NHS
South Sefton
Clinical Commissioning Group

Agenda

Governing Body Meeting in Public
Agenda

Date: Thursday 30th March 2017, 13:00 to 15:30 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
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		
Davina Hanlon	Consultant in Public Health	DH
Tracy Jeffes	Chief Delivery & Integration Officer	TJ
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Alison Ormrod	Deputy Director of Finance	AO
Mel Wright	Planning Lead	MW
Judy Graves	*(Minute taker)*	

Quorum: Majority of voting members.

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
General					**13:15hrs**
GB17/40	Apologies for Absence	Chair	Verbal	R	3 mins
GB17/41	Declarations of Interest	Chair	Verbal	R	2 mins
GB17/42	Minutes of Previous Meeting	Chair	Report	A	5 mins

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
GB17/43	Action Points from Previous Meeting	Chair	Report	A	5 mins
GB17/44	Business Update	Chair	Verbal	R	5 mins
GB17/45	Chief Officer Report	FLT	Report	R	10 mins
Finance and Quality Performance					
GB17/46	Quality, Innovation, Productivity and Prevention (QIPP) Plan and Progress Report	MMcD	Report	R	10 mins
GB17/47	Integrated Performance Report	KMcC/ MMcD/DCF	Report	R	30 mins
Governance					
GB17/48	Memorandum of Understanding (MOU) between Sefton Council Public Health and NHS Southport and Formby Clinical Commissioning Group	Davina Hanlon	Report	A	10 mins
Service Improvement/Strategic Delivery					
GB17/49	Single Service, System Wide Delivery: Overview	KMcC	Report	R	10 mins
GB17/50	Strengthening Commissioning: Joint Working across Southport & Formby, South Sefton and Liverpool CCGs	FLT	Report	A	10 mins
GB17/51	Better Care Fund Section 75 Agreement: Extension	MMcD	Report	A	10 mins
GB17/52	Shaping Sefton to the five Year Forward View	Mel Wright	Report	A	10 mins
For Information					
GB17/53	Key Issues Reports: a) Finance & Resource (F&R) Committee: November 2016 and January 2017 b) Quality Committee: November 2016 and January 2017 c) Audit Committee: None	Chair	Report	R	5 mins
GB17/54	F&R Committee Approved Minutes: - November 2016 and January 2017		Report	R	5 mins

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
GB17/55	Quality Committee Approved Minutes: - November 2016 and January 2017		Report	R	
GB17/56	Audit Committee Approved Minutes: - None: Quarterly Meeting		Report	R	
GB17/57	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting*				5 mins
GB17/58	Date of Next Meeting **Thursday 1st June 2017, 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 PTI public meetings will commence 13:00hrs and be held in the Boardroom, 3rd Floor Merton House.				-
Estimated meeting close					**15:30 hrs**

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

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
DRAFT Minutes

Date: Thursday 26th January 2017, 13:00 to 15:40 hrs
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
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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
Andrea Watts	Head of Communities, Sefton MBC	AW
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

No	Item	Action
Public	**Questions from the Public** **(1) What is South Sefton CCG's objectives for service change and efficiency savings and what cuts will be made?** The CCG is part of a network of CCG's across Merseyside that include Southport & Formby, Liverpool, Warrington, West Lancashire and St Helens. The CCG's started meeting in that format prior to CCG's being authorised . Under that footprint, own finances were kept. There are a number of programmes being worked through that look at efficiencies and transformation of services. Shaping Sefton is being worked on jointly with the Local Authority and looks at the priorities and strategic delivery as well as prevention and self-care. Other programmes are also in place including Healthy Liverpool and the investment in community services and support to General Practice. The CCG are now part of the North Mersey Local Delivery System which includes and tries to bring together the standards of care and services as uniformly as possible, whilst trying to transform and invest in community services.	

No	Item	Action
	General Practice is contracted to NHS England. CG leads on Primary Care and is currently looking at building the workforce and work load. A plan for a "GP Five Year Forward View" has been submitted for Sefton, if successful this will bring in further investment for Sefton. The CCG continually monitor and review QIPP opportunities for efficiency savings. MMcD expanded on the savings being made via QIPP and as outlined in the meeting report (item 17.07). The CCG continued to work hard to identify savings. MMcD gave an example of estimated £5m worth of unused prescriptions per year across the South Sefton and Southport and Formby footprint. Other examples were given as; CHC budgets; respiratory service and tailored interventions to stop prolonged hospital stays. Any savings proposed have to go through a Quality Impact Assessment process. The process includes a review of the proposal together with the identification of risks and risk mitigation. This is then commented on by the Clinical GP Leads and management leads and then presented to the Chief Nurse & Quality Officer and Clinical Chair or Vice Chair. Any decision which has an impact on quality has to evidence the reason for investment and disinvestment. **(2) How will you consult with the public before the changes are made? Bridgewater and Merseycare were highlighted as an example of where community services where decisions for change had been made and actioned but the public were not consulted. The member of the public considered that sometimes what is recommended is not necessarily the best option i.e. May Logan Centre in Bootle, no one wanted any of the services moved out.** FLT briefed on the events that had been held, namely Shaping Sefton and Big Chat which FLT understood the member of the public had attended. FLT accepted that the events had not been as good as a consultation, but the events did provide a platform for the CCG to update the community on its activities and an opportunity for the community to engage with the CCG. Health Watch had also been involved. FLT added that there wasn't always the opportunity to consult for every procurement. However, there is the opportunity to capture community opinions through feedback and learning on the delivery those services, this was assisted by the involvement of Healthwatch. **(3) What affect have those savings had on patients?** There has been an increase in the contract value to providers and more people are being treated. There is Urgent Care in the community and the Care Home Improvement programme. The programmes are reported through the Governing Body papers. The CCG have an Engagement and Patient Experience Group (EPEG) which feeds through to the Quality Committee and the Governing Body. Healthwatch are a member of both the EPEG and the Governing Body. MK agreed that it was important to capture and feedback the experiences of the patients and considered that Healthwatch could help more with any engagement activities. **(4) How is the pilot scheme on the pharmacies going?** The CCG were waiting the evaluation but the programme was going well.	

No	Item	Action
	The member of the public thanked the Governing Body for the detailed responses.	
Presentation	**Partnership Locality Model: Early Intervention & Prevention** Charlotte Bailey (CB) and Andrea Watts (AW) presented the members and the public with a presentation on the "Partnership Locality Model" which aimed to put the model into context in terms of the 2030 vision, the pledges made, making the model real in how the services need to be connected and the next steps. The following was highlighted: The vision for 2030 and the pledges made by the partnership to achieve the model. Following the pledges CB explained the next level of thinking in relation to the wider system change needed for the benefit of children, adults and the communities, and the involvement of the public, community, voluntary and private sector's It was further explained the steps that need to be taken to achieve the model. The first being the consideration and alignment of the diverse footprints. The second being the alignment of the services and how the teams would work, taking into consideration the resources available in each area. The third being the alignment of assets, looking at building close relationships and agile working. The next steps being taken where highlighted and it was asked to be noted that at this stage no decisions had been made on the proposed model, it was currently going through the council processes. Once a decision was made there would be full consultation and engagement. Presentation would be made available on the Council website and in different written materials. A discussion was held in relation to the potential impact on the GP five year forward view, optimising the third (community/voluntary) sector, advantages in co-location, the investment needed in estates and the potential for grants. MMcD expanded on the discussions already held in relation to estates and the assistance that can be offered to those who have an interest in health and wish to co-locate, as well as the meeting that was held with the planners to look at potential sites. **RESOLUTION** **The members thanked CB and AW for the presentation.**	
GB17/01	**Apologies for Absence** Apologies were received from Graham Morris who was unable to attend and Dr Sinha who would be late due to surgery.	
GB17/02	**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.	
GB17/03	**Minutes of Previous Meeting** GB16/188: Looked After Children Annual Report 2015/16	

No	Item	Action
	Page 16, 3rd paragraph: LAC should refer to Corporate Parenting Board Page 16, 5th paragraph: Sefton Health Professionals should refer to Sefton Health Protection. GB16/191 CRR & GBAF Page 18, SS019: risk score should read 20 (5x4). **RESOLUTION** **The minutes of the meeting held 24th November 2017 were approved as an accurate record subject to the amendments listed.**	
GB17/04	**Actions from Previous Meeting: 24th November 2017** ***Questions: November 2017:*** **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. *Update* It was confirmed that PC had taken action forward. Meeting had been arranged but member of the public had been unable to attend. The comments and concerns had been taken forward but there had not been the opportunity to explore further. **GB16/183: Action Points from Previous Meeting: September 2017** *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. Original meeting postponed. Another meeting now set for 2nd December 2016. Clinical Leads to be in attendance. *Update* Meeting held to discuss cost improvement programmes. Further information was received. Dr Mulla attended Merseycare Contract meeting. Will continue to monitor through CQPG and feed through to the Quality Committee.	Closed Closed

No	Item	Action
	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* Deadline for feedback closed. *GB16/151 Safeguarding Annual Report 2015/16: PLT Review* Following discussion regarding Safeguarding and LAC training members had been reminded of the 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. JG had requested the agenda and signing in sheet is forwarded to order in order to ensure any Governing Body training is captured. FLT then suggested it would be useful to get a working group together to review the PLT events and see how effective they had been. *Update* Being reviewed. **Actions from Previous Meeting: 24th November 2017** *GB16:185: Chief Officer Report* **Primary Care Support Services** 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. *Update* CG updated members on the meeting held with NHS England to discuss the on-going issues being experienced with Capita, including issues relating to the delay in GP's getting on the Performers List and the resulting impact. FLT will discuss further with Jan Leonard. Issues were made more difficult as the CCG were not responsible for managing the GP contracts, the responsibility of which sat with NHS England. Issues will now be formalised at the next Quarterly Assurance Meeting with NHS England so as to ensure concerns are documented. *GB16:187: Integrated Performance Report* **Unplanned Care** 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	Closed Closed FLT FLT/CG

No	Item	Action
	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. *Update* Information on the Stroke target was included within the IPF report, item 17/8. Activity item for the Governing Body Development Session planned for February 2017. **Report Content and Format** Discussion was had in relation to the Improvement and Assessment Framework Dashboard. KMcC offered to circulate the guidance for the dashboard. *Update* Planned for discussion at Development Session. **Primary Care** 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. *Update* KMcC updated members on the primary care dashboard being configured, which will enable quality and performance data at practice level. First view was due end of January 2017, with the intention of being in place from April 2017 **Finances** 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 DCF to look at referral optimisation. *Update* All practices, through localities, have an opportunity to engage and discuss. Three different options are currently being process mapped, these of which will need further discussion. *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 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.	Closed Closed Closed PC/MMcD

No	Item	Action
	DH highlighted item 8.4 in relation to immunisations and whether the issues had been presented to the Sefton Health Protection 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. *Update* DCF updated on a recent meeting attended where the concerns had been highlighted. The outcome will be reported through to the Safeguarding Business Meeting. The Local Authority and the CCG will continue to work together to resolve, inclusion in the CRR will be as necessary. DH clarified her assurance on the matter being progressed and would report such to the Sefton Health Protection Forum in April. *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 (5 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. *Update* All recommendations were taken into consideration during the update process and 1:1's with each of the respective leads, including clarity in relation to the new risk. *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. *Update*	Closed Closed Closed

No	Item	Action
	Changes finalised and document published on website.	
GB17/05	**Business Update** AM reiterated the difficult challenges that the CCG were experiencing given the CCG's financial position. QIPP remained high on the CCG agenda, as did the need to ensure quality of service. **RESOLUTION** **The Governing Body received the verbal update.**	
GB17/06	**Chief Officer Report** The members and the public were presented with the Chief Officer's monthly update and the following areas were highlighted: <u>1. QIPP</u> An update was given on the progress of the "Deep Dive" assessments being carried out during January 2017. This is in in addition to the routine scrutiny of schemes to ensure that as the CCG progress through the last quarter of the financial year, it 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 2017. <u>2. Executives Meeting</u> The CCG continues to engage with partners to discuss and progress the work across the North Mersey footprint and look at opportunities for broader collaboration. <u>5. Information Governance</u> 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 continually monitor the organisations compliance with protocols and report all IG related matters to the Joint Quality Committee. <u>6. Joint Local Area Special Educational Needs and Disability (SEND) Inspection in Sefton</u> Inspection outcome letter was published on 13th January 2017 and contains areas of both strength and development along with some areas of significant weakness. An action plan is in place and is being progressed. It was noted that some of the criticisms are in relation to the LCH transaction. DCF confirmed that CCG support had been offered and that the CCG were working together with the Local Authority and Health Watch to progress the action plan. <u>9. GP Five Year Forward View (GP5YFV)</u> Submission sent to NHS England. Currently awaiting response. <u>10. Whistleblowing in the NHS</u> NHS England circulated guidance to primary care providers on supporting	

No	Item	Action
	whistleblowing in the NHS. The CCG are currently refreshing. A link to the guidance can be found here: https://www.england.nhs.uk/wp-content/uploads/2016/11/whistleblowing-guidance.pdf 14. Sefton Metropolitan Borough Council Budget – 2017/2020 The Local Authority have recently published the budget for the next three years, with savings of £64million to be found. The members and public were referred to the presentation by Charlotte Bailey at the beginning of the meeting, where some of the methodologies for delivering those savings had been touched upon. DJ provided an overview of the savings to be found which included a year 1 target of £33million. A discussion was held on the areas where the main savings were expected. This included Adult Social Care. The areas being looked at included high cost packages of care, front of house savings and self directed support strategy for which the first stage had been implemented. DJ explained that there were a number of stages involved and some will include consultation with the public and service users. DJ informed the members and the public that there had been a total agreement that cuts should not be made in the voluntary sector unless there was a duplication of service. **RESOLUTION** **The Governing Body received the verbal update.**	
GB17/07	**Quality, Innovation, Productivity and Prevention (QIPP) Plan and Progress Report** The members and the public were presented with the report which provided 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. Within each domain there are a number of schemes or actions that all have savings identified against them. The report also included the QIPP Plan the QIPP performance dashboard (Appendix 1). The following areas were highlighted: The CCG had an annual QIPP plan of £10m which equated to over 4% savings. This was a more challenging target than most CCG's in the North. Year to date actual was £4.9m. The members had a discussion in relation to the Governing Body being clear on what needs to and is being achieved. Further discussion was had with regards Urgent Care and discretionary spend, and the need to understand any escalating costs and trends. FLT requested this was added to the "Deep Dive" exercise being carried out (as explained under item 17/05, Chief Officer Report) in relation to understanding unintended consequences of savings. **RESOLUTION** **The Governing Body received the report and noted the update.**	MMcD
GB17/08	**Integrated Performance Report** The members and the public were presented with the Integrated Performance Report which updated on aspects of finance, quality and performance against	

No	Item	Action
	key strategic targets for South Sefton CCG. The following areas were highlighted: **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%. There are a number of actions that the Trust have put in place, these are detailed on page 58 of the meeting pack. One concern included Dermatology; Trust were down to the last dermatologist from four. It was highlighted that there was a shortage of Dermatologists nationally, with over 250 vacancies. 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%. **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 which is below the recovery target agreed by NHS Improvement. 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. Further update was provided on the support being provided to the department and the ongoing work of the CCG's Quality team who continue to monitor progress. 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. 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. A meeting is due to be held in February between Aintree University Hospital and Southport & Ormskirk Hospital, with Clinical Leads, in order to look at ways of improving joint working, pathways, quality and sustainability. 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%).	

No	Item	Action
	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. 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. An update was given on the work being carried out by GP Clinical Leads in monitoring the rates and the Quality Committee being kept up to date. **Mental Health** The was a slight decrease of patients entering first treatment for Improving Access to Psychological Therapies (IAPT) compared to the previous month. The access standard 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. Reference was made to item 5.1.2. AM highlighted prior concern raised in relation to patient safety at the removal of the KPI CQUIN target 'timeliness of GP Communications / Discharge Letters'. Since the KPI had stopped being a CQUIN, the Trust had failed to meet the targets. It was hoped that the role out of the RIO clinical IT system would have a positive impact on performance. However, the Trust confirmed in December 2016 that the RIO roll out had been put on hold due to 'technical issues'. The Trust has indicated that a formal communication relating RIO implementation will be sent to CCGs later in January 2017. **Community Health Services** 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 forms part of an improvement plan. **Improvement and Assessment Framework** The members and the public were referred to item 10.2 which was the new dashboard for performance reporting. **Primary Care** A number of practices in South Sefton CCG have been visited by the Care Quality Commission (CCG). Details of inspection results are published on the CQC website. South Sefton CCG did not have any GP practices with CQC inspection results published in the past month. All results are as listed in figure 24, page 85. Any practices rated "requiring improvement" or "inadequate" are contacted by the CCG and offered support. The relevant practices would be contacted.	

No	Item	Action
	Finance MMcD presented the CCG's finance report for the end of December 2016 (Month 9). The members and the public were updated on the CCG's risk rated financial position with MMcD noting that the CCG's likely case scenario was predicted as a £2.3m deficit having been updated from the £2.1m reported in the paper. The revised position included a year-end settlement with Aintree University Hospitals following a discussion with the Trust, CCG Officers and Drs. Wray and Halstead as lead clinicians for the contract and quality respectively. The Governing Body accepted the CCG's revised likely case scenario as £2.3m deficit and MMcD agreed to notify NHS England of this position. **RESOLUTION** **The Governing Body approved the increased deficit of £2.3m. NHS England to be notified.** **The recommendations on page 54 were highlighted and the Governing Body noted:** • **The Finance and Resource Committee (recommendation, page 54) should refer to the Governing Body** • **The CCG were now forecasting a most likely deficit of £2.332m against a planned surplus of £1.250m following the discussion at Governing Body. This compared with a likely deficit reported at £2.115m in the report.** • **Delivery of the revised deficit of £2.332m requires further QIPP savings of £2.125m in the remaining three months of the 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.**	MMcD
GB17/09	**Corporate Risk Register & Governing Body Assurance Framework Update** The members and the public were presented with the updated CRR and the GBAF as at December 2016. Both of which continue to be fully reviewed, scrutinised and approved by the Audit Committee. The following areas where highlighted: The CRR and GBAF have both been reviewed and updated by members of the Leadership Team. QIPP remains a significant challenge and risk. Review of all potential areas of efficiency continues. Two new risks had been recorded on the CRR: - SS042: APMS procurement in relation to the procurement process	

No	Item	Action
	- SS043: Significant work load pressures on primary medical care services SS016: Concern was raised on the lack of impact the controls were having on the risk for A&E and patient flow. Members were reminded of the discussion under item 17/08 and the work being done to support the service. It was noted that there were a number of pressures that were adding to the difficulties. Further discussion was had in relation to primary care and General Practice and understanding issues in relation to demand and supply. Was recommended that the ECIP (Emergency Care Improvement Programme) report is presented to the Quality Committee, with the Governing Body to be updated on the actions that were to be implemented and the risk to be updated accordingly. SS011: The members were reminded of the concerns previously raised in relation to the IAPT service. It was confirmed that the issues had been escalated to the provider. Provider had also attended a recent EPEG meeting which enabled some questions to be explored. **RESOLUTION** **The Governing Body approved the updates to the CRR and GBAF following review and scrutiny.**	KMcC
GB17/010	**Making Integration Happen Strategy** The members and public were presented with the strategy which had been produced jointly with Sefton Council in order 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 was now being presented to the Public Governing Body meeting. The members and public were informed that it was a working document to steer the work on integration and therefore is informal in its presentation style and will evolve as the work develops. The following areas were highlighted: The members and public where taken through the document with the following areas highlighted: The four distinct and interrelated elements identified in bringing health and social care together and as detailed in section 6, page 135: Integrated Governance; Integrated Commissioning; Pooled Budgets; Integrated Delivery. How things will be different for citizens (page 145, item 8). Areas are already being worked up by the Integrated Commissioning Group. This has included four areas outlined for review and prioritisation and which are described as “System Enablers” and include: Intermediate Care and Reablement; Nursing/Residential Homes; Domiciliary Care; Continuing Health Care Funding. A discussion was held in relation to pooled budgets and finances. Members were informed that a ‘Governance’ paper had already been submitted to the Finance & Resource Committee. Further papers would follow. It was highlighted that there were certain elements of spends that the CCG were not able to pool. Further clarification was given on the coding used on page 150. S referred to “shadow period” and N referred to “not pooled at this stage”. It was clarified that approving the strategy did not commit the CCG to the pooling of budgets. Such would need to be presented back to the Governing Body.	

No	Item	Action
	RESOLUTION **The members noted that the document was for approval and not noting.** **Reference was made to page 150. Members were advised that pooled budgets were in relation to £000's. Key to be added to the appendices and to also include the codes S, P and N.** **Members approved the strategy and reiterated that any decision on the pooling of budgets would need to come back to the Governing Body.**	TJ
GB17/011	**Two Year Operational Plan** The members and public were presented the proposed Operational Plan 2017-19. Developed in response to the requirements of NHS England and NHS Improvement's 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. The following areas were highlighted: The plan gives providers and the CCG clarity and surety on the levels of activity being planned and commissioned. Because of the advanced timeline NHS England undertook the process using a month 3 2016/17 baseline to calculate a forecast outturn. The CCG struggled to replicate this so, whilst being sensitive to what NHS England have produced, the CCG have recalculated this using month 6. Following first draft submissions of CCG plans, NHS England issued six key lines of enquiry (KLOE) for CCGs. These are addressed in section 3.2 to 3.7 (page 162 to 166) and include: • Affordability • Adjustments • Transformation Schemes • Alignment with other plans (including QIPP) • NHS Constitution Measures • NHS England Assessment and Assurance of Plans Members were updated on the Operational Planning templates presented in December and NHS England's announcement on the assurance process that plans will be tested against and as identified in section 3.7 (page 166). There has been a further regional review of CCG Operational Plans with recasting and emphasis on finance and QIPP. South Sefton CCG's Activity Plan was rated as was the 'Mental Health Investment Standard', this of which was rated red. It was clarified that the red rating was given as per NHS England's opinion that the level of CCG investment is below the committed level for Mental Health, although the CCG had evidence to the contrary. It was asked to be noted that NHS England take into consideration only that which is put into Merseycare and not the full Mental Health investment that the CCG put in which also includes primary care. It was expected that the CCG would achieve an overall red/amber rating, impacts for which included the CCG's financial position in relation to QIPP. It was expected that NHS England will expect additional supporting information and assurance.	

No	Item	Action
	Further discussion was had in relation to the organisations QIPP position and the need for a clear financial plan to support the document. **RESOLUTION** **Members approved the Operational Plan subject to an agreed financial plan that sits alongside.**	MMcD/ KMcC
GB17/012	**Key Issues Reports:** a) Finance & Resource (F&R) Committee: October 2016 The organisations position had intensified, this of which was reflected in the key issues. b) Quality Committee: October 2016 Further information received from NHS England in relation to the CQC Inspection judgement, action now closed. DCF to ensure update is made on the Risk Register. IAPT continues to be a priority and monitored. c) Audit Committee: July & October 2016 Information Governance Toolkit: members were update on the work being carried out on the toolkit and the need for such to be signed off in March. GM requested delegated authority to GM and MMcD to sign off the toolkit. Members approved. d) Locality Meetings: Key issues October 2016 to January 2017 (3.) Crosby: Financial representation had been identified as needed however, in terms of balancing issues, finance is the biggest. It was explained that historically two senior staff (Leadership Team) were assigned to two localities each. It was further explained that the meetings had been held at a difficult time; David Smith had left, MMcD had not been in and Rebecca McCullough was covering. (3.) Seaforth & Litherland: on-going WIFI issues. MMcD offered to look into. **RESOLUTION** **The Governing Body received the key issues reports.** **As discussed under the Audit Committee, members approved delegated authority to GM and MMcD to sign off the Information Governance Toolkit.**	DCF MMcD
GB17/013	**F&R Committee Approved Minutes:** - October 2016 **RESOLUTION** **The Governing Body received the approved minutes.**	
GB17/014	**Quality Committee Approved Minutes:** - October 2016 **RESOLUTION**	

No	Item	Action
	The Governing Body received the approved minutes.	
GB17/015	**Audit Committee Approved Minutes** - July and October 2016 **RESOLUTION** **The Governing Body received the approved minutes.**	
GB17/016	**Any Other Business** <u>17/016.1 Improving Access to Psychological Therapies (IAPT)</u> MK acknowledged the work that was being done to advertise the service but suggested that some of the issues relating to the service might be to do with people not wanting to use the service. The CCG needed to ensure that the service is fit for purpose and identify the reasons why the service was not working.	
GB17/017	**Date of Next Meeting** Thursday 1st June 2017 at 13:00 hrs in the Boardroom, 3rd Floor Merton House, Bootle, L20 3DL.	
Meeting concluded 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)		15:40 hrs

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Governing Body Meeting in Public
Actions from meeting held 26th January 2017

No	Item	Action
GB17/04	**Actions from Previous Meeting: 24th November 2017** *GB16:185: Chief Officer Report* **Primary Care Support Services** 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. *Update* CG updated members on the meeting held with NHS England to discuss the on-going issues being experienced with Capita, including issues relating to the delay in GP's getting on the Performers List and the resulting impact. FLT will discuss further with Jan Leonard. Issues were made more difficult as the CCG were not responsible for managing the GP contracts, the responsibility of which sat with NHS England. Issues will now be formalised at the next Quarterly Assurance Meeting with NHS England so as to ensure concerns are documented. *GB16:187: Integrated Performance Report* **Finances** 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 DCF to look at referral optimisation. *Update* All practices, through localities, have an opportunity to engage and discuss. Three different options are currently being process mapped, these of which will need further discussion.	FLT FLT/CG PC/MMcD
GB17/07	**Quality, Innovation, Productivity and Prevention (QIPP) Plan and Progress Report** The members had a discussion in relation to the Governing Body being clear on what needs to and is being achieved. Further discussion was had with regards Urgent Care and discretionary spend, and the need to understand any escalating costs and trends. FLT requested this was added to the "Deep Dive" exercise being carried out (as explained under item 17/05, Chief Officer Report) in relation to understanding unintended consequences of savings.	MMcD

No	Item	Action
GB17/08	**Integrated Performance Report** **Finance** The members and the public were updated on the CCG's risk rated financial position with MMcD noting that the CCG's likely case scenario was predicted as a £2.3m deficit having been updated from the £2.1m reported in the paper. The revised position included a year-end settlement with Aintree University Hospitals following a discussion with the Trust, CCG Officers and Drs. Wray and Halstead as lead clinicians for the contract and quality respectively. The Governing Body accepted the CCG's revised likely case scenario as £2.3m deficit and MMcD agreed to notify NHS England of this position.	MMcD
GB17/09	**Corporate Risk Register & Governing Body Assurance Framework Update** SS016: Concern was raised on the lack of impact the controls were having on the risk for A&E and patient flow. Members were reminded of the discussion under item 17/08 and the work being done to support the service. It was noted that there were a number of pressures that were adding to the difficulties. Further discussion was had in relation to primary care and General Practice and understanding issues in relation to demand and supply. Was recommended that the ECIP (Emergency Care Improvement Programme) report is presented to the Quality Committee, with the Governing Body to be updated on the actions that were to be implemented and the risk to be updated accordingly.	KMcC
GB17/10	**Making Integration Happen Strategy** The pooled budgets were in relation to £000's. Key to be added to the appendices and to also include the codes S, P and N.	TJ
GB17/11	**Two Year Operational Plan** The Operational Plan 2017-19 was presented for approval, developed in response to the requirements of NHS England and NHS Improvement's jointly issued guidance. Members approved the Operational Plan subject to an agreed financial plan that sits alongside.	MMcD/ KMcC
GB17/12	**Key Issues Reports:** b) Quality Committee: October 2016 Further information received from NHS England in relation to the CQC Inspection judgement, action now closed. DCF to ensure update is made on the Risk Register. d3.) Seaforth & Litherland: on-going WIFI issues. MMcD offered to look into.	DCF MMcD

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MEETING OF THE GOVERNING BODY
MARCH 2017

Agenda Item: 17/45	**Author of the Paper:** Fiona Taylor Chief Officer Email: fiona.taylor@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: March 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.

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
March 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

Intensive work continues in the CCG led by the interim Chief Operating Officer/Programme Lead. Currently the CCG has Mersey Internal Audit Agency (MIAA) undertaking a supportive review on behalf of NHS England.

In order to ensure sound governance and continued delivery of our QIPP programme the Senior Leadership Team approved the continued utilisation of the QIPP Programme Lead role for a further twelve months to drive this critical agenda.

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. North Mersey Local Delivery System (NM LDS) – Estates Working Group

The CCG has been working with both Liverpool and Southport and Formby CCGs to develop a Terms of Reference (ToR) to establish the above group which will take a strategic overview of Estates and Facilities across the NM LDS. The Group has membership from all local Trusts along with key estates delivery partners (NHS PropCo and CHP). Liverpool and Sefton Council representatives are also in attendance so that we can look to maximise the value of integrated services through the delivery of the "One Public Estate" agenda.

The CCG has agreed the Terms of Reference through the Sefton Property and Estates Partnership (SPEP) and the F&R Committee. It is expected that the SPEP will continue with a clear focus on matters relating to Sefton.

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

3. NHS England Quarter 3 Improvement and Assessment Meeting

The CCG had its Quarter 3 meeting with NHS England on 16th March. The meeting reviewed the IAF components in relation to Key Lines of Enquiry (KLOE):

- Leadership;
- Sustainability:
  - Financial sustainability in year;
  - Probity and Corporate Governance;
- Better Health;
- Better Care;

- Key areas of strength & good practice;
- Key areas of challenge, interdependencies and associated issues;

The discussion focussed on the Improving Access to Psychological Therapies (IAPT) service and the financial position of the CCG. The new Quality of Leadership Indicator was also highlighted by NHS England.

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

The CCG Chief Nurse and the Sefton Council's Director of Children's Services have attended the first joint Department for Education/NHS England Improvement Meeting which was chaired by the NHSE Cheshire & Merseyside Director of Nursing. Work is continuing on the development of the Improvement Plan in readiness for the April 2017 submission date to the CQC and OfSTED.

Staff briefing sessions have commenced with the Community Paediatric Team from Alder Hey Hospital and the Paediatric Therapy Team from Liverpool Community Health. This has included awareness raising on the role and function of the Designated Clinical Officer/Designated Medical Officer. Contact has been made with Five Boroughs Partnership NHS Foundation Trust regarding staff briefings going forward as the new provider of the LA commissioned 0-19 services.

The Chief Nurse and Children's Commissioning Manager have attended a NHSE (North) SEND development session in March 2017.

Work continues on the development of the model for Designated Clinical Officer/Designated Medical Officer function across the health economy.

5. Quality Handover Process for Liverpool Community Health NHS Trust

The CCG continues to be represented at the NHS Improvement Clinical Quality Oversight Group by the Quality Team. The Quality Risk Profile Tool has been completed for a final time and agreed with commissioners, regulators and provider the provider. The completion of an Enhanced Surveillance document has been co-ordinated by NHSE (C&M) with input from the CCG. These have been received by the CCG Quality Committee in March 2017. The CCG was represented at the recent Liverpool Community Health Quality Handover event on 16th March 2017 as part of the Quality Handover process.

6. Mersey Internal Audit Agency – Assurance on Quality of Services Commissioned Review (Liverpool Community Health NHS Trust) – Assignment Report 2016/17

Mersey Internal Audit Agency has completed the commissioned CCG review regarding the Assurance on Quality of Services in relation to Liverpool Community Health NHS Trust which looked at the CCG systems and processes. The outcome was 'Significant Assurance' and the recommendations in the report are being actioned. The detail has been presented to the CCG Quality Committee and plans are in place for the Chief Nurse to facilitate a discussion regarding lessons learnt at the next Governing Body Development Session.

7. Combined Safeguarding Adult Board

Development sessions have continued in readiness for the Combined Safeguarding Adult Board which will commence from 1st April 2017 across Sefton, Liverpool, Wirral and Knowsley. Due to this development, the Sefton Safeguarding Adult Boards met for the last time in March 2017. The CCGs will be represented at the new combined Board by the Chief Nurse and Designated Nurse Safeguarding Adults.

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.

8. Primary Care Procurement

The CCG has been working with NHS England (Cheshire and Merseyside) to put new, long-term arrangements in place for a number of GP Practices. The new contracts will begin on 1st April 2017.

Urgent Care 24 (UC24) has been awarded contracts to run five of the seven practices which were out to open tender. These practices are Crosby Village Surgery, Crossways Practice and Thornton Practice – which will be operated as a group of practices at their current locations by one provider. This fits with the vision set out in the NHS Five Year Forward View of larger practices that can offer improved services to their patients and provide stability for the future.

Litherland Practice and Seaforth Village Surgery, as in Crosby, will be operated as a single practice but they will continue to operate in their existing premises. Patients will be able to continue to access the same services that they receive currently and may also benefit from some additional flexibility as a result of a single provider delivering services across the two sites.

Two practices, Netherton Practice and Maghull Practice, were part of the open procurement but the appointment of a permanent provider at this stage has not occurred. Work is underway to appoint new interim providers to run the practices whilst a longer term provider is identified.

The two practices not included in the procurements Hightown Surgery and Freshfield Surgery have had their interim contracts extended whilst an engagement exercise is undertaken with patients and key stakeholders. The outcome of the engagement will inform the options appraisal being written. Engagement events will begin in April 2017.

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

9. Community Services – Mobilisation Update

In south Sefton where services are transferring from Liverpool Community Health (LCH) to Mersey Care NHS Foundation Trust, work continues through the NHS Improvement transaction process. There is likely to be a delay in the south Sefton handover date, as the current and new providers work through the technicalities of the handover process.

This is separate and unrelated to the nationally announced pause in the Liverpool CCG transaction. The team from NHS South Sefton CCG is working closely with all partners to facilitate a safe and effective transfer of services to ensure a seamless transfer for patients. The CCG acknowledges the sterling contribution that LCH and S&O staff continue to make to the delivery of patient care on a day to day basis for Sefton residents in this period of considerable change.

As already mentioned in item 4 of this report, the quality handover took place on 16th March with the CCG clearly sighted on the pertinent issues.

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

10. Making It Happen – Sefton's Health and Wellbeing Integration Strategy

On 28th February the Overview and Scrutiny Committee (Adult Social Care and Health) received the Sefton's Health and Wellbeing Board's integration strategy "Making It Happen". The committee considered the report and further to this discussion amendments were made which crystallised the focus on the local delivery system and Shaping Sefton.

Work continues on the three work streams which underpin the strategy.

11. Section 75 of the National Health Act 2006

In anticipation of the expiry of the current Section 75 Agreement - March 2017 there is work underway to progress towards a new Section 75 Agreement with Southport & Formby CCG and Sefton MBC covering the population of Sefton. The Agreement would enable pooled budget arrangements to be renewed as well as facilitating the work identified within the "Making It Happen" document.

12. Corporate Review

MIAA recently undertook a review of corporate services which resulted in a positive report. A small number of recommendations were made, which are now the subject of an action plan, which has been reviewed by the Senior Leadership Team and against which significant progress has already been made.

13. Recommendation

The Governing Body is asked to formally receive this report.

Fiona Taylor
Chief Officer
March 2017

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MARCH 2017

Agenda Item: 17/46	**Author of the Paper:** Martin McDowell Chief Finance Officer Email: martin.mcdowell@southseftonccg.nhs.uk Tel: 0151 247 7071
Report date: March 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 is 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
March 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 March 2017.

