During January 2016 there were 13,562 Type 1 and Type 3 attendances with 2,062 breaches which equates to combined performance of 84.80%. The following 5 key actions are a priority:

1. Ensuring medically accepted GP patients go direct to AMU or AEC and delivery of a rapid assessment model in AMU.
2. Delivery of ambulatory emergency care in the AEC Unit in Acute Medicine and the Observation Unit in A&E.
3. Ensure SAU and GPAU can accept all emergency surgical patients.
4. Increase the number of patients seen by GP out of hours service (UC24) and relocation of the service to Room 1 in UCAT
5. Use the support from the Utilisation Management Team and Tessa Walton, with additional support from senior managers for all areas, to improve patient flow.

An action plan to reduce the numbers of medically optimised patients remains in place. To ensure sustained improvement, the following actions remains in place:

• Full utilisation of the step down facility, Aintree 2 Home, which opened in December 2015 and Aintree @ Home, including for Discharge to Assess.
• Implementation of the mobilisation plan for the transfer of the Discharge Planning Team to be community based.
• Evaluating alternative models to support reducing delays for medically optimised patients, including the provision of a second step down facility within the Trust.
• Weekly MADEs and implementation of actions from Safer Start/MADE.

A&E Waits (Type 1) – The CCG have failed the 95% target in January reaching 74.83%, and year to date reaching 82.84%. In January 987 attendances out of 3922 were not admitted, transferred or discharged within 4 hours. Aintree have failed the target in January reaching 70.52%, and year to date reaching 83.56%. In January 2062 attendances out of 6995 were not admitted, transferred or discharged within 4 hours.

Ambulance Activity - The CCG are failing one ambulance indicator, Cat A (Red2) indicator achieving 71.40% year to date and in month (January) recording 59.6%. NWAS are failing 2 of the ambulance indicators Category A (Red 2) achieving 72.70% and in month 63.49% and Category 19 transportation time, achieving 94.70% year to date, in month achieving 89.85%. The delivery and sustainability of emergency ambulance performance remains a key priority for commissioners. Performance continues to be closely monitored with the support of lead

commissioner Blackpool CCG and through monthly contract and Strategic Partnership Board meetings with the NWAS executive team and commissioning leads. Locally the Mersey CCGs continue to meet with NWAS monthly to review performance at county and CCG level.

Cancer Indicators – The CCG and Aintree achieved all the cancer indicators year to date as at January 2016.

Diagnostics – The CCG are over plan for diagnostics in January. Out of 2,333 patients 37 waited over 6 weeks for a diagnostic test. Of the 37, 23 were for non-obstetric ultrasound. Aintree also failed the target for diagnostics and had 72 patients out of 4,612 waiting over 6 weeks for a diagnostic test, of the 72, 51 were for non-obstetric ultrasound. This is somewhat due to increased demand from Trauma & Orthopaedics department for ultrasound guided joint injectons which the Trust has assured the CCG is likely to be resolved fully by August 2016 but they have some interim plans in place using clinicians from other Trusts on the bank to do some sessions/reporting. The CCG clinical lead is also working with the Trust to understand the increase in demand for these tests.

Emergency Admissions Composite Measure – For January the CCG is over the monthly plan and had 42 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 – C Difficile – Aintree had 9 new cases reported in January of C Difficile, year to date there have been 42 cases against a plan of 38. There have been 16 cases upheld by the CCG's CDI appeal panel, therefore for performance purposes, from April 15 – January 16 there are 26 cases . The March appeals panel was cancelled due to the junior doctors strike, the next panel is due to meet in April. Year end plan is 46.

HCAI – MRSA – No new cases have been reported in January of MRSA for South Sefton CCG. Year to date they has now been 3 cases attributed to the CCG against a zero tolerance target. No new cases have been reported at Aintree in January but there was 1 case in December a PIR was held on 4-1-16 and the case was attributed to Aintree Hospital.

IAPT Access – Roll Out – The CCG are under plan for Q3 for IAPT Roll Out and reached 2.89% which shows an improvement on Q2 (2.48%) plan 3.75%. This equates to 703 patients having entered into treatment out of a population of 24298 (Psychiatric Morbidity Survey). January data shows the CCG are under plan with 343 patients having entered into treatment (1.40%). This is an increase from last month when 1.10% was reported.

IAPT - Recovery Rate – The CCG are under the 50% plan for recovery rate in Q3 reaching 46.4%. This equated to 160 patients who moved to recovery out of 368 who completed treatment. This is slightly lower than quarter 2 when the CCG recorded 48.5%. January data shows the CCG are under plan for recovery rate reaching 38.60%. This equates to 38 patients who have moved to recovery out of 117 who have completed treatment. This is a decrease from last month when 38.6% was reported.

Mixed Sex Accommodation – In January the CCG had 1 mixed sex accommodation breach (4 year to date) which is above the target and as such are reporting red. The breach occurred at Liverpool Heart & Chest, this is the third month in a row the Trust has reported a breach. The fourth breach was reported at Southport & Ormskirk in September.

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 January, year to date are reporting 31 in total, 1 surgical error (recorded as a Never Event) and 1 unexpected death.

Patient reported outcomes measures (PROMS) for elective procedures: **Groin hernia** – Provisional data (Apr 14 – Mar 15) shows South Sefton CCG reported 0.083 for average health gain following a groin hernia operation which is higher than the previous year which was 0.107 for 2013-14, and over the plan of 0.0697. England average being 0.084. This indicator is flagged as amber.
Hip replacement - Provisional data (Apr 14 – Mar 15) shows South Sefton CCG reported 0.408 for average health gain following a hip operation which is lower than the previous year which was 0.446 for 2013-14 and under the plan of 0.430. England average being 0.437. This indicator is flagged as red
Knee replacement - Provisional data (Apr 14 – Mar 15) shows South Sefton CCG reported 0.294 for knee replacement operation this is lower than the previous year which was 0.313 for 2013-14 and under the plan of 0.341. England average being 0.315. This indicator is flagged as red.
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.

RTT – Admitted patients – The CCG narrowly failed the 90% target reaching 89.36%, out of 628 patients 70 were not seen within 18 weeks. The measure is no longer a national performance target but it is monitored locally.

Stroke – The CCG have failed to achieve the target in January reaching 75%, only 9 patients out of 12 spending at least 90% of their time on a stroke unit. Aintree also failed to achieved the target achieving 71% have 22 patients out of 31 spending at least 90% of their time on a stroke unit.

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

Local Measure – Access to Community Mental Health Services by BME – The latest data shows access to community mental health services by people from BME groups is over the CCG plan (actual 2451.5 / plan 2400). This is also improvement on the previous year when the CCG rate was 2309.0.

2. Financial Position

2.1 Summary

This report focuses on the financial performance for South Sefton CCG as at 29 February 2016 (Month 11). The financial position is £2.836m overspent at Month 11 on operational budget areas before the application of reserves or contingency.

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 is unlikely to deliver its financial target for 2016/17.

The CCG Clinical QIPP Committee is responsible for identifying and implementing schemes to deliver required savings, a work programme is ongoing to ensure delivery of the QIPP requirement. In addition, the CCG has started a review of discretionary expenditure to identify areas where the CCG has control on spending decisions and the impact of a funding reduction.

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	£1.967m
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 11 as follows:

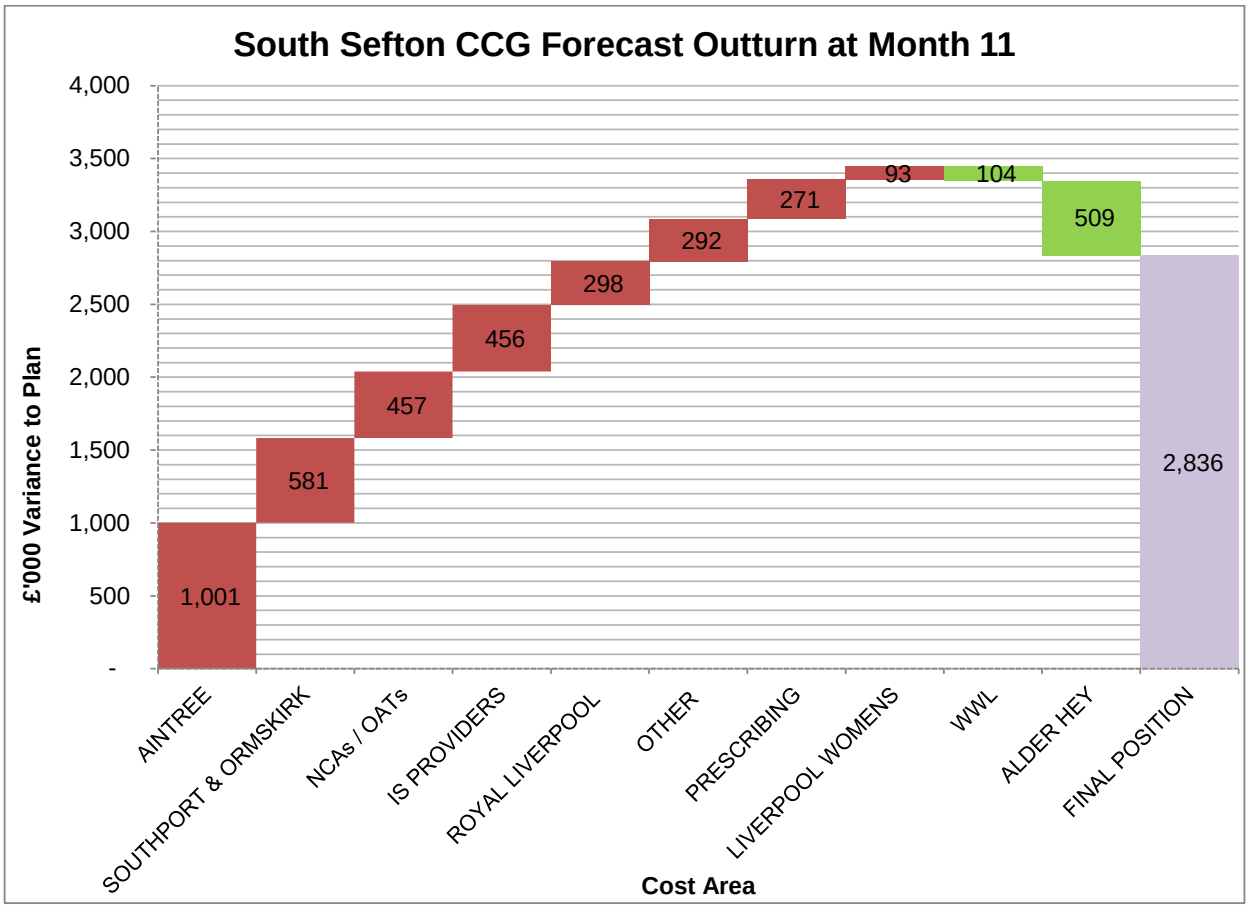
- Cataract Funding - £0.011m
- Net allocation adjustment in respect of specialised commissioning for wheelchairs and neurology – (£0.078m)
- Mental Health IAPT - £0.016m

2.3 Position to date

There are forecast overspends within acute care across a range of providers, particularly Aintree, Southport & Ormskirk and Royal Liverpool Hospitals, Ramsay Healthcare for orthopaedics and Spa Medical for ophthalmology. In addition, a high overspend on the non-contract / out of area activity (NCAs/OATs) budgets.

The overspend is partly supported by underspends with other acute providers, particularly Alder Hey due to underperformance against contract. It should be noted that whilst the financial reporting period runs to the end of February 2016, the CCG has based its reported position on the latest information received from Acute and Independent providers which is up to the end of January 2015.

Figure 2 – Forecast Outturn



Acute commissioning

Aintree University Hospital Foundation Trust

The year to date overspend reported for Aintree is £0.727m and the year-end forecast is £1.001m overspent. This position is reported after a budget reduction of £0.208m due to QIPP savings 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 10 performance information received from the Trust, with overspends in day cases of £0.632m (particularly within Gastro and Cardiology), excluded drugs £0.519m, direct access £0.241m and outpatients £0.734m. This was partly offset by continued underspends in emergency admissions, the rate of underspend in Non Elective has however reduced significantly in December and January. It has been indicated by the Trust that this level of underspend is unlikely to continue once the new building work is completed in Summer 2016.

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 Costs

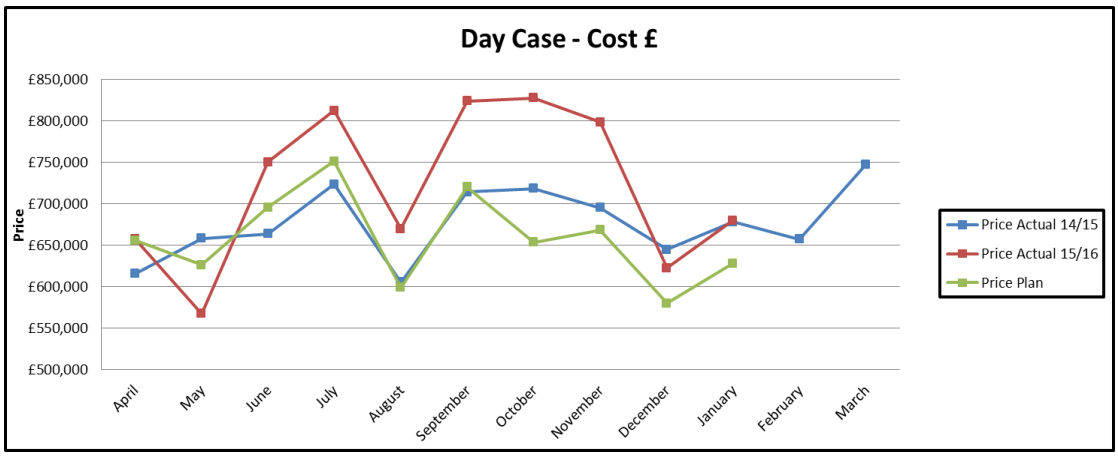


Figure 4 – Non Elective Costs

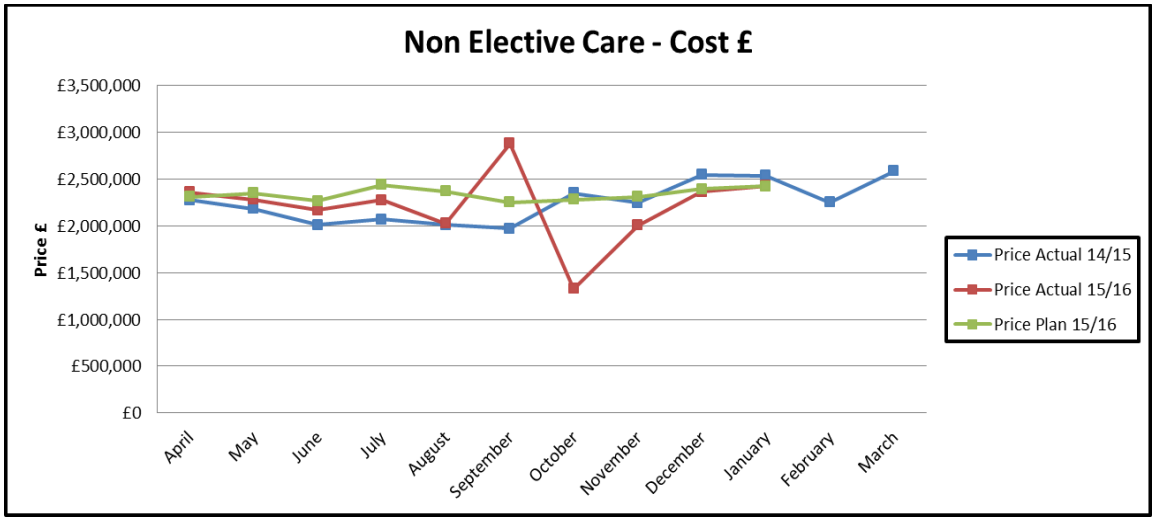


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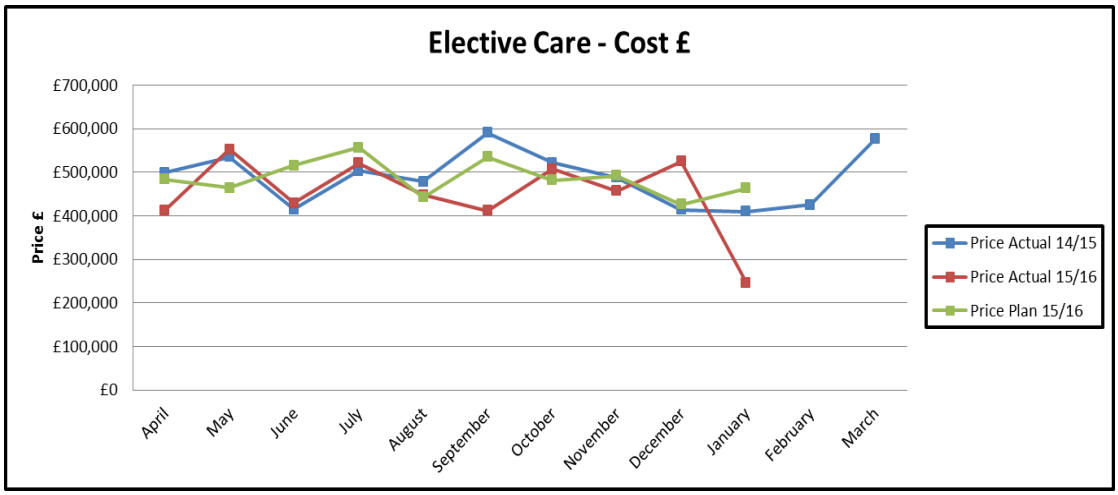
Figure 5 – Elective Costs



Southport and Ormskirk NHS Trust

The forecast overspend for Southport and Ormskirk is £0.591m and relates to over performance within a range of areas:

- Maternity pathway payments (£0.061m variance at month 10)
- Outpatient procedures (£0.128m variance at month 10)
- Day Cases (£0.045m at month 10)
- A&E (£0.067m at month 10)

Royal Liverpool Hospital Foundation Trust

The forecast overspend for Royal Liverpool Hospital is £0.298m. Overspending areas include non-elective - general medicine and vascular surgery, planned care, trauma and orthopaedics, anti-TNF drugs and ARMD.

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 £0.509m.This underspend has been a consistent trend throughout the year.

NCAs/OATs

The forecast overspend for non-contract activity (NCA) and Out of Area Treatments (OATs) in Month 10 is £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 £0.456m for the financial year and has increased 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.

There are also additional costs at Spa Medica for ophthalmology treatment reporting a forecast overspend of £0.191m. Spa Medica is a new provider of this service in the region, and it is likely that this trend will continue. The CCG is reviewing the referral pathway to ensure adequate patient choice is offered to patients.

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.

Prescribing

The prescribing forecast deteriorated in Month 11 due to a change in the forecast received from the PPA, the forecast overspend has increased to £0.271m.

The CCG prescribing budget is £30m in total and represents 1% of the total CCG budget, a small percentage change in the forecast position has a significant impact on the financial position for the CCG.

The forecasts provided by the PPA are volatile and can change significantly each month, this risk is increased by the introduction of a new electronic payment mechanism in place at community pharmacies.

Continuing Health Care and Funded Nursing Care

The forecast for the CHC and FNC budget has increased during the month to £0.053m overspent. The main reason for this are two additional high cost packages of care have been approved on the system.

The current 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 was £3.441m for 2015/16. This has reduced to £1.967m following delivery of schemes totalling £1.474m

	£'m
QIPP schemes reported at Month 10	**1.474**
QIPP schemes identified in current Month:	0
QIPP schemes reported as at Month 11	**1.474**

The CCG established a 1% Transformation Fund in the 2015/16 budget. 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 £1.646m due to slow uptake of projects and 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 forecast underspend of £0.040m. This is mainly due to non-recurrent savings made on vacant positions within the CCG.

Budgets for 2016/17 are currently being finalised and prepared against the revised running cost allocations that have now been confirmed. Running costs are presently within the CCGs allocation for 2016/17.

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 order to achieve financial stability required to deliver NHS business rules. 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 is evident in planned care in both the independent sector and in the NHS.

- 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 resulting in significant movements month on month. In addition to this, the forecast includes a saving relating to Cat M drugs over and above estimates provided by the PPA, which is based on some modelling work undertaken locally by the medicines management team on Cat M actual activity over the year. There is a risk that these savings may have been over-estimated.

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 majority of this is a result of non-recurrent measures and the recurrent position shows a deficit. This is primarily due to the failure to deliver QIPP schemes and is directly linked to the unachieved QIPP figure of £1.967m. This presents a financial pressure for the CCG in 2016/17.

Whilst the CCG remains on target to deliver its financial duties for 2015/16, it must not become complacent in terms of future sustainability. On this basis, the financial risk facing the CCG should be escalated to the Governing Body and considered as the CCG's top priority, alongside commissioning 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)	(1.736)	(1.100)	(2.836)
Transformation Fund slippage		1.646	1.646
Reserves	1.306	2.339	3.645
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
Management Action Plan:			
Contract Penalties		0.657	0.657
CQUIN		0.050	0.050
BCF Payment review		(0.300)	(0.300)
Reorganisation Costs		(0.262)	(0.262)
Expenditure Review		(0.633)	(0.633)
Forecast surplus / (deficit)	0.003	2.397	2.400
Risks	(0.450)		(0.450)
Mitigations	0.450		0.450
Risk adjusted forecast surplus / (deficit)	0.003	2.397	2.400

2.7 Conclusions and Recommendations

- The CCG is on target to meet the required surplus target of £2.400m for 2015/16.

- Whilst the forecast position indicates that the CCG is on target to deliver its financial plans for 2015/16, the recurrent position is a deficit, this is 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 for 2016/17 and actions are required to address the situation.

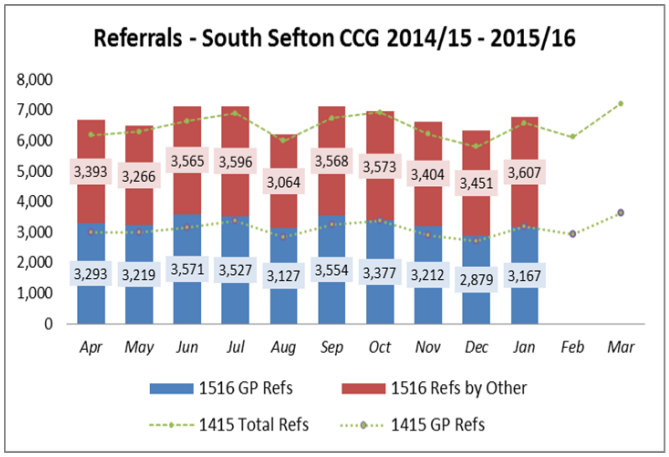
- Whilst the CCG remains on target to deliver its financial duties for 2015/16, it must not become complacent in terms of future sustainability. On this basis, the financial risk facing the CCG should be escalated to the Governing Body and considered as the CCG's top priority, alongside commissioning safe services.

- These actions will require significant engagement and support from all member practices, to be supported by Governing Body GP members, with a focus on reducing access to clinical services that provide low or little clinical benefit for patients.

