NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public Agenda

Date: **Thursday 1st March 2018, 13:00 to 15:05 hrs**
Venue: **Boardroom, 3rd Floor, Merton House, Bootle, L20 3DL**

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

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

The Governing Body Members		
Dr Andrew Mimnagh	Chair & GP Clinical Director	AM
Dr Craig Gillespie	Clinical Vice Chair	CG
Graham Morris	Deputy Chair & Lay Member - Governance	GM
Matthew Ashton	Director of Public Health *(co-opted member)*	MA
Graham Bayliss	Lay Member, Patient & Public Involvement	GB
Dr Peter Chamberlain	GP Clinical Director	PC
Debbie Fagan	Chief Nurse & Quality Officer	DCF
Dr Gina Halstead	GP Clinical Director	GH
Dwayne Johnson	Director of Social Services & Health, Sefton MBC *(co-opted member)*	DJ
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Martin McDowell	Chief Finance Officer	MMcD
Dr Sunil Sapre	GP Clinical Director	SS
Dr Jeff Simmonds	Secondary Care Doctor	JS
Dr Ricky Sinha	GP Clinical Director	RS
Fiona Taylor	Chief Officer	FLT
Dr John Wray	GP Clinical Director	JW
In Attendance		
Tracy Jeffes	Chief Delivery & Integration Officer	TJ
Jan Leonard	Chief Redesign and Commissioning Officer	JL
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Martin Seymoor	Consultant in Public Health, Sefton MBC	MS
Judy Graves	*Minutes*	

Quorum: Majority of voting members.

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
General					**13:15hrs**
GB18/40	Apologies & Welcome	Chair	Verbal	Receive	2 mins
GB18/41	Declarations of Interest	Chair	Verbal	Receive	3 mins
GB18/42	Minutes of Previous Meeting held on 1st February 2018	Chair	Report	Approve	5 mins
GB18/43	Action Points from Previous Meeting held on 1st February 2018	Chair	Report	Approve	5 mins
GB18/44	Business Update	Chair	Verbal	Receive	5 mins

No	Item	Lead	Report/ Verbal	Receive/ Approve	Time
GB18/45	Chief Officer Report	FLT	Report	Receive	10 mins
Finance and Quality Performance					
GB18/46	Quality, Innovation, Productivity and Prevention (QIPP) Plan and Progress Report	MMcD	Report	Receive	10 mins
GB18/47	Integrated Performance Report	KMcC/ MMcD/DCF	Report	Receive	30 mins
GB18/48	NWAS Performance Briefing	FLT/KMcC	Report	Receive	5 mins
Governance					
GB18/49	Refreshed Communications & Engagement Strategy	LC	Report	Approve	5 mins
GB18/50	Annual Accounts Process 2017/18 - Governing Body Member's Declaration	MMcD	Report	Receive	5 mins
Service Improvement/Strategic Delivery					
GB18/51	Planning Guidance 2018/2019	KMcC	Presentation	Receive	15 mins
For Information					
GB18/52	Key Issues Reports: a) Quality Committee: October and November 2017	Chair	Report	Receive	5 min
GB18/53	Joint Quality Committee Approved Minutes: October and November 2017		Report	Receive	
GB18/54	CIC Realigning Hospital Based Care: November 2017		Report	Receive	
GB18/55	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting*				5 mins
GB18/56	Date of Next Meeting **Thursday 3rd May 2018, 13:00 hrs in the Boardroom, 3rd Floor, Merton House.** <u>Future Meetings:</u> The Governing Body meetings are held on the first Thursday of the month. Dates for 2018/19 are as follows: 5th July 2018 6th September 2018 1st November 2018 7th February 2019 4th April 2019 6th June 2019 5th September 2019 All PTI public meetings will commence 13:00hrs and be held in the Boardroom, 3rd Floor Merton House.				-
Estimated meeting close					**15:05 hrs**

Motion to Exclude the Public:
Representatives of the Press and other members of the Public 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 1st February 2018, 13:00 – 15:30-pm
Venue: Boardroom, 3rd Floor, Merton House, Bootle, L20 3DL

The Governing Body Members in Attendance

Dr Andrew Mimnagh	Chair & GP Clinical Director	AM
Dr Craig Gillespie	Clinical Vice Chair	CG
Graham Morris	Deputy Chair & Lay Member - Governance	GM
Graham Bayliss	Lay Member, Patient & Public Involvement	GB
Dr Jeff Simmons	Secondary Care Doctor	JS
Dr Peter Chamberlain	GP Clinical Director	PC
Debbie Fagan	Chief Nurse & Quality Officer	DCF
Dwayne Johnson	Director of Social Services & Health, Sefton MBC *(co-opted member)*	DJ
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Martin McDowell	Chief Finance Officer	MMcD
Dr Sunil Sapre	GP Clinical Director	SS
Dr Ricky Sinha	GP Clinical Director	RS
Fiona Taylor	Chief Officer	FLT
Dr John Wray	GP Clinical Director	JW

In Attendance

Jan Leonard	Chief Redesign and Commissioning Officer	JL
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Tracy Jeffes	Director of Corporate Services	TJ
Lyn Cooke	Head of Communications and Engagement	LC
Janet Spallen	Urgent Care Lead (South)	JS
Linda Turner	Deputy for Matthew Ashton	
Natalie Daniels	Alder Hey Hospital	MMcM
Michelle McNulty	PA to Chief Officer (note taker)	

Quorum: Majority of voting members.

Name	Governing Body Membership	Jan 17	Mar 17	May 17	July 17	Sept 17	Nov 17	Feb 18
Dr Andrew Mimnagh	Chair & GP Clinical Director	✓	✓	✓	✓	✓	✓	A
Dr Craig Gillespie	Clinical Vice Chair & GP Clinical Director	✓	✓	✓	✓	✓	✓	✓
Graham Morris	Vice Chair & Lay Member - Governance	A	✓	✓	✓	✓	✓	✓
Matthew Ashton *or deputy*	Director of Public Health, Sefton MBC (co-opted member)	✓	✓	A	A	✓	✓	✓
Graham Bayliss	Lay Member for Patient & Public	✓	✓	✓	✓	✓	✓	✓
Lin Bennett	Practice Manager	✓	✓	✓	✓	✓	✓	A
Dr Peter Chamberlain	GP Clinical Director	✓	A	✓	✓	✓	✓	✓
Debbie Fagan	Chief Nurse & Quality Officer	✓	✓	A	✓	✓	✓	✓
Dwayne Johnson	Director of Social Service & Health, Sefton MBC	✓	A	A	A	✓	✓	✓
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	✓	A	✓	N	N	✓	✓
Dr Dan McDowell	Secondary Care Doctor	✓	✓	✓	A	✓	A	n/a
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓

Name	Governing Body Membership	Jan 17	Mar 17	May 17	July 17	Sept 17	Nov 17	Feb 18
Dr Ricky Sinha	GP Clinical Director	A	✓	A	A	A	✓	A
Dr Sunil Sapre	GP Clinical Director	✓	A	✓	✓	✓	✓	A
Fiona Taylor	Chief Officer	✓	A	✓	A	✓	✓	✓
Dr John Wray	GP Clinical Director	✓	A	A	A	A	✓	A

No	Item	Action
Public	**Questions from the Public** 1. No questions were received from the public.	
Presentation		
GB18/01	**Apologies for Absence** Apologies were received on behalf of Dr Andrew Mimnagh, Dr John Wray, Dr Sunil Sapre, Dr Matt Ashton, Dr Ricky Sinha and Dr Jeff Simmons.	
GB18/02	**Declarations of Interest** Those holding dual roles across both South Sefton CCG and Southport & Formby CCG declared their interest; Debbie Fagan, Martin McDowell and Fiona Taylor. It was noted that these interests did not constitute any material conflict of interest with items on the agenda. Dr Peter Chamberlain declared a conflict of interest in connection with his secondment to Mersey Care NHS Foundation Trust (a provider of services to South Sefton CCG).	
GB18/03	**Minutes of Previous Meeting: 2nd November 2017** **RESOLUTION:** The minutes of the previous meeting held 2nd November 2017 were accepted as a true and accurate record.	
GB18/04	**Action points from meeting held on 2nd November 2017** Actions from previous meeting will be covered under the agenda today. Under Matters Arising – FLT reported that in relation to the Better Care Fund, she was pleased to advise that this had now been fully authorised.	
GB18/05	**Business Update** CG advised that he is acting up as chair for Dr Mimnagh who is currently unwell, and thanks were given to Dr Wray who is stepping up to acting vice chair. Lin Bennett has stepped down from the governing body and will be missed – thanks were offered for her service. Tracy Jeffes is commencing the process to secure a replacement and the other Practice Manager vacancy. Dr Jeff Simmons has been appointed as Secondary Care Doctor, but was unable to attend today. Dr Gina Halstead has joined the Governing Body and was welcomed.	

No	Item	Action
	360 Share Stakeholder feed-back – CG stated that it was important we get as much feedback as possible from our partner organisations. All Governing Body members were asked to encourage their contacts to complete the questionnaire. Currently on 6% completion rate with 23rd February being the deadline for completion.	All
GB18/06	**Chief Officer Report** The Governing Body received the Chief Officer Report. This highlighted the landscape of change in the NHS advising that the Sefton Health & Care Transformation Board has been launched which will enable the CCG to consolidate its strategic priorities and take the 'Shaping Sefton' strategic plan further with partners across the system. The Governing Body will receive further updates as this work progresses. Thanks were given to Debbie Fagan and her team for delivering key programmes of work. The Chief Officer reported that Healthier You, the National Diabetes Prevention Programme shows that over 1,000 patients across Sefton have been registered with the service and the uptake is around 86%. In addition to improving care, with the CCG being noted for its good practices, the programme is also expected to make savings of £48,500 across the two CCGs in Sefton in this year. Cancer outcomes performance is not as strong in South Sefton compared to Southport and Formby. There are learning opportunities across both CCGs to highlight best practices, and further discussion is required to ensure these are implemented. The Chief Officer advised of a national visitation yesterday from The Better Care Support Team, on a 'Local Learning Visit'. They visited services in the Community and were impressed, with the Integrated Care and Reablement Scheme (ICRAS). A joint development session with SFCCG is being held this evening to discuss the strategic direction for CCGs for the next 12 to 24 months. MK asked about the impact of the folding of Carillion – Chief Officer reported the Royal Liverpool University Hospital is managing the situation. MMcD advised that an insurance clause had been activated to deliver the outstanding pieces of work on the new hospital. It was noted that there may be some delay as work has currently stopped. Action - Lyn Cooke to circulate the statement from the Royal. **RESOLUTION:** The governing body received the report.	LC
GB18/07	**Quality, Innovation, Productivity and Prevention (QIPP) Plan and Progress Report** The Chief Finance Officer highlighted the summary position in his report which provided an update on the progress being made to implement the QIPP plan schemes and activities. The QIPP savings requirement to deliver the agreed financial plan is £8.480m and year to date shows a shortfall of just under £3.6m.	

No	Item	Action
	The Chief Finance Officer advised that Acting as One arrangement across North Mersey health care system means it has been difficult to deliver any planned care savings, but that plans remain active. 'Check and Challenge' session has been held which was felt to be a good opportunity to establish that saving plans were realistic and reinforced the contribution the prescribing team have made. The Dynamic Purchasing System is giving real time information in the market and it will be difficult to deliver any further savings. Our Shaping Sefton programme continues to deliver better care for patients. GH asked about paying Aintree for Dermatology services which are not currently being received. MMcD reported that this will be in the main finance report. Aintree are over performing on other aspects of the contract, but there is a need to review this and a piece of work is being undertaken. RESOLUTION: The governing body received the report and noted the update.	
GB18/08	**Integrated Performance Report** KMcC presented the report to members and highlighted key areas in terms of performance, quality and finance. KMcC reported that there had been liaison with Governing Body members consider how further scrutiny and assurance could be given to performance review. The intention is that an easy table based report will be brought to ensure Governing Body have sight of exceptions. The main report will form part of an appendix going forward. Governing Body members were invited to future integrated performance meetings for scrutiny. **Planned Care** KMcC advised the Governing Body that referrals for urgent outpatient appointments for those with breast symptoms, where cancer is not initially suspected is at 90.61% against a target of 93%. The Governing Body were advised that work is being undertaken with General Practitioners and that a protected learning event took place in November around this issue. 31 days targets for subsequent treatment by surgery, Governing Body advised that Aintree just missed target (93.13% against a target of 94%). KMcC reassured members that any breaches were minimal and this involved four patients, all of which had been validated and reviewed. 62 days for first treatment at both provider level and 62 days for referral from screening service failed to achieve targets. Continued challenges highlighted in Chief Officers report and a session planned around cancer performance to look at issues to consider what else can be done to improve performance. The Governing Body were advised that several actions have been put in place initially, and these include: Continued monitoring and intervention by the Clinical Business Unit to manage the patient pathways and remove any barriers which may be preventing treatment; Escalate constraints to the patient pathway to the weekly Cancer Performance meeting (CPG) and to the Divisional Director of Operations; Escalate constraints to the patient pathway to the daily Cancer Performance briefing led by the Divisional Director of Operations Diagnostics and Support Services; Delay of the recovery plan in collaboration with the Divisional Director of Operations Diagnostics and Support Services. **Unplanned care** Conscious of winter pressures Aintree have achieved 90% against 95% target. There has been a stepped increase of patients admitted from A&E with zero	

No	Item	Action
	length of stay, and this will be discussed next week at a meeting with the Trust to review the pathway for admissions from A&E. KMcC advised the Governing Body that with regard to Emergency care there has been a reduction in Directory of Services (111) calls and also calls to the GP out of hours service. The Governing Body were advised that Stroke performance in November at Aintree failed the 80% target of stroke patients spending at least 90% of their time on a stroke unit - Aintree achieved 59%. There are strategic changes being progressed for North Mersey. CG noted that stroke performance has been lagging for some time. There is a variance in provision and pressures on providers, with great concern re shifting stroke activity from one part of the system to another. Southport and Formby and Aintree CEO's have met and are looking for clarity around strategic direction. There is a willingness to engage in substantive solutions from the Stroke Network. GH advised that to move people to the right beds requires hospital beds being at 80% capacity, whereas Aintree operates at over 90% bed usage and recruiting the right staff is also an issue. Delayed transfers of care – the Governing Body were advised that there is a change in how this is reported. Originally snapshot view was utilised, but now average number delays per day in the month are to be used. Aintree have shown an increase to 38 days in November from 24 in October. Mersey Care remains consistent and has increased by 1 day. Social care and the CCG are working together to find solutions. DCF added that to support winter pressures there have been conversations with Commissioning Support Unit to ensure safe patient flow out of the hospital. Although we may start to see a backlog of some CHC reviews, but collective agreement had been reached. DJ asked for more discussion around this, as he is concerned that when a CHC assessment is requested, there are considerable delays from community nurses in completing them. CCG funding will only be backdated 28 days and assessment teams are being impacted on. Any current assessments outstanding have been requested by DCF for assurance to go to quality committee. A CHC Programme Board is being devised which will include social care and community colleagues –DCF and DJ will meet to discuss issues. Prioritisation will be given to taking away unnecessary bureaucracy and data to be made transparent. The Chief Officer will report back to the Governing Body on progress.	DJ/DCF
	Mental Health KMcC reported that people under CPA followed up within 2 days and 7 days of discharge failed to achieve their targets, and that it was unusual not to hit these targets. Reasons for these breaches were known and will be monitored going forward. Early Intervention in Psychosis (EIP) 2 week wait for this service failed to reach the 50% target, achieving 40% i.e. three breaches. Improving Access to Children & Young People's Mental Health Services KMcC reported that referrals have significantly improved. **Quality** The Performance Report is discussed at Quality Committee. Mental Health Commissioning Manager is to have a deep dive around Mental Health performance and to attend next Governing Body meeting. GPs reporting seeing an impact in primary care.	KMcC

No	Item	Action
	Clinical Leads will be attending Governing Body this year going forward – giving them the opportunity to discuss if our commissioning, its impact and what can be changed. Three out of four localities report having had difficulty accessing Crisis Team. JL to take this forward.	JL
	E-Referral utilisation rate has increased by 1% to 22% with the national NHS ambition that coverage should be 80% by the end of Q2 2017/18. Difficult for individual practices to find their own data – Action – KMcC is to look at providing this.	KMcC
	Diagnostic test waiting time performance for cancer – potential link around endoscopy/colonoscopy with both seeing an increase in the number of patients waiting more than 6 weeks for a diagnostic test in November. Collaborative Commissioning Forum has agreed a system approach with providers and commissioners. GH suggested that there may be an over utilisation of gastro services with no triage system. PC suggested completing case reviews as late presentation to the GP is an issue across Merseyside. KMcC reported that the Sefton diagnostic performance is being affected by the Royal's performance. The Governing Body were advised that 38 serious incidents remain open on StEIS for 100 days which are being followed up – referral back to providers, awaiting information etc. **Finance** MMcD reported to the Governing Body that pressures have emerged around Continuing Health Care with this being driven up to £775,000. Chief Financial Officer reported the deficit will be in the region of £4.4m. Financial pressures on Aintree contract re drugs, sleep service, the acute visiting scheme together with independent sector activity. Acting as one has resulted in a saving of £1m compared to what we would have paid Aintree if this had not been in place. It was reported that there was an underperformance on the Liverpool Women's contract. MMcD reported that the CCGs would have broken even if four pressures had not been there re HRG4, pharmacy stock, intermediate care and community contract. PC asked if there will be any further things outside our control which might present before year end – Alder Hey may present an issue around drugs; there may be a reduction in FNC cases and an increase in CHC cases. Potential risk for increased referrals to Southport and Ormskirk Hospitals once paper referrals cease as they are not part of Acting as One. DJ stated that the increase in the number of beds at Aintree paid for by winter pressure bids, was paid directly to the Trust and anything else will show as an overspend which is capped by Acting as One.	
	We have an agreed urgent care pathway with Aintree. JS is to review it to clarify if there have been any changes, as there has been an increase in zero length stays.	JS
	RESOLUTION: The governing body received the report.	
GB18/09	**Improvement Assessment Framework** Governing Body was advised that the Framework draws together 51 core	

No	Item	Action
	performance and clinical areas. NHSE provide the dashboards – Q1 in November shows leadership team and managerial teams against indicators. FLT asked that this come through Leadership Team. DJ noted indicator 104a – injuries from falls in people aged 65 years+ and asked what can we do together to improve this across social care and hospital services. Learning Disability annual health checks are noted to be the worst nationally. Chief Officer advised that at the Health & Wellbeing Board this had been discussed with Matt Ashton and at the Primary Care Joint Commissioning Group and Geraldine O'Carroll has picked up this piece of work to go into the Integrated Commissioning Group as an agenda item. DJ advised that Social Care can help with getting people to GP surgeries for health checks. Falls – has been difficult to address and needs to be rethought with a population approach. Falls identified in the Better Care Fund. PC advised that the Learning Disability Enhanced Scheme has changed for GPs – funding has increased but template is unmanageable. Need to look at good practice in other areas. Healthwatch have done some good work and Geraldine will be taking this forward. Action – GO'C to take the item to the Integrated Commissioning Group.	KMcC GO'C GO'C GO'C
GB18/10	**GBAF and CRR** Paper prepared by Debbie Fairclough which has gone through audit and fully explains the risks. DCF explained that SS034 risk remains regarding commissioned service around looked after children and has been on risk register for some time. The service was transferred from LCH to Mersey Care and is now subcontracted to NWBH. Looking at pathways across the teams, but not seeing pace of improvement we would like to see. Deputy and Director level talks with NWBH and MCT being held to try and resolve this. Contract meeting being held next week where concerns will be raised. June is the cut off point for improvement of service delivery around this area. LAC nurse being recruited for full time post across Sefton. LT advised that Public Health has also been involved in these discussions. SS047 felt that the scoring needs reviewing in light of recent conversation and how agenda is supported going forward. GM noted that Q4 financial risks are going up. **RESOLUTION:** The governing body approved the report. Dwayne Johnson left the meeting.	
GB18/11	**Register of Interests** The Governing Body were advised that an updated register of interest as at December 2017 was required. There is also an on-line tool is available for Conflicts of Interest.	All All
GB18/12	**Joint Committee Terms of Reference** Chief Officer presented a paper relating to the establishment of a North Mersey Joint Committee of Clinical Commissioning Groups. The wider membership	