3. Recommendations

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

Appendices

Appendix 1 – NHS South Sefton CCG Month 11 Performance Dashboard

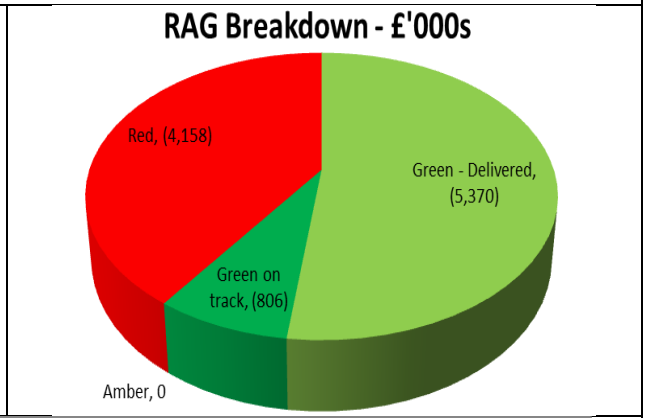
Martin McDowell
Chief Finance Officer
March 2016

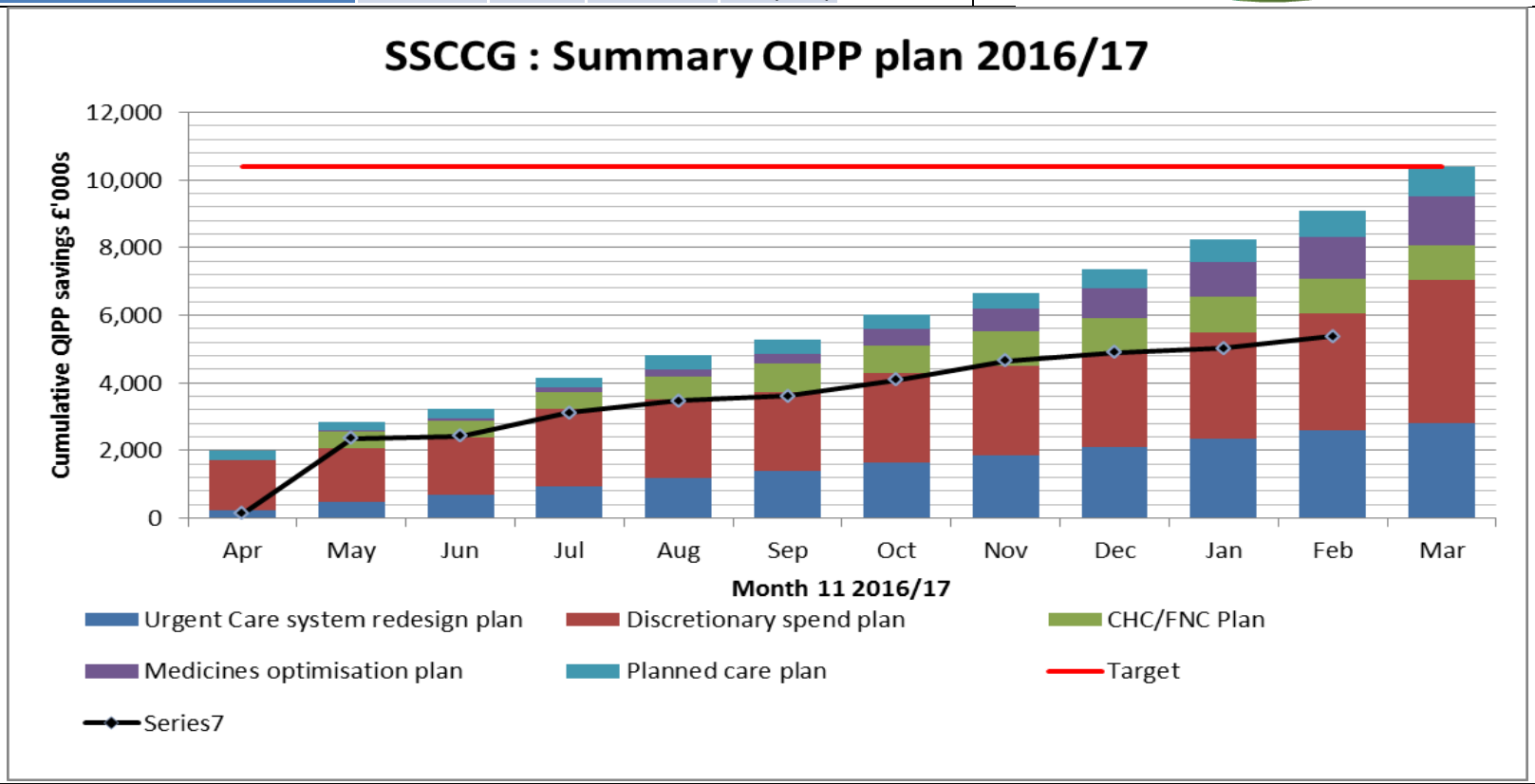
QIPP DASHBOARD – SUMMARY SSCCG AT MONTH 11

South Sefton CCG

£'000s

Scheme	Annual Plan	YTD Plan	YTD Actual	Variance
Planned care plan	872	772	388	(384)
Medicines optimisation plan	1,429	1,237	868	(369)
CHC/FNC Plan	1,055	1,045	1,025	(20)
Discretionary spend plan	4,211	3,463	3,078	(385)
Urgent Care system redesign	2,817	2,580	11	(2,569)
Total	10,384	9,096	5,370	(3,726)





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)	🔴	202	0	(202)	🔴		270	172	(98)	🔴
Review of OPP T&O coding (S&O)	7	0	(7)	🔴	78	0	(78)	🔴		85	0	(85)	🔴
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)	🔴	21	0	(21)	🔴		25	0	(25)	🔴
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)	🔴	82	0	(82)	🔴		102	0	(102)	🔴
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)	(5)	0	5	🟢	(27)	0	27	🟢		(32)	0	32	🟢
CQUIN - C2C reduction S&O	1	0	(1)	🔴	5	0	(5)	🔴		6	7	1	🟢
CQUIN - 1st:Fup ratio S&O	5	0	(5)	🔴	23	0	(23)	🔴		28	28	0	🟢
Total	**100**	**0**	**(100)**		**772**	**388**	**(384)**			**872**	**595**	**(277)**	

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	🟢	433	508	76	🟢		519	519	0	🟢
Individual patient reviews (Generics / Optomise / Quick Wins)	39	0	(39)	🔴	336	330	(6)	🔴		375	375	0	🟢
Additional rebate schemes	27	0	(27)	🔴	213	0	(213)	🔴		240	44	(196)	🔴
Blood Glucose Monitoring strips	13	0	(13)	🔴	63	0	(63)	🔴		75	75	0	🟢
Apixiban Price Reduction	0	0	0	🟢	30	30	0	🟢		30	30	0	🟢
High Cost Drugs and Biosimilars	23	0	(23)	🔴	117	0	(117)	🔴		140	0	(140)	🔴
Community service - Dermatology	4	0	(4)	🔴	46	0	(46)	🔴		50	0	(50)	🔴
Review other expenditure - Care at the chemist	0	0	0	🟢	0	0	0	🟢		0	0	0	🟢
Total	**192**	**150**	**(42)**		**1,237**	**868**	**(369)**			**1,429**	**1,043**	**(386)**	

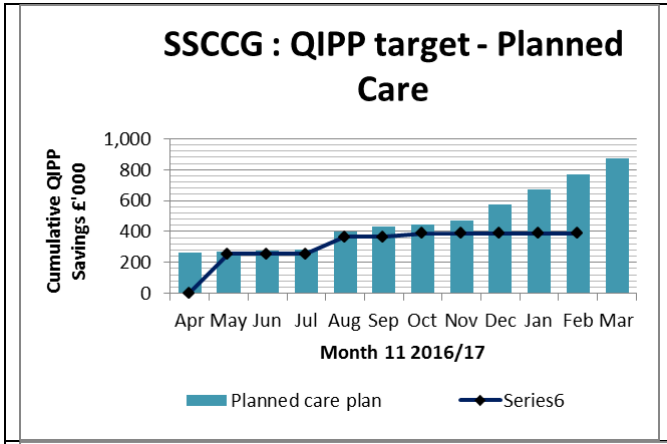
QIPP DASHBOARD SSCCG – Detail by scheme – Themes 3 & 4

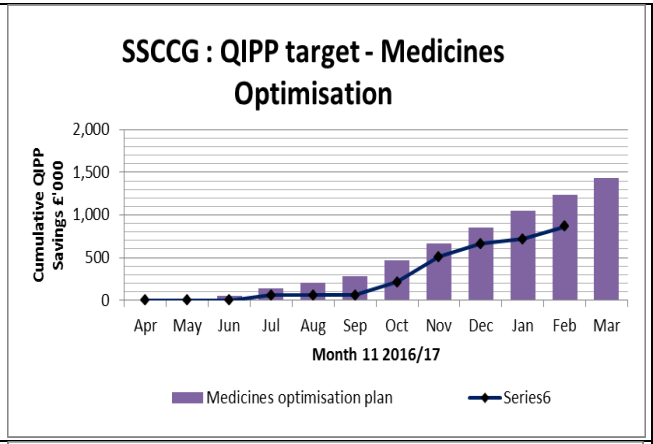
Individual packages of care	In month plan	In month actual	Variance		YTD Plan	YTD Actual	Variance			Annual Plan	Forecast out-turn savings	Forecast Variance	
CHC reduction - No growth	0	0	0		500	500	0			500	500	0	
CHC prior year	0	0	0		525	525	0			525	525	0	
Implementation of ADAM procurement system (net savings)	10	0	(10)		20	0	(20)			30	0	(30)	
Total	**10**	**0**	**(10)**		**1,045**	**1,025**	**(20)**			**1,055**	**1,025**	**(30)**	

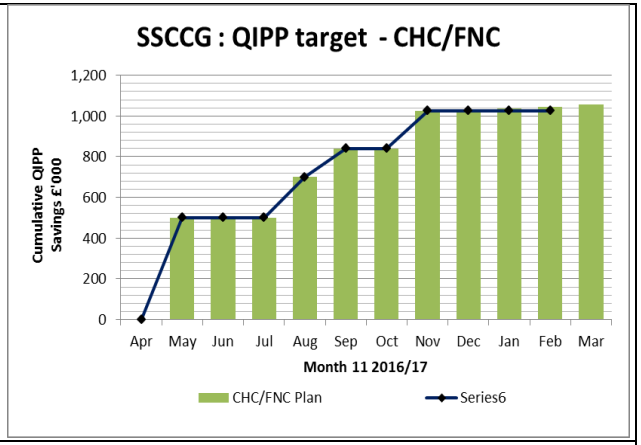
Discretionary spend	In month plan	In month actual	Variance		YTD Plan	YTD Actual	Variance			Annual Plan	Forecast out-turn savings	Forecast Variance	
Review other Expenditure - 3rd Sector	0	0	0		34	0	(34)			34	34	0	
Prior year spend	0	0	0		1,600	1,600	0			1,600	1,600	0	
Reduction in iLinks investment	0	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	200	0	(200)		400	70	(330)			600	420	(180)	
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	100	200	100		200	200	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	0	(41)	
Provider Sanctions - S&O	0	0	0		0	0	0			3	0	(3)	
Running Cost Contingency	0	0	0		106	106	(0)			106	106	0	
Move to bi monthly locality meetings	4	0	(4)		21	0	(21)			25	0	(25)	
Total	**304**	**200**	**(104)**		**3,463**	**3,078**	**(385)**			**4,211**	**3,462**	**(749)**	

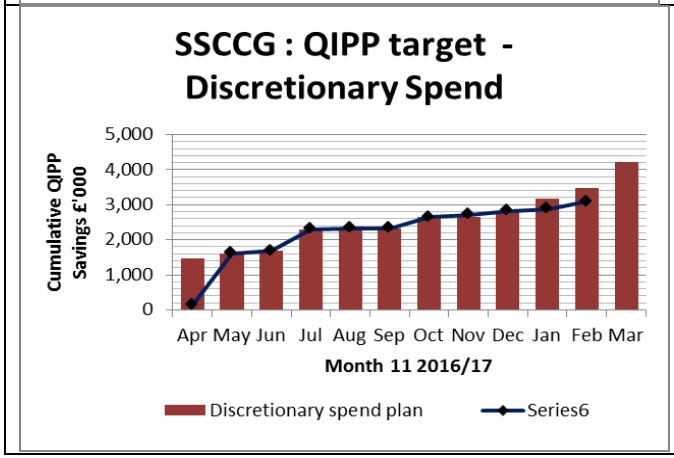
Urgent care system redesign	In month plan	In month actual	Variance		YTD Plan	YTD Actual	Variance			Annual Plan	Forecast out-turn savings	Forecast Variance	
Respiratory	123	0	(123)		1,357	0	(1,357)			1,480	0	(1,480)	
Telehealth	39	0	(39)		424	0	(424)			463	0	(463)	
AVS	69	0	(69)		754	0	(754)			823	0	(823)	
CQUIN - Zero LoS - S&O	7	0	(7)		33	0	(33)			40	40	0	
Cease GP Hotline	0	0	0		11	11	0			11	11	0	
Total	**238**	**0**	**(238)**		**2,580**	**11**	**(2,569)**			**2,817**	**51**	**(2,766)**	

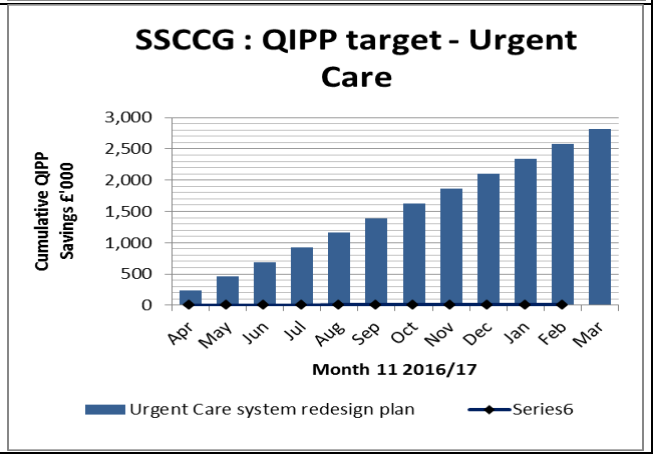
QIPP DASHBOARD SFCCG – Detail by scheme – Theme 5











NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MARCH 2017

Agenda Item: GB17/47	**Author of the Paper:** Karl McCluskey Chief Strategy & Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk Tel: 0151 247 7000
Report date: March 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.	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.

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

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

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South Sefton Clinical Commissioning Group

Integrated Performance Report

Contents

List of Tables and Graphs

1. Executive Summary

This report provides summary information on the activity and quality performance of South Sefton Clinical Commissioning Group at Month 10 (note: time periods of data are different for each source).

CCG Key Performance Indicators

NHS Constitution Indicators	CCG	Main Provider
A&E 4 Hour Waits (All Types)		Aintree
Ambulance Category A Calls (Red 1)		NWAS
Cancer 2 Week GP Referral		Aintree
RTT 18 Week Incomplete Pathway		Aintree
Other Key Targets	**CCG**	**Main Provider**
A&E 4 Hour Waits (Type 1)		Aintree
Ambulance Category A Calls (Red 2)		NWAS
Ambulance Category 19 transportation		NWAS
Cancer 14 Day Breast Symptom		Aintree
Cancer 31 Day First Treatment		Aintree
Cancer 31 Day Subsequent - Drug		Aintree
Cancer 31 Day Subsequent - Surgery		Aintree
Cancer 31 Day Subsequent - Radiotherapy		Aintree
Cancer 62 Day Standard		Aintree
Cancer 62 Day Screening		Aintree
Cancer 62 Day Consultant Upgrade		Aintree
Diagnostic Test Waiting Time		Aintree
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
NHS E-Referral Service Utilisation		

Key information from this report

Financial position

The forecast outturn position after the application of reserves is a deficit of £2.332m against a planned surplus of £2.450m. The forecast position is subject to delivery of remaining QIPP schemes in 2016/17. Release of the 1% uncommitted non recurrent reserve, currently held uncommitted as directed by NHS England, would achieve a surplus position of £0.100m. The financial position relating to operational budgets at Month 11, before the application of reserves is £0.954m overspend against plan with a year-end forecast of £0.913m overspend following mitigation of cost pressures with the CCG contingency budget. The forecast position is showing an in month improvement of £0.286m relating to a decrease in forecasts within acute care and CHC. However the improvement is partially offset by underperformance against the QIPP plan and by cost pressures relating to the national increase in the costs of Funded Nursing Care.

The QIPP requirement to deliver the planned surplus for the financial year was £10.384m. QIPP delivered at the end of Month 11 is £5.370m with a further £0.806m worth of savings to be delivered in the remainder of the financial year. The total projected QIPP delivery is therefore £6.176m.

Planned Care

Local referrals data from our main providers shows no change in the overall level of referrals comparing months 1-10 of 2016/17 with the previous year. GP referrals are slightly above comparing against the same period last year (1%, 277 referrals). Discussions regarding referral management, prior approval, cataracts and consultant-to-consultant referrals continue.

In January the CCG failed the less than 1% target for diagnostics. 28 out of 2,312 patients waited over 6 weeks for their diagnostic test, 2 waited over 13 weeks, recording 1.20%. Aintree also failed the diagnostic monitoring standard reporting 1.40% of patients waiting in excess of 6 weeks. The number of patients waiting over 6 weeks decreased to 67 in January (72 in the previous month). The diagnostic areas with over 1% of patient waiting more than 6 weeks are Endoscopy and MR Cardiac Imaging. There are plans in place to reduce all waits to within the 6-week timeframe.

For Aintree the RTT performance remains below the required DoH standard of 92% for all incomplete pathways at 91.5% during January 2017. This represents an improvement from the previous month. Underperformance was seen in Dermatology, MFU, Ophthalmology and Thoracic. A number of action plans are in place, including the securing of additional monies from NHSE England to tackle challenged specialties such as dermatology and ophthalmology at Aintree University Hospital.

All of the cancer indicators are performing favourably for the CCG and Aintree year to date, apart from 62 day wait for first definitive treatment following a consultant's decision to upgrade. The CCG failed the local target of 85% recording 55.56% in January (5 breaches out of 9), and are failing year to date recording 79.69, a decline on last month's performance.

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, inpatient response rates are now reporting under target (England average) for January at 22.1% (December also failed at 18.7%). The proportion of patients who would recommend has remained static at 97% (above the England average of 96%), as well as the proportion who would not recommend, which remains at 1% in January compared to an England average of 2%.

Performance at Month 10 of financial year 2016/17, against planned care elements of the contracts held by NHS South Sefton CCG shows an over-performance of £751k, which is a percentage variance of 2%. At specific trusts, Renacres are reporting the largest cost variances with a total of £314k/23%.

Unplanned Care

Aintree have revised their Cheshire & Merseyside 5 Year Forward View (STP) trajectory for January to March and has achieved 79.25% which is over the 75% plan agreed with NHS Improvement. Implementation of the AED stream of the Emergency and Acute Care Plan commenced in August last year and embedding of the new model is ongoing.

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. There has been an agreement to use additional area as Ambulance Pitstop until end of January 2017, with commitment to agree long term plan, including appropriate staffing model. Agreement was given to source additional nursing staff and medical staff until end of January 2017. Band 4 Emergency Medical Technician or Ambulance Liaison Officer is also being provided by NWAS to support.

The CCG and Aintree are both under plan and achieving their C.difficile plans for 2016/17. The CCG has had 1 new case of MRSA in January and is therefore reporting a total of 2 MRSA cases YTD. They reported their first case in September; this was a non-trust apportioned case. Aintree has reported 2 cases of MRSA in January, following consideration by NHSE the MRSA case at AUH (Case 1) presented to the Committee in February 2017 has been attributed to a third party. This is the first time an MRSA case has been attributed to another party as opposed to the Provider or the CCG. Aintree had their first case of MRSA in December. Following the national post infection review process, the final assignment of the MRSA case was to the Trust, so 2 cases YTD.

There are a total of 120 serious incidents open on StEIS where South Sefton CCG are either lead or responsible commissioner. Of the 120, there were 89 applicable to South Sefton CCG patients and 31 for Aintree University NHS Foundation Trust (UHA), 7 of these from South Sefton CCG.

Delayed Transfers of Care (DTOC's) increased slightly in January recording 29 compared to December recording 22 (+31.8%). Patient and/or family choice resulted in 9 delayed transfers (31%), a further 14 were due to delays incurred whilst awaiting further NHS non acute care (48%), 4 were due to awaiting care package in own home (14%), 1 due to completion of assessment (3%) and 1 due to community equipment/adaptations (3%). Analysis of delays in January 2017 compared to January 2016 illustrates a 62% increase in total number of delays. The number of patients awaiting further NHS non-acute care has shown an increase of 7 (+50%) from the previous year and 6 more delays due to patient or family choice (+67%).

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 Trust has recovered from a drop in performance in December reaching 16.7%, above the England average of 12.3%. The percentage of people that would recommend A&E has recently fallen and is now under the England average reporting 80% in January compared to an England average of 87%. The not recommended percentage follows a similar pattern with performance at 11% in January compared to a 7% average.

Performance at Month 10 of financial year 2016/17, against unplanned care elements of the contracts held by NHS South Sefton CCG shows an under-performance of circa -£867k/-2%.This under-performance is clearly driven by Aintree Hospital reporting an under performance of -£714k/-2%. Alder

Hey Hospital is reporting the largest year to date over performance with a £181/11% 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.

Mental Health

The 95% target for the percentage of people under CPA followed up within 7 days of discharge was narrowly missed by Mersey care in January, reporting 94% (1 breach out of 17 patients). This is the third time the target has failed this year. The target was also missed in August at 94% and October at 93%.

In terms of Improving Access to Psychological Therapies (IAPT), the provider reported a 54% increase 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 13.2% against the 15% standard at year-end. There was an increase of 59% in referrals compared to the previous month; of these 59.3% were Self-referrals. GP Referrals decreased to 100 compared to 66 in Month 9. 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 40.6% in Month 10, which does not meet the minimum standard of 50%. A forecast outturn at Month 10 gives a year-end position of 38.3%. 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 an increase in Month 10 from 84 to 91.

Commissioners continue to be involved in the Mersey care'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.

Community Health Services

The Trust continues to deliver this service and send through their usual reports until the new contract with Mersey care commences in June 2017. Sefton Physio Service continues to report a high rate of DNAs (15%) in January, a slight improvement on the previous month. Adult Dietetics is also high this month at 21.8% compared to 19.3% last month, as well as Paediatric Dietetics at 15.7% compared to 20% last month. Total DNA rates at Sefton are green for this month at 8%.

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 January 2017. Total patient cancellations for Sefton have improved slightly in January 2017, decreasing from 11.5% to 10.8%.

Adult SALT: This service had issues with long waiting times at the beginning of the financial year. The Trust did work to improve this, and waiting times were reduced significantly between July and

November 2016. However, December data shows that waiting times are beginning to increase again over the 18 week threshold.

Paediatric SALT had 1 patient waiting at 55 weeks at the end of December. This service continues to breach the 18 week target.

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 December 2016, 98% of patients who responded to FFT positively recommended the Trust as a place to receive treatment and care.

Primary Care

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

Work has been progressing throughout 2016/17 to develop a primary care dashboard to present through the Aristotle business intelligence portal. A draft version of the dashboard is currently being tested and reviewed with clinical leads and primary care leads to assess the content, format and functionality of the report. There are various “views” of the data, for CCG level users to view the indicators across the CCG area with the ability to drill to locality and practice level. Once the testing and review process is complete and the dashboard is live in Aristotle, information may 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.

Better Care Fund

A Better Care Fund monitoring report was submitted to NHS England relating to Quarter 3 of 2016/17. The guidance for BCF 2017/18 is awaited but due for imminent release.

CCG Improvement & Assessment Framework

A dashboard is released each quarter by NHS England consisting of sixty indicators. Performance is reviewed quarterly at CCG Senior Management Team meetings, and Senior Leadership Team, Clinical and Managerial Leads have been identified to assign responsibility for improving performance for those indicators. This approach allows for sharing of good practice between the two CCGs, and beyond.

2. Financial Position

2.1 Summary

This report focuses on the financial performance for South Sefton CCG as at 28 February 2017 (Month 11).

The forecast outturn position after the application of reserves is a deficit of **£2.332m** against an original planned surplus of £2.450m. The forecast position is subject to delivery of remaining QIPP schemes of £0.806m in 2016/17. Release of the 1% uncommitted non recurrent reserve, currently held uncommitted as directed by NHS England, would achieve a surplus position of £0.100m for the CCG.

At Month 11, operational budgets are showing an overspend of £0.954m against plan before the application of reserves. The year-end forecast is for an overspend of £0.913m following mitigation of cost pressures with the CCG contingency budget. The forecast position is showing an in month improvement of £0.286m relating to a decrease in forecasts within acute care and CHC. However the improvement is partially offset by underperformance against the QIPP plan and by cost pressures relating to the national increase in the costs of Funded Nursing Care.

The QIPP requirement to deliver the planned surplus for the financial year was £10.384m. QIPP delivered at the end of Month 11 is £5.370m with a further £0.806m worth of savings to be delivered in the remainder of the financial year. The total projected QIPP delivery is therefore £6.176m. The impact of under delivery of QIPP has been the main factor affecting achievement of the original plan position.

The high-level CCG financial indicators are listed below:

Figure 1 – Financial Dashboard

Report Section	Key Performance Indicator		This Month	Prior Month
1	Business Rule (Forecast Outturn)	1% Surplus	✓	✓
		0.5% Contingency Reserve	✓	✓
		1% Non-Recurrent Headroom	✓	✓
2	Surplus	Financial Surplus / (Deficit)	**(£2.332m)**	**(£2.332m)**
3	QIPP	QIPP Plan delivered – *(Red if shortfall against planned delivery)*	**£5.370m**	**£5.020m**
4	Running Costs (Forecast Outturn)	CCG running costs < CCG allocation 2016/17	✓	✓
5	BPPC	NHS - Value YTD > 95%	**100.00%**	**99.98%**
		NHS - Volume YTD > 95%	**96.14%**	**95.47%**
		Non NHS - Value YTD > 95%	**90.40%**	**90.42%**
		Non NHS - Volume YTD > 95%	**96.08%**	**95.45%**

2.2 Resource Allocation

Additional allocations have been received in Month 11 as follows:

- Running costs - impact of NHS Property Services move to market rents - £0.011m
- Programme costs - impact of NHS Property Services move to market rents - £0.080m

These allocations reflect increased costs in respect of accommodation charges and will be utilised within the financial year.

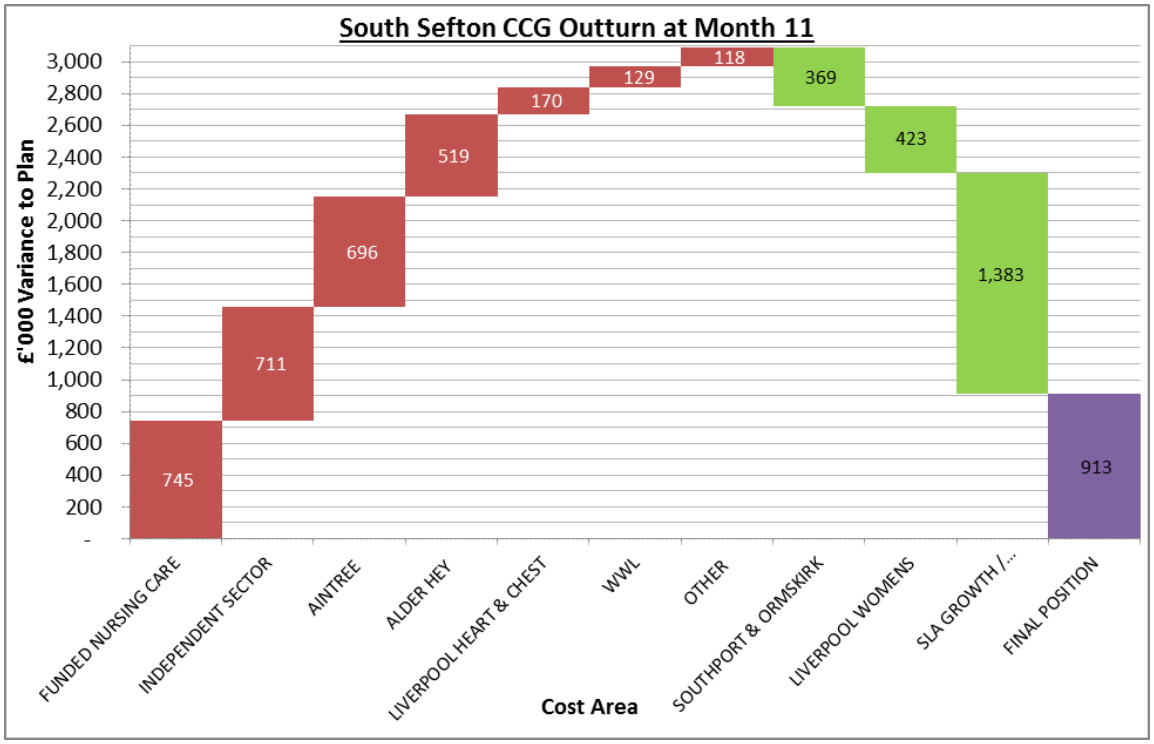
2.3 Position to date and forecast

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 Aintree, Alder Hey, 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.

It should be noted that whilst the financial report is up to the end of February 2017, the CCG has based its reported position on the latest information received from Acute and Independent providers which is up to the end of January 2017.

Figure 2 – Forecast Outturn



Independent Sector

The year to date position on the budget for Independent Sector is an overspend of £0.623m mainly due to Ramsay Healthcare experiencing an over performance against plan. The year-end forecast is an overspend of £0.711m. The majority of the overspend relates to Ramsay Healthcare in respect of Trauma and Orthopaedic activity over performance against plan.

Prescribing

The year to date position on the prescribing budget is an overspend of £0.024m after adjusting for QIPP savings of £0.868m delivered year to date. 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 £0.943m, 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 £0.969m 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

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 determine whether they can be delivered in full. The detailed QIPP plan is shown in Appendix 3 and is projected to deliver **£6.176m** 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	(984)	113	(871)	(594)	0	(277)	(871)
Medicines optimisation plan	(1,429)	0	(1,429)	(1,043)	0	(386)	(1,429)
CHC/FNC plan	(530)	(525)	(1,055)	(1,025)	0	(30)	(1,055)
Discretionary spend plan	(235)	(3,976)	(4,211)	(3,462)	0	(749)	(4,211)
Urgent Care system redesign plan	(2,817)	0	(2,817)	(51)	0	(2,766)	(2,817)
Total QIPP Plan	**(5,995)**	**(4,389)**	**(10,384)**	**(6,176)**	**0**	**(4,208)**	**(10,384)**
Risk rated QIPP plan				**(6,176)**	**0**	**0**	**(6,176)**

As shown in **Figure 4** and **5** below, £5.370m has been actioned at Month 11 against a phased plan of £8.253m.

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

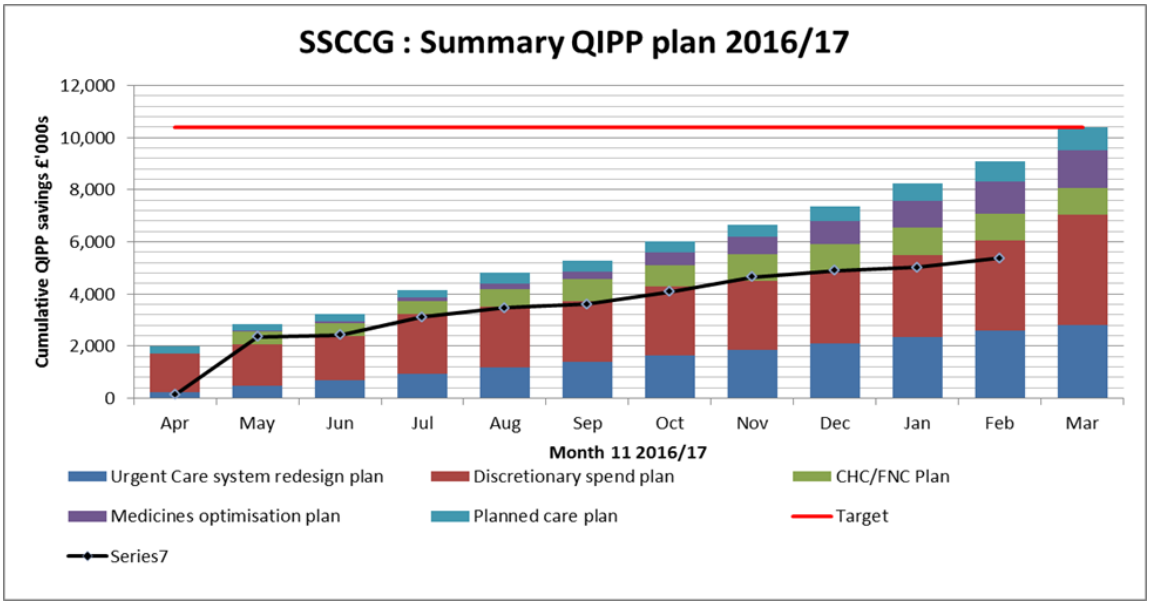


Figure 5 – QIPP performance at month 11

Scheme	In month current month (M11)					
	In month plan	In month actual	Variance	YTD Plan	YTD Actual	Variance
Planned care plan	100	0	(100)	772	388	(384)
Medicines optimisation plan	192	150	(42)	1,237	868	(369)
CHC/FNC Plan	10	0	(10)	1,045	1,025	(20)
Discretionary spend plan	304	200	(104)	3,463	3,078	(385)
Urgent Care system redesign plan	238	0	(238)	2,580	11	(2,569)
Total	**844**	**350**	**(494)**	**9,096**	**5,370**	**(3,726)**

QIPP delivery is **£3.726m** below plan at Month 11, largely in respect of the urgent care scheme. Although Non Elective costs have reduced compared to plan it is difficult to attribute these to specific schemes.

A critical review of outstanding schemes has been undertaken and an assessment of expected delivery for the remainder of the financial year. The CCG expects to deliver a further **£0.806m** in Month 12, scheme leads in particular, must work to ensure delivery of the identified schemes. **Figure 6** below shows the expected delivery of QIPP schemes for the remainder of the financial year.

Figure 6 - QIPP Schemes to be delivered

2016/17 QIPP Plan	£000
PLCV procedures	(172)
Medicines Optimisation	(175)
CQUIN - 1st:Fup ratio S&O	(28)
Review other Expenditure - 3rd Sector	(34)
LQC under-performance in 16/17	(350)
CQUIN Underperformance 16/17 - Aintree	0
CQUIN - Zero LoS - S&O	(47)
Total All Schemes	**(806)**

Total QIPP delivery is anticipated to be £6.176m for the financial year which is an underperformance of £4.208m against the original plan of £10.384m. The underperformance, together with an overspend on operational budgets has led to a deterioration in the forecast from a planned surplus of £2.450m to a deficit of £2.332m.

2.5 CCG Running Costs

The running cost allocation for the CCG is £3.270m 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 £0.293m.

2.6 CCG Cash Position

In order to control cash expenditure within the NHS, limits are placed on the level of cash available to organisations for use 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 11 position

Following the month 9 submissions the MCD limit for South Sefton CCG for 2016/17 was increased from £241.032m to £249.833m. Up to Month 11, the actual cash received is £225.564m (90.1% of MCD) against a target of £229.014m (91.7% of MCD).

A full year cash flow forecast, based on information available at month 11, 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 £320k) as detailed below the CCG is forecasting to meet this target.

NHS England have confirmed that the usual year end process regarding the request for additional cash, and return of excess cash, will be in operation for 2016/17. This means the CCG will have the ability to request additional cash on 21 March 2017. At this stage, we do not anticipate the CCG using this facility. It should be noted that as a result of the finance team having to maintain a managed cash position, there may be a potential increase in year-end creditors.

2.7 Evaluation of risks and opportunities

The primary financial risk for the CCG continues to be non-delivery of the QIPP target in the financial year. The forecast position is dependent on delivery of £0.806m QIPP schemes in the remainder of the financial year.

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

- Acute contracts – The CCG has experienced significant growth in acute care year on year, and this trend has continued in the current financial year. Further risk in relation to over performance at Aintree has been mitigated with an agreed year end position. There remains risk on other NHS contracts in respect of quarter 4 performance.

- 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.

1% Non-Recurrent reserve

As part of NHS England business rules for 2016/17 CCGs were required to set aside 1% (£2.432m) uncommitted funds non-recurrently. The CCG is expecting these funds to be released within the financial year.

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 figure 7 below. This demonstrates that the CCG plans to deliver a total management action plan of £6.176m in 2016/17 which will result in a deficit of £2.332m.

In order to deliver the CCG statutory duty to break even, the CCG is reliant on return of the 1% non-recurrent reserve, which remains uncommitted as directed by NHS England. It is anticipated that this funding will be released to the CCG late in the financial year and is expected to improve the CCG's financial position from £2.332m deficit to £0.100m surplus.

Delivery of the remaining QIPP plan is challenging and requires co-operation with partners across the healthcare economy. The CCG has 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 7 – Forecast Outturn 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)	(0.573)	(0.341)	(0.914)
Reserve Budgets	0.340	(0.000)	0.340
Management action plan			
Actioned QIPP to date	2.071	3.298	5.369
Additional QIPP required	0.209	0.598	0.807
Total Management Action Plan	**2.280**	**3.896**	**6.176**
Year End Surplus / (Deficit)	**(0.424)**	**(1.908)**	**(2.332)**

Figure 8 below outlines the best, most likely and worst case scenarios. The best case scenario assumes achievement of the remaining QIPP plan.

The most likely case is a deficit of £2.332m which assumes delivery of the remaining risk adjusted QIPP plan.

The worst case scenario assumes achievement of the remaining risk adjusted QIPP plan and increased risk in respect of Acute Care.

Figure 8 – Risk Rated Financial Position

South Sefton	Best Case £m	Most Likely £m	Worst Case £m
QIPP Target	(10.384)	(10.384)	(10.384)
QIPP achieved to date	5.369	5.369	5.369
Remaining QIPP requirement	**(5.015)**	**(5.015)**	**(5.015)**
Month 11 Forecast (I&E)	(0.914)	(0.914)	(0.914)
Reserve Budgets	0.341	0.341	0.341
Remaining QIPP requirement	**(5.588)**	**(5.588)**	**(5.588)**
Predicted QIPP achievement (M12)	0.806	0.806	0.806
Planned Surplus	2.450	2.450	2.450
Forecast Surplus / (Deficit)	**(2.332)**	**(2.332)**	**(2.332)**
Further Risk			
Acute Care	-	-	(0.200)
Risk adjusted Surplus / (Deficit)	**(2.332)**	**(2.332)**	**(2.532)**

2.9 Recommendations

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

- The likely outturn position is a deficit of **£2.332m**. This includes the expenditure forecast delivery of QIPP savings for the remainder of the financial year. NHS England expects that the CCG will achieve this position.
- It should be noted that the forecast deficit does not include the 1% non-recurrent reserve which is held uncommitted as directed by NHS England.
- Release of the 1% reserve (£2.432m) will result in a surplus of £0.100m which delivers the CCG statutory financial duty to achieve a break even position.
- The CCG is undertaking an urgent and critical review of the remaining QIPP programme areas to provide assurance that the anticipated 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

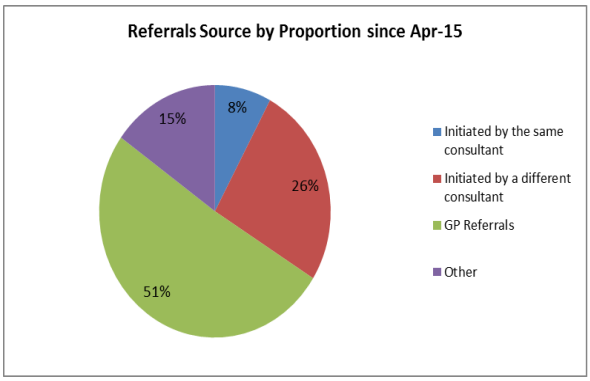
accordingly. High levels of engagement and support is required from member practices to enable the CCG to reduce levels of low value healthcare and improve value for money.

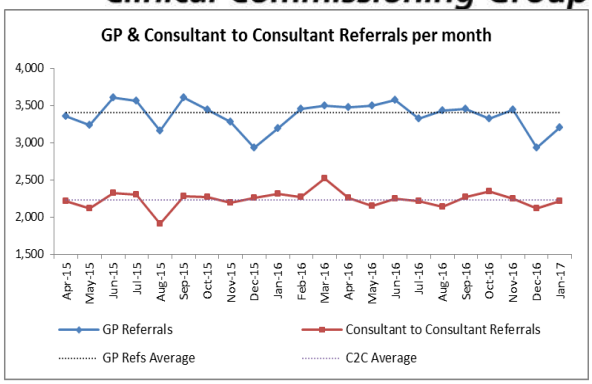
3. Planned Care

3.1 Referrals by source

Figure 9 - GP and 'other' referrals for the CCG across all providers for 2015/16 & 2016/17

Referral Type	DD Code	Description	1516 YTD	1617 YTD	Variance	% Variance
GP	03	GP Ref	33,386	33,663	277	0.8%
GP Total			33,386	33,663	277	0.8%
Other	01	following an emergency admission	1,651	1,422	-229	-13.9%
	02	following a Domiciliary Consultation	13	7	-6	0.0%
	04	An Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)	4,180	4,174	-6	-0.1%
	05	A CONSULTANT, other than in an Accident and Emergency Department	12,909	12,839	-70	-0.5%
	06	self-referral	3,039	2,803	-236	-7.8%
	07	A Prosthetist	14	11	-3	-21.4%
	08	Royal Liverpool Code (TBC)	689	775		
	10	following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)	962	985	23	2.4%
	11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	2,462	2,774	312	12.7%
	12	A General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)	63	62	-1	-1.6%
	13	A Specialist NURSE (Secondary Care)	96	80	-16	-16.7%
	14	An Allied Health Professional	1,190	1,462	272	22.9%
	15	An OPTOMETRIST	9	7	-2	-22.2%
	16	An Orthoptist	3	4	1	0.0%
	17	A National Screening Programme	58	59	1	1.7%
	92	A GENERAL DENTAL PRACTITIONER	1,293	1,393	100	7.7%
	93	A Community Dental Service	16	3	-13	-81.3%
	97	other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	3,490	3,057	-433	-12.4%
Other Total			32,137	31,917	-220	-0.7%
Unknow n			19	1	-18	-94.7%
Grand Total			**65,542**	**65,581**	**39**	**0.1%**





Local referrals data from our main providers shows no change in the overall level of referrals comparing months 1-10 of 2016/17 with the previous year. GP referrals are slightly above comparing against the same period last year (1%, 277 referrals).

Discussions regarding referral management, prior approval, and consultant-to-consultant referrals continue. A paper will be presented to March QIPP Clinical Advisory Group to update on the development of a Referral Optimisation and Support System (ROSS) and explore preferences with the clinical members of the group with regards to approaches to referral management.

Data quality note: Walton Neuro Centre & Renacres Hospital has been excluded from the above analysis due to validation errors in month 10 submission.

3.1.1 E-Referral Utilisation Rates

NHS E-Referral Service Utilisation				
NHS South Sefton CCG	16/17 - Dec	80% or 20% increase on previous year (42%)	18.00%	↓

The national NHS ambition is that E-referral Utilisation Coverage should be 80% by end of Q2 2017/18 and 100% by end of Q2 2018/19.

The latest data for E-referral Utilisation rates reported 18%; a decline on the previous two month's when 20% and 19% were recorded.

3.2 Diagnostic Test Waiting Times

Diagnostic test waiting times					
% of patients waiting 6 weeks or more for a Diagnostic Test **(CCG)**	16/17 - Jan	1.00%	1.20%	↑↓	30 out of 2,312 patients waited over 6 weeks for their diagnostic test. 2 of these patients waited over 13 weeks.
% of patients waiting 6 weeks or more for a Diagnostic Test **(Aintree)**	16/17 - Jan	1.00%	1.40%	↓	67 out of 4,323 patients waited over 6 weeks for their diagnostic test. 6 of these patients waited over 13 weeks.

