NHS
South Sefton
Clinical Commissioning Group

Agenda

Governing Body Meeting in Public
Agenda

Date: Thursday 26th January 2017, 13:00 to 15:15 hrs
Venue: Boardroom, 3rd Floor, Merton House, Bootle, L20 3DL

PLEASE NOTE: we are committed to using our resources effectively, with as much as possible spent on patient care so sandwiches will no longer be provided at CCG meetings.

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
Lin Bennett	Practice Manager & Governing Body Member	LB
Mr Graham Bayliss	Lay Member, Patient & Public Involvement	GB
Dr Peter Chamberlain	GP Clinical Director & Governing Body Member	PC
Debbie Fagan	Chief Nurse & Quality Officer	DCF
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
Dr Sunil Sapre	GP Clinical Director & Governing Body Member	SS
Fiona Taylor	Chief Officer	FLT
Dr John Wray	GP Clinical Director & Governing Body Member	JW
In Attendance		
Charlotte Bailey	Executive Director, Sefton MBC	CB
Tracy Jeffes	Chief Delivery & Integration Officer	TJ
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Alison Ormrod	Deputy Director of Finance	AO
Judy Graves	*(Minute taker)*	JG

"Partnership Locality Model"
presentation by Charlotte Bailey, Executive Director, Sefton MBC

Quorum: Majority of voting members.

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
General					**13:30hrs**
GB17/1	Apologies for Absence	Chair	Verbal	R	3 mins

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
GB17/2	Declarations of Interest	Chair	Verbal	R	2 mins
GB17/3	Minutes of Previous Meeting	Chair	Report	A	5 mins
GB17/4	Action Points from Previous Meeting	Chair	Report	A	5 mins
GB17/5	Business Update	Chair	Verbal	R	5 mins
GB17/6	Chief Officer Report	FLT	Report	R	10 mins
Finance and Quality Performance					
GB17/7	Quality, Innovation, Productivity and Prevention (QIPP) Plan and Progress Report	MMcD	Report	R	10 mins
GB17/8	Integrated Performance Report	KMcC/ MMcD/DCF	To Follow	R	30 mins
Governance					
GB17/9	Corporate Risk Register & Governing Body Assurance Framework Update	DFair	Report	A	5 mins
Service Improvement/Strategic Delivery					
GB17/10	Making Integration Happen Strategy	TJ	Report	R	5 mins
GB17/11	Two Year Operational Plan	KMcC	Report	A	10 mins
For Information					
GB17/12	Key Issues Reports: a) Finance & Resource (F&R) Committee: October 2016 b) Quality Committee: October 2016 c) Audit Committee: July & October 2016 d) Locality Meetings: Key issues October 2016 to January 2017	Chair	Report	R	5 mins
GB17/13	F&R Committee Minutes - October 2016		Report	R	5 mins
GB17/14	Quality Committee Minutes - October 2016		Report	R	
GB17/15	Audit Committee - July and October 2016		Report	R	
GB17/16	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting*				5 mins

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
GB17/17	Date of Next Meeting **Thursday 30th March 2017, at 13:00 hrs in the Boardroom, 3rd Floor, Merton House.** <u>Future Meetings:</u> From 1st April 2017, the Governing Body meetings will be held on the first Thursday of the month rather than the last. Dates for 2017/18 are as follows: Thursday 1st June 2017 Thursday 3rd August 2017 Thursday 5th October 2017 Thursday 7th December 2017 Thursday 1st February 2018 Thursday 5th April 2018 Thursday 7th June 2018 All meetings will commence 13:00hrs and be held in the Boardroom, 3rd Floor Merton House.				-
Estimated meeting close					**15:15 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 24th November 2016, 13:00 hrs to 15:40hrs
Venue: Boardroom, 3rd Floor, Merton House, Bootle, L20 3DL

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
Lin Bennett	Practice Manager & Governing Body Member	LB
Mr Graham Bayliss	Lay Member, Patient & Public Involvement	GB
Dr Peter Chamberlain	GP Clinical Director & Governing Body Member	PC
Debbie Fagan	Chief Nurse & Quality Officer	DCF
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
Dr Sunil Sapre	GP Clinical Director & Governing Body Member	SS
Fiona Taylor	Chief Officer	FLT
Dr John Wray	GP Clinical Director & Governing Body Member	JW
In Attendance		
Anne Dunne	Head of Safeguarding Children	AD
Davina Hanlon	Consultant in Public Health	DH
Tracy Jeffes	Chief Delivery & Integration Officer	TJ
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Helen Smith	Head of Safeguarding Adults	HS
Judy Graves	*(Minute taker)*	JG

No	Item	Action
Public	**Questions from the Public** **1. Joan Carton asked if there is a way GPs could standardise information around dementia care and give this out to families and inform carers so roles are clearly defined.** FLT explained that standard information was available from General Practice, as was leaflets for the Alzheimer's Society. FLT suggested that the CCG could work with the local authority and Lin Bennett, Practice Manager and Governing Body Member, in order to review what is currently available to practices and how it can be improved. **Joan explained her father's experiences since being sent home from hospital after a fall. 24hour, one to one care was needed however there was nothing that provided clearly defined information as to what was available, from whom and areas of responsibility. Was only after constantly pursuing that it was eventually possible to find out the information.** Members considered that the information was probably available within each team, but just needed pulling together. PC added that complex needs care planning also needed to be taken into consideration. All agreed a more co-	TJ, LC & LB

No	Item	Action
	ordinated approach was needed. FLT suggested that LC and TJ work with JC to pull something together.	LC & TJ
Presentation	**Sustainability and Transformation Plans** FLT gave a presentation on the Sustainability and Transformation Plans (STP) which updated the members and public on the national and local intentions and provided an update on progress. FLT highlighted the following: There were 44 areas ("footprints") established across England. The collective look at ways in which money can be saved and transforming the delivery of care, and take the opportunity to look at the work of Shaping Sefton which shapes the STP. The NHS is facing increased challenges and pressures, both service demand and finance driven. FLT emphasised that the local authority were due to loose 50% of their total budget by 2019. The area covered by the Cheshire and Merseyside STP is the second largest in England, with a population of 2.5 million, 12 CCGs, 20 providers and 9 local authorities. FLT highlighted the need to change the way we operate. The STP enables a more collaborative way of working which will assist in the reduction of duplication and unnecessary waste. With the priority being to ensure continued access to safe, good quality and sustainable services, and making the best use of the funding received. FLT briefed the members and public on the four priorities: • Support for people to live better quality lives • Designing hospital services to meet modern clinical standards and reducing variation in quality • Working together with partners in social care and the voluntary sector • Being more efficient by reducing duplication and suing the latest technology: reducing costs in managerial and administrative areas FLT further explained the variances between those proposals that can be delivered across the whole of Cheshire and Merseyside, and because of the diversity of the region, some will need to be more localised. There are three Local Delivery Systems (LDS) that have been established to assist this process – North Mersey, the Alliance and Cheshire and Wirral. Each of which will work to the same STP priorities but may need to tailor the way they are delivered for their area. FLT provided an update on the current position of each LDS and highlighted the progress for North Mersey. FLT referred to the community centred health and care five year vision and emphasised the patient being at the centre. Investment had increased for community services and hospitals. FLT briefed on the vision for integrated community centred healthcare. FLT advised all that the information was available on the CCG website.	
GB16/180	**Apologies for Absence** Apologies were received from Daniel McDowell, Maureen Kelly, Ritesh Sinha and Dwayne Johnson. Davina Hanlon, Consultant in Public Health, attended on behalf of Matthew Ashton.	

No	Item	Action
GB16/181	**Declarations of Interest** Those holding dual roles across both South Sefton CCG and Southport & Formby CCG declared their interest; Fiona Taylor, Debbie Fagan and Martin McDowell. . It was noted that these interests did not constitute any material conflict of interest with items on the agenda.	
GB16/182	**Minutes of Previous Meeting** The minutes of the previous meeting were accepted as a true and accurate record subject to the following amendments: 16/148: to be noted that the event was in relation to the pre-consultation engagement exercise held in August 2016.	
GB16/183	**Action Points from Previous Meeting** ***Presentation: Independent Inquiry into Child Sexual Abuses (IICSA)*** DCF briefed the members and public on the IICSA inquiry as per the presentation with the intention of ensuring the Governing Body were aware of the expectations on the CCG and to highlight actions undertaken to date. Clarification was requested on the 13 incidents and whether (a) any local to Merseyside and (b) what areas the investigations were taking place. Update to be provided within the Chief Officer report for March 2017. *Update* A discussion was had with the NHSE National Lead regarding the 13 incidents. DCF was informed that no individual case information will be shared due to matters of confidentiality. It was therefore not possible to identify if any cases were specific to local CCGs. The interviews would identify themes. Any information or learning will be fed back to the Governing Body accordingly, as per the scheduled update planned for March 2017 or sooner if required. Update added to planner for March 2017. ***GB16/142: Minutes of Previous Meeting*** The minutes of the previous meeting were accepted as a true and accurate record subject to the following amendments: GB16/105: Dr Craig Gillespie also declared an interest in relation to QIPP and Integrated Performance Report. GB16/109: Safeguarding Children's Board and Safeguarding Adults Board Chair name spelling is Paula St Aubyn. *Update* Wording and pack updated. ***GB16/148: Action Points from Previous Meeting: July 2016*** **Presentation: Liverpool Women's Hospital and Neonatal Review**	Closed Closed Closed

No	Item	Action
	Engagement Process: Planned Activities Scheduled dates and activities had been organised as part of the early engagement pre consultation process for the Liverpool Women's Hospital and Neonatal Review. Scheduled information on events to be circulated to the Governing Body as available. Updated information had been received from Liverpool CCG. Was currently being reviewed before being put on website. *Update* Information had been added to the website and was in relation to the pre-consultation engagement exercise held in August 2016. *Video Presentation* YouTube video presented to the Governing Body is to be placed on the CCG website. *Update:* Link is available via the Governing Body minutes. A link had also been added to the Liverpool Women's website. ***GB16/112 Integrated Performance Report*** **Reserves Analysis: Cost Improvement Programmes** More dialogue needed with Mersey Care in order to ascertain the potential impact on quality of referrals as a result of the cost improvement programmes received from Mersey Care. *Update* Original meeting postponed. Another meeting now set for 2nd December 2016. Clinical Leads to be in attendance. ***GB16/145 Chief Officer Report*** **Conflicts of Interest: third lay member proposal** GM requested that it be noted that Southport & Formby CCG should, in this instance, refer to South Sefton CCG. The CCGs constitution to be updated to reflect the agreement of the Governing Body to seek support from the South Sefton CCG Audit Committee Chair as needed, rather than an additional Lay Member serve on the Governing Body. This also be notified to NHSE following confirmation of that approach by the CCG. *Update* Wording changed. Constitution updated. Will also be shared with the wider group for ratification. ***GB16/147 Quality, Innovation, Productivity and Prevention (QIPP) Plan & Progress Report***	Closed Closed DCF Closed

No	Item	Action
	Page 37 was highlighted in relation to the position as at "July" 2016, should read "August". *Update* Wording changed and pack updated. ***GB16/148 Integrated Performance Report*** **IAPT** Concern was raised in relation to the excessive waiting times. FLT requested that the issues regarding access and waiting times be escalated to the Chief Executive of the provider; provider had now been in place for 18 months. CCG needed to be clear on why there were difficulties and what was being done to resolve such. *Update* Discussed within update meetings. Updates would be provided through normal reporting: CO Report and Integrated Performance Report. **A&E** Trajectory was below, not with-standing the 18 week pathway. Detail required in update meetings with KMcC. *Update* Discussed within update meetings. **Stroke** Concerns were raised regarding Stroke in relation to: • Patients admitted who died within 24 hours • De-escalation of patients from a stroke ward to a general ward FLT highlighted the need to understand the breaches on a regular basis and requested that the lead, Nigel Taylor, through KMcC, with Jenny Kristiansen and the team, provide the necessary detail and it be presented to the Quality Committee. *Update* Detail being provided to the Quality Committee with updates being fed through the normal Governing Body reporting; CO Report and Integrated Performance Report. ***GB16/149 Corporate Risk Register & Governing Body Assurance Framework Update*** FLT referred to previous discussions (GB16/148) and requested they be actioned accordingly on the risk register: • IAPT: needs to be escalated • 1% surplus: additional challenge In addition, SS008 will need updating in light of the agreement by the Governing Body on the discretionary spend. Further discussion was had in relation to the scoring. GM considered the scoring for this risk will increase as time goes on. Members agreed and requested consideration to be given to the risk score and an	Closed Closed Closed

No	Item	Action
	increase in the likelihood to 4x5. The members referred to page 102 and the format of the report. AM requested risks be presented in risk order, with the largest to smallest, with all reds then being pulled into the main report. *Update* All risk comments have been actioned in the new version of the report. ***GB16/150 Joint Children & Young People's Emotional Health and Wellbeing Strategy 2016-17*** Governing Body to feedback any comments on the strategy direct to PW. *Update* Members to note this is still open for feedback. ***GB16/151 Safeguarding Annual Report 2015/16*** 1.) Section 6, page 206: Learning and Development. The members discussed in relation to the figures provided for the percentage take up of Governing Body training and were made aware that it was a total Sefton figure. FLT explained that the GPs and Practice Managers undertake practice training. As such it was expected that the figures would be transferred accordingly. FLT requested the figures be checked and detail of what, if anything, is due. AM requested Level 2 and 3 is also featured in the information. 2.) FLT congratulated the team on the "green" rated risks however requested clarification on the position of those that were "amber" rated. Progress report to be presented to the Quality Committee 3.) Protected Learning Time (PLT) events regularly held and normally well attended. DCF offered to ensure that any attendance by Governing Body members were recorded and mentioned accordingly. 4.) 4.3, Looked After Children, page 202: Separate Annual Report will be presented to the Quality Committee and following Governing Body Committee in November 2016. *Update* 1.) Safeguarding figures were reviewed: - There is specific safeguarding training for Governing Body members, the last training for which was held in January 2014. The training figures within the Safeguarding Annual Report relate to 2015/16 and those that were members for 2015/16. The low percentage of Governing Body Safeguarding training is as a result of (1) the apologies given at the time of the training; but more so (2) some members in 2015/2016 were not members in 2014/15 when the training was undertaken. Safeguarding training is scheduled for January 2017 and valid for three years. It has been suggested that the training is held annually so as to ensure that (i) those that give apologies are captured the following year and (ii) new Governing Body members are captured each year. - Training carried out by Governing Body GPs and Practice Managers is not	Closed Closed Closed

No	Item	Action
	fed through to the CCG learning system. Sometimes multiple systems depending on the training undertaken, is the same for CCG staff. CCG looking at pulling all system information to a central point for all staff and Governing Body members, this includes the process for feeding the data through. 2.) Safeguarding Service will incorporate into future routine assurance report. 3.) Practice Nurse Leads have been asked to ensure that attendance of governing body members are highlighted to Judy Graves so aware for purposes of mandatory training requirements. JG has requested agenda and signing in sheets from each PLT event so as to monitor training carried out by GB members. FLT suggested that it would be useful to get a working group together to review the PLT events and see how effective they had been. In relation to QIPP, the organisation needed to review to ensure effective and value for money. 4.) November 2016 agenda item	TJ
GB16/184	**Business Update** AM advised that the main areas of work continue to focus on STP and QIPP, in addition to the formation of the new contracts with the new providers. AM extended his congratulations to Liverpool CCG who had been awarded 'CCG of the Year' for 2016 at the Health Service Journal Awards. AM further extended his congratulations and thanks to Dr Peter Chamberlain and his team on being named a finalist at the Healthcare Transformation Awards for the work on the CCG's community services transformation scheme.	
GB16/185	**Chief Officer Report** FLT presented the Chief Officer Report and highlighted: <u>QIPP</u> The CCG continues to focus on QIPP which continues to be underpinned by focused sessions at the Leadership Team, Senior Management Team and Operational Team. This is in addition to the work of the Joint QIPP Committee and the robust discussions at the Wider Group. <u>Repeat Prescribing</u> The repeat prescription ordering system (RPOS) pilot started on 1st September with currently 9 out of 30 GP practices participating in the pilot. Initial evaluation is to be produced the end of November 2016 however, feedback to date has been positive. <u>Strengthening Commissioning for the Future</u> FLT is working together with Katherine Sheerin, Liverpool CCG, to explore options for more formal joint working arrangements between the organisations in the future. The work will involve the Local Authority and Governing Body in the shaping of any opportunities. <u>IAPT</u> Concerns had been raised with the Governing Body regarding the poor performance of the IAPT service. An action plan was now in place and was being	

No	Item	Action
	closely monitored. FLT emphasised the need for risks to be emergent and the Governing Body to be kept up to date. <u>Contract Agreement for 2017/19</u> The normal signoff for contracts is March however, the national deadline had been brought forward to 23rd December 2016. A robust detailed timetable is in place to achieve contract sign off with major providers. <u>Southport & Ormskirk NHS Trust (S&O) Executive Improvement Board</u> The outcome of the CQC inspection had now been received. Urgent Care "still required improvement" however, the inspection had recognised that some improvements had been made in women's services. The Urgent Care service have started to make changes as per inspection recommendations. <u>Local Area Inspection for Meeting the Needs of Children with Special Education Needs and/or Disabilities</u> An inspection was currently underway by Ofsted and the CQC who were looking at the effectiveness in identifying and meeting the needs of children and young people who have special education needs and/or disabilities. The Chief Nurse is leading the CCG input. Inspection points include areas of good practice and improvement. <u>Primary Care Support Services</u> The shadow Joint Commissioning Committee have received an update on issues being experience by GP practices since the contract for Primary Care Support Services was awarded to Capita in September 2015. CG is a member of a number of other forums where issues have also been highlighted. FLT and CG to meet to discuss prior to the next shadow Joint Commissioning Committee being held in January 2017. <u>New Community Services Provider for Southport & Formby CCG</u> Lancashire Care NHS Foundation Trust were appointed the new provider of community services for Southport & Formby CCG. **RESOLUTION** **The Governing Body received the report.**	FLT & CG
GB16/186	**Quality, Innovation, Productivity and Prevention (QIPP) Plan & Progress Report** MMcD presented the members and the public with the QIPP plan and progress report which provided an update on the progress being made in implementing the QIPP plan schemes and activities. The joint QIPP Committee continues to monitor performance against the plan and receives updates across the five domains; planned care, medicines optimisation, CHC/FNC, discretionary spend and urgent care. MMcD highlighted the following: The QIPP comprises five strategic domains: planned care, medicines optimisation, CHC/FNC, discretionary spend and urgent care. With discretionary spend and continuing health care being the main areas of current savings. With a current year to date actual of £4m against a year to date plan of £6m, therefore £2m adrift. MMcD pointed out the key area of concern being Urgent Care System Redesign.	

No	Item	Action
	The Joint QIPP Committee continue to monitor performance against the QIPP plan objectives and is supported by the Clinical QIPP Advisory Group that reviews all cases for change and clinical schemes ensuring robust clinical input at every level. **RESOLUTION** **The Governing Body received the report.**	
GB16/187	**Integrated Performance Report** KMcC presented the Integrated Performance Report which updated on aspects of finance, quality and performance against key strategic targets. KMcC highlighted the following: <u>Planned Care</u> Local referrals data from our main providers shows no change in the overall level of referrals comparing months 1-6 of 2016/17 with the previous year.GP referrals are slightly above comparing against the same period last year (1%, 229 referrals). Discussions regarding referral management, prior approval, cataracts and consultant to consultant referrals continue, but a decision is yet to be reached. KMcC added that the referral figures were encouraging in relation to managing demand however, in context of finances, there was still more to do. September saw the CCG fail the 92% target for RTT reaching 91.3%. Out of 10759 patients on the pathway, 939 patients were still waiting to receive treatment after 18 weeks. Target remains challenging. RTT external and internal Audits were undertaken in July and a draft report has now been received. Will be presented to the next CQPG meeting. KMcC referred to page 65 and highlighted that at specialty level, Thoracic Medicine (76.61%), Oral Surgery (76.46%), Ophthalmology (78.70%), Dermatology (38.86%) and ENT (90.12%) fell below the mandated threshold. The Trust is reviewing long waiting patients and capacity within the Divisions. Additional activity is being undertaken to improve the current situation. In addition to this the RTT Improvement Group meets fortnightly and focuses on caseload, long waiters and capacity issues. The CBU management teams have been encouraged to ensure the Access Policy is followed and patients are booked for treatment to reduce the open pathways. Members discussed in relation to Dermatology and the issues being system wide and the work being done to review the case load to see if there are any other opportunities for assistance. Members discussed Screening services referral had a two patient breach. The first breach was a bowel screening patient. Offered their first outpatient appointment, on day 13 following referral which was cancelled by the patient due to holiday, reappointed on day 40, colonoscopy day 48, followed by further investigations, decision to treat was day 60, surgery carried out on day 70. The second half breach was due to patient with complex needs. Actions include raising awareness at the Clinical Quality & Performance Group meeting regarding the need to minimise patient deferral within the pathway, plus continued engagement with McMillan GP Lead to emphasise the need for adequate preparation of patients prior to referral to the service. Overall planned care as at month 6 was £94k overspent. <u>Unplanned Care</u>	

No	Item	Action
	Aintree failed to meet the Sustainability & Transformation Fund (STF) trajectory of 95% by September 2016 as agreed with NHS Improvement. Many actions are in place (detailed on page 76 of report, item 4.1) including changes to ward rounds, streaming in the A&E department, additional recruitment and staffing reviews. Following a recruitment campaign, one substantive consultant was appointed in September 2016. Support is being used from a recruitment company to further develop the recruitment strategy and recruit to the 4 vacancies. Maternity leave and paternity leave across the remaining Consultant staff is making cover of all shifts challenging. The use of Locum Consultants and GPs is being made to support the rota in the short term. Aintree failed to achieve the Stroke target in September with only 20 out of 33 patients spending at least 90% of their time on a stroke unit. The current capacity pressures and delays to discharge are contributing towards lower than expected compliance against the standards. The Division is developing a refreshed stroke action plan to outline how risks to delivery will be mitigated and when performance will be improved which will be finalised in November. All patients are validated and those failing the standard are audited so lessons can be learned. It is noted that the Trust overall SSNAP score for January 2016 to March 2016 has dropped from B to a C. Members discussed in relation to how the STP can help support hyper acute stroke services and the ring fenced beds that are under pressure due to the number of patients admitted through A&E. Clarification was requested on the reasons for the drop in score from B to C. Was suggested that Dr Debbie Lowe, Arrow Park Hospital, be invited to a Governing Body meeting to update the members on their planned approach to stroke. DCF highlighted that the CQPG also had concerns with regards Aintree stroke services. Delayed Transfers of Care (DTOC's) increased to 33 during September 2016 (3.1%). Patient and/or family choice resulted in 14 delayed transfers (42.4%) and a further 11 were due to delays incurred whilst awaiting further NHS non acute care (33.3%). Analysis of delays in September 2016 compared to September 2015 illustrates a 43% increase in the number of patients awaiting further NHS non acute care (+4) and 27% increase in delays due to patient or family choice (+3). Further plans to support the reduction of delayed transfers of care are being discussed within the CCG and include a comprehensive review of at least one DTOC each week with the aim of identifying key points of learning and improve future systems and processes. Further discussion was had in relation to unplanned care activity and finance for all providers (page 82) and the importance of the Governing Body understanding the information presented in relation to the figures provided by NHSE. KMcC to do a briefing at a future Development Session on the differing activity methods. The members had an in-depth discussion regarding delayed transfer of care and the difficulties being experienced, some of which is an impact of the reduction of social care funding. A review was being carried out by Dave Warwick and KMcC team, PC to discuss further with KMcC outside of the meeting. <u>Quality</u> DCF referred to page 72 (item 3.6), Patient Experience of Planned Care and updated members on the downturn in performance. The downward trend was due to an unsuccessful pilot for collecting data by text message which impacted on both the number of responses and the performance. Once the poor response was realised the Trust immediately returned to using cards and for those wards were responses were reduced extra cards were put in place and are now being monitored.	KMcC/JG KMcC KMcC/JG

No	Item	Action
	The members and public were updated on the current position of the Healthcare associated infections (4.3.3.) and were informed that there had been one new MRSA case, attributable to the CCG. Section 4.4 provided a summary on Serious Incident Management. DCF highlighted the number of cases open longer than 100 days for each provider. Incidents were discussed at the SI meetings which had GP clinical input. <u>Report Content and Format</u> Members had a discussion on the content and presentation of the IPF and the work that had been done by the teams in pulling the final format together. KMcC referred the members and the public to page 95 of the report, item 10.2, Improvement and Assessment Framework Dashboard. The Q2 dashboard was based on NHSE requests for test and assurance and identifies what the CCG are doing in relation to specific performance categories. Further work is still needed on the dashboard in relation to assigning responsibility for each indicator, this will be ongoing. The format is nationally provided and has been refined from Q1 to Q2. KMcC advised that there was some guidance on the dashboard, KMcC offered to circulate. Dashboard would be monitored via the Shadow Co-Commissioning Meeting. DH noted that some of the indicators were contained within the Outcomes Framework. FLT suggested a general discussion was needed with DH on how the LA and CCG work these together. DH with take back to the LA. <u>Primary Care</u> FLT referred to 8.1, Primary Care Dashboard, which was currently under review with a view to understanding the needs for reporting across the organisation from a quality, improvement, QIPP perspective. The members and public were informed that a number of practices in South Sefton CCG had been visited by the Care Quality Commission. The latest results for which could be seen in page 92 and 93 (item 8.2 and 8.3). Two surgeries, Drs Misra & Bird and Kingsway, had both received a “good”. A discussion was had in relation to ensuring that the rating was shared with members. Members further discussed statistics in relation to other services. For example Dental and pharmacies. FLT clarified that the CCG were accountable for the quality of general practice. FLT suggested other possible areas could be considered for inclusion as part of the work that was being done to review the dashboard. <u>Finances</u> MMcD referred to page 55 which provided a summary on the financial performance for the CCG as at 31st October 2016 (month 7). The forecast outturn position after the application of reserves is a surplus of £1.250m against a planned surplus of £2.450m. The forecast position is subject to delivery of the QIPP programme in 2016/17. Delivery of the planned surplus would require release of the 1% uncommitted non recurrent reserve, which is currently held uncommitted as directed by NHS England. The QIPP requirement to deliver the planned surplus of £2.450m for the financial year is £10.384m. QIPP delivered at the end of Month 7 is £4.087m and the forecast underspend on operational budgets is £0.032m. At this stage, the CCG has identified a further £2.187m worth of savings to be delivered in year (risk	KMcC KMcC KMcC

No	Item	Action
	adjusted QIPP schemes to be delivered). The result of all these factors means that the CCG is forecasting a deficit of £1.428m. The CCG needs to deliver a further £2.751m of further savings in addition to the risk adjusted QIPP plan to deliver the revised surplus of £1.250m. This is before release of the 1% uncommitted reserve. Members discussed the main financial pressures show in figure 2 page 56, and highlighted the forecast pressures within funded nursing care due to the nationally mandated and acute care. An in-depth discussion was had in relation to the financial challenges, the need for additional QIPP savings and the importance of ensuring quality throughout. FLT formally requested the Clinical Directors come together under the leadership of the Chair, MMcD and DCG to look at referral optimisation. **RESOLUTION** **The Governing Body received the report and noted:** • **At Month 7, the CCG is forecasting a revised surplus of £1.250m which is deterioration from the agreed NHS target surplus of £2.450m. The likely scenario predicts a deficit of £1.428m and further work is required to mitigate cost pressures and deliver the CCG's revised forecast surplus position.** • **The CCG has a challenging QIPP programme in the current year, although progress has been made against the phased QIPP plan at month 7, there remains a gap in terms of both in year and forecast outturn delivery. It is imperative that the identified QIPP programme is delivered in order to achieve the agreed financial plan.** • **The CCG is working closely with the transformation advisor to continue to develop further the QIPP programme areas in order to achieve the required level of savings in the year.** • **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**	AM, MMcD, DCF, CG, PC, RS, SS, JW.
GB16/188	**Looked After Children: Annual Report 2015/16** AD and HS presented the members and the public with the Looked After Children (LAC) Annual Report. Purpose being to assure the Governing Body and members of the public that the CCG is fulfilling its statutory duties in relation to safeguarding and LAC. The report also takes into account the national changes and influences and local developments, activity, governance arrangement sand the challenges for 2016/17. The CCG makes a significant contribution to embedding the principles, quality and requirements of national frameworks by its partnership work with Sefton local authority and the commissioned health providers. The following areas were highlighted: The report had also been presented to a prior Quality Committee so as to ensure compliance.	

No	Item	Action
	The review of Health Assessments is improving and now running at 86%. As outlined on page 111 and 112, the assessments are a statutory requirement for all LAC and are required to be completed every six months for children under the age of 5 years and annually for children over this age. When a placement for a child is given, it is done so because it is deemed the best place for the child. This can quite often mean out of area placements (item 11). This then causes difficulties in relation to Health Assessments and records. Nationally work is being done however the process is complex and has an impact on services. DCF confirmed that the report had been submitted to the Quality Committee and would now be presented to the LAC Board. DCF further highlighted the issues in relation to the Health Assessments which had previously been listed on the risk register. DCF advised that a conversation was needed strategically in order to (a) put a plan in place for the improvement in the Health Assessments (b) again be reviewed for inclusion on the risk register. DH highlighted item 8.4 in relation to immunisations and whether the issues had been presented to the Sefton Health Professionals Forum, specifically in relation to reporting and data quality as highlighted in 8.4.4, and the need to be assured. DCF and DH to discuss further. FLT highlighted the need for clarity in relation to the data collection issues and the need to be clear exactly what those issues were. **RESOLUTION** **The Governing Body approved the report subject to clarification on the data collection issues. The Safeguarding team were thanked for their work.**	DCF DCF and DH AD
GB16/189	**Mental Capacity Act: Annual Report 2015/16** HS presented the members and the public with the first annual Mental Capacity Act/Deprivation of Liber Safeguards (MCA/DoLs) report. The purpose being to assure the Governing Body and members of the public that the CCG is fulfilling its statutory duties in relation to people requiring care and treatment in the Borough who lack capacity to make best interest decisions. The following areas were highlighted: The CCG makes a significant contribution to embedding the principles of the Mental Capacity Act and DoLS by its partnership work with the National Forum, Sefton local authority and the commissioned health providers. The Annual Report provides the Governing Body with an update of the developing and emerging MCA/DoLS agenda, which the CCG has supported throughout the 2015-16 reporting period. This includes updates on the National Context (The Deprivation of Liberty Safeguards, Article 5 of the Human Rights Act 1998, Supreme Court ruling P v Cheshire West and Chester and P and Q v Surrey Council, CQC Document "The State of Health Care and Adult Social care in England 2015/16", The Chief Coroners Guidance No 16 in December 2014, Birmingham City Council v D & Another [2016] EWCOP 8 and requirements under the Court of protection) and the Local Context (NHSE North region MCA/DoLS Network, NHSE Designated Professionals Network, Partnership working and Training) and activity for	

No	Item	Action
	commissioned health providers in relation to DoLS. It also outlines the future implications, challenges and key work streams for 2016/17. HS highlighted the importance of compliance with DoLs, which forms part of the Quality Contract Schedule. Support was being provided to Sefton LA who were struggling with capacity, highlighted through the DoLs incidents. Has been recognised as a national problem. Sefton LA had reconfigured their services and it is hoped that this will provide better support. DJ referred to page 131 item 2.5, Chief Coroner Guidance. DJ explained that on original judgement the local authority were dealing with approximately 100 DoLs per year. This had now increased to 100 per month. Additional staff have had to be identified which has been at the cost of the LA. There are currently four LA's challenging the Government through the courts. However, the High Court keep moving the item back. It was hoped that once the LA's are given the opportunity to challenge, more funding will be forth coming. FLT requested future reports be split for South Sefton CCG and Southport & Formby CCG. **RESOLUTION** **The Governing Body approved the report.**	
GB16/190	**Southport & Formby CCG Community Services Procurement: Notification of Contract Award** The paper presented noted the formal award of the Community Services Contract for Southport and Formby CCG. A paper was taken to the private session of the Southport and Formby Governing Body on 26 October 2016 with a full description of the procurement process. The purpose of the report was to update the members of the procurement process that had been used and seek a recommendation to award the contract. To re-enforce the integrity of the procurement process used, the bidder's identities were anonymised in the report. A recommendation was made to award to Bidder A. Lancashire Care NHS Foundation Trust was the successful bidder. **RESOLUTION** **The Governing Body received the update and noted the contract had been awarded to Lancashire Care NHS Foundation Trust.** **The Governing body also noted service mobilisation had commenced.**	
GB16/191	**Corporate Risk Register and Governing Body Assurance Framework Update** TJ presented the Governing Body with the updated CRR and the GBAF as at November 2016. The CRR and GBAF have both been reviewed and updated by members of the leadership team. The Governing Body reviewed and scrutinised the report and highlighted the following areas: • SS019: Risk is in relation to A&E. PC considered that given the data contained	DL & PC

No	Item	Action
	within the IPF, the risk score should be 20 (4 x 4). DL to discuss with PC on next update of risk. • SS002: Risk is in relation to locality working and clinical engagement. GM considered that, although the actions were being carried out, there were other risks issues that needed to be taken into consideration. GM to discuss with TJ outside of the meeting. • SS037: Capsticks report and outcome of parliamentary adjournment. Risk needs to be reviewed in light of parliamentary adjournment. Risk needs to be looked at in relation to the regulator and the CCG as commissioner. • New risk: FLT considered that, given all the issues highlighted, a new risk was needed in relation to risk • New risk: CG raised concern regarding frailty as part of the Local Quality Contract. The members and public were informed that the level of underperformance was so much s that the strategic objective was not being achieved. • 4.1: was considered that the main issue was in relation to clinical capacity. Risk to be reviewed with a potential to increase to 4x3. **RESOLUTION** **Following review and scrutiny, the Governing Body approved the report presented.**	TJ DCF & DL DL & KMcC DL DL & JL
GB16/192	**Appointment of External Auditor 2017/8: Update** Members were reminded that in July 2016 six CCGs (St. Helens, Halton, Southport and Formby, South Sefton, Wirral and Knowsley) approached the market through the Crown Commercial Service's Framework in order to identify an appropriate external audit provider from April 2017. The procurement was required as per guidance from the Department of Health, which required all CCGs to make an appointment for an external auditor by no later than 31 December 2016. The audit chairs from each CCG acted as the evaluation panel for the procurement scoring each element of each bid. Presentations and interviews took place on 12 September 2016. Based on these presentations and interviews, the panel recommended that the contract for the service is awarded to Grant Thornton. The decision of the panel was then to be taken back to each respective CCGs Governing Body. The decision was presented to the South Sefton CCG Governing Body on 29th September 2016 who approved the decision of the panel to appoint Grant Thornton. It was confirmed that the decision had now been taken back to each respective Governing Body who where in agreement of the decision made to award Grant Thornton. FLT requested clarification on formal notification to the successful applicant. MMcD confirmed that the guidance would be followed. This included the correct process for making the information publically available, once formal notification had been given to the successful bidder. **RESOLUTION** **Governing Body received the update on the appointment of Grant Thornton as External Auditor for 2017/18**	

No	Item	Action
GB16/193	**Disinvestment Policy and Procedure (Cessation and significant reduction of services) and prioritisation principles.** TJ presented the South Sefton CCG Disinvestment Policy. She advised that the policy will supersede all previous policies and procedures in respect of the approach to disinvestment and to connect all key programmes within the CCG, including QIPP, that generate proposals for disinvestment or service reduction with one single process and oversight procedure. This will ensure the CCG's decision making process operates within legal requirements. Members noted that the policy included roles and responsibilities, decision making requirements, stages of disinvestment and prioritisation principles. The main aims of the policy are to ensure that the disinvestment procedure is robust, lawful, open, and transparent and focussed on enabling the CCG to make the necessary efficiencies across the whole system. The policy also provides a framework for making sure the CCG continues to allocate its resources on the provision services for the highest priority areas whilst sustaining its focus on the quality and safety of those services. TJ highlighted the need to ensure that any decision made on the allocation of resources was done so lawfully, hence for the need for the framework, which had been developed by Andrew Woods, the CCG E&D Lead, with support from key officers. Members considered it critical that the organisation lawfully complies with any decision made and therefore the need of a framework was crucial. However members considered that it needed further work, in relation to presentation, wording and diagrams. **RESOLUTION** **The Governing Body approved the framework and policy, with further work needed on the presentation, wording and diagrams but to ensure that any changes in such does not affect its content. Members agreed that the policy should be published on the website once all changes were complete.**	TJ/DFair & LC
GB16/194	**North Mersey LDS Plan** FLT presented the members and the public with the North Mersey Local Delivery System Plan (NM LDS Plan). The purpose being to update on the content of the plan which is a component part of the Cheshire & Merseyside Sustainability & Transformation Plan (C&M STP). The C&M STP was submitted to NHS England on 21st October 2016. It is currently being reviewed and until that process has been completed and feedback NHS organisations have been instructed that they should not publish the NM LDS Plan. However, it is possible to share the three local delivery system plans which represent the majority of the content of the STP. FLT highlighted page 218, Primary Care Transformation. Use of the word "adoption" has been changed to "consideration". This is following discussions with localities, it was felt as presumptuous **RESOLUTION** **The Governing Body received the report.**	

No	Item	Action
	Key Issues Reports: a) Finance & Resource (F&R) Committee (July and September 2016) b) Quality Committee (September 2016) c) Joint Commissioning Committee (October 2016) d) Audit Committee (July 2016) No comments given. **RESOLUTION** **The Governing Body received the key issues reports**	
GB16/117	**F&R Committee Minutes Approved Minutes** - July 2016 - September 2016 **RESOLUTION** **The Governing Body received the approved F&R Committee minutes.**	
GB16/118	**Quality Committee Minutes Approved Minutes** - July 2016 - September 2016 **RESOLUTION** **The Governing Body received the approved Quality Committee minutes.**	
GB16/119	**Audit Committee Approved Minutes** None.	
GB16/120	**Any Other Business** 196.1 HSJ Awards: Quality Team had been nominated in the Workforce Category section in relation to the work with the youth and apprentices. 196.2 Sefton Youth: Sefton youth had made an impressive input in their involvement with the Emotional Health and Wellbeing Strategy. They showed role modelling and value set. Was important to consider what the CCG can give and offer. Currently two apprentices within the CCG; Reception and Business Intelligence.	
GB16/121	**Date of Next Meeting** Thursday 26th January 2017 13:00 hrs, Boardroom, 3rd Floor Merton House.	
Meeting concluded		15:40hrs

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
Actions from meeting held 24th November 2016

No	Item	Action
Questions	**Joan Carton asked if there is a way GPs could standardise information around dementia care and give this out to families and inform carers so roles are clearly defined.** FLT offered the CCG to work with the local authority and Lin Bennett in order to review what was currently available to practices **Joan further explained her father's experiences since being sent home from hospital after a fall. 24hour, one to one care was needed however there was nothing that provided clearly defined information as to what was available, from whom and areas of responsibility. Was only after constantly pursuing that it was eventually possible to find out the information.** All agreed a more co-ordinated approach was needed. FLT suggested that LC and TJ work with JC to pull something together.	 TJ/LC & LB LC & TJ
GB16/183	**Action Points from Previous Meeting** ***GB16/112 Integrated Performance Report*** **Reserves Analysis: Cost Improvement Programmes** More dialogue needed with Mersey Care in order to ascertain the potential impact on quality of referrals as a result of the cost improvement programmes received from Mersey Care. *Update* Original meeting postponed. Another meeting now set for 2nd December 2016. Clinical Leads to be in attendance. ***GB16/150 Joint Children & Young People's Emotional Health and Wellbeing Strategy 2016-17*** Governing Body to feedback any comments on the strategy direct to PW. *Update* Members to note this is still open for feedback. ***GB16/151 Safeguarding Annual Report 2015/16*** 3.) Protected Learning Time (PLT) events regularly held and normally well attended. DCF offered to ensure that any attendance by Governing Body members were recorded and mentioned accordingly. *Update* 3.) Following the request for agenda and signing in sheets from each PLT event, FLT suggested that it would be useful to get a working group together to	 DCF TJ

No	Item	Action
	review the PLT events and see how effective they had been. In relation to QIPP, the organisation needed to review to ensure effective and value for money.	
GB16/185	**Chief Officer Report** <u>Primary Care Support Services</u> The shadow Joint Commissioning Committee have received an update on issues being experience by GP practices since the contract for Primary Care Support Services was awarded to Capita in September 2015. CG is a member of a number of other forums where issues have also been highlighted. FLT and CG to meet to discuss prior to the next shadow Joint Commissioning Committee being held in January 2017.	FLT & CG
GB16/187	**Integrated Performance Report** <u>Unplanned Care</u> In-depth discussion was held in relation to Aintree and the failed Stroke target in September, with only 20 out of 33 patients spending at least 90% of their time on a stroke unit. The SSNAP score for January 2016 to March 2016 had dropped from B to a C. the Governing Body members requested clarification on the reason for this. Was suggested that Dr Debbie Lowe, Arrow Park Hospital, be invited to a Governing Body meeting to update the members on their planned approach to stroke. Further discussion was had in relation to unplanned care activity and finance for all providers (page 82) and the importance of the Governing Body understanding the information presented in relation to the figures provided by NHSE. KMcC to do a briefing at a future Development Session on the differing activity methods. <u>Report Content and Format</u> Discussion was had in relation to the Improvement and Assessment Framework Dashboard. KMcC offered to circulate the guidance for the dashboard. <u>Primary Care</u> FLT referred to 8.1, Primary Care Dashboard, which was currently under review with a view to understanding the needs for reporting across the organisation from a quality, improvement, QIPP perspective. Was requested for statistics from other services also be included within the dashboard i.e. Dental and pharmacies. <u>Finances</u> An in-depth discussion was had in relation to the financial challenges, the need for additional QIPP savings and the importance of ensuring quality throughout. FLT formally requested the Clinical Directors come together under the leadership of the Chair, MMcD and DCG to look at referral optimisation.	KMcC KMcC KMcC/JG KMcC KMcC AM, MMcD, DCF, CG, PC, RS, SS, JW.
GB16/188	**Looked After Children: Annual Report 2015/16** DCF further highlighted the issues in relation to the Health Assessments which had previously been listed on the risk register. DCF advised that a conversation	

No	Item	Action
	was needed strategically in order to (a) put a plan in place for the improvement in the Health Assessments (b) again be reviewed for inclusion on the risk register. DH highlighted item 8.4 in relation to immunisations and whether the issues had been presented to the Sefton Health Professionals Forum, specifically in relation to reporting and data quality as highlighted in 8.4.4, and the need to be assured. DCF and DH to discuss further. FLT highlighted the need for clarity in relation to the data collection issues and the need to be clear exactly what those issues were.	DCF DCF and DH AD
GB16/191	**Corporate Risk Register and Governing Body Assurance Framework Update** The Governing Body highlighted the following in relation to the CRR and GBAF: • SS019: Risk is in relation to A&E. PC considered that given the data contained within the IPF, the risk score should be 20 (4 x 4). DL to discuss with PC on next update of risk. • SS002: Risk is in relation to locality working and clinical engagement. GM considered that, although the actions were being carried out, there were other risks issues that needed to be taken into consideration. GM to discuss with TJ outside of the meeting. • SS037: Capsticks report and outcome of parliamentary adjournment. Risk needs to be reviewed in light of parliamentary adjournment. Risk needs to be looked at in relation to the regulator and the CCG as commissioner. • New risk: FLT considered that, given all the issues highlighted, a new risk was needed in relation to risk • New risk: CG raised concern regarding frailty as part of the Local Quality Contract. The members and public were informed that the level of underperformance was so much s that the strategic objective was not being achieved. • 4.1: was considered that the main issue was in relation to clinical capacity. Risk to be reviewed with a potential to increase to 4x3.	DL & PC TJ DCF & DL DL & KMcC DL DL & JL
GB16/193	**Disinvestment Policy and Procedure (Cessation and significant reduction of services) and prioritisation principles.** The Governing Body approved the framework and policy, with further work needed on the presentation, wording and diagrams but to ensure that any changes in such does not affect its content. Members agreed that the policy should be published on the website once all changes were complete.	TJ/DFair & LC

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2017

Agenda Item: 17/06	**Author of the Paper:** Fiona Taylor Chief Officer Email: fiona.taylor@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: January 2017	

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

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
January 2017

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 Update

During December the CCG has continued to make good progress implementing its QIPP priorities and staff and clinical leads continue to focus on these. The Clinical QIPP Advisory Group and Joint QIPP Committee continue work well together ensuring there is robust and thorough scrutiny of all QIPP related activity as well as the evaluation of clinical schemes. The assessment of those schemes enables the CCG to test whether or not the schemes are achieving the anticipated objectives and provides a framework for identifying any risks to scheme delivery at an early stage. Leads are continuing to look across all areas of spend to ensure that every opportunity to make efficiencies is being explored.

During January 2017 each scheme is being subject to a "deep dive" assessment in addition to the routine scrutiny of schemes to ensure that as we progress through the last quarter of the financial year, the CCG is very clear about any risks to delivery and what the mitigating actions are. The outcome of this work will be reported to both the leadership team and the Joint QIPP Committee in February.

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. Executives Meeting – 13th January 2017

Katherine Sheerin and Fiona Taylor met with Ged Fitzgerald – Chief Executive of Liverpool City Council and Margaret Carney – Chief Executive of Sefton Metropolitan Borough Council on Friday 13th January 2017 to discuss our work across the North Mersey footprint and opportunities for broader collaboration building on the Shaping Sefton and Healthy Liverpool transformation programmes. Going forward our Knowsley colleagues will be involved in our continued discussions.

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

3. NHSE/CCG Q2 Improvement and Assessment Framework Meeting – 4th January 2017

A full review of progress to date was undertaken with particular focus on areas of performance – RTT, stroke, signing of contracts and the state of play of the CCG IAF dashboard. The CCG's contribution to the broader STP was recognised through our key leadership roles.

4. Migration to the Health and Social Care Network (HSCN)

NHS Digital is planning to replace the current N3 data network for the health sector with a new HSCN when the N3 contract ends in March 2017. This will provide a relative, efficient and flexible way for health and social care organisations to access and share information by being more cost effective; reducing complexity by standardising networks; enabling service sharing and extending the parameters of collaborative working.

We have confirmed to iMerseyside that as we currently have COIN (Community of Interest Network) in place and operate collaboratively across the LDR footprint, we plan to procure through local organisations in a collaborative procurement deal. It is anticipated that migrations to the new network will begin late May or June 2017.

5. Information Governance

The CCG's Information Governance (IG) Policy and IG Handbook were ratified by the Finance and Resource Committees in November 2016.