3. Referrals

3.1 Referrals by source

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



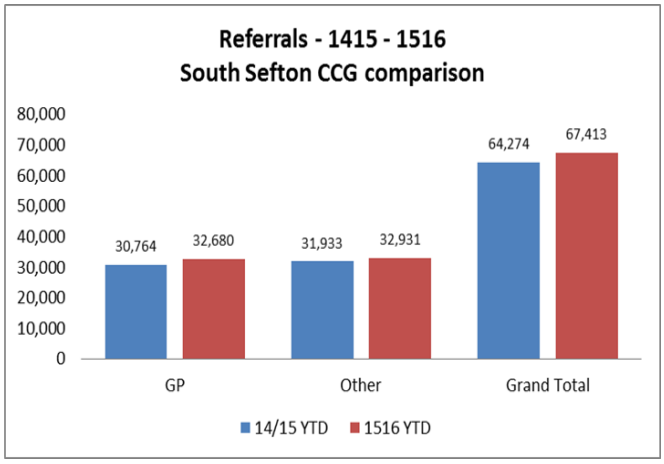


Figure 8 - GP and 'other' referrals for the CCG across all providers comparing 2014/15 and 2015/16 by month

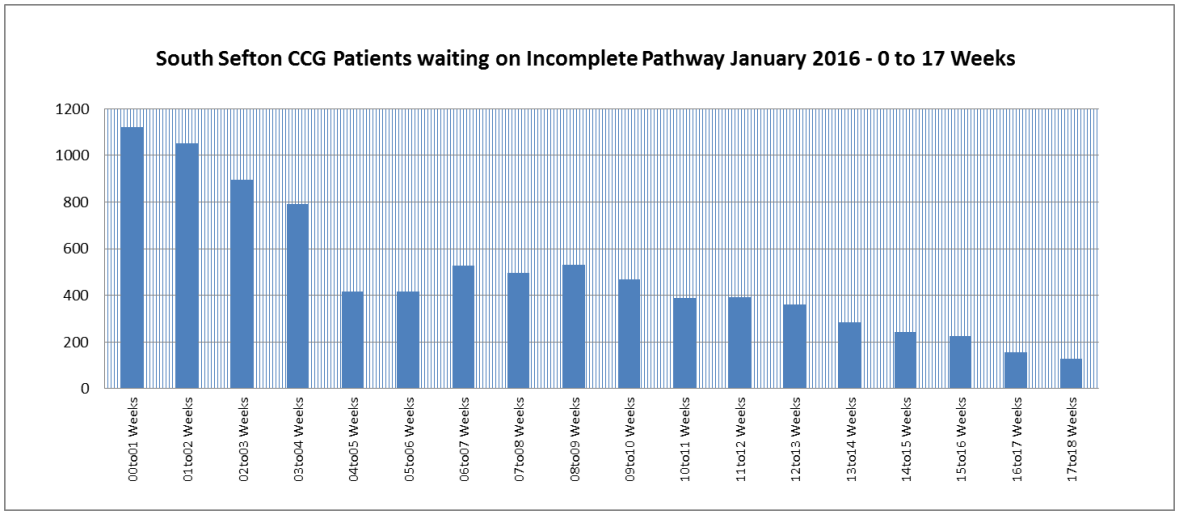
Referral Type	DD Code	Description	1314 Q1	1314 Q2	1314 Q3	1314 Q4	1415 Q1	1415 Q2	1415 Q3	1415 Q4	1516 Q1	1516 Q2	1516 Q3 FOT	1314 YTD	1415 YTD	1516 YTD	% Variance 1415 - 1516	1314-1516 Trendline
GP	03	GP Ref	8,766	8,709	8,563	9,073	9,130	9,480	8,953	9,773	10,078	10,211	9,466	26,038	27,563	29,755	8%	
GP Total			8,766	8,709	8,563	9,073	9,130	9,480	8,953	9,773	10,078	10,211	9,466	**26,038**	**27,563**	**29,755**	**8%**	
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	6	21	15	13	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	1,189	2,620	2,339	3,782	62%	
	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	3,971	10,913	11,536	11,761	2%	
	06	self-referral	827	672	703	756	731	786	811	889	861	900	890	2,202	2,328	2,651	14%	
	07	A Prosthetist	1	16	10	14	3	4	4	7	6	2	1	27	11	9	-18%	
	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	283	1,931	2,236	842	-62%	
	11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	571	551	568	594	631	788	738	674	593	720	866	1,690	2,157	2,179	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	19	41	47	56	19%	
	13	A Specialist NURSE (Secondary Care)	35	21	19	30	21	18	21	22	18	30	34	75	60	82	37%	
	14	An Allied Health Professional	224	214	195	179	311	272	233	204	280	352	393	633	816	1,025	26%	
	15	An OPTOMETRIST	20	22	19	19	28	25	23	19	26	28	42	61	76	96	26%	
	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	24	62	36	47	31%	
	92	A GENERAL DENTAL PRACTITIONER	589	568	568	617	602	538	536	524	539	502	509	1,725	1,676	1,550	-8%	
	93	A Community Dental Service	6	9	12	5	8	8	12	5	5	0	7	27	28	12	-57%	
	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	1,226	4,288	3,833	3,809	-1%	
Other Total			9,514	9,264	9,143	9,514	9,535	9,661	9,522	9,625	9,765	9,727	9,969	**27,921**	**28,718**	**29,461**	**3%**	
Unknown			315	485	511	509	446	492	471	515	458	491	435	1,311	1,409	1,384	-2%	
Grand Total			**18,595**	**18,458**	**18,217**	**19,096**	**19,111**	**19,633**	**18,946**	**19,913**	**20,301**	**20,429**	**19,870**	**55,270**	**57,690**	**60,600**	**5%**	

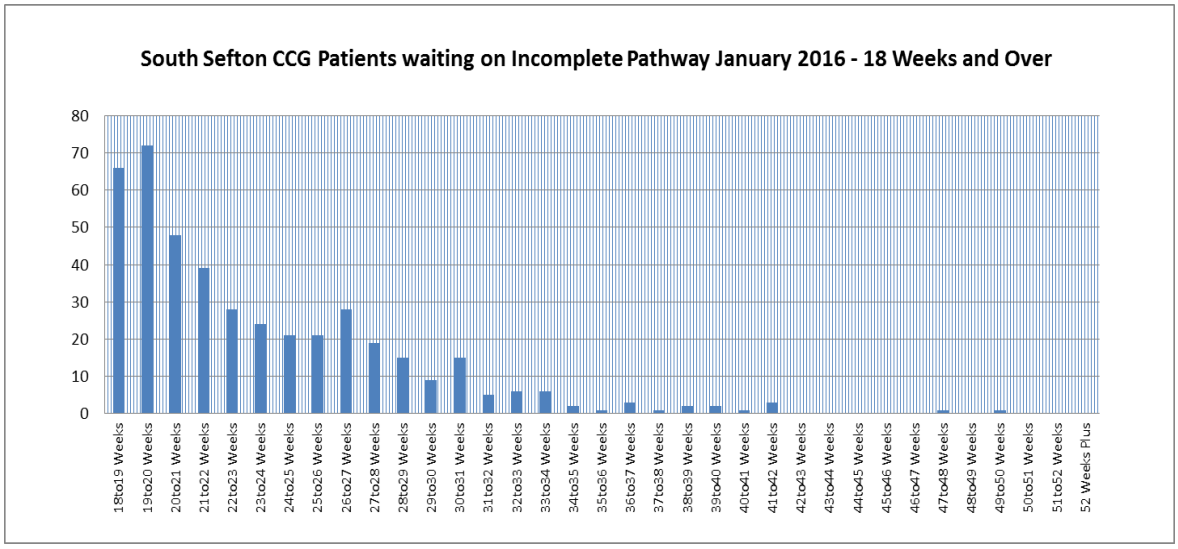
GP Referrals have been increasing since March 2015. Analysis by specialty and provider reveals that ENT at Aintree receives the most GP Referrals and has seen an increase since the middle of 2014/15. Gastroenterology referrals also continue to increase. General Medicine is showing a dramatic increase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

4. Waiting Times

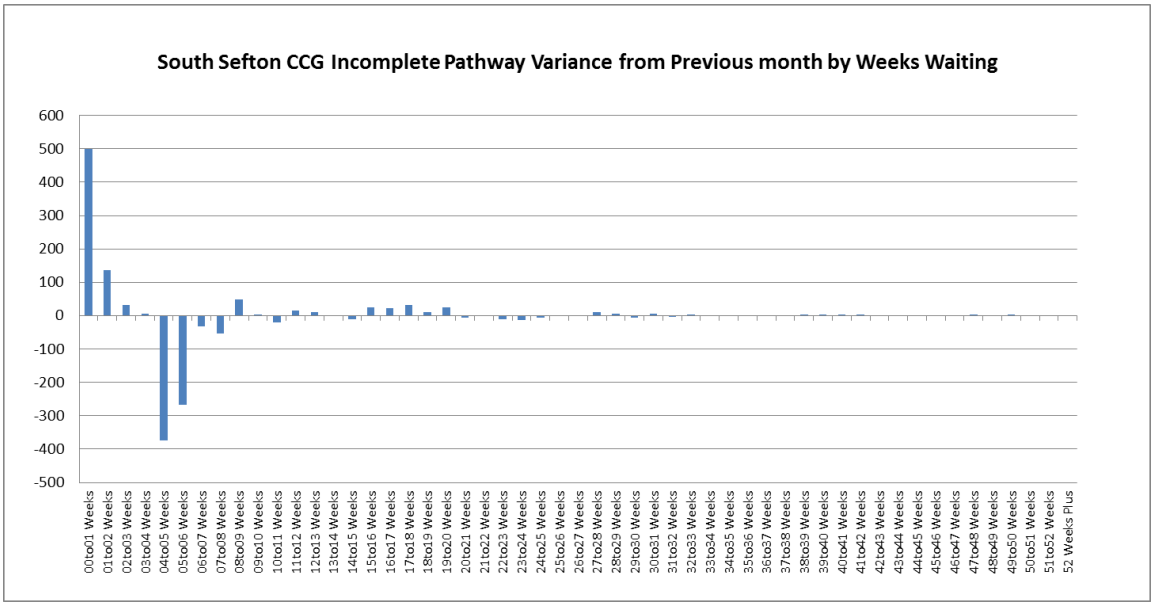
4.1 NHS South Sefton CCG patients waiting

Figure 9 Patients waiting on an incomplete pathway at the end of January 2016 by weeks waiting.





There were 439 patients (4.7%) waiting over 18 weeks on Incomplete Pathways at the end of January 2016, an increase of 14 patients (3.3%) from Month 9 (15/16).
There were no patients waiting over 52 weeks at the end of January 2016.



There were 9,332 patients on the Incomplete Pathway at the end of January 2016, an increase of 86 patients (0.9%) from December 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	4405	1343	5748	138	69	16	223	5971
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	621	255	876	62	28	16	106	982
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	391	159	550	36	3	2	41	591
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	451	85	536	7	0	1	8	544
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	259	183	442	15	7	8	30	472
Other Providers	590	151	741	19	6	6	31	772
Total All Providers	6717	2176	8893	277	113	49	439	9332

4.3 Provider assurance for long waiters

Trust	Speciality	No of weeks waited	Has patient been seen / has a TCI date?	Reason for the delay
RJ&AH	T&O	52	Clock Stop	A spinal long waiter removed from the pathway due to patient choice to not have surgery.
Aintree	ENT	41	Clock Stop	Clock was stopped on 29/02/2016 (active monitoring by patient), they had cancelled 2 previous appointments in Jun-15 & Feb-16 & DNA'd an appointment May-15, all of which we rebooked & the patient attended
Alder Hey	Other	41		Awaiting response from Trust
Central Man	ENT	41	Removal	This patient does not appear on the pathway at the end of February.

5. Planned Care

5.1 All Providers

Performance at Month 10 2015/16, against planned care elements of the contracts held by NHS South Sefton CCG shows an over-performance of £925k.This over-performance is driven by increases at Aintree Hospital (£1m), Southport & Ormskirk Hospital (£205k) and Renacres (£270k). Overspends are offset at Royal Liverpool (-£227k) and Alder Hey (-£276k).

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	141,951	147,346	5,395	4%	£31,071	£25,834	£26,837	£1,004	4%
Alder Hey Childrens NHS F/T	14,711	12,173	10,312	-1,861	-15%	£2,326	£1,926	£1,651	-£276	-14%
Countess of Chester Hospital NHS FT	0	0	149	149	0%	£0	£0	£20	£20	0%
Liverpool Heart and Chest NHS F/T	1,273	1,057	898	-159	-15%	£578	£480	£325	-£155	-32%
Liverpool Womens Hospital NHS F/T	15,539	13,055	13,363	308	2%	£3,282	£2,751	£2,809	£58	2%
Royal Liverpool & Broadgreen Hospitals	29,929	24,842	23,830	-1,012	-4%	£5,827	£4,837	£4,610	-£227	-5%
Southport & Ormskirk Hospital	13,390	11,280	11,913	633	6%	£2,753	£2,308	£2,512	£205	9%
ST Helens & Knowsley Hospitals	4,070	3,386	3,420	34	1%	£1,014	£844	£874	£30	4%
Wirral University Hospital NHS F/T	462	385	304	-81	-21%	£123	£102	£77	-£26	-25%
Central Manchester University Hosp Nhs FT	86	72	116	44	62%	£22	£18	£26	£8	43%
Fairfield Hospital	95	79	125	46	57%	£20	£16	£30	£14	84%
ISIGHT (SOUTHPORT)	262	218	341	123	56%	£65	£54	£81	£27	49%
Renacres Hospital	3,913	3,248	4,608	1,360	42%	£1,265	£1,052	£1,322	£270	26%
SPIRE LIVERPOOL HOSPITAL	3,334	2,778	2,273	-505	-18%	£999	£832	£737	-£95	-11%
University Hosp South Manchester Nhs FT	108	90	0	-90	-100%	£16	£13	£17	£3	24%
Wrightington, Wigan And Leigh Nhs FT	846	705	906	201	29%	£305	£254	£319	£65	26%
Grand Total	**258,704**	**215,319**	**219,904**	**4,585**	**2%**	**£49,666**	**£41,322**	**£42,247**	**£925**	**2%**

5.2 Aintree University Hospital NHS Foundation Trust

Figure 12 Month 10 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	10,478	11,112	634	6%	£7,916	£6,575	£7,214	£639	10%
Elective	2,171	1,805	1,636	-169	-9%	£5,849	£4,864	£4,512	-£352	-7%
Elective Excess BedDays	1,134	943	603	-340	-36%	£252	£210	£132	-£77	-37%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	633	526	361	-165	-31%	£113	£94	£65	-£29	-31%
OPFANFTF - *Outpatient first attendance non face to face*	716	595	564	-31	-5%	£28	£24	£22	-£1	-5%
OPFASPCL - *Outpatient first attendance single professional consultant led*	31,994	26,605	27,938	1,333	5%	£4,593	£3,820	£4,155	£335	9%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	1,577	1,311	1,254	-57	-4%	£172	£143	£136	-£7	-5%
OPFUPNFTF - *Outpatient follow up non face to face*	1,251	1,040	2,868	1,828	176%	£30	£25	£69	£44	176%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	83,804	69,689	69,714	25	0%	£6,558	£5,454	£5,527	£73	1%
Outpatient Procedure	20,122	16,733	18,301	1,568	9%	£3,254	£2,706	£2,968	£262	10%
Unbundled Diagnostics	13,104	10,920	11,705	785	7%	£1,147	£956	£1,061	£105	11%
Wet AMD	1,566	1,305	1,290	-15	-1%	£1,157	£964	£977	£13	1%
Grand Total	**170,685**	**141,951**	**147,346**	**5,395**	**4%**	**£31,071**	**£25,834**	**£26,837**	**£1,004**	**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 has continued to over perform throughout the year with an approx. variance of 10% each month. Month 10 is showing a variance of £639k/10%.

This is primarily driven by Gastroenterology's over performance of £357k. 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*"

The new ambulatory heart failure pathway continues to influence the combined Daycase/Elective performance in Cardiology (£250k). This activity continues to be 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. £334k over performance for month 10 is driven by Clinical Haematology which is showing a £159k/118% 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 £116k/59% and Interventional Radiology £72k/65%. 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.

5.3 Southport & Ormskirk Hospital

Figure 13 Month 10 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	859	796	-63	-7%	£702	£586	£631	£45	8%
Elective	194	161	181	20	13%	£583	£483	£506	£22	5%
Elective Excess BedDays	13	11	26	15	136%	£3	£3	£8	£5	188%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	113	95	232	137	144%	£18	£15	£34	£19	125%
OPFASPCL - *Outpatient first attendance single professional consultant led*	2,611	2,202	1,834	-368	-17%	£366	£309	£269	-£39	-13%
OPFUPMPCL - *OP follow up Multi-Professional Outpatient First. Attendance (Consultant Led)*	210	177	503	326	184%	£21	£18	£49	£31	173%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	5,260	4,436	4,294	-142	-3%	£456	£384	£381	-£3	-1%
Outpatient Procedure	3,070	2,589	3,340	751	29%	£537	£453	£581	£128	28%
Unbundled Diagnostics	889	750	707	-43	-6%	£66	£56	£53	-£3	-6%
Grand Total	**13,390**	**11,280**	**11,913**	**633**	**6%**	**£2,753**	**£2,308**	**£2,512**	**£205**	**9%**

5.3.1 Southport & Ormskirk Hospital Key Issues

Outpatients Procedures is seeing increased activity in Trauma & Orthopaedics and Dermatology. HRG “HB56C Minor Hand 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.

5.1 Renacres Hospital

Figure 14 Month 10 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	416	479	63	15%	£622	£517	£532	£15	3%
Elective	72	60	89	29	49%	£308	£256	£414	£158	62%
OPFASPCL - *Outpatient first attendance single professional consultant led*	1,021	847	965	118	14%	£136	£113	£131	£18	16%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	1,264	1,048	2,426	1,378	131%	£100	£83	£140	£57	69%
Outpatient Procedure	662	549	293	-256	-47%	£63	£52	£69	£17	32%
Unbundled Diagnostics	394	327	356	29	9%	£37	£31	£37	£6	19%
Grand Total	**3,913**	**3,248**	**4,608**	**1,360**	**42%**	**£1,265**	**£1,052**	**£1,322**	**£270**	**26%**

5.1.1 Renacres Hospital Key Issues

2015/16 activity within T&O is showing a marked increase in Major Hip & Knee Procedures. Activity in both of these major treatments is over performing by 56%, with the combined cost variance of £122k. This is a change in the level of procedure complexity the Trust is taking on.

Outpatient Follow Ups are over performing by £32k/53%, although this is an improvement on previous months.

Contract negotiations with Ramsey Healthcare are underway and the CCG has signalled an intention to closely monitor First: Follow Up outpatient ratios in 21016/17.

6. Unplanned Care

6.1 All Providers

Unplanned Care at Month 10 of financial year 2015/16, shows an under-performance of circa -£1.3m for contracts held by NHS South Sefton CCG.

This underspend is clearly driven by the -£1.6m under spend at Aintree Hospital and -£175k at Alder Hey. If we exclude Aintree, we would be reporting a month 10 over spend of £330k/1%. The two main Trusts over spending are Liverpool Women's £138k and Royal Liverpool £189k.

Figure 15 Month 10 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	81,769	78,065	-3,704	-5%	£34,338	£28,863	£27,238	-£1,625	-6%
Alder Hey Childrens NHS F/T	8,868	7,328	7,443	115	2%	£1,905	£1,597	£1,422	-£175	-11%
Countess of Chester Hospital NHS FT	0	0	90	90	0%	£0	£0	£37	£37	0%
Liverpool Heart and Chest NHS F/T	171	143	177	34	24%	£144	£121	£257	£136	113%
Liverpool Womens Hospital NHS F/T	3,458	2,900	3,154	254	9%	£3,009	£2,531	£2,670	£138	5%
Royal Liverpool & Broadgreen Hospitals	5,851	4,892	5,208	316	6%	£2,145	£1,793	£1,982	£189	11%
Southport & Ormskirk Hospital	6,978	5,842	6,602	760	13%	£2,492	£2,092	£2,093	£1	0%
ST Helens & Knowsley Hospitals	850	712	735	23	3%	£361	£303	£292	-£11	-4%
Wirral University Hospital NHS F/T	245	204	295	91	45%	£90	£74	£85	£10	14%
Central Manchester University Hospitals Nhs FT	67	56	62	6	11%	£16	£14	£17	£4	27%
University Hospital Of South Manchester Nhs FT	41	34	27	-7	-21%	£14	£12	£8	-£4	-31%
Wrightington, Wigan And Leigh Nhs FT	42	35	54	19	54%	£15	£13	£17	£4	35%
Grand Total	**124,272**	**103,916**	**101,912**	**-2,004**	**-2%**	**£44,538**	**£37,420**	**£36,117**	**-£1,303**	**-3%**

6.2 Aintree University Hospital NHS Foundation Trust

Figure 16 Month 10 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	35,049	34,243	-806	-2%	£953	£796	£794	-£2	0%
A&E - *Accident & Emergency*	30,956	25,861	25,301	-560	-2%	£3,646	£3,046	£3,053	£7	0%
NEL - *Non Elective*	13,932	11,722	10,530	-1,192	-10%	£25,986	£21,863	£20,795	-£1,069	-5%
NELNE - *Non Elective Non-Emergency*	44	37	37	-0	0%	£122	£102	£102	-£1	-1%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	40	34	121	87	260%	£10	£8	£25	£17	210%
NELST - *Non Elective Short Stay*	2,732	2,299	1,806	-493	-21%	£1,764	£1,484	£1,214	-£270	-18%
NELXBD - *Non Elective Excess Bed Day*	8,044	6,768	6,027	-741	-11%	£1,858	£1,563	£1,256	-£307	-20%
Grand Total	**97,701**	**81,769**	**78,065**	**-3,704**	**-5%**	**£34,338**	**£28,863**	**£27,238**	**-£1,625**	**-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. In the first 6 months of the financial year, Non Elective activity was showing an under performance due to the impact of the NEL pathway changes implemented earlier this year. Over the last 3 months, the

levels of NEL activity has returned back to the levels prior to the changes and Aintree advise us that they expect that this will continue into 2016/17.

6.3 Alder Hey Hospital

Figure 17 Month 10 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	6,516	6,728	212	3%	£688	£568	£565	-£3	0%
NEL - *Non Elective*	854	715	697	-18	-3%	£1,174	£993	£851	-£142	-14%
NELNE - *Non Elective Non-Emergency*	1	1	0	-1	-100%	£1	£1	£0	-£1	-100%
NELXBD - *Non Elective Excess Bed Day*	113	96	18	-78	-81%	£42	£36	£6	-£29	-82%
Grand Total	**8,868**	**7,328**	**7,443**	**115**	**2%**	**£1,905**	**£1,597**	**£1,422**	**-£175**	**-11%**

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 11% below plan. The Trust has been asked to provide further information into the variances, highlighting key specialties and possible reasons.

6.4 Royal Liverpool and Broadgreen Hospitals

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	3,697	3,920	223	6%	£397	£332	£357	£25	7%
AMAU - *Acute Medical unit*	63	53	47	-6	-11%	£6	£5	£4	-£1	-11%
NEL - *Non Elective*	692	578	553	-25	-4%	£1,355	£1,133	£1,311	£178	16%
NELNE - *Non Elective Non-Emergency*	24	20	14	-6	-30%	£179	£150	£99	-£50	-34%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	149	124	0	-124	-100%	£33	£28	£0	-£28	-100%
NELST - *Non Elective Short Stay*	268	224	229	5	2%	£137	£115	£126	£11	10%
NELXBD - *Non Elective Excess Bed Day*	234	195	445	250	128%	£50	£42	£96	£54	128%
readmissions	0	0	0	0	0%	-£13	-£10	-£10	£0	0%
Grand Total	**5,851**	**4,892**	**5,208**	**316**	**6%**	**£2,145**	**£1,793**	**£1,982**	**£189**	**11%**

6.4.1 Royal Liverpool and Broadgreen Hospitals Key Issues

Non Electives make up £138k of the total £189k unplanned over spend. Malignant Pancreatic Disorders and Surgery make £100k of the total over spend Hepatobiliary & Pancreatic Surgery has a £90k over spend against a zero plan. Further analysis will be undertaken against this recent activity increase and revealed that this Trust deals with patients with these conditions as opposed to Aintree University Hospital (Aintree tend to deal with liver related conditions in return).

