NHS
South Sefton
Clinical Commissioning Group

Agenda

Governing Body Meeting in Public
Agenda

Date: Thursday 26th May 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 Sunil Sapre	GP Clinical Director & Governing Body Member	SS
Dr John Wray	GP Clinical Director & Governing Body Member	JW
Mr Graham Bayliss	Lay Member, Patient & Public Involvement	GB
In Attendance		
Danielle Love	*(Minute taker)*	
Tracy Jeffes	Chief Delivery & Integration Officer	TJ
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Peter Wong	Children, Young People & Maternity Commissioning Manager	PW

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
Governance					
GB16/74	Apologies for Absence	Chair	Verbal	R	3 mins
GB16/75	Declarations of Interest	Chair	Verbal	R	2 mins
GB16/76	Minutes of Previous Meeting	Chair	Report	A	5 mins
GB16/77	Action Points from Previous Meeting	Chair	Report	A	5 mins
GB16/78	Business Update	Chair	Verbal	R	5 mins
GB16/79	Chief Officer Report	FLT	Report	R	10 mins
GB16/80	LCR NHS CCG Alliance – Revised Terms of Reference	FLT	Report	A	5 mins
Quality & Safety					
GB16/81	SEND Briefing	PW	Report	R	10 mins

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
Service Improvement/Strategic Delivery					
GB16/82	Sustainability and Transformation Plan (STP) for Cheshire and Merseyside	KMcC	Report	A	10 mins
GB16/83	Shaping Sefton - Plans on a Page	KMcC	Report	A	15 mins
GB16/84	Joint Commissioning Status	JL	Report	A	10 mins
Finance and Quality Performance					
GB16/85	2016/17 Revised CCG Budgets/ QIPP	MMcD	Report	A	10 mins
GB16/86	Integrated Performance Report	KMcC/ MMcD/DF	Report	R	10 mins
For Information					
GB16/87	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 ○ Seaforth & Litherland ○ Crosby	Chair	Report	R	5 mins
GB16/88	F&R Committee Minutes - Feb 2016 - Mar 2016	Chair	Report	R	5 mins
GB16/89	Quality Committee Minutes - Feb 2016 - Mar 2016		Report	R	
GB16/90	Audit Committee - Jan 2016		Report	R	
GB16/91	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting*				
GB16/92	Date of Next Meeting Thursday 28th July 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
Draft Minutes

Date: Thursday 31 March 2016, 13:00 to 15:30 hrs
Venue: Boardroom, 3rd Floor, Merton House, Bootle, L20 3DL

The Governing Body		
Dr Craig Gillespie	GP Clinical Director	CG
Dr Andrew Mimnagh	Chair & Governing Body Member	AM
Graham Morris	Lay Member, Audit/Governance	GM
Debbie Fagan	Chief Nurse & Quality Officer	DF
Martin McDowell	Chief Finance Officer	MMcD
Dr Clive Shaw	GP Clinical Director & Governing Body Member	CS
Dr Ricky Sinha	GP Clinical Director & Governing Body Member	RS
Fiona Taylor	Chief Officer	FLT
Dr Paul Thomas	GP Clinical Director & Governing Body Member	PT
Dr John Wray	GP Clinical Director & Governing Body Member	JW
In Attendance		
Jayne Williams	Minute Taker	JW
Lyn Cooke	Head of Communications	LC
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Brendan Prescott	Deputy Chief Nurse/Head of Quality & Safety	BP
Carmel Farmer	Designated Nurse, Looked After Children	CF

Presentation: 'Looked After Children' Carmel Farmer

No	Item	Action
GOVERNANCE		
GB16/36	**Apologies for Absence** Apologies were received from Dr Peter Chamberlain, Dr Dan McDowell , Dwayne Johnson & Matthew Ashton	
GB16/37	**Declarations of Interest** All GPs and those holding hold dual roles across Southport & Formby CCG and South Sefton CCG declared their interest.	
GB16/38	**Minutes of Previous Meeting** GB16/34 **Any Other Business** **Financial Plan** MMcD outlined the discussions that had taken place around a further review of expenditure to ensure that all activity had been correctly assigned to the 2 CCGs. MMcD noted that that this review would not alter his view that South Sefton CCG remained on target to deliver its financial duties for 2015/16. MMcD will continue to report progress to SLT. **Outcome: The Governing Body supported MMcD's proposal** The minutes of the previous meeting were accepted as a true and accurate record	

No	Item	Action
GB16/39	**Update on Action Points from Previous Meeting** • 15/204 – Safeguarding Children & Vulnerable Adults – GH confirmed spiritual abuse definition was acceptable. • GB16/11 Children & Young Peoples Plan – Actions completed • GB16/12 Primary Care Transformation Plan – Actions completed • GB16/13 Delivering the Forward View – FLT advised further update • GB16/14 Shaping Sefton – JL to take forward. PC on annual leave • GB16/15 Integrated Performance Report: Mixed accommodation at Liverpool Heart & Chest Hospital, has not been addressed properly, needs resubmitting second time.	FLT
GB16/40	**Business Update** The new Chair – Dr Andy Mimnagh, was delayed, therefore CG deputised as chair for the meeting. Andy reported he was settling into his new role and would give a more detailed business update in May 2016.	AM
GB16/41	**Chief Officer Report** FLT presented the Governing Body with highlights from her report: **Delivering the Forward View:** Submitted second iteration of one year operational plan, additional date was added by NHSE to enhance the level of assurance. Next iteration due for submission 11/04/2016. **Sustainability & Transformation Plan (STP)** South Sefton remains part of North Mersey Local Delivery Systems (LDS) with Liverpool, Knowsley and Southport & Formby CCGs. The CCG is working in the LDS footprints on the Sustainability Transformation Plan (STP) towards a June 2016 deadline. FLT advised Louise Shepherd had taken the chair role of the STP to ensure delivery across Cheshire & Merseyside (C & M) additional to her Chief Executive role at Alder Hey Hospital. **Shaping Sefton** Launched in Feb 2015. Currently the communications team are working to present the vision and outcomes of the programmes and translate to our annual report. Working closely with colleagues at Liverpool CCG, shaping the 'in hospital model of care' around Aintree footprint and wider health economy. New Director of Public Health 'Matthew Ashton', holds a joint role with Sefton and Knowsley, he plans to build on Health & Wellbeing strategy. The CCG be working closely with the Local Authority around the prevention agenda and are aiming to gain closer alignment; the CCG will be appointing a programme manager to lead on this work. **Better Care Fund** Policy Framework published 08/01/2016 covers the legal and financial basis of the Better Care Fund (BCF) and sets out how the fund will be implemented in 2016/2017. Targets and timescale are tight and maybe unable to submit to required timescale, NHS England have been advised. The CCG is working with Sefton MBC, supported by Sharon Lomax, Integrated Health & Social Care Manager. Due to tight timescales, the Governing Body is asked to give delegated authority to Chief Officer to sign off the BCF on its behalf in line with our standing orders/strategy and financial instructions. FLT will keep senior leadership informed.	

No	Item	Action
GB16/41	**Quality** **Student Nursing Time Awards** Southport and Formby and South Sefton CCGs, have been shortlisted in the Student Nursing Times Award 2016. They have made it into the final round of 'Student Placement of the Year category. BP will travel to London on 28/04/2016 to attend 'finalist' ceremony. **Students Placements in CCG** An article written regarding student placements within the CCGs has been accepted for publication in the Nursing Times, promoting the work of the SS & S&F CCGs. **Mental Health Task Force** Nationally established in March 2015, aimed at improving mental health across the NHS. The first report published in Feb 2016 is part of the ten-year plan for the transformation of mental health services, tackling inequalities at local and national level. FLT reported on some of the key issues. The recommendations will be given due consideration by the CCG. **Diabetes Prevention Programme (NHS DPP)** NHS DPP will start this year in 27 areas including South Sefton. Sharon Forrester, Programme Lead at South Sefton CCG, Dr Nigel Taylor & Dr Doug Callow worked with Dr Davina Hanlon in the Council's Public Health Team to submit a successful bid. The Governing body will be kept updated on the progress. **Governing Body Changes:** Dr Peter Chamberlain – Re-elected Dr Craig Gillespie – Re-elected & taken Clinical Vice Chair Role Dr Andy Mimnagh – Re-elected and taken Chair role Dr Sinha – Re-elected Dr Sapre – Newly elected GP Vacancy – To be re-advertised Vacancy for two practice managers – recruitment is underway **Retired Members** Dr Paul Thomas – Retired Member Dr Clive Shaw – Retired Member Roger Driver – Retired Member **New Members** Graham Bayliss – South Sefton (Lay Member) – to replace Roger Driver, to start mid-April 2016 FLT thanked Dr Clive Shaw and Dr Paul Thomas on behalf of the group for their work and commitment on the Governing Body and wished them well for their future endeavours. **Outcome: The Governing Body received the report, ratified the appointment of the new Chair and approved delegated authority to the Chief Officer to sign off the BCF on its behalf.**	
GB16/42	**GP Pressures and Supporting Practices** Local Quality Contract Funding – Delivery issues for local practices, amendments agreed with local practices and LMC subject to approvals committee. FLT met with Maghull locality and NHSE, the meeting was well attended. Various matters were aired and actions were agreed. **Outcome: The Governing Body approved the paper**	

No	Item	Action
GB16/43	**LCR NHS CCG Alliance – Revised Terms of Reference** 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. Wirral are out with Liverpool City Region for planning (but still in alliance), ToR needs updating, cannot be approved yet, awaiting update from Knowsley CCG. **Outcome: The Governing Body was unable to approve the Terms & Conditions at this meeting, to be revisited at next meeting.**	FLT
GB16/44	**Corporate Objectives** KMcC presented the Corporate Objectives Report for 2016/2017, advising the CCG has revisited its current 2015/2016 Corporate Objectives and developed a proposal for 2016/2017. The Governing Body is asked to approve the proposed Corporate Objectives for 2016/2017. **Outcome: The Governing Body approved the Proposed Corporate Objectives**	
GB16/45	**Equality and Diversity Annual Report** The report outlines the CCGs approach to embedding Equality & Diversity within the organisations via the EDS2. The Governing Body were asked to: Receive the Equality & Diversity Annual Report (Appendix A). Receive the CCGs approach to Equality Delivery Systems 2 Assessment (EDS2), (Appendix A, section 2) Receive the NHSE EDS2 Summary Report (Appendix B) Approve the 3 year Equality Objectives Plan (Appendix A, Section 3) in light of the EDS2 Assessment **Outcome: The Governing Body received the report** **The Governing Body approved the 3 year objectives**	
QUALITY & SAFETY		
GB16/46 Action	**Personal Health Budgets (PHB)** BP presented the paper on behalf of TF who is currently on annual leave. BP advised that it has been a positive experience for patients who have already come forward but at present it is hard to evaluate due to small numbers. There are challenges in getting people involved, but we are working with the Carers' Centre and other local groups to improve awareness. FLT advised the Policy submitted has been subject to wide engagement and robust consultation, in support of PHBs for Adults & Children, in line with current Government Policy and National Guidance and will be made available on the CCG website. The Governing Body were asked to approve the Policy and Guidance, from which the CCG can base its 'local offer' for PHBs. Report refers to 'NHS Southport & Formby CCG' which is incorrect; amend to read South Sefton CCG and telephone contact details. **Outcome: The Governing Body approved the Policy and Guidance.**	BP

No	Item	Action
GB16/47	**Safeguarding Peer Review Action Plan** DF presented the Governing Body with the updated CCG Safeguarding Peer Review Action Plan (V9i). The action plan was 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. The following assurance mechanisms are in place: CCG Safeguarding Network Steering Group MIAA – safeguarding review as part of work plan LSCB – Section 11 audit NHSE – CCG Safeguarding Assurance Tool 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. **Outcome: The Governing Body approved the closure of the action plan**	
GB16/48	**Looked After Children Strategy** CF presented the report 'Looked after Strategy' to the Governing body for approval. The 'Looked After Children Strategy' was developed in accordance with current legislation and guidance, to understand and plan for the current and future needs of looked after children and care leavers. Once approved the work plan will continue to be developed and updated in line with current CCG governance arrangements. The strategy will be delivered through a work plan, working alongside existing partnerships for children and adult safeguarding, and will be reviewed through CCG Quality Committees. Any concerns against delivery to be escalated to the Governing Body. Correction to report 4.1 Strategy, not 'South Sefton CCGs' Vision, should read 'Vison for Sefton' **Outcome: The Governing Body approved the strategy**	DF/CF
SERVICE IMPROVEMENT /STRATEGIC DELIVERY`		
GB16/49	**Dementia Friendly Communities and the CCGs Role** CF presented the report 'Developing Dementia-friendly communities and the Sefton Dementia Action Alliance' for approval by the Governing Body: To identify key changes required to make Sefton a dementia friendly community. To join the Sefton Dementia Action Alliance. To promote dementia friendly training and awareness. Champion provide 'blue forget me nots' when dementia friendly. **Outcome: The Governing Body approved this report**	

No	Item	Action
GB 16/50	**Transforming Care for People with Learning Disabilities: Implementing of National Plan** BP Presented the report Following the Winterbourne View Review (2012). NHS England is committed to improving health care for people with learning disabilities and autism by transforming the care programme. Significant shift in commissioning over next 3 years. The paper was to update the CCG Governing Body, on national, regional and local programmes with the aim of transforming care for children, young people and adults with learning disabilities. Health & Wellbeing Board to receive report. **Outcome: The Governing Body received the report**	DF
FINANCE AND QUALITY PERFORMANCE		
GB16/51	**Integrated Performance Report** KMcC asked the Governing Body to receive this report, he briefed the Governing Body on highlights from the report: **Financial Performance – £**2.84m overspend as of February 2016 on operational budget before application of reserves. Non recurrent benefits will not be available beyond April 2016. Overall forecast is £2.4m, against planned surplus of £2.4m after application of reserves. CCG to develop plans to reduce expenditure. **Referrals** – Increasing since March 2015. ENT at Aintree receives high level of GP referrals. GP hotline in place – CCG advised Aintree that they will not be funding these referrals. **A & E Waits (all types)** Aintree Trust failed the 95% target. Recovery plan with the CCG to reach 95% target by 2017. AM said the target challenging as reasons for failure, can change hour by hour. **Ambulance Activity** CAT A (Red 2) CCG failing Delivery and sustainability of emergency ambulance performance remains a key priority for CCGs. Care Home Improvement Programme (CHIP) data shows 40% reduction in conveyances from care homes. Additional data is required from the Acute Visiting Team Ambulance activity - work with Blackpool CCG CCG to support a comprehensive action plan **Cancer Indicators -** CCG and Aintree achieved all the cancer indicators year to date as at January 2016 A summary of the CCG Key performance indicators was provided. **Diagnostics** The CCG are over plan for diagnostics in January, out of 2,333 patients 37 waited over 6 weeks for a diagnostic test, 23 were for non-obstetric ultrasound. Aintree failed to reach its target as 72 patients waited over six weeks for diagnostic test, 51 of these patients waited for non-obstetric ultrasound, somewhat due to increased demand from Trauma and Orthopaedics. The Trust has assured the CCG this will be resolved by August 2016.	KM

No	Item	Action
	Mixed Sex Accommodation Liverpool Heart and Chest Hospital had its 4th breach in a row, CG asked if we knew why this was happening, BP advised this was due to RTT. *Action: to be brought back to next meeting* **Patient Safety Incidents Reported** 2 new Serious Untoward Incidents in January **Patient reported outcomes measures (PROMS) for elective procedures** Discussions with clinicians have centred on the proposal to use 'Shared Decision Aids' for a number of surgical areas, proposal is awaiting approval. Problems with the questionnaire. **Outcome: The Governing Body received the report**	BP
GB16/52	**2016/2017 Opening Financial Budgets** MMcD delivered the financial budgets and advised the governing body that the CCG was on target to deliver its financial duties for 2015/2016. However he reminded members that the recurrent position is a deficit, due to the underperformance of QIPP schemes. As a financial risk to the CCG for 2016/2017 actions are required to address the situation, the governing body should consider this as the CCG's top priority along with commissioning safe services. The Governing body was asked to receive the financial budgets for 2016/2017 **Outcome: The Governing Body received the financial budgets**	
GB16/53	**Revised Financial Strategy 2016/2017 to 2021/21** MMcD present the Revised Financial Strategy to the Governing Body. Following national planning guidance, including funding allocation for CCGs published (January 2016), the Governing Body is asked to approve the CCG financial strategy for the 5 year planning period. **Outcome: The Governing Body approved the paper**	
FOR INFORMATION		
GB16/54	**Key Issues reports from committees of Governing Body:** **a) Finance & Resource Committee -** Report incorrect - page 330 £6.4m QIPP savings should read £2.25m **b) Quality Committee –** No update **c) CIC: Realigned Hospital Based Care –** No update **d) CIC LCR NHS CCG -** Report received **e) Audit Committee** No update **f) 4-Monthly Reports** **Bootle - report received** **Maghull - no update**	MMcD

No	Item	Action
	Seaforth & Litherland - report received **Crosby - no update** **Outcome: The Governing Body received the key issues reports**	
GB16/55	**Finance & Resource Committee Minutes** **Outcome: The Governing Body received the minutes**	
GB16/56	**Quality Committee Minutes** **Outcome: The Governing Body received the minutes**	
GB16/57	**Approvals Committee Minutes** **Outcome: The Governing Body received the minutes**	
GB16/58	**Any Other Business** **None**	
GB16/59	**Date of Next Meeting** May 26th 2016 at 13:00 hrs in the Boardroom, 3rd Floor, Merton House, Bootle	

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Governing Body Meeting in Public
Actions from meeting held 31 March 2016

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
GB16/14	**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
GB16/43	**LCR NHS CCG Alliance – Revised Terms of Reference** The Governing Body was unable to approve the Terms & Conditions at this meeting, to be revisited at next meeting.	FLT
GB16/46	**Personal Health Budgets (PHB)** FLT advised the Policy submitted has been subject to wide engagement and robust consultation, in support of PHBs for Adults & Children, in line with current Government Policy and National Guidance and will be made available on the CCG website.	BP
GB16/48	**Looked After Children Strategy** The strategy will be delivered through a work plan, working alongside existing partnerships for children and adult safeguarding, and will be reviewed through CCG Quality Committees. Any concerns against delivery to be escalated to the Governing Body.	DF/CF
GB16/50	**Transforming Care for People with Learning Disabilities: Implementing of National Plan** Health & Wellbeing Board to receive report.	DF
GB16/51	**Integrated Performance Report** **Ambulance Activity** CCG to support a comprehensive action plan **Mixed Sex Accommodation** Liverpool Heart and Chest Hospital had its 4th breach in a row, CG asked if we knew why this was happening, BP advised this was due to RTT.	KM BP
GB16/54	**Key Issues reports from committees of Governing Body:** **a) Finance & Resource Committee -** Report incorrect - page 330 £6.4m QIPP savings should read £2.25m	MMcD

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MEETING OF THE GOVERNING BODY
May 2016

Agenda Item: 16/79	**Author of the Paper:** Fiona Taylor Chief Officer Email: fiona.taylor@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: May 2016	

Title: Chief Officer Report

Summary/Key Issues:

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

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.
x	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.
x	To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.
x	To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
x	To advance integration of in-hospital and community services in support of the CCG locality model of care.
x	To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

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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

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Report to Governing Body
May 2016

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.

1. QIPP

Intense work is underway within the CCG to review and focus work on the achievement of the 16/17 QIPP target. The CCG has now appointed a QIPP Lead to strengthen the Leadership Team. Since 9th May Debbie Fairclough is in post and has the task of crystallising the 2016/17 QIPP plan. This will sit alongside the CCG financial recovery plan.

The CCG has also appointed an independent leadership role to support the QIPP agenda. This role is being fulfilled by a very experienced ex Chief Executive who has a track record of QIPP delivery across England. This role is providing challenge into the CCG and also support to ensure clarity of programmes and depth of focus on achievable areas of QIPP savings. We are focussing on three key areas:

- Transactional
- Transformation
- Portfolio

This will be achieved through delivery of clear programmes of work connected to our strategic aims:

- Planned Care
- Prescribing
- CHC/FNC
- Discretionary/Other
- Non-Elective/System Redesign

The organisational development work focused on localities and the role of the GP in supporting the demand management agenda is also crucial to the QIPP delivery.

At the same time work is being carried out to ensure a robust performance management reporting system is in place and PMO coverage is supported. A tighter performance framework is being developed through the QIPP lead, with work throughout the organisation and across the membership to ensure the ownership and delivery at all levels. The focus in our localities and with our clinical leadership is vital to the successful delivery of QIPP.

Communication and engagement with our wider public will be continued through our 'Big Chat' events which are scheduled over the next few months. These events will present the public with some of the choices and decision making the CCG will need to undertake in 16/17, gathering inclusive input, views and actions.

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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.

2. Shaping Sefton

Work continues to form an oversight group for the Shaping Sefton transformation programme –this has resulted in the Chief Executives from local NHS providers and the LA Chief Executive and Director of Health & Social Care. This work is part of the System Leadership programme which underpins the transformation programme and is being facilitated by Chris Lawrence-Pietroni and Liz Goold.

A plan on a page for each programme has now been developed for 16/17 and is presented on today's agenda.

The work of Shaping Sefton is very much at the forefront of the development within the Sustainability and Transformation plan for the North Mersey local delivery system, as part of the wider Cheshire & Merseyside. A full operational plan will be brought back to the July governing body.

Work is nearly complete with the clinical changes to ensure all aspects of line management and delivery is clear. The CCG Chair has undertaken a performance review with governing body members. Where clinical leads are employed by the CCG, line management arrangements are being clarified.

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

3. Nurse Revalidation

The Governing Body have previously received updates on the preparation for revalidation. Nurse revalidation came into effect from 1st April 2016. The first registered nurse within the CCG senior management team has successfully revalidated with the Nursing and Midwifery Council (NMC).

4. Article for publication- Student Nurse placements

The Governing Body have previously received an update regarding an article that was written regarding Student Placements within the CCG being accepted for publication in The Nursing Times. At the time a date was awaited for publication. This article was published in April 2016.

5. Quality Risk Summit- Southport & Ormskirk Hospitals NHS Trust

A Quality Risk Summit was held with respect to Southport & Ormskirk Hospitals NHS Trust on 13th May 2016 chaired by NHS England (North) with a focus on A&E performance, safeguarding, governance and leadership. Remedial and supportive actions were agreed by partners with updates to be received by the Governing Body as appropriate.

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6. Safeguarding

6.1 NHS England CCG Quality Assurance Process

The CCG submitted their CCG assurance information which was reviewed at a meeting between the CCG Safeguarding Service and NHS England in April 2016. The self-assessment was reviewed by the Quality Committee prior to submission. The outcome was received by the Chief Nurse on 16th May 2016 and reported to the Quality Committee. In total, there were 28 Key Lines of Enquiries (KLOE). NHSE upgraded the CCG self-assessment from AMBER to GREEN (fully compliant) in 3 KLOE areas relating to Safer Recruitment and Policies, Procedures & Guidance and agreed with the CCG AMBER rating (partial compliance with progress being made within agreed timescales) in 4 KLOE areas relating to Supervision, Policies / Procedures / Guidance, Assurance (relating to Special Educational Needs & Disability) and Leadership (relating to Designated Doctor / Looked After Children Capacity). The CCG Safeguarding Service will develop an action plan which will be monitored at the Quality Committee.

5.2 OFSTED Single Agency Safeguarding Inspection

OFSTED have undertaken in Sefton, over a 4 week period in April 2016 – May 2016, an inspection of services for children in need of help and protection, children looked after and care leavers and a review of the Local Safeguarding Children Board under their Single Inspection Framework. The outcome of the inspection is awaited and health partners, including the CCG and general practice, have received thanks from the Director of Social Care & Health in Sefton MBC for their support and input into the process. The CCG Chief Officer has written to the relevant membership practices within the CCG formally acknowledging their involvement and expressing her thanks.

7. Leadership for Integration Venice Study Tour - May 2016

The Chief Nurse received a funded place to participate in the North West Leadership Academy 'Leadership for Integration Programme 2016', in association with the International Federation for Integrated Care. This study visit to the Veneto Region (Venice and Treviso) took place between 11th May – 13th May 2016 and feedback and learning is being brought back into the CCG to support the further development of our own local integration agenda.

8. 360º Stakeholder Review

The CCG has received the annual 360 degree feedback report and work is currently underway to do the detailed analysis and ensure that all areas for improvement are considered within the CCG organisational development plan (OD plan).

9. Business Intelligence- Practice support

The roll out of the Aristotle intelligence system is underway with practice over the next few weeks. This timely intelligence at locality/practice level will very much support the underpinning work of the CCG membership in delivery of plans.

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10. Contracting 16/17

All contracts with our main providers are signed off for 16/17.

Work is now underway as part of the QIPP work to strengthen our contracting function and its focus. This work will require an agreed and clear performance management framework. The changes in the contracting team, brought about by the transfer from CSU into the CCG are now being consolidated and clear lines of accountability will be developed for the end of June 2016, with clarity of the roles and relationships between senior managerial and clinical leadership and current governance structures.

11. Increase in number of Lay Members on Governing Bodies

NHS England has announced CCGs will be required to nominate a "conflicts of interest guardian" as part of a system-wide overhaul of conflicts of interest policy. Among the changes will be a requirement for a guardian in each CCG to act as a point of contact and expertise on procurement decisions and interaction with commercial organisations.

The proposals were presented to NHS England's board meeting in April, and have been produced to accompany the publication of an audit reviewing conflicts of interest management in CCGs that co-commission primary care.

Other changes include:

- requiring CCGs to have at least three lay members on each governing body to better manage conflicts of interest (COI);
- mandating commissioners to have "robust" processes for managing breaches in their COI policy – and to publish any breaches on their website; and
- the introduction of compulsory online COI training for CCG staff and the workforce in all member practices, provided by NHS England.

Currently CCGs are only required by law to have two lay members on their governing bodies. NHS England said it was aware of the additional financial burden this may have on commissioners. The CCG will undertake a review through the Audit & Governance framework to consider the implementation and implications of these recommendations.

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

12. Co-commissioning of Primary Care

The CCG membership discussed the movement from greater involvement in co-commissioning to being the joint co-commissioner of general practice at the wider membership on the 5th May 2016. Further news from the membership are now being sought for the 1st June 2016 NHSE application deadline. Subject to this membership support and formal Governing Body approval, the CCG is working more closely with NHSE, but a formal joint committee of the Governing Body will need to be established.

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South Sefton
Clinical Commissioning Group

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

13. Locality Development

As part of our organisational development work and support to clinical engagement and leadership it is vital that we further enhance the functionality of the CCG localities. Several pieces of work are crucial to this including clarifying the locality managers role, ensuring good 'wrap around' support services; such as finance and business intelligence as well as ensuring the required clinical support and leadership to augment the GP leads.

14. Community Services Acquisition

The first element of the process is now complete and work is on schedule via NHS Improvement to identify a preferred provider for April 2017.

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

15. Integration/Better Care Fund (BCF)

The CCG submitted a plan to NHSE to ensure it was compliant with its statutory requirements to secure funding for Sefton. Unfortunately, the CCG and Sefton MBC were unable to agree a joint Better Care fund plan for 2016/17 and as a consequence Sefton has been entered into the escalation process by NHS England. This will mean that the Chief Officer will be in attendance with the Chief Executive Sefton MBC and the Chair of the Health & Wellbeing Board at a meeting chaired by NHSE on 7th June 2016.

In the meantime work will continue under the umbrella of the Health & Wellbeing Board to drive forwards the opportunities for integration between the CCG and Sefton MBC.

16. Recommendation

The Governing Body is asked to formally receive this report.

Fiona Taylor
Chief Officer
May 2016

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2016

Agenda Item: 16/80	**Author of the Paper:** Fiona Taylor Chief Officer Email: fiona.taylor@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: May 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.

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

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

Liverpool City Region (LCR) NHS Clinical Commissioning Group Alliance

(Committee in Common)

Terms of Reference

1. Purpose of the Alliance

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

- 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
May 2016

Agenda Item: GB 16/81	**Author of the Paper:** Peter Wong Children, Young People & Maternity Commissioning Manager Peter.wong@southseftonccg.nhs.uk
Report date: May 2016	

Title: Children with Special Educational Needs and Disabilities (SEND) – Current Position and Inspection Framework

Summary/Key Issues: The Children & Families Act (2014) introduced new duties on local areas (including health) regarding provision and support for children and young people with special educational needs and/or disabilities (SEND).

From the 1st of May 2016 Ofsted and CQC will undertake joint inspections of local areas to evaluate how well local areas carry out their statutory duties in relation to children and young people with SEND.

The CCG have worked in partnership with the local authority to have a fully compliant local offer and supporting the delivery of Education, Health and Care Plans being issued within statutory timescales.

The CCG and health providers will need to continue to work in partnership to prepare for an inspection. This process will involve a local area self-assessment which will identify strengths and areas for improvement.

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

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Clinical Commissioning Group

Links to Corporate Objectives *(x those that apply)*	
	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.
	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.
X	To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.
	To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
	To advance integration of in-hospital and community services in support of the CCG locality model of care.
X	To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

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
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

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
May 2016

Children with Special Educational Needs and Disabilities (SEND).
Current Position and Inspection Regime.

1. Executive Summary

The Children & Families Act (2014) introduced new duties on local areas (including health) regarding provision and support for children and young people with special educational needs and/or disabilities (SEND).

From the 1st of May 2016 Ofsted and CQC will undertake joint inspections of local areas to evaluate how well local areas carry out their statutory duties in relation to children and young people with SEND.

The CCG have worked in partnership with the local authority to have a fully compliant local offer and supporting the delivery of Education, Health and Care Plans being issued within statutory timescales.

The CCG and health providers will need to continue to work in partnership to prepare for an inspection. This process will involve a local area self-assessment which will identify strengths and areas for improvement.

2. Introduction and Background

A comprehensive set of reforms for children and young people with Special Educational Needs and Disabilities (SEND) was introduced in Children and Families Act 2014. This is underpinned by a Statutory Code of Practice to implement the reforms.

The principles underpinning the Code are as follows:

- taking into account the views of children, young people and families
- enabling children, young people and parents to participate in decision-making
- collaborating with partners in education, health and social care to provide support
- identifying children and young people's needs
- making high quality provision to meet the needs of children and young people
- focusing on inclusive practice and removing barriers to learning
- helping children and young people to prepare for adulthood

From September 2014 CCGs must:

- Commission services jointly for children and young people (up to age 25) with SEND, including those with Education Health and Care Plans (EHCP).
  NHS South Sefton CCG (SSCCG) and Sefton Council have existing arrangements for jointly funding packages between health, education and social care. There is a commitment to develop a joint commissioning strategy for SEND.
- Work with the local authority to contribute to the Local Offer of services available
  SSCCG has contributed all necessary information to the Local Offer, which is fully complaint.
- Have mechanisms in place to ensure practitioners and clinicians will support the integrated EHC needs assessment process, and

SSCCG have appointed a Designated Clinical Officer – Debbie Fagan

SSCCG have commissioned Liverpool Community Health to co-ordinate and support integrated EHC needs assessment process and provide health information, outcomes and provision into statutory Education Health and Care Plans. For the last 12 months 100% of EHCP have been issued with the statutory timescales.

- Agree Personal Budgets where they are provided for those with EHC plans
  SSCCG has an agreed process and policy on PHBs.

Inspection

From the 1st of May 2016 Ofsted and CQC will undertake joint inspections of local areas to evaluate how well local areas carry out their statutory duties in relation to children and young people with SEND.

For the purposes of the reforms and inspection 'local area' is not just the local authority it also includes CCGs, public health, NHSE, early year settings, schools and further education providers.

The inspection will involve visits to providers and agencies to understand how they work collaboratively to improve the life chances of children and young people with SEND. However, visits to providers are not in themselves inspections of those providers.

Local areas will be inspected at least once every five years and they will be flexibly scheduled, but if there are significant concerns then an area can be inspected earlier than first scheduled.

Inspections will make their judgement based on three key questions. How effectively doe the local area:

a) Identify children and young people with SEND?
b) Meet the needs of children and young people with SEND?
c) Improve the outcomes for children and young people with SEND?

In considering these questions and reaching judgement the inspection will pay particular attention to:

- Robustness of the local self-assessment.
- To what extent collaboration between local agencies contributes to improved outcomes.
- Efficiency of identification of SEND.
- Timeliness and usefulness of assessment.
- How agencies plan and co-ordinate their work to assess and meet need, including joint commissioning.
- How public engagement informs strategic commissioning (JSNA).
- Individual involvement in assessing their own needs.
- How well identification, assessment and criteria are communicated.
- Due regard to Equality Act (2010).
- The Local Offer
- Leadership, including understanding of the Local Offer.

Inspections will last 5 days and local areas will be given 5 days notification.

3. Key Issues

The local authority has already undertaken some preparation in advance of the final inspection framework being issued at the end of April 2016. They have also scheduled in further planning

meetings and discussions about how the local area will prepare for any inspection. In the main this will focus on completing a self-assessment.

From a health perspective the likely issues and challenges that will be flagged up as part of this process are:

- Ability to demonstrate how feedback from children and young people with SEND and parents have influenced commissioning and service improvement across all relevant areas of health provision.
- Intelligence and data not as robust as required, specifically in identifying children and young people with SEND in all relevant areas/pathways of health provision.
- Possible examples where services/pathways do not effectively collaborate to maximise outcomes for children with SEND
- Challenged service delivery (inc. waiting times) in key services e.g. community paediatrics, speech and language and occupational therapy.
- Formal Joint Commissioning Strategy for children and young people with SEND.
- Adult services, given that reforms relate to people aged 0-25.
- Additional service challenges during Liverpool Community Health transitional arrangements, including co-ordination and health input to EHCPs.

4. Conclusions

The CCG has been fully engaged and supported the implementation of SEND reforms and contributed to excellent performance in issuing EHCPs with statutory timescales.

It is expected that the required local area self-assessment will not only identify strengths but various areas for improvement, especially if inspected early within the five year cycle.

A number of the key services are experiencing some pressures and there will be some risks associated with the transition of services to new providers which will need to be mitigated. However, improvements re: SEND feature in key developments for future service models and provision, as does improved integration and joint commissioning. Also during the transitional period there will be continued support and scrutiny to ensure that health input into EHCPs continues to meet statutory requirements.

5. Recommendations

That the Governing Body note the contents of this report, in particular the duties of the CCG re: SEND and the introduction of a new inspection regime.

Peter Wong
May 2016

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2016

Agenda Item: GB 16/82	**Author of the Paper:** Karl McCluskey Chief Strategy and Outcomes Officer E mail: Karl.mcluskey@southportandformbyccg.nhs.uk Tel no: 0151 247 7000
Report date: May 2016	

Title: Sustainability and Transformation Plan (STP) for Cheshire and Merseyside

Summary/Key Issues:

This paper provides the Governing Body with a briefing on the approach that is being taken locally in terms of building the Sustainability & Transformation Plan (STP) for Cheshire & Merseyside.