No	Item	Action
	would need to approve and ensure appropriate amendments to the constitution to enable this provision. Principle of Governance is about patient care, supporting us to ensure decisions are made through legal process. A joint committee is a way of making joint decisions where that makes sense. Remit of the Joint Committee: FLT went through the various points of the Terms of Reference for the Governing Body. They propose an annual work plan, which must come back to the Governing Body for sign off. There will be full members and associate members (not legally bound by the committee). Executive Governing Body Member and two others from this organisation to represent South Sefton CCG. Comments: GM supported the establishment of a governance framework – without this we would have to bring back items to the individual CCGs causing issues if the meetings are out of step. The three representatives have to be people who will actively represent the CCG and speak out with the views of the CCG. PC agreed with recommendation 1 but has concerns with recommendation 2 i.e. the wording around accountability and responsibility needs to be stronger rather than generic. Concerned that it needs to support the plans of the CCGs rather than other organisations. A vote could be used by proxy. There was concern that there can be competing pressures that could be applied for an individual which could change their vote. It was clarified that the committee and decision making would be subject to scrutiny whether solely or jointly and the meetings would be in public. MK suggested that it would require more than one representative from Healthwatch. Recommendation 1 was approved unanimously by the Governing Body. Recommendation 2 – was not approved as some specificity and clarity around the mandate required further consideration. Action – For SLT to revise the specific wording and to re-present this at the next Governing Body Meeting. Nominations will be made at that time for the representatives. **RESOLUTION:** The Governing Body deferred the approval of the TOR	FLT
GB18/13	**Disinvestment Policy & Procedure (Cessation and Significant Reduction of Services)** Andrew Woods gave the Governing Body an overview of this policy, with the original Policy having been agreed and approved by Governing Body in 2016. Policy is aligning with QIPP and operates within legal parameters. The Governing Body was asked to approve revised policy. Third sector Voluntary Organisations are also subject to this policy. 4.5.1 – title of role needs to be amended to QIPP Lead. Government recommended 3 month notice is incorporated into this policy. RESOLUTION: The Governing Body approved the report.	AW

No	Item	Action
GB18/14	**Equality and Diversity Annual Report 2017** Andrew Wood presented the CCG Equality & Diversity Annual Report to the Governing Body. Appendix – 207 – all Merseyside CCGs have taken cautious approach. Toolkit will be delivered collaboratively in line with the five year forward view. Plan on 211 – access improved and quality project plan was approved in 2016. Lots of progress but work to do. GB – wide range of work going on, which is commendable. FLT noted that Mersey Care was mostly green and could there be lessons learned across the system. RESOLUTION: The Governing Body was asked to receive this report.	
GB18/15	**Commissioning Policies:** SLT approved – Due to time constraints Appendix A summarised all policies. Changes to cataract policy – second eye issues clarified. Will be made available on the intranet. RESOLUTION: The Governing Body received and ratified the policies.	
GB18/16	**Key Issues Reports:** a) Finance & Resource (F&R) Committee: October and November 2017 b) Quality Committee: September 2017 c) Audit Committee: October 2017 d) Joint Commissioning Committee: June and November 2017 e) Locality Meetings: Q3 2017/18 **RESOLUTION:** The Governing Body received the key issues reports	
GB18/17	**Finance and Resources Committee Approved Minutes:** October and November 2017 **RESOLUTION:** The Governing Body received the approved minutes.	
GB18/18	**Joint Quality Committee Approved Minutes:** September 2017 **RESOLUTION:** The Governing Body received the approved minutes.	
GB18/19	**Audit Committee Approved Minutes:** October 2017 **RESOLUTION:** The Governing Body received the approved minutes.	
GB18/20	**Joint Commissioning Committee Approved Minutes:** June and November 2017	
GB87/21	**CIC Realigning Hospital Based Care Key Issues –** No issues reported. **RESOLUTION: None**.	
GB18/22	**Any Other Business**	

No	Item	Action
	Noted that it was Linda Turner's last meeting after many years of working in Sefton and she was thanked for her input.	
GB18/23	**Date of Next Meeting** 1st March 2018, 1 p.m. Boardroom, Merton House, Bootle.	
Meeting concluded Motion to Exclude the Public: Representatives of the Press and other members of the Public 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)		**15:35hrs**

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Action Notes

Date: Thursday 1st February 2018, 13:00 – 15:30-pm
Venue: Boardroom, 3rd Floor, Merton House, Bootle, L20 3DL

No	Item	Action
GB18/05	**Business Update** 360 Share Stakeholder feed-back : All Governing Body members were asked to encourage their contacts to complete the questionnaire.	All
GB18/06	**Chief Officer Report** Action - Lyn Cooke to circulate the statement from the Royal.	LC
GB18/08	**Integrated Performance Report** **Unplanned care** DCF added that to support winter pressures there have been conversations with Commissioning Support Unit to ensure safe patient flow out of the hospital. Although we may start to see a backlog of some CHC reviews, but collective agreement had been reached. DJ asked for more discussion around this, as he is concerned that when a CHC assessment is requested, there are considerable delays from community nurses in completing them. CCG funding will only be backdated 28 days and assessment teams are being impacted on. Any current assessments outstanding have been requested by DCF for assurance to go to quality committee. A CHC Programme Board is being devised which will include social care and community colleagues –DCF and DJ will meet to discuss issues. Prioritisation will be given to taking away unnecessary bureaucracy and data to be made transparent. The Chief Officer will report back to the Governing Body on progress. **Quality** The Performance Report is discussed at Quality Committee. Mental Health Commissioning Manager is to have a deep dive around Mental Health performance and to attend next Governing Body meeting. GPs reporting seeing an impact in primary care. Three out of four localities report having had difficulty accessing Crisis Team. JL to take this forward. E-Referral utilisation rate has increased by 1% to 22% with the national NHS ambition that coverage should be 80% by the end of Q2 2017/18. Difficult for individual practices to find their own data – Action – KMcC is to look at providing this. **Finance** We have an agreed urgent care pathway with Aintree. JS is to review it to clarify if there have been any changes, as there has been an increase in zero length stays.	DJ/DCF KMcC JL KMcC JS

No	Item	Action
GB18/09	**Improvement Assessment Framework** Framework to be presented through the Leadership Team. DJ noted indicator 104a – injuries from falls in people aged 65 years+ and asked what can we do together to improve this across social care and hospital services. Learning Disability annual health checks are noted to be the worst nationally. Chief Officer advised that at the Health & Wellbeing Board this had been discussed with Matt Ashton and at the Primary Care Joint Commissioning Group and Geraldine O'Carroll has picked up this piece of work to go into the Integrated Commissioning Group as an agenda item. DJ advised that Social Care can help with getting people to GP surgeries for health checks. PC advised that the Learning Disability Enhanced Scheme has changed for GPs – funding has increased but template is unmanageable. Need to look at good practice in other areas. Healthwatch have done some good work and Geraldine will be taking this forward. Action – GO'C to take the item to the Integrated Commissioning Group.	KMcC GO'C GO'C GO'C
GB18/11	**Register of Interests** The Governing Body were advised that an updated register of interest as at December 2017 was required.	All
GB18/12	**Joint Committee Terms of Reference** Action – For SLT to revise the specific wording and to re-present this at the next Governing Body Meeting. Nominations will be made at that time for the representatives.	FLT
GB18/13	**Disinvestment Policy & Procedure (Cessation and Significant Reduction of Services)** 4.5.1 – title of role needs to be amended to QIPP Lead.	AW

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MARCH 2018

Agenda Item: 18/45	**Author of the Paper:** Fiona Taylor Chief Officer Email: fiona.taylor@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: March 2018	

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 and as part of the North Mersey LDS.
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.

NHS
South Sefton
Clinical Commissioning Group

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 2018

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

Delivery of the CCG's QIPP challenge remains a key priority for the CCG and staff are continuing to focus their efforts on implementation of schemes and identifying new opportunities.

During February members of the Leadership Team presided led the second in a series of "check and challenge" sessions that enabled in depth scrutiny of QIPP schemes and anticipated spend in respect of medicines optimisation, planned care, urgent care. Whilst good progress has been made it is essential that every effort continues to be made to release efficiencies whilst maintaining the quality of the services we commission.

The QIPP savings requirement, assessed at the start of the year to deliver the agreed financial plan is £8.480m. Work remains ongoing to develop a fully identified plan to achieve the required efficiencies in year to deliver the financial target. As at Month 9, £1.806m QIPP savings have been achieved in the financial year to date.

On 2nd February NHSE and NHSI published the planning guidance for 2018/19, and on 5th February the CCG received notification of its control total for the coming year. The leadership team and relevant leads are now in the process of assessing the impact of that on any QIPP schemes and developing an updated QIPP plan for 2018/19.

The Chief Finance Officer will provide a full overview of the financial position as part of the Integrated Performance Report discussions.

2. Planning Guidance 2018/19

On 2nd February 2018, NHS England and NHS Improvement published planning guidance[1] that requires commissioners and providers to refresh the existing two year operational plans. The CCG's Executive Team and relevant leads are now working through the guidance to apply the activity and financial assumptions to facilitate the refresh. The draft plan will be submitted to NHS England (Cheshire and Merseyside) by 2nd March, with a final submission being made by 30th April following approval by the Governing Body.

The key headlines for commissioners are as follows:

- Resources available to CCGs will be increased reflecting realistic levels of emergency activity, additional elective activity to tackle waiting lists, universal adherence to the Mental Health Investment Standard and a commitment to reaching standards set for cancer services and primary care.

[1] Available at https://www.england.nhs.uk/publication/refreshing-nhs-plans-for-2018-19/

- Creation of a new Commissioner Sustainability Fund (CSF) to enable CCGs to return to in year financial balance
- The two year tariff remains in place
- Improvements are expected in A&E performance, Delayed Transfers of Care (DTOC), Referral to Treatment (RTT) targets as well as ensuring compliance with the Mental Health Investment Standard (MHIS) and Cancer waiting time standards.
- Further guidance in respect of Commissioning for Quality and Innovation (CQUIN) and the Quality Premium is due to be published soon.

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 as part of the North Mersey LDS.

3. Sefton Place Based-Care closer to home

The first workshop took place on 31st January and was well attended by stakeholders. The session was focussed on developing a vision for local out of hospital services. The outputs of the workshop are being collated and will be discussed in more detail with the strategic lead for this programme area.

Any integrated model will be based around the CCG's Shaping Sefton Strategy and focussed on improving health and well-being outcomes for the populations we serve.

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

4. Kirkup Review of Liverpool Community Health

The Report of the Liverpool Community Health Independent Review undertaken by Dr. Bill Kirkup was published on 8th February 2018. The role of the CCG along with other commissioners and regulators are reflected in the report and the Quality Team are in the process of reviewing the report and reflecting on lessons to be learnt in order to build upon what has been identified previously in the Capsticks Report and the CCG commissioned MIAA report all of which have previously been taken through the CCGs' internal governance processes.

The link to the report is as follows: https://improvement.nhs.uk/news-alerts/independent-review-liverpool-community-health-nhs-trust-published/

5. Provider Cost Improvement Plans

The CCGs are working collaboratively with Liverpool CCG (LCCG) to introduce a new Cost Improvement Plan (CIP) process which is based on the "Star Chamber" model. This is to ensure that we standardise our process for reviewing CIPs to better enable a consistent and systematic approach to evaluation of impact and also fairness within the process. At the day scheduled for 12th March 2018, commissioners will review progress against 2017/18 CIP plans and review planned CIPs for 2018/19.

NHS
South Sefton
Clinical Commissioning Group

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.

6. Items which should not be routinely prescribed in primary care

NHS England has partnered with NHS Clinical Commissioners (NHSCC) to support CCGs in ensuring they can use their prescribing resources effectively and deliver best patient outcomes from the medicines that their local population uses. National guidance on medicines which should no longer be routinely prescribed in primary care has been published to ensure people receive the safest and most effective treatment available, aiming to save the NHS up to £141m a year[2].

The CCG's Medicines Management Team is now considering how to implement the national guidance, with due regard to our local circumstances.

7. Primary care commissioning

Primary care co-commissioning is part of the NHS Five Year Forward View. It gives Clinical Commissioning Groups (CCGs) an opportunity to take on greater responsibility for general practice commissioning. It was introduced in 2014/15 to support the development of integrated out-of-hospital services, based around the needs of local people.

Three models of commissioning were introduced

1. Greater involvement – an invitation to CCGs to work more closely with their local NHS England teams in decisions about primary care services
2. Joint commissioning – enables one or more CCGs to jointly commission general practice services with NHS England through a joint committee
3. Delegated commissioning –an opportunity for CCGs to take on full responsibility for the commissioning of general practice services

The CCG has been at level 2 – joint commissioners of general practice with NHSE since 2017, however we feel it is time to review this arrangement with a view to move to level 3 and become a fully delegated commissioners.

The CCG's Constitution does include a provision to enable this to happen, but it will require a further application to NHS England to approve the delegation of this responsibility to the CCG. The early benefits of delegated commissioning have been reported as:-

- The development of clearer, more joined up vision for primary care, aligned to wider CCG and health economy plans for improving health services
- Improved access to primary care
- Improved quality of care being delivered to patients
- Improved CCG relationships with member practices, including greater local ownership of the development of primary care services

[2] Available at: https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/

South Sefton
Clinical Commissioning Group

- Increased clinical leadership in primary care commissioning, enabling more local decision making
- Greater involvement of patients in shaping services
- A more sustainable primary care system for the future

We will be writing out to the CCG member practices asking them to vote in favour of taking the application forward, with a view to becoming delegated during 2018/19

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

The CCG is currently in the process of reviewing the proposed Section 75

8. Recommendation

The Governing Body is asked to formally receive this report.

Fiona Taylor
Chief Officer
March 2018

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MARCH 2018

Agenda Item: 18/46	**Author of the Paper:** Martin McDowell Chief Finance Officer Email: martin.mcdowell@southseftonccg.nhs.uk Tel: 0151 247 7071
Report date: February 2018	

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.

Recommendation

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

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.

South Sefton
Clinical Commissioning Group

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 monthly performance was presented in an alternative format to Joint QIPP Committee representatives on 16th January 2018.

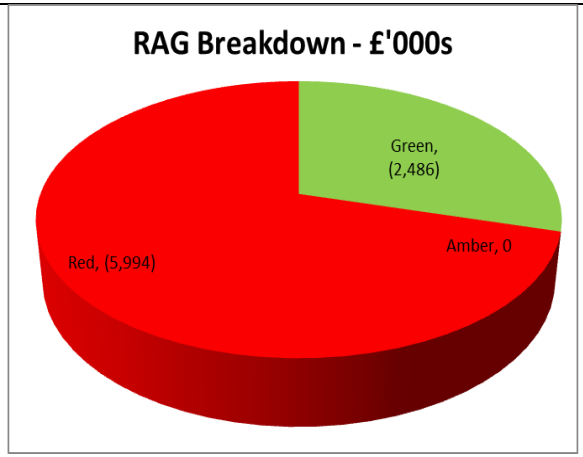
Links to National Outcomes Framework *(x those that apply)*	
x	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
x	Helping people to recover from episodes of ill health or following injury
x	Ensuring that people have a positive experience of care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

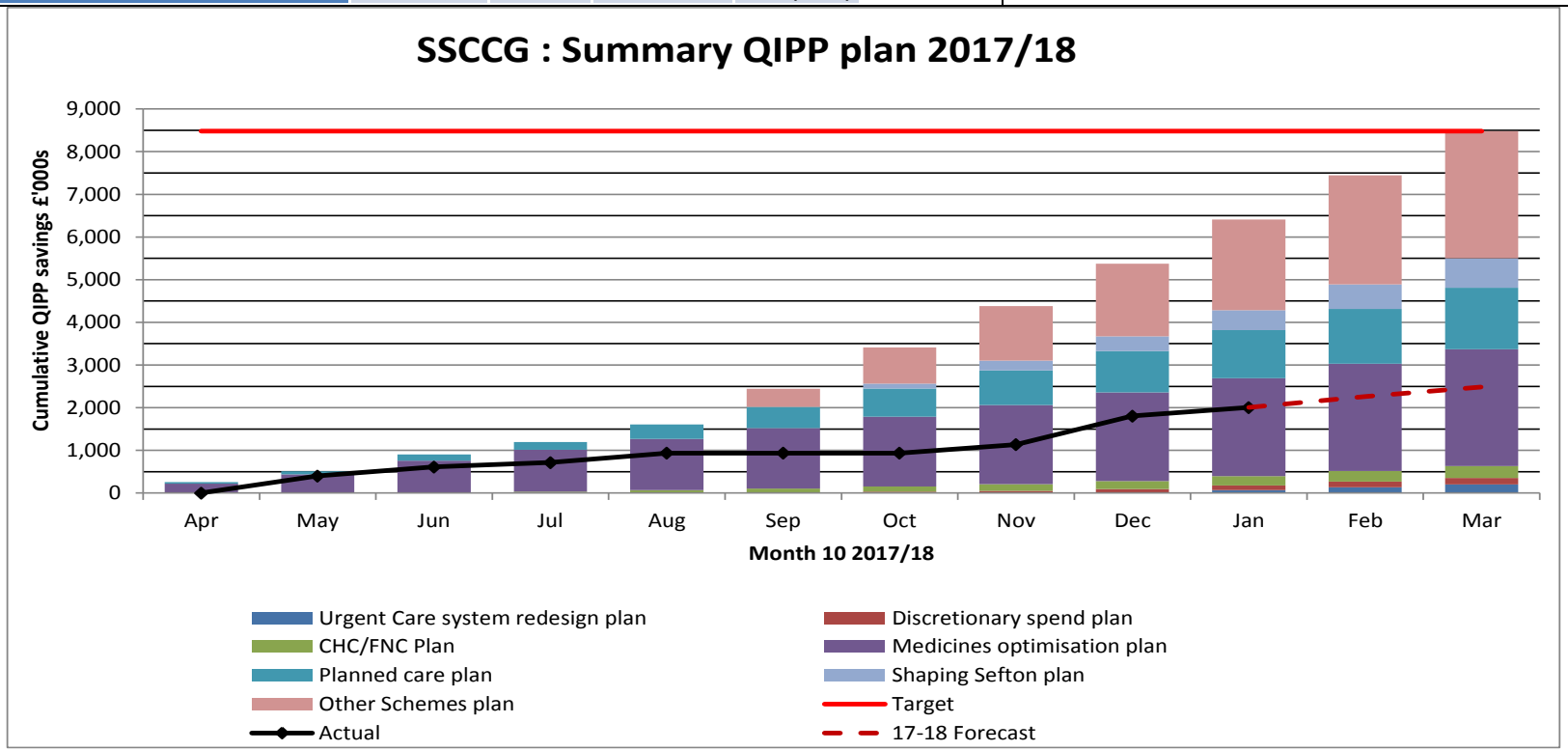
QIPP DASHBOARD – SUMMARY SOUTH SEFTON CCG AT MONTH 10

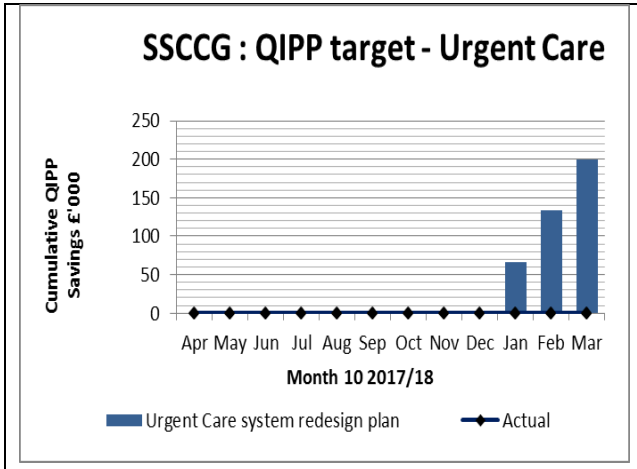
South Sefton CCG

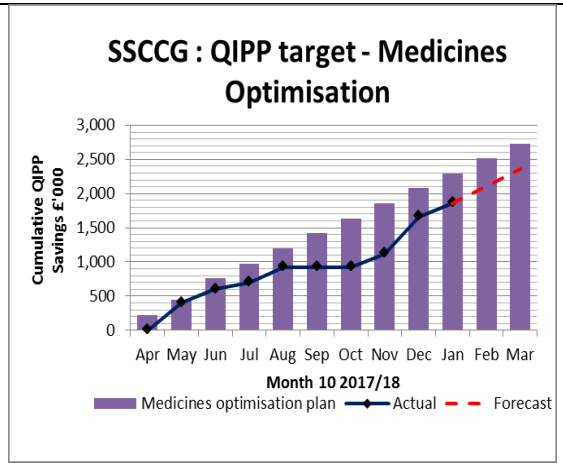
£'000s

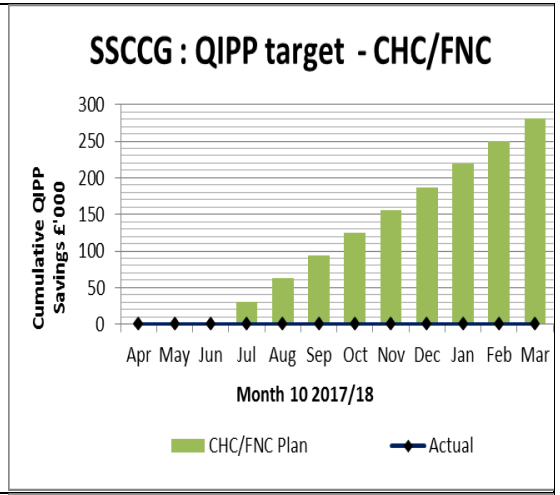
Scheme	Annual Plan	YTD Plan	YTD Actual	Variance
Planned care plan	1,442	1,127	0	(1,127)
Medicines optimisation plan	2,734	2,295	1,660	(435)
CHC/FNC Plan	281	219	0	(219)
Discretionary spend plan	130	113	23	(90)
Urgent Care system redesign	200	67	0	(67)
Shaping Sefton Plan	693	462	0	(462)
Other Schemes	3,000	2,126	123	(2,003)
Total	8,480	6,409	2,006	(4,463)