7. Mental Health

7.1 Mersey Care NHS Trust Contract

Figure 18 NHS South Sefton CCG – Shadow PbR Cluster Activity

	NHS South Sefton CCG			
PBR Cluster	Plan	Caseload	Variance from Plan	% Variance
0 Variance	34	97	63	185%
1 Common Mental Health Problems (Low Severity)	23	40	17	74%
2 Common Mental Health Problems (Low Severity with greater need)	48	28	(20)	-42%
3 Non-Psychotic (Moderate Severity)	274	215	(59)	-22%
4 Non-Psychotic (Severe)	169	222	53	31%
5 Non-psychotic Disorders (Very Severe)	32	64	32	100%
6 Non-Psychotic Disorder of Over-Valued Ideas	43	46	3	7%
7 Enduring Non-Psychotic Disorders (High Disability)	133	206	73	55%
8 Non-Psychotic Chaotic and Challenging Disorders	83	98	15	18%
10 First Episode Psychosis	93	142	49	53%
11 On-going Recurrent Psychosis (Low Symptoms)	414	440	26	6%
12 On-going or Recurrent Psychosis (High Disability)	312	305	(7)	-2%
13 On-going or Recurrent Psychosis (High Symptom & Disability)	112	115	3	3%
14 Psychotic Crisis	17	18	1	6%
15 Severe Psychotic Depression	7	6	(1)	-14%
16 Psychosis & Affective Disorder (High Substance Misuse & Engagement)	33	33	-	0%
17 Psychosis and Affective Disorder – Difficult to Engage	58	55	(3)	-5%
18 Cognitive Impairment (Low Need)	347	232	(115)	-33%
19 Cognitive Impairment or Dementia Complicated (Moderate Need)	462	503	41	9%
20 Cognitive Impairment or Dementia Complicated (High Need)	148	333	185	125%
21 Cognitive Impairment or Dementia (High Physical or Engagement)	45	92	47	104%
Reviewed Not Clustered	36	253	217	603%
No Cluster or Review	144	195	51	35%
Total	3,067	3,738	671	22%

Figure 19 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	Dec-15	Jan-16
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%	100%	100%

Figure 20 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	Dec-15	Jan-16
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%	100%	100%

Quality Overview

At Month 10, Merseycare are compliant with quality schedule reporting requirements. The Trust is working with the CCG Quality team to develop the safer staffing report. At the lat CQPG the

Trust provided an update on the Quality Strategy and Nurse revalidation. In addition work continues 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. Meetings have already been held with the Trust, South Sefton CCG, Liverpool CCG and Knowsley CCG. An Escalation Plan has been developed between Merseycare and Aintree, to date there have not been any further mental health long waits. 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 10 (8.85%) is below the target (however this is an improvement on last month) and current activity levels would indicate that the trust will fall below the 15% target. To achieve the prevalence target of 15% between month February and March 1,500 more people would have to enter treatment.

The Recovery rate in month 10 is 32.5% against the target of 50% and this is a decrease on the position last month when it was 38.6% and the decrease attributed to the Christmas period. It would have been expected that this position would have improved. The trust has had a slight increase in the number of cancellations by the provider and this requires explanation.
The number of patients self-referring and all referrals is up on last month when the service will have been affected by the Christmas period. There is an increase in the number and percentage of GP referrals. This may be a result of provider initiatives to raise awareness of the service with GPs. The percentage of patients entering treatment in 28 days or less is up on last month.

Cancellations by patients at month 10 are up slightly on last month's position. Appointments cancelled by the provider remain at levels that have and continue to be questioned. The provider has again offered no current explanation to the reasons for this and have previously attributed it to staff sickness.

Step 2 staff have previously 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 think 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 past. At month 10 the number of DNAs at step 2 remain static. The level of self- referrals may be impacting on the "watchful wait" that is usually managed by the GP as this 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.

It should be noted that the level of DNA at step 3 have doubled on last month and this requires investigation. The service text reminder service could 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.

Opt in rates are up on the previous month and this is a possible refection of the increased referrals into the service.

In January a Contract Performance Notice was 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. The gap in activity figures between the data sets has narrowed in the latest month.

Figure 21 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	Dec-15	Jan-16	TOTALS
Population (Paychiatric Morbidty Survey)			24298	24298	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	267	343	2150
Prevelance Trajectory (%)			1.25%	1.25%	1.25% (q1=3.75%)	1.25%	1.25%	1.25% (q2=3.75%)	1.25%	1.25%	1.25% (q3=3.75%)	1.25%	**15.00%**
Prevelance Trajectory ACTUAL			0.59%	0.65%	0.83%	0.84%	0.68%	0.95%	0.76%	1.04%	1.10%	1.41%	8.85%
National definition of those who have completed treatment (KPI5)			134	117	120	136	119	143	117	132	119	124	
National definition of those who have entered Below Caseness (KPI6b)			9	4	11	9	10	8	5	13	5	7	
National definition of those who have moved to recovery (KPI6)			75	51	61	66	49	65	60	56	44	38	
Recovery - National Target			50.0%	50.0%	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%	38.6%	32.5%	
Referrals Received			435	395	355	405	331	335	400	429	317	397	
Gp Referrals			289	215	152	161	115	114	107	108	94	143	
% GP Referrals			66%	54%	43%	40%	35%	34%	27%	25%	30%	36%	
Self referrals			114	149	175	205	184	207	235	271	196	215	
% Self referrals			26%	38%	49%	51%	56%	62%	59%	63%	62%	54%	
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-		32	31	28	39	32	14	58	50	27	39	
% Other referrals			7%	8%	8%	10%	10%	4%	15%	12%	9%	10%	
Referral not suitable or returned to GP			0	0	0	0	0	0	0	0	0	0	
Referrals opting in			415	355	285	299	259	249	288	284	238	341	
Opt-in rate %			95%	90%	80%	74%	78%	74%	72%	66%	75%	86%	
Patients starting treatment by step (Local Definition)		Step 2	94	119	142	157	125	178	137	240	248	324	
		Step 3	49	39	59	47	41	54	47	12	19	11	
		Step 4											
		Total	143	158	201	204	166	232	184	252	267	335	
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%	23.8%	22.2%	
Completed Treatment Episodes by Step (Local Definition)		Step 2	138	175	128	203	127	240	172	201	293	248	
		Step 3	341	329	363	383	287	462	377	245	268	334	
		Step 4									7	2	
		Total	479	504	491	586	414	702	549	446	568	584	
Activity	Attendances	Step 2	369	456	536	788	618	645	621	662	541	631	
		Step 3	389	422	547	460	466	507	412	499	365	461	
		Step 4		1	2	3	6	17	13	12	14	16	
	DNA's	Step 2	80	92	146	179	129	175	149	90	124	124	
		Step 3	52	49	75	56	55	60	45	45	36	61	
		Step 4		1					2		1	0	
	Cancels	Step 2	40	82	159	225	137	176	180	198	189	193	
		Step 3	62	89	107	95	81	99	116	119	97	112	
		Step 4						6	4	1	1	2	
	Attendances	Total	758	879	1085	1251	1090	1169	1046	1173	920	1108	
	DNAs	Total	132	142	231	235	184	235	196	135	161	185	
	Cancelled	Total	102	171	266	320	218	281	300	318	287	307	
	Number Cancelled by patient	Total	45	109	194	253	181	239	205	243	209	224	
	Number Cancelled by provider	Total	57	62	72	67	37	42	95	75	78	83	
		Total											

NHS South Sefton Clinical Commissioning Group

Figure 22 IAPT Waiting Time KPIs

	Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	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	113	116	1290
	Denominator		124	121	136	145	130	179	146	131	115	124	1351
	%		97%	94%	94%	97%	95%	97%	94%	95%	98%	94%	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	115	123	1347
	Denominator		124	121	136	145	130	179	146	131	115	124	1351
	%		99%	99%	100%	100%	100%	100%	99%	100%	100%	99%	100%

8. Community Health

Liverpool Community Health Services (by exception)
Community Equipment: Community Equipment: The increase in demand is attributed to a number of factors: Staffing resources in the warehouse, availability of delivery slots, and operational issues. 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 £41,250 non-recurrently 2015/16 for the provision of Community Equipment Store.

A number of actions have also been identified for this service
• Trust to provide a detailed overview of current waiting list. This has not been provided as yet and is being followed up
• 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. Patients are being triaged at Aintree and are not being received by the service. Discussions are on-going between the service lead and the commissioners in relation to the set baseline.

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 the term vacancy and long term sickness .At month 10 activity is at expected levels.

Dietetics: The service has been affected by long term sickness that has been backfilled by using resources from other parts of the service and overtime. The resources are being used more efficiently to target those in the most need. The trust have asked to discuss baselines with the commissioner.

Palliative Care: Staff are working in localities. The service performance has been affected by long term sickness and vacancies 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 communicating effectively with each other and are able to provide appropriate advice at that point in time for example within GP surgeries therefore reducing the level of inappropriate referrals. 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.The service has now recruited to the vacancies.

Physiotherapy: Activity and referrals are above planned thresholds and this has impacted on the waiting times. The level of contacts has increased due to the service re-design and the additional support from locum and agency staff. The service will continue with this due to the increased demand and the increase in waiting times. The service has developed a business plan that has been shared with commissioners. The trust has been asked to develop the case further.

Treatment Rooms: Demand and activity continues to be up for this service and additional capacity has been created through the introduction of specific ear syringing clinics. The change in the delivery model has resulted in an increase in referrals from District Nurses. The trust will be monitoring this going forward. The service continues to ensure that the majority of (98%) patients receive an appointment within 2 weeks of referral in Sefton and this is above the target of 95%. 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 it is anticipated that this will reduce 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. This was provided last year and can be calculated from the activity provided in the monthly reports. The ratio 2015/16 shows an upward trend in the ratio of contacts to referrals.

Intravenous Therapy (IV)- The continued over performance in year 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 continued 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.

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.

Virtual Ward-The trust had 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 picked up as part of contract re-negotiation for 2016/17 and these uplifts will be documented against the relevant services for audit purposes.

Wheelchairs: Following on from the review of the service specification waiting times will be reported separately for urgent and routine referrals going forward with targets of 4 and 12 weeks respectively. A new administration system is in place to release clinicians and allow them to undertake more clinical work. A new forecast is in position that the service will achieve all KPIs by February 2016. Additional capacity will also be released in February when then new staff are signed off for their competencies. A separate briefing paper has been submitted to the Strategy & Performance Committee in January 2016. In the trusts January board report it was reported that a detailed deep dive is due to take place in January of the wheelchair service. An integrated performance report submitted to the Quality Committee in December 2015 on the issues being experienced around accessing specialist equipment for children highlighted the broader agenda around specialist schools. This meeting had been arranged with head teachers of special schools in order to discuss these issues. A report was to be submitted to the Quality Committee in December 2015. The Board is to be updated on this action in January 2016.Awaiting update.

Delayed Transfer of Care (DToC) / Intermediate Care (Ward 35): Although increased in January, the delays remain above target in Sefton. The percentage of bed days occupied by delayed transfers of care in Sefton during January 2016 was 16.4% which is an increase compared to the previous month. This is above the TDA target of 7.5%. The 2 main causes of delay in Sefton was “patient (or family) choice” (40% - attributable to Social services) and “awaiting care package” (29% - attributable to Social services). Currently delays in packages of care are reducing LCHs response to the wider whole system pressures in emergency care and the delays are significant in LCH Bed Base, Community Emergency Response Team and Frailty.

Podiatry: The service are reporting that there are staffing shortages and a difficulty in recruiting permanent ,temporary and locum staff despite repeated rounds of recruitment. This is affecting the performance contact wise of this service.

Phlebotomy: Both clinic and domiciliary activity is above planned levels with the service reporting increased levels of referrals. The trust are utilising all clinics along with bank and agency staff together with overtime to keep pace and support permanent staff. The trust has been asked to provide further information in relation to where these referrals are coming from.

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 30 weeks for NHS South Sefton CCG. This is an increase in length of wait on previous months.

Adult speech and language therapy: The current waiting time is 36 weeks.
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 or not at all. LCH has not responded.

Wheelchairs: Waiting times are reported to be 39 Weeks overall at Month 9 for both urgent and routine. The service is fully staffed however in earlier months has been affected by vacancies. From February the service is achieving the targets of 4 weeks for urgent and 12 weeks for routine. This is being maintained by the additional support still in place. A number of clinicians will soon have completed their preceptorship and will add additional capacity to the service. The service is over performing and intends to submit a new business case to the commissioner at the end of Feb 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 was due to go to the trust board in November.

Waiting time Information was discussed at the Collaborative Commissioning Forum. The Trust advised that a Waiting List Management Task and Finish group has been established and trajectories are being developed to get waiting times back in target. The Co-ordinating Commissioner is to share these with GP Leads for further discussion and the Trust are considering the implications of adopting the proposals.

Any Qualified Provider

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

Patient Identifiable Data

The Trusts Caldicott guardian had requested that no patient identifiable data sets are to be released from the trust. 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 Caldicot guardian about what the trust plans to do at the last LCH finance and information group meeting. The letter that was sent out was in reference to the Liverpool CCG walk in centres. At present there is building work taking place at Litherland and it has not been possible to display the relevant information to patients in relation to information sharing. Once the refurbishment is complete and the literature is available this process will commence and patient identifiable WIc data will flow as part of the SUS submissions.

Quality Overview

Liverpool Community Health 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. The CQC re-inspected the Trust w/c 1st February, initial feedback from the Trust at the joint CQPG meeting in March was positive, particularly regarding culture and staff feedback – it is anticipated the rating will remain 'Needs Improvement' with elements of 'Good'.

Delayed Transfers of Care
The Trust are working closely with the Local Authority to review delayed transfers of care, discussions are taking place through the SRG.

Serious Incidents / Pressure Ulcers
Key areas of risk identified 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. LCCG are leading on this piece of work with LCH although SS CCG are an active member of this group. This approach is in line with the RASCI model.

SALT & Physiotherapy Waiting Times
The CCG continues to experience longs waits for both paediatric and adult SALT and Physiotherapy, this has been raised at CQPG and Contract meetings, the Trust has been asked to resubmit a business case regarding SALT and Physiotherapy this will be reviewed by the CCG clinical leads. The Trust has also been asked to provide monthly progress reports and recovery plans for CCG assurance regarding patient safety.

Southport and Ormskirk Hospitals NHS 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.

The CCG is working with the Trust to develop a suite of Community specific KPIs, these will be incorporated into the Quality Schedule in 16/17

9. Third Sector Contracts

All Third Sector Contracts and Grant agreements are due to expire on 31st March 2016.

Planning for the coming year is in progress and further meetings are to take place shortly to discuss commissioning intentions for 2016-17.

Full and detailed reports containing service outcomes for each provider have now been finalised, these are now with commissioners. A piece of work has been undertaken to establish commissioning priorities and funding for 2016-17, this is to be presented and discussed at the next full board meeting at the end of March. Letters requesting contract documentation are pending until a final decision has been made.

IG Toolkit compliancy assessments are underway and are expected to be finalised prior to 31st March 2016.

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 - January	45	41	↑	There were 8 new cases reported in January 2016, year to date there have been 41 cases against a plan of 45. Of the 41 cases reported in year to date 37 have been aligned to Aintree Hospital and 4 to the Royal Liverpool Broadgreen Hospital (19 apportioned to acute trust and 22 apportioned to community).	
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(Aintree)**	15/16 - January	38	42 (26 following appeal)	↑	There were 9 new cases have been reported in January. Year to date there have been 42 cases against a plan of 38, the year to date plan is 46.	Cumulatively there have been 42 patients with Trust apportioned CDI; there were 9 patients in January. There have been 16 cases upheld by the CCG's CDI appeal panel, therefore for performance purposes, from April 15 – January 16 there are 26 cases . The March appeals panel was cancelled due to the junior doctors strike, the next panel is due to meet in April. Actions taken by the Trust to reduce C.difficile include - 1. Implementation of a more robust weekly review of patients with CDI infection. In Aintree, this is currently undertaken by the Infection Control Doctor and Infection Prevention Nurse. In Wrightington Wigan and Leigh, there is also a dietician review and an antimicrobial pharmacist. 2. The Trust has a programmed deep clean and minor works programme. This is undertaken bay by bay on wards. Minor works are undertaken and the bays are repainted annually. They are subsequently deep cleaned. The Trust stated this is turned around in 24 hours maximum.

Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(CCG)**	15/16 - January	0	3	↔	There were no new cases reported in January of MRSA for South Sefton CCG. Year to date there has now been 3 cases attributed to the CCG against a zero tolerance target.	The first case was reported in September 2015, 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 was reported in November 2015 and was also attributed to the CCG, the third case reported in December 2015, the PIR attributed the case to Aintree Hospital.
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(Aintree)**	15/16 - January	0	1	↔	No new cases reported in January, there was 1 case reported in December. 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.	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.
Mixed Sex Accommodation Breaches						
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(CCG)**	15/16 - January	0.00	0.20	↔	In January the CCG had 1 mixed sex accommodation breach (4 year to date) which is above the target and as such are reporting red for this indicator. The breach occurred in Liverpool Heart & Chest, this is the third month in a row the Trust has reported a breach. The fourth breach was reported at Southport & Ormskirk in September.	The CCG is working with colleagues from LCCG to review the Root Cause Analysis (RCAs) from Liverpool Heart & Chest Hospital and Southport & Ormskirk Trust.
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(Aintree)**	15/16 - January	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. This was 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 - January	1953.61	2,128.34	↑	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 42 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 - January	266.58	173.59	↓	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 30 less than the same period last year.	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	15/16 - January	955.31	962.38	↑	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 11 more than the same period last year.	
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	15/16 - January	195.29	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 being 12 less that same period last year.	
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	15/16 - January	1107.98	1,135.68	↑	This measure now has a plan which is based on the same period previous year. The CCG is over plan, actual admissions is 43 more than the same period last year.	
Emergency readmissions within 30 days of discharge from hospital (Cumulative)	15/16 - January	No Plan	15.18	↓	The emergency readmission rate for the CCG is lower than previous month (16.74) and also lower than the same period last year (17.69).	

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	0.083	Provisional data (Published Feb 2016)	Provisional data shows the CCG achieved 0.083 which is lower than the previous years rate of 0.107 (2013/14) and lower than that of the England average 0.084. But above the plan of 0.0697.	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	0.408	Provisional data (Published Feb 2016)	Provisional data shows the CCG has declined on the previous years rate of 0.446 in 2013/14 and are reporting 0.408, they are also achieving a score lower than the England average 0.437, and the plan of 0.430.	
Patient reported outcomes measures for elective procedures: Knee replacement	Apr 14 - Mar 15 (Prov data)	0.341	0.294	Provisional data (Published Feb 2016)	Provisional data shows the CCG's rate has declined from previous year rate of 0.313 in 2013/14 recording a rate of 0.294 and is under the England average 0.315 and yearly plan.	
% who had a stroke & spend at least 90% of their time on a stroke unit **(CCG)**	15/16 - January	80%	75.00%	↑	The CCG have failed to achieve the 80% target in January, only 9 patients out of 12 spending at least 90% of their time on a stroke unit.	The majority of stroke patients breached at Aintree, please see below for Trust narrative .
% who had a stroke & spend at least 90% of their time on a stroke unit **(Aintree)**	15/16 - January	80%	71.00%	↑	Aintree have failed to achieve the target in January only 22 patients out of 31 spending at least 90% of their time on a stroke unit.	31 patients were discharged from the Trust in January 2016 with a diagnosis of stroke. 71% of these patients (22) spent 90% of their stay on the Stroke Unit, against a standard of 80%. 29% of these patients (9) failed the standard. Of the 9 patients who failed the standard, 8 arrived by ambulance and 1 patient was an existing inpatient. Of the 9 patients who failed the standard: - 1 patient was identified as requiring direct admission to the Stroke Unit on admission but no stroke bed was available and medical outliers were occupying stroke beds. - 1 patient was transferred to the Stroke Unit within 2hrs but died 2 hours after admission. - 1 patient was palliative and transferred to a side-room on AMU and died within 24 hours. - 1 patient had a Stroke whilst an inpatient but no stroke bed was available for 48hrs and medical outliers were occupying stroke beds. - 3 patients were transferred to the Stroke Unit but discharged early and therefore failed the standard. - 2 patients arrived during the night when there was no Stroke Nurse Clinician on duty and they were not assessed by the medical team until 4 hours and 9 hours respectively. Both patients were assessed and transferred to the Stroke Unit the following day.

% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(CCG)**	15/16 - January	60%	100%	↔		
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(Aintree)**	15/16 - January	60%	100%	↔		
Mental health						
Mental Health Measure - Care Programme Approach (CPA) - 95% (Cumulative) **(CCG)**	15/16 - Qtr3	95%	100.00%	↑		
IAPT Access - Roll Out	15/16 - Qtr3	3.75%	2.89%	↑	The CCG are under plan for Q3 for IAPT Roll Out, this equates to 703 patients having entered into treatment out of a population of 24298 (Psychiatric Morbidity Survey).	See section 7 of main report for commentary.
IAPT Access - Roll Out	15/16 - January	1.25%	1.40%	↑	The CCG are under plan in January for IAPT Roll Out, out of a population of 24298, 343 patients have entered into treatment. There has been a increase from last month when 1.10% was reported.	See section 7 of main report for commentary.
IAPT - Recovery Rate	15/16 - Qtr3	50%	46.40%	↓	The CCG are under plan for recovery rate reaching 46.4% in Q3. This equates to 160 patients who have moved to recovery out of 368 who have completed treatment.	See section 7 of main report for commentary.
IAPT - Recovery Rate	15/16 - January	50%	32.50%	↓	The CCG are under plan for recovery rate reaching 32.5% in January. This equates to 38 patients who have moved to recovery out of 117 who have completed treatment. This is a decrease from last month when 38.6% 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 - Qtr3	75%	95.40%	↓	January data shows 93.5%, a decrease from December when 98.3% was recorded.	
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 - Qtr3	95%	99.70%	↓	January data shows 99.2%, a slight decrease from December when 99.7% was recorded.	

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 - January	93%	96.47%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Aintree)**	15/16 - January	93%	96.09%	↔		
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 - January	93%	94.31%	↔		
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 - January	93%	95.10%	↔		

Cancer waits – 31 days						
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(CCG)**	15/16 - January	96%	98.50%	↔		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Aintree)**	15/16 - January	96%	99.17%	↔		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	15/16 - January	94%	96.51%	↔		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Aintree)**	15/16 - January	94%	100.00%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	15/16 - January	94%	95.35%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Aintree)**	15/16 - January	94%	98.73%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	15/16 - January	98%	99.04%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(Aintree)**	15/16 - January	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 - January	85% local target	88.14%	↓		
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 - January	85% local target	89.63%	↓		

Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(CCG)**	15/16 - January	90%	91.89%	↑		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(Aintree)**	15/16 - January	90%	95.38%	↓		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(CCG)**	15/16 - January	85%	85.22%	↓		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(Aintree)**	15/16 - January	85%	85.87%	↓		
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 - January	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted) **(Aintree)**	15/16 - January	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(CCG)**	15/16 - January	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(Aintree)**	15/16 - January	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(CCG)**	15/16 - January	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(Aintree)**	15/16 - January	0	0	↔		

Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(CCG)**	15/16 - January	90%	89.36%	↓	The CCG have failed the 90% target reaching 89.36%. This equates to 70 patients out of 628 not seen within 18 weeks.	No longer a national performance target but continue to monitor locally
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(Aintree)**	15/16 - January	90%	91.02%	↓		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(CCG)**	15/16 - January	95%	95.68%	↔		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(Aintree)**	15/16 - January	95%	95.84%	↔		
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 - January	92%	95.30%	↑		
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 - January	92%	94.40%	↔		

A&E waits						
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG) All Types**	15/16 - January	95.00%	95.00%	↓		
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG) Type 1**	15/16 - January	95.00%	82.84%	↓	The CCG have failed the target in January reaching 74.83%, and year to date reaching 82.84%. In January 987 attendances out of 3922 were not admitted, transferred or discharged within 4 hours	Aintree - During January 2016 there were 13,562 Type 1 and Type 3 attendances with 2,062 breaches which equates to combined performance of 84.80%. The following 5 key actions are a priority: 1. Ensuring medically accepted GP patients go direct to AMU or AEC and delivery of a rapid assessment model in AMU. 2. Delivery of ambulatory emergency care in the AEC Unit in Acute Medicine and the Observation Unit in A&E. 3. Ensure SAU and GPAU can accept all emergency surgical patients. 4. Increase the number of patients seen by GP out of hours service (UC24) and relocation of the service to Room 1 in UCAT 5. Use the support from the Utilisation Management Team and Tessa Walton, with additional support from senior managers for all areas, to improve patient flow. An action plan to reduce the numbers of medically optimised patients remains in place. To ensure sustained improvement, the following actions remains in place: • Full utilisation of the step down facility, Aintree 2 Home, which opened in December 2015 and Aintree @ Home, including for Discharge to Assess. • Implementation of the mobilisation plan for the transfer of the Discharge Planning Team to be community based. • Evaluating alternative models to support reducing delays for medically optimised patients, including the provision of a second step down facility within the Trust. • Weekly MADEs and implementation of actions from Safer Start/MADE.
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Aintree) All Types**	15/16 - January	95.00%	91.30%	↓	Aintree have failed the target in January reaching 84.8%, and year to date reaching 91.3%. In January 2062 attendances out of 13562 were not admitted, transferred or discharged within 4 hours. This is the seventh 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 - January	95.00%	83.56%	↓	Aintree have failed the target in January reaching 70.52%, and year to date reaching 83.56%. In January 2062 attendances out of 6995 were not admitted, transferred or discharged within 4 hours.	