Recommendation

Receive	x
Approve	
Ratify	

The Governing Body is asked to:
1. Receive this report.
2. Approve delegated authority to sign off our contribution to the STP submission for 30th June

Links to Corporate Objectives *(x those that apply)*	
x	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.
x	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.
x	To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.
x	To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
x	To advance integration of in-hospital and community services in support of the CCG locality model of care.
x	To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

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South Sefton
Clinical Commissioning Group

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

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
x	Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
May 2016

1. Introduction

1.1 This paper provides the Governing Body with a briefing on the approach that is being taken locally in terms of building the Sustainability & Transformation Plan (STP) for Cheshire & Merseyside.

1.2 The background to the STP and an outline of the guidance set out in "Delivering the Five Year Forward View" is described, together with a more specific overview update on the development of the Local Delivery System Plans for North Mersey and the LDS Alliance respectively.

2. Background

2.1 The NHS Five year Forward View published in October 2014 considered the progress made in improving health and care services in recent years and the challenges that we face leading up to 2020/21. These challenges include:-

- the **quality of care** that people receive can be variable
- **preventable illness** is common
- growing demands on the NHS means that local health and care organisations are facing **financial pressure**
- the **needs and expectations of the public are changing**. New treatments options are emerging, and we rightly expect **better care closer to home**.

2.2 The way that health and care is provided has dramatically improved over the past fifteen years – thanks to the commitment of NHS staff and protected funding in recent years. But some challenges remain. The quality of care that people receive can be variable; preventable illness is common; and growing demands on the NHS means that local health and care organisations face financial pressure.

2.3 The needs and expectations of the public are also changing. Fortunately we are living longer, but we often require different, more complex care as a result. New treatments options are emerging, and we rightly expect better care closer to home. There is broad agreement that, in order to create a better future for the NHS, we have to adapt the way we do things. This doesn't mean doing less for patients or reducing the quality of care. It means more preventative care; finding new ways to meet people's needs; and identifying ways to do things more efficiently.

2.4 The Five Year Forward View brings together this agreement in a future vision for the NHS. It highlights three areas where there are growing gaps between where we are now and where we need to be in 2020/21. These gaps are:-

- the **health and wellbeing** of the population;
- the **quality of care** that is provided; and
- **finance and efficiency** of NHS services.

2.5 The Five Year Forward View is a vision where patients are in control of consistently high-quality care that meets their needs – regardless of where they live. It is a vision where everyone takes prevention and healthy living seriously – helping to reduce the

damage caused by unhealthy lifestyles. And it is a vision where everyone with a stake in health and care comes together to find ways to reduce inefficiency.

2.6 It is an ambitious vision, but there is widespread agreement among those working in the NHS, clinicians and people who use services that it can be achieved. The growing gaps in the quality of care, our health and wellbeing and NHS finances can be shrunk over the next five years by collectively adapting what we do, how we think, and how we act.

3. Closing the three gaps by working together: Developing local area Sustainability and Transformation Plans (STPs)

3.1 The Five Year Forward View vision will be achieved by everyone who has a stake in health and care adapting what they do, how they think, and how they act – at both local and national levels.

3.2 As part of this, there is a growing consensus that one of the most powerful ways to achieve change is through local services working together - across entire communities and pathways of care - to find ways to close the gaps between where we are now, and where we need to be in the future. (For example, it doesn't make sense to for a hospital to develop isolated plans to improve diabetes care without working with local GPs and local authorities on how to help prevent people from having diabetes in the first place. Planning by place – rather than by individual organisation – will support the transformation of care for local populations as a whole.)

3.3 As a result, neighbouring NHS providers, CCGs, and other health and care services, have come together to form 'footprints': geographic areas in which people and organisations will work together and at scale to develop robust plans to transform the way that care is planned and delivered and to narrow the three gaps outlined in the Forward View – bringing benefit to all.

3.4 These 44 footprints in England will now develop multi-year, place-based Sustainability and Transformation Plans (STPs) for 2016 - 2021, which have input from patients, people and communities to ensure they truly respond to local needs. This means that areas will still be focusing on what needs to be delivered today, but also with an eye on where they need to be to meet longer-term needs.

3.5 The area-wide footprint will primarily be based on the way people access health and care services, but will also take into account the finances of an area, and its leadership capacity.

3.6 An STP will not necessarily replace existing plans to improve services in an area. Instead it will act as an 'umbrella' plan for change: holding underneath it a number of different specific plans to address certain challenges, such as cancer, mental health, or urgent and emergency care.

3.7 Having a shared STP across a local community also does not mean that NHS organisations – like a local hospital, or a primary care centre – will have to lose their own autonomy or identity. But it does means that organisations will be working to a shared, agreed plan which addresses how they will collectively improve health, care and finance for their local population by 2021.

3.8 The task ahead is one that needs energy and ambition. It will require the NHS, at both the local and national level, to work beyond the boundaries of its own organisations, and to work in a more collective, less hierarchical way for the benefit of the people we serve – ultimately delivering the Five Year Forward View and a sustainable, transformed NHS.

4. The Cheshire & Merseyside STP

4.1 Locally, commissioners and providers across Cheshire & Merseyside have come together to build the Cheshire & Merseyside STP. The nominated lead for the footprint is Louise Shepherd (Chief Executive Officer Alder Hey Children's Hospital).

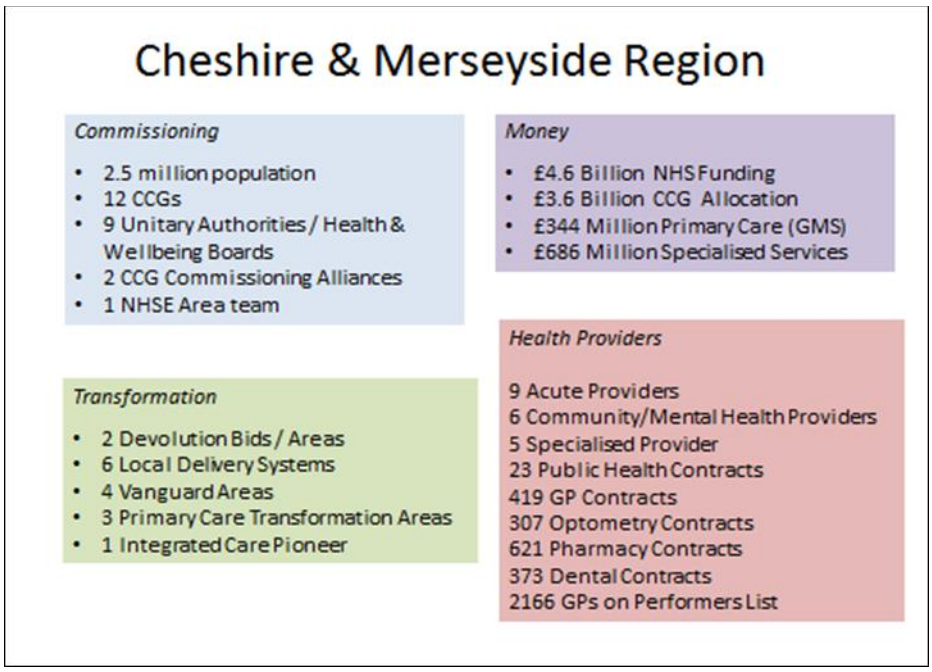
4.2 We are clear in Cheshire and Merseyside (C&M) that the Five Year Forward View (FYFV) sets out the vision for the future of the NHS based around the new models of care. The C&M STP will be our plan to deliver that and C&M NHS and Local Authority organisations will develop a blueprint for how we will deliver clinically and financially sustainable services. ***Our focus must be on people and place. We know that people who have jobs, good housing and are connected to families and community feel, and stay, healthier*.**

4.3 In developing our response in this checkpoint and the STP submission in June we will reflect:-

- The NHS Five Year Forward View.
- An emerging understanding of the current major local challenges against the 3 gaps.
- The 10 key areas where we needs to make progress across the Health and Social Care system.
- The 15 key areas from the Carter Review.
- The key health, care, financial and productivity issues that arise from the 6 Local Delivery Systems that are common across Cheshire and Merseyside.
- The triple aim of Better Health, Better Care and Better Financial
- Sustainability.

4.4 The table overleaf sets out the key components of the Cheshire & Merseyside STP in terms of commissioning, finance, transformation and health providers.

Table 1.0 Cheshire & Merseyside STP – Key Components



4.5 Table 2.0 sets out the key gaps across the footprint that are evident and need to be tackled as part of the five year forward view.

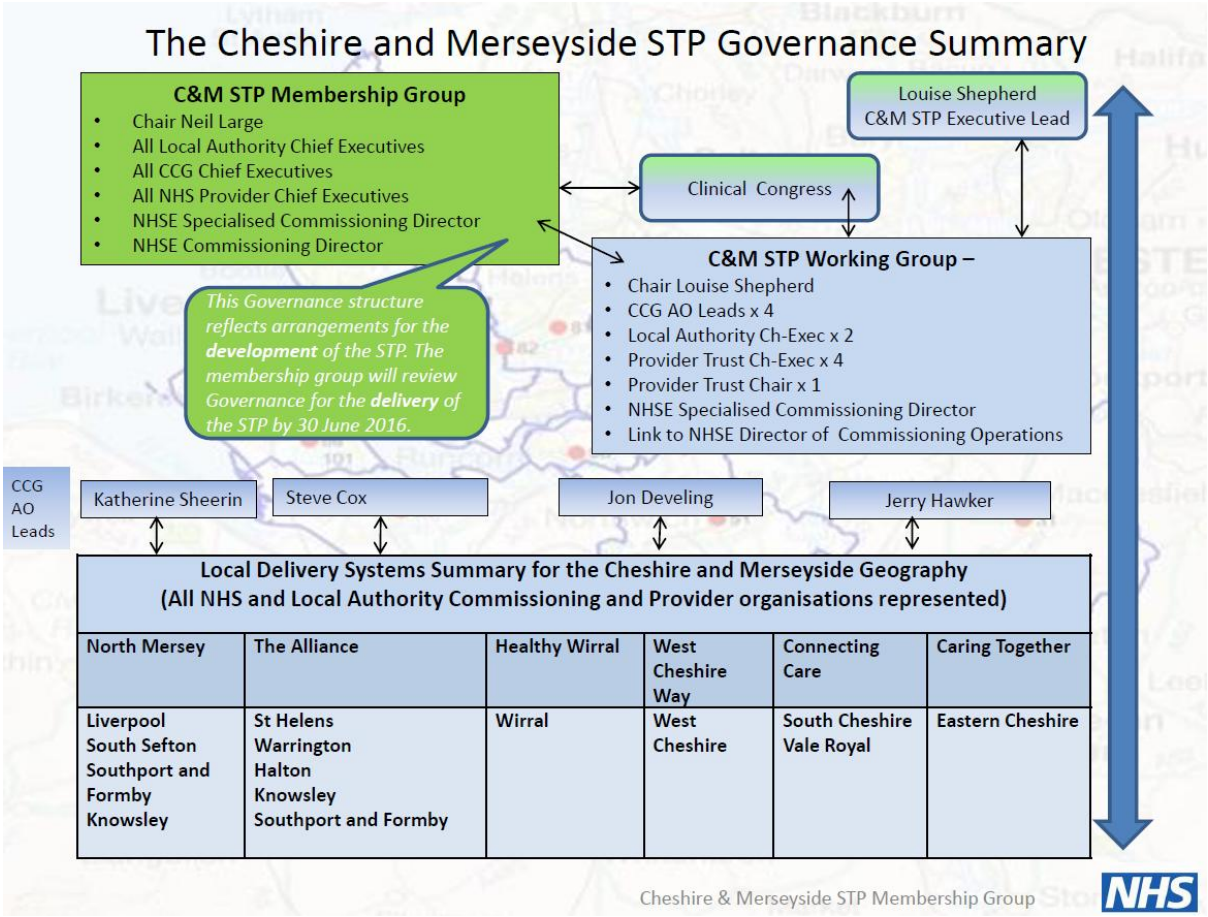
Table 2.0 Cheshire & Merseyside STP – Key Gaps

The Key Gaps in Cheshire and Merseyside	
Health and Wellbeing	**12 years difference in life expectancy One of the highest child obesity rates in England**
Better Care and Quality	**Variances in life expectancy and fast growing ageing population needs new model of care**
Better Finance and Productivity	**The financial gap dramatically deteriorates in 16/17. 6 out of 12 CCGs planning a deficit, 12 out of 19 Providers in deficit. This is estimated to be in the region of £200m (to be confirmed for June submission)**
The STP Submission in June will need to reflect a reconfiguration of health and care services to the population of C&M.	

4.6 Cheshire and Merseyside (C&M) is the 3rd largest STP footprint with a population of 2.4 million people, covering some of the richest and poorest parts of the UK within a distinctly varied Geography that impacts on how Health and Care services are accessed, delivered and financed. There is a long history of collaboration between providers in C&M. Work on the STP will be able to use existing networks of acute, mental health and community providers. Relevant examples of this are the Urgent Care Network, Major Trauma (2nd best outcome in England), Transforming Care for Learning Difficulties.

4.7 In recognition of the Cheshire & Merseyside STP footprint size, it has been decided the STP will have a number of Local Delivery Systems (LDS's) which are more homogenous in terms of populations, commissioners, providers and local authorities. These LDS's and the supporting governance structure is set out in the diagram below.

Diagram 1.0 Cheshire & Merseyside LDS's & Governance Structure



4.8 In relation to the STP, in 5 of the 6 Local Delivery Systems (LDSs) that exist there are well established system wide Transformation Programmes. As a result each LDS already has strong and legitimised collaborative leadership and decision making arrangements. Commissioners and Providers within each LDS are well versed in partnership working and collectively changing outcomes.

4.9 The development of a C&M STP and governance structure enables all parts of the system to contribute to a C&M wide plan and is highlighted on the next slide.

4.10 It is recognise that the boundaries used for STPs will not cover all planning eventualities. As with the current arrangements for planning and delivery, there are layers of plans which sit above and below STPs. For example, neighbouring STP areas will need to work together when planning specialised or ambulance services or working with multiple local government authorities and, for areas within a proposed devolution footprint that cross STP boundaries, further discussion will be required in working through the implications. Other issues will be best planned at Clinical Commissioning Group (CCG) level.

4.11 The LDS Transformation Programmes have an established and strong focus on both public and staff engagement and inclusion. Where LDS have come together since the development of the C&M STP (for example the Alliance LDS) they have developed links to Health Watch, CCG level PPG, Health & Wellbeing Boards, Overview & Scrutiny Committee, and a Clinical Congress. It is proposed that LDS steering continue to develop their engagement strategy linking their Health Watch groups and existing CCG and Trust linked PPI groups. And LDS plans will be shared with the linked Health and Wellbeing Boards prior to June submission.

5. Local Government Involvement

5.1 C&M leaders recognise that it is not possible to transform health and health care without understanding what our communities want and without our partners in Local Government. In C&M all LDS have strong existing engagement through the 9 Health and Wellbeing Boards and other existing local arrangements. Each of the 6 Delivery systems has Local Authorities included and involvement in their plans. Governance Groups include Local Authority Chief Executives.

5.2 The engagement of local councillors and MPs in the LDS and STP will be central to any successful plan. We will ensure the devolution deals agreed and in discussion across the two local authority sub -regions read across the STP.

6. Clinicians, Care Professionals and NHS Staff

6.1 The LDS Transformation Programmes are clinically-led programmes of change, led by clinical commissioners.

6.2 Engagement is already a hallmark of the LDS Transformation programme. For example, the Connecting Care model was developed through a series of engagement events with public and professionals from all provider organisations, in addition to social and health commissioners.

6.3 The region has an established track record of working collectively with clinicians, professionals and workforce. This includes the development of a Cheshire & Merseyside policy on procedures of limited clinical value, a shared approach to commissioning support services and in 2016/17 the CCGs will be working collective to share and implement QIPP initiatives. This can be achieved through linking into Clinical Networks and the development of a Clinical Reference Group.

6.4 The C&M STP is currently establishing a Clinical Congress to ensure clinical buy in. Prof Steve Cox, Kieran Murphy and the new Nurse Director for NHSE are coordinating a multidisciplinary congress reflecting clinicians across all LDS's, professional sectors of service delivery and commissioning within the STP area. This sub group will receive relevant LDSP's and overarching work streams for approval and comment as appropriate. The Clinical Congress may utilise the independent expertise of the Clinical Senate and other specific networks.

7. Improving Peoples Health

7.1 "The future health of millions of children, the sustainability of the NHS and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health.**" (**NHS 5 Year Forward View).**

7.2 Cheshire and Merseyside (C&M) is a hugely diverse area covering some of the richest and poorest parts of the UK. Health outcomes are closely related to levels of deprivation and this is reflected in below England average life expectancy for many of our local communities. Despite progress in reducing smoking prevalence, school age obesity and hip fractures we still have many challenges including high rates of respiratory disease and early years and adult obesity, high hospital admissions for alcohol, poor mental health and wellbeing and high rates of teenage conceptions. These are alongside high rates of diseases associated with ageing, including dementia and cancers. Parts of Cheshire and Merseyside are the fastest ageing populations in England and this impacts across C&M.

7.3 We propose that we start now to radically change the way we do things so that by 2021 fewer people will be suffering from poor health. Effective prevention and early action can deliver a 'triple dividend' by helping people to stay well and live healthy lives, thus reducing the demand for costly services and creating the conditions for a prosperous economy. We will take a whole systems approach and focus on people and place. We know that people who have jobs, good housing and are connected to families and community feel, and stay, healthier. We will work in collaboration and at scale to implement evidence based interventions and mobilise local communities to engage in their own health. We recognise the need to shift services into the community and make use of and build upon community assets. We aim to improve the health of the most disadvantaged the fastest and reduce differences in health outcomes across the region and between us and England. We will work with all NHS and Local Authority provider organisations to develop a clear Making Every Contact Count plan which follows NICE guidance which provides at scale consistent approaches to key prevention messages from front line staff, including non-clinical staff (e.g. housing), quality assured and co-ordinated at scale.

7.4 Across C&M we have identified the following ***high level prevention opportunities*** for children, young people and adults that we can deliver at scale:-

1. **Diabetes prevention** – including addressing healthy weight / obesity, high risk prevention programmes, awareness, early detection and improving and reducing variation in outcomes.
2. **Cancer** – including lifestyle interventions: smoking, alcohol, obesity, screening, early identification, treatment and survivorship.
3. **Mental health and wellbeing** – including prevention, promotion of resilience training, quality standards to ensure physical health issues are identified and addressed in those with mental health conditions. All stakeholders signup to the suicide plan. Mental health and wellbeing of older people is important including dementia and social isolation. Likewise emotional wellbeing in children is a concern for our population.
4. **High blood pressure strategy** – as is being developed across Cheshire and Merseyside to improve identification, support health checks programme, control of blood pressure as well as upstream prevention.

8. Improving Care & Quality of Services

8.1 In order to achieve this hypothesis, the following areas will be transformed

8.2 We expect ***every person*** in C&M to be able to access the ***highest standards of specialist and acute care 24 hours a day, 7 days per week***. This will require our ***hospitals to be reconfigured***, consolidated with less sites and clinicians and consultants working increasingly in new emerging networks.

- We expect our ***growing elderly population*** to be able to access the ***best integrated health and social care*** systems, locally in our communities. New ***out-of-hospital care models*** supported by ***enhanced primary care*** will improve access to self care, early interventions and support a move to ***risk based preventative care*** that reduces demand for urgent care services.
- ***Every new mother to be and child*** will be able to access ***improved maternity and paediatric services*** through our comprehensive redesign of these services in-line with the better births report and our Vanguard programme, delivering financially and clinically sustainable better care.
- We commit to improving the ***Mental Wellbeing*** of every person in C&M including our own NHS staff. Delivery of NHS mental health priorities are paramount in order to ensure parity of esteem with physical health, treating individuals on the basis of need not condition to enable the right care at the right time in the right place.

8.3 More specifically, the STP Membership has articulated the following:

8.4 **Secondary Care Services** lines will be reviewed for both clinical and financial sustainability with an emphasis on “hot, warm and cold sites” This will require services to be reconfigured so that they are clinically and financially sustainable, based on levels of demand and the appropriate level of geographic access.

8.5 **Primary Care**: the enhancement of Primary care as the centre of community models is critical to delivery of new models of care. This includes the improvement of infrastructure (primary care estates, IT etc.) and the opportunity for practices to work together in hubs/clusters to provide 7 day primary care services. The STP will include the enhancement and reconfiguration of Primary Care.

8.6 **Mental Health Services:** Mental Health: delivery of NHS mental health priorities are paramount in order to ensure parity of esteem with physical health. Collaborative work across providers and commissioners, to enable right care at the right time, in the right place. Particular focus on patients' treated closer to home, reducing variation and out of area treatments.

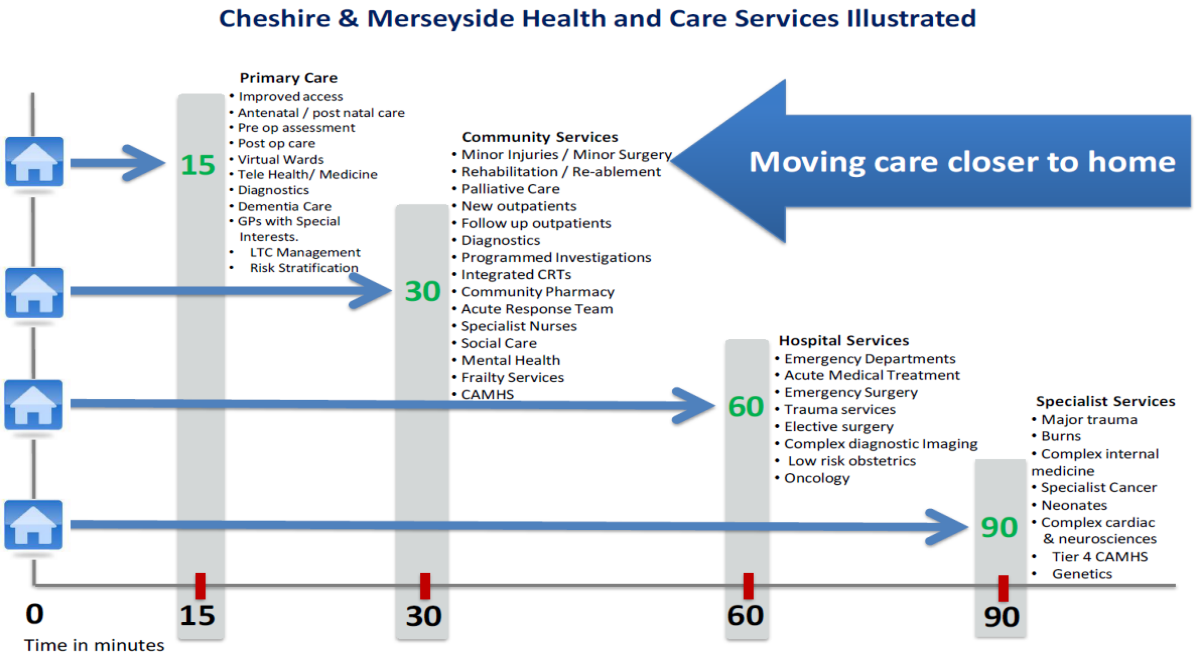
8.7 **Urgent Care:** by taking a whole system approach to deliver an urgent and emergency care pathway that is simple and responsive and clear to all. To deliver the right care in the right place and first time, large scale system change is required, which will include co-location of services and changes to the payment system irrespective of service demand. The STP will include supporting older people differently out of hospital, in hospital and in care homes such as the AVS and Elder Care Services.

8.8 **Models of care delivery:** with the large transformation in Primary and Community services and philosophy based on care closer to home, the shape and size of the hospital 's bed base will need to be reconfigured to ensure the sustainability in the future. With clinicians driving this change in the system this will reduce variation and improve quality in all clinical services but particularly in vascular, cancer, maternity, stroke and care of older people.

8.9 The planning of this transformation and the clinical priorities identified have been identified in the Joint Strategic Needs Assessment (JSNA) and the use of benchmarking data (Right care). Creating a change in culture and placing the individual in the centre with a focus on prevention will create an environment of continuous improvement.

8.10 The diagram below depicts the model of care that the STP proposes to advance.

Diagram 2.0 The Model of Care



9. Improving Productivity & Closing the Financial Gap

9.1 The Cheshire & Merseyside region receives approximately £4.63 Billion of NHS Funding per year, equivalent to £1795/ person which is notionally 1.4% above its target allocation. Spend on Specialist services are particularly high at 5.7% above target with significant inter-regional variation. The region also receives approximately £850 Million of Adult social care funding each year. Across the region there is large variation in spending across different health and social care areas and represents a major opportunity to share best practice building from use of NHS Right Care.

9.2 Six CCGs and twelve Providers are planning deficits for 2016/17 that could total up to £200m. In relation to this the plan will model information relating to hospital utilisation to understand if there is a difference between the C&M footprint and national average.

9.3 The expenditure on social care is known but as part of the June submission the quantum of savings in social care, agreed by individual councils, will also form part of the economic profile for the plan. This will include the pooling of budgets through the BCFs aggregated up to a LDS footprint. Health and Wellbeing boards have been involved in discussions about the STP and will look to use their democratic accountability to help shape and influence the plan.

9.4 Across the region there are significant financial challenges; either at individual organisational level or across whole economies and each local delivery system has established its own approach to delivering improved productivity and closing the financial gap. Whilst each LDS will focus on delivering improved productivity at a local level, the region has an established track record of working collectively. This includes the development of a Cheshire & Merseyside policy on procedures of limited clinical value and a shared approach to commissioning support services. In 2016/17 the CCGs will be working collective to share and implement QIPP initiatives.

9.5 The organisations in C&M will also reflect the 15 key points in the Carter review in their development of the C&M STP Plan as well as within their own organisations. Collectively we have identified a number of key drivers that the STP will focus on to improve productivity and finance:

- **Prevention** – The region will be committed to supporting and developing initiatives that promote prevention and early detection & intervention working closely with local authorities and CHAMPS.
- **Better out of hospital Care –** Delivering the highest standard of care in the least intensive setting is a collective priority, reducing hospital admissions through building better primary care and introducing new integrated community care models that target those at greatest risk.
- **Provider Reform & Reconfiguration –** A number of providers across Cheshire & Merseyside are unsustainable and require significant reform. Service reconfiguration will also be required to improve standards, 7 day services, support clinical sustainability and improve workforce productivity. This includes estates/asset rationalisation and as mentioned above an understanding of hospital utilisation and variation.
- **Innovation & Use of Technology –** The region will use innovation and use of technology to drive productivity using our digital roadmaps and building on an established track record in shared care records, digital media, and assistive technologies.

9.6 These priorities will enable us to make progress towards addressing the scale of the financial challenge in the 5 year forward, but are committed to exploring more radical options to use our geographic scale to drive change. This may include STP wide approaches to QIPP, collective consultation on difficult areas like IVF and over the counter drugs, alcohol pricing and reduction in organisational estates and management costs.

10. Emerging Priorities

10.1 This table below illustrates a high level view of the emerging priorities. However, it does offer the C&M Working Group and Membership Group the opportunity to review and develop this information ahead of the C&M STP submission in June. There is an emerging view in C&M that systems leadership is a key enabler to better health, care, finance and productivity and this is reflected below.

Table 3.0 Cheshire & Merseyside STP Emerging Priorities

Emerging Common Priorities for the Cheshire & Merseyside STP			
Better Health & Wellbeing	**Better Care**	**Better Finance & Productivity**	**Enablers**
Children's Health & Wellbeing	Maternity & Children's Services	Prevention	✓ Workforce ✓ Cultural Change ✓ I.T/Care Records ✓ Communications ✓ Insight ✓ Engagement ✓ Partnership Arrangements ✓ Managing Demand ✓ Integration ✓ Capital Money ✓ Support (next slide)
Alcohol	Mental Health and Wellbeing	Integrated Out of Hospital Care	
Staff Wellbeing	Neurology	Provider/System Reform and Reconfiguration	
Diabetes Prevention	Integrated Out of Hospital Care, focussing on older people and frailty.	Innovation and Use of Technology	
Cancer prevention, screening and survivorship	Transforming Care for Learning Disabilities	Modernisation and efficiency of assets.	
	Urgent Care - whole system approach.	System controls total	

11. CCG Operational Plan

As part of the annual planning process, which commenced in December, the CCG has been working in conjunction with NHSE to build activity plans for 2016/17. These plans have been built with detailed analysis and consideration of;

- historical CCG and provider performance and activity levels.

- demographic changes influencing demand and activity from a CCG and provider basis.
- known transformation, QIPP and contractual changes influencing activity levels.

These plans have had numerous iterations with NHSE and will be finalised by 20th May in the ultimate submission to NHSE. Following this, the detail on these activity plans will be taken to Governing Body development sessions in June, with a view to sign off in July.

It is envisaged that these activity plans will also contribute to LDS and STP plans for the 30th June STP submission.

12. Timetable for STP Development

12.1 The Table below sets out the national timetable for the development and progression of STP's. As can be seen throughout this paper, detailed work has been undertaken to describe and identify gaps in the health and social care system for our population, both on an LDS and LDS level. Governance arrangements have been developed and are in place.

11.2 The emerging detail on the local priorities set out in this paper, together with further detail on tackling the quality and financial gap and challenges will form the basis of the STP submission on 30th June.

Table 4.0 National STP Timetable

What	When
Publication of agreed footprints, plus further support for STP footprints on how to analyse their local gaps in quality, health and finance	March 2016
Work with footprints on gap analysis	Throughout March 2016
Footprints to make a short submission to national bodies setting out: **1. Governance arrangements (including lead)** **2. Emerging priorities for action**	15 April 2016
Regional development days for STP footprint leads	Late April/Early May 2016
Each footprint to submit their STP to the national bodies	30 June 2016
Series of regional conversations between national bodies and footprints	Throughout July 2016

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13. Recommendations

13.1 The Governing Body is requested to note the approach that is being taken across Cheshire and Merseyside in terms of developing the STP and underpinning LDSs and is asked to support this approach and provide the commitment of the CCG to the collective work with partners on this.

13.2 There is a requirement for the CCG to sign off our contribution to the STP submission for 30th June; therefore the Governing Body is requested to provide delegated authority in this regard.

Karl McCluskey
May 2016

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MEETING OF THE GOVERNING BODY
May 2016

Agenda Item: 16/83	**Author of the Paper:** Karl McCluskey Chief Strategy and Outcomes Officer E mail: Karl.mcluskey@southseftonccg.nhs.uk Tel no: 0151 247 7000
Report date: May 2016	
Title: Shaping Sefton: Plans on a Page	

Summary/Key Issues:

This paper sets out the emerging "plan on a page" for each of the CCG Transformational Blueprints and Programme areas. Each plan summarises the key contribution to the National Outcomes as set out in the Forward View.

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	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.
x	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.
x	To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.
x	To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
x	To advance integration of in-hospital and community services in support of the CCG locality model of care.
x	To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

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

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
x	Treating and caring for people in a safe environment and protecting them from avoidable harm

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Report to Governing Body
May 2016

1. Introduction

This paper sets out the emerging "plan on a page" for each of the CCG Transformational Blueprints and Programme areas. Each plan summarises the key contribution to the National Outcomes as set out in the Forward View.

2. Background

The CCG's Strategic Plan, Shaping Sefton is being delivered and progressed through 6 Transformational Blueprints and 2 Programmes:-

Transformational Blueprints

1) Primary Care
2) Community Care
3) Unplanned Care
4) Mental Health
5) Planned Care
6) Medicines Management

Transformational Programmes

1) Cardiovascular Disease (Including Diabetes)
2) Respiratory Disease

3. Plan on a Page

As part of the planned / system development of these, the CCG has built a clear and definitive construct to ensure that each Blueprint and Programme clearly describes and sets out the following;

a) How the blueprint or programme contributes to the 6 outcomes set out by the CCG;

   i. Reduce the number of unplanned and emergency admissions.
   ii. Reduce bed days (length of stay.
   iii. Reduce re-admission rates to hospital.
   iv. Increase the percentage of people dying in their usual place of residence
   v. Provide care closer to home
   vi. Ensure that people have a positive experience of care

b) The planned QIPP contribution made by the blueprint or programme.

c) The key enablers to delivery and success of the blueprint or programme.

d) The key milestones for delivery on the blueprint or programme for 2016/17.

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The plans on a page set out a) to d) above in a simple and observable format. Each plan on a page represents the work programme that has been built with the respective blueprint and programme leads. Further work is required to cement additional metrics over the next month, these plans will then be used as part of the monthly blueprint and performance reviews with respective leads.