Aintree aims to achieve the standard of less than 1% of patients waiting 6 weeks or more for their diagnostic test. During January 2017, the Trust failed the diagnostic monitoring standard, reporting 1.40% of patients waiting in excess of 6 weeks. This is a slight improvement on last month.

The number of patients waiting over 6 weeks decreased to 67 in January (72 in the previous month). The diagnostic areas with over 1% of patient waiting more than 6 weeks are Endoscopy and MR Cardiac Imaging. There are plans in place to reduce all waits to within the 6-week timeframe.

The Endoscopy department has experienced considerable pressure over the last quarter which has resulted in the undertaking of extensive additional activity in order to meet the trusts 2ww cancer pathways. This has made it difficult to support the non-urgent 6 week performance targets. It has been identified that 25% of patients had a DNA recorded and 50% of the patients need their procedure under general anaesthetic.

There has been an increase in waiting times in MR Cardiac Imaging as a result of increased demand above funded capacity and loss of service due to the 10 day breakdown of the scanner in December and the subsequent loss of service over Christmas and New Year. The delay to MR imaging is related to additional demand and lost activity associated with Consultant on Call. The CSI service currently has 2.2 whole time equivalent radiographer vacancies which is having an effect on service provision. The current waiting time for CT Cardiac imaging is above 6 weeks. There has been an increase in waiting times as a result of increased demand above funded capacity and loss of service due to the breakdown of the scanner used to perform cardiac imaging in November and the subsequent loss of service over Christmas and New Year.

The CSI service currently has 2.2 WTE radiographer vacancies and nursing vacancies which is having an effect on service provision.

3.3 Referral to Treatment Performance

Referral To Treatment waiting times for non-urgent consultant-led treatment				
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(CCG)**	16/17 - Jan	0	0	↔
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(Aintree)**	16/17 - Jan	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 - Jan	92%	92.70%	↑
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 - Jan	92%	91.50%	↑

For Aintree the RTT performance remains below the required DoH standard of 92% for all incomplete pathways at 91.5% during January 2017. This represents an improvement from the previous month. Underperformance was seen in Dermatology, MFU, Ophthalmology and Thoracic.

There are multiple actions in place to reduce the over 18 week waiters including:

- A weekly Trust wide PTL meeting
- Recruitment of both medical and nursing staff
- Weekly validation of pathways
- Additional WLI activity, job plan reviews
- RTT training
- Theatre and outpatient transformation programmes, negotiations with external care providers.

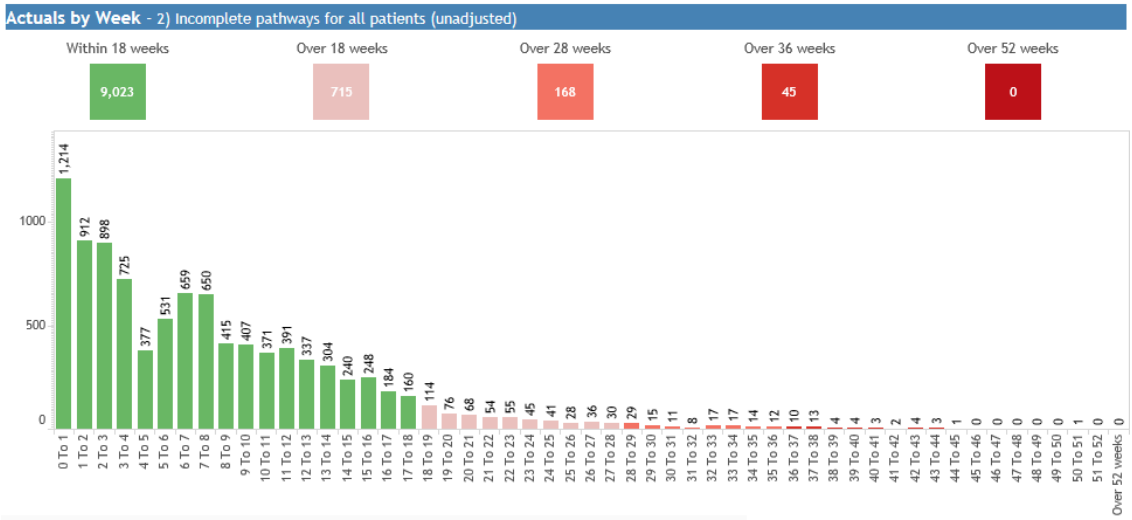
South Sefton CCG supported an application by Aintree University Hospital Trust to secure additional RTT funding from NHS England in February. This additional funding has been used to for two of the main specialties with difficulty meeting the target; dermatology and ophthalmology.

An agreement with a community dermatology provider has been reached for them to virtually review 3,000 dermatology cases with an expected discharge rate of 75%. Patients who require an outpatient review or procedure will be seen & treated by the contracted provider. All 90 open pathways are expected to be reviewed and have a clock stop as part of this process. An implementation plan has been drafted, aiming to start on 13th February 2017 and completed by 31st March 2017.

The ophthalmology department leads at Aintree has identified 265 possible new patients that could be outsourced to an Independent Sector provider, who the trust currently works with on cataract pathways. This is expected to improve the RTT position by alleviating pressure on the pathway.
An implementation plan and workflows have been drafted and is expected to start on Monday 13th February 2017 and completed by 31st March 2017.

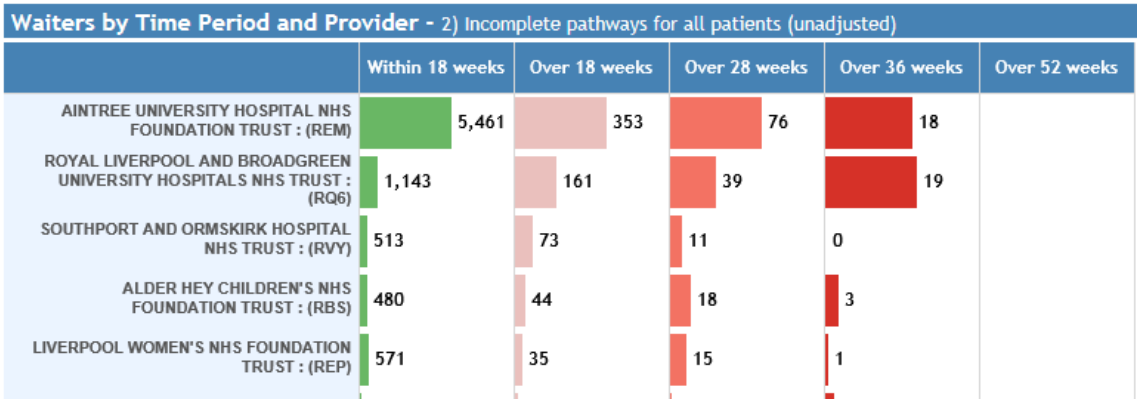
3.3.1 Incomplete Pathway Waiting Times

Figure 10 - South Sefton CCG Patients waiting on an incomplete pathway by weeks waiting



3.3.2 Long Waiters analysis: Top 5 Providers

Figure 11 - 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 12 - Patients waiting (in bands) on incomplete pathways by Speciality for Aintree University Hospitals NHS Foundation Trust

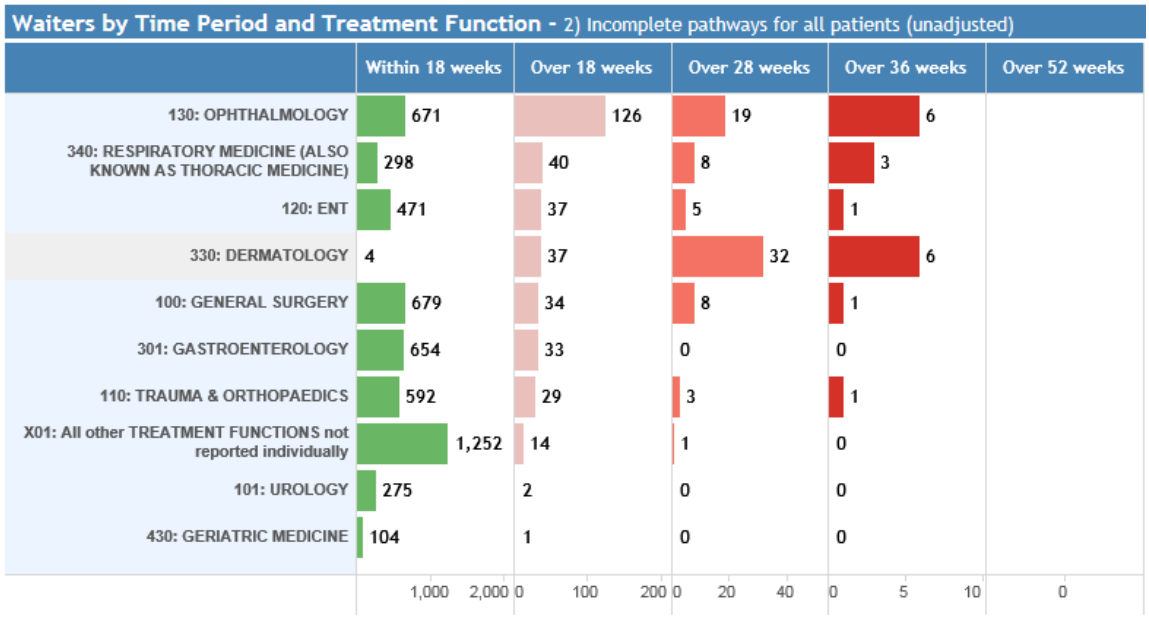
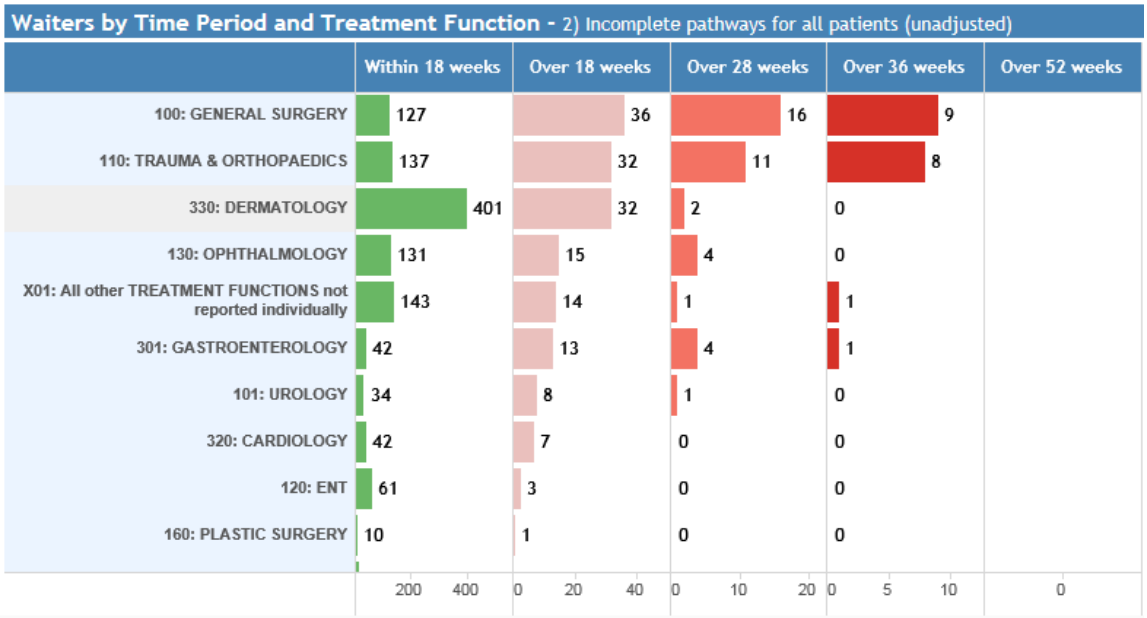


Figure 13 - Patient waiting (in bands) on incomplete pathway by Specialty for Royal Liverpool & Broadgreen University Hospital NHS Foundation Trust



3.3.4 Provider assurance for long waiters

Trust	Speciality	No of weeks	No of patients	Has patient been seen / has a TCI date?	Reason for the delay
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	Ophthalmology	40	1	Clock stopped 6/2/17 - Decision not to treat	Patient declined treatment
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	Ophthalmology	41	1	Clock stopped 7/2/17 - TCI	Capacity issue
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	Respiratory	44	1	Clock stopped 10/2/17 - Active Monitoring	Capacity issue
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	General Surgery	41	1	Pathway Stopped	
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	General Surgery	42	1	Pathway Stopped	
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	General Surgery	42	1	Pathway Stopped	
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	General Surgery	42	1	Pathway Stopped	
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	General Surgery	42	1	16/03/2017	Long Wait on Waiting List
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	General Surgery	43	1	Pathway Stopped	
ALDER HEY	All other	40	1	AUD -28/03/2017	Capacity
ALDER HEY	All other	43	1	AUD - 28/03/2017	Capacity
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	Plastic Surgery	40	1	28/02/2017	Patient listed for surgery at week 6 of 18 week pathway, patient listed for MOHS surgery.
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS	T&O	50	1	Admitted 27.2.17	Spinal Disorders is a Nationally Pressured Area
ROYAL FREE LONDON HOSPITAL	Plastic Surgery	43	1	Awaiting a response from the Trust	

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 - Jan	0	0	↔

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

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

3.5 Cancer Indicators Performance

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 - Jan	93%	95.70%	↔
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Aintree)**	16/17 - Jan	93%	95.69%	↔
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 - Jan	93%	94.27%	↔
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 - Jan	93%	94.52%	↔

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 - Jan	96%	98.22%	↔
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Aintree)**	16/17 - Jan	96%	99.01%	↔
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	16/17 - Jan	94%	96.20%	↔
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Aintree)**	16/17 - Jan	94%	0 Patients	↔
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	16/17 - Jan	94%	97.09%	↔
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Aintree)**	16/17 - Jan	94%	98.25%	↓
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	16/17 - Jan	98%	98.74%	↓
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(Aintree)**	16/17 - Jan	98%	99.58%	↓

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 - Jan	85% local target	79.69%	↓
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 - Jan	85% local target	89.22%	↓
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(CCG)**	16/17 - Jan	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 - Jan	90%	91.45%	↑
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(CCG)**	16/17 - Jan	85%	87.65%	↓
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(Aintree)**	16/17 - Jan	85%	85.61%	↓

The CCG failed the 85% local target in January reporting 55.56%, 4 out of 9 patients were not upgraded within 62 days. All four patients were lung patients: two patients were in admitted care; the first patients upgrade was delayed to 66 days as they were unfit for surgery, the second patients delay was due to a late referral (complex diagnostics needed). Two patients were in non-admitted care, delays due to referrals from Clatterbridge. Year to date the CCG are failing at 79.69%, a decline on last month's performance.

3.6 Patient Experience of Planned Care

Friends and Family Response Rates and Scores
Aintree University Hospital NHS Foundation Trust
Latest Month: **Jan-17**

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	23.6%	22.1%		96%	97%		2%	1%	

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, inpatient response rates are now reporting under target (England average 23.6%) for January at 22.1%. However, this is a significant increase from Decembers rate of 18.7%). The proportion of patients who would recommend has remained static at 97% (above the England average of 96%), as well as the proportion who would not recommend, which remains at 1% in January compared to an England average of 2%.

The Trust reverted back to using cards following an unsuccessful pilot for collecting FFT. Response rate was improving although not to levels seen previous to the pilot. November and December both saw reductions with an increase noted now for January.

Aintree's Patient Experience Lead is presenting an update in April to the CCG Engagement and Patient Experience Group. The Trust will provide feedback in how FFT serves to inform 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 have created 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 10 of financial year 2016/17, against planned care elements of the contracts held by NHS South Sefton CCG shows an over-performance of £751k, which is a percentage variance of 2%. At specific trusts, Renacres are reporting the largest cost variances with a total of £314k/23%.

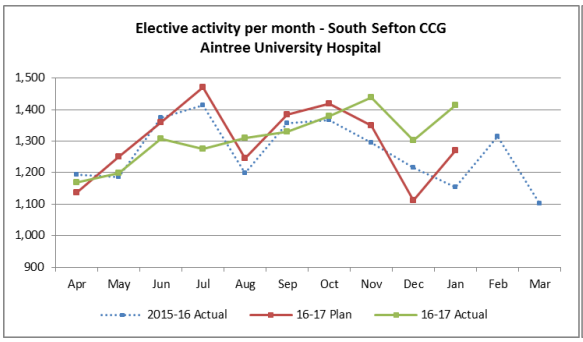
Figure 14 - Planned Care - All Providers

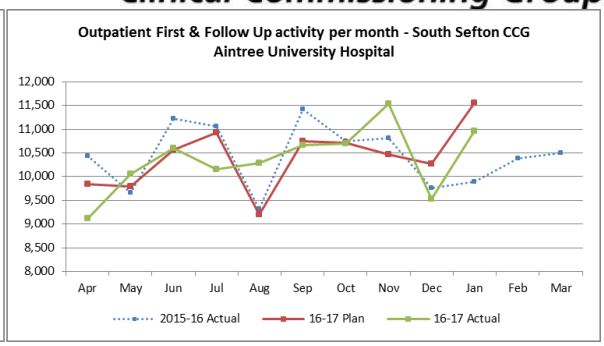
Provider Name	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	148,857	149,226	369	0%	£27,320	£27,385	£64	0%
Alder Hey Childrens NHS F/T*	5,587	11,602	6,015	108%	£1,389	£1,703	£314	23%
Central Manchester University Hospitals Nhs Foundation Trust	72	0	-72	-100%	£18	£0	-£18	-100%
Countess of Chester Hospital NHS Foundation Trust	0	138	138	0%	£0	£21	£21	0%
East Cheshire NHS Trust	0	6	6	0%	£0	£3	£3	0%
Fairfield Hospital	104	157	53	50%	£19	£43	£24	128%
ISIGHT (SOUTHPORT)	441	673	232	53%	£100	£154	£54	54%
Liverpool Heart and Chest NHS F/T	961	1,000	39	4%	£318	£381	£64	20%
Liverpool Womens Hospital NHS F/T	13,418	13,529	111	1%	£2,780	£2,738	-£42	-2%
Renacres Hospital	3,742	4,900	1,158	31%	£1,317	£1,467	£150	11%
Royal Liverpool & Broadgreen Hospitals	25,663	26,831	1,168	5%	£4,782	£4,951	£169	4%
Southport & Ormskirk Hospital*	12,074	12,341	267	2%	£2,594	£2,388	-£206	-8%
SPIRE LIVERPOOL HOSPITAL	2,386	1,994	-392	-16%	£751	£709	-£42	-6%
ST Helens & Knowsley Hospitals	3,429	3,614	185	5%	£900	£973	£73	8%
University Hospital Of South Manchester Nhs Foundation Trust	90	100	10	11%	£13	£19	£6	41%
Walton Neuro	2,795	2,834	39	1%	£710	£686	-£24	-3%
Wirral University Hospital NHS F/T	385	348	-37	-10%	£102	£94	-£8	-8%
Wrightington, Wigan And Leigh Nhs Foundation Trust	705	1,011	306	43%	£254	£403	£149	59%
Grand Total	**220,710**	**230,304**	**9,594**	**4%**	**£43,367**	**£44,118**	**£751**	**2%**
*PbR Only								

3.7.1 Planned Care Aintree University Hospital NHS Foundation Trust

Figure 15 - 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	11,290	11,617	327	3%	£7,309	£7,447	£139	2%
Elective	1,707	1,509	-198	-12%	£4,766	£4,554	-£212	-4%
Elective Excess BedDays	670	532	-138	-21%	£148	£117	-£31	-21%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	375	266	-109	-29%	£68	£52	-£16	-23%
OPFANFTF - *Outpatient first attendance non face to face*	2,094	2,767	673	32%	£59	£71	£12	20%
OPFASPCL - *Outpatient first attendance single professional consultant led*	27,972	28,326	354	1%	£4,203	£4,362	£159	4%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	1,255	944	-311	-25%	£137	£124	-£14	-10%
OPFUPNFTF - *Outpatient follow up non face to face*	2,704	4,080	1,376	51%	£65	£99	£33	51%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	69,714	67,225	-2,489	-4%	£5,561	£5,410	-£151	-3%
Outpatient Procedure	18,165	18,358	193	1%	£3,002	£3,098	£95	3%
Unbundled Diagnostics	11,690	12,314	624	5%	£1,070	£1,095	£25	2%
Wet AMD	1,221	1,287	66	5%	£932	£957	£24	3%
Grand Total	**148,857**	**149,225**	**368**	**0%**	**£27,320**	**£27,384**	**£64**	**0%**





Planned Care at Aintree University Hospital is recording comparable year to date costs against plan with a £64k/0% over performance.

Planned Care is showing a £-67k/0.1% over performance for Month 10. Day cases, outpatient first attendances and outpatient procedures are the PODs reporting a significant over performance within planned care. Elective inpatients are under performing by -£212k/-4%.

Cardiology is showing the largest cost variance in month 10 (£965k/33%) with £409k of this applicable to South Sefton CCG. The cardiology over performance is largely related to day case activity.

ENT is also showing an over performance of £265k/6% against plan with South Sefton seeing an increase of £69k/6%. Knowsley are also seeing an over performance of £105k/25%. Day cases are a key driver for over performance within ENT.

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	435	£384,090	-3	-£4,512	-22	-£4,673	622	£61,567	148	-£49,616	129	£22,204	1,308	£409,061
Clinical haematology	72	£16,147	-6	-£1,620	-46	-£10,746	268	£80,106	143	£17,791	4	£816	435	£102,494
Colorectal surgery	-12	£14,702	-11	£99,518	-188	-£40,781	6	-£3,442	-173	-£15,669	243	£44,374	-133	£98,703
Physiotherapy							43	£873	2,182	£70,174	1	£33	2,226	£71,080
Ent	18	£28,979	-22	£29,186	14	£3,127	-77	-£8,441	-4	£398	122	£16,545	52	£69,794
Rheumatology	-3	-£1,629	-1	-£368	6	£1,309	74	£17,414	519	£47,180	7	£1,239	603	£65,145
General surgery	18	£19,809	-11	£15,626	71	£14,775	114	£11,969	-92	-£10,305	2	£490	103	£52,364
Acute internal medicine	-4	-£1,703	0	-£5,368	-4	-£819	733	£63,879	-19	-£3,340	-47	-£6,890	660	£45,759
Nephrology	15	£11,975	-15	-£21,587	-9	-£2,334	188	£52,992	-193	-£8,843	-8	-£1,420	-23	£30,782
Respiratory medicine	-1	-£24,718	-10	-£13,071	-4	-£664	86	£39,309	233	£3,043	117	£25,687	423	£29,585
Upper gastrointestinal surgery	-24	-£34,777	4	£48,061	15	£3,169	-23	-£2,736	-23	-£1,972	-1	-£510	-53	£11,235
Endocrinology	-4	-£2,723	-1	-£2,423			6	£1,126	143	£14,526			144	£10,507
Geriatric medicine	-3	-£4,613	0	-£965	-13	-£2,731	26	£6,742	-83	-£11,773	0	-£101	-72	-£13,441
Vascular surgery	-14	-£14,098	-3	-£3,168			26	£4,472	-24	-£2,660	-1	-£197	-15	-£15,652
Interventional radiology	15	£833	-6	-£23,976	-4	-£773	70	£10,282	-18	-£1,492	-64	-£17,164	-7	-£32,290
Diabetic medicine	51	£19,652	1	£2,519	-12	-£2,928	-124	-£26,173	-174	-£18,095	-74	-£9,713	-332	-£34,738
Anticoagulant service									-2,694	-£69,279			-2,694	-£69,279
Gastroenterology	-15	-£66,563	-14	-£24,146	17	£3,769	-108	-£19,678	-19	£18,862	31	£8,912	-109	-£78,843
Hepatobiliary & pancreatic surgery	8	£13,730	-17	-£90,798	-2	-£424	15	£3,302	-46	-£4,691			-43	-£78,880
Dermatology	-38	-£21,795	1	£539			-413	-£45,858	-599	-£43,583	55	-£3,755	-994	-£114,452
Urology	-15	-£36,099	-44	-£107,966	-54	-£11,195	-336	-£45,081	149	£10,783	4	£44,836	-296	-£144,723
Trauma & orthopaedics	4	-£58,599	-56	-£112,550	95	£20,719	-40	-£5,418	-56	-£5,641	-64	£119	-117	-£161,371
Ophthalmology	-194	-£138,164	5	£2,487			-248	-£29,614	10	£30,301	-276	-£32,303	-702	-£227,896
Grand Total	**327**	**£138,625**	**-198**	**-£212,460**	**-138**	**-£31,200**	**917**	**£155,379**	**-1,423**	**-£131,225**	**193**	**£95,467**	**-322**	**£14,586**

NHS South Sefton Clinical Commissioning Group

3.7.2 Planned Care Southport & Ormskirk Hospital

Figure 16 - 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	790	748	-42	-5%	£640	£545	-£94	-15%
Elective	188	159	-29	-16%	£544	£457	-£87	-16%
Elective Excess BedDays	1	36	35	2804%	£0	£8	£8	2940%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	238	84	-154	-65%	£35	£14	-£22	-61%
OPFASPCL - *Outpatient first attendance single professional consultant led*	1,867	1,971	104	6%	£277	£288	£10	4%
OPFUPMPCL - *OP follow up Multi-Professional Outpatient First. Attendance (Consultant Led)*	491	197	-294	-60%	£48	£21	-£27	-56%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	4,394	4,204	-190	-4%	£394	£377	-£17	-4%
Outpatient Procedure	3,368	3,109	-259	-8%	£597	£536	-£61	-10%
Unbundled Diagnostics	722	714	-8	-1%	£55	£54	-£1	-1%
Grand Total	**12,060**	**11,222**	**-838**	**-7%**	**£2,591**	**£2,300**	**-£291**	**-11%**

* PbR only

Elective care elements of the contract continue to under-perform against planned levels with all areas, with the exception of Elective excess bed days and Outpatient first attendances, below. Pressures remain on Elective and Day Case procedures with low theatre staff levels a problem for the Trust throughout the year.

An added pressure within the planned care sections of the contract was the cancellation of a number of Elective procedures in January. Under the advice of NHS Improvement the Trust cancelled a number of Elective operations to better cope with winter pressures, these cancellations took place during the first two weeks of January.

Outpatient attendances have reduced across a number of specialities, most significantly in Urology, Trauma & Orthopaedics, and Gynaecology. Outpatient procedures have also reduced with the main focus within T&O.

Referral to Treatment has been adversely affected with December failing for the first time in the year but the Trust has improved its position and achieved in January.

Further reductions are expected due to the implementation of the Joint Health service and the installation of the Blueteq system to identify and authorise procedures of low clinical value.

3.7.3 Renacres Hospital

Figure 17 - 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	481	466	-15	-3%	£539	£560	£21	4%
Elective	86	104	18	21%	£409	£495	£86	21%
OPFASPCL - *Outpatient first attendance single professional consultant led*	1,018	922	-96	-9%	£146	£132	-£14	-10%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	1,219	2,623	1,404	115%	£102	£152	£51	50%
Outpatient Procedure	585	351	-234	-40%	£86	£83	-£3	-4%
Unbundled Diagnostics	353	434	81	23%	£35	£45	£10	27%
Grand Total	**3,742**	**4,900**	**1,158**	**31%**	**£1,317**	**£1,467**	**£150**	**11%**

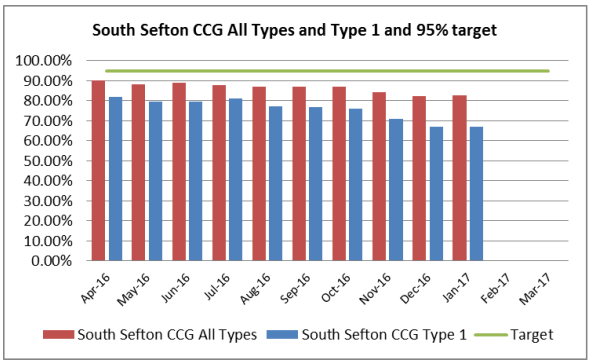
Renacres over performance of £150/11% is largely driven by a £86k over performance in Electives. Major Hip Procedures is the largest over performing HRG followed by Reconstruction Procedures. Combined costs for these two HRG's are £98k. The over performance at Renacres is mirrored by underperformance at other Trusts, namely Spire and Southport and Ormskirk Hospitals suggesting a shift in patient and GP choice. This situation will be monitored closely, particularly alongside any future reductions in activity at Aintree alongside increases at Renacres. The introduction of MCAS in Southport & Formby has reduced activity at Renacres. If a similar approach is adopted in South Sefton this could potentially mitigate the Renacres over performance.

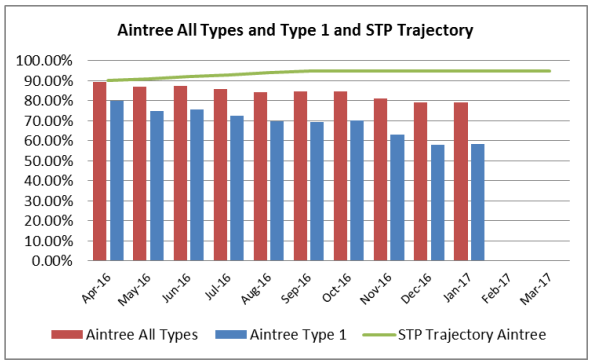
4. Unplanned Care

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 - Jan	95%	86.50%	↓	The CCG have failed the target in January reaching 82.61% and year to date reaching 86.5%. In month 1,416 attendances out of 8,143 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 - Jan	95%	77.65%	↔	The CCG have failed the target in January reaching 66.89% (year to date 77.65%). In month 1,411 attendances out of 4,262 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 - Jan	STP Trajectory Target 75%	84.23%	↓	Aintree have achieved their revised target of 75% in January reaching 84.23% YTD and 79.25% in month; 2,880 attendances out of 13880 were not admitted, transferred or discharged within 4 hours.
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Aintree) Type 1**	16/17 - Jan	95%	86.12%	↑	Aintree have failed the target in January reaching 58.24% and year to date reaching 86.12%. In month 2,880 attendances out of 6,896 were not admitted, transferred or discharged within 4 hours.

A&E All Types	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
STP Trajectory Aintree	90%	91%	92%	93%	94%	95%	95%	95%	95%	75%
Aintree All Types	89.48%	86.88%	87.50%	85.95%	84.10%	84.46%	84.76%	81.11%	79.05%	79.25%





Aintree have revised their Cheshire & Merseyside 5 year Formal View (STP) trajectory for January to March and has achieved over the 75% plan agreed with NHS Improvement.

The Trusts' performance is similar to the previous month for the 4-hour standard and remains below the national required 95% at 79.25% for January 2017.

Trust Actions

- Continue to embed all aspects of the AED stream of the Emergency and Acute Care Plan and regularly monitor performance. Continue to progress the recruitment strategy. A Consultant is due to commence in February 2017 and a recruitment company has been identified to help with further recruitment. Whilst recruitment is underway, arrange additional sessions to fill gaps in the existing rota. Continue discussions with UC24 to improve out of hours GP provision and utilisation of available slots.
- Review current structures and develop a workforce plan which will deliver sustained performance levels. Following implementation of the new frailty model, next steps have been agreed. These include development of an in-reach model, development of the Advanced Nurse Practitioner role, further discussions with the site team to improve patient flow out of the unit and progress with the medical recruitment strategy.
- Continue to embed the AED input in to purple to gold programme (which now includes the Observation Ward).
- Continue to improve ambulance turnaround times by implementing agreed actions. An additional area in ED is currently being used to facilitate timelier turnaround times of ambulances. A SOP has been agreed and a staffing plan has been finalised. Additional nursing staff have been funded on a fixed term basis to support this area and a longer term plan is being developed. NWAS have also provided technician support for this area.
- Follow-up review on ambulance handover processes is to be undertaken by ECIP in February 2017 to review progress made to date and identify further areas for improvement.

4.2 Ambulance Service Performance

Ambulance					
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	16/17 - Jan	75%	70.59%	↓	The CCG is under the 75% target year to date reaching 70.59%. In January out of 62 incidents, 37 were within 8 mins (59.68%)
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	16/17 - Jan	75%	59.71%	↓	The CCG is under the 75% target year to date reaching 59.71%. In January out of 904 incidents, 502 were within 8 mins (55.52%).
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	16/17 - Jan	95%	90.24%	↔	The CCG is under the 95% target year to date reaching 90.24%. In January out of 966 incidents, 847 were within 19 mins (87.67%)
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	16/17 - Jan	75%	68.29%	↓	NWAS reported under the 75% target year to date reaching 68.29%. In the month of January 61.79% was reported.
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	16/17 - Jan	75%	62.75%	↓	NWAS failed to achieve the 75% target year to date reaching 62.75%. In the month of January 58.78% was reported.
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	16/17 - Jan	95%	88.98%	↓	NWAS failed to achieve the 95% target year to date reaching 89.98%. In the month of January 85.74% was reported.

Handover Times					
All handovers between ambulance and A & E must take place within 15 minutes (between 30 - 60 minute breaches) - **Aintree**	16/17 - Jan	0	190	↓	The Trust recorded 190 handovers between 30 and 60 minutes, this is an improvement on last month when 241 was reported but is still breaching the zero tolerance threshold.
All handovers between ambulance and A & E must take place within 15 minutes (>60 minute breaches) - **Aintree**	16/17 - Jan	0	261	↓	The Trust recorded 261 handovers over 60 minutes, an improvement on the previous month when 287 was reported but is still breaching the zero tolerance threshold.

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. Work with NWAS and all partners, including ECIP, is ongoing to ensure delivery of agreed actions.

There has been an agreement to use additional area with Aintree as Ambulance Pitstop until the end of January 2017, with commitment to agree long term plan, including appropriate staffing model. Interim SOP and staffing plan finalised. Agreement was given to source additional nursing staff and medical staff until end of January 2017. Band 4 Emergency Medical Technician or Ambulance Liaison Officer is also being provided by NWAS to support.

Aintree are collaborating with ECIP (Emergency Care Improvement Programme) to identify reasons for delayed ambulance hand over and agree actions to recurrently improve ambulance handover performance.

The Trust experienced a decrease in the number of delays in excess of 30 minutes during January 2017. The number of ambulance waits exceeding 30 minutes decreased to 451 (-77). Of the 451, 261 were delayed in excess of 60 minutes which again is a decrease of -26.

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 - Jan	80%	86.10%	↑
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(Aintree)**	16/17 - Jan	60%	100%	↔

4.3.2 Mixed Sex Accommodation

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

4.3.3 Healthcare associated infections (HCAI)

HCAI				
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(CCG)**	16/17 - Jan	45	39	↑
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(Aintree)**	16/17 - Jan	38	40 (24 following appeal)	↑
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(CCG)**	16/17 - Jan	0	2	↑
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(Aintree)**	16/17 - Jan	0	2	↑

The CCG has had 1 new C.difficile case reported in January, a total of 39 cases year to date against a year to date plan of 45.

For Aintree this year there have been 40 patients with Trust apportioned C.difficile including 4 new cases reported in January, compared to a year to date plan of 38. There has been 16 successful appeals year to date and there are a further 4 cases for review at the appeals panel in February giving a total of 24 cases following appeal.

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 1 new case1 of MRSA in January and is therefore reporting a total of 2 MRSA cases YTD. They reported their first case in September; this was a non-trust apportioned case.

Aintree has reported 2 cases of MRSA in January, following consideration by NHSE the MRSA case at AUH (Case 1) presented to the Committee in February 2017 has been attributed to a third party. This is the first time an MRSA case has been attributed to another party as opposed to the Provider or the CCG, please note this case is still showing in the live database and we are awaiting a refresh of the information. Aintree had their first case of MRSA in December. Following the national post infection review process, the final assignment of the MRSA case was to the Trust, so 2 cases YTD.

4.3.4 Mortality

Mortality				
Hospital Standardised Mortality Ratio (HSMR)	16/17 - Jan	100	93.32	↓
Summary Hospital Level Mortality Indicator (SHMI)	Jul-15 to June 16	100	107.59	↓

HSMR is reported for the period October 2015 to September 2016. In January performance remains below expected at 93.32, a slight decline on last month's performance.

SHMI for the period July 2015 – June 2016 is as expected at 107.59.

4.4 CCG Serious Incident Management

Serious incidents reporting within the integrated performance report is in line with the CCG reporting schedule for Month 10.

There are a total of 120 serious incidents open on StEIS where South Sefton CCG are either lead or responsible commissioner. Of the 120, there were 89 applicable to South Sefton CCG patients and 31 for Aintree University NHS Foundation Trust (UHA), 7 of these from South Sefton CCG.

Aintree University Hospitals NHS Foundation Trust - 31 open Serious Incidents on StEIS with 1 reported in January 2017 making a total of 24 year to date. 25 remain open for >100 days. 4 cases are subject to Safeguarding Adult Board (SAB) processes (Liverpool, West Lancashire and Knowsley CCGs) and 1 subject to police investigation now completed with the CCG serious incident process now progressing.

Liverpool Community Health NHS Trust - 43 open serious incidents on StEIS affecting South Sefton CCG patients. 19 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 8 serious incidents reported in January 2017, a total of 41 year to date, 21 year to date relate to pressure

ulcers. The Trust has a composite pressure ulcer action plan in place; this continues to be monitored at the monthly Clinical Quality and Performance meeting.

Mersey Care NHS Foundation Trust - 19 incidents open on StEIS for South Sefton CCG patients, with 14 remaining open >100 days. 1 serious incident was reported in January 2017 making a total of 18 year to date. Two incidents reported in June relate to Secure Services and 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 in January with 29 compared to December recording 22 (+31.8%). Patient and/or family choice resulted in 9 delayed transfers (31%), a further 14 were due to delays incurred whilst awaiting further NHS non acute care (48%), 4 were due to awaiting care package in own home (14%), 1 due to completion of assessment (3%) and 1 due to community equipment/adaptations (3%).

Analysis of delays in January 2017 compared to January 2016 illustrates a 62% increase in total number of delays. The number of patients awaiting further NHS non-acute care has shown an increase of 7 (+50%) from the previous year and 6 more delays due to patient or family choice (+67%).

Delayed Transfers of Care April – January 2017

	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	Dec	Jan
A) COMPLETION ASSESSMENT	0	0	0	0	1	0	0	1	1	0	0	0	0	0	3	2	3	4	0	0	2	1
B) PUBLIC FUNDING	0	0	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	6	14
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	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	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	5	4
F) COMMUNITY EQUIPMENT/ADAPTIONS	2	1	0	0	0	1	0	0	0	1	1	1	1	0	1	1	0	0	0	0	0	1
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	9	9
H) DISPUTES	1	1	1	0	0	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	0	0
Grand Total	**20**	**22**	**24**	**13**	**16**	**20**	**27**	**24**	**17**	**11**	**18**	**30**	**33**	**30**	**36**	**35**	**32**	**33**	**18**	**23**	**22**	**29**

In terms of actions taken by the CCG to reduce the number of Delayed Transfers of Care within the acute setting, the Urgent 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.

Additionally, the Urgent Care Commissioning Lead attends a focused MADE (Multi Agency Discharge Event) on the Aintree site each Wednesday. The event focuses on a small number of themes associated with delayed discharges and seeks to achieve rapid change to systems and processes which have the potential to extend patients stay within the acute setting.

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: **Jan-17**

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	12.3%	16.7%		87%	80%		7%	11%	

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 Trust has recovered from a drop in performance in December reaching 16.7%, above the England average of 12.3%.

The percentage of people that would recommend A&E has recently fallen and is now under the England average reporting 80% in January compared to an England average of 87%. However this is an increase on December. The not recommended percentage follows a similar pattern with performance at 11% in January compared to a 7% average.

An alternative method for collecting data by text message was deemed unsuccessful. The Trust reverted back to using cards. Response rate was improving although not to levels seen previous to the pilot however January saw an increase in response rate for A&E reductions.