Diagnostic test waiting times						
% of patients waiting 6 weeks or more for a Diagnostic Test **(CCG)**	15/16 - January	1.00%	1.59%	↑	The CCG had 37 patients, out of 2333 waiting over 6 weeks for a diagnostic test in January, this is the second month in a row the target has been failed. Of the 37, 23 were for non-obstetric ultrasound.	
% of patients waiting 6 weeks or more for a Diagnostic Test **(Aintree)**	15/16 - January	1.00%	1.56%	↔	Aintree had 72 patients, out of 4612 waiting over 6 weeks for a diagnostic test in January, failing the target. Of the 72,51 were for non-obstetric ultrasound.	Performance relates to delays to CT Cardiac, MRI and MSK USS. The radiology team have undertaken a number of actions to improve performance in relation to the DM01 standard. These include; • Weekly Performance Meeting – Highlighting issues and putting action plans into place to improve current position in MRI, CT and MSK USS. • Reviewed sessions with Radiologist in attempt to increase the number of sessions available for Ultrasound MSK injections. • Increased Sonographer sessions for non-injection MSK to ensure those Radiologists with the necessary skills are undertaking sessions for injections only. • MSK Radiologist appointed, commences August 2016 • WLI's for Cardiac CT to be arranged to take place during February.
Category A ambulance calls						
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	15/16 - January	75%	78.40%	↓		The onset of winter has seen the whole of the urgent care system coming under pressure due to high levels of demand. Overall demand in January for NWAS was 6.9% higher than planned for and 7.2% for South Sefton CCG. For the most time critical response times (Red) was 9.0% higher than plan for NWAS as a whole and 10% higher than plan for South Sefton. The average turnaround times at Aintree Hospital was one of the longest of any Cheshire & Merseyside Hospitals in January at over 41 minutes on average.
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	15/16 - January	75%	71.40%	↓	The CCG failed to achieve the 75% year to date or in month (Jan) recording 59.6%.	
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	15/16 - January	95%	96.00%	↔		
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	15/16 - January	75%	76.10%	↔		
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	15/16 - January	75%	72.70%	↓	NWAS failed to achieve the 75% year to date or in month (Jan) recording 63.49%.	
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	15/16 - January	95%	93.70%	↓	NWAS failed to achieve the 95% year to date or in month (Jan) recording 89.85%.	

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 23 Friends and Family – Aintree University Hospital NHS Foundation Trust

Clinical Area	Response Rate (RR) Target	RR Actual (Jan 2016)	RR - Trajectory From Previous Month (Dec 15)	Percentage Recommended (Eng. Average)	Percentage Recommended (Jan 2016)	PR - Trajectory From Previous Month (Dec 2015)	Percentage Not Recommended (Eng. Average)	Percentage Not Recommended (Jan 2016)	PNR - Trajectory From Previous Month (Dec 15)
Inpatients	25%	47.6%	↑	96.0%	97%	↔	1.0%	2%	↔
A&E	15%	19.7%	↔	86.0%	85%	↓	7%	9%	↑

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

- % Response Rate
- % Recommended
- % Not Recommended

10.3 Complaints

Aintree University Hospital

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 slightly above the England average and has remained static compared to the previous month (Dec 2015). The percentage of people who would not recommend the inpatient service has remained static on the previous month and is slightly above the England average.

The percentage of people that would recommend A&E has fallen slightly since December, and remains marginally below the England average. The percentage of people who would not recommend the A&E service has declined marginally compared to the previous month and is slightly above the England average.

The trust consistently returns response rates and recommendation percentages significantly higher than the regional and national averages, as observed in the table.

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.

Aintree are coming to EPEG in May 2016 to give an update on the continued patient experience work the trust are doing and the group look forward to this presentation.

10.4 Serious Untoward Incidents (SUIs)

SUIs Reported at South Sefton CCG level

These are serious incidents involving South Sefton CCG patients irrespective of their location of care.

This data relates to month 11, which is the latest data. There were 5 Serious Incidents in February involving South Sefton CCG patients.

For the year 15/16 up to and including February there have been 89 Serious Incidents involving South Sefton CCG patients.

CCG SUIs Never Event

Type of Incident	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
Abscond		2										2
Adverse media coverage or public concern about the organisation or the wider NHS										1		1
Allegation Against HC Professional										1		1
Child Abuse (family)										1		1
Child Death										1		1
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	2
Other								1				1
Pressure Sore - (Grade 3 or 4)			1	2							1	4
Pressure ulcer - (Grade 3)	6	6	3	3	3	16	1		2		1	41
Pressure ulcer - (Grade 4)	1	1	2	2								6
Serious Incident by Outpatient (in receipt)									1			1
Serious Self Inflicted Injury Inpatient										1		1
Serious Self Inflicted Injury Outpatient	1			1		1				2		5
Slips/Trips/Falls				2								2
Sub-optimal care of the deteriorating patient			1									1
Surgical Error		1						1			1	3
Treatment						1						1
Unexpected Death		2							4		1	7
Unexpected Death (general)						2						2
Wrong site surgery			1									1
Grand Total	**9**	**12**	**10**	**11**	**4**	**21**	**1**	**2**	**7**	**7**	**5**	**89**

Number of Never Events reported in period

One never event reported in June 15, and one reported February 2016. (South Sefton CCG patient in Alder Hey- wrong site surgery, South Sefton CCG patient in Aintree – surgical error)

Number of South Sefton CCG Incidents reported by Provider

The following are the organisations where SS CCG patinets have been subjected to serious incidents:

- Aintree University Hospital NHS Foundation Trust – 8
- Airedale NHS Foundation Trust – 1
- Alder Hey Children's NHS Foundation Trust – 2
- Liverpool Community Health NHS Trust – 56

- Liverpool Women's NHS Foundation Trust – 3
- Mersey Care NHS Trust – 12
- Southport and Ormskirk Hospital NHS Trust – 6

Incident Split by Provider Never Event

Provider / Type of Incident	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	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
Surgical Error											1	1
Treatment						1						1
Unexpected Death									1			1
Unexpected Death (general)						1						1
Airedale NHS Foundation Trust												
Serious Self Inflicted Injury Outpatient										1		1
Alder Hey Children's NHS Foundation Trust												
Unexpected Death									1			1
Wrong site surgery			1									1
Liverpool Community Health NHS Trust												
Child Abuse (family)										1		1
Child Death										1		1
Medical Devices/Equipment			1								1	2
Pressure Sore - (Grade 3 or 4)			1	2							1	4
Pressure ulcer - (Grade 3)	5	5	3	3	3	16	1		1		1	38
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				1		4
Slips/Trips/Falls				1								1
Unexpected Death									1		1	2
Southport & Formby CCG												
Serious Self Inflicted Injury Outpatient										1		1
Southport and Ormskirk Hospital NHS Trust												
Adverse media coverage or public concern about the organisation or the wider NHS										1		1
Allegation Against HC Professional										1		1
Maternity services - unexpected neonatal death.					1							1
Pressure ulcer - (Grade 3)	1	1										2
Pressure ulcer - (Grade 4)	1											1
Grand Total	**9**	**12**	**10**	**11**	**4**	**21**	**1**	**2**	**7**	**7**	**5**	**89**

SUIs Reported at Aintree University Trust level

Aintree University Hospital Foundation Trust reported 2 serious incidents in February 2016 with 31 incidents reported YTD by the provider.

Number of Never Events reported in period

One Never Event reported by Aintree University Hospital Foundation Trust in February 2016 (surgical error)

Number of incidents reported split by type

Provider SUIs Never Event

Incident Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	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		2
Sub-optimal care of the deteriorating patient	2		1							2		5
Surgical Error											1	1
Treatment						2						2
Unexpected Death						1	1		1		1	4
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**	**3**	**2**	**31**

Number of Incidents reported by CCG

CCG Name / Incident Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
Knowsley CCG												
Delayed diagnosis			1									1
Sub-optimal care of the deteriorating patient	1									2		3
Liverpool CCG												
Accident Whilst in Hospital							1					1
Critical Care Transfer								1				1
Pressure ulcer - (Grade 3)								1				1
Results					1							1
Slips/Trips/Falls							1					1
Sub-optimal care of the deteriorating patient	1											1
Unexpected Death						1					1	2
Unexpected Death (general)					1							1
South Sefton CCG												
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
Surgical Error											1	1
Treatment						1						1
Unexpected Death									1			1
Unexpected Death (general)						1						1
Southport & Formby CCG												
Treatment						1						1
Unexpected Death (general)	1											1
St Helens CCG												
Slips/Trips/Falls										1		1
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												
Failure to act upon test results			1									1
Pressure ulcer - (Grade 4)					1							1
Grand Total	**3**	**0**	**4**	**1**	**3**	**5**	**6**	**2**	**2**	**3**	**2**	**31**

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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

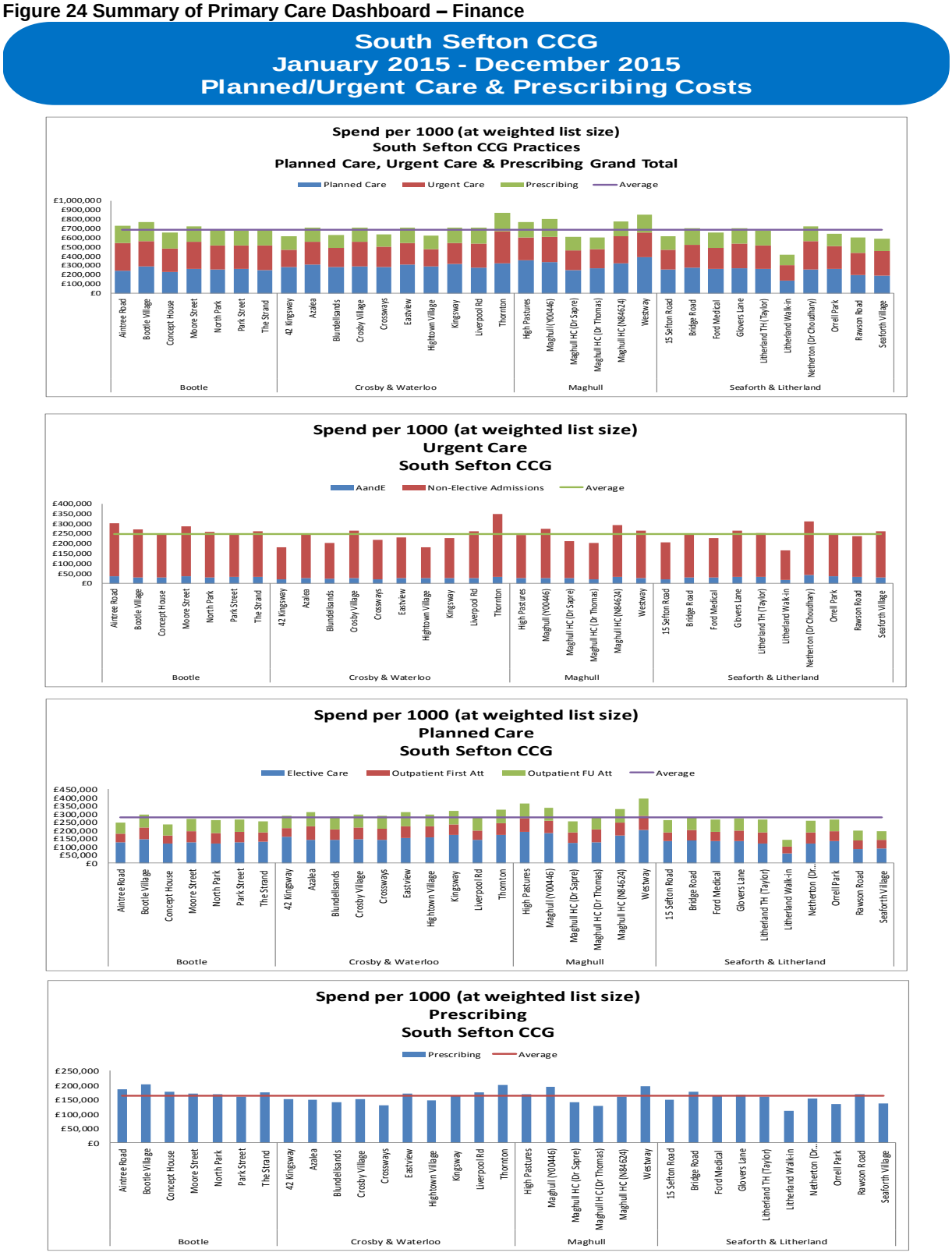
11.3 Format

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 24 Summary of Primary Care Dashboard – Finance



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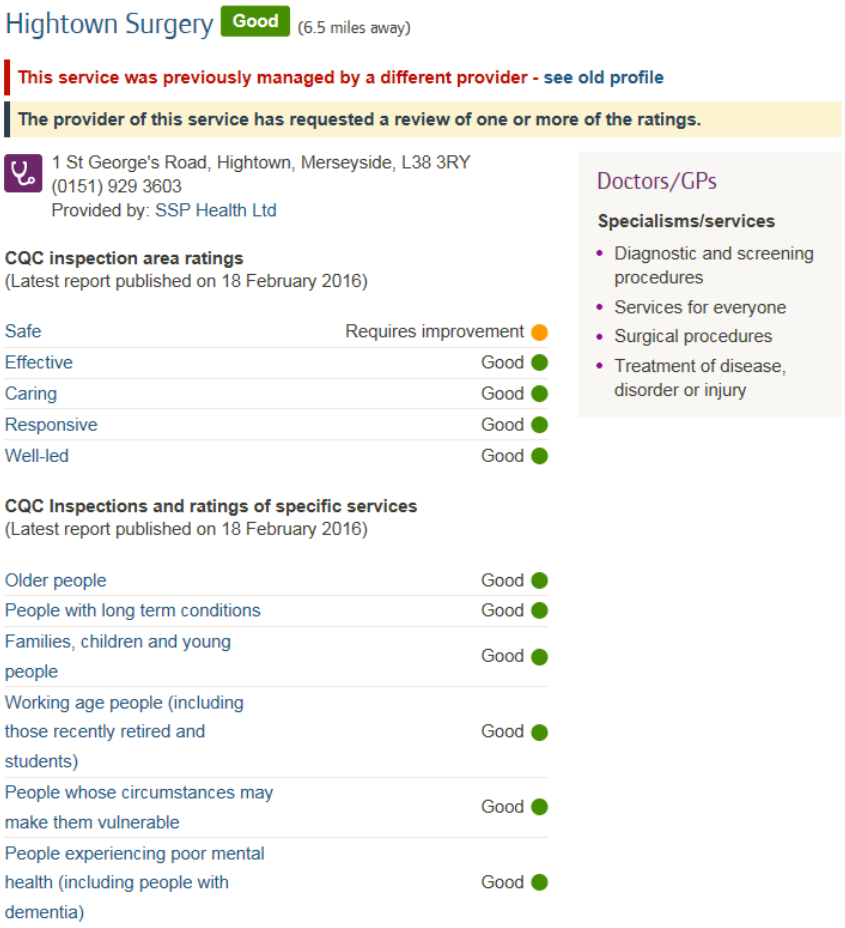
11.5 CQC Inspections

A number of practices in South Sefton CCG have been visited by the Care Quality Commission in 2015/16. CQC publish all inspection reports on their website. There has been one further inspection result published in February, for Hightown Surgery:



Hightown Surgery **Good** (6.5 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.

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 18 February 2016)

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

CQC Inspections and ratings of specific services
(Latest report published on 18 February 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

12. Better Care Fund update

Whilst the payment for performance element of the 2015/16 Better Care Fund has now ended, discussions are underway for planning the 2016/17 Better Care Fund.

13. NHS England Activity Monitoring

Figure 25 NHS England Activity Monitoring

Source	Referrals (G&A)	*Month 10 YTD* *PLAN*	*Month 10 YTD* *ACTUAL*	*Month 10 YTD* *Variance*	ACTIONS being Taken to Address Cumulative Variances GREATER than +/-3%
	Referrals (G&A)				
MAR	GP	30248	33102	9.4%	Please see previous months report detailing issues with GP hotline at Aintree. Local figures report a much lower variance but with increases above the 3% threshold.
MAR	Other	17972	20568	14.4%	Please see previous months report detailing issues. Local referral data for the CCG suggests a much lower increase within the 3% threshold.
MAR	Total	48220	53670	11.3%	As above. Overall increase much less than plan v actual shows when looking at local referral data flows.
	Outpatient attendances (G&A)				
SUS	All 1st OP	51164	50851	-0.6%	
SUS	Follow-up	128453	133605	4.0%	Please see previous report detailing the problems with the plans (based on MAR) against the actuals (based on SUS). Actual activity when comparing Apr-Jan 14/15 with the same period in 15/16 shows a variance of 1.2%, within the 3% threshold.
SUS	Total OP attends	179617	184456	2.7%	As above.
SUS	Outpatient procedures (G&A) (included in attends)				
	Admitted Patient Care (G&A)				
SUS	Elective Day case spells	18350	16294	-11.2%	As with previous months comments day case procedures have increased against last year with figures remaining at the 6% mark.
SUS	Elective Ordinary spells	3045	2826	-7.2%	As noted in previous returns, plan v actual remains in line with the year to date comparison of last year to this years activity levels.
SUS	Total Elective spells	21395	19120	-10.6%	Overall when comparing last year to the same period this year the increase is approx. 4%. This is due to increases in day case procedures.
SUS	Non-elective spells complete	17604	16437	-6.6%	The closure of CDU within Aintree has had an impact on the NEL figures. An estimated increase was used to gauge the potential increase within the plan but a much lower impact has been felt. Increase from last years activity to this years is approx. 4.5%, due to the CDU effect.
SUS	Total completed spells	38999	35557	-8.8%	As above.
	Attendances at A&E				
SUS	Type 1				
SUS	All types	42384	45540	7.4%	As per the comments from previous months, the variance of actual activity from April to January 2014/15 compared with the same period this year shows a slight decrease of less than 1%, within the 3% threshold.

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MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/52	**Author of the Paper:** Martin McDowell Chief Finance Officer Email: martin.mccdowell@southseftonccg.nhs.uk Tel: 0151 247 7000
Report date: March 2016	
Title: 2016/17 Opening Financial Budgets	
Summary/Key Issues: This paper presents the Governing Body with the 2016/17 Budget.	
Recommendation The Governing Body is asked to approve this report	Receive [ ] Approve [x] Ratify [ ]

Links to Corporate Objectives *(x those that apply)*	
X	To place clinical leadership at the heart of localities to drive transformational change.
X	To develop the integration agenda across health and social care.
	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.

16/52

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

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Report to Governing Body
March 2016

1. Summary

1.1 This paper provides details of the CCG's 2016/17 proposed opening budgets for consideration and approval.

1.2 At the time of preparing this report, there remain uncertainties in some areas (including the impact of contract negotiations) and it is proposed that an updated report will be presented to the Governing Body in May 2016.

1.3 The budgets have been prepared reflecting all available planning guidance and the assumptions are consistent with those outlined in the financial plan.

1.4 The budgets reflect national guidelines and local arrangements and are based on 2015/16 Forecast Outturn as the start point for operational budgets.

1.5 A summary of the proposed 2016/17 Budget is presented below.

Table 1 *- Summary 2016/17 Opening Budgets*

Budget Area	2015/16		
	Rec	Non Rec	Total
	£m	£m	£m
Resources			
Base Allocation	226.817		226.817
Growth funding	5.556		5.556
Better Care Fund allocation	4.105		4.105
Running Cost Allowance	3.259		3.259
Agreed Allocation Adjustments	1.024		1.024
Surplus b/f		2.400	2.400
Available Resources	**240.761**	**2.400**	**243.161**
Commissioning Budgets			
NHS Commissioned Services	167.547	5.125	172.672
Corporate & Support Services: admin	3.216	0.043	3.259
Corporate & Support Services: programme	3.540	0.067	3.607
Independent Sector	2.951	0.061	3.012
Medicines Management	30.746	0.000	30.746
Primary Care	3.014	0.319	3.333
Non NHS Commissioning	18.033	0.020	18.053
Sub total Operational budgets	**229.047**	**5.636**	**234.682**
Reserves			
QIPP requirement	(8.282)		(8.282)
Non Recurrent schemes		3.061	3.061
Better Care Fund investment	4.572		4.572
Other Committed Plans	5.464		5.464
Contingency	1.214		1.214
Sub total Reserves	**2.968**	**3.061**	**6.029**
Total Anticipated Spend	**232.015**	**8.697**	**240.711**
Forecast Surplus/ (Deficit)	**8.746**	**(6.297)**	**2.450**
Expressed as %			**1%**

1.6 The financial plan presents a surplus of £2.450m which delivers the NHS business requirement of a 1% surplus.

1.7 The £5.464m funding for Other Committed Plans includes:

- £2.4m Transformation Fund
- £1.4m Contingency Budget
- £1.0m Allocation transfers for Specialised Commissioning

1.8 The planning guidance requests that an uncommitted reserve of 1% (£2.4m) is held and only released following agreement with NHS England. In previous financial years, this reserve was committed against non-recurrent schemes.

2. National Context

2.1 **Guidance**

The Department of Health (DH) issued planning guidance for CCG's: *Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21.* This publication sets out the DH's expectations for health service priorities for the forthcoming year and confirms a number of "business rules" for financial planning purposes.

The CCG's budget setting approach has taken these priorities and business rules into account when establishing the proposed 2016/17 budgets. However, the budget does not meet the business rules, particularly the need to deliver a 1% surplus.

2.2 **Resource Allocations**

In November 2015, the government announced a five year funding settlement for the NHS. In January 2016, detailed allocations for CCGs for the three year period 2016/17 to 2018/19 were published, with indicative allocations for the following two years to 2020/21.

The CCG's resource allocation for 2016/17 has been set at **£243.161m** in total and comprises the following elements:

a) Baseline allocation **£226.817m.**

b) Growth - With priority given to under-funded CCGs, South Sefton CCG received allocation growth of 2.4%; the average uplift received by CCGs in England was 3.74%. Growth funding for the CCG equates to **£5.556m**.

c) Better Care Fund – The additional better care fund allocation now flows to CCGs. This equates to **£4.105m.**

d) The CCG running cost allowance was set at **£3.259m** based on £22.07 per head for a population of 147,687. This compares to a running cost allocation of £3.296m in 2015/16.

e) Funding transferred to the CCG from Specialised Commissioning relating to Neurology and Wheelchairs following a change in commissioning responsibility. This equates to **£1.024m**

2.3 **Business Rules & Metrics**

The key business rules prescribed by "*Delivering the Forward View*…" are:

- To produce a surplus of 1% of resource allocation
- 1% non-recurrent reserve which must be uncommitted at the start of the year and only released following agreement with NHS England.
- To set aside a Contingency reserve of at least 0.5% of the total allocation.
- No overspend against the running cost allocation.

The proposed budget meets the business rules with the exception of the 1% surplus. The budget proposed will deliver a deficit of £6m (3%).

2.4 **Inflation & efficiency targets**

The national tariff is currently in consultation, the final tariff will be published following this process.

The current tariff assumptions are outlined in **Table 2**. The efficiency factor is lower than in previous years, and the pay cost inflation reflects a step change in pension related costs. CCG allocations have been increased to reflect the increased tariff pressure.

Table 2 – Tariff assumptions

Uplift / efficiency factors	**weighted average estimate**
Efficiency factor	(2.00%)
Labour cost inflation	2.18%
Drugs cost inflation	0.37%
Non-pay, non-drugs inflation	0.34%
Changes in capital costs	0.15%
Clinical Negligence scheme for Trusts (CNST) inflation	0.03%
Total	**1.07%**

For services covered by the PR tariff (most acute services), there is an additional 0.70% inflation. This is applied differentially dependent on HRG, with maternity tariffs receiving the highest increase.

Budgets have been set in line with the above tariff assumptions.

2.5 **Commissioning for Quality and Innovation schemes (CQUIN)**

The amount available for Trusts to earn via CQUIN remains at 2.5%. A proportion of the funding (0.5%) is retained to fund national schemes where appropriate with providers, whilst the balance of 2.0% is available to fund agreed local priorities.