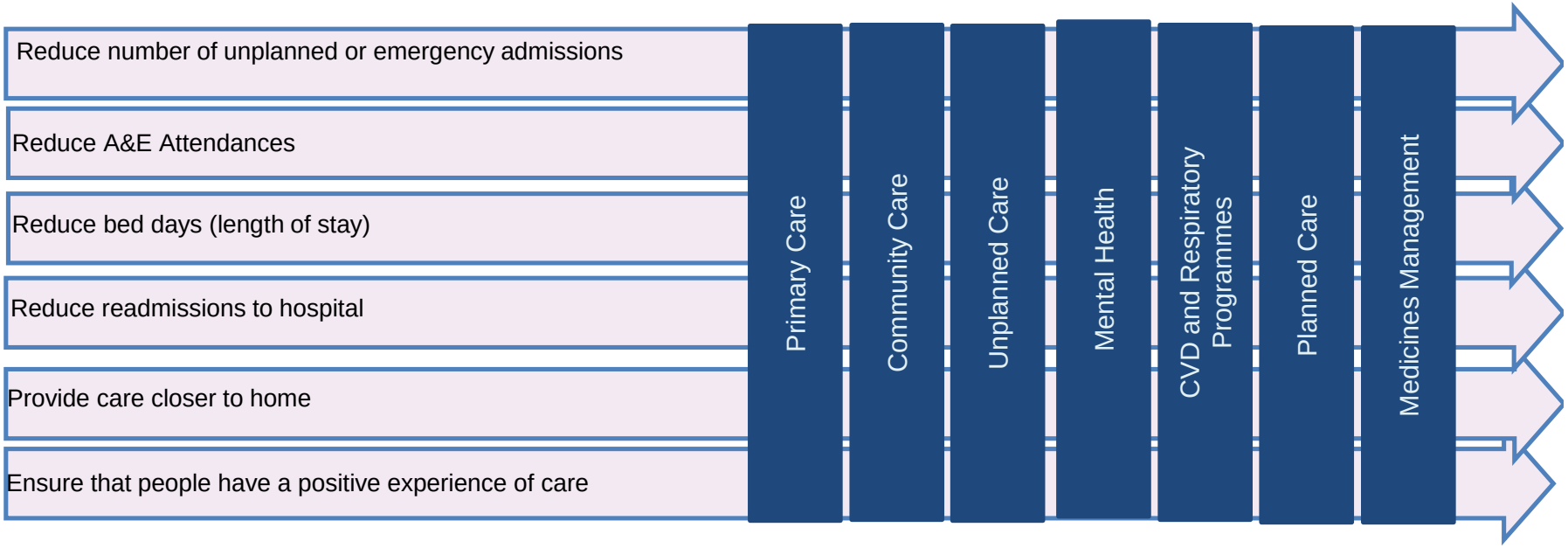
4. Recommendation

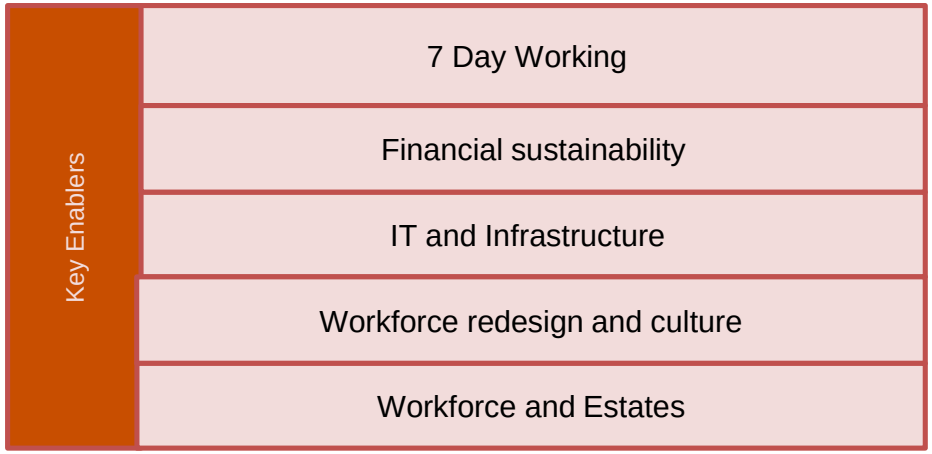
The Governing Body is requested to endorse the project management approach set out by the plans on a page and satisfies itself that this is ensuring a focused approach to the development, delivery and performance management of the blueprints and programmes.

Karl McCluskey
May 2016

Transformation Blueprints & Outcomes

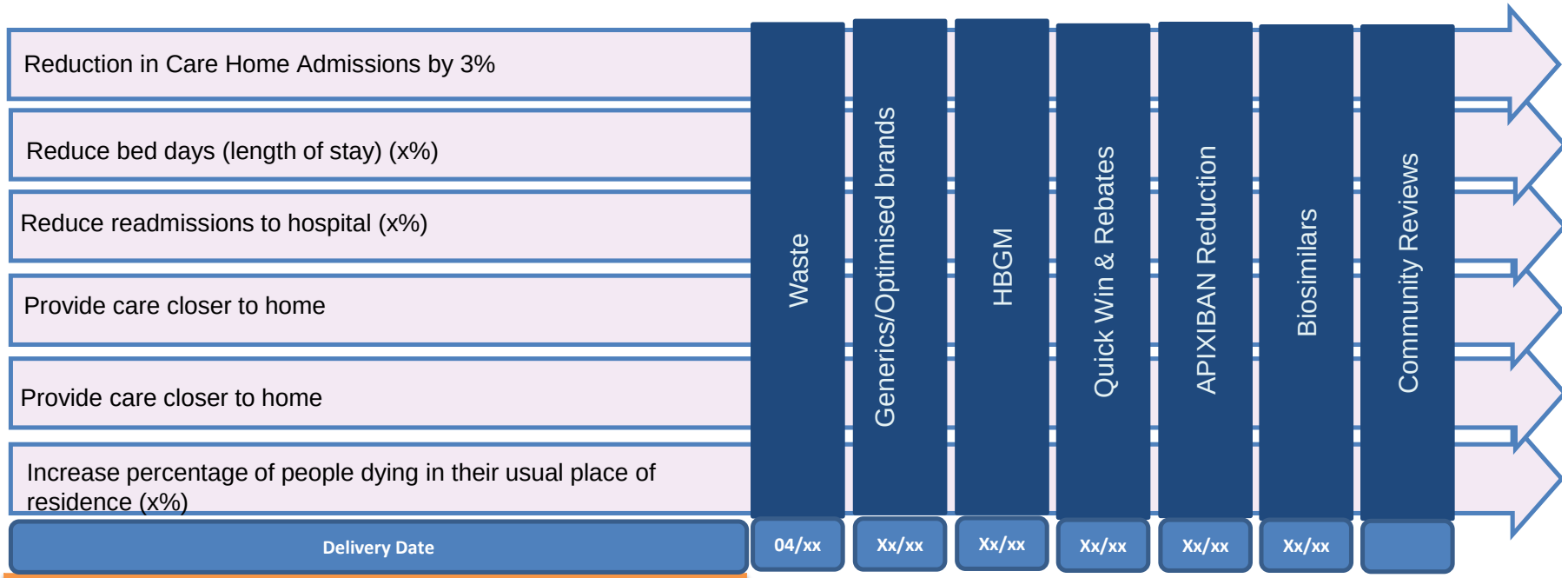
NHS South Sefton Clinical Commissioning Group





Medicines Management Blueprints & Outcomes

NHS South Sefton Clinical Commissioning Group



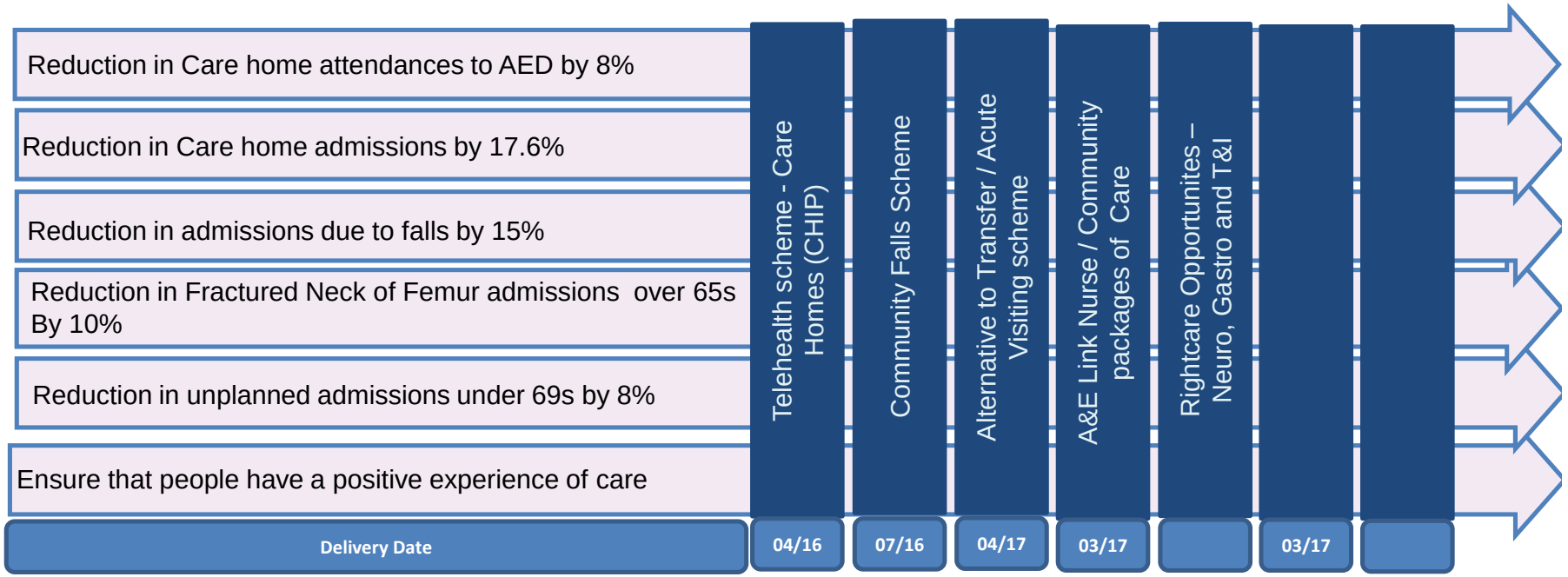
QIPP Schemes	POD	Activity	QIPP £ (16/17)
Waste			(502,000)
Generics/Optimised brands			(470,400)
HBGM/APIXIBAN			(130,000)
Quick Win & Rebates			(105,000)
Biosimilars			(210,000)
Community Reviews	NEL	(35)	(116,000)
Other Schemes			(538,000)

Key Enablers

- 7 Day Working
- Financial sustainability
- IT and Infrastructure
- Workforce redesign and culture
- Workforce and Estates

Community and Urgent care Blueprints and Outcomes

NHS South Sefton Clinical Commissioning Group



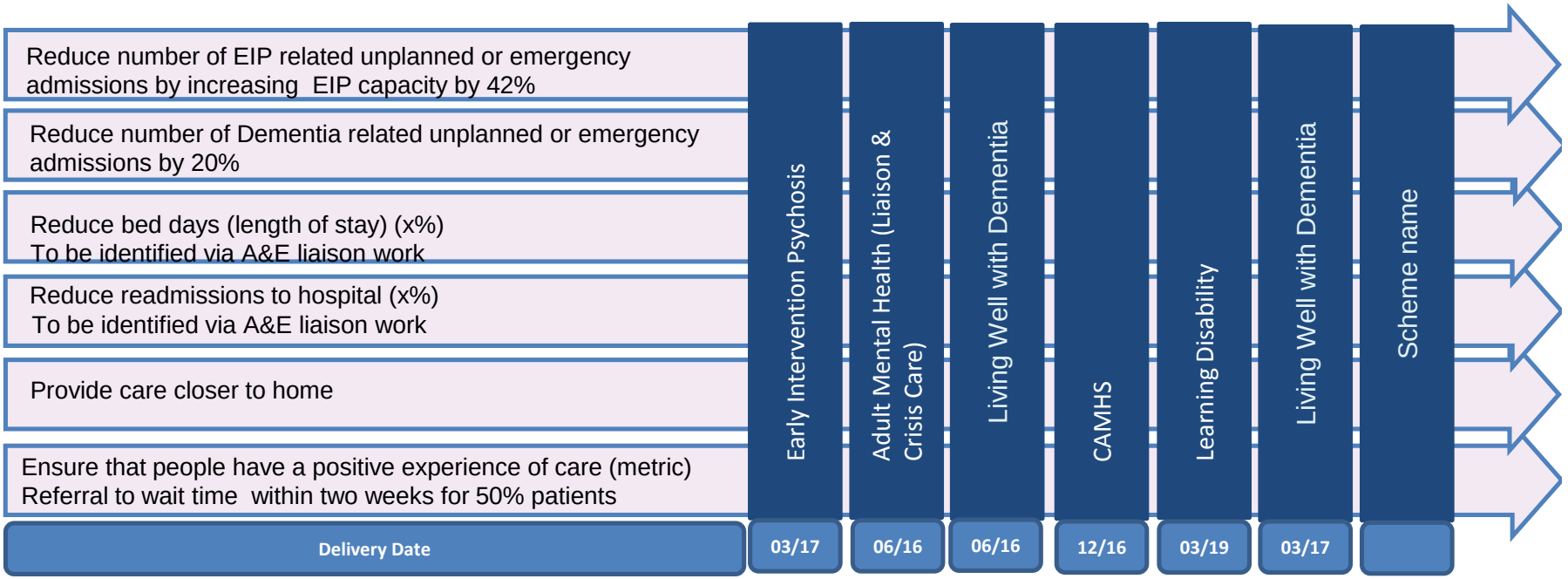
QIPP Schemes	POD	Activity	QIPP £(16/17)
Telehealth Care Homes (CHIP)	NEL	(176)	(463,936)
Community Falls Scheme	NEL	(148)	(439,383)
Alternative to Transport / AVS	NEL	(464)	(823,600)
Critical Care @ Aintree review of Block		N/A	TBC

Key Enablers

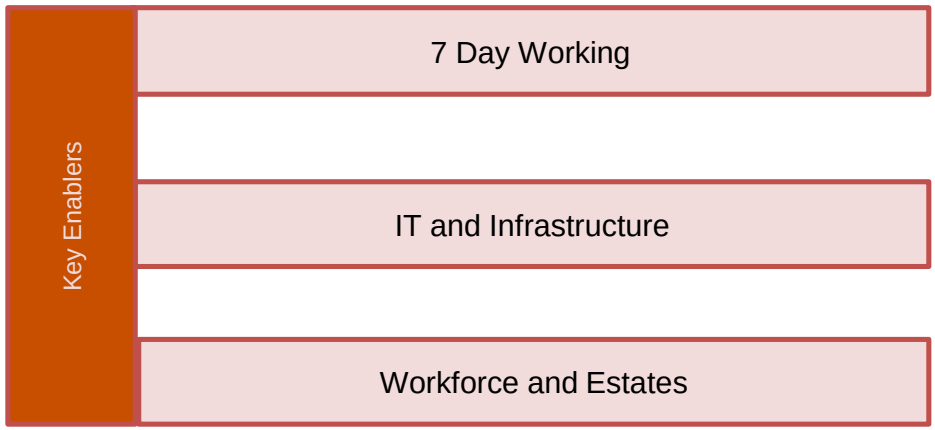
- 7 Day Working
- Financial sustainability
- IT and Infrastructure
- Workforce redesign and culture
- Workforce and Estates

Mental Health Care Blueprints & Outcomes

NHS South Sefton Clinical Commissioning Group

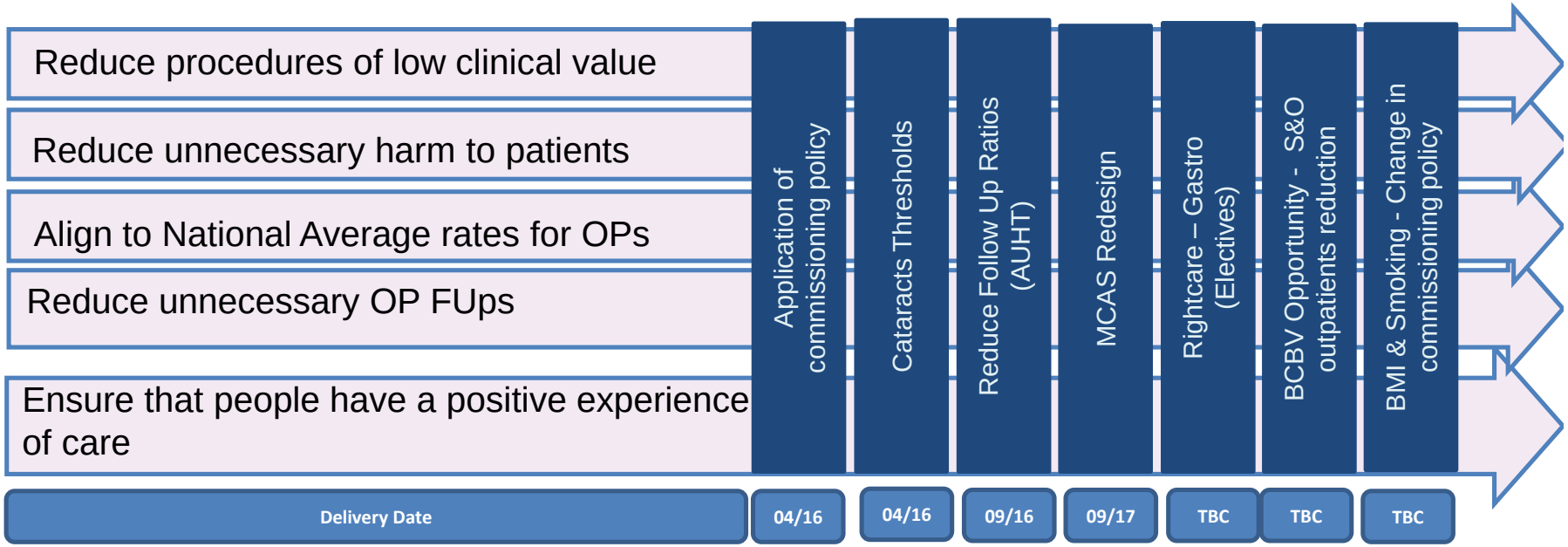


QIPP Schemes	POD	Activity	QIPP £
Early Intervention Psychosis	NEL	TBC	TBC
Dementia	NEL	TBC	TBC
Liaison (TBD)	NEL	TBC	TBC
CAMHS Prevention of future secondary care usage		TBC	TBC
Learning Disability Reduction in inpatient activity			TBC

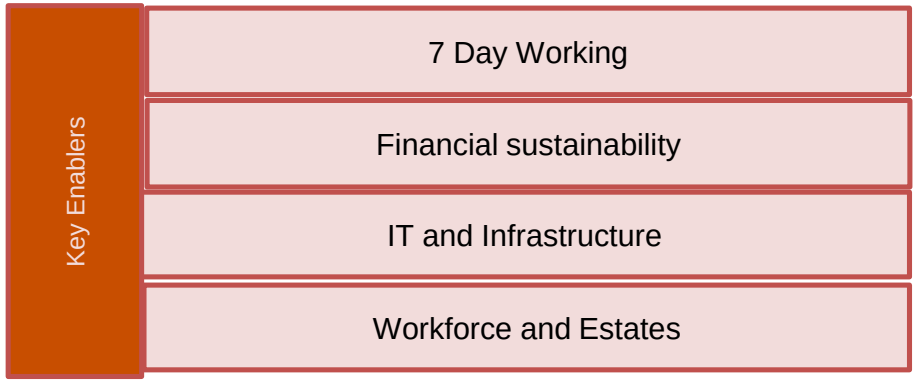


Planned care Blueprints & Outcomes

NHS South Sefton Clinical Commissioning Group

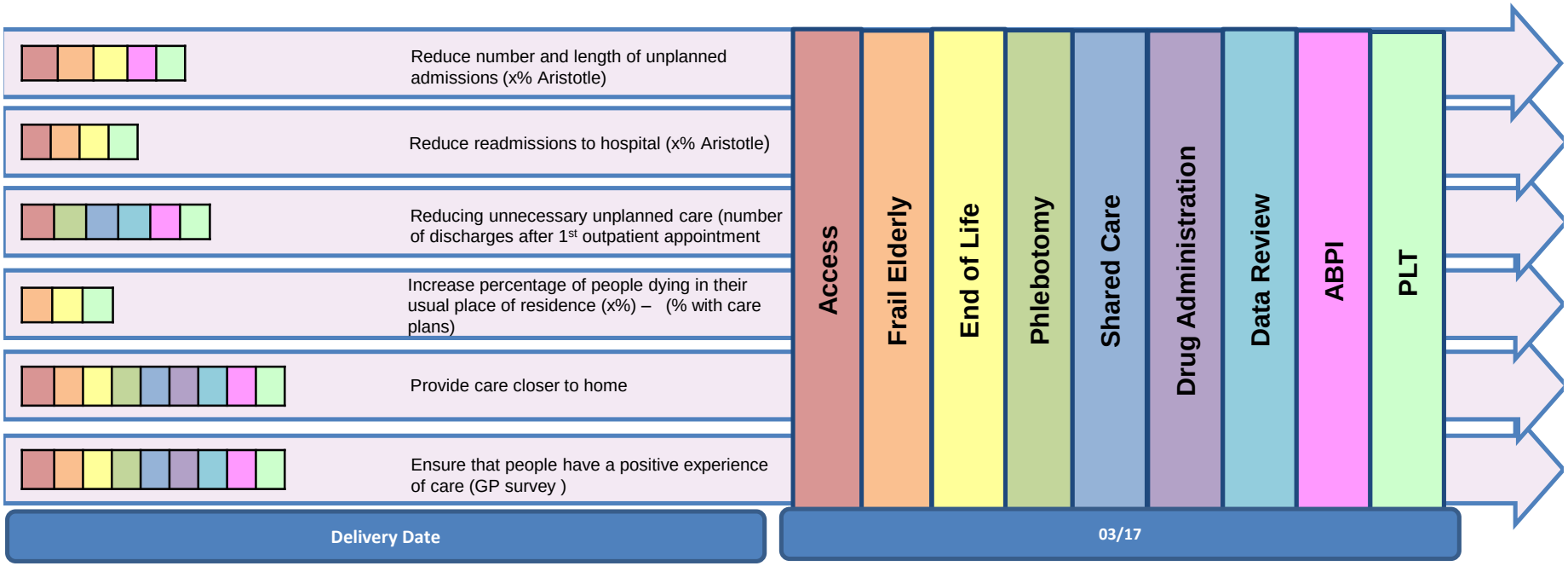


QIPP Schemes	POD	Activity	QIPP £(16/17)
Application PLCV	EL	(386)	(581,000)
Reduce Follow Up Ratios	OFU	(5454)	(546,000)
MCAS Redesign		TBC	(250,000)
Cataract Procedures	EL	TBC	
Rightcare – Gastro	EK	TBC	(0)
BMI & Smoking Policy	EL	TBC	
Dermatology – Reduce Block		N/A	(40)
Review of OP coding		N/A	(50)



Primary Care Blueprints & Outcomes

NHS South Sefton Clinical Commissioning Group



QIPP Schemes	POD	Activity	QIPP £(16/17)
LQC - Access	NEL	(144)	(333,000)
LQC – Frailty	NEL	(216)	(TBC)

Key Enablers

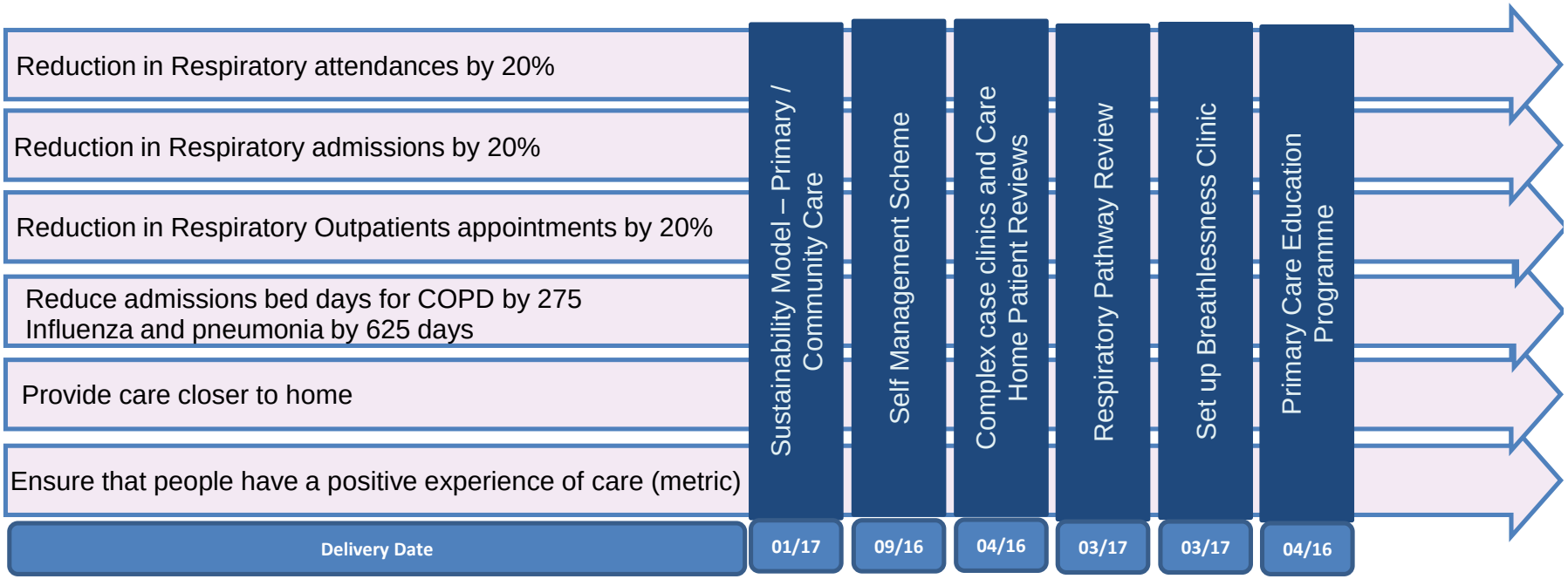
7 Day Working:
GP Out of Hours Contract

IT and Infrastructure
Explore Federations/ Collaborative/New Models of Working, Co-Commissioning, "Time for Care" development programme, Premises and Technology Infrastructure investment

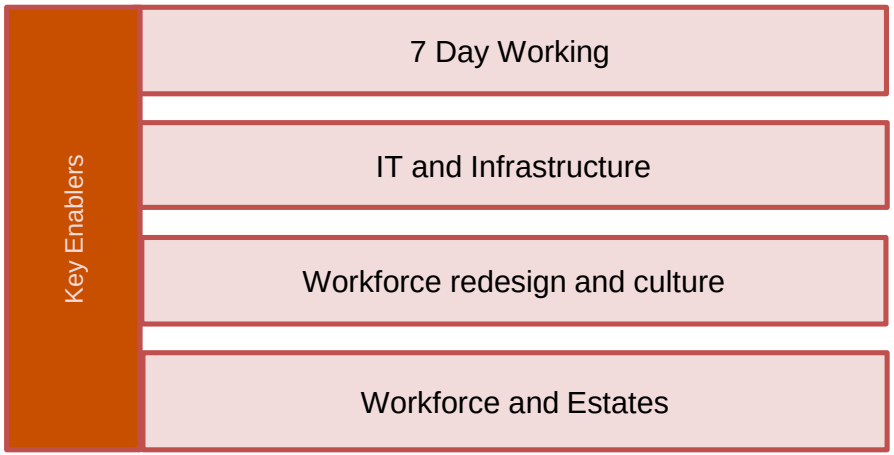
Workforce and Estates
Procurement of APMS contracts; Estates Strategy,Local Authority, HENW, New Practice Resilience programme, Workforce measures to grow medical and non-medical workforce, Premises and Technology Infrastructure investment

Respiratory Programme Blueprints & Outcomes

NHS South Sefton Clinical Commissioning Group

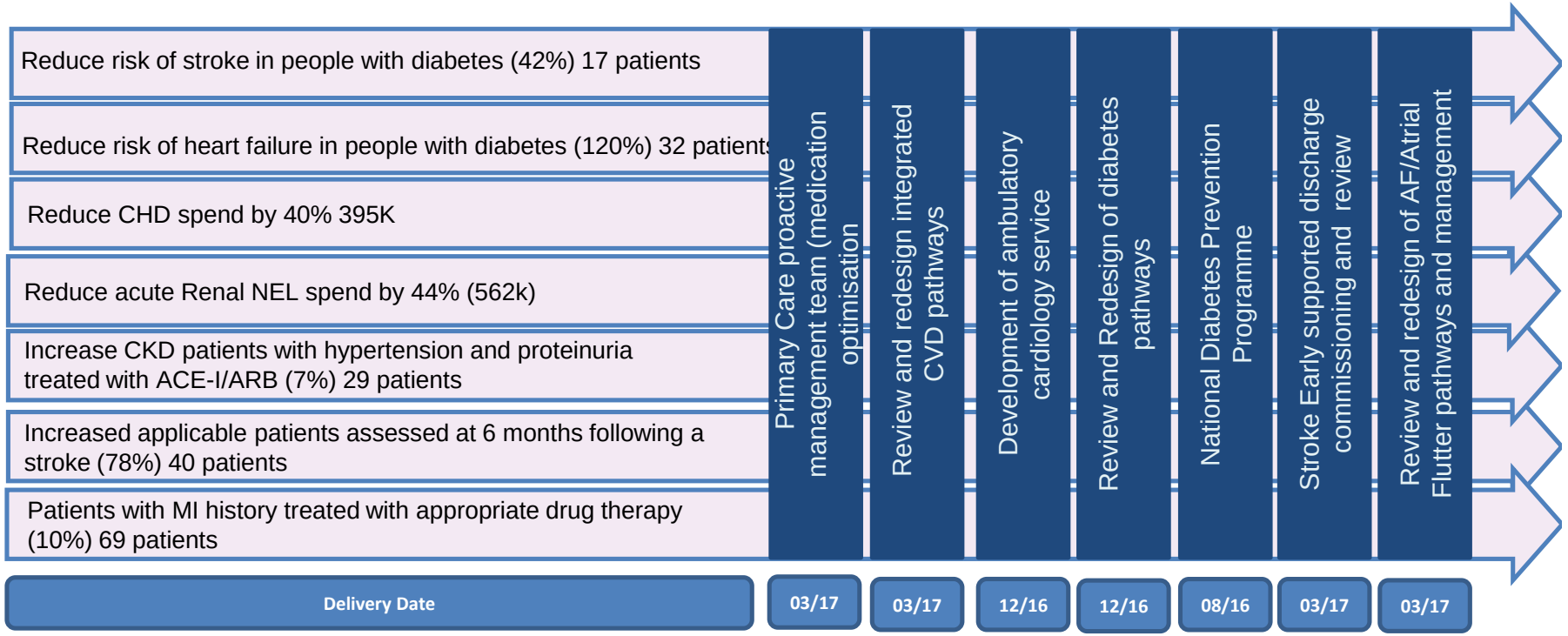


QIPP Schemes	POD	Activity	QIPP £(16/17)
Primary Care Training & Clinics	NEL	(579)	(1,479,992)
Primary Care Training & Clinics	1OP	(243)	(32,562)
Primary Care Training & Clinics	OFU	(390)	(30,420)

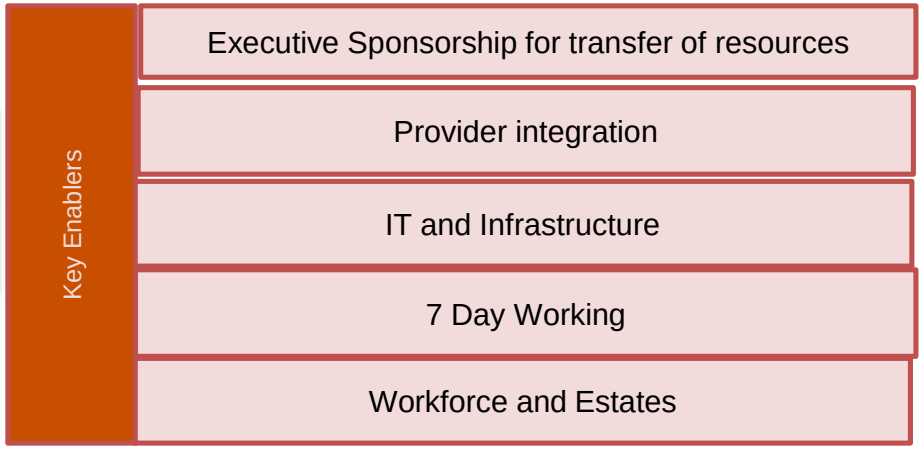


CVD Blueprints & Outcomes

NHS South Sefton Clinical Commissioning Group

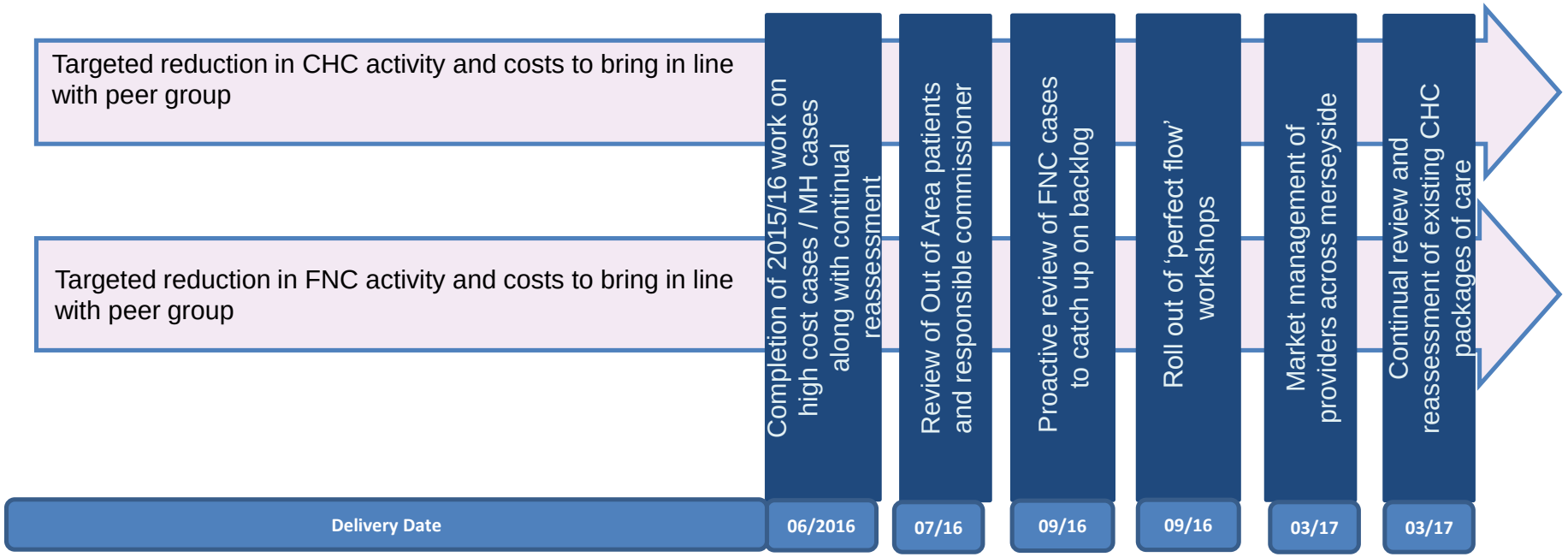


QIPP Schemes */Opportunities*	POD	Activity	QIPP £(16/17)
BCBV Opportunities – Outpatient appointments	OP1		Included in Planned Care



CHC/FNC Blueprints & Outcomes

NHS South Sefton Clinical Commissioning Group



QIPP Schemes	POD	Activity	QIPP £
CHC/FNC reduction – No growth in 16/17		n/a	£500,000
CHC/FNC – Further continued reduction in spend		n/a	£500,000

Key Enablers

- Closer integration with Local Authority
- Continual development of good working relationship with CSU
- CSU increase resources allocated to support MH reviews (at CSU cost)

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Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2016

Agenda Item: 16/84	**Author of the Paper:** Jan Leonard Chief Redesign and Commissioning Officer Email: jan.leonard@southportandfrombyccg.nhs.uk Tel: 0151 247 7000
Report date: May 2016	

Title: Joint Commissioning of Primary Medical Care

Summary/Key Issues:

South Sefton CCG have been engaged in 'greater involvement' in joint commissioning of Primary Medical Care services with NHSE since April 2015. This paper proposes to take the next step of applying for joint commissioning status following discussion at the wider membership meeting in May 2016.