The Corporate Governance Support Group, on behalf of the Joint Quality Committee and the Senior Information Risk Owner, continually monitors the CCG's compliance with IG protocols and statutory compliance. The Corporate Governance Support Group has scrutinised the CCG's IG strategy 16/17, which forms a large part of the IG toolkit submission and this work is on track for submission of the IG Toolkit in March 2017.

To support the IG Policy and Handbook, staff are required to annually undertake Mandatory Information Governance refresher training, this training can be done virtually or face to face and sessions have also been facilitated for staff. Confidentiality Audits and Information Security Audits have been undertaken by the CSU IG Lead on behalf of the CCG, the actions from which are being progressed and continually monitored. The CCG also continues to raise awareness of the requirement for Privacy Impact Assessments to be undertaken for any new programmes which require the use of personal data.

The Corporate Governance Group will continue to report on all IG related matters to the Joint Quality Committee as part of the key issues reporting.

6. Joint Local Area Special Educational Needs and Disability (SEND) Inspection in Sefton

The inspection outcome letter was published on 13th January 2017. It contains areas of both strength and development along with some areas of significant weakness. The areas identified as being of significant weakness are as follows:

- The poor progress made from starting points by pupils with a statement of special educational needs and/or disabilities and their families;
- The poor operational oversight of the Designated Clinical Officer (DCO) across health services in supporting children and young people who have special educational needs and/or disabilities and their families;
- The lack of awareness and understanding of health professionals in terms of their responsibilities and contribution to Education Health Care Plans (EHCPs);
- The weakness of co-production with parents, and more generally in communications with parents;

- The weakness of joint commissioning in ensuring that there are adequate services to meet local demand.

The Chief Nurse is co-ordinating a meeting across the local system to discuss the future model for the DCO / DMO function and where this is best placed as a result of the inspection outcome and the recently published guidance from September 2016. Contact has also been made with the CCGs' GP Clinical Lead for Children & Young People to support this discussion.

The local area is required to produce and submit a Written Statement of Action to Ofsted that explains how the local area will tackle the areas of weakness.

7. Quality Risk Profile Tool – Liverpool Community Health NHS Trust

The Quality Risk Profile Tool for LCH has been jointly reviewed and updated by the Quality Teams from Southport & Formby CCG, South Sefton CCG and Liverpool CCG. This has been submitted to NHS England (Cheshire & Merseyside).

8. PHE Commissioned Screening Hub – Cancer Performance

A teleconference has taken place between the SSCCG GP Clinical Quality Lead for AUH and Dr Dan Seddon from Public Health England, supported by the Quality Team, to discuss the recent screening hub related issue which impacted upon cancer performance within Aintree University Hospital NHS Trust. Dr Seddon is now taking this issue forward and will liaise back with the CCGs, as appropriate.

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.

9. GP Five Year Forward View (GP5YFV)

The CCG sent its submission for the GP5YFW to NHS England on 23rd December 2016. Feedback is awaited.

10. Guidance to primary care providers on supporting whistleblowing in the NHS

NHS England circulated a document last November entitled "Freedom to Speak Up in Primary Care" aimed at providing guidance to primary care providers on supporting whistleblowing in the NHS. A link to the document can be found here: https://www.england.nhs.uk/wp-content/uploads/2016/11/whistleblowing-guidance.pdf

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

11. Community Services – Mobilisation Update

Mersey Care NHS Foundation Trust has been identified as the preferred acquirer of the South Sefton bundle of services transacting from Liverpool Community Health NHS Trust. There are a small number of paediatric services that will be transacted as a direct award. Work is underway to

mobilise services for the 1st April 2017. Regular meetings are taking place between the CCG team and Mersey Care NHS Foundation Trust to ensure smooth transition.

The NHSE Transition Board continues to meet to give oversight to the process.

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

12. Making Integration Happen

Work continues on the integration agenda through the Integrated Commissioning Group and the paper on today's agenda, "Making Integration Happen", outlines the type of work being undertaken.

13. Social Services Visit – 5th January 2017

I was able to spend some time with the Sefton Metropolitan Borough Council's Hospital Social Work team on 5th January 2017. I took the opportunity to understand their working context. I will be taking some of the discussion into our ongoing work on CHC/FNC in supporting the improvement of the unplanned care system.

14. Sefton Metropolitan Borough Council Budget – 2017/2020

The Council has published the proposed budget for 2017/18 and the medium term financial plan 2018/19 – 2019/20.

The report provided to Cabinet reflects the current financial challenges facing the Council during the period, the proposed approach to meeting these challenges and how they reflect the Council's statutory requirement to remain financially sustainable and the desire to deliver Sefton 2030 Vision and the Council's core purpose.

15. Recommendation

The Governing Body is asked to formally receive this report.

Fiona Taylor
Chief Officer
January 2017

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2017

Agenda Item: 17/07	**Author of the Paper:** Martin McDowell Chief Finance Officer Email: martin.mcdowell@southseftonccg.nhs.uk Tel: 0151 247 7071
Report date: January 2017	

Title: Quality, Innovation, Productivity and Prevention (QIPP) Plan and Progress Report

Summary/Key Issues:

The report provides the Governing Body with an update on the progress being made in implementing the QIPP plan schemes and activities. The Joint QIPP Committee continues to monitor performance against the plan and receives updates across the five domains: planned care, medicines optimisation, CHC/FNC, discretionary spend and urgent care.

Attached with this report are the QIPP Plan the QIPP performance dashboard (Appendix 1).

Recommendation

The Governing Body is asked to receive the 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.
	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 and 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.
	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	Y			Relevant QIPP schemes have been developed following engagement with the public.
Clinical Engagement	Y			The Clinical QIPP Advisory Group and the Joint QIPP Committee provide forums for clinical engagement and scrutiny. Key schemes have identified clinical leads
Equality Impact Assessment	Y			All relevant schemes in the QIPP plans have been subject to EIA
Legal Advice Sought				
Resource Implications Considered	Y			The Joint QIPP Committee considers the resource implications of all schemes
Locality Engagement	Y			The Chief Integration Officer is working with localities to ensure that key existing and new QIPP schemes are aligned to locality work programmes.
Presented to other Committees	Y			The performance dashboard was presented to the Joint QIPP Committee at its meeting on 12th September 2016.

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

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
January 2017

1. Executive Summary

The Joint QIPP Committee continues to monitor performance against the QIPP plan objectives and is supported by the Clinical QIPP Advisory Group that reviews all cases for change and clinical schemes ensuring robust clinical input at every level.

2. Key Issues

The QIPP plan comprises five strategic domains: planned care, medicines optimisation, CHC/FNC, discretionary spend and urgent care and within each domain there are number of schemes or actions that all have savings identified against them.

The QIPP plan is under regular review and as new opportunities are identified they are reflected in the plan. The plan has been reviewed and some changes were made, these are summarised below in the report.

The QIPP dashboard and the QIPP plan were received at a meeting of the Joint QIPP Committee on 10th January 2017.

3. Recommendations

The Governing Body is asked to receive the report and note the update.

Appendices

Appendix 1 – NHS South Sefton CCG Month 7 QIPP Plan and Performance Dashboard

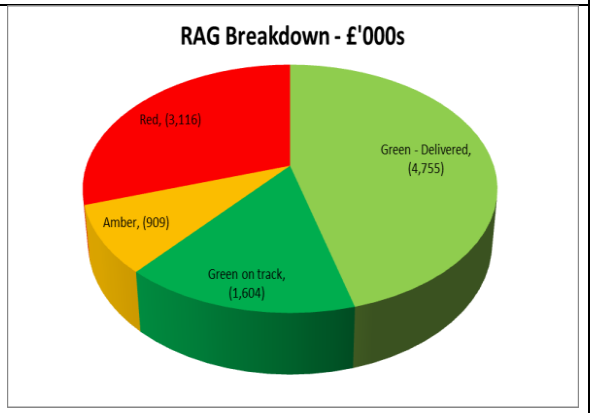
Martin McDowell
Chief Finance Officer
January 2016

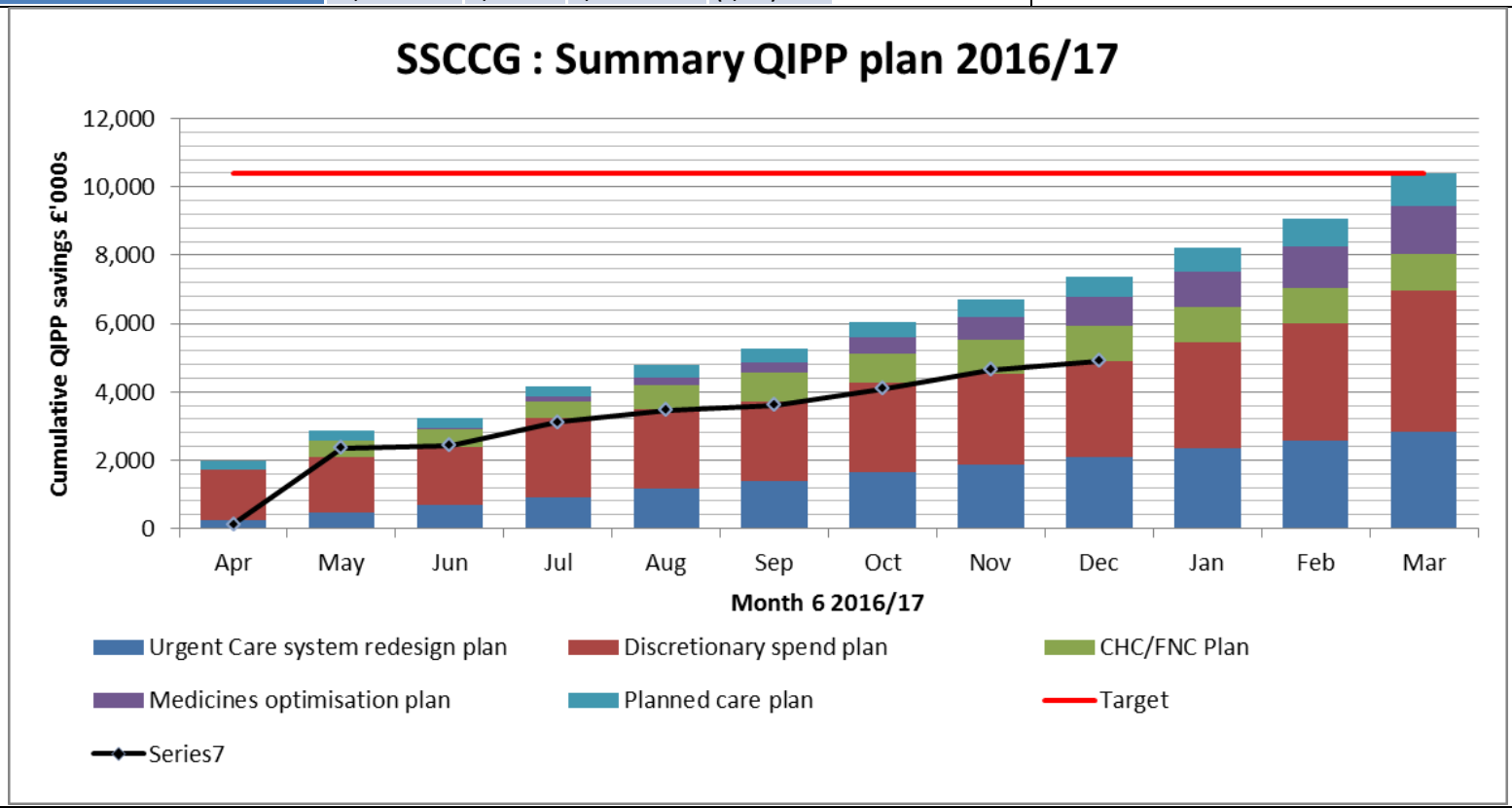
QIPP DASHBOARD – SUMMARY SSCCG AT MONTH 9

South Sefton CCG

£'000s

Scheme	Annual Plan	YTD Plan	YTD Actual	Variance
Planned care plan	929	651	388	(213)
Medicines optimisation plan	1,429	1,023	660	(193)
CHC/FNC Plan	1,055	1,025	1,025	0
Discretionary spend plan	4,154	2,798	2,821	23
Urgent Care system redesign	2,817	2,105	11	(2,094)
Total	10,384	7,381	4,905	(2,476)





QIPP DASHBOARD SSCCG – Detail by scheme – Themes 1 & 2

Planned care	In month plan	In month actual	Variance		YTD Plan	YTD Actual	Variance			Annual Plan	Forecast out-turn savings	Forecast Variance	
Sub total PLCV procedures (allow 10% to go through - Dec start)	67	0	(67)		67	0	(67)			270	270	0	
Review of OPP T&O coding (S&O)	7	0	(7)		64	0	(64)			85	28	(58)	
MCAS / T&O - S&O MCAS scheme	0	0	0		0	0	0			0	0	0	
Implement cataracts revised threshold (5% reduction only as under national benchmarking)	4	0	(4)		13	0	(13)			25	25	0	
Dermatology - reduce block	0	0	0		30	30	0			30	30	0	
C2C referral Policy - 10% reduction from 1st November (20,373 C2C appointments)	20	0	(20)		41	0	(41)			102	51	(51)	
Critical care @Aintree (rebase between CCGs)	0	0	0		225	225	0			225	225	0	
Reduction of Merseycare contract for DISH	0	0	0		109	109	(0)			109	109	0	
Review of other expenditure - Reduction of spirometery service Aintree	0	0	0		24	24	0			24	24	0	
Contract Challenges (Phase 1)	4	0	(4)		13	0	(13)			25	0	(25)	
CQUIN - C2C reduction S&O	1	0	(1)		3	0	(3)			6	3	(3)	
CQUIN - 1st:Fup ratio S&O	5	0	(5)		13	0	(13)			28	14	(14)	
Total	**109**	**0**	**(109)**		**601**	**388**	**(213)**			**929**	**778**	**(151)**	

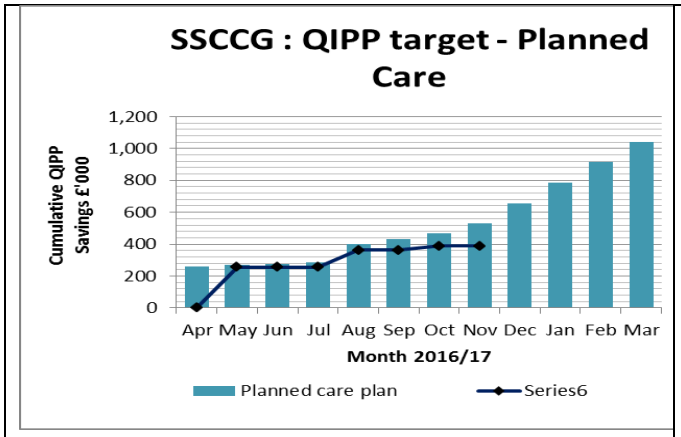
Medicines optimisation	In month plan	In month actual	Variance		YTD Plan	YTD Actual	Variance			Annual Plan	Forecast out-turn savings	Forecast Variance	
Focus on reduced waste (repeat prescribing)	87	150	64		260	300	41			519	519	0	
Individual patient reviews (Generics / Optomise / Quick Wins)	39	0	(39)		258	330	72			375	375	0	
Additional rebate schemes	27	0	(27)		160	0	(160)			240	240	0	
Blood Glucose Monitoring strips	13	0	(13)		38	0	(38)			75	75	0	
Apixiban Price Reduction	0	0	0		30	30	0			30	30	0	
High Cost Drugs and Biosimilars	23	0	(23)		70	0	(70)			140	70	(70)	
Community service - Dermatology	4	0	(4)		38	0	(38)			50	50	0	
Review other expenditure - Care at the chemist	0	0	0		0	0	0			0	0	0	
Total	**192**	**150**	**(42)**		**853**	**660**	**(193)**			**1,429**	**1,359**	**(70)**	

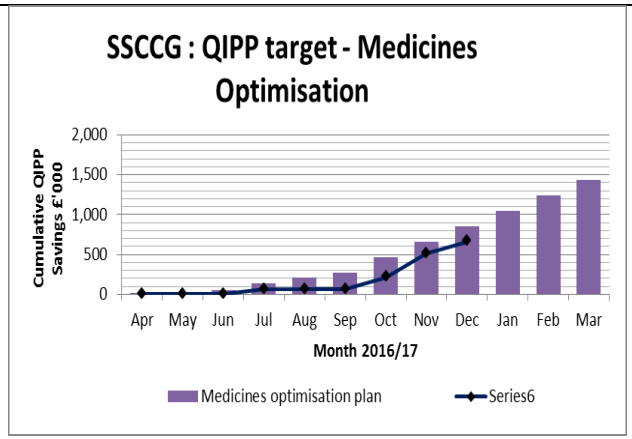
QIPP DASHBOARD SSCCG – Detail by scheme – Themes 3 & 4

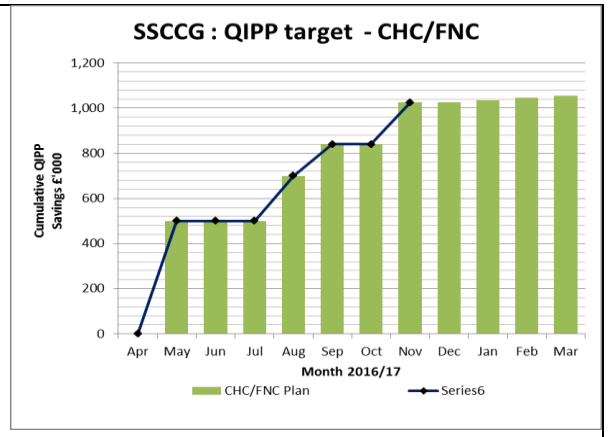
Individual packages of care	In month plan	In month actual	Variance		YTD Plan	YTD Actual	Variance			Annual Plan	Forecast out-turn savings	Forecast Variance	
CHC reduction - No growth	0	0	0		500	500	0			500	500	0	
CHC prior year	0	0	0		525	525	0			525	525	0	
Implementation of ADAM procurement system (net savings)	0	0	0		0	0	0			30	20	(10)	
Total	**0**	**0**	**0**		**1,025**	**1,025**	**0**			**1,055**	**1,055**	**(10)**	
Discretionary spend	**In month plan**	**In month actual**	**Variance**		**YTD Plan**	**YTD Actual**	**Variance**			**Annual Plan**	**Forecast out-turn savings**	**Forecast Variance**	
Review other Expenditure - 3rd Sector	34	0	(34)		34	0	(34)			34	17	(17)	
Prior year spend	113	113	0		1,600	1,600	0			1,600	1,600	0	
Reduction in iLinks investment	0	0	0		53	53	0			53	53	0	
GPIT - Reduction on IM SLA	0	0	0		40	40	0			40	40	0	
LQC under-performance in 16/17	0	0	0		0	70	70			600	600	0	
Quality Premium 16/17	0	0	0		0	0	0			300	0	(300)	
Primary Care Collaborative Fees budget correction	0	0	0		30	30	0			30	30	0	
CQUIN Underperformance 16/17	0	0	0		0	0	0			400	200	(200)	
CQUIN Underperformance 15/16 (S&O)	0	0	0		42	42	0			42	42	0	
Slippage in Transformation Fund / SRG Funding (In year slippage)	0	0	0		937	937	0			937	937	0	
Provider Sanctions - Aintree	0	0	0		0	0	0			41	21	(21)	
Provider Sanctions - S&O	0	0	0		0	0	0			3	2	(2)	
Running Cost Contingency	0	0	0		49	49	(0)			49	49	0	
Move to bi monthly locality meetings	4	0	(4)		13	0	(13)			25	0	(25)	
Total	**151**	**113**	**(38)**		**2,798**	**2,821**	**23**			**4,154**	**3,590**	**(564)**	

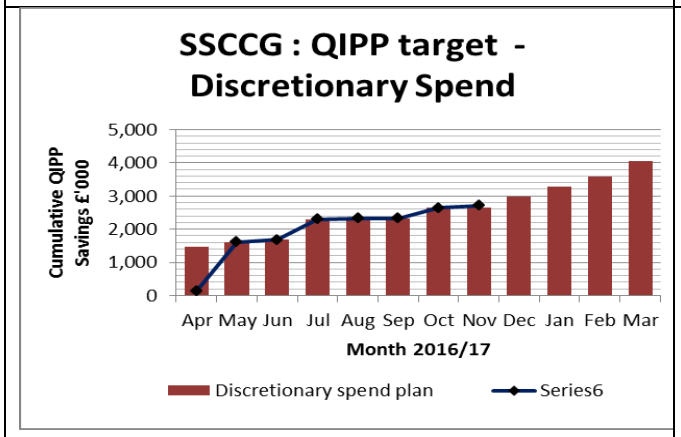
QIPP DASHBOARD SFCCG – Detail by scheme – Theme 5

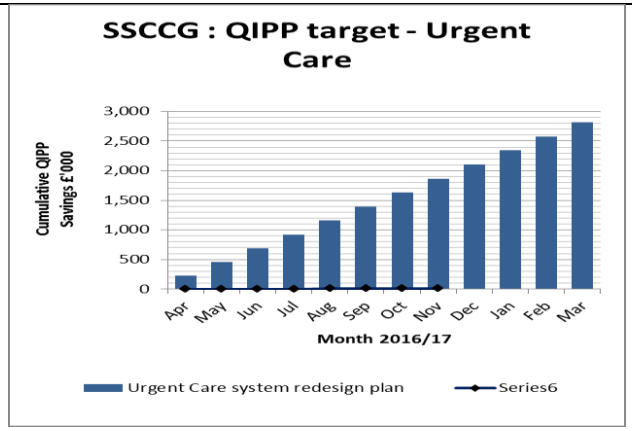
Urgent care system redesign	In month plan	In month actual	Variance		YTD Plan	YTD Actual	Variance		Annual Plan	Forecast out-turn savings	Forecast Variance	
Respiratory	123	0	(123)		1,110	0	(1,110)		1,480	0	(1,480)	
Telehealth	39	0	(39)		347	0	(347)		463	0	(463)	
AVS	69	0	(69)		617	0	(617)		823	0	(823)	
CQUIN - Zero LoS - S&O	7	0	(7)		19	0	(19)		40	20	(20)	
Cease GP Hotline	0	0	0		11	11	0		11	11	0	
Total	**238**	**0**	**(238)**		**2,105**	**11**	**(2,094)**		**2,817**	**31**	**(2,786)**	











NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2017

Agenda Item: 17/08	**Author of the Paper:** Karl McCluskey Chief Strategy & Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk Tel: 0151 247 7000
Report date: January 2017	
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.	Receive [x] Approve [ ] Ratify [ ]

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.
	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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South Sefton
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South Sefton Clinical Commissioning Group

Integrated Performance Report

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NHS
South Sefton
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1. Executive Summary

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

CCG Key Performance Indicators

NHS Constitution Indicators	CCG	Main Provider
A&E 4 Hour Waits (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
HCAI - C.Diff		Aintree
HCAI - MRSA		Aintree
IAPT Access - Roll Out		
IAPT - Recovery Rate		
Mixed Sex Accommodation		Aintree
RTT 18 Week Incomplete Pathway		Aintree
RTT 52+ week waiters		Aintree
Stroke 90% time on stroke unit		Aintree
Stroke who experience TIA		Aintree

E

Key information from this report

Financial position

The forecast outturn position after the application of reserves is a surplus of £1.250m against a planned surplus of £2.450m. The forecast position is subject to delivery of the QIPP programme in 2016/17. Delivery of the planned surplus would require release of the 1% uncommitted non-recurrent reserve, which is currently held uncommitted as directed by NHS England. The financial position relating to operational budgets at Month 9 before the application of reserves is £0.390m overspend against plan with a year-end forecast of £0.994m overspend following mitigation of cost pressures with the CCG contingency budget. The forecast position deteriorated by £0.633m overall during the month, the financial position has deteriorated during the financial year, mainly due to increased expenditure forecasts within acute care as well as the national increase in the costs of Funded Nursing Care.

The QIPP requirement to deliver the planned surplus of £1.250m for the financial year is £10.384m. QIPP delivered at the end of Month 9 is £4.905m and the forecast overspend on operational budgets is £0.994m. At this stage, the CCG has identified a further £1.908m worth of savings to be delivered in year (risk adjusted QIPP schemes to be delivered). The result of all these factors means that the CCG is forecasting a likely position of a £2.115m. The CCG needs to deliver a further £3.365m of further savings in addition to the risk adjusted QIPP plan to deliver the revised surplus of £1.250m. This is before release of the 1% uncommitted reserve. The CCG is undertaking an urgent and critical review of the remaining QIPP programme areas to provide assurance that the required level of savings can be achieved in the financial year

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.

Planned Care

Local referrals data from our main providers shows little change in the overall level of referrals comparing months 1-8 of 2016/17 with the previous year (+0.5%). GP referrals are above comparing against the same period last year (1%, 264 referrals). Discussions regarding referral management, prior approval, cataracts and consultant-to-consultant referrals continue, but a decision is yet to be reached.

November saw the CCG achieve 92% target for RTT reaching 92.26%. For Aintree the RTT performance remains below the required DoH standard of 92% for all incomplete pathways at 90.21% during November 2016. This represents a marginal improvement from the previous month at 89.22%.

All cancer indicators performed favourably except the CCG failed the local target of 85% for 62 day wait for first definitive treatment following a consultant's decision to upgrade in November, recording 60% (year to date 82.6%). The two breaches were lung patients, one was due to a late referral and the second had a complex pathway, the patient needed a repeat CT so was an unavoidable breach. Year to date the CCG are failing at 82.6%.

Aintree University Hospital NHS Foundation Trust routinely achieves the response rate target in excess of the regional and national response rates for both inpatients and A&E for Friends and Family, however, inpatients is slightly under target for November. The percentage who 'would recommend' has decreased from previous month, from 97% to 96% in November, and the

percentage who 'would not recommended' remains the same as previous month (2%), although both measures are within target range.

Performance at Month 8 of financial year 2016/17, against planned care elements of the contracts held by the CCG shows an over-performance of £553k, which is a percentage variance of 2%. At specific trusts, Renacres are reporting the largest cost variances with a total of £272k/25%. Major Hip Procedures is the largest over performing HRG followed by Reconstruction Procedures. Combined costs for these two HRG's are £98k. The over performance at Renacres is mirrored by underperformance at other Trusts, namely Spire and Southport and Ormskirk Hospitals suggesting a shift in patient and GP choice.

Unplanned Care

Aintree failed to meet the Sustainability & Transformation Fund (STF) trajectory of 95% by September 2016 as agreed with NHS Improvement. The Trusts' performance has improved marginally against the 4-hour standard year to date, but remains below the required 95% and recorded 81.1% for November 2016. Implementation of the AED stream of the Emergency and Acute Care Plan commenced from 24th August 2016. Streaming and Pitstop work streams have been implemented and support to the team to ensure these are embedded is in progress.

At both a regional and county level, NWAS failed to achieve any of the response time targets. Activity levels continue to be significantly higher than was planned for and this (together with the ongoing issues regarding turnaround times) continues to be reflected in the performance against the response time targets. Ambulance turnaround times remain a key focus for improvement. In order to mitigate the problems caused by lack of available assessment space in the Emergency Department and prolonged ambulance handover delays; on 24 November 2016 Ambulance Pitstop was relocated to a new area within the Emergency Department.

Aintree have achieved the Stroke target in November 2016 for the first time since November 2015. The Trust have worked hard to implement the action plans described in previous months' reports, however sustainability of meeting the target longer term remains challenging.

The CCG and Aintree are both under plan and achieving their C.difficile plan for 2016/17. The CCG has had no new cases of MRSA in October and only reported their first case in September; this was a non-trust apportioned case.

There are a total of 110 serious incidents open on StEIS where South Sefton CCG are either lead or responsible commissioner. 79 of these affect South Sefton CCG patients with seven reported in November.

Delayed Transfers of Care (DTOC's) increased to 23 in November from 18 in October 2016 (21.74%). Patient and/or family choice resulted in 16 delayed transfers (69.57%), a further 5 were due to delays incurred whilst awaiting further NHS non acute care (21.74%) and 2 were due to awaiting care package in own home. (8.70%). Analysis of delays in November 2016 compared to November 2015 illustrates a 4.3% decrease in total number of delays. For the number of patients awaiting further NHS non-acute care is the same as previous year (5) and 25% increase in delays due to patient or family choice (4).

Aintree University Hospital NHS Foundation Trust routinely achieves A&E Friends and Family response rates in excess of the regional and national response rates. The percentage of people that would recommend A&E has recently fallen and is now below the England average along with the not recommended percentage.

Performance at Month 8 of financial year 2016/17, against unplanned care elements of the contracts held by NHS South Sefton CCG shows an under-performance of circa -£612k/-2%.This under-performance is clearly driven by Aintree Hospital reporting an under performance of -£564k/-2%. Alder Hey Hospital is reporting the largest year to date over performance with a £110/8%. Further analysis is taking place of the Alder Hey contract to understand the key areas of over performance alongside population measures such as birth rates.

Mental Health

The three Key Mental Health Performance Indicators of Care Programme Approach and Early Intervention in Psychosis are achieving.

In terms of Improving Access to Psychological Therapies (IAPT), the provider reported a slight decrease of patients entering first treatment compared to the previous month. The access standard (access being the number of patients entering first treatment as a proportion of the number of people per CCG estimated to have common mental health issues) is currently forecasting 13.4% against the 15% standard at year-end. There was an increase of 16% in referrals compared to the previous month; of these 65% were Self-referrals. GP Referrals increased also. The provider is working closely with Clock View, attending weekly MDT meetings to agree appropriateness of clients for service. The percentage of people moved to recovery was 44.4% in month 8, which does not meet the minimum standard of 50%. A forecast outturn at month 8 gives a year-end position of 43.2%. It is possible recovery will dip as the longest waiters are brought into service, as more are likely to disengage without completing treatment. However, as waits reduce this is expected to improve. Cancelled appointments by the provider saw a slight increase in month 8.

Commissioners continue to be involved in Merseycare's review of the acute care pathway (including crisis). This initial scoping and gathering of evidence and intelligence is expected to be completed by February 2017. The review will consider system wide issues that impact on the effective delivery of the acute care pathway, functions in the pathway and specialist pathways. At the December 2016 Clinical Quality and Performance Group meeting the CCG raised concerns regarding the underperformance in relation to the 'timeliness of GP Communications / Discharge Letters, since this KPI ceased to be a CQUIN the Trust has failed to meet the targets. The Trust confirmed that there are issues particularly from the Clock View site regarding timeliness of discharge summaries due to clinical staffing capacity. The Trust has added this to their Risk Register. The roll out of the RIO clinical IT system should have a positive impact on performance. However, the Trust confirmed in December 2016 that the RIO roll out has been put on hold due to 'technical issues'. The Trust has indicated that a formal communication relating RIO implementation will be sent to CCGs January 2017.

Community Health Services

There is currently a District Nursing systems review taking place across LCH. This is to review processes in relation to manual and electronic requirements. Sefton Physio Service reported a high rate of DNAs in November but this is an improvement on the previous month. Adult Dietetics is also high as well as Paediatric. However overall DNA rates for Sefton are green for November at 6.5%. Provider cancellation rates remain relatively static this month, with the exception of Adult Dietetics and Paediatric Dietetics reporting increases compared to last month. The total Trust cancellation rate for Sefton is green at 2% this month. Treatment rooms, Podiatry, Physio, Adult Dietetics, and Paediatric Dietetics have all continued the trend of previous years showing high numbers of patient cancellations. All services are above 10% for November 2016.

The CCG has agreed a revised waiting time trajectory for Paediatric SALT with LCH to allow the Trust to develop a new service model; this will be reviewed at the end of the financial year. Patient

experience and complaints / feedback are regularly monitored at CQPG meetings. At the end of November 2016, 96.7% of patients who responded to FFT positively recommended the Trust as a place to receive treatment and care.

Therapies waiting times are being monitored through the CQC Action Plans at the Collaborative Forum (CF) and CQPGs. The Trust's Executives and the CQC have been invited to the January 2017 CF to review progress against the Action Plans.

Primary Care

Work is now progressing with MLCSU to produce the indicators for a Primary Care Dashboard to be released on Aristotle with a first live version available in Aristotle at the end of January 2017. There will be various "views" of the data, for CCG users to view the indicators across the CCG area with the ability to drill to locality and practice level, plus practice level views allowing authorised practice users to drill to patient level. A core set of indicators allowing benchmarking across a number of areas will be produced first (practice demographics, GP survey patient satisfaction, secondary care utilisation rates, CQC inspection status), followed by further indicators and bespoke information (e.g. GP Spec).

South Sefton CCG did not have any GP practices with CQC inspection results published in the past month.

Better Care Fund

A Better Care Fund Plan for 2016/17 has been agreed and submitted to the national Better Care Support Team and joint work has been undertaken to develop these plans for implementation. In the meantime, a Quarter 2 performance report has been prepared for NHSE for submission on 22nd November 2016. Guidance for BCF 2017/18 is delayed.

2. Financial Position

2.1 Summary

This report focuses on the financial performance for South Sefton CCG as at 31st December 2016 (Month 9).

The forecast outturn position after the application of reserves is a surplus of £1.250m against a planned surplus of £2.450m. The forecast position is subject to delivery of the QIPP programme in 2016/17. Delivery of the planned surplus would require release of the 1% uncommitted non-recurrent reserve, which is currently held uncommitted as directed by NHS England.

The financial position relating to operational budgets at Month 9 before the application of reserves is £0.390m overspend against plan with a year-end forecast of £0.994m overspend following mitigation of cost pressures with the CCG contingency budget. The forecast position deteriorated by £0.633m overall during the month, the financial position has deteriorated during the financial year, mainly due to increased expenditure forecasts within acute care as well as the national increase in the costs of Funded Nursing Care

The QIPP requirement to deliver the planned surplus of £1.250m for the financial year is £10.384m. QIPP delivered at the end of Month 9 is £4.905m and the forecast overspend on operational budgets is £0.994m. At this stage, the CCG has identified a further £1.908m worth of savings to be delivered in year (risk adjusted QIPP schemes to be delivered). The result of all these factors means that the CCG is forecasting a likely position of a £2.115m.

The CCG needs to deliver a further £3.365m of further savings in addition to the risk adjusted QIPP plan to deliver the revised surplus of £1.250m. This is before release of the 1% uncommitted reserve.

The high-level CCG financial indicators are listed below:

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)	£1.250m	£1.250m
QIPP	QIPP Plan delivered – *(Red if shortfall against planned delivery)*	£4.905m	£4.462m
Running Costs (Forecast Outturn)	CCG running costs < CCG allocation 2016/17	✓	✓

2.2 Resource Allocation

Additional allocations have been received in Month 9 as follows:

- Quality Premium Awards 2015/16 - £0.116m

This allocation was not anticipated at the 2015/16 year end and is therefore a benefit to the financial positon. The benefit has been included in the forecast for operational budgets.

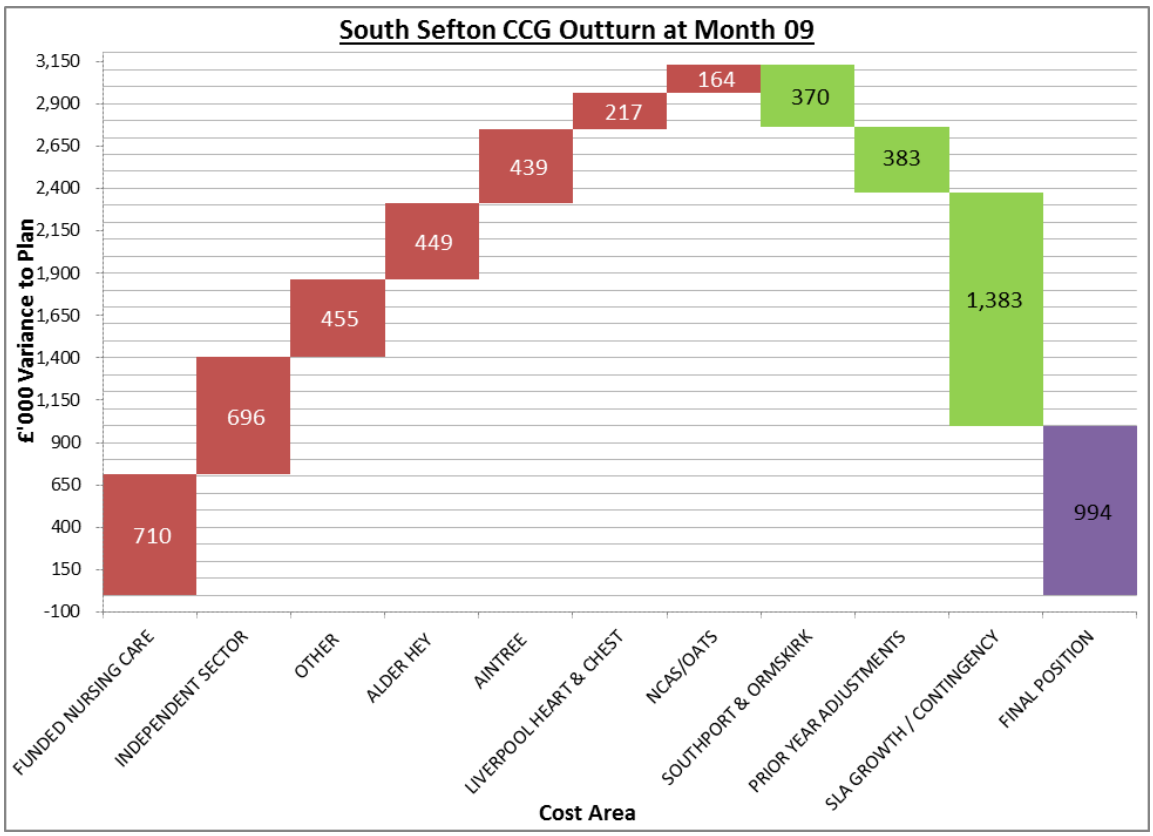
2.3 Position to date and forecast

The main financial pressures included within the financial position are shown below in figure 2, which presents the CCGs forecast outturn position for the year.

There are forecast pressures within funded nursing care due to the nationally mandated uplift, and in acute care. Pressures on acute budgets are particularly evident at Alder Hey, Aintree, Liverpool Heart & Chest and in the Independent Sector, mainly with Ramsay Healthcare.

The overspend is supported by underspends with other acute providers, notably Southport & Ormskirk Hospital and Liverpool Women's Hospital.

Figure 2 – Forecast Outturn



Prescribing

There is a year to date position is break even after adjusting for QIPP savings of £0.360m. The year-end forecast is breakeven.

Continuing Health Care and Funded Nursing Care (Non-NHS Commissioning)

The year to date position for the continuing care and funded nursing care (FNC) budget is an overspend of £0.606m, which reflects the current number of patients, average package costs, the nationally mandated FNC increase (£0.745m) and an uplift to CHC providers of 1.1% until the end of the financial year which has been communicated.

Year to date QIPP savings have been actioned against this budget to the value of £1.025m, relating to the additional growth budget of 5% included at budget setting and other efficiencies relating to prior year charges. The forecast financial position is taken following this budget reduction, and has been included in the QIPP plan for 2016/17.

The full year forecast is an overspend of £0.972m mainly due to the increased costs in respect to Funded Nursing Care of £0.745m. These costs are included within the CCG forecast position.

2.4 QIPP and Transformation Fund

The 2016/17 identified QIPP plan is **£10.384m.** This plan has been phased across the year on a scheme-by-scheme basis and full detail of progress at scheme level is monitored at the QIPP committee.

Figure 3 shows a summary of the current risk rated QIPP plan approved at the Governing Body in May 2016. This demonstrates that although recurrently there are a significant number of schemes in place, further work is being done to review red and amber rated schemes to determine whether they can be delivered before the end of the financial year. The detailed QIPP plan is projected to deliver £6.812m in total during the year

Figure 3 – RAG rated QIPP plan

2016/17 QIPP Plan	Rec	Non Rec	Total	Green	Amber	Red	Total
Planned care plan	(1,041)	113	(928)	(682)	(221)	(25)	(928)
Medicines optimisation	(1,429)	0	(1,429)	(1,289)	(140)	0	(1,429)
CHC/FNC plan	(530)	(525)	(1,055)	(1,025)	(30)	0	(1,055)
Discretionary spend plar	(178)	(3,976)	(4,154)	(3,351)	(478)	(325)	(4,154)
Urgent Care system rede	(2,817)	0	(2,817)	(11)	(40)	(2,766)	(2,817)
Total QIPP Plan	**(5,995)**	**(4,389)**	**(10,384)**	**(6,358)**	**(909)**	**(3,116)**	**(10,382)**
Risk rated QIPP plan				**(6,358)**	**(454)**	**0**	**(6,812)**

As shown in **Figure 4** and **5** below, £4.905m has been actioned at Month 9 against a phased plan of £7.381m.

Figure 4 – Phased QIPP plan for the 2016/17 year

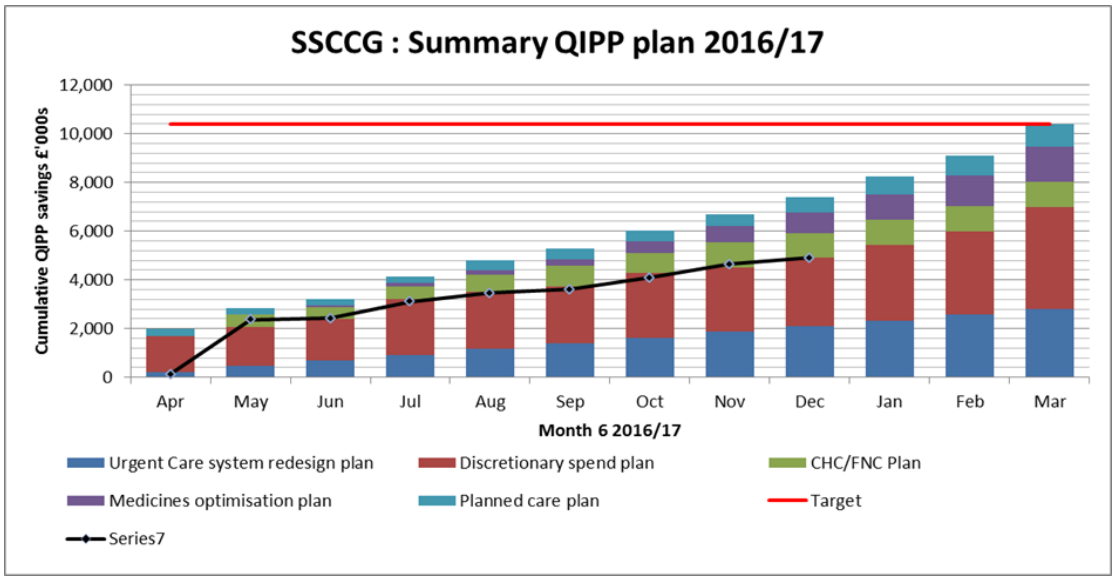


Figure 5 – QIPP performance at month 9

Scheme	In month current month (M8)					
	In month plan	In month actual	Variance	YTD Plan	YTD Actual	Variance
Planned care plan	60	0	(60)	529	388	(142)
Medicines optimisation plan	192	300	108	660	510	(150)
CHC/FNC Plan	185	185	0	1,025	1,025	0
Discretionary spend plan	4	70	66	2,647	2,708	61
Urgent Care system redesign plan	237	0	(237)	1,867	11	(1,856)
Total	**677**	**555**	**(122)**	**6,728**	**4,642**	**(2,086)**

QIPP delivery is **£2.476m** below plan at Month 9, largely due to urgent care. Although Non Elective costs have reduced compared to plan it is difficult to attribute these to specific schemes. There is a significant risk of delivery of the remaining plan with a high proportion of schemes rated red or amber meaning an increased target over the later months in the financial year.

Delivery of the agreed year-end surplus requires a saving of **£5.273** in the remaining three months of the financial year. An urgent and critical review of outstanding schemes is in progress and will be closely monitored between now and the year end. The CCG and scheme leads in particular, must work together to provide further assurance regarding the delivery of schemes.

2.5 CCG Running Costs

The running cost allocation for the CCG is £3.259m and the CCG must not exceed this allocation in the financial year.

The current year-end outturn position for the running cost budget is an underspend of £0.180m.

2.6 CCG Cash Position

In order to control cash expenditure within the NHS, limits are placed on the level of cash an organisation can utilise in each financial year.

The Maximum Cash Drawdown (MCD) is the maximum amount of cash available to a CCG each financial year and is made up of:

- Total Agreed Allocation
- Opening Cash Balance (i.e. at 1st April 2016)
- Opening creditor balances less closing creditor balances

Cash is held centrally at NHS England and is allocated monthly to CCGs following notification of cash requirements.

As well as managing the financial position, organisations must manage their cash position. The monthly cash requested should cover expenditure commitments as they fall due and the annual cash requested should not exceed the maximum cash drawdown limit.

The CCG is required to take part in an MCD submission to NHS England at months 6 and 9 to incorporate any changes in the CCGs forecast cash position to ensure sufficient cash is available throughout the financial year. An increase in MCD cannot always be accommodated.

Month 9 position

Following the month 6 submission, the MCD limit for South Sefton CCG for 2016/17 was increased from £241.032m to £250.582m. Up to Month 9, the actual cash received is £185.918m (74.2% of MCD) against a target of £187.937m (75.0% of MCD).

A full year cash flow forecast, based on information available at month 9, has been produced. This shows the CCG will have sufficient cash to meet its liabilities as they fall due. At month 12, the CCG is required to meet a cash target of 1.75% of its monthly cash drawdown (approximately £0.320m) as such where there is excess cash above this threshold; this will need to be returned to NHS England.

2.7 Evaluation of risks and opportunities

The primary financial risk for the CCG continues to be non-delivery of the QIPP target in this financial year. There are still a significant number of QIPP programmes that are currently rated as 'Red' or 'Amber' and work is underway to provide the required level of assurance to change these schemes to 'Green'.

In addition, a critical review of schemes rated 'Green' is currently being undertaken to ensure delivery is on target. Failure to do this will mean the CCG will not achieve the forecast surplus.

There are also a number of other risks that require ongoing monitoring and managing:

- Acute contracts – The CCG has historically experienced significant growth in acute care year on year, and this trend has continued in the current financial year. There is a particular risk in relation to overperformance at Aintree following the opening of its new urgent care centre as previously reported.

All members of the CCG have a role to play in managing these risks including GPs and other Health professionals to ensure individuals are treated in the most clinically appropriate and cost effective way to ensure that the acute providers are charging correctly for the clinical activity that is undertaken. This is continually reviewed during the financial year.

- Prescribing - This is a volatile area of expenditure but represents one of the biggest opportunities for the CCG, and as such, this makes up a significant element of the QIPP programme for 2016/17. The monthly expenditure and forecast is monitored closely as QIPP schemes continue to be delivered.