Aintree's Patient Experience Lead will provide an update in April to the CCG Engagement and Patient Experience Group. The Trust will provide feedback in how FFT serves to inform 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 have created a dashboard to incorporate information available from FFTs, complaints and compliments.

4.7 South Sefton Urgent Care Dashboard

An urgent care system dashboard has been developed by Dr Pete Chamberlain incorporating 12 key measures of urgent care. It forms part of a wider project to develop system-wide cascading dashboards to bring multiple indicators together to provide oversight of care in different settings.

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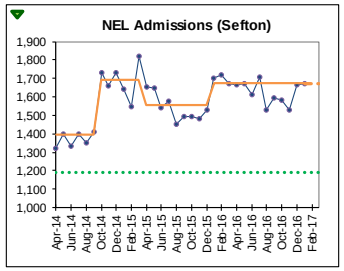
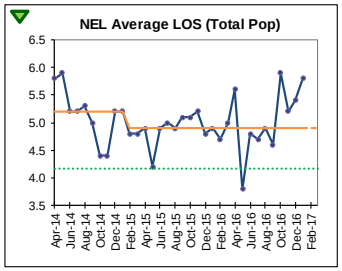
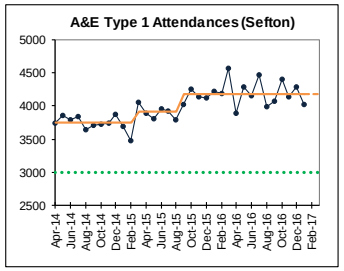
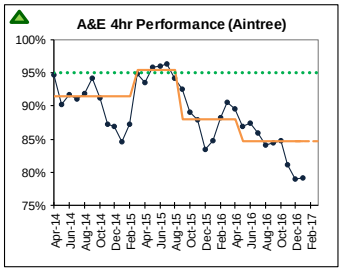
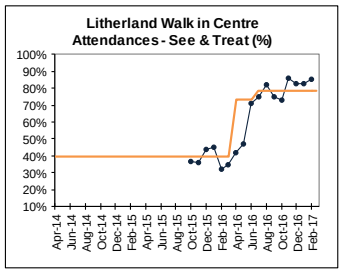
SOUTH SEFTON URGENT CARE DASHBOARD

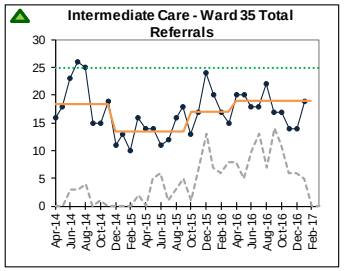


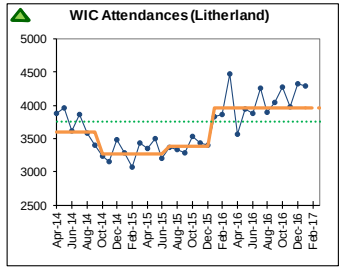


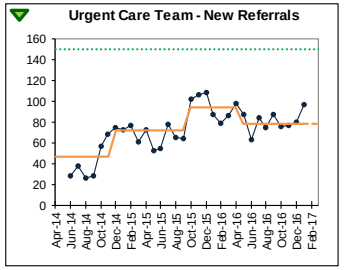


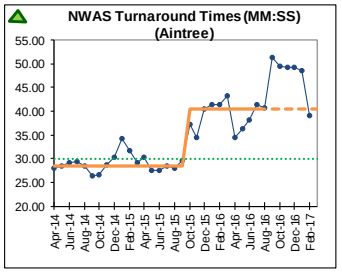


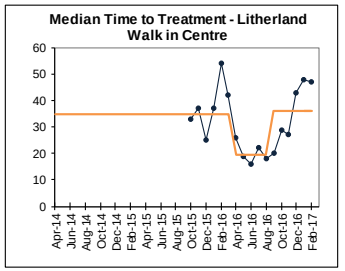


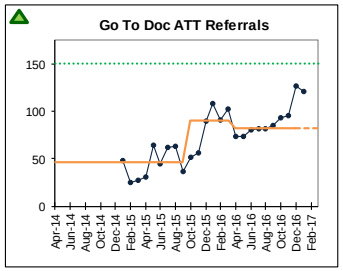


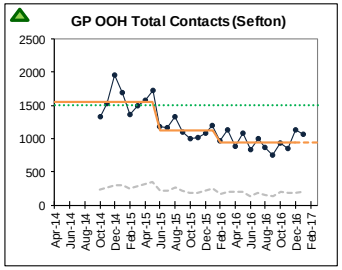


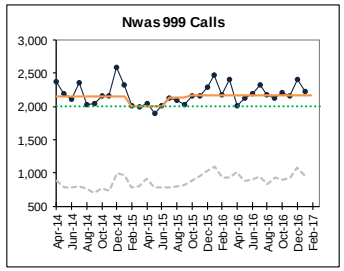


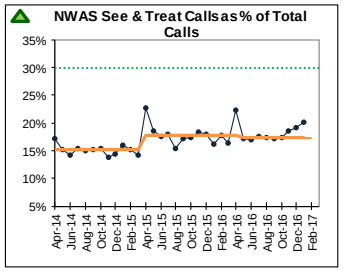












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Definitions

Measure	Description	Expected Directional Travel	
Non-Elective Admissions (O#1)	Spells with an admission method of 21-28 where the patient is registered to a South Sefton GP practice.	↓	Commissioners aim to reduce non-elective admissions by 15%
Non-Elective Admissions Length of Stay (O#2)	The average length of stay (days) for spells with an admission method of 21-28 where the patient is registered to a South Sefton GP practice.	↓	Commissioners aim to see a reduction in average non-elective length of stay.
A&E Type 1 Attendances (O#3)	South Sefton registered patients A&E attendances to a Type 1 A&E department i.e. consultant led 24 hour service with full resus facilities and designated accommodation for the reception of A&E patients.	↓	Commissioners aim to see fewer patients attending Type 1 A&E departments.
A&E 4hr % Aintree - All Types (O#4)	The percentage of A&E attendances where the patient spends four hours or less in A&E from arrival to transfer, admission or discharge. Refers to Aintree University Hospital Trust catchment activity across all A&E department types (including walk-in centres).	↑	Commissioners aim to improve A&E performance to ensure that it meets/exceeds the 95% target.
Walk-in Centre Attendances (P#1)	All attendances (irrespective of patient registered GP practice) to Litherland walk-in centre.	↑	Commissioners aim to see an increase in patients attending walk-in centres (thus avoiding Type 1 A&E departments where possible).
Urgent Care Team New Referrals (P#2)	New patients seen by the Community Urgent Care Team in South Sefton.	↑	Commissioners aim to see an increase in patients being referred to the Community Urgent Care Team.
Intermediate Care - Ward 35 Total Referrals (P#3)	New referrals for South Sefton patients to Ward 35 Intermediate Care Unit at Aintree University Hospital.	↑	Commissioners aim to see an increase in patients being referred to Ward 35 Intermediate Care Unit.
Go to Doc ATT Referrals (P#4)	All South Sefton referrals to the Alternative to Transfer (ATT) service.	↑	Commissioners aim to see an increase in referrals to the ATT service.
Go to Doc Out of Hours Activity (P#5)	Total contacts to the South Sefton out of hours provider.	↑	Commissioners aim to see an increase in out of hours contacts.
NWAS Turnaround Times - Aintree (P#6)	Average time of Ambulance arrival (geofence or button press) to Ambulance clear and available (of All attendances) at Aintree University Hospital.	↓	Commissioners aim to see a reduction in average turnaround times so that they are less than or meet the 30 minute standard.
NWAS 999 Calls (B#1)	South Sefton - The total number of emergency and urgent calls presented to switchboard and answered.	↓	Commissioners aim to see a decrease in the number of emergency calls.
NWAS Cat Red Calls (B#2)	South Sefton - A combination of Red 1 and Red 2 Calls. Red 1 refers to life-threatening requiring intervention and ambulance response. Red 2 refers to immediately life-threatening requiring ambulance response.	↓	Commissioners aim to see a decrease in the number of life-threatening emergency calls.
NWAS See & Treat Calls	South Sefton - The number of incidents, following emergency or urgent calls, resolved with the patient being treated and discharged from ambulance responsibility on scene. There is no conveyance of any patient.	↑	Commissioners aim to see an increase in the number of patients who can be seen and treated on scene (where possible) to avoid an unnecessary conveyance to hospital.

4.8 Unplanned Care Activity & Finance, All Providers

4.8.1 All Providers

Performance at Month 10 of financial year 2016/17, against unplanned care elements of the contracts held by NHS South Sefton CCG shows an under-performance of circa -£867k/-2%.This under-performance is clearly driven by Aintree Hospital reporting an under performance of -£714k/-2%. Alder Hey Hospital is reporting the largest year to date over performance with a £181/11% 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.

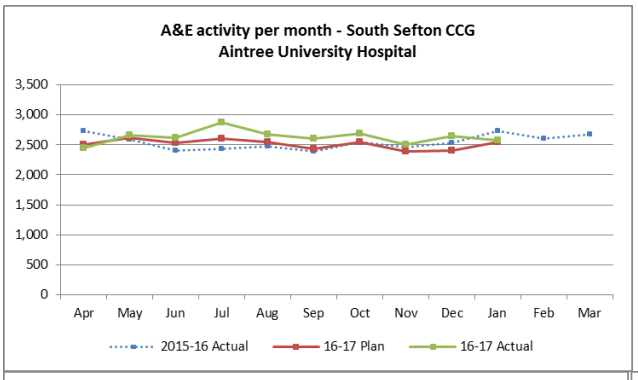
Figure 18 - Month 10 Unplanned Care – All Providers

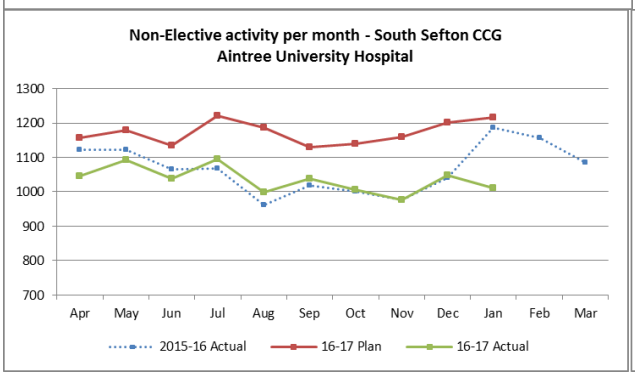
Provider Name	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	79,648	88,305	8,657	11%	£29,307	£28,593	-£714	-2%
Alder Hey Childrens NHS F/T	7,967	8,063	96	1%	£1,668	£1,849	£181	11%
Central Manchester University Hospitals Nhs Foundation Trust	56	50	-6	-10%	£14	£5	-£9	-63%
Countess of Chester Hospital NHS Foundation Trust	0	55	55	0%	£0	£21	£21	0%
Liverpool Heart and Chest NHS F/T	191	89	-102	-53%	£217	£242	£24	11%
Liverpool Womens Hospital NHS F/T	3,232	2,910	-322	-10%	£2,876	£2,787	-£90	-3%
Royal Liverpool & Broadgreen Hospitals	5,476	4,864	-612	-11%	£2,028	£1,728	-£300	-15%
Southport & Ormskirk Hospital	10,728	10,786	58	1%	£2,423	£2,413	-£10	0%
ST Helens & Knowsley Hospitals	740	838	98	13%	£299	£334	£35	12%
University Hospital Of South Manchester Nhs Foundation Trust	34	30	-4	-12%	£12	£13	£1	8%
Wirral University Hospital NHS F/T	204	176	-28	-14%	£74	£59	-£15	-21%
Wrightington, Wigan And Leigh Nhs Foundation Trust	35	36	1	3%	£13	£22	£9	74%
Grand Total	**108,311**	**116,202**	**7,891**	**7%**	**£38,932**	**£38,064**	**-£867**	**-2%**

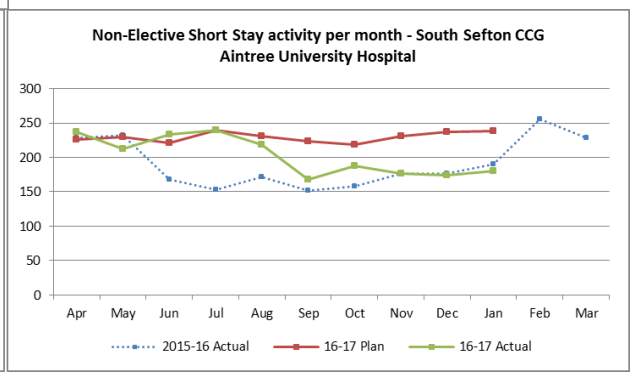
4.8.2 Aintree University Hospital NHS Foundation Trust

Figure 19 - Month 10 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	33,735	40,338	6,603	20%	£803	£803	£0	0%
A&E - *Accident & Emergency*	25,104	26,292	1,188	5%	£3,105	£3,275	£170	5%
NEL - *Non Elective*	11,687	10,322	-1,365	-12%	£22,330	£21,017	-£1,313	-6%
NELNE - *Non Elective Non-Emergency*	37	31	-6	-16%	£104	£103	-£1	-1%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	34	89	55	164%	£8	£19	£11	130%
NELST - *Non Elective Short Stay*	2,296	2,027	-269	-12%	£1,506	£1,430	-£77	-5%
NELXBD - *Non Elective Excess Bed Day*	6,755	9,206	2,451	36%	£1,451	£1,947	£496	34%
Grand Total	**79,648**	**88,305**	**8,657**	**11%**	**£29,307**	**£28,593**	**-£714**	**-2%**







4.8.3 Aintree Hospital Key Issues

Urgent Care under spend of -£714k is driven by a -£1.3m under performance in Non Elective activity. This under performance offsets the £496k 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 20 - NHS South Sefton CCG – Shadow PbR Cluster Activity

	NHS South Sefton CCG			
PBR Cluster	Caseload as at 31/01/2017	2016/17 Plan	Variance from Plan	Variance on 31/01/2016
0 Variance	110	88	22	13
1 Common Mental Health Problems (Low Severity)	54	42	12	19
2 Common Mental Health Problems (Low Severity with greater need)	29	22	7	4
3 Non-Psychotic (Moderate Severity)	137	217	(80)	(63)
4 Non-Psychotic (Severe)	292	215	77	76
5 Non-psychotic Disorders (Very Severe)	80	62	18	18
6 Non-Psychotic Disorder of Over-Valued Ideas	48	40	8	3
7 Enduring Non-Psychotic Disorders (High Disability)	277	192	85	73
8 Non-Psychotic Chaotic and Challenging Disorders	144	98	46	48
10 First Episode Psychosis	152	138	14	12
11 On-going Recurrent Psychosis (Low Symptoms)	381	433	(52)	(55)
12 On-going or Recurrent Psychosis (High Disability)	377	307	70	73
13 On-going or Recurrent Psychosis (High Symptom & Disability)	107	112	(5)	(7)
14 Psychotic Crisis	28	21	7	11
15 Severe Psychotic Depression	6	6	-	-
16 Psychosis & Affective Disorder (High Substance Misuse & Engagement)	38	34	4	6
17 Psychosis and Affective Disorder – Difficult to Engage	51	58	(7)	(3)
18 Cognitive Impairment (Low Need)	241	223	18	14
19 Cognitive Impairment or Dementia Complicated (Moderate Need)	453	505	(52)	(43)
20 Cognitive Impairment or Dementia Complicated (High Need)	415	332	83	86
21 Cognitive Impairment or Dementia (High Physical or Engagement)	141	76	65	53
Cluster 99	696	402	294	288
Total	4,257	3,623	634	626

5.1.1 Key Mental Health Performance Indicators

Figure 21 - 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	Dec-16	Jan-17
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%	96%	94%

There was 1 breach out of a total of 17 CPA discharges in South Sefton, this was due to a service user who moved into the Warrington area and a referral was made for Warrington services (5 Boroughs Partnership) to complete the 7 day follow up.

Figure 22 - 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	Dec-16	Jan-17
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%	100%	100%

Figure 23 - Figure 16 EIP 2 week waits

	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
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%	50.00%	50%	86%	100%	75%	83%	50%
Rolling Quarter				37.50%	50.00%	50%	73%	100%	86%	85%	50%

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 March 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 February 2017 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 that the RIO roll out has been put on hold due to 'technical issues' The CCGs are awaiting correspondence from Mersey Care that will provide more detail concerning this delay. 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.

5.2 Improving Access to Psychological Therapies

Figure 24 - Monthly Provider Summary including (National KPI s Recovery and Prevalence)

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	294	293	272	246	268	269	253	197	303		
2016/17 approx. numbers required to enter treatment to meet monthly Access target of 1.25%	*Target*	*303*	*303*	*303*	*303*	*303*	*303*	*303*	*303*	*303*	*303*	*303*	*303*
	Variance	*-21*	*-9*	*-10*	*-31*	*-57*	*-35*	*-34*	*-50*	*-106*	*0*		
	%	*-6.8%*	*-2.8%*	*-3.1%*	*-10.1%*	*-18.7%*	*-11.4%*	*-11.1%*	*-16.4%*	*-34.9%*	*0.2%*		
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%	0.8%	1.2%		
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	40.5%	38.2%	30.7%	38.6%	35.0%	41.3%	38.6%	41.5%	36.3%	40.6%		
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%	98.0%	98.8%		
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%	99.3%	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	166	162	156	165	146	170	161	210	151	167		
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	3	10	3	7	6	10	8	10	5	12		
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	66	58	47	61	49	66	59	83	53	63		
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	87.9%	89.4%	91.3%	84.2%	85.7%	84.2%	88.2%	83.0%	76.6%	81.3%		

The provider (Cheshire & Wirral Partnership) reported 303 South Sefton patients entering treatment in Month 10, which is a 54% increase to the previous month. This also represents the highest total of 2016/17 to date and is the only month where the monthly access target has been achieved (a similar profile was evident in 2015/16). 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 13.2% 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 428 Referrals in Month 10, which was an increase of 59% compared to the previous month. This is also the highest monthly total of 2016/17 to date. Of these, 59.3% were Self-referrals, which is the lowest monthly proportion of the year. GP Referrals increased to 100 compared to 66 for Month 9. 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 40.6% in Month 10, which does not meet the minimum standard of 50%. A forecast outturn at Month 10 gives a year end position of 38.3%, 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 an increase for the second consecutive month with 91 reported in Month 10 compared to 84 in Month 9.

There was an increase of 7% in DNAs in Month 10 (from 153 in Month 9 to 164 in Month 10); 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 ten months of 2016/17 for South Sefton CCG.

5.3 Dementia

Summmary for NHS South Sefton dementia registers at 31-01-2017

People Diagnosed with Dementia (Age 65+)	1,194
Estimated Prevalence (Age 65+)	2,091
Gap - Number of addition people who could benefit from diagnosis (all ages)	980
NHS South Sefton - Dementia Diagnosis Rate (Age 65+)	**57.1%**
National estimated Dementia Diagnosis Rate	67.4%

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 latest data on the NHS England site (in the above table) is not using the new methodology until April 2017; hence a lower rate than the new methodology will show.

6. Community Health

6.1 Liverpool Community Health Contract

The Trust continues to deliver this service and send through their usual reports until the new contract with Mersey care commences in June 2017.

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 15% in Jan-17, a slight improvement on last month's performance. Adult Dietetics is also high this month at 21.8% compared to 19.3% last month, as well as Paediatric Dietetics at 15.7% compared to 20% last month. Total DNA rates at Sefton are green for this month at 8%.

Provider cancellation rates remain relatively static this month with the exception of Paediatric Dietetics reporting an improvement at 2.8% compared to 18.2% last month. Total hospital cancellation rate for Sefton is green at 2.3% 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 January 2017. Total patient cancellations for Sefton have improved slightly in January 2017, decreasing from 11.5% to 10.8%.

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

Waiting times are reported a month in arrears. The following issues have arisen in December 2016;

Adult SALT: This service had issues with long waiting times at the beginning of the financial year. The Trust did work to improve this, and waiting times were reduced significantly between July and November 2016. However, December data shows that waiting times are beginning to increase again over the 18 week threshold, with an average (92nd percentile) wait on the incomplete pathway of 19 weeks and an average (95th percentile) wait of 20 weeks on the completed pathway. The longest waiting patient is currently at 22 weeks. 8 patients were breaching the 18 week target at this point compared to just 1 last month.

Physiotherapy: Waiting times have steadily increased over the past 6 months, resulting in this service failing the 18 week target again in December for completed pathways at 25 weeks. However performance on the incomplete pathway has improved from 20 weeks in November to 15 in December with 8 patients over 18 weeks compared to 47 last month. The longest waiter was 1 patient waiting at 28 weeks.

Occupational Therapy: Waiting times on the completed pathways (95th Percentile) have gradually increased over the past 4 months resulting in a breach of the 18 week target. An average of 21

weeks was reported in December, a slight improvement on last month. The longest waiter was at 24 weeks with the number of patients breaching remaining static.

Nutrition & Dietetics: Waiting times on the completed pathways have increased to 20 weeks from the 22 weeks reported in November, 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 31 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 December, on the incomplete pathway the average waiting time (92nd percentile) improved slightly from 36 weeks to 34 weeks, however this is still breaching the 18 week target. The longest waiting patient was waiting at **55 weeks**. This service has consistently breached the 18 week target since it began reporting in August, showing no signs of improvement.

6.2 Any Qualified Provider LCH Podiatry Contract

The trust continues to use the £25 local tariff. At Month 10 2016/17 the YTD costs for the CCG are £262,647 with attendances at 2,802. At the same time period last year the costs were £305,620 and attendances at 3,308.

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 CQPG.

A Quality Handover document has been developed with NHSE and stakeholders incorporating the Risk Profile Tool to share with the new community providers, this will be monitored at the new CQPGs. In addition

The following has occurred and continues regarding Quality Handover of LCH services:

- CCG represented at the NHSI Clinical Quality Oversight Group
- Quality Risk Profile Tool has been completed for a final time and agreed with commissioners, regulators and provider (separate agenda item at Quality Committee)
- Enhanced Surveillance document completed by NHSE with input from the CCG
- CCGs attended Quality Handover event on 16th March 2017

6.3 Southport and Ormskirk Trust Community Services

<u>EMIS Migration</u>

The Trust has migrated over from the old IPM clinical system to EMIS. However due to the contract transferring over to a different provider for June 2017 onwards, they did not commence phase 2 of this migration. Phase 2 was meant to ensure that all services were recording data properly and allow for any variances from previous activity to be investigated and accounted for. Due to limited staffing and the implementation of MCAS taking priority, phase 2 was delayed.

<u>New Community Provider</u>

The Trust is currently liaising with the new community provider, Lancashire Care, to arrange to share their instance of EMIS for a temporary period. Although concerns over information governance issues have been raised with regards to this proposal, it has been agreed that this is the only safe option for patients, to ensure that no records are lost during the handover. However this will mean that the level of detail in terms of reporting will be limited to basic information reporting such as contacts and referrals. The proposal will be for 6 months and in the meantime the receiving organisation, Lancashire Care, will be expected to take steps towards getting their own instance of EMIS.

Members of both the CCG BI team and the new provider's BI team have met on a couple of occasions to establish relationships and form an information sub group, which will be a monthly meeting where any data quality issues can be raised by either party. Initial discussions have been around improving on existing reports, firstly by making sure the quality of the data is to a high standard, and eventually moving towards creating new activity plans, waiting times targets, and key performance indicators.

7. Third Sector Contracts

Consultations and Impact Assessments are near completion with our Third Sector providers and letters requesting organisational documentation and details have been sent to all in order to enable the population of these NHS Standard Contracts for 2017-18. Commissioners are currently working with providers to tailor service specifications and activity expectations in line with local requirement and CCG plans. It is anticipated that all NHS Standard Contracts for Third Sector providers will be finalised prior to 1st April 2017.

8. Primary Care

8.1 Primary Care Dashboard progress

Work has been progressing throughout 2016/17 to develop a primary care dashboard to present through the Aristotle business intelligence portal. A draft version of the dashboard is currently being tested and reviewed with clinical leads and primary care leads to assess the content, format and functionality of the report. There are various "views" of the data, for CCG level users to view the indicators across the CCG area with the ability to drill to locality and practice level. A core set of indicators allowing benchmarking across a number of areas has been produced first (practice demographics, GP survey patient satisfaction, secondary care utilisation rates, CQC inspection status), followed by further indicators and bespoke information to follow in phase II of this dashboard. Another report requiring further development will allow individual practices to review individual patients where the practice may have been identified as an outlier in the benchmarking dashboard. It will allow patients to be identified to support local schemes for example A&E frequent attenders, alcohol related admissions etc.

Once the testing and review process is complete and the dashboard is live in Aristotle, information may 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.

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 25 - CQC Inspection Table

South Sefton CCG								
Practice Code	Practice Name	Date of Last Visit	Overall Rating	Safe	Effective	Caring	Responsive	Well-led
N84002	**Aintree Road Medical Center**	**n/a**	**Not yet inspected the service was registered by CQC on 20 July 2016**					
N84015	Bootle Village Surgery	03 August 2016	Good	Good	Good	Good	Good	Good
N84016	Moore Street Medical Center	17 June 2016	Good	Good	Good	Good	Good	Good
N84019	**North Park Health Center**	**n/a**	**Not yet inspected the service was registered by CQC on 20 July 2016**					
N84028	The Strand Medical Center	19 February 2015	Good	Good	Good	Good	Good	Good
N84034	Park Street Surgery	17 June 2016	Good	Good	Good	Good	Good	Good
N84038	Concept House Surgery	23 April 2015	Good	Good	Good	Good	Good	Good
N84001	42 Kingsway	07 November 2016	Good	Good	Good	Good	Good	Good
N84007	Liverpool Rd Medical Practice	10 November 2016	Good	Requires Improvement	Good	Good	Good	Good
N84011	Eastview Surgery	07 January 2016	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
N84020	Blundellsands Surgery	24 November 2016	Good	Good	Good	Good	Good	Good
N84026	Crosby Village Surgery	29 October 2015	Requires Improvement	Good	Good	Good	Good	Requires Improvement
N84041	Kingsway Surgery	07 November 2016	Good	Good	Good	Good	Good	Good
N84621	THORNTON - ASHURST HEALTHCARE LTD	19 February 2015	Good	Requires Improvement	Good	Good	Good	Good
N84627	Crossways Practice	06 August 2015	Good	Good	Good	Good	Good	Good
N84626	HIGHTOWN - ASHURST HEALTHCARE LTD	18 February 2016	Requires Improvement	Good	Good	Good	Good	Good
N84003	High Pastures Surgery	05 March 2015	Good	Requires Improvement	Good	Good	Good	Good
N84010	**Maghull Family Surgery (Dr Sapre)**	**n/a**	**Not yet inspected the service was registered by CQC on 20 July 2016**					
N84025	Westway Medical Center	23 September 2016	Good	Good	Good	Good	Good	Good
N84004	Glovers Lane Surgery	10 May 2016	Good	Good	Good	Good	Good	Good
N84023	Bridge Road Medical Center	15 June 2016	Good	Good	Good	Good	Good	Good
N84029	Ford Medical Practice	31 March 2015	Good	Good	Good	Good	Good	Good
N84035	15 Sefton Road	23 November 2016	Good	Requires Improvement	Good	Good	Good	Good
N84605	**Litherland Town Hall Hth Ctr (Taylor)**	**n/a**	**Not yet inspected the service was registered by CQC on 13 November 2014**					
N84630	**Netherton Health Center (Dr Jude)**	**n/a**	**Not yet inspected the service was registered by CQC on 21 July 2016**					

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

9. Better Care Fund

A Better Care Fund monitoring report was submitted to NHS England relating to Quarter 3 of 2016/17. The guidance for BCF 2017/18 is awaited but due for imminent release.

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.

A dashboard is released each quarter by NHS England consisting of sixty indicators. Performance is reviewed quarterly at CCG Senior Management Team meetings, and Senior Leadership Team, Clinical and Managerial Leads have been identified to assign responsibility for improving performance for those indicators. This approach allows for sharing of good practice between the two CCGs, and the dashboard is released for all CCGs nationwide allowing further sharing of good practice.

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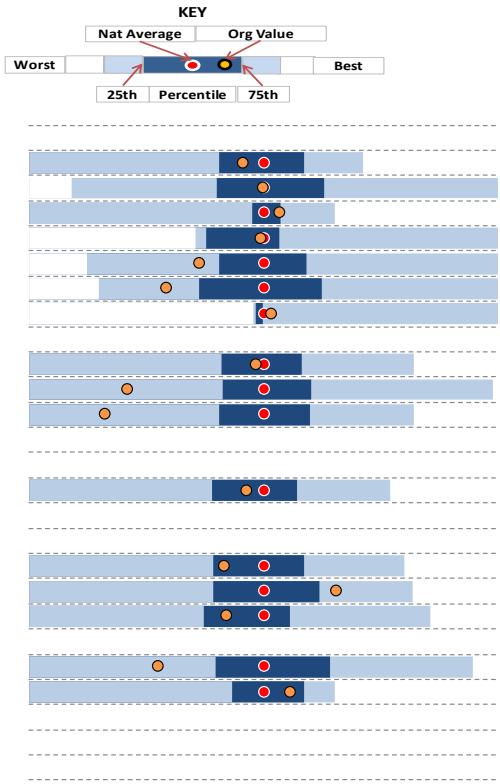
10.2 Q3 Improvement & Assessment Framework Dashboard

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...
	Better Health					
▼	Maternal smoking at delivery	Q2 16/17	12.3%	10.4%		L
◀▶	Percentage of children aged 10-11 classified as overweight or obese	2014-15	33.3%	33.2%		L
▼	Diabetes patients that have achieved all the NICE recommended treatment targets:	2014-15	42.4%	39.8%		H
▼	People with diabetes diagnosed less than a year who attend a structured education	2014-15	5.4%	5.7%		H
▼	Injuries from falls in people aged 65 and over	Jun-16	2,479	1,985		L
▲	Utilisation of the NHS e-referral service to enable choice at first routine elective	Sep-16	21.1%	51.1%		H
▲	Personal health budgets	Q2 16/17	31.0	18.7		H
▼	Percentage of deaths which take place in hospital	Q1 16/17	50.3%	47.1%		<>
▲	People with a long-term condition feeling supported to manage their condition(s)	2016	63.8%	64.3%		H
▲	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive	Q4 15/16	1,537	929		L
▼	Inequality in emergency admissions for urgent care sensitive conditions	Q4 15/16	3,643	2,168		L
▲	Anti-microbial resistance: appropriate prescribing of antibiotics in primary care	Sep-16	1.2	1.1		<>
▼	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in	Sep-16	7.9%	9.1%		<>
▲	Quality of life of carers	2016	0.79	0.80		H
	Better Care					
◀▶	Provision of high quality care	Q3 16/17	61.0			H
◀▶	Cancers diagnosed at early stage	2014	47.7%	50.7%		H
▼	People with urgent GP referral having first definitive treatment for cancer within 62	Q2 16/17	87.9%	82.3%		H
▲	One-year survival from all cancers	2013	69.1%	70.2%		H
◀▶	Cancer patient experience	2015	8.8			H
▲	Improving Access to Psychological Therapies recovery rate	Sep-16	40.2%	48.4%		H
▲	People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	Nov-16	85.7%	77.2%		H
▼	Children and young people's mental health services transformation	Q2 16/17	35.0%			H
◀▶	Crisis care and liaison mental health services transformation	Q2 16/17	42.5%			H
◀▶	Out of area placements for acute mental health inpatient care - transformation	Q2 16/17	12.5%			H



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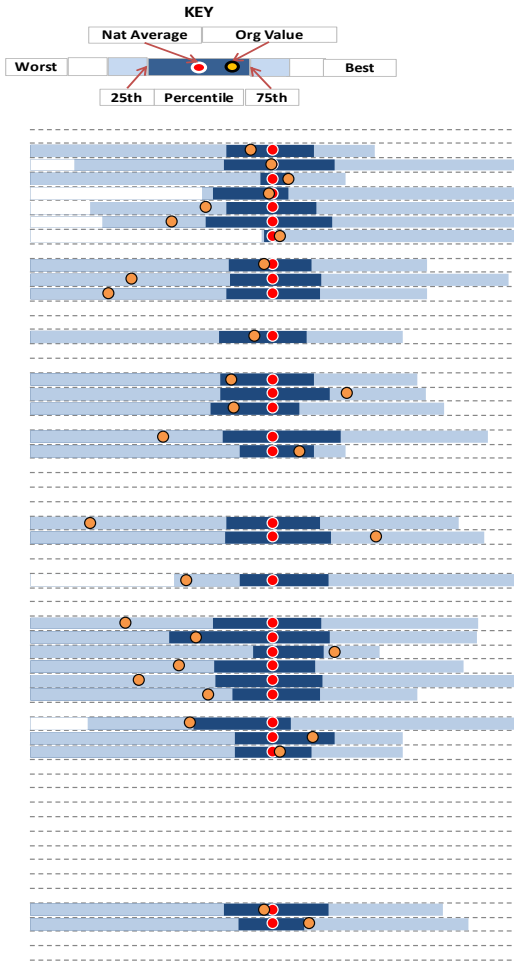
Please Note: If indicator is highlighted in GREY, this indicator will be available at a later date

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...
Reliance on specialist inpatient care for people with a learning disability and/or autism	Q2 16/17	66			L
Proportion of people with a learning disability on the GP register receiving an annual health check	2015/16	10.4%	37.1%		H
Neonatal mortality and stillbirths	2014-15	4.5	7.1		L
Women's experience of maternity services	2015	81.2			H
Choices in maternity services	2015	67.0			H
Estimated diagnosis rate for people with dementia	Nov-16	56.6%	68.0%		H
Dementia care planning and post-diagnostic support	2015/16	73.9%			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	Nov-16	84.4%	88.4%		H
Delayed transfers of care per 100,000 population	Nov-16	7.2	15.0		L
Population use of hospital beds following emergency admission	Q1 16/17	1.2	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 access	Q3 16/17	0.0%			H
Primary care workforce	H1 2016	0.9	1.0		H
Patients waiting 18 weeks or less from referral to hospital treatment	Nov-16	92.3%	90.6%		H
People eligible for standard NHS Continuing Healthcare	Q2 16/17	43.7	46.2		<>
Sustainability					
Financial plan	2016	Amber			<>
In-year financial performance	Q2 16/17	Red			<>
Outcomes in areas with identified scope for improvement	Q2 16/17	CCG not include			H
Expenditure in areas with identified scope for improvement	Q2 16/17	Not included in '			H
Local digital roadmap in place	Q3 16/17	Yes			<>
Digital interactions between primary and secondary care	Q3 16/17	60.0%			H
Local strategic estates plan (SEP) in place	2016-17	Yes			<>
Well Led					
Probity and corporate governance	Q2 16/17	Fully compliant			H
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			H
Quality of CCG leadership	Q2 16/17	Green			<>



NHS South Sefton Clinical Commissioning Group

Appendix – Summary Performance Dashboard

Aristotle Business Intelligence

South Sefton CCG - Performance Report 2016-17

NHS Midlands and Lancashire Commissioning Support Unit

Metric	Reporting Level		2016-17 Q1 Apr	Q1 May	Q1 Jun	Q2 Jul	Q2 Aug	Q2 Sep	Q3 Oct	Q3 Nov	Q3 Dec	Q4 Jan	YTD
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	G	G
		Actual	94.772%	94.697%	95.563%	96.604%	96.918%	97.661%	94.505%	95.971%	95.879%	94.005%	95.703%
		Target	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
1879: % Patients seen within two weeks for an urgent GP referral for suspected cancer (QUARTERLY) The % 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
		Actual	95.021%			96.99%			95.489%				95.832%
		Target	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	G	G
		Actual	100.00%	96.078%	89.091%	94.118%	94.34%	95.455%	90.00%	92.727%	96.104%	95.522%	94.272%
		Target	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
1880: % of patients seen within 2 weeks for an urgent referral for breast symptoms (QUARTERLY) 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			G				G
		Actual	95.062%			94.706%			93.145%				94.138%
		Target	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	G	G
		Actual	96.61%	98.305%	98.387%	100.00%	98.795%	100.00%	98.507%	96.471%	98.529%	96.97%	98.222%
		Target	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
1881: % of patients receiving definitive treatment within 1 month of a cancer diagnosis (QUARTERLY) 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
		Actual	97.253%			99.522%			97.727%				98.20%
		Target	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	R	G
		Actual	90.909%	100.00%	100.00%	91667%	100.00%	100.00%	100.00%	100.00%	100.00%	91667%	97.087%
		Target	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
1882: % of patients receiving subsequent treatment for cancer within 31 days (Surgery) (QUARTERLY) 31-Day Standard for Subsequent Cancer Treatments where the treatment function is (Surgery)	South Sefton CCG	RAG	G			G			G				G
		Actual	96.774%			96.552%			100.00%				97.802%
		Target	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	R	G
		Actual	100.00%	100.00%	100.00%	94.737%	100.00%	100.00%	100.00%	100.00%	100.00%	93.75%	98.739%
		Target	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
1883: % of patients receiving subsequent treatment for cancer within 31 days (Drug Treatments) (QUARTERLY) 31-Day Standard for Subsequent Cancer Treatments (Drug Treatments)	South Sefton CCG	RAG	G			G			G				G
		Actual	100.00%			98.734%			100.00%				99.446%
		Target	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	R	G
		Actual	100.00%	93.333%	100.00%	91667%	95.238%	93.548%	100.00%	100.00%	100.00%	90.909%	96.50%
		Target	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
1884: % of patients receiving subsequent treatment for cancer within 31 days (Radiotherapy Treatments) (QUARTERLY) 31-Day Standard for Subsequent Cancer Treatments where the treatment function is (Radiotherapy)	South Sefton CCG	RAG	G			R			G				G
		Actual	97.674%			93.75%			100.00%				97.125%
		Target	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	R	R	G
		Actual	88.462%	91429%	92.105%	90.323%	86.957%	86.667%	96.97%	81818%	77.778%	83.333%	87.842%
		Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
1885: % of patients receiving 1st definitive treatment for cancer within 2 months (62 days) (QUARTERLY) 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
		Actual	90.099%			87.85%			87.097%				88.372%
		Target	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%
1886: % of patients receiving treatment for cancer within 62 days from an NHS Cancer Screening Service (QUARTERLY) 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
		Actual	100.00%			100.00%			100.00%				100.00%
		Target	90.00%			90.00%			90.00%			90.00%	90.00%

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	R	R
		Actual	76.47%	74.28%	73.06%	70.45%	72.60%	69.49%	64.59%	62.80%	61.63%	61.79%	68.289%
		Target	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	R	R
		Actual	76.56%	78.00%	74.50%	71.43%	72.92%	77.55%	62.50%	68.89%	66.67%	59.68%	70.589%
		Target	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	NORTH WEST AMBULANCE SERVICE NHS TRUST	RAG	R	R	R	R	R	R	R	R	R	R	R
		Actual	67.46%	66.26%	66.20%	62.69%	65.25%	61.75%	63.05%	60.35%	57.31%	58.78%	62.746%
		Target	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	R	R	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%	49.50%	55.52%	59.708%
		Target	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	NORTH WEST AMBULANCE SERVICE NHS TRUST	RAG	R	R	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%	85.42%	85.74%	88.983%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
	South Sefton CCG	RAG	G	R	R	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%	83.77%	87.67%	90.236%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

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		G
		Actual	98.14%	98.00%	96.72%		97.576%
		Target	95.00%	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	G	G
		Actual	0.00%	100.00%	33.333%	50.00%	50.00%	85.714%	100.00%	75.00%	83.333%	50.00%	67.647%
		Target	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	G	G	R
		Actual	0	0	0	1	4	0	3	0	0	0	8
		Target	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	R	G	G		R
		Actual	-	-	-	0.25	1.01	-	0.35	-	-		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

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	R	G	G
		Actual	94.954%	95.213%	93.919%	93.33%	92.354%	91.272%	91.919%	92.263%	91.289%	92.658%	92.939%
		Target	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	G	G	R
		Actual	1	0	1	0	0	0	0	0	0	0	2
		Target	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	R	R	G
		Actual	0.748%	1.001%	0.494%	0.711%	1.418%	0.527%	0.403%	0.85%	1.792%	1.211%	0.914%
		Target	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%

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	G	G
		Actual	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0

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	R	R
		YTD	0	0	0	0	0	1	1	1	1	3	3
		Target	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	G	G
		YTD	3	9	14	18	23	27	29	36	38	39	42
		Target	5	11	14	18	23	28	34	39	43	45	48

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	R	R
		Actual	90.124%	88.35%	89.13%	87.648%	86.873%	86.836%	87.066%	84.323%	82.247%	82.611%	86.501%
		Target	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	R	R
		Actual	89.484%	86.885%	87.505%	85.955%	84.103%	84.458%	84.763%	81.108%	79.046%	79.251%	84.225%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
1927: A&E Attendances: All Types Number of attendances at all A&E depts	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RAG	G	R	R	R	R	R	R	R	R	R	R
		YTD	12,667	26,315	39,928	54,353	67,997	81,689	95,701	108,648	122,574	136,454	136,454
		Target	13,065	25,953	38,549	51,546	63,742	75,688	88,051	100,015	112,407	124,538	124,538
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	R	R
		Actual	5	0	0	0	2	2	1	0	5	34	49
		Target	0	0	0	0	0	0	0	0	0	0	0

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MARCH 2017

Agenda Item: 17/48	**Author of the Paper:** Davina Hanlon Consultant in Public Health, Sefton Council Email: Davina.Hanlon@sefton.gov.uk Tel: 0151 934 3175
Report date: March 2017	

Title: Memorandum of Understanding (MOU) between Sefton Council Public Health and NHS Southport and Formby Clinical Commissioning Group

Summary/Key Issues:

To seek approval from the Governing Body to the Memorandum of Understanding (MOU) between Sefton Council Public Health (the Council) and NHS Southport and Formby Clinical Commissioning Group

Recommendation

The Governing Body is asked to approve this report.