Recommendation

Receive	
Approve	X
Ratify	

The Governing Body is asked to approve the recommendation that the CCG applies to NHSE for joint commissioning status, subject to the support of a majority of member practices.

Links to Corporate Objectives *(x those that apply)*	
x	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.
x	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.
X	To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.
X	To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
X	To advance integration of in-hospital and community services in support of the CCG locality model of care.
	To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement		x		
Clinical Engagement	x			At wider membership meeting May 2016 and further correspondance
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

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
May 2016

1. Introduction and Background

Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (CCGs) to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England and CCGs would jointly commission primary medical services.

Statutory Framework

The National Health Service Act 2006 (as amended) ("**NHS Act**") provides, at section 13Z, that NHS England's functions may be exercised jointly with a CCG, and that functions exercised jointly in accordance with that section may be exercised by a joint committee of NHS England and the CCG. Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions as may be agreed between NHS England and the CCG.

2. Role of Joint Commissioning

A joint committee (with NHSE) would be established to take forward the work programme. The role of the Joint Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management, which have been reserved to NHS England

This includes the following activities:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

In performing its role the Joint Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG, which will sit alongside the delegation and terms of reference.

3. Engagement with CCG Membership

The proposal to move towards joint commissioning has been discussed on a number of occasions at Wider Group Meetings, most recently on May 5th 2016. At this meeting there was a general consensus to support a proposal for NHS South Sefton CCG to proceed with an application to NHS England to move to joint commissioning of General Medical Practice. This has been followed up by discussions with Sefton Local Medical Committee and an email to the membership to ensure those who were not present have an opportunity to comment by 30 May 2016.

NHS
South Sefton
Clinical Commissioning Group

4. Recommendations

The Governing Body is asked to approve the recommendation that the CCG applies to NHSE for joint commissioning status, subject to the support of a majority of member practices.

Jan Leonard
May 2016

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MAY 2016

Agenda Item: 16/85	**Author of the Paper:**
Report date: May 2016	Martin McDowell Chief Finance Officer Email: martin.mccdowell@southseftonccg.nhs.uk Tel: 0151 247 7000

Title: Revised 2016/17 Financial Budgets/ QIPP - South Sefton Clinical Commissioning Group

Summary/Key Issues:

This paper presents the Governing Body with the revised 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 focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.
X	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.
X	To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.
X	To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
X	To advance integration of in-hospital and community services in support of the CCG locality model of care.
X	To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

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

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

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
May 2016

1. Summary

1.1 The opening financial budgets for 2016/17 were approved at the Governing Body Meeting in March 2016. The March meeting noted that there remained uncertainties in some areas and that an update report would be presented to the Governing Body meeting in May 2016.

1.2 This paper provides details of the CCG's 2016/17 proposed revised financial budgets for consideration and approval.

1.3 The financial budgets have been prepared in conjunction with budget holders and reflect all available planning guidance and metrics requirements. A summary of the proposed revised 2016/17 Financial Budget is presented in **Table 1**.

Table 1 - Summary 2016/17 Revised Financial Budgets

Budget Area	2016/17		
	Rec	Non Rec	Total
	£m	£m	£m
Resources			
Base Allocation	226.750		226.750
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	**240.694**	**2.400**	**243.094**
Commissioning Budgets			
NHS Commissioned Services	172.986	4.506	177.493
Corporate & Support Services: admin	3.196	0.063	3.259
Corporate & Support Services: programme	3.612	0.026	3.638
Independent Sector	3.046	0.000	3.046
Medicines Management	30.746	0.000	30.746
Primary Care	3.014	0.319	3.333
Non NHS Commissioning	18.041	0.020	18.061
Sub total Operational budgets	**234.641**	**4.935**	**239.577**
Reserves			
QIPP requirement	(4.706)	(5.463)	(10.169)
Non Recurrent schemes		2.928	2.928
Transformation Fund	0.597		0.597
Better Care Fund investment	4.572		4.572
Other Committed Plans	1.924		1.924
Contingency	1.215		1.215
Sub total Reserves	**3.602**	**(2.535)**	**1.067**
Total Anticipated Spend	**238.244**	**2.400**	**240.644**
Forecast Surplus/ (Deficit)	**2.450**	**0.000**	**2.450**
Expressed as %			**1%**

2. Changes from Opening Budgets

2.1 Overview

There has been an increase in operational budgets of **£4.895m** as a result of contract negotiations and the review of opening budgets. This has been met by a reduction in the reserves budget as well as a small increase in allocation.

Appendix 1 illustrates the changes at cost centre level.

£1.100m of the budget increase is due to the outcome of the arbitration process in respect of the Aintree contract. The decisions in favour of the Trust have led to increased cost pressures for the CCG. Further analysis is provided in section 2.3 below.

The net impact of budget changes has increased the QIPP requirement to **£10.169m**. **Table 2** outlines how the QIPP requirement has changed since the report to the Governing Body in March 2016.

Table 2: QIPP Target

QIPP Target	Rec	Non-Rec	Total
	£m	£m	£m
Opening QIPP Target (March 2016)	(4.050)	(4.232)	(8.282)
Amendments:			
Adjustment for 1516 Outurn	(0.450)	0.450	-
Quarter 4 Cost increase	(0.762)		(0.762)
Cost Pressure - Contract negotiations	(1.471)		(1.471)
Cost Pressure - Budget Revisions	(0.041)		(0.041)
High Cost Drugs Budget	0.250		0.250
CEOV reserves budget	0.137		0.137
Adjust to meet 1% surplus target	1.681	(1.681)	-
Revised QIPP Target (May 2016)	**(4.706)**	**(5.463)**	**(10.169)**

Following these budget revisions, the CCG continues to deliver a planned surplus of 1% (£2.450m). The detail by cost centre and the change since the draft budget presented in March 2016 is included at Appendix 1.

The major movements are described under the relevant sections below.

2.2 Resource Allocations and Surplus

The Resource allocation has reduced by £0.067m since the March report, to a total Allocation for 2016/17 of **£243.094m**. This reduction relates to the following amendments:

- £0.011m increase in funding for Cataract services.
- (£0.078m) reduction in funding to reflect the net allocation adjustment for specialised commissioning budgets (Wheelchairs and Neurology).

2.3 Key Changes in Operational Budgets

NHS Commissioned Services

Overall the budget for NHS Commissioned Services has increased by **£4.820m** since the March report. It was noted in the March report that the CCG had not reached agreement with all providers and that this area could change significantly.

The majority of the budget increase (£3.349m) is a result of a transfer of funding previously held in reserves to contract budgets where investments have been agreed during contract negotiations.

£1.1m of the increase is as a result of the outcome of arbitration with Aintree Hospital Trust. Analysis of changes is provided in **Table 3.**

Table 3 – Aintree Contract Changes

	£m
Contract increases:	
NEL Growth	2.269
Aintree to Home	0.675
Aintree @ Home	0.405
Acute Frailty Unit	0.495
Ambulance handover	0.135
Contract budgets:	
Growth budget	(0.424)
NEL Growth budget	(0.750)
Contract budget adj	(0.100)
Cost Pressure	**2.705**
Reserves budgets:	
Intermediate Care	(0.350)
SRG Fund	(0.700)
Q4 Growth	(0.554)
Revised Cost Pressure	**1.101**

Contract negotiations have now been finalised and the total cost increases (including Aintree) are provided in **Table 4** below.

Table 4 – Cost Pressures - NHS Commissioned Services

Budget	Budget increase / (decrease)	Reserves funding	Net Cost Pressure	Notes
	£m	£m	£m	
Aintree	2.705	1.604	1.101	Arbitration Outcome
Alder Hey	0.070	-	0.070	ED coding change - subject to external verification
Southport and Ormskirk	0.081	-	0.081	
St Helens & Knowsley	0.099	-	0.099	
Walton Centre	0.926	0.862	0.064	£0.862m Neurology funding transfer (Spec Comm)
Other contracts	- 0.146	- 0.145	- 0.001	Other changes - various contracts
Liverpool Community Health	0.747	0.707	0.040	
Mersey Care	0.325	0.321	0.004	
NWAS	0.012	-	0.012	Overperformance
Contract Cost Pressures	**4.820**	**3.349**	**1.471**	

Where agreed in contracts, funding previously held in reserves has been transferred to NHS Commissioning budgets. The net cost pressure of **£1.471m** requires an increase to the CCG budget and a corresponding increase in the QIPP target.

Non-NHS Commissioning
The non-NHS budgets have been increased by £0.011m to reflect an increase in the cost of a private provider of continuing healthcare. On other budgets, the year-end outturn was in line with the forecast when the budget was calculated.

Anticipated cost savings in respect of continuing healthcare have been included as part of the QIPP plan.

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

The Programme Costs budget has increased by £0.032m due to an allocation of resource for CCG management posts previously recorded under the Running Costs budget for which the costs meet the definition of Programme Costs.

Medicines Management
There have been no revisions to the Prescribing Budget for the revised budget. The year-end costs for prescribing are higher than those anticipated when the budget was calculated, however, actions to reduce costs have been implemented recently.

Further anticipated cost savings have been included as part of the QIPP plan.

2.4 **Reserves**
There has been a reduction in the 2015/16 Reserves budget of **£4.962m** since the opening budgets were presented. This reflects the increase in operational budgets (£3.349m), the increased QIPP target (£1.887m) and a reduction in reserves budgets (£0.274m).

2.5 **Transformation Fund**
Within the Reserves budget, the CCG has allocated £2.400m resource for the Transformation Fund. Schemes funded through the use of this resource must demonstrate improved efficiency and cost savings for the CCG.

During contract negotiations, schemes which have been approved have been included in contracts where appropriate.

Within the 2016/17 budget, £1.803m of the £2.400m resource has been included within provider contracts and the remaining £0.597m held in reserves budgets.

2.6 **QIPP**
The QIPP target for the CCG is **£10.169m**. The QIPP budget is set as a negative budget in reserves, and when schemes are identified, their associated resource is transferred to reserves to achieve the requirement.

3 Key Financial Risks and Pressures

3.1 Contract negotiations have been finalised and provider contracts have been agreed, however, there are a number of risks noted which will require resolution in 2016/17.

The CCG does not have available reserves to support contract risks, any increase in funding will require an increase to the QIPP target.

3.2 The CCG plans have been prepared using the 2015/16 financial year out-turn position so any growth in demand will need to be funded using CCG contingency plus growth reserves.

3.3 The commissioning of individual packages of care within Mental Health and Continuing Health Care (CHC) was identified as a major risk area for the CCG through 2015/16, however targeted review and case management led to a reduction in cost. The 2016/17 budgets have been set on the basis of 2015/16 outturn. The pricing framework has been revised, and providers may seek for an increase to current prices, cost increases to date have been supported by a reduction in overall costs within the budget.

3.4 Prescribing - It should be noted that aspects of prescribing remain volatile and this area could present risks to budgets in 2016/17. Continued support from community pharmacist teams and practices will be required to deliver a balanced position, particularly after QIPP targets have been applied.

3.5 Continuing Healthcare (CHC) restitution payments – The CCG has included provision for CHC restitution payments of £0.396m in Reserves. The value of this reserve is based on the most recent guidance from NHS England which indicates that, in 2016/17, CCGs will be required to contribute to a national risk pool non-recurrently.

4. Conclusions & Recommendations

4.1 The Governing Body is asked to:-

- Approve the revised financial budgets for the financial year 2016/17; and
- Note that the revised QIPP target is **£10.169m** (£4.706m Recurrent and £5.463m Non-Recurrent).

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

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

5. Appendices

Appendix 1 Analysis by Cost Centre – Opening 2016/17 Budget compared to Revised 2016/17 Budget.

Appendix 1

Comparison of 2016/17 Opening Budget (March 2016) to 2016/17 Revised Budget (May 2016)

Cost centre Number	Cost Centre Description	Budget Holder	Opening Budget 2016/17 March 2016	Revised Budget 2016/17 May 2016	Increase / (Decrease)
			£000	£000	£000
COMMISSIONING - NON NHS					
598501	Mental Health Contracts	Jan Leonard	1,053	1,053	0
598506	Child And Adolescent Mental Health	Jan Leonard	238	249	11
598511	Dementia	Jan Leonard	118	118	0
598521	Learning Difficulties	Debbie Fagan	545	545	0
598596	Collaborative Commissioning	Jan Leonard	521	521	0
598661	Out Of Hours	Jan Leonard	1,195	1,203	8
598682	Chc Adult Fully Funded	Debbie Fagan	6,776	6,776	0
598684	Chc Adult Joint Funded	Debbie Fagan	1,409	1,409	0
598685	Chc Adult Joint Funded Personal Health Budget	Debbie Fagan	107	107	0
598687	Chc Children	Debbie Fagan	534	534	0
598691	Funded Nursing Care	Debbie Fagan	2,166	2,166	0
598711	Community Services	Jan Leonard	447	436	(11)
598721	Hospices	Jan Leonard	1,479	1,479	0
598726	Intermediate Care	Jan Leonard	218	218	0
598796	Reablement	Jan Leonard	1,245	1,245	0
Sub-Total			**18,053**	**18,061**	**8**
CORPORATE & SUPPORT SERVICES					
600251	Administration & Business Support	Tracey Jeffes	161	161	0
600271	CEO/ Board Office	Karl McKluskey	531	541	10
600276	Chair and Non Execs	Fiona Taylor	185	181	(4)
600296	Commissioning	Jan Leonard	727	668	(59)
600311	Contract Management	Jan Leonard	114	116	2
600316	Corporate Costs & Services	Tracey Jeffes	402	405	4
600346	Estates and Facilities	Martin McDowell	334	334	1
600351	Finance	Martin McDowell	395	436	41
600266	Business Informatics	Karl McKluskey	348	352	4
600426	Quality Assurance	Debbie Fagan	63	63	1
	Sub-Total Running Costs		**3,259**	**3,259**	**(0)**
598646	Commissioning Schemes (Programme Cost)	Fiona Taylor	1,011	987	(24)
598656	Medicines Management (Clinical)	Susanne Lynch	730	736	7
598810	Nursing and Quality Programme	Debbie Fagan	280	329	49
598676	Primary Care IT	Martin McDowell	1,586	1,586	0
	Sub-Total Programme Costs		**3,607**	**3,638**	**32**
Sub-Total			**6,866**	**6,897**	**32**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS					
598571	Acute Commissioning	Jan Leonard	118,572	122,238	3,666
598576	Acute Childrens Services	Jan Leonard	8,130	8,200	70
598586	Ambulance Services	Jan Leonard	6,091	6,103	12
598616	NCAs/OATs	Jan Leonard	1,947	1,947	0
598631	Winter Pressures	Jan Leonard	1,423	1,423	0
598756	Commissioning - Non Acute	Jan Leonard	36,509	37,581	1,072
Sub-Total			**172,672**	**177,493**	**4,820**
INDEPENDENT SECTOR					
598591	Clinical Assessment and Treatment Centres	Jan Leonard	3,012	3,047	35
Sub-Total			**3,012**	**3,047**	**35**
PRIMARY CARE					
598651	Local Enhanced Services and GP Framework	Jan Leonard	3,014	3,014	0
598791	Programme Projects	Jan Leonard	319	319	0
Sub-Total			**3,333**	**3,333**	**0**
PRESCRIBING					
598606	High Cost Drugs	Jan Leonard	547	547	0
598666	Oxygen	Jan Leonard	455	455	0
598671	Prescribing	Jan Leonard	29,744	29,744	0
Sub-Total			**30,746**	**30,746**	**0**
Sub-Total Operating Budgets pre Reserves			**234,682**	**239,577**	**4,895**
RESERVES					
598761	Commissioning Reserves	Martin McDowell	6,029	1,067	(4,962)
Sub-Total			**6,029**	**1,067**	**(4,962)**
Grand Total I & E			**240,711**	**240,644**	**(67)**

NHS
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Clinical Commissioning Group

REPORT TO THE GOVERNING BODY
MAY 2016

Agenda Item: 16/86	**Author of the Paper:** Karl McCluskey Chief Strategy & Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk
Report date: May 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

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South Sefton Clinical Commissioning Group

Integrated Performance Report

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NHS
South Sefton
Clinical Commissioning Group

1. Executive Summary

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

CCG Key Performance Indicators

NHS Constitution Indicators	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 - Whilst the CCG has delivered its financial plan for 2015/16, recurrent cost pressures are evident which require immediate reductions in the expenditure profile to ensure that the CCG can deliver its financial targets for 2016/17.

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.

A&E waits (All Types) – The CCG was just under the 95% target in March with a performance of 94.16% year to date (in month achieving 87.29%). Aintree failed the target in March recording 86.39%, and are also failing year to date reaching 90.57%. In March 2008 out of 14753 attendances where not admitted, transferred or discharged within 4 hours.
Provider comment - During March 2016 there were 14,753 Type 1 and Type 3 attendances with 2008 breaches which equates to combined performance of 86.39%. Type 1 attendances were 6.3% higher in March 2016 than the same month in 2015 and cumulatively 7.5% higher during Q4 of this year compared to last. The following 5 key actions implemented in February 2016 remain 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 via the implementation of the Emergency and Acute Care Plan.

An action plan to reduce the numbers of medically optimised patients also remains in place. To ensure sustained improvement, the following actions remain in place:

- Full utilisation of the step down facility, Aintree 2 Home, 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 March reaching 74.33%, and year to date reaching 81.36%. In March 962 attendances out of 3747 were not admitted, transferred or discharged within 4 hours. Aintree have failed the target in March reaching 72.36%, and year to date reaching 82.0%. In March 2008 attendances out of 7264 were not admitted, transferred or discharged within 4 hours.

Ambulance Activity - The CCG are failing Cat A (Red2) indicator achieving 68.70% year to date and in month (March) recording 54.2%, they are also failing Category 19 transportation achieving 94.10% year to date, in month (March) 87.3%. NWAS are failing all 3 ambulance indicators, Category A (Red1) achieving 74.80% year to date and in month 67.34%, Category A (Red 2) achieving 70.40% year to date and in month 58.88% and Category 19 transportation time, achieving 92.60% year to date, in month achieving 86.66%. 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 achieved all the cancer indicators year to date as at March 2016 apart from two, the 62 day standard, which narrowly failed the target reaching 84.28% year to date, in month achieving 76.92%, out of 26 patients there were 6 patient breaches, of which 3 were delays between trusts, 1 a late referral, 1 a complex pathway and final 1 admin delay to 1st oppointment with oncologist. The second being 62 day consultant upgrade, which failed local target of 85% reaching 83.33% year to date, (in month 62.50%), in March there were 3 patient breaches out to a total of 8 patients. Of the 3 breaches 1 patient required multiple biopsies, 1 patient had a fall and fractured their back so unavoidable breach and the final patient had a delay due to referral between trusts on day 87. Aintree achieved all the cancer indicators year to date as at March 2016.

Diagnostics – The CCG are over plan for diagnostics in March. Out of 2275 patients 36 waited over 6 weeks for a diagnostic test (1.35%), this is the fourth month in a row the target has been failed. Aintree also failed the target for diagnostics and had 64 patients out of 4552 waiting over 6 weeks for a diagnostic test (1.41%). This is somewhat due to increased demand from Trauma & Orthopaedics department for ultrasound guided joint injections 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. (See comments in dashboard).

Emergency Admissions Composite Measure – For March the CCG is over the monthly plan and had 72 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 6 new cases reported in March of C Difficile, year to date there have been 54 cases against a plan of 46. The last local appeals panel met 14th April, 7 cases were submitted, all upheld. Taking into account 15/16 appeals year to date the Trust is below trajectory (31 cases following appeal).

HCAI – MRSA – No new cases have been reported in March of MRSA for South Sefton CCG. Year to date they has now been 3 cases attributed to the CCG against a zero tolerance target. One new case has been reported at Aintree in March year to date total now 2. A Post Infection Review undertaken in collaboration with the local CCG on the 18th April concluded that no specific actions that could have been taken to prevent the patient developing the bacteraemia.

IAPT Access – Roll Out – The CCG are under plan for Q4 for IAPT Roll Out and reached 2.54% which shows a slight decrease on Q3 (2.89%) plan 3.75%. This equates to 861 patients having entered into treatment out of a population of 24298 (Psychiatric Morbidity Survey). This target has been failed for 2015-16.

IAPT - Recovery Rate – The CCG are under the 50% plan for recovery rate in Q4 reaching 43.6%. This equated to 168 patients who moved to recovery out of 385 who completed treatment. This is lower than quarter 3 when the CCG recorded 46.4%. This target has been failed for 2015-16.

Mixed Sex Accommodation – In March the CCG had 1 mixed sex accommodation breach (6 year to date) which is above the target and as such are reporting red. The breach occurred at the Royal Liverpool Broadgreen. This is the first breach rot the CCG for this Trust. Four breaches were reported at Liverpool Heart & Chest for the previous 4 month. The sixth 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 March, year to date are reporting 33 in total, 1 failure to act upon test results and 1 grade 3 pressure ulcer.

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 - The CCG failed the 90% target in March, out of 84 patients, 72 were treated within 18 weeks. Admitted and non-admitted RTT is no longer a national performance target but the CCG continue to monitor locally.

Stroke – The CCG have failed to achieve the target in March reaching 76.19%, only 16 patients out of 21 spending at least 90% of their time on a stroke unit. Aintree also failed to achieve the target achieving 72.20% have 26 patients out of 36 spending at least 90% of their time on a stroke unit. It is noted that the Trust overall SNAPP score for October 2015 to December 2015 has been maintained at B.

Friends and Family Test - Aintree University Hospital NHS Foundation Trust achieved the response rate target in both inpatients and A&E in March, 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.

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2. Financial Position

2.1 Summary

This section of the report provides an overview of the year-end financial position for NHS South Sefton Clinical Commissioning Group as at 31st March 2016.

Whilst the CCG has delivered its financial plan for 2015/16, recurrent cost pressures are evident which require immediate reductions in the expenditure profile to ensure that the CCG can deliver its financial targets for 2016/17.

The financial position is £2.981m overspent at Month 12 on operational budget areas before the application of reserves.

It should be noted that achievement of the planned surplus was reliant on a number of non-recurrent benefits which will not be available beyond Q1 of the next financial year. It is imperative that the CCG implements plans to reduce expenditure immediately; otherwise it will not deliver financial targets in 2016/17.

In 2015/16, the CCG identified £1.474m QIPP savings against a target of £3.441m (43%), leaving £1.967m unidentified. The unidentified QIPP has been achieved non-recurrently and has been added to the 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 is undertaking a review of all 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 as reflected in the Table B.

2.2 Resource Allocation

Additional allocations have been received in Month 12 as follows:

- Approved capital scheme (Woodlands Hospice) - £0.012m

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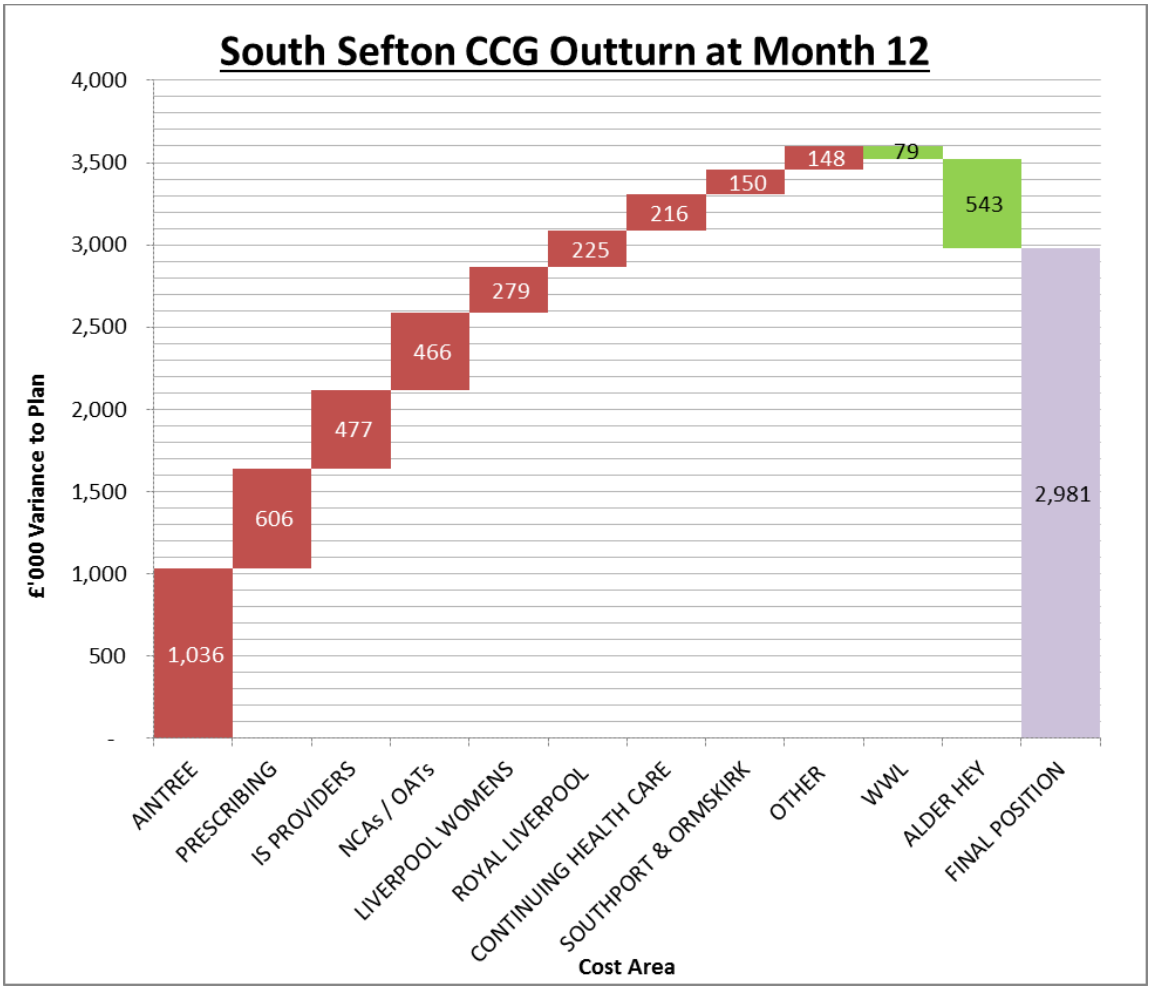
2.3 Position to date

There are forecast overspends within acute care across a range of providers, particularly Aintree, Liverpool Women's, Royal Liverpool Hospital, and Southport & Ormskirk Hospital, as well as Ramsay Healthcare for orthopaedics and Spa Medica for ophthalmology within the independent sector. In addition, there was 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.

The financial reporting period runs to the end of March 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 February 2016. Where year-end financial settlements have been agreed, the year-end financial position has been based on these figures.

Figure 2 – Outturn



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Acute commissioning

Aintree University Hospital Foundation Trust

The overspend reported for Aintree for the financial year is £1.036m. 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 financial position is based on a year-end settlement agreed with the Trust. The settlement was based on Month 11 outturn with adjustments for contract reductions:

- Contract Penalties – £0.633m
- Removal of GP Hotline – £0.045m
- Heart Failure Pathway - £0.223m

Total contract penalties were £1.007m but these were reduced to reflect part reimbursement of ambulance fines and 50% of the quarter four penalties as agreed through the CCF.

The Month 11 performance information received from the Trust identifies overspends in day cases of £0.804m (particularly within Gastro and Cardiology), excluded drugs £0.551m, direct access £0.277m and outpatients £0.890m. This was partly offset by underspends in emergency admissions. It is however noted that the underspend within Non Electives deteriorated in M11 with an in month adverse variance of £0.227m (£1.570m M10 underspend compared to £1.318k M11 underspend).

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 Activity

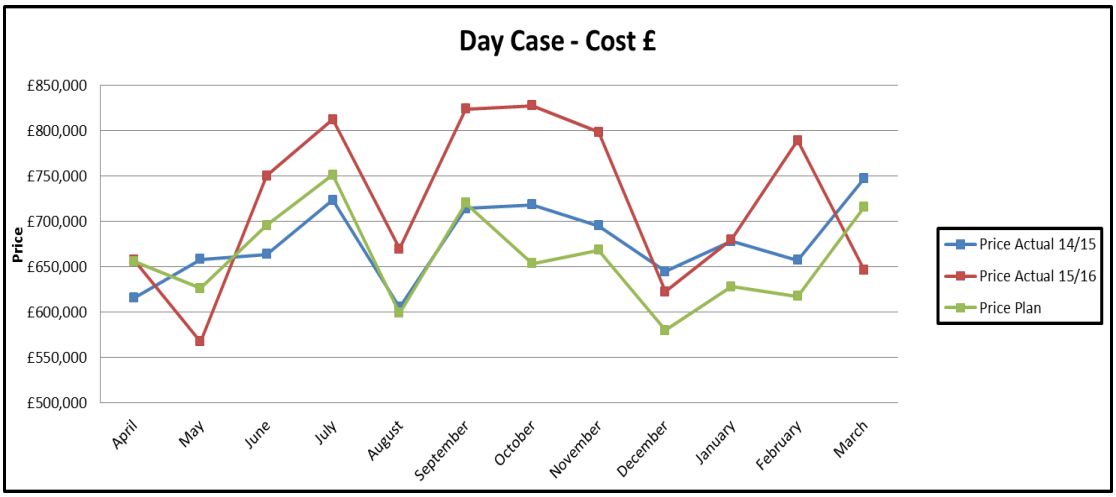


Figure 4 – Non Elective Activity

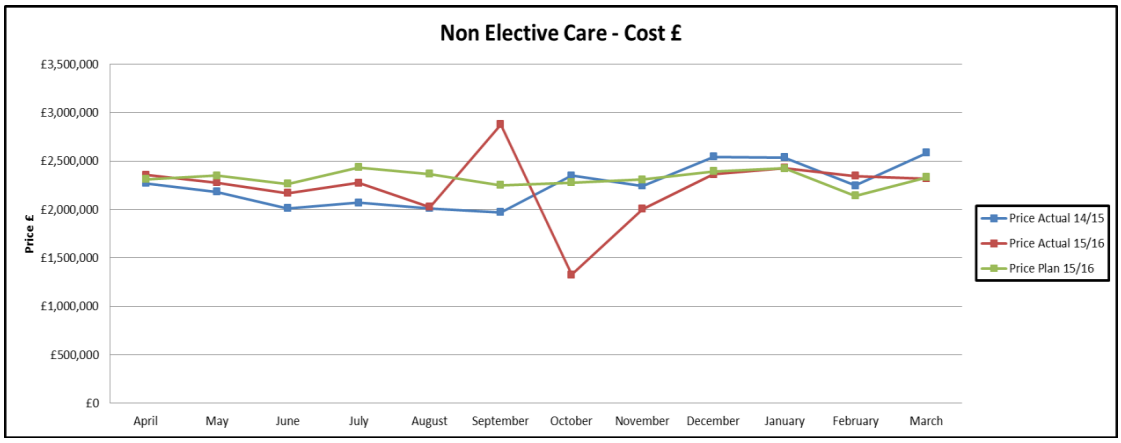
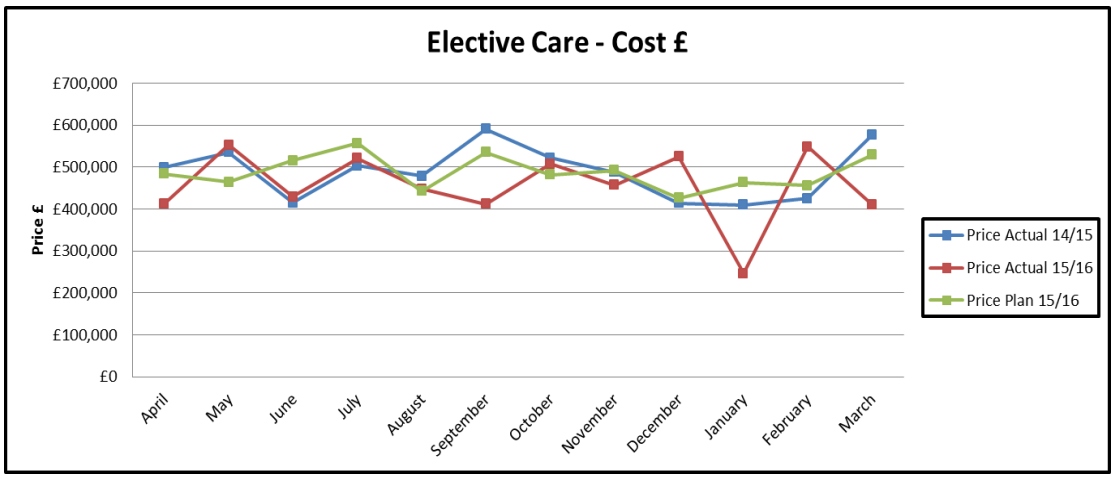


Figure 5 – Elective Activity



Southport and Ormskirk NHS Trust

The financial position for Southport and Ormskirk Hospital is based on a year-end agreement with the Trust. It should be noted that this was not an agreed settlement but an agreed year end position. Adjustments will be made in the new financial year when the final 2015/16 information is available in relation to CQUIN, and the final outcome of the orthopaedic outpatient procedures coding review has been agreed.

The year-end agreement was based on the Month 12 activity data, adjusted for a number of items:

- Contract Penalties - £0.100m
- CQUIN reduction - £0.020m
- Orthopaedic outpatient procedures coding review - £0.050m

Royal Liverpool Hospital Foundation Trust

The overspend for Royal Liverpool Hospital is £0.225m. 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 M11 outturn position for Alder Hey is an underspend of £0.543m.This underspend has been a consistent trend throughout the year.

NCAs/OATs

The overspend for non-contract activity (NCA) and Out of Area Treatments (OATs) in Month 12 is £0.466m. 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 overspend for the independent sector providers is £0.477m 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 has been undertaken across the CCG and a case for change presented to the Clinical QIPP committee in May. Proposed redesign of the service aims to reduce referrals and activity through increased triage by the MCAS community service.

There were also additional costs at Spa Medica for ophthalmology treatment reporting an overspend of £0.198m for the financial year. 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 outturn position deteriorated in Month 12 due to a change in the forecast received from the PPA, the forecast overspend has increased to £0.613m.

The CCG prescribing budget is £29.7m in total and represents 13% 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. The position is based on activity information up to M11.

Continuing Health Care and Funded Nursing Care

The outturn position for the CHC and FNC budget has increased during the month to a £0.216m overspend (after reducing the budget by £0.460m for QIPP). The main reason for this is two additional high cost packages of care included in the Month 11 report.

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.

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. There were no additional schemes achieved during the month, any further reductions since budget setting have been reflected in the 2016/17 plans.

	£'m
QIPP schemes reported at Month 11	**1.474**
QIPP schemes identified in current Month:	0
QIPP schemes reported as at Month 12	**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 underspent in 2015/16 by £1.711m due to delayed start 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 operated within its running cost target of £3.296m, with a small underspend of £0.038m. This is mainly due to non-recurrent savings made on vacant positions within the CCG.