2.8 Reserves budgets / Risk adjusted surplus

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.

The assessment of the financial position is set out in in figure 6 below. This demonstrates that the CCG is required to deliver a total management action plan of £10.178m in 2016/17 in order to meet a revised surplus of £1.250m.

In order to deliver the planned surplus of £2.450m, the CCG is reliant on return of the 1% non-recurrent reserve, which remains uncommitted as directed by NHS England.

Delivery of the QIPP plan is extremely challenging and requires co-operation with partners across the healthcare economy. The CCG has recently allocated GP Governing Body member leads to each QIPP programme along with executive leads, and the leads meet on a monthly basis to report progress against their own programme to the Senior Team.

Figure 6 – Summary of Financial Position

	Recurrent £000	Non-Recurrent £000	Total £000
Target surplus	2.450		2.450
QIPP Target	(4.921)	(5.463)	(10.384)
Revised surplus / (deficit)	(2.471)	(5.463)	(7.934)
Forecast Outturn (against operational budgets)	(1.073)	0.079	(0.994)
Management action plan			
Actioned QIPP to date	1.863	3.042	4.905
Additional QIPP required	4.132	1.141	5.273
Total Management Action Plan	**5.995**	**4.183**	**10.178**
Year End Surplus / (Deficit)	**2.451**	**(1.201)**	**1.250**

Figure 7 below outlines the best, most likely and worst case scenarios. The best-case scenario assumes achievement of the remaining risk adjusted QIPP plan plus mitigation of £1.000m and additional QIPP of £2.147m.

The most likely case is a deficit of £2.115m which excludes mitigation but at this stage, assumes delivery of the remaining risk adjusted QIPP plan.

The worst case assumes only QIPP schemes rated Green in the current plan will be delivered for the remainder of the financial year as well as increased risk in respect of Acute Care.

Figure 7 – Risk Rated Financial Position

South Sefton	Best Case £m	Most Likely £m	Worst Case £m
Total QIPP Plan (to achieve 1% surplus)	(10.384)	(10.384)	(10.384)
QIPP achieved to date	4.905	4.905	4.905
Remaining QIPP requirement	**(5.479)**	**(5.479)**	**(5.479)**
Month 9 Forecast (I&E)	(0.994)	(0.994)	(0.994)
Remaining QIPP requirement to deliver NHSE plan (1% surplus)	**(6.473)**	**(6.473)**	**(6.473)**
Predicted QIPP achievement (M10-12)	1.908	1.908	1.453
Planned Surplus	2.450	2.450	2.450
Forecast Surplus / (Deficit)	**(2.115)**	**(2.115)**	**(2.570)**
Further Risk			
Acute Care	-	-	(1.000)
Management Action Plan			
Mitigation	1.000	-	-
Further QIPP delivery	2.365	-	-
Risk adjusted Surplus / (Deficit)	**1.250**	**(2.115)**	**(3.570)**

2.9 Recommendations

The Finance and Resource Committee is asked to receive the finance update, noting that:

- At Month 9, the CCG is forecasting a revised surplus of £1.250m which is deterioration from the agreed NHS target surplus of £2.450m.

- The financial position has deteriorated further during the month which means that the likely position is a deficit of £2.115m unless further QIPP savings can be delivered.
- Delivery of the £1.250m surplus requires QIPP savings of £5.273m in the remaining three months of the financial year.
- The CCG is undertaking an urgent and critical review of the remaining QIPP programme areas to provide assurance that the required level of savings can be achieved in the financial year
- 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.

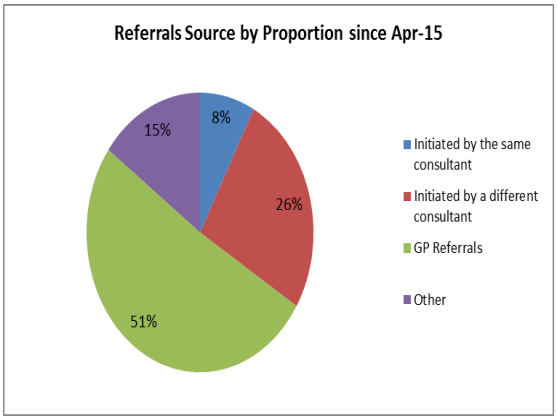
3. Planned Care

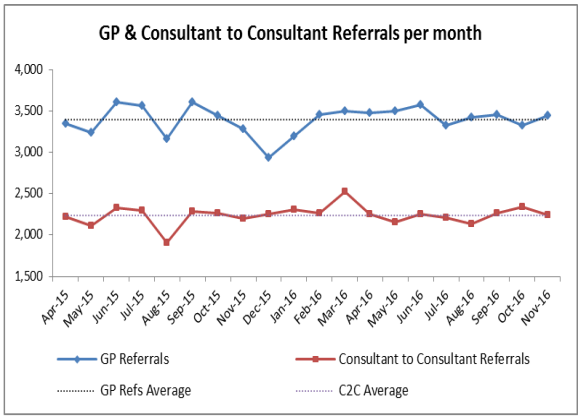
3.1 Referrals by source

Figure 8 - GP and 'other' referrals for the CCG across all providers for 2015/16 & 2016/17

NHS
South Sefton
Clinical Commissioning Group

Referral Type	DD Code	Description	1516 YTD	1617 YTD	Variance	% Variance
GP	03	GP Ref	27,260	27,524	264	1.0%
GP Total			27,260	27,524	264	1.0%
Other	01	following an emergency admission	1,359	1,140	-219	-16.1%
	02	following a Domiciliary Consultation	9	5	-4	0.0%
	04	An Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)	3,386	3,445	59	1.7%
	05	A CONSULTANT, other than in an Accident and Emergency Department	10,250	10,281	31	0.3%
	06	self-referral	2,377	2,202	-175	-7.4%
	07	A Prosthetist	11	10	-1	-9.1%
	08	Royal Liverpool Code (TBC)	554	612		
	10	following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)	787	781	-6	-0.8%
	11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	1,820	2,189	369	20.3%
	12	A General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)	52	45	-7	-13.5%
	13	A Specialist NURSE (Secondary Care)	70	63	-7	-10.0%
	14	An Allied Health Professional	873	1,140	267	30.6%
	15	An OPTOMETRIST	4	6	2	50.0%
	16	An Orthoptist	2	4	2	0.0%
	17	A National Screening Programme	39	43	4	10.3%
	92	A GENERAL DENTAL PRACTITIONER	1,027	1,107	80	7.8%
	93	A Community Dental Service	12	3	-9	-75.0%
	97	other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	2,849	2,407	-442	-15.5%
Other Total			25,481	25,483	2	0.0%
Unknown			19	0	-19	-100.0%
Grand Total			**52,760**	**53,007**	**247**	**0.5%**





Local referrals data from our main providers shows no change in the overall level of referrals comparing months 1-8 of 2016/17 with the previous year. GP referrals are slightly above comparing against the same period last year (1%, 264 referrals).

Discussions regarding referral management, prior approval, cataracts and consultant-to-consultant referrals continue, but a decision is yet to be reached.

Data quality note: Walton Neuro Centre & Renacres Hospital has been excluded from the above analysis due to validation errors in month 8 submission.

3.2 Diagnostic Test Waiting Times

Diagnostic test waiting times				
% of patients waiting 6 weeks or more for a Diagnostic Test **(CCG)**	16/17 - Nov	1.00%	0.85%	↑
% of patients waiting 6 weeks or more for a Diagnostic Test **(Aintree)**	16/17 - Nov	1.00%	0.78%	↑

Aintree aims to achieve the standard of less than 1% of patients waiting longer than 6 weeks for their diagnostic test. During November 2016, the Trust achieved the diagnostic monitoring standard reporting 0.78% of patients waiting in excess of 6 weeks.

The number of patients waiting over 6 weeks has increased to 35 in November (21 in the previous month). The diagnostic areas with over 1% of patient waiting more than 6 weeks are Flexi Sigmoidoscopy, Gastroscopy, Colonoscopy and CT. There are plans in place to reduce all waits to within the 6-week timeframe.

3.3 Referral to Treatment Performance

Referral To Treatment waiting times for non-				
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(CCG)**	16/17 - Nov	0	0	↔
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(Aintree)**	16/17 - Nov	0	0	↔
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(CCG)**	16/17 - Nov	92%	92.26%	↑
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(Aintree)**	16/17 - Nov	92%	90.21%	↑

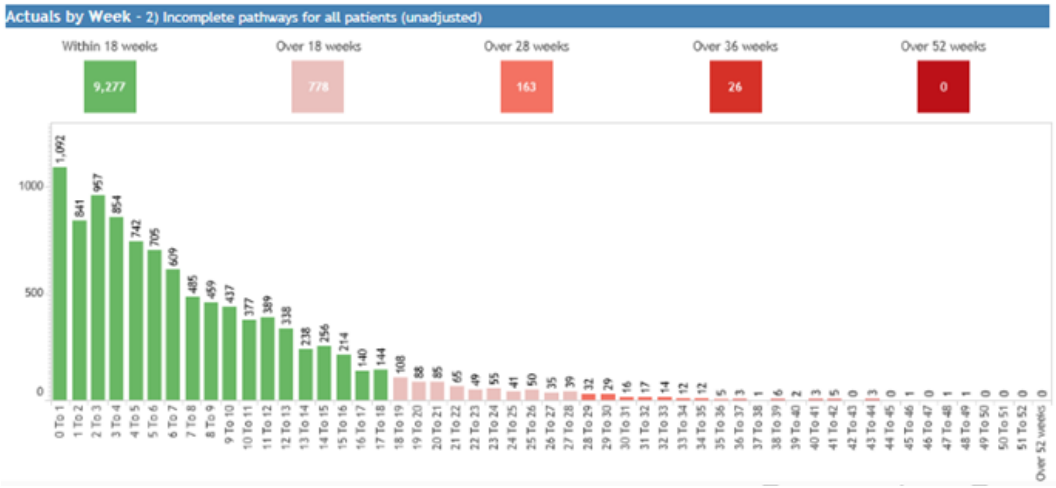
November saw the CCG achieve 92% target for RTT reaching 92.26%. Out of 10055 patients on the pathway, 778 patients were still waiting to receive treatment after 18 weeks.

For Aintree the RTT performance remains below the required DoH standard of 92% for all incomplete pathways at 90.21% during November 2016. This represents a marginal improvement from the previous month at 89.22%. Below are actions the Trust has put in place:

- Dermatology - An advert for the Specialty Doctor post was extended with one person moving to interview who subsequently withdrew.
- Support from a band 8a Pharmacist currently working part time at RLBHT has been secured and has now commenced in post. She will shortly begin seeing her own cohort of patients.
- Additional activity is being planned to be undertaken at weekends by a locum from Whiston.
- ENT surgeons have undertaking simple skin, head and neck cases.
- A Surgical Care Practitioner has an independent weekly list.
- A Locum Consultant commenced in September for 3 months but has now terminated his contract and left the Trust. The agency has one candidate who may be suitable but he is not available until January 2017 and an offer has not been made to secure his service.
- An initial discussion with commissioners and with Cheshire & Merseyside Providers of Dermatology services has been held with future follow-up meetings planned.
- Ophthalmology - Ophthalmic diagnostic technicians to increase diagnostic capacity to facilitate virtual clinics and streamline pathways have been appointed.
- The clinic template review has been completed for all medical staff and the nursing review is to be completed by the Matron
- External project management support commenced in June has now been extended until March to review pathways for both medical retina and glaucoma.
- Clinical Nurse Specialists are delivering IVI treatments. There are now 9 weekly clinical sessions.
- RTT PTLs are in operation and are conducted weekly by the Office Manager.
- An SAS doctor has started and her primary focus will be glaucoma outpatients.
- Isight capacity has been reviewed. Meetings are taking place between Isight Chief Operating Officer and the Trust to review the SLA and identify suitable patients to attend and increase throughput.
- Thoracic - Bank band 2 admin calling patients ahead of clinic weekdays between 4 and 6pm
- WLI clinics have been offered to all Thoracic consultants with an emphasis on General Respiratory.
- Appointment of agency consultant in lieu of filling vacancy (ref post approved as business case review group). Start date 14th November. Added clinic capacity 2.5 clinics per week.
- Management restructure proposal in Thoracic Labs planned.
- Agency physiologist in place from 10th October to cover maternity leave.
- Focus on reduction of patient cancellation and DNA rates to maximise clinic utilisation.
- All day Sleep clinics are being held most weekends as additional activity.

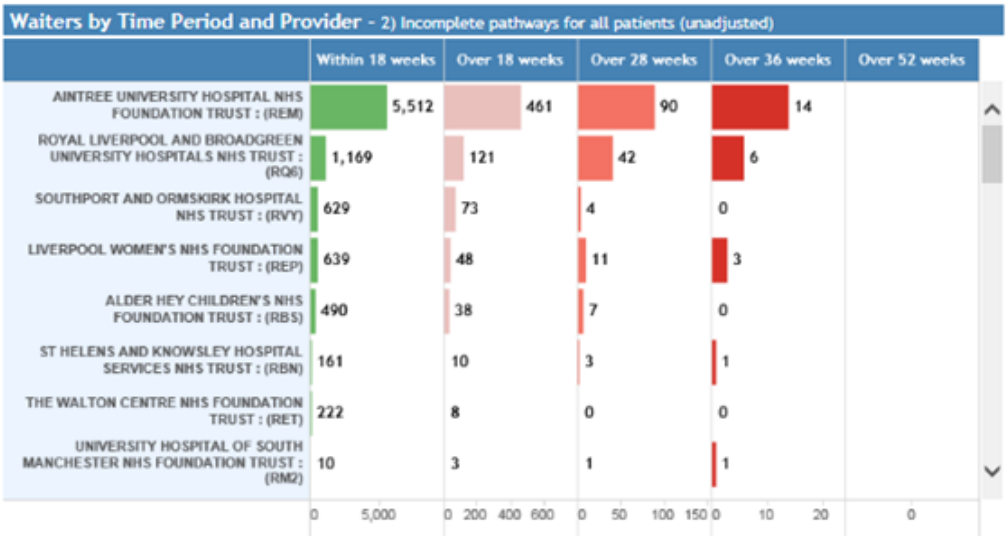
3.3.1 Incomplete Pathway Waiting Times

Figure 9 - South Sefton CCG Patients waiting on an incomplete pathway by weeks waiting



3.3.2 Long Waiters analysis: Top 5 Providers

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



3.3.3 Long Waiters analysis: Top 2 Providers split by Specialty

Figure 11 - Patients waiting (in bands) on incomplete pathways by Speciality for Aintree University Hospitals NHS Foundation Trust

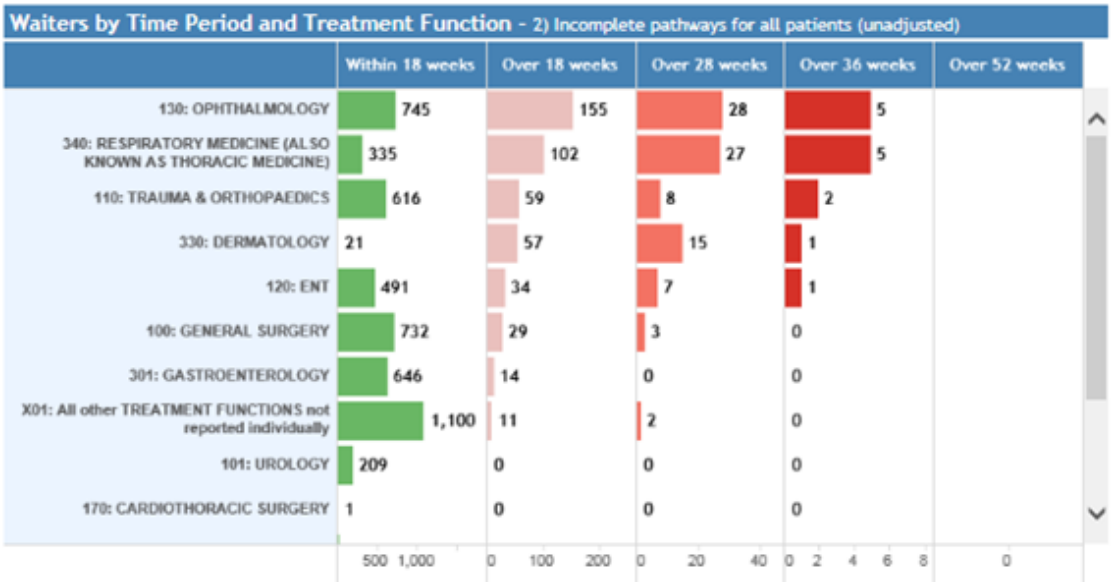
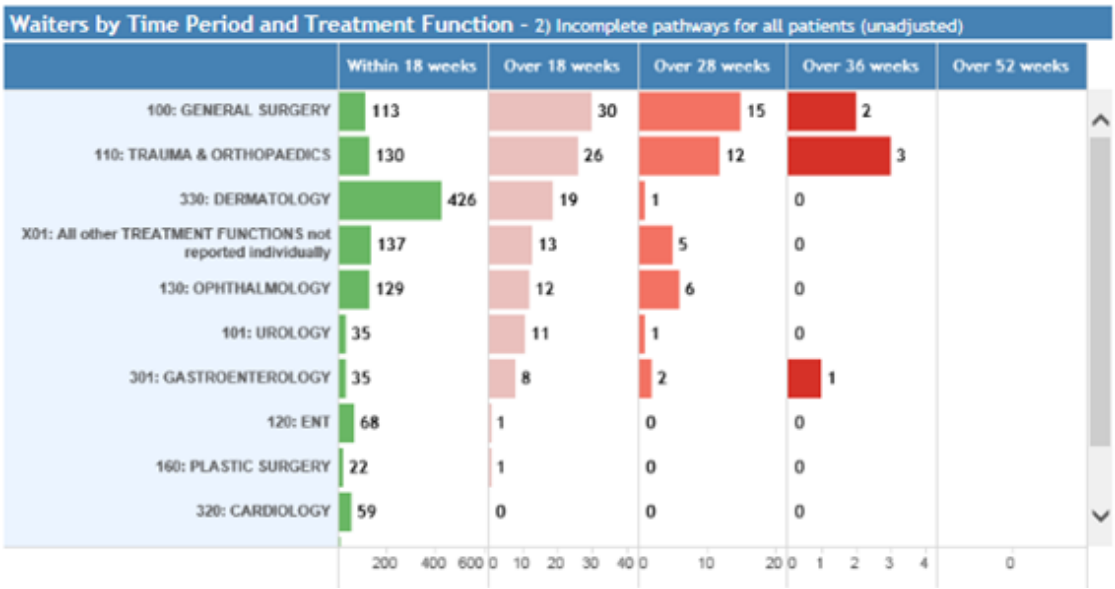


Figure 12 - Patient waiting (in bands) on incomplete pathway by Specialty for Royal Liverpool & Broadgreen University Hospital NHS Foundation Trust



3.3.4 Provider assurance for long waiters

NHS
South Sefton
Clinical Commissioning Group

CCG	Trust	Speciality	No of weeks waited	No of patient	Has patient been seen / has a TCI date?	Reason for the delay
South Sefton CCG	AINTREE	T&O	41	1	Yes TCI 15/12/2016	Capacity issue
South Sefton CCG	AINTREE	T&O	43	1	Yes TCI 23/12/2016	Capacity issue
South Sefton CCG	AINTREE	Ophthalmology	40	1	Clock stopped 05/12/2016 - patient declined treatment	Patient declined treatment
South Sefton CCG	AINTREE	Ophthalmology	47	1	Clock stopped 21/12/2016 - decision not to treat	Capacity issue
South Sefton CCG	AINTREE	Respiratory	40	1	Yes TCI 06/12/2016	Capacity issue
South Sefton CCG	AINTREE	Respiratory	44	1	Clock stopped 09/12/2016	Capacity issue
South Sefton CCG	ROYAL LIVERPOOL	T&O	41	1	Trust only provides updates for 42 plus week waiters	
South Sefton CCG	ROYAL LIVERPOOL	T&O	43	1	Validated - no longer long waiter	
South Sefton CCG	ROYAL LIVERPOOL	T&O	45	1	Clock Stop - 16/12/16	Capacity
South Sefton CCG	ROYAL LIVERPOOL	General Surgery	48	1	Clock Stop - 06/12/16	Capacity
South Sefton CCG	ROYAL LIVERPOOL	Gastroenterology	41	1	Trust only provides updates for 42 plus week waiters	
South Sefton CCG	LIVERPOOL WOMENS	Gynaecology	40	1	Yes	Patient initiated delay
South Sefton CCG	LIVERPOOL WOMENS	Gynaecology	41	1	Yes	Patient initiated delay
South Sefton CCG	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUSTT	T&O	43	1	TCI 27/02/2017	A spinal patient for removal of metalwork. The patient requested a date in February 2017 onwards as the family have plans over Christmas and also in Feb half-term. They are dated for 27/02/2017.

3.4 Cancelled Operations

3.4.1 All patients who have cancelled operations on or day after the day of admission for non-clinical reasons to be offered another binding date within 28 days

Cancelled Operations				
All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice - **Aintree**	16/17 - Nov	0	3	↑

Aintree had 3 cancelled operations in November failing the target. All patients were offered another treatment date within the 28 day period but refused this and chose to wait until January. Unfortunately as the patients were not offered 2 dates with 3 weeks' notice these are reported as a breach of the standard. Use of the access policy has been re-enforced to all admin teams.

3.4.2 No urgent operation to be cancelled for a 2nd time

Cancelled Operations				
No urgent operation should be cancelled for a second time - **Aintree**	16/17 - Nov	0	0	↔

3.5 Cancer Indicators Performance

NHS
South Sefton
Clinical Commissioning Group

3.5.1- Two Week Waiting Time Performance

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)**	16/17 - Nov	93%	95.85%	↔
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Aintree)**	16/17 - Nov	93%	95.82%	↔
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(CCG)**	16/17 - Nov	93%	93.82%	↔
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(Aintree)**	16/17 - Nov	93%	93.83%	↔

3.5.2 - 31 Day Cancer Waiting Time Performance

Cancer waits – 31 days				
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(CCG)**	16/17 - Nov	96%	98.34%	↔
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Aintree)**	16/17 - Nov	96%	99.21%	↔
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	16/17 - Nov	94%	96.50%	↔
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Aintree)**	16/17 - Nov	94%	0 Patients	↔
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	16/17 - Nov	94%	97.56%	↔
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Aintree)**	16/17 - Nov	94%	99.46%	↔
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	16/17 - Nov	98%	99.46%	↔
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(Aintree)**	16/17 - Nov	98%	100.00%	↔

3.5.3 - 62 Day Cancer Waiting Time Performance

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)**	16/17 - Nov	85% local target	82.61%	↓
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)**	16/17 - Nov	85% local target	90.88%	↔
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(CCG)**	16/17 - Nov	90%	100.00%	↔
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(Aintree)**	16/17 - Nov	90%	90.32%	↑
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(CCG)**	16/17 - Nov	85%	89.14%	↓
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(Aintree)**	16/17 - Nov	85%	87.09%	↔

The CCG failed the 85% local target in November achieving 60%, 3 out of 5 patients were upgraded within 62 days. The 2 breaches were lung patients, 1 was due to a late referral and the second had a complex pathway, the patient needed a repeat CT so was an unavoidable breach. Year to date the CCG are failing at 82.6%.

3.6 Patient Experience of Planned Care

Friends and Family Response Rates and Scores
Aintree University Hospital NHS Foundation Trust
Latest Month: **Nov-16**

Clinical Area	Response Rate (RR) Target	RR Actual	RR Trend Line	% Recommended (Eng. Average)	% Recommended	PR Trend Line	% Not Recommended (Eng. Average)	% Not Recommended	PNR Trend Line
Inpatient	25%	24.6%		95%	96%		2%	2%	

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

- % Response Rate
- % Recommended
- % Not Recommended

Aintree University Hospital NHS Foundation Trust routinely achieves the response rate target in excess of the regional and national response rates for both inpatients and A&E, however, inpatients is slightly under target for November. The proportion of patient who would recommended has decreased from previous month, decreasing from 97% to 96% in November, whilst the proportion who would 'not recommend' remains the same as previous month, both are within target range.

A pilot for collecting data by text message was deemed unsuccessful and affected both the number of responses and the performance. The Trust quickly returned to using cards with extra cards in place to encourage feedback. Response rate has improved, continues to rise and now approaching the usual rate displayed by the Trust.

Aintree's Patient Experience Lead will provide an update in April to the CCG Engagement and Patient Experience Group. The Trust will discuss how feedback obtained is informing the Trust where to improve services for its patients. This presentation is welcomed by EPEG and gives assurances that patient engagement and experience is considered as important as clinical effectiveness and safety in making up quality services.

The CCG Experience and Patient Engagement Group are in the process of creating a dashboard to incorporate information available from FFTs, complaints and compliments.

The Trust readily engages with Healthwatch and welcomes visits from the organisation.

3.7 Planned Care Activity & Finance, All Providers

Performance at Month 8 of financial year 2016/17, against planned care elements of the contracts held by NHS South Sefton CCG shows an over-performance of £553k, which is a percentage variance of 2%. At specific trusts, Renacres are reporting the largest cost variances with a total of £272k/25%.

Figure 13 - Planned Care - All Providers

NHS
South Sefton
Clinical Commissioning Group

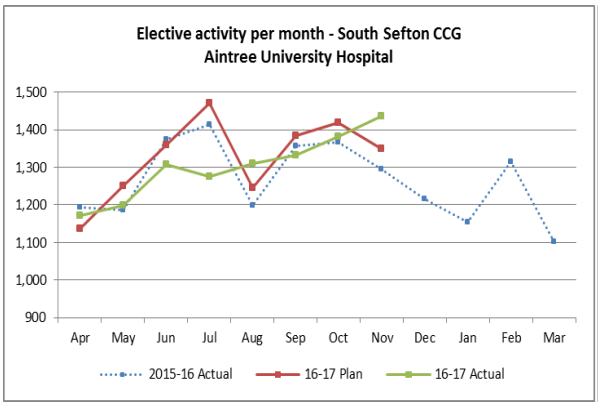
Provider Name	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	118,195	119,463	1,268	1%	£21,935	£21,942	£7	0%
Alder Hey Childrens NHS F/T	3,114	3,107	-7	0%	£909	£1,034	£125	14%
Central Manchester University Hospitals Nhs Foundation Trust	57	95	38	66%	£14	£19	£5	32%
Countess of Chester Hospital NHS Foundation Trust	0	119	119	0%	£0	£19	£19	0%
East Cheshire NHS Trust	0	5	5	0%	£0	£1	£1	0%
Fairfield Hospital	85	130	45	53%	£15	£36	£20	132%
ISIGHT (SOUTHPORT)	353	473	120	34%	£80	£104	£24	30%
Liverpool Heart and Chest NHS F/T	772	815	43	6%	£255	£309	£53	21%
Liverpool Womens Hospital NHS F/T	10,813	10,922	109	1%	£2,240	£2,196	-£44	-2%
Renacres Hospital	3,063	4,433	1,370	45%	£1,078	£1,350	£272	25%
Royal Liverpool & Broadgreen Hospitals	20,698	21,775	1,077	5%	£3,857	£4,006	£149	4%
Southport & Ormskirk Hospital*	9,683	9,140	-543	-6%	£2,080	£1,854	-£226	-11%
SPIRE LIVERPOOL HOSPITAL	1,909	1,562	-347	-18%	£601	£562	-£39	-6%
ST Helens & Knowsley Hospitals	2,757	2,833	76	3%	£723	£785	£62	9%
University Hospital Of South Manchester Nhs Foundation Trust	73	91	18	24%	£11	£18	£7	63%
Walton Neuro	2,230	2,314	84	4%	£568	£565	-£3	-1%
Wirral University Hospital NHS F/T	308	283	-25	-8%	£82	£78	-£4	-5%
Wrightington, Wigan And Leigh Nhs Foundation Trust	564	824	260	46%	£203	£328	£125	61%
Grand Total	**174,674**	**178,384**	**3,710**	**2%**	**£34,652**	**£35,204**	**£553**	**2%**

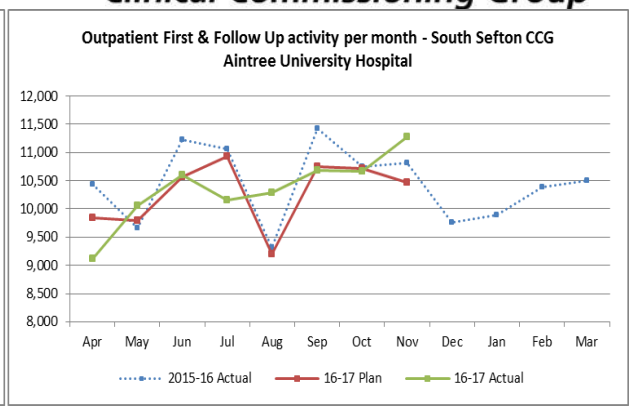
3.7.1 Planned Care Aintree University Hospital NHS Foundation Trust

Figure 14 - 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	9,221	9,159	-62	-1%	£5,969	£5,839	-£130	-2%
Elective	1,394	1,252	-142	-10%	£3,898	£3,742	-£156	-4%
Elective Excess BedDays	545	495	-50	-9%	£121	£109	-£12	-10%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	298	211	-87	-29%	£54	£42	-£12	-23%
OPFANFTF - *Outpatient first attendance non face to face*	1,637	2,202	565	35%	£46	£56	£10	22%
OPFASPCL - *Outpatient first attendance single professional consultant led*	22,186	22,809	623	3%	£3,322	£3,509	£188	6%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	993	754	-239	-24%	£108	£98	-£11	-10%
OPFUPNFTF - *Outpatient follow up non face to face*	2,123	2,958	835	39%	£51	£71	£20	39%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	55,050	53,897	-1,153	-2%	£4,383	£4,331	-£52	-1%
Outpatient Procedure	14,422	14,838	416	3%	£2,384	£2,496	£112	5%
Unbundled Diagnostics	9,352	9,839	487	5%	£856	£871	£15	2%
Wet AMD	974	1,049	75	8%	£743	£778	£35	5%
Grand Total	**118,195**	**119,463**	**1,268**	**1%**	**£21,935**	**£21,942**	**£7**	**0%**

NHS
South Sefton
Clinical Commissioning Group





Planned Care at Aintree University Hospital is recording comparable year to date costs against plan with a £7k over performance.

Cardiology is showing the largest cost variance in month 8 (£321k/27%). The cardiology over performance is largely related to day case activity.

Clinical Haematology is showing an over performance of £104k which is driven by Outpatient First Attendances.

Table below shows the Planned Care year to date variance by Specialty. Specialties have been filtered on anything more than £10k or below -£10k:

Specialty above £10k or below -£10k	DAY CASES		ELECTIVE INPATIENTS		ELECTIVE XBDS		OUTPATIENT FIRST ATT		OUTPATIENT FU ATT		OUTPATIENT PROCEDURES		Total Activity YTD Var	Total Price YTD Var
	Activity YTD Var	Price YTD Var	Activity YTD Var	Price YTD Var	Activity YTD Var	Price YTD Var	Activity YTD Var	Price YTD Var	Activity YTD Var	Price YTD Var	Activity YTD Var	Price YTD Var		
Cardiology	292	£269,662	2	£5,504	-19	-£4,095	572	£62,454	208	-£31,643	114	£19,541	1,168	£321,422
Clinical haematology	45	£12,634	2	£7,282	-19	-£4,370	229	£68,589	158	£19,637	3	£728	418	£104,501
Rheumatology	3	£1,253	0	£641	6	£1,309	89	£20,752	566	£49,613	9	£1,624	672	£75,191
Ent	8	£17,649	-17	£27,441			-67	-£7,339	3	£825	157	£20,240	84	£58,815
Physiotherapy							38	£891	1,587	£52,535	3	£99	1,628	£53,526
General surgery	6	£14,566	2	£34,727	72	£14,923	28	-£923	-99	-£10,950	1	£243	11	£52,585
Acute internal medicine	-2	-£1,425	1	-£3,363	-3	-£660	598	£48,829	-1	-£1,087	-32	-£4,647	561	£37,646
Nephrology	3	£4,101	-11	-£15,013	-5	-£1,351	154	£43,206	-122	-£3,260	-5	-£921	14	£26,761
Respiratory medicine	-14	-£32,355	-6	-£6,696	2	£548	26	£21,388	238	£4,117	160	£35,816	406	£22,817
Upper gastrointestinal surgery	-20	-£31,596	4	£43,512	14	£2,952	-20	-£2,321	3	£280	-1	-£406	-20	£12,420
Endocrinology	-3	-£2,399	-1	-£1,954			10	£1,910	143	£14,643			149	£12,200
Transient ischaemic attack							31	£9,891	-3	£0			28	£9,891
Interventional radiology	12	£5,849	-5	-£15,685	-3	-£632	55	£8,079	-11	-£910	-41	-£10,268	7	-£13,567
Diabetic medicine	36	£14,014	1	£2,770	-8	-£2,071	-87	-£18,266	-32	-£3,860	-66	-£8,598	-155	-£16,010
Vascular surgery	-16	-£16,913	-2	-£2,594			26	£4,509	-15	-£1,623	0	-£27	-6	-£16,648
Breast surgery	3	£16,257	5	-£17,744			-121	-£20,912	-117	-£3,868	16	£3,508	-215	-£22,759
Anticoagulant service									-1,819	-£46,792			-1,819	-£46,792
Dermatology	-26	-£14,537	1	£539			-274	-£30,400	-391	-£28,407	214	£12,177	-475	-£60,627
Hepatobiliary & pancreatic surgery	0	£3,060	-13	-£69,575	-1	-£232	10	£2,046	-42	-£4,036			-46	-£68,738
Gastroenterology	-147	-£114,327	-9	-£21,340	19	£3,982	-9	-£580	37	£23,089	29	£8,144	-80	-£101,033
Urology	-43	-£36,909	-34	-£77,255	-40	-£8,223	-268	-£35,756	111	£8,114	48	£44,436	-225	-£105,593
Trauma & orthopaedics	-14	-£124,941	-48	-£68,872	91	£19,806	46	£6,203	-99	-£9,018	-48	-£3,843	-72	-£180,665
Ophthalmology	-166	-£116,919	5	£881			-185	-£22,052	-333	-£31,957	-301	-£35,647	-979	-£205,695
Grand Total	**-62**	**-£130,273**	**-142**	**-£156,378**	**-50**	**-£11,610**	**1,101**	**£185,429**	**-557**	**-£42,209**	**416**	**£112,358**	**706**	**-£42,682**

3.7.2 Planned Care Southport & Ormskirk Hospital

Figure 15 - 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	634	576	-58	-9%	£514	£403	-£110	-21%
Elective	151	131	-20	-13%	£436	£390	-£47	-11%
Elective Excess BedDays	1	22	21	2110%	£0	£5	£5	2220%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	191	52	-139	-73%	£28	£9	-£20	-69%
OPFASPCL - *Outpatient first attendance single professional consultant led*	1,499	1,657	158	11%	£222	£240	£18	8%
OPFUPMPCL - *OP follow up Multi-Professional Outpatient First. Attendance (Consultant Led)*	394	134	-260	-66%	£39	£15	-£24	-61%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	3,528	3,486	-42	-1%	£316	£311	-£5	-2%
Outpatient Procedure	2,704	2,538	-166	-6%	£479	£438	-£41	-9%
Unbundled Diagnostics	579	544	-35	-6%	£44	£42	-£2	-4%
Grand Total	**9,683**	**9,140**	**-543**	**-6%**	**£2,080**	**£1,854**	**-£226**	**-11%**
* PbR only								

Planned care continues to underperform against plan but a number of areas have started to increase in the past few months. Elective procedures have increase slightly in the past three months but only just to planned levels. The Trust previously commented the shortage of theatre staff has affected the ability to perform higher levels of activity.

Outpatient first attendances remain above plan at month 8 and have consistently been above plan throughout 2016/17. The main influence for the increase is located within ENT and Ophthalmology.

3.7.3 Renacres Hospital

Figure 16 - Planned Care - Renacres Hospital by POD

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	393	416	23	6%	£441	£499	£58	13%
Elective	71	99	28	40%	£335	£474	£140	42%
OPFASPCL - *Outpatient first attendance single professional consultant led*	834	844	10	1%	£120	£121	£1	1%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	998	2,352	1,354	136%	£83	£136	£53	64%
Outpatient Procedure	479	329	-150	-31%	£70	£79	£8	12%
Unbundled Diagnostics	289	393	104	36%	£29	£41	£12	41%
Grand Total	**3,063**	**4,433**	**1,370**	**45%**	**£1,078**	**£1,350**	**£272**	**25%**

Renacres over performance of £272/25% is largely driven by a £140k over performance in Electives. Major Hip Procedures is the largest over performing HRG followed by Reconstruction Procedures. Combined costs for these two HRG's is £98k. The overperfomance at Renacres is mirrored by underperformance at other Trusts, namely Spire and Southport and Ormskirk Hospitals suggesting a shift in patient and GP choice.

4. Unplanned Care

4.1 Accident & Emergency Performance

A&E waits					
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG) All Types**	16/17 - Nov	95%	87.54%	↔	The CCG have failed the target in November reaching 84.34% and year to date reaching 87.54%. In November 1222 attendances out of 7801 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**	16/17 - Nov	95%	77.65%	↓	The CCG have failed the target in November reaching 70.94% (year to date 77.65%). In November 1221 attendances out of 4202 were not admitted, transferred or discharged within 4 hours.
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Aintree) All Types**	16/17 - Nov	STP Trajectory Target for Nov 95%	85.52%	↓	Aintree have failed the STP target of 95% in November reaching 81.11%. In November, 2446 attendances out of 12947 were not admitted, transferred or discharged within 4 hours. Year to date they are achieving 86.36%.
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Aintree) Type 1**	16/17 - Nov	95%	72.43%	↓	Aintree have failed the target in November reaching 62.98% and year to date reaching 73.81%. In November 2446 attendances out of 6607 were not admitted, transferred or discharged within 4 hours.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
STP Trajectory Aintree	90%	91%	92%	93%	94%	95%	95%	95%
Aintree Actual	89.48%	86.9%	87.50%	86.0%	84.10%	84.46%	84.76%	81.11%

Aintree failed to meet the Sustainability & Transformation Fund (STF) trajectory of 95% by September 2016 as agreed with NHS Improvement.

The Trusts' performance has improved marginally against the 4-hour standard, but remains below the required 95% at 81.11% for November 2016.

Implementation of the AED stream of the Emergency and Acute Care Plan commenced from 24th August 2016. Streaming and Pitstop have been implemented and support to the team to ensure these are embedded is in progress. Relaunch of the patient flow principles took place on 21 November followed by a relaunch of the AED model on 23 November. A presentation was delivered to the Intensive Recovery Programme Group on 24 November 2016 outlining work stream progress to date, remaining challenges/opportunities and support required.

- Following a recruitment campaign, one substantive consultant was appointed in September 2016. Support is being used from a recruitment company to further develop the recruitment strategy and recruit to the remaining two substantive vacancies.
- Maternity leave and paternity leave across the remaining Consultant staff is making cover of all shifts challenging. The use of Locum Consultants and GPs is being made to support the rota in the short term.
- Additional Emergency Nurse Practitioners (ENP) have been recruited and the hours of the nurse practitioners extended to 23:00. Four-week training programme for ENPs in expanded clinical areas is ongoing.
- A review of the portering workforce to support A&E and Acute Medical Unit has been undertaken and the Business Case submitted to Business Case Review Group. Further

detail is required with regards to patterns of demand. Information has been requested from the information team. Business Case to be re-submitted to BCRG in January 2017.

- Frailty Assessment Unit (FAU) opened on 6 December 2016. The unit comprises three functions: Rapid Assessment – early Multi-Disciplinary Team (MDT) and consultant geriatrician assessment within 1 hour of admission between 9am and 5pm, Monday to Friday.
- Ambulatory Care – same day treatment and discharge between 9am and 9pm, Monday to Friday.
- Short Stay – 48-hour length of stay area accepting admissions 24/7.
- Workstreams to progress actions arising from the rapid improvement event to reduce delayed discharges remain in place with action plans in progress. A 120 day event was held on 30th September and a follow-up event planned for February. The trajectory for reducing delayed discharges has been agreed with partners.
- A phased implementation of 'Purple to Gold' ('Value Add') commenced in October with a roll out plan agreed by December to cover all medical and surgical wards with dedicated input from Ward teams, CBU triumvirates, Divisional leadership across the Trust, Support Service teams and Executive leadership. Changes to job plans to support the implementation of this with daily ward and board rounds in Medicine specialties is in progress.

4.2 Ambulance Service Performance

Ambulance					
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	16/17 - Nov	75%	72.70%	↓	The CCG is under the 75% target year to date reaching 72.70%. In November out of 45 incidents there were 14 breaches (68.89%)
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	16/17 - Nov	75%	61.76%	↓	The CCG is under the 75% target year to date reaching 61.76%. In November out of 890 incidents there were 390 breaches (56.19%).
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	16/17 - Nov	95%	91.52%	↓	The CCG is under the 95% target year to date reaching 91.52%. In November out of 935 incidents there were 121 breaches (87.03%)
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	16/17 - Nov	75%	70.35%	↓	NWAS reported under the 75% target year to date reaching 70.35%. November reaching 62.80%.
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	16/17 - Nov	75%	64.07%	↔	NWAS failed to achieve the 75% target year to date reaching 64.07%. November reaching 60.35%.
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	16/17 - Nov	95%	89.95%	↓	NWAS failed to achieve the 95% target year to date reaching 89.95%. November reaching 86.79%.

Handover Times					
All handovers between ambulance and A & E must take place within 15 minutes (between 30 - 60 minute breaches) - **Aintree**	16/17 - Nov	0	227	↓	The Trust recorded 227 handovers between 30 and 60 minutes, this is a slight decline on last month when 281 was reported but still over the zero plan.
All handovers between ambulance and A & E must take place within 15 minutes (>60 minute breaches) - **Aintree**	16/17 - Nov	0	270	↓	The Trust recorded 270 handovers over 60 minutes, thisbelow the previous month when 294 were reported, but still over plan.

The CCG achieved none of 3 indicators for ambulance service performance. (See above of number of incidents / breaches).

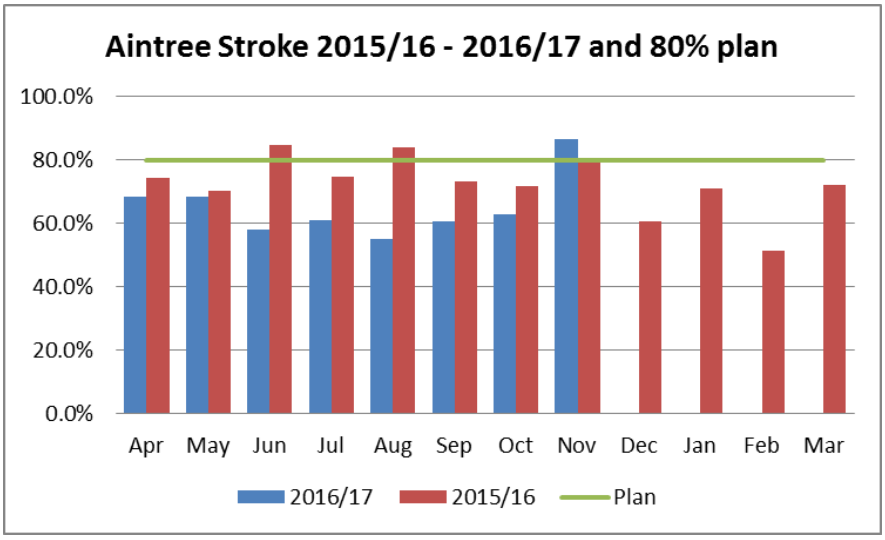
Ambulance turnaround times remain a key focus for improvement. In order to mitigate the problems caused by lack of available assessment space in the Emergency Department and prolonged ambulance handover delays; on 24 November 2016 Ambulance Pitstop was relocated to a new area within the Emergency Department comprising the following:

- Two x 7 mixed-sex trolley spaces within a self-contained unit within the ED with ward based facilities, toilet and shower and designated nursing staff.
- 1 x side room
- Substantial improvement in ambulance handover performance was recorded and between 26 November and 30 November there were no delays >2h. The area ceased to function as Ambulance Pitstop on 3 December due to staffing issues. At this time, it was used for patients with a DTA awaiting transfer to the main hospital bed base.
- Work with NWAS and all partners, including ECIP, is in place to ensure delivery of agreed actions in respect of ambulance handover, including final agreement on the function and SOP for the Ambulance Pitstop area.

4.3 Unplanned Care Quality Indicators

4.3.1 Stroke and TIA Performance

Stroke				
% who had a stroke & spend at least 90% of their time on a stroke unit **(Aintree)**	16/17 - Nov	80%	86.40%	↑
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(Aintree)**	16/17 - Nov	60%	100%	↔



Aintree have achieved the Stroke target in November 2016 for the first time since November 2015. The Trust have worked hard to implement the action plans described in previous months' reports, however sustainability of meeting the target longer term remains challenging.

4.3.2 Mixed Sex Accommodation

Mixed Sex Accommodation Breaches				
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(CCG)**	16/17 - Nov	0.00	0.00	↓
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(Aintree)**	16/17 - Nov	0.00	0.00	↓

4.3.3 Healthcare associated infections (HCAI)

HCAI				
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(CCG)**	16/17 - Nov	39	36	↑
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(Aintree)**	16/17 - Nov	30	31 (23 following appeal)	↑
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(CCG)**	16/17 - Nov	0	1	↔
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(Aintree)**	16/17 - Nov	0	0	↔

The CCG has had seven new C.difficile cases reported in November, a total of 36 cases year to date against a year to date plan of 39.

For Aintree this year there have been 31 patients with Trust apportioned CDT including 4 cases in November. However, 8 cases have been upheld following appeal year to date.

The National HCAI data capture system does not reflect appeal decisions taken locally therefore regional and national reporting of cases still includes those, which have been successfully appealed.

The CCG has had no new cases of MRSA in November and only reported their first case in September; this was a non-trust apportioned case.

4.3.4 Mortality

Mortality				
Hospital Standardised Mortality Ratio (HSMR)	16/17 - Nov	100	93.43	↔
Summary Hospital Level Mortality Indicator (SHMI)	16/17 - Q2	100	106.40	↑

HSMR is reported for the period September 2015 to August 2016 remains below expected at 93.83 after rebasing, this is slightly lower than last month when 93.83 was reported.

SHMI for the period April 2015 – March 2016 is as expected at 106.40 this has increased by 3 points and further analysis is planned by the Trust.

4.4 CCG Serious Incident Management

Serious incidents reporting within the integrated performance report is in line with the CCG reporting schedule for Month 8.