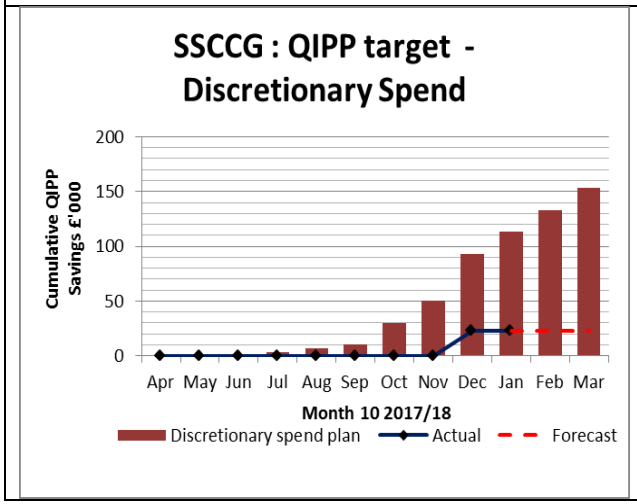


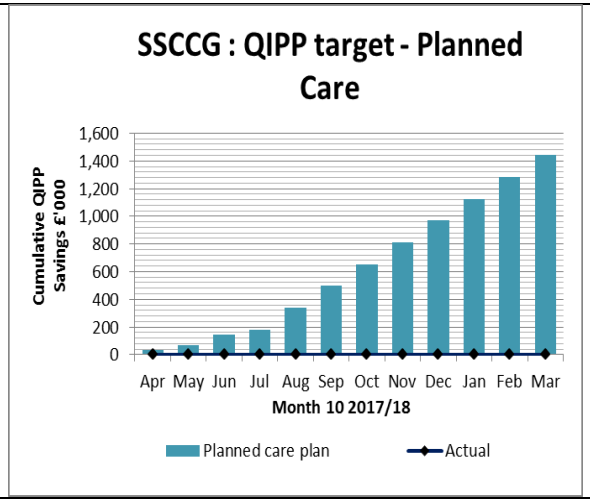


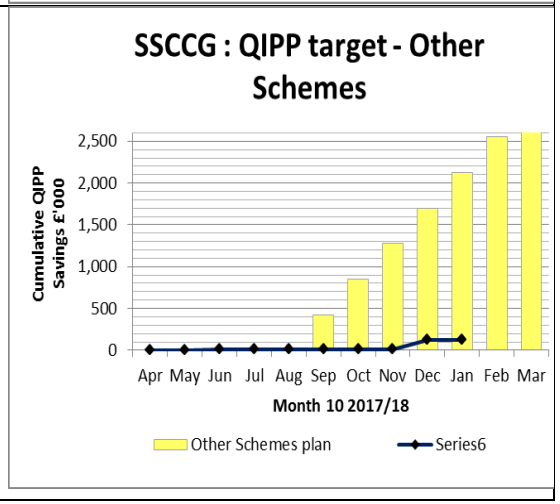

SSCCG : QIPP target - Urgent Care
Cumulative QIPP Savings £'000
250
200
150
100
50
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Month 10 2017/18
Urgent Care system redesign plan
Actual


SSCCG : QIPP target - Medicines Optimisation
Cumulative QIPP Savings £'000
3,000
2,500
2,000
1,500
1,000
500
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Month 10 2017/18
Medicines optimisation plan
Actual
Forecast


SSCCG : QIPP target - CHC/FNC
Cumulative QIPP Savings £'000
300
250
200
150
100
50
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Month 10 2017/18
CHC/FNC Plan
Actual


SSCCG : QIPP target - Discretionary Spend
Cumulative QIPP Savings £'000
200
150
100
50
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Month 10 2017/18
Discretionary spend plan
Actual
Forecast


SSCCG : QIPP target - Planned Care
Cumulative QIPP Savings £'000
1,600
1,400
1,200
1,000
800
600
400
200
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Month 10 2017/18
Planned care plan
Actual


SSCCG : QIPP target - Other Schemes
Cumulative QIPP Savings £'000
2,500
2,000
1,500
1,000
500
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Month 10 2017/18
Other Schemes plan
Series6

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MARCH 2018

Agenda Item: 18/47	**Author of the Paper:** Karl McCluskey Chief Strategy & Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk Tel: 0151 247 7000
Report date: February 2018	
Title: 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 and as part of the North Mersey LDS.
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.

NHS
South Sefton
Clinical Commissioning Group

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

South Sefton Clinical Commissioning Group

Integrated Performance Report

NHS
South Sefton
Clinical Commissioning Group

Contents

NHS
South Sefton
Clinical Commissioning Group

List of Tables and Graphs

NHS
South Sefton
Clinical Commissioning Group

Summary Performance Dashboard

Metric	Reporting Level		2017-18									
			Q1			Q2			Q3			YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
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	R	G	G	G	G	G	G	G
		Actual	93.573%	94.653%	83.002%	95.404%	95.159%	95.842%	96.209%	94.484%	95.804%	93.728%
		Target	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	R			G			G			G
		Actual	89.917%			95.455%			95.466%			93.731%
		Target	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	R	R	R	G	R	G	R	R	R
		Actual	93.846%	86.486%	84.416%	88.462%	93.182%	91.803%	95.775%	91.667%	91.045%	90.658%
		Target	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	R			R			R			R
		Actual	87.963%			91.189%			92.857%			90.658%
		Target	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 (31 days) 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
		Actual	100.00%	98.507%	97.143%	98.876%	97.647%	96.341%	99.029%	97.468%	98.551%	98.166%
		Target	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%

NHS
South Sefton
Clinical Commissioning Group

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 (31 days) of a decision to treat (as a proxy for diagnosis) for cancer	South Sefton CCG	RAG	G			G			G			G
		Actual	98.537%			97.683%			98.419%			98.187%
		Target	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	G	G	R	G	G	R	G
		Actual	93.333%	100.00%	100.00%	100.00%	100.00%	77.778%	94.118%	100.00%	85.714%	95.495%
		Target	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	97.297%			94.595%			94.737%			95.536%
		Target	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	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%	100.00%
		Target	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%			100.00%			100.00%			100.00%
		Target	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	G	G	G	G	G	R	G	G	G
		Actual	100.00%	96.875%	100.00%	95.652%	100.00%	100.00%	91.667%	100.00%	100.00%	98.062%
		Target	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			G			G			G
		Actual	98.718%			98.837%			96.809%			98.062%
		Target	94.00%			94.00%			94.00%			94.00%

NHS
South Sefton
Clinical Commissioning Group

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	R	R	G	G	R	G	R	G	G	G
		Actual	83.871%	83.333%	85.714%	89.474%	80.00%	86.486%	82.051%	90.323%	93.548%	86.159%
		Target	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	R			G			G			G
		Actual	84.524%			86.364%			88.119%			86.441%
		Target	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	R	G	G	R	G	G
		Actual	100.00%	100.00%	100.00%	92.857%	83.333%	100.00%	100.00%	87.50%	100.00%	95.775%
		Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

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			R			G
		Actual	97.143%			96.667%			93.548%			95.833%
		Target	95.00%			95.00%			95.00%			95.00%
Episode of Psychosis												
2099: First episode of psychosis within two weeks of referral The percentage of people experiencing a first episode of psychosis with a NICE approved care package within two weeks of referral. The access and waiting time standard requires that more than 50% of people do so within two weeks of referral.	South Sefton CCG	RAG	R	G	G	G	G	G	G	R	G	G
		Actual	-	100.00%	66.667%	100.00%	50.00%	100.00%	75.00%	40.00%	100.00%	77.419%
		Target	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
Dementia												
2166: Estimated diagnosis rate for people with dementia Estimated diagnosis rate for people with dementia	South Sefton CCG	RAG	R	R	R	R	G	G	G	G	R	R
		Actual	66.07%	65.52%	65.97%	66.43%	67.02%	66.77%	67.52%	67.12%	65.01%	
		Target	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%

NHS
South Sefton
Clinical Commissioning Group

IAPT (Improving Access to Psychological Therapies)						
2183: IAPT Recovery Rate (Improving Access to Psychological Therapies) The percentage of people who finished treatment within the reporting period who were initially assessed as 'at caseness', have attended at least two treatment contacts and are coded as discharged, who are assessed as moving to recovery.	South Sefton CCG	RAG	R	R	R	R
		Actual	41.40%	46.90%	44.10%	44.20%
		Target	50.00%	50.00%	50.00%	50.00%
2131: IAPT Roll Out The proportion of people that enter treatment against the level of need in the general population i.e. the proportion of people who have depression and/or anxiety disorders who receive psychological therapies	South Sefton CCG	RAG	R	R	R	R
		Actual	3.60%	3.59%	3.64%	10.8%
		Target	3.75%	3.75%	3.75%	15.0%
2253: IAPT Waiting Times - 6 Week Waiters The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number who finish a course of treatment.	South Sefton CCG	RAG	G	G	G	G
		Actual	98.5%	99.3%	99.4%	99.1%
		Target	75.00%	75.00%	75.00%	75.00%
2254: IAPT Waiting Times - 18 Week Waiters The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment, against the number of people who finish a course of treatment in the reporting period.	South Sefton CCG	RAG	G	G	G	G
		Actual	99.8%	100%	100%	99.9%
		Target	95.00%	95.00%	95.00%	95.00%

Children and Young People with Eating Disorders						
2096: The number of completed CYP ED urgent referrals within one week The number of completed CYP ED care pathways (urgent cases) within one week (QUARTERLY)	South Sefton CCG	RAG	R	R	G	G
		Actual	0%	0%	100%	100%
		Target	95%	95%	95%	95%
2097: The number of incomplete pathways (routine) for CYP ED Highlights the number of people waiting for assessment/treatment and their length of wait (incomplete pathways) - routine CYP ED	South Sefton CCG	RAG	G	R	G	R
		Actual	0	1	0	1
		Target	1	1	1	1
2098: The number of incomplete pathways (urgent) for CYP ED Highlights the number of people waiting for assessment/treatment and their length of wait (incomplete pathways) - urgent CYP ED	South Sefton CCG	RAG	G	G	R	R
		Actual	0	0	1	1
		Target	1	1	1	1

NHS
South Sefton
Clinical Commissioning Group

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	G	G	G	G	G	G	G
		Actual	0	0	0	0	0	0	0	0	0	0
		Target	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	G	G	G	G	G	G	G
		Actual	-	-	-	-	-	-	-	-	-	-
		Target	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	G	G	G	R	G
		Actual	93.733%	94.171%	93.624%	92.599%	92.405%	92.295%	92.25%	92.22%	91.308%	92.719%
		Target	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%
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	R	R	R	R	R	R	R	R	R	R
		Actual	2.207%	3.755%	4.059%	4.632%	6.418%	3.312%	2.612%	4.535%	4.925%	4.036%
		Target	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
		Actual	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0

NHS
South Sefton
Clinical Commissioning Group

E-Referrals												
2142: NHS e-Referral Service (e-RS) Utilisation Coverage Utilisation of the NHS e-referral service to enable choice at first routine elective referral. Highlights the percentage via the e-Referral Service.	South Sefton CCG	RAG	R	R	R	R	R	R	R	R	R	R
		Actual	22.059%	19.884%	20.428%	18.783%	21.392%	21.33%	21.496%	21.758%	22.667%	20.879%
		Target	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%

Personal Health Budgets						
2143: Personal health budgets Number of personal health budgets that have been in place, at any point during the quarter, per 100,000 CCG population (based on the population the CCG is responsible for).	South Sefton CCG	RAG	R	R	R	R
		Actual	7.1	15.49	16.78	
		Target	0.10	0.10	0.10	0.10

Wheelchairs						
2197: Percentage of children waiting less than 18 weeks for a wheelchair The number of children whose episode of care was closed within the reporting period, where equipment was delivered in 18 weeks or less of being referred to the service.	South Sefton CCG	RAG	R	R	R	R
		Actual	N/A	N/A	N/A	-
		Target	92.00%	92.00%	92.00%	92.00%

NHS
South Sefton
Clinical Commissioning Group

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	R	R	R	R	R	R	R	R
		YTD	0	0	1	1	1	1	1	1	1	1
		Target	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
		YTD	3	9	12	15	21	26	28	29	33	33
		Target	5	11	14	18	23	28	34	39	43	43

Accident & Emergency

2123: 4-Hour A&E Waiting Time Target (Monthly Aggregate based on HES 15/16 ratio) % of patients who spent less than four hours in A&E (HES 15/16 ratio Acute position from Unify Weekly/Monthly SitReps)	South Sefton CCG	RAG	R	R	R	R	R	R	R	R	R	R
		Actual	88.069%	82.213%	82.323%	83.40%	85.006%	86.063%	86.245%	87.27%	85.90%	85.288%
		Target	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
		Actual	86.125%	78.775%	78.421%	80.811%	82.35%	84.469%	84.414%	86.58%	84.791%	83.206%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
1928: 12 Hour Trolley waits in A&E Total number of patients who have waited over 12 hours in A&E from decision to admit to admission	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RAG	G	R	R	G	G	G	G	G	R	R
		Actual	0	9	2	0	0	0	0	0	4	18
		Target	0	0	0	0	0	0	0	0	0	0

South Sefton
Clinical Commissioning Group

1. Executive Summary

This report provides summary information on the activity and quality performance of South Sefton Clinical Commissioning Group at Month 9 (note: time periods of data are different for each source).

Financial position

The agreed financial plan for 2017/18 requires the CCG to break even in year, whilst the cumulative CCG position is a surplus of £0.1m which incorporates the historic surplus brought forward from the previous financial year. The CCGs strategic financial plan was set to deliver a 0.5% surplus in 2018/19 and a 1% surplus in 2019/20, the plan will be revised based on likely performance in 2017/18.

The QIPP savings requirement to deliver the agreed financial plan is £8.480m. As at Month 10, £2.006m QIPP savings have been achieved in the financial year to date.

The year to date financial position is a year to date deficit of £3.6m, which represents deterioration against the planned deficit of £0.1m. The full year forecast financial position for the CCG is a deficit of £4.3m. As we enter the final quarter of the year, it is unlikely that the CCG will deliver its agreed plan of break even.

Planned Care

Referrals in December 2017 have seen a significant decrease. GP referrals in 2017/18 to date are 5% down on the equivalent period in the previous year. There have been significant reductions in GP referrals to Gastroenterology, Trauma & Orthopaedics and Dermatology. Consultant to consultant referrals are currently 2% higher when comparing to 2016/17 with General Medicine and Clinical Physiology seeing substantial increases.

The latest data (December) for E-referral Utilisation rates reported for the CCG as a whole is 23%; up by 1% from November and have not achieved the 80% ambition by October 2017.

The CCG failed the target for less than 1% of patients waiting more than 6 weeks for a diagnostic test in December 4.93%. Aintree also failed in December recording 4.88%. An action plan is in place.

The CCG has fallen below the 92% threshold for patients on an incomplete pathway waiting no more than 18 weeks from referral, recording 91.31%. Aintree also failed this standard recording 91.06% in December. During December there was significant pressure on the hospital bed base which resulted in the cancellation of routine elective cases, and impact of the commencement of the theatre refurbishment programme. In addition, both the outpatient cancellation and Did Not Attend (DNA) rates rose across the board.

The CCG are failing 1 of the 9 cancer measures. This is the 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms; year to date the CCG is recording 90.66% below the 93% target. Aintree are failing 5 of the 9 cancer measures. Firstly 2 week breast symptom recorded 91.43% year to date, 31 day subsequent treatment (surgery) recorded 92.97% year to date, 62 day upgrade year to date 81.15%, 62 day screening recording 86.96% year to date and lastly the 62 day standard recording 84.20% year to date. The Trust has actions in place to improve performance, see main body of the report.

Friends and Family measure inpatient response rates at Aintree are under target for December at 16.3% (and have been for all of 2017/18 so far). The proportion of patients who would recommend has declined since last month recording 93% in December (England average 96%). The proportion who would not recommend is higher than last month at 5%, which is 3% higher than the England average.

Performance at Month 9 of financial year 2017/18, against planned care elements of the contracts held by NHS South Sefton CCG show an under performance of -£1.4m/-3.8%. However, applying a neutral cost variance for those Trusts within the Acting as One block contract arrangement results in there being a total under spend of approximately -£345k/-0.9%.

Unplanned Care

Aintree have revised their Cheshire & Merseyside 5 year Forward View (STP) trajectory for A&E 2017/18 and have failed the 90% December plan agreed with NHS Improvement recording performance with 84.79% (for all A&E department types) representing a -1.79% decrease compared to November 2017.

There was a 3 month moratorium in data reporting to allow NWAS to understand and learn from the Ambulance Response Programme (ARP) and to redraft and reformulate reports. The first set of reporting will be at NWAS and County level, it is unlikely that there will be CCG level data for this financial year. Early indications are showing a positive impact with more time to assess calls resulting in the right vehicle response being dispatched first time and reduced number of vehicles being stood down; there have been improvements in ambulance utilisation and reductions in the long waits for lower acuity calls.

The number of 111 calls in December from South Sefton CCG patients have risen, when compared to the same 9 months of the previous year, there have been 269 more contacts in 2016/17, an increase of 1.5%.

The number of calls from South Sefton patients to the GP OOH service has risen in December. When compared to the same point in the previous year, there have been 601 more calls so far in the first 9 months of 2017/18, an increase of 7.2%.

Aintree failed the 80% target of stroke patients spending at least 90% of their time on a stroke unit in December, achieving 67.5%. All breaches of the standard are reviewed and reasons for underperformance identified. The Trust continues to achieve their TIA target.

The CCG achieved their C.difficile plans for December. Aintree had 5 new cases reported in December (50 year to date) against a year to date plan of 34. (There have been 15 successful appeals upheld at panel, so 35 cases following appeal). The year-end plan is 46.

The CCG and Aintree recorded one case of MRSA in June and therefore have failed the zero tolerance plan for the whole of 2017/18.

The average number of delayed transfer of care per day in Aintree hospital decreased in December to 26 from 38 reported in December. Analysis of average delays in December 2017 compared to December 2016 shows an increase of 18.8% in the average number of patients from 32 to 26.

The percentage of people that would recommend A&E is above the England average (85%) reporting 87% in December the same as November. The not recommended percentage is at 9% in December which again is the same as the previous month, England average 8%.

Performance at Month 9 of financial year 2017/18, against unplanned care elements of the contracts held by NHS South Sefton CCG shows an over performance of circa £1.5m/4.1%. However, applying a neutral cost variance for those Trusts within the Acting as One block contract arrangement results in there being a total under spend of approximately -£180k/-0.5%.

Mental Health

All of the three of the CPA mental health measures were achieved in December.

The CCG is therefore currently in line with the target to reduce Out of Area Placements by 33% based on quarter 4 2016/17 activity.

In terms of Improving Access to Psychological Therapies (IAPT), Cheshire & Wirral Partnership reported fewer patients entering treatment in Month 9. The access rate for Month 9 was 0.95% and therefore failed to meet the standard. The percentage of people moved to recovery was 42.1% in Month 9, which is a decrease from 46.8% for the previous month and failing to meet the target of 50%.

The CCG recorded dementia diagnosis rate in December 2017 of 65.01% failing the national dementia diagnosis ambition of 66.7% after achieving for the previous 4 months, an action plan is in place.

Community Health Services

A number of services have seen a high number of DNA's and Provider cancellations so far in 2017/18. For patient DNAs, Sefton Physio Service reports a deterioration in cancelation rates with 14.3% in December compared to 8.2% reported last month. Adult Dietetics also continues to report high rates at 14.5% in December, a deterioration from 10.8% in November.

Better Care Fund

A quarter 3 performance monitoring return was submitted on 19th January on behalf of the Sefton Health and Wellbeing Board. This reported that all national BCF conditions were met; progress against national metric targets for non-elective hospital admissions, admissions to residential care, reablement and Delayed Transfers of Care; assessment against the High Impact Change Model; and narrative of progress to date.

CCG Improvement & Assessment Framework

A full exception report for each of the indicators citing performance in the worst quartile of CCG performance nationally or a trend of three deteriorating time periods is presented to Governing Body as a standalone report. This outlines reasons for underperformance, actions being taken to address the underperformance, more recent data where held locally, the clinical, managerial and SLT leads responsible and expected date of improvement for the indicators.