Draft budgets for 2016/17 have been approved by the Governing Body. Running cost budgets are within the CCG allocation for 2016/17.

2.6 Evaluation of Risks and Opportunities

The CCG's primary risk in 2015/16 was non-achievement of the QIPP requirement. This risk will continue in the new financial year. In order to achieve financial stability required to deliver NHS business rules £1.967m of recurrent savings must be realised in addition to the requirement for the new financial year. In addition, there are a number of other risks that require ongoing monitoring and managing:

- Acute 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. This requires a sustained effort by all CCG members to reduce this risk.

- Prescribing / Drugs costs – This is a volatile area of spend, and prescribing spend has increased significantly in the final quarter of 2016/17. This also represents one of the biggest opportunities for the CCG and a critical review of all opportunities in this area is underway as part of the development of the QIPP plans for 2016/17.

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.

Although the CCG delivered the financial plan for 2015/16, the majority of this is a result of non-recurrent measures, 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.

The financial risk facing the CCG is 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 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
QIPP Target	(3.441)		(3.441)
Revised surplus / (deficit)	(1.041)		(1.041)
Outturn(against operational budgets)	(1.459)	(1.522)	(2.981)
Transformation Fund slippage		1.711	1.711
Reserves	1.083	2.154	3.237
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
Year End Surplus / (deficit)	**0.057**	**2.343**	**2.400**

2.7 Conclusions and Recommendations

- The CCG met the required surplus target of £2.400m for 2015/16.
- The underlying position is a surplus of £0.057m, 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.
- The financial risk facing the CCG is considered as the CCG's top priority, alongside commissioning safe services.
- Actions to address the financial risk 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.

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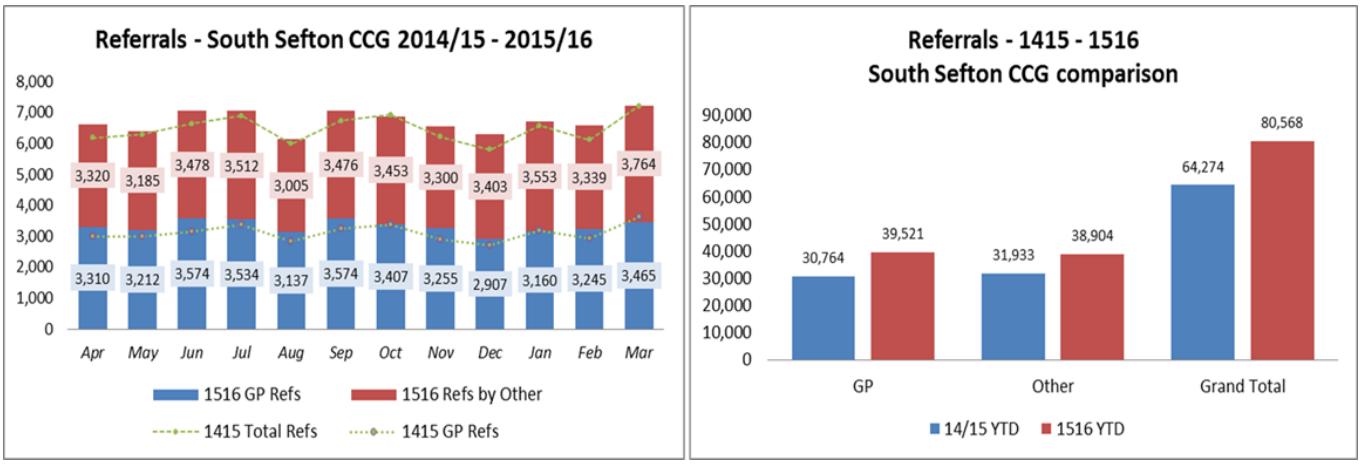
3. Referrals

3.1 Referrals by source

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

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	1516 Q4	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	10,096	10,245	9,569	9,870	35,111	37,336	39,780	7%	
GP Total			8,766	8,709	8,563	9,073	9,130	9,480	8,953	9,773	10,096	10,245	9,569	9,870	**35,111**	**37,336**	**39,780**	**7%**	
Other	01	following an emergency admission	553	513	538	469	517	534	473	511	526	502	497	410	2,073	2,035	1,935	-5%	
	02	following a Domiciliary Consultation	7	6	8	1	2	5	8	7	5	2	4	9	22	22	20	0%	
	04	An Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)	1,024	875	721	806	832	780	727	762	1,367	1,212	1,180	1,321	3,426	3,101	5,080	64%	
	05	A CONSULTANT, other than in an Accident and Emergency Department	3,689	3,556	3,668	3,681	3,788	3,829	3,919	4,077	3,883	3,781	3,906	3,973	14,594	15,613	15,543	0%	
	06	self-referral	827	672	703	756	731	786	811	889	866	893	892	1,006	2,958	3,217	3,657	14%	
	07	A Prosthetist	1	16	10	14	3	4	4	7	7	2	3	3	41	18	15	-17%	
	10	following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)	561	659	711	811	775	738	723	676	298	282	289	246	2,742	2,912	1,115	-62%	
	11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	571	551	568	594	631	788	738	674	580	709	846	1,015	2,284	2,831	3,150	11%	
	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	14	66	70	70	0%	
	13	A Specialist NURSE (Secondary Care)	35	21	19	30	21	18	21	22	18	30	35	20	105	82	103	26%	
	14	An Allied Health Professional	224	214	195	179	311	272	233	204	281	361	415	479	812	1,020	1,536	51%	
	15	An OPTOMETRIST	20	22	19	19	28	25	23	19	2	1	5	5	80	95	13	-86%	
	16	An Orthoptist	0	0	1	0	0	0	0	0	2	0	0	1	1	0	3	0%	
	17	A National Screening Programme	3	39	20	7	8	21	7	6	7	17	24	19	69	42	67	60%	
	92	A GENERAL DENTAL PRACTITIONER	589	568	568	617	602	538	536	524	402	379	371	460	2,342	2,200	1,612	-27%	
	93	A Community Dental Service	6	9	12	5	8	8	12	5	6	0	10	0	32	33	16	-52%	
	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	1,266	1,313	1,226	1,164	5,788	5,052	4,969	-2%	
Other Total			9,514	9,264	9,143	9,514	9,535	9,661	9,522	9,625	9,533	9,504	9,722	10,145	**37,435**	**38,343**	**38,904**	**1%**	
Unknown			315	485	511	509	446	492	471	515	450	489	434	511	1,820	1,924	1,884	-2%	
Grand Total			**18,595**	**18,458**	**18,217**	**19,096**	**19,111**	**19,633**	**18,946**	**19,913**	**20,079**	**20,238**	**19,725**	**20,526**	**74,366**	**77,603**	**80,568**	**4%**	

Figure 8 - GP and 'other' referrals for the CCG across all providers comparing 2014/15 and 2015/16 by month



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 and have since removed from the above referrals analysis.

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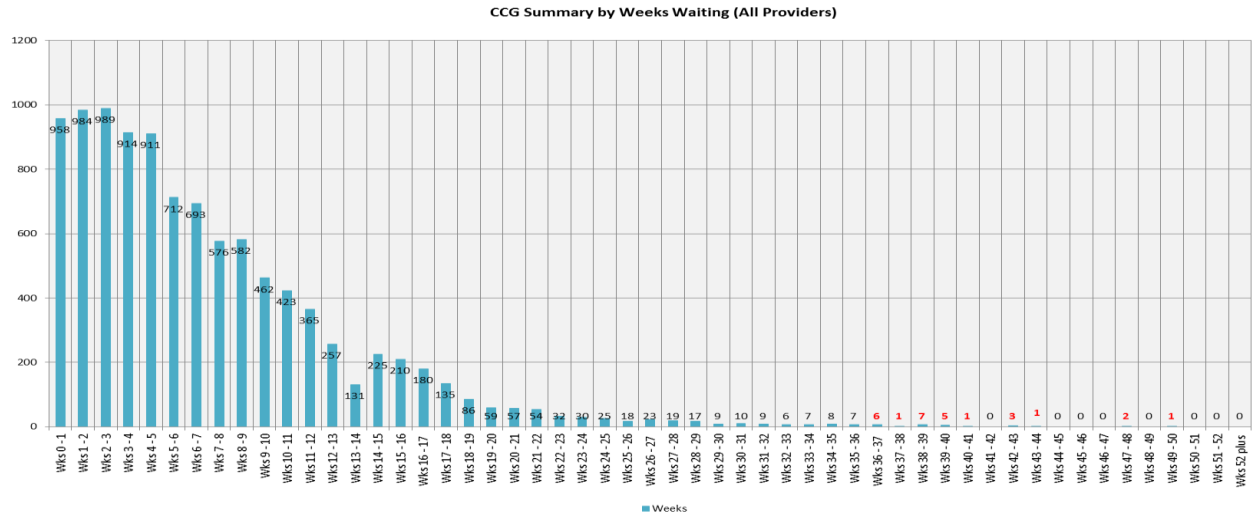
4. Waiting Times

4.1 NHS South Sefton CCG patients waiting

Figure 9 Patients waiting on an incomplete pathway at the end of March 2016 by weeks waiting.



4.2 Top 5 Providers

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

	2) Incomplete pathways for all patients (unadjusted)				
Provider	Under 18 Weeks	Over 18 Weeks	The Total	% in 18 Weeks	RAG
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST : (RQ6)	927	99	1,026	90.35%	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST : (RRF)	33	5	38	86.84%	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST : (RJR)	13	2	15	86.67%	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST : (RXN)	11	1	12	91.67%	
UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST : (RM2)	7	2	9	77.78%	
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST : (RL1)	4	4	8	50.00%	
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST : (RRV)	3	2	5	60.00%	
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST : (RRK)	3	1	4	75.00%	
SURREY AND SUSSEX HEALTHCARE NHS TRUST : (RTP)	1	1	2	50.00%	
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST : (RKB)	0	1	1	0.00%	

Provider	Total Patients	>18 Weeks	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	Over 52
Aintree	6615	285	7	16	8	3	3	7	4	5	5	3	3		3	1													
RLBUHT	1026	99	9	1	3	6	5		1	1	2	3	2		4	3	1		1					1		1			
Womens	631	32	2	3				2												1									
Alder Hey	502	37			3		1					1	1	1					2										
RJ&H	8	4	1													1								1					

4.3 Provider assurance for long waiters

Trust	Speciality	No of weeks waited	No patients	Has patient been seen / has a TCI date?	Reason for the delay
Alder Hey	Other	42	2		Awaiting provider comment
Womens	Gynaecology	43	1	The patients has been seen / treated	The reason for their delay was a combination of complex diagnosis coupled with patient initiated delays for inpatient dates (both diagnostic & treatment)
RLBUHT	General Surgery	43	1	TCI 30/04/2016	
RLBUHT	T&O	42	1	Validated, no longer long waiter	
RLBUHT	T&O	49	1	Validated, no longer long waiter	
RLBUHT	Ophthalmology	40	1	Clock Stopped 13/04/16	
RJ&AH	T&O	47	1		Awaiting provider comment

5. Planned Care

5.1 All Providers

Final performance for financial year 2015/16, against planned care elements of the contracts held by NHS South Sefton CCG shows an over-performance of £1.3m or a 3% cost variance against plan. This over-performance is driven by increases at Aintree Hospital (£1.28/4%), Southport & Ormskirk Hospital (£274k/10%) and Renacres (£522k/41%). Overspends are offset at Royal Liverpool (-£312k/-5%) and Alder Hey (-£306k/-13%).

Figure 11 Planned Care - All Providers

Provider Name	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	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	178,851	8,166	5%	£31,071	£32,351	£1,280	4%
Alder Hey Childrens NHS F/T	14,711	12,851	-1,860	-13%	£2,326	£2,020	-£306	-13%
Central Manchester University Hospitals Nhs Foundation Trust	86	146	60	70%	£22	£30	£8	36%
Countess of Chester Hospital NHS Foundation Trust	0	183	183	0%	£0	£24	£24	0%
East Cheshire NHS Trust	0	2	2	0%	£0	£0	£0	0%
Fairfield Hospital	95	153	58	61%	£20	£42	£22	111%
ISIGHT (SOUTHPORT)	262	427	165	63%	£65	£99	£34	52%
Liverpool Heart and Chest NHS F/T	1,273	1,101	-172	-14%	£578	£433	-£145	-25%
Liverpool Womens Hospital NHS F/T	15,811	16,038	227	1%	£3,320	£3,349	£29	1%
Renacres Hospital	3,913	6,639	2,726	70%	£1,265	£1,788	£522	41%
Royal Liverpool & Broadgreen Hospitals	29,929	28,510	-1,419	-5%	£5,827	£5,516	-£312	-5%
Southport & Ormskirk Hospital	13,390	14,787	1,397	10%	£2,761	£3,035	£274	10%
SPIRE LIVERPOOL HOSPITAL	3,334	2,642	-692	-21%	£999	£846	-£153	-15%
ST Helens & Knowsley Hospitals	4,070	4,015	-55	-1%	£986	£996	£10	1%
University Hospital Of South Manchester Nhs Foundation Trust	108	114	6	6%	£16	£20	£4	25%
Walton Neuro	3,293	3,350	57	2%	£850	£860	£10	1%
Wirral University Hospital NHS F/T	462	387	-75	-16%	£123	£103	-£20	-16%
Wrightington, Wigan And Leigh Nhs Foundation Trust	846	1,006	160	19%	£305	£374	£69	23%
Grand Total	**262,269**	**271,202**	**8,933**	**3%**	**£50,534**	**£51,885**	**£1,351**	**3%**

5.2 Aintree University Hospital NHS Foundation Trust

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

Aintree University Hospitals Planned Care PODS	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	12,615	13,201	586	5%	£7,916	£8,650	£733	9%
Elective	2,171	1,953	-218	-10%	£5,849	£5,472	-£377	-6%
Elective Excess BedDays	1,134	733	-401	-35%	£252	£161	-£91	-36%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	633	422	-211	-33%	£113	£77	-£37	-32%
OPFANFTF - *Outpatient first attendance non face to face*	716	2,793	2,077	290%	£28	£76	£48	169%
OPFASPCL - *Outpatient first attendance single professional consultant led*	31,994	33,651	1,657	5%	£4,593	£5,010	£417	9%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	1,577	1,538	-39	-2%	£172	£170	-£2	-1%
OPFUPNFTF - *Outpatient follow up non face to face*	1,251	3,584	2,333	186%	£30	£86	£56	186%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	83,804	83,256	-548	-1%	£6,558	£6,621	£63	1%
Outpatient Procedure	20,122	22,049	1,927	10%	£3,254	£3,589	£335	10%
Unbundled Diagnostics	13,104	14,133	1,029	8%	£1,147	£1,278	£130	11%
Wet AMD	1,566	1,538	-28	-2%	£1,157	£1,163	£6	1%
Grand Total	**170,685**	**178,851**	**8,166**	**5%**	**£31,071**	**£32,351**	**£1,280**	**4%**

5.2.1 Aintree University Hospital NHS Foundation Trust Key Issues

Daycase over performed throughout 2015/16 with an approx. variance of 10% each month. 2015/16 outturn is showing a cost variance of £733k/9%.

This is primarily driven by two specialties, Gastroenterology and Cardiology which are reporting a final 2015/16 over-performance of £360k / 15% and £362k / 83% respectively.

75% of Gastro activity is made up of 7 HRGs shown below:

HRG CODE	HRG DESCRIPTION	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
FZ61Z	Diagnostic Endoscopic Procedures on the Upper GI Tract with biopsy 19 years and over	1797	2035	238	13%	£688,768	£779,990	£91,222	13%
FZ51Z	Diagnostic Colonoscopy 19 years and over	447	513	66	15%	£201,510	£231,263	£29,753	15%
FZ60Z	Diagnostic Endoscopic Procedures on the Upper GI Tract 19 years and over	342	482	140	41%	£124,690	£175,733	£51,043	41%
FZ52Z	Diagnostic Colonoscopy with biopsy 19 years and over	417	463	46	11%	£201,846	£224,112	£22,266	11%
FZ53Z	Therapeutic Colonoscopy 19 years and over	402	455	53	13%	£196,256	£222,130	£25,875	13%
FZ54Z	Diagnostic Flexible Sigmoidoscopy 19 years and over	359	422	63	18%	£125,977	£148,159	£22,182	18%
FZ37F	Inflammatory Bowel Disease with length of stay 1 day or less	168	257	89	53%	£54,097	£82,755	£28,658	53%
All Other		1440	1576	831	58%	£741,411	£830,752	£89,342	15%
Grand Total		**5372**	**6203**	**1526**	**28%**	**£2,334,554**	**£2,694,894**	**£360,340**	**15%**

Within Cardiology, the new ambulatory heart failure pathway influences the combined Daycase/Elective performance of £291k. This activity continued to be coded as Daycase & Electives rather than Outpatient procedures. For year end agreement we have agreed to replace the proposed Day Case charges with the income that would have been generated when the patients would have been non electively admitted.

The main driver of Outpatient over performance was Clinical Haematology which showed a £193k/115% over performance. This area has been raised at the Contract Review Meeting and the Trust was asked for further info regarding the increase in Clinical Haematology. Lines of enquiry have been around the possible new Clinical Haematology Outpatient clinics set up in 2015/16.

Outpatient Procedure over performance is attributable mainly to Cardiology £150k/66%. Cardiology over performance is solely attributable to Electrocardiogram Monitoring and stress testing.

5.3 Southport & Ormskirk Hospital

Figure 13 Month 12 Planned Care - Southport & Ormskirk Hospital by POD

Southport & Ormskirk Hospital Planned Care PODS	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	1,030	974	-56	-5%	£702	£736	£34	5%
Elective	194	221	27	14%	£583	£617	£34	6%
Elective Excess BedDays	13	30	17	126%	£3	£9	£5	170%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	113	261	148	132%	£18	£38	£20	112%
OPFANFTF - *Outpatient first attendance non face to face*	0	13	13	0%	£0	£0	£0	0%
OPFASPCL - *Outpatient first attendance single professional consultant led*	2,611	2,374	-237	-9%	£366	£346	-£21	-6%
OPFUPMPCL - *OP follow up Multi-Professional Outpatient First. Attendance (Consultant Led)*	210	586	376	179%	£21	£57	£35	165%
OPFUPNFTF - *Outpatient follow up non face to face*	0	79	79	0%	£0	£2	£2	0%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	5,260	5,456	196	4%	£456	£482	£26	6%
Outpatient Procedure	3,070	3,937	867	28%	£545	£680	£135	25%
Unbundled Diagnostics	889	856	-33	-4%	£66	£69	£2	3%
Grand Total	**13,390**	**14,787**	**1,397**	**10%**	**£2,761**	**£3,035**	**£274**	**10%**

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 14/15. 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.

A review of outpatient coding is currently being undertaken at the Trust with an increase in multi professional attendances seen in 2015/16 as well as an increase in procedures. West Lancashire CCG along with MIAA is currently investigating the increase in one specific area of outpatient procedures relating to ‘Examination of Joint NEC’. The findings of the reviews and audit are expected in the near future.

5.4 Renacres Hospital

Renacres Hospital Planned Care PODS	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	500	600	100	20%	£622	£707	£85	14%
Elective	72	113	41	58%	£308	£527	£219	71%
OPFASPCL - *Outpatient first attendance single professional consultant led*	1,021	1,386	365	36%	£136	£188	£51	38%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	1,264	3,562	2,298	182%	£100	£202	£102	102%
Outpatient Procedure	662	450	-212	-32%	£63	£110	£47	75%
Unbundled Diagnostics	394	528	134	34%	£37	£55	£18	48%
Grand Total	**3,913**	**6,639**	**2,726**	**70%**	**£1,265**	**£1,788**	**£522**	**41%**

5.4.1 Renacres Hospital Key Issues

62% of 2015/16 Planned Care activity at Renacres Hospital is within the Elective and Outpatient-Follow Up points of delivery.

T&O Elective activity within 2015/16 showed a marked increase in Major Hip & Knee Procedures. Combined activity in both of these major treatments make up 87% of the total Elective over performance. Combined cost over performance for the two procedures is £168k. The CCG is currently investigating the increase in Major Hip and Knee procedures to understand why this has occurred.

Outpatient Follow Ups are over performing by £102k/102%, 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.

Given the size of this contract, CCG representation at contract review meetings will be increased in 2016/17, with additional support from finance and business intelligence colleagues to the contracts team. The CCG have redesigned the Musculoskeletal Clinical Assessment Service (MCAS) which will operate across all providers in 2016/17 including Renacres, meaning overall direct referrals to this provider without an MSK assessment should reduce. This will ensure that patients are seen in the most appropriate setting and get the most appropriate care. A review of New:Follow Up outpatient rates have been benchmarked; Renacres tends to be lower than average in a number of specialties except spinal, which the provider is reviewing.

6. Unplanned Care

Unplanned Care for the financial year 2015/16, shows an under-performance of circa -£759k for contracts held by NHS South Sefton CCG.
This underspend is clearly driven by the -£1.2m/-4% under spend at Aintree Hospital and -£120k/-6% at Alder Hey. If we exclude Aintree, we would be reporting a final over spend of £523k/1%.

The four main Trusts over spending are Liverpool Heart & Chest £187k/130%, Liverpool Women's £149k/5%, Royal Liverpool £123k/6% and Southport & Ormskirk Hospital £157k/6%.

6.1 All Providers

Figure 14 Month 12 Unplanned Care – All Providers

Provider Name	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	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	95,847	-1,854	-2%	£34,338	£33,056	-£1,282	-4%
Alder Hey Childrens NHS F/T	8,868	9,244	376	4%	£1,905	£1,786	-£120	-6%
Central Manchester University Hospitals Nhs Foundation Trust	67	77	10	15%	£16	£21	£4	26%
Countess of Chester Hospital NHS Foundation Trust	0	102	102	0%	£0	£42	£42	0%
East Cheshire NHS Trust	0	10	10	0%	£0	£2	£2	0%
Liverpool Heart and Chest NHS F/T	171	201	30	18%	£144	£331	£187	130%
Liverpool Womens Hospital NHS F/T	3,458	3,742	284	8%	£3,009	£3,158	£149	5%
Royal Liverpool & Broadgreen Hospitals	5,851	6,086	235	4%	£2,145	£2,267	£123	6%
Southport & Ormskirk Hospital	6,978	9,270	2,292	33%	£2,492	£2,650	£157	6%
ST Helens & Knowsley Hospitals	850	871	21	2%	£351	£328	-£23	-7%
University Hospital Of South Manchester Nhs Foundation Trust	41	33	-8	-20%	£14	£10	-£3	-25%
Walton Neuro	2	0	-2	-100%	£9	£0	-£9	-100%
Wirral University Hospital NHS F/T	245	333	88	36%	£90	£98	£8	9%
Wrightington, Wigan And Leigh Nhs Foundation Trust	42	62	20	48%	£15	£20	£5	30%
Grand Total	**124,272**	**125,878**	**1,606**	**1%**	**£44,528**	**£43,769**	**-£759**	**-2%**

6.2 Aintree University Hospital NHS Foundation Trust

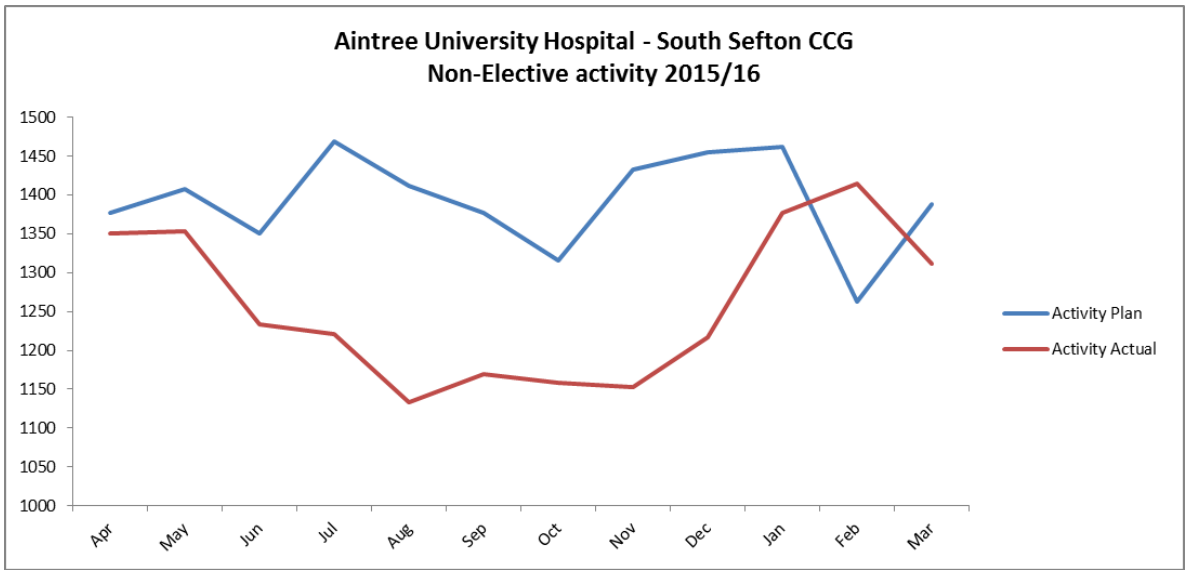
Figure 15 Month 12 Unplanned Care – Aintree University Hospital NHS Foundation Trust by POD

Aintree University Hospitals Urgent Care PODS	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
A&E WiC Litherland	41,953	42,363	410	1%	£953	£953	£0	0%
A&E - *Accident & Emergency*	30,956	30,583	-373	70%	£3,646	£3,696	£50	41%
NEL - *Non Elective*	13,932	12,760	-1,172	-8%	£25,986	£25,133	-£853	-3%
NELNE - *Non Elective Non-Emergency*	44	39	-5	-11%	£122	£109	-£12	-10%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	40	122	82	205%	£10	£25	£16	163%
NELST - *Non Elective Short Stay*	2,732	2,291	-441	-16%	£1,764	£1,538	-£226	-13%
NELXBD - *Non Elective Excess Bed Day*	8,044	7,689	-355	-4%	£1,858	£1,602	-£255	-14%
Grand Total	**97,701**	**95,847**	**-1,854**	**-2%**	**£34,338**	**£33,056**	**-£1,282**	**-4%**

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. A chart below illustrates the Non Elective activity in 2015/16:



6.3 Alder Hey Hospital

Figure 16 Month 12 Unplanned Care – Alder Hey Hospital by POD

Alder Hey Childrens Hospital Urgent Care PODS	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Activity YTD % Var
A&E - *Accident & Emergency*	7,899	8,317	418	5%	£688	£687	-£1	0%
NEL - *Non Elective*	854	880	26	3%	£1,174	£1,082	-£92	-8%
NELNE - *Non Elective Non-Emergency*	1	0	-1	-100%	£1	£0	-£1	-100%
NELXBD - *Non Elective Excess Bed Day*	113	47	-66	-58%	£42	£16	-£26	-62%
Grand Total	**8,868**	**9,244**	**376**	**4%**	**£1,905**	**£1,786**	**-£120**	**-6%**

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 13% 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	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
A&E - *Accident & Emergency*	4,422	4,647	225	5%	£397	£423	£26	7%
AMAU - *Acute Medical unit*	63	55	-8	-12%	£6	£5	-£1	41%
NEL - *Non Elective*	692	635	-57	-8%	£1,355	£1,487	£133	41%
NELNE - *Non Elective Non-Emergency*	24	18	-6	-25%	£179	£120	-£60	-33%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	149	0	-149	-100%	£33	£0	-£33	-100%
NELST - *Non Elective Short Stay*	268	264	-4	-2%	£137	£145	£8	6%
NELXBD - *Non Elective Excess Bed Day*	234	467	233	100%	£50	£100	£50	100%
readmissions	0	0	0	0%	-£13	-£13	£0	0%
Grand Total	**5,851**	**6,086**	**235**	**4%**	**£2,145**	**£2,267**	**£123**	**6%**

6.4.1 Royal Liverpool and Broadgreen Hospitals Key Issues

Non Electives make up £133k of the total £123k unplanned over spend. Lower Limb surgery and amputations make up £116k of the total over spend.

Further analysis was undertaken against this recent activity increase and revealed that this Trust deals with patients with these conditions as opposed to Aintree University Hospital.

6.5 Liverpool Heart & Chest Hospital

Liverpool Heart & Chest Hospital Urgent Care PODS	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Activity YTD % Var
NEL - *Non Elective*	119	155	36	30%	£356	£463	£106	30%
NELNE - *Non Elective Non-Emergency*	56	79	23	40%	£179	£265	£86	48%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	0	7	7	0%	£0	£2	£2	0%
NELST - *Non Elective Short Stay*	7	9	2	35%	£5	£7	£2	39%
NELXBD - *Non Elective Excess Bed Day*	121	95	-26	-22%	£25	£20	-£4	-18%
Grand Total	**303**	**345**	**42**	**14%**	**£565**	**£756**	**£191**	**34%**

6.5.1 Liverpool Heart & Chest Hospital Key Issues

Non-Elective & Non-Elective Non-Emergency make up the £191k unplanned over spend.
One particular HRG – "EA36A - Catheter 19 years and over" – makes up £96k of the over spend. Trend shows us that 48% of the over performance was carried out in the last 4 months of the financial year.

NHS
South Sefton
Clinical Commissioning Group

7. Mental Health

7.1 Mersey Care NHS Trust Contract

Figure 17 NHS South Sefton CCG – Shadow PbR Cluster Activity

PBR Cluster	Caseload as at 31/03/2016	2015/16 Plan	Variance from Plan	Variance on 31/03/2015
0 Variance	97	34	63	20
1 Common Mental Health Problems (Low Severity)	46	23	23	7
2 Common Mental Health Problems (Low Severity with greater need)	31	48	(17)	2
3 Non-Psychotic (Moderate Severity)	211	274	(63)	(20)
4 Non-Psychotic (Severe)	215	169	46	2
5 Non-psychotic Disorders (Very Severe)	63	32	31	13
6 Non-Psychotic Disorder of Over-Valued Ideas	48	43	5	8
7 Enduring Non-Psychotic Disorders (High Disability)	219	133	86	23
8 Non-Psychotic Chaotic and Challenging Disorders	114	83	31	17
10 First Episode Psychosis	140	93	47	27
11 On-going Recurrent Psychosis (Low Symptoms)	438	414	24	-
12 On-going or Recurrent Psychosis (High Disability)	308	312	(4)	(7)
13 On-going or Recurrent Psychosis (High Symptom & Disability)	107	112	(5)	5
14 Psychotic Crisis	18	17	1	(4)
15 Severe Psychotic Depression	7	7	-	5
16 Psychosis & Affective Disorder (High Substance Misuse & Engagement)	37	33	4	2
17 Psychosis and Affective Disorder – Difficult to Engage	54	58	(4)	(4)
18 Cognitive Impairment (Low Need)	232	347	(115)	22
19 Cognitive Impairment or Dementia Complicated (Moderate Need)	484	462	22	(130)
20 Cognitive Impairment or Dementia Complicated (High Need)	364	148	216	102
21 Cognitive Impairment or Dementia (High Physical or Engagement)	103	45	58	54
Reviewed Not Clustered	294	36	258	174
No Cluster or Review	199	144	55	2
Total	3,829	3,067	762	320

Figure 18 CPA – Percentage of People under CPA followed up within 7 days of discharge

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%	95%	100%

Figure 19 CPA Follow up 2 days (48 hours) for higher risk groups

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%	100%	100%

Quality Overview

At Month 12, 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 last 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 the Clock View Site, GP referral pathways were discussed at CQPG on 15th April 16 with the Trust's Director of Nursing who was taking this away as an action. The CCG are monitoring this through the CQPG.

In March 2016, the CCG Chief Nurse shadowed the Trust's Director of Nursing when he undertook unannounced night visits to Trust facilities across the patch in order 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 Quality Team has offered a reciprocal arrangement to the Trust to see how the CCGs' Quality Team operates as part of a 'commissioner / provider knowledge exchange' and to further support joint working and learning opportunities across the local system.

Contract Query

The contract query relating to 12 hour breaches at Aintree which occurred in August 2015 has formally been closed, however commissioners are continuing to monitor performance.

8. Cheshire Wirral Partnership - Improving Access to Psychological Therapies Contract

The access rate in month 12 is 1.05%, which is a slight decrease to the previous month and is below the monthly target. There has been only one month during 2015/16 when monthly performance has met or exceeded the target (January 2016) and year to date access at month 12 is 10.98%. Therefore, the Trust has not achieved the year end access target of 15%.

The Recovery rate in month 12 is 50% which represents an improvement to the previous month when 46.4% was achieved. This is also one of five months during the year when recovery has met or exceeded the monthly target of 50%. Year-end recovery for 2015/16 is 48.0%.

The number of patients self-referring in month 12 increased by 10% to the previous month. The numbers of referrals of all types to date have been affected by the usual seasonal factors. There has been a fall in the number of GP referrals this month with the 74 reported being the lowest monthly total in 2015/16 (a decrease of 36% to the previous month). The numbers had increased in January 2016 and this may have been a result of provider initiatives to raise awareness of the service with GPs. However, a sharp decline has been evident in the two months following.

The percentage of patients entering treatment in 28 days or less was 96.9% in month 12, which is down on last month (when the highest monthly percentage in 2015/16 was reported). The high rates reported in the majority of months may be affected by not enough people entering treatment.

Cancellations by patients at month 12 are down 5% on last month's position. Appointments cancelled by the provider have seen a significant decrease (39%) in month 12 when compared to the previous month. Provider cancellations have been at levels in 2015/16 that were questioned and the provider has previously attributed it to staff sickness, which the service continues to manage. All cancelled appointments are rebooked immediately.

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 passed. At month 12 the number of DNAs at step 2 has decreased by 12%.

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 have remained at the same level as last month.

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It was agreed at the February contract meeting that the contract performance notice would be closed. It is recognised that there is still a discrepancy between provider and HSCIC data but the gap in figures has narrowed once again in the latest month (January 2016 is the latest HSCIC data available).