Receive	
Approve	X
Ratify	

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

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement			X	
Clinical Engagement		X		
Equality Impact Assessment			X	
Legal Advice Sought	X			From the council - the MOU describes a mutually beneficial agreement between the Council's public health function and the CCG's. It expresses a convergence between the parties, indicating an intended common line of action in this case for the effective and efficient commissioning of health care services to secure improvements in health and to reduce health inequalities amongst the Sefton population. It is not intended to imply a legal commitment.
Resource Implications Considered	X			There are no resource implications
Locality Engagement			X	
Presented to other Committees	X			Report to Councillor Moncur, Health and Wellbeing Briefing Meeting on 7th November 2016. Published as a "Decision" on Council Website in January 2017

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
March 2017

1. Executive Summary

The purpose of this MOU is to establish a framework for relationships between the Council's Public Health functions and the CCG ***outlining the expectations and responsibilities of each party and the principles and ways of working. It will be accompanied by an agreed CCG-Council Public Health work plan for each year.***

The benefits of an MOU include clarity around an agreed annual work programme across both parties (within available resources); and efficient use of these resources (campaigns; data).

2. Introduction and Background

The Health and Social Care Act (2012) (the Act) established new arrangements in England for health improvement, health protection and for commissioning health services.

The Act gave local authorities statutory duties to improve the health of the population from April 2013. CCGs also have a duty to secure improvement in health and to reduce health inequalities, utilising the role of health services. This requires joint action between the Council and the CCGs along the entire care pathway from prevention and early years to end of life.

Joint action also supports system level prevention, health promotion and health protection opportunities in the emerging Sustainability and Transformation Plan for Cheshire and Merseyside. A good example of this is ensuring a system wide approach to 'Making Every Contact Count' to ensure key health messages are joined up, and to foster a holistic approach to the broader prevention agenda.

Nationally joint action supports the ambitions set out in the Five Year Forward View, published in October 2014, with a specific focus on making improvements to the health and wellbeing of the population.

Locally, joint action is also a prerequisite to supporting "Making Integration Happen: Sefton's Health and Social Care Integration Strategy 2016-2020", which identifies six commissioning priority areas for review, with a strong focus on public health and prevention.

3. Recommendations

The Governing Body approve the MOU, attached as an Appendix

Appendix

Memorandum of Understanding (MOU) between Sefton Council Public Health and NHS South Sefton and NHS Southport and Formby Clinical Commissioning Groups

Name **Davina Hanlon**
Title **Consultant in Public Health, Sefton Council**
Month **March 2017**

NHS South Sefton Clinical Commissioning Group

NHS South Sefton Clinical Commissioning Group

Sefton Council

NHS Southport and Formby Clinical Commissioning Group

Memorandum of Understanding

Between

Sefton Council (Public Health)

And

NHS South Sefton Clinical Commissioning Group and NHS Southport and Formby Clinical Commissioning Group (CCGs)

March 2017

NHS
South Sefton
Clinical Commissioning Group

Memorandum of Understanding

Between
Sefton Council (Public Health)
And
NHS South Sefton Clinical Commissioning Group and NHS Southport and Formby Clinical Commissioning Group

1. Purpose and Scope

The purpose of this Memorandum of Understanding (MOU) is to establish a framework for relationships between Sefton Council (the Council) Public Health and NHS South Sefton Clinical Commissioning Group and NHS Southport and Formby Clinical Commissioning Group (CCG's) ***outlining the expectations and responsibilities of each party and the principles and ways of working. It will be accompanied by an agreed CCG-Council Public Health work plan for each year.***

This framework recognises that the provision of good quality health care services plays a key role in improving population health outcomes and in reducing health inequalities. The Health and Social Care Act (2012) (the Act) established new arrangements in England for health improvement, health protection and for commissioning health services.

2. Context

Health Improvement:

The Act gave local authorities statutory duties to improve the health of the population from April 2013. CCGs also have a duty to secure improvement in health and to reduce health inequalities, utilising the role of health services. This requires joint action between the Council and the CCGs along the entire care pathway from prevention and early years to end of life. Prevention is also a key theme within the Local Delivery Systems (LDS).

Health Protection:

Under the Act, the Council must appoint a Director of Public Health (DPH) who has local responsibilities in respect of health protection, in conjunction with Public Health England. These include preventing and responding to outbreaks of communicable disease, planning for and mitigating the effects of environmental hazards, and NHS resilience. The Act gave CCGs a duty to ensure that they are properly prepared to deal with relevant emergencies.

Health Care Public Health:

The functions that public health will offer to the CCGs within this domain are outlined in guidance by the Department of Health (Healthcare Public Health Advice to Clinical Commissioning Groups, June 2012). This relates to public health input to the

commissioning of health services, improving quality and evidence of effectiveness and improving care pathways.

IT IS AGREED AS FOLLOWS:

A. Principles and Values

The Council and the CCGs will

- Work in partnership to achieve agreed outcomes and ensure that a productive and constructive relationship continues to be developed and maintained
- Recognise and respect each other's roles in improving the health of the population and reduce health inequalities
- Support each other in finding the most efficient ways to deliver project requirements.
- Put patients /service users / citizens at the heart of all collaborative work
- Be honest, constructive and communicative in all dealings with each other.
- Have reasonable expectations of each other, consistent with Public Health / CCGs operating model.
- Use the content and terms of this MOU to help in resolving any conflicts that arise in the working relationship.
- Be responsive to each other's needs during the year, within the flexibility of a planned programme of work (as described in an annual work plan).
- Commit to working closely on matters that require consistency across organisations eg campaigns; dealing with the media in relation to specific incidents; LDS work.
- Owe each other a duty of confidentiality regarding business sensitive issues.

B. Objectives

The Council and the CCGs will work together

- to deliver improvements in the health of the borough's population, through disease prevention, health improvement, health protection and commissioning health services;
- to maintain performance against locally agreed outcome measures and priorities;
- to ensure that local commissioning fully reflects the population perspective;

- to implement a mutually agreed joint work plan to deliver both NHS commissioning and Public Health priorities for the local population as set out in the Sefton Strategic Needs Assessment and Health and Well-Being Strategy.

C. Governance and Accountability

- The **joint CCG / Public Health senior leadership group** will be the governing body for this agreement.

- The **Director of Public Health (DPH) or nominated representative** will attend the Clinical Commissioning Groups Governing Body, as a non-voting member, to provide public health advice, support and challenge to commissioning discussions and decision-making.

- The DPH or nominated representative may attend other CCG committees, if requested.

- There will be **one named Public Health consultant** to act as the key relationship manager to the CCG and **one named senior lead** to link with from the CCG.

- The CCG will designate named **clinical leads** for population health

- The work-plan will be developed by negotiation and be based on CCG and public health and Council priorities drawn from respective commissioning intentions and strategies, including the Sefton Health and Wellbeing Strategy, Sefton 2030, Shaping Sefton, Making Integration Happen: Sefton's Health and Social Care Integration Strategy 2016-2020 and the Cheshire and Merseyside Sustainability and Transformation Plan (STP)

3. The "Core Offer"

Population Healthcare/ Health Services

This core offer is based on the Department of Health issued guidance (July 2012) and includes the generic activities listed below. The specific offer is defined and limited by the work-plan, which is mutually agreed and consistent with the needs and capacity of the CCGs and Public Health.

The Council will

- Provide specialist, objective public health advice to the CCGs in its strategic, commissioning and decision-making processes.

- Assess the health needs of the local population, through use and interpretation of data and other sources of intelligence, and analysis of how the needs can best be met using evidence-based interventions.

- Contribute towards the Sefton strategic needs assessment (SSNA)
- Support actions within the commissioning cycle to prioritise and reduce health inequalities and better meet the needs of vulnerable/ excluded communities
- Support the clinical effectiveness and quality functions of the CCGs, including input into assessing the evidence in commissioning decisions and individual funding requests, e.g. NICE or other national guidance, critical appraisal and evidence review, effective use of resources.
- Support the CCGs in its work in developing health care strategies, evidence based care pathways, service specifications and quality indicators to monitor and improve patient outcomes.
- Provide support to the CCG's QIPP (Quality Innovation Productivity Prevention) programme and other strategic commissioning plans and processes.
- Assist in the process for setting priorities or making decisions about best use of scarce resources, for example through decision-making frameworks, benchmarking/ 'comparative effectiveness' approaches linked to population need.
- Support the CCGs in the achievement of NHS Outcomes Framework indicators, particularly as regards action on Domain One – preventing people from dying prematurely, and in support of its contribution to the Public Health Outcomes Framework.
- Support the development of Public Health skills for CCG staff eg MECC
- Promote and facilitate joint working with local authority and wider partners to maximise health gain through integrated commissioning practice and service design.
- Contribute to the development of and professional support for the Sefton Health and Wellbeing Board and Health and Wellbeing Strategy.
- Provide support in relation to individual funding requests.

The CCGs will:

- Seek specialist Public Health advice to ensure that prioritisation and decision making processes are robust and based on population need, evidence of effectiveness and cost effectiveness.
- Work with the Council to develop its Public Health commissioning intentions in line with the HWB priorities, as informed by the SSNA.

- Utilise specialist Public Health skills to identify and understand high risk and/or under-served populations in order to target services at greatest population need and towards a reduction of health inequalities

- Utilise specialist Public Health skills to support development of its commissioning strategies, pathways and service improvement plans

- Contribute intelligence and capacity to the production of the SSNA, including through data-sharing agreements and support for key public health programmes eg NHS Health Checks and substance misuse services.

- Ensure necessary arrangements are in place to enable the Council to deliver the core Public Health offer and facilitate joint working,

Health Improvement

The Council will:

- Support primary care to deliver health improvements (appropriate to its provider healthcare responsibilities)–e.g. by offering training opportunities for staff and through targeted health behaviour change programmes and services

- Ensure commissioned health improvement services support the CCGs in its role of improving health and addressing health inequalities

- Support health improvement partnership working between the CCG, local partners and residents through the Health and Well-Being Board, to integrate and optimise local efforts for health improvement and disease prevention

The CCGs will:

- Contribute to strategies and action plans to improve health and reduce health Inequalities

- Encourage constituent practices to maximise their contribution to disease prevention – e.g. by taking every opportunity to encourage uptake of screening opportunities; Health Checks; flu vaccination programme etc

- Encourage constituent practices to maximise their contribution to health improvement – e.g. by taking every opportunity to address smoking, alcohol, drugs, hypertension and obesity in their patients and by optimising management of long term conditions

- Ensure primary and secondary prevention are included within all commissioned pathways

- Commission to reduce health inequalities and inequity of access to services

- Support and contribute to local, regional and national Public Health campaigns

Health Protection

The Council will:

- Assure that local strategic plans are in place for responding to the full range of potential emergencies – e.g. pandemic flu, major incidents and provide assurance to PHE regarding the arrangements
- Assure that these plans are adequately tested
- Assure that the CCG has access to these plans and an opportunity to be involved in any exercises
- Assure that the capacity and skills are in place to co-ordinate the response to emergencies, through strategic command and control arrangements
- Assure adequate advice is available to the clinical community via Public Health England and any other necessary route on health protection and infection control issues
- Keep the CCG and other local partners appraised of local and national health protection arrangements as details are made available by Public Health England through communications and the Sefton Health Protection Forum.

The CCGs will:

- Familiarise themselves with strategic plans for responding to emergencies
- Participate in emergency planning exercises when requested to do so
- Ensure that provider contracts include appropriate business continuity arrangements
- Support EPRR (Emergency Preparedness, Resilience and Response) activity, to ensure that health providers engage in contingency and business continuity planning, to ensure as far as possible their continued operation during a crisis.
- Ensure that providers have and test business continuity plans and emergency response plans covering a range of contingencies
- Assist with co-ordination of the response to emergencies, through local command and control arrangements

- Ensure that resources are available to assist with the response to emergencies, by invoking provider business continuity arrangements and through action by constituent practices

- Encourage constituent practices to maximise their contribution to health protection, e.g. by taking every opportunity to promote the uptake of screening and providing immunisations.

- Contribute to the assurance role of the Sefton Health Protection Forum

Term

This agreement commences on the date signed by both parties and will continue thereafter subject to an annual review and refresh or until reviewed by mutual agreement.

Signature:	Signature:
Date:	Date:
Matthew Ashton **Director of Public Health** **Sefton Council (the Council)**	**Fiona Taylor** **Chief Officer** **S&FCCG & SSCCG (CCG's)**

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MARCH 2017

Agenda Item: 17/49	**Author of the Paper:** Liverpool CCG Karl McCluskey Chief Strategy & Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk Tel: 0151 247 7251
Report date: March 2017	

Title: Single Service, System Wide Delivery: Overview

Summary/Key Issues:

This paper summarises the Healthy Liverpool Programme and describes the approach being taken by Liverpool CCG to develop a more integrated Hospital System across Liverpool City & North Mersey which is described as a "single system" with underpinning principles. The case for change is set out with supporting opportunities.

Priorities workpieces on clinical standards are described with specific reference to Orthopaedics, which the Governing Body has considered previously. The review of Liverpool Womens NHS Foundation Trust is also referenced as part of this system approach along with Electronic Patient Records and the Merger of the Royal Liverpool and Aintree.

Recommendation

To receive this paper on behalf of Liverpool CCG and note the system approach to transformation that is set out.

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.

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				

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

HEALTHY LIVERPOOL TRANSFORMING THE HEALTH OF OUR CITY

Single Service, System Wide Delivery

Overview Paper

1. Healthy Liverpool Background

The 2013 Mayoral Health Commission set out a vision for an integrated health and social care system for Liverpool, with prevention and self-care at its core. NHS Liverpool Clinical Commissioning Group took up the challenge of delivering the recommendations of the Commission. Healthy Liverpool will realise this vision for improved health and wellbeing and a sustainable health and care system.

This paper is intended to remind readers of the Healthy Liverpool **hospitals** vision for "a centralised University Teaching Hospital Campus with a single service, system-wide delivery, through centres of clinical and academic excellence." The case for change for single service, city wide adult acute services has been clearly articulated in the Healthy Liverpool "Prospectus" and subsequent "Blueprint"..

This vision is now being translated into implementation plans. The wider North Mersey health economy has embraced Heathy Liverpool's intentions around service reconfigurations. We must address the duplication and fragmentation of service delivery that has led to unwarranted variation in the quality of care. Our aim is to ensure clinical and financial sustainability with services provided as local as practicable and centralised where necessary.

North Mersey is a unique health economy with 2 major university teaching hospitals fewer than six miles apart acting as district general hospitals for the City along with 5 separate specialist providers serving a broader population base and 3 further general hospitals within ten miles. The commissioning landscape is represented by four CCG commissioners - NHS Liverpool CCG, NHS South Sefton CCG, NHS Knowsley CCG and Southport and Formby CCG, 3 local authorities – Liverpool, Sefton and Knowsley and NHS England Specialised Commissioning. The North Mersey footprint includes 9 provider trusts:

- Liverpool Community Health NHS Trust
- Aintree University Hospital NHS Foundation Trust
- Liverpool Heart and Chest Hospital NHS Foundation Trust
- Clatterbridge Cancer Centre NHS Foundation Trust
- Royal Liverpool and Broadgreen University Hospitals NHS Trust
- Walton Centre NHS Foundation Trust
- Alder Hey Children's NHS Foundation Trust
- Liverpool Women's NHS Foundation Trust
- Mersey Care NHS Foundation Trust

It is widely accepted that the North Mersey hospital system has too many hospital trusts delivering care from too many sites to be either clinically or financially sustainable. The Mayoral Health Commission advocated for the "…reduction of duplication and unnecessary competition (particularly in secondary care) and for the restructuring of care in all settings to improve the patient pathway and quality of care." This was adopted as the direction of travel by Healthy Liverpool, the whole-system programme that was established to deliver this transformation on behalf of all partners. There is ongoing consideration as to how the next iteration of service reconfiguration would transition into a more formalised North Mersey arrangement.

The challenges we face in the North Mersey hospital system are significant and if left unaddressed will undermine service delivery, sustainability and health outcomes. We must find new and innovative ways to deliver better services at lower cost if we are to ensure clinical and financial sustainability for our hospital system, and meet the future needs of our population. We also need to create financial and workforce capacity to enable a shift of care from acute to community settings where appropriate.

The university hospital trusts and specialist trusts across the region have been working together more closely over recent years. Aintree University Hospital NHS Trust (AUH) and Royal Liverpool & Broadgreen University Hospitals NHS Trust (RLBUH) have come together to deliver Major Trauma services and joint venture partnerships have been established for both Vascular and Clinical Laboratory Services. AUH, RLBUH and Liverpool Women's NHS Foundation Trust (LWH) have also collaborated to produce the full business case for a single IT system and Electronic Patient Record (EPR). These partnerships have highlighted a consistent clinical view that joint working is essential to improve patient outcomes and to sustain clinical services in the local health economy. This paper describes how single services between local providers of care will develop. It describes the opportunities for the trusts to deliver substantial patient benefits and to maintain the long term clinical and financial sustainability of adult hospital services across the city by working together.

2. The changing context

The Five Year Forward View (5YFV) sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health. It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions

we need to take to provide better care, better value and better health to our local population.

Growing demand for services is placing substantial and increasing strain on the health and social care system and, in particular, acute hospital services. The scale of the challenge facing the health and social care system is widely recognised and clinicians are vigorously pursuing a number of integrated service models which will drive radical change and reconfiguration in the health and social care system as a whole, and particularly in the acute sector.

For hospital services, a key current focus is to ensure that patients have access to hospital care, delivered by consultants with the requisite sub-specialty skills, 7-days a week, and (where appropriate) 24-hours a day. New, nationally set clinical standards for 7-day working, present all small-medium sized acute providers, with challenges and a potential need for investment with no prospect of additional income.

Trusts in the city have a track record of providing high quality care as evidenced by CQC reports; however, emerging clinical standards will be very difficult indeed for each Trust to meet independently due to the current fragmentation of many clinical services.

Healthy Liverpool Vision

The Healthy Liverpool vision aims for "a healthcare system in Liverpool that is person-centred, supports people to stay well and provides the very best care." It aims are:

- To improve health outcomes for people in Liverpool relative to the rest of England and to reduce health inequalities within the city;
- To ensure that the quality of healthcare is consistent and first class; and,
- To create a new model of care that is clinically and financially sustainable.

The single service model is centred on the principle of a central university teaching hospital campus on the site of the new Royal Liverpool University Hospital and Clatterbridge Cancer Care Centre, providing an axis against which specialised and general services can be built. This model for hospital services will see delivery of specialised and general services delivered from a network of centres, including the centralised campus site and neighbouring District General Hospitals, alongside the shift to more services being provided by hospitals in neighbourhoods across the city. This will bring health and academia together in one location, allowing maximum advantage of the city's research and development capabilities.

The plan for hospital care to be delivered as a single service, by single teams, across the city will reduce variation and improve patient care, while allowing us to

find long-term solutions to some of the shared challenges we face, particularly around workforce and finance. By transforming hospital services we aim to:

- Have the best hospital care system in the country
- Have all patients receive the right care in the right place first time
- Have a safe health care system that is sustainable clinically and financially into the future
- Maximise patient outcomes and experience

This transformation is based on the following principles:

- Services will be delivered by single teams
- Services will be of high quality, delivered to consistent best practice standards and unwarranted variation will be eliminated
- Services will be local whenever practicable, central where necessary
- Services will be delivered by a workforce that is sustainable, motivated and champions improved patient care, experience and outcomes.

Variation in clinical services means that patients do not always get the best possible care; the Healthy Liverpool Programme is aiming to address this by adopting single service pathways across organisations and hospital sites.

A 'single service' will be underpinned by:

- Single clinical leadership and unified governance arrangements
- Combined medical and senior nursing workforce; delivering standardised patient pathways
- Standard operating procedures and clinical policies
- A single performance management framework
- Combined training, education and research arrangements
- A single shared patient record
- Single point of referral

Our focus for single service, system wide delivery for hospital services is primarily on the major trusts that provide adult services in the city. Hospital transformation also recognises the importance of hospital care for children, delivered by Alder Hey Children's NHS Foundation Trust. We recognise the importance of transitional care, specialist care, the delivery of neonatal support in partnership with Liverpool Women's Hospital and the wider contribution the Trust makes to the health and wellbeing of the next generation. Alder Hey in the Park, which opened in October 2015, is one of the city's centres of academic and clinical excellence. The important role of Mersey Care NHS Foundation Trust as the principal provider of mental health services is recognised, with the delivery of community and hospital-based mental health care making a significant contribution to the wellbeing of the North Mersey population.

In North Mersey, hospitals are not just about services that are provided under their roof but increasingly they will be the providers of specialist care and treatment out in the community, working in partnership with primary and community services, with an emphasis upon sharing and transferring skills between health care professionals.

3. Case for Change

The case for change for hospitals in the city is compelling. The challenges we face are significant and if left unaddressed will undermine service delivery, sustainability and health outcomes. The economic climate in which the NHS operates means that we must find new and innovative ways to deliver better services at a lower cost if we are to meet the future needs of our population.

Whilst the required scale of challenge is daunting, we have a great opportunity to deliver this change due to a high level of clinical collaboration, alignment about the solutions and a shared commitment to transform the way we deliver hospital services in the city.

There are a number of other reasons why change is necessary:

Provider Sustainability

The large number of Trusts in Liverpool presents challenges for our health economy. Historically, Trusts have competed with each other, with many key adult services duplicated, leading to inefficiencies and a shortage of clinical expertise, impacting on workforce sustainability, training and education. Our priority is to secure long-term clinical and financial sustainability of services in the city, rather than protect the status quo. Collaboration and a whole-system strategy for service delivery are crucial to the aim of having the best hospital care system in the country.

Clinical Variation

Variation in the quality of services means that patients do not always get the best possible care, first time and every time. This is unacceptable and a key driver for change, as reduced variation will directly improve patient outcomes.

Estate Challenge

We have a wide variation in the quality and functionality of the NHS estate in the city, despite a significant investment of £100m in primary care premises and the new Alder Hey Children's Hospital (£240m) and Royal Liverpool University Hospital (£430m), alongside investment of in Mersey Care mental health facilities (£25m) and the planned relocation of the Clatterbridge Cancer Centre from the Wirral onto the Royal Liverpool Hospital campus.

The current configuration of NHS sites has developed in a piecemeal way rather than by design, informed by individual organisational needs rather than a whole system approach. Two new hospitals and the relocation of Clatterbridge Cancer Centre onto the Royal Liverpool campus, together with the developments at Aintree, will direct the core shape of key elements of the hospital estate infrastructure for the next twenty years or more across the region.

Specialised Commissioning

NHS England (NHSE) has responsibility for commissioning specialist services.

Liverpool has a number of hospital providers that collectively deliver a wide range of specialist services to the value of circa £300 million per year to Liverpool, the city region, the North West, Isle of Man and a large part of North Wales. Many of these services have a national and international reputation.

Working in partnership with our NHSE specialist commissioning colleagues Healthy Liverpool aims to harness opportunities for specialist services to support their development and as regional centres of excellence.

Specialist services are likely to be consolidated into 20-30 national centres, with 6-8 in the North and a maximum of 3 in the North West. This smaller number of specialist centres, serving larger catchment populations, will allow these hospitals to maintain a larger, more sustainable body of clinical expertise.

Workforce Challenge

The current configuration of services, set alongside the challenge of delivering 7 day services, presents significant challenges for the recruitment, retention and training of clinicians across all settings of care and other key staff groups. The duplication of many services means that Trusts are often competing against each other for scarce staff resources. Competition for medical training places is also problematic in a number of key specialties.

Quality & Outcomes Challenge

Patients and the public have high expectations for the quality and safety of the care they receive. There is currently immense public interest, and an increasing level of public and regulatory scrutiny of the quality of care provided by the NHS. This is underpinned by a growing number of standards, many requiring additional investment, and a drive to centralise specialist services. The high profile recent Francis, Berwick and Keogh reports are illustrative of the increasing focus in the NHS on quality and quality assurance.

For core hospital services, a key current focus is to ensure that patients have access to hospital care, delivered by consultants with the requisite sub-specialty skills, 7-days a week, and (where appropriate) 24-hours a day. New, nationally set, clinical

standards for 7-day services present all acute providers with a challenging need for investment or reorganisation where their services do not have the 'critical mass' to allow for a sustainable 7/7 rota.

For core adult acute services, our acute hospitals have a track record of providing high quality care; the clinical bodies of the two adult acute Trusts and Liverpool Women's believe that emerging clinical standards will be very difficult indeed for each trust to meet independently.

The FYFV defines quality in health care in three components: patient safety, clinical effectiveness and patient experience. High quality health service exhibits all three. Organisations currently operate different models of care, leading to variations in patient experience and outcomes. Variation in the quality of services across our trusts means that patients do not always get the best possible care, first time and every time. This is unacceptable and a key driver for change.

4. Opportunities

Clinicians have been working together to develop a strong consensus concerning the potential for delivery of real patient benefits through joint working to minimise duplication and remove inefficiencies. Specifically, by working together, the trusts have the opportunity to deliver substantial benefits for patients that improve both outcomes and experience by:

- Delivering a comprehensive portfolio of sub-specialist acute services which are fully compliant with and, in some respects, exceed NHS England's emerging standards for 7-day working;
- Increasing the scale at which the Trusts deliver specialty care, enabling the maintenance of a comprehensive service portfolio and providing patients with access to the greatest range of high quality specialist services locally; and,
- Offering patients improved access to cutting edge treatments and innovative, clinically-led "best in class" care pathways
- Ease of access to information for both clinicians and patients wherever the care is delivered with unified patient records

A closer partnership will also provide a strong platform for the trusts to support and shape the transformation of the health and social care system in North Mersey and beyond. For example, working in close partnership, the trusts will be able to:

- Support the drive towards integrated care. There is ample evidence that the most effective, patient friendly and cost effective care is delivered in well-coordinated, integrated systems. The catchments of the trusts, taken together, cover a sufficiently large geography in which to establish a viable integrated care model

- Work constructively with other major providers across Cheshire and Merseyside to secure and maximise the local delivery of tertiary work
- Work with academic and NHS partners to secure the full potential of our academic partnerships and establish the City of Liverpool as a centre excellence for research, education, and innovative with clinically-led services that improve the health, wealth and wellbeing of our community.

5. Priorities for implementation

Our focus for single service system wide transformation is on major trusts that provide adult services in the city. Clinicians from across our health and care system have been leading the strategic clinical direction of this component of Healthy Liverpool; developing clinical standards that set quality and operational delivery requirements based upon best practice and guidance.

Whilst Liverpool CCG is the major commissioner of services for the Liverpool population, the city's hospital services are delivered to a wider population, particularly the two neighbouring populations of South Sefton and Knowsley and to a regional and in part national footprint through NHSE specialist commissioning. From the outset, Liverpool CCG has recognised this complexity and has put in place governance arrangements to ensure that the programme is inclusive and taking into account the needs and interests of the wider population.

Potential merger between the Royal Liverpool & Broadgreen University Hospitals and Aintree University Hospital would enable standardisation, single service pathways, delivered against high quality one-system clinical standards, one system workforce, with single clinical leadership across these hospitals and sites.

Orthopaedics is one of a number of areas being considered for single, system wide services as part of Healthy Liverpool. Other areas include cardiology, cancer services, emergency care and stroke. In 2015 it was proposed that blood cancer services currently delivered at both the Royal Liverpool Hospital and Aintree Hospital should come together as a single service based at the new Clatterbridge Cancer Centre, which is set to open in 2019.

In addition, in January 2017 the draft pre-consultation business case for the review of services at Liverpool Women's NHS Foundation Trust was published. This explains the work undertaken to set out four potential options for delivering women's and neonatal services including an identified preferred option. Further assurance from NHS England is required before full formal public consultation.

Hospital Services Digital Transformation - Electronic Patient Record

A key aim of the hospital services digital transformation is joined up electronic patient records, so that every health and social care practitioner has access to the information they need to treat individuals safely and improve quality of care.

Delivery of urgent and emergency care services requires access to data, and common infrastructure. Improving quality and productivity through being paper free at the point of care by 2020 is a key national ambition. Our plan for a shared electronic patient record has its roots in an innovative collaborative, shared by 3 North Mersey providers - Aintree University Hospital, Liverpool Women's Hospital and the Royal Liverpool & Broadgreen University Hospitals. The three providers have recognised the necessity and significance of a move to joint hospital electronic patient records and the interoperability benefits that would come with that. Organisations in North Mersey, through the shared records (ILINKS) component of the Healthy Liverpool Digital Care and Innovation Programme, will collaborate to deliver this key enabler to improved quality, safety and efficiency across the North Mersey hospital system.

Merger of Major Teaching Hospitals

The trust boards of the Royal Liverpool and Aintree have agreed to move forward with a process to merge. This initiative may be extended to include other trusts in due course and one of these trusts may include LWH. The development of this proposal has been clinically-led and is intended to be an enabler for clinical service reconfiguration which will deliver significant patient benefits as well as ensuring financial sustainability. Merger could facilitate the delivery of significant **patient benefits** through:

- Improved patient outcomes
- Improved efficiency
- Improved staff retention/resilience
- Improved access to research & innovation funding, patient trials and healthcare innovation
- Equity of access across North Mersey and reduced waiting times from economies of scale

A Strategic Options Case has been endorsed by the trust boards which recommended a transaction to create a new, single, multi-site trust under a unified single management as the organisational form most likely to facilitate the delivery of re-aligned hospital-based care.

The merger qualifies both as a 'significant transaction' subject to detailed review by NHSI and a 'statutory transaction' subject to review by the Competition and Markets Authority.

An Outline Business Case in development will be considered in 2017 and an indicative timescale, developed with NHS Improvement, could see the merger complete by spring / summer 2018.

6. Conclusion

The creation of single services would be significant for the local health economy, providing better health, better care and better value by:

- Supporting commissioners to implement the improvements in patient care through further joint working identified by clinicians under the Healthy Liverpool Programme
- Ensuring the provision of both clinically and financially sustainable secondary care and tertiary care services in North Mersey for the future
- Providing a strong platform to support further consolidation and to shape the transformation of health and social care across North Mersey.
- Supporting the shared vision developed under the Healthy Liverpool Programme for the creation of a single adult acute teaching hospital campus for the city.

ENDS

Appendix 7 – ENT (Final Draft)

Ear Nose and Throat (ENT)

Contents

Background

16.2. The primary reason for the review of ENT services and the preliminary measure discussed in this paper is due to the proposed reconfiguration of Orthopaedic Services.

16.3. Currently there is a full ENT service at Broadgreen Hospital that includes Outpatient, Inpatient and Day Surgery. The service also provides A & E cover at Royal Liverpool Hospital (RLUH) and an Audiology clinic in South Liverpool NHS Treatment centre (Outpatients and Audiology clinic would not be affected by any proposed options to move the service).

16.4. The inpatient and day surgery activity that takes place at Broadgreen Hospital (BGH) currently uses 10 theatre sessions across 5 days Tuesday to Saturday. The volume of ENT activity split by BGH/Aintree University Hospital (AUH) site is shown below:

RLBUHT Broadgreen Site ENT Inpatient and Day Surgery Activity. 15/16		AUH Inpatient and Day Surgery Activity 15/16	
Inpatient	Day Surgery	Inpatient	Day Surgery
204	919	910	1,039

16.5. Whilst ultimately this service will become a single service (subject to further design and consultation), delivered through the Healthy Liverpool-led process to reconfigure all adult acute services in the city, this proposal is about establishing an preliminary arrangement to co-locate the two services delivered by RLUH and Aintree onto the Aintree site, in order to facilitate proposals for a single orthopaedics service. The work to develop a single ENT service will take place as part of the wider programme of reconfiguration.

Reason

16.6. Whilst a single ENT service is in line with the Healthy Liverpool strategy and would allow for increased flexibility through combined service capacity, the principle reason for adopting an earlier phased preliminary approach to integration would be to facilitate the delivery of the single Elective Orthopaedic Centre at BGH.

16.7. Therefore the purpose of this document is to provide an outline of the proposed preliminary reconfiguration of ENT, which will facilitate the delivery of the proposal in the orthopaedics options appraisal; which identifies a preferred option of a two site model, with all orthopaedic trauma at AUH and all existing AUH orthopaedic inpatient and day surgery activity proposed to be delivered at an Elective Centre at BGH.

Case for change

16.8. The requirement for change is twofold:

- To facilitate the preferred option of a two site orthopaedic service with a single elective service at BGH;
- To support the future development of an integrated Ear Nose and Throat Service for the city.

16.9. As part of clinical service reconfiguration, an integrated ENT service, with all inpatient and day case activity at AUH would provide:

- A pool of medical resource able to deliver elective demand more efficiently.
- The opportunity for sharing of junior medical staff and increased flexibility of cover.
- Elective patients with 24/7 access to higher care beds/ critical care beds that are not currently available at BGH.
- The opportunity to consolidate services and co-locate them with the regional Head and Neck Specialist Centre at Aintree. This preliminary change would begin the phased development of a single service with designated specialist skills including ward and theatre staff.

16.10. The financial and sustainability case for change:

- Improved value for money due to a reduction of waste through duplication of multidisciplinary pathways
- Opportunity for delivery of improved theatre scheduling services and efficiency
- Opportunity to merge capacity and increase flexibility of capacity to meet demand and reduce wait times for surgery due to pooling of resources
- Increased procurement efficiencies due to combined purchase volumes
- Future proofing the service against growth in demand.

Options Appraisal

16.11. As part of the review of ENT it was agreed that a full options appraisal was not necessary after reviewing the possible options available. See the table below for a list of other possible options and reasons for/against exploring these further:

Possible Options	
Base Line (Do Nothing)	The ENT changes are being proposed in line with the proposed orthopaedic reconfiguration and the requirement for a two site Orthopaedic service
Move ENT into the New Royal Hospital	- There is not sufficient space to move the service into the new Royal. - AUH is the Merseyside regional head and neck cancer centre
New Build for ENT	- In the current financial climate the funds are not immediately available for a new build for ENT
Wait to become a complete single service	- The timelines for this are not in line with the proposed orthopaedics changes, this would result in a delay and challenges in opening the new Royal.

A full options appraisal for ENT services will be undertaken as part of the AUH and RLBUH clinical integration programme to support the production of the Outline Business Case for the proposed merger of the two Trusts.

Proposal

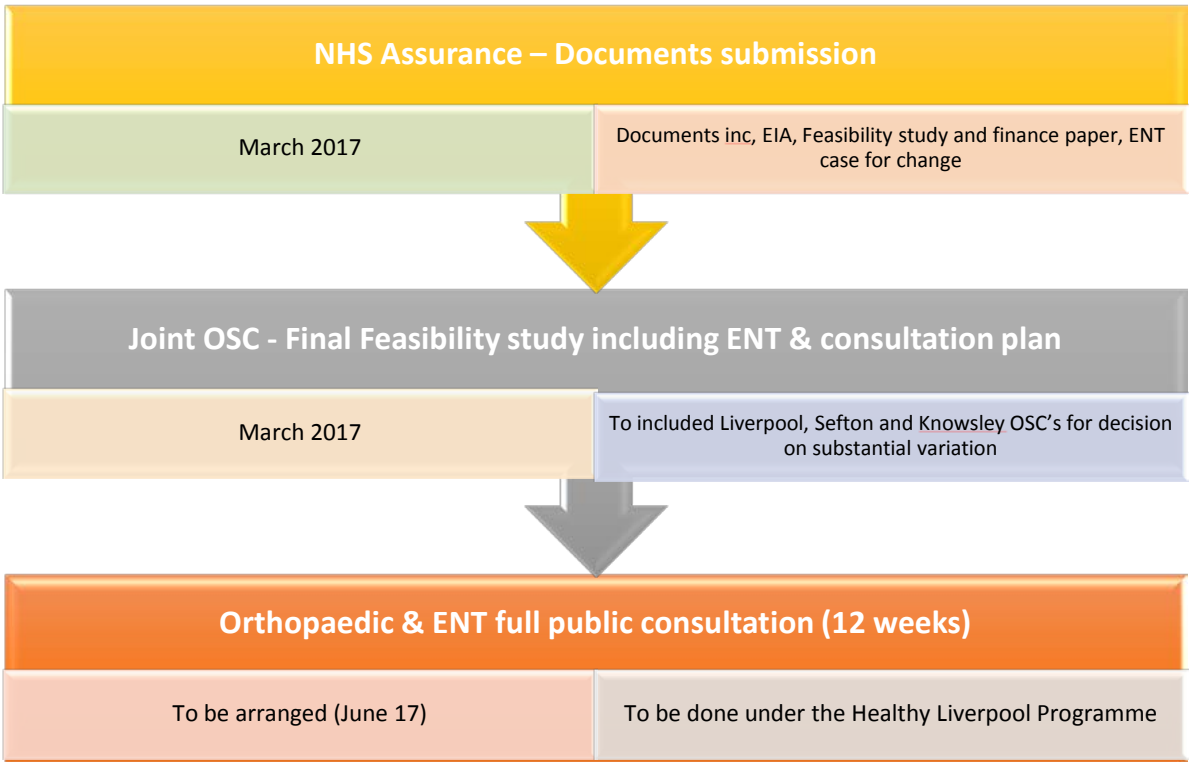
16.12. The proposal is for existing ENT day case and inpatient activity to be transferred to AUH from BGH (10 theatres sessions per week/over 5 days). Capacity at AUH has been identified as part of the Liverpool Orthopaedic and Trauma Service work stream.

16.13. Existing ENT outpatient services would remain at BGH and would be unaffected by the proposal, patients would continue to be triaged and assessed at BGH (including pre-op appointments). Patients presenting at RLUH Emergency Department with ENT complaints will continue to be seen and treated at RLUH.