NHS
South Sefton
Clinical Commissioning Group

2. Financial Position

2.1 Summary

This report focuses on the financial performance of South Sefton CCG as at 31st January 2018.

The year to date financial position is a deficit of £3.600m which represents deterioration against the planned deficit of £0.100m. The CCG forecasts a deficit of £4.300m and as we enter the final quarter of the year, it is unlikely that the CCG will deliver its plan.

The cumulative CCG position is a surplus of £0.100m which incorporates the historic surplus brought forward from previous financial years.

Cost pressures have emerged in the ten months of the financial year which are balanced out to a certain extent by underspends in other areas. The main areas of forecast overspend are within Continuing Healthcare relating to Continuing Healthcare packages; cost pressure within Mersey Care relating to intermediate care, discharge planning and transitional community funding; costs in respect of pass through payments for PbR excluded drugs and devices; full year costs for the Acute Visiting Scheme (AVS) and overperformance at Spire and Ramsay hospitals.

The forecast cost pressures are supported by underspends in the acute commissioning budget, mainly due to underperformance on the contract with Southport and Ormskirk NHS Trust.

QIPP savings anticipated for the financial year to date have not been delivered in full meaning that delivery of the CCG financial plan is at risk. QIPP opportunities in the current financial year are reduced as a result of the Acting as One contract agreement. This agreement protects the CCG against contract overperformance but also limits the CCG's potential to deliver efficiency savings in the secondary care sector.

The CCG is working on a revised trajectory for delivery of savings for the remainder of the financial year.

The high level CCG financial indicators are listed below:

Figure 1 – Financial Dashboard

Key Performance Indicator		This Month
Business Rules	1% Surplus	✗
	0.5% Contingency Reserve	✓
	0.5% Non-Recurrent Reserve	✓
Breakeven	Financial Balance	✓
QIPP	QIPP delivered to date *(Red reflects that the QIPP delivery is behind plan)*	**£2.006m**

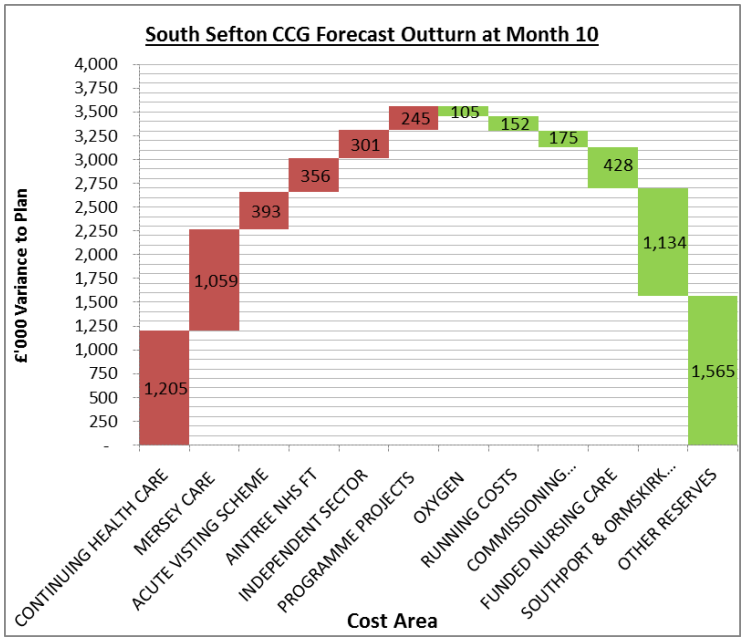
Key Performance Indicator		This Month
Running Costs	CCG running costs < 2017/18 allocation	✓
BPPC	NHS - Value YTD > 95%	99.88%
	NHS – Volume YTD > 95%	97.28%
	Non NHS - Value YTD > 95%	97.28%
	Non NHS – Volume YTD > 95%	95.99%

- The CCG will not achieve the NHS England business rule to deliver a 1% Surplus. This was agreed in the CCG financial plan approved by NHS England.
- 0.5% Contingency Reserve is held as mitigation against potential cost pressures.
- 0.5% Non-Recurrent Reserve is held uncommitted as directed by NHS England.
- The current financial plan is to achieve a break even position in year. The likely case scenario is a deficit of £4.300m.
- QIPP Delivery is £2.006m to date; this is £4.403m behind the planned delivery at Month 10.
- The forecast expenditure for the Running Cost budget is below the allocation by £0.152m for 2017/18.
- BPPC performance is above the 95% target in all areas for the year to date.

2.2 CCG Financial 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.

Figure 2 – Forecast Outturn



- The CCG forecast position for the financial year is a deficit of £4.300m.
- The main financial pressures relate to
  - Cost pressures relating to Continuing Healthcare packages.
  - Cost pressure within Mersey Care relating to intermediate care, discharge planning and transitional community funding.
  - Full year costs for the Acute Visiting Scheme (AVS)
  - Overspend for PbR excluded drugs and devices at Aintree FT.
  - Over performance at Spire and Ramsay hospitals
- The forecast cost pressures are supported by underspends in the Acute Commissioning budget, mainly due to underperformance on the contract with Southport and Ormskirk Trust and on Funded Nursing Care packages.

2.3 Provider Expenditure Analysis – Acting as One

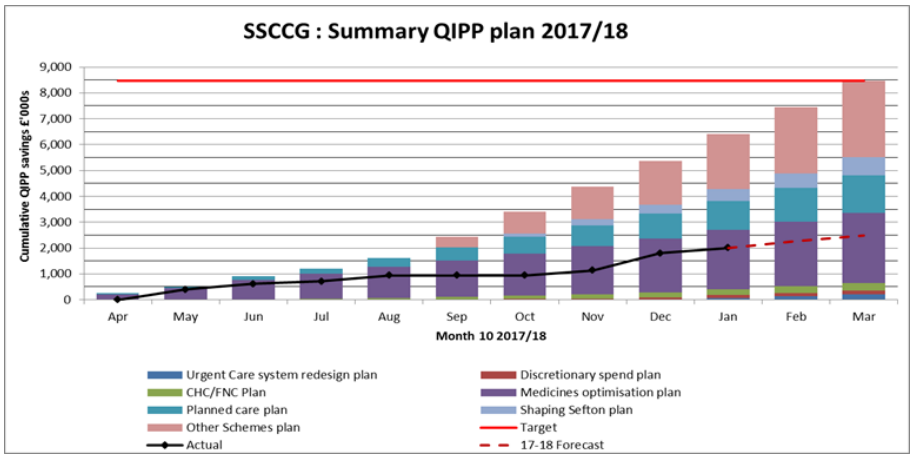
Figure 3 – Acting as One Contract Performance (Year to Date)

Provider	Pressure/(Benefit) £m
Aintree University Hospital NHS Foundation Trust	£1.179
Alder Hey Children's Hospital NHS Foundation Trust	-£0.230
Liverpool Women's NHS Foundation Trust	-£0.128
Liverpool Heart & Chest NHS Foundation Trust	£0.010
Royal Liverpool and Broadgreen NHS Trust	£0.259
Mersey Care NHS Foundation Trust	£0.000
The Walton Centre NHS Foundation Trust	-£0.095
Grand Total	£0.993

- The CCG is included in the Acting as One contracting arrangements for the North Mersey LDS. Contracts have been agreed on a block contract basis for the financial years 2017/18 and 2018/19.
- The agreement protects against overperformance with these providers but does present a risk that activity could drift to other providers causing a pressure for the CCG.
- Due to fixed financial contract values, the agreement also removes the ability to achieve QIPP savings in the two year contract period. However, QIPP schemes should continue as this will create capacity to release other costs and long term efficiencies within the system.
- The year to date performance for the Acting as One providers shows an overperformance spend against plan, this would represent a year to date overspend of £0.993m under usual contract arrangements.

2.4 QIPP

Figure 4 – QIPP Plan and Forecast



	Rec	Non Rec	Total	Green	Amber	Red	Total
Planned Care plan	1,442	0	1,442	41	0	1,401	1,442
Medicines optimisation plan	2,734	0	2,734	2,415	0	319	2,734
CHC/FNC plan	281	0	281	0	0	281	281
Discretionary spend plan	100	53	153	53	0	100	153
Urgent Care system redesign plan	200	0	200	0	0	200	200
Shaping Sefton Plan	693	0	693	0	0	693	693
Other Schemes Plan	2,677	300	2,977	(23)	0	3,000	2,977
Total QIPP Plan	**8,127**	**353**	**8,480**	**2,486**	**0**	**5,994**	**8,480**
QIPP Delivered 2017/18				**(2,006)**		**0**	**(2,006)**

- The opening QIPP plan for 2017/18 was **£5.880m** Pressures have emerged in year as further work has established that the CCG has incurred a pressure of £1.300m as a result of the introduction of the new HRG4+ payment system. Finalisation of the new community contract has also created a pressure of £1.300m including planned £0.500m non-recurrent transitional support to the new provider.

- The revised QIPP target is **£8.480m** which incorporates the two additional pressures. Options to identify and prioritise future projects were discussed at the Governing Body development session in December. The CCG will continue to hold challenge and confirm sessions with QIPP Leads to inform QIPP delivery to 31 March 2018.
- The CCG has identified **£2.006m** QIPP savings at Month 10, the majority of this relates to savings within the prescribing budget.
- The forecast QIPP delivery for the year is **£2.486m** which represents 100% of schemes rated Green. A high proportion of the plan remains rated red. Further work is required to provide assurance that additional savings can be delivered.

Figure 5 – Risk Adjusted Financial Position

	Recurrent £000	Non-Recurrent £000	Total £000
Agreed Financial Position	0.000	0.000	0.000
QIPP Target	(6.414)	(2.066)	(8.480)
Revised surplus / (deficit)	(6.414)	(2.066)	(8.480)
Forecast Outturn (Operational budgets)	0.440	(2.130)	(1.690)
Risks / Mitigations	0.757	2.583	3.340
Management action plan			
QIPP Achieved	0.759	1.247	2.006
Remaining QIPP to be delivered	0.480	0.000	0.480
Total Management Action plan	**1.239**	**1.247**	**2.486**
Year End Surplus / (Deficit)	**(3.978)**	**(0.366)**	**(4.344)**

Financial Position

- The CCG forecast financial position is a deficit of £4.300m.
- The underlying position is a deficit of £4.344m. This position removes non-recurrent expenditure commitments and QIPP savings from the forecast position.

South Sefton CCG	Best Case £m	Most Likely £m	Worst Case £m
QIPP requirement (to deliver agreed forecast)	(6.474)	(6.474)	(6.474)
Predicted QIPP achievement	0.480	0.480	0.480
Forecast Surplus / (Deficit)	**(7.684)**	**(7.684)**	**(7.684)**
Further Risk	(2.071)	(2.071)	(2.635)
Management Action Plan	5.455	5.455	3.709
Risk adjusted Surplus / (Deficit)	**(4.300)**	**(4.300)**	**(6.610)**

Risk Adjusted Position

- The risk adjusted position provides an assessment of the best, likely and worst case scenarios in respect of the CCGs year end outturn.
- The best case and likely case is a deficit of **£4.300m** and assumes that QIPP delivery will be **£2.486m** in total with further risk and mitigations as per the best case scenario.

- The worst case scenario is a deficit of **£6.610m** and assumes reduced QIPP delivery, additional risks in respect of elective activity, outpatient procedure coding and CQUIN.

2.5 Contract Alignment – Month 6

Figure 6 – Contract Alignment table

	2017/18 YTD		2017/18 YTD	
	£000		£000	Formula
Provider	YTD	Commissioner	YTD	YTD Variance
Alder Hey Children's NHS Foundation Trust	5,027	NHS South Sefton CCG	4,903	(124)
Aintree University Hospitals NHS Foundation Trust	43,338	NHS South Sefton CCG	43,135	(203)
Liverpool Women's NHS Foundation Trust	5,089	NHS South Sefton CCG	5,064	(25)
Royal Liverpool and Broadgreen University Hospitals NHS Trust	4,797	NHS South Sefton CCG	4,694	(103)
Southport and Ormskirk Hospital NHS Trust	2,969	NHS South Sefton CCG	2,657	(312)
Mersey Care NHS Foundation Trust	12,006	NHS South Sefton CCG	11,971	(35)
Total	**73,226**		**72,424**	**(802)**

- CCGs and Providers were required to report a contract alignment position at Month 6 to highlight any areas of dispute.
- The main issues highlighted relate to the contract with Southport & Ormskirk NHS Trust on a number of outstanding issues:
  - £0.182m - CQUIN
  - £0.021m – ACU Follow ups
  - £0.078m – Contract Sanctions
  - £0.094m - Outpatient Procedure Coding
  - £0.012m – PLCP
- The CCG has sent a formal response to issues raised by the Trust and continues with the mediation process which was initiated in December. Three issues were taken forward for expert determination – CQUIN, ACU Follow ups and Outpatient Procedure Coding. The outcome of the expert determination should be finalised in the next few weeks so the CCG will have an agreed position before Year End. Other issues are expected to be resolved locally and the CCG has sent a proposal to the provider.

NHS
South Sefton
Clinical Commissioning Group

2.6 Statement of Financial Position

Figure 7 – Summary of working capital

	2016/17	2017/18				
	M12	M6	M7	M8	M9	M10
	£'000	£'000	£'000	£'000	£'000	£'000
Non Current Assets	14	14	14	14	14	14
Receivables	1,817	2,918	2,313	1,934	1,373	1,766
Cash	139	2,609	3,836	1,841	3,456	3,509
Payables & Provisions	(11,850)	(13,819)	(14,686)	(13,231)	(14,680)	(15,567)
Value of debt > 180 days old (6months)	76	87	140	136	128	142
BPPC (value)	98%	100%	100%	100%	100%	100%
BPPC (volume)	96%	96%	96%	97%	97%	97%

- The non-current asset balance relates to assets inherited from Sefton PCT at the inception of the CCG.
- The receivables balance includes invoices raised for services provided accrued income and prepayments. Outstanding debt in excess of 6 months old stands at £142k. This consists of:
  - CQUIN payment recovery (£72k) with Southport & Ormskirk NHS Trust. The CCG continues to pursue resolution to the outstanding balance and work continues to be progressed as part of actions in response to the NHS England Contract Alignment Exercise in December 2017.
  - LQC reclaim invoices (£56k). All four practices were placed into voluntary liquidation in January 2018 with no distributions to creditors.
- The Maximum Cash Drawdown (MCD) is the maximum amount of cash available to a CCG each financial year. Cash is allocated monthly following notification of cash requirements. The CCG MCD was set at £245.208m at Month 10. The actual cash utilised at Month 10 was £204.585m which represents 83.4% of the total allocation. The balance of MCD to be utilised over the rest of the year is £40.624m.
- The CCG aims to pay at least 95% of invoices within 30 days of the invoice date in line with the BPPC. 2017/18 performance exceeds 95% for invoices by number and value for NHS and Non NHS suppliers. Performance will continue to be reviewed monthly.

2.7 Recommendations

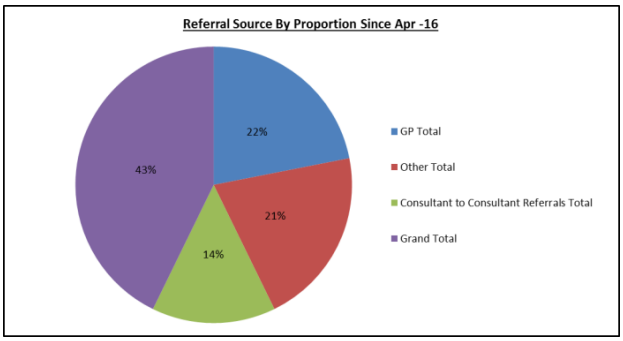
The Governing Body is asked to receive the finance update, noting that:

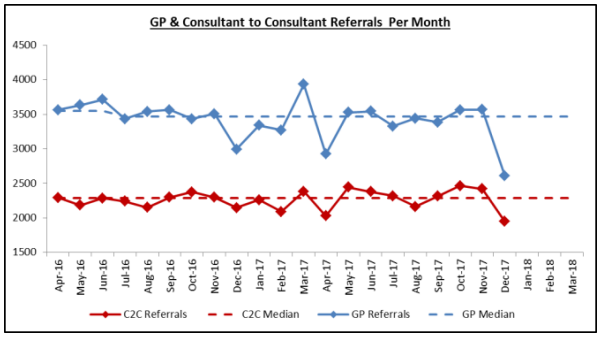
- The year to date financial position is a deficit of £3.600m, which represents deterioration against the planned deficit of £0.100m. The CCG likely case scenario forecasts a deficit after risk and mitigation of £4.300m.
- The year to date planned QIPP savings for the first ten months of the financial year (£6.409m) have not been achieved. Delivery at month 10 is £2.006m, therefore at this stage; the CCG is below its financial plan.
- 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 from the use of the CCGs resources.
- In order to deliver the long term financial recovery plan, the CCG requires ongoing and sustained support from member practices, supported by Governing Body GP leads to identify and implement QIPP plans which deliver the required level of savings to meet its statutory financial duties into 2018-19 and future years.

3. Planned Care

3.1 Referrals by source

Figure 8 - GP and 'other' referrals for the CCG across all providers for 2015/16, 2016/17 and 2017/18





NHS
South Sefton
Clinical Commissioning Group

Figure 9 - Breakdown of referrals for the CCG across all providers for 2016/17, 2017/18

Referral Type	Referral Source Code	Referral Source Name	2017/18									2016/17 YTD	2017/18 YTD	YTD Variance	YTD %
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec				
GP	3	referral from a GENERAL MEDICAL PRACTITIONER	2,923	3,529	3,545	3,329	3,441	3,385	3,564	3,568	2,606	31,390	29,890	-1,500	-5%
GP Total			**2,923**	**3,529**	**3,545**	**3,329**	**3,441**	**3,385**	**3,564**	**3,568**	**2,606**	**31,390**	**29,890**	**-1,500**	**-5%**
Other	1	following an emergency admission	149	146	139	135	133	174	179	145	123	1,611	1,323	-288	-18%
	2	following a Domiciliary Consultation		3	3	5	8	1	3	13		5	36	31	620%
	4	referral from an Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)	419	424	378	408	366	392	374	412	349	3,774	3,522	-252	-7%
	5	referral from a CONSULTANT, other than in an Accident and Emergency Department	1,149	1,504	1,488	1,386	1,346	1,419	1,509	1,468	1,165	11,523	12,434	911	8%
	6	self-referral	251	269	255	256	251	265	305	270	227	2,485	2,349	-136	-5%
	7	referral from a Prosthetist		1				1		3	1	11	6	-5	-45%
	8	Royal Liverpool Code (TBC)	74	59	83	66	102	87	89	75	64	696	699	3	0%
	10	following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)	122	138	148	126	106	90	112	116	98	873	1,056	183	21%
	11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	191	230	223	258	206	238	288	264	211	2,488	2,109	-379	-15%
	12	referral from a General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)	5	5	2	2	4	5	9	8	1	49	41	-8	-16%
	13	referral from a Specialist NURSE (Secondary Care)	7	4	5	6	6	5	5	5	1	29	44	15	52%
	14	referral from an Allied Health Professional	131	212	164	144	134	157	158	136	82	1,288	1,318	30	2%
	15	referral from an OPTOMETRIST	1	1	4	5			4	3		6	18	12	200%
	16	referral from an Orthoptist		1		1				1		4	3	-1	-25%
	17	referral from a National Screening Programme	3	2	1	13	1	9	4	5	3	49	41	-8	-16%
	92	referral from a GENERAL DENTAL PRACTITIONER	137	142	165	193	180	202	171	127	131	1,224	1,448	224	18%
	93	referral from a Community Dental Service										3	0	-3	-100%
	97	other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	248	334	344	389	353	329	357	364	303	2,743	3,021	278	10%
	Unknown	Unknown	1		1					1	1	0	4	4	0%
Other Total			**2,888**	**3,475**	**3,403**	**3,393**	**3,196**	**3,374**	**3,567**	**3,416**	**2,760**	**28,861**	**29,472**	**611**	**2%**
Consultant to Consultant Referrals Total			2,030	2,445	2,379	2,318	2,165	2,314	2,465	2,418	1,946	20,274	20,480	206	1%
Grand Total			**5,811**	**7,004**	**6,948**	**6,722**	**6,637**	**6,759**	**7,131**	**6,984**	**5,366**	**60,251**	**59,362**	**-889**	**-1%**

A significant decrease in referrals occurred in April 2017 with the total number of referrals within this month representing the lowest monthly total from April 2015 onwards. Referrals increased in May 2017 and were above average but this was followed by three consecutive monthly decreases in activity. Referrals in December 2017 have a significant decrease as activity drops in all areas significantly, with close analysis the main causes seem to be in Ophthalmology with a decrease of 47%.