Figure 20 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	Feb-16	Mar-16	TOTALS
Population (Paychiatric Morbidty Survey)			24298	24298	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	262	256	2668
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%	1.25%	1.25% (q4=3.75%)	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%	1.08%	1.05%	10.98%
National definition of those who have completed treatment (KPI5)			134	117	120	136	119	143	117	132	119	124	114	162	1537
National definition of those who have entered Below Caseness (KPI6b)			9	4	11	9	10	8	5	13	5	7	2	6	89
National definition of those who have moved to recovery (KPI6)			75	51	61	66	49	65	60	56	44	38	52	78	695
Recovery - National Target			50.0%	50.0%	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%	46.4%	50.0%	48.0%
Referrals Received			435	395	355	405	331	335	400	429	317	397	372	359	4530
Gp Referrals			289	215	152	161	115	114	107	108	94	143	116	74	1688
% GP Referrals			66%	54%	43%	40%	35%	34%	27%	25%	30%	36%	31%	21%	37%
Self referrals			114	149	175	205	184	207	235	271	196	215	200	220	2371
% Self referrals			26%	38%	49%	51%	56%	62%	59%	63%	62%	54%	54%	61%	52%
Other referrals	Other Referrals are 34 - Assessment and Immediate Care, 6 - Other, 1-WaltonNeuro, 2- Acute Care Team, 3 - Secondary Care, 1-Community(Adult), 2-Health Visitor, 1-Practice Nurse		32	31	28	39	32	14	58	50	27	39	56	65	471
% Other referrals			7%	8%	8%	10%	10%	4%	15%	12%	9%	10%	15%	18%	10%
Referral not suitable or returned to GP			0	0	0	0	0	0	0	0	0	0	0	0	0
Referrals opting in			415	355	285	299	259	249	288	284	238	341	307	300	3620
Opt-in rate %			95%	90%	80%	74%	78%	74%	72%	66%	75%	86%	83%	84%	84%
Patients starting treatment by step (Local Definition)		Step 2	94	119	142	157	125	178	137	240	248	259	193	178	2070
		Step 3	49	39	59	47	41	54	47	12	19	84	69	78	598
		Step 4													0
		Total	143	158	201	204	166	232	184	252	267	343	262	256	2668
Percentage of patients entering in 28 days or less			60.1%	68.9%	82.3%	95.2%	97.0%	96.1%	97.8%	94.4%	83.0%	97.2%	98.1%	96.9%	
Completed Treatment Episodes by Step (Local Definition)		Step 2	138	175	128	203	127	240	172	201	293	248	222	290	2437
		Step 3	341	329	363	383	287	462	377	245	268	334	271	391	4051
		Step 4									7	2	2	0	11
		Total	479	504	491	586	414	702	549	446	568	584	495	681	6499
Activity	Attendances	Step 2	369	456	536	788	618	645	621	662	541	631	684	680	7231
		Step 3	389	422	547	460	466	507	412	499	365	461	408	408	5344
		Step 4		1	2	3	6	17	13	12	14	16	16	16	116
	DNA's	Step 2	80	92	146	179	129	175	149	90	124	124	165	145	1598
		Step 3	52	49	75	56	55	60	45	45	36	61	31	56	621
		Step 4		1					2		1	0	1	3	8
	Cancels	Step 2	40	82	159	225	137	176	180	198	189	193	198	166	1943
		Step 3	62	89	107	95	81	99	116	119	97	112	119	114	1210
		Step 4						6	4	1	1	2	3	3	20
	Attendances	Total	758	879	1085	1251	1090	1169	1046	1173	920	1108	1108	1104	12691
	DNAs	Total	132	142	231	235	184	235	196	135	161	185	197	204	2237
	Cancelled	Total	102	171	266	320	218	281	300	318	287	307	320	283	3173
	Number Cancelled by patient	Total	45	109	194	253	181	239	205	243	209	224	258	245	2405
	Number Cancelled by provider	Total	57	62	72	67	37	42	95	75	78	83	62	38	768

Figure 21 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	Feb-16	Mar-16	Year To Date
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	112	155	1557
Denominator		124	121	136	145	130	179	146	131	115	124	113	161	1625
%		97%	94%	94%	97%	95%	97%	94%	95%	98%	94%	99%	96%	96%
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	113	161	1621
Denominator		124	121	136	145	130	179	146	131	115	124	113	161	1625
%		99%	99%	100%	100%	100%	100%	99%	100%	100%	99%	100%	100%	100%

9. Community Health

Community Equipment: Community Equipment: Despite an increase in demand, the Community Equipment Service continues to exceed delivery targets for equipment orders. 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: A reduction in referrals is due to the change in the cardiac rehabilitation 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 rehabilitation 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 development of an alternative service specification as the changes to the pathway are not accounted for in the current plan. A greater proportion of these patients are seen at home rather than in clinic and this issue has been raised with both performance and the commissioning lead.

Diabetes specialist nurse: This service has experienced issues with staffing since January 2015. The service is focusing on providing clinic based delivery to maximise efficiency and domiciliary activity is therefore reduced; the long term vacancy and long term sickness have also contributed to this.

Dietetics: The service has been affected by long term sickness and this has been covered by utilising resources from other parts of the service and the use of overtime. Resources are being used efficiently to target those in the most need. In the meantime a locum has been appointed to cover until substantive staff commence employment.

Palliative Care: The staff are now working in localities and are more accessible for advice face to face. 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. This way of working has enabled the district nurse team to fully understand the role of the palliative care team. 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.

Physiotherapy: There has been an improvement in performance with a locum in place however this is a temporary improvement. Both activity and referrals are above planned thresholds and this has impacted on the waiting times for the service. The level of contacts has increased due to service re-design. A data recording issue was identified with a member of staff who delivers the MSK service that had experienced difficulty inputting onto Emis. This has now been addressed.

Treatment Rooms: At month 11 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%. 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. The ratio 2015/16 shows an upward trend in the ratio of contacts to referrals.

Intravenous Therapy (IV) - Continued over performance in year is due to an increase in long term antibiotic referrals, increased demand from secondary care, 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 within the team .The IV team are training district nurses with monthly theory sessions ,planned assessments and bespoke sessions. Previously there has been 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. Additional staff has been agreed in the interim
to address the waiting times and new trajectories have been agreed.

Walk in Centre - The trust is continuing to work towards achieving the stretch target of all patients seen within 2 hours. There is increased demand for the service and the service is monitoring the attendances and providing the capacity by the use of overtime and agency staff to ensure patient safety.

Virtual Ward - 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. The service is now staffed to full establishment, with vacancies causing a reduction in capacity in previous months. From February 2016 the service has been achieving its targets for 4 weeks for urgent and 12 weeks for routine. Two clinicians will come out of their preceptorship in March 2016 which will add additional capacity to the services.

Delayed Transfer of Care (DToC) / Intermediate Care (Ward 35): Although increased in February, the delays remain above target in Sefton. The percentage of bed days occupied by delayed transfers of care in Sefton during February 2016 was 17.4% 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 were “patient (or family) choice and “awaiting care package. 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. In Sefton, there has been a reduction in Care Home beds which has impacted on the number of delays on Ward 35.

Podiatry: The service are still 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 in terms of activity against plan for 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. The service is reviewing the demand compared to capacity.

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 31 weeks for NHS South Sefton CCG. This is an increase in length of wait on previous months.

Adult speech and language therapy: Consistency in approach to the management of waiting times is moving forward. A new clinical project lead has commenced in post and a project team commenced in post 22nd February and a project team involving clinicians, admin staff, analysts and communications team has been identified to develop a centralised waiting list management office. This will release clinicians to focus on clinical duties and bring in centralised and a consistent waiting list office for the Trust. Adult SALT has recruited to full establishment which is expected to ensure that waiting times will reduce.

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. The service is now staffed to full establishment, with vacancies causing a reduction in capacity in previous months. From February 2016 the service has been achieving its targets for 4 weeks for urgent and 12 weeks for routine.

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.

Further to the above LCH have adopted elements of the capacity and demand model in order to understand if demand is a contributing factor to increasing wait times. This tool has been developed following consultation with the intensive support team and has been clinically led by North locality clinical lead. It has led to trajectories for improvement, and operational plans to drive improvements in wait times and a centralised waiting list management office.

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 a reversal of this approach is being implemented starting with the trust 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 Walk In Centre 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'. Formal feedback is due in June 2016.

The Capsticks 'Quality, Safety and Management Assurance Review' of Liverpool Community Health was published in March 2016. The review was conducted in two distinct phases, the first phase looked at governance issues within the Trust from its creation in 2010 until the appointment of a new leadership team in the middle of 2014, the second phase of the Capsticks report looked at the Trust today. It found that while there is still work to do, the organisation has made significant progress and turned an important corner 98% of the Trust's patients now say they would recommend the care they receive to their friends and family.

The report identified several areas for further improvement which the Trust is addressing through a detailed action plan, progress against this action plan is also monitored through the monthly CF and joint CQPG meetings with Liverpool CCG.

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, Month 12 data has shown a slight improvement for South Sefton CCG.

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, the Trust are still awaiting formal feedback.

SALT Waiting Times

The CCG continues to experience longs waits for both paediatric and adult SALT, this has been raised at CQPG and Contract meetings, the Trust has been asked to resubmit a business case regarding SALT 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.

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 has 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 is an active member of this group. This approach is in line with the RASCI model

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.

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10. Third Sector Contracts

Senior CCG Management updated the Contracting Team in regard to Third Sector contracts, all commissioned services are currently under review as part of the CCG Value for Money exercise. All providers have now been informed that if they are affected by change as a result of these reviews, further discussion will take place and applicable notice periods will be applied if services are to be de-commissioned.

NHS Standard Contracts and Grant agreements have been put in place for most providers and reference to the above has been made within the Contract Term for each. These contracts and Grants continue to be for a maximum of 12 months until reviews have taken place.
IG Toolkit Compliancy Assessments (V13) is now complete for all providers for 2015-16. Once the new assessment is released at the end of May, work will commence to update for 2016-17 (v14).

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11. Quality and Performance

11.1 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 - March	54	51	↑	There were 7 new cases reported in March 2016, year to date there have been 451 cases against a plan of 54. Of the 51 cases reported in year to date 43 have been aligned to Aintree Hospital, 6 to the Royal Liverpool Broadgreen Hospital, 1 to Walton and 1 to Southport & Ormskirk (24 apportioned to acute trust and 27 apportioned to community).	
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(Aintree)**	15/16 - March	46	54 (31) following appeal)	↑	There were 6 new cases have been reported in March. Year to date there have been 48 cases against a plan of 42, the year to date plan is 46.	Several wards experienced increased incidence of CDT during Q4 2016. Key IPC messages continue to be reinforced corporately and within the divisions • The IPC matron attends the matron safety huddle daily to update the matrons • The Assistant DIPC and IPC Matron have visited all wards with an increase burden and have encouraged discussing the increase burden on the safety huddles. • Multidisciplinary IPC sweeps continue after every case of CDI. • A review of the antibiotic ward rounds is being undertaken in order to further improve clinical engagement and education regarding antibiotic prescribing • The daily side room plan risk assesses patients in isolation and continues to be of benefit to the bed managers. • The use of fidaxomicin for patients with moderate to severe CDI. The last local appeals panel met on 14th April, 7 cases were submitted, all were upheld. Taking into account 15/16 appeals YTD, the Trust is below trajectory.

Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(CCG)**	15/16 - March	0	3	↔	There were no new cases reported in March of MRSA for the 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. The CCG has been informed that another case of MRSA has been reported in March 2016, this is likely to be attribruted to Aintree.
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(Aintree)**	15/16 - March	0	2	↑	The Trust recorded 1 new case of MRSA in March, bringing the year to date total to just 2. Initially there has been another 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 Trust reported a single case of MRSA Bacteraemia during March 2016 which brings the YTD total to 2 cases of Trust apportioned MRSA Bacteraemia. A post infection review undertaken in collaboration with the local Clinical Commissioning Group on 18/04/2016 concluded that no specific actions that could have been taken to prevent the patient developing the bacteraemia.
Mixed Sex Accommodation Breaches						
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(CCG)**	15/16 - March	0.00	0.20	↔	In March the CCG had 1 mixed sex accommodation breach (6 year to date) which is above the target and as such are reporting red for this indicator. The breach occurred in the Royal Liverpool Broadgreen. This is the first breach for South Sefton CCG for this Trust. Four breaches were reported at Liverpool Heart & Chest for the previous 4 months. The sixth breach was reported at Southport & Ormskirk in September.	The CCG is working with colleagues from LCCG and NHSE Specialist Commissioning 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 - March	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 - March	2395.60	2,622.42	↑	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 72 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 - March	316.18	201.49	↓	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 37 less than the same period last year.	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	15/16 - March	1153.1	1,192.35	↑	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 61 more than the same period last year.	
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	15/16 - March	254.18	179.79	↓	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 24 less that same period last year.	
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	15/16 - March	1374.70	1,395.28	↑	This measure now has a plan which is based on the same period previous year. The CCG is over plan, actual admissions is 32 more than the same period last year.	
Emergency readmissions within 30 days of discharge from hospital (Cumulative)	15/16 - March	No Plan	12.30	↓	The emergency readmission rate for the CCG is lower than previous month (13.19) and also lower than the same period last year (16.60).	

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 - March	80%	76.19%	↑	The CCG have failed to achieve the 80% target in March only 16 patients out of 21 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 - March	80%	72.20%	↑	Aintree have failed to achieve the target in March only 26 patients out of 36 spending at least 90% of their time on a stroke unit.	Stroke performance deteriorated to 72.2% 51.2% (+21%). 36 patients were admitted to the Trust with a diagnosis of Stroke during March 2016 of which 26 spent at least 90% of their time on the stroke unit. • Of the 10 patients who failed the standard: - 5 patients were 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 admitted to the Stroke Unit within 4hrs but discharged within 24hrs with Early Supported Discharge - 1 patients was on the Stroke Unit within 4hrs of admission but transferred to Ward 31 to be nursed in a side-room when found to be GDH positive - 1 patient was palliative, kept comfortable and died on Ward 22 - 1 patient was seen by the Stroke Nurse on arrival but atypical symptoms and was referred to the stroke team after a CT scan diagnosed a Stroke - 1 patients case notes were not available to validate at the time of the report It is noted that the Trust overall SNAPP score for October 2015 to December 2015 has been maintained at B.

% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(CCG)**	15/16 - March	60%	100%	↔		
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(Aintree)**	15/16 - March	60%	100%	↔		
Mental health						
Mental Health Measure - Care Programme Approach (CPA) - 95% (Cumulative) **(CCG)**	15/16 - Qtr4	95%	100.00%	↔		
IAPT Access - Roll Out	15/16 - Qtr4	3.75%	2.54%	↑	The CCG are under plan for Q4 for IAPT Roll Out, this equates to 861 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 - March	1.25%	1.10%	↔	The CCG are under plan in March for IAPT Roll Out, out of a population of 24298, 256 patients have entered into treatment and are reporting the same as last month 1.10%.	See section 7 of main report for commentary.
IAPT - Recovery Rate	15/16 - Qtr4	50%	43.64%	↓	The CCG are under plan for recovery rate reaching 43.6% in Q4. This equates to 168 patients who have moved to recovery out of 385 who have completed treatment.	See section 7 of main report for commentary.
IAPT - Recovery Rate	15/16 - March	50%	50.00%	↑	The CCG are at plan for recovery rate reaching 50.0% in March. This equates to 78 patients who have moved to recovery out of 156 who have completed treatment. This is an increase from last month when 46.4% 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 - Qtr4	75%	96.23%	↓	March data shows 96.3%, a slight decrease from February when 99.1% 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 - Qtr4	95%	99.75%	↑	March data shows 100%, February also recorded 100%.	

Preventing people from dying prematurely						
Under 75 mortality rate from cancer	2014		152.20	↓	Under75 mortality rate from Cancer has dropped from 158.7 in 2013 to 152.20 in 2014.	
Under 75 mortality rate from cardiovascular disease	2014		72.90	↑	Under 75 mortality rate from cardiovascular disease increased slightly from 72.60 in 2013 to 2.90 in 2014.	
Under 75 mortality rate from liver disease	2014		29.10	↑	Under 75 mortality rate from liver disease has increased from 22.6 in 2013 to 29.1 in 2014.	
Under 75 mortality rate from respiratory disease	2014		40.50	↑	Under 75 mortality rate from respiratory disease increased from 38.0 in 2013 to 40.50 in 2014.	
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Person)	2014	2,022.6	2,660.6	↓	South Sefton achieved a rate of 2660.6 in 2014 which has failed against the plan of 2022.6. For 2014 the rate for Males was 2981.1, a increase from the previous year (2669.2). Females had a decrease with a rate of 2349.2 compared with 2517.7 in 2013.	The annual variation is significant and the CCG is working with Public Health locally and regionally to understand this. Indications at present are that the PYLL is significantly susceptible to fluctuations due to changes such as young deaths, which introduces major swings, particularly at CCG level.
Cancer waits – 2 week wait						
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(CCG)**	15/16 - March	93%	96.06%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Aintree)**	15/16 - March	93%	95.99%	↔		
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 - March	93%	94.26%	↔		
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 - March	93%	94.86%	↔		

Cancer waits – 31 days						
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(CCG)**	15/16 - March	96%	98.35%	↔		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Aintree)**	15/16 - March	96%	99.03%	↔		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	15/16 - March	94%	96.39%	↔		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Aintree)**	15/16 - March	94%	100.00%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	15/16 - March	94%	95.92%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Aintree)**	15/16 - March	94%	98.85%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	15/16 - March	98%	98.89%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(Aintree)**	15/16 - March	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 - March	85% local target	83.33%	↓	The CCG have narrowly failed the target year to date reaching 83.33%. In March they achieved 62.50% there were 3 patient breaches out of a total of 8 patients.	
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 - March	85% local target	87.04%	↔		

Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(CCG)**	15/16 - March	90%	93.48%	↑		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(Aintree)**	15/16 - March	90%	95.92%	↑		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(CCG)**	15/16 - March	85%	84.28%	↓	The CCG have narrowly failed the target year to date reaching 84.28%. In March they achieved 76.92% there were 6 patient breaches out of a total of 26 patients.	
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(Aintree)**	15/16 - March	85%	85.24%	↔		
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 - March	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted) **(Aintree)**	15/16 - March	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(CCG)**	15/16 - March	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(Aintree)**	15/16 - March	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(CCG)**	15/16 - March	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(Aintree)**	15/16 - March	0	0	↔		

Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(CCG)**	15/16 - March	90%	85.71%	↓	The CCG failed the 90% target in March, out of 84 patients, 72 were treated 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 - March	90%	90.15%	↔		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(CCG)**	15/16 - March	95%	95.99%	↔		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(Aintree)**	15/16 - March	95%	95.90%	↔		
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 - March	92%	95.10%	↔		
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 - March	92%	93.60%	↓		
A&E waits						
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG) All Types**	15/16 - March	95.00%	94.16%	↔	The CCG have failed the target in March reaching 87.29% and are just under year to date reaching 94.16%. In March 972 attendances out of 7650 were not admitted, transferred or discharged within 4 hours.	

Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG) Type 1**	15/16 - March	95.00%	81.36%	↔	The CCG have failed the target in March reaching 74.33%, and year to date reaching 81.36%. In February 962 attendances out of 3747 were not admitted, transferred or discharged within 4 hours	During March 2016 there were 14,753 Type 1 and Type 3 attendances with 2008 breaches which equates to combined performance of 86.39%. Type 1 attendances were 6.3% higher in March 2016 than the same month in 2015 and cumulatively 7.5% higher during Q4 of this year compared to last. The following 5 key actions implemented in February 2016 remain 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 via the implementation of the Emergency and Acute Care Plan (Appendix 1). An action plan to reduce the numbers of medically optimised patients also remains in place. To ensure sustained improvement, the following actions remains in place: • Full utilisation of the step down facility, Aintree 2 Home, 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 - March	95.00%	90.57%	↓	Aintree have failed the target in March reaching 86.39%, and year to date reaching 90.57%. In March 2008 attendances out of 14753 were not admitted, transferred or discharged within 4 hours. This is the eigth 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 - March	95.00%	82.00%	↓	Aintree have failed the target in March reaching 72.36%, and year to date reaching 82.00%. In March 2008 attendances out of 7264 were not admitted, transferred or discharged within 4 hours.	

% of patients waiting 6 weeks or more for a Diagnostic Test **(CCG)**	15/16 - March	1.00%	1.35%	↔ ↑	The CCG had 36 patients, out of 2675 waiting over 6 weeks for a diagnostic test in March, this is the fourth month in a row the target has been failed.	The majority of breaches at Aintree, please see below for Trust narrative .
% of patients waiting 6 weeks or more for a Diagnostic Test **(Aintree)**	15/16 - March	1.00%	1.41%	↔	Aintree had 64 patients, out of 4552 waiting over 6 weeks for a diagnostic test in March failing the target.	Actions taken to improve performance include: • Radiology are working with T&O to manage the demand into MSK USS and radiologists have been employed on zero hours contracts until vacant positions are filled in August 2016, weekly performance meetings are taking place top highlight issues and take actions to improve current position in MSK USS. Additional actions include: - 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. • Endoscopy are maintaining levels of activity despite a number of vacancies - Recruitment is ongoing and additional sessions are taking place each Saturday to replace those that cannot run in the week due to staffing constraints (vacancies & sickness). The unit expects to achieve full establishment by the end of quarter 1. • Cardiology Echocardiography waiting times have increased during March 2016 as a result of staff sickness. The service is delivered by a single imaging nurse (6 sessions) and Consultants (2.5 sessions) however the loss of the imaging nurse had led to a dramatic reduction in capacity. A bid has been submitted for a 2nd imaging nurse to provide business continuity. As yet the service does not have a return to work date for the imaging nurse however all urgent referrals are being prioritised.

Category A ambulance calls						
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	15/16 - March	75%	76.14%	↓		Performance issues continue to affect figures with the whole of the urgent care system coming under pressure due to high levels of demand. Overall demand in March for NWAS was 9.8% higher than planned for and 13.9% for South Sefton CCG. For the most time critical response times (Red) was 16.2% higher than plan for NWAS as a whole and 12.9% higher than plan for South Sefton. The average turnaround times at Aintree Hospital in March was over 43 minutes an increase from previous 2 month when over 41 minutes was recorded.
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	15/16 - March	75%	68.70%	↓	The CCG failed to achieve the 75% year to date or in month (Mar) recording 54.2%. Out of 886 incidents there were 406 breaches.	
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	15/16 - March	95%	94.10%	↔	The CCG has narrowly failed the 95% year to date target reaching 94.10%, also failing in month (Mar) 87.3%, out of 936 incidents there were 119 breaches.	
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	15/16 - March	75%	74.80%	↓	NWAS failed to achieve the 75% year to date or in month (Mar) recording 67.34%.	
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	15/16 - March	75%	70.40%	↓	NWAS failed to achieve the 75% year to date or in month (Mar) recording 58.88%.	
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	15/16 - March	95%	92.60%	↓	NWAS failed to achieve the 95% year to date or in month (Mar) recording 86.66%.	
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.

11.2 Friends and Family – Aintree University Hospital NHS Foundation Trust

Figure 22 Friends and Family – Aintree University Hospital NHS Foundation Trust

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

- % Response Rate
- % Recommended
- % Not Recommended

Aintree University Hospital NHS Foundation Trust routinely achieves the response rate target way in excess of the regional and national response rates. This is for both inpatients and A&E, as outlined above.

For Inpatient services, the percentage of people who would recommend that service is above the England average and has increased compared to the previous month (Feb 2016). The percentage of people who would not recommend the inpatient service is in line with the England average

The percentage of people that would recommend A&E has risen since February, and is above the England average. The percentage of people who would not recommend the A&E is marginally below the England average.

The patient experience lead within the trust presented to the May 2016 EPEPG group the ongoing work the organisation is doing against their patient experience strategy and focussed on the Friends and Family data. 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.

11.3 Serious Untoward Incidents (SUIs)

The Programme manager for Quality and Safety meets on a monthly basis with the Aintree Hospital to discuss all open serious incidents and their progression. The CCG hold regular internal SI meetings, where submitted reports are reviewed and assurance gained to enable closure of incidents.

Both the CQPG and the CCG Quality Committee have sight of both the serious incidents that involve South Sefton CCG patients, irrespective of the location of the incident, and also those serious incidents that occur in Aintree Hospital, irrespective of the CCG of the patient.

The data that feeds the monthly SI report is currently being cleansed so that the reports for 16/17 are of greater accuracy. The CCG has of May 2016 adopted a new database in order to be able to record data better and thus generate more meaningful reports to give greater assurance.

As a result, the month 1 data to be presented at the June Governing Body, will be reflective of accurate cleansed data.

11.4 Complaints Quarter 3 – Aintree University Hospital

Quarter 3 Summary

Concerns
There has been a rise in concerns to 292 in comparison with 279 concerns in Quarter 2 2015/2016. In Quarter 3 2014/2015 there were 295 concerns.

The top three most frequently occurring concern themes recorded this quarter are:
- Clinical Treatment
- Appointments
- Staff Attitude/Conduct

Comparison ratings from Q2 to Q3
1. Clinical Treatment: shows a rise from 68 to 88.
2. Appointments: remain the same as the previous quarter at 57.
3. Staff Attitude/Conduct: quarter 2 36 to 34 in quarter 3.
4. Implementation of Care has shown a further drop from 23 to 15
5. Discharge concerns have shown a small increase from 17 to 22 from the previous quarter.

Complaints
There has been an increase in the number of complaints from 83 to 104 from the last quarter (Quarter 2) and the same period last year of 75 (Quarter 3 2014/15).

The top three most frequently occurring complaint themes recorded this quarter are:
- Clinical Treatment
- Implementation of Care
- Appointments

Comparison ratings from Q2 to Q3
1. Clinical Treatment: shows a rise from 43 to 50
2. Implementation of Care: has risen from 13 to 17
3. Appointments: there were no Appointment complaints last quarter; however, this quarter Appointments received 10.
4. Diagnosis has dropped from 12 to 5 complaints from the last quarter.
5. Staff Attitude/Conduct is much the same at 7 (8 in Quarter 2).

Graph 1 demonstrates the overall numbers of formal complaints received for Quarter 3 remaining steady throughout the span of the graph, with a peak in December 2015 possibly due to winter pressures. Overall, there has been a small rise in the number of complaints since January 2014.

Response Rates
Long-term complaints have been a priority and following a considerable improvement to reduce the number of complaints over 60 days; there are currently 10 complaints which have breached the 60 day target, 7 from the Division of Medicine and 3 from the Division of Surgery & Anaesthetics.
- Complaints closed within 25 working days: a rise from 15% to 29%
- Complaints closed over 25 working days: a drop from 19% to 17%

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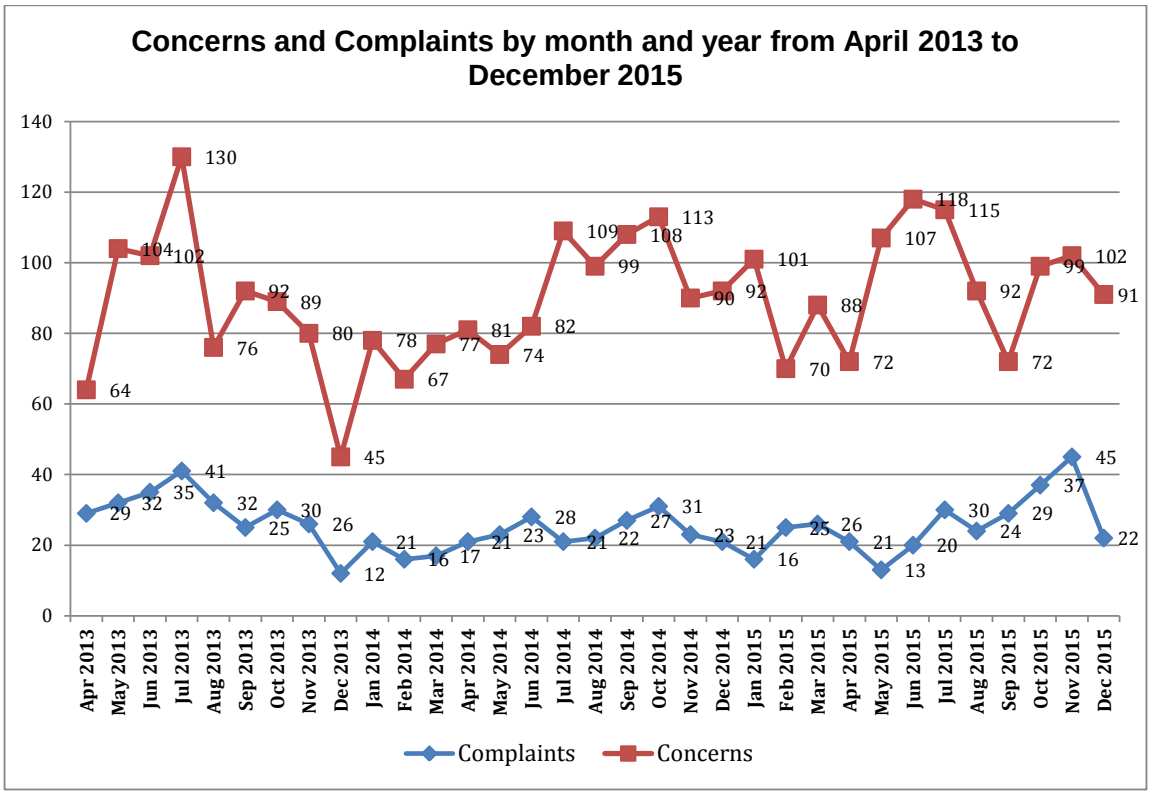
Number of Concerns & Complaints received from April 2013 to December 2015.



Graph 1

Commentary

- Graph 1 looks at the number of issues being raised each month for both concerns & complaints information.
- Overall the number of concerns has risen this quarter from 279 in Quarter 2 to 292. Concerns for this quarter (Quarter 3) over a 3 year period in comparison with previous years have been 214 in Quarter 3 2013/2014 and 295 in Quarter 3 2014/2015.
- In relation to complaints, numbers have risen from the previous Quarter 2 corresponding with a rise over a 3 year period i.e. 58 in Quarter 3 2013/14, 75 in Quarter 3 2014/15 and 104 in Quarter 3 2015/16.

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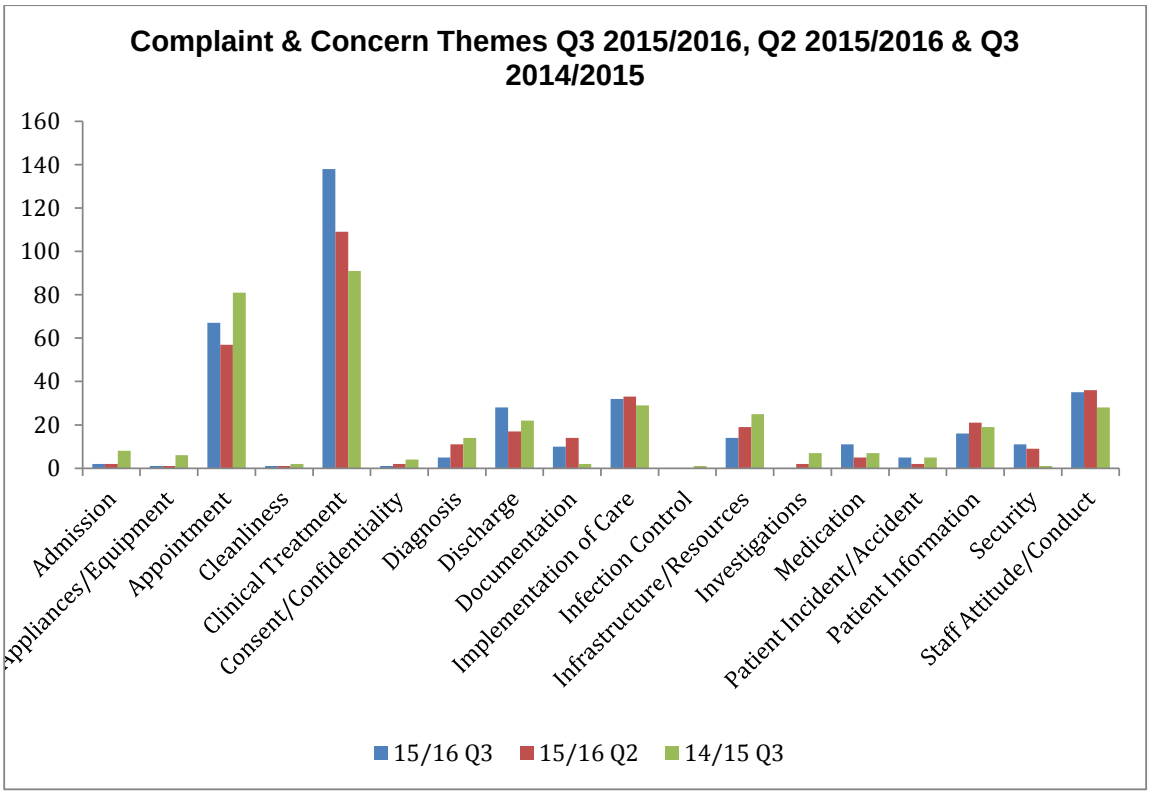
Comparison of Complaint & Concern themes for Q3 of this financial year (2015/2016), Q2 of this financial year (2015/2016) & Q3 of the previous financial year (2014/2015)



Graph 2

12. Primary Care

12.1 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.

12.2 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

12.3 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).

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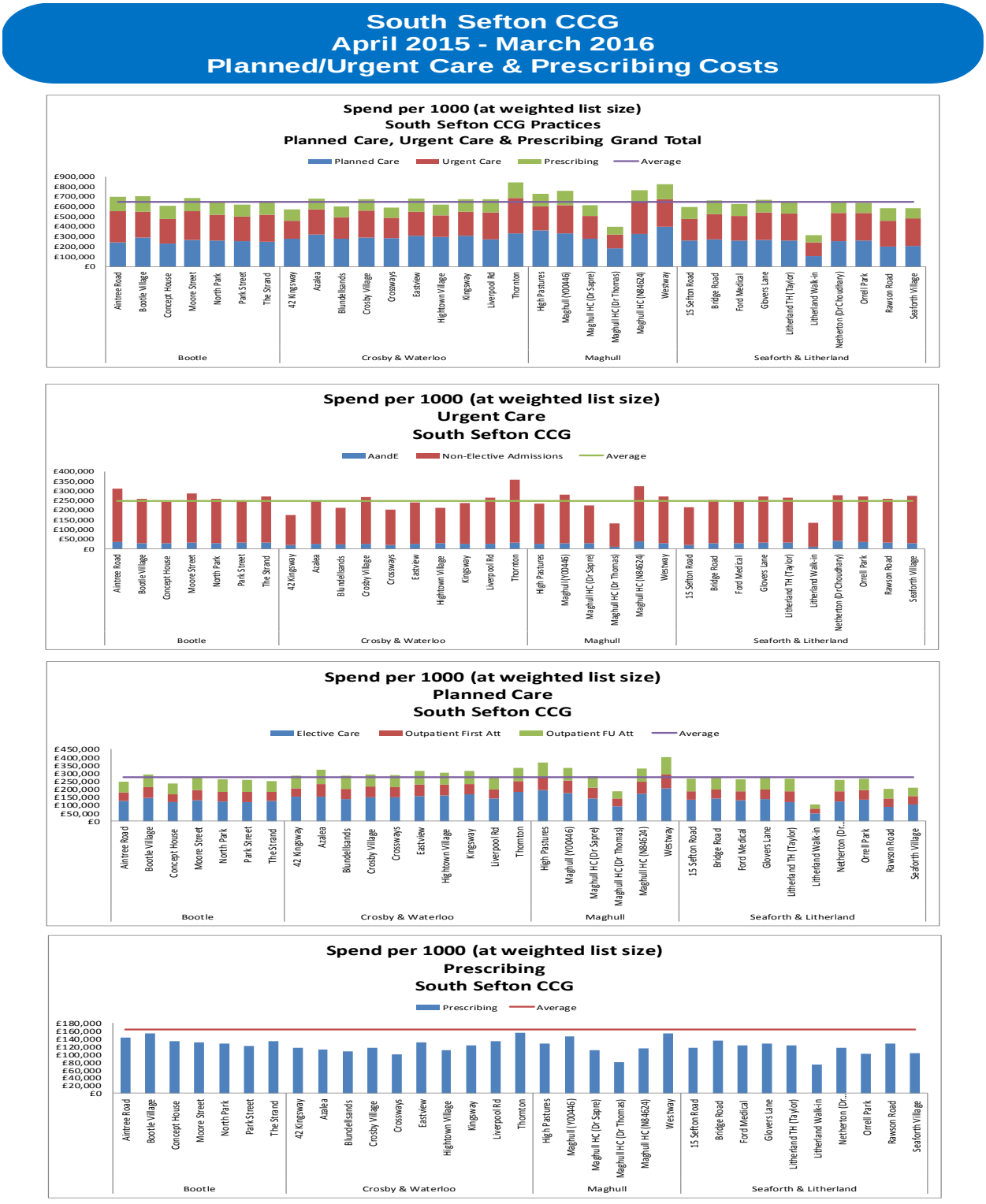
12.4 Summary of performance

Figure 23 Summary of Primary Care Dashboard – Finance



12.5 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 have been further inspection results published in April and May, for Glovers Lane, 42 Kingsway, and Azalea practices.