3 2014/15 Opening Expenditure Budgets

3.1 The opening budgets for the CCG have been constructed using the forecast position at month 10, and appropriate data currently available to the CCG. The assumptions reflected in the CCGs financial plan have been replicated in the budgets. These are outlined below:

a) Continuing Healthcare (adults) – adjust start point to reflect costs experienced in 2015/16 plus 5% inflation.
b) All other individual packages of care cost areas (egg. Funded Nursing Care and Learning Disabilities) – 5% increase.
c) Prescribing – 3% increase.
d) Demographic growth – based on statistical analysis, costs associated with activity based budgets have been uplifted by 0.01%.
e) Acute growth – a reserve has been set up to accommodate a 0.5% increase in acute costs.

3.2 The opening budgets will be subject to verification once the final outcome of negotiation has been assessed and final 2016/17 contracts have been agreed. The outcome of this review will be presented to the Governing Body in May 2016.

3.4 **Table 3** below shows the opening budgets for each expenditure area compared to the Forecast Outturn (FOT) 2015/16 position as at Month 10. A more detailed analysis is provided at Appendix 1.The key factors for any variances are described below.

Table 3 *– Comparison of Opening 2016/17 Budgets to 2015/16 Forecast Outturn (FOT)*

Operating Budgets	FOT (M10) 2015/16 £m	BUDGET 2016/17 £M	INCREASE/ (DECREASE) £M
NHS Commissioned Services	170.412	172.672	2.260
Corporate & Support Services: admin	3.256	3.259	0.003
Corporate & Support Services: programme	3.184	3.607	0.422
Independent Sector	3.100	3.012	(0.088)
Medicines Management	29.893	30.746	0.853
Primary Care	2.688	3.333	0.645
Non NHS Commissioning	20.122	18.053	(2.069)
Total Operating budgets	**232.655**	**234.682**	**2.027**

3.5 The opening budget for NHS Commissioned services is £2.3m higher than the 2015/16 forecast outturn. The main reason for this increase is uplifts to contracts of 1.8% for PbR services and 1.1% for non-PbR services.

3.5 The Corporate & Support Services programme budget is higher than the 2015/16 forecast outturn due to non-recurrent efficiency savings within the 2015/16 budget.

3.6 The Medicines Management budget has been based on forecast outturn. The increase of £0.85m compared to forecast outturn relates to the net 3% drug inflation.

3.7 Non NHS Commissioning – this budget is predominantly based on forecast outturn. This area includes individual packages of care for Mental Health, Funding Nursing Care and Continuing Health Care. The reduction in the opening budget compared to the forecast outturn relates to funding relating to Estates and the Better Care Fund held in the reserves budget in the new financial year

4 2016/16 Opening Reserves

4.1 QIPP Plans

4.1.1 Included in the 2016/17 financial plan is a QIPP target of £8.2m, identification and delivery of the QIPP efficiency saving is managed by the Clinical QIPP Committee. **Table 4** shows the QIPP schemes currently in progress.

Table 4: QIPP Schemes

QIPP Efficiency Savings	2016/17		
	Recurrent £m	Non-Recurrent £m	Total £m
Opening QIPP position	4.05	4.23	8.28
15/16 Expenditure Review		(1.80)	(1.80)
Release 1% uncommitted reserve		(2.43)	(2.43)
Existing Schemes			
Respiratory Training programme	(0.83)		(0.83)
Telehealth in Care Homes	(0.43)		(0.43)
Prescribing - Waste and Generics	(0.50)		(0.50)
Outpatient reductions: First Attendance	(0.17)		(0.17)
Outpatient reductions: Follow up	(0.65)		(0.65)
Legacy Review			0.00
Rationalise Voluntary Sector			0.00
Estates Rationalisation			0.00
Additional Schemes			
Manage Growth to 2015/16 levels: Acute	(0.65)		(0.65)
Manage Growth to 2015/16 levels: CHC	(0.50)		(0.50)
LQC savings / disinvestment			0.00
Clinical QIPP Group Restrictions			0.00
Remaining Balance / Unidentified QIPP	**0.32**	**0.00**	**0.32**

4.2.2 Whilst a number of QIPP schemes have been identified by the CCG, they require additional work to make them implementation ready. With these additional schemes implemented, there still remains an unidentified QIPP balance of £0.32m in 2016/17.

4.3 1% Non-Recurrent Reserve

4.3.1 NHS England's guidance includes the requirement for a 1% non-recurrent reserve to remain uncommitted at the start of the financial year and to only be released following agreement with NHS England.

4.3.2 In the previous financial year, the CCG was required to hold a 1% reserve but this could be committed and planned at the start of the year.

4.3.3 The effect of the requirement to hold this reserve uncommitted is that non-recurrent schemes previously committed against this funding which need to be continued are included elsewhere within the CCG financial plan. This creates an additional cost pressure in the budget.

4.4 Other Investment Plans

4.4.1 **Table 7** outlines the other recurrent investments as agreed in the Financial Strategy. These are all provided in the budget. The CCG has pre-commitments against the majority of these schemes and there is little room for reduction

Table 7: Recurrent Investment plans

RECURRENT INVESTMENT PLAN 2016/17	Total £m
CAMHS Transformation	0.335
IVF Change in Criteria	0.092
Community Services	0.275
Street Cars	0.019
Spirometry	0.083
Cheshire & Mersey Rehab	0.470
Transformation Fund	1.975
Mental Health Contracts	0.425
Total non-recurrent schemes	**3.674**

4.5 Contingency Reserve

4.5.1 The contingency reserve has been set at £1.214m, which is the required 0.5% of CCG allocation as per NHS England guidelines. The CCG has agreed to make this reserve recurrent, as opposed to the guidance which asks for it to be set aside non- recurrently, as this is likely to be more reflective of spending patterns that emerge through the year.

5 Key Financial Risks and Pressures

5.1 At the time of writing this paper, the CCG had not reached agreement with all providers in respect of agreeing 2016/17 contracts. Therefore commissioning budgets remain indicative at this stage, based on the assumptions outlined above, and subject to changes arising from final agreements with providers. Any further pressures that arise will be an increased cost pressure for the CCG and will increase the QIPP requirement.

5.2 There are a number of other risks, which have been reported to NHS England in CCG financial plans are outlined in **Table 8**, and detailed further below.

Table 8: Quantification of risks

Risk	Full Risk Value	%	Weighted Risk Value	Commentary
QIPP Under-Delivery	6.477	47%	3.057	High risk of under-delivery
Mental Health SLAs	0.215	50%	0.108	Mental health provider contract negotiation
Continuing Health Care SLAs	0.500	50%	0.250	New framework prices - a volatile area of spend
Prescribing	0.500	50%	0.250	A volatile area of expenditure
Total Risks	**7.692**		**3.665**	

5.3 The CCG plans have been prepared using 2015/16 financial year forecast outturn position; therefore any growth in demand in 2016/17 will create an additional pressure on the CCG budget.

5.4 Mental Health – in 2015/16, Mersey Care made a claim that services provided to the CCG are underfunded. This is a claim that is disputed by the CCG and work is ongoing to resolve the issue. The CCG provided £0.271m non-recurrent funding in 2015/16 to fund transformation schemes to address the shortfall in funding.

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

5.7 Continuing Health Care (CHC) – Expenditure on CHC has seen significant growth in recent years although this has been mitigated through effective review of individual packages. There is a risk that costs will increase due to both increased packages and increases to framework prices.

6. Strategic Transformation Fund / System Resilience Fund

6.1 A Strategic Transformation Fund of 1% (£2.4m) was established in 2015/16 which is aimed at 'spend to save' schemes. This commitment will continue in 2016/17 and a number of schemes have been proposed for inclusion.

6.2 Funding allocated for System Resilience in 2015/16 and resources retained from the decommissioned Darzi practice have been combined with the Transformation Fund in 2016/17. Total funding is £4.528m as shown in Table 9 below. A number of schemes have been committed against this fund with further proposals in progress.

Table 9 – Transformation / System Resilience Fund

Transformation / Resilience funding	**2016/17 (FYE)**
Resource - Transformation Fund	2,400
Resource - Darzi practice	458
System resilience fund - recurrent resource	1,200
System resilience fund - non recurrent resource	470
Total funding	**4,528**

6.4 It is imperative that the CCG manages to budget during the year, and takes quick, effective remedial action where necessary to address any financial variances during the year. The CCG's Governing Body should focus its attention on reducing clinical variation in referral patterns, prescribing practice and deflecting urgent activity away from hospital settings. The CCG should take steps to establish the following task and finish groups, which will need to be clinically led:

- Referral Management scheme which seeks to reduce variation in individual / practice referrals into secondary care.
- Prescribing review – peer to peer reviews supported by the CCGs Medicines Management Team to identify areas of improved prescribing.
- Continued development of the CCGs 'Virtual Ward' programme with a clear emphasis upon 'spend to save' schemes.

7. Conclusions & Recommendations

7.1 The Governing Body are asked to approve the CCGs opening budgets, noting compliance with NHS business rules for CCGs.

7.2 The Governing Body is asked to note that negotiations are still ongoing in key areas, notably agreement of contracts with NHS providers. A revised budget will be presented to the Governing Body in May 2016.

7.3 The Governing Body is asked to note that the value of unidentified QIPP is at £8.2m, there are schemes planned to address this in part but these require significant work to implement.

7.4 The Governing Body is asked to recognise that the CCG faces a significant financial challenge which will require support for changes from all members, with a key role for Governing Body GP members and Programme Leads to provide leadership required to deliver change.

Appendices

Appendix 1 - Analysis by Cost Centre - Opening 2016/17 Budget compared to forecast outturn

Appendix 1

NHS
South Sefton
Clinical Commissioning Group

Appendix 1

Comparison of 2016/17 Opening Budget to 2015/16 Forecast Outturn

Cost centre Number	Cost Centre Description	Budget Holder	Forecast Outturn 2015/16	Annual Budget 2016/17	Increase (Decrease)
			£000	£000	£000
COMMISSIONING - NON NHS					
598501	Mental Health Contracts	Jan Leonard	1,033	1,053	20
598506	Child And Adolescent Mental Health	Jan Leonard	342	238	(104)
598511	Dementia	Jan Leonard	118	118	0
598521	Learning Difficulties	Debbie Fagan	562	545	(17)
598541	Mental Health Services - Collaborative Commissioning	Debbie Fagan	574	0	(574)
598596	Collaborative Commissioning	Jan Leonard	511	521	10
598661	Out Of Hours	Jan Leonard	1,223	1,195	(28)
598682	Chc Adult Fully Funded	Debbie Fagan	5,726	6,776	1,050
598684	Chc Adult Joint Funded	Debbie Fagan	1,490	1,409	(81)
598685	Chc Adult Joint Funded Personal Health Budget	Debbie Fagan	50	107	58
598687	Chc Children	Debbie Fagan	511	534	24
598691	Funded Nursing Care	Debbie Fagan	2,064	2,166	102
598711	Community Services	Jan Leonard	2,890	447	(2,443)
598721	Hospices	Jan Leonard	1,457	1,479	22
598726	Intermediate Care	Jan Leonard	569	218	(351)
598796	Reablement	Jan Leonard	1,003	1,245	243
Sub-Total			**20,122**	**18,053**	**(2,069)**
CORPORATE & SUPPORT SERVICES					
600251	Administration & Business Support	Tracey Jeffes	168	161	(7)
600266	Business Informatics	Karl McKluskey	151	348	197
600271	CEO/ Board Office	Fiona Taylor	495	531	36
600276	Chair and Non Execs	Tracey Jeffes	169	185	15
600296	Commissioning	Jan Leonard	897	727	(171)
600311	Contract Management	Jan Leonard	235	114	(121)
600316	Corporate Costs & Services	Tracey Jeffes	359	402	43
600346	Estates and Facilities	Martin McDowell	352	334	(19)
600351	Finance	Martin McDowell	341	395	53
600391	Medicines Management	Susanne Lynch	26	0	(26)
600426	Quality Assurance	Debbie Fagan	61	63	2
	Sub-Total Running Costs		**3,256**	**3,259**	**3**
598646	Commissioning Schemes (Programme Cost)	Fiona Taylor	835	1,011	176
598656	Medicines Management (Clinical)	Susanne Lynch	592	730	137
598810	Nursing and Quality Programme	Debbie Fagan	267	280	13
598776	Non Recurrent Programmes (NPfIT)	Martin McDowell	0	0	0
598676	Primary Care IT	Martin McDowell	1,490	1,586	96
600371	IM&T				
	Sub-Total Programme Costs		**3,184**	**3,607**	**422**
Sub-Total			**6,440**	**6,866**	**425**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS					
598571	Acute Commissioning	Jan Leonard	117,143	118,572	1,430
598576	Acute Childrens Services	Jan Leonard	8,033	8,130	97
598586	Ambulance Services	Jan Leonard	5,764	6,091	327
598616	NCAs/OATs	Jan Leonard	1,812	1,947	135
598631	Winter Pressures	Jan Leonard	950	1,423	474
598756	Commissioning - Non Acute	Jan Leonard	36,711	36,509	(202)
598786	Patient Transport	Jan Leonard	0	0	0
Sub-Total			**170,412**	**172,672**	**2,260**
INDEPENDENT SECTOR					
598591	Clinical Assessment and Treatment Centres	Jan Leonard	3,100	3,012	(88)
Sub-Total			**3,100**	**3,012**	**(88)**
PRIMARY CARE					
598651	Local Enhanced Services and GP Framework	Jan Leonard	2,449	3,014	565
598791	Programme Projects	Jan Leonard	239	319	80
Sub-Total			**2,688**	**3,333**	**645**
PRESCRIBING					
598606	High Cost Drugs	Jan Leonard	545	547	2
598666	Oxygen	Jan Leonard	388	455	67
598671	Prescribing	Jan Leonard	28,960	29,744	784
Sub-Total			**29,893**	**30,746**	**853**
Sub-Total Operating Budgets pre Reserves			**232,655**	**234,682**	**2,027**
RESERVES					
598761	Commissioning Reserves	Martin McDowell	4,354	6,029	1,675
Sub-Total			**4,354**	**6,029**	**1,675**
Grand Total I & E			**237,010**	**240,711**	**3,702**

NHS
South Sefton
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MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/	**Author of the Paper:** Martin McDowell Chief Finance Officer martin.mcdowell@southseftoncg.nhs.uk Tel: 0151 247 7065
Report date: 15 March 2016	

Title: Financial Strategy update: 2016/17 – 2020/21

Summary/Key Issues:

This report sets out an update to the longer term financial strategy and the assumptions which underpin it. This has been updated to reflect changes in expenditure patterns in 2015/16, and also reflects the latest planning guidance and allocations issued by NHS England.

The primary purpose is to influence decision making and to guide the CCG as it seeks to meet financial obligations in future years. The CCG is operating in an increasingly challenging financial environment, and must improve its financial performance, particularly in 2016/17.

The report provides an update to the underlying risks facing the CCG.

Recommendation

Receive	
Approve	X
Ratify	

The Governing Body is asked to approve the Financial Strategy for the 5 year planning period, specifically noting:

- the required QIPP challenge over the time period, noting the need to frontload savings in early years of the plan;
- the increasingly challenging financial environment that the CCG and its providers are operating in, and the need to work collaboratively to reduce spend;
- the principle that any slippage against planned investments will be used to support QIPP;
- the changes in assumptions, and the impact on estimated spend in future year planning periods;
- the changes in funding allocations for 2016/17, and future years, recognising that growth in funding doesn't match inflation and represents a real terms cut;
- the changes in planning guidance and business rules outlined by NHS England, particularly the need to hold a 1% uncommitted reserve;
- the potential risks concerning future CCG Resources; and
- the requirement to deliver annual recurrent QIPP plans of 1-2% to maintain a surplus position.

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.
X	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
X	To achieve financial duties and commission high quality care.

Process	**Yes**	**No**	**N/A**	**Comments/Detail *(x those that apply)***
Patient and Public Engagement		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)*	
	Preventing people from dying prematurely
	Enhancing quality of life for people with long-term conditions
	Helping people to recover from episodes of ill health or following injury
	Ensuring that people have a positive experience of care
	Treating and caring for people in a safe environment and protecting them from avoidable harm

Report to Governing Body
March 2016

1. Executive Summary

1.1 The purpose of this paper is to provide an update to the Financial Strategy previously reported to Finance and Resource Committee in October 2015. This has been updated to reflect national planning guidance published in December 2015 and January 2016, including confirmation of funding allocations for CCGs.

1.2 The Strategy has also been updated to demonstrate the impact of current expenditure patterns and assumptions. The CCG has experienced some expenditure pressures in 2015/16, coupled with under-delivery against its QIPP target. Through a number of non-recurrent measures the CCG has been able to meet its surplus target in 2015/16. However, this has meant that the CCG starts the new year in a challenging financial position. This report describes what the CCG must do to remain in surplus in 2016/17 and throughout the 5 year planning period.

1.3 The Strategy is a dynamic plan that will adjust in line with changes to the external environment such as government policy and the development of the CCGs commissioning plans. One of the key outputs outlined in the planning guidance is the need for local health economies to work collaboratively to produce a Sustainability and Transformation Plan (STP) over a large geographical footprint. This work in Cheshire and Merseyside is ongoing, and therefore the iteration of the Strategy presented in this report does not reflect the outputs of that economy-wide plan. Rather, it helps to identify the size of the challenge, and a realistic timescale over which that challenge can be addressed. The Strategy will assist the development of the STP.

2. Funding allocations and impact of planning guidance

Funding allocations

2.1 On 25 November 2015, the government announced a five year funding settlement for the NHS. Annual funding will rise in real terms by £3.8bn in 2016/17 and £8.4bn by 2020/21. In January 2016, NHS England published the detailed allocations for CCGs for the three year period of 2016/17 to 2018/19, with indicative allocations for the following two years to 2020/21. With inflation estimated to be 1.7%, the total cash increase to NHS funding in England was £5.5bn for 2016/17. **Table A** below outlines how the additional funding was distributed.

Table A – National Headline Funding – 2016/17

Area of investment	Additional allocation	Comments
Clinical Commissioning Groups (CCGs)	£2.4bn	Growth in funding varied from 1.39% to 9.65%, with funding channelled to those CCGs that are considered to be the most under-funded.
Primary Care (GP)	£0.3bn	4.2% growth in primary care funding
Specialised Commissioning	£0.7bn	7.0% growth in specialised commissioning
Sustainability Fund	£1.8bn	Targeted funding for providers
Transformation Fund	£0.1bn	Representing an increase in the national transformation fund, as it grows from £0.2bn to £0.3bn
Other NHS England budgets	(£0.1bn)	Reduction in other NHS England budgets

2.2 For this round of allocations the core structure of the CCG formula remains the same, but underlying data have been updated, and a number of revisions have been made for sparsity and inequalities. The CCG's distance from its target level of funding has moved from 6.81% to 5.56% above target in 2016/17 (equating to £13.52m). Under the rationale of the allocation formula this means that the CCG has been given £13.52m more than required to deliver healthcare to its population. With the advent of multi-year allocations, this funding is not at risk, although the CCG will continue to need to manage its expenditure whilst receiving comparatively low levels of growth.

2.3 With higher funding growth directed to CCGs that are considered under-funded, the CCG received modest growth of 2.40%. This compared to the national average of 3.74%. It is important to note that additional expenditure commitments were also handed down to CCGs, most notably:

- Increased tariff to providers (detailed later)
- GP IT expenditure previously funded by NHS England
- CAMHS transformation initiatives commenced in 2015/16 and previously funded by NHS England

These expenditure commitments equate to just less than 1.4%. With GDP deflator (a measure of inflation) estimated at 1.7%, the CCGs funding growth does not represent real terms growth, but rather a reduction.

2.4 In context, the CCG's allocation of £1,532 per head is 25.5% higher than the English average of £1,221.

2.5 The allocations for future years have also been published and are outlined in **Table B**. This table also shows the estimated level of inflation and the impact of policy pressures that have been built into CCG allocations, most notably the additional cost of 7 day working factored into 2020/21 allocations. The table identifies that the CCG's funding represents a reduction in real terms in each of the years of the planning period.

Table B – Allocation profile

	2016/17	2017/18	2018/19	2019/20	2020/21
GDP deflator	1.7%	1.8%	1.9%	2.1%	2.2%
Non-routine policy pressures	1.4%	0.2%	0.1%	0.0%	1.5%
GDP deflator plus non-routine policy pressures	**3.0%**	**2.0%**	**2.0%**	**2.1%**	**3.7%**
South Sefton CCG allocation growth	2.4%	1.5%	1.5%	1.5%	3.1%

Business Rules

2.6 For 2016/17 the business rules for commissioners will remain similar to those for last year. The expectation is that CCGs will be required to meet a surplus of 1%. Commissioners who are unable to meet the surplus requirement are expected deliver a break-even position.

2.7 However, there is one significant difference in the business rules regarding the non-recurrent headroom. Previously, CCGs were asked to have a 1% reserve to fund non-recurrent initiatives. This reserve could be fully committed and planned for at the beginning of the year. This has now changed. In order to provide funds to insulate the health economy from financial risks, the 1% non-recurrent reserve should be uncommitted at the start of the year, to enable progressive release in agreement with NHS England as evidence emerges of risks not arising or being mitigated through other means.

2.8 The uncommitted 1% reserve is a stipulation of HM Treasury, and creates an £800m resource nationally to mitigate financial risk. In-year the financial position will be reviewed by HM Treasury in conjunction with NHS England and NHS Improvement. Based on the outcome of these reviews the transformational footprints will either be required to hold the 1% or will be able to release it for investment. If part of the 1% is required to be used to offset provider deficits the financial impact of this will be pro-rated over all commissioners in a transformational footprint; the contribution is linked to footprints and not contractual relationship with providers.

2.9 Setting aside this uncommitted 1% reserve creates additional financial pressure for the CCG of £2.4m in 2016/17. It is unclear at this stage whether this will be spent in 2016/17 or not. The CCG will be looking to offset this funding against its QIPP plans at the earliest opportunity.

2.10 The CCGs Financial Strategy includes a 0.5% contingency reserve in accordance with the business rules.

2.11 Business rules stipulate that commissioners should continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase (referred to as the Parity of Esteem requirement). Exceptions may be permitted where the CCG is in deficit, or where there was non-recurrent investment in mental health services in 2015/16. The CCG had non-recurrent costs in 2015/16 as a result of start-up costs for the new IAPT contract provider, this reduction means the CCG does not meet the Parity of Esteem requirement. When the non-recurrent start-up costs are stripped out of the Parity of Esteem calculation, the CCG can demonstrate compliance (see **Table C**).

Additional investment is set aside for CAMHS as outlined in the investment appendix (see **Appendix 1**), and the CCG continues to work with Mersey Care to channel resources from the Transformation Fund into priority areas.

Table C – Mental Health Parity of Esteem

Areas of spend	2015/16 FOT	2016/17 Plan
Individual packages of care for mental health and Learning Disabilities	3,338	3,367
Primary and community care prescribing - mental health conditions	2,027	2,091
Mersey Care contract	14,066	13,998
Expected increase - Mersey Care business cases		425
CAMHS	2,589	2,672
Other mental health contracts	2,990	2,675
Reduce for non-recurrent IAPT start up costs, and non-recurrent funding	-338	
	24,672	**25,228**

Growth	556
Growth %	2.3%
Programme growth %	2.2%

Tariff Assumptions

2.12 The consultation document on the tariff was released on 11 February 2016, with the deadline for responses of 10 March 2016. The final tariff will then be published shortly thereafter. The current tariff assumptions are outlined in **Table D**. The efficiency factor is lower than in previous years, and the pay cost inflation reflects a step change in pension related costs. CCG allocations have been increased to reflect the increased tariff pressure.

Table D – Tariff assumptions

Uplift / efficiency factors	**16/17 weighted average estimate**
Efficiency factor	(2.00%)
Labour cost inflation	2.18%
Drugs cost inflation	0.37%
Non-pay, non-drugs inflation	0.34%
Changes in capital costs	0.15%
Clinical Negligence scheme for Trusts (CNST) inflation - services not covered by PbR	0.03%
Total	**1.07%**

2.13 For services covered by the PbR tariff (most acute services), there is an additional 0.70% inflation to reflect increased costs of CNST to providers. This is applied differentially dependent on HRG, with maternity tariffs receiving the highest increase.

3. Provider landscape and Sustainability Funding

3.1 As part of the government's spending review £2.14 billion has been established as a sustainability & transformation fund (STF) in 2016/17, with £1.8 billion of this being made available to stabilise the financial position of the provider sector.

3.2 NHS providers have each been given a 2015/16 control total, a 2016/17 control total, a proportion of the national £1.8bn STF and a residual QIPP target. There remains a significant challenge for local providers to meet their QIPP targets and, although the guidance states that income growth should not be used to meet provider financial targets, there remains a risk to the CCG.