GP referrals in 2017/18 to date are 5% down on the equivalent period in the previous year. There have been significant reductions in GP referrals to Gastroenterology, Trauma & Orthopaedics and Dermatology. Consultants to consultant referrals are currently 2% higher when comparing to 2016/17 with General Medicine and Clinical Physiology seeing substantial increases.

A Referral Optimisation and Support System (ROSS) is being developed for South Sefton following engagement with members on approaches to elective demand management. Key work-streams include offer of Advice and Guidance services as an alternative to referral and promotion

of pathways and protocols visible on the EMIS Clinical system through EMIS Protocols functionality.

Data quality note: Walton Neuro Centre has been excluded from the above analysis due to data quality issues.

3.1.1 E-Referral Utilisation Rates

Figure 10 - South Sefton CCG E Referral Performance

NHS E-Referral Service Utilisation				
NHS South Sefton CCG	17/18 - Dec	80% by End of Q2 2017/18 & 100% by End of Q2 2018/19	23%	↑

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 (December) for E-referral Utilisation rates reported for the CCG as a whole is 23%; up by 1% from November and have not achieved the 80% by end of Q2.

Aintree Hospital is undergoing a Paper Switch off Programme with NHS Digital which will be fully implemented by August 2018. This is supported by:

- CQUIN in relation to all services being available on the Electronic Referral System (e-RS) and appointment slot issues being minimised through alignment of appointment polling ranges with waiting times at a specialty level
- Relaunch and training on e-RS with general practices
- Communications Plan to include utilisation rates by practice

In addition, practice level E-referral uptake reports have been developed to identify practices who may require some extra support being offered by the national NHS Digital E-referral implementation team. In addition, the Local Quality Contract for General Practice supports the period prior to full paper switch off (October 2018) by asking practices to identify training needs, monitor utilisation rates, and be aware of the timetable for local Providers becoming paper free.

3.2 Diagnostic Test Waiting Times

Figure 11 - Diagnostic Test Waiting Time Performance

Diagnostic test waiting times				
% of patients waiting 6 weeks or more for a Diagnostic Test **(CCG)**	17/18 - Dec	1.00%	4.93%	↓
% of patients waiting 6 weeks or more for a Diagnostic Test **(Aintree)**	17/18 - Dec	1.00%	4.88%	↓

The CCG failed the target for less than 1% of patients waiting more than 6 weeks for a diagnostic test in December. Out of 2,680 patients, 132 waited longer than 6 weeks and of them 20 waited longer than 13 weeks. The majority of breaches were for colonoscopy (65), flexi sigmoidoscopy (32) and gastroscopy (22). This is a slight decline in performance on last month when the CCG recorded 4.53%. Performance at the Royal Liverpool and Broadgreen is having an impact on the CCG's overall performance as they continue to report significantly above the threshold, at 19.9% in December, a slight decrease in long waiters compared to 22.5% reported in November. The biggest pressure is in Colonoscopy with the Trust reporting a total of 594 patients waiting over 6 weeks.

Aintree failed the target for less than 1% of patients waiting longer than 6 weeks for a diagnostic test in December recording 4.88%. Out of 5120 patients, 250 waited longer than 6 weeks with 19 of them waiting over 13 weeks. The majority of breaches were waiting for a colonoscopy (108) and flexi sigmoidoscopy (75). This is a decline in performance from last month when 3.73% was recorded.

Endoscopy has continued to experience pressures with capacity due to sickness of both Consultants and Nurse endoscopists and a consultant vacancy during December. There has also been short term sickness in the endoscopy booking team. The overall number of patients waiting over 6 weeks has increased as has the number on the waiting list. Additional activity continues through Waiting List Initiatives and PA sessional rates. Due to staff availability in December, there have been a reduced number of WLI sessions and this has resulted in an increase in patients waiting over 6 weeks. The department has continued to prioritise cancer and urgent referrals which has made recovery of the 6 week routine standard difficult.

Proposed Actions:

- Additional WLI activity continues to cover the long term sickness.
- Weekly capacity meetings continue with operational and clinical teams to maximise the utilisation of capacity.
- The substantive ACBM has been recruited to and is due to commence in post mid-January 2018.
- Reporting functionality is being explored to allow closer scrutiny of slot utilisation and management of DNA rates.
- Endoscopy recovery meetings commenced in August. Activity against plan and DNA rates are discussed in detail. Weekly actions are monitored for recovery.
- Consultant capacity increased during January for 2 x colon lists and 1 x clinic at WLI rate. Provided by a visiting Consultant known to the department.
- An external performance consultant will undertake a diagnostic review of the endoscopy services on 1st and 2nd February. Following this review an improvement programme will be put in place.
- NHS England have recently made some funding available to support virtual gastroenterology clinics

Radiology continues to experience a sustained increase in demand for Imaging (CT Cardiac, MR Cardiac, MR MSK and Ultrasound MSK). Demand is in excess of funded capacity.
Additional sessions for CT and MR cardiac imaging have been carried out during December and the wait for this imaging has been reduced as a result.
Currently the wait for routine MR is above 6 weeks with 4.5% of the total patients waiting over 6 weeks, 3 patients waiting 8 weeks - MSK (Arthrograms), 36 patients waiting 6 weeks.

This is as a result of activity lost over the Christmas and New Year Bank holidays (3 days/132 appointment slots).

Further Outpatient activity lost to accommodate influx of Inpatients (approximately 20 appointment slots).

Proposed Actions:

- Weekly capacity meetings with operational and clinical teams to monitor performance and maximise capacity ongoing.
- Mobile MR Van has been arranged to come on site to provide Cardiac Imaging for 5 days, 29th, 30th and 31st January, 1st and 9th February to reduce waits. Total number of 115 patients will be imaged on mobile scanner. Wait below 6 weeks not expected until approximately 8th February. This will depend on future demand.
- A temporary funding transfer has been agreed with the Deputy Director of Finance and Cardiology Clinical Business Unit. This will facilitate additional Cardiac CT sessions being delivered, although this will still not fully meet the scale of demand.

3.3 Referral to Treatment Performance

Figure 12 - Referral to Treatment Time (RTT) 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)**	17/18 - Dec	0	0	↔
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(Aintree)**	17/18 - Dec	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)**	17/18 - Dec	92%	91.31%	↓
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(Aintree)**	17/18 - Dec	92%	91.1%	↓

Due to the declining performance in recent months the CCG has now fallen below the 92% threshold for patients on an incomplete non-emergency pathway waiting no more than 18 weeks from referral, recording 91.31%. In December out of 10170, there were 884 patients waiting over 18 weeks on the incomplete pathway. As previous reported declining performance at the Royal Liverpool Broadgreen is having an adverse impact on South Sefton CCG performance in particular, again did not achieve RTT standard for December reporting 83.7%. The issues were in Urology (89.5%), General Surgery (81.6%), T&O (79.1%), ENT (91.7%), Ophthalmology (76.9%), Gastro (82.6%), Cardiology (89.5%), and Dermatology (86.8%).

Aintree are now also failed this standard recording 91.06% in December, out of 15923, there were 1424 waiting over 18 weeks on the incomplete pathway. During December there was significant

pressure on the hospital bed base which resulted in the cancellation of routine elective cases to accommodate medical outlying patients the under-performance also correlates closely with the commencement of the theatre refurbishment programme. In addition, both the outpatient cancellation and Did Not Attend (DNA) rates rose across the board within the month.

Urgent/Emergency cases and Cancer patients were prioritised making wait times for routine patients more of a challenge.

Proposed Actions:

- Proposed review of the theatre refurbishment theatre displacements to ensure parity of share across specialties.
- Regular review of all long waiting patients within the clinical business units to address capacity issues and undertake WLI's where available in conjunction with a relaunch of weekly performance meetings with planning and performance/business intelligence leads.
- Business cases for 2 additional, Emergency General Surgery Unit Consultants has been submitted to Hospital Management Board, this will provide additional theatre activity and ambulatory surgical clinics.
- Continue to support the reduction in endoscopy waits by supporting WLI scope lists using dropped sessions in the week and additional sessions at the weekend.
- Meet weekly with the PAC team to analyse the ongoing referral numbers and wait times and the efficiency of virtual clinics in terms of discharge rates.
- Work on validation and communication with other referring providers in the health economy to reduce demand in specific areas along with ensuring inter provider transfer (IPT) forms are correctly filled in by referring organisations.

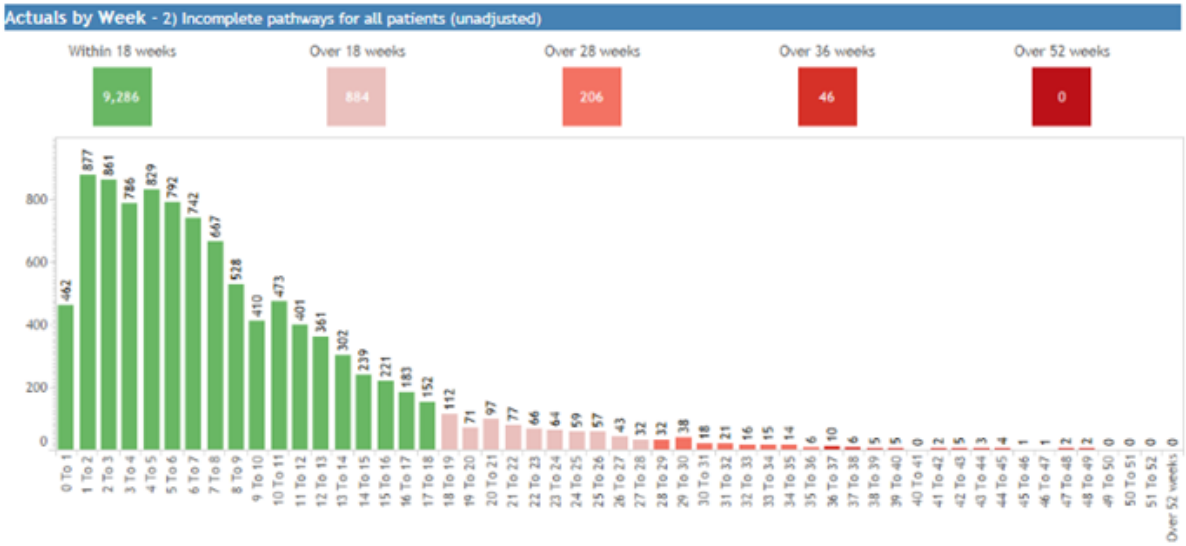
Advice and guidance has now been rolled out to a number of specialities, as part of the national CQUIN, although the use of this service by GPs is limited. Increases in referrals are also being monitored as a direct consequence of certain Trusts E-referral polling ranges being extended to reduce the number of slot issues. Within Dermatology, South Sefton CCG are leading a Dermatology review working with other commissioners and providers as a result of service closures across the Merseyside area.

Liverpool CCG, as lead commissioner for the Royal, is currently exploring all available options in terms of contractual levers to address RTT performance levels. Liverpool CCG's Chief Officer has also formally written to the Royal Liverpool's Chief Executive regarding the Trust's deteriorating RTT performance, expressing their Governing Body's concerns and seeking assurances of recovery and sustainability of RTT performance going forward.

In addition, RTT performance for the CCG is at risk due to poor performance at University Hospital of North Midlands NHS Trust in Stoke. This provider is commissioned to deliver bariatric surgery for Cheshire and Merseyside CCGs. December performance for this Trust overall for incomplete pathways was 79%. This is being followed up by South Sefton CCG on behalf of all Cheshire and Merseyside CCGs seeking reasons for underperformance and actions being taken to address.

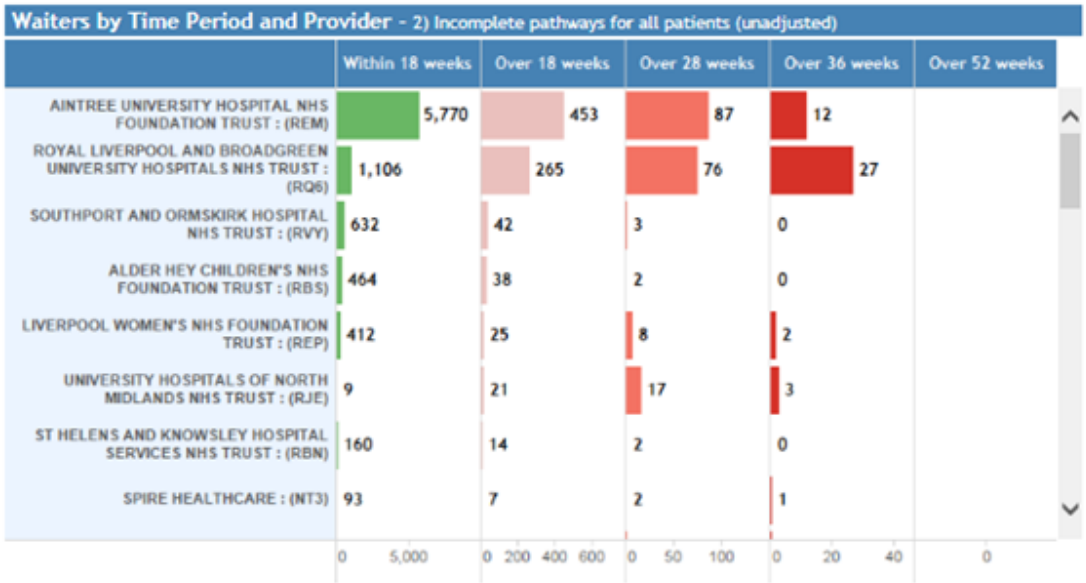
3.3.1 Incomplete Pathway Waiting Times

Figure 13 - South Sefton CCG Patients waiting on an incomplete pathway by weeks waiting



3.3.2 Long Waiters analysis: Top 5 Providers

Figure 14 - 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 15 - Patients waiting (in bands) on incomplete pathways by Speciality for Aintree University Hospitals NHS Foundation Trust

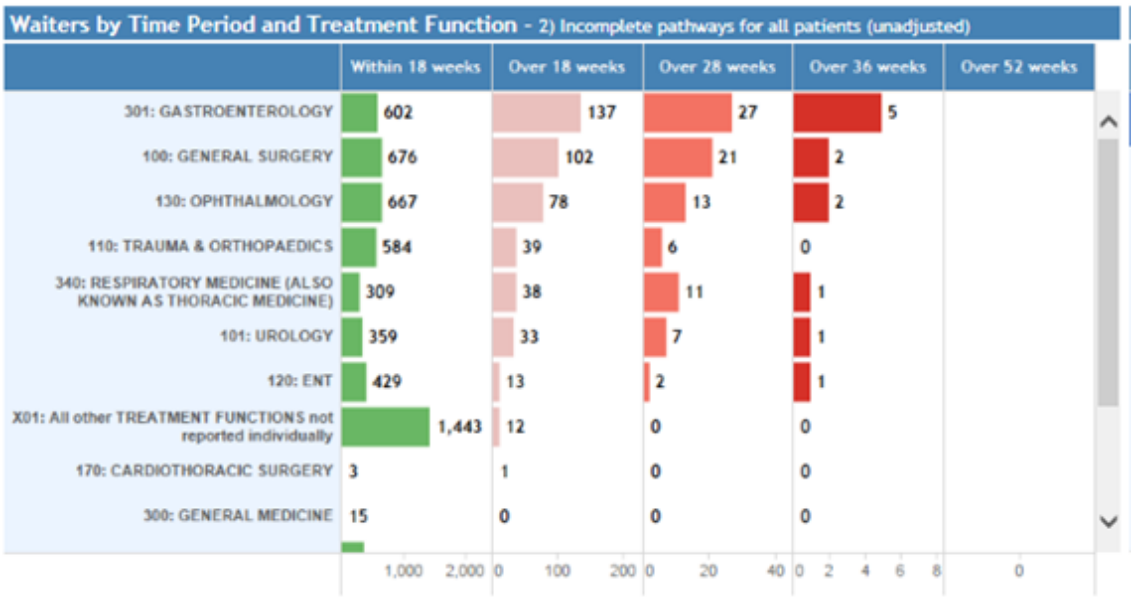
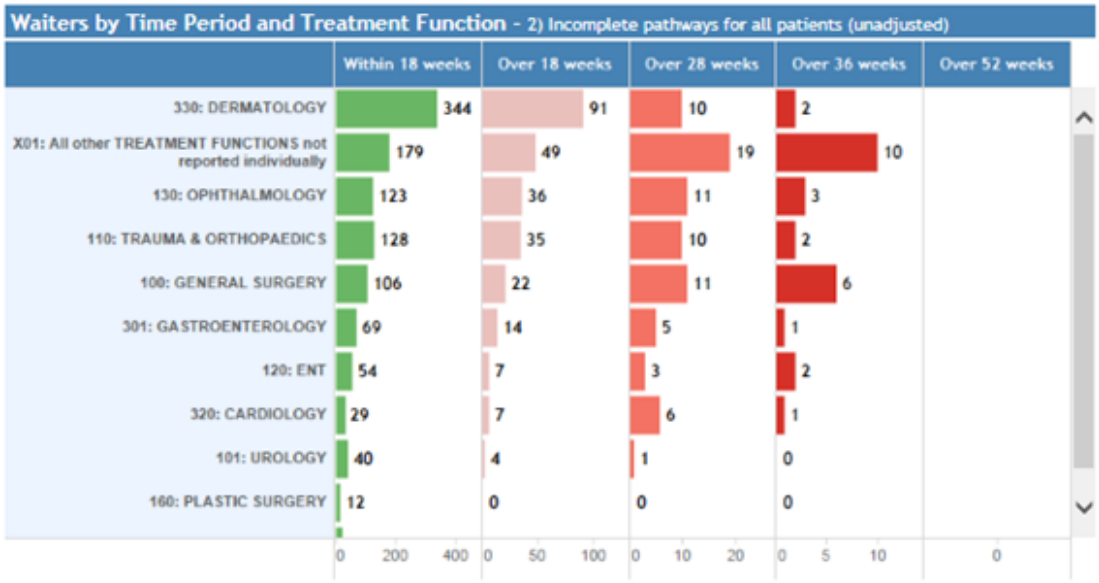


Figure 16 - Patient waiting (in bands) on incomplete pathway by Specialty for Royal Liverpool & Broadgreen University Hospital NHS Foundation Trust



3.3.4 Provider assurance for long waiters

Figure 17 - South Sefton CCG Provider Assurance for Long Waiters

CCG	Trust	Specialty	Wait band	Has the patient been seen/has a TCI date?	Detailed reason for the delay
South Sefton CCG	Aintree	General Surgery	45	Clock stopped 26/01/2018 - Decision not to treat	
South Sefton CCG	Aintree	General Surgery	46	Clock stopped 26/01/2018 - Decision not to treat	
South Sefton CCG	Royal Liverpool	All Other	41	Patient Treated in January	Capacity
South Sefton CCG	Royal Liverpool	Dermatology	41	Patient Treated in January	Capacity
South Sefton CCG	Royal Liverpool	Ent	42	Patient Treated in January	Capacity
South Sefton CCG	Royal Liverpool	Ophthalmology	42	Patient Treated in January	Capacity
South Sefton CCG	Royal Liverpool	All Other	42	Patient Treated in January	Capacity
South Sefton CCG	Royal Liverpool	General Surgery	43	No Date Yet	Long Wait on Waiting List
South Sefton CCG	Royal Liverpool	All Other	43	Patient Treated in January	Capacity
South Sefton CCG	Royal Liverpool	All Other	43	Patient Treated in January	Capacity
South Sefton CCG	Royal Liverpool	General Surgery	44	Patient Treated in January	Capacity
South Sefton CCG	Royal Liverpool	All Other	44	Patient Treated in January	Capacity
South Sefton CCG	Royal Liverpool	All Other	44	Patient Treated in January	Capacity
South Sefton CCG	Royal Liverpool	All Other	45	Patient Treated in January	Capacity
South Sefton CCG	Royal Liverpool	General Surgery	47	TCI 01/05/2018	Long Wait on Waiting List - No further updated provided by the Trust
South Sefton CCG	Royal Liverpool	Gastroenterology	47	Patient Treated	Capacity
South Sefton CCG	Royal Liverpool	All Other	48	Patient Treated in January	Capacity
South Sefton CCG	Royal Liverpool	All Other	48	Patient Treated in January	Capacity
South Sefton CCG	North Midlands	General Surgery	42	*No response from the Trust - CSU chasing up*	

The Royal Liverpool has a 47 week waiter with a to come in date of the 1st May this patient is on course to breach 52 weeks.