Glovers Lane Surgery Good

Magdalen Square, Netherton, Bootle, L30 5TA
(0151) 524 2444
Provided by: Glovers Lane Surgery

CQC inspection area ratings
(Latest report published on 10 May 2016)

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

CQC Inspections and ratings of specific services
(Latest report published on 10 May 2016)

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

Doctors/GPs and Clinics

Specialisms/services

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

NHS
South Sefton
Clinical Commissioning Group

Drs Vitty, Pfeiffer and Berni Requires improvement

We are carrying out checks at Drs Vitty, Pfeiffer and Berni using our new way of inspecting services. We will publish a report when our check is complete.

40-42 Kingsway, Waterloo, Liverpool, L22 4RQ
(0151) 928 2415
Provided by: Drs Berni and Vitty

CQC inspection area ratings
(Latest report published on 5 May 2016)

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

CQC Inspections and ratings of specific services
(Latest report published on 5 May 2016)

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

Doctors/GPs

Specialisms/services

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

Dr Doran and Dr Navaratnam Good

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

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

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

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

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

Doctors/GPs and Clinics

Specialisms/services

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

NHS
South Sefton
Clinical Commissioning Group

13. NHS England Activity Monitoring

Figure 24 NHS England Activity Monitoring

Source	Referrals (G&A)	*Month 12 YTD PLAN*	*Month 12 YTD ACTUAL*	*Month 12 YTD Variance*	ACTIONS being Taken to Address Cumulative Variances GREATER than +/-3%
	Referrals (G&A)				
MAR	GP	36547	40069	9.6%	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. A further issue have been noticed within the MAR data: The Walton Neuro has started reporting in Oct 15, previously had not reported and as such affecting figures adversely.
MAR	Other	21714	25060	15.4%	Please see previous months report detailing issues. Local referral data for the CCG suggests a much lower increase. Also increased activity at Aintree due to GP hotline and breast surgery shift.
MAR	Total	58261	65129	11.8%	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	61922	61667	-0.4%	
SUS	Follow-up	155471	160914	3.5%	Please see previous report detailing the problems with the plans (based on MAR) against the actuals (based on SUS). Actual activity when comparing 2014/15 to 2015/16 shows a small increase of approx. 0.4%. The variance against plan is slightly outside of the 3% threshold.
SUS	Total OP attends	217393	222581	2.4%	
SUS	Outpatient procedures (G&A) (included in attends)				
	Admitted Patient Care (G&A)				
SUS	Elective Day case spells	22149	19824	-10.5%	As with previous months comments day case procedures have increased against last year. A higher then expected increase in February has seen the variance against last year increase to 7.3%. March activity has reduced against February. The increase appears to be mainly due to Gastroenterology which is being investigated.
SUS	Elective Ordinary spells	3671	3400	-7.4%	As noted in previous returns, plan v actual remains in line with the year to date comparison of last year to this year's activity levels.

Source	Referrals (G&A)	*Month 12 YTD PLAN*	*Month 12 YTD ACTUAL*	*Month 12 YTD Variance*	ACTIONS being Taken to Address Cumulative Variances GREATER than +/-3%
SUS	Total Elective spells	25820	23224	-10.1%	Overall when comparing last year to the same period this year the increase is approx. 5%. This is due to increases in day case procedures, especially in Feb 16.
SUS	Non-elective spells complete	21281	20084	-5.6%	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 year's activity to this years is approx. 5%, due to the CDU effect. Recent increases in Jan and Feb due to system changes at Aintree have also seen a higher than expected increase.
SUS	Total completed spells	47101	43308	-8.1%	As above.
	Attendances at A&E				
SUS	Type 1				
SUS	All types	42384	45540	7.4%	As per previous months comments the actual increase from 2014/15 to 2015/16 is within the 3% threshold at approx. 1%.

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 by1st 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 - pay protection applies for two year period
- 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

Finance and Resource Committee Meeting held on Thursday 24th March 2016	Chair: Graham Morris

Key Issue	Risk Identified	Mitigating Actions
• CCG remains on target to delivery 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 scheme required in place for delivery for 1st April 2016. • CCG required to continue to develop further QIPP schemes.
• CCG will be responsible for appointing auditors from April 2017.	• CCG needs to develop plan to appoint auditors.	• Working with other local CCGs to develop auditor appointment panel.

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

- Agreed 2016/17 Prescribing Quality Scheme.
- Expansion to the Primary Care Rebate Scheme approved, covering:
  - Mezolar patches;
  - Lixiana (NOAC); and
  - Tresiba (long-acting insulin analogue (black rated, although existing patients receiving treatment).
- CCG Assurance Framework due to be published end March.
- OD implementation plan reported to Committee and agreed.
- IEFR Q3 Report received.

Key Issues Report to Governing Body

NHS South Sefton Clinical Commissioning Group

Quality Committee Meeting held on 18th February 2016	Chair: Dr Gina Halstead

Key Issue	Risk Identified	Mitigating Actions
Not applicable	Not applicable	Not applicable

Information Points for South Sefton CCG Governing Body (for noting)
CCG Safeguarding Peer Review Action Plan – Recommended to be presented to the Governing Body for closure.
NHSE CCG Safeguarding Assurance Process – Safeguarding Service to complete assurance tool and exception report to be submitted to the Quality Committee prior to submission. The assurance tool once completed will be submitted to NHSE via the CCG single point process.
CCG Looked After Children Strategy – Challenges to the delivery of the vision and outcomes for LAC discussed. Meeting to be arranged with the Sefton DCS. Strategy to be re-submitted to March 2016 meeting of the Quality Committee for recommendation for approval by the Governing Body.
CRR/GBAF – CRR/GBAF reviewed. The Committee made the recommendation to review rating given to both (1) 4.2 of the GBAF (Risk relating to the delivery of community services as specified by the CCG and (2) STA038 of the CRR (Looked After Children Health Assessments and Reviews).
Respiratory Programme – Report received on the work commissioned to improve the Respiratory Care Pathway for the patients of SSCCG.
NHS111 – Performance letter to CCG Chief Officers re NHS111 was noted following verbal report from GP Clinical Lead/Clinical Vice-Chair for the CCG.

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Quality Committee Meeting held on 24th March 2016	Chair: Dr Gina Halstead

Information Points for South Sefton CCG Governing Body (for noting)
Safeguarding Contract Queries: • Southport & Ormskirk Hospitals NHS Trust – contract query / contract performance notice remains open. Assurance level remains limited. Letter has been sent to Trust from the Collaborative Commissioning Forum • Alder Hey Hospital – Contract Performance Notice remains open but good progress reported.
Looked After Children Health Reviews – Although improvements in performance have been seen, some challenges are still apparent. Chief Nurse is Chairing a follow-up lessons learnt event to review progress against actions as agreed by CCGs, LCH and Sefton Local Authority. This remains on the CCG Corporate Risk register
Merseyside Care Mental Capacity Act / DoLS performance – CCG Chief Nurse as discussed this issue with the Trust Director of Nursing. The CCG Safeguarding Service have confirmed that the Trust have been in contact and an administration error prevented the required data from being submitted. This has now been addressed.
Care Home Challenges – Sefton has lost 93 care home beds since October 2015 due to 3 care home closures, 2 of which were as a result of CQC inspections. This had had an impact on staffing resource in the CCG Quality Team, CCG Medicines Management Team and CSU. The CCG investment in the post of Head of Vulnerable People has had a positive impact in supporting our response as part of a local mobilisation plan.
Provider Quality Performance report was received and discussed.

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

HEALTHY LIVERPOOL PROGRAMME
RE-ALIGNING HOSPITAL BASED CARE

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

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

1.	Welcome introductions	NF
2.	Declaration of interests	All
3.	Note of meeting held 2nd March 2016 **(attached)**	All
4.	Matters arising	NF
5.	Update on North Mersey Local System Delivery Plan	KS
6.	Board sign off	All
7.	Health and Wellbeing Board sign off	All
8.	LWH update **(attached)**	FL
9.	RLUBH / Aintree update	FL
10.	Feedback from NHSE	AB
11.	Next steps	All
12.	Any other business	All
13.	Date and time of next meeting – 1st June 2016, 4pm-6pm. Venue to be confirmed	

NHS

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Key Issues Log

Title of Meeting	Realigned Hospital Based Care
Chair	Dr Nadim Fazlani
Date of Meeting	4th May 2016

Issue	Risk Identified	Mitigating Action
1. Options Appraisal for Women's services	• That governance of decision making is not robust, leading to challenge later in the process.	• Paper to each Governing Body setting out process and decision making requirements (June 2016). • CIC to confirm criteria for options appraisal. • LA scrutiny requirements to be confirmed.
2. Alignment between North Mersey Local Delivery System Plan/Healthy Liverpool Hospitals Programme	• That given the STP timescales, stakeholders are not fully engaged in the process.	• Stakeholder engagement plan to beshared at next CIC.

Recommendations to NHS Southport & Formby Governing Body and NHS Sefton CCG Governing Body:
• To note the key issues and risks.

LCR NHS CCG Alliance

Wednesday 4th May 2016
Chief Officers Pre-Meet - 12.00 pm to

12.45 pm Lunch 12.45 pm

Meeting: 1.00 pm
Boardroom, Nutgrove
Villa
Westmorland Road, Huyton, L36 6GA

TIME		
1	**Welcome and Introductions**	*Chair*
2	**Apologies for Absence**	*Chair*
3	**Declarations of Interest**	*Chair*
4	**Minutes from the meeting held on Wednesday 2nd March 2016**	*All*
5	**Terms of Reference**	*All*
6	**Update on STP/LDS:** • **Wirral & West Cheshire LDS** • **North Mersey LDS** • **Mid Mersey (Alliance) LDS**	*Jon Develing* *Katherine Sheerin* *Dr Steve Cox*
7	**Cheshire & Merseyside Women's and Children's Services Partnership Vanguard Update**	*Simon Banks*
8	**Feedback from Mike Farrar Workshop**	*Dianne Johnson*
9	**Any Other Business**	*All*
	DATE AND TIME OF NEXT MEETING:	

Wednesday 6th July 2016 1pm
Venue TBC

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Key Issues Log

Title of Meeting	Liverpool City Region NHS CCG Alliance
Chair	Dianne Johnson
Date of Meeting	4th May 2016

Issue	Risk Identified	Mitigating Action
1. Speed of delivery required for STP and lack of alignment with LCR footprint	• That Local Authority colleagues are not effectively engaged in the development of the STP and then do not support the plan.	• Workshop to engage Local Authority colleagues in North Mersey LDS to be scheduled. • Membership of working groups to be strengthened in terms of Local Authority input. • Meeting to be held with LA colleagues on LCR footprint to explore how STP and devolution options align.
2. Work programme for LCR NHS CCG Alliance	• That opportunities for joint working are not optimised.	• Workshop to be held in June 2016 to develop and confirm the work programme, taking account of STP/LDS arrangements

Recommendations to NHS Southport & Formby and NHS Sefton CCG Governing Body:
• The draft Terms of Reference were agreed for approval by each Governing Body.

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
Southport and Formby
Clinical Commissioning Group

Key Issues Report
Bootle Locality
December 2015 – March 2016

Date of Meeting & Chair	Key Issues	Risks Identified	Mitigating Actions
10 March 2016 Dr S Sapre	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 concerns over cost effectiveness in terms of practice staff time	• 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.

Date of Meeting & Chair	Key Issues & discussion
December 2015	• No meeting held in December
27 January 2016 Dr S Sapre	• The group were asked to input to and ask questions of the draft community services specification before the community they are finalised • The group discussed the subject of Federating it was agreed that the whole of the CCG need to be included. Dr Jude from Liverpool to speak to the group at a Wider Group event. • A discussion took place regarding the dermatology service, it was noted that the service is currently being re-procured. Findings from the groups audit of the service to be feedback to Billie Dodd.
10 February, 2016 Dr S Sapre	• Patient safety and quality issues were raised, TE to report these issues to the appropriate CCG • The LMC election was discussed and colleagues were urged to vote. There are currently 2 vacancies, nominations are required
10 March 2016 Dr S Sapre	• Following Bootle Dermatology audit, GPs highlighted the need for the sebaceous cysts to be actioned by the new Dermatology Service, TE has informed the CCG and this is being actioned. • A DOLS presentation was provided by Coroner's Office. A number of GP concerns were raised regarding the accurate and effective identification of DOLS patients. o The HM Coroner office indicated they are looking to have DOLS put on to EMIS for ease of GP access/input; o Dr Roberts commented his practice has already applied a DOLS flag system alert on EMIS; o It was clarified the HM Coroner office is the first line of contact to call to find out if a patient has a DOLS in place. • It was noted that from 1st April 2016, patients will be able to access their records online. • From April 2016, patients aged 11-18 will not be able to order prescriptions online unless deemed mentally capable by their GP practice.

NHS
Southport and Formby
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Key Issues Report
Crosby Locality
December 2015 – March 2016

Date of Meeting & Chair	Key Issues	Risks Identified	Mitigating Actions
2 December 2015 Dr R Huggins	1. The discharge summary at the Women's hospital lists the medicines and dosage, but not the amount given.	• Incomplete discharge information provided to GPs around TTOs and the quantity of medications prescribed/dispensed.	• This is a known issue with Alder Hey discharge summaries also. AJ has asked the CCG Quality Team to raise with LWH.
2 March 16 Dr R Huggins	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.

Date of Meeting & Chair	Key Issues & discussion
2 December 2015 Dr R Huggins	• The community services review was discussed by the group and feedback was provided to be fed back into the service specifications. • The group discussed the issue of out of hours 'expected deaths' and the inappropriate initiation of the unexpected death

Date of Meeting & Chair	Key Issues & discussion
	response by 111 (sending paramedics and police), this is a known issue and is being raised with 111. An update to be provided to the group at the next meeting. • The group discussed the issue of a formalised Federation and it was agreed to go on a future agenda.
6 January 2016 Dr R Huggins	• The group discussed Virtual Ward, • An update was provided to the group regarding the inappropriate response to 'expected death' 111 calls. CG suggested a possible solution, involving District Nurses.
3 February 2016 Dr R Huggins	• There was a discussion regarding estates and the CCGs aim to develop a coherent strategy over the next 15 years to develop multi occupied sites. • Sefton Veterans Project was discussed and GP's were asked to signpost veterans to the project for help and support.
2 March 16 Dr R Huggins	• 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

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Key Issues Report
Maghull Locality
December 2015 – March 2016

Date of Meeting & Chair	Key Issues	Risks Identified	Mitigating Actions
24 March 2016 Dr J Clarkson	1. Dementia diagnosis/prevalence rates	• Accuracy of diagnosis/prevalence rates	• Dementia lead to identify practice level diagnosis and prevalence rates • Information facilitators to audit practice coding and identify a list of patients that require a verification in coding

Date of Meeting & Chair	Key Issues & discussion
17 December 2015 Dr J Clarkson	• Estates were discussed and feedback from Martin McDowell was requested by the group. • Over-performance was with Spa Medica for Ophthalmology treatment across the CCG was noted, members requested further information on where the referrals came from. This is currently being reviewed and will be feedback to the group.
21 January 2016 Dr J Clarkson	• The group received an overview of the Palliative Care / ACP Facilitator role and members were invited to a frailty education event in February. • The group discussed the Dementia Strategy and the estimated prevalence for people over 65 with dementia in the area. Some data cleansing would be required to allow this will be feedback to practices electronically when available
18 February 2016 Dr J Clarkson	• Members discussed disaster planning and it was agreed that a proper agreement was needed between surgeries and officers of the Council.
24 March 2016 Dr J Clarkson	• There was a discussion regarding estates and issues raised will be picked up by the CCG, NHS and Local Authorities where appropriate. • General Practice staffing and capacity issues were discussed and a number of issues were raised, NHSE and the CCG to be engaged to help progress these issues.

NHS
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Key Issues Report
Seaforth and Litherland Locality
January 2015 – March 2016

Date of Meeting & Chair	Key Issues	Risks Identified	Mitigating Actions
2 March 2016 Dr Colette McElroy	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.

Date of Meeting & Chair	Key Issues & discussion
6 January 2016 Dr Colette McElroy	• The group received a presentation from Kevin Thorne and discussed the Dementia Strategy and the estimated prevalence for people over 65 in the locality. Issues were noted in relation to the availability of dementia diagnoses which was often not on first referral to Mersey Care, which may contribute to the figures. • The group discussed Healthwatch and the way in which feedback on same was received from practices and the timeliness thereof.
3 February 2016 Dr Colette McElroy	• Practices were asked to signpost to Sefton Veterans Project for help and support for ex forces personnel. • The Advanced Care Practitioner for Aintree attended and described their role; practices were asked to provide any feedback on how this role could be more collaborative with general practice.
2 March 2016 Dr Colette McElroy	• Issues were raised regarding communication in relation to Community Gynaecology referrals were discussed and Dr McElroy agreed to pick this up with Dr Paula Briggs, Clinical Lead for the Service.

NHS
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Finance and Resource Committee Minutes

Thursday 18th February 2016, 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
Martin McDowell	Chief Finance Officer	MMcD
James Bradley	Head of Strategic Finance Planning	JB
Debbie Fagan	Chief Nurse & Quality Officer	DF
Steve Astles	Head of CCG Development	SA
Janet Fay	Senior Pharmacist	JF
Ex-officio Member*		
Fiona Taylor	Chief Officer	FLT
Apologies		
Paul Thomas	GP Governing Body Member	PT
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Susanne Lynch	CCG Lead for Medicines Management	SL
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	A								
Martin McDowell	Chief Finance Officer	✓	✓								
Andy Mimnagh	GP Governing Body Member	✓	✓								
Graham Morris	Lay Member	✓	✓								
Paul Thomas	GP Governing Body Member	✓	A								
John Wray	GP Governing Body Member	A	A								
Fiona Taylor	Chief Officer	*	*								
James Bradley	Head of Strategic Finance Planning	✓	✓								
Malcolm Cunningham	Head of Primary Care & Contracting	A	N								
Jan Leonard	Chief Redesign & Commissioning Officer	✓	A								
Susanne Lynch	CCG Lead for Medicines Management	✓	A								
David Smith	Deputy Chief Finance Officer	✓	N								

No	Item	Action
FR16/19	**Apologies for Absence** Apologies for absence were received from Paul Thomas, Fiona Taylor, Jan Leonard, Susanne Lynch, Tracy Jeffes and John Wray.	
FR16/20	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both Southport and Formby and South Sefton CCGs declared their potential conflicts of interest.	
FR16/21	**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.	
FR16/22	**Action points from the previous meeting** ***FR16/12 QIPP Update*** – please see agenda item FR16/28. ***FR16/16 Committee Meeting Dates 2016/17*** – additional dates have now been scheduled for 16th February and 16th March 2017, and respective meeting requests have been issued.	
FR16/23	**Month 10 Finance Report** JB presented this report which provided the Committee with an overview of the Financial position for the CCG as at 31st January 2016, and the Committee noted that the CCG is on target to meet its target surplus. The Committee noted that the financial risk facing the CCG is to be escalated to Governing Body as a priority, alongside the commissioning of safe services, given the projected position for 2016/17 financial year. **Action by the Committee** The Committee received this report by way of assurance and noted the recommendations therein.	
FR16/24	**Financial Strategy Update** MMcD advised the Committee that SSCCG will be presenting the financial outlook at the Governing Body Development Session on Thursday 25th February. **Action by the Committee** The Committee noted this update.	
FR16/25	**Prescribing Performance Report** JF presented this report to the Committee. The Committee noted that pressures on the prescribing budget remain, in particular an increase in spends for pregabalin. GM queried electronic prescribing and JF advised that training for this had been on an ad hoc basis; despite this the Committee noted that the CCG is top nationally in terms of percentage of electronic prescribing submissions. MMcD suggested next month's report contain both January's and February's figures for comparative purposes. AM said he will work with JL regarding the work stream on pregabalin. **Action by the Committee** The Committee noted the content of this report.	

No	Item	Action
FR16/26	**HR Performance Report** This report provided an overview of key HR performance indicators. The Committee noted that there had been some slight variations to the way in which data had been collated. Regarding statutory and mandatory training MMcD said SLT will be monitoring this to bring it in line with the IG Toolkit. **Action by the Committee** The Committee received this report by way of assurance.	
FR16/27	**HR Policies** On behalf of TJ, MMcD presented this Pay Protection Policy for approval, and the Committee noted the primary focus was to bring the CCG in line with other local NHS bodies. **Action by the Committee** The Committee approved this policy.	
FR16/28	**QIPP Update** MMcD informed the Committee that the first Monthly Blueprint Reviews and Support meeting was held on 16th February with an interview session with QIPP leads. Any issues and potential barriers were discussed, together with programme leads, and a number of action points are being drawn up. MMcD also referred to Right Care Health and discussions on how their healthcare compares to the CCG. **Action by the Committee** The Committee noted this update.	
FR16/29	**Better Care Fund Update** MMcD updated the Committee regarding the BCF, and the Committee noted that the CCG is awaiting further discussions from NHSE. **Action by the Committee** The Committee noted this update.	
FR16/30	**Primary Care Rebate Scheme** This item is to be deferred to March.	
FR16/31	**Committee Meeting Dates 2016/17** The Committee noted the additional scheduled dates of 16th February and 16th March 2017, completing the 2016/17 financial year.	
FR16/32	**Any Other Business** The Committee noted that Roger Driver's membership of the Finance and Resource Committee will cease following today's meeting. The Chair and Committee therefore took this opportunity to thank Roger formally for his support and contribution to the CCG since its establishment, and the PCT prior to this time, and offered their best wishes for the future.	
FR16/33	**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 24th March 2016 1.00pm to 3.00pm 3rd Floor Board Room, Merton House	

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Minutes

Thursday 24th March 2016, 1.00pm to 3.00pm
3rd Floor Board Room, Merton House

Membership		
Graham Morris	Lay Member	GM
Paul Thomas	GP Governing Body Member	PT
Martin McDowell	Chief Finance Officer	MMcD
David Smith	Deputy Chief Finance Officer	DS
Debbie Fagan	Chief Nurse & Quality Officer	DF
Steve Astles	Head of CCG Development	SA
Susanne Lynch	CCG Lead for Medicines Management	SL
Ex-officio Member*		
Fiona Taylor	Chief Officer	FLT
Apologies		
Andy Mimnagh	GP Governing Body Member	AM
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
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	A	A							
Martin McDowell	Chief Finance Officer	✓	✓	✓							
Andy Mimnagh	GP Governing Body Member	✓	✓	A							
Graham Morris	Lay Member	✓	✓	✓							
Paul Thomas	GP Governing Body Member	✓	A	✓							
John Wray	GP Governing Body Member	A	A	A							
Fiona Taylor	Chief Officer	*	*	*							
James Bradley	Head of Strategic Finance Planning	✓	✓								
Malcolm Cunningham	Head of Primary Care & Contracting	A	N	N							
Jan Leonard	Chief Redesign & Commissioning Officer	✓	A	A							
Susanne Lynch	CCG Lead for Medicines Management	✓	A	✓							
David Smith	Deputy Chief Finance Officer	✓	N	✓							

No	Item	Action
FR16/34	**Apologies for Absence** Apologies for absence were received from John Wray, Fiona Taylor, Jan Leonard, Andy Mimnagh and Tracy Jeffes.	
FR16/35	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both Southport and Formby and South Sefton CCGs declared their potential conflict of interest. The Committee noted a potential conflict of interest by Members employed in, or having interests in, general practice with regard to item FR16/39(c) Prescribing Quality Scheme for 2016/17 and FR16/40 Primary Care Rebate Scheme.	
FR16/36	**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.	
FR16/37	**Action points from the previous meeting** **FR16/09 *Sefton Property Estate Partnership Group (SPEP)* –** see agenda item FR16/44. ***FR16/11 CCG Assurance*** – see agenda item FR16/41.	
FR16/38	**Month 11 Finance Report** DS presented this report which provided the Committee with an overview of the Financial position for the CCG as at 29th February 2016. The Committee noted that whilst the CCG is on target to deliver its financial plan for 2015/16, recurrent cost pressures are evident which require reductions in the CCG's expenditure profile to ensure that the CCG can deliver its financial targets for 2016/17. **Action by the Committee** The Committee received this report by way of assurance noting the recommendations therein.	
FR16/39	**Prescribing Performance Report** (a) Prescribing Report Month 9 SL presented this report which detailed the month 9 position with an overspend of £0.484m on a budget of £27.708m. (b) Prescribing Performance Quarter 3 This paper highlighted the prescribing performance and compared activity of the 3rd quarter 2015/16 against 3rd quarter 2014/15. PT said testing strips for glucose need to be reviewed as pharmacies have run out of supplies. SL advised that there is new Pan Mersey guidance for blood glucose monitoring meters, and has asked another pharmacist to look at other options. MMcD asked about the possibility of seconding-in pharmacists with specialist knowledge, with the possibility of working across both CCGs. SL is to look into this and bring an update to the next meeting.	SL

No	Item	Action
	Prescribing Performance Report (Continued) (c) Prescribing Quality Scheme for 2016/17 The Committee noted the aim of this scheme is to provide an incentive to GP practices in order to deliver medicines optimisation. MMcD asked SL to provide a list of the highest pregabalin users, ie asking GP surgeries for sight of patient lists, and SL confirmed that this is already presented at localities. **Action by the Committee** The Committee received these reports by way of assurance and, with the exception of PT whose interest is noted in FR16/35 above, approved the Proposed Prescribing Quality Scheme for 2016/17.	
FR16/40	**Primary Care Rebate Scheme** SL presented this paper which provided an update on total prescribing rebate claims for month 9, together with a request to approve three further rebate schemes being: • Mezolar patches (fentanyl patch) • Lixiana (an anticoagulant) • Tresiba (long-acting insulin analogue rated black) MMcD noted that other CCGs have developed successful schemes for reducing pharmacy waste through restrictions on repeat prescription ordering. The Committee supported further investigation in this area. MMcD and SL will bring a proposal to a future meeting. **Action by the Committee** The Committee, with the exception of PT whose interest is noted in FR16/35 above, approved these three rebate schemes.	MMcD/ SL
FR16/41	**CCG Assurance** MMcD informed the Committee that the CCG assurance framework was still under consultation, and the link provided in the report is for use as a factual update. He advised that publication is expected at the end of March, and he expects the CCG to be assessed under this framework in 2016/17, at which time this will be brought back to the Committee. The Committee also noted that FLT has been part of the working group with NHS Clinical Commissioners and NHSE. **Action by the Committee** The Committee noted this update.	
FR16/42	**QIPP Update** MMcD informed the Committee that proposals are to be developed to consider the threshold for cataract surgery and consideration to be given to other areas of commissioning policies to review. He also highlighted a possible need to distinguish between statutory and non-statutory funding responsibilities, with the possibility that funding will be discontinued in some instances. GM asked when this work is to commence, and MMcD said the CCG hoped to have this up and running by 1st April, for an intensive three month period. **Action by the Committee** The Committee noted this update.	

No	Item	Action
FR16/43	**Better Care Fund Update** MMcD informed the Committee that the 2015/16 final figures are still to be agreed. The 2016/17 plan has not been submitted yet, but the CCG has had a positive meeting with Sefton Council regarding progress and review of potential areas to pool budgets. **Action by the Committee** The Committee noted this update.	
FR16/44	**Sefton Property Estate Partnership Group (SPEP)** This item has been postponed to May's meeting when MMcD will bring an 18 month timeline. **Action by the Committee** The Committee noted this update.	
FR16/45	**OD Implementation Plan** DF presented this report on behalf of TJ. The Committee noted that all costs were contained within the budget held by TJ, and that if there were any additional funding requirements outside of TJ's budget, then a formal request will be made, and the relevant papers completed and presented. **Action by the Committee** The Committee noted this update.	
FR16/46	**IFR Update** DS presented this report on behalf of JL, which updated and informed the CCG on the application of the IEFR Policy and activity during the Q3 reporting period October to December 2015. *PT noted a typing error in page 5 of the report, Chart 1b to read Sapre and* ***not*** *Saper.* **Action by the Committee** The Committee noted this update.	
FR16/47	**Joint CCG Audit Panel** GM presented this paper and informed the Committee that from April 2017 the CCG is responsible for the appointment of its own auditors. Knowsley CCG has asked if SSCCG is interested in a Pan Mersey type procurement, with the aim of receiving a better service. GM is to attend a joint working panel where a decision is to be made as to whether the CCG will collaborate or procure their own auditors. The outcome will be taken to Governing Body in November for formal approval. **Action by the Committee** The Committee noted this update.	
FR16/48	**Terms of Reference Governing Body** The Committee reviewed the updated Terms of Reference and noted the following changes to be made, before being passed to Governing Body for formal approval. 2.4. Replace the words "Cheshire and Mersey Commissioning Support Unit (CMSCU)" with **"the CSU"** 4.3. Remove the words "***Commissioning Plan ("One Plan")"*** 4.7. Remove the *words* ***"and One Plan"*** 4.14. Replace the words ***"****notably Cheshire and Merseyside CSU"* with *"****such as the CSU"*** Regarding 7.1, DF asked for clarity as to whether quoracy depends on one "Clinical Governing Body Member" or one "Clinical Member"; RM is to clarify with Danielle Love, Programme Lead, Community Services Procurement.	RM

No	Item	Action
	Action by the Committee The Committee approved the updated Terms of Reference subject to the changes detailed above. Also, the Committee recommended and approved that SL become a full Committee Member.	
FR16/49	**Any Other Business** The Committee noted that Paul Thomas' membership of the Finance and Resource Committee will cease following today's meeting. The Chair and Committee therefore took this opportunity to thank Paul formally for his support and contribution to the CCG since its establishment, and offered their best wishes for the future.	
FR16/50	**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 19th May 2016 1.00pm to 3.00pm 3rd Floor Board Room, Merton House	

NHS
South Sefton
Clinical Commissioning Group

Quality Committee - External Minutes

Date: Thursday, 18th February 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		
Anne Dunne	Designated Nurse, CCG Safeguarding Service	AD
James Hester	Programme Manager – Quality	JH
Apologies		
Dr Dan McDowell	Secondary Care Doctor	DMcD
Helen Roberts	Senior Pharmacist	HR
Observing		
Dan Wise	F2 Doctor	
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	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	√	√	√	√	A	
Martin McDowell	Chief Finance Officer	√	√			A	A	√	√	√	√	√	
Sharon McGibbon	Practice Manager / Governing Body Member	A	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
16/015	**Apologies for Absence** Apologies for absence were received from Dr DMcD and HR. The Chair introduced F2 Doctor Dan Wise who was attending as an observer.	
16/016	**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.	
16/017	**Minutes of the previous meeting and Key Issues Log** The minutes of 21st January 2016 were accepted as an accurate reflection of the meeting subject to the following amendments detailed below: Matters Arising / Action Tracker 15/097(ii) Audit of Cold chain management in GP Practices – wording in Minutes to be amended to read…' *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'…* 15/119 Freedom to Speak Up – wording to be amended to read… 'to raise a concern about their immediate *Manager* with the policy writers' … 16/005 CCG Safeguarding Service Quarterly Report – Child Sexual Exploitation – Action after 2nd paragraph -16/005(vi) - to be added to Action Tracker for response at March meeting. 16/007 NHS England Action Plan for Cold Chain Management in GP Practices – Action (ii) to read: '*BP* requested to compile'… 16/009 Serious Incident Report – Final paragraph and Action (iii) to be recorded under heading of *Mersey Care Provider Trust*	
16/018	**Matters Arising / Action Tracker** **15/084(iii) Safeguarding Service Update Report** – Accountability Framework included within Safeguarding Update on today's agenda. **Action: Action complete – remove from tracker.** **15/101 CCG Safeguarding Peer Review Action Plan (v8)** – A report on CCG Safeguarding Peer Review Action Plan (V9) is included on today's agenda. **Action: Action complete – remove from tracker.** **15/119 Freedom to Speak Up** – BP confirmed the comments made by the Committee on this policy had been fed back to Adam Burgess who will discuss with the report writers and present the revised policy to the Committee in April 2016. **Action: Action complete – remove from tracker.** **15/131(i) Safeguarding Children & Vulnerable Adults Policy 2015 (Incorporating Safeguarding and Mental Capacity Act Standards for Commissioned Services** – This action has now been completed. **Action: Action complete – remove from tracker.** **15/131(iv) Safeguarding Children & Vulnerable Adults Policy 2015 (Incorporating Safeguarding and Mental Capacity Act Standards for Commissioned Services** – This action has now been completed. **Action: Policy has been submitted to the Governing Body. Action complete – remove from tracker.**	