16.14. As this is the preliminary phase the next step will be for ENT services at BGH and the ENT/Head and Neck Service at AUH, to form a single integrated service as part of the wider trust reconfiguration of services. This requires full integration and combined on call rotas. It would also continue to provide emergency cover at the RLUH site as per the existing model. This is out of scope for this piece of work, but will progress at a later date.

Timescales

16.15. The below diagram shows the decision making points and timescales for consultation;



Public Engagement

16.16. NHS Liverpool Clinical Commissioning Group (LCCG) is leading a programme, Healthy Liverpool, which aims to transform health within the city. The plan has been part of ongoing discussions with Liverpool communities over the last two years and has 5 priority areas:-

- Hospital Services - Creating a co-ordinated service approach across the city's hospitals which maximises clinical staff skills, other resources and expertise to improve the quality of services available to patients and improve health outcomes and efficiency.
- Community Services – improving GP and other non-hospital services and the way they interact to improve access, serve patients better and enable more care closer to people's homes where appropriate
- Living Well - Supporting people to become healthier and more physically active
- Urgent Care - To deliver an urgent and emergency care route that is recognisable and clear to patients, the public and health care professionals that delivers the right care, in the right place first time.

- Digital Innovation - Ensuring all our services make best use of developing technologies.

16.17. From June 2016 to August 2016 public engagement took place regarding the case for change and principles of Healthy Liverpool Single Service proposals. The aims of the engagement was to:-

a) Increase understanding of CCG role and intent

b) Raise awareness of Healthy Liverpool aims/benefits

c) Raise awareness and understanding of why there is a need and opportunity for change

d) Present thoughts so far and seek views on

• The need to make changes

• The priority areas for change

• People's approach to priorities and resource allocation

e) Build capacity for detailed discussion and community empowerment to collaborate in healthcare design

f) Gather knowledge, experience, information and perspectives to help improve proposals

g) Ensure diverse communities of Liverpool consider proposals and improve content so that they are appropriate to support reduction in health inequalities

h) Ensure no service is designed without input from people with patient experience

i) Make the engagement activity a positive experience for health and wellbeing

16.18. More than 14,000 people responded to this call to action, giving Liverpool CCG a rich amount of feedback.

16.19. 85% of respondents supported the priority areas set out for the Hospitals programme but felt more detail was required.

16.20. From January to March 2016 Liverpool communities were asked to comment on the next stage of Healthy Liverpool planning and in more detail about each of the programme areas. The specific aims for the hospital programme were:-

a) Understand how Liverpool people feel about a co-ordinated service approach across the city to create one team and service for specialist areas.

b) Understand how Liverpool people feel about hospital specialists working more closely with Community Care Teams and others

c) Understand attitudes to travelling for care and use of digital healthcare

were held by the Commissioning Support Unit in areas of high footfall.

It shared with people the vision for single service city wide and how specialist services could work in a more coordinated way with community care teams. The

example of a single cardiology services was shared as an example of how the approach may work.

16.21. Additional pre-consultation engagement on single service has taken place in February 2017 in Sefton and Knowsley.

16.22. Following Board approval of the Orthopaedic feasibility study including the proposed preliminary changes to co-locate ENT services on one site, a programme of public consultation will be launched prior to service mobilisation.

16.23. Following completion of a full public consultation a service mobilisation task and finish group will be established with clinical and management representation from both Trusts. Key workstreams will include: workforce focusing on staff consultation and workforce change, preparing for operational delivery on the orthopaedic trauma site, preparing for operational delivery on the elective care site, preparing for operational delivery of ENT on AUH site, communications and governance.

Expected Benefits

16.24. The following benefits are expected from the integration of ENT inpatient and day surgery at AUH;

- Full access to Critical Care beds
- Aintree is the larger provider of ENT services forming part of the Merseyside Regional Head and Neck Cancer Centre and the quality and safety of surgery would remain the same
- Sustainable service delivery
- Opportunities for improved theatre efficiency through pooling of capacity
- Co-locating will provide the right conditions for development of shared learning and relationships to support future single service work

Expected Dis-benefits

16.25. **Patient Travel Time**

The movement of inpatient and day case ENT services from Broadgreen Hospital means that some patients from the South of Liverpool could have to travel up to 90 minutes for their procedure (total travel time not additional minutes) if they do not have access to private transport (this information was taken from heat maps provided by Mersey travel), as well as increasing the travel time of those with access to private transport to an additional 7 to 17 minutes. It is estimated that this will affect only a very small number of patients (approx. 1000 patients in total had ENT surgery at Broadgreen in 15/16, from across the whole city).

16.26. **Patient Choice**

The choice of day case and NHS provider location would be reduced, however patients would still receive the same high quality ENT care at Aintree Hospital with high quality clinical outcomes and experience being maintained.

16.27. **Acute site**

There may be an increased risk that services will be affected by operational pressures on the AUH site compared to the BGH site. This would only apply to inpatient surgery, not day surgery. However AUH Head and Neck beds are currently ring fenced – so this is not expected to be an operational risk

Risks, Issues and Financial Impact

Risks

Strategic	• No strategic risks identified.
Operational	• Outpatient services are unaffected, so choice of site remains same. However choice of location for surgery would be reduced. • Day surgery beds at AUH would have to be ring fenced as part of current plans at AUH

Issues

A requirement would be that equity of on call delivery and management resource to deliver existing quality and levels of outpatient/ emergency and inpatient cover would need to be agreed. This is not a risk however it needs to be acknowledged. This is being discussed as part of the clinical workstream.

Clinical Co-dependencies

No clinical co-dependencies have been identified at present

Programme

16.28. The proposed move for ENT has come from the development of options and the proposed model for orthopaedics. This work has been undertaken, by the Collaborative Orthopaedic Project Team (COPT), with joint representation from Clinicians, Management, Business Intelligence, Finance and Liverpool CCG.

16.29. Throughout the review process the Collaborative Orthopaedic Project Team (COPT) has been committed to ensure that it informs, engages and consults with stakeholders and governance to the project has been through an Orthopaedic

Executive Oversight Group which was established to take forward this review process. Discussions have taken place with ENT clinical and managerial representatives to discuss the proposed preliminary changes.

16.30. This group included clinical, managerial representation from both AUH and RLBUHT. With representation from Liverpool CCG, the Walton Centre, North of England Specialised Commissioning Team, Cheshire & Mersey Major Trauma & Adult Critical Care Operational Delivery Networks and the North West Ambulance Service NHS Trust (NWAS).

16.31. ENDS

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MARCH 2017

Agenda Item: 17/50	**Author of the Paper:** Fiona Taylor Chief Officer Tel: 0151 247 7061 Email: fiona.taylor@southsefton.nhs.uk
Report date: March 2017	

Title: Joint Working across South Sefton, Southport & Formby and Liverpool CCGs

Summary/Key Issues:

NHS South Sefton, NHS Southport & Formby and NHS Liverpool CCG Governing Bodies have agreed to work together in more formal arrangements in order to optimise health services for their populations.

The Governing Bodies have considered a number of options for how the CCGs could operate, and measured these against a set of criteria. This resulted in reaching a preferred option to merge with the establishment of a joint committee as a step towards this.

This paper:

i) Proposes how a joint committee could operate and a timetable for implementation;
ii) Summarises the steps required for CCG mergers;
iii) Outlines how the joint committee could be used as a forerunner for merger and potential timescales for this to happen;
iv) Sets out the requirements for practice member support and proposes how this is sought.

It should be noted that this paper is being considered by NHS South Sefton, NHS Southport & Formby and NHS Liverpool CCG Governing Bodies at each of their meetings in March 2017.

Recommendation

Receive	x
Approve	x
Ratify	

The Governing Body is asked to:

a) Approve formal consultation with member practices to merge South Sefton, Southport & Formby and Liverpool CCGs (from April 2018);
b) Note the steps required for a formal CCG merger;
c) Approve the establishment of a Joint Committee across South Sefton, Southport & Formby and Liverpool CCGs, to be responsible for strategy, performance, governance and oversee the merger process for the period to April 2018.

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.

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			Tri Board meetings on 15/12/16, 26/1/17 and 2/3/17.

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

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Joint Working Across Liverpool, Southport & Formby and South Sefton CCGs

Report to Governing Body

March 2017

1. Introduction

NHS Liverpool, NHS Southport & Formby and NHS South Sefton CCG Governing Bodies have agreed to work together in more formal arrangements in order to optimise health services for their populations.

The Governing Bodies have considered a number of options for how the CCGs could operate, and measured these against a set of criteria. This resulted in reaching a preferred option to merge with the establishment of a joint committee as a step towards this.

This paper:

i) Proposes how a joint committee could operate and a timetable for implementation;

ii) Summarises the steps required for CCG mergers;

iii) Outlines how the joint committee could be used as a forerunner for merger and potential timescales for this to happen;

iv) Sets out the requirements for practice member support and proposes how this is sought.

It should be noted that this paper is being considered by Liverpool, Southport & Formby and South Sefton CCG Governing Bodies at each of their meetings in March 2017.

2. Recommendations

The Governing Body is asked to:

a) Approve formal consultation with member practices to merge Liverpool, Southport & Formby and South Sefton CCGs (from April 2018);

b) Note the steps required for a formal CCG merger;

c) Approve the establishment of a Joint Committee across Liverpool, Southport & Formby and South Sefton CCGs, to be responsible for strategy, performance, governance and oversee the merger process for the period to April 2018.

3. Background

CCGs were established from April 2013 as the local statutory bodies to commission the majority of health services for their populations. A key difference between CCGs and predecessor organisations such as PCTs was the emphasis on clinical leadership and the nature of the relationship with General Practice, whereby practices were 'members' of CCGs, thereby

responsible for their work. This resulted in the creation of Governing Bodies which had a significant number of GPs and other clinicians as members, and thus in leadership roles in commissioning. This has enabled commissioning strategies to be more clinically driven, with a greater understanding of patient needs.

Local areas spent considerable time to develop the right footprint for the shape of CCGs which would best optimise commissioning for their populations, taking account of Local Authority boundaries. However, the demand for health and social care continues to grow and to outstrip the expected growth in resources available, and service quality and access are being increasingly affected by cuts in Local Authority spending. In response to this, organisations across North Mersey have been 'acting as one', signing up to a programme of work to make best use of resources across primary, social care, community and hospital settings. As part of this, commissioning organisations need to have clarity of vision on a footprint which makes sense for taking strategic decisions which will enable change to happen and which also maximises resources and improves patient outcomes.

4. Case for Change

At an informal meeting of the three CCG Governing Bodies in November 2016, a discussion paper on the future working arrangements across Liverpool, Southport & Formby and South Sefton CCGs was considered (Appendix 1). This paper was the result of previous discussions across Merseyside CCGs which considered the optimum footprint for joint working.

From these discussions, the three Governing Bodies feel they have a compelling case for joining together on a formal basis. First and foremost they believe by coming together they will be able to make a greater difference to the health of and services for their individual populations than they would do in their current organisational forms.

The reasons for this include:

Strengthening commissioning capacity and leadership – Local System Delivery Plans are describing hugely ambitious programmes of change, which will require strong clinical leadership from commissioners as well as providers. By combining our existing CCG skills and resources, we will arguably strengthen our commissioning capacity and capability to deliver the ambitious transformational programmes described in Healthy Liverpool and Shaping Sefton.

Commissioning in a changing provider landscape – as a bigger commissioning organisation we will more closely mirror the form of our providers and the populations they serve, as they continue their active discussions to merge. We will be better placed to drive improved outcomes for our patients, in line with our vision to enhance community services and optimise spend in hospitals in order to free up resources and skills to treat people in their own homes.

Responding to the Five Year Forward View – the Five Year Forward View describes a number of organisational models in which financial and clinical risks are shared across providers, with some elements of more traditional commissioning functions built in to enable this to happen – for example pathway redesign. By joining, the CCGs are in a much stronger position to consider these new integrated models in the future.

An agenda for change – NHS England clearly recognises the appetite amongst some CCGs to come together to more effectively address the growing challenges being faced across health and social care. In acknowledgement of this, NHS England for the first time issued guidance in November 2016 around CCG mergers, paving the way for this to happen. This move will ensure

that the CCGs proactively strengthen the commissioning role across the health and social care system across the bigger geographical footprint in response to the five-year forward view agenda.

By taking action now, the CCGs will be better able to shape a strengthened commissioning entity around their distinct health and social care system. This will create a CCG that can deliver improved outcomes across a bigger geographical footprint, whilst retaining the ability to respond sensitively to its local communities.

It is probably fair to say that the level of change needed across the health system over the next five years is greater than anything which has gone before. No one organisation has the capacity and capability to lead these changes.

The work undertaken with AQuA led to the product described in Appendix 1, which concluded that the optimum footprint for CCGs was to work in pairs or trios as follows:

- Liverpool, Southport & Formby and South Sefton CCGs
- Knowsley and St Helens CCGs
- Halton and Warrington CCGs

The paper also set out a range of options for how joint working could be strengthened across Liverpool, Southport & Formby and South Sefton CCGs.

5. Way Forward

NHS Liverpool, NHS Southport & Formby and NHS South Sefton CCGs' Governing Bodies considered the paper and supported the case for change and to work on this footprint. They signed up to a process whereby the organisational options (Appendix 1 & 3) would be reviewed by each Governing Body individually against a set of agreed criteria (Appendix 2); with the results to be shared to see if a preferred option could be reached. If so, the aim was to present that preferred option to the formal Governing Body meetings of each CCG in March 2017.

At the Tri Governing Body discussion on 26th January 2017, it was concluded that options 1, 2 and 3 did not support improved commissioning and thereby would not improve health service delivery. As such, they were discounted. This debate led to an agreed direction of travel, concluding that merger (Appendix 4a-4C) would best enable us to meet the future challenges. It was also agreed that a joint committee with delegated responsibility for all the CCGs' work is established to achieve this.

By merging, the Governing Bodies believe this will strengthen the focus on both transformation programmes, Shaping Sefton and Healthy Liverpool. Importantly, the Governing Bodies felt this would enable them to achieve more together for their local populations, utilising talent and skills across the three organisations, building on positive relationships whilst responding to increasing financial challenges.

Some key principles for how this is taken forward were agreed (Appendix 5); these underpin the approach described below.

6. Establishing a Joint Committee

In line with the direction of travel set out above, the first step would be to establish a Joint Committee across the three CCGs for the period to April 2018.

The legal basis on which the CCGs can agree to jointly exercise a group of their functions through delegating them to a joint committee is through the powers under section 14Z3 of the NHS Act 2006 (amended) which provides that:

'(1) Any two or more clinical commissioning groups may make arrangements under this section

(2) The arrangements may provide for:

(a) One or more of the clinical commissioning groups to exercise any of the commissioning functions of another on its behalf, or

(b) All the clinical commissioning groups to exercise any of their commissioning functions jointly.

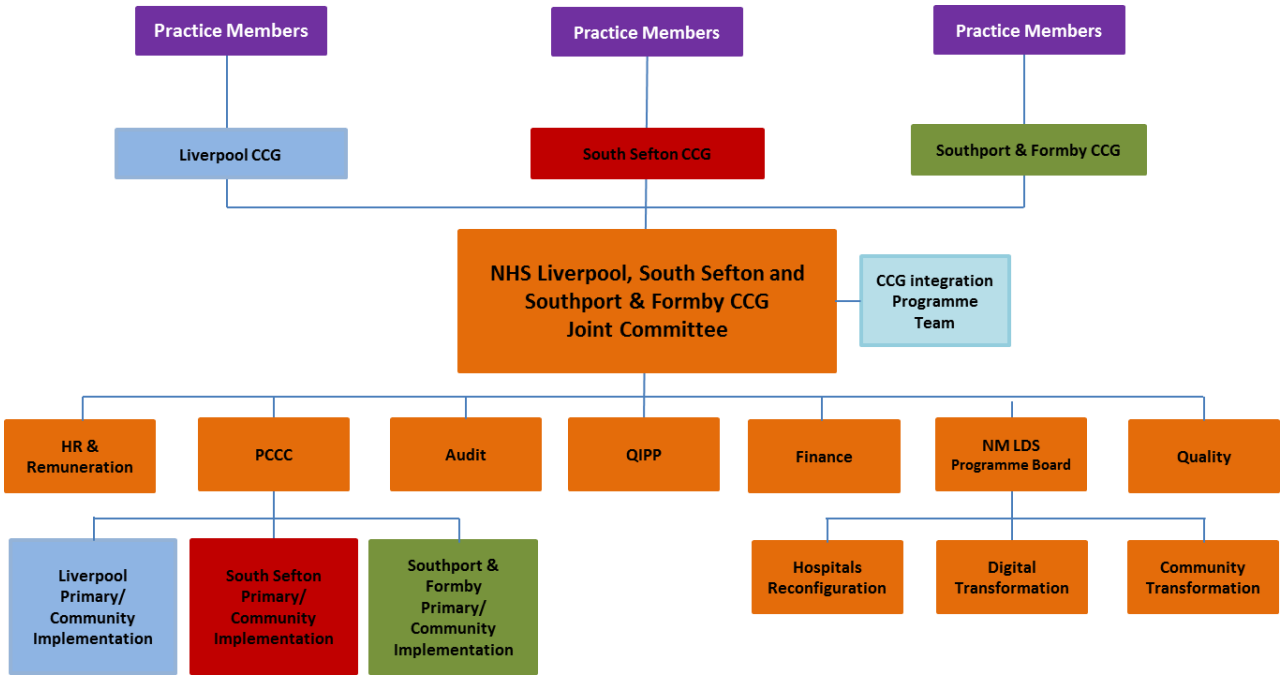
(2A) Where any functions are, by virtue of subsection (2) (b) exercisable jointly by two or more clinical commissioning groups, they may be exercised by a joint committee of the groups ….

(7) In this section, 'commissioning functions' means the functions of clinical commissioning groups in arranging for the provision of services as part of the health service (including the function of making a request to the Board for the purposes of section 14Z9).'

This is confirmed in each of the CCG Constitutions.

7. Proposed Governance Structure for the Joint Committee arrangement

A proposed governance structure is as follows:



Some key points to note:

a) Joint Committee

This will have delegated responsibilities for the commissioning functions of each CCG and so be responsible for strategy, performance and governance. The Joint Committee would also oversee the merger process. As such, the membership is required from each constituent CCG. The detail of which will need to be developed within the planned timelines.

b) Audit (Committees In Common)

Each CCG is required to have an Audit Committee with membership drawn from its constituent Governing Body. It is suggested that these meet as Committees in Common, ie each committee meets concurrently. Each Audit Committee requires its own Chair, and it is proposed that the three Audit Chairs are members of the Joint Committee.

c) Remuneration (Committees In Common)

As with the Audit Committee, each CCG is required to have a Remuneration Committee. It is suggested that these also meet as Committees in Common.

d) Primary Care Commissioning Committee (PCCC)

NHS Liverpool CCG has delegated responsibility for primary care commissioning. NHS Southport & Formby CCG is co-commissioning with NHSE (level 2) from April 2015 and NHS South Sefton CCG will move to (level 2) in April 2017. As such, the committee needs to be structured to enable the different responsibilities across the CCGs to be discharged. This will need further consideration and discussion with NHSE.

e) Other Committees

All other committees will operate in a fully integrated way, taking responsibility for the range of work of all three CCGs.

f) Primary / Community Services Transformation

In order to ensure that commissioning strategies for primary / community services are developed and implemented in a way which meets local needs, it is proposed that three separate Primary / Community Services Implementation Groups are established, with membership drawn primarily from the respective Governing Bodies to include practice representatives such as Practice Nurse and Practice Manager. This could also include Healthwatch and Public Health input as required. These groups will report into both the PCCC and the North Mersey Local Delivery System Board.

g) CCG Integration Programme Board

A CCG Integration Programme Board will be established, responsible for overseeing bringing the organisations together and reporting into the Joint Committee. This will be led by a Programme Director, Lay Member and Clinical Lead, all of whom will be co-opted onto the Joint Committee.

h) Quality, Innovation, Productivity, Prevention Committee (QIPP)

The QIPP Committee will oversee programmes across the three CCGs, ensuring co-ordinated approaches where this makes sense and maximising their impact.

i) Health and Wellbeing Boards

Recognising the importance of maintaining a local focus, the CCGs will of course still be full partners on the Health and Wellbeing Boards for Sefton and Liverpool, and continue to support the development of and response to the respective Joint Strategic Needs Assessment.

8. Timescales for establishing the Joint Committee (please see note on member / stakeholder engagement and approval below)

It is proposed that the Joint Committee is in place by June 2017. In order for this to happen, the membership needs to be confirmed by each Governing Body, including the Accountable Officer, Chief Finance Officer and Chief Nurse. It is suggested that these posts are recruited to during May 2017. This would then enable the management teams across the three CCGs to be brought together, with a new structure in place by October 2017, with the joint committee structure operational from this point. It should be highlighted that NHSE's approval for sharing a managerial leadership team (AO / CFO / Chief Nurse) across CCGs is required.

All other members of the Joint Committee can be nominated by each Governing Body.

9. Merging the CCGs - Steps required

'Procedures for clinical commissioning groups to apply for constitution change, merger or dissolution' sets out the procedure to agree a CCG merger (NHSE 2016). It highlights that mergers require the commitment of and leadership of CCG Governing Bodies and should only be considered when there are demonstrable benefits to patients.

In considering the new arrangements, NHSE will take into account the following factors:

- **Coterminosity with local authorities**
- **Clinically-led** – including how members will participate in decision making
- **Financial Management** – proper stewardship of financial funds
- **Arrangements with other CCGs** – for example to lead commissioning arrangements
- **Commissioning support** – whether there are good arrangements for commissioning support
- **Strategic purpose** – to provide a logical footprint for sustainability and transformation
- **Prior progress** – that mergers are a 'natural next step' building on existing joint working
- **Leadership support** – of Governing Bodies and wider strategic support, or as part of an agreed turnaround plan
- **Future-proofed** – in terms of new arrangements eg MCPs, PACs, devolution, etc
- **Ability to engage with local communities** – the larger geography cannot be at the expense of GP / community engagement
- **Optimising use of administrative resources** – merger should show how 20% in running costs is released to support local system transformation[1]

[1] Such as Healthy Liverpool, Shaping Sefton and the requirements of the North Mersey LDS. By coming together we would be able to reduce cost in a number of non-staffing areas, such as the costs associated with holding three governing body meetings instead of one. These areas of duplication would greatly contribute to this efficiency savings target.

CCGs wishing to merge are required to apply in writing by no later than 31 July of the year preceding the intended merger date, which should commence from the start of a financial year. A single application must set out how it meets all the eleven tests described above, and it should have been discussed and ideally agreed with CCG member practices and considered by local stakeholders including the Local Authorities and local Healthwatchs.

NHS England's Commissioning Committee will approve the final decision on merger proposals, based on recommendations from the executive board, co-ordinated by the National Director of Operations and Information.

10. Joint working with the Local Authorities

A key relationship in all of this is with the Local Authorities. As stated above, the CCGs will still be full partners on the Health and Wellbeing Boards for Sefton and Liverpool, and continue to support the development of and response to the respective Joint Strategic Needs Assessments.

In addition, work is progressing across Liverpool, Sefton and Knowsley Local Authorities to bring together adult social care commissioning, with a tri-partite agreement in place setting out how this will work. At CCG level, there are joint posts with the Local Authorities. In Liverpool, there are joint programmes with the City Council for Mental Health, Healthy Ageing and Living Well. Whilst in Sefton joint roles include Mental Health and Children's Services with Knowsley enjoying joint roles for Urgent Care and discharge planning. These are key to sustainability and improved outcomes for patients. Therefore, bringing the CCGs together needs to be done in such a way that joint working with the Local Authorities is both maintained and further strengthened. This is being considered with Local Authority Chief Executives and other colleagues. Given the relationship between Liverpool, Sefton and Knowsley Local Authorities, the three CCGs have been clear that Knowsley CCG can be part of new joint arrangements in the future.

11. Public Engagement

Whilst there is no requirement for formal public consultation on these changes, the Governing Bodies are keen that the changes are explained to the public, so they are assured of their continued ability to inform the shape their local NHS. As such, a programme of public engagement will be scheduled during this period of change to include working with Healthwatch organisations in both areas.

12. Practice Member Engagement

Practice members will need to support the proposal to form a new CCG across Liverpool, Southport & Formby and South Sefton. If this direction of travel is endorsed by the Governing Bodies, there will need to be a formal mechanism to assess this support.

Whilst existing CCG constitutions allow for the establishment of a Joint Committee and delegation of commissioning responsibilities to that Committee and as such formal approval is not required, it will still be important that practices understand the changes and how they can continue to shape commissioning locally.

13. Challenges and risks

As well as the opportunities described above, there are undoubtedly some challenges and risks in moving forward in this way. These include:

- Bringing together the different cultures across three organisations;
- Ensuring a bigger structure connects with the local communities;
- Managing the differences across Governing Bodies and its constituent practices, including the makeup and remuneration of the governing bodies;
- Ensuring that the skills of all Governing Body members and CCG staff are used to optimum effect in the new arrangements;
- Maximising local clinical input;
- Maintaining delivery of cost savings and financial duties;
- Managing the differences in financial position across the three CCGs in an equitable way;
- Ensuring existing strategies are built upon;
- Ensuring that local relationships are not lost, recognising differences in key community influencers and decision makers;
- Ensuring a smooth transition for staff;

The CCG Integration Programme team will need to identify all such challenges and risks and ensure they are managed and mitigated effectively.

14. Next steps

If approved by the Governing Body of each CCG, the next steps would be as follows:

MAR 2017	Formal discussion with NHSE regarding direction of travel, including seeking approval for establishment of single management team in order to set up the Joint Committee.
APRIL 2017	Approval sought from membership for establishment of single CCG across Liverpool, South Sefton and Southport & Formby. Confirmation of support sought from Local Authorities and Healthwatchs Confirm arrangements for informing the wider public
MAY 2017	Membership/Terms of reference for Joint Committee approved by each Governing Body. Each Governing Body to confirm membership of Joint Committee. Appointment of AO, CFO and Chief Nurse posts, subject to NHSE support.
JUNE 2017	1st meeting of Joint Committee – will include signing off senior management structure and process for appointments. Monthly meetings thereafter to consider and take actions on strategy, performance and governance in an integrated way across all three CCGs.
JULY 2017	Senior management team in place (including identifying person to oversee the merger). Application for the merger from April 2018 (subject to practice member support).
AUG-OCT 2017	New structure agreed.
OCT-MAR 2018	All work required to merge the three CCGs undertaken.
APRIL 2018	New CCG established.

15. Conclusion

The demand for health and social care continues to grow and to outstrip the expected growth in resources available. In response to this, organisations across North Mersey have been 'acting as one', signing up to a programme of work to make best use of resources across primary, social care, community and hospital settings. As part of this, commissioning organisations need to have clarity of vision on a footprint which makes sense for taking strategic decisions which enable change to happen.

Bringing together Liverpool, South Sefton and Southport & Formby CCGs will consolidate clinical leadership capacity and maintain credibility with member practices or local communities.

Katherine Sheerin & Fiona Taylor
March 2017

Appendices

Appendix 1 – Discussion paper (extract) to explore future joint working arrangements across Liverpool, South Sefton and Southport & Formby CCGs (Nov 2016)

Appendix 2 – Organisational options

Appendix 3 – Criteria for assessing the options

Appendix 4a-4c – Results of the options appraisal

Appendix 5 – Principles for taking this forward (agreed by CCG GBs Jan 2017)

Appendix 1

DISCUSSION PAPER TO EXPLORE FUTURE WORKING ARRANGEMENTS ACROSS LIVERPOOL, SOUTH SEFTON AND SOUTHPORT & FORMBY CCGS

1. PURPOSE

The purpose of this paper is to update the three Governing Bodies (Liverpool, South Sefton and Southport & Formby CCGs) on discussions regarding joint working across CCGs, and to propose some options for the future for debate.

2. BACKGROUND

At its meeting in July, the Liverpool City Region CCG Alliance considered a paper which outlined a case for change for how clinical commissioning is organised, presented some options for how CCGs across North Mersey / the Alliance could work together in the future and provided a framework for discussion.

3. DRIVERS FOR CHANGE

The paper set out the following drivers for change:

- Capacity of CCGs to lead the changes needed
- A strengthening provider landscape
- The advent of accountable care systems
- Lack of clear national direction in relation to clinical commissioning

It is probably fair to say that the level of change needed across the health system across the next five years is greater than anything which has gone before. No one organisation has the capacity and capability to lead these changes.

4. OUTCOME OF DISCUSSIONS

The CCGs agreed to undertake a series of workshops, facilitated by AQUA, which explored further:

- The case for change
- The options for geographic configuration
- The organisational models
- Criteria against which to assess models

in order to arrive at recommended options for the future.

These workshops took place in August, September and October 2016. The output of the workshops offering, in summary the preferred way forward was for local groupings of CCGs to work together to explore future organisational arrangements and how best to achieve system changes whilst maintaining an emphasis on local needs.

The groupings are as follows:

- Halton and Warrington CCGs
- Knowsley and St Helens CCGs
- Liverpool, South Sefton and Southport & Formby CCGs

However, the work did not reach conclusions about organisational models, given it will be for the local groupings to determine. The rest of this paper considers the options and some of the issues in relation to this.

5. ORGANISATIONAL / GOVERNANCE OPTIONS

Whatever the preferred option, a robust governance framework will need to be developed to ensure that changes all are considered and decisions made in accordance with due and diligent process following legal requirements. This will require further work as part of the agreed next steps, to support the required organisational model.

Option 1

Run all / most programmes jointly with individual senior management teams in place (ie three Governing Bodies and separate governance structures are maintained).

Option 2

Create a joint committee with delegated responsibilities for work programmes and decisions which are best taken at North Mersey level with individual management teams remaining in place (ie each Governing Body delegates responsibilities and decision making to the joint committee).

Option 3

Run all / most programmes jointly with shared management team but not a joint committee (ie three Governing Bodies and separate governance structures are maintained).

Option 4

Create a joint committee with delegated responsibilities for all CCG responsibilities with shared management team (similar to the arrangement which operated in the PCT Cluster).

Option 5

Full merger.

To summarise the changes -

Option	Each Governing Body is maintained?	Decision making is kept within each CCG?	Each Management Team is maintained?
1	Yes	Yes	Yes
2	Yes	No	Yes
3	Yes	Yes	No
4	Yes	No	No
5	No	No (one CCG)	No

NB - A ‘yes’ answer above indicates no change from now.

6. CRITERIA FOR ASSESSING OPTIONS

The criteria used to assess geographic options should be reviewed and adapted to assess the organisational models described above.

7. NEXT STEPS

It is suggested that a process to define the organisational model is agreed, and then a project plan for implementing the change is drawn up. This needs to be overseen by members of each GB and Senior Management Team, with regular reports back to full Governing Bodies.

8. QUESTIONS FOR CONSIDERATION

a. Do the three GBs support the case for change?

b. Do the three GBs support the working footprint to be Liverpool, South Sefton and Southport & Formby CCGs?

c. What further organisational models could there be?

d. Are there any which we can rule out?

e. What criteria should we use to assess the models?

f. How should this be done?

g. What timeframe should we work to?

Appendix 2

Criteria mapped to CCG Improvement and Assurance Framework 16/17

Better Health
- Address health inequalities
- Enables health outcomes to be improved for all

Sustainability
- VFM
- Enables system level change
- Enables Greater integration between Health and Social Care
- maximum opportunities for social value

Leadership
- Enhancing effective and efficient clinical leadership
- Greater influence over provider for commissioners one single voice
- Acceptability to membership
- Maximise workforce talent
- Able to manage complexity of System
- Enables local sensitivities to be recognised

Better Care
- Optimize local patient flows
- Improve access to services
- Improve quality of services

Appendix 3

Organisational options

- **Option 1** Run programmes jointly with individual senior management teams in place (ie three Governing Bodies and separate governance structures are maintained)
- **Option 2** Create a joint committee with delegated responsibilities for work programmes and decisions which are best taken at North Mersey level with individual management teams remaining in place (ie each Governing Body delegates responsibilities and decision making to the joint committee)
- **Option 3** Run programmes jointly with shared management team but not a joint committee (ie three Governing Bodies and separate governance structures are maintained)
- **Option 4** Create a joint committee with delegated responsibilities for all CCG responsibilities with shared management team (similar to the arrangement which operated in the PCT Cluster).
- **Option 5** Full merger

Appendix 4a – Results of options appraisal by each GB

Southport & Formby[2]	Better Health	Leadership	Sustainability	Better Care	Total
Option 1 Run programmes jointly with individual senior management teams in place (ie three Governing Bodies and separate governance structures are maintained).	**7**	**11**	**10**	**8**	**36**
Option 2 Create a joint committee with delegated responsibilities for work programmes and decisions which are best taken at North Mersey level with individual management teams remaining in place (i.e. each Governing Body delegates responsibilities and decision making to the joint committee).	**7.5**	**10**	**10**	**6**	**33.5**
Option 3 Run programmes jointly with shared management team but not a joint committee (i.e. three Governing Bodies and separate governance structures are maintained).	**6**	**10**	**10**	**6**	**32.0**
Option 4 Create a joint committee with delegated responsibilities for all CCG responsibilities with shared management team (similar to the arrangement which operated in the PCT Cluster)	**9**	**17**	**12**	**10**	**48**
Option 5 Full Merger	**6**	**16**	**13**	**10**	**45**

[2] Governing body members agreed that by scoring option 4 the highest they were expressing their judgement that this would be the best way to retain their locality structure whilst moving to their preferred option to merge - 5 - as quickly as possible.

Appendix 4b – Results of options appraisal by each GB

South Sefton	Better Health	Leadership	Sustainability	Better Care	Total
Option 1 Run programmes jointly with individual senior management teams in place (i.e. three Governing Bodies and separate governance structures are maintained).	**7**	**10**	**15**	**4**	**36**
Option 2 Create a joint committee with delegated responsibilities for work programmes and decisions which are best taken at North Mersey level with individual management teams remaining in place (i.e. each Governing Body delegates responsibilities and decision making to the joint committee).	**5**	**9**	**12**	**4**	**30**
Option 3 Run programmes jointly with shared management team but not a joint committee (i.e. three Governing Bodies and separate governance structures are maintained).	**8**	**10**	**14**	**7**	**39**
Option 4 Create a joint committee with delegated responsibilities for all CCG responsibilities with shared management team (similar to the arrangement which operated in the PCT Cluster)	**4**	**14**	**14**	**8**	**40**
Option 5 Full Merger	**8**	**18**	**15**	**10**	**51**

Appendix 4c – Results of options appraisal by each GB

Liverpool	Better Health	Leadership	Sustainability	Better Care	Total
Option 1 Run programmes jointly with individual senior management teams in place (i.e. three Governing Bodies and separate governance structures are maintained).	**34**	**45**	**36**	**24**	**139**
Option 2 Create a joint committee with delegated responsibilities for work programmes and decisions which are best taken at North Mersey level with individual management teams remaining in place (i.e. each Governing Body delegates responsibilities and decision making to the joint committee).	**42**	**52**	**49**	**31**	**174**
Option 3 Run programmes jointly with shared management team but not a joint committee (i.e. three Governing Bodies and separate governance structures are maintained).	**36**	**58**	**54**	**35**	**183**
Option 4 Create a joint committee with delegated responsibilities for all CCG responsibilities with shared management team (similar to the arrangement which operated in the PCT Cluster)	**38**	**76**	**81**	**50**	**245**
Option 5 Full Merger	**41**	**75**	**91**	**51**	**258**

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Appendix 5 – Principles agreed by the three Governing Bodies in taking this approach forward

Principles

'Celebrate the differences - All come together'

- Locality v Big Footprint
- Staff involvement/Celebrating the talent
- Membership decision making
- Stakeholder/Partner communication
- Pace/Clarity of timelines
- Social Value-local economies
- Learning from the past
- The 'trade-offs'
- Future state gives greater benefits
- Completed for April 2018

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MARCH 2017

Agenda Item: 17/51	**Author of the Paper:** Martin McDowell Chief Finance Officer Email: Martin.McDowell@southseftonccg.nhs.uk Tel: 0151 247 7000
Report date: March 2017	

Title: Better Care Fund Section 75 Agreement: Extension

Summary/Key Issues:

Work is progressing to establish a new Section 75 which is underpinned by the new Health and Wellbeing Board governance structures.

The guidance supporting the Better Care Fund (and pooled budget) has been delayed and is not available at this time. The CCG's will need to understand the implications of this guidance before they can agree a new Section 75 agreement. It is therefore recommended the CCG continues with the existing section 75 agreement, by agreeing the extension for a further year, with a view to an in-year revision once the implications of the new guidance are understood and a revised plan agreed with other partners.

Recommendation

The Governing Body is asked to :-

- Approve the extension of the Better Care Fund Section 75 agreement for a further 12months by invoking the extension clause which exists in the current agreement.
- Give delegated authority to the CCG Chair, the Chief Officer and the Chief Finance Officer to sign off a revised BCF and section 75.

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 and quality across the mandated constitutional measures.

x	To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
x	To advance integration of in-hospital and community services in support of the CCG locality model of care.
x	To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

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

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

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
March 2017

1. Background

Both Southport and Formby and South Sefton CCGs entered into a partnership arrangement with Sefton MBC under section 75 of the National Health Act 2006, to enable the establishment of pooled budgets to operate across the three parties. This was undertaken in line with the establishment of the Better Care Fund.

The Agreement established that the "term" was 2 years from 1st April 2015 to 31st March 2017, with an option to extend for a further year with the agreement of all parties.

All parties are currently collaborating to establish a revised version of the section 75 for implementation in 2017/18 financial year.

2. Proposed new Section 75

The work to establish a new Section 75 is being progressed and is underpinned by the new governance structures supporting the Health and Wellbeing Board, notably through the Executive Management Group (EMG) and Integrated Commissioning Group (ICG), with the latter having identified the key priorities for focus across Sefton. In addition there is a Pooled Budget group which focuses on the financial detail of the pool and risk share and reporting arrangements.

The guidance supporting the Better Care Fund (and pooled budget) has been delayed and is not available at the time of writing this paper, although thought to be imminent. The CCG will need to understand the implications of this guidance before they can agree a new Section 75 agreement. On this basis, the CCG is advised to continue with the existing Section 75 agreement by agreeing the extension for a further year with a view to an in-year revision once the implications of the new guidance are understood and a revised plan agreed with other partners. At the point such an agreement was reached all parties would be in a position to revoke the extension clause.

3. Next steps

As the Better Care Fund (BCF) guidance is expected imminently, and a tight timescale delivery expected, the proposed next steps are:-

- That key managerial leads for both Sefton CCGs and Sefton Council respond to the BCF guidance, when published, to design the 17/18 BCF and associated new Section 75 agreement, working though the Integrated Commissioning Group and

Pooled budget group as appropriate and reporting to the Health and Wellbeing Board Executive Group.

- The Integrated Commissioning Group to confirm the criteria for pooling resources for 2017-18 and beyond in line with the direction of travel approved in the Making It Happen: Sefton's Health and Social Care Integration Strategy, approved by the Governing Body in January 2017, in order to underpin the above work.
- That the two Sefton CCG Chairs, Chief Officer and Chief Finance Officer are given delegated authority to sign off a revised BCF and Section 75 to facilitate action to meet possible tight timescales.
- That the Governing Body be given regular updates on progress and ratification of any key decisions made, if delegated authority is given to proceed.

4. Recommendation

The Governing Body is asked to:

- Approve the extension of the Better Care Fund Section 75 agreement for a further 12months by invoking the extension clause which exists in the current agreement.
- Give delegated authority to the CCG Chair, the Chief Officer and the Chief Finance Officer to sign off a revised BCF and section 75.

Martin McDowell
Chief Finance Officer
March 2017

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MARCH 2017

Agenda Item: 17/52	**Author of the Paper:**
Report date: March 2017	Mel Wright Planning Lead melanie.wright@southseftonccg.nhs.uk

Title: Shaping Sefton to the Five Year Forward View

Summary/Key Issues:

The purpose of this report is to consider the CCG's Shaping Sefton schemes and priorities understand how these translate on a North Mersey footprint and to review the organisation's corporate objectives.