There are a total of 110 serious incidents open on StEIS where South Sefton CCG are either lead or responsible commissioner. 79 of these affect South Sefton CCG patients with seven reported in November.

Aintree University Hospitals NHS Foundation Trust - 31 open Serious Incidents on StEIS and no serious incident reported in November 2016 making a total of 20 year to date. 22 remain open for >100 days. 3 cases are subject to Safeguarding Adult Board (SAB) processes (Liverpool and Knowsley) and 1 subject to police investigation.

Liverpool Community Health NHS Trust - 35 open serious incidents on StEIS affecting South Sefton CCG patients. 15 remain open for >100 days, 1 case is subject to management by NHS England and another is under Local Safeguarding Children Board processes. There were 5 serious incidents reported in November 2016, a total of 33 year to date, 19 year to date relate to pressure ulcers. The Trust has a composite pressure ulcer action plan in place, which continues to be monitored at the monthly Clinical Quality and Performance meeting.

Mersey Care NHS Foundation Trust - 17 incidents open on StEIS for South Sefton CCG patients, with 11 remaining open >100 days. 1 serious incident was reported in November making a total of 14 year to date. Two incidents reported in June relate to Secure Services which are managed by NHS England Specialist Commissioning.

4.5 CCG Delayed Transfers of Care

Delayed transfers of care data is sourced from the NHS England website. The data is submitted by NHS providers (acute, community and mental health) monthly to the Unify2 system.

Delayed Transfers of Care (DTOC's) increased to 23 in November from 18 in October 2016 (21.74%). Patient and/or family choice resulted in 16 delayed transfers (69.57%), a further 5 were due to delays incurred whilst awaiting further NHS non acute care (21.74%) and 2 were due to awaiting care package in own home. (8.70%).

Analysis of delays in November 2016 compared to November 2015 illustrates a 4.3% decrease in total number of delays. For the number of patients awaiting further NHS non-acute care is the same as previous year (5) and 25% increase in delays due to patient or family choice (4).

Delayed Transfers of Care April – November 2016

	2015-16												2016-17							
Reason For Delay	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
A) COMPLETION ASSESSMENT	0	0	0	0	1	0	0	1	1	0	0	0	0	0	3	2	3	4	0	0
B) PUBLIC FUNDING	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
C) WAITING FURTHER NHS NON-ACUTE CARE	8	8	9	7	7	7	11	5	8	7	11	6	15	8	7	12	10	11	8	5
DI) AWAITING RESIDENTIAL CARE HOME PLACEMENT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DII) AWAITING NURSING HOME PLACEMENT	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
E) AWAITING CARE PACKAGE IN OWN HOME	3	1	0	1	3	1	2	6	0	0	1	2	3	4	7	6	5	4	4	2
F) COMMUNITY EQUIPMENT/ADAPTIONS	2	1	0	0	0	1	0	0	0	1	1	1	1	0	1	1	0	0	0	0
G) PATIENT OR FAMILY CHOICE	6	11	14	5	5	11	14	12	8	3	5	20	14	18	17	14	14	14	6	16
H) DISPUTES	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
I) HOUSING	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Grand Total	**20**	**22**	**24**	**13**	**16**	**20**	**27**	**24**	**17**	**11**	**18**	**30**	**33**	**30**	**36**	**35**	**32**	**33**	**18**	**23**

In terms of actions taken by the CCG to reduce the number of Delayed Transfers of Care within the acute setting, the Acute Care Commissioning Lead participates in the system wide teleconference each Monday at 12:30. This review of DTOC's, with participation from the acute Trust, Local Authorities and CCG's, assigns actions to key individuals and aims to remove those blockages which prevent a patient being discharged to their chosen place of care.

At times of severe pressure and high escalation the CCG Urgent Care lead participates in a system wide teleconference, which incorporates all acute trusts within the North Mersey AED delivery board, NWAS, local authorities, intermediate care providers, community care providers and NHSE to work collaboratively and restore patient flow.

Further plans to support the reduction of delayed transfers of care are being discussed within the CCG and include a comprehensive review of at least one DTOC each week with the aim of identifying key points of learning and improve future systems and processes.

The CCG is currently reviewing intermediate care services (ICB) to ensure sufficient capacity exists to expedite appropriate discharges at the earliest opportunity. Transitional beds are discussed between the acute provider, local authority and the CCG and agreed on an individual patient basis to facilitate early discharge to the most appropriate community setting.

4.6 Patient Experience of Unplanned Care

Friends and Family Response Rates and Scores
Aintree University Hospital NHS Foundation Trust

Latest Month: **Nov-16**

Clinical Area	Response Rate (RR) Target	RR Actual	RR Trend Line	% Recommended (Eng. Average)	% Recommended	PR Trend Line	% Not Recommended (Eng. Average)	% Not Recommended	PNR Trend Line
A&E	15%	17.2%		87%	85%		7%	9%	

The Friends and Family Test (FFT) Indicator 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 for A&E.

The percentage of people that would recommend A&E has recently fallen and is now under the England average along with the not recommended percentage.

As mentioned with the planned care FFT, the underperformance and downward trend was due to an unsuccessful pilot for collecting data by text message, affecting both the number of responses and the performance. The Trust immediately returned to using cards following which the response rate has been improving with a slight reduction noted in November. The rate is above target. The Trust FFT indicators are monitored monthly at their Patient Experience Executive Led Group.

Aintree's Patient Experience Lead is due to attend the CCG's EPEG group in April. This will provide an update of the Trusts Patient Experience Strategy and how they use Friends and Family data to inform the Trust on improving services for their patients and provide assurance that patient engagement and experience is considered as important as clinical effectiveness and safety in making up quality services.

The Trust engages readily with Healthwatch and welcomes visits from the organisation.

4.7 Unplanned Care Activity & Finance, All Providers

4.7.1 All Providers

Performance at Month 8 of financial year 2016/17, against unplanned care elements of the contracts held by NHS South Sefton CCG shows an under-performance of circa -£612k/-2%.This under-performance is clearly driven by Aintree Hospital reporting an under performance of -£564k/-2%. Alder Hey Hospital is reporting the largest year to date over performance with a £110/8% variance. Further analysis is taking place of the Alder Hey contract to understand the key areas of over performance alongside population measures such as birth rates.

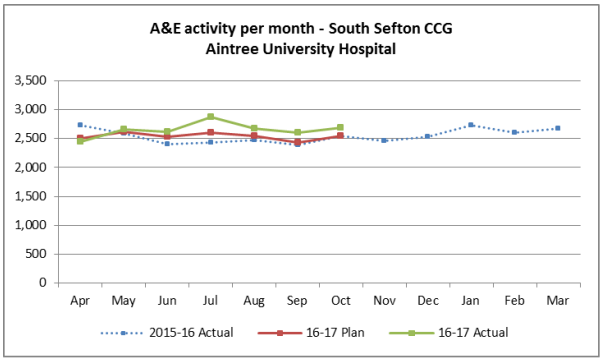
Figure 17- Month 8 Unplanned Care – All Providers

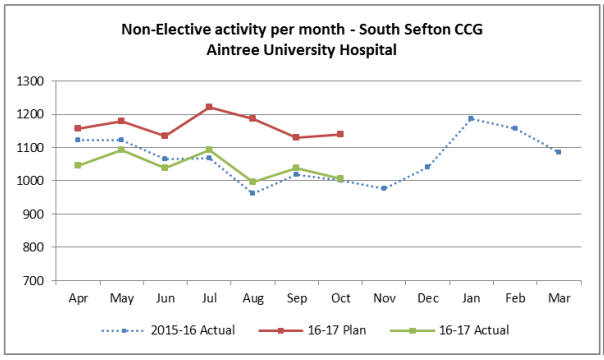
Provider Name	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	63,661	70,330	6,669	10%	£23,303	£22,739	-£564	-2%
Alder Hey Childrens NHS F/T	6,353	6,407	54	1%	£1,330	£1,440	£110	8%
Central Manchester University Hospitals Nhs Foundation Trust	45	47	2	5%	£11	£8	-£3	-25%
Countess of Chester Hospital NHS Foundation Trust	0	41	41	0%	£0	£18	£18	0%
Liverpool Heart and Chest NHS F/T	153	80	-73	-48%	£175	£221	£47	27%
Liverpool Womens Hospital NHS F/T	2,586	2,340	-246	-10%	£2,299	£2,295	-£4	0%
Royal Liverpool & Broadgreen Hospitals	4,367	3,949	-418	-10%	£1,617	£1,388	-£229	-14%
Southport & Ormskirk Hospital	8,586	8,705	119	1%	£1,943	£1,941	-£3	0%
ST Helens & Knowsley Hospitals	596	675	79	13%	£240	£260	£21	9%
University Hospital Of South Manchester Nhs Foundation Trust	27	24	-3	-13%	£9	£7	-£2	-20%
Wirral University Hospital NHS F/T	163	138	-25	-15%	£59	£44	-£15	-26%
Wrightington, Wigan And Leigh Nhs Foundation Trust	28	30	2	7%	£10	£22	£12	115%
Grand Total	**86,565**	**92,766**	**6,201**	**7%**	**£30,996**	**£30,383**	**-£612**	**-2%**

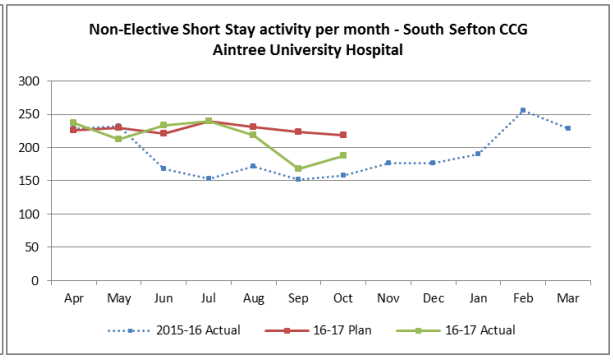
4.7.2 Aintree University Hospital NHS Foundation Trust

Figure 18 - Month 8 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	26,988	31,719	4,731	18%	£642	£642	£0	0%
A&E - *Accident & Emergency*	20,156	21,067	911	5%	£2,493	£2,611	£118	5%
NEL - *Non Elective*	9,278	8,264	-1,014	-11%	£17,732	£16,620	-£1,113	-6%
NELNE - *Non Elective Non-Emergency*	29	28	-1	-5%	£82	£94	£12	14%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	27	89	62	234%	£6	£19	£12	190%
NELST - *Non Elective Short Stay*	1,821	1,675	-146	-8%	£1,195	£1,170	-£25	-2%
NELXBD - *Non Elective Excess Bed Day*	5,362	7,488	2,126	40%	£1,152	£1,584	£432	38%
Grand Total	**63,661**	**70,330**	**6,669**	**10%**	**£23,303**	**£22,739**	**-£564**	**-2%**







4.7.3 Aintree Hospital Key Issues

Urgent Care under spend of -£564k is driven by a -£1.1m under performance in Non Elective activity. This under performance offsets the £432k over performance seen in Non Elective Excess Bed Days. Excess bed days has been raised through the official challenge process and reported through the various exec boards.

5. Mental Health

5.1 Mersey Care NHS Trust Contract

Figure 19 - NHS South Sefton CCG – Shadow PbR Cluster Activity

	NHS South Sefton CCG			
PBR Cluster	Caseload as at 30/11/2016	2016/17 Plan	Variance from Plan	Variance on 30/11/2015
0 Variance	100	88	12	9
1 Common Mental Health Problems (Low Severity)	42	42	-	(1)
2 Common Mental Health Problems (Low Severity with greater need)	25	22	3	1
3 Non-Psychotic (Moderate Severity)	150	217	(67)	(47)
4 Non-Psychotic (Severe)	272	215	57	53
5 Non-psychotic Disorders (Very Severe)	67	62	5	6
6 Non-Psychotic Disorder of Over-Valued Ideas	46	40	6	9
7 Enduring Non-Psychotic Disorders (High Disability)	252	192	60	60
8 Non-Psychotic Chaotic and Challenging Disorders	122	98	24	24
10 First Episode Psychosis	143	138	5	7
11 On-going Recurrent Psychosis (Low Symptoms)	393	433	(40)	(37)
12 On-going or Recurrent Psychosis (High Disability)	353	307	46	42
13 On-going or Recurrent Psychosis (High Symptom & Disability)	102	112	(10)	(7)
14 Psychotic Crisis	28	21	7	5
15 Severe Psychotic Depression	6	6	-	2
16 Psychosis & Affective Disorder (High Substance Misuse & Engagement)	38	34	4	6
17 Psychosis and Affective Disorder – Difficult to Engage	50	58	(8)	(9)
18 Cognitive Impairment (Low Need)	220	223	(3)	(4)
19 Cognitive Impairment or Dementia Complicated (Moderate Need)	446	505	(59)	(56)
20 Cognitive Impairment or Dementia Complicated (High Need)	397	332	65	67
21 Cognitive Impairment or Dementia (High Physical or Engagement)	139	76	63	68
Cluster 99	553	402	151	184
Total	3,944	3,623	321	382
	-		8.14%	-

5.1.1 Key Mental Health Performance Indicators

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

		Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
E.B.S.3	The % of people under mental illness specialities who were followed up within 7 days of discharge from psychiatric inpatient care	95%	100%	100%	100%	100%	94%	100%	93%	95%

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

		Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
KPI_19	CPA follow up 2 days (48 hours) for higher risk groups are defined as individuals requiring follow up within 2 days (48 hours) by appropriate Teams	95%	100%	100%	No Patients	100%	100%	100%	100%	100%

Figure 22 - Figure 16 EIP 2 week waits

		Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
NR_08	Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral (in month)	50%	0%	100%	33.33%	50%	50%	86%	100%	75%
	Rolling Quarter				37.50%	50%	50%	73%	100%	86%

5.1.2 Mental Health Contract Quality Overview

Commissioners continue to be involved in the Trust's review of the acute care pathway (including crisis). This initial scoping and gathering of evidence and intelligence is expected to be completed by February 2017. The review will consider system wide issues that impact on the effective delivery of the acute care pathway, these will include pathways in and out of the Mersey Care services and the interfaces with other providers and partners and will recommend models for each of the Mersey Care services (e.g. Access Service, A&E Liaison, Community Mental Health Teams), functions in the pathway (Stepped Up Care, Bed Management, Single Point of Access) and specialist pathways (e.g. personality disorder pathway, in-patient pathway).

The recommendations from the Review will be considered by both Mersey Care NHS Foundation Trust and the North Mersey Transformation. If accepted, the implementation of the recommendations will form a key area of work for both the Trust and the Transformation Board to begin from 2017/18 onwards.

At the December 2016 CQPG, the CCG raised concerns regarding the underperformance in relation to the 'timeliness of GP Communications / Discharge Letters, since this KPI stopped being a CQUIN, the Trust has failed to meet the targets. A meeting was held with the Trust in December 2016 to discuss the underperformance in relation to GP communication KPIs, in South Sefton and Southport & Formby CCGs. The Trust confirmed that there are issues particularly from the Clock View site regarding timeliness of discharge summaries due to clinical staffing capacity. The Trust has added this to their Risk Register. The roll out of the RIO clinical IT system should have a positive impact on performance. However, the Trust confirmed in December 2016 that the RIO roll out has been put on hold due to 'technical issues'. Performance will continue to be monitored via the CQPG and a full report and action will be requested for submission at the February 2017 CQPG. The Trust has indicated that a formal communication relating RIO implementation will be sent to CCGs later in January 2017.

5.2 Improving Access to Psychological Therapies

Figure 23 - **Monthly Provider Summary including (National KPI s Recovery and Prevalence)**

NHS
South Sefton
Clinical Commissioning Group

Performance Indicator	Year	April	May	June	July	August	September	October	November	December	January	February	March
National defininiton of those who have entered into treatment	2015/16	143	158	201	204	166	232	184	252	267	343	262	256
	2016/17	282	295	293	272	244	268	269	253				
2016/17 approx. numbers required to enter treatment to meet monthly Access target of 1.3%	*Target*	*306*	*306*	*306*	*306*	*306*	*306*	*306*	*306*	*306*	*306*	*306*	*306*
	Variance	*-24*	*-11*	*-13*	*-34*	*-62*	*-38*	*-37*	*-53*				
	%	*-7.9%*	*-3.6%*	*-4.3%*	*-11.2%*	*-20.3%*	*-12.5%*	*-12.1%*	*-17.4%*				
Access % ACTUAL *- Monthly target of 1.3%* *- Year end 15% required*	2015/16	0.6%	0.7%	0.8%	0.8%	0.7%	1.0%	0.8%	1.0%	1.1%	1.4%	1.1%	1.1%
	2016/17	1.2%	1.2%	1.2%	1.1%	1.0%	1.1%	1.1%	1.0%				
Recovery % ACTUAL *- 50% target*	2015/16	60.0%	45.1%	56.0%	52.0%	45.0%	48.1%	53.6%	47.1%	38.6%	32.5%	46.4%	50.0%
	2016/17	40.9%	45.4%	45.7%	41.4%	42.7%	43.5%	41.5%	44.4%				
ACTUAL % 6 weeks waits *- 75% target*	2015/16	96.8%	94.2%	94.1%	96.6%	95.4%	97.2%	93.8%	94.7%	98.3%	93.5%	99.1%	96.3%
	2016/17	93.5%	98.5%	96.4%	97.4%	97.7%	95.5%	98.0%	99.5%				
ACTUAL % 18 weeks waits *- 95% target*	2015/16	99.2%	99.2%	100.0%	100.0%	100.0%	100.0%	99.3%	100.0%	100.0%	99.2%	100.0%	100.0%
	2016/17	100.0%	100.0%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%				
National definition of those who have completed treatment (KPI5)	2015/16	134	117	120	136	119	143	117	132	119	124	114	162
	2016/17	163	147	141	153	133	163	150	199				
National definition of those who have entered Below Caseness (KPI6b)	2015/16	9	4	11	9	10	8	5	13	5	7	2	6
	2016/17	4	6	3	1	2	9	8	10				
National definition of those who have moved to recovery (KPI6)	2015/16	75	51	61	66	49	65	60	56	44	38	52	78
	2016/17	65	64	63	63	56	67	59	84				
Referral opt in rate (%)	2015/16	95.4%	89.9%	80.3%	73.8%	78.2%	74.3%	72.0%	66.2%	75.0%	86.0%	83.0%	84.0%
	2016/17	85.1%	88.3%	88.3%	81.9%	80.2%	80.4%	84.0%	76.8%				

The provider (Cheshire & Wirral Partnership) reported 253 South Sefton patients entering treatment in month 8, which is a slight decrease to the previous month. The access standard (access being the number of patients entering first treatment as a proportion of the number of people per CCG estimated to have common mental health issues) is currently set at 15% for 2016/17 year end. Current activity levels provide a forecast outturn of 13.4% against the 15% standard. This would represent an improvement to 2015/16 when South Sefton CCG reported a year end access rate of 11.0%.

There were 383 Referrals in Month 8, which was an increase of 16% compared to the previous month; of these 65% were Self-referrals. GP Referrals increased to 75 compared to 61 for Month 7. The provider is working closely with Clock View, attending weekly MDT meetings to agree appropriateness of clients for service.

The percentage of people moved to recovery was 44.4% in month 8, which does not meet the minimum standard of 50%. A forecast outturn at month 8 gives a year end position of 43.2%, which is below the year- end position of 2015/16 (48.0%). The provider believes that it is possible recovery will dip as the longest waiters are brought into service, as more are likely to disengage without completing treatment. However, as waits reduce, this is expected to improve.

Cancelled appointments by the provider saw a slight increase in month 8 from 58 reported in month 7 to 63 in month 8.

There was an increase of 28% in DNAs in Month 8 (from 137 in month 7 to 176 in month 8); the provider has commented that the DNA policy has been tightened with all clients made aware at the outset. Cancelled slots are being made available for any assessments/entering therapy appointments.

To date in 2016/17, 96% of patients that finished a course of treatment waited less than 6 weeks from referral to entering a course of treatment. This is against a standard of 75%. 100% of patients have waited less than 18 weeks (against a standard of 95%). The provider has achieved the monthly RTT targets throughout 2015/16 and in the first eight months of 2016/17 for South Sefton CCG.

5.2.1 Improving Access to Psychological Therapies Contract Quality Overview

Internal waiting lists within the service are impacting on both recovery and access KPIs and the service continues to implement the actions identified in month 7 through additional staff/sessions, group work and changing working practices.

At the end of October 2016 a total of 798 patients were identified within the service as waiting for their second appointment with an average wait time of 61.4 days.

At the end of November 2016 a total of 714 patients were identified within the service as waiting for their second appointment with an average wait time of 54.9 days. Internal wait information is being submitted weekly by the provider.

In South Sefton the provider has forged links with the VCF sector and in particular the SWAN Centre that has enabled joint working opportunities including counselling room capacity which commenced late in November 2016.

Progress will be continue to be monitored via the Quality and Contract meetings

Efforts continue to receive a copy of the Intensive Support Team report following their visit on 21st October 2016.

5.3 Dementia

Summmary for NHS South Sefton dementia registers at 30-11-2016

People Diagnosed with Dementia (Age 65+)	1,183
Estimated Prevalence (Age 65+)	2,091
Gap - Number of addition people who could benefit from diagnosis (all ages)	994
NHS South Sefton - Dementia Diagnosis Rate (Age 65+)	56.6%
National estimated Dementia Diagnosis Rate	68.0%
Target	66.70%

Latest guidance from Operations and Guidance Directorate NHS England has confirmed that following a review by NHS Digital a decision has been made to change the way the dementia diagnosis rate is calculated for April 2017 onwards. The new methodology is based on GP

registered population instead of ONS population estimates. Using registered population figures is more statistically robust than the previous mixed approach. The new methodology takes the calculation of South Sefton's diagnosis rate to 63.5% for November 2016, an increase of 7%.

The latest data on the NHS England site (in the above table) is not using the new methodology as yet, hence a lower rate.

6. Community Health

6.1 Liverpool Community Health Contract

There is currently a District Nursing systems review taking place across LCH. This is to review processes in relation to manual and electronic requirements. EMIS mobile is not yet available for DNs and so there is a requirement to duplicate information on paper and on EMIS. This is known to impact on the level of information added to the system. The current variance though is within agreed tolerance levels and the Trust is forecasting that activity levels will be higher than last year.

An EMIS mobile app was trialled in Adult Physio, so staff can enter information straight onto the system in the community rather than making paper records and then having to duplicate the information in EMIS. This programme was delivered by informatics Merseyside. In addition, a report has been produced in relation to the pilot which will be shared with the CCG shortly.

6.1.1 Patient DNA's and Provider Cancellations

A number of services have seen a high number of DNA's and Provider cancellations so far in 2016/17.

For patient DNAs, Sefton Physio Service reported a high rate of 10.6% in November, however this is an improvement on last month. Adult Dietetics is also high this month at 23.8% compared to 20% last month, as well as Paediatric Dietetics at 14.8% compared to 10% last month. Total DNA rates for South Sefton are green for this month at 6.5%.

Provider cancellation rates remain relatively static this month, with the exception of Adult Dietetics reporting 6.3% compared to 10.8% last month and Paediatric Dietetics reporting 13.2% compared to 0% last month (7 cancellations this month). Total Trust cancellation rate for Sefton is green at 2% this month.

Treatment rooms, Podiatry, Physio, Adult Dietetics, and Paediatric Dietetics have all continued the trend of previous years showing high numbers of patient cancellations. All services are above 10% for November 2016. Total patient cancellations for Sefton have decreased in November to 10.6%.

The following policies are in place in the Trust to try to reduce patient cancellations and DNA's:-

- An "opt-in" policy where patients are asked to ring up to book an appointment.
- Information posters in some buildings on DNA/cancellation rates.
- Text reminders to reduce DNA's.

Patient cancellation rates have been discussed in previous contract review meetings. In instances where appointments are rearranged, the only way to take the original appointment off the system is to cancel it and then re-book. It was agreed that this does not necessarily mean this is having a

negative effect on the patient or the utilisation of the clinic, as that slot could potentially be rebooked. It was suggested that a clinic utilisation report may be useful but the Trust has not yet provided one.

6.1.2 Waiting Times

The following issues have arisen in November 2016:

Physiotherapy: Waiting times have steadily increased over the past 5 months, resulting in this service failing the 18-week target again in November – 20 weeks on the incomplete pathway and 28 weeks on the completed pathway. The longest waiters were two patients waiting at 26 weeks.

Occupational Therapy: Waiting times on the completed pathways (95th Percentile) have gradually increased over the past 3 months resulting in a breach of the 18-week target, an average of 23 weeks being reported in November. The longest waiter was at 21 weeks.

Podiatry: Waiting times on the completed pathways have steadily declined over the past 5 months, whilst the incomplete have remained relatively steady. The average wait (95th percentile) on the completed pathway was 19 weeks in November. The longest waiter was at 34 weeks.

Nutrition & Dietetics: Waiting times on the completed pathways have increased to 22 weeks from the 19 weeks reported in October, therefore this service is still reporting a breach of the 18-week target, whilst the incomplete pathway is still achieving. The longest waiter was at 34 weeks.

Paediatric SALT: A new reporting process has now been set up for this service, and the Trust has begun to report waiting times information from August. In November, on the incomplete pathway the average waiting time (92nd percentile) increased from 33 weeks to 36 weeks, with the longest waiting patient increasing to 3 patients at 42 weeks. This service has consistently breached the 18 week target since it began reporting in August, with waiting times steadily increasing.

6.2 Any Qualified Provider LCH Podiatry Contract

The trust continues to use the £25 local tariff. At month 8 2016/17 the YTD costs for the CCG are £206,821 with attendances at 2,200. At the same time period last year the costs were £261,246 and attendances at 2,839.

6.2.1 Liverpool Community Health Quality Overview

The Trust regularly revises their CQC Action Plan and shared with commissioners, the Trust will be supported with progressing actions up until services are transferred to the new providers. Therapies waiting times are being monitored through the CQC Action Plans at the Collaborative Forum (CF) and CQPGs. The Trust's Executives and the CQC have been invited to the January 2017 CF to review progress against the Action Plans.

The CCG has agreed a revised waiting time trajectory for Paediatric SALT with LCH to allow the Trust to develop a new service model, this will be reviewed at the end of the financial year. Patient experience and complaints / feedback are regularly monitored at CQPG meetings. At the end of November 2016, 96.7% of patients who responded to FFT positively recommended the Trust as a place to receive treatment and care.

Healthwatch Sefton have produced a draft Patient Experience Report for Litherland (WIC) Walk in Centre - for outreach carried out during August and September 2016 at the December CQPG LCH's Sefton Locality Team reported that it was a 'really positive report', with the overall score being 4.5 out of 5 stars. The report is to be reviewed for factual accuracies and action plan to be completed and shared with Healthwatch by 13th January 2017.

6.3 Southport and Ormskirk Trust Community Services

EMIS Switch Over

Activity

The Trust continue to progress in moving over services from the old IPM clinical system to EMIS. As this continues potential data quality and reporting issues may arise. The CCG has requested from the Trust a detailed report on the issues affecting each service and actions on how these are to be resolved.

Since the shift from IPM to EMIS reporting on Referrals, Contacts and Waiting times have been affected. The CCG and Trust are working together to resolve the issues. The Trust has advised of the following issues and is continuing to work through them service by service;

- The Trust is unable to split out domiciliary and clinic activity from EMIS, activity is currently being reported as a combined figure for the time being.
- There are some duplicates in the referrals data as all open caseloads had to be migrated across.

All services have now gone live on the new system.

Waiting times

At the latest Information Sub Group meeting the Trust presented a waiting times report which highlighted the extent of the current data quality issues since the system switch over. The Trust will continue to provide the waiting times report monthly and highlight the services where the data quality has been corrected for the CCG to monitor.

The report highlights issues in Phlebotomy and Treatment Rooms with waiting times increasing over recent weeks. The Trust continues to monitor this and update the CCG.

This service is going to be discussed at the next contract meeting with the Trust and the CCG.

7. Third Sector Contracts

It has been agreed that funding for all contracted Third Sector providers will continue to provide services at their current contract value until 31st March 2016. Letters have been sent to providers to inform of this decision and to propose reduced funding levels from 1st April 2017. Meetings and consultations with providers are underway to discuss the potential impact upon services as a result of these changes.

8. Primary Care

8.1 Primary Care Dashboard progress

The primary care dashboard that has been used in 2015/16 is being reviewed with a view to understanding the needs for reporting across the organisation from a quality, improvement, QIPP perspective. Work with other CCGs is also underway to look at practice elsewhere, and the ability of Midlands and Lancashire Commissioning Support Unit's Business Intelligence tool, Aristotle to be able to report practice level primary care information across CCGs in Cheshire & Merseyside. Information would be made available to practices in a timely and consistent format to aid locality discussions. 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.

Work is now progressing with MLCSU to further define the indicators for the dashboard. A further meeting was held on 15th December, where it was agreed to begin to produce the dashboards with a first live version available in Aristotle at the end of January 2017. There will be various "views" of the data, for CCG users to view the indicators across the CCG area with the ability to drill to locality and practice level, plus practice level views allowing authorised practice users to drill to patient level. A core set of indicators allowing benchmarking across a number of areas will be produced first (practice demographics, GP survey patient satisfaction, secondary care utilisation rates, CQC inspection status), followed by further indicators and bespoke information (e.g. Liverpool CCG GP Spec).

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8.2 CQC Inspections

A number of practices in South Sefton CCG have been visited by the Care Quality Commission and details of any inspection results are published on their website. South Sefton CCG did not have any GP practices with CQC inspection results published in the past month. All the results are listed below:

Figure 24 - CQC Inspection Table

South Sefton CCG								
Practice Code	Practice Name	Date of Last Visit	Overall Rating	Safe	Effective	Caring	Responsive	Well-led
N84001	42 Kingsway	7th November 2016	Good	Good	Good	Good	Good	Good
N84002	Aintree Road Medical Centre	n/a	Not yet inspected the service was registered by CQC on 20 july 2016					
N84003	High Pastures Surgery	5th March 2015	Good	Requires Improvement	Good	Good	Good	Good
N84004	Glovers Lane Surgery	10th May 2016	Good	Good	Good	Good	Good	Good
N84007	Liverpool Rd Medical Practice	10th November 2016	Good	Requires Improvement	Good	Good	Good	Good
N84010	Maghull Health Centre (Dr Sapre)	n/a	Not yet inspected the service was registered by CQC on 20 july 2016					
N84011	Eastview Surgery	7th January 2016	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
N84015	Bootle Village Surgery	3rd August 2016	Good	Good	Good	Good	Good	Good
N84016	Moore Street Medical Centre	17th June 2016	Good	Good	Good	Good	Good	Good
N84019	North Park Health Centre	n/a	Not yet inspected the service was registered by CQC on 8 December 2014					
N84020	Blundellsands Surgery	24th November 2016	Good	Good	Good	Good	Good	Good
N84023	Bridge Road Medical Centre	15th June 2016	Good	Good	Good	Good	Good	Good
N84025	Westway Medical Centre	23rd September 2016	Good	Good	Good	Good	Good	Good
N84026	Crosby Village Surgery	n/a	Not yet inspected the service was registered by CQC on 19 August 2016					
N84027	Orrell Park Medical Centre	20th August 2015	Good	Good	Good	Good	Good	Good
N84028	The Strand Medical Centre	19th February 2015	Good	Good	Good	Good	Good	Good
N84029	Ford Medical Practice	31st March 2015	Good	Good	Good	Good	Good	Good
N84034	Park Street Surgery	17th June 2016	Good	Good	Good	Good	Good	Good
N84035	15 Sefton Road	23rd April 2015	Good	Good	Good	Good	Good	Good
N84038	Concept House Surgery	23rd April 2015	Good	Good	Good	Good	Good	Good
N84041	Kingsway Surgery	7th November 2016	Good	Good	Good	Good	Good	Good
N84043	Seaforth Village Practice	n/a	Not yet inspected the service was registered by CQC on 19 August 2016					
N84605	Litherland Town Hall Hth Ctr (Taylor)	n/a	Not yet inspected the service was registered by CQC on 19 August 2016					
N84615	Rawson Road Medical Centre	10th September 2015	Good	Good	Good	Good	Good	Good
N84621	Thornton SSP Practice	n/a	Not yet inspected the service was registered by CQC on 19 August 2016					
N84624	Maghull Health Centre	5th February 2015	Good	Good	Good	Good	Good	Good
N84626	Hightown Village Surgery	n/a	Not yet inspected the service was registered by CQC on 19 August 2016					
N84627	Crossways SSP Practice	n/a	Not yet inspected the service was registered by CQC on 19 August 2016					
N84630	Netherton SSP Practice (Dr Choudhary)	24th September 2015	Good	Requires Improvement	Good	Good	Good	Good
Y00446	Maghull SSP Practice	n/a	Not yet inspected the service was registered by CQC on 19 August 2016					

Key	
	= Outstanding
	= Good
	= Requires Improvement
	= Inadequate
	=Not Rated
	= Not Applicable

9. Better Care Fund

A Better Care Fund Plan for 2016/17 has been agreed and submitted to the national Better Care Support Team and joint work has been undertaken to further develop these plans for implementation. In the meantime, a Quarter 2 performance report has been prepared for NHSE for submission on 22nd November 2016. Guidance for BCF 2017/18 is delayed.

10. CCG Improvement & Assessment Framework (IAF)

10.1 Background

A new NHS England improvement and assessment framework for CCGs became effective from the beginning of April 2016, replacing the existing CCG assurance framework and CCG performance dashboard. The new framework aligns key objectives and priorities, including the way NHS England assess and manage their day-to-day relationships with CCGs. In the Government's Mandate to NHS England, the framework takes an enhanced and more central place in the overall arrangements for public accountability of the NHS.

The framework draws together in one place NHS Constitution and other core performance and finance indicators, outcome goals and transformational challenges. These are located in the four domains of better health, better care, sustainability and leadership.

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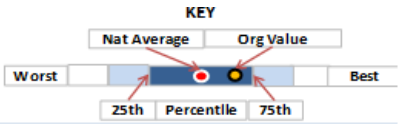
10.2 Q2 Improvement & Assessment Framework Dashboard

Please Note: If indicator is highlighted in GREY, this indicator will be available at a later date

If indicator is highlighted in BLUE, this value is in the lowest performance quartile nationally.

KEY
H = Higher
L = Lower
<> = N/A



	Improvement and Assessment Indicators	Latest Period	CCG	England	Trend	Better is...	Range
	Better Health						
▲	Maternal smoking at delivery	Q1 16/17	13.2%	10.2%		L	
◀▶	Percentage of children aged 10-11 classified as overweight or obese	2014-15	34.5%	33.2%		L	
▼	Diabetes patients that have achieved all the NICE recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	2014-15	44.7%	39.8%		H	
▲	People with diabetes diagnosed less than a year who attend a structured education course	2014-15	4.1%	5.7%		H	
◀▶	Injuries from falls in people aged 65 and over	Mar-16	1,810	2,014		L	
▼	Utilisation of the NHS e-referral service to enable choice at first routine elective referral	Jul-16	78.2%	52.0%		H	
◀▶	Personal health budgets	Q1 16/17	22.4	11.3		H	
▲	Percentage of deaths which take place in hospital	Q4 15/16	42.5%	47.0%		<>	
▲	People with a long-term condition feeling supported to manage their condition(s)	2016	73.0%	64.3%		H	
▲	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q4 15/16	1,226	929		L	
▲	Inequality in emergency admissions for urgent care sensitive conditions	Q4 15/16	2,837	2,168		L	
▼	Anti-microbial resistance: appropriate prescribing of antibiotics in primary care	Jul-16	1.2	1.1		<>	
◀▶	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	Jul-16	6.5%	9.3%		<>	
▼	Quality of life of carers	2016	77.7%	80.0%		H	
	Better Care						
◀▶	Cancers diagnosed at early stage	2014	54.8%	50.7%		H	
▲	People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Q1 16/17	73.4%	82.2%		H	
▲	One-year survival from all cancers	2013	67.1%	70.2%		H	

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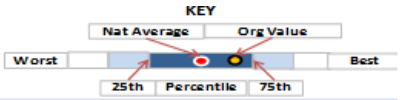
Please Note: If indicator is highlighted in GREY, this indicator will be available at a later date

If indicator is highlighted in BLUE, this value is in the lowest performance quartile nationally.

KEY
H = Higher
L = Lower
<> = N/A



	Improvement and Assessment Indicators	Latest Period	CCG	England	Trend	Better is...	Range
	Better Care						
◀▶	Cancer patient experience	2015	8.8	SN/A		H	
▼	Improving Access to Psychological Therapies recovery rate	Jun-16	37.1%	48.9%		H	
▲	People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	Jul-16	44.4%	72.0%		H	
◀▶	Reliance on specialist inpatient care for people with a learning disability and/or autism	Q1 16/17	64	SN/A		L	
◀▶	Proportion of people with a learning disability on the GP register receiving an annual health check	2014-15	58.0%	47.0%		H	
◀▶	Neonatal mortality and stillbirths	2014-15	4.5	7.1		L	
◀▶	Women's experience of maternity services	2015	81.2	SN/A		H	
◀▶	Choices in maternity services	2015	67.0%	SN/A		H	
▼	Estimated diagnosis rate for people with dementia	Aug-16	56.6%	67.3%		H	
◀▶	Dementia care planning and post-diagnostic support	2014/15	77.6%	77.0%		H	
◀▶	Achievement of milestones in the delivery of an integrated urgent care service	August 2016	4			H	
▼	Emergency admissions for urgent care sensitive conditions	Q4 15/16	3,338	2,359		L	
▼	Percentage of patients admitted, transferred or discharged from A&E within 4 hours	Aug-16	86.9%	91.0%		H	
▼	Delayed transfers of care per 100,000 population	Aug-16	10.7	14.1		L	
▲	Population use of hospital beds following emergency admission	Q4 15/16	1.3	1.0		L	
▼	Management of long term conditions	Q4 15/16	1,193	795		L	
▲	Patient experience of GP services	H1 2016	81.2%	85.2%		H	
◀▶	Primary care workforce	H1 2016	0.9	1.0		H	
▼	Patients waiting 18 weeks or less from referral to hospital treatment	Aug-16	92.4%	91.0%		H	
▲	People eligible for standard NHS Continuing Healthcare	Q1 16/17	44.5	46.0		H	
	Sustainability						
◀▶	Financial plan	2016	Amber	SN/A		H	
◀▶	In-year financial performance	Q1 16/17	Amber			H	
◀▶	Outcomes in areas with identified scope for improvement	Q1 16/17	CCG not i	58.3%		H	
▲	Digital interactions between primary and secondary care	Q2 16/17	59.6%			H	
◀▶	Local strategic estates plan (SEP) in place	2016-17	Yes	SN/A		H	
	Well Led						
◀▶	Staff engagement index	2015	3.8	3.8		H	
◀▶	Progress against workforce race equality standard	2015	0.2	0.2		L	
◀▶	Effectiveness of working relationships in the local system	2015-16	69.4	SN/A		H	
◀▶	Quality of CCG leadership	Q1 16/17	Green	SN/A		H	

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Appendix – Summary Performance Dashboard

Aristotle Business Intelligence

South Sefton CCG - Performance Report 2016-17

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Midlands and Lancashire Commissioning Support Unit

Metric	Reporting Level		2016-17												
			Q1			Q2			Q3			Q4			YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Preventing People from Dying Prematurely															
Cancer Waiting Times															
191: % Patients seen within two weeks for an urgent GP referral for suspected cancer (MONTHLY) The percentage of patients first seen by a specialist within two weeks when urgently referred by their GP or dentist with suspected cancer	South Sefton CCG	RAG	G	G	G	G	G	G	G	G					G
		Actual	94.772%	94.697%	95.563%	96.604%	96.918%	97.661%	94.505%	95.971%					95.848%
		Target	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
17: % of patients seen within 2 weeks for an urgent referral for breast symptoms (MONTHLY) Two week wait standard for patients referred with 'breast symptoms' not currently covered by two week waits for suspected breast cancer	South Sefton CCG	RAG	G	G	R	G	G	G	R	R					G
		Actual	100.00%	96.078%	89.091%	94.118%	94.34%	95.455%	90.00%	92.727%					93.825%
		Target	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
535: % of patients receiving definitive treatment within 1 month of a cancer diagnosis (MONTHLY) The percentage of patients receiving their first definitive treatment within one month (31days) of a decision to treat (as a proxy for diagnosis) for cancer	South Sefton CCG	RAG	G	G	G	G	G	G	G	G					G
		Actual	96.61%	98.305%	98.387%	100.00%	98.795%	100.00%	98.507%	96.471%					98.336%
		Target	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
26: % of patients receiving subsequent treatment for cancer within 31 days (Surgery) (MONTHLY) 31-Day Standard for Subsequent Cancer Treatments where the treatment function is (Surgery)	South Sefton CCG	RAG	R	G	G	R	G	G	G	G					G
		Actual	90.909%	100.00%	100.00%	91.667%	100.00%	100.00%	100.00%	100.00%					97.561%
		Target	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
1170: % of patients receiving subsequent treatment for cancer within 31 days (Drug Treatments) (MONTHLY) 31-Day Standard for Subsequent Cancer Treatments (Drug Treatments)	South Sefton CCG	RAG	G	G	G	R	G	G	G	G					G
		Actual	100.00%	100.00%	100.00%	94.737%	100.00%	100.00%	100.00%	100.00%					99.457%
		Target	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%

25: % of patients receiving subsequent treatment for cancer within 31 days (Radiotherapy Treatments) (MONTHLY) 31-Day Standard for Subsequent Cancer Treatments where the treatment function is (Radiotherapy)	South Sefton CCG	RAG	G	R	G	R	G	R	G	G					G
		Actual	100.00%	93.333%	100.00%	91667%	95.238%	93.548%	100.00%	100.00%					96.855%
		Target	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
539: % of patients receiving 1st definitive treatment for cancer within 2 months (62 days) (MONTHLY) The % of patients receiving their first definitive treatment for cancer within two months (62 days) of GP or dentist urgent referral for suspected cancer	South Sefton CCG	RAG	G	G	G	G	G	G	G	R					G
		Actual	88.462%	91429%	92.105%	90.323%	86.957%	86.667%	96.97%	81818%					89.338%
		Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
540: % of patients receiving treatment for cancer within 62 days from an NHS Cancer Screening Service (MONTHLY) Percentage of patients receiving first definitive treatment following referral from an NHS Cancer Screening Service within 62 days.	South Sefton CCG	RAG	G	G	G	G	G	G	G	G					G
		Actual	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					100.00%
		Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
541: % of patients receiving treatment for cancer within 62 days upgrade their priority (MONTHLY) % of patients treated for cancer who were not originally referred via an urgent GP/GDP referral for suspected cancer, but have been seen by a clinician who suspects cancer, who has upgraded their priority.	South Sefton CCG	RAG													
		Actual	100.00%	100.00%	85.714%	80.00%	83.333%	88.889%	66.667%	60.00%					82.609%
		Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
Ambulance															
1887: Category A Calls Response Time (Red1) Number of Category A (Red 1) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes	NORTH WEST AMBULANCE SERVICE NHS TRUST	RAG	G	R	R	R	R	R	R	R					R
		Actual	76.47%	74.28%	73.06%	70.45%	72.60%	69.49%	64.59%	62.80%					70.35%
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%
	South Sefton CCG	RAG	G	G	R	R	R	G	R	R					R
		Actual	76.56%	78.00%	74.50%	7143%	72.92%	77.55%	62.50%	68.89%					72.704%
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%
1889: Category A (Red 2) 8 Minute Response Time Number of Category A (Red 2) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes	South Sefton CCG	RAG	R	R	R	R	R	R	R	R					R
		Actual	72.10%	66.50%	62.40%	57.55%	62.18%	54.78%	62.05%	56.19%					61755%
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%
	NORTH WEST AMBULANCE SERVICE NHS TRUST	RAG	R	R	R	R	R	R	R	R					R
		Actual	67.46%	66.26%	66.20%	62.69%	65.25%	6175%	63.05%	60.35%					64.07%
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%

546: Category A calls responded to within 19 minutes Category A calls responded to within 19 minutes	South Sefton CCG	RAG	G	R	R	R	R	R	R	R					R
		Actual	95.08%	94.50%	91.20%	91.44%	93.48%	87.91%	91.61%	87.03%					91.521%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
	NORTH WEST AMBULANCE SERVICE NHS TRUST	RAG	R	R	R	R	R	R	R	R					R
		Actual	92.01%	91.47%	91.49%	89.81%	91.09%	89.04%	88.23%	86.79%					89.946%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
1932: Ambulance: 30 minute handover delays Number of ambulance handover delays over 30 minutes	UNIVERSITY HOSPITAL AINTREE	Actual	285	326	318	520	446	603	575	497	528				4,098
		Target	0	0	0	0	0	0	0	0	0				
1933: Ambulance: 60 minute handover delays Number of ambulance handover delays over 60 minutes	UNIVERSITY HOSPITAL AINTREE	Actual	106	137	146	258	195	342	294	270	287				2,035
		Target	0	0	0	0	0	0	0	0	0				

Enhancing Quality of Life for People with Long Term Conditions

Mental Health

138: Proportion of patients on (CPA) discharged from inpatient care who are followed up within 7 days The proportion of those patients on Care Programme Approach discharged from inpatient care who are followed up within 7 days	South Sefton CCG	RAG	G				G								G
		Actual	98.148%				98.00%								98.077%
		Target	95.00%				95.00%				95.00%				95.00%

Episode of Psychosis

2099: First episode of psychosis within two weeks of referral The percentage of people experiencing a first episode of psychosis with a NICE approved care package within two weeks of referral. The access and waiting time standard requires that more than 50% of people do so within two weeks of referral.	South Sefton CCG	RAG	R	G	R	G	G	G	G	G					G
		Actual	0.00%	100.00%	33.333%	50.00%	50.00%	85.714%	100.00%	75.00%					65.385%
		Target	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%

Ensuring that People Have a Positive Experience of Care

EMSA

1067: Mixed sex accommodation breaches - All Providers No. of MSA breaches for the reporting month in question for all providers	South Sefton CCG	RAG	G	G	G	R	R	G	R	G					R
		Actual	0	0	0	1	4	0	3	0					8
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
1812: Mixed Sex Accommodation - MSA Breach Rate MSA Breach Rate (MSA Breaches per 1,000 FCE's)	South Sefton CCG	RAG	G	G	G	R	R	G	G	G					R
		Actual	-	-	-	0.25	101	-	0.00	-					8.00
		Target	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Referral to Treatment (RTT) & Diagnostics

1291: % of all Incomplete RTT pathways within 18 weeks Percentage of Incomplete RTT pathways within 18 weeks of referral	South Sefton CCG	RAG	G	G	G	G	G	R	R	G					G
		Actual	94.954%	95.213%	93.919%	93.33%	92.354%	91.272%	91.919%	92.263%					93.167%
		Target	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%
1839: Referral to Treatment RTT - No of Incomplete Pathways Waiting >52 weeks The number of patients waiting at period end for incomplete pathways >52 weeks	South Sefton CCG	RAG	R	G	R	G	G	G	G	G					R
		Actual	1	0	1	0	0	0	0	0					2
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
1828: % of patients waiting 6 weeks or more for a diagnostic test The % of patients waiting 6 weeks or more for a diagnostic test	South Sefton CCG	RAG	G	R	G	G	R	G	G	G					G
		Actual	0.748%	1.001%	0.494%	0.711%	1.418%	0.527%	0.403%	0.85%					0.769%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Cancelled Operations

1983: Urgent Operations cancelled for a 2nd time Number of urgent operations that are cancelled by the trust for non-clinical reasons, which have already been previously cancelled once for non-clinical reasons.	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RAG	G	G	G	G	G	G	G	G					G
		Actual	0	0	0	0	0	0	0	0					0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0

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Treating and Caring for People in a Safe Environment and Protect them from Avoidable Harm

HCAI

497: Number of MRSA Bacteraemias Incidence of MRSA bacteraemia (Commissioner)	South Sefton CCG	RAG	G	G	G	G	G	R	R	R					R
		YTD	0	0	0	0	0	1	1	1					1
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
24: Number of C.Difficile infections Incidence of Clostridium Difficile (Commissioner)	South Sefton CCG	RAG	G	G	G	G	G	G	G	G					G
		YTD	3	9	14	18	23	27	29	36					36
		Target	5	11	14	18	23	28	34	39	43	45	48	54	43

Accident & Emergency

2123: 4-Hour A&E Waiting Time Target (Monthly Aggregate based on HES 15/16 ratio) % of patients who spent less than four hours in A&E (HES 15/16 ratio Acute position from Unify Weekly/Monthly SitReps)	South Sefton CCG	RAG	R	R	R	R	R	R	R	R					R
		Actual	90.124%	88.35%	89.13%	87.648%	86.873%	86.836%	87.066%	84.323%					87.537%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
431: 4-Hour A&E Waiting Time Target (Monthly Aggregate for Total Provider) % of patients who spent less than four hours in A&E (Total Acute position from Unify Weekly/Monthly SitReps)	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RAG	R	R	R	R	R	R	R	R					R
		Actual	89.484%	86.885%	87.505%	85.955%	84.103%	84.458%	84.763%	81.108%					85.525%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
1928: 12 Hour Trolley waits in A&E Total number of patients who have waited over 12 hours in A&E from decision to admit to admission	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RAG	R	G	G	G	R	R	R	G					R
		Actual	5	0	0	0	2	2	1	0					10
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0

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MEETING OF THE GOVERNING BODY
January 2017

Agenda Item: 17/09	**Author of the Paper:** Danielle Love Programme Lead – Community Services Procurement Email: danielle.love@southportandformbyccg.nhs.uk Tel: 07917 551 806
Report date: January 2017	

Title: Corporate Risk Register and Governing Body Assurance Framework Update

Summary/Key Issues:

The Governing Body is presented with the updated CRR and the GBAF as at December 2016.