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

Figure 18 – Aintree Cancelled Operations

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**	17/18 - Dec	0	0	↔

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

Figure 19 – Aintree Cancelled Operations for a second time

NHS
South Sefton
Clinical Commissioning Group

Cancelled Operations				
No urgent operation should be cancelled for a second time - **Aintree**	17/18 - Dec	0	0	↔

3.5 Cancer Indicators Performance

3.5.1- Two Week Waiting Time Performance

Figure 20 – Two Week Cancer Performance measures

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)**	17/18 - Dec	93%	93.73%	↔
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Aintree)**	17/18 - Dec	93%	94.49%	↔
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(CCG)**	17/18 - Dec	93%	90.66%	↔
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(Aintree)**	17/18 - Dec	93%	91.43%	↔

The CCG failed the 93% target for 2 week waits for first outpatient appointments for patients referred urgently with breast symptoms in December, with 91.04% and it is currently failing year to date at 90.66% due to lower rates in May, June and July. In December there were 6 breaches out of a total of 67 patients.

Aintree also failed the 93% breast target for December reaching 92.16% and are also failing year to date 91.43%. In December, out of 153 patients there were 12 breaches. The majority of breaches were due to patient choice.

A Be Clear on Cancer campaign will be launched in late February targeting breast symptoms in the over 70s. This could increase demand on breast services and negatively affect performance against this target.

NHS
South Sefton
Clinical Commissioning Group

3.5.2- 31 Day Cancer Waiting Time Performance

Figure 21 – 31 Day Cancer Performance measures

Cancer waits – 31 days				
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(CCG)**	17/18 - Dec	96%	98.17%	↔
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Aintree)**	17/18 - Dec	96%	97.66%	↔
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	17/18 - Dec	94%	98.06%	↔
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Aintree)**	17/18 - Dec	94%	100.00%	↔
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	17/18 - Dec	94%	95.50%	↓
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Aintree)**	17/18 - Dec	94%	92.97%	↓
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	17/18 - Dec	98%	100.00%	↔
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(Aintree)**	17/18 - Dec	98%	100.00%	↔

Aintree failed the 94% target for 31 day wait for subsequent treatment (surgery) in December recording 91.3% and are now under plan year to date (92.97%). In December there were 2 breaches out of a total of 23 patients. The first patient waited was 37 days and the reason was multiple diagnostic investigations and MDT discussions needed before treatment could commence. The second patient waited 34 days and the delay was due to capacity.

NHS
South Sefton
Clinical Commissioning Group

3.5.3 - 62 Day Cancer Waiting Time Performance

Figure 22 – 62 Day Cancer Performance measures

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)**	17/18 - Dec	85% local target	90.63%	↑
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)**	17/18 - Dec	85% local target	81.15%	↓
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(CCG)**	17/18 - Dec	90%	95.77%	↔
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(Aintree)**	17/18 - Dec	90%	86.96%	↔
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(CCG)**	17/18 - Dec	85%	86.01%	↑
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(Aintree)**	17/18 - Dec	85%	84.20%	↑

Aintree achieved the local 85% target in December for 62 day wait for definitive treatment following consultant's decision to upgrade, recording 88% but failed year to date (81.15%) partly due to previous months breaches. In December the equivalent of 1.5 out of 12.5 patients breached the target. Reasons for breaches include late referral, delay between trusts and patient undiagnosed from referring Trust. Longest wait was 158 days.

Aintree also achieved the 90% target for 62 day screening in December with a 0.5 patient breach out of a total of 5.5 patients - recording 90.91%. The Trust is also failing year to date, reaching 86.96%, partly due to previous breaches. The patient whose pathway breached this target was a breast patient who was referred to the Trust from another Organisation's Screening programme as the patient opted for treatment at Aintree. The patient then required additional investigations which resulted in the breach. The Trust failed the 90% plan for Q3 achieving 85.7%, having just 3 breaches out of a total of 21 patients.

It should be noted that the Trust undertakes Bowel screening and only and so treatment numbers are low in comparison to other organisations. Therefore just 1 breach will result in the Trust failing this standard unless treatments are higher.

Aintree also achieved the 85% target in December for 2 month wait from urgent GP referral to first definitive treatment recording 92.3%, and are still failing year to date with 84.20%. In December, the equivalent of 4 breaches out of a total of 52 patients occurred.

3.6 Patient Experience of Planned Care

Figure 23 – Aintree Inpatient Friends and Family Test Results

Friends and Family Response Rates and Scores
Aintree University Hospital NHS Foundation Trust
Latest Month: **Dec-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	25.0%	16.3%		96%	93%		2%	5%	

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

- % Response Rate
- % Recommended
- % Not Recommended

The Trust has failed patient response rates and are reporting under target for December at 16.3%. The proportion of patients who would recommend has declined since last month recording 93% in December (England average 96%). The proportion who would not recommend is higher than last month at 5%, which is 3% higher than the England average.

Plans are in place for the Trust to present an update on their FFT and patient experience later in the year to the CCG Engagement and Patient Experience Group (EPEG).

3.7 Planned Care Activity & Finance, All Providers

Performance at Month 9 of financial year 2017/18, against planned care elements of the contracts held by NHS South Sefton CCG show an under performance of -£1.4m/-3.8%. However, applying a neutral cost variance for those Trusts within the Acting as One block contract arrangement results in there being a total under spend of approximately -£345k/-0.9%.

At specific over performing Trusts, Royal Liverpool are reporting the largest cost variance with a total of £188k/5% followed by Spire Liverpool (£129k/23%). In contrast, Aintree and Southport & Ormskirk are under performing by -£879k/-4% and -£498k/23% respectively.

NHS
South Sefton
Clinical Commissioning Group

Figure 24 - 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	Acting as One Adjustment	Total Price Var (following AAO Adjust)	Total Price Var %
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	134,462	131,559	-2,903	-2%	£23,243	£22,364	-£879	-4%	£879	£0	0.0%
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	10,285	10,554	269	3%	£1,294	£1,216	-£78	-6%	£78	£0	0.0%
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	908	1,052	144	16%	£309	£342	£33	11%	-£33	£0	0.0%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	11,960	10,837	-1,123	-9%	£2,272	£2,060	-£211	-9%	£211	£0	0.0%
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	22,767	24,772	2,005	9%	£3,802	£3,990	£188	5%	-£188	£0	0.0%
WALTON CENTRE NHS FOUNDATION TRUST	2,331	2,308	-23	-1%	£749	£631	-£118	-16%	£118	£0	0.0%
ACTING AS ONE PROVIDERS TOTAL	182,713	181,082	-1,631	-1%	£31,669	£30,604	-£1,065	-3%	£1,065	£0	0%
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	64	191	127	196%	£16	£36	£20	124%	£0	£20	124%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	0	119	119	0%	£0	£17	£17	0%	£0	£17	#DIV/0!
FAIRFIELD HOSPITAL	143	117	-26	-18%	£39	£28	-£10	-27%	£0	-£10	-27%
ISIGHT (SOUTHPORT)	384	412	28	7%	£89	£77	-£12	-14%	£0	-£12	-14%
RENACRES HOSPITAL	4,711	4,473	-238	-5%	£1,324	£1,332	£8	1%	£0	£8	1%
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST*	11,479	9,648	-1,831	-16%	£2,138	£1,640	-£498	-23%	£0	-£498	-23%
SPIRE LIVERPOOL HOSPITAL	1,783	2,145	362	20%	£554	£683	£129	23%	£0	£129	23%
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	2,758	3,416	658	24%	£762	£734	-£28	-4%	£0	-£28	-4%
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	762	845	83	11%	£180	£185	£5	3%	£0	£5	3%
UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	81	124	43	53%	£12	£23	£11	89%	£0	£11	89%
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	0	78	78	0%	£0	£8	£8	0%	£0	£8	#DIV/0!
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	346	251	-95	-27%	£92	£58	-£34	-37%	£0	-£34	-37%
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	889	1,138	249	28%	£360	£399	£39	11%	£0	£39	11%
ALL REMAINING PROVIDERS TOTAL	23,402	22,957	-445	-2%	£5,566	£5,221	-£345	-6%	£0	-£345	-6%
GRAND TOTAL	**206,114**	**204,039**	**-2,075**	**-1%**	**£37,234**	**£35,824**	**-£1,410**	**-3.8%**	**£1,065**	**-£345**	**-0.9%**

*PbR Only

NHS
South Sefton
Clinical Commissioning Group

3.7.1 Planned Care Aintree University Hospital NHS Foundation Trust

Figure 25 - 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	10,796	9,463	-1,333	-12%	£6,425	£6,134	-£291	-5%
Elective	1,502	1,227	-275	-18%	£4,258	£3,699	-£559	-13%
Elective Excess BedDays	495	243	-252	-51%	£120	£58	-£62	-52%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	330	171	-159	-48%	£69	£38	-£31	-45%
OPFANFTF - *Outpatient first attendance non face to face*	1,875	2,690	815	43%	£53	£71	£17	33%
OPFASPCL - *Outpatient first attendance single professional consultant led*	24,692	23,346	-1,346	-5%	£3,883	£3,803	-£79	-2%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	1,070	685	-385	-36%	£90	£69	-£22	-24%
OPFUPNFTF - *Outpatient follow up non face to face*	2,426	6,195	3,769	155%	£59	£150	£91	155%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	62,094	57,492	-4,602	-7%	£4,280	£4,130	-£150	-3%
Outpatient Procedure	17,496	17,874	378	2%	£2,313	£2,345	£32	1%
Unbundled Diagnostics	10,588	10,978	390	4%	£855	£964	£109	13%
Wet AMD	1,098	1,195	97	9%	£839	£904	£65	8%
Grand Total	**134,462**	**131,559**	**-2,903**	**-2%**	**£23,243**	**£22,364**	**-£879**	**-4%**

Non face to face activity (both first and follow up attendances) are reporting an over performance within planned care at month 9 with the majority of other areas within outpatients currently under performing (the exception being outpatient procedures). The over performance for non-face to face first outpatient activity is focussed within Acute Internal Medicine (GP Hotline at £24 per call) whereas non face to face follow up over performance is credited to the Ophthalmology, Cardiology and Dermatology specialties.

Unbundled diagnostics is the highest over performing POD in planned care with a cost variance of £109k/13% against plan. This is followed by non-face to face outpatient follow up attendances (£91k/155% above plan at month 9).

Cardiology is showing the largest cost variance at month 9 (£633k/57%). The cardiology over performance is largely related to day case activity, which can be attributed to the heart failure pathway. Conversely, Trauma & Orthopaedics is under performing by -£703k/-17% against plan.

Overall, year to date costs for planned care PODs at Aintree University Hospital are currently -£879k/-4% down against plan at month 9. Despite this indicative underspend; there is no financial impact of this to South Sefton CCG due to the Acting As One block contract arrangement.

The table below illustrates the Planned Care year to date variance by Specialty, focussing on the top and bottom 10 specialties in terms of cost variances against plan at month 9:

NHS
South Sefton
Clinical Commissioning Group

Figure 26 - Planned Care - Aintree University Hospital NHS Foundation Trust Variance from plan by Specialty and by POD

Specialty	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	740	£608,865	7	£20,400	31	£7,491	244	(-£5,402)	129	(-£49,314)	437	£51,049	1,589	£633,090
Acute internal medicine	2	£162	1	(-£529)	-15	(-£3,477)	1,137	£123,625	43	£4,951	-67	(-£9,549)	1,102	£115,184
Geriatric medicine	3	(-£1,318)	3	(-£3,363)	-6	(-£1,267)	215	£59,085	408	£55,071	3	£353	625	£108,561
Colorectal surgery	-26	(-£6,194)	-2	£149,921	-237	(-£55,776)	-56	(-£15,519)	257	£13,836	30	£3,907	-33	£90,175
Breast surgery	58	£120,838	-13	(-£38,812)			-88	(-£17,600)	-94	(-£6,745)	94	£13,490	-44	£71,171
Nephrology	29	£11,206	-4	(-£5,956)	-3	(-£611)	322	£86,567	-220	(-£25,709)	17	£1,930	140	£67,428
Physiotherapy							-263	(-£12,721)	1,624	£53,344	1	£33	1,362	£40,656
Rheumatology	40	£11,268	-3	(-£2,276)	-8	(-£1,979)	25	£6,409	402	£33,964	-28	(-£6,758)	427	£40,627
Respiratory medicine	-23	(-£5,629)	-16	(-£18,991)	4	£1,088	44	£27,245	141	(-£530)	174	£31,490	325	£34,673
Transient ischaemic attack							184	£56,016	-28	£0	-188	(-£23,778)	-31	£32,238
Cardiothoracic surgery							-7	(-£2,845)	-80	(-£12,100)	-1	(-£231)	-89	(-£15,176)
Upper gastrointestinal surgery	-28	(-£41,223)	4	£20,256	-3	(-£625)	-36	(-£5,418)	-112	(-£7,207)	-2	(-£311)	-177	(-£34,529)
Clinical haematology	-577	(-£76,375)	-12	(-£20,595)	-45	(-£12,698)	-91	(-£23,128)	676	£75,150	2	£588	-47	(-£57,059)
Anticoagulant service									-3,879	(-£99,932)			-3,879	(-£99,932)
General surgery	-73	(-£86,874)	-31	(-£46,208)	0	(-£59)	-19	(-£3,236)	-220	(-£16,021)	-8	(-£1,079)	-352	(-£153,477)
Dermatology	-39	(-£19,330)					-621	(-£85,824)	153	(-£20,051)	-689	(-£65,559)	-1,197	(-£190,763)
Urology	-134	(-£27,363)	-37	(-£94,271)	43	£9,616	-487	(-£71,566)	-7	(-£921)	-201	(-£33,270)	-823	(-£217,776)
Ophthalmology	-365	(-£276,243)	0	(-£296)	4	£992	-359	(-£52,564)	1,200	£9,665	689	£68,492	1,168	(-£249,955)
Gastroenterology	-800	(-£345,706)	-34	(-£72,811)	-34	(-£8,363)	-463	(-£91,199)	-1,029	(-£65,662)	-22	(-£207)	-2,383	(-£583,948)
Trauma & orthopaedics	-193	(-£211,567)	-105	(-£371,574)	17	£3,937	-157	(-£24,604)	-509	(-£31,406)	-544	(-£68,359)	-1,491	(-£703,573)
Grand Total	**-1,333**	**(-£291,201)**	**-275**	**(-£558,546)**	**-252**	**(-£61,732)**	**-690**	**(-£92,832)**	**-1,218**	**(-£80,391)**	**378**	**£32,418**	**-3,390**	**(-£1,052,284)**

NHS
South Sefton
Clinical Commissioning Group

3.7.2 Planned Care Southport & Ormskirk Hospital

Figure 27 - 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	714	618	-96	-14%	£518	£389	-£129	-25%
Elective	150	116	-34	-23%	£422	£264	-£158	-37%
Elective Excess BedDays	26	1	-25	-96%	£10	£0	-£9	-98%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	183	99	-84	-46%	£30	£17	-£13	-43%
OPFASPCL - *Outpatient first attendance single professional consultant led*	1,714	1,295	-419	-24%	£282	£211	-£71	-25%
OPFUPMPCL - *OP follow up Multi-Professional Outpatient First. Attendance (Consultant Led)*	420	214	-206	-49%	£32	£18	-£14	-45%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	3,650	3,073	-577	-16%	£279	£238	-£41	-15%
Outpatient Procedure	3,958	3,630	-328	-8%	£517	£456	-£61	-12%
Unbundled Diagnostics	664	602	-62	-9%	£49	£47	-£2	-3%
Grand Total	**11,479**	**9,648**	**-1,831**	**-16%**	**£2,138**	**£1,640**	**-£498**	**-23%**

* PbR only

Planned care elements of the contract continue to underperform against plan in month 9 2017/18 as they had throughout 2016/17 and previous months in 2017/18, with all areas below plan year to date. The largest variance against plan is within elective and day case procedures at a combined underspend of -£288k, however all points of delivery are under performing.

A number of issues, as previously reported, affected the Trusts performance earlier in the year with Elective and Day Case cancellations required but all have since rebooked. The main problem the Trust has faced is reduced levels of GP referrals flowing into the Trust.

Lower referrals than expected and previously seen in prior years will impact across all points of delivery in planned care from Outpatients through to planned procedures. Reductions can be seen across the majority of specialties with Trauma & Orthopaedics, and General Surgery notably below plan. Trust service issues such as staffing is also a factor for such specialties as Dermatology and Pain Management.

The Trust has stated they are actively trying to bring activity levels back in line with planned values and are looking to repatriate work they feel has been lost to other providers. Discussions are on-going to the levels of planned activity required for the 2018-19 contract.

Despite the problems noted in the contract for planned care in 2017-18 for the Trust they continually achieve the RTT target for 18 weeks.

3.7.3 Renacres Hospital

Figure 28 - 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	464	369	-95	-20%	£560	£436	-£123	-22%
Elective	86	123	37	43%	£408	£564	£157	38%
OPFASPCL - *Outpatient first attendance single professional consultant led*	959	777	-182	-19%	£153	£128	-£25	-17%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	1,182	1,248	66	6%	£74	£79	£5	7%
Outpatient Procedure	610	294	-316	-52%	£63	£46	-£17	-27%
Unbundled Diagnostics	382	309	-73	-19%	£36	£30	-£6	-17%
Physio	1,028	1,056	28	3%	£30	£31	£1	3%
Grand Total	**4,711**	**4,176**	**-535**	**-11%**	**£1,324**	**£1,315**	**-£10**	**-1%**

Renacres under performance of -£10k/-2% is driven by a -£123k/-22% under performance in day cases with reduced activity focussed particularly in the Trauma & Orthopaedic and General Surgery specialties. In contrast, elective activity is currently over performing by £157k/38%, which can be attributed to activity within Trauma & Orthopaedics and related to very major hip and knee procedures.

3.7.4 Spire Liverpool

Spire Liverpool 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	156	236	80	51%	£222	£292	£70	32%
Elective	41	46	5	11%	£213	£237	£25	12%
OPFASPCL - Outpatient first attendance single professional consultant led	203	292	89	44%	£33	£48	£14	43%
OPFUPSPCL - Outpatient follow up single professional consultant led	1,078	1,210	132	12%	£49	£64	£16	32%
OPFUPSPNCL - Outpatient follow up single professional non-consultant led	34	58	24	70%	£2	£3	£1	70%
Outpatient Procedure	167	170	3	2%	£23	£23	£0	2%
Unbundled Diagnostics	104	133	29	28%	£13	£15	£2	19%
Grand Total	**1,783**	**2,145**	**362**	**20%**	**£554**	**£683**	**£129**	**23%**

Spire Liverpool is over performing across all PODs in 2017/18. However, total over performance of £129k/23% is driven by a £70k/32% increase in day cases. The majority of activity at Spire Liverpool is within the Trauma & Orthopaedics specialty. Pain Management has also seen an increase in activity against plan (£28k/196%). At HRG level, activity has been recorded across a number of HRGs, many against a zero plan.

3.8 Personal Health Budgets

Figure 29 - South Sefton CCG – 2017/18 PHB Plans

	Q1 Plan	Q1 Actual	Q2 Plan	Q2 Actual	Q3 Plan	Q3 Actual	Q4 Plan	Q4 Actual
1) Personal health budgets in place at the beginning of quarter (total number per CCG)	48	11	52	23	56	24	60	
2) New personal health budgets that began during the quarter (total number per CCG)	4	0	4	1	4	2	4	
3) Total numer of PHB in the quarter = sum of 1) and 2) (total number per CCG)	52	11	56	24	60	26	64	0
4) GP registered population (total number per CCG)	154916	154916	154916	154916	154916	154916	154916	154916
Rate of PHBs per 100,000 GP registered population	**33.57**	**7.10**	**36.15**	**15.49**	**38.73**	**16.78**	**41.31**	

The CCG reported 26 personal health budgets at the end of Q3, which is an increase of 2 from Q2. This remains below the trajectory for the targets set by NHS England. The CCG continues to look for potential ways to increase the numbers of PHB and collaborative work continues with other CCGs. The management of PHBs is being supported though CSU colleagues.

3.9 Continuing Health Care (CHC)

A number of measures are reported nationally on the NHS England website relating to Continuing Health Care (CHC). Three are reported in this report, and further indicators will be added to the report in the coming months.