	15/138 Locality Update (Respiratory Programme Report) – A report is included on today's agenda. **Action: Action complete – remove from tracker.** **16/004 (Originally 15/116) Ensuring the Effectiveness of the Process for Review of Previously Unassessed Periods of Care –** Discussion has now taken place at the CQPG. **Action: Action complete – remove from tracker.** **16/005(v) CCG Safeguarding Service Quarterly Report –** GH confirmed that she had now received a copy of the Learning Disability CQUIN. **Action: Action complete – remove from tracker.**	
16/019	**CCG Safeguarding Service Update** <u>CCG Quality Assurance Template and Process</u> AD presented the report and highlighted the NHS England (NHSE) CCG Quality Assurance Template and Process. The CCG needs to send the completed template to NHSE by 23rd April 2016 for review on April 28th 2016. DF requested that a position document be presented to the Quality Committee prior to submission and that the Assurance Template and Process be sent to NHSE via the usual single point process that is in place within the CCG. Following discussion of issues raised by AD in relation to governance and timescales in relation to the submission, DF requested that an overarching exception report of the Assurance Template and Process be prepared and presented when the Quality Committee meet on 20th April 2016 prior to submitting the full report to NHSE. In addition to the exception report, the CCG Safeguarding Service will also be meeting with the CCG Chief Nurse / Deputy Chief Nurse to discuss the submission prior to being sent to NHSE. **Action: AD is to submit an overarching exception report of the Assurance Template and Process to the Quality Committee meeting to be held on 20th April 2016.** <u>Joint Targeted Area Inspections</u> The Committee were advised of the new national Joint Targeted Area Inspections which were launched from 1st February 2016, the first of which commenced 2 weeks ago with a total of 6 to take place throughout the year. The inspection will include a deep dive into Child Sexual Exploitation. AD advised that meetings with members of the LA had already taken place to discuss the local process and management in readiness for inspection. <u>Section 11 Action Plan Update</u> An update on the report presented to the Quality Committee in December 2015 was provided. AD confirmed that the Safeguarding Policy was now accessible on the CCG intranet with further work underway with the Communications Team to further develop the Safeguarding page on the CCG intranet. AD referred to on-going work around the Induction process with some work delayed due to capacity within the HR service. DF stated that the Safeguarding Service needed to escalate to the CCG Senior Management Team if they required support in expediting the input of the HR team with regard to the induction process. <u>Care Homes</u> Discussion took place in relation to the risks associated with the level of supervision of care workers within Domiciliary Care Providers. DF clarified that both SS and S&F CCGs have put a process into action around performance monitoring and contracts following an incident which occurred in December 2015. A paper around governance had also recently been submitted to the Leadership Team. The CHIP programme also helps support improving quality in Care Homes, including safeguarding. PC suggested that the CCG Safeguarding Service attend a meeting	**AD**

	of the CHIP Quality Improvement Collaborative. GH voiced concerns around care workers directly employed by a patient with regard to infection control training for those in receipt of Direct Payments and for those who may have a Personal Health Budget (PHB). BP explained CCG policy recommends an independent third party takes on employer status for patients in receipt of a PHB. The third party would be responsible in providing assurance on the employee being competent to undertake the role of care provider. This is not compulsory and if the patient chooses to undertake employer status the CCG would have to seek assurance from the patient on employee competencies being able to meet the health needs of the patient safely and effectively. <u>Safeguarding Service Update</u> AD advised the Committee that a Designated Nurse from the children's team had now left the service on a fixed term secondment with NHSE. Recruitment for a replacement had subsequently taken place. The Safeguarding Team were currently analysing Q3 data. AD said that although progress had been made, some issues still required further action in relation to the timeliness of assessments for LAC. DF stated she will discuss further with the Designated Nurse for Looked After Children and arrange a further meeting with local partners. **Action: DF to discuss Looked After Children (LAC) reviews further with the Designated Nurse for LAC and arrange a further meeting with local partners.**	**DF**
	The Committee received the report noting the Safeguarding Services engagement in the Safeguarding Children and Adult agenda	
16/020	**CCG Safeguarding Peer Review Action Plan (v9)** DF presented the Quality Committee with the updated CCG Safeguarding Peer Review Action Plan (v9) advising that positive progress has been made against the one remaining AMBER action with regard to supervision for the CCG Safeguarding Service. DF stated that there were various mechanisms in place to support on-going assurance which include: • CCG Safeguarding Network Steering Group – via MoU and KPIs for the service • MIAA – Safeguarding review as part of the annual workplan • LSCB – Section 11 Audit • NHSE – CCG Safeguarding Assurance Tool The Quality Committee were asked to receive the report and recommend presentation to the Governing Body for closure due to the CCG Scheme of delegation and reservation. The Committee supported the recommendation.	
	The Committee received the report and recommended the CCG Safeguarding Peer Review Action Plan presentation to the Governing Body for closure due to the CCG Scheme of delegation and reservation	
16/021	**CCG Looked After Children Strategy** AD presented this report on behalf of CF which provided 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. The strategy has been developed in accordance with current legislation and guidance published in 2015 with the content used to inform the latest KPIs. GH agreed with the aspiration but expressed some reservations in relation to the timeframes for delivery as outlined the strategy. It was acknowledged that certain aspects of delivery against the strategy will require multi-agency working locally. Following discussion by the Quality Committee (QC), DF clarified that the QC were	

	not being asked to approve the strategy due to the Scheme of Reservation and Delegation but to recommend approval to the Governing Body. DF suggested a meeting was arranged with Dwayne Johnson DCS in the LA to highlight the conversation and support the commitment to multi-agency working and integrated commissioning in order to support delivery as required. Following the meeting the policy should be brought back to the QC in March 2016 in order to discuss recommendation to the Governing Body. **Action: DF is to meet with Dwayne Johnson and the Safeguarding service to advise of the discussion and bring back the LAC Strategy to the March 2016 meeting.** PC spoke about quality assurance and what else could be done and suggested more discussion needed to take place outside of this meeting. It was suggested that Dr Wendy Hewitt be invited to the meeting that needed to take place. AD happy to support such discussion but stressed the strategy was based on national guidance and was a requirement for the CCG. **Action: Wendy Hewitt is to be invited to join the meeting to be arranged with the Safeguarding Service re: Looked After Children.**	**DF** **DF**
	The LAC Strategy is to be re-presented to the Committee at the March 2016 meeting following the proposed meeting with the DCS in the local authority.	
16/022	**Governing Body Assurance Framework & Corporate Risk Register** TJ presented the Quality Committee with the updated CCG Corporate Risk Register (CRR) as at December 2015 and the Quarter 3 (end December 2015) Governing Body (GB) Assurance Framework (GBAF) for appropriate review and scrutiny. Due to the scheduling of meetings, it was noted that these had been presented directly to the Governing Body in January 2016 without being presented to the Quality Committee. The areas discussed at GB in January 2016 had now been updated within the register with changes highlighted. <u>GBAF Highlights</u> 4.2 Risk: Current provider unable to deliver community service as specified by the CCG – GH discussed the positive work the Community Matron had been undertaking and the issues that were becoming apparent regarding establishment. SA understood this issue had been resolved following discussion by CMs at the CQPG last week. The QC discussed the recommendation for the rating with assurance to be sought by SA from LCH and an update provided to GH. **Action: SA to seek assurances from LCH and will update GH.** The risk rating for STA038 (LAC Health Assessments) was discussed and the Committee challenged whether it could be reduced due to some positive progress being made across the system. DF stated that she would take the view of the committee on board and use the next scheduled meeting with the Safeguarding Service to gain a comprehensive update and update the risk accordingly. **Action: STA 038 (LAC Health Assessments) risk rating can be recommended to be reduced and this will be actioned by DF.**	**SA** **DF**
	The Committee received the report and asked for further clarification around GBAF Highlight 4.2 which it was considered should be reduced. The Committee also recommended the reduction of the risk rating against STA038	
16/023	**Corporate Governance Support Group Key Issues Report** JH presented a summary of the notes taken from a meeting held on 7th January 2016. The Committee noted that the updated Whistleblowing policy had been presented by Adam Burgess and would be brought to Quality Committee in April 2016, following review by the Staff Partnership Forum.	

	The Committee received the verbal report	
16/024	**Respiratory Programme Report** JK, Respiratory Programme Lead for the CCG, presented a report to the Committee which shared the work from the recently commissioned Respiratory Scheme which had included case. The findings were presented at SMT on 10th November 2015 and it was agreed that the Respiratory Programme Manager would provide an update to the Quality Committee on what is being put in place to improve outcomes for patients as a result of this programme of work. The CCG Respiratory Programme Lead, Lead GP and key partners are developing an on-going training plan for primary care and a locality based proactive care model that will ensure patients receive a post hospital review and case finding is part of the future care process. This is planned to be presented at the March 2016 QIPP Committee. The QC were pleased to hear about the outcomes of this piece of work.	
	The Committee received the report	
16/025	**Quality Committee Workplan 2016/17** JH confirmed that the proposed dates for joint internal Committee meetings with Southport & Formby CCG had now been approved by both CCGs with VT to send out calendar invites to meetings for 2016/17 over the next couple of weeks. Members were asked to note the venue and timings of the Away Day to be held on 23rd June 2016 which should read that the meeting will be held 'All Day'. The Workplan for 2016/17 and revised Meeting schedule will be sent out to all Committee Members after this meeting. **Action: JH to circulate copies of proposed Workplan to Committee members.**	**JH**
	The Committee received the report	
16/026	**Performance Letter to NW CCG Accountable Officers re NHS111** AM informed the Committee of a recent letter received by the CCG confirming that a contract query had been raised re: NHS111. The QC considered it appropriate for the lead commissioners to manage through the contract query.	
	The Committee received the verbal report	
16/027	**EPEG Key Issue Log** RD presented a verbal summary of the Key Issues discussed at the recent EPEG meeting: • Issues with Southport and Ormskirk's challenging performance regarding Family and Friends Test results continue to be escalated to Quality Committee • Healthwatch Sefton have been asked to contact practice managers directly to discuss queries with their patient experience reports resulting from Seaforth and Litherland practice reviews, prior to the publication of individual practice reports • NHS England are to give an update to the Sefton Council's Consultation and Engagement Standards Panel about its consultation on Litherland Darzi • Healthwatch are to share LCH's action plan for podiatry services at the next meeting • EPEG have requested that they be kept updated about Sefton Council's review of the VCF sector, as well as the restructure of the Health and Wellbeing Board including any changes in areas of responsibility of the new forums (particularly in relation to transport issues following earlier discussions at EPEG) • A future meeting of EPEG is to be organised to focus on activities amongst	

	partners to improve engagement with children and young people with an agenda to be shaped and informed by young advisers • Feedback from Sefton CVS concerning long waits for physiotherapy and mobility aids is to be escalated to commissioning leads • The CCG is to give consideration on how Dementia Friends training can be further rolled out amongst their staff • EPEG is to be kept appraised of the community services exercise, with partners asked to suggest additional meetings / forums that could be included on the engagement timetable. Equality impact assessments for both CCGs are to be shared at the February meeting. An overview is to be provided to both the Healthwatch Steering Group and Sefton Council's Consultation and Engagement Standards Panel	
	The Committee received the verbal report	
16/028	**Locality Update** SA felt all items had been discussed throughout the meeting with Physiotherapy, Community Matrons and SALT all known issues. AM considered the CCG should make it clear that staff absence within providers is not an excuse for deterioration in service. DF stated that staffing is a regular agenda item at the regular provider contract meeting.	
	The Committee received the verbal update	
16/029	**GP Quality Lead Report** The CQPG at Aintree University Hospital FT was not held this month due to the strike by Junior Doctors.	
	The Committee received the verbal report	
16/030	**Key Issues Log** • CCG Safeguarding Peer Review Action Plan • NHSE CCG Safeguarding Assurance Process • CCG Looked After Children Strategy • Review of CRR/GBF • Respiratory programme • NHS111	
16/031	**Any Other Business** GH thanked RD for his work with the Quality Committee and the health services noting that this was his final meeting. • CHC Programme Board DF advised the Committee of the establishment of a new CHC Programme Board (PB) for SSCCG, S&FCCG, LCCG and the new Commissioning Support Unit (CSU) provider with an initial meeting to discuss the remit of the PB to be held later today. It is anticipated the first meeting of the PB will take place on 29th February 2016.	
16/032	**Date of Next Meeting** Thursday 24th March 2016 at 3 pm – 5 pm 3rd Floor Board Room - Merton House, Stanley Road, Bootle.	

NHS
South Sefton
Clinical Commissioning Group

Quality Committee - External Minutes

Date: Thursday, 24th March 2016 3 pm – 5 pm
Venue: 3rd Floor Board Room, Merton House, Stanley Road, Bootle.

Membership		
Dr Gina Halstead	Chair & GP Governing Body Member	GH
Steve Astles	Head of CCG Development	SA
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	PC
Malcolm Cunningham	Head of Contracting & Procurement	MC
Debbie Fagan	Chief Nurse & Quality Officer	DF
Martin McDowell	Chief Finance Officer	MMcD
Dr Dan McDowell	Secondary Care Doctor	DMcD
Dr Andy Mimnagh	GP Governing Body Member	AM
Ex Officio Member		
Fiona Taylor	Chief Officer	FT
In attendance		
Julie Cummins	Clinical Quality & Performance Co-ordinator	JC
Helen Roberts	Senior Pharmacist	HR
Jo Simpson	Quality & Performance Manager	JS
Helen Smith	Head of Safeguarding Adults	HS
Apologies		
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	PC
Malcolm Cunningham	Head of Primary Care & Contracting	MC
Dr Dan McDowell	Secondary Care Doctor	DMcD
Dr Andy Mimnagh	GP Governing Body Member	AM
Minutes		
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	√	A
Malcolm Cunningham	Head of Contract and Procurement	√	√			A	A	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	√	√	√	√	A	A
Martin McDowell	Chief Finance Officer	√	√			A	A	√	√	√	√	√	√
Sharon McGibbon	Practice Manager / Governing Body Member	A	A			√	A	A	A	A	A	A	
Dr Andrew Mimnagh	Clinical Governing Body Member	√	√			√	√	√	A	√	√	√	A
Dr Craig Gillespie	Chair and Governing Body Member to April	√											

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

No.	Item	Action by
16/033	**Apologies for Absence** Apologies for absence were received from Dr PC, MC, DMcD and AM.	
16/034	**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.	
16/035	**Minutes of the previous meeting and Key Issues Log** The minutes of 18th February 2016 were approved subject to amendment to: 16/019 CCG Safeguarding Service Update paragraph 6 on page 6 of the Minutes which now reads: *BP explained CCG policy recommends an independent third party takes on employer status for patients in receipt of a PHB. The third party would be responsible in providing assurance on the employee being competent to undertake the role of care provider. This is not compulsory and if the patient chooses to undertake employer status the CCG would have to seek assurance from the patient on employee competencies being able to meet the health needs of the patient safely and effectively.*	
16/036	**Matters Arising / Action Tracker** **15/134(i) Provider Quality Reports (inc NHS111)** *Alder Hey Hospital Foundation Trust (AHHFT)* GA requested a one month extension to this action in order to forward the appropriate examples to JS. **Action: Action extended for one month** **16/005(iii) CCG Safeguarding Service Quarterly Report** *Alder Hey Children's Hospital Trust* The Committee were advised that this action had now been discussed with a briefing paper presented to the Collaborative Forum. **Action: Action closed – to be removed from the tracker** **16/005(vi) CCG Safeguarding Service Quarterly Report - *Child Sexual Exploitation Update*** HS confirmed AD has received a satisfactory response in relation to the cases discussed at the MACSE meetings. **Action: Action closed – to be removed from the tracker** **16/007(i) NHS ENGLAND Action Plan for Cold Chain Management in GP Practices** An updated report was included in today's agenda. **Action: Action closed – to be removed from the tracker** **16/008(i) Provider Quality Reports** *Aintree University Hospital FT* JS confirmed to the Committee that the information within the report had been recorded incorrectly. **Action: Action closed – to be removed from the tracker** **16/008(ii) Provider Quality Reports** *Aintree University Hospital FT* JS confirmed that 12 appeals had been upheld by RLBUHT in comparison with 16 at AUHT. However it was acknowledged that the Aintree Appeals Panel had been	**GH/JS**

	in existence for a longer period of time. **Action: Action closed – to be removed from the tracker** **16/008(iii) Provider Quality Reports** *Mersey Care Provider Trust* JS received confirmation from GJ that the procedures are under review. The Committee agreed to extend the action until May to enable the revised version of the Care Pathway/Operation Procedures for the Clockview site to be circulated to Committee members. **Action: Action extended until May 2016** **16/008 (iv) Provider Quality Reports** *LCH* SA advised that LCH had confirmed that District Nurses were up to capacity in Sefton with recruitment of Community Matrons underway. SA to investigate claims that Care Home Matrons do not work on Wednesdays and confirm outcome to the Committee in May. **Action: Action extended until May 2016** **16/009(i) Serious Incident Report** *Aintree University Hospital FT* On behalf of BP, JS advised the Committee that a process in relation to the submission of RCA reports had now been agreed with Knowsley CCG. **Action: Action closed – to be removed from the tracker** **16/009(ii) Serious Incident Report** *Liverpool Community Health NHS Trust* On behalf of JH, JS confirmed that regular monthly meetings had now been set up with LCH and a full stand-alone report would be received in May. **Action: Action closed – to be removed from the tracker** **16/009(iii) Serious Incident Report** An invitation has been extended to Dr Sue Gough to attend SI meetings. **Action: Action closed – to be removed from the tracker** **16/019 CCG Safeguarding Service Update** DF confirmed she had now met with the Designated Nurse for LAC. A follow up meeting to the Lessons Learnt event chaired by DF in the summer of 2015 has been arranged for 31st March 2016 with representatives from LCH and the LA invited to attend. **Action: Action closed – to be removed from the tracker** **16/021(i) CCG Looked After Children Strategy** A process for quality assurance of reviews undertaken on children placed outside of area has been agreed. No SLAs will be signed with other providers. **Action: Action closed – to be removed from the tracker** **16/021(ii) CCG Looked After Children Strategy** Graham John son (LA) confirmed to DF during a recent meeting that he had not seen the LAC Strategy which resulted in feedback not being submitted by the requested deadline. The Strategy will be scheduled in the Quality Committee's Workplan to ensure it is reviewed regularly, with an action plan brought back to the QC following approval by Governing Body. **Action: Action closed – to be removed from the tracker** **16/022(i) Governing Body Assurance Framework & Corporate Risk Register** *GBAF Highlights*	**JS** **SA**

	Action discussed under 16/008 (iv) above and will now be merged with this action. **Action: Action closed – to be removed from the tracker** **16/022(ii) Governing Body Assurance Framework & Corporate Risk Register** *GBAF Highlights* DF confirmed the risk has now been updated. **Action: Action closed – to be removed from the tracker** **16/025 Quality Committee Workplan 2016/17** The Workplan will be circulated to Committee members shortly. **Action: Action closed – to be removed from the tracker**	
16/037	**CCG Safeguarding Service Update (Q3)** HS presented the report to the Committee which contained information on the following: • Q3 2015/16 provider performance – level of assurance • Update on child sexual exploitation • Update on the on-going Domestic Homicide Review • Care Homes <u>Q3 2015/16 provider performance – level of assurance</u> Aintree University Hospital – The Trust remains on reasonable assurance for adults and children although it was noted they are performing slightly below compliance of children's Level 1 and 2 training with plans to address due to be submitted for Q4 2015/16. Liverpool Community Health NHS Trust – The Trust have a level of 'reasonable assurance' against the Safeguarding Children and Adult KPIs / Quality Schedule overall and 'significant assurance' in relation to Safeguarding Adults. However, the Trust have 'limited assurance' in relation to Looked After Children although an improving picture is reported for initial health assessments and there is a static picture reported for review health assessments in Q2 and Q3 2015/16. DF reported that this is on the CCG Risk Register and provided information on the actions being taken by the CCG including the follow-up Lessons Learnt Event planned for 31st March 2016. Alder Hey Children's NHS Foundation Trust – The Trust remain on reasonable assurance overall, with significant improvements being seen in relation to safeguarding adults training. Although the Trust has demonstrated significant progress with compliance for Level 3 safeguarding children training, the contract performance notice remains in place. HS confirmed that The Trust is keen for the contract performance notice to be removed once training compliant. Royal Liverpool and Broadgreen University Hospital Trust – Reasonable assurance is demonstrated from the data submitted. Liverpool Heart & Chest Hospital Trust – The Trust remains on reasonable assurance however training compliance re the Mental Capacity Act has reduced with a plan requested for Q4 2015/16. Liverpool Women's NHS Foundation Trust – The Trust have progressed to reasonable assurance overall for both Safeguarding Children and Adults with performance considered to be on an upward trajectory. MerseyCare – The Trust remains on reasonable assurance. Non submission of DoLS for Q3 2015/16 an issue. DF advised the Committee that she has raised her concerns in relation to the non-submission of DoLs data for Q3 2015/16 with the	

	Director of Nursing. Sue Norbury confirmed that the Trust had now confirmed that the data was available but not submitted due to an administration error. Southport & Ormskirk Hospitals NHS Trust – The Trust remain on limited assurance although it was noted that there had been evidence of some improvement in relation to Policies and activity data systems to capture referral and performance information. Safeguarding Adults training remains a concern along with the timelines for trajectories for completion of training. DF stated that the Contract Query remains in place, a letter has been sent to the Trust from the Collaborative Commissioning Forum detailing commissioners concerns and this was raised as part of the recent Single Item Quality Surveillance Group Chaired by NHSE. <u>2016/17 Safeguarding Quality Standards</u> The work in relation to the 2016/17 Safeguarding Quality Standards is nearing completion. <u>Domestic Homicide Reviews (DHR)</u> A report on DHR6 will follow completion of court case. The Committee also received brief updates on: • Care Homes • Lampard Enquiry • Safeguarding Children Awareness Audit • MCA/DoLS	
	The Committee received and noted the content of the report	
16/038	**CCG Looked After Children Strategy** The Committee considered this agenda item had been sufficiently discussed during agenda item 16/037.	
	The Committee received the verbal report	
16/039	**Continuing Healthcare/ Complex Care Services** **Quality & Performance Quarter 3 Updates for South Sefton CCG** JC presented the Care Home Quality report. It was reported that the number of Nursing Homes now submitting CQUIN information had increased. The Quality Committee noted the updated guidance and home by home information provided with regard to: • Clinical Quality activity • Care Quality Commissioning (CQC) status • Aspects of Safeguarding Activity • Submission of CQUIN information • Clinical Quality Activity and Integrated Practice DF commented on the actions taken by the CQC which had resulted in a loss of 93 beds since October 2015. The Committee recognised the impact on the workloads of CCG teams such as the Quality Team, Medicines Management and CSU. The CCG has also recently invested in the appointment of a Head of Vulnerable People whose support has been of significant benefit. The issue re: quality in care homes / care home closures has also been escalated to NHS England as this is not unique to the Sefton area. The Committee also noted the impact that the implementation of the living wage may have on Care Homes.	
	The Committee received and considered the report	
16/040	**NHS ENGLAND Revised Action Plan for Cold Chain Management in GP Practices** The Committee received the report acknowledging the addition of a Status column	

	within the Action Plan.	
	The Committee received the report	
16/041	**CQUINs and Quality Schedules and current positions for 2016/17** JS provided the Committee with a verbal update on the progression of CQUINs and Quality Schedules for 2016/17. The Committee noted the slight delay experienced with Aintree KPIs and the proposed new local and national CQUINs. JS advised that Mersey Care have taken on a Super CQUIN on Primary Care Liaison. LCH CQUINs include Care Planning and Admission Avoidance with a Band 7 nurse to be placed at AUHT's A&E site.	
	The Committee received the verbal report	
16/042	**Provider Quality Reports** JS presented the provider Quality Performance Report by exception. <u>Aintree University Hospital</u> Issues have been reported in relation to the Cancer 62 day wait. System issues highlight with the requirement for greater scrutiny and escalation of histology delays and a continued focus on administration processes. GH also shared plans to have The Trust take a more proactive stance with patients to ensure they attend appointments within the 62 day pathway. Stroke performance was discussed and the Trust's failure to meet the indicator of % of stroke patients spending more than 90% of their hospital stay on a stroke unit. The impact on pressures within the Trust in terms of flow were discussed. Patient Reported Outcome Measures (PROMs) are unlikely to be achieved. The impact caused by the cancellation of patient operations and the possibility that such patients were being targeted for feedback was noted. A&E Indicators suggest the Trust is failing in this area. Two 12 hour trolley breaches were reported 5-6 weeks ago with BP and Jane Lunt of LCCG liaising to gain assurances regarding the quality of care received. The Committee considered the comments recorded against MRSA Screening were out of date and should be replaced with more timely data. <u>Mersey Care</u> Changes to the data capture system have led to improvements against Every Contact Counts. Proportion of adults on Care Programme Approach receiving secondary mental health services in settled accommodation by CCG – Mersey Care need to work with 3rd party providers to comply with this KPI, JS will raise this with the Trust at the next CQPG. Referral to Treatment - Psychotherapy – A business case is being submitted for three additional therapists for this service which has been underperforming throughout the year. Falls – presentation coming to next CQPG as requested by the CCG GP Clinical Lead for Mental Health at February 2016 CQPG.	

	Liverpool Community Health NHS Trust SA considered more could be done within the providers to bring about improvements in relation to delayed discharges from Ward 35. DF said Staff Sickness had been discussed at the recent CQPG with the triangulation of sickness absence and harms discussed – the Trust reported that this was more visible to the localities and contained within the locality performance reports due to the changing model of operation. An overview of the performance of other Liverpool providers was noted. CAMHs waiting times were raised and the difficulty experienced in obtaining accurate data. JS trying to obtain information for April 2016. **Action: GH is to email Locality Leads to ascertain whether there are any issues with delays around CAMHS.** HS asked whether any impact from the Junior Doctors strike days had been reported. JS stated that any impact on performance would be captured in the appropriate Q4 2015/16 reports.	**GH**
	The Committee received the report	
16/043	**Serious Incident Report** GH welcomed the inclusion of the explanation of a SI. The Committee discussed the care of deteriorating patient /safeguarding issues in relation to two patients. JS and HS are to discuss how to put measurements in place. GH confirmed that actions were being taken at the Trust to prevent such incidents reoccurring.	
	The Committee received the report	
16/044	**Key Issues Log** • Safeguarding assurance report • Issues around LAC health assessment within LCH • Concerns regarding return of information on MCA/DoLS to provide assurance (MerseyCare) • Care Home challenges and resultant impact • Provider Quality performance report received and discussed	
16/045	**Administration procedures for first joint CCG Quality Committees meeting 20th April 2016** VT proposed that the March draft minutes and Actions of each Committee are presented for approval by the respective Chairs and that the Chair of the host Committee (S&F for first joint QC Committee meeting to be held on 20th April) continue to officiate the meeting on behalf of both CCGs.	
16/046	**Any Other Business** 1. Merseyside Feedback October 15 LEVEL 4 HPFs – This was deferred as AM was not in attendance 2. Minutes of NWAS/NHS111 – AM Move to May as AM not present 3. LCH CQC Inspection – The CQC Report is still awaited. This was discussed at the last CQPG and the Trust DoN reported some positive initial feedback from the CQC. The Capsticks report was in the public domain 4. S&O Single Item Quality Surveillance Group Meeting – no further meetings due to CQC inspection in April 2016. Quality Summit meeting will be held post inspection. 5. S&O CQC announced inspection will commence on 12th April 2016	

	6. AQUa quarterly mortality report at Aintree considers mortality falling at Aintree. Some interesting statistics within report. GH has emailed AQuA to present on the report regarding the Trust. RCoding discussed.	
	Date of Next Meeting Wednesday 20th April 2016 – To be held jointly with S&F CCG Quality Committee Members 11.30 am – 1.30 pm Family Life Centre, Ash street, Southport, PR8 6JH	

NHS
South Sefton
Clinical Commissioning Group

Audit Committee
Minutes

Thursday 14th January 2016, 1.00pm to 2.30pm
3rd Floor Board Room, Merton House

Attendees		
Graham Morris	Lay Member (Chair)	GM
Dr Dan McDowell	Secondary Care Doctor	DMcD
Martin McDowell	Chief Finance Officer	MMcD
Debbie Fagan	Chief Nurse & Quality Officer	DFa
Adrian Poll	Senior Audit Manager, MIAA	AP
Michelle Moss	Local Counter Fraud Specialist, MIAA	MM
Amanda Latham	Audit Director, KPMG	AL
Jerri Lewis	Audit Manager, KPMG	JL
Roger Driver	Lay Member	RD
David Smith	Deputy Chief Finance Officer	DS
Leah Robinson	Chief Accountant	LR
Apologies		
Tracy Jeffes	Head of Corporate Delivery and Integration	TJ
Roger Causer	Senior Local Counter Fraud Specialist, MIAA	RC
Jillian Burrows	Audit Senior Manager, KPMG	JB
Minutes		
Ruth Moynihan	PA to Chief Finance Officer	RM

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

Name	Membership	Jan 16	April 16	May 16	July 16	Oct 16	Jan 17
Graham Morris	Lay Member (Chair)	✓					
Roger Driver	Lay Member	✓					
Dan McDowell	Secondary Care Doctor	✓					
Martin McDowell	Chief Finance Officer	✓					
Debbie Fagan	Chief Nurse & Quality Officer	✓					
David Smith	Deputy Chief Finance Officer	✓					
Tracy Jeffes	Head of Corporate Delivery and Integration	A					
Leah Robinson	Chief Accountant	✓					
Debbie Fairclough	Head of Client Relations, CMCSU	N					
Roger Causer	Senior Local Counter Fraud Specialist, MIAA	A					
Michelle Moss	Local Counter Fraud Specialist, MIAA	✓					
Adrian Poll	Audit Manager, MIAA	✓					
Ann Ellis	Audit Manager, MIAA	N					
Amanda Latham	Audit Director, KPMG	✓					
Jillian Burrows	Audit Senior Manager	A					

No	Item	Action
A16/01	**Apologies for absence** Apologies for absence were received from Tracy Jeffes, Roger Causer and Jillian Burrows.	
A16/02	**Declarations of interest** Declarations of interest were received from CCG officers who hold dual posts in both South Sefton CCG and Southport and Formby CCG.	
A16/03	**Advance notice of items of other business** The Chair had not been advised of any items of other business.	
A16/04	**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.	
A16/05	**Action points from previous meeting** ***A15/71 Internal Audit Progress Report*** – MM confirmed final report has now been approved by MMcD and issued, with all follow up actions complete. ***A15/78 Recommendations Tracker*** – see agenda item A16/13. ***A15/79 Whistle Blowing Policy Review*** – as this policy is not going to Quality Committee until next week, this action has been delayed and DS will email policy to Committee Members in due course.	DS
A16/06	**Correspondence** MMcD brought to the Committee's attention a letter from NHSE regarding "Planning for Commencement of the Local Audit Arrangements". He informed the Committee that an auditor appointment panel is being explored which may involve other CCGs. He advised that a final decision was required by 31st December 2016 and that the CCG was required to put a plan in place. The Committee noted that Audit Chairs, from both Wirral and Merseyside, are being invited to meet to consider this paper, with a scheduled date for 9th March.	
A16/07	**Review of Losses and Special Payments** DS presented this report and advised that there had been no losses or special payments made in the period since the last Audit Committee. **Action by the Committee** The Committee received this report by way of assurance.	
A16/08	**Internal Audit Progress Report** AP presented this report which provided an update to the Audit Committee in respect of the assurances, key issues and progress against the Internal Audit Plan for 2015/16. **Action by the Committee** The Committee received this report by way of assurance.	
A16/09	**Internal Audit Counter Fraud Progress Report** MM presented this report which detailed the work undertaken during the period September 2015 to December 2015, highlighting activities and outcomes. **Action by the Committee** The Committee received this report by way of assurance.	

No	Item	Action
A16/10	**External Audit Plan** The following reports were presented to the Committee: • Summary of financial and VFM areas of focus for the 2015/16 audit • The new NAO VFM approach • Appointing your external auditor – NHS briefing AL informed the Committee that KPMG are in the process of developing the full plan which will be reported to a future Committee. **Action by the Committee** The Committee received this report by way of assurance.	
A16/11	**Macpherson Report** DS presented this report which provided a review of estimation techniques against the Macpherson review. MMcD informed the Committee that this review will be included in the Annual Governance Statement. **Action by the Committee** The Committee received this report by way of assurance.	
A16/12	**Review of NFI Matches** To be discussed in agenda item A16/13.	
A16/13	**Audit Committee Recommendations Tracker** DS presented this tracker which summarised the various recommendations that have been presented to the Audit Committee over the past 12 months. The Committee noted the NFI matches shown on this tracker, and DS advised that the CCG was working closely with its LCFS on this matter. GM suggested that the Review owner column of the tracker should state the job role rather than the individual's name, and DS is to update the tracker for the next presentation. MMcD referred to the IG Framework Review within the tracker. He informed the Committee that the IG Toolkit framework will need to be reviewed and submitted by 31st March 2016. As the Committee will not meet again until 21st April, he sought delegated authority from the Committee for both himself and GM to sign-off on behalf of the CCG once the content is agreed. RM to arrange for MMcD and GM to meet with Suzanne Crutchley, Senior Governance Manager, before the end of this month to outline the plan. **Action by the Committee** The Committee received this report by way of assurance, and delegated approval to MMcD and GM to sign-off the IG Toolkit submission, and report results back.	DS MMcD/GM RM
A16/14	**Committee Work Schedule 2016/17** The Committee received the work schedule for 2016/17 and noted the following additions to be made: • MIAA Anti-Fraud Services Annual Report to be presented at April meeting. • Counter Fraud Plan to be presented at April meeting.	RM
A16/15	**Committee Meeting Dates 2016/17** The Committee received the meeting dates for 2016/17 and noted that the final accounts need to be in by Friday 27th May 2016. GM asked Committee Members to advise RM if they are unable to attend future meetings in advance of the meeting, so that any quoracy issues can be dealt with in a timely manner.	

No	Item	Action
A16/16	**Key Issues of other Committees** The following Key Issues reports were received by the Committee: • Finance and Resource: September, October and November 2015 • Quality Committee: September, October and November 2015 **Action by the Committee** The Committee noted the contents therein.	
A16/17	**Any other business** **1. Practice Manager** The Committee noted there is currently no Practice Manager in situ at SSCCG. MMcD informed the Committee that Sharon McGibbon, who was the main representative, has resigned, and that Tanya Mulvey has also resigned from her post in practice. The Chair and Committee took this opportunity to thank both Sharon and Tanya formally for their support and contribution to SSCCG. **2. Roger Driver** The Committee was informed that Roger Driver's membership of the Audit Committee will cease following today's meeting. The Chair and Committee therefore took this opportunity to thank Roger formally for his support and contribution to South Sefton CCG since it was established, and the Chair also added his sincere personal thanks to Roger.	
A16/18	**Key Issues Review** MMcD highlighted the key issues from the meeting and these will be circulated as a Key Issues Report to Governing Body.	
	Date and time of next meeting Thursday, 21st April 2016 1.00pm to 2.30pm 3rd Floor Board Room, Merton House	