3.3 Quarterly release of the Sustainability Funds to providers will depend on achieving recovery milestones for:

- Deficit reduction (Financial performance)
- Access standards (operational performance)
- Progress on transformation

3.4 Where access targets are not currently being met, providers are required to produce a trajectory for improvement. These require co-ordinating commissioner sign-off. For the access targets affected, contract financial penalties are not applied in 2016/17.

4. Expenditure assumptions and investment strategy

4.1 The CCG experienced a number of cost pressures in 2015/16 which have been built in to the starting budgets for 2016/17. The start point of the Financial Strategy is the 2015/16 forecast outturn. The cost pressures in-year are primarily in the area of acute care (both NHS and independent sector provision). The CCG performed well in controlling spend in Continuing Healthcare (CHC) costs, and showed progress in reducing spend in some areas of emergency care (eg. Respiratory), but it failed to meet its recurrent QIPP target.

4.2 A list of assumptions is outlined in **Appendix 2**, and are described below:

4.3 **Costs of acute care (including ambulance services)** – In addition to the tariff increasing in 2016/17, growth of 0.5% has been added to the baseline costs. Additional costs following the procurement of patient transport services have also been added.

4.4 **Continuing Healthcare** – The CCG has held CHC costs stable in 2015/16. This represents a significant achievement in an area that had seen annual increases of over 15% in previous years. From November 2015, new Framework prices were put in place. This only affects new packages that commence from that date, and so the cost increase will have an incremental effect. The 5% increase added to the baseline spend is an estimate of the expected increase in costs in 2016/17.

4.5 **Prescribing** – The CCG has added 3% to prescribing expenditure for next year's budget. No notional cost reduction element has been built in to the starting budgets, but the CCG maintains that there is an element of waste in prescribing expenditure which will remain a focus of the QIPP programme, and will need to be released over the next few years.

4.6 **Demographic growth** – The NHS England allocation figures for 2016/17 indicate a 0.01% population growth next year for the CCG, and this has been added to all variable costs (eg. Acute costs).

4.7 The investment plans for the CCG are outlined in **Appendix 1**. The main points to note are:

- CAMHS transformation – The CCG has submitted transformation plans to NHS England which have been scrutinised and approved. Non-recurrent funding was given to the CCG in 2015/16 to commence this transformation agenda, and this funding has been added to the CCGs recurrent baseline. Though not currently ring-fenced by government, the CCG is committed to invest in this important area.
- Transformation Fund – The CCG continues with its 1% transformation fund, though it becomes recurrent in 2016/17. In 2015/16 there was a significant amount of slippage in investment plans. This slippage is not expected to continue, but if it does, the recommendation is that this is taken to assist in meeting the QIPP target.
- CHC restitution – the CCG continues to work with the CSU to process outstanding CHC restitution cases. This work has progressed significantly in 2015/16, but there remain a number of cases still outstanding. CCG funding is top-sliced to feed into a national risk pool. The top slice reduces in 2016/17, and NHS England has stated that this will be the final year of top slice. A reserve is required to fund the administration of the restitution process.
- Community Services – additional funding of £0.275m is held in each of the next two years to invest in community services. An independent review of the CCGs Liverpool Community Health contract identified potential shortfalls in funding.
- Uncommitted 1% reserve – The purpose of this reserve is outlined in sections 2.7 to 2.9.

5. Impact of assumptions and QIPP

5.1 The CCG started the 2015/16 year with a recurrent QIPP target of £3.441m, but only delivered £1.474m.Through a range of non-recurrent measures, the CCG has been able to deliver its planned surplus position in 2015/16, but the under-delivery of QIPP returns to place financial pressure on the CCG in 2016/17. In addition, the CCG experienced rising costs particularly in the area of acute care. Despite additional national investment in the NHS, the CCG received growth to its allocation that was lower than inflation.

5.2 A summary financial position is outlined in **Appendix 3**. Adding the assumptions outlined above to the already challenging starting position creates a balancing QIPP target of £8.3m. This would enable the CCG to achieve a 1% surplus position next year. This reflects the draft plan submitted to NHS England on 2 March. A further iteration of the plan will be submitted on 11 April.

5.3 The CCG has reviewed its current QIPP schemes and looked at benchmarking to identify further opportunities. A breakdown of the CCG schemes entered in the submitted Financial Plan is outlined in **Table E**. Given the challenging opening position, it is the view of the CCG that the 1% uncommitted reserve will not be utilised in year, but rather be released to support the QIPP position.

Table E – QIPP schemes

	2016/17		
	Recurrent	**Non-recurrent**	**Total**
Opening QIPP position	**4.049**	**4.228**	**8.277**
Expected savings from review of expenditure		(1.800)	**(1.800)**
Carry forward of unidentified QIPP			0.000
Release 1% uncommitted non-recurrent reserve (to be confirmed)		(2.428)	(2.428)
Existing schemes:			
Respiratory training programme	(0.830)		(0.830)
Telehealth in care homes	(0.430)		(0.430)
Prescribing - eg. Waste and generics	(0.500)		(0.500)
Outpatient reductions: First attendance	(0.170)		(0.170)
Outpatient reductions: Follow up	(0.650)		(0.650)
Rationalise voluntary sector			0.000
Estates rationalisations			0.000
Additional schemes:			
Manage growth to 2015/16 levels: Acute	(0.650)		(0.650)
Manage growth to 2015/16 levels: CHC	(0.500)		(0.500)
Clinical QIPP group review			0.000
Remaining balance / Unidentified QIPP	**0.319**	**0.000**	**0.319**

5.4 The additional schemes of managing both acute growth and CHC growth at 2015/16 levels are at different levels of progression. The CHC spend has been well controlled in 2015/16, and there is a level of confidence that continuation of the scrutiny and use of the Decision Tool will continue to realise savings into future years. However, further work is required to obtain the same level of confidence over reductions in acute care.

5.5 There is still a shortfall of £0.319m. Recognising that, historically, not all QIPP schemes have delivered at the pace and extent as planned, it is essential that the CCG increases both the number and the value of the schemes in place. In addition, it is recommended that any slippage on investment plans should not be utilised in-year, but rather be used to support on a non-recurrent basis. The CCG will need to have addressed this gap by the time it confirms revised budgets in May.

5.6 To assist identification of cost reduction schemes, the CCG participates in benchmarking to compare expenditure levels with similar CCGs. The CCG has received a Right Care information pack that seeks to identify which programmes offer the best value opportunities. In addition, Better Care Better Value also looks at relative levels of spend across a range of hospital based care. These have identified a range of opportunities in elective inpatient care, emergency care and outpatient attendances.

5.7 It is clear that cost reduction cannot be done in isolation. With both providers and CCGs operating in an increasingly challenging financial environment, the need has never been greater to work in collaboration to reduce costs in the health economy. All sectors have a role to play in working in an integrated fashion to deliver these efficiency savings. The CCG has commenced discussions with its main acute provider (Aintree University Hospital) to expedite this important work. Indeed, the thrust behind Sustainability and Transformation Plans (STP) is for health economies to work together to ensure the sustainability of health services into the future.

5.8 All providers have received information packs originating from the Lord Carter review to help them to identify cost reduction opportunities. Where there is overlap with our benchmarking outputs, there exists an opportunity for both parties to benefit, and there is clearly an appetite on both sides to make this work.

5.9 To achieve the 1% surplus in 2016/17, further savings are required beyond those that have been identified to date. To this end, the CCG is reviewing all non-recurrent expenditure including payments made to the voluntary sector. The expenditure plans as currently devised are unaffordable, and it is recommended that reductions in spend in this sector will need to be made in areas that represent little benefit in value for money terms, or where outcomes cannot be demonstrated.

5.10 For the same reason, existing commissioning policies are also under review to ensure best value for money and appropriate targeting of resources to deliver maximum health gain.

5.11 Appendix 3 identifies the QIPP proposals over the 5 year planning period, and the impact on overall financial performance. This is summarised in Table F, and identifies that the CCG will continue to achieve a 1% surplus each year, through the delivery of recurrent QIPP schemes that range from 1-2% over the next 3 years. This is considered achievable, but will require concerted effort and change.

Table F – Summary financial position and QIPP

	2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Recurrent QIPP as % of allocation	1.7%	1.3%	1.3%	0.2%	0.3%
Year-end surplus / (deficit)	£2.45m	£2.50m	£2.55m	£2.55m	£2.65m

6. Other risks

6.1 In addition to the risks identified above, there are other factors that the CCG should be cognisant of and plan for where possible. This section reviews risks associated with changes in commissioning responsibilities, local authority budget cuts, estates and community investment.

6.2 **Transfers from Specialised Commissioning** – In 2015/16 responsibility for commissioning a number of services transferred from Specialised Commissioning to CCGs. This included some neurology services. The CCG has reviewed the detail behind these transfers to ensure that any financial pressures were not transferred to the CCG. This due diligence will need to continue as further services are transferred to CCGs in 2016/17 (eg. Bariatric surgery).

6.3 **Local Authority funding** – Local Authorities continue to experience reductions in their budgets, and this has led to reductions in both social care and public health provision. This has both an indirect and direct effect on health spend, and it is important that the CCG works in partnership with the Local Authority to mitigate this risk.

6.4 **Estates** – Investment is required to ensure that both community and primary care estate is fit for purpose and configured efficiently. The CCG is working with local partners on an estates strategy to identify investment plans and funding requirements.

6.5 **Community investment** – There are a number of risks associated with community investment. The CCG, working with other local commissioners and NHS Improvement, is partway through a procurement/acquisition process. This procurement is significant in its magnitude, and the transition to a new provider(s) will need to be managed effectively.

7. Conclusions

7.1 The CCG faces challenging years ahead. Because of rising acute care costs and under-delivery on its QIPP programme, the CCG starts the year with a larger QIPP challenge than it has ever delivered. To achieve its surplus target, the CCG needs to deliver an £8.3m QIPP programme and mitigate any risks that materialise in year.

7.2 To achieve this, the CCG must expedite both its QIPP plans and its collaborative work with local partners to achieve the cost reductions necessary. It is also important to continue to express to NHS England that the 1% uncommitted reserve will be needed to deliver the financial plan.

7.3 Underpinning this QIPP effort is the need to work collaboratively with other commissioners and local providers to plan for a sustainable future and reduce costs in the health economy.

7.4 The Financial Strategy plans for a 1% surplus in each year of the planning period through achievement of a 1-2% recurrent cost reduction in the first 3 years of the planning period.

8. Recommendations

8.1 The Governing Body is asked to approve the Financial Strategy for the 5 year planning period, specifically noting:

- the required QIPP challenge over the period, noting the need to frontload savings in early years of the plan;
- the surplus plan for 2016/17, including its investment plan;
- the increasingly challenging financial environment that the CCG and its providers are operating in, and the need to work collaboratively to reduce spend;
- the principle that any slippage against planned investments will be used to support QIPP;
- the changes in assumptions, and the impact on estimated spend in future year planning periods;
- the changes in funding allocations for 2016/17, and future years, recognising that growth in funding doesn't match inflation and represents a real terms cut;
- the changes in planning guidance and business rules outlined by NHS England, particularly the need to hold a 1% uncommitted reserve;
- the potential risks concerning future CCG Resources; and
- the requirement to deliver annual recurrent QIPP plans of 1-2% to maintain a surplus position.

Appendices

Appendix 1 – Investment strategy
Appendix 2 – Assumptions
Appendix 3 – Summary Financial position

Martin McDowell
March 2016

NHS South Sefton Clinical Commissioning Group

NHS South Sefton CCG

APPENDIX 2

Investment Profile 2015-21	**2015/16**			**2016/17**			**2017/18**			**2018/19**			**2019/20**			**2020/21**		
	Rec £000's	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**
Investment Plans																		
Mersey Care TIME project	1,020	0	**1,020**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
NHS COIN Infrastucture Costs	55	0	**55**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
EMIS Web Licences - Support Costs	195	0	**195**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Pick-up of MacMillan GP Sessions	28	0	**28**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Adoption of IVF amendments	136	0	**136**	92	0	**92**	46	0	**46**	0	0	**0**	0	0	**0**	0	0	**0**
CAMHS transformation, including Eating Disorders	0	275	**275**	335	0	**335**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
"Parity of Esteem" - Other mental health initiatives	0	0	**0**	0	0	**0**	117	0	**117**	113	0	**113**	100	0	**100**	116	0	**116**
National policy pressures	0	0	**0**	0	0	**0**	486	0	**486**	237	0	**237**	0	0	**0**	3,704	0	**3,704**
Aspergers	23	0	**23**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Virtual Ward	1,600	0	**1,600**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Home Oxygen Service	40	0	**40**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Transforming Primary Care	1,242	0	**1,242**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
System resilience	1,200	0	**1,200**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Community Services	0	0	**0**	275	0	**275**	275	0	**275**	0	0	**0**	0	0	**0**	0	0	**0**
Street Cars	0	19	**19**	19	0	**19**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Sub-Total - investment plans	**5,539**	**294**	**5,833**	**721**	**0**	**721**	**924**	**0**	**924**	**349**	**0**	**349**	**100**	**0**	**100**	**3,820**	**0**	**3,820**
Non-Recurrent Investment Plan		**1.00%**			**1.00%**			**1.00%**			**1.00%**			**1.00%**			**1.00%**	
CVS	0	0	**0**	0	0	**0**	0	720	**720**	0	720	**720**	0	720	**720**	0	720	**720**
Advancing Quality Infrastructure	0	80	**80**	0	72	**72**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Community Spirometry	0	83	**83**	83	0	**83**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Winter Pressures	0	470	**470**	0	470	**470**	0	470	**470**	0	470	**470**	0	470	**470**	0	470	**470**
EOL Facilitator	0	44	**44**	0	44	**44**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
CHC Restitution	0	575	**575**	0	230	**230**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
CHC Restitution admin	0	120	**120**	0	166	**166**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
IM&T (incl iLinks)	0	0	**0**	0	246	**246**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Transformation Fund	0	2,400	**2,400**	2,400	0	**2,400**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Cheshire / Mersey Rehab	0	616	**616**	470	0	**470**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Other (uncommitted 1%)	0	0	**0**	0	2,432	**2,432**	0	2,468	**2,468**	0	2,504	**2,504**	0	2,541	**2,541**	0	2,618	**2,618**
Sub-Total - non-recurrent investment plan	**0**	**4,388**	**4,388**	**2,953**	**3,660**	**6,613**	**0**	**3,658**	**3,658**	**0**	**3,694**	**3,694**	**0**	**3,731**	**3,731**	**0**	**3,808**	**3,808**
Total - Investment Plans	**5,539**	**4,682**	**10,221**	**3,674**	**3,660**	**7,334**	**924**	**3,658**	**4,582**	**349**	**3,694**	**4,043**	**100**	**3,731**	**3,832**	**3,820**	**3,808**	**7,628**

Assumptions **APPENDIX 1**

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
	%	%	%	%	%	%
Allocation assumptions						
CCG Allocation Growth	1.9%	2.4%	1.5%	1.5%	1.5%	3.1%
Running Costs assumptions						
Running Cost Allowance	-10.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Cost increase assumptions						
Tariff assumptions - provider inflation	3.0%	3.8%	3.1%	3.2%	3.3%	3.3%
Tariff assumptions - provider inflation (non-acute)	3.0%	3.1%	3.1%	3.2%	3.3%	3.3%
Tariff assumptions - Efficiency Savings	-3.5%	-2.0%	-3.0%	-3.0%	-3.0%	-3.0%
Tariff leakage - acute care	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Tariff leakage - non acute care	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Non-demographic growth - Prescribing	4.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Non-demographic growth - Acute	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
Non-demographic growth - Continuing Healthcare	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Demographic Growth	0.2%	0.0%	0.0%	0.1%	0.1%	0.1%
Business Rules						
Non Recurrent requirement for CCGs	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
CCG Surplus	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Contingency	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%

NHS South Sefton Clinical Commissioning Group

NHS South Sefton CCG

APPENDIX 3

Summary of Financial Position 2015-21	**2015/16**			**2016/17**			**2017/18**			**2018/19**			**2019/20**			**2020/21**		
	Rec £000's	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**
Base Allocation	222,806	0	222,806	226,817	0	226,817	232,373	0	232,373	236,020	0	236,020	239,569	0	239,569	243,268	0	243,268
Growth	3,124	0	3,124	5,556	0	5,556	3,647	0	3,647	3,549	0	3,549	3,699	0	3,699	7,655	0	7,655
System resilience (in baeline from 16/17)	1,200	0	1,200	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Agreed allocation adjustments	711	1,371	2,082	1,024	0	1,024	1,024	0	1,024	1,024	0	1,024	1,024	0	1,024	1,024	0	1,024
Better Care Fund - Additional allocation	4,105	0	4,105	4,105	0	4,105	4,105	0	4,105	4,105	0	4,105	4,105	0	4,105	4,105	0	4,105
PY Surplus / Lodgement returned non-rec	0	2,848	2,848	0	2,400	2,400	0	2,450	2,450	0	2,500	2,500	0	2,550	2,550	0	2,550	2,550
Running Cost Allocation	3,296	0	3,296	3,259	0	3,259	3,237	0	3,237	3,216	0	3,216	3,196	0	3,196	3,176	0	3,176
Total Resources	**235,242**	**4,219**	**239,461**	**240,761**	**2,400**	**243,161**	**244,386**	**2,450**	**246,836**	**247,914**	**2,500**	**250,414**	**251,593**	**2,550**	**254,143**	**259,228**	**2,550**	**261,778**
Planned Application of Funds																		
Acute Health Expenditure	125,948	3,861	129,809	130,271	4,119	134,389	131,537	4,143	135,681	132,525	4,173	136,698	133,651	4,206	137,857	134,784	4,240	139,024
Community Expenditure	26,896	445	27,341	27,405	934	28,339	27,713	1,611	29,324	27,776	1,612	29,388	27,862	1,615	29,477	27,948	1,617	29,566
Mental Health Expenditure	18,233	1,367	19,600	18,788	362	19,150	18,929	362	19,291	19,087	363	19,450	19,251	364	19,615	19,431	366	19,797
Continuing Care Expenditure	11,059	261	11,319	11,613	396	12,008	12,197	(0)	12,197	12,814	(0)	12,814	13,462	(0)	13,462	14,142	(0)	14,142
Prescribing Expenditure	29,623	(188)	29,435	30,594	234	30,828	31,523	234	31,757	32,487	234	32,720	33,479	234	33,713	34,501	234	34,735
Other Primary Care Expenditure	3,755	455	4,210	4,657	(0)	4,657	4,659	(0)	4,659	4,661	(0)	4,661	4,664	(0)	4,663	4,666	(0)	4,665
Other Costs Expenditure	2,695	385	3,079	3,277	173	3,450	3,277	1	3,278	3,277	1	3,278	3,277	1	3,278	3,277	1	3,278
Contingency Reserve	0	0	0	1,216	0	1,216	2,438	0	2,438	3,677	0	3,677	4,935	0	4,935	6,231	0	6,231
Specialised co-commissioning	987	0	987	1,014	0	1,014	1,014	0	1,014	1,014	0	1,014	1,014	0	1,014	1,014	0	1,014
Estates Reserves	718	425	1,143	1,143	0	1,143	1,143	0	1,143	1,143	0	1,143	1,143	0	1,143	1,143	0	1,143
Better Care Fund (investments)	4,573	0	4,573	4,573	0	4,573	4,573	0	4,573	4,573	0	4,573	4,573	0	4,573	4,573	0	4,573
Other committed reserves	122	2,190	2,312	2,537	2,432	4,969	3,023	2,468	5,492	3,260	2,504	5,764	3,260	2,541	5,801	6,964	2,618	9,582
Unidentified QIPP	0	0	0	(4,054)	(4,228)	(8,282)	(7,278)	(2,468)	(9,746)	(10,532)	0	(10,532)	(11,134)	0	(11,134)	(11,798)	0	(11,798)
Total Programme Expenditure Commitments	**224,608**	**9,200**	**233,808**	**233,033**	**4,420**	**237,452**	**234,749**	**6,350**	**241,099**	**235,762**	**8,886**	**244,648**	**239,436**	**8,961**	**248,397**	**246,877**	**9,075**	**255,952**
Running cost expenditure	3,230	23	3,253	3,259	0	3,259	3,237	0	3,237	3,216	0	3,216	3,196	0	3,196	3,176	0	3,176
Total Expenditure Commitments	227,838	9,223	237,061	236,292	4,420	240,711	237,986	6,350	244,336	238,978	8,886	247,864	242,632	8,961	251,593	250,053	9,075	259,128
Planned Surplus / (Deficit) (£000)	**7,404**	**(5,004)**	**2,400**	**4,469**	**(2,020)**	**2,450**	**6,400**	**(3,900)**	**2,500**	**8,936**	**(6,386)**	**2,550**	**8,961**	**(6,411)**	**2,550**	**9,175**	**(6,525)**	**2,650**
Planned Surplus / (Deficit) (%)	**3.1%**		**1.0%**	**1.9%**		**1.0%**	**2.6%**		**1.0%**	**3.6%**		**1.0%**	**3.6%**		**1.0%**	**3.5%**		**1.0%**
Incremental recurrent QIPP requirement			**(1,474)**			**(4,054)**			**(3,224)**			**(3,254)**			**(602)**			**(664)**

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

Finance and Resource Committee Meeting held on Thursday 21st January 2016	Chair: Graham Morris

Key Issue	Risk Identified	Mitigating Actions
• CCG remains on course to deliver financial duty.	• Needs to deliver recurrent QIPP to enable 2016/17 recurrent balance.	• Ongoing review/delivery of QIPP schemes.

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

- Adopted Pan Mersey APC recommendations:
  - Tolvaptan tablets for the treatment of Autosomal Dominant Polycystic Kidney Disease;
  - Omalizumab 150mg solution for injection (Xolair®) for previously treated spontaneous chronic urticaria by specialists only.

- Midlands and Lancashire CSU remain on course to take over provision of services to CSU on 1st March. The Transaction and Mobilisation groups have reported that all risks are being managed.

- BCF
  - 2015/16 – Dwayne Johnson will provide an updated paper to Governing Body next week;
  - 2016/17 – Revised Policy Framework recently published;
  - The payment for performance element (ie achievement of non-elective activity reductions) has been removed for 2016/17.
  - More focus upon:
    - local targets for delayed transfers of care;
    - NHS commissioned out of hospital services, which may include a wide range of services including social care.

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Thursday 18th February 2016	Chair: Roger Driver

Key Issue	Risk Identified	Mitigating Actions
• CCG remains on target to deliver 2015/16 financial position. • The CCG does not have plans to deliver recurrent financial balance in 2016/17.	• Potential non-delivery of NHS business rules in 2016/17.	• QIPP schemes required in place for delivery wef 1st April 2016. • Clinical QIPP group to decide on commissioning approach.

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

- The HR performance report was presented to Committee.
  - Focus on ensuring that statutory/mandatory training including IG information will be sustained. Reminder emails to be sent out to all teams.
- The Pay Protection Policy was approved/adopted by the CCG which is now in line with other local health organisations.
- Better Care Fund (2015/16) update received, noting further discussions required with NHS England.
- The Committee thanked Roger Driver for his contribution to the Committee over the last three years and wished him well for the future.

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.	Update 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).

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Quality Committee Meeting held on 21st January 2016	Chair: Dr Gina Halstead

Key Issue	Risk Identified	Mitigating Actions
LCHT Looked After Children (LAC) assurance is limited.	Appropriate and timely assessments not being carried out.	Safeguarding team requesting actions from steering group.
Letter on the Safeguarding / LD audit and leadership for this in Aintree.	Risk of there not being strategic leadership at Aintree.	Letter to be drafted about LD and safeguarding leadership at Aintree – Brendan Prescott has contacted Nicola Firth about this. GH to review LD CQUIN.
Assurance on safe staffing levels at LCHT is limited.	Risk of being able to deliver safe care to residents of SSCCG.	Discuss at CCF, CQPG item on specific breakdown of sickness rates per locality team.
RLUH and AUH ambulance handover times.	Timeliness of care provision.	Contract letter has been issued.