Figure 30 - People eligible (both newly eligible and existing patients) at the end of the quarter (snapshot) divided by the population aged 18+, and expressed as a rate per 50,000 population

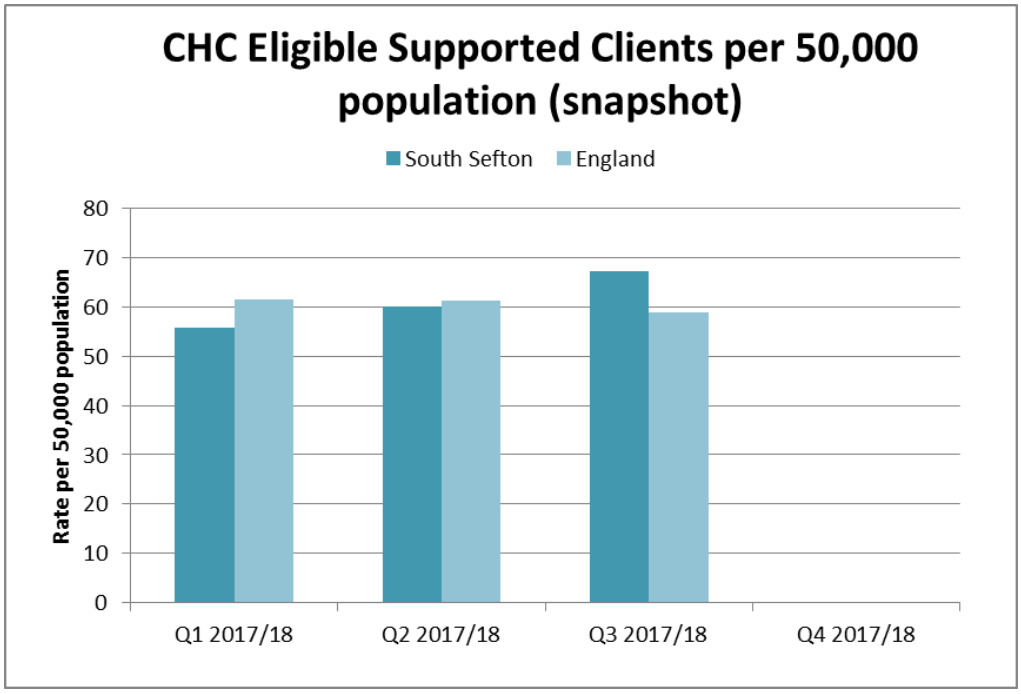


Figure 31 - People eligible (both newly eligible and existing patients) at the end of the quarter (cumulative) divided by the population aged 18+, and expressed as a rate per 50,000 population

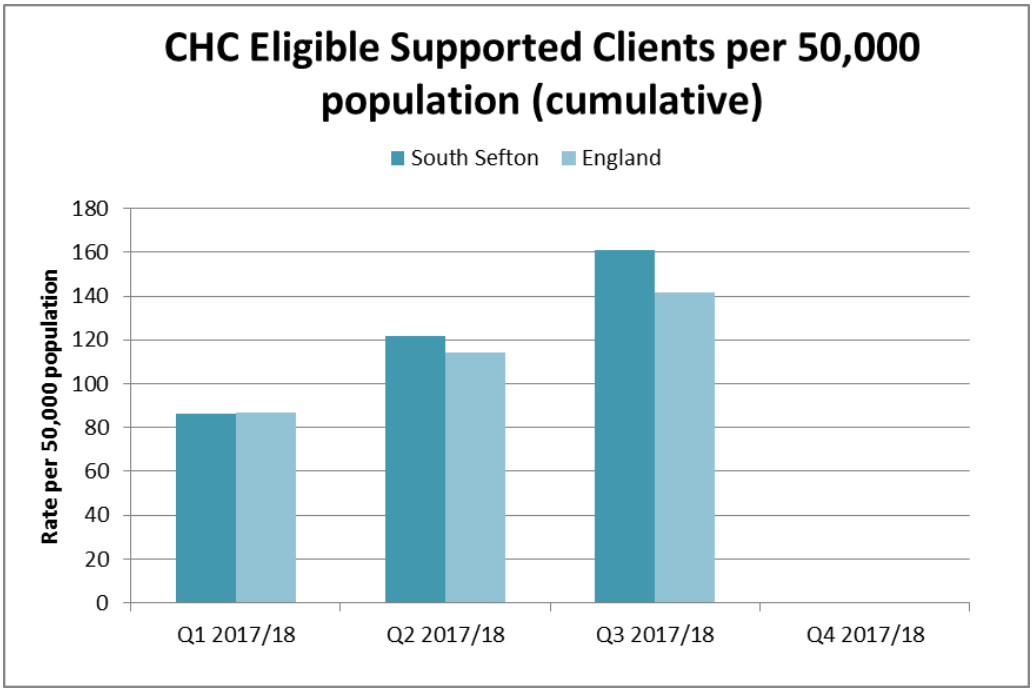
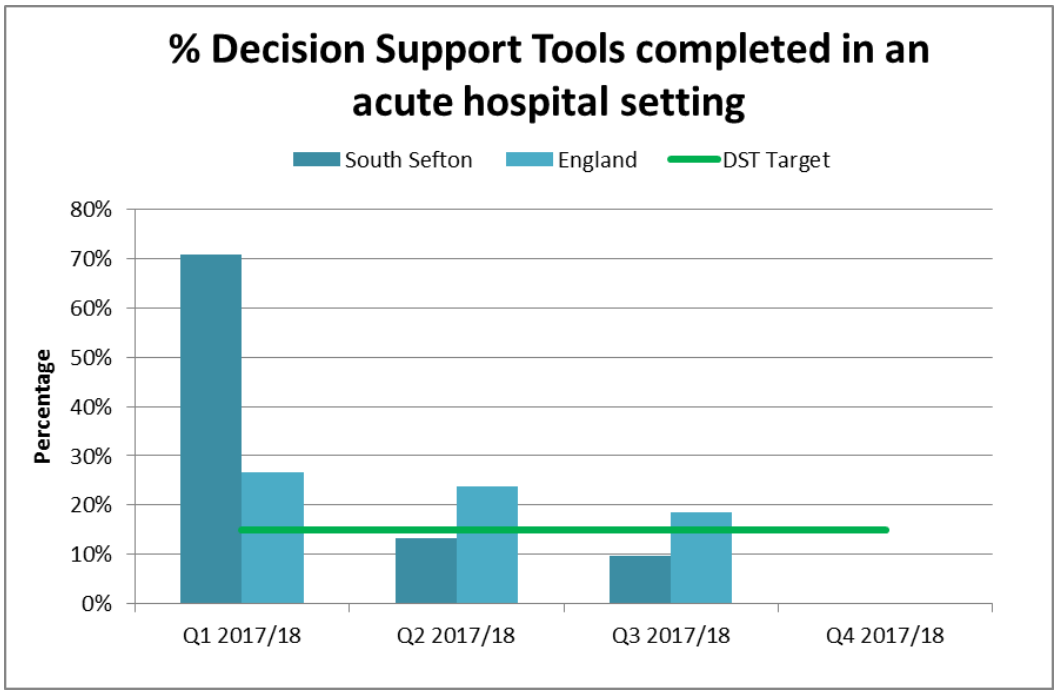


Figure 32 - Proportion of Decision Support Tool (DST) CHC assessments occurring in an acute hospital bed



The proportion of DST assessments occurring in an acute hospital bed in South Sefton was significantly higher than the national average of 27% in Q1. Data submissions were validated to ensure accuracy, and a significant improvement was recorded at both Q2 with 13.3% and Q3 with 9.8% occurring in an acute setting.

A CHC Programme Board has been established to replace the CHC Steering Group. The new board met in January, bringing together commissioners, providers and Local Authority colleagues.

3.10 Smoking at Time of Delivery (SATOD)

Figure 33 - Smoking at Time of Delivery (SATOD)

	South Sefton				
	Actual Q1	Actual Q2	Actual Q3	YTD	FOT
Number of maternities	367	452	402	1221	1628
Number of women known to be smokers at the time of delivery	56	62	69	187	249
Number of women known not to be smokers at the time of delivery	310	389	332	1031	1375
Number of women whose smoking status was not known at the time of delivery	1	1	1	3	4
Data coverage %	99.7%	99.8%	99.8%	99.8%	99.8%
Percentage of maternities where mother smoked	15.3%	13.7%	17.2%	14.4%	14.4%

The CCG is again above the data coverage plan of 95% at Q3, meaning the data is generally robust, but currently above the national ambition of 11% for the percentage of maternities where

mother smoked the ambition will be 6% by the end of 2022. There is no national target for this measure. Performance against this metric is discussed with Providers at Maternity Commissioning Leads meetings attended by the CCG managerial lead for Children and Maternity Services.

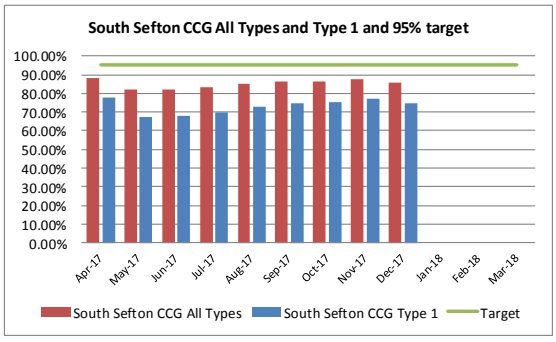
4. Unplanned Care

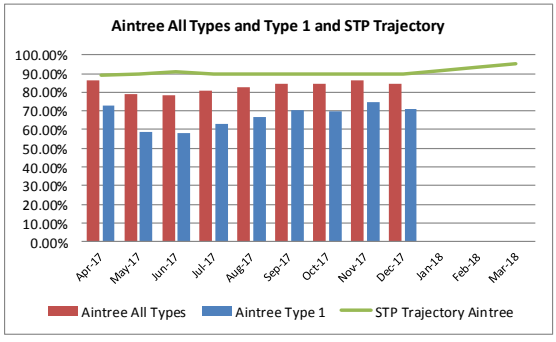
4.1 Accident & Emergency Performance

Figure 34 - A&E Performance

A&E waits				
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG) All Types**	17/18 - Dec	95%	85.15%	↔
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG) Type 1**	17/18 - Dec	95%	73.07%	↔
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Aintree) All Types**	17/18 - Dec	STP Trajectory Dec Target 90%	82.93%	↔
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Aintree) Type 1**	17/18 - Dec	95%	67.21%	↑

A&E All Types	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	YTD
STP Trajectory Aintree	89%	90%	91%	90%	90%	90%	90%	90%	90%	%
Aintree All Types	86.13%	78.78%	78.42%	80.81%	82.35%	84.47%	84.41%	86.58%	84.79%	82.93%





Aintree have revised their Cheshire & Merseyside 5 year Forward View (STP) trajectory for 2017/18 and have failed the 90% December plan agreed with NHS Improvement recording performance with 84.79% (for all A&E department types) in December 2017.

Performance against the 4 hour standard was 84.79% (T1 and T3) in December 2017 representing a -1.79% decrease compared to November 2017.

Actions for improvement include:

- Continue to embed all aspects of the Emergency and Acute Care Plan and regularly monitor performance to ensure delivery of 90% ED performance and 75% notification to handover (N2H) performance.
- Complete review of the medical workforce establishment and submit for consideration at BCRG. Additional sessions are being arranged to cover gaps in the existing rotas. This project is being supported by EY to ensure realignment of current workforce is undertaken prior to business case completion.
- Fully implement PCS by UC24 to start at the beginning of February.
- NWAS 90 day project completed. Awaiting start date agreement for direct conveyancing to AEC. Raised at NWAS meeting 13/11 and action was for NWAS to inform the Trust of start date.
- Recruitment of Acute Physicians and ED Consultants was successful with 3 consultants appointed for AMU and 1 consultant for ED. Start dates to be confirmed.
- Complete full ED nurse establishment review. Completing a dependency study within the department which will complete on 19/11. The findings will be fed into the review.
- EY and Exec support is in place to ensure delivery of the KPI's to improve quality and performance. A rapid improvement event Operation Frosty began in the first two weeks of January to focus on flow through ED, with the capacity to free up beds earlier and focus on SAFER.
- Develop series of PDSA cycles to test improvements in the following elements of EACP:
  - See and Treat – Allocation of rooms has been introduced and patient allocated to room for review
  - Board rounds - walk arounds have commenced to ensure staff are redirected to any hot spots.
  - Direct pathways to assessment areas

From A Multi Agency Discharge Event (MADE) held a number of recommendations were made following the event of which 4 were classified as "urgent";

- Half day MADE once a week, every week.
- A dedicated social worker on the Frailty Unit and Aintree to Home
- Roll out the SAFER patient flow bundle and Red2Green as soon as possible on the high traffic wards. ECIP would recommend commencing roll out on the Frailty Unit, Aintree to Home and Ward 35
- The ambulatory area within the Frailty Unit at Aintree must function at all times. The common practice of increasing the bed base within the frailty Unit must stop with immediate effect in order for the ambulatory area to function.

Figure 35 - A&E Performance – 12 hour breaches

12 Hour A&E Breaches				
Total number of patients who have waited over 12 hours in A&E from decision to admit to admission - **Aintree** (cumulative)	17/18 - Nov	0	15	↓

Aintree had 4 12-hour breaches in December. 15 have been reported year to date; (9 in May and 2 in June). Root Cause Analyses of the breaches are awaited from the Trust.

4.2 Ambulance Service Performance

In August NWAS went live with the implementation of the Ambulance Response Programme (ARP). NWAS performance is measured on the ability to reach patients as quickly as possible. Performance will be based upon the average (mean) time for all Category 1 and 2 incidents. Performance will also be measured on a 90th percentile (9 out of 10 times) for Category 1, 2, 3 and 4 incidents.

There was a 3 month moratorium in data reporting agreed with the commissioners, this was to allow some time to allow the Trust to understand and learn from ARP and time to start to redraft and reformulate reports. The first lot of reporting will be at NWAS and County level, it is unlikely that there will be any CCG level data for this financial year.

A separate report around the new ambulance performance targets will be presented to the Governing Body at the March meetings.

Figure 36 – Ambulance handover time performance

Handover Times					
All handovers between ambulance and A & E must take place within 15 minutes (between 30 - 60 minute breaches) - **Aintree**	17/18 - Dec	0	167	↑	The Trust recorded 167 handovers between 30 and 60 minutes, this is 1 less than last month when 168 was reported and is still breaching the zero tolerance threshold.
All handovers between ambulance and A & E must take place within 15 minutes (>60 minute breaches) - **Aintree**	17/18 - Dec	0	91	↓	The Trust recorded 114 handovers over 60 minutes, this is more than the previous month when 91 was reported and is still breaching the zero tolerance threshold.

December saw a slight decrease in the number of handover delays in excess of 30 minutes to 167 (-1), delays in excess of 60 minutes have increased to 114 (+23). The average time from notification to handover standard of 15 minutes increased to 17:47 mins compared to 17:39 mins in November. The overall number of ambulances attending increased by 208 in December. The time to see 1st clinician has increased to 77 minutes, against the 60 minute clinical quality indicator which is an increase of 5 minutes against November 2017. The clinical quality indicators for the number of patients who leave the department before being seen and the 15 minute from registration to triage are being met month on month.

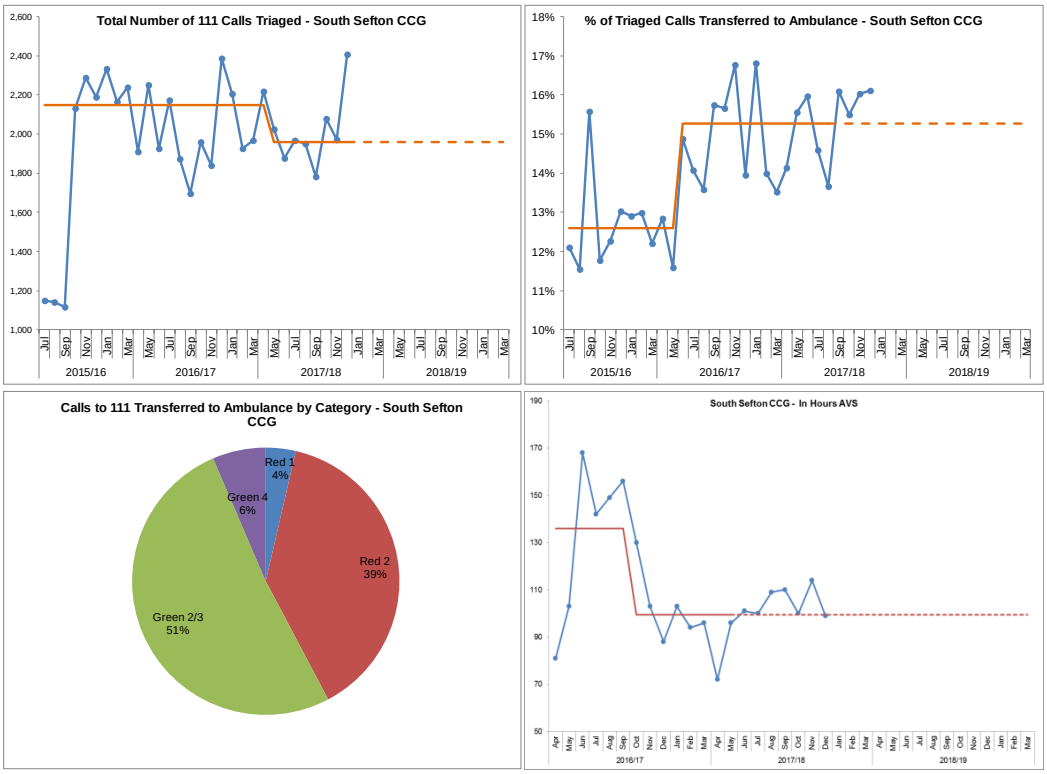
In mid-November, a guidance letter was issued to CCGs, Providers, and A&E Delivery Boards from the National Directors for Acute and Urgent Care at NHS England. The guidance 'Addressing ambulance handover delays: Actions for Local A&E Delivery Boards' sets out the main points from recent guidance documents, and separates them into actions to be embedded as part of normal working practice, and actions to be taken should ambulances begin to queue. There are 4 key principles that local systems should note:

- The patients in the urgent care pathway who are at highest risk of preventable harm are those for whom a high priority 999 emergency call has been received, but no ambulance resource is available for dispatch.
- Acute Trusts must always accept handover of patients within 15 minutes of an ambulance arriving at the ED or other urgent admission facility (e.g. medical/surgical assessment units, ambulatory care etc.).

- Leaving patients waiting in ambulances or in a corridor supervised by ambulance personnel is inappropriate.
- The patient is the responsibility of the ED from the moment that the ambulance arrives outside the ED department, regardless of the exact location of the patient.

4.3 NWAS, 111 and Out of Hours

4.3.1 111 Service Calls



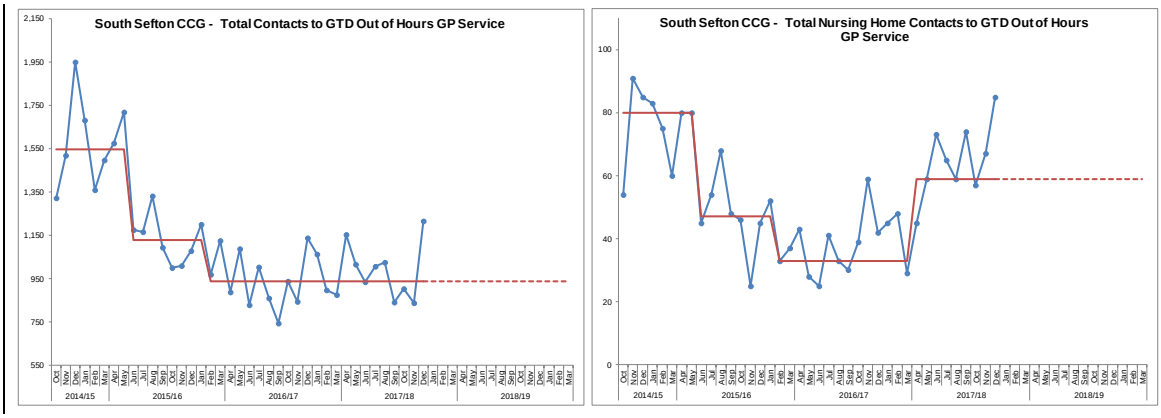
The number of calls in December from South Sefton CCG patients have risen to 2,409 from 1,971 in November, an increase of 438 calls. When compared to the same 9 months of the previous year, there have been 269 more contacts in 2016/17, an increase of 1.5%. There are a similar number of calls when comparing December 2017 to December 2016.

The breakdown for outcomes of 111 calls in December 2017 is as follows:

- 58% advised to attend primary and community care
- 15% closed with advice only
- 16% transferred to ambulance
- 6% advised to attend A&E
- 4% advised to other service.

The number of calls closed with advice only in the first 8 months of the year is 3,092. This is 12.1% lower than the same point in the previous year, when 3,517 calls ended this way.

4.3.2 GP Out of Hours Service Calls



The number of calls from South Sefton patients to the GP OOH service has risen in December to 1,215. When compared to the same point in the previous year, there have been 601 more calls so far in the first 9 months of 2017/18, an increase of 7.2%.

GP OOH calls from nursing homes within South Sefton have increased in December to 85, the most calls in one month since December 2014. There are more than double the numbers of calls in December 2017 compared to December 2016. When compared to the same point in the previous year, the first 9 months of 2017/18 have received 244 more calls to nursing homes, an increase of 72%.

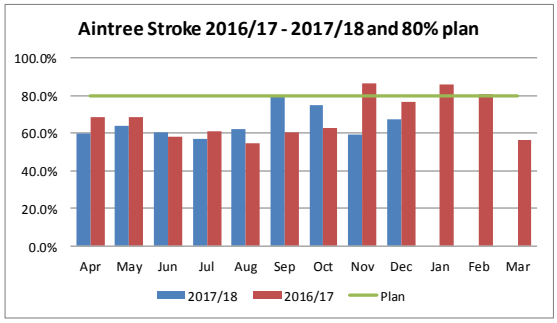
South Sefton CCG, in collaboration with Go To Doc (GTD) and NWAS, has now gone live with their out of hours Clinical Assessment Service (CAS) in June 2017.