The CRR and GBAF have been fully reviewed, scrutinised and approved by the Audit Committee.

Recommendation
The Governing Body is asked to fully review, scrutinise and if satisfied, approve the updates.

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				
Clinical Engagement				
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement				
Presented to other Committees	X			Reviewed by Senior Management Team Approved by Audit Committee

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 the Governing Body
January 2017

1. Executive Summary

The Governing Body is presented with the updated CRR and the GBAF as at January 2017.

The CRR and GBAF have been fully reviewed, scrutinised and approved by the Audit Committee.

2. Position Statements January 2017

2.1. Governing Body Assurance Framework (GBAF)

There are a total of 7 risks against the 6 strategic objectives for South Sefton CCG:

GBAF Risk Positions

Risk	Score	Number of Risks
Low	1-3	0
Moderate	4-6	1
High	8-12	5
Extreme	15 - 25	1

GBAF Highlights

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

GBAF Highlights	Update
1.1 Insufficient governance and monitoring of the QIPP plan could result in a failure to deliver the objectives of identified schemes and adversely impact on the CCGs statutory financial duties.	Extreme Risk • Ongoing review of the impact of all clinical schemes by the Clinical QIPP Advisory Group
2.1 CCG QIPP position reduces the CCGs ability to progress planned transformational schemes	Risk Reduced • Revised outline for Shaping Sefton due to be drafted

2.2. Corporate Risk Register

There are 14 operational risks recorded on the South Sefton CCG CRR as at January 2017:

- 2 new risk has been recorded – SS042, SS043

CRR Risk Positions

Risk	Score	Number of Risks
High	8-12	10
Extreme	15 - 25	4

CRR Highlights

Please see the following which updates on the extreme risks:

ID	Description of Risk	Update On Mitigating Action	Score Post Mitigation
SS008	Financial duties in 2016/17 will not be met due to significant unidentified QIPP 2016/17 and other emerging expenditure pressures resulting in statutory duties not met	• QIPP Committee is now operating well and receiving regular updates on QIPP progress • Leadership Team receives update on QIPP • Further measures to control expenditure are required to mitigate risk - awaiting first cut of Month 9 finances	**20**
SS019	Risk of poor quality patient care as a result of not delivering against A&E target due to patient flow in the trust	• The consequence and impact scores remains higher than the initial score due to lack of sustained month on month performance. • Not meeting constitutional target or STF trajectory • Increased number of 12 hour breaches for which RCAs are being completed • Frailty unit opened in Dec to support patient flow and turnaround	**16**
SS041	There is a risk that the CCG will not meet the constitutional IAPT target for access and treatment	• Early indications of reduced DNAs and heightened level of self-referral • Target remains challenging in terms of patient numbers • Requested expert team to support the CCG in improving performance • NHSI team have been formally engaged and awaiting report.	**16**
SS042	Key local stakeholders involved in the APMS procurement have raised concerns about the consultation process being undertaken by NHSE and the CCG.	• New Risk	**16**

3. Appendices

Appendix A – Corporate Risk Register
Appendix B – Governing Body Assurance Framework

Danielle Love
January 2017

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Corporate Risk Register

Current Version	v5		
Previous Version	v4	**Updated Date**	**Jan-17**
Document File Path	20170117 - SSCCG CRR - v5 17 Jan 17 Update.xlsx		

ID	Date Risk Added	Previous ID	Risk Owner	Responsible Function	Description of Risk (Description of the actual risk i.e. There is a risk that X risk caused by Y event resulting in Z effect)	Key controls and assurances in place (What controls/ systems are already in place to prevent the risk from being realised)	Likelihood	Consequence	Current Score	Mitigating Action (What additional controls/ systems need to be put in place to reduce the risks rating)	Update On Mitigating Action (Update on the additional controls and progress)	Likelihood Post Mitigation	Consequence Post Mitigation	Score Post Mitigation	Date Reviewed	Trend
SS008	Revised Q1 2016/17	FIN009	Martin McDowell	Finance	Financial duties in 2016/17 will not be met due to significant unidentified QIPP 2016/17 and other emerging expenditure pressures resulting in statutory duties not met	1. Monthly contracting meetings with main acute providers 2. Information shared with GP leads 3. Practice level reporting of financial information 4. Monthly monitoring of financial position	3	5	15	QIPP Committee established and meet monthly. Review of discretionary spend to go to GB end July	Management responses to PWC report compiled in an action plan - under leadership from DF QIPP Committee is now operating well and receiving regular updates on QIPP progress Leadership Team receives update on QIPP Further measures to control expenditure are required to mitigate risk - awaiting first cut of Month 9 finances	4	5	20	Dec-16	↔
SS019	Apr-15	QUA024	Karl McCluskey	Redesign & Commissioning	Risk of poor quality patient care as a result of not delivering against A&E target due to patient flow in the trust	1. Strategic Resilience Group (SRG) in place. Meetings held on a monthly basis and feed into Governing Body. 2. Operational Service level meetings held: currently weekly. 3. Monthly contractual performance meetings 4. Monthly Integrated Performance Report: reported to Governing Body. 5. Monthly Quality meeting: reported to Governing Body	3	3	9	Recovery plan agreed STF trajectory agreed	The consequence and impact scores remains higher than the initial score due to lack of sustained month on month performance. Not meeting constitutional target or STF trajectory Increased number of 12 hour breaches for which RCAs are being completed Frailty unit opened in Dec to support patient flow and turnaround	4	4	16	Dec-16	↔
SS041	Nov-16	N/A	Karl McCluskey	Redesign & Commissioning	There is a risk that the CCG will not meet the constitutional IAPT target for access and treatment	Monthly performance meeting with Provider Contract challenges being raised monthly as appropriate Monthly review of performance with the managerial and clinical leads Agreed action plan with the provider NHS Improvement assistance on operational actions	4	4	16	NHSE support requested	Early indications of reduced DNAs and heightened level of self-referral Target remains challenging in terms of patient numbers Requested expert team to support the CCG in improving performance NHSI team have been formally engaged and awaiting report.	4	4	16	Dec-16	↔
SS042	Dec-16	N/A	Jan Leonard	Redesign & Commissioning	Key local stakeholders involved in the APMS procurement have raised concerns about the consultation process being undertaken by NHSE and the CCG.	Issue being addresses by shadow joint commissioning committee Robust support from Comms and Engagement External comms support sourced by NHSE	5	4	20	Operational meeting of stakeholders Revised timetable agreed Revised comms agreed	New Risk	4	4	16	Dec-16	New Risk
SS001	Prior Q3 2013/14	BUO001	Karl McCluskey	Redesign & Commissioning	There is a risk the CCG will not meet the constitutional 62 day target for cancer caused by patient choice and complex pathways between providers resulting in delayed cancer treatment for patients	1. Monthly contract meetings 2. Clinical Quality and performance meetings 3. Clinical lead for contracts and quality 4. Clinical meetings with Cancer Leads and Manager. 5. Managerial lead for cancer has action plan in place. 6. Weekly and monthly monitoring through SMT and contractual performance. 7. RCA for any 62 day breaches 8. Reporting system developed that provides earlier notification of waiting time concerns. Is reviewed on a weekly basis and reported to SMT (Senior Management Team and SLT (Senior Leadership Team). 9. Integrated Performance Report developed and presented to Governing Body. 10. Action plans in place for failed areas: progress being monitored via SMT, contractual performance and continued reviews.	3	3	9	There are no additional systems or controls that can be put in place currently Performance of providers against constitutional target is monitored monthly with individual exceptions being addresses in turn	The likelihood score remains higher than the initial score due to lack of sustained month on month performance. Challenges in managing referrals from NHS screening service due to complicated pathways, issue raised with Spec Comm & NHSE CCG to escalate at Q2 assurance review with NHSE	4	3	12	Dec-16	↔

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SS002	Apr-15	BUO017	Tracy Jeffes	Corporate	CCG Locality working does not lead to greater clinical engagement with CCG plans and objectives resulting in disengaged membership	1. Roles of Locality Managers and Team reviewed 2. Locality Plan in place 3. Key issues reported to Governing Body 4. Wrap around support team identified to support localities 5. Key priority in Organisational Development plan	3	4	12	Clear focus for localities in relation to the QIPP agenda and influence over commissioning priorities Clear role out plan for use of Aristotle	Monthly Locality meetings reinstated, new locality manager appointed across all localities. GB Development session focusing on localities with clear areas for engagement identified.	3	4	12	Dec-16	↔
SS029	Q1 2016/17	QUA045	Jenny Kristiansen	Quality	Risk of infection/ hospital admission and harm to patients from poorly maintained nebuliser equipment	Identifying short term solution for patients currently prescribed a nebuliser to be reviewed, be given advice on cleaning equipment and have access to replacement filters and tubing. Long term liaising with respiratory teams, consultants, LCH and GP teams to ensure basics are right for the future. JK and HRo to raise at quality committee. HRo to add to corporate risk register.	4	5	20	• All providers informed of risk • LCH & Aintree have this on their risk registers • Pan Mersey Sub Group informed • All organisations to follow guidance from governance leads within their organisations • Regarding primary care prescribing – JK requested practice information facilitators to run a search on all patients prescribed nebules. This will identify the size of the problem and enable patients to receive a review & education. • An update to be presented at the August Quality Committee Meeting • A meeting will be held with all providers to work up a longer term solution.	Clinical Leads have received the data which is currently being reviewed to ascertain. Due to numbers of patients identified and capacity issues to conduct patient reviews, it has been agreed that the Respiratory Lead will work with Clinical Leads to put forward a business case with a number of options for agreement at the QIPP committee in February 2017.	4	3	12	Dec-16	↔
SS035	Jun-16	N/A	Tracy Jeffes	Corporate	There is a risk that changes to services caused by current financial position results in inability to deliver on strategic objectives and the reputation of CCG	1. Clear plans are being created which are going through a rigorous governance and decision making 2. Plans to have full quality and equality impact assessments 3. Effective consultation and engagement with key stakeholder and the public 4. Clear communication of changes to any services	4	4	16	1. Clear QIPP plans being developed 2. Governance arrangements reviewed to strengthen effective decision making 3. Planning for future communications/ engagement activities if required 4. Clear plans for alternatives if required and clear communication of these	Proposed disinvestment within the VCF sector now communicated pending consultation and final decision Medicines waste pilot now live - on-going evaluation and engagement with key stakeholders Work continues on the QIPP plans and governance arrangements have been strengthened	4	3	12	Dec-16	↔
SS036	Jun-16	N/A	Tracy Jeffes	Corporate	There is a risk that gaps in workforce across the healthcare system caused by insufficient national workforce planning and funding pressures resulting in additional pressure on services	1. Participating in the Health Education North West workforce planning process. 2. Work with Sefton Council on wider strategies to promote Sefton as a 'great place to work'	4	3	12	1. Through STP process seek additional investment to fill identified gaps 2. Implementation of the 'blueprints ' to transform models of care to enable appropriate skill mix to support delivery	On-going work through STP	4	3	12	Dec-16	↔
SS037	Sep-16	N/A	Debbie Fagan	Quality	Risk of reputational damage to CCG as commissioner of LCH in light of media interest following Capsick's report and outcome of parliamentary adjournment debate.	Mersey QSG CCF CQPG Pro-active comms team	3	4	12	Discussed at QSG regarding plans for lessons learned in May & July 2016 Discussions at Quality Committee in May and July 2016 & GB July 2016 Meeting of MPs by Chief Officer July & Aug 2016 Chronology of CCG involvement in performance management of provider - on-going to provide assurance of CCG actions Chronology discussed at CCG GB development session Aug 2016 Consideration of joint MIAA review Sept 2016	Joint presentation to QSG made in October 2016 regarding recommendations and lessons learnt for Cheshire & Merseyside Commissioning colleagues. MIAA TOR for review to be agreed October 2016. Quality Risk Profile (QRP) meeting planned with providers to agree consistent approach to management of current risks with LCH. MIAA review on-going - reporting date likely to be spring 2017	3	4	12	Dec-16	↔

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SS038	Sep-16	N/A	Debbie Fagan	Quality	Provider quality of care provision negatively impacted by Transaction process.	Transaction Board CQOG CCF CQPG LCH Improvement Plan QSG	3	4	12	Report through to CQPG and Chief Nurse having regular meetings with Director of Nursing on plans and issues	Quality Walkabouts now agreed with Deputy Director of Nursing at LCH and one team visited in October 2016 with highlight on safer working practices and management of staffing levels. Further quality walk rounds planned across localities over rest of the financial year Quality risks reported up to CQOG attended by CCG and risks managed by LCH Current operational risks managed through CQPG	3	4	12	Dec-16	↔
SS039	Sep-16	N/A	Karl McCluskey	Redesign & Commissioning	There is a risk the CCG will not meet the constitutional RTT target for 18 weeks caused by lack of clinical capacity resulting in delayed treatment for patients	1. Monthly contract meetings 2. Clinical Quality and performance meetings 3. Clinical lead for contracts and quality 4. Clinical meetings with RTT Lead and Manager. 5. Weekly and monthly monitoring through SMT and contractual performance. 6. Reporting system developed that provides earlier notification of waiting time concerns. Is reviewed on a weekly basis and reported to SMT (Senior Management Team and SLT (Senior Leadership Team). 7. Integrated Performance Report developed and presented to Governing Body.	4	4	16	1. RTT provider/ commissioning group being re-established 2. Completed internal and external audits on RTT to be taken through CQPG	New RTT/Stroke plan workgroup has been established. Reviews of individual specialties being undertaken and escalated through CQPG or Contract Reviews	4	3	12	Dec-16	↔
SS040	Sep-16	N/A	Tracy Jeffes	Corporate	There is a risk that financial pressures across health and social care impacts negatively on local services and prevents implementation of integration plans	1. Health and wellbeing board executive in place 2. Review of current BCF and Section 75 arrangements 3. New integration role within the local authority to support further integration. 4. Number of key joint commissioning posts in place 5. New integrated commissioning group now established 6. Initial meeting held regarding development of multi-disciplinary teams	4	4	16	Establish a revised integrated commissioning group Agree joint commissioning priorities Development of a route map for integration Initial pooled budget arrangements within BCF agreed Further develop of pooled/aligned budgets Joint CCG and Public Health Plan	Route map for integration finalised Joint working with LA regarding CHC Further joint development of intermediate care plans	3	4	12	Dec-16	↔
SS043	Jan-17	N/A	Jan Leonard	Quality	Primary medical care services are under significant pressure due to increased workload, workforce issues.	GP Five Year Forward View Plan Local Quality Contract - increased investment	4	3	12	Reviewing LQC for 17-18 Working with LMC on options GP Five Year Forward View Implimentation on STP footprint	New risk	4	3	12	Jan-17	New Risk

ID	Date Risk Added	Previous ID	Risk Owner	Responsible Function	Description of Risk (Description of the actual risk i.e. There is a risk that X risk caused by Y event resulting in Z effect)	Key controls and assurances in place (What controls/ systems are in place to prevent the risk from being realised)	Likelihood	Consequence	Current Score	Mitigating Action (What additional controls/ systems need to be put in place to reduce the risks rating)	Update On Mitigating Action (Update on the additional controls and progress)	Likelihood Post Mitigation	Consequence Post Mitigation	Score Post Mitigation	Date Closed	Trend
SS007	Q3 Dec 2014	FIN008	Chief Financial Officer (Martin McDowell)	Finance	Reductions in local authority expenditure may impact on NHS services and delivery of BCF schemes	1. Monitoring progress of BCF schemes 2. Continued work with local authority	4	3	12	Financial risks merged into SS008		4	3	12	Jun-16	
SS006	Revised Q1 2015/16	FIN003	Chief Financial Officer (Martin McDowell)	Finance	Changes in patient flow causes financial issues, due to increases in activity overall and the financial implications on the 15/16 Financial performance of the CCG. Increased activity has resulted in a QIPP saving required of 3.4 million to be delivered for 15/16. Predominant risk areas are: CHC and Urgent Care which have both seen significant growth in demand. Significant QIPP scheme to be delivered during year totalling 3.4 million.	1. Monthly contracting meetings with main acute providers 2. Information shared with GP leads 3. Practice level reporting of financial information 4. Monthly monitoring of financial position 5. QIPP Working Group established and meet monthly. 6. CHC Working Group established	4	3	12	Financial risks merged into SS008		2	3	6	Jun-16	
SS016	Apr-15	QUA021	Tracy Jeffes		Impact on ability to deliver as a result of not being able to maintain Commissioning Support Services, neither via sustainability of existing services from NWCSU nor suitability of locally responsive Commissioning Support Services through the LPF	1. Working collaboratively with Merseyside and Cheshire CCG's as part of Transformation Board to identify and look at any concerns regarding sustainability. 2. Collaborative working with neighbouring CCGs to secure best value for money from the LPF	4	3	12		CSU now transferred to Mids and Lancs CSU.	1	1	1	Jun-16	
SS005	Dec-15	BUO020	Mel Wright		No additional community beds available during Winter 2015	1. Investigation of alternative suppliers for bed base 2. Longer term procurement process commenced 3. Alternative scheme developed, commencing Jan 2016	5	3	15	Alternative scheme developed and agreed to commence in January 2016. Will not deliver the same level of care as a bedded unit, but will support another cohort of patients to remain in their usual place of residence/be discharged from hospital promptly.	Closed alternative plans being put in place for 2016	3	2	6	Jun-16	↓
SS009	Prior Q3 2013/14	QUA002	Debbie Fagan		Need for clarity of roles and responsibilities between Safeguarding Hosted Service, CSU CHC team and LCH Provider Safeguarding Team to enable CCG to discharge their safeguarding function. Need for further clarity between health and social care commissioning / safeguarding for vulnerable adults.	1. Regular 1:1 meetings between safeguarding adults lead in hosted service and CHC locality lead. 2. Identified a single point of contact system for Safeguarding Adults between the Safeguarding Service and hosted service. 3. Standard Operating Procedure developed, includes recommendations as per review.	4	5	20	Awaiting feedback from Quality Committee on draft SOP - April 15 Review required on the needs of the Sefton patch in order to determine commissioning responsibilities and necessary specification. - TBC To obtain the recommendations from Liverpool Community Health's internal Safeguarding review that explored the role of the Safeguarding Adults team. Part 1 received: Awaiting part II which looks at progress against ongoing recommendations. - March 15	CLOSED delinieation of safeguading services is now clear from commissioning perspective. Oppoprtnity to raise any ongoing issues available via formal and informal meeting structure. Head of vuneralbel people in post fpr CCG who is able to identify any early signs ofoperationnal issues	1	5	5	Jun-16	

ID	Date Risk Added	Previous ID	Risk Owner	Responsible Function	Description of Risk (Description of the actual risk i.e. There is a risk that X risk caused by Y event resulting in Z effect)	Key controls and assurances in place (What controls/ systems are in place to prevent the risk from being realised)	Likelihood	Consequence	Current Score	Mitigating Action (What additional controls/ systems need to be put in place to reduce the risks rating)	Update On Mitigating Action (Update on the additional controls and progress)	Likelihood Post Mitigation	Consequence Post Mitigation	Score Post Mitigation	Date Closed	Trend
SS010	Q3 2013/14	QUA006	Debbie Fagan		Providers RAG rating in relation to robust Safeguarding systems and processes presents lack of assurance for CCG based upon validation of information presented by the Trust.	1. Assurance process paper presented to LSCB on processes in place. 2. RAG rating monitored via Quality Contract meetings. Reported to Quality Committee and escalated to Governing Body as required. Chief Nurse informed NHS England (M) and safeguarding will be included in the quality review process with the Trust. 3. Monitored through quality contract meetings with CSU 4. Agenda item for discussion at provider Quality Contract meetings. 5. Safeguarding performance discussed at Quality Committee. 6. Process developed between CSU and Safeguarding service to further develop information flow across the two services. 7. Quality 'Walk Around' carried out with feedback and outcomes reported to Executive Nurse, contract meetings, Quality Committee. 8. Contract reviewed to ensure in line with KPI's 9. Quality Surveillance agenda item for February 2015.	4	4	16	- Formal processes now in place and reportedly working well between provider, CSU and Safeguarding Services. Systems in place between CSU and Safeguarding Services which is working well. Quality and performance function in-housed from 1st June which will enable tighter controls. - Increased level of assurance reported from CCG Safeguarding Service for the main commissioned providers. One contract query was issued in March 2015 and remains open. Although action plan has already been put in place in response to the contract query. Contract query remains in place with Southport & Ormskirk hospital due to limited assurance still being reported by CCG and Safeguarding Services. Is being closely monitored. Contract Query remains in place with S&O. Discussion of other provider performance where CCG is not the co-ordinating commissioner discussed at QC in September 2015 . Chief Nurse in contact with co-ordinating CCG to discuss concerns raised at the QC and for the purposes of assurance that all providers are being performance managed using a consistent approach. Awaiting formal Q1 feedback from Safeguarding Service	CLOSED Contract governance mechanisims in place to monitor provider status fed through Quality Committee performance managed at CQPG and QSG	1	4	4	Jun-16	
SS022	Apr-15	QUA028	Debbie Fagan/ Brendan Prescott		Lab results not being communicated to GP practices (from the Lab provider) due to IT system/technical issues that may have an impact on patient safety.	1. CCG/CHC Steering Group: issue raised with CHC team leads and strategic leads 2. Specification developed for PHB support 3. Fixed term 1 year role Programme Manager Role agreed 4. Regular Local Authority meetings held	3	3	9	1. Meeting to be held with Department of Health appointed facilitator and attendance at regular events. Meeting held. Linked into Learning Network on PHB's. Out to provider for response on costings and timings. 2. Further meeting with LA to be arranged for July in order to discuss potential shared use of Direct Payment system. 3. Position appointed to. Awaiting start date. 4. Discussions regarding integrated back room functions with the LA continue as part of the integration work plan. 5. Additional Programme Management support procured from CSU Stability Partner and work commenced in August 2015. Paper on CCG process for PHB approved at September 2015 Governing Body. Programme Manager Vulnerable People now in post from 1st September 2015 who will take a lead on this area of work reporting to the CCG Deputy Chief Nurse. 6. Risk Rating to remain the same until process is operational.	CLOSED Policy now in place and approved by GB in March 16 regular contact at Northern Region level on national developments Proposed PHB in place	1	3	3	Jun-16	
SS033	Jun-15	STA037	Brendan Prescott		Unable to deliver Personal Health Budgets (PHB) to patients as a result of CCG not having a governance system nor process in place to develop the provision of personal health budget's (PHB) to eligible patients choosing the PHB option.	1. CCG systems and processes in place 2. CCG members of SEND Steering Group 3. Children's Commissioning Manager in regular contact with LA and provider to support system and flow 4. Regular reporting of position to Leadership Team	5	4	20		CLOSED Provider now continuing to meet statutory timefrane Update to May 2016 GB Continued monitoring of process via Childrens commissioning manager as servicce transitions to alternative provider Any issues identified will be escallated and mitigated appropriatly	2	3	6	Jun-16	

ID	Date Risk Added	Previous ID	Risk Owner	Responsible Function	Description of Risk (Description of the actual risk i.e. There is a risk that X risk caused by Y event resulting in Z effect)	Key controls and assurances in place (What controls/ systems are in place to prevent the risk from being realised)	Likelihood	Consequence	Current Score	Mitigating Action (What additional controls/ systems need to be put in place to reduce the risks rating)	Update On Mitigating Action (Update on the additional controls and progress)	Likelihood Post Mitigation	Consequence Post Mitigation	Score Post Mitigation	Date Closed	Trend
SS013	Q3+1 January 2015	QUA011	Jan Leonard		The closure of Breast Surgery Service (for new patients) at Southport & Ormskirk poses a risk to the CCG and concerns for local residents.	2. Remedial action plan in place - which is reviewed monthly with provider 3. Performance and contractual meetings and reporting process in place 4. paper presented to Governing Body November 2014 5. Enhanced open access provision for patients to self refer	4	3	12	1. Additional focus on Did Not Attends 2. Re-advertising service with GP practice 3. Using CVS to advertise to general public	CLOSED Meeting held with existing breast providers issues recognised and picked up by breast CNG assurances given by current provider that follow up service will continue.	1	3	3	Sep-16	↓
SS032	Q1 2016/17	REP037	Karl McCluskey		There is a risk that the Local Authority will not agree to a joint Better Care Fund (BCF) plan caused by failure to agree CCG to fund social care	1. Operating structure as part of HWB and BCF	5	5	25	CCG standalone BCF plan to be drafted	CLOSED BCF now agreed	5	5	25	Sep-16	↔

Risk Matrix

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

Risk Ratings

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

Significant Risks

Significant Risks

A risk which attracts a score of 12 or above on the risk grading matrix constitutes a significant risk and must be recorded on the Corporate Risk Register.

Consequence Score for the CCG if the event happens		
Level	**Descriptor**	**Description**
1	Negligible	• None or very minor injury. • No financial loss or very minor loss up to £100,000. • Minimal or no service disruption. • No impact but current systems could be improved. • So close to achieving target that no impact or loss of external reputation.
2	Minor	• Minor injury or illness requiring first aid treatment e.g. cuts,bruises due to fault of CCG. • A financial pressure of £100,001 to £500,000. • Some delay in provision of services. • Some possibility of complaint or litigation. • CCG criticised, but minimum impact on organisation.
3	Moderate	• Moderate injury or illness, requiring medical treatment (e.g. fractures) due to CCG's fault. • Moderate financial pressure of £500,001 to £1m. • Some delay in provision of services. • Could result in legal action or prosecution. • Event leads to adverse local external attention e.g. HSE, media.
4	Major	• Individual death / permanent injury/disability due to fault of CCG. • Major financial pressure of £1m to £2m. • Major service disruption/closure in commissioned healthcare services CCG accountable for. • Potential litigation or negligence costs over £100,000 not covered by NHSLA. • Risk to CCG reputation in the short term with key stakeholders, public & media.

Level	Descriptor	Description
5	Catastrophic	• Multiple deaths due to fault of CCG. • Significant financial pressure of above £2m. • Extended service disruption/closure in commissioned healthcare services CCG accountable for. • Potential litigation or negligence costs over £1,000,000 not covered by NHSLA. • Long term serious risk to CCG's reputation with key stakeholders, public & media. • Fail key target(s) so that continuing CCG authorisation may be put at risk.

Likelihood Score for the CCG if the event happens		
Level	**Descriptor**	**Description**
1	Rare	• The event could occur only in exceptional circumstances. • No likelihood of missing target. • Project is on track.
2	Unlikely	• The event could occur at some time. • Small probability of missing target. • Key projects are on track but benefits delivery still uncertain. • Less important projects are significantly delayed by over 6 months or are expected to deliver only 50% of expected benefits.
3	Possible	• The event may occur at some time. • 40-60% chance of missing target. • Key project is behind schedule by between 3-6 months. • Less important projects fail to be delivered or fail to deliver expected benefits by significant degree.
4	Likely	• The event is more likely to occur in the next 12 months than not. • High probability of missing target. • Key project is significantly delayed in excess of 6 months or is only expected to deliver only 50% of expected benefits.
5	Almost Certain	• The event is expected to occur in most circumstances. • Missing the target is almost a certainty. • Key project will fail to be delivered or fail to deliver expected benefits by significant degree.

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Governing Body Assurance Framework

2016/2017

Update: January 2017

The Governing Body Assurance Framework (GBAF) aims to identify the principal or strategic risks to the delivery of the CCG's strategic objectives. It sets out the controls that are in place to manage the risks and the assurances that show if the controls are having the desired impact. It identifies the gaps in control and the key mitigating actions required to reduce the risks towards the appetite risk score. The GBAF also identifies any gaps in assurance and what actions can be taken to increase assurance to the CCG.

The table below sets out the strategic objectives lists the various principal risks that relate to them and highlights where gaps in control or assurance have been identified. Further details can be found on the supporting pages for each of the Principal Risks.

Strategic Objective	Principal Risk identified	Risk Owner	Risk Initial Score	Risk current Score	Key changes since last Review?
1. To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.	1.1 Insufficient governance and monitoring of the QIPP plan could result in a failure to deliver the objectives of identified schemes and adversely impact on the CCGs statutory financial duties.	Debbie Fairclough	20	16	• Ongoing review of the impact of all clinical schemes by the Clinical QIPP Advisory Group
2. To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the "Forward View", underpinned by transformation through the agreed strategic blueprints and programmes.	2.1 CCG QIPP position reduces the CCGs ability to progress planned transformational schemes	Karl McCluskey	15	9	• Revised outline for Shaping Sefton due to be drafted
3. To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.	3.1 There is a risk that identified areas of adverse performance are not managed effectively or initially identified	Karl McCluskey	16	8	• Continued monitoring of associated risks
	3.2 Failure to have in place robust emergency planning arrangements and associated business continuity plans could result in the CCG failing to meet its statutory duties as a Category 2 responder.	Tracy Jeffes	5	4	• Date for operational team discussion agreed to review Business Continuity Plans
4. 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.	4.1 Current work pressures reduce ability to engage on GP Five Year Forward View implementation.	Jan Leonard	9	9	• Further engagement session held by NHSE on GP 5YFV • NHSE return due 23 Dec on implementation plan presented to SLT • Concern that current LQC will not deliver, leaving practices less resilient. Approvals panel met to

Strategic Objective	Principal Risk identified	Risk Owner	Risk Initial Score	Risk current Score	Key changes since last Review?
					consider proposed changes. • Joint commissioning application being considered by NHSE, prospective start date 1 Jan 17 • LQC discussions advanced regarding 17-18 plan
5. To advance integration of in-hospital and community services in support of the CCG locality model of care.	5.1 Community Service currently going through transaction process which increasing risk of instability in services.	Jan Leonard	9	9	• Preferred provider for core services announced – Merseycare • Preferred provider for non-core services announced – Alder Hey
6. To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.	6.1 There is a risk that financial pressures across health and social care impacts negatively on local services and prevents implementation of integration plans	Tracy Jeffes	16	12	• Joint working with LA regarding CHC • Route map for integration finalised

Strategic Objective 1	**To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.**
Risk 1.1	**Insufficient governance and monitoring of the QIPP plan could result in a failure to deliver the objectives of identified schemes and adversely impact on the CCGs statutory financial duties.**

Risk Rating Initial Score **5x4=20** Current Score **4x4=16**	**Lead Director** Debbie Fairclough **Date Last Reviewed** December 16

Controls (what are we currently doing about the risk?):

- Secured senior dedicated support for designing and implementing a PMO approach to QIPP
- Accountable leads have been identified for each contract and are responsible for ensuring that all QIPP schemes are supported by appropriate contracting mechanisms.
- Clinical Advisory Group TOR has been updated to enable the group to identify additional areas of improvement and support the CCG in respect of its PSED and other statutory duties associated with any proposed service changes.
- Schemes have been re-evaluated and risk assessed to allow focus of those that are deliverable in year, as well as looking at medium to long term plans
- QIPP committee TOR have been revised and the relationship between QIPP and F&R has been formalised.
- KPIs and monitoring criteria are being designed for every QIPP scheme so that any risks to delivery are identified and mitigated at the earliest possible opportunity.
- PMO structure now in place and all schemes have supporting “plans on a page”
- Highlight reports across strategic domains (planned care, CHC/FNC, medicines optimisation, discretionary spend and urgent care) are reviewed by QIPP Committee
- Contracting team has been restructured and aligned to key business functions of BI, Finance and Quality

Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):

Action	Responsible Officer	Due By
• Further work to take place to ensure QIPP embedded in localities	Debbie Fairclough/ Tracy Jeffes	Nov 16
• Further work to ensure QIPP continues to have high profile in CCG	Debbie Fairclough	Nov 16
• Continued focus on ensuring all contracting mechanisms are utilised	Jan Leonard	Ongoing
• Ongoing review of all potential areas of efficiency	Debbie Fairclough	Ongoing
• Ongoing review of the impact of all clinical schemes by the Clinical QIPP Advisory Group	Debbie Fairclough	Ongoing

Strategic Objective 1	**To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.**
Risk 1.1	**Insufficient governance and monitoring of the QIPP plan could result in a failure to deliver the objectives of identified schemes and adversely impact on the CCGs statutory financial duties.**

Assurances (how do we know if the things we are doing are having an impact?):	**Gaps in assurances (what additional assurances should we seek):**
• SMT and SLT will review progress on a weekly basis and QIPP Committee, with support from Finance and Resources will monitor all activity on a monthly basis. The QIPP dashboard will be the monitoring tool for all QIPP schemes and will provide assurances to the Governing Body on progress. A reduction in spend will demonstrate the impact of the implementation of the QIPP plan. • From November the data from providers will be available to demonstrate impact on activity levels as a result of RMS, MCAS, PCLP, prior approval and the new CQUIN. • From November the data showing the impact of the Medicines Management schemes will be available	Monthly run rate monitoring so that the CCG can mitigate early any risks to delivery of the schemes.
Additional Comments:	**Link to Risk Register:**

Strategic Objective 2	**To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the "Forward View", underpinned by transformation through the agreed strategic blueprints and programmes.**		
Risk 2.1	**CCG QIPP position reduces the CCGs ability to progress planned transformational schemes**		
Risk Rating Initial Score **5 x 3 = 15** Current Score **3 x 3 = 9**		**Lead Director** Karl McCluskey **Date Last Reviewed** December 2016	
Controls (what are we currently doing about the risk?):		**Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):**	
• Current transformational schemes under rigorous review to ensure that those progress provide both Transformational change and contribute to QIPP • Secured senior dedicated support for designing and implementing a PMO approach - June 2016 • STP lead post recruited - to ensure dedicated resource ensures CCG has key role in local planning and transformational scheme development • Joining up QIPP and blueprint process, the transformational plans have been recast to align with QIPP plan • Strengthening links between transformational process and CCG contract management to ensure that all cases agreed link directly to provider contracts. • Reviewing transformational schemes in line with Cheshire and Merseyside STP plans • Joint work with Liverpool CCG to integrate plans across North Mersey		**Action** Revised outline for Shaping Sefton due to be drafted	**Responsible Officer**	**Due By** End Jan 17
Assurances (how do we know if the things we are doing are having an impact?):		**Gaps in assurances (what additional assurances should we seek):**	
• Delivery of QIPP targets. • CCG vision for Shaping Sefton will be reflected in STP plans.			
Additional Comments:		**Link to Risk Register:**	

Strategic Objective 3	**To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.**
Risk 3.1	**There is a risk that identified areas of adverse performance are not managed effectively or initially identified**

Risk Rating Initial Score 4x4 = **16** Current Score 2x4 = **8**	**Lead Director** Karl McCluskey **Date Last Reviewed** December 2016

Controls (what are we currently doing about the risk?):

- Roll out of Aristotle Business Intelligence portal makes performance information available to all CCG staff at all times
- Integrated Performance Report framework means all key constitutional and other performance is reported on, and actions agreed at monthly Integrated Performance meeting with leads allocated
- Performance is standing agenda item at Leadership Team/Senior Leadership Team/Senior Management Team meetings each week.
- New management structure put in place with clear lines of accountability and responsibility
- Identified individuals update monthly through integrated performance meetings

Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):

Action	Responsible Officer	Due By
Continued monitoring of associated risks	All	on-going

Assurances (how do we know if the things we are doing are having an impact?):

- Weekly discussions of performance issues at LT/SLT/SMT and progress on actions checked
- Integrated Performance Report shows CCG understanding of issues and oversight of actions
- Integrated Performance Reports may show improved performance as a result of robust management by CCG
- Assurance from MIAA review of performance reporting

Gaps in assurances (what additional assurances should we seek):

Additional Comments:	**Link to Risk Register:**

Strategic Objective 3	**To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.**		
Risk 3.2	**Failure to have in place robust emergency planning arrangements and associated business continuity plans could result in the CCG failing to meet its statutory duties as a Category 2 responder.**		
Risk Rating Initial Score 1 x 5 = 5 Current Score 1 x 4 = 4		**Lead Director** Tracey Jeffes **Date Last Reviewed** December 2016	
Controls (what are we currently doing about the risk?):		**Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):**	
• CCG Commissions EPRR and Business Continuity support from MLCSU • CCG has in place business continuity plans • Emergency Planning training taken place in last12 months • Corporate Governance Group has responsibility for ensuring compliance • CCG Statutory Lead is Chief Delivery and Integration Officer		**Action**	**Responsible Officer** / **Due By**
		Self-assessment and action improvement developed	Tracy Jeffes / Sept 2016
		Refresh of the business continuity plans and business self assessment	Tracy Jeffes/ CCG / Jan 2017
		Ongoing training for key staff	Tracy Jeffes / March 2017
		Date for operational team discussion agreed to review Business Continuity Plans	Tracy Jeffes / Dec 2016
Assurances (how do we know if the things we are doing are having an impact?):		**Gaps in assurances (what additional assurances should we seek):**	
• NHSE assurance through self-assessment and improvement plan			
Additional Comments:		**Link to Risk Register:**	

Strategic Objective 4	**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.**
Risk 4.1	**Current work pressures reduce ability to engage on GP Five Year Forward View implementation.**

Risk Rating Initial Score 3x3=**9** Current Score 3x3=**9**	**Lead Director** Jan Leonard **Date Last Reviewed** December 2016

Controls (what are we currently doing about the risk?):

- Shadow Joint Commissioning Committee
- LQC in place
- NHSE workshops for GP five year forward view.

Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):

Action	Responsible Officer	Due By
Supported emergent Federation.	Jan Leonard	Ongoing
Working Group on STP	Jan Leonard	Ongoing
Further engagement session held by NHSE on GP 5YFV	Jan Leonard	Nov 16
NHSE return due 23 Dec on implementation plan presented to SLT	Jan Leonard	Dec 16
Concern that current LQC will not deliver, leaving practices less resilient. Approvals panel met to consider proposed changes.	Jan Leonard	Jan 17
Joint commissioning application being considered by NHSE, prospective start date 1 Jan 17	Jan Leonard	Jan 17
LQC discussions advanced regarding 17-18 plan	Jan Leonard	Jan 17

Assurances (how do we know if the things we are doing are having an impact?):

- Developing quality reports for Primary Care with NHSE and other CCGs.
- Transformation agenda is continually monitored through Governing Body and Committee structure.

Gaps in assurances (what additional assurances should we seek):

Additional Comments:

Link to Risk Register:

Strategic Objective 5	**To advance integration of in-hospital and community services in support of the CCG locality model of care.**		
Risk 5.1	**Community Service currently going through transaction process which increasing risk of instability in services.**		
Risk Rating **Initial Score** 3x3=**9** **Current Score** 3x3=9		**Lead Director** Jan Leonard **Date Last Reviewed** December 2016	
Controls (what are we currently doing about the risk?):		**Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):**	
• Community Services contract monitoring meetings • EPEG monitor feedback on services • Quality Committee monitoring of services • Data room now opened up for Providers to directly access information • Preferred provider for core services announced – Merseycare • Preferred provider for non-core services announced – Alder Hey		**Action**	**Responsible Officer** / **Due By**
		Community Services Steering Group Developed	Jan Leonard / Ongoing
		Transaction Board overseeing transaction	Martin McDowell / Ongoing
Assurances (how do we know if the things we are doing are having an impact?):		**Gaps in assurances (what additional assurances should we seek):**	
• Providers have expressed interest in acquiring services • No increase in complaints/comments on Community Services		• During transaction process we are unable to progress integration.	
Additional Comments:		**Link to Risk Register:**	

Strategic Objective 6	**To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.**
Risk 6.1	**There is a risk that financial pressures across health and social care impacts negatively on local services and prevents implementation of integration plans**

Risk Rating **Initial Score** 4x4=16 **Current Score** 3x4=12	**Lead Director** Tracy Jeffes **Date Last Reviewed** December 2016

Controls (what are we currently doing about the risk?):	**Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):**		
1. Health and wellbeing board executive in place 2. Review of current BCF and Section 75 arrangements 3. New integration role within the local authority to support further integration. 4. Number of key joint commissioning posts in place 5. New integrated commissioning group now established 6. Initial meeting held regarding development of multi-disciplinary teams 7. Route map for integration finalised 8. Joint working with LA regarding CHC 9. Further joint development of intermediate care plans 10. Route map for integration finalised	**Action**	**Responsible Officer**	**Due By**
	Establish a revised integrated commissioning group	Tracy Jeffes	Sept 2016
	Agree joint commissioning priorities	Jan Leonard	Sept 2016
	Initial pooled budget arrangements within BCF agreed	Martin McDowell	Aug 2016
	Further develop of pooled/aligned budgets	Martin McDowell	March 2017
	Joint working with LA regarding CHC	Tracy Jeffes	Jan 2017

Assurances (how do we know if the things we are doing are having an impact?):	**Gaps in assurances (what additional assurances should we seek):**
1. Agreed route map for integration signed by all parties and assured by NHSE through BCF team.	

Additional Comments:	**Link to Risk Register:**
	SS040

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MEETING OF THE GOVERNING BODY
January 2017

Agenda Item: 17/10	**Author of the Paper:** Tracy Jeffes Chief Delivery and Integration Officer Email: Tracy.Jeffes@southseftonccg.nhs.uk Tel: 0151 247 7000
Report date: January 2017	

Title: Making Integration Happen Strategy

Summary/Key Issues:

This strategy has been produced jointly with Sefton Council to provide a strategic framework for integrated commissioning. It has been reviewed and recommended by the Integrated Commissioning Group and supports the implementation of the Better Care Fund.

The strategy was approved by the PTII Governing Body in December 2016 and is now being presented to the Public Governing Body meeting. Please note that this is a working document to steer the work on integration and therefore is informal in its presentation style and will evolve as the work develops.

Recommendation

The Governing Body is asked to receive this report.

Receive	X
Approve	
Ratify	

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.
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.
	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				
Clinical Engagement				
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement				
Presented to other Committees				

Links to National Outcomes Framework *(x those that apply)*	
	Preventing people from dying prematurely
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

Sefton Council

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

Making Integration Happen
Sefton`s Health and Social Care Integration Strategy
2016-2020

Sefton Council

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1. Introduction

Health and social care integration has been a constant and dominant policy theme for a long time, and many places around the country are already demonstrating the potential to do things differently. Here in Sefton we are now keen to progress our Strategic Vision into operational reality as quickly as possible and to make integration "business as usual". We believe it is time to change gear. Doing the same is not option. We must work to transform the whole system at pace and scale.

The imperative to integrate and transform has never been greater. We will need to find ways to organise services around the demands of a population with more complex and chronic health and social needs whilst responding to the extremely challenging financial context for the NHS and Local Government.

Integration itself is not a panacea for the system's financial challenges. Its primary purpose is to shift the focus of health and care services to improving public health and meeting the needs of individuals by drawing together all services across a 'place' for greatest benefit, and of investing in services which maximise wellbeing throughout life.

We now restate our commitment to come together as a Health and Social care system to describe what a fully integrated, transformed care and support system should look like. This builds on our joint work over many years and reflects our recent call to work at an accelerated pace. This we hope will take integration to another level and on towards 2020 whereby integration is "business as usual".

To make this happen, we need everyone to develop and agree the principles and practices set out in this vision, to learn and to share, to challenge and to deliver. This will involve pushing ourselves and our partners to make sure we deliver the best outcomes for our communities.

We need to prepare, as we have much to do. It will mean making sure we understand the big issues that need to be addressed – at a local and national level – to make integration not only happen but to make sure it improves the health and wellbeing of our populations.

It will mean being clear why partners stand together, stepping outside institutional siloes and navigating multiple meanings of 'place'. It means redesigning the health and social care landscape together, decommissioning services as well as creating new ones, sharing risks and jointly being responsible for what may be difficult decisions within a complex, challenging and changing system. To really make a difference, it will be a demanding task.