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

Committee:	Meeting Date	Chair:
Healthy Liverpool Realigning Hospital Based Care Committees in Common (CIC)	2nd March 2016	Dr Nadim Fazlani

Key issues:	Risks Identified:	Mitigating Actions:
1 Need to understand the role of the Committee in Common for the North Mersey Local System Delivery Plan (part of the overarching Cheshire & Mersey Sustainability and Transformation Plan).	• Lack of clarity regarding decision making thereby hindering progress on changes.	• Separate Steering Group for the North Mersey Local System Delivery Plan to be established. • Committee in Common to remain in place to ensure statutory duties are met by each commissioning body.
2 Need for clear process for future service reconfigurations which works across all Statutory Bodies in line with NHS England Guidance.	• That different statutory bodies have different processes which are not recognised/understood, thereby hindering progress on changes.	• CCG/Local Authority communication and engagement leads to work together across Liverpool to ensure both national and local processes are adhered to.
3 Delivery of single receiving site for Major Trauma.	• That public engagement requirements have not been met thus delaying the service change.	• Refreshed public consultation to be undertaken.

Recommendations to NHS Liverpool CCG Governing Body:
• To note the above issues, risks and mitigating actions.

Key Issues Log

Committee: Liverpool City Region NHS CCG Alliance	**Meeting Date**: 2nd March 2016	**Chair:** Dr Andrew Pryce

Key issues:	**Risks Identified:**	**Mitigating Actions:**
1 Misalignment between draft Terms of Reference for the Alliance and new planning arrangements.	• Confusion with partners regarding decision making.	• Liverpool City Region NHS CCG Alliance prime role to be the voice of NHS Commissioners in the development of devolution of health responsibilities. • Terms of Reference to be amended to reflect this and agreed by each CCG Governing Body.
2 Planning footprints.	• That existing plans (e.g. Healthy Liverpool) are slowed down given requirement to work across Cheshire & Mersey.	• Clear financial and governance between Local System Delivery Plans confirmed.

Recommendations to NHS Liverpool CCG Governing Body:
• To note the key issues and risks.

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Audit Committee Meeting held on Thursday, 15th October 2015	Chair: Graham Morris

Key Issue	Risk Identified	Mitigating Actions

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

- Internal audit plan on target. Significant assurance levels reported for safeguarding/outcome based commissioning reviews.
- HMRC investigation complete. CCG to make small payment in respect of NI employer contributions to ensure compliance for 2013/14 and 2014/15.
- GBAF/CRR reviewed – agreed by Committee.

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Audit Committee Meeting held on Thursday, 14th January 2016	Chair: Graham Morris

Key Issue	Risk Identified	Mitigating Actions

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

- Note requirement to convene panel to reappoint External Audit providers with effect from 1st April 2017. Decision required by December 2016.
- Internal Audit report – on target to complete workplan in year; no significant items to report.
- LCFS report – on target to complete workload. Progress on suspected fraud cases ongoing.
- External Audit report:
  - Summary of financial audit/Value for Money approach for 2015/16.
  - The new NAO Value for Money Approach.
  - NHS briefing – appointing your external audit (see point above).
- IG Toolkit review; delegated authority given to MMcD/GM in order to meet submission deadline of 31st March 2016.
- Report on Macpherson review – estimation techniques applied in key areas.
- Agreed work schedule and meeting dates for 2016/17.

NHS
South Sefton
Clinical Commissioning Group

Key Issues
Bootle Locality

Meeting Date	**10/3/16**
Chair	**Dr Sunil Sapre**

Key Issues	Risks Identified	Mitigating Actions
1. Integrated model to deliver Healthy Child Programme (HCP) 0-19yrs for Sefton	• Dr Sapre suggested there be one reference point for all service areas of HCP • Pauline Sweeney asked about Immunisations • Dr Fergusson raised the issue of mental health and noted that often children do not fit the threshold for CAMHS. She would like to see HCP address mental health and the issues around this - and noted that the Bootle area has significant social and family issues	• Julie Murray from Public Health acknowledged request • confirmed NHSE will continue to provide this service • Acknowledged - currently in consultation and engagement phase.
2. Locality Requested Wider Group dedicate a whole session to discuss Federation status, requesting Dr Jude from Liverpool be invited to share experience, knowledge and effort.	• 3rd time of requesting this • Locality keen to make positive changes, lack of sustainable input avail from GPs, therefore wish to open discussion with peers via Wider Group	• TE informed Stephen Astles requesting action for Wider Group May 2016
3. 24 hour BP monitoring - Community Service Required	• Dr Anna Fergusson reported that whilst she was in favour of financial savings, the time involved in dealing with the patient, interpreting the 24 hour BP results did not make it very cost effective in terms of practice staff time • AF felt it would be more cost effective (in terms of practice staff time) to send the patients to hospital	• TE to poll all GP practices in the locality about their utilisation of hospital diagnostic service and views • TE to write a Board paper re views/ commissioning Local Community 24 hr BP monitoring service. DMcD offered to support.

Information Points for Governing Body to Note:

• Following Bootle Dermatology audit, GPs highlighted the need for the sebaceous cysts to be actioned by the new Dermatology Service (Dulwich Health). The current provider does not provide this and increases unnecessary hospital referrals. TE has informed Billie Dodd: Malcolm Cunningham responsible for this area.
 	
• DOLS Presentation from Coroner's Office - GP concerns re accurate and effective identification if DOLS in place or not for patients:
  • Margi Daw (from HM Coroner office) indicated they are looking to have DOLS put on to EMIS for ease of GP access/input;
  • Dr Roberts commented his practice has already applied a DOLS flag system alert on EMIS;
  • Albie Howard Murphy (from HM Coroner office) is the first line of contact to call to find out if a patient has a DOLS in place.
  • Plus 2 alternative colleagues and Margie Daw details shared for any queries in relations to DOLS.
 	
• 1st April 2016, patients will be able to access their records online. This means that a huge piece of work needs to be done.
 	
• From April 2016, patients aged 11-18 will not be able to order prescriptions online unless deemed mentally capable by their GP practice.

NHS
South Sefton
Clinical Commissioning Group

Key Issues
Seaforth and Litherland

Meeting Date 2 March 2016

Chair Dr Colette McElroy

Key Issues	Risks Identified	Mitigating Actions
1. Local Quality Contract	• The group reiterated their shared view that the LQC contract is not fit for purpose or deliverable in its current format.	• Escalated to Clinical Lead for Primary Care/Managerial Lead for Primary Care.
2. Healthwatch	• Concerns were raised over (i) the time take to receive reports; and (ii), how feedback from practices on reports was managed prior to reports going into the public domain; and (iii) the rights of Healthwatch to enter and view practices.	• Raised and discussed with Healthwatch. Rights of Healthwatch clarified.
3. Community Gynaecology referrals.	• Issues with communications identified.	• Dr McElroy continues to raise issues with Dr Briggs.

NHS
South Sefton
Clinical Commissioning Group

Key Issues
Crosby

Meeting Date	**02/03/2016**
Chair	**Dr Rebecca Huggins**

Key Issues	Risks Identified	Mitigating Actions
1. Out of area transfers into Ward 35 needing significant GP/patient family input to coordinate.	• Delay in transfer of the patient. • Delay in intermediate care/rehabilitation for the patient.	• Intermediate Care Lead informed and anonymised patient details have been passed to Ward 35 for investigation. • Ward 35 to confirm Trust to Trust transfer procedure (assumption is this is the same for both within and out of area).
2. Quality of electronic discharge information (specifically around TTOs) from RLUH/Alder Hey/LWH.	• Incomplete discharge information provided to GPs around TTOs and the quantity of medications prescribed/dispensed.	• Quality/Contracting teams have been informed and provided with examples. • Trusts involved are investigating. • Expected outcome to be discharge template to include quantity prescribed/dispensed so that this information is available for all medications listed on the discharge letter.

Information Points for Governing Body to Note:
▪ The locality is moving forward with the implementation of Phase 1 of the CCGs Improvement Plan to improve Dementia Diagnosis Rates ▪ The locality discussed the Dragon's Den project proposal by Dr Gus Berni (Crosby GP Collaborative Model for Urgent Appointments) ▪ The locality undertook their Antimicrobial Audit Peer Review

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Minutes

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

Membership		
Roger Driver	Lay Member (Chair)	RD
Graham Morris	Lay Member	GM
Andy Mimnagh	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
Ex-officio Member*		
Fiona Taylor	Chief Officer	FLT
Minutes		
Jayne Byrne	PA to Chief Officer	JBy

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	✓	A	
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	
Andy Mimnagh	GP Governing Body Member	✓	A	✓	✓	✓	✓	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	N	
Fiona Clark	Chief Officer	*	*	*	*	*	*	*	*	*	*	
James Bradley	Head of Strategic Finance Planning	✓	✓	✓	A	✓	✓	✓	✓	✓	A	
Malcolm Cunningham	Head of Primary Care & Contracting	✓	A	A	✓	✓	✓	N	A	✓	N	
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
FR15/128	**Apologies for Absence** Apologies for absence were received from James Bradley, Tracy Jeffes and Dr Andy Mimnagh.	
FR15/129	**Declarations of interest regarding agenda items** Those holding dual roles across both Southport & Formby CCG and South Sefton CCG declared their interest.	
FR15/130	**Minutes of the previous meeting and key issues** The minutes of the previous meeting were approved once the following change was made to the October's minutes (FR15/119a): *"Concern was voiced regarding distribution of pharmaceutical items and there was a desire to find out the scale of the problem."* The key issues log was approved as an accurate reflection of the main issues from the previous meeting.	RM
FR15/131	**Action points from the previous meeting** *FR15/119 Prescribing Performance Report - SL to provide feedback following a meeting with Mersey Care and LMC* – SL reported the meeting the previous week had been very productive and a way forward devised in relation to pathways for shared care and looking at amber drugs. SL suggested that further work was required to confirm arrangements. RD asked what the current scale was linked to waste. SL confirmed waste can't be counted as NHSE manage it and it will come back as 'no. of bins'. RD suggested taking one random bin and allocating a cost to it. MMcD suggested equating possible savings to something the public can relate to, eg number of district nurses. SL reported that NHSE was interested in supporting the CCG to undertake work to introduce 'repeatable dispensing'. This would enable a better assessment of the scale of the problem. SL reported that there had been positive engagement events held with the public and further events were planned. *FR15/121 External Updates/Benchmarking and VFM Reports - DF to raise Committee's concerns with Gina Halstead re outpatient referrals and follow ups* - DF reviewed benchmarked data with Dr Gina Halstead. It was felt this was not a quality issue, but sits with QIPP.	SL
FR15/132	**Month 7 Finance Report** The CCG financial position improved during the month and the CCG remains on target to deliver its planned surplus. DS reported upon a review that was being undertaken in respect of pricing of Age Related Macular Degeneration (ARMD) at local providers. The Committee noted the underspend on the Alder Hey contract. DS indicated that there were risks associated with assuming this position for the remainder of the year. SA noted that feedback from the hospital was that the new site appeared to be busier than the old site. **Outcome:** The Committee noted the finance update, particularly that: • The CCG was on target to meet the required surplus target of £2.400m for 2015/16; • The position was reliant on non-recurrent measures to deliver against the planned surplus in 2015/16 which is not sustainable in the longer term; • In order to deliver the CCGs financial duties going forward, the CCG needs to deliver the unidentified recurrent QIPP target of £2.385m in 2015/16.	

No	Item	Action
FR15/133	**Month 5 Prescribing Performance Report** SL presented the updated position for Month 5, noting an overspend of £0.167m year to date. SL highlighted the significant increase in Pregabalin expenditure as a main cause. After a discussion, the Committee recommended that the CCG undertakes a review of pain relief prescribing practice, to review variation between individual practices. It was proposed that a PLT session be used for this issue. SL brought up the issue that the dedicated home care pharmacists' reviews were not being followed up by GPs on a consistent basis and this meant that pharmacist time was being spent on unproductive tasks. JL noted that a number of new providers will be delivering services from next year and it may be helpful to draw up a list of items that are reviewed. **Outcome:** The Committee noted the content of the report.	SL
FR15/134	**External Updates/Benchmarking and VFM Reports** No report this month.	
FR15/135	**QIPP Update** MMcD reported that the QIPP Committee met last week. A review of low value clinical procedures is being undertaken with Dr Andy Mimnagh leading on behalf of the CCG. PT noted that decisions on clinical services needed to be backed with clinical evidence. He suggested that locum/inexperienced GPs may not manage the clinical risk as effectively as senior GPs and that this could be an area to explore. MMcD suggested that the CCG could adopt a mentoring programme involving experienced/ recently retired GPs to help in these areas. MMcD will review with KMcC/TJ. SA noted that it would help if we could describe the potential consequences of not delivering QIPP targets. MMcD re-affirmed that the CCG needs to deliver £6.4m worth of QIPP savings by March 2017 to remain in recurrent surplus. The CCG shouldn't be complacent given its good financial position. He further advised that it was vital that savings be delivered as early as possible.	MMcD
FR15/136	**IFR Update** The report informed the Committee on the application of the IEFR Policy and activity during the reporting period Quarter 2 - July to September 2015. The report also considered compliance, effectiveness and outcomes and provided details of the range of treatments and procedures requested by GPs and provider trusts. It also highlighted the number of cases considered (31) and the number of requests approved (6) and declined and the decisions made by the IEFR panel on behalf of the CCG. The number and type of complaints relating to IEFRs was also addressed. Dedicated care home pharmacists may visit localities to explain their role and secure support from practices as approximately only half of the reviews are being actioned by GPs. PT believed that some practices may think it was a review and not something that needed changing and this may account for the limited uptake. JL suggested drawing up a list of areas supported by the medicines management team to assist new interim providers for APMS practices.	JL
FR15/137	**Better Care Fund Update** The CCG is in process of returning Quarter 2 (to end September). Current projections suggested that the pay for performance element of the BCF is unlikely to be exercised. Further discussions are taking place with the Council regarding this issue.	
FR15/138	**Any Other Business** Recruitment and Selection Process Policy Outcome: The Committee approved the above policy.	

No	Item	Action
FR15/139	**Key Issues Review** MMcD highlighted key issues from them meeting which will be circulated on the log for Governing Body.	
	Date of Next Meeting Thursday 21st January 2016 1.00pm to 3.00pm 3rd Floor Board Room, Merton House	

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Minutes

Thursday 21st January 2016
1.00pm to 3.00pm
3rd Floor Board Room, Merton House

Membership		
Graham Morris	Lay Member (Deputy Chair)	GM
Andy Mimnagh	GP Governing Body Member	AM
Paul Thomas	GP Governing Body Member	PT
Martin McDowell	Chief Finance Officer	MMcD
David Smith	Deputy Chief Finance Officer	DS
Steve Astles	Head of CCG Development	SA
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Susanne Lynch	CCG Lead for Medicines Management	SL
Brendan Prescott	Deputy Chief Nurse/Head of Quality and Safety	BP
Ex-officio Member*		
Fiona Taylor	Chief Officer	FLT
Apologies		
Roger Driver	Lay Member (Chair)	RD
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Debbie Fagan	Chief Nurse & Quality Officer	DF
Malcolm Cunningham	Head of Primary Care & Contracting	MC
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	Jan 16	Feb 16	Mar 16	May 16	June 16	July 16	Sept 16	Oct 16	Nov 16	Jan 17
Roger Driver	Lay Member (Chair)	A									
Steve Astles	Head of CCG Development	✓									
Debbie Fagan	Chief Nurse & Quality Officer	A									
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A									
Martin McDowell	Chief Finance Officer	✓									
Andy Mimnagh	GP Governing Body Member	✓									
Graham Morris	Lay Member	✓									
Paul Thomas	GP Governing Body Member	✓									
John Wray	GP Governing Body Member	A									
Fiona Taylor	Chief Officer	*									
James Bradley	Head of Strategic Finance Planning	✓									
Malcolm Cunningham	Head of Primary Care & Contracting	A									
Jan Leonard	Chief Redesign & Commissioning Officer	✓									
Susanne Lynch	CCG Lead for Medicines Management	✓									
David Smith	Deputy Chief Finance Officer	✓									

No	Item	Action
FR16/01	**Apologies for Absence** Apologies for absence were received from Roger Driver, Fiona Taylor, John Wray, Debbie Fagan, Malcolm Cunningham and Tracy Jeffes.	
FR16/02	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both South Sefton and Southport and Formby CCGs declared their potential conflicts of interest.	
FR16/03	**Minutes of the previous meeting and key issues** The minutes of the previous meeting were approved as a true and accurate record and signed-off by the Chair. The key issues log was approved as an accurate reflection of the main issues from the previous meeting.	
FR16/04	**Action points from the previous meeting** ***FR15/130 Minutes of the previous meeting*** *– these were amended accordingly.* ***FR15/131 (FR15/119) Prescribing Performance Report*** *- SL to provide feedback re NHSE supporting repeatable dispensing implementation* – SL sent NHSE proposed plan and confirmed that feedback was positive. ***FR15/133 Month 5 Prescribing Performance Report*** *– SL to undertake a review of pain relief prescribing practice, to review variation between individual practices* – SL confirmed this will be done at the May PLT event. ***FR15/135 QIPP Update*** *– MMcD to review adopting a mentoring programme involving experienced/recently retired GPs to help in these areas* – MMcD said NHSE were broadly supportive and looking to fund this work, and an update will be brought to the next meeting. ***FR15/136 IFR Update*** *– JL to draw up a list of areas supported by the medicines management team* – JL confirmed this is in progress. ***FR15/41 Primary Care Rebate Scheme*** – this item is scheduled for review in March 2016, but will be brought forward to February's agenda.	
FR16/05	**Month 9 Finance Report** DS presented this paper which provided an overview of the financial position for the CCG as at 31 December 2015. JL brought the Committee's attention to Spa Medica who offer a follow up scheme, and said the CCG is seeing an increase in flow of patients from South Sefton due to this scheme. She has written to the Choice and Competition Panel to seek advice on this matter. **Action by the Committee** The Committee received this report by way of assurance and approved the recommendations therein.	

No	Item	Action
FR16/06	**Financial Strategy Update** MMcD gave a verbal update informing the Committee that the CCG had received its 3 year allocations with 2016/17 confirmed at 2.4%, with the national average being 3.5%. He noted that this uplift would have to fund extra pressures in areas including mental health investment, NHS pension reforms and other areas where funding responsibilities have transferred to the CCG (eg GP IT funding). MMcD is to present a report at the next meeting which will also go to the next Governing Body Development Session. **Action by the Committee** The Committee noted this update.	
FR16/07	**Prescribing Performance Report** SL presented the following reports to the Committee: (a) Quarter 2 Report (b) Month 7 Report (c) APC Recommendations November 2015 (d) APC Recommendations December 2015 **Action by the Committee** The Committee noted these reports and approved the APC recommendations therein, noting that MMcD has already approved the use of Omalizumab utilising his delegated authority.	
FR16/08	**NWCSU Performance Report** MMcD gave a verbal update regarding closure of the CSU and informed the Committee that everything was on track. However the closedown of the unit itself is likely to run beyond the transfer date, as it will be necessary to ensure all residual issues are addressed and any legacy issues transferred back to NHSE. He advised that the new provider, Lancashire and West Midlands CSU are due to provide a new service to the Trust on 1st March 2016. **Action by the Committee** The Committee noted this update.	
FR16/09	**Sefton Property Estate Partnership Group (SPEP)** MMcD informed the Committee that the initial draft strategy was submitted in November, and it was now necessary to flesh this out. The next SPEP meeting is on 3rd February and further discussions will take place around this. He also raised the possibility of a workshop, and potentially working towards a number of hubs that serve the population and take control of delivery services around the hospital. MMcD is to bring a timeline for the coming year to the March meeting for discussion, and this will be added to the agenda accordingly. **Action by the Committee** The Committee noted this update.	MMcD
FR16/10	**External Updates/Benchmarking and VFM Reports** No update was given at this meeting.	
FR16/11	**CCG Assurance** MMcD informed the Committee that clarity over the Q2 assurance meeting dates is still required. Regarding the framework, he advised that a dashboard/ league table type approach has been suggested. MMcD is to bring a paper back to the March meeting with plans for this framework. **Action by the Committee** The Committee noted this update.	MMcD

No	Item	Action
FR16/12	**QIPP Update** MMcD gave highlights from the QIPP Committee, being introduction of reviews for cataracts, IVF, smoking cessation and facet joints. He said there is another clinical QIPP group meeting on 26th January which will take forward work on this. GM asked if the finance element of the QIPP Committee could be dealt with by the Finance and Resource Committee, and MMcD is to discuss this with FLT. **Action by the Committee** The Committee noted this update.	MMcD
FR16/13	**Quality Premium Dashboard** SA presented this report to the Committee and stated that if the CCG does not achieve financial balance it will lose 50%. He said if the CCG could combine quality premium with QIPP then the CCG could prioritise these schemes. **Action by the Committee** The Committee received this report by way of assurance.	
FR16/14	**Better Care Fund Update** MMcD gave the following update to the Committee: **2015/16** - the BCF included payment for performance of £1.8m across Sefton, which was quite evenly split across both CCGs. If the CCG had been able to reduce non electives then it would be able to transfer funding to the Council. The Governing Body will receive a paper in Part 2 meeting outlining the CCG's position with recommendations around next steps. **2016/17** – Revised Policy Framework recently published. • The payment for performance element (ie achievement of non-elective activity reductions) has been removed for 2016/17. • More focus upon: - local targets for delayed transfers of care; - NHS commissioned out of hospital services, which may include a wide range of services including social care. **Action by the Committee** The Committee noted this update.	
FR16/15	**Committee Work Schedule 2016/17** The Committee noted this schedule and agreed the content therein.	
FR16/16	**Committee Meeting Dates 2016/17** The Committee agreed these meeting dates. Dates for February and March 2017 will be scheduled and added to this list in order to complete the 2016/17 financial year.	RM
FR16/17	**Any Other Business** GM advised that he had met with Audit Committee Chairs from other CCGs via an MIAA organised event. He felt the event was very worthwhile and has agreed to meet up on a quarterly basis with his peers at Wirral and St Helens CCGs, planning to work more closely with them. He is to provide feedback following these meetings.	
FR16/18	**Key Issues Review** MMcD highlighted the key issues from the meeting and these will be presented as a Key Issues Report to Governing Body.	
	Date of Next Meeting Thursday 18th February 2016 1.00pm to 3.00pm 3rd Floor Board Room, Merton House	

NHS
South Sefton
Clinical Commissioning Group

Quality Committee - Internal Minutes

Date: Thursday 17th December 2015, 11.30 am - 12.30 pm
Venue: 3rd Floor Board Room, Merton House, Stanley Road, Bootle.