Recommendation

Receive	x
Approve	x
Ratify	

The Governing Body are asked to:

(i) receive assurance that the CCGs' work programmes and priorities are adequately represented within the North Mersey Demand Management workstream and that appropriate managerial and clinical support remains;

(ii) approve the corporate objectives set out in point 4 above.

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

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

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

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
March 2017

1. Introduction

1.1. The purpose of this report is to consider the CCG's Shaping Sefton schemes and priorities set out in 2015 as part of the 5-year strategic planning process and understand how these are now incorporated into the future planning process on a North Mersey footprint.

1.2. Given this review, it would also seem an appropriate juncture at which to review the organisation's corporate objectives.

2. Background

2.1. In 2015, the CCGs produced Shaping Sefton[1] which set out our 5-year strategy for improving health and healthcare in Sefton and identifying eight priority transformational programmes in support thereof:

- Primary care
- Community care
- Urgent care
- Mental health
- Care for older and more frail people
- Intermediate care
- Cardiovascular disease
- Respiratory disease.

Shaping Sefton also set out our aspirations:

- *"To spend less of our money on hospital based care, so we can spend more on services that are based closer to people's homes in places like GP practices, clinics and other community centres. A range of different health and social care services will be wrapped around our GP practice localities and their patients. This will make it easier for you to access healthcare, as well as improving your experience of the support you receive.*

- *Health and care services to be more joined up, so you don't have to tell your story over and over again to all the different organisations involved in your care because they work better together. We expect hospitals, community services, GP practices and even social care will work together more seamlessly using up to date technology, so your care is more effective.*

- *Hospitals to concentrate on providing you with the most effective care should you be seriously ill, along with any specialist services you may need – some of these could also be delivered by hospital staff in community clinics, so they come to you.*

[1] http://www.southseftonccg.nhs.uk/media/1312/ssccg-shaping-sefton-september-2015.pdf / http://www.southportandformbyccg.nhs.uk/media/1386/sfccg-shaping-sefton-september-2015.pdf

- *More support so you can better manage your health and wellbeing to prevent you from becoming ill. If you have a long term condition like diabetes or asthma, we want to provide services that help you stay as well as possible for as long as possible.*

- *You to have the confidence to care for minor illnesses and ailments yourself – known as self-care - through better information and advice that is easier to find, which could be from the internet, over the phone, or your local chemist.".*

2.2. These plans were refined and set out in more detail in our Commissioning Strategy and Blueprint (2015)[2] when the need for a whole system approach to transformation was also identified (page 9) as a necessity in terms of delivery:

"Our vision will be delivered in collaboration with our partners through our high impact transformation programmes. These programmes will focus on three key principles:

- *Whole system transformation with collective ownership and culture change of all partners*
- *Patient pathways rather than organisational structures*
- *Clinical and patient led.".*

The Blueprint goes on to describe the appropriate next steps to progress the vision and objectives set out in The NHS Five Year Forward View (FYFV):[3]

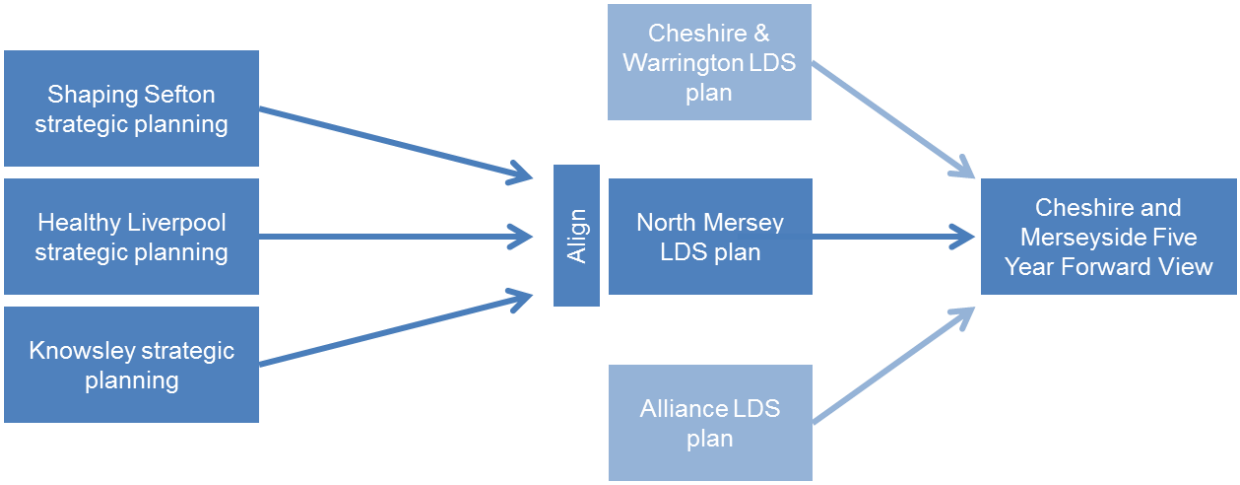
- *Undertake an in depth process with our partners to include more detailed agreement of the whole system programmes enabled through the overarching Shaping Sefton programme.*
- *Establish cross-organisation governance protocols.*
- *Agree phased priority approach.*
- *On-going evidence-based analysis of outcomes of new care models.*
- *Regular review of programmes against plan.*
- *Changes to be implemented from years 2015/16, with whole system change embedded by 2020.*

3. Informing the Development of the Cheshire and Merseyside Five Year Forward View

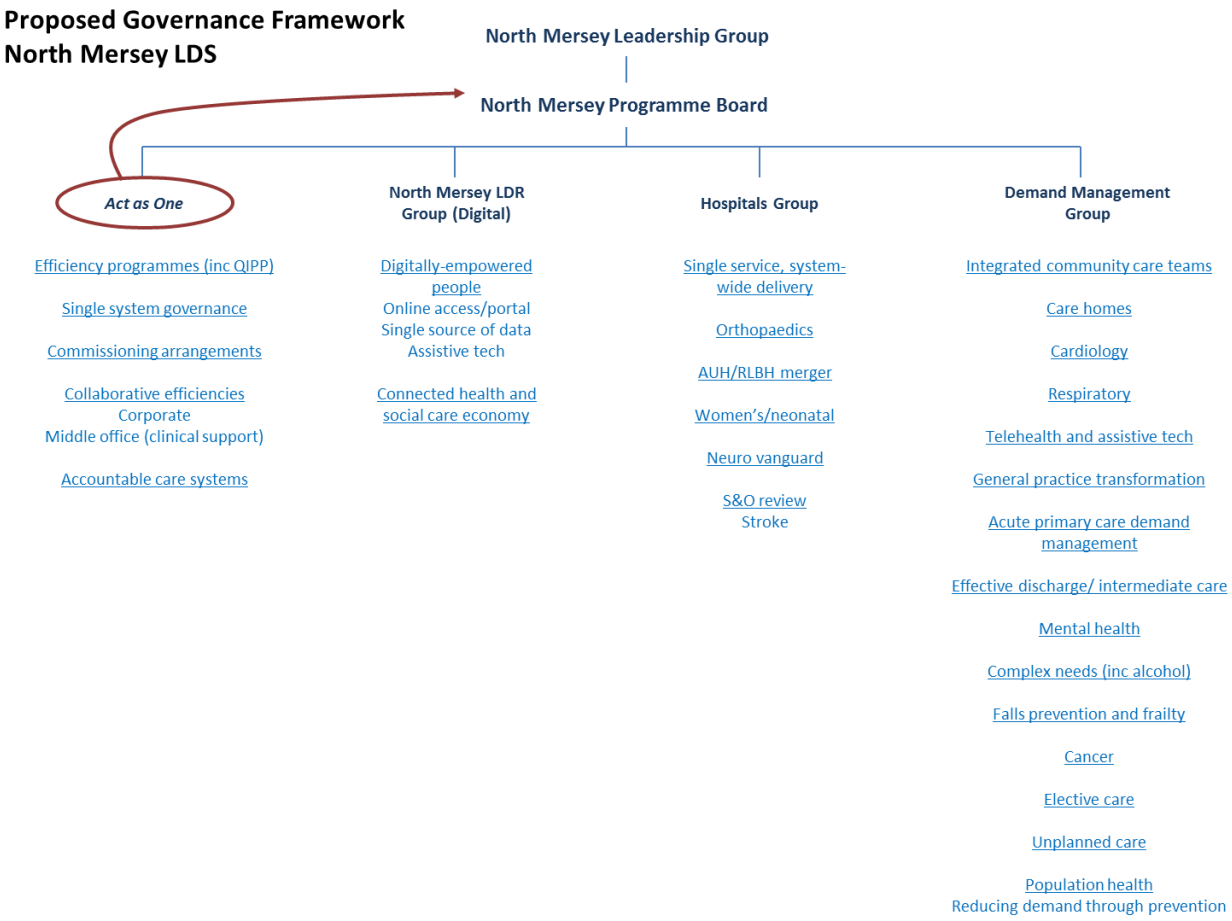
3.1. During the last six months, the schemes and programmes described in paragraph 2 above, have been used to shape and inform the development of the North Mersey Local Delivery System schemes and priorities and, in turn, those of the Cheshire and Merseyside Five Year Forward View.

[2] http://www.southseftonccg.nhs.uk/media/1157/blueprint-for-transforming-services-june-2015.pdf

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



3.2. These work programmes have also been considered at a North Mersey as part of the joint commissioning agenda to understand the synergies and combine efforts to create a single plan. A governance framework has been created to ensure all priorities are appropriately captured and it can be seen that all of the Shaping Sefton priorities are included.



3.3. Each of these programme areas are now considered in turn.

Demand Management workstream	Elements of Shaping Sefton incorporated
Integrated community care teams	Considerable synergy identified between Sefton and Liverpool schemes, although acknowledgement as to need for local approach.
Care homes	Sefton's Care Homes Improvement Project being considered for rollout across North Mersey.
Cardiology	Considerable synergy identified between Sefton and Liverpool schemes. Joint working group established to refine.
Respiratory	Considerable synergy identified between Sefton and Liverpool schemes.
Telehealth and assistive tech	Considerable synergy identified between Sefton and Liverpool schemes.
General practice transformation	Considerable synergy identified between Sefton and Liverpool schemes, although acknowledgement as to need for local approach.
Acute primary care demand management	Considerable synergy identified between Sefton and Liverpool schemes, although again, acknowledgement as to need for local approach.
Effective discharge/ intermediate care	North Mersey Integrated Community Reablement and Assessment Service developed collaboratively.
Mental health	Considerable synergy identified between Sefton and Liverpool schemes. Joint working group established to refine
Complex needs (inc alcohol)	New specific workstream for Sefton, although some work on Alcohol is already in place.
Falls prevention and frailty	Frailty case for change being developed at a North Mersey level.
Cancer	Considerable synergy identified between Sefton and Liverpool schemes. Joint working group established to refine.
Elective care	Considerable synergy identified between Sefton and Liverpool schemes.
Unplanned care	Considerable synergy identified between Sefton and Liverpool schemes.
Population health	New specific workstream for Sefton.
Reducing demand through prevention	New specific workstream for Sefton.

4. Corporate Objectives

As the CCGs' strategic aims remain the same for the year 2017/18, it is suggested that the current corporate objectives of 2016/17 remain appropriate and relevant, save for the following minor update, underlined below:

- 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 and as part of the North Mersey LDS;
- 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.

5. Conclusions

5.1. Further guidance on the delivery of the FYFV notwithstanding, the direction of travel in terms of whole system programmes/large scale change by 2020 and the need for cross-organisational governance protocols was clearly identified as a requirement by the CCGs as early as 2015.

5.2. As part of the commissioning system local evolution, the strategic priorities and programmes identified within Shaping Sefton have been adequately captured and are represented within the North Mersey Demand Management workstream. Further assurance can be gained by managerial and clinical leads remaining static pending full assurance on delivery during the transition process.

6. Recommendations

The Governing Body are asked to:

6.1. receive assurance that the CCGs' work programmes and priorities are adequately represented within the North Mersey Demand Management workstream and that appropriate managerial and clinical support remains;

6.2. approve the corporate objectives set out in point 4 above.

Mel Wright
Planning Lead
March 2017

Key Issues Report to Governing Body

NHS South Sefton Clinical Commissioning Group

Finance and Resource Committee Meeting held on Thursday 17 November 2016	Chair: Graham Morris

Key Issue	Risk Identified	Mitigating Actions
• CCG is reporting a likely case scenario of £0.5m deficit.	• Threat to deliver the CCG statutory duty. • Financial sustainability should be considered as the key risk facing the CCG.	• CCG must find additional savings to deliver its statutory duty.

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

- Month 7 finance report noted best case scenario case as a surplus of £1.250m, most likely case as a £0.501m deficit and the worst case as a £3.315m deficit.
  - Requirement to deliver RAG QIPP plan and additional schemes to be identified of £1.750m in order to reach £1.250m revised surplus control total.
- Main financial risk is under delivery of QIPP.
- Following policies approved: Security Management Policy, Health & Safety Policy and Information Governance Policy and Handbook.
- Notification has been received from NHSE that the CCG's BCF plan for 16/17 has been formally approved.
- Pan Mersey APC recommendation for the commissioning of the following medicines approved:
  - SECUKINUMAB injection (Cosentyx®▼) injection for Ankylosing Spondylitis
  - AFLIBERCEPT intravitreal injection (Eylea®▼) injection for Branch Retinal Vein Occlusion

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Thursday 19th January 2017	Chair: Graham Morris

Key Issue	Risk Identified	Mitigating Actions
• CCG likely case deficit of £2.1m which will deteriorate to £2.7m taking account of proposed settlement with Aintree University Hospital.	• CCG not on course to deliver its statutory duty even taking account of the 1% risk reserve expected to be included in the final accounts.	• Further focus on all aspects of expenditure in Q4 to improve the CCG's forecast outturn position.

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

- Committee approved the following policies:
  - Capability Policy
  - Equality & Diversity Policy
  - Grievance & Disputes Policy
  - Secondment Policy
  - Special Leave Policy
  - Mobile Device/Smartphone Policy.

  The Out of Hours/Lone Worker Procedure was approved subject to a minor amendment.

- Close review around QIPP for extra services undertaken by the CSU.

- Committee approved the proposed settlement discussed with Aintree University Hospital to pay £600k over contract for 2016/17.

- Joint estates group that covers the LDS was discussed - Committee gave Chief Finance Officer approval to discuss further on basis that a Terms of Reference paper is brought to a future Committee meeting.

- Repeat Prescription Ordering Service (RPOS) Pilot.
  - Practices involved in the pilot (excluding Hightown) show a reduction of 5.1% in items dispensed.
  - Practices not involved in the pilot show an increase of 1.5% in items dispensed.

- More practices asked to join the Repeat Prescription Ordering Service (RPOS) Pilot.

- Pan Mersey APC recommendations.
  - SODIUM OXYBATE Oral Solution (Xyrem®) for narcolepsy with cataplexy in adult patients: approved but requires prior approval.
  - BIOLOGICAL AGENTS (Anakinra, Etanercept, Infliximab or Tocilizumab) in adult onset Still's Disease: approved.
- Individual Exceptional Funding Request Summary Quarter 2 report received.

- Benchmarking: review of further areas to be actioned – RightCare / other CCGs.

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Joint Quality Committee Meeting held on 16th November 2016	Chair: Dr Rob Caudwell

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

- AUH Stroke Performance – Joint letter from both CCG Chairs re need to expedite plans across STP LDS' network
- Looked after Children Annual Report received – recommended presentation to the Governing Bodies
- Mental Capacity Act Annual Report received – recommended presentation to the Governing Bodies
- Serious Incident Standard Operating Procedures approved
- Whistle Blowing Policy (Revised) approved

Key Issues Report to Governing Body

NHS
South Sefton
Clinical Commissioning Group

Joint Quality Committee Meeting held on 18th January 2017	Chaired by: Dr Gina Halstead

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

- Corporate Risk Register – Quality Risk Register presented to the Quality Committee
- S&O Mortality – Issue identified with national data upload and has been reported to NHS Digital. NHSE are aware. This may impact on Trust mortality rates. CCG to await confirmation from national data cleansing / review as it may affect other Trusts.
- CCG Research Strategy – Updated strategy approved

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Minutes

Thursday 17th November 2016, 1.00pm to 3.00pm
3rd Floor Board Room, Merton House

Attendees (Membership)		
Graham Morris	Lay Member (Chair)	GM
Graham Bayliss	Lay Member	GB
Lin Bennett	Practice Manager & Governing Body Member	LB
Susanne Lynch	CCG Lead for Medicines Management	SL
Debbie Fagan	Chief Nurse & Quality Officer	DF
Rebecca McCullough	Head of Strategic Financial Planning	RM
Fiona Taylor	Chief Officer	FLT
In attendance		
David Smith	Deputy Chief Finance Officer	DS
Rebecca McCullough	Head of Strategic Financial Planning	RM
Mark Jump	Midlands & Lancashire CSU	MJ
Linda Pickup	Midlands & Lancashire CSU	LP
Ex-officio Member*		
Fiona Taylor		FLT
Apologies		
Dr Sunil Sapre	GP Governing Body Member	SS
Martin McDowell	Chief Finance Officer	MMcD
Jan Leonard	Chief Redesign & Commissioning Officer	JL
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	✓	✓	✓	✓	✓	✓	✓	✓	A	
Dr Sunil Sapre	GP Governing Body Member				A	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	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	✓	✓	✓	✓	✓	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
FR16/123	**Apologies for absence** Apologies for absence were received from Dr Sapre, Martin McDowell and Jan Leonard.	
FR16/124	**Declarations of interest regarding agenda items** Committee members were reminded of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NHS South Sefton Clinical Commissioning Group. Declarations declared by members of the South Sefton Finance & Resource Committee are listed in the CCG's Register of Interests. The Register is available via the CCG website at the following link: www.southseftonccg.nhs.uk/media/1858/ssccg-register-of-interests.pdf. **Declarations of interest from today's meeting** None declared.	
FR16/125	**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.	
FR16/126	**Action points from the previous meeting** **FR16/93: Estates Working Group** – Action complete and on agenda. **FR16/105: Terms of Reference** – Action complete and on agenda. **FR16/112: Month 6 Finance Report** – DS noted that a graph relating to outpatients at Aintree University Hospital has not been included in the report but distributed a separate graph showing the outpatient costs per month at Aintree Hospital from April 2015 to September 2016. **FR16/112: Month 6 Finance Report** - DS said LR has contacted NHSE to seek assurance that the CCG will receive sufficient cash during the year. A cash submission to request further cash has been completed by the CCG. It is expected that the response to the cash submission will be received by the end of November. MMcD to update at next meeting. **FR16/116: Prescribing Pilot Update** – SL confirmed a paper on the prescribing pilot will not be taken to the November Governing Body meeting, as the Medicines Management team is still in the process of gathering data. Furthermore, she wants to ensure the information is shared with the Local Pharmaceutical Committee prior to making it public. She confirmed that an update on the prescribing pilot has been included in the Chief Officer's report for the November Governing Body meeting. Action closed. **FR16/121: Any Other Business** – Action complete.	MMcD
FR16/127	**Security Management Policy** MJ said all CCGs need to comply with the Security Management Policy. FLT said the Security Management Policy will go through CCG internal communication channels (staff bulletin, Senior Management Team members disseminating to respective teams etc.) to ensure all staff members are aware of the policy. ***The Committee approved the Security Management Policy.***	

No	Item	Action
FR16/128	**Health & Safety Policy** MJ provided an overview of the Health & Safety policy. LB said there is a spelling error on page 18 of the policy: 'Lordlord' should be 'Landlord'. MJ confirmed this change would be made. FLT said the Health & Safety Policy will go through CCG internal communication channels (staff bulletin, Senior Management Team members disseminating to respective teams etc.) to ensure all staff members are aware of the policy. ***The Committee approved the Health & Safety Policy subject to the change discussed at the meeting.***	
FR16/129	**Information Governance Policy and Handbook** LP said all CCG staff members will need to sign to confirm they have read and understood the Information Governance Policy. DF said the Caldicott Guardian section on page 14 of the policy document refers to Southport and Formby CCG; the reference should be South Sefton CCG. LP said this would be changed and a full check would be done of the document to ensure all references are to the correct CCG. FLT said the Information Governance Policy and Handbook will go through CCG internal communication channels (staff bulletin, Senior Management Team members disseminating to respective teams etc.) to ensure all staff members are aware of both. ***The Committee approved the Information Governance Policy and Handbook subject to the changes discussed at the meeting.***	
FR16/130	**Estates Working Group – Utilisation Action Plan** The Utilisation Action plan was received; no questions were raised. ***The Committee received this report.***	
FR16/131	**Month 7 Finance Report** DS provided an overview of the year-to-date financial position for NHS South Sefton Clinical Commissioning Group as at 31 October 2016. The following was highlighted. • Forecast outturn position (after application of reserves) is a surplus of £1.250m against planned surplus of £2.450. • The main financial risk for the CCG is the non-delivery of the QIPP target in this financial year. • QIPP performance: £4.087m has been actioned at Month 7 against a phased plan of £6.062m. • Main financial pressure is with Funded Nursing Care. • Table F (Risk Rated Financial Position) shows the forecast deficit is £1.428m before any mitigating actions. After mitigation and further QIPP delivery, the best case scenario is a surplus of £1.250m, most likely case is a £0.501m deficit and the worst case is a £3.315m deficit. The CCG's most likely case scenario is £1.751m away from its planned position and further reductions on expenditure is required to deliver the plan.	
FR16/132	**Prescribing Performance Report** SL noted the South Sefton position for month 5 shows an underspend of £742k (-2.6% on a budget of £28,567,866). Overall South Sefton GP surgeries are	

No	Item	Action
	forecasting an underspend. LB spoke about the Repeat Prescribing Ordering Service Pilot and commented that overall it has been a positive pilot. ***The Committee received this report.***	
FR16/133	**Pan Mersey APC Recommendations** SL asked for the committee's approval of the Pan Mersey APC recommendation for the commissioning of the following medicines: • SECUKINUMAB injection (Cosentyx®▼) injection for Ankylosing Spondylitis • AFLIBERCEPT intravitreal injection (Eylea®▼) injection for Branch Retinal Vein Occlusion ***The Committee approved the Pan Mersey APC recommendation for the commissioning of the above medicines.***	
FR16/134	**Merseyside Local Digital Roadmap** The report provides details of further information submitted re. the Merseyside Local Digital Roadmap in response to gaps identified by NHS England. ***The Committee received this report.***	
FR16/135	**Better Care Fund Update** DS said notification has been received from NHSE that the CCG's BCF plan for 16/17 has been approved.	
FR16/136	**Terms of Reference** The changes to the Terms of Reference were noted. ***The Committee approved the changes to the Terms of Reference.***	
FR16/137	**Any Other Business** GM noted that this meeting is DS's last South Sefton Finance & Resource Committee meeting, as he will be leaving the CCG this week. GM thanked DS for his support to the Committee and contribution to the CCG.	
FR16/138	**Key Issues Review** DS highlighted the key issues from the meeting and these will be presented as a Key Issues Report to Governing Body.	
	Date of Next Meeting Thursday 19th January 2017 1.00pm to 3.00pm 3rd Floor Board Room, Merton House	

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee Minutes

Thursday 19th January 2017, 1.00pm to 3.00pm

3rd Floor Board Room, Merton House

Attendees (Membership)		
Graham Morris	Lay Member (Chair)	GM
Graham Bayliss	Lay Member	GB
Lin Bennett	Practice Manager & Governing Body Member	LB
Dr Sunil Sapre	GP Governing Body Member	SS
Martin McDowell	Chief Finance Officer	MMcD
Alison Ormrod	Deputy Chief Finance Officer	AO
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Susanne Lynch	CCG Lead for Medicines Management	SL
Debbie Fagan	Chief Nurse & Quality Officer	DF
In attendance		
Tracy Jeffes (for items FR/1701-FR17/07 and FR17/21)	Chief Delivery and Integration Officer	TJ
Ex-officio Member*		
Fiona Taylor	Chief Officer	FLT
Apologies		
Dr John Wray	GP Governing Body Member	JW
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	✓	✓	✓	✓	✓	✓	✓	✓	A	✓
Alison Ormrod	Deputy Chief Finance Officer										✓
Dr Sunil Sapre	GP Governing Body Member				A	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	N	A
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	✓	✓	✓	✓	✓	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
FR17/01	**Apologies for absence** Apologies for absence were received from Dr John Wray.	
FR17/02	**Declarations of interest regarding agenda items** Committee members were reminded of their obligation to declare any interest they may have on any issues arising at Committee meetings which might conflict with the business of NHS South Sefton Clinical Commissioning Group. Declarations declared by members of the South Sefton Finance & Resource Committee are listed in the CCG's Register of Interests. The Register is available via the CCG website at the following link: www.southseftonccg.nhs.uk/media/1858/ssccg-register-of-interests.pdf. **Declarations of interest from today's meeting** Declarations of interest were received from CCG officers who hold dual posts in both South Sefton CCG and Southport and Formby CCG.	
FR17/03	**Minutes of the previous meeting and key issues** The minutes of the previous meeting were approved as a true and accurate record and signed-off by the Chair. The key issues log was approved as an accurate reflection of the main issues from the previous meeting.	
FR17/04	**Action points from the previous meeting** **FR16/126: Action points from the previous meeting (FR16/112: Month 6 Finance Report)** - MMcD confirmed NHSE has written to the CCG to confirm there will be adequate cash to cover the CCG's liabilities for this financial year. Action closed.	
FR17/05	**HR policies and procedures** TJ presented the following policies: Capability Policy, Equality & Diversity Policy, Grievance & Disputes Policy, Secondment Policy, Special Leave Policy and Out of Hours/Lone Working Procedure. She confirmed these policies have been supplied by the CSU and are consistent with policies across Cheshire and Merseyside. DF referred to Section 1 of the Out of Hours / Lone Working Procedure and said the title currently states 'during office hours' but should state 'out of office hours.' TJ confirmed this will be amended. ***The Committee approved all policies subject to the discussed amendment being made to the Out of Hours / Lone Working Procedure.***	
FR17/06	**HR Performance Report** TJ presented the latest HR Performance Dashboard (December 2016) compiled by Midlands & Lancashire CSU. She said this is a high level dashboard. TJ noted that the CCG continues to be compliant with its mandatory and statutory training target. The report shows that the ethnicity profile continues to be low. TJ to liaise with the CSU over how the target is derived and to see if there is any other action the CCG should take. TJ to report back to the Committee. ***The Committee received this report.***	TJ
FR17/07	**CSU Service Report** TJ said this report provided an overview of the range of work that the CSU has supported the CCG with.	

No	Item	Action
	It was agreed that further scrutiny is required regarding the extra CSU services that the CCG has procured to enable QIPP delivery to determine whether value for money is being achieved. ***The Committee received this report.***	
FR17/08	**Estates Working Group** MMcD asked for the Committee's support in principle for widening the membership and remit of the estates working group so that it covers a Local Delivery System (LDS) footprint. This would entail having a membership that includes Southport & Formby CCG, South Sefton CCG and Liverpool CCG. The group would have a more strategic remit whilst retaining the operational Sefton footprint that the current Sefton Property Estate Partnership (SPEP) group has. MMcD said he would bring a draft terms of reference for the group, incorporating the proposed changes, to a future Committee meeting for review. ***The Committee agreed in principle for MMcD to proceed with the proposed changes to the estates working group subject to bringing a Terms of Reference to the Committee to review.*** LB informed the Committee that the local Champion paper has detailed planned improvements as part of the Road Investment Strategy. Public Consultation will close on 27th February 2017 for the A5036 Port of Liverpool Access Scheme. There are two planned routes: Options A and B. Option B involves a new dual carriage way bypass through the Rimrose Valley; if chosen, this route will have direct impact on the surrounding area for Litherland Town Hall. MMcD noted this information should it impact the CCG estates work.	MMcD
FR17/09	**Update on IM&T Funding** MMcD provided an update on IM&T funding and gave an overview of the proposed BIDs for the next financial year. He said there is an expectation that the CCG will receive the funding for Cohort 1 schemes in this financial year. ***The Committee received this report.***	
FR17/10	**Month 9 Finance Report** MMcD provided an overview of the year-to-date financial position for NHS South Sefton CCG as at 31 December 2016. The following was highlighted. • The CCG is forecasting a likely case scenario of 2.115m deficit. • Forecast outturn position after application of reserves is a surplus of £1.250m against a planned surplus of £2.450m. • The QIPP requirement to deliver the planned surplus of £1.250m for the financial year is £10.384m. • The CCG's detailed QIPP plan is projected to deliver £6.812m in total during the year. • The CCG will now need to report a deficit to NHSE. • A meeting has taken place with Aintree University Hospital where a proposed settlement was discussed for the payment of £600k over the contract for 2016/17. Both Dr John Wray and Dr Gina Halstead were in attendance at the meeting. MMcD asked for the Committee's approval to take this forward. The Committee approved this as the best pragmatic solution. ***The Committee approved the proposed settlement discussed with Aintree University Hospital to pay £600k over the contract for 2016/17.***	

No	Item	Action
	The Committee received the Finance Report.	
FR17/11	**Finance & Resource Committee Risk Register** MMcD said there is a requirement for individual committees to hold their own risk register and therefore this register would be included on the agenda for review for every Finance & Resource Committee meeting going forward. Risk FR001 (*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*) was discussed. MMcD said the 1% reserve that is likely to be released by NHSE at the end of the financial year could reduce this risk. GM commented that there is a need for the Committee to be aware of other committees' risks that may have a financial impact. DF said the Joint Quality Committee has its own risk register and she will update F&R on an ongoing basis if there are any risks that have a financial impact. ***The Committee received and approved the Committee Risk Register.***	
FR17/12	**Prescribing Spend Report – Month 7 2016/17** SL noted the South Sefton position for month 7 shows an underspend of £850k (-3% on a budget of £28,567,866). Overall South Sefton GP surgeries are forecasting an underspend. ***The Committee received this report.***	
FR17/13	**Quarter 2 Prescribing Performance Report 2016/17** SL presented the report noting prescribing performance for the second quarter of 2016/17 for South Sefton CCG constituent practices. The report compares activity against the second quarter of 2015/16. SL confirmed there has been a reduction of 2.2% in actual cost growth and an increase of 1.2% of items dispensed compared to the previous year. There has been a reduction of £160k in spend from Q2 2015/16 in relation to level 3 QIPP areas. LB raised Pregabalin prescribing. SL discussed variance across the CCG and confirmed the Medicines Management team are supporting individual practices. ***The Committee received this report.***	
FR17/14	**Repeat Prescription Ordering Service (RPOS) Pilot Report** SL provided an update on the RPOS pilot and confirmed the CCG has two months of data available (for September and October 2016). She said the report is focussed on the number of items dispensed compared to the same point in the previous year. She confirmed practices involved in the pilot (excluding Hightown) show a reduction of 5.1% in items dispensed, whilst practices not involved in the pilot show an increase of 1.5% in items dispensed. ***The Committee received this report.***	
FR17/15	**APC Recommendations – Sodium Oxybate & Biological Agents** SL asked the Committee to consider approving the following Pan Mersey APC	

No	Item	Action
	recommendations: • SODIUM OXYBATE Oral Solution (Xyrem®) for narcolepsy with cataplexy in adult patients • BIOLOGICAL AGENTS (Anakinra, Etanercept, Infliximab or Tocilizumab) in adult onset Still's Disease SL confirmed that these are not NICE recommendations. The high cost of Sodium Oxybate was noted. SL said there are currently two patients in South Sefton that have been prescribed the drug. ***The Committee approved the Pan Mersey APC recommendation for the commissioning of SODIUM OXYBATE, on the basis that it is prescribed via a prior approval system, which SL and JL are to facilitate.*** ***The Committee approved the Pan Mersey APC recommendation for the commissioning of BIOLOGICAL AGENTS.***	
FR17/16	**Individual Exceptional Funding Request Summary - Quarter 2** JL provided an overview of this report which provides a summary of individual exceptional funding requests for quarter 2. ***The Committee received this report.***	
FR17/17	**Better Care Fund Update** MMcD said the CCG is in the process of signing off Section 75 for 16/17. He confirmed the work on pooled budgets is ongoing and will be discussed further in January's Governing Body meeting.	
FR17/18	**Committee Work Plan 2017/18** The work plan for 2017/18 was reviewed. It was agreed that the BCF update did not need to be on every meeting agenda and instead was to be presented when there would likely be an update on the process. It was agreed for the BCF update to be on the agenda for the May, August, November and February F&R meetings. GM raised the External Updates / Benchmarking and VFM Reports on the workplan. It was agreed for AO to work on benchmarking and VFM by reviewing other CCGs and liaising with Fiona Doherty (Strategy & Outcomes Officer) re. RightCare. ***The Committee received the work plan 2017/18.***	AO
FR17/19	**Committee Meeting Dates 2017/18** The list of meeting dates for 2017/18 was reviewed. ***The Committee received the meeting dates for 2017/18.***	
FR17/20	• **Sefton Property Estate Partnership (SPEP) Group** • **Information Management & Technology (IM&T) Steering Group** • Sefton Property Estate Partnership (SPEP) Group – October 2016 • Information Management & Technology (IM&T) Steering Group – November 2016. ***The Committee received the minutes of the SPEP and IM&T steering groups.***	

No	Item	Action
FR17/21	**Any Other Business** Mobile Device/Smartphone Policy – Allocation and Use TJ presented the Mobile Device/Smartphone Policy. GB commented on the importance of ensuring training is provided with policies such as this. TJ said a CSU colleague will be providing training on this policy later in the year. ***The Committee approved the Mobile Device/Smartphone Policy.***	
FR17/22	**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 16th February 2017 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: **Wednesday, 16th November 2016, 11.30am to 1.30 pm**
Venue: **The Marshside Surgery, 117 Fylde Road, Southport, PR9 9XL**

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

Julie Cummins	Clinical Quality & Performance Co-ordinator	JC
Tracey Forshaw	Head of Vulnerable People	TF
Brendan Prescott	Deputy Chief Nurse & Head of Quality and Safety	BP
Helen Roberts	Senior Pharmacist	HR
Jo Simpson	Programme Manager – Quality and Performance	JS

Apologies

Graham Bayliss	Lay Member	GB
Lin Bennett	Practice Manager, Ford	LB
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	PC
Julie Cummins	Clinical Quality & Performance Co-ordinator	JC
Tracey Forshaw	Head of Vulnerable People	TF
Dr Gina Halstead	Vice Chair & Clinical Lead for Quality	GH
Dr Dan McDowell	Secondary Care Doctor	DMcD
Martin McDowell	Chief Finance Officer	MMcD
Helen Roberts	Senior Pharmacist	HR
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		√	√	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			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	A				
Dr Dan McDowell	Secondary Care Doctor	A	√		A		A	A	A				
Martin McDowell	Chief Finance Officer	A	A		√		√	A	A				
Dr Andrew Mimnagh	Clinical Governing Body Member	√	√		A		A	√	√				
Dr Jeffrey Simmonds	Secondary Care Doctor						√	A	A				

✓ Present
A Apologies
L Late or left early

No.	Item	Action
16/136	**Apologies for Absence** Apologies for absence were received from GB, LB, Dr PC, JC, TF, Dr GH, Dr DMcD, MMcD, JR and Dr JSi	
16/137	**Declarations of interest regarding Agenda items** Dr RC reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Southport & Formby Clinical Commissioning Group (SFCCG) or South Sefton Clinical Commissioning Group (SSCCG). Declarations declared by members of the Joint Quality Committee are listed in the CCG's Registers of Interests. The Registers are available either via the secretary to the governing bodies or the CCG websites at the following links: www.southportandformbyccg.nhs.uk/media/1760/sfccg-register-of-interests.pdf www.southseftonccg.nhs.uk/media/1858/ssccg-register-of-interests.pdf **Declarations of interest from today's meeting** CCG Officers holding dual roles in both Southport & Formby and South Sefton CCGs declared their potential conflict of interest. Dr RC welcomed FLT to the meeting and declared that the meeting is quorate.	
16/138	**Minutes and Key Issue Logs from the previous meetings** The Minutes of the Joint Quality Committee (JQC) were agreed as an accurate reflection of the previous meeting. The Key Issues for SFCCG and SSCCG were approved.	
16/139	**Matters Arising/Action Trackers** There were no matters arising. **Action Tracker** **16/054 Whistle Blowing Policy and Procedure (Raising Concerns at Work) - *SFCCG & SSCCG*** The Whistle Blowing Policies for SFCCG and SSCCG will be presented to the JQC for approval under agenda item 16/145. **Outcome: The JQC agreed that this action could now be closed.** **16/091 NWAS Quality Performance Report - *SFCCG*** The JQC were advised that a plan is in the course of preparation to address performance issues. **Outcome: The JQC agreed that this action could now be closed.** **16/109(i) Provider Quality Performance Reports – *SFCCG & SSCCG*** Aintree University Hospital (AUH) BP had provided a verbal update at the JQC meeting held on 20th October 2016, adding that a meeting had subsequently been held with the CCGs' Chief Strategy & Outcomes Officer and the Deputy Medical Director at Aintree University Hospital (AUH) to explore dermatology demand and options. The JQC were also advised of the imminent retirement of one of the Consultant Dermatologists. **Outcome: The JQC agreed that this action could now be closed.** **16/109(ii) Provider Quality Performance Reports – *SFCCG*** DC confirmed that the issue he had previously raised concerning poor quality responses /lack of narrative appeared to have been resolved and confirmed the	

action could be closed.
Outcome: The JQC agreed that this action could now be closed.

16/109(iii) Provider Quality Performance Reports – *SFCCG* Southport & Ormskirk Hospital NHS Trust (S&O) DF advised this issue had been raised formally at a recent Clinical Quality & Performance Group / Contract Review Meeting with the Trust. Directors will now have sight of the information leaving the Trust before receipt by commissioners.
Outcome: The JQC agreed that this action could now be closed.

16/109(iv) Provider Quality Performance Reports – *SFCCG* Mersey Care NHS Foundation Trust JS confirmed that delays with submission of data had been raised formally with the Trust. Discussions were also taking place with LCCG to determine whether the issue will be taken forward as a contract query.
Outcome: The JQC agreed that this action could now be closed.

16/110 Safeguarding Service – CCG Safeguarding Service Quarterly Report – *SFCCG & SSCCG* DF advised that the Safeguarding Team had been looking at alternative means of providing training and that the Designated Nurse, Looked After Children had already delivered a training session to Governing Body members last month.
Outcome: The JQC agreed that this action could now be closed.

16/111 Safeguarding Annual Reports 2015/126 for SFCCG and SSCCG - *SFCCG & SSCCG*
DF confirmed the amendment to the annual reports had been completed and this action could be closed.
Outcome: The JQC agreed that this action could now be closed.

16/115(ii) Dementia Diagnosis Rates – Improvement Plan for South Sefton - *SSCCG*
FLT confirmed that this issue was currently with the LMC for validation however it would appear the work is covered by existing contracts.
Outcome: The JQC agreed to receive a further update at their January 2017 meeting.

16/124 Quality Surveillance Report – October 2016 *SFCCG & SSCCG*
BP confirmed that a response had been received from NHS E confirming that patients with an end of life plan can access out of hours dental services.
Outcome: The JQC agreed that this action could now be closed.

16/125 Quality Team Risk Registers *SFCCG*
BP confirmed that discussions had taken place with MMcD regarding item SF004 of the Quality Team Risk Register as requested at the last meeting.
Outcome: The JQC agreed that this action could now be closed.

16/128 Southern Health Report *SFCCG & SSCCG* – BP is to address for the JQC to review at their next meeting and Margie Dawe will distribute the response re DoLs.
Outcome: The JQC agreed to receive a further update at their January 2017 meeting.