2. Vision

Our vision for integration is to **deliver personalised coordinated care, health and wellbeing services with, and around, the person.**

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

This was articulated in our original BCF submission in 2014 in the following way:

"By working together and aligning our resources, we aim by 2020 to:

- promote self-care, independence and help build personal and community resilience
- improve the care, health and wellbeing of all Sefton residents
- support people early to make the right choices to maintain or improve their own health and wellbeing deliver personalised, co-ordinated care around the person and their family and / or carer
- deliver integrated care at a locality level through a single point of access, a single integrated assessment and 7 day working
- narrow the gap between those communities with the best and worst health and wellbeing outcomes."

Our roadmap will move us towards the vision in the "Five Year Forward View" and the move towards full integrated health and social care services by 2020. Underpinning our Vision is the promise that in commissioning and delivering services the different partners, stakeholders and organisations in Sefton will work together to seek to improve the health and wellbeing of everyone, with the resources available.

By working together and aligning our resources, we aim by 2020 to improve the care, health and wellbeing of all Sefton residents and narrow the gap between those communities with the best and worst health and wellbeing outcomes. We will promote independence and help build personal and community resilience. We will work with parents and carers so that all children and young people have opportunities to become healthy and fulfilled adults and create a place where older people can live, work and enjoy life as valued members of the community. We will seek to improve opportunities and support residents to make choices so that people are able to live, work and spend their time in a safe and healthy environment and provide early support so that people can remain independent for longer.

3. Principles and A Framework for Action

In terms of working together it will be important to establish and agree the methodology of how we will work together and the principles that we will use to guide our joint work. This is important in all partnership working, whether across a wide geography for example a number of councils, across a number of Clinical Commissioning Groups or even on smaller scale in a locality or neighbourhood.

The following 10 stages will be the stages we use to describe our approach and to help identify our integrated work plan going forward.

3.1. Co-create a vision that is understood in which partners are united to a common outcome for an integrated system.

Success Factor
Ensure this is understood at all levels across all organisations.

3.2. Prepare a robust and comprehensive business case/s which identifies clear priorities between efficiencies, improved outcomes and increased customer experience. The business case must identify tangible intervention, be explicit about the delivery of timescales.

Success Factor
Targets set are achievable and with realistic trajectories for change.

3.3. Creating the environment and conditions for change by ensuring that the vision and business case ensures ownership and buy in from all partners. Building trust and engagement from all senior leaders will be essential at an early stage.

Success Factor
Ownership is evidenced.

3.4. Identify interventions and system enablers by creating high impact interventions based on evidence. Map the needs of the population and be clear about which interventions will provide the most significant efficiencies and delivering the same or better outcomes.

Success Factor
Population needs mapped and interventions based on these needs with outcomes and outputs agreed and delivered.

3.5. Co-design system and interventions which include the involvement of the community and are led by the workforce, which reinforce multi-disciplinary approaches.

Success Factor
Systems and interventions are owned by the community and the workforce.

3.6. Identify clear metrics to measure outcomes and performance. Ensure that these also include intangibles such as trust, and relationships across communities and organisations.

Success Factor
Metrics which are clear and are collectable and measurable.

3.7. Be clear about the evaluation, how the evidence will be collected and collated. Agree an evaluation framework and identify who will undertake the evaluation on either a live model/programme or at staging points.

Success Factor
Evaluation agreed at an early stage and who will undertake the evaluation.

3.8. Identify key Governance structures which are inclusive and adaptable which focus upon ownership and accountability.

Success Factor
Governance agreed at the beginning with clear terms of reference.

3.9. Consider internal and external organisations that can support and accelerate progress.

Success factor
Identification of organisations, with clear agreement on support.

3.10. Be clear about leadership both individually and system wide. Ensure involvement at the commencement of the programme.

Success Factor
Leadership is evident from the start.

4. The Case for Change

4.1. Our Population

The Sefton Strategic Needs Assessment (SSNA) shows there more than 18,000 residents over 65 living in single occupancy households, making up 16% of the total households.

Future projection predicts that by 2030 the number of over 65s in Sefton living alone will increase by 65% to in excess of 30,000. Sefton would appear to have more service users that struggle with everyday tasks than any of the comparator groups used and there has been an increase in the proportion of service users who find everyday tasks more difficult. This may be as a result of the age profile of Sefton's population and the increasing number of residents in the Borough over the age of 65, and with population projection estimating a 46% increase in residents over 65 by 2037 this may become more of an issue, with increased demand for services.

The Council`s Business and Intelligence and Performance Team and the Clinical Commissioning Group Strategy & Outcomes Lead are an integral part of the work to advance integration. As such reports have been prepared to assist and inform commissioning conversations and help identify the 1st Priorities.

4.2. Local Strategies

The development over the past three years of the Shaping Sefton vision to create a community-centred health and care delivery system has been very much aligned to the overarching Sefton Health and Wellbeing Strategy.

The Shaping Sefton vision describes our aspiration whereby we want all health and social care services to work together and to be more joined up – with as many as possible provided in our local communities, so it is easier (for you) to get the right support and treatment first time to help (you) live a healthy life and improve your wellbeing.

Community-centred health and care brings together eight priority health and transformation programmes, wrapped around our GP practices and their partners. These are

- Primary Care
- Community Care
- Urgent Care

- Mental Health
- Care for Elderly People with Frailty
- Intermediate Care
- Cardiovascular Disease
- Respiratory Disease.

The NHS and Local Government face many challenges ahead. Like all public sector organisations, we are working in tighter times. At the same time, demand on health and social care is increasing and locally, there are a number of reasons why this is the case.

- A growing number of older residents with more complex health conditions - this is much higher than the national average.
- Residents living in some parts of the borough can expect to live unacceptably shorter lives than their neighbours in more affluent areas of Sefton.

Together, these factors mean we need to prioritise the money we have, spending it on the most efficient treatments and services that offer the best outcomes.

The Shaping Sefton vision is the driver for the local implementation of the Five Year Forward View (FYFV) for our community. In recent months, NHSE guidance has required the local NHS to mobilise itself into working closely and collectively across organisations, instead of in individual silos to maximise its efforts.

Partners across Cheshire and Merseyside (C&M) have been working together to develop further the blueprint we set out in June 2016 to accelerate the implementation of the 5YFV for our Communities. We have come together to address head on the challenges we articulated then: that people are living longer, but not always healthier, lives; that care is not always joined up for patients in their local community, especially for the frail elderly and those with complex needs; that there is, as a result, an over-reliance on acute hospital services that often does not provide the best setting for patients; that there is a need to support children, young people and adults more effectively with their mental health challenges. At the same time, there is enormous pressure on health and social care budgets.

We are clear that these issues require us to think much more radically about how best to address the problems we face together; otherwise we will fail to support the needs of our Communities into the future. The C&M blueprint summarises the plans developed to-date to address these challenges across all the different communities in Cheshire and Merseyside and fall into four common themes:

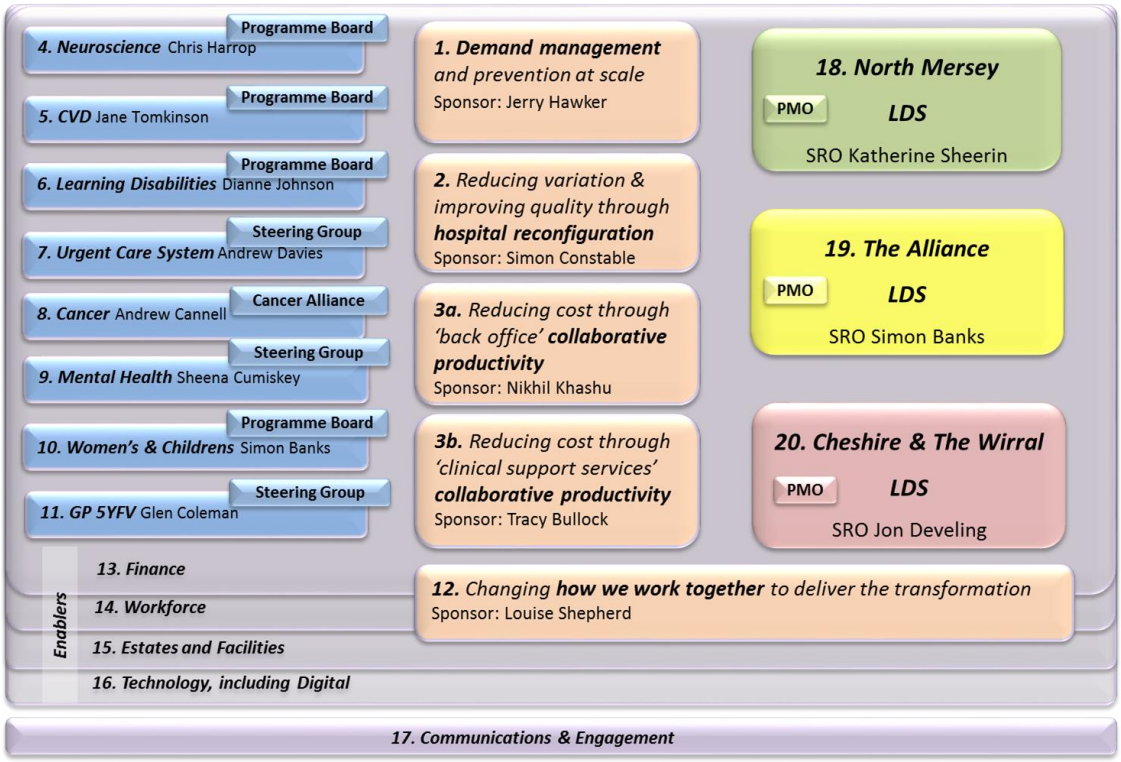
- Support for people to live better quality lives by actively promoting the things we know have a really positive effect on health and wellbeing.
- Working together with partners in local government and the voluntary sector to develop more joined up models of care, outside of traditional acute hospitals, to give people the support they really need in the most appropriate setting.
- Designing an acute care system for our communities that meets current modern standards and reduces variation in quality.
- Making ourselves more efficient by joining up non front-line functions and using the latest technology to support people in their own homes.

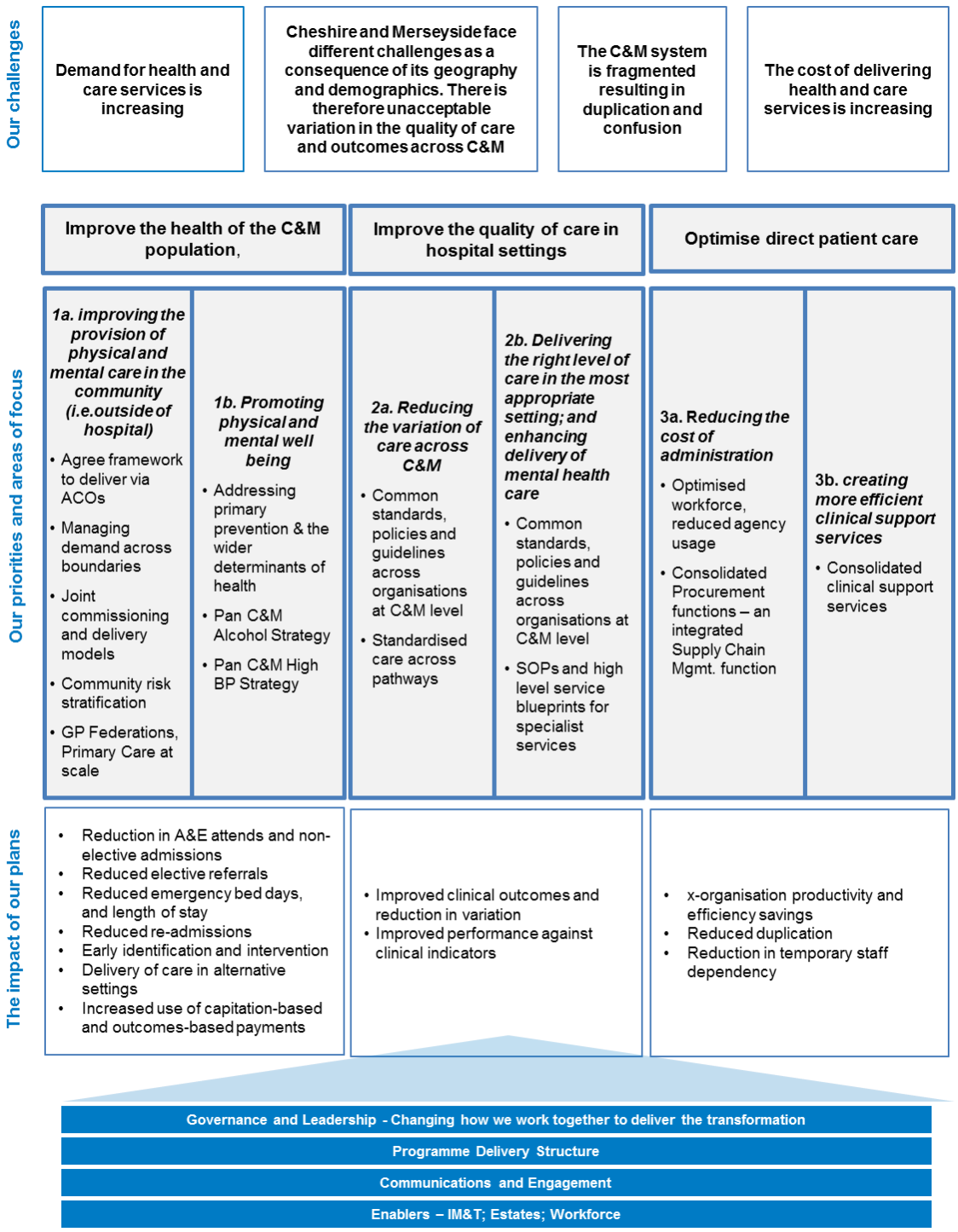
Much of this work is already underway at local level but there is also still much to do. The role of the Sustainability and Transformation Plan (STP) for C&M is to co-

ordinate our efforts, ensuring we promote the best ideas and expertise to provide for the needs of the whole region in the future.

The emergent STP is informed and shaped by local plans and Shaping Sefton.

This STP does not capture everything that we are doing as a health and care economy. Instead it focuses on the priority areas of focus that we believe will have the greatest impact on health, quality and finance.





The C&M STP is supported by three local delivery systems and the work in Sefton at level one is now captured in the North Mersey LDS at level 2.

Working across a larger footprint will bring economies of scale; however, we will need to ensure delivery at a local level to maximise resilience and create the transformational change required.

This will need leaders to work across the system to navigate differing, volatile, uncertain, complex, ambiguous and diverse environments, creating opportunity, working with partners, taking stakeholders with us on the journey and grounding its purpose back into the heart of the communities we serve in Sefton, to best meet its needs.

4.3. Citizen Experience

In 2013, the LGA, as part of the Integrated Care and Support Collaborative commissioned National Voices to develop a definition of integrated care:

"My care is planned with people who work together to understand me and my carer(s), put me in control, and to coordinate and deliver services to achieve my best outcomes."

It is recognised by key partners in health and social care that the current system does not do enough to meet these basic requirements. As well as offering poor user experience and outcomes, poor integration between health and social care is judged to result in services that are inefficient and offer poor value for money. Care that is better integrated is a priority for most health and care partners, driven by increasing demand, greater complexity.

4.3.1. Sefton's Citizen Experience

Consultation was conducted in 2012 Sefton. A report Our Lives Our Health summarised what was important to Citizens.

Messages from the consultation and engagement:

- People of all ages wanted choice and control over their lives
- Maintaining independence by supporting people to remain well, with care close to home, Combat social isolation through access to local services, accessible information and support networks
- Access to work, training and volunteering for all ages and abilities.

- Access to affordable, good quality housing.
- Services provided from children's centres which support vulnerable families and children, in particular those in the poorest neighbourhoods.
- Primary health services need to be local and accessible.
- Inequity in drug treatment and mental health services.
- Protect children and adults from harm.
- Accessible community information and support.

Local Authorities in England with responsibility for providing adult social care services are required to conduct an annual postal survey of their service users. The **Personal Social Services Adult Social Care Survey** asks questions about quality of life and the impact that the services they receive have on their quality of life.

Areas for Focus are identified:

- Social Isolation
- Access to Information
- Planning for the Future

In respect of our Citizens who are Carers. All Local Authorities with Adult Social Care responsibilities are required to undertake a **Biennial survey of people who are formal or informal carers** for any of the Local Authority's Social Care clients.

Whilst generally overall satisfaction has remained relatively high with services and support carers have received there are some potential gaps and concerns. The following summarises the themes from the survey.

Areas for Focus:

- Social isolation and provision of things to do.
- Lack of easy to access support and advice.
- Lack of control over day to day life.
- Possibly a lack in some areas of involvement in the decision making processes.

4.3.2. Sefton Patients' Experiences of Healthcare

The CCGs` Annual Engagement and Patient Experience Group report2 sets out how the CCGs` respond to the statutory requirements placed upon them by developing an annual work plan. The report also sets out the key areas of work undertaken during the previous financial year. As a result of our engagement exercises, the work plan for next 3 years 2015/16 included:

- Alignment of EPEG work streams to commissioning priorities and develop a programme management approach.
- Training and updates, to support understanding of the CCGs' statutory and technical requirements around consultation and Public Sector Equality duty, specifically in relation to transformational commissioning decisions.
- Development of the Patient Experience Dashboard to include Mersey Care NHS Trust and Liverpool Community Health NHS Trust.

- Further develop the SharePoint system to enable the triangulation of patient experience data and engagement feedback for the benefit of all partners.
- Develop more effective two way reporting and communication mechanisms between EPEG and the Quality Committee to ensure that key issues are captured, escalated and addressed.
- With providers and partners, continue to develop structures and processes to ensure that the Voice of the Child is captured and effectively embedded into all aspects of CCGs plans and activities.
- Further develop the 'You said. We did' feedback mechanism.
- Consider EPEG's role in supporting the cultural shift from the focus on clinical healthcare provision to community- based self-care and self- management.
- Develop an EPEG work plan which supports task and action focussed partnership working.
- Continue to develop a more coherent package of support for Patient Participation Groups and build on the engagement opportunities and intelligence that they offer.
- Continue to work in partnership to develop the locality/community model of engagement.

5. What do we mean by "Integration"

5.1. Definition

There is no one definition of what integration means. The notion of integrated care dates back to before the start of the NHS. The concern that care is fragmented and disconnected has focused on delivery that allows at times for individuals to fall through the gaps in care e.g. primary care/secondary care, health/social care, mental/physical health.

Approaches that seek to address fragmentation of care are common across many health systems, and the need to do so is increasing as more people live longer and live with complex health conditions impacted by social and social care needs.

There are many approaches to integration. Integration can be undertaken between organisations, or between different clinical or service departments within and between organisations. Integration may focus on joining up primary, community and hospital services or involve multi-disciplinary teamwork between health and social care professionals ('horizontal' integration). Integration may be 'real' (i.e. into a single new organisation) or 'virtual' (i.e. a network of separate providers, often linked contractually). Integration may involve providers collaborating, but it may also entail integration between commissioners, as when budgets are pooled. Integration can also bring together responsibility for commissioning and provision. When this happens, clinicians and managers are able to use budgets either to provide more services directly or to commission these services from others: so-called 'make or buy' decisions. (Curry and Ham 2010).

Key forms of integrated care:

- Integrated care between health services, social services and other care providers. (horizontal integration)
- Integrated care across primary, community, hospital and tertiary care services. (vertical integration)
- Integrated care within one sector. (e.g., within mental health services through multi-professional teams or networks)

- Integrated care between preventive and curative services.
- Integrated care between providers and patients to support shared decision-making and self-management.
- Integrated care between public health, population-based and patient-centred approaches to health care. This is integrated care at its most ambitious since it focuses on the multiple needs of whole populations, not just to care groups or diseases.

Source: adapted from International Journal of Integrated Care

5.2. National Policy and Integration

5.2.1. Five Year Forward View

The NHS Five Year Forward View[1] published in October 2014 considered the progress made in improving health and care services in recent years and the challenges that the NHS faces 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**.

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.

The Five Year Forward View 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.

The FYFV describes combining groups of "community health services…and social care services to create integrated out-of-hospital care" and describes the direction of travel for integrated health and social care which will support closing the gaps outlined above and as described in this document.

5.2.2. Care Act and "the duty" to Integrate

The **Care Act 2014** replaces nearly all the old legislation and supporting guidance covering the care needs and rights to support of both adults with social care needs and adult informal or family carers.

Most of it came into force in England from April 2015, but the planned new developments in paying for care will not now take effect until April 2020. The

original plan was for April 2016 implementation. In April 2015, the government decided to delay the implementation of the funding element of the reforms until the later date.

The act sets out some key responsibilities of Local Authorities, Clinical Commissioning Groups and specifically Health and Wellbeing Boards to:

1. Promoting individual well being
2. Preventing people's care and support needs from becoming more serious
3. Promoting integration of care and support with health services etc.
4. Providing information and advice
5. Promoting diversity and quality in provision of services
6. Co-operating generally with its relevant partners, such as other Local Councils, the NHS and Police
7. Co-operating in specific cases with other Local Authorities and their Relevant partners.

"Local Authorities must exercise its functions under this Part with a view to ensuring the integration of care and support provision with health provision and health-related provision…"

"Clinical Commissioning Groups must exercise its functions with a view to securing that health services are provided in an integrated way…"

"Health and Wellbeing Boards must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner."

5.2.3. Stepping up to the place

The Local Government Association, The NHS Confederation, ADASS, NHS Clinical Commissioners July 2016 published a resource guide "**Stepping up to the place - The key to successful health and care integration**" The guide includes a self-assessment tool designed to support local health and care leaders through Health and Wellbeing boards (HWBs) to critically assess ambitions, capabilities and capacities to integrate services to improve the health and wellbeing of local citizens and communities.

It focuses on "**10 key elements"** and the characteristics needed for successful integration. It offers insight to measure "where we are now" and helps steer the right way forward. The resource guide identifies ways to help;

- Local systems embed integration as 'business as usual'.
- Build a collective approach to achieving integration by 2020.
- Create a consensus and action on the barriers to making integration happen.

Along with, articulating some expectations on a national level to help create the right circumstances.

- Dialogue with national policy makers to ensure integration is effective.
- Ongoing testing and evaluation to develop the evidence base.
- National partner action to enable the minimum requirements to integrate effectively.

We propose that we use the **"The 10 Key Elements"** to frame our assessment of where we are, help us focus more on what we need to do.

6. What Integration means to us in Sefton – four key elements

Bringing health and social care together is a complex job and we have identified four distinct and interrelated elements.

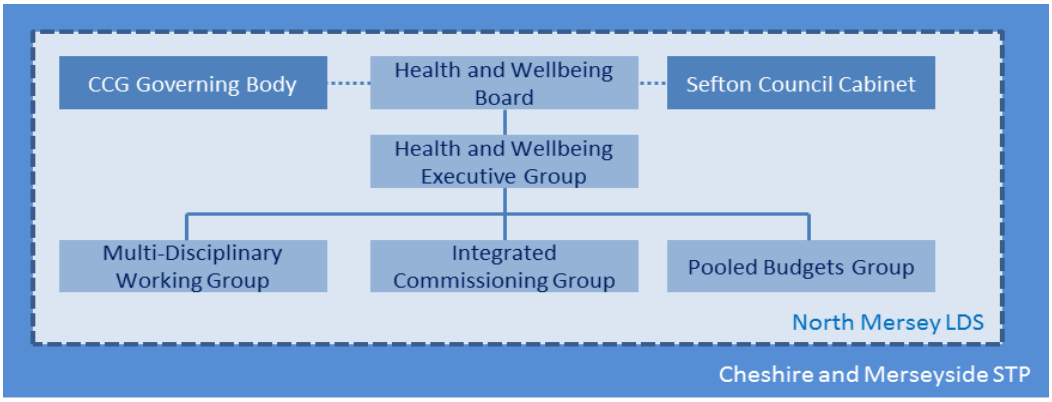
- Integrated Governance - Making decisions together
- Integrated Commissioning - Deciding what needs to be done
- Pooled Budgets - Using all of our resources in the best way
- Integrated Delivery - Working together to support our citizens.

6.1. Integrated Governance - Making decisions together

A review of the Health and Wellbeing Board's governance arrangements has recently been completed to reduce complexity and improve decision-making.

A new governance structure (figure 1 below) was agreed at the HWBB meeting in March 2016, which confirmed the establishment of a Health and Wellbeing Executive Group and Integrated Commissioning Group to oversee and drive integration in Sefton, together with delivery of the HWBB's action plan for the year.

The Health and Wellbeing Board gave support to the Executive to create any other groups and forums to enable the progression of integration. As such two further groups have been set up. A **Multi-Disciplinary Working Group** to progress help develop a model for multi-disciplinary working and the other, a **Pooled Budget Group** to accelerate the work on pooling budgets.



6.1.1. **The Health and Wellbeing Executive Group** will:
(Extract from Terms of Reference)

- determine and ensure delivery of a Strategy for Integrated Commissioning, to drive forward performance, own and manage risks relating to Integrated Commissioning and strategically lead the change programme towards full integration by 2020;
- hold organisations to account for the delivery of better outcomes for citizens and efficient use of combined/pooled resources;

- provide peer to peer leadership support in order to build resilient relationships between senior leaders and thus organisations;
- enable a consistent and collaborative leadership approach and a presence at local, regional and national NHS and Local Authority initiatives for betterment of the population of Sefton.

6.1.2. **Integrated Commissioning Group** will work to maximise combined resources across the commissioning function in both Health and Social Care and (extract from Terms of Reference):

- promote integrated working across all organisations in Sefton;
- encourage the use of flexibilities, including joint investment and pooled budgets;
- agree the strategy and planning processes for the development of areas of priority as detailed in all agreed joint strategies;
- develop the role of integrated commissioner;
- manage and co-ordinate commissioning under s75 agreements for Better Care Fund and any further agreements made;
- be accountable to the Health and Wellbeing Board for alignment of commissioning decision-making with the priorities of the Joint Health and Wellbeing Strategy;
- report progress and outcomes to the HWBB as part of the agreed performance reporting framework, operating within the schemes of delegation and accountability arrangements of Sefton Council and the CCGs;
- provide assurance that services commissioned by Sefton Council and the CCGs, including Independent Contractors services are safe, effective and provide the best possible experience for service users.
- advise on commissioning and monitoring services;
- oversee Joint Integrated Needs Assessments of the whole population;
- monitor the delivery and performance of the commissioned services and the performance of delegated functions;
- evaluate the way in which the services are delivered;
- ensure service users' and carers' views are represented through any integrated commissioning arrangements; ensure best value for money, that the parties' commissioning strategies and intentions are consistent with each other and agree jointly eligibility criteria where possible; and achieving combined organisational development programmes and joint human resources planning in relation to the services.

6.2. Integrated Commissioning - deciding what needs to be done

Underpinning our Vision is the promise that in commissioning and delivering services the different partners, stakeholders and organisations in Sefton will work together to seek to improve the health and wellbeing of everyone, with the resources available.

6.2.1. What is Commissioning?

"*Deciding how to use the total resource available in order to achieve desired outcomes in the most efficient, effective and sustainable way.*"

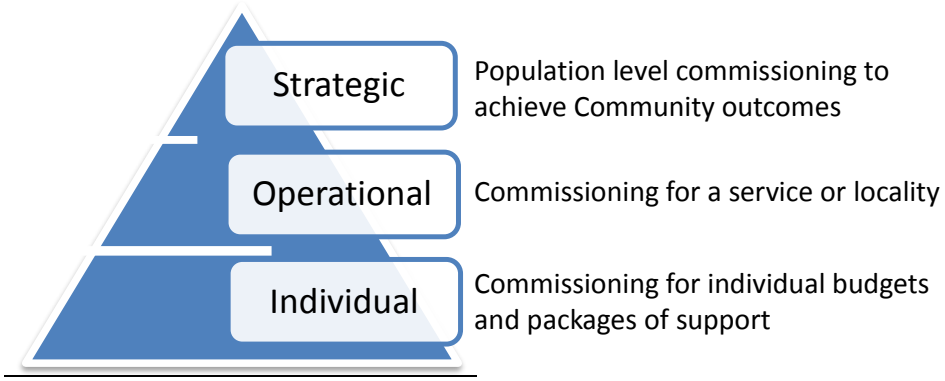
6.2.2. **What is required to commission effectively?**

Effective Commissioning processes:

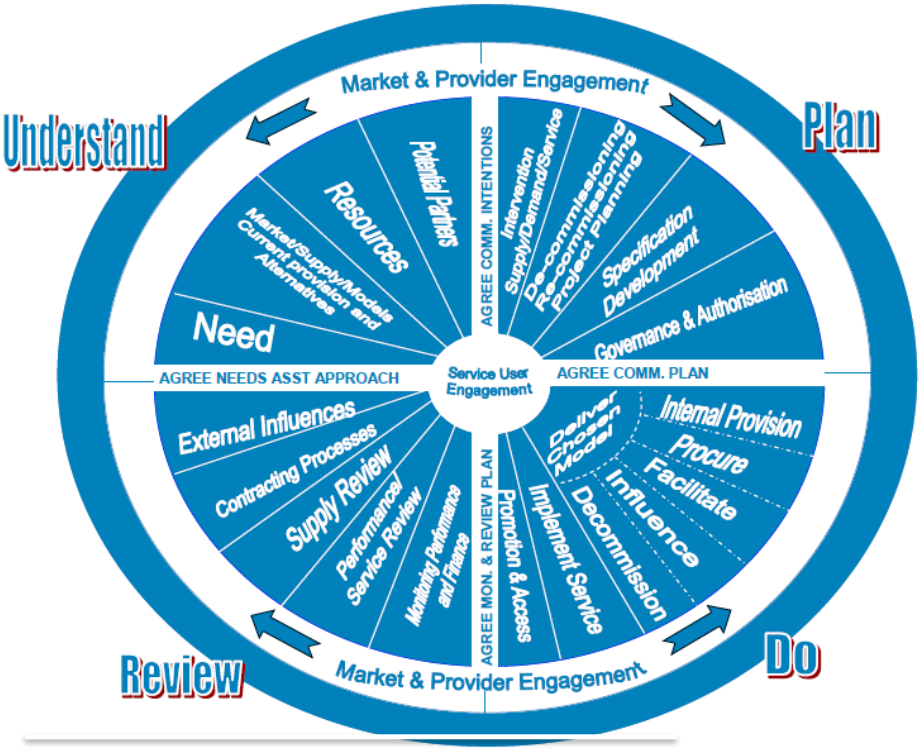
- sound understanding of what is needed in order to achieve desired outcomes
- a series of planned actions/activities intended to achieve those outcomes
- including, but not solely, the provision and procurement of services.

Commonly represented as a cyclical process of **Understand, Plan, Do** and **Review**.

6.2.3. **Levels of Commissioning**



6.2.4. **Sefton Commissioning Cycle**



6.2.5. **How we will Commission**

So we are clear, over the next 4 years we will commit to using potentially "6 commissioning arrangements". These are

1. **Lead Commissioning with Council as Lead Partner**. In this option the Council will be commissioning services in exercise of both CCG and Council Functions. The CCG will have delegated its Commissioning Function in respect of those services to the Council.

2. **Lead Commissioning with CCG as Lead Partner.** In this option the CCG will be commissioning services in exercise of both CCG and Council Functions. The Council will have delegated its Commissioning Function in respect of those services to the CCG.

3. **Aligned Commissioning with Council as Lead Partner**. Here the Council is commissioning the Services in exercise of Council Functions. There is no delegation of Functions from the CCG. However, the CCG and Council are co-operating in identifying and aligning services that need to be provided.

4. **Aligned Commissioning with CCG as Lead Partner**. Here the CCG is commissioning the Services in exercise of CCG Functions. There is no delegation of Functions from the Council to the CCG. However, the CCG and Council are co-operating in identifying and aligning services that need to be provided.

5. **Integrated Commissioning** – both the CCG and the Council enter into a contract for the commissioning of services in exercise of both CCG and Council Functions.

6. **Integrated Commissioning Unit** – this can be either Lead Commissioning (one Partner hosts the Unit as Lead and all functions are delegated to that Partner) or Joint Commissioning (the staff of each Partner work together but retain their separate roles) or using a s.113 Arrangement where the staff act as Council officers when undertaking Council roles and CCG officers when undertaking CCG roles.

The **"6 commissioning arrangements**" will also provide, in the next few years, a useful framework and the opportunity to evolve and mature our journey towards full integration by 2020, help partners to have a common language and terminology, reduce the potential for misunderstanding and help to mitigate the potential for disputes.

6.2.6. Our Commissioning Priorities

The Integrated Commissioning Group has recently been established. The outcome of the early meetings has led to six pathway areas as **1st priority areas** for reviewing the opportunity to develop joint commissioning arrangements.

- Obesity
- Falls
- COPD
- Mental Health and Learning Disabilities
- Stroke
- Hypertension.

These six priorities have been identified following an in depth analysis of the local joint strategic needs assessment, historical performance data, including trends and predictive analysis and a comprehensive review of existing policies and strategies. In terms of service delivery, the group has outlined the following areas for review and prioritisation, described as "System Enablers."

- Intermediate Care and Reablement
- Nursing /Residential Homes
- Domiciliary Care
- Continuing Health Care Funding.

These areas were identified because in some circumstances they provide the support necessary to prevent hospital admission; they avoid the requirement for longer term services and avoid delayed discharges. In addition some of these key services maintain and protect social care. The "system" recognises the fragility of the nursing, residential and domiciliary care market and the six pathways identified above are critical to focus on prevention and early intervention to avoid admission to hospital and subsequently the residential and nursing care system. It is recognised that there are significant difficulties within the care market. Whilst Sefton is not the largest in the Liverpool City Region, it does have more care homes than the other two larger Councils. Sefton has 7% of its care homes rated "Inadequate" by the Care Quality Commission and 34% that "Require Improvement". Over the last 2 years 3 Care Homes have closed in Sefton. Significant numbers of patients in Aintree Hospital currently reside in Hospital

wards because of patient choice into care homes – clearly there is a direct link between the number of inadequate care homes and the remaining beds we have available now in Sefton, which is now critically low. The majority of care homes now pay a 'top up' to their care fees ranging from £20 - £150 per week. Therefore these factors require significant investigation.

Intermediate Care and reablement continues to be another key area of joint development. Implementation of our joint strategy will show real examples of how our integrated work will bring about integrated delivery, with agreed plans for a multi- agency team approach to bring about more streamlined and co-ordinated care for local residents.

Whilst we have begun to determine a **1st list of priorities** for us to focus on and identified the enablers we have not sought at this point to shape our structures or move and align commissioning or commissioning support. In the future this may be an important step but for the time being we commit that form will follow.

6.3. Pooled Budgets - Using all of our resources in the best way

6.3.1. The Better Care Fund

The Better Care Fund has been established to help support integrated between the NHS and Local Authorities. It has been in place since April 2015. The 2015 Spending review set out a clear commitment around furthering health and social care integration across the country by 2020. In practical terms, CCG's and Local Authorities are required to develop a Plan to reach "full integration" for the financial year 2020/21. The Plan should be agreed in the form of a roadmap by March 2017. The creation of the pooled budget presents an opportunity to secure better value for money by avoiding duplication and streamlining contractual arrangements.

6.3.2. Section 75 Agreements and Pooled Budgets

A Pooled Budget is a shared budget between organisations supported by appropriate governance structures to enable shared decision making to take place. Arrangements between NHS and Local Authority bodies have been reflected as Pooled Budgets through a section 75 agreement (NHS 2006 Act), and will include specific directions to reflect appropriate contribution levels and any further adjustments required should the budget overspend or underspend. The agreement will also highlight the appropriate risk shares for each party. These risk sharing arrangements should be set up to confirm the further adjustments to the pool in the event of an over spend or underspend compared with the original pool contributions.

For the purposes of this paper, budgets that are subject to agreed joint working through integrated commissioning but not reflected in a section 75 agreement will be referred to as "aligned budgets". It is good practice to agree aligned budgets as a step towards establishing pooled budgets so that shadow monitoring can take place to understand the impact across the whole health and social care economy. Aligned budgets should be in operation for a minimum of six months prior to a pooled budget being established. The important point is that both parties should be in agreement before confirming pooled budget arrangements and appropriate risk shares.

6.3.3. **What we have already pooled**

See appendix C.

6.3.4. **Where exclusions currently apply**

It should be noted that section 75 is applicable only to prescribed health-related services and prescribed local authority services. It precludes CCGs from delegating any functions relating to family health services, the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services. These services will require changes in legislation before they could be considered for inclusion in pooled budgets.

For Local Authorities, the services that can be included within section 75 arrangements are broad in scope although detailed exclusions exist. It is therefore imperative to check that services considered for inclusion in the pooled budget can be incorporated legitimately and that no ultra vires spending is incurred.

6.3.5. **Pooling Budgets and Integrated Commissioning Priorities**

In respect of the "**1st Priority"** areas for reviewing existing NHS expenditure covering these pathway areas relates to providers from primary care across through to secondary acute care and in some cases specialised commissioning. There will be further work required to establish the financial flows across all commissioning budgets for the CCG Sefton`s Integrated Commissioning Group has recently highlighted six pathway.

In terms of service delivery, the group has outlined the following areas for review and prioritisation, described as system enablers

- Intermediate Care
- Reablement
- Nursing /Residential Homes
- Domiciliary Care

Expenditure in these areas is relatively easy to define and has been earmarked for inclusion within the pooled budget for 2017/18.

6.3.6. **What do we need to do next**

Further work is required to determine the extent that services could be included within a pooled budget during the timescale and this is reflected in Appendix B. The Appendix identifies the potential contribution and agreements are still to be confirmed in a number of cost centre areas.

Most of these services are delivered through secondary care arrangements and therefore will need further work to separate out what potentially could be included in a pooled budget as shown in Appendix B.

The scope of the CCG commissioning arrangements is expected to grow given that CCGs` will be responsible for additional delegated responsibilities including commissioning of both primary care, covering GP's and likely to extend to

pharmacies, dentists, etc. and also specialised commissioning (e.g. cancer services, neurology services and a range of low volume / high cost treatments.

Further work to understand the detail around elements of proposed pooled budgets will be progressed. A more granular review of key areas will need to be undertaken in key areas (e.g. to identify community services within the CCGs` main Mental Health contract).

The Pooled Budget Group should look to develop the rationale for entering into pooled budgets using appropriate criteria which builds upon the joint priorities of both parties.

6.4. **Integrated Delivery - Working together to support our Citizens**

Integrating care is a about ensuring that health and care services are planned and delivered around the needs and wishes of patients and service users and that they are well coordinated across the different organisations involved in providing these services.

Bringing health and social care together is a complex job and we propose our work plan in terms of integrated delivery is:

- **Giving people more information, support and tools to manage their own health** - A new Integrated Wellness Service will offer targeted holistic support and advice to people to help keep them healthy, independent and connected to their community.

- **Being proactive and getting better at preventing ill health** - Working with GPs and other health and social care staff to deliver community-centred health and care help to identify patients at highest risk of becoming ill so that the right care and support can be offered to keep patients independent and well.

- **Health and social care services working more closely together** - For many years, health and social care professionals have been working more closely together but this has often taken a piecemeal approach and has depended on where you live. We are committing to working in a more connected way across Sefton. As part of our programme for community-centred health and social care, we will now explore how we build on this to support more citizens to remain independent and in their own homes.

There is an increasingly challenging position around the financial sustainability of the Health and Social Care system. Doing nothing different is not an option.

Sefton Council is exploring opportunities to work differently in the future with two other Councils in particular. A potential work programme may be progressed subject to all of the appropriate approvals/decisions and governance routes. Although at very early stages this dynamic needs to be declared as a potential opportunity. The Case for Change at this point identifies an “Alliance of Councils” with three Councils with common characteristics. These characteristics being:

1. Ageing populations
2. High levels of deprivation
3. Common NHS providers
4. Similar aspirations in terms of multi-disciplinary working

Councils also share a similar vision with a focus upon improving the health and well-being of people living and working in their areas in order to prevent, reduce or delay the need for care. In addition the Councils wish to work towards an integrated health and social care system to ensure that people get the right choice to care closer to home and support people to return home safely reducing the pressure on social care and health services. These common aims are the basis for taking the conversation further and does not preclude the opportunity to work more locally and with as health partners.

Similarly, from a local NHS perspective and as part of the aforementioned work as part of both Shaping Sefton and the C&M STP, both healthcare providers and commissioners are also reviewing service provision with a view to improving quality and sustainability of services, while reducing variation.

This forms our 4th potential approach with two distinct strands one strand driven by local NHS and a second strand driven by an “Alliance of Councils”.

So to summarise our approach to integrated delivery will have four approaches.

- Giving people more information, support and tools to manage their own health
- Being proactive and getting better at preventing ill health
- Health and Social Care services working more closely
- On a footprint bigger than Sefton
  - Shaping Sefton and the C&M STP
  - “Alliance” with other Councils.

We have established a working group to explore “Multi-disciplinary” approaches as we recognise and confirm that joint working across agencies are a pre-requisite to delivering improved outcomes for citizens.

At this stage there are distinct differences in approaches because of health configurations and a mixed economy within the social care sector, with a fragile residential, nursing and home care market.

In addition whilst the aspiration is for neighbourhood\locality working the resources to deliver such models are finite and a review of models is required so a blueprint can be agreed. There is a desire to address multi-disciplinary working and a mapping exercise of key NHS community and social care services is required to identify opportunities for joint working. This is underway and agreement on future modelling is expected to be agrees by the end of the calendar year.

Building on the existing, well documented, Community Transformation programmes and Care Closer to Home programmes to deliver integrated care at a locality level - we have refreshed the approach to look at how we deliver greater coherence of processes, methods and tools used by all at a locality level with a model for community-centred health and care, supported by integrated teams. We have established a working group to explore “Integrated Delivery” in particular we have:

- Worked to understand the needs for our citizens in respect of prevention, early intervention and how this fits together with other community based services.
- Started to articulate what is our offer of access to advice information, support and services on a locality/neighbourhood basis.
- Linked to the Virtual Ward/Care Closer to Home schemes to those above and, in turn;

- Agreed implementation of our Intermediate care strategy by April 2017 in particular the scheme developed to improve access to reablement and our admission avoidance and transition from hospital scheme.

6.4.1. **New Models of Out-of-Hospital Care** - (Community Integrated Neighbourhood Teams Virtual Ward, Care Closer to Home)

An acquisition process and a formal procurement process haven taken place in both south Sefton and within Southport and Formby, with operational dates for new models of care scheduled for April/May 2017. Community teams will transition to this new way of working through robust mobilisation plans.

6.4.2. **Integrated Community Urgent Care** - (Admission Avoidance and Transition from Hospital Scheme)

Significant work has already taken place to redesign the range of services available in the community setting to support avoiding hospital admission. Following the collaborative development of the AATHS (intermediate care) scheme, implementation is scheduled for April 2017.

6.4.3. **Integrated/streamlined pathways for Long Term Conditions**

Again, pathways have been refreshed and the specifications for delivery of same have been revised. These are also subject to the procurement/acquisition processes that are underway and the larger schemes also form part of the C&M STP and LDS work.

6.4.4. **Care Home Improvement Project** (South Sefton)

- A comprehensive remote and local televideo urgent care network is now in place across the majority of care homes facilitated by Community Matron and Community Geriatrician both inreach and are supported by Rapid response teams (Urgent Care Team and Community Emergency Response Teams).
- This increased locality focus supports care homes and primary care to manage residents within their usual place of residence, reducing the risks associated with a hospital admission.
- Incentivised and standardised advanced care planning has been agreed via Local Quality Contract and is shared with Urgent Care providers (NWAS/GoToDoc etc.).
- Work is also under way regarding standardisation of care home protocols.

6.4.5. **Telemedicine** (Southport and Formby)

The Care Homes pilot is now under way in Southport and Formby and includes linking telehealth to five practices. Subject to positive evaluation and affordability there are plans to extend out to all practices/care homes.

7. The Challenges we will have to Overcome

Integrating is not a simple task. We will need to look beyond our own organisational issues, at times we will need to share risks, be open, be willing to challenge and be challenged. We will need to work with our citizens, communities, providers of care and support in a way which will harness the skills and assets to greater benefit. Some of our challenges are identified at this stage as:

- An ageing population with increased needs, particularly around Long Term Conditions.
- Unacceptably high health and wellbeing inequalities in a diverse borough with different challenges in different parts - deprivation in south Sefton (high levels of benefits reliance and social housing) compared with a popular seaside town in the north of the Borough attracting an older retirement age population.
- National and local growth in non-elective admissions.
- Continuing to meet ever increasing external standards and financial pressures across commissioners and providers over the next 5 years.
- The nursing, residential and domiciliary care market needs to be sustainable to avoid hospital admissions and delayed discharges and to maintain and protect social care.

These challenges are further compounded by a significantly reduced (and reducing) resource within the Local Authority as a result of the austerity measures and considerable pressures on the health system to make on-going efficiencies, while maintaining quality and reducing secondary care activity. This means Sefton's Health and Wellbeing Board's developing and on-going cohesive plan for the integration of Health and Wellbeing services in the Borough must be refocused and requires further efforts to stimulate change.

8. How will things be different for Citizens

Who is Mrs Sefton?
Mrs Sefton is 78 years old and lives alone. She has arthritis, chronic obstructive pulmonary disease, anxiety and high blood pressure. She gets out once a week, she is shaky walking and uses a stick. She wants to continue to living at home.

What does integration mean for Mrs Sefton?

Integrated commissioning in Sefton
We are making the best use of our scarce resources by sharing our budgets. Decisions are made jointly to avoid 'buck passing'. Working together means communication is much better.

Integrated delivery in Sefton
Services all accessed in one way, with care joined up care across health and social care. You'll be assessed once, with one care plan. Your care will be personalised and delivered as close to your home as possible. We will support you to live longer in your own home, reduce the number of times you are admitted to hospital and, if you are admitted, get you home quickly

Integrated delivery across North Mersey
No 'postcode lottery' – your care comes first, not which local authority provides your wheelie bin.

Health and social care services working more closely together

We will establish integrated working across Sefton to support patients and service users to remain independent and in their own homes. All of these services will be accessed via single point of contact/assessment, meaning residents will not be required to reiterate their story multiple times.

Investing in community based care

We will refocus Intermediate Care and reablement services to get people home sooner and to help avoid the need for going into hospital in the first place. Further changes will see more urgent assessments being offered to patients and service users to arrange support and care to avoid hospital stays and keep people at home. Home support and district nursing will be available 24 hours a day to help make this happen.

Being proactive and getting better at preventing ill-health

We will work with GPs and other health and social care staff to identify patients at highest so that the right care and support can be offered to keep patients independent and well.
We will also work to support patients and service users with very complex needs often related to drug or alcohol dependency and/or enduring mental health issues and whose needs extend beyond health and social care for example supporting with debt or housing issues.

Giving people more information, support and tools to manage their own health

We will offer targeted holistic support and advice to older people to help keep them healthy, independent and connected to their community.