Membership Attendance Tracker

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		
Karen Garside	Designated Nurse Safeguarding Children	KG
James Hester	Programme Manager Quality & Safety	JH
Kate Mahon	Student Nurse	KM
Brendan Prescott	Deputy Chief Nurse / Head of Quality and Safety	BP
Helen Roberts	Senior Pharmacist	HR
Apologies		
Roger Driver	Lay Member	RD
Debbie Fagan	Chief Nurse	DF
Gina Halstead	GP Lead for Quality (Chair)	GH
Sharon McGibbon	Practice Manager/Governing Body Member	SMcG
Fiona Taylor	Chief Officer	FT
Minute Taker		
Vicky Taylor	Quality Team Business Support Officer	VT

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	√	√			√	√	√	√	A			
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	√	√	A			
Debbie Fagan	Chief Nurse & Quality Officer	√	√			√	√	√	√	A			
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	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
15/142	**Apologies for Absence** Apologies for absence were received from: RD, DF, SMcG, FT, GH. In light of apologies received from the Chair and Vice Chair, the meeting was not quorate and BP chaired the meeting.	
15/143	**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.	
15/144	**Minutes of the previous meeting and Key Issues Log** The minutes of 19th November were approved subject to the following amendments: • Attendance of Helen Roberts and Kate Mahon to be noted • 15/138, Locality Update, second bullet to be amended to read 'PC advised the Committee of *the scoping of a Breathlessness service'*	
15/145	**Matters Arising / Action Tracker** **15/113(i) Governance Body Assurance Framework & Corporate Risk Register** PC confirmed that the risk relating to a lack of intermediate care beds available under the Winter Plan had not yet been added to the Corporate Risk Register. BP will liaise with TJ and report back to the Committee next month. **Action: Action extended for one month.** **15/115 Professional Registration Policy** The policy has now been amended and this action can be closed. **Action: Action completed – remove from the tracker.** **15/116 Ensuring the Effectiveness of the Process for Review of Previously Unassessed Periods of Care** The Committee agreed to extend the action for one month. **Action: Action extended for one month.** **15/119 Freedom to Speak Up** The Committee agreed to extend the action for one month. **Action: Action extended for one month.** **15/122 AOB** The Committee agreed to extend the action for one month. **Action: Action extended for one month.** **15/131(i) Safeguarding Children & Vulnerable Adults Policy 2015 (Incorporating Safeguarding and Mental Capacity Act Standards for Commissioned Services** The GB was happy to approve and ratify the policy subject to the changes suggested being made. Gina Halstead (Chair of Quality Committee) was asked to confirm in writing to the Governing Body that the Quality Committee were happy with the 'spiritual abuse (brainwashing)' definition. The Committee agreed to defer the action January's meeting due to the absence of the Chair. **Action: Action extended for one month.** **15/131(ii) Safeguarding Children & Vulnerable Adults Policy 2015 (Incorporating Safeguarding and Mental Capacity Act Standards for Commissioned Services** The Committee agreed to extend the action for one month. **Action: Action extended for one month.**	**BP**

	15/131(iii) Safeguarding Children & Vulnerable Adults Policy 2015 (Incorporating Safeguarding and Mental Capacity Act Standards for Commissioned Services This action has been completed and can be closed. **Action: Action completed – remove from the tracker.** **15/131(iv) Safeguarding Children & Vulnerable Adults Policy 2015 (Incorporating Safeguarding and Mental Capacity Act Standards for Commissioned Services** This action could not be completed as the Governing Body do not meet until January. Committee agreed to extend until February. **Action: Action extended for until February.** **15/140(i) Any Other Business** This action has been completed and can be closed. **Action: Action completed – remove from the tracker.** **15/140(ii) Any Other Business (Terms of Reference)** A paper is due to come to the Committee in January which will address the issue of the status of the Committee Chair and provide a review of the Terms of Reference. **Action: Action extended for one month.** A number of items were put forward to January due to apologies received.	
15/146	**Section 11 Compliance Outcomes (Safeguarding)** KG presented background on why paper brought to Committee, which provided the current position against the Section 11 of the Children's Act Audit Standards. An action plan has been developed to support the progression against standards where full compliance has not been evidenced. Karen Garside, Designated Nurse Safeguarding Children had carried out an audit, with recommended changes made to the HR Induction process to ensure new starters are directed to appropriate policies and have undergone appropriate training from the outset of their employment. The Safeguarding Team is to inform what such training will comprise of in liaison with Adam Burgess, HR Business Partner at North West CSU. Copies of evidence which have informed the Action Plan are included within the report with issues highlighted as amber being addressed. KG confirmed that areas rated 'red' require further development and are progressing with work already underway to ensure CCG policies are fully accessible. Development of the CCGs intranet pages for easier access to all policies as well the safeguarding policy is underway. The resolution of HR induction process and policy availability will ensure compliance with Section 11.	
	The Committee received the report	
15/147	**Chief Nurse Report** All relevant issues conveyed within the verbal update were reported to the Governing Body. BP advised the Committee of CCG notification received from the CQC of the potential issue of a Letter of Intent to withdraw a contract to provide services from a domiciliary care provider working with patients across the wider Sefton area following the outcome of a CQC inspection.	

	The CCG had identified an alternative provider should the CQC decide to terminate the contract. The Committee noted the constraints placed on the CCG and LA due to the tight timescale given by the CQC. Tracey Forshaw, Programme Manager Vulnerable People is liaising directly with the CQC as the Letter of Intent was not served due to Action Plan submitted by the provider. CQC have visited the provider on a number of occasions since action plan submission to monitor and the provider cannot currently provide care for any new packages of care. The CSU are also providing support. A CCG de-brief session will be held initially, which will be extended to include the LA and CQC. It was recognised that there is a need for closer performance management of the quality indicators which need to be developed to ensure a quality service can be provided by domiciliary care providers. DF has convened a meeting w/c 4th January 2016 with the LA to progress this. BP added for the longer term the adoption of the Manchester Framework for domiciliary care is being considered by the CCG to support the CCG's ability to hold providers accountable under contractual requirements with robust performance management. The Committee noted the concerns raised in relation to potential implications for the CCG when identifying suitable care home accommodation with patients and families having a greater awareness with access to CQC reports. TF is working closely with the CQC in order to improve the CCG's learning, and a meeting with CQC has been arranged for 19th January 2016. Committee members thanked all involved for their support in managing the situation.	
	The Committee received the verbal report	
15/148	**Draft CCG Personal Health Budget Policy and Practice Guidelines** BP presented this paper on behalf of Tracey Forshaw, Programme Manager – Vulnerable People, explaining that SS CCG is legally required to have policies and procedures in place to support the extended rollout and implementation of Personal Health Budgets from April 2016. The Committee were asked to receive and approve the draft policy whilst noting that further work is due to be carried out before it is submitted for final approval to the Governing Body in March 2016. However, the draft policy was fully supported and will be represented for approval in January as the Committee was not quorate. It is expected that implementation of PHBs should effectively prove cost neutral for the CCG . The specification for the new CSU Provider providing support for Continuing Health Care has identified more support for PHBs in terms of administrative support, management of applications and quality assurance of care plans. TF is also providing support in this area as CCG link when liaising with families. The Committee discussed what PHB funds could be spent on by patients with BP clarifying that the Contract clearly explains what monies can be spent on. The	

	CCG have the ability to monitor how and where monies are being spent and as accountable organisation the CCG can look to reclaim any monies not spent in support of care funded by PHBs. In conclusion BP advised that with the development of the PHB policy, future work would look to include local providers across Sefton in terms of support to the individuals requesting PHBs and in the process of payment of PHBs either as a third party or directly to the individual. There would be the requirement to ensure providers can monitor spend on behalf of the CCG.	
	The Committee received and recommended the report for approval in its current form when it is resubmitted to the Committee in January	
15/149	**Key Issues** • Care Home. • Safety of patients when sourcing alternative community care providers. • CQC relationship building and notification. • Safeguarding officer role continuing to contribute to Safeguarding Quality reports as current officer leaving role at the end of January 2016.	
15/150	**Any Other Business** There was no further business.	
15/151	**Date of Next Meeting** Thursday 21st January 2016 at 3 pm – 5 pm 3rd Floor Board Room - Merton House, Stanley Road, Bootle.	

Chair : _____ _____

PRINT NAME **SIGNATURE**

Date : _____

NHS
South Sefton
Clinical Commissioning Group

Quality Committee - External Minutes

Date: Thursday, 21st January 2016 3 pm – 5 pm
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
Anne Dunne	Designated Nurse, CCG Safeguarding Service	AD
James Hester	Programme Manager – Quality	JH
Pauline Jones	NHSE (Until & Including Item 16/007)	PJ
Brendan Prescott	Deputy Chief Nurse / Head of Quality and Safety	BP
Helen Roberts	Senior Pharmacist	HR
Jo Simpson	Quality & Performance Manager	JS
Apologies		
See below		
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	√	√			√	√	√	√	A	√		
Steve Astles	Head of CCG Development	A	√			√	A	A	√	√	A		
Dr Peter Chamberlain	Clinical lead Strategy & Innovation					√	√	√	√	√	A		
Malcolm Cunningham	Head of Contract and Procurement	√	√			A	A	A	A	√	A		
Roger Driver	Lay Member	A	√			A	L	√	√	A	A		
Debbie Fagan	Chief Nurse & Quality Officer	√	√			√	√	√	√	A	L		
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	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
16/001	**Apologies for Absence** Apologies for absence were received from SA, Dr PC, MC, RD and SMcG.	
16/002	**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.	
16/003	**Minutes of the previous meeting and Key Issues Log** The minutes of 17th December were approved as an accurate reflection.	
16/004	**Matters Arising / Action Tracker** **15/038 Safeguarding Service Update Report** – This issue was escalated to the South Sefton Governing Body and a proforma is now available which has been approved by Liverpool Community Health Trust. **Action: Action completed – remove from the tracker** **15/070 Toolkit to Support NHS Commissioners to reduce poor experience of Patient Care** – Aintree University Hospital Trust attending an EPEG meeting in November 2015 where a satisfactory response was given to all questions raised. **Action: Action completed – remove from the tracker** **15/081(i) Provider Quality Performance Reports** – Draft reports are now being developed by the BI Team to improve reporting and will be shared with Committee members when they become available. New style reports should be in place by April / May 2016 for 16/17 reporting. **Action: Action completed – remove from the tracker** **15/082(ii) Serious Incident Report (SUI)** – The definition of a SUI has been shared with the compiler of the report and will be included in future reports. **Action: Action completed – remove from the tracker** **15/084(iii) Safeguarding Service Update Report** – As the Accountability Framework was not included in the January 2016 report, the Committee requested this be brought to the February 2016 meeting. **Action: Action extended until Committee meet in February 2016.** **15/097(i) Audit of Cold chain Management in GP Practices** – This issue is included in the update report on today's agenda and the Committee agreed the action could be closed. **Action: Action completed – remove from the tracker** **15/097(ii) Audit of Cold chain Management in GP Practices** - PJ to ask Julie Kelly, Head of Public Health Commissioning, NHS England to ensure Practices are advised of availability of funds in relation to the storage of vaccinations for housebound patients. **Action: Action completed – remove from the tracker** **15/101 CCG Safeguarding Peer Review Action Plan (v8)** – An updated report will be brought to the Committee's internal meeting in February 2016. **Action: Action extended until Committee meet in February 2016.** **15/102(vii) Provider Quality Performance Reports CAMHS Waiting Times** – This action has been assigned to Peter Wong and will be monitored through Alder Hey's CQPG. JS will provide CAMHs waiting times as part of the	**AD** **AD/Safe-guarding**

	Performance Report due to be presented in March. **Action: Action completed – remove from the tracker** **15/113(i) Governing Body Assurance Framework & Corporate Risk Register** – BP confirmed that this action had now been completed with the issue around intermediate beds featuring on the Corporate Risk Register. **Action: Action completed – remove from the tracker** **15/116 Ensuring the Effectiveness of the Process for Review of Previously Unassessed Periods of Care** – BP discussed SSCCGs responsibilities with IG management as the CCG is only accountable for certain records. A new action is to be created to alert LCH to ensure issues with their record keeping are addressed via the CQPG. **Action: Action completed – remove from the tracker** **16/004 (Originally 15/116) Ensuring the Effectiveness of the Process for Review of Previously Unassessed Periods of Care –** Action to be assigned to the CQPG for LCH to review their record keeping/storage systems. **Action: Action to be completed by February 2016.** **15/119 Freedom to Speak Up** – JH confirmed that he had raised the issue around the Whistleblowing Policy through the Corporate Governance Support Group earlier this month. The policy is a generic version in use across a number of CCGs, however Adam Burgess will raise the issue in relation to the route to be followed should a member of staff wish to raise a concern about their immediate manager with the policy writers. The Committee will receive a further update in February. **Action: Action to be updated when Committee meet in February 2016.** **15/122 AOB** – An update on the actions arising from the Quality Team Away Day held in June 2015 will be presented under AOB as part of today's agenda. **Action: Action completed – remove from the tracker** **15/131(i) Safeguarding Children & Vulnerable Adults Policy 2015 (Incorporating Safeguarding and Mental Capacity Act Standards for Commissioned Services** – BP advised that he has seen the form of words suggested by the Dioceses, however this needs to be shared with the Chair of the QC before this action can be closed. BP to request Helen Smith (Safeguarding) to send a copy of the words around 'spiritual abuse (brainwashing)' to Gina Halstead. **Action: Action extended until Committee meet in February 2016.** **15/131(ii) Safeguarding Children & Vulnerable Adults Policy 2015 (Incorporating Safeguarding and Mental Capacity Act Standards for Commissioned Services** – BP confirmed that DF had emailed Wendy Hewitt to ensure the most up to date version of the escalation of concern regarding a child or adult are currently being used in practices. **Action: Action completed – remove from the tracker** **15/132 CSU Q2 2015/16 Quality Report** – This item is covered under 16/006 on today's agenda. **Action: Action completed – remove from the tracker** **15/134(i) Provider Quality Reports, *Alder Hey Hospital Foundation Trust (AHHFT)* – Discharge Summaries**. JS awaiting examples from GH and the localities for examples of poor discharge summaries / communications from the Trust. JS to ask for this to be included on the locality meeting agendas in February / March.	**BP** **BP/JH** **BP**

	Action: Action extended until Committee meet in March 2016. **15/134(ii) Provider Quality Reports (inc NHS111)** ***KPI16g Total Number of patients presenting at A&E who had previously contacted their GP prior to attending A&E*** – JS established that this was a 'local' KPI suggested by LCCG which will be removed from future SSCCG reports. **Action: Action completed – remove from the tracker** **15/134(iii) Provider Quality Reports (inc NHS111)** ***KPI 16g Total Number of patients presenting at A&E who had previously contacted their GP prior to attending A&E*** – Although GH commented that unexplained acronyms continue to feature within this report, JS confirmed that steps are being taken to address this issue. **Action: Action completed – remove from the tracker** **15/135(i) Serious Incident Report (SUI)** ***Aintree University Hospital FT*** – This action was progressed with the outcome covered within today's report. **Action: Action completed – remove from the tracker** **15/135(ii) Serious Incident Report** – Additional resources are now in place in relation to the administration of SUIs. **Action: Action completed – remove from the tracker** **15/136(i) EPEG issues Update** ***Podiatry*** – BP confirmed necessary action taken to address concerns raised. **Action: Action completed – remove from the tracker** **15/136(ii) EPEG issues Update** ***NHS111*** – Feedback regarding this item will be forwarded to Terry Hill. **Action: Action completed – remove from the tracker** **15/138 Locality Update (**Respiratory Programme Report) – This item will be part of the agenda for when the Committee meet in February. **Action: Action extended until Committee meet in February 2016.** **15/140 (ii) Any Other Business** – The Terms of Reference of the Committee have been reviewed and will be taken to the next Governing Body meeting for approval. **Action: Action completed – remove from the tracker**	**JS** **SA**
16/005	**CCG Safeguarding Service Quarterly Report** AD presented the report and the assurance level of providers was discussed. • LCH – The Committee noted the Trust is providing 'reasonable assurance', although there are some issues in relation to adults. AD advised she had met with the CCG and the Head of Looked after Children (LAC) who expressed some concerns in relation to LAC. It was noted that no centralised systems appear to be in place for LAC which the CCG has been working with LCH to address. AD has agreed with DF that the CCG will support together with Children's Commissioner. • Alder Hey Children's NHS Foundation Trust – The Trust is providing 'limited assurance' with the Safeguarding Team continuing to work with the Trust to support putting systems and processes in place. **Action (i): The Trust is to be in concordance by the end of March with a report to be submitted to the Committee in April 2016.**	**AD**

	The Committee noted that there has been improvement in training compliance within the Trust but concerns were expressed in relation to the trajectory of compliance. **Action (ii): Due to concerns raised by the Committee in relation to the trajectory on training compliance, an Action Plan is to be presented to the Committee in May 2016.**	**AD**
	AD advised that the Business Plan in relation to support for adults has not yet progressed. BP spoke of a similar situation at Broadgreen Hospital in relation of training in place primarily for safeguarding adults and not children. **Action (iii): The issue regarding safeguarding training in relation to children is to be discussed at the next CQPG meeting with the outcome reported back to the Committee in March 2016.**	**AD**
	• Merseycare – The Trust has provided reasonable assurance in relation to both safeguarding adults and safeguarding children, however supervision in relation to safeguarding of children requires tightening up. The Committee noted that policies are up to date and compliant. • Aintree - The Committee noted that there have been 3 safeguarding incidents in recent months at the Aintree site. BP stated that the STEIS forms do not include any suggestion of involving the Safeguarding Team. A meeting is due to take place with Liverpool CCG to look at mechanisms of involving the Safeguarding Team. **Action (iv): Serious Case Review to take place regarding a recent SI at Aintree. Findings of Serious Adult Review to come to Committee in June 2016 with JH to add to SI agenda. JH to draft letter re safeguarding concerns in SIs to Nicola Firth to be signed by GH.**	**JH**
	Action (v): GH requested a copy of the Learning Disability CQUIN.	**JS**
	Child Sexual Exploitation Update The Committee received the update submitted by the Safeguarding Team noting a handbook is to be provided to support staff knowledge. The Committee sought clarity around the number of Multi Agency Child Sexual Exploitation (MACSE) meetings attended as to the significance of the noting that LCH attended only 3 meetings involving 41 cases. **Action: AD to query the MACSE meetings attended by LCH with the Designated Nurse Safeguarding Children who was the author of the report.**	**AD**
	The Committee noted that the Risk Matrix showed the Royal Liverpool & Broadgreen University Hospital Trust on 'red' re. compliance however, data cleansing is underway to clarify the accuracy of data. The Committee were assured that a plan is in place to address with additional monitoring taking place through Health sub group.	
	The Committee received the report	
16/006	**Continuing Healthcare/ Complex Care Services** **Quality & Performance Quarter 3 Updates for South Sefton CCG** JC presented the report which highlighted performance and quality monitoring information for Nursing Homes in SSCCG. The Chair raised a question on behalf of PC re care homes taking on CQUINs.	

	JC responded that whilst care homes were encouraged to participate in CQUINs they were not attracted to do so due to the small amount of monies involved.	
	The Committee received the report	
16/007	**NHS ENGLAND Action Plan for Cold Chain Management in GP Practices** PJ attended today's meeting to answer any questions the Committee might have arising from NHSE's report and action plan submitted in response to the SSCCG's request for an audit to be carried out following a number of Cold Chain Audit issues. Following the submission of this report to the SFCCG yesterday a similar request was made by the Committee that an additional column be added to the Action Plan to demonstrate when an action had been completed. **Action (i): Revised Action Plan to include record of completion of actions to come back to the Committee in February.** PS advised that she expected to receive feedback of a higher uptake of portable systems being purchased by practices. It was also recommended that Data Loggers which monitor changes in temperature of fridges are purchased and used by practices, which would lead to financial efficiencies for the NHS. The Committee discussed issues around fridge servicing, although it was recognised some servicers were likely to decline to service older fridges. **Action (ii): BP requested to compile a list of reputable fridge servicers together with costs for submission to the Committee in April 2016.**	**PJ** **BP**
	The Committee received the report	
16/008	**Provider Quality Reports** 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: • A&E Measures - remain a concern due to the Trust failing to achieve A&E Quality measures • Rapid Access Chest Pain - performance remains a concern but is discussed at the CQPG • Mortality – positive performance noted by the Committee. Data will be included in future reports. **Action (i): A&E Quality Measures - JS to check accuracy of data entered on line 17 of the report (page 48) as 80.3% does not reflect performance recorded.** • PROMS – Partial success in performance noted but concerns remain that target may not be achieved. • A&E All Handovers – A Contract query was issued in December to Aintree University Hospital Trust and the Royal Liverpool & Broadgreen University Hospital Trust (RLBUHT) at the recommendation of NWAS with a response and action plan awaited. This is being followed up at the next CQPG with update to the Committee in March. • Diagnostics - GH raised issues with ultrasound and patients with polycystic ovaries with the Committee advised that Dr Paula Briggs is due to present to PLT where it is likely to be suggested that patients are referred to community services for this type of scan. • Infection Control - BP advised the Committee of an event he was due to attend together with Aintree and Southport colleagues which will look at the	**JS**

	appeals process. **Action (ii): JS to establish how many Clostridium Difficile appeals are successfully appealed by RLBUHT.** *Mersey Care Provider Trust* • Every contact Counts – JS referred to issues with data collection under Every Contact Counts with discussions ongoing as to whether this should continue as a KPI in 16/17. • CPA – Performance noted as slightly under, however improvement seen from Q1. • Referral to Treatment – Psychotherapy - Waiting times were raised at CQPG in December. Dr Andrews Sedgewick is due to present a paper on this together with a business case for consideration by commissioners. • Referral to Treatment – Eating disorders – Whilst this is not considered to be an underfunded service, the very high levels of demand are recognised. • DNA & Cancellation appointments - The Audit has now been completed with the outcome of the report awaited. BP advised that he had accompanied, DF and JS on a recent visit to Clockview with Ray Walker (Director of Nursing). Whilst the Committee recognised the effort made to ensure patients attend appointments, assurance was required as to whether sufficient support was in place for patients who needed to be seen on the day. BP said steps have been taken re telephone requests by GPs with examples requested. **Action (iii): Care pathway/Operating Procedures for the Clockview site to be circulated by Gordon Jones, Mental Health Commissioning Manager.** *LCH* Issues with Sefton District Nursing (DN) levels were raised by GH. A breakdown of Staffing numbers had been provided to the CQPG by LCH. A recruitment drive had been completed recently; however staff training was an issue due to the loss of experienced staff. The Committee also sought confirmation around the issue of the progression of a SUI through the Whistleblowing policy. JH suggested raising these issues with Liverpool CCG. **Action (iv): The Committee were not currently assured of safe levels of DN staffing in Sefton and would ask through the CCG that the DoN of the provider supply assurance to the CQPG.** The Committee noted that unnecessary delays in accessing domiciliary physio will be addressed at the CQPG.	**JS** **JS** **DF/JS**
	The Committee received the report	
16/009	**Serious Incident Report** JH presented the report to the Committee. *Aintree University Hospital FT* Many SUIs listed within the report have been progressed since the report was prepared. Additional members have been identified to attend the group to address issues arising at meetings which is expected to improve performance. The Committee noted that some issues continue with closing down SUIs. Numbers left open are likely to have been reported in November and December with cases allowed 60 days to complete. **Action (i): BP to speak to Knowsley CCG re submission of commentary on SUI which contained a significant number of questions at a very late stage**	**BP**

	in the process and report back to the Committee with their response in March 2016. *Liverpool Community Health NHS Trust* The SUIs in relation to Pressure Ulcers (PUs) have now been closed following agreement from NHSE that this action could be taken if an overarching action plan was provided. Although new PUs have been reported subsequently, LCH cannot be asked to report until the action plan is implemented. AM questioned deadlines for completion of actions stating that explanations should be provided to give required assurance that issues are being appropriately addressed. DF was supportive of working in partnership with NHSE and LCCG. Reports go to LCCG with SIs across both CCGs discussed jointly. In addition issues can be raised at the CCF. **Action (ii): In view of lack of in depth reporting the Committee requested that data from report be included to give assurance.** *Mersey Care Provider Trust* GH suggested Sue Gough attend SI meetings. **Action (iii): JH to invite Dr Sue Gough to attend SI meetings.**	**JH** **JH**
	The Committee received the report	
16/010	**Proposed Meeting Schedule for Quality Committee 2016/17** JH presented the report which followed a review of the existing meeting schedule for the Quality Committee and proposed a new schedule for 2016/17. The reasons for recommending the changes were presented with internal meetings proposed to take place jointly with Southport & Formby CCG. Issues in achieving a quorum were also being addressed through a review of the Terms of Reference. JH assured the Committee that the proposals were in line with the constitution and alignment with F&R to meet 9 times per year. The proposal also afforded the two QCs to hold joint internal meetings, thereby providing QIPP and time savings. The Committee supported the proposal with members having amended their schedules for the next 12 months to accommodate changes to the dates of some meetings.	
	The Committee received and approved the proposal within this report	
16/011	**EPEG Key Issues Report** The Committee did not receive a report due to apologies received from RD. An update is to be provided when the Committee meet in March.	
	The Committee note the report was not received	
16/012	**Key Issues Log** • LCHT Looked After Children (LAC) assurance is limited - Appropriate and timely assessments not being carried out • Letter on the Safeguarding / LD audit and leadership for this in Aintree - Risk of there not being strategic leadership at Aintree • Assurance on safe staffing levels at LCHT is limited - Risk of being unable to deliver safe care to residents of SSCCG • RLUH and AUH ambulance handover times - timeliness of care provision	
16/013	**Any Other Business** *Patient feedback*	

	AM relayed patient thanks to JH and asked that it be formally noted in the minutes *Actions Arising from Away Day* BP provided a verbal update on Actions arising from Away Day: • Data recommendations made • Quality Team presence at locality meetings improved to address quality issues • Quality Committee Workplan changes recommended following review by JH, VT, JS • CQUIN early planning – JS progressing to ensure early sign off wherever possible • Clinical QIPP • Escalation of concerns/issues – trigger-points – forum currently says through CCF, can also report through Chief Nurse	
16/014	**Date of Next Meeting** Thursday 18th February 2016 at 3 pm – 5 pm 3rd Floor Board Room - Merton House, Stanley Road, Bootle.	

Chair : _____ _____

PRINT NAME **SIGNATURE**

Date : _____