16/129(i) Quality Impact Assessment Policy to support commissioning decisions *SFCCG & SSCCG* BP confirmed he had amended the document which will now be distributed to the wider CCG management team.
Outcome: The JQC agreed that this action could now be closed.

16/129(ii) Quality Impact Assessment Policy to support commissioning

	decisions *SFCCG & SSCCG* DF confirmed that LCCG had agreed that the policy and QIA could be shared with providers. **Outcome: The JQC agreed that this action could now be closed.** **16/130 Access Sefton IAPT Performance *SFCCG & SSCCG*** The JQC agreed to receive an update through GO'C in January 2017. **Outcome: The JQC agreed to receive a further update at their January 2017 meeting.** **16/131 Dementia Diagnosis Rates – Sefton *SFCCG & SSCCG*** FLT has raised at LT and confirmed this action could be closed. **Outcome: The JQC agreed that this action could now be closed.** **16/135(i) Chief Nurse Report *SFCCG & SSCCG*** Nursing Home Update BP confirmed that the Risk Register now contained an item relating to inspections where quality is an issue. **Outcome: The JQC agreed that this action could now be closed.** **16/135(ii) Chief Nurse Report *SFCCG & SSCCG*** (Discussion Point) BP confirmed this action had been completed and could be closed. **Outcome: The JQC agreed that this action could now be closed.** **16/135(iii) Chief Nurse Report *SFCCG & SSCCG*** (Discussion Point) DF confirmed she had contacted NHS E and that further information on the CQC process had been forwarded to them with Dr AM being included in the e-mail exchanges. The CQC have also been requested to forward details of their inspection process and associated timeframes including that for when a provider may be in dispute of the judgement – this is to include inspection of general practice. **Outcome: The JQC agreed that this action could now be closed.**	
16/140	**Chief Nurse Report** DF presented the Committee with a number of key issues which had occurred since the Chief Nurse report submitted in October 2016. Stroke Services at Southport & Ormskirk NHS Trust (S&O) The Chief Strategy & Outcomes Officer has been asked to contact relevant partners to expedite the work regarding stroke services across the STP/LDS footprint. Southport & Ormskirk NHS Trust (S&O) CQC Report The Trust's CQC Report entered the public domain yesterday with the Trust awarded an overall rating of 'requires improvement'. A Quality Risk Summit is expected to take place and the CCGs await communication regarding this from the CQC/NHSE. Southport & Ormskirk NHS Trust (S&O) Executive Improvement Board Margaret Kitching, Director of Nursing for NHS E (North Region) attended a recent Executive Improvement Board meeting to enable it to fulfil the function of the Interim Risk Summit Review. The Trust remain at a Risk Summit level of surveillance. Care Homes A Care Home update was provided detailing concerns with quality. *Dovehaven Care Group* Following the approval by both Governing Bodies to provide an uplift in-line with the proposal presented to them in October 2016, a meeting took place with the	

	provider management. As a result, the provider has withdrawn the notice served to the CCGs.	
	The Committee received the report	
16/141	**Provider Quality Performance Reports** JS presented the Provider Quality Performance Reports relating to both SFCCG and SSCCG by exception. <u>Aintree University Hospital (AUH)</u> JS confirmed that additional information was now being provided by the Trust within the report including Delayed Transfers of Care (DTOC), Crude Mortality and Dermatology. VTE Risk Assessment - DF referred to concerns raised re VTE performance at CQPG last week. This was originally a CQUIN and the Trust performance is red rag rated. Concerns were raised with the Trust at the last CQPG and a presentation has been built into the workplan so the provider can demonstrate how they intend to improve performance. Stroke - FLT noted the declining position with performance recorded as 58.33%. DF advised performance had been discussed at the CQPG held on 9th November 2016 with issues remaining unchanged in relation to time on stroke bed. Difficulties with recruitment of staff were also noted, although it is understood a strategy in place. BP was also aware that the Trust is reviewing its Stroke Action Plan. FLT requested CCG Chairs write to the Stroke Network to seek a solution to hyper acute stroke issues. **ACTION: Joint letter to be prepared for both chairs to sign to seek a solution to hyper acute stroke issues.** CQC Report / A&E Quality Visit – An update on the 'Must Do' key lines of enquiry will be provided to the JQC in January 2017. DF commented that the CCGs Quality and Ops Team, accompanied by GP Clinical leadership, had undertaken a quality walkaround of AED at AUH and had utilised the key issues from the CQC report to inform their KLOEs. DTOC – FLT requested details of the relevant financial costs of the reported loss of bed days. **ACTION: JS to advise FLT of costs of loss of reported 1,385 bed days.** Friends & Family – Although performance appears to be declining, JS said this was not indicative of usual performance with the cause identified as data capture rather than quality Cancer Measures E.B.13 – This service is not commissioned by the CCGs, however DF has liaised with the lead in PHE who will get a member of his team to set up a meeting to include concerns with the screening hub. DF advised this request was made 3 weeks ago and will chase this up. **ACTION: DF will pursue a response from PHE lead to ensure the meeting takes place.** Rapid Access Chest Pain – BP advised that Dr GH is working with the trust on the referral form with an audit of patient harm expected to be completed by January 2017. Currently, the Trust have reported at the CQPG that no harms have been identified and no patients have been waiting more than 14 days. JS advised that the quality elements of the contract for 2017/18 are being undertaken as per the CCGs contract planning work schedule.	**DF** **JS** **DF**

	Southport & Ormskirk Hospital NHS Trust (S&O) Cancer Measures – It was acknowledged that the Trust is experiencing issues with the screening hub which will be discussed at the CQPG later today. FLT noted some good reporting in this area but raised concerns that the Trust were performing just below target. JS reported that RCAs are undertaken for all breaches. Mixed Sex Accommodation - Three breeches were reported in September 2016. The Trust has requested that the CCG re-invests any possible penalties back with the Provider in order to support improvements in this area – this is being addressed outside of the Quality Committee. DF stated that she had recently responded to an enquiry from NHSE regarding the number of recent MSA breaches in both S&O and AUH. DC raised his concerns in relation to stroke cases arising from Out of Hours (OoH) or weekend admissions and asked what could be done to address issues around weekend admissions. DF suggested DC could raise these concerns at today's CQPG and also highlighted the recent presentation to the Governing Bidy by the Interim Chief Executive of the Trust. FLT believes the CCGs are doing everything they can to seek improvement in this area but made the suggestion for the GP Clinical lead from the CCG to discuss with Trust re weekend care of patients presenting with stroke/TIA and undertake a forensic analysis **ACTION: The GP Clinical lead from the CCG is to discuss the weekend care of patients presenting with stroke/TIA with the Trust and undertake a forensic analysis.** Dementia – Targets relating to Dementia were not achieved last year and this was reflected in the CQUIN payment made. Issues remain in the Trust achieving this target with the suggestion made that liaison takes place with two other providers who are meeting targets with an update provided for Q3. JS is also liaising with the CCGs' Integrated Commissioning Team Manager who has responsibility for dementia performance. The JQC were advised that the Q2 complaints report had been received today with no specific complaints around stroke; fuller details will be included in January 2017's JQC reports. However, FLT was aware that the Interim Chief Executive of the Trust has been taking a personal interest in the complaints process in place. GB has offered to work with the Trust to offer support. **ACTION: JS will forward the Q2 complaints report to GB for progression through the Interim Chief Executive or the Director of Nursing.** Referral to Treatment – Performance was noted as on a downward trajectory with monitoring to be maintained. A position statement is to go back to SMT if any specific specialties are an issue. FLT questioned the reasons behind cancelled operations and asked that explanations be provided in future reports to enable JQC members to understand the cause. Falls – Improved performance seen and well below trajectory. DF said conversations had taken place with the Trust regarding the use of agency staff and their subsequent induction and training. **ACTION: JS is to request an action plan to demonstrate the changes in induction and training of agency staff.**	**DC** **JS** **JS**

	GB referred to the comments recorded against Falls which she considered were inappropriate. DF stated that concerns regarding the quality of the accompanying performance narrative being provided by the Trust had been raised at the last CQPG and the Directors present had agreed to review this process due to the changes in leadership recently. FLT recognised there had been changes in leadership and is aware of concerns regards appropriate levels of management to deal with issues occurring. DF will raise concerns of the JQC again at today's CQPG. The Committee were also asked to note that an information sub group was in operation as part of the contract process and that they had a role in providing challenge to ensure data flow from the Trust improves. FLT suggested an invitation to attend the next meeting of the JQC should be extended to the new Chief Operating Officer (COO) and Director of Nursing (DoN). **ACTION: DF to invite the COO and DoN to the January 2017 meeting of the JQC which is due to take place on Wednesday 18th January 2017.** <u>Liverpool Community Health (Sefton) (LCH)</u> JS assured members of the JQC that the majority of areas of concern have been raised at CQPGs, including waiting time for SALT and other therapies. Data cleansing of waiting lists is continuing throughout December 2016. A more accurate waiting list should then be available. AM also confirmed that the announcement of the future provider of these services was imminent. BP confirmed that progress on the CQC action plan is expected between now and the middle of February 2016. Ear Irrigation - FLT questioned why no narrative was recorded against this KPI and sought confirmation of what is being done about performance in this area. <u>Other Providers</u> The JQC were advised that work was underway with the Chief Strategy & Outcomes Officer's team to extract performance information to make it more precise. DF assured FLT that the same level of scrutiny was undertaken by the lead Liverpool CCG with providers for which they were lead commissioner and that members of the Quality Team attending the CCFs and CQPGs of other Trusts. <u>Mersey Care NHS Foundation Trust – Mental Health</u> <u>Cheshire Wirral Partnership (CWP) - IAPT</u> JS apologised for the late circulation of the Mersey Care report which was received by the JQC. FLT confirmed that IAPT performance was receiving scrutiny from both of the Governing Bodies.	**DF**
	The Committee received the report.	
16/142	**Continuing Healthcare/Complex Care Services Quality & Performance Q2 Updates for South Sefton and Southport & Formby CCG's** BP presented the Quarter 2 Update report on behalf of the Clinical Quality &	

	Performance Co-ordinator from CSU, highlighting the following issues: <u>South Sefton CCG area</u> Care home compliance highlight along with providers that have restrictions in place. <u>Southport & Formby CCG area</u> No homes are currently non-complaint with regards to clinical standards. A provider rated overall inadequate by the CQC was discussed and the JQC was highlight along with progress against the regulator action plan to bring about required improvements. BP assured the JQC that overall capacity of the homes is monitored by the CCGs through CSU.	
	The Committee received the report.	
16/143	**South Sefton CCG and Southport and Formby CCG Serious Incident Reports** BP presented this report on behalf of the Head of Vulnerable People. BP explained that the information within the report was presented separately for each CCG, highlighting the number of incidents relating to Pressure Ulcers at Southport and Ormskirk Hospitals NHS Trust. The Trust remains an outlier for the number of incidents open on StEIS compared to other Trusts (125). 90 relate to pressure ulcers, 26 of which relate to this financial year. A contract query remains open with a formal letter submitted to the Trust in October 2016. An updated thematic analysis has been requested. The CCG's are required to have in place a Standard Operating Procedure (SOP) for managing Serious Incidents in line with NHS England Serious Incident Framework (2015) and Never Events Policy (2015). The JQC approved the draft (SOP) included under Appendix 3. RC questioned the cause of delays of two Serious Incidents (SIs) which have been open for two years. BP explained that all SIs open for more than 100 days are being reviewed and tracked by the Head of Vulnerable People. **ACTION: Future reports are to include narrative against SIs open for more than 100 days with an indication of the timescale for resolution**. FLT noted the statement within the report referring to the CCGs Programme Manager Quality & Safety being on secondment and questioned the relevance, asking whether it was perceived as a risk. DF and BP assured the JQC that the inclusion of the comment was solely for awareness purposes to explain the change in report author. As information of this nature is not required, it should not be included in any future reports.	**BP/TF**
	The Committee received the report and approved the Standard Operating Procedure.	
16/144a	**Safeguarding Service:** **Looked After Children Annual Report 2015/16** The Designated Nurse Looked After Children (CB) presented the JQC with the first Looked After Children (LAC) Annual Report. The purpose of the report is to assure the Governing Bodies and members of the public that NHS Southport & Formby CCG and NHS South Sefton CCG are fulfilling their statutory duties in relation to safeguarding and LAC The annual report takes account of national changes and influences and local developments, activity, governance arrangements and the challenges for 2016/17.	

	FLT thanked CB for the informative report suggesting she flag any issues in terms of volume of LAC. DF explained that although this was a joint report, it would be presented individually to the two Governing Bodies. GB was concerned by the number of Sefton placements at 30% out of area. CB said Sefton did tend to have a high number of out of area placements and numbers of children placed on care orders remaining with parents.	
	The Committee received the report.	
16/144b	**Safeguarding Service:** **Mental Capacity Act/Deprivation of Liberty Safeguards (MCA/DoLS) Annual Report 2015/16** The Safeguarding and MCA/DoLS Coordinator (MD) presented the JQC with the first Mental Capacity Act/ Deprivation of Liberty Safeguards (MCA/DoLS) Annual Report. The purpose of the report is to assure the Governing Bodies and members of the public that the CCGs are fulfilling their statutory duties in relation to people requiring care and treatment in the Borough who lack capacity to make best interest decisions. The annual report takes account of national changes and influences and local developments, activity, governance arrangements and the challenges for 2016/17. The Local Authority is the authorising authority for DoLS and the data provided within the report is collated by the health trusts and the Local authority and does identify and reflect some of the gaps in methods and systems to support the collection of data. This therefore presents a challenge to assess whether the data provided is effective until the systems are in place. Sefton Local Authority has seen an increase in requests and some of that is reflected in some of the data reported within the annual report. Numbers of referrals have posed capacity concerns for the local authorities – for example particularly being able to meet the required timeframes. The report also outlines some possible future implications in relation to the evolving agenda for MCA /DoLS. These have been identified within the current work plan for this year and will be reported and monitored via the quality Committee and any risks will be identified. MD raised the issue of the impact of MCA / DoLS in the commissioning of domiciliary care placements and nursing home placements. DF requested assurances that this was being taken into account and asked MD to set up a meeting with CSU colleagues and the Head of Vulnerable People and report back for the purposes of assurances. DF stated that she would also raise this issue with the HS at the next 2:2 meeting. **ACTION: DF asked that at 2:2 meeting with Safeguarding service on Monday, HS provide an update regarding patients care packages for patients on DoLs or MCA. MD is also to set up a meeting with TF and staff setting up PHBs regards DoLs and MCAs for patients within their own homes.**	**MD**
	The Committee received the report.	
16/145	**Revised Whistle Blowing Policy and Procedure (Raising Concerns at Work)** • **Southport & Formby CCG** • **South Sefton CCG** The JQC were asked to approve the updated policy which contained elements suggested by the CCGs' Safeguarding Service.	

	The Committee approved the Revised Whistle Blowing policies for Southport & Formby CCG and South Sefton CCG	
16/146	**Corporate Governance Support Group Key issues Report** BP presented the JQC with the Key Issues from the recent meeting of the Corporate Governance Support Group held on 6th October 2016, relating to: • Whistle Blowing Policy (due to still being under revision) • Changes to the Governing Body Assurance Framework/CRR • Requirement for the CCGs to have a Security Management Policy and Strategy in place • EPRR Core Standards are method by which assurance is gained. 2016 submission recently completed, which declared 34 areas substantial assurance, and 4 areas to have action plans developed. FLT also mentioned the recent changes to the On Call System.	
	The Committee received the report	
16/147	**Quality Team Away Day : 23 June 2016** **Key Issues (summarise)** The JQC received an update from BP which provided the Committee with feedback from the Quality Team Time Out session held on 23rd June 2016. The feedback reflected the four themes of the session; celebrating success; CQUIN plans for 2017-18; Quality Strategy Refresh and embedding the quality model.	
	The Committee received the report	
16/148	**GP Quality Lead Update:** • **Locality** • **Provider** No further information to be reported other than what has been discussed throughout the meeting.	
	The Committee received the report	
16/149	**Key Issue Logs:** **EPEG** This agenda item was deferred until the next meeting of the JQC to be held on 19th January 2017.	
	The Committee noted the report had been deferred until the January 2017 meeting.	
16/150	**Any Other Business** 1. Laboratory process issue - AM advised of an issue arising from reporting of Vitamin D results coming from the laboratory. It was suggested the issue be reviewed at the next meeting of the LCL Post Review Actions Group due to be held on 12th December 2016. AM assured the JQC that no immediate risk of harm to patients was likely, or had been identified **ACTION: BP to add this agenda item to the next LCL Post Review Actions Group meeting and report back to the JQC in January 2017.** 2. Diabetes S&O – RC and DC raised possible issues relating to Diabetes Services following a complaint raised to Dr DC. It was reported that Dr DC had contacted the Trust and was to date awaiting a response. FLT stated that this needed to be managed via the CCG complaints process. FLT also stated the need for escalation to herself if clinicians are not receiving responses in a	**BP**

	timely manner so she could address with the interim Trust CEO. 3. DF has asked LG to determine whether any other complaints about the service have been received and checks are to be made to determine whether there is any mention of this issue on the Trust's Governance Risk Register. FLT will manage the Patient complaint discussed which had been forwarded to DC as GP, following receipt by the CCG and will discuss the Community Diabetic Nursing service with the new provider. 4. SEND Inspection – The CCG had received notification of an integrated inspection for Sefton and the LA of children under SEND which will commence on Monday 21st November 2016. 5. NHSE documentation on CCG safeguarding assurance – Information has been sent out across NHSE C&M for all organisations and will be in a report to be discussed at the Chief Nurse / Director of Nursing Meeting. DF has queried some of the Amber rather than Green RAG rating for the CCGs and has had confirmation back from NHSE via the Safeguarding Service that the RAG rating had been amended and it was a timing issue.	
16/151	**Key Issues Log** The following key issues were raised to be informed to the Governing Bodies: <u>Southport & Formby CCG</u> • S&O CQC Chief Inspector of Hospitals Report – published on 16th November 2016. Overall rating 'Requires Improvement'. Caring rated 'good' • S&O Stroke Performance – GP Clinical lead from CCG to discuss with Trust re weekend care of patients presenting with stroke/TIA and undertake a forensic analysis • Looked after Children Annual Report received – recommended presentation to the Governing Bodies • Mental Capacity Act Annual Report received – recommended presentation to the Governing Bodies • Serious Incident Standard Operating Procedures approved • Whistle Blowing Policy (Revised) approved <u>South Sefton CCG</u> • AUH Stroke Performance – Joint letter from both CCG Chairs re need to expedite plans across STP LDS' network • Looked after Children Annual Report received – recommended presentation to the Governing Bodies • Mental Capacity Act Annual Report received – recommended presentation to the Governing Bodies • Serious Incident Standard Operating Procedures approved • Whistle Blowing Policy (Revised) approved	
	Date of Next Meeting The next meeting will be held on Wednesday 18th January 2017, 11.30 am -1.30 pm Chapel Lane Surgery, 13 Chapel Lane, Formby, Liverpool, Merseyside, L37 4DL	

Chair : _____ _____

PRINT NAME **SIGNATURE**

Date : _____

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

Joint Quality Committee Minutes

Date: Wednesday, 18th January 2017, 11.30am to 1.30 pm
Venue: Chapel Lane Surgery, 13 Chapel Lane, Formby, Liverpool, Merseyside, L37 4DL

Membership

Dr Rob Caudwell	Chair & GP Governing Body Member	RC
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
Brendan Prescott	Deputy Chief Nurse & Head of Quality and Safety	BP
Helen Roberts	Senior Pharmacist	HR
Jo Simpson	Programme Manager – Quality and Performance	JS

Apologies

Lin Bennett	Practice Manager, Ford	LB
Gill Brown	Lay Member	GB
Dr Doug Callow	GP Quality Lead S&F	DC
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	PC
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		√	√	A		√		
Lin Bennett	Practice Manager, Ford				√		A	√	A		A	A	
Gill Brown	Lay Member for Patient & Public Involvement	√	A		√		√	A	√		A		
Dr Doug Callow	GP Governing Body Member /Clinical Quality Lead	√	A		L		L	A	√		A	A	
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	A	√		√		A	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	A		√		
Dr Dan McDowell	Secondary Care Doctor	A	√		A		A	A	A		√		
Martin McDowell	Chief Finance Officer	A	A		√		√	A	A		√		
Dr Andrew Mimnagh	Clinical Governing Body Member	√	√		A		A	√	√		√		
Dr Jeffrey Simmonds	Secondary Care Doctor						√	A	A		A		

✓ Present
A Apologies
L Late or left early

No.	Item	Action
17/001	**Apologies for Absence** Apologies for absence were received from GB, LB, Dr DC, Dr PC and Dr JSi The meeting was declared quorate.	
17/002	**Declarations of interest regarding Agenda items** Dr GH reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Southport & Formby Clinical Commissioning Group (SFCCG) or South Sefton Clinical Commissioning Group (SSCCG). Declarations declared by members of the Joint Quality Committee are listed in the CCG's Registers of Interests. The Registers are available either via the secretary to the governing bodies or the CCG websites at the following links: www.southportandformbyccg.nhs.uk/media/1760/sfccg-register-of-interests.pdf www.southseftonccg.nhs.uk/media/1858/ssccg-register-of-interests.pdf **Declarations of interest from today's meeting** CCG Officers holding dual roles in both Southport & Formby and South Sefton CCGs declared their potential conflict of interest.	
17/003	**Minutes and Key Issue Logs from the previous meetings** The Minutes of the Joint Quality Committee (JQC) were agreed as an accurate reflection of the previous meeting. The Key Issues for SFCCG and SSCCG were approved.	
17/004	**Matters Arising/Action Trackers** There were no matters arising. **Action Tracker** **16/115(ii) Dementia Diagnosis Rates – Improvement Plan for South Sefton - *SSCCG*** JS to contact GO'C and / or GJ to provide an update to the JQC in February 2017. **Outcome: JS to request an update from GO'C and / or GJ and forward to DF to present at the February 2017 meeting.** **16/128 Southern Health Report *SFCCG & SSCCG*** BP asked that this item be carried over until next month. **Outcome: BP to provide an update at the February 2017 meeting.** **16/130 Access Sefton IAPT Performance *SFCCG & SSCCG*** JS will check with GO'C and provide an update to the JQC in February 2017. **Outcome: JS to request an update from GO'C and / or GJ and forward to DF to present at the February 2017 meeting.** **16/141(i) Provider Quality Performance Reports -** *Aintree University Hospital (AUH) – Stroke* ***SFCCG & SSCCG*** DF confirmed that a letter had been sent to Kieran Murphy from FLT. **Outcome: The JQC agreed that this action could be closed.** **16/141(ii) Provider Quality Performance Reports -** *Aintree University Hospital (AUH) – DTOC* ***SFCCG & SSCCG*** JS confirmed that work was underway looking at patient flows with results to be built into the work programme.	**JS** **BP** **JS/DF**

	Outcome: The JQC agreed that this action could be closed. **16/141(iii) Provider Quality Performance Reports -** *Aintree University Hospital (AUH) – Cancer Measures* ***SFCCG & SSCCG*** Initial discussions have been held and will continue outside of the meeting. **Outcome: The JQC agreed that this action could be closed.** **16/141(iv) Provider Quality Performance Reports -** *Southport & Ormskirk Hospital NHS Trust (S&O)* ***SFCCG*** JS confirmed that communications were underway **Outcome: The JQC agreed that this action could be closed.** **16/141(v) Provider Quality Performance Reports -** *Southport & Ormskirk Hospital NHS Trust (S&O)* ***SFCCG*** JS confirmed that this action will be picked up as part of other work. **Outcome: The JQC agreed that this action could be closed.** **16/141(vi) Provider Quality Performance Reports -** *Southport & Ormskirk Hospital NHS Trust (S&O)* ***SFCCG*** JS confirmed that the action plan had now been received. **Outcome: The JQC agreed that this action could be closed.** **16/141(vii) Provider Quality Performance Reports -** *Southport & Ormskirk Hospital NHS Trust (S&O)* ***SFCCG*** DF discussed the invitation to JQC with the new Director of Nursing however an invite was not extended as discussions have taken place regarding the issues at other meetings including Executive to Executive. **Outcome: The JQC agreed that this action could be closed.** **16/143 South Sefton CCG and Southport and Formby CCG Serious Incident Reports *SFCCG & SSCCG*** BP had discussed the requirement for the inclusion of narrative against SIs open for more than 100 days with TF. **Outcome: The JQC agreed that this action could be closed.** **16/144b Safeguarding Service:** **Mental Capacity Act/Deprivation of Liberty Safeguards (MCA/DoLS) Annual Report 2015/16 *SFCCG & SSCCG*** HS confirmed on behalf of MD that the meetings had been set up. **Outcome: The JQC agreed that this action could be closed.** **16/150 Any Other Business -** *Laboratory process issue – Vitamin D* ***SSCCG*** GH advised that she and and a GP colleague had arranged for LCL to meet with EMIS to progress this issue outside of the meeting. AM was asked to email GH with details of Vitamin D issues. RC suggested LCL liaise with S&O who could share best practice. **Outcome: GH to provide an update at the February 2017 meeting.**	**GH**
17/005	**Chief Nurse Report** DF presented the Committee with a number of key issues which had occurred since the Chief Nurse report submitted in November 2016. <u>Joint local area special educational needs and disability (SEND) inspection in Sefton (SSCCG & SFCCG)</u> Following the recent inspection, DF confirmed that the SEND report had been received and was now in the public domain. A joint press statement issued on behalf of the CCGs and the Local Authority (LA).	

	Meetings have been held with the LA to look at the improvement plan. CCG support from NHSE (C&M) has been identified. A revised performance trajectory, regarding Paediatric Speech & Language Therapy has been agreed with Liverpool Community Health (LCH) and a future service model will be discussed. LCH have informed the CCGs that they have informed the Care Quality Commission (CQC) of the CCGs' support for this trajectory. <u>CQUIN Update (SSCCG & SFCCG)</u> The Quality Team and Finance Team have been working collaboratively to identify the current performance of the Trust in terms of delivery against CQUIN. S&O information is not yet available. This is being discussed at the Executive to Executive and Contract meetings. AM reminded the JQC of the importance of imposing any penalties for failure to submit information on time to ensure consistency within other areas. <u>MRSA – Aintree University Hospital NHS Foundation Trust – AUH (SSCCG)</u> A case of MRSA was reported from AUH on a LCCG patient. The Post Infection Review (PIR) Meeting took place on 9th January 2017. The case was attributed to the Trust. <u>Quality Risk Profile Tool – Liverpool Community Health NHS Trust (SSCCG & SFCCG)</u> DF confirmed that the quality risk profile tool for this provider has recently been reviewed and sent to NHSE (C&M).. <u>AQuA Mortality Reports</u> The latest mortality reports have been circulated to GP Quality Leads for review and to the CCGs' Business Intelligence Team. GH has reviewed AUHs noting that the SHIMI is marginally raised. GH confirmed that she was not aware of any new issues to report and noted that AUH are no longer an outlier. However, work continues to monitor the position of the Trust and a further update will be given at the AUH CCF.. Feedback from DC awaited re S&O but nothing significant to report from the AQuA data. DF stated that the Trust have identified a possible national IT issue when uploading mortality data to the NHS digital system. This could have an impact on the Trust mortality rates. National and local work is being undertaken and the CCGs await the outcome. NHSE (C&M) are aware and were informed by both the Trust and the CCGs.	
	The Committee received the report	
17/006	**Provider Quality Performance Reports** JS presented the Provider Quality Performance Reports relating to both SFCCG and SSCCG by exception. <u>Aintree University Hospital (AUH)</u> Stroke - Month 8 performance under Stroke has been achieved. A&E measures – System pressures were discussed and work is being progressed Discussions being had at the A&E Delivery Boards and other appropriate forums. Rapid Access Chest Pain – GH provided a rationale behind recent underperformance which had been discussed at the CQPG and with clinicians from the Trust. DF added that a review to ensure no harms occurred had also been completed.	

Cancelled Operations – Performance against this KPI has been on track throughout 16/17, however the Trust reported 3 non-clinical cancellations in November 16, this KPI carries a financial penalty for underperformance which will be implemented by the CCG.

DF and BP visited AUH A&E and Frailty Unit last week with a more comprehensive walk around due to take place. Staff who were spoken with during the visit reported good management support and the Acting Director of Nursing gave a positive account of work being undertaken by the Corporate Nursing team which includes daily auditing to ensure quality standards are being met.

E Referrals Choose & Book - GH felt that reducing secondary care referrals though Advice and Guidance would shift the appointments the patients would otherwise have into primary care instead although she accepts there may be some small reduction in overall activity.

The CCG needs to consider how it will fund this increased primary care activity in order for Advice and Guidance to be used fully and it may be helpful to liaise with the local GP federation.

MUST – AM commented on whether assessments were being carried out in this area. JS confirmed that significant improvement work had been undertaken and presented through the CQPG

Southport & Ormskirk Hospital NHS Trust (S&O)
Cancer Measures - JS reported that the Trust had failed to submit a complete Month 8 KPI and Quality Schedule report and as a result there are significant gaps in narrative for Southport & Ormskirk Hospital. This will be raised at the CQPG and Executive to Executive meeting later today.

The JQC wished to send a formal note to the Executive to Executive meeting and Contracts meeting regarding the lack of submission of data and the potential for financial penalties.
ACTION: DF to send a formal note to the Executive to Executive meeting and CQPG meeting regarding the lack of submission of data and the possibility of applying contract sanctions in relation to the timeliness and quality of data submitted. **DF**

Stroke / TIA - The TIA target on November 16 has been achieved. BP provided the Committee with the background to work undertaken as part of an ongoing patient complaint with the Trust around Stroke. BP asked whether the Committee considered it necessary to do a further Case Review. BP has looked at previous reviews that had been undertaken and asked the Committee for their view in this. RC felt that work already undertaken was adequate with all appropriate bodies sited on the outcomes. The Committee agreed that it was appropriate to progress the outcomes of the investigation rather than conduct another review at this time.

Mersey Care NHS Foundation Trust – Mental Health

Referral to Treatment-Psychotherapy – JS informed the committee that the CCG was still awaiting an action plan and / or business case from Mersey Care in relation to psychotherapy. A more detailed report from the Trust is due to be presented at the CQPG in February 2017.

RTT - Eating Disorders – The Trust provided assurance earlier in the year that performance would improve following a successful recruitment programme, however, some staff recruited failed to commence their employment with the Trust.

	RC was concerned about the work being directed to GPs to complete physical health checks in relation to eating disorders. DF suggested the concerns of the JQC be raised at CCF for discussion at the CQPG. The JQC were advised that a Physical Health Matron is now in post. Smoking Indicators – Overall performance continues to improve against smoking indicators. DNA & Cancellation appointments – Work continues on the development of the Trust's DNA policy which is due to be completed in December 16, work is ongoing with commissioners and primary care in order to establish appropriate referral flows. <u>Cheshire & Wirral Partnership NHS Trust – IAPT Performance</u> IAPT- South Sefton IAPT KPI Summary – It was noted that referrals by GPs to Access Sefton are made by handing out a leaflet to patients. RC suggested if electronic versions of the leaflet were available they could be logged on the EMIS system. This is to be raised with CCG Mental Health Commissioners. **ACTION: DF to raise suggestion with CCG Mental Health Commissioners of e-versions being made available of the IAPT leaflets that are given out to patients so these could be logged on the GP system.** DF questioned the difference in IAPT performance between SF and SS and asked whether more could be done with regards to service delivery. **ACTION: JS to clarify cause of differences in performance between SFCCG and SSCCG.** <u>Liverpool Community Health NHS Trust</u> Minimise rates of Clostridium Difficile (CDif) - GH asked whether four cases of CDif reported on Ward 35 were correct and asked that an investigation be held given past good performance. **ACTION: JS will liaise with Martin Jones of Infection control to progress review.** DF stated that the Chair of SSCCG was copied into an anonymous whistleblowing letter regarding an LCH service. This has been forwarded to the Chief Executive of LCH for investigation. The CCG will also be looking at what intelligence they may have received previously in relation to this service by way of commissioner assurance. <u>NWAS Quarterly Update</u> BD provided the JQC with a quarterly update on local North West Ambulance Service (NWAS) performance which showed deterioration in turnaround times. BD gave an explanation regarding how improvement in performance across the system is being monitored.	**DF** **JS** **JS**
	The Committee received the report.	
17/007	**CCG Safeguarding Service Quarter 2 Update** This report provided the JQC with an update in relation to adults and children's safeguarding and an analysis of the Q2 data submitted by commissioned health services as part of the Safeguarding quality schedule. <u>Southport & Ormskirk Hospital NHS Trust</u> HS advised that S&O remains on limited assurance and that although an increase in training compliance figures has been noted for Levels 1 and 2, training targets have not been met against trajectories and they had not met their own internal set trajectory. DF confirmed this had been discussed at the Executive Improvement	

	Board and that NHSE had offered support to increase the Trusts training figures. KG was conscious that some improvements had been seen with a training needs analysis submitted and data cleansing undertaken of training data. AM asked what next steps should be. DF considered the CCG's concerns are well documented and have been escalated up to the Risk Summit level of surveillance and also to the CQC prior to the Chief Inspector of Hospitals Inspection. The concerns of the JQC were noted as sufficient assurance could not be given and it was agreed that the CCG was therefore unable to close the contract query until performance improved. This issue has been escalated and will be raised again at the CQPG and Executive to Executive meetings today. DF advised that the Safeguarding Board is also aware of the contract query. DF has met with the new Director of Nursing (DoN) at S&O who will be the Executive lead on this issue and asked that the Safeguarding Team ensure the DoN is made aware of the problems with training and requested that a review is undertaken after the next quarter to determine whether there have been any improvements in performance. **ACTION: Safeguarding to inform the DoN at S&O of issues with training trajectories not being met at S&O and undertake a further review of performance after the next quarter.** Joint Targeted Area Inspection (JTAI) update - A brief presentation was presented by the CCG Safeguarding Service at the December 2016 LSCB Board mapping the findings from the Salford JTAI against the CCG's perspective in Sefton. A number of areas were highlighted to explore further with key services which will be progressed via the LSCB Health sub group including the Voice of the Child. The NHSE Safeguarding Assurance information was discussed. DF stated that she had challenged the NHSE 3 amber RAG rating via the Safeguarding Service that was in the final report and had received confirmation back that this was a timing issue and that the CCGs only had 1 remaining amber rating and that was with regard to reviewing on an annual basis capacity within the team – all the rest of the performance areas were RAG rated green. Report on Actions in Response to Kate Lampard Report Recommendations - The Safeguarding Service will complete this report on behalf of the CCGs prior to the submission date of 20th January 2017. The Safeguarding Service confirmed that they were on track to meet the submission deadline.	**KG / HS**
	The Committee received the report.	
17/008	**Commissioner Quarter 2 and Quarter 3 Controlled Drug (CD) Reports to NHS England CD Accountable Officer (AO)** This paper provides the JQC with the quarter 2 and quarter 3 2016-17 Commissioner Quarterly CD Reports to NHS England CDAO. SSCCG is deemed an outlier in terms of Schedule 2 CD prescribing (quantity x items per 1000 PU) compared with other CCGs in Q2 i.e. the amount of CDs prescribed. These concerns will be raised at quarterly meetings with practices. The JQC discussed its concerns relating to the mis-use of CDs prescribed to some patients in support of pain management within primary care. The Committee discussed the potential role for urine testing where considered appropriate to support safe CD prescribing. The JQC were also keen to have it determined whether usage of prescribed CDs	

	was due to population or individual prescriber and were aware that the Medicines Management Team have been requested to take this further through JMOG. GH thanked the Medicines Management team for the work undertaken.	
	The Committee received the report.	
17/009	**Corporate Risk Register** This report provides a summary of the risks currently managed by the Quality Team on behalf of NHS South Sefton and NHS Southport and Formby CCGs, with risks with a post mitigation score of 12 or above presented to the respective Governing Bodies. The Likelihood and Consequence columns for QUA002 (SFCCG) and QUA006 (SSCCG) are to be amended to ensure the risk scores reflect the same content. **ACTION: BP to amend Likelihood and Consequence columns for QUA002 (SFCCG) and QUA006 (SSCCG) to ensure the risk scores reflect one another** QU019 AND QUA020 (SFCCG) - DF asked whether the JQC were satisfied with the mitigating actions given performance is deteriorating. The Committee acknowledged the pressures in the system but considered more needed to be done. **ACTION: BP to ensure the narrative by risk owners is revised.** **ACTION: AM requested that the process of presenting the Risk Register to the JQC is revised to ensure changes requested by the JQC are carried out by risk owners and the outcome brought back to the Committee for assurance.** **ACTION: Risk registers to be presented to JQC in A3 print at future meetings.**	**BP** **BP** **BP** **VT**
	The Committee ratified the report.	
17/010	**Revised Research Strategy** BP presented the JQC with a revised research strategy for NHS South Sefton and NHS Southport and Formby CCGs following its original approval in 2014. Changes to the revised strategy were highlighted in blue with the Committee's attention drawn to the link with QIPP under 'Strategic Objectives'. The JQC approved the amended version of the report and thanked BP for the work undertaken.	
	The Committee approved the revised policy.	
17/011	**Joint Medicines Operational Group (JMOG) Terms of Reference (TOR)** The JQC were asked to approve the changes to the TOR which was updated to reflect that the SMOOG are no longer held.	
	The Committee approved the revised Terms of Reference	
17/012	**Southport & Ormskirk Mortality Rate** The issues regarding the Mortality Rates at S&O were discussed earlier in the meeting.	
	The Committee received the verbal report	
17/013	**GP Quality Lead / Locality Update** There were no new matters to report.	
	The Committee received the report	
17/014	**Key Issue Logs:**	

	EPEG GB presented the JQC with a verbal report following items reported at a recent meeting of EPEG on 14th December 2016. • A very successful Young Advisers meeting was held in December 2016. GB very impressed with the professionalism of the group. GB noted that the group membership has a number of Looked After Children (LAC). DF advised that the group have been involved in the CCGs work around CAMHs with the Local Authority and the Voice of the Child. DF also advised that she has invited members to get involved in the work of the CCG by experiencing sitting in the seat of the 'Chief Nurse' for a day. • MacMillan Centre Update - EPEG was pleased to note that there had been a 2% increase in 'face to face' and 147% increase in 'indirect' contacts' in Consultation and Engagement. Freshfield and Hightown engagement feedback was discussed and it was agreed that further comments will be fed back to Head of Communications to share with NHS E and H2A (consultation project team). • AUHT parking – A sub group within the Trust is to be set up to review charges • Access Sefton – performance perceived to have improved, however GB will feedback JQC comments.	
	The Committee received the report	
17/015	**Any Other Business** There were no matters to report under AOB.	
17/016	**Key Issues Log** The following key issues were raised to be informed to the Governing Bodies: <u>Southport & Formby CCG</u> • Corporate Risk Register – Quality Risk Register presented to the Quality Committee • S&O Safeguarding Performance – Contract Query remains in place due to limited assurance from the CCG Safeguarding Service • S&O Mortality – Issue identified with national data upload and has been reported to NHS Digital. NHSE are aware. This may impact on Trust mortality rates. CCG to await confirmation from national data cleansing / review as it may affect other Trusts. • CCG Research Strategy – Updated strategy approved. <u>South Sefton CCG</u> • Corporate Risk Register – Quality Risk Register presented to the Quality Committee • S&O Mortality – Issue identified with national data upload and has been reported to NHS Digital. NHSE are aware. This may impact on Trust mortality rates. CCG to await confirmation from national data cleansing / review as it may affect other Trusts. • CCG Research Strategy – Updated strategy approved	
	Date of Next Meeting The next meeting will be held on Wednesday 15th February 2017, 11.30 am -1.30 pm at The Marshside Surgery, 117 Fylde Road, Southport PR9 9XL	

Chair : _____ _____

PRINT NAME **SIGNATURE**

Date : _____