Appendices

Appendix A	Our route map – work plan
Appendix B	Our route map (i) Pooled Budget – Sefton Council
	(ii) Pooled Budget – South Sefton and Southport and Formby CCGs
Appendix C	Our BCF Section 75 summary for 2016/17
Appendix D	Where we think we are against the 10 key elements

References

Stepping up to the place - The key to successful health and care integration http://www.local.gov.uk/web/guest/publications//journal_content/56/10180/7867709/PUBLICATION

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[2]The CCGs' Annual Engagement and Patient Experience Group report (http://www.southseftonccg.nhs.uk/media/1406/epeg-annual-report-2014-15-final.pdf)

Appendix A Our Route Map – Work Plan

2016 - 17 Actions
Embed the new Governance structure to help integration become business as usual and review before the end of 2017.
Move on integrated commissioning in Sefton the future approach by using any of the "6 commissioning approaches."
Pool budgets of circa 26 million.
Identify the areas of commissioning priority for the year and develop an Integrated Commissioning Strategy for the next 5 years.
Explore effective models of care to support the most vulnerable.
Complete the work to be ready to Pool X in the areas of Y.
2017 - 18 Actions
Following review at end of 2016, progress any actions identified to ensure Governance is fit for the purpose of supporting and developing integration (commissioning and delivery).
Implement the agreed approach in terms of Commissioning.
Review the areas of commissioning priority for the year and refresh intensions against the Commissioning Strategy in terms of commission, decommission, review and innovate.
Pool X in the areas of Y.
Complete the work to be ready to Pool X in the areas of Y.
Begin to prepare for the agreed future model to deliver the most efficient and effective way to support the most vulnerable.
2018 - 19 Actions
Pool X in the areas of Y.
Complete the work to be ready to Pool X in the areas of Y.
Review the areas of commissioning priority for the year and refresh intensions against the Commissioning Strategy in terms of commission, decommission, review and innovate.
Implement the agreed model to deliver the most efficient and effective way to support the most vulnerable.
2019 - 2020 Actions
Pool X in the areas of Y.
Complete the work to be ready to Pool X in the areas of Y beyond 2019- 2020.
Review the areas of commissioning priority for the year and refresh intensions against the Commissioning Strategy in terms of commission, decommission, review and innovate.
Roll out the model to deliver the most efficient and effective way to support the most vulnerable.
Complete any outstanding tasks around delivering an integrated commissioning function in Sefton.
2020 - 2021 Actions
Pool X in the areas of Y.
Review the areas of commissioning priority for the year and refresh intensions against the Commissioning Strategy in terms of commission, decommission, review and innovate.
Roll out the model to deliver the most efficient and effective way to support the most vulnerable.

Appendix B Our Route Map i) Pooled Budget – Sefton Council

SEFTON COUNCIL						
Service	**Budgets 16/17 Net £**	**Amounts Net in BCF £**	**17-18**	**18-19**	**19-20**	**20-21**
Adult Social Care						
Assessment	9,792,500	561,000	P			
Business Support	6,112,350	0	P			
Support to Carers	763,200	20,000	P			
Equipment & Adaptations	1,222,900	373,000	P			
Early Intervention & Information	824,450	50,000	P			
Community Care	67,055,550	7,348,000	P			
New Direction related including contract	9,710,550	1,127,000	P			
Central ILF grant, Local Reform & Community Voices, Prisons	-2,552,050		P			
BCF additional equipment, Care For You, Care Act, Manchester Rd	1,420,000	1,420,000	P			
Other Services (HRS,ELAS)	1,057,000	0	P			
BCF Income funding Council expenditure	-10,899,000	-10,899,000				
	84,507,450	**0**				
Commissioning, Business Intelligence & Strategic Support						
Commissioning and Central Procurement	853,700		P			
Business Intelligence	766,300		P			
Service Development - IT budget	118,000		P			
Corporate Communications	635,800		P			
Strategic Support	379,500		P			
	2,753,300					
Public Health						
Admin and Development	1,372,300		P			
Collaborative Working	105,100		P			
Health Protection	115,900		P			
Children's 0-19	5,560,700		P			
Substance Misuse	4,367,900		P			
Sexual Health	2,725,100		P			
Health Checks	300,000		P			
Integrated Wellness	2,270,850		P			
Funding Other Council Services	1,339,950		N			
	18,157,800					
Children's Social Care						
Admin and Management	3,879,650			P		
Community Adolescent Service	1,497,400			P		
Corporate Parenting	4,007,200			P		
Duty & Assessment	2,065,600			P		
Locality	2,080,350			P		
Placements & Care Packages	13,434,850			P		
Safeguarding	622,400			P		
	27,587,450					

Assumptions
Does not include any savings that will be required relating to contribution towards Council budget deficit of £64m over the next three years
Does not include any pay increases 17/18 and onwards
Does not include any uplift for NLW 17/18 onwards
Assumes £750k currently in MTFP will be allocated to ASC budget in 17/18

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Print date: 19 January 2017

Includes MTFP price inflation for PFI contracts for Sports and New Formby Pool Contract cost for 17/18
Education Services Grant is expected to reduce significantly over the next few years and mitigation will need to be identified in the budget for Schools and Families
Care Act increase not included
The above figures are budgets not actuals

Note - need clarification on the following which are currently included in the figures:
Specialist Transport Unit
Proportion of central admin costs and admin buildings
Capital Costs
Children's Social Care includes LSCB which is externally funded but with contribution from Children's Social Care.
Similar Position with adults
ASG centrally held grants included. PH grant isn't. Treatment clarification needed

Appendix B Our Route Map ii) Pooled Budget – South Sefton CCG and Southport and Formby CCG

SEFTON CCGS' COMBINED BUDGETS					
Service	**16/17 £**	**17-18**	**18-19**	**19-20**	**20-21**
Non NHS					
Mental Health Contracts	1,882	S/P	P	P	P
Child And Adolescent Mental Health	427	N	S	P	P
Dementia	211	N	S	P	P
Learning Difficulties	1,943	P	P	P	P
Mental Health - Collaborative Commissioning	400	P	P	P	P
Collaborative Commissioning	931	P	P	P	P
Out Of Hours	2,175	N	N	S	P
CHC Adult Fully Funded	12,250	S	P	P	P
CHC Ad Full Fund PHB	214	S	P	P	P
CHC Adult Joint Funded	3,346	P	P	P	P
CHC and Joint Fund PHB	23	S	P	P	P
CHC Children	893	S	P	P	P
Funded Nursing Care	5,106	S	P	P	P
Community Dermatology	818	TBC	TBC	TBC	TBC
Hospices	2,439	S	P	P	P
Intermediate Care	652	P	P	P	P
Reablement	2,224	P	P	P	P
	35,934				
Corporate & Support Services					
Running Cost Allowance	5,877	N	N	S	P
Commissioning Schemes	1,991	N	N	S	P
Medicines Management - Clinical	1,308	N	N	S	P
Primary Care IT	2,602	N	N	N	N
Nursing And Quality Programme	549	N	N	S	P
Corporate IM&T	0	N	N	S	P
	12,326				
NHS					
Acute Commissioning	212,051	TBC	TBC	TBC	TBC
Acute Children's Services	10,483	TBC	TBC	TBC	TBC
Non Acute	35,845	S	P	P	P
Mental Health SLA	29,130	TBC	TBC	TBC	TBC
NHS 111	621	TBC	TBC	TBC	TBC
Ambulance Services	11,316	TBC	TBC	TBC	TBC
NCA/OATS	3,193	TBC	TBC	TBC	TBC
Winter Resilience	1,423	TBC	TBC	TBC	TBC
	304,063				
Independent Sector					
Clinical Assessment & Treatment Centres	8,595	TBC	TBC	TBC	TBC
	8,595				
Primary Care					
Local Enhanced Services	6,045	N	N	S	P
Programme Projects	797	N	N	S	P
	6,843				
Prescribing					
High Cost Drugs	2,293	N	N	S	P
Oxygen	618	N	N	S	P

SEFTON CCGS' COMBINED BUDGETS					
Service	**16/17 £**	**17-18**	**18-19**	**19-20**	**20-21**
Prescribing	51,927	N	N	S	P
	54,838				
Sub-Total Operating Budgets pre Reserves	**422,598**				
Reserves					
Commissioning Reserve	1,432	N	N	S	P
Non Recurrent Reserve	1,810	N	N	S	P
	3,242				
TOTAL: CCG`s EXPENDITURE	**425,840**				
Place Based Expenditure					
Primary Care	35,910	N/S	N	S	P
Specialised Commissioning	82,290	N/S	N	S	P
	118,200				
TOTAL: NHS E and CCGs' EXPENDITURE	**544,040**				

Appendix C: Our BCF Section 75 Summary for 16/17

Theme	Scheme Name	Funded by	LA	SS CCG £	SF CCG £	Approach	Risk and benefit approach	
							Overs	Unders
Carers	Carers Grant	CCG		280,000	220,000	Lead Council	100% to Council	ICG and PBG to Exec
	Carers Card	CCG		12,000	8,000			
	Short Breaks and Respite	CCG		117,000	83,000			
	Total			**490,00**	**311,000**			
Equipment	Sensory Support	CCG		9,000	7,000	Joint	By utilisation Health to Health, Social Care to Social Care	ICG and PBG to Exec
	Care Line	CCG		58,000				
	Community Equipment	CCG		230,000	161,000			
	Community Equipment	CCG		427,000	350,000			
	Community Equipment	CCG		165,000	135,000			
	DFG	LA	3,349,000					
	Contribution to provision of care line				42,000			
	Contribution to provision of care line				42,000			
	Delivering integrated care and supporting discharge (equipment and telecare)	CCG			30,000			
	Total		**3,349,000**	**880,000**	**767,000**			
Children and Young People	Child and Adolescent Mental Health	CCG		702,000	188,000	Lead CCG	100% to CCGs	ICG and PBG to Exec
	Total			**702,000**	**188,000**			
Int` Care and Reablement	Care Services	CCG			7,000	Joint	Determined by who commissioner is and who provider is	ICG and PBG to Exec
	Sefton MBC Home from Hospital	CCG		96,000	76,000			
	End of Life Service	CCG		3,000	2,000			
	Community Beds and Medical Cover	CCG		235,000	165,000			
	Reablement	CCG		503,000	396,000			
	Early Discharge	CCG		95,000	121,000			
	Chase Heys	CCG			211,000			
	Care Worker	CCG			17,000			
	Ward 35	CCG		976,000				
	Int Care	CCG		688,000	500,000			

Theme	Scheme Name	Funded by	LA	SS CCG £	SF CCG £	Approach	Risk and benefit approach	
							Overs	Unders
	Services							
	Total			**295,600**	**1,495,500**			
Community Services Transform-ation	Virtual Ward/CC2H	CCG		1,632,000	888,000	Lead CCG	100% with CCGs	ICG and PBG to Exec
	Community Matrons	CCG		280,000	198,000			
	CCNOT	CCG		75,000	188,000			
	DN's twilight	CCG		895,000	1,000			
	DN's OOH	CCG		494,000				
	Alcohol Nurse	CCG		24,000				
	Community Treatment Rooms	CCG			280,000			
	GP Call handling	CCG			68,000			
	Discharge planning	CCG			135,000			
	DN's OOH	CCG			61,000			
	DN's OOH	CCG			162,000			
	Falls	CCG			67,000			
	HALS	CCG			82,000			
	Respiratory	CCG		587,000				
	Heart Failure	CCG		402,000				
	Community Nursing Children's	CCG		58,000				
	Community Paediatrics	CCG		229,000	61,000			
	Phlebotomy	CCG			110,000			
	Respiratory	CCG			273,000			
	Cardiac rehab	CCG			217,000			
	Community Dietetics	CCG			328,000			
	Community Nursing	CCG			15,000			
	Total			**4,676,000**	**3,134,000**			
Long Term Care and Adult Social Care	People First Advocacy	CCG		19,000	15,000	Lead Council	100% to Council	ICG and PBG to Exec
	Support to community care services	CCG		3,347,000	2,363,000			
	Performance money 2015.16 to support ASC	CCG		175,000	126,000			
	1.1% minimum uplift on social care min contribution	CCG		59,000	47,000			
	Social worker capacity and supporting	CCG		299,000	207,000			

Theme	Scheme Name	Funded by	LA	SS CCG £	SF CCG £	Approach	Risk and benefit approach	
							Overs	Unders
	discharge							
	Social worker capacity - mobile working	CCG		30,000	21,000			
	Reablement vouchers and telecare	CCG		53,000	42,000			
	Care Act	CCG		491,000	386,000			
	ASC Capital Funding 2015/16	LA	780,000					
	Total			**4,473,000**	**3,207,000**			
	TOTAL			**26,967,000**				

Appendix D: Where we think we are against the 10 key elements

Key Element
1. A shared commitment to improving local people's health and wellbeing using approaches which focus on what is the best outcome for citizens and communities.
What good looks like
Moving away from a focus on episodic care and treating ill health towards an emphasis on independence, wellbeing and holistic care for everyone. Understanding the needs and wishes of citizens, including the resources they and those around them can contribute to their own health and wellbeing. Bringing together all the assets in a place to stimulate and support individuals, families and communities to be more able to lead happy, safe, independent and fulfilled lives.
Where we are
What we need to do

Key Element
2. Services and the system are designed around the individual and the outcomes important to them, and developed with people who use or provide services and their communities.
What good looks like
Involving individuals and communities in decisions at all levels of the system, from jointly writing a care and support plan with service providers, to groups of community stakeholders playing a central role in designing, implementing and reviewing services. Ensuring services treat people with dignity and are personalised to their needs, and are based on a single system-wide assessment of the needs of the whole population. Giving citizens greater choice and control of services and support, including encouraging the use of a personal budget for health and social care.
Where we are
What we need to do

Key Element
Everyone – leaders, practitioners and citizens – is committed to making changes and taking responsibility for their own contribution to improving health and wellbeing
What good looks like
Offering information, education, advice and support to enable everyone to understand how to make changes for a healthier lifestyle and support their care needs. Building capacity in the community to be able to support all citizens to make full use of community and social networks and activities. All system leaders and practitioners actively ensuring their actions support their shared vision and their contribution to improving health and wellbeing.

Where we are
What we need to do

A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens.
What good looks like Changing the perception of health and care from just treating ill health or substantial care needs to one which keeps people well and safe, leading happy and fulfilled lives. Redirecting investment to prioritise public health and community services, as well as wider issues affecting health such as education, housing and jobs for all citizens. Having open and trusting relationships with partners, stakeholders and the public from which to make effective, targeted and needs-based decisions about service provision.
Where we are
What we need to do

Shared Leadership and Accountability Locally accountable governance arrangements encompassing community, political, clinical and professional leadership which transcend organisational boundaries are collaborative, and where decisions are taken at the most appropriate local level.
What good looks like Leaders stepping beyond their organisation's walls to listen and understand each other, and to lead and make decisions collectively for the benefit of citizens. Local leaders being best placed to interpret and respond to community needs drawing in wider services and local resources where appropriate to improve health and wellbeing. Leaders being inclusive and collegiate, investing time and energy in relationships, ceding some control, and navigating complexity across multiple accountabilities.
Where we are
What we need to do

Locally appropriate governance arrangements which, by local agreement by all partners and through health and wellbeing boards, take account of other governance such as combined authorities, devolved arrangements or NHS planning requirements.
What good looks like Navigating across footprints and local identities which exist within any one place, ensuring that the focus remains on what most benefits local populations taking account of whole community need and multiple organisational governance.

It can mean health and wellbeing boards agreeing to sit within larger arrangements as well as establishing alternative partnerships to carry out business effectively.

It can mean multiple arrangements for different purposes – the key is ensuring decision-making is with the right people and in the right place.

Where we are

What we need to do

A clear vision, over the longer term, for achieving better health and wellbeing for all, alongside integrated activity, for which leadership can be held to account by citizens.

What does good look like

Working together to align priorities and responsibilities, including overcoming cultural and performance challenges to establish a common language and set of objectives.

Exploring the many ways to integrate health and care to find the models and approaches which best meet local needs and aspirations.

Developing a system which works cohesively, with individual services that are high-quality and safe, and is sustainable in terms of services, markets and workforce.

Where we are

What we need to do

Shared systems

Common information and technology at individual and population level shared between all relevant agencies and individuals, and use of digital technologies.

What does good look like

A common information basis and sharing for planning purposes and shared care records – both for individual care and population-based planning.

Service arrangements and plans involve enabling and empowering people through technology, and also meaning they tell their story only once.

Developing a shared risk stratification model to identify individuals most at risk

Where we are

What we need to do

Long-term payment and commissioning models – including jointly identifying and sharing risk, with a focus on independence and wellbeing for people and sector sustainability

What does good look like

Aligning commissioning across all budgets, whether pooled or not, focusing on outcomes and increasing investment in community services that build independence.

Agreeing how to assess and share risk between partners. Shared long-term planning, which charts an achievable course to transform services and improve health, wellbeing and financial sustainability.
Where we are
What we need to do

Integrated workforce planning and development, based on the needs and assets of the community, and supporting multi-disciplinary approaches.
What does good look like Developing a joint workforce strategy across the health and care system, involving formal and informal workforces, and based on the needs of the population. Investing in changing skills and behaviours towards ones which enable person-centred, coordinated care in order to promote people's independence and wellbeing. Practitioners across health and care disciplines working seamlessly together to plan and provide care which is proactive and holistic, and supports independence.
Where we are
What we need to do

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2016

Agenda Item: 17/11	**Author of the Paper:** Becky Williams Strategy & Outcomes Officer Email: Becky.Williams@southseftonccg.nhs.uk Tel: 01512477000
Report date: January 2017	

Title: Two Year Operational Plan

Summary/Key Issues:

This report presents to the Governing Body the South Sefton CCG Operational Plan 2017-19 in response to the requirements of NHS England and NHS Improvement jointly issued guidance. It further presents a chronological record of the work, assumptions, analysis and discussions undertaken to develop a two year CCG operational plan as required and the assurance activities NHS England have announced they will undertake when reviewing CCG plans.

Recommendation

The Governing Body is asked to approve this report.

Receive	
Approve	X
Ratify	

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.
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.
	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.
	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 Governing Body Development session 15/12/2016.
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 Governing Body
January 2017

1. Executive Summary

This report presents to the Governing Body the South Sefton CCG Operational Plan 2017-19 in response to the requirements of NHS England and NHS Improvement jointly issued guidance. It further presents a chronological record of the work, assumptions, analysis and discussions undertaken to develop a two year CCG operational plan as required.

Following final submission of the Operational Planning templates on 23rd December 2016, NHS England has announced details of the assurance process plans will be tested against. The latest version of the ratings was shared with CCGs on 9th January 2017 and South Sefton CCG is adjudged Amber/Green for activity plans and a combination of Red and Green for Mental Health.

2. Introduction and Background

2.1 Planning Guidance

CCG Operational Planning guidance for 2017-19 was jointly published by NHS England and NHS Improvement 22nd September 2016 (see Appendix 1 for the link to the official planning guidance publication). This planning guidance describes to CCGs the expectations of the two regulatory organisations with respect to planning and also references support to Sustainability and Transformation Plans (STPs), and the NHS Five Year Forward View (NHS5YFV) and the 'NHS Reset'. It reaffirms national priorities and sets out the financial and business rules for both 2017/18 and 2018/19. CCGs were required to complete submission of plans in line with the published planning timetable (see Appendix 2 for a copy of the planning timetable).

There are direct links between CCG Operational Plans (which primarily focus on activity and meeting NHS Constitutional targets), CCG Financial Plans, and the negotiation and agreement of CCG and Provider contracts.

Significant differences should be noted in that final CCG Operational Plans and CCG Financial Plans were required to be submitted at a point three months' earlier in the year than previous years, concurrently with contract sign-off, and that plans should be derived for two financial years as opposed to one year. The rationale for this being to allow organisations to "provide certainty earlier" and "devote more of our energies towards getting on with the job of redesigning and delivering better, more efficient care".

3. Key Issues

3.1 Planning Template

The Operational Planning template required CCGs to review an NHS England pre-populated 2016/17 month 3 based Forecast Outturn activity. CCGs were permitted to make adjustments if necessary, to reflect local intelligence and knowledge of activity and forecasting, and then create monthly CCG level activity plans across several Points of Delivery (POD) for both 2017/18 and 2018/19. Plans should take into account non-recurrent activity changes, trend and demographic growth, transformational change and policy changes. Unlike previous years, provider level plans were not required to be completed by CCGs for this planning round.

As described throughout the 2016/17 planning process, activity numbers were provided to CCGs and pre-populated in planning templates using the Temporary National Repository (TNR), and

CCGs have struggled to replicate their local data to this data source for a number of detailed technical reasons which have been raised with Local Area Teams in the 2016/17 planning round.

Following the first draft submissions of CCG plans on 24th November 2016, NHS England issued six key lines of enquiry for CCGs to ensure they addressed in their final 23rd December submission. These are addressed in the following sections:

3.2 Affordability

The North Mersey LDS approach to "Acting as One" for provider contracts has agreed a block contract arrangement. This means that the vast majority of contract value including all under national tariff will be guaranteed (blocked) to the provider at the 2016/17 forecast outturn levels (plus some growth), for both 2017/18 and 2018/19. The rationale for doing so is that Providers will have the certainty of being able to cover their fixed costs over the period whilst North Mersey providers and commissioners work collaboratively to reduce demand on secondary care in line with the solutions identified within the North Mersey LDS section of the Cheshire & Merseyside STP, resulting in providers being able to permanently remove some of their fixed costs.

Providers have agreed to deliver the nine 'Must Do's' required in the planning guidance as key North Mersey Local Delivery System milestones when signing up to the 'Acting as One' contracting principles.

The activity figures are in line with contract values included within the CCG financial plan. It should be noted that delivery of the financial plan requires a QIPP saving of £10.7m in 2017/18 and £6.4m in 2018/19.

3.3 Adjustments (Forecast Outturn, Growth, Trend Analysis, Counting and Coding Changes)

The NHS England produced month 3 based Forecast Outturn was tested against a number of CCG internal forecasting methodologies. These were straightforward twelfths and a seasonally profiled forecast, both of which based on month 6 of 2016/17 as opposed to the month 3 based NHSE forecasts. These CCG generated methods resulted in forecast outturns on the whole lower than the NHSE generated FOTs which were felt to be too high, likely because the NHSE forecast was subject to high variation given that it only took 3 months of the year into account. An issue has been noted with A&E data, particularly for South Sefton, where it is suspected that data for Litherland Walk In Centre reporting from January 2016 onwards has been incorrectly assigned to South Sefton CCG, regardless of the CCG an attending patient is registered to meaning that A&E type 3 attendances are artificially high for South Sefton (and correspondingly too low for other local commissioners, namely Liverpool CCG). The choice of profile for each measure was then based on the degree of variation from the NHSE produced forecast.

Code	Activity Line	17/18 Annual Plan	18/19 Annual Plan	Forecast Growth from CCG 16/17 FOT to 17/18	17/18 to 18/19 Forecast Growth
E.M.7	Total Referrals (General and Acute)	67,381	67,067	-0.2%	-0.5%
E.M.7a	Total GP Referrals (General and Acute	42,318	41,755	1.0%	-1.3%
E.M.7b	Total Other Referrals (General and Acute)	25,063	25,312	-2.1%	1.0%
E.M.8	Consultant Led First Outpatient Attendances	60,601	60,220	-0.3%	-0.6%
E.M.9	Consultant Led Follow-Up Outpatient Attendances	133,265	132,300	0.9%	-0.7%
E.M.10	Total Elective Admissions	23,662	23,899	0.2%	1.0%
E.M.11	Total Non-Elective Admissions	21,164	20,545	1.0%	-2.9%
E.M.12	Total A&E Attendances excluding Planned Follow Ups	111,466	112,581	1.1%	1.0%
E.M.18	Number of Completed Admitted RTT Pathways	8,234	8,314	1.0%	1.0%
E.M.19	Number of Completed Non-Admitted RTT Pathways	46,311	46,774	1.0%	1.0%
E.M.20	Number of New RTT Pathways (Clockstarts)	61,800	61,440	-0.3%	-0.6%
E.J.3	Number of specific acute bed days relating to hospital provider spells	134,973	136,324	1.0%	1.0%

Growth calculations mirror those used in financial plans as follows:

Growth	2017/18	2018/19
South Sefton	1.00%	1.00%

The South Sefton CCG growth figure of Forecast Outturn plus 1% growth is based on the North Mersey LDS “Acting as One” approach offered to all contracts in the LDS (see section 3.2). This means that the vast majority of contract value including all under national tariff will be blocked to the provider at the 2016/17 forecast outturn levels (plus some growth at equivalent 1%), for both 2017/18 and 2018/19.

Activity trends over the past three years have been analysed, however it was concluded that to take account of activity from 2013/14 and 2014/15 would skew activity projections as in most areas, activity has grown in the last 18 months. A three year average would generate activity figures that would look too low when compared to 2015/16 activity; therefore plans are based on activity from the last 18 months.

After consultation with CCG leads in planned and unplanned care, contracts and other commissioning leads, there are no significant counting, coding or policy changes to account for in CCG Operational Plans.

3.4 Transformation Schemes

A number of transformational schemes are planned for implementation in 2017/18 and 2018/19. Note that they do not include plans that have materialised in that activity and costs have been avoided, saved or diverted by schemes in previous years as these will already be reflected in the baseline forecast outturn.

SSCCG	Schemes	POD	2017/18	2018/19	
	Total PLCV procedures	EL / DC	(196)	0	
	C2C referral Policy - 10% reduct	OPF	(808)	0	
	STP - LCCG - PC Spec	OPF	0	(985)	
	STP - LCCG - Manage Fups	OPFU	0	(2,299)	
	STP - LCCG - Shared NEL plan	NEL	0	(832)	
			(1,004)	(4,116)	(5,120)

Transformation schemes have been presented to and agreed at QIPP committee (a sub group of the CCG's Finance and Resource committee). All schemes are based on best practice, evidence from academic literature, and activity and financial impacts have been modelled. Draft activity plans have been presented to Governing bodies. Once these have been agreed, schemes are added to the CCG QIPP dashboards and monitored on a monthly basis to assess progress and measure impact.

Note that the impact of Non Elective schemes on A&E attendances was modelled through based on historic activity splits of method of admission, and the impact of referral management schemes on GP and other referrals was apportioned modelled on historic activity.

The transformational change via the STP from 2018/19 onwards focusing on Outpatient and Elective activity schemes are described below in more detail:

Musculoskeletal Clinical Assessment Service (MCAS)
Discussions are ongoing to replicate in South Sefton CCG the Southport & Formby CCG scheme for a Musculoskeletal Clinical Assessment Service (MCAS) with an estimated implementation date of January 2018.

Procedures of Limited Clinical Value (PLCV)
The Midlands and Lancashire Commissioning Support Unit (MLCSU) have been commissioned to deliver clinical commissioned policies that will prioritise procedures of limited clinical value against value and cost over a 3 year period. The Individual Funding Requests (IFR) team have also offered a prior approval service to implement a process and an IT system to enforce the eligibility of treatment with respect to the procedures of limited clinical value. MLCSU will process and administer this service on behalf of the CCG. The scheme implementation timetable is under discussion for South Sefton CCG.

Referral Management Scheme (RMS)
In response to NHS England concerns regarding referrals, schemes have been explored in South Sefton CCG.

Consultant to Consultant Referral Policy (C2C)
A consultant to consultant policy is currently under discussion with Aintree.

Follow Up Ratios
Ongoing review of the Top 9 specialities with high demand identified and benchmarked using Better Care Better Value to compare local and national rates. South Sefton CCG is working with Trusts to support changes to pathways and protocols in order to meet reductions. Progress will be monitored via monthly Contract Review meetings.

The transformational change for Non Electives via the STP originally stated a number of activity reductions in 2017/18. However in order to ensure plans are realistic and achievable STP activity changes are now reflected in 2018/19 onwards. The schemes are described below in more detail:

Cardiology
The implementation of a North Mersey-wide cardiology redesign initiative, one aim of which is to reduce emergency admissions. This is an opportunity identified from the Right Care programme.

Community
The development of integrated multi-disciplinary care teams, on a neighbourhood footprint, designed to meet the specific care needs of local populations has been specified for the forthcoming Community Services acquisition led by NHS England.

Digital
The Assistive Technology Programme will support not only the future development of community services but will also greatly impact of how services will be provided across primary and secondary care. The ability to access and deploy the latest technology to support diagnosis, monitoring and self-care coupled with enhanced patient relations through consumer devices offers a viable route to redesigning care pathways capable of meeting future demands. Published research from Liverpool shows a reduction of 22-32% in emergency admissions and secondary care costs for patients using telehealth technology in chronic condition pathways.

Primary Care
Implementation of a new GP specification supporting greater capacity and resilience within primary care with increased same day access to routine and urgent primary care seven days a week, enabling a single pathway for access. The spec will continue to provide direct incentives for localities and practices to reduce emergency admissions by providing regular review and proactive care to patients with Long Term Conditions. This is incentivised via the Local Quality Contract.

3.5 Alignment with other plans (CCG financial, activity, QIPP, STP, Providers)

The transformation schemes for 2017/18 described earlier are detailed in financial terms in the CCG financial plan with direct read-across to CCG QIPP plans. Note that they differ from the October 2016 submission of the North Mersey LDS STP. This is because the October 2016 submission has been reviewed and further refined, with growth and demographic changes updated and aligned with financial plans, while the initial STP was based on a 'Do Nothing' IHAM scenario. Another key difference is the starting points for the STP versus the CCG operational plans: STP uses Month 5 FOT, and the Operational plan uses various starting points.

The contribution to the STP submission from the two CCGs has been reviewed to ensure that transformational schemes are achievable and realistic. As stated in the original STP submission the modelling demonstrated sound ideas, however would require further analysis and challenge to convert them into more robust plans Following this review 2017/18 QIPP plans have been aligned with CCG financial plans, and reflected impacts of STP schemes that were submitted for 2017/18 against 2018/19 instead.

Whilst Providers have been fully engaged in the STP process and have agreed to the activity and finance plans submitted, there is likely to be divergence between separate organisational plans (CCG and Provider). This is because in contract negotiations, Provider organisations are cautious to agree activity and financial plans for CCG schemes that are yet to deliver. This means for example that Providers are unlikely to have accounted for the impact of Demand Management schemes in their plans. Provider organisations tend to prefer to build activity changes into plans the year following implementation once impacts have actually been observed. Given the "Acting as One" approach, there has been a focus on the overall size of the contract values, tariff impacts and Identification Rule impacts rather than individual scheme impacts. In terms of POD by POD alignment of plans, see below:

Consultant led First Outpatient attendances (Specific Acute)	Broadly align but as described above, Providers reticent to include demand management impacts
Consultant led Follow up Outpatient attendances (Specific Acute)	Align

Total elective admissions spells (Specific Acute)	Align
Total non-elective admissions (Specific Acute)	Align
Total A&E attendances (excluding planned follow up)	Non alignment due to inclusion of Walk In Centre activity – see section 3.2 above for explanation

Following the North Mersey LDS approach to "Acting as One" for provider contracts has agreed a block contract arrangement. Following this agreement, a North Mersey Joint Directors of Finance Group will be established, and the Group will need to consider potential implications of the Cheshire and Merseyside Sustainability and Transformation Planning Assumptions with regards to additional solutions that may have an impact upon the North Mersey Local Delivery System.

3.6 NHS Constitution Measures

Activity is deemed to be both affordable and sufficient to meet the NHS constitutional standards. The North Mersey LDS approach to "Acting as One" for provider contracts could allow for further activity to be commissioned should the need arise. However confidence remains high that the transformation schemes described above will manage demand sufficiently to permit planned activity levels be manageable enough to meet the constitution targets. Following NHSE feedback from draft submission one, the RTT clock starts were reviewed alongside referrals. Colleagues at NSHE highlighted a disparity between the number of first outpatient attendances and Clock starts, noting they would not expect to see a higher number of Clock starts than first outpatient appointments. On review of local data, clock starts historically are higher than first Outpatient appointments but lower than referrals. It is believed that there are a number of legitimate reasons why clock starts may be higher than outpatient firsts which has been fed back to NHS England local DCO.

A further more detailed technical planning narrative document has been shared with the NHS England local area team to enable assessment and assurance of CCG Operational Plans. Each indicator within the planning template was assigned a managerial lead form the within the Commissioning team and a dedicated analyst from the CCG Business Intelligence team to review and then plan for those indicators aligned to their area of work (Appendix 3).

3.7 NHS England Assessment and Assurance of Plans

Following final submission of the Operational Planning templates on 23rd December 2016, NHS England has announced details of the assurance process plans will be tested against. Local NHS England area teams have been asked by NHS England North counterparts to form an initial assessment of CCG Operational Plans using a template to RAG rate two main aspects of the plans; overall credibility of activity pans (a single overall RAG rating on a scale of Red, Red/Amber, Amber/Green, Green), and compliance with the Mental Health Investment standard and achievement of Mental Health performance trajectories.

The assessment approach is to revisit the overall assurance RAG ratings that were undertaken on the first draft submissions made on 24th November 2016 where an assessment was made against four key questions described in section 3.1 of this report and the sections that follow it.

• Q1 – Is activity affordable and in line with financial plans?: Factors which move a CCG towards red are setting a deficit plan/being in recovery or directions/having a high % QIPP and the overall scale of these issues.

• Q2 – Sufficient activity to deliver NHS Constitution standards?: All CCGs rated Green where CCGs are planning to meet an NHS Constitution standard and red where they are not.
• Q3 – Credible plans to reduce demand?: Assessment is somewhat subjective, but the most robust plans clearly quantify the impact of specific transformational initiatives on each point of delivery within the narrative supplied, and include clear milestones for delivery as well as narrative around the evidence base/rationale that supports a sense that the initiatives are deliverable. Factors which drive ratings in a negative direction are either lack of information e.g. the narrative supplied doesn't support an analysis of how CCG plans will produce the activity reductions within the planning templates, or the information supplied indicates that the initiatives are high risk or at a very early stage of development such that limited benefit will be seen in 2017/18.
• Q4 – How does activity align to provider plans?: In the absence of provider activity data, overall CCG contract sign off status has been used as a proxy, so all contracts signed gives a Green, major contracts heading for arbitration is a Red, and issues still outstanding but unlikely to lead to arbitration is Amber/Green.

In terms of overall rating, any Red means that the overall rating is Amber/Red at best. Overall ratings of Red or Amber/Red are likely to entail further assurance questions in due course. The latest version of the ratings was shared with CCGs on 9th January 2017:

Activity plan assurance for South Sefton CCG:

Is activity affordable & in line with financial plans?	Sufficient activity to deliver the NHS constitution standards?	Are there credible plans in place to reduce demand?	How does activity align to provider plans?	Overall Activity Plan RAG
A/G	G	A/G	G	A/G

Mental Health plan assurance for South Sefton CCG:

Mental Health Investment Standard*	Performance Trajectories**	Comments
Not assured - both		For MHIS, CCG in deficit, in financial recovery and is not planning to meet business rules.

* DCO to highlight if not assured that the Mental Health Investment Standard will be met (specifying whether this is with reference to MHIS including or excluding LD & Dementia)

** DCO to highlight if not assured that the performance trajectories for the following standards are credible: Dementia Diagnosis Rate, IAPT Access, IAPT Recovery, IAPT 6ww, IAPT 18ww, EIP RTT, CYP Access, ED Routine, ED Urgent (please list as appropriate)

A comprehensive email has been sent to NHS England to query the reasons for the rating against the MH Investment Standard rating. A letter from national mental health lead, Anne Rainsberry suggests that a CCG will be flagged as an outlier where "one or more of the performance standards outlined in the table below are not planning to be met for three out of the four quarters (or monthly equivalent) for their respective year AND; the CCG does not plan on meeting the MH Investment Standard for 2017/18 and/or 2018/19 (for both plans including and excluding LD & Dementia)". Therefore the table above suggests that the CCG meets one of those criteria but not both. There is a section in the CCG financial plans for the Mental Health Investment standard and

where a CCG is adjudged to have not met the investment standard, then the CCG has to provide a valid reason code. In the South Sefton CCG plan the following reason was submitted; "Commissioners in deficit, not achieving 1% plan metric or with very low growth – in this case MH Parity of Esteem will be measured against increase in overall planned spend, recognising that growth will need to support the improvement in the financial position". A response from NHS England is awaited.

4. Conclusions

The South Sefton CCG Operational Plan details the key activity and performance metrics the CCG will aim to meet in order to meet the requirements of the NHS England and NHS Improvement CCG planning guidance 2017-19.

Following final submission of the Operational Planning templates on 23rd December 2016, NHS England has announced details of the assurance process plans will be tested against. The latest version of the ratings was shared with CCGs on 9th January 2017 and South Sefton CCG is adjudged Amber/Green for activity plans and a combination of Red and Green for Mental Health.

5. Recommendations

The Governing Body is asked to note the contents of this report and approve the South Sefton CCG 2017-19 Operational Plan.

Appendices

Appendix 1: Link to NHS England, NHS Improvement CCG Operational Planning Guidance 2017-19
https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

Appendix 2: NHS England, NHS Improvement CCG Operational Plan 2017-19 timetable

Timetable Item (applicable to all bodies unless specifically referenced)	Date
Planning Guidance published	**22 September 2016**
Technical Guidance issued	**22 September 2016**
Commissioner Finance templates issued (commissioners only)	22 September 2016
Draft NHS Standard Contract and national CQUIN scheme guidance published	22 September 2016
National Tariff draft prices issued	22 September 2016
Provider control totals and STF allocations published	30 September 2016
Commissioner allocations published	21 October 2016
NHS Standard Contract consultation closes	21 October 2016
Submission of STPs	**21 October 2016**
National Tariff section 118 consultation documents issued	31 October 2016[1]
Final CCG and specialised services CQUIN scheme guidance issued	4 November 2016[2]
Provider finance, workforce and activity templates issued with related Technical Guidance (providers only)	1 November 2016
Submission of summary level 2017/18 to 2018/19 operational financial plans (commissioners only)	1 November 2016 (noon)
Commissioners (CCGs and direct commissioners) to issue initial contract offers that form a reasonable basis for negotiations to providers	4 November 2016
Final NHS Standard Contract published	4 November 2016
National Tariff section 118 consultation opens	9 November 2016[3]
Providers to respond to initial offers from commissioners (CCGs and direct commissioners)	11 November 2016[4]
Submission of full draft 2017/18 to 2018/19 operational plans	**24 November 2016 (noon)**
Weekly contract tracker to be submitted by CCGs, direct commissioners and Providers	Weekly from: 21/22 November 2016 to 30/31 January 2017
Where CCG or direct commissioning contracts not signed and contract signature deadline of 23 December at risk, local decisions to enter mediation	5 December 2016
Contract mediation	5 – 23 December 2016
National Tariff section 118 consultation closes	6 December 2016[5]
National Tariff section 118 consultation results announced	w/c 12 December 2016
Publish National Tariff	20 December 2016[6]
National deadline for signing of contracts	**23 December 2016**
Final contract signature date for CCG and direct commissioners for avoiding arbitration	23 December 2016
Submission of final 2017/18 to 2018/19 operational plans, aligned with Contracts	**23 December 2016**
Final plans approved by Boards or governing bodies of providers and Commissioners	By 23 December 2016
Submission of joint arbitration paperwork by CCGs, direct commissioners and providers where contracts not signed	By 9 January 2017
Arbitration outcomes notified to CCGs, direct commissioners and providers	Within two working days after panel date
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 31 January 2017

[1] The first set of documents that make up the s 118 National Tariff consultation were published on the 31 October. The remaining documents were published on the 8 November, and the statutory consultation period commenced on the 9 November. The consultation period closes on the 6 December.
[2] The final CQUIN and Prescribed Specialised Services CQUIN guidance were published on 4 November rather than 31 October as included in the original timetable.
[3] See footnote 1 above.
[4] Row 16 footnote: The date 4 November for 'Providers to respond to initial offers from commissioners (CCGs and direct commissioners)' was incorrect. It has been corrected to 11 November.
[5] See footnote1 above.
[6] The National Tariff publication date is dependent upon the completion of a 28-day consultation period.

Appendix 3: CCG Internal Management Oversight and Planning for Constitution Indicators

	Indicator	Managerial Lead	BI Lead
Activity	Total Referrals (General and Acute)	Karl McCluskey	Luke Garner
	Consultant Led First Outpatient Attendances	Karl McCluskey	Luke Garner
	Consultant Led Follow-Up Outpatient Attendances	Karl McCluskey	Luke Garner
	Total Elective Admissions (Ordinary Electives + Daycase)	Karl McCluskey	Luke Garner
	Ordinary Elective Admissions	Karl McCluskey	Luke Garner
	Daycase Elective Admissions	Karl McCluskey	Luke Garner
	Total Non-Elective Admissions	Karl McCluskey	Luke Garner
	Total A&E Attendances excluding Planned Follow Ups	Karl McCluskey	Luke Garner
	Number of Completed Admitted RTT Pathways	Karl McCluskey	Luke Garner
	Number of Completed Non-Admitted RTT Pathways	Karl McCluskey	Luke Garner
	Number of New Incomplete RTT Pathways (Clock starts)	Karl McCluskey	Luke Garner
Constitution	RTT - Incomplete	Sarah McGrath	Emily Golightly
	Diagnostics	Sarah McGrath	Emily Golightly
	Cancer Waiting Times - 2 Week Wait	Sarah McGrath	Ally Dwyer
	Cancer Waiting Times - 2 Week Wait (Breast Symptoms)	Sarah McGrath	Ally Dwyer
	Cancer Waiting Times - 31 Day First Treatment	Sarah McGrath	Ally Dwyer
	Cancer Waiting Times - 31 Day Surgery	Sarah McGrath	Ally Dwyer
	Cancer Waiting Times - 31 Day Drugs	Sarah McGrath	Ally Dwyer
	Cancer Waiting Times - 31 Day Radiotherapy	Sarah McGrath	Ally Dwyer
	Cancer Waiting Times - 62 Day GP Referral	Sarah McGrath	Ally Dwyer
	Cancer Waiting Times - 62 Day Screening	Sarah McGrath	Ally Dwyer
	Cancer Waiting Times - 62 Day Upgrade	Sarah McGrath	Ally Dwyer
	Ambulance Calls Closed by Telephone Advice	N/A	N/A
	Incidents Managed Without Need for Transport to A&E Departments	N/A	N/A
	A&E Performance Provider 1	David Warwick	Becky Williams
	A&E Performance Provider 2	David Warwick	Becky Williams
	A&E Performance Provider 3	David Warwick	Becky Williams
Quality & Mental Health	Dementia	Kevin Thorne	Debbie Fahy
	IAPT roll-out	Geraldine O'Carroll	Debbie Fahy
	IAPT Recovery	Geraldine O'Carroll	Debbie Fahy
	IAPT Waiting Times - 6 Weeks	Geraldine O'Carroll	Debbie Fahy
	IAPT Waiting Times - 18 Weeks	Geraldine O'Carroll	Debbie Fahy
	EIP - Psychosis treated with a NICE approved package within two weeks	Gordon Jones	Debbie Fahy
	Improve access rate to CYPMH	Peter Wong	Becky Williams
	Waiting Times for Routine Referrals to CYP Eating Disorder Services - Within 4 Weeks	Peter Wong	Becky Williams
	Waiting Times for Urgent Referrals to CYP Eating Disorder Services - Within 1 Week	Peter Wong	Becky Williams
	Reliance on Inpatient Care for People with LD or	N/A	N/A

	Autism		
Other Commitments	Total Bed Days	Karl McCluskey	Luke Garner
	E-Referral Coverage	Sarah McGrath	Becky Williams
	Personal Health Budgets	Tracy Forshaw	Becky Williams
	Children Waiting more than 18 Weeks for a Wheelchair	Peter Wong	Becky Williams
	Extended access (evening and weekends) at GP services	Angela Price	Becky Williams

Becky Williams
Strategy & Outcomes Officer
January 2017

Key Issues Report to Governing Body

NHS South Sefton Clinical Commissioning Group

Finance and Resource Committee Meeting held on Thursday 20th October 2016	Chair: Graham Morris

Key Issue	Risk Identified	Mitigating Actions
• CCG is reporting a likely case scenario of £1m deficit.	• Threat to deliver the CCG's statutory duty of breakeven financial position.	• The CCG must find additional £1m savings to deliver its statutory duty plus a further £1.2m to deliver its revised forecast outturn position. • The CCG must continue to explore all options to reduce cost in the remaining part of the financial year.

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

- Positive feedback reported from the Repeat Prescribing Ordering Service Pilot in terms of patient safety / reducing unnecessary prescriptions.
- Concerns raised about the CCG cash position. The CCG is to write to NHS England seeking assurance that it will receive sufficient cash during the year.
- The CCG is unlikely to qualify for the Quality Premium payments following reduction to its forecast outturn position at Month 6. The CCG must meet its planned target of £2.4m to qualify for quality premium.
- Update to 5 year financial strategy received. The key message is that the CCG needs to find £12.7m worth of savings from October 2016 to March 2018. A further update will be given in the Governing Body Development Session. A paper will be received by the Governing Body in March 2017.
- ETTF Bids evaluated. The CCG has been given approval to proceed with four IM&T schemes in the year and to start business cases for key estates developments.
- The CCG agreed support for improvement grants but noted that further information on costing is required. It was noted that some bids may be affected by proposed ETTF developments.
- Pooled budget report received. Governing Body discussion is scheduled for January / March regarding sign off.

NHS
South Sefton
Clinical Commissioning Group

Key Issues Report to Governing Body

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

Joint Quality Committee Meeting held on 20th October 2016	Chair: Dr Rob Caudwell

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

- **High Court Judgement: CQC Inspections of GP Practice** – To request further information from NHSE regarding this judgement. Issue to be placed on the Risk Register.
- **Quality Team Risk Register** – Received by the Quality Committee.
- **Dermatology Update** – Strategic Review Group has been established by the CCGs. Terms of Reference are being finalised. Participation from Secondary Care colleagues and patients is to be secured.
- **Southern Health Report** – Report received by the Committee and recommendations for commissioners noted. Progress against the recommendations highlighted particularly in relation to Serious Incident Management and impact on the proposed CQUIN for 2017/18 due to recent planning guidance. Relationships between DoLS and the Coroner to be explored.
- **Quality Impact Assessment Policy** – Approved by the Committee.
- **IAPT** – National IAPT Support Team are working with Access Sefton to improve processes and performance. Concern remains regarding 'hidden waits' and the remedial action plan had been received. Concern regarding prioritisation remains. An update has been presented to the Overview & Scrutiny Committee and a Chief Officer to Chief Executive conversation has taken place.
- **Dementia** – Challenges evident with Dementia diagnosis. A discussion is to be had at Leadership Team

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Audit Committee Meeting held on Thursday 6th October 2016	Chair: Graham Morris

Key Issue	Risk Identified	Mitigating Actions

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

- Outcome of Accounts payable review now finalised.
  - Identified 19 overpayments in total after reviewing all payments made by the CCG from its inception in 01/04/13. These total £30,039.49.
  - £29,956.13 has been recovered already.
  - 16 of the 19 payments occurred in 2013 or 2014.
- Risk register received and updates that were presented were approved.
- Internal Audit Progress Report received.
- External Audit Technical Update received.
- Counter Fraud Progress Report received.

Key Issues Report
South Sefton Localities

October – January 2017

NHS
South Sefton
Clinical Commissioning Group

Bootle Locality		
Key Issues	**Risks Identified**	**Mitigating Actions**
1. PCSE ongoing issues with delays in receiving patient records.	• Patient care	• Escalated to Jan Leonard in the CCG and Tom Knight in NHSE
2. Lack of Mersey Care provision for Crisis Team at staff at weekends and evening in AUH.	• Patient care	• Reported to Gordon Jones, Senior Programme Manager for Mental Health in the CCG. • Feedback – no reduction in mental health AED liaison service by Mersey Care, reported back to Locality
3. Attendance from all Practices is an issue within this Locality.	• Engagement with peer	• Draft letter has been produced and passed to CCG Chair for approval
4. Lack of Finance Representation has been raised by Locality.	• Knowledge of current financial status	• Escalated to Head of Strategic Financial Planning to identify representative
5. Issues with Dermatology provision at Aintree.	• Patient care	• Planned Care Lead for SSCCG provided an update to Locality Manager from the Dermatology Unit at AUH. Letter sent to Locality
6. Concerns regarding the atria-fibrillation audit on the number of patients required to meet 1% of list size for LQC.	• Non-compliance with LQC	• Numbers confirmed by iMerseyside and Primary Care Clinical Lead notified that some practices may fall short by a small number to meet 1% of list size
7. A patient had been re-referred back to GP as DMC, the community dermatology service in relation to removal of a lesion.	• Patient care • Patient quality	• Escalated to DMC who attended December Locality meeting and subsequently provided a list of inclusions/exclusions. Locality accepted, patient has been seen.
8. Ophthalmology/Hearing Service – GPs are being asked to re-refer patients if they have not been seen for 2 years.	• Patient care	• Contract Lead for Specsavers has provided feedback to the Locality.
9. Review of inappropriate requests of primary care to secondary care	• Patient care	• Escalated to LMC and CCG.

Key Issues Report
South Sefton Localities

October – January 2017

NHS
South Sefton
Clinical Commissioning Group

		• Jan Leonard has passed all information to AUH for a response.

Key Issues Report
South Sefton Localities

October – January 2017

NHS
South Sefton
Clinical Commissioning Group

Crosby Locality		
Key Issues	**Risks Identified**	**Mitigating Actions**
1. Issue with Bridging Therapy, secondary care are only prescribing 7 days medication for patients.	• Patient care	• Medicines Management suggested that GPs report this back to the hospital.
2. A Practice Manager raised a concern in relation to a relative being refused an x-ray at LWiC due to the fact they suffered from dementia and were unable to articulate how the injury occurred. Patient was re-directed to AED at Aintree.	• Patient care • Patient experience	• Escalated to Wider Group meeting. • Further information required from patient's relative to investigate with LWiC.
3. Lack of Finance Representation has been raised by Locality.	• Knowledge of current financial status	• Escalated to Head of Strategic Financial Planning to identify representative
4. Reported that a number of practices within Crosby Locality have closed their lists and are not accepting new patients.	• Patient care	• Escalated to Primary Care Programme Lead and Jan Leonard at CCG. • Discussed as part of the agenda on the SSCCG/SFCCG/NHSE Joint Operational Group meeting where resolution has been sort to develop a Task & Finish Group. Outcome due to be reported to Crosby Locality at the next meeting on 25th January.
5. PCSE ongoing issues with delays in receiving patient records.	• Patient care	• Escalated to Jan Leonard in the CCG and Tom Knight in NHSE
6. Review of inappropriate requests of primary care to secondary care	• Patient care	• Escalated to LMC and CCG. • Jan Leonard has passed all information to AUH for a response.

Key Issues Report
South Sefton Localities

October – January 2017

NHS
South Sefton
Clinical Commissioning Group

Seaforth & Litherland Locality		
Key Issues	**Risks Identified**	**Mitigating Actions**
1. PCSE ongoing issues with delays of receiving patient records and delays in responses to queries raised by Practices.	• Patient care	• Escalated to Jan Leonard in the CCG and Tom Knight in NHSE
2. Ongoing IT issues with soft blocking within the practice. Has been reported to IT.	• Information technology	• Reported to iMerseyside. Paul Shillcock and Alan Richmond to action. • Locality Manager has provided email addresses for GPs/PMs/PNs within this locality for iMerseyside to remove soft block.
3. Ongoing IT issues for practices in relation to WiFi to currently in use	• Information technology	• Reported to Alan Richmond in iMerseyside • Response has been feedback to Locality
4. Lack of Finance Representation has been raised by Locality.	• Knowledge of current financial status	• Escalated to Head of Strategic Financial Planning to identify representative
5. Review of inappropriate requests of primary care to secondary care	• Patient care	• Escalated to LMC and CCG. • Jan Leonard has passed all information to AUH for a response.

Key Issues Report
South Sefton Localities

October – January 2017

NHS
South Sefton
Clinical Commissioning Group

Maghull Locality		
Key Issues	**Risks Identified**	**Mitigating Actions**
1. DNACPR –Community Matrons refusing to counter sign and are requesting GPs sign.	• Patient care	• Escalated to Dr Debbie Harvey who has provided feedback from the Resuscitation Council (UK) to be given to the Locality at the January meeting.
2. Issues with soft blocking for internet use.	• Information technology	• Reported to iMerseyside. Paul Shillcock and Alan Richmond to action. • Locality Manager has provided email addresses for GPs/PMs/PNs within this locality for iMerseyside to remove soft block
3. Lack of Finance Representation has been raised by Locality.	• Knowledge of current financial status	• Escalated to Head of Strategic Financial Planning to identify representative
4. PCSE ongoing issues with delays in receiving patient records.	• Patient care	• Escalated to Jan Leonard in the CCG and Tom Knight in NHSE
5. Review of inappropriate requests of primary care to secondary care	• Patient care	• Escalated to LMC and CCG. • Jan Leonard has passed all information to AUH for a response.

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Minutes

Thursday 20th October 2016, 3.00pm to 5.00pm
3rd Floor Board Room, Merton House

Attendees		
Graham Morris	Lay Member (Chair)	GM
Graham Bayliss	Lay Member	GB
Martin McDowell	Chief Finance Officer	MMcD
David Smith	Deputy Chief Finance Officer	DS
Susanne Lynch (present for items FR16/115 & FR16/116 only)	CCG Lead for Medicines Management	SL
Jan Leonard (present for items FR16/115 - FR16/117 only)	Chief Redesign & Commissioning Officer	JL
Debbie Fagan	Chief Nurse & Quality Officer	DF
Rebecca McCullough	Head of Strategic Financial Planning	RM
Fiona Taylor	Chief Officer	FLT
Ex-officio Member*		
Fiona Taylor	Chief Officer	FLT
Apologies		
Dr Sunil Sapre	GP Governing Body Member	SS
Lin Bennett	Practice Manager & Governing Body Member	LB
Minutes		
Tahreen Kutub	PA to Chief Finance Officer	TK

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	A	✓								
Graham Bayliss	Lay Member				✓	✓	A	✓	✓		
Steve Astles	Head of CCG Development	✓	✓	✓	A	✓	N				
Debbie Fagan	Chief Nurse & Quality Officer	A	✓	✓	✓	A	✓	A	✓		
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A	A	A	A	A	A	✓			
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓		
Dr Sunil Sapre	GP Governing Body Member				A	A	✓	✓	A		
Andy Mimnagh	GP Governing Body Member	✓	✓	A							
Graham Morris	Lay Member (Chair)	✓	✓	✓	✓	✓	✓	✓	✓		
Paul Thomas	GP Governing Body Member	✓	A	✓							
John Wray	GP Governing Body Member	A	A	A	A	A	N	N	N		
Fiona Taylor	Chief Officer	*	*	*	*	*	*	✓	✓		
James Bradley	Head of Strategic Finance Planning	✓	✓								
Malcolm Cunningham	Head of Primary Care & Contracting	A	N	N	N	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	✓	✓	✓	✓	✓	✓		
Lin Bennett	Practice Manager & Governing Body Member					✓	✓	✓	A		

No	Item	Action
FR16/108	**Apologies for absence** Apologies for absence were received from Dr Sunil Sapre and Lin Bennett.	
FR16/109	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both South Sefton and Southport and Formby CCGs declared their potential conflict of interest. SL declared an interest in relation to item *FR16/116 Prescribing Pilot Update*, as her husband is a community pharmacy services contractor in Sefton.	
FR16/110	**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.	
FR16/111	**Action points from the previous meeting** **FR16/93: Estates Working Group** – MMcD said an action plan to address the under-utilisation of Litherland Town Hall will be brought to the November F&R meeting. He also updated that Louise Hallaron from GB Partnerships has been appointed as the Estates Implementation Manager to take forward the utilisation action plan. She is currently undertaking work to support the STP. **FR16/94: Month 5 Finance Report –** DS confirmed 'Care Homes' has been added under the 'Increased Cost Pressure / Efficiency' heading in Table F (Risk Rated Financial Position) in the Finance Report. In regards to the action to see how the CCG is doing compared to other CCGs, DS distributed a document entitled, '2016/17 Financial Monitoring Month 6, NHS England (North) CCG Dashboard, NHS South Sefton CCG'. A discussion took place in regards to this document. Action closed. **FR16/96 and FR16/104** – Actions completed and closed. **FR16/105: Terms of Reference** – TK said she has sent changes to Debbie Fairclough on MMcD's behalf. Debbie Fairclough has been on leave and therefore unable to meet the deadline for papers for this meeting. Therefore an updated Terms of Reference will be brought to the November F&R meeting. Action still open.	MMcD
FR16/112	**Month 6 Finance Report** DS provided an overview of the year-to-date Month 6 financial performance for South Sefton CCG as at 30th September 2016. The following was highlighted: • The forecast outturn position after the application of reserves is a surplus of £1.250m against a planned surplus of £2.450m. • QIPP delivered at the end of Month 6 is £3.623m and the forecast underspend on operational budgets is £0.761m. • The detailed QIPP plan (shown in Appendix 3) is projected to deliver £6.344m in total during the year. • CCG Cash position - if expenditure levels continue and the CCG does not achieve the planned QIPP targets to deliver the planned surplus, the CCG will need to develop plans to manage the additional cash requirement or this will require an additional cash allocation requested from NHS England which cannot be guaranteed. The following comments were made: • DS said outpatients is a significant pressure at Aintree University Hospital. There is not a graph on outpatients in the report but one needs to be included. DS to action. • GM raised concerns about the CCG's cash position and suggested the	DS

No	Item	Action
	CCG write to NHS England seeking assurance that it will receive sufficient cash during the year. MMcD to ask Leah Robinson to action. ***The Committee received this report.***	MMcD
FR16/113	**Financial Strategy Update** RM provided an overview of the Financial Strategy update 2016/17-2020/21, highlighting the following: • The report is an update to the long term financial strategy for the CCG and the assumptions that underpin it. • This is an update to the strategy presented in March which was based on the 15/16 outturn. This plan has been updated to reflect the current financial position – Month 6 16/17. A further update will be presented in January, with a view to having a final strategy for approval in March 2017. • 2017/18 business rules (NHSE) for commissioners will remain similar to those in 2016/17 – expected that CCGs will be required to meet a surplus of 1%. • CCG needs to deliver £12.7m savings to achieve required 1% surplus in 2017/18. • The CCG allocations have not yet been published. Contract negotiations are still in progress. The plan will be updated once these are finalised. • A key output outlined in the planning guidance was the need for local health economies to work collaboratively to produce a Sustainability and Transformation Plan (STP) over a large geographical footprint. This work has progressed during 2016/17. A discussion followed about the strategy. FLT raised queries in regards to the strategy presented and explanations were provided. MMcD said a further update will be given to the Governing Body Development Session this month. A paper will be received by the Governing Body in March 2017. ***The Committee received this report.***	
FR16/114	**Estates Working Group** MMcD provided an update on the outcome of the first stage of the Estates and Technology Transformation Fund (ETTF), highlighting the following: • The ETTF has been oversubscribed. The value of bids received has exceeded the available resources allocated to deliver the programme. • MMcD provided a brief overview of Cohort 1, Cohort 2 and Cohort 3 schemes which are detailed in the report. • MMcD said four digital schemes have been assessed as Cohort 1: 1) Videoconferencing and telehealth solution 2) Mobile enabled kit purchase 3) Envisage and Patient Partner 4) CDA E-discharge summaries MMcD said the first three could be completed by the end of the financial year but E-discharge summaries could take longer. Full business cases will be worked up in the next 3-6 months. MMcD provided an overview of the schemes assessed as Cohort 2. He noted the New Maghull Health & Well-being Neighbourhood Centre has been identified as Cohort 2, when it may prove difficult to comply with the relevant timescales. MMcD confirmed he will be writing to the practices who submitted bids to inform them of the outcomes.	

No	Item	Action
	The Committee received this report.	
FR16/115	**Prescribing Performance Report** SL provided an overview of the prescribing report for Month 4 2016/17. She noted the position for month 4 (July 2016) is forecasting an underspend of £839k for the year. Overall the CCG is forecasting an underspend. FLT noted the good work being done by the Medicines Management team. ***The Committee received this report.***	
FR16/116	**Prescribing Pilot Update** SL provided an update on the Repeat Prescribing Ordering Service Pilot to stop repeat ordering / waste medicines. She said Epact data for September will not be available until mid-November. However, practice level searches on EMIS are already showing a difference between pilot sites and non-pilot sites. Pilot sites (excluding Hightown) are showing an average 4% greater reduction in items prescribed than non-pilot sites. SL said she will take this item to Clinical QIPP with a recommendation to roll out the project. FLT asked for a paper to be taken to the November Governing Body meeting. SL to action. ***The Committee received this report.***	SL
FR16/117	**IFR Update** JL provided an overview of this report which provides a summary on individual exceptional funding requests for quarter 1. JL noted the new design of the report as it is now provided by Midlands & Lancashire CSU. ***The Committee received this report.***	
FR16/118	**NHSE Improvement Grants** MMcD gave an overview of the paper on GP Practice Expressions of Interest for NHS England Improvement Grants. Five bids have been received from the following practices: Blundellsands, Crosby Village Surgery, Glovers Lane, Rawson Road and Orrell Park. MMcD asked the committee for agreement in principle to the bids received with a view to further information on costing being received and further discussion. It was noted that some bids may be affected by proposed ETTF developments. ***The Committee did not raise any objections to the bids received. The Committee received the report.***	
FR16/119	**Quality Premium Dashboard** MMcD provided an update on the Quality Premium Dashboard. He said the CCG is unlikely to qualify for the Quality Premium Payments following reduction to its forecast outturn position at Month 6. The CCG must meet its planned target surplus of £2.4m to qualify for quality premium. ***The Committee received this report.***	

No	Item	Action
FR16/120	**Better Care Fund Update / Pooled Budgets** MMcD said that by the end of March 2017, the CCG and local authority need to identify the integration plan for health and social care for 2020-21. The report and outline financial plan submitted for this meeting is the first stage of this process. As detailed in the report, further work to determine the scope of integrated commissioning is ongoing and will inform the pace in terms of adoption of pooled budgets. MMcD said he has met with Dwayne Johnson, Director of Social Care and Health at Sefton Council, in regards to the Better Care Fund / pooled budgets to specifically identify what criteria should be used to determine whether budgets should be pooled or not. He highlighted two key things that came out of the discussion: • Avoidance of duplication of services • Clear focus on getting better outcomes DF said that at the Southport & Formby Finance & Resource meeting yesterday, it was noted that the paper does not focus on the quality aspect and benefits to patients. GB noted the challenges of the quality aspect when pooling budgets. MMcD said a Governing Body discussion is scheduled for January / March regarding sign off. ***The Committee received the report and would like to see further detail and criteria developed in due course.***	
FR16/121	**Any Other Business** <u>December F&R meeting</u> As a December F&R meeting has not been scheduled, it was agreed to have a one hour finance session during the December Governing Body Development Session. MMcD to liaise with Judy Graves.	MMcD
FR16/122	**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 17th November 2016 1.00pm to 3.00pm 3rd Floor Board Room, Merton House	

NHS

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Joint Quality Committee Minutes

Date: **Thursday 20th October 2016, 1.00 pm – 3 pm**
Venue: **The Board Room, 3rd Floor, Merton House, Bootle L20 3DL**

Membership

Dr Rob Caudwell	Chair & GP Governing Body Member	RC
Paul Ashby	Practice Manager, Ainsdale Medical Centre	PA
Lin Bennett	Practice Manager, Ford	LB
Graham Bayliss	Lay Member	GB
Gill Brown	Lay Member	GBr
Dr Doug Callow	GP Quality Lead S&F	DC
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	PC
Billie Dodd	Head of CCG Development	BD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Dr Gina Halstead	Vice Chair & Clinical Lead for Quality	GH
Dr Dan McDowell	Secondary Care Doctor	DMcD
Martin McDowell	Chief Finance Officer	MMcD
Dr Jeffrey Simmonds	Secondary Care Doctor	JSi

Ex Officio Member

Fiona Taylor	Chief Officer	FT

In attendance

Tracey Forshaw	Head of Vulnerable People	TF
Gordon Jones	Mental Health Programme Manager	GJ
Brendan Prescott	Deputy Chief Nurse & Head of Quality and Safety	BP
Helen Roberts	Senior Pharmacist	HR

Apologies

Paul Ashby	Practice Manager, Ainsdale Medical Centre	PA
Gill Brown	Lay Member	GBr
Dr Doug Callow	GP Quality Lead S&F	DC
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	PC
Dr Gina Halstead	Vice Chair & Clinical Lead for Quality	GH
Dr Dan McDowell	Secondary Care Doctor	DMcD
Dr Jeffrey Simmonds	Secondary Care Doctor	JSi

Minutes

Vicky Taylor	Quality Team Business Support Officer	VT

Membership Attendance Tracker

Name	Membership	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Dr Rob Caudwell	GP Governing Body Member	√	√		√		L	L					
Paul Ashby	Practice Manager, Ainsdale Medical Centre	√	A		L		√	A					
Graham Bayliss	Lay Member for Patient & Public Involvement	A	√		A		√	√					
Lin Bennett	Practice Manager, Ford				√		A	√	A			A	
Gill Brown	Lay Member for Patient & Public Involvement	√	A		√		√	A					
Dr Doug Callow	GP Governing Body Member /Clinical Quality Lead	√	A		L		L	A					
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	A	√		√		A	A				A	
Billie Dodd	Head of CCG Development	√	√		√		√	L					
Debbie Fagan	Chief Nurse & Quality Officer	√	√		√		√	√					
Dr Gina Halstead	Chair and Clinical Lead for Quality	√	A		√		√	A					
Dr Dan McDowell	Secondary Care Doctor	A	√		A		A	A					
Martin McDowell	Chief Finance Officer	A	A		√		√	A					
Dr Andrew Mimnagh	Clinical Governing Body Member	√	√		A		A	√					
Dr Jeffrey Simmonds	Secondary Care Doctor						√	A					

✓ Present
A Apologies
L Late or left early

No.	Item	Action
16/120	**Apologies for Absence** Apologies for absence were received from PA, GB, Dr DC, Dr PC, Dr GH, Dr DMcD and Dr JS. DF welcomed everyone to the meeting noting that there were a number of conflicting meetings being held today which prevented some Committee members from attending. LB gave advanced apologies that she would be unable to attend any JQCs held on Wednesdays due to existing commitments.	
16/121	**Declarations of interest regarding Agenda items** CCG Officers holding dual roles in both Southport & Formby and South Sefton CCGs declared their potential conflict of interest. RC declared an interest with regard to the Dermatology agenda item.	
16/122	**Minutes and Key Issue Logs from the previous meetings** The Minutes of the Joint Quality Committee were agreed as an accurate reflection of the previous meeting. The Key Issues for SFCCG and SSCCG were approved.	
16/123	**Matters Arising/Action Trackers** There were no matters arising. **<u>Action Tracker</u>** **16/054 Whistle Blowing Policy and Procedure (Raising Concerns at Work) - *Southport & Formby CCG & South Sefton CCG*** DF has not yet received a response from AB and will liaise with Tracy Jeffes to ensure this matter is resolved. **Outcome: The JQC agreed that this action could be reviewed in one month** **16/114 Improving access to Psychological Therapies (IAPT) Quality Performance Reports - *Southport & Formby CCG & South Sefton CCG*** DF confirmed a more comprehensive report was on today's agenda following a presentation given to the JQC last month. **Outcome: Action completed – remove from the tracker.** **16/115(i) Dementia Diagnosis Rates – Improvement Plan for South Sefton - *South Sefton CCG*** DF confirmed a more comprehensive report was on today's agenda following a presentation given to the JQC last month. **Outcome: Action completed – remove from the tracker.** **16/115(ii) Dementia Diagnosis Rates – Improvement Plan for South Sefton - *South Sefton CCG*** In the absence of MMcD, it was agreed that a response would be sought outside of the meeting. FLT added that she was aware of a number of non-commissioned pieces of work being undertaken by GPs and that discussions with the LMC and CCG will be undertaken to address and will bring an action back into Leadership Team as required. LB was aware that the CCGs Programme Manager for dementia has already asked practices for information. **ACTION: FLT agreed to ensure this will be discussed with the LMC and will add to the Leadership Team agenda.** **16/117 Key Issue Logs: EPEG - *Southport & Formby CCG & South Sefton***	

	CCG GBa confirmed he hadn't received any feedback regarding the Healthwatch website. DF confirmed that discussion regarding the site had been raised at the S&O so that the Trust were aware and could have a look at the site. Contracts meetings. GBa explained that as EPEG had been cancelled this month, no further updates were available. **Outcome: Action completed – remove from the tracker.** **16/118 Any Other Business - *Southport & Formby CCG & South Sefton CCG*** FLT confirmed that the issue relating to the requirement for Lay Members from both SF and SS CCGs to attend each meeting had been raised at GB with agreement that the JQC Terms of Reference could be amended to reflect the need for only one Lay Member to be present to achieve quoracy. **Outcome: Action completed – remove from the tracker.**	
16/135	**Chief Nurse Report** DF presented the Committee with a number of key issues which had occurred since the Chief Nurse report submitted in September 2016. <u>Court of Protection (Southport & Formby CCG)</u> The Head of Vulnerable People represented the CCG at the Court of Protection for a final hearing in relation to a patient who SFCCG had been identified as the responsible commissioner. DF added that Hill Dickinson has passed on positive feedback from the Judge in relation to commissioner support and co-operation. <u>MRSA Post Infection Review (PIR) Meeting (South Sefton CCG)</u> The CCG chaired a MRSA PIR meeting in relation to a SSCCG patient who was diagnosed during a recent admission to AUH. The case was assigned to the CCG. <u>Nursing Home Update</u> An update on the latest position relating to the previously agreed financial uplift for this sector was shared with the JQC who were advised that a report is scheduled for presentation to the next meeting of both Governing Bodies 2016. The Knight Frank Research Report which looks at the Care Home market was discussed and this report is to be circulated after the meeting. FLT informed the Committee that the CCGs would be jointly commissioning with the LA a care home market analysis exercise so we can all better understand the market position as part of our commitment to the integration agenda. **ACTION: The Knight Frank report is to be circulated to Committee members**. <u>Local Safeguarding Children Board/Safeguarding Adult Board</u> The Chief Nurse and Deputy Chief Nurse have met with the new Chair of the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adults Board (SAB) as part of her induction. The LSCB met on the 5th October 2016 and received/approved: • Private Fostering Annual Report 2015/16 and Forward Plan 2016-2018 • The Local Safeguarding Children Board Annual Report 2015/16 • Sefton LSCB Improvement Plan August 2016-2017 (To meet OFSTED recommendations) • Sefton Multi Agency Safeguarding Hub Annual Report 2015-2016 • Integrated Early Help Strategy • Multi-Agency Neglect Strategy 2016-2018 The CCGs Safeguarding Annual report is due to be presented to the LSCB and SAB following review of the training statistics.	**VT**

	Safeguarding performance at Southport & Ormskirk Hospital NHS Trust (S&O) was discussed at the LSCB due to concerns raised in relation to current oerformance. A joint presentation with NHS England (NHS E) to the LSCB will be undertaken to provide further information to this Board in relation to systems of assurance in place across the health sector.. <u>S&O CQC Inspection Report</u> S&O has now received its CQC report. The Trust is within the 10 days checking period for factual accuracy and a response is expected to be submitted to the CQC by mid-November 2016. An update is likely to be provided at the next meeting of the Southport & Ormskirk Hospital NHS Trust Executive Improvement Board. <u>Sefton Emotional Health & Wellbeing Strategy</u> The Committee were advised that the Child & Adolescent Mental Health Services (CAMHS) partnership were due to meet later in the day with a view to finalising the strategy. <u>MIAA Review re CCG Systems and processes to quality assure LCH</u> The Chief Nurses of SF and SS CCGs and LCCG recently met with MIAA to discuss the Terms of Reference (TOR) for this review. A draft TOR is currently with the CCGs for review and feedback is likely to take approximately 6 weeks. AM highlighted the recent High Court challenge to the CQC Inspection in Primary Care. The High Court ruled that the CQC must allow GP Providers to submit evidence against any challenge within the report that may affect the outcome. AM also highlighted the timeliness of CQC reports, which may include quality concerns. BP acknowledged that this would be included on the Risk Register. DF stated she would contact NHSE colleagues to find out if they had any further information on this. **ACTION: BP to ensure the timeliness of CQC reports which involve quality concerns are included on the Quality Risk Register.** **ACTION: DF to contact NHSE colleagues to find out if they had any further information on the High Court challenge with respect to the CQC and GP practice inspections.**	**BP** **DF**
	The Committee received the report	
16/124	**Quality Surveillance Report – October 2016** The JQC received an exception report on quality issues for providers which incorporated Healthwatch Sefton reports and Local Authority issues with regard to the quality of care. The purpose of the report is to highlight issues across the wider Merseyside and Cheshire footprint which may have a bearing regionally and to discuss any potential solutions with support from NHS E or colleagues across the system. DF stated that this was the first time the JQC had received this report and asked whether the Committee considered it would be of value to receive such an update when performance reports were not scheduled as part of the workplan. BP considered local intelligence of issues experienced by GPs could be fed up through this route. FLT agreed that whilst it was a very helpful and comprehensive report, the timing	

	of some of the content needed to be borne in mind. BP referred to the dental issues in Southport &Formby and understood a plan was in place to address. Short term and long term actions were discussed during the meeting. AM raised issues regarding patients requiring out of hours dental support. Whilst BP was unaware of out of hours issues with the Dental service, he agreed to look into this further. RC said he had been contacted by a nursing home on behalf of a patient requiring dental support but could only signpost the caller to the Out of Hours service whilst recognising that the patient could only be transferred to a dentist by ambulance. **ACTION: BP to look into issues with out of hours Dental services as raised by AM and RC and feed back to the JQC.**	**BP**
	The Committee noted and received the report	
16/125	**Quality Team Risk Registers** BP presented this report which provides a summary of the risks currently managed by the Quality Team (QT) on behalf of NHS South Sefton and NHS Southport & Formby CCGs. The Quality Risk Register is to be shared with the JQC for review prior to submission to the Audit Committee. BP clarified actions taken by the QT in relation to reviewing and updating items on the register with the comments from the latest review highlighted within the report. The Committee discussed the revised process for the Corporate Risk Register / Governing Body Assurance Framework and how the loop was closed within the organisations subject to the specific risk ratings. RC raised concerns over SF004 which was a finance related risk. BP explained this had been discussed at QT but as it was a Finance Risk it should not have been included in the pack however he offered to share RC's concerns with MMcD. **ACTION: BP will raise the cause for the deteriorating position with MMCD.**	**BP**
	The Committee received the report	
16/126	**Dermatology** BP presented the JQC with a verbal update on Dermatology services. The Dermatology Strategy Review Group led by Karl McCluskey, Chief Strategy & Outcomes Officer will include Dr Gina Halstead and Dr Chris Randall of S&FCCG who has dermatology expertise and who has also agreed to be part of group. Representation from West Lancashire CCG, patient representation and a secondary care clinician will also be sought. Terms of Reference for the group are to be drawn up with a proposal that the main group meet monthly with a working group held fortnightly with an agreed way forward recognised by April 2017. . The mapping of services and different models in operation across different CCGs using community services is to be undertaken utilising Better Care Better Value and reviewed for benchmarking purposes. BP confirmed that Dermatology is discussed regularly at the Aintree CQPG, following Dr Steve Evans' letter advising that the Trust is unable to accept new referrals. The Trust is due to review its position at the end of October 2016 with	

	discussion to take place at the November 2016 CQPG. The Trust Dermatology Action Plan was circulated at the October 2016 CQPG and shared with the working group. RC reminded the Committee of a previously declared conflict of interest regarding dermatology services working out of his practice which is recorded on the CCGs Declarations of Interest Register. BP confirmed to FLT that the Quality Team (QT) were not aware of any safety issues at present. FLT suggested the QT be made aware of any risks by BD's team who are reviewing dermatology services to enable assurance to be provided.	
	The Committee received the verbal update	
16/127	**TRANSFORM (Hospice at Home)** BD presented this report which comprised details of the success and good quality care delivered by the TRANSFORM service provided by Southport & Ormskirk Hospital NHS Trust (S&O) which supported end of life patients. RC recognised the merits of the service, however AM understood there was no similar service in the South Sefton area. RC recognised that whilst the TRANSFORM service is continuing, there is a separate piece of work underway relating to the Woodlands. AM considered the quality of the work provided as reported was excellent. BD and RC agreed to discuss the service further outside of the meeting in terms of quality and value for money.	
	The Committee received the report	
16/128	**Southern Health Report** BP presented the JQC with a summary of a review carried out by Southern Health following the preventable death of Connor Sparrowhawk in 2013. This led to a number of investigations and enquiries into practices at Southern Health NHS FT. Recommendations for Commissioners were included within the report and BP stated that whilst some actions had already been undertaken as detailed on page 64 of the report, issues around contracting required further work to be undertaken. RC recognised the increased focus by the Head of Vulnerable People in ensuring improvement in the timeliness of reporting and closing down of provider incidents on StEIS. Steps have also been taken to address the quality of reports to ensure appropriate levels of assurance are provided.. BP highlighted recent positive conversations with Mersey Care Foundation Trust (MC) who were very open and welcoming in relation to discussions with the CCG and they are keen to continue to work with commissioners in order to further improve the quality of reporting. AM thanked BP for sharing the comprehensive report but considered the impact of DoLs assessments was inadequately reflected within the report. AM therefore suggested that this should be identified as part of our mitigation. **ACTION: BP is to look into the conclusions listed within the report in light of the DoLs issue raised by AM.**	**BP**
	The Committee received the report and noted the recommendations	

16/129	**Quality Impact Assessment Policy to support commissioning decisions** BP presented this policy which has been developed to support CCG officers and clinicans in the completion of Quality Impact Assessments. The policy was developed alongside Liverpool CCG to enhance QIA systems with the more comprehensive reasons behind the work explained under key issues within the report. It was noted that there was an incomplete sentence on page 73 of the pack (page 5 of the policy). **ACTION: BP will provide the additional wording that is missing from page 5 of the policy.** DF thanked BP for the work undertaken with the QIA process which will be utilised across the SS, SF and LCCGs. FLT asked whether providers would be clear on what was required of them and whether it was any different to what had been requested before, now that a policy was in place. DF clarified this process was for the CCGs and not providers as they would have their own QIA process. FLT asked if this could be shared with providers so they were aware about what was in use within commissioning for the purposes of transparency. DF stated that this could be done and that the policy would also be put with others from the CCGs on the respective websites **ACTION: DF to discuss with LCCG whether they would be happy to share the policy and QIA with providers.**	**BP** **DF**
	The Committee received the report and approved the policy subject to the amendment to page 5	
16/130	**Access Sefton IAPT Performance** GO'C attended the meeting to present the report and summarised the content drawing particular attention to the major issues caused by 'hidden waits' and actions being taken to address. NHS E are working with the Access Sefton service to manage the 'hidden waits' with work underway to ensure patients are fully aware of what they can expect from the service. RC was concerned that he could not identify how 'hidden wait' patients were prioritised in order to demonstrate recognition of their different levels of need. AM suggested 5 levels which could be used to assess patients requiring help in order to identify their needs and how soon they should be seen. GO'C explained joint work was underway to try and address this issue between the local Mental Health provider and the provider of the IAPT service. GO'C advised that a KPI on 'hidden waits' was to be included in next year's contracts with a potential shadow sanction. FLT confirmed that conversations had taken place at Governing Body from which she had taken an action to provide an IAPT update and have a discussion with the CEO of the IAPT provider. The CCGs concerns are recognised and the Overview & Scrutiny Committee pleased to see actions are being undertaken. FLT anticipates a response shortly from the national team and is satisfied all is being done by the CCGs to deal with the issue. **ACTION: GO'C to ascertain whether a prioritisation service is in place for patients accessing the service and report back to RC/JQC.**	**GO'C**

	The Committee received the report	
16/131	**Dementia Diagnosis Rates – South Sefton** GO'C presented this report which outlines the efforts and actions South Sefton CCG has taken to support people with memory issues, cognitive impairment and dementia to enable them to access appropriate and timely diagnosis and post diagnostic support. As part of the 'SAFE' assessment, GO'C advised that Kevin Thorne, Integrated Commissioning Manager has contacted practices to ask that they use the '6CIT' tool for initial screening / follow up to identify deterioration in a patient's condition which enables a GP to refer on for a full dementia assessment by Mersey Care Foundation Trust, with the NHS E in receipt of` monthly updates. GO'C is confident that SS CCG will have achieved the planned trajectory submitted and reminded JQC members that the targets are from the Prime Ministers ambition. RC referred to the disparity in some practices receiving baseline support to undertake the reviews. FLT recognised SS colleagues had been requested to undertake a piece of work without remuneration which it was believed S&F colleagues had received funding to carry out. FLT undertook to speak to MMcD regarding where these funds have come from. (BD left the meeting 15.02) **ACTION: FLT will discuss the source of funding with Leadership Team and asked that DF update the JQC with the response.**	**FLT / DF**
	The Committee received the report	
16/132	**GP Quality Lead Update:** • **Locality** • **Provider** RC and LB spoke of the increasing number of additional work requests being made of GPs.	
	The Committee received the report	
16/133	**Any Other Business** 1. DF advised that following the CQC report on Aintree University Hospital Trust's A&E department, the CCG Quality Team and Operational Team had undertaken a walk around of the new department accompanied by Dr Gina Halstead and Dr John Wray. The opportunity was taken to look at the SEPSIS pathway, staff training and priority for training, lessons learnt from SIs (particularly in relation to Learning Disability and Mental Health) and MEWS / NEWS. Patient entry through AED by the three different routes were also reviewed. Patient feedback on experience of AED was positive on the visit. Further visits are planned 2. At the Aintree CQPG last week a presentation on Advancing Quality and fractured neck of femur was made highlighted challenges and successes. The CCGs team accepted an invite from the Orthopaedic Clinical Team at the Trust and visited the unit and spoke with the clinical team today. A member of the team will be visiting the unit again to support from a commissioning perspective the reduction in any delayed transfers of care.	
16/134	**Key Issues Log** The following key issues were raised to be informed to the Governing Bodies:	

	South Sefton CCG • **High Court Judgement: CQC Inspections of GP Practice** – To request further information from NHSE regarding this judgement. Issue to be placed on the Risk Register. • **Quality Team Risk Register** – Received by the Quality Committee. • **Dermatology Update** – Strategic Review Group has been established by the CCGs. Terms of Reference are being finalised. Participation from Secondary Care colleagues and patients is to be secured. • **Southern Health Report** – Report received by the Committee and recommendations for commissioners noted. Progress against the recommendations highlighted particularly in relation to Serious Incident Management and impact on the proposed CQUIN for 2017/18 due to recent planning guidance. Relationships between DoLS and the Coroner to be explored. • **Quality Impact Assessment Policy** – Approved by the Committee. • **IAPT** – National IAPT Support Team are working with Access Sefton to improve processes and performance. Concern remains regarding 'hidden waits' and the remedial action plan had been received. Concern regarding prioritisation remains. An update has been presented to the Overview & Scrutiny Committee and a Chief Officer to Chief Executive conversation has taken place. • **Dementia** – Challenges evident with Dementia diagnosis. A discussion is to be had at Leadership Team Southport & Formby CCG • **High Court Judgement: CQC Inspections of GP Practice** – To request further information from NHSE regarding this judgement. Issue to be placed on the Risk Register. • **Quality Team Risk Register** – Received by the Quality Committee. • **Dermatology Update** – Strategic Review Group has been established by the CCGs. Terms of Reference are being finalised. Participation from Secondary Care colleagues and patients is to be secured. • **Southern Health Report** – Report received by the Committee and recommendations for commissioners noted. Progress against the recommendations highlighted particularly in relation to Serious Incident Management and impact on the proposed CQUIN for 2017/18 due to recent planning guidance. Relationships between DoLS and the Coroner to be explored. • **Quality Impact Assessment Policy** – Approved by the Committee. • **IAPT** – National IAPT Support Team are working with Access Sefton to improve processes and performance. Concern remains regarding 'hidden waits' and the remedial action plan had been received. Concern regarding prioritisation remains. An update has been presented to the Overview & Scrutiny Committee and a Chief Officer to Chief Executive conversation has taken place.	
	Date of Next Meeting The next meeting will be held at 11.30 am – 1.30pm on Wednesday 16th November 2016 – venue TBC	

Chair : _____ _____

PRINT NAME **SIGNATURE**

Date : _____

NHS
South Sefton
Clinical Commissioning Group

Audit Committee Minutes

Thursday 6th October, 1.00pm to 2.30pm
3rd Floor Board Room, Merton House

Attendees		
Graham Morris	Lay Member (Chair)	GM
Graham Bayliss	Lay Member	GB
Dr Dan McDowell	Secondary Care Doctor	DMcD
David Smith	Deputy Chief Finance Officer, SSCCG	DS
Michelle Moss	Local Counter Fraud Specialist, MIAA	MM
Ann Kyffin Ellis	Audit Manager, MIAA	AE
Andrew Smith	Director, KPMG	AS
Leah Robinson	Chief Accountant, SSCCG	LR
Danielle Love	Programme Lead – Community Services Procurement, SSCCG	DL
Apologies		
Martin McDowell	Chief Finance Officer	MMcD
Adrian Poll	Senior Audit Manager, MIAA	AP
Minutes		
Tahreen Kutub	PA to Chief Finance Officer	TK

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	✓	A	✓	✓	✓	
Graham Bayliss	Lay Member		✓	✓	N	✓	
Martin McDowell	Chief Finance Officer	✓	✓	A	A	A	
Debbie Fagan	Chief Nurse & Quality Officer	✓	✓	✓	A	N	
David Smith	Deputy Chief Finance Officer	✓	✓	✓	✓	✓	
Tracy Jeffes	Head of Corporate Delivery and Integration	A	N	N	N	N	
Leah Robinson	Chief Accountant	✓	✓	✓	✓	✓	
Debbie Fairclough	Head of Client Relations, CMCSU	N					
Roger Causer	Senior Local Counter Fraud Specialist, MIAA	A	N	N	N	N	
Michelle Moss	Local Counter Fraud Specialist, MIAA	✓	✓	N	N	✓	
Adrian Poll	Audit Manager, MIAA	✓	✓	A	✓	A	
Ann Ellis	Audit Manager, MIAA	N	A	N	N	✓	
Amanda Latham	Audit Director, KPMG	✓					
Jillian Burrows	Audit Senior Manager	A					
Andrew Smith	Audit Director, KPMG		✓	✓	N	✓	
Jerri Lewis	Audit Manager, KPMG		✓	✓	✓	N	

No	Item	Action
A16/68	**Apologies for absence** Apologies for absence were received from Martin McDowell and Adrian Poll.	
A16/69	**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.	
A16/70	**Advance notice of items of other business** None.	
A16/71	**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.	
A16/72	**Action points from previous meeting** ***A16/23: A16/05 (A15/79) - Whistle Blowing Policy*** – DMcD said the Whistle Blowing Policy was presented to the Quality Committee. The policy was not approved at this meeting as it was agreed that changes were required. Amendments are still required; DF is awaiting Adam Burgess's return from leave to liaise with him re. the changes with a view to providing an update at the Joint Quality Committee meeting in October 2016. Action still open. ***A16/23: A16/13 IG Toolkit Submission*** – Action still open. ***A16/34: External Audit Technical Update*** *(DS to liaise with the Communications team on the communications statement re. the UK Modern Slavery Act)*. DS said a policy/statement has been finalised for the CCG and will be put up on the website. Action closed. ***A16/35: Register of Interests 2015/16*** – Action complete and on agenda. ***A16/59: Liaison Accounts Payable Review*** – Action complete and on agenda. ***A16/61: MIAA Anti-Fraud Conflicts of Interest Report*** - LR confirmed details of four staff who had completed a declaration were not provided by the CCG for the following reasons: • One staff member was on maternity leave • One staff member opted out as they were leaving the CCG • Two of the four staff members were leavers Action closed. ***A16/64: Register of Interests 2015/16*** - re. NHSE recommendation for CCGs to have a minimum of three lay members on the Governing Body – DL confirmed that having considered the options, the Chief Officer's report (in the Governing Body meeting on 29th September – item GB16/145), proposed that the CCG does not appoint a third lay member but will seek support from South Sefton CCG Audit Committee Chair in respect of conflicts of interest should the need arise. The Governing Body supported this proposal. Action closed. ***A16/66: Any other business (Anti-Fraud, Bribery and Corruption Policy)*** – Action complete. The Anti-Fraud, Bribery and Corruption policy is now on the CCG website.	

A16/73	**Losses and Special Payments** LR said the outstanding debt has only been reviewed up to 28th September due to the timing of this meeting and deadline for distributing meeting papers. The report details two items above the £5k threshold which are greater than 6 months old: NHS West Lancashire CCG (value £19,052) and NHS West Lancashire CCG (value £18,143). LR confirmed both have now been paid. ***The Committee received this report.***	
A16/74	**Audit Committee Recommendations Tracker** LR reported on the audit recommendation tracker and highlighted the following: • The External Audit recommendations have been added to the bottom of the summary table. • HMRC Review – LR is still awaiting a final figure for this. HMRC had said they were hoping to have this resolved by August but this has not happened. • Re. CCG Board Advisory Paper: Proposed Anti-Bribery Strategy – LR said she has contacted the CCG's Head of Communications to check whether a clear, joint statement from the Board Chair and AO/CFO had been fully communicated. She is waiting to hear back. In reference to the Patient Engagement table, LR said she had kept the following two risks as ongoing (and therefore in amber) as by their nature they would always be ongoing: • Continuation of collection of patient experience data to inform commissioning decisions. • Research & Development. It was agreed by the committee that as the above risks are meant to be ongoing, they should be turned to green. LR to action. ***The Committee received this report.***	LR
A16/75	**Liaison Accounts Payable Review** Following review of all payments made by the CCG from its inception on 1st April 2013, 19 overpayments were identified - 16 of which occurred in 2013 or 2014. LR said £26,956.13 of the overpayments balance (which totalled £30,039.49) has been recovered. This leaves £3,083.36 to be recovered which is in progress. The overpayments were a result of duplicate invoices being scanned onto the general ledger by SBS. SBS have improved their systems and applied controls (detailed in the report) to ensure that this risk is reduced. LR said the Liaison Accounts Payable Review could potentially be done on an annual basis. ***The Committee received this report.***	
A16/76	**Review of Internal Audit Progress Report** AE provided a brief overview of this report and highlighted the pieces of work that are in progress, including primary care commissioning, conflicts of interest and assurance on quality of services commissioned. ***The Committee received this report.***	

A16/77	**Review of Counter Fraud Progress Report** MM provided an overview of the MIAA anti-fraud work undertaken during the period of April-September 2016. She spoke about the reporting dashboard and highlighted the *fraud proofing policy and procedure – policy tracker document.* She asked if the committee would like a policy tracker that would detail when policies are due to be reviewed, who the responsible officer is etc. The committee agreed to the tracker and asked for it to be brought to each meeting. DL to action with Judy Graves and Debbie Fairclough. MM spoke about an investigation which has been closed as it did not provide a fraud risk to the CCG. ***The Committee received this report.***	DL
A16/78	**External Audit Technical Update** AS said this report is for the committee's info and has links to further information. AS referred to the area of NHS action to strengthen trusts' and CCGs' financial and operational performance for 2016/17. He said the announcement of a *two-year NHS planning and contracting round for 2017/18-2018/19, to be completed by December 2016, and linked to agreed Sustainability and Transformation Plans* will present a significant shift in timetable for CCGs and providers. ***The Committee received this report.***	
A16/79	**Risk Registers** DL said due to the timing of meetings, the risk registers had gone to the Governing Body meeting before the Audit Committee meeting. She said the paper submitted for Audit Committee does not include any updates since the Governing Body meeting. DL is working with risk owners to mitigate and reduce risks as much as possible. She confirmed the registers will now only report risks with a score of 12 and above; anything lower will be on committee registers. DS said he thought risk SS040 should not be scored as high as it is, which GM agreed with. SS040 is the risk that financial pressures across health and social care impacts negatively on local services and prevents implementation of integration plans. DL will feedback to the risk owner. ***The Committee received this report and approved the updates presented by DL.***	DL
A16/80	**Register of Interests (CoI)** DL distributed an updated version of the Register of Interests which contains revisions since the Governing Body meeting. DL noted that the governance team is working on finalising a process whereby a COI template will be circulated with the agenda for each committee meeting and that any conflicts of interest in relation to agenda items will need to be declared at least two days prior to the meeting. It was agreed that the Register of Interests (COI) item is to be brought to the Audit Committee on an annual basis.	

	The Committee received this report and approved the updates presented by DL.	
A16/81	• **Finance and Resource Committee - Key Issues Report** • **Quality Committee – Key Issues Report** ***The Committee received the key issues of the Finance and Resource Committee and the Quality Committee.***	
A16/82	**Top 10 Reports of Fraud Bribery and Corruption** MM said this paper is for the committee's info. She said the information is specific to CCGs nationally. ***The Committee received this paper.***	
A16/83	**Any other business** GM noted that this will be DS's last Audit Committee meeting, as he will be leaving the CCG in November. GM thanked DS for his support to the Committee and contribution to the CCG.	
A16/84	**Key Issues Review** DS 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 12th January 2017 1.00pm to 2.30pm 3rd Floor Board Room, Merton House	