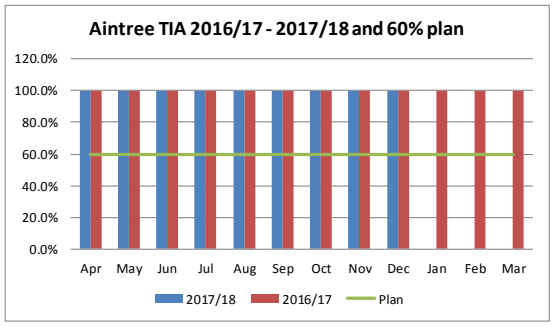
4.4 Unplanned Care Quality Indicators

4.4.1 Stroke and TIA Performance

Figure 37 - Stroke & TIA performance

Stroke				
% who had a stroke & spend at least 90% of their time on a stroke unit **(Aintree)**	17/18 - Dec	80%	67.50%	↑
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(Aintree)**	17/18 - Dec	60%	100%	↔





Aintree failed the 80% target of stroke patients spending at least 90% of their time on a stroke unit in December, achieving 67.5%. 40 patients with a diagnosis of stroke were discharged from the Trust during the month. 27 patients spent 90% of their stay on the Stroke Unit, the standard was not achieved for 13 patients. All breaches of the standard are reviewed and reasons for underperformance identified:
- 10 patients required admission to the Stroke Unit but no beds were available
- 1 patient was an inpatient Stroke and for palliative care and not suitable to transfer
- 2 patients were diagnosed as a stroke after MRI

Lack of available stroke beds remains a recurring theme and biggest contributor to the inability to achieve the standard. This is being addressed through implementation of a business case for Stroke inpatient capacity.

Actions:

- Continue Registered Nurse and Therapy recruitment for funded HASU beds.
- Ensure timely step down of patients from stroke unit to a medical bed.
- Stroke meetings to discuss outliers and delayed transfers of care, daily monitoring.
- Discuss late referrals to the Stroke Team and Acute and Emergency Medicine to ensure lessons learnt – patient journeys to be shared with relevant teams.
- Weekly breach meeting with Dr Cullen and Stroke Nurse Clinicians to discuss failed patients pathways, reasons for not achieving the 4 hour time target.

4.4.2 Mixed Sex Accommodation

Figure 38 - Mixed Sex Accommodation breaches

Mixed Sex Accommodation Breaches				
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(CCG)**	17/18 - Dec	0.00	0.00	↔
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(Aintree)**	17/18 - Dec	0.00	0.00	↔

4.4.3 Healthcare associated infections (HCAI)

Figure 39 - Healthcare associated infections (HCAI)

NHS
South Sefton
Clinical Commissioning Group

HCAI				
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(CCG)**	17/18 - Dec	41	33	↓
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(Aintree)**	17/18 - Dec	34	50 (35 following appeal)	↓
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(CCG)**	17/18 - Dec	0	1	↔
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(Aintree)**	17/18 - Dec	0	1	↔
Incidence of healthcare associated infection (HCAI) E.Coli (Cumulative) **(CCG)**	17/18 - Dec	101	102	↑
Incidence of healthcare associated infection (HCAI) E.Coli (Cumulative) **(Aintree)**	17/18 - Dec	No Plan	222	↑

The CCG had 4 new cases of Clostridium Difficile reported in December 2017 (33 year to date) against a year to date plan of 41 (18 apportioned to acute trust and 15 apportioned to community). The year-end plan is 54. Aintree had 5 new cases reported in December (50 year to date) against a year to date plan of 34. (There have been 15 successful appeals upheld at panel, so 35 cases following appeal). The year-end plan is 46.

Aintree had no new cases of MRSA in December and just 1 case of MRSA in June. The case was subject to the national Post Infection Review (PIR) process and the case was finally assigned to the Trust. The PIR review team could not identify any lapses in care, however the patient was screened negative on admission and the first indication of MRSA was the confirmation of the bacteraemia.

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.

NHS Improvement and NHS England have set CCG targets for reductions in E.coli for 2017/18 which is 142 for South Sefton CCG, in December there were 6 cases bringing the year to date total to 102 which is over the 101 year to date plan. There are no targets set for Trusts at present.

4.4.4 Hospital Mortality

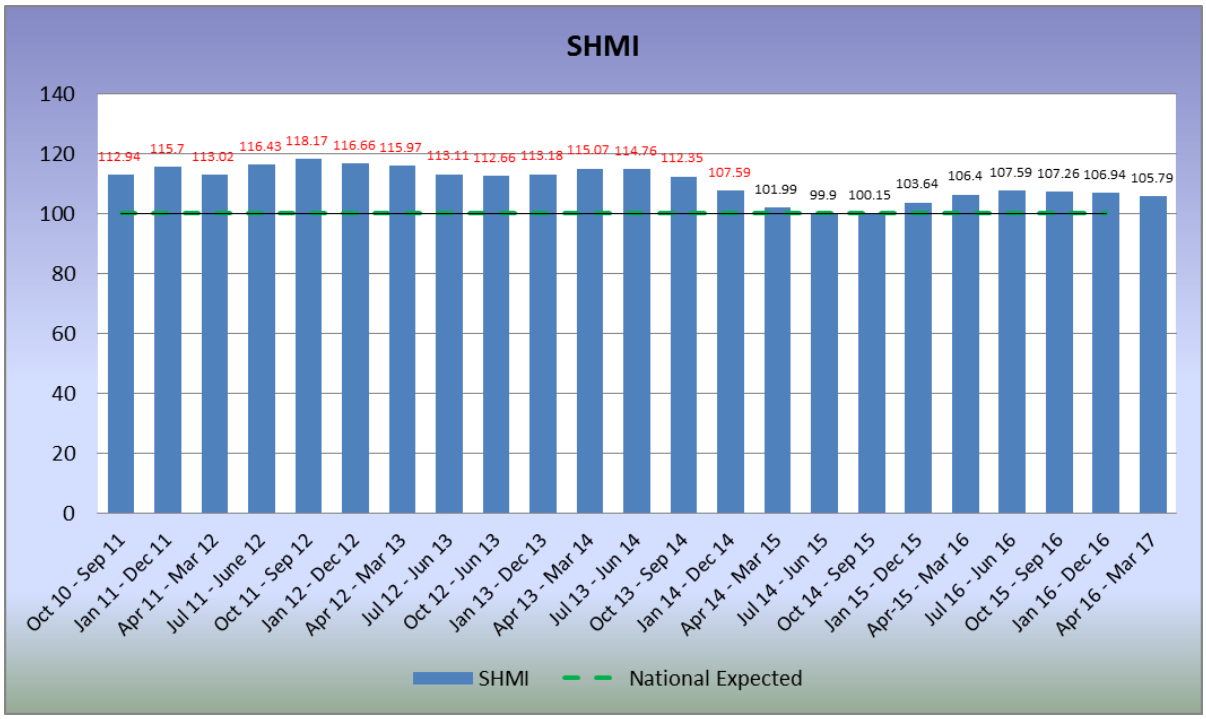
Figure 40 - Hospital Mortality

Mortality				
Hospital Standardised Mortality Ratio (HSMR)	17/18 - Dec	100	95.49	↓
Summary Hospital Level Mortality Indicator (SHMI)	Apr 16 - Mar 17	100	105.79	↑

HMSR is reported for the rolling 12 months to September 2017 with the latest data showing a marginal increase to 95.49 from 94.24 previously reported. Position remains better than expected. A ratio of greater than 100 means more deaths occurred then expected, while the ratio is fewer than 100 this suggest fewer deaths occurred than expected.

SHMI at 105.79 is marginally better at March 2017 and within tolerance levels.

Figure 41 - Summary Hospital Mortality Indicator



4.5 CCG Serious Incident Management

Serious incidents reporting within the integrated performance report is in line with the CCG reporting schedule for Month 9.

There are a total of 100 serious incidents open on StEIS where South Sefton CCG are either responsible or accountable commissioner. Of the 100, 68 apply to South Sefton patients. 32 are attributed to Aintree University Hospitals NHS Trust, 8 of these apply to South Sefton CCG. There was 1 Never Event reported in month for SSCCG patient (6 YTD). 5 incidents were closed in month (54 YTD). 41 remain open on StEIS for > 100 days for South Sefton patients.

Aintree University Hospitals NHS Foundation Trust reported 5 incidents in month (32 YTD), with 1 Never Event (6 YTD), 3 closed in month (22 YTD). 32 remain open with 13 open for > 100 days. Never Events have been discussed at the Aintree CQPG. Assurance was provided that the orthopaedic surgeons (hand, spine) as no longer operating. The CQPG has supported individual review for each incident as per SI process, with the Trust appointing an external

independent reviewer to undertake a cluster review. A review has been undertaken of safety plans in theatre including consent, 2nd person checking procedures. The CCG is reporting assurance through to NHS E C&M

Mersey Care NHS Foundation Trust reported 3 incidents in month (36 YTD), 22 reported by Mental Health Services and 14 by Community Division. 30 related to South Sefton CCG patients with zero Never Events (0 YTD). There was one incident closed in month (30 YTD). 40 remain open on StEIS with 19 remaining open > 100 days, 16 for South Sefton patients.

Four incidents remain open for South Sefton CCG, 2 were reported in Dec which are being managed by NHS E C&M internal Serious Incident processes. Two remain under the management of the CCG. One is an Oromorph incident in Primary Care and the other relates to DMC Healthcare Ltd.

4.6 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.

NHS England are replacing the previous patient snapshot measure with a DTOC Beds figure, which is the delayed days figure divided by the number of days in the month. This should be a similar figure to the snapshot figure, but more representative.

Figure 42 - Average Delayed Transfers of Care per Day at Aintree April 2016 – December 2017

Average Delays per Day

	2016-17												2017/18								
Reason for Delay	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
A) COMPLETION ASSESSMENT	1	1	1	1	3	6	1	0	0	2	2	0	0	0	2	1	2	2	1	1	0
B) PUBLIC FUNDING	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	9	8	8	6	7	19	9	6	10	10	8	7	11	9	11	7	8	9	9	16	5
DI) AWAITING RESIDENTIAL CARE HOME PLACEMENT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DII) AWAITING NURSING HOME PLACEMENT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E) AWAITING CARE PACKAGE IN OWN HOME	3	5	4	6	5	7	3	4	4	5	5	3	4	1	6	1	3	2	5	4	5
F) COMMUNITY EQUIPMENT/ADAPTIONS	2	1	1	1	0	1	0	0	0	0	0	0	0	0	1	0	1	0	1	0	0
G) PATIENT OR FAMILY CHOICE	15	16	19	15	12	13	12	11	18	5	7	10	13	18	20	8	14	15	8	17	15
H) DISPUTES	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
I) HOUSING	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
O) OTHER	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	**30**	**31**	**34**	**29**	**27**	**46**	**25**	**21**	**32**	**22**	**22**	**22**	**28**	**29**	**39**	**18**	**28**	**29**	**24**	**38**	**26**

The average number of delays per day in Aintree hospital decreased in December to 26 from 38 reported in November. Of the 26, 15 were patient or family choice (57.7%), 5 were awaiting further NHS non-acute care (19.2%), 5 were awaiting care package in own home (19.2%) and 1 dispute (3.8%).

Analysis of average delays in December 2017 compared to December 2016 shows a decrease of 18.8% in the average number of patients from 32 to 26.

Figure 43 - Agency Responsible for Days Delayed at Aintree April 2016 – December 2017

	2016-17												2017/18								
Agency Responsible	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
NHS - Days Delayed	808	773	863	677	677	1,093	664	516	880	519	490	565	726	852	962	515	725	800	584	991	665
Social Care - Days Delayed	85	184	153	228	167	292	98	118	121	177	133	106	112	45	221	34	134	93	176	134	164
Both - Days Delayed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

The total number of days delayed due to the NHS was 665 in December, a decrease of 326 from November when 991 was reported. Delays due to social care was 164 in December, an increase from 134 reported in November. No delays due to both were reported in December.

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 a weekly system wide teleconference.

Figure 44 - Average Delayed Transfers of Care per Day - Merseycare - April 2016 – December 2017

Average Delays per Day

	2016/17												2017/18								
Reason for Delay	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
A) COMPLETION ASSESSMENT	3	5	7	9	7	8	8	8	9	7	6	6	8	4	6	6	6	5	6	5	4
B) PUBLIC FUNDING	5	2	3	6	5	3	2	3	4	4	7	12	8	6	5	3	2	1	2	2	2
C) WAITING FURTHER NHS NON-ACUTE CARE	3	6	3	9	6	5	12	12	15	18	12	14	9	6	7	6	6	6	6	5	5
DI) AWAITING RESIDENTIAL CARE HOME PLACEMENT	2	3	2	5	4	2	1	2	3	2	1	2	3	1	0	3	4	3	2	3	3
DII) AWAITING NURSING HOME PLACEMENT	3	5	5	9	9	10	9	7	5	3	3	2	4	4	4	7	8	8	7	8	5
E) AWAITING CARE PACKAGE IN OWN HOME	2	3	1	3	4	3	4	4	4	3	3	2	2	1	5	5	3	3	4	3	0
F) COMMUNITY EQUIPMENT/ADAPTIONS	1	2	2	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0
G) PATIENT OR FAMILY CHOICE	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	2	3	3	2
H) DISPUTES	4	5	6	7	4	4	4	3	2	2	2	0	0	0	0	1	1	1	1	1	1
I) HOUSING	4	3	4	2	3	2	2	2	1	1	0	2	1	4	5	3	8	10	10	8	8
O) OTHER	0	0	0	0	0	0	0	0	0	0	0	0	0	3	2	1	1	1	0	2	2
Grand Total	**28**	**34**	**33**	**51**	**42**	**37**	**42**	**41**	**43**	**40**	**34**	**40**	**35**	**29**	**34**	**37**	**41**	**40**	**41**	**40**	**32**

The average number of delays per day at Merseycare decreased to 32 in December. Of the 32 delays, 8 were due to housing, 5 were awaiting nursing home placements, 5 waiting further NHS non-acute care, 4 awaiting completion assessments, 3 awaiting residential care home placements, 2 patient or family choice, 2 public funding, 2 patient or family choice and 1 dispute. Analysis of average delays in December 2017 compared to December 2016 shows them to be lower by 11.

Figure 45 - Agency Responsible and Total Days Delayed - Merseycare - April 2016 – December 2017

	2016/17												2017/18								
Agency Responsible	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
NHS - Days Delayed	430	550	409	566	477	343	507	604	616	678	436	591	409	488	447	403	613	680	704	705	587
Social Care - Days Delayed	264	337	359	670	545	505	572	530	537	428	356	343	351	243	367	574	526	406	396	327	218
Both - Days Delayed	153	144	227	350	391	379	230	180	186	160	179	303	285	197	217	149	132	151	178	166	179

The total number of days delayed caused by NHS was 587 in December, compared to 705 last month. Analysis of these in December 2017 compared to December 2016 shows a decrease from 616 to 587 (29). The total number of days delayed caused by Social Care was 218 in December, compared to 327 in November, showing a decrease of 109. Merseycare also have delays caused by both which was 179 in December, an increase from the previous month which reported 166.

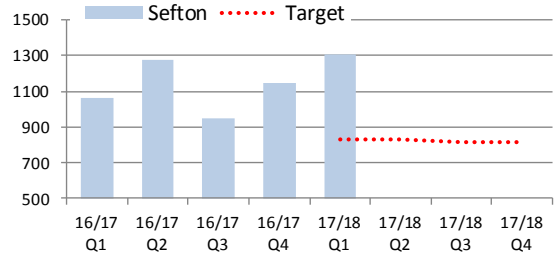
4.7 ICRAS

The Integrated Community Reablement and Assessment Service (ICRAS) commenced in October 2017 with phase 1, introducing a series of discharge 'lanes' for patients to speed up transition from hospital. The teams are working together to not only support discharge from hospital, but significant progress is being made in supporting people to avoid unnecessary hospital admission as well. Reports from colleagues within the system, particularly in South Sefton, are reporting the positive impact of the scheme, both personally and professionally and how this has improved the patients' journeys. Phase 2 (incorporating patients with more complex discharge needs) is planned for 1 April 2018. Specific metrics for the service are still being developed, but the metrics below are

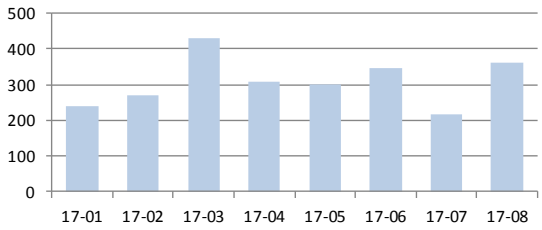
NHS
South Sefton
Clinical Commissioning Group

some of the outcomes being reported to Sefton Health and Wellbeing Board as part of an integration dashboard.

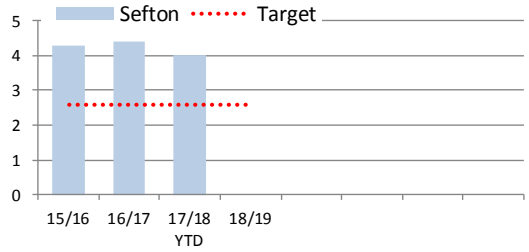
Delayed Transfers of Care - Delayed Days - Rate per 100,000 (iBCF Target)



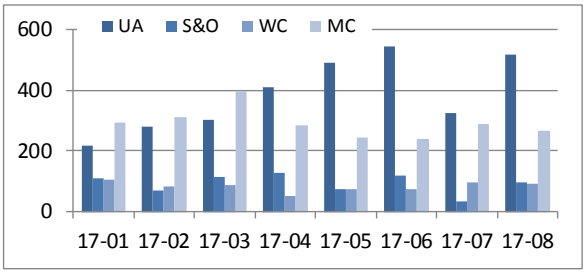
Delayed Transfers of Care - Non-Acute Days Attributed to NHS



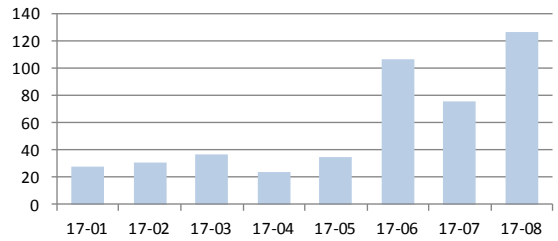
Delayed Transfers of Care - ASC Beds - Rate per 100,000 (National Target)



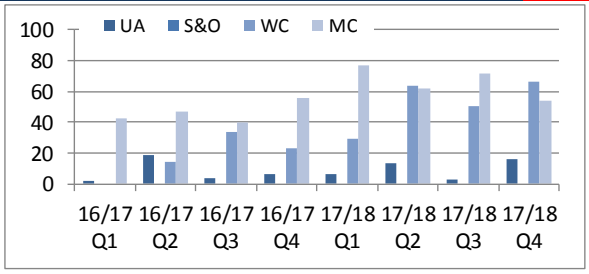
Delayed Transfers of Care - Total Days by Key Providers (in Sefton)



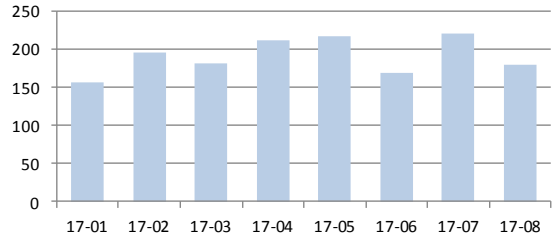
Delayed Transfers of Care - Acute Days Attributed to Adult Social Care



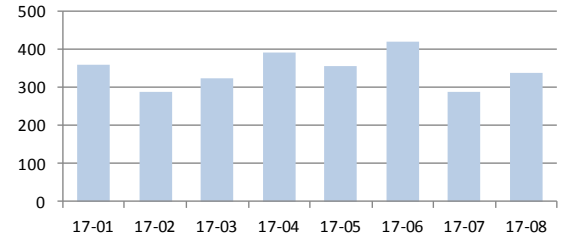
Delayed Transfers of Care - Total Days by Key Providers (in Sefton) % Attributable to ASC



Delayed Transfers of Care - Non-Acute Days Attributed to Adult Social Care



Delayed Transfers of Care - Acute Days Attributed to NHS



4.8 Patient Experience of Unplanned Care

Figure 46 - Aintree A&E Friends and Family Test performance

Friends and Family Response Rates and Scores
Aintree University Hospital NHS Foundation Trust
Latest Month: **Dec-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	15.0%	15.9%		85%	87%		8%	9%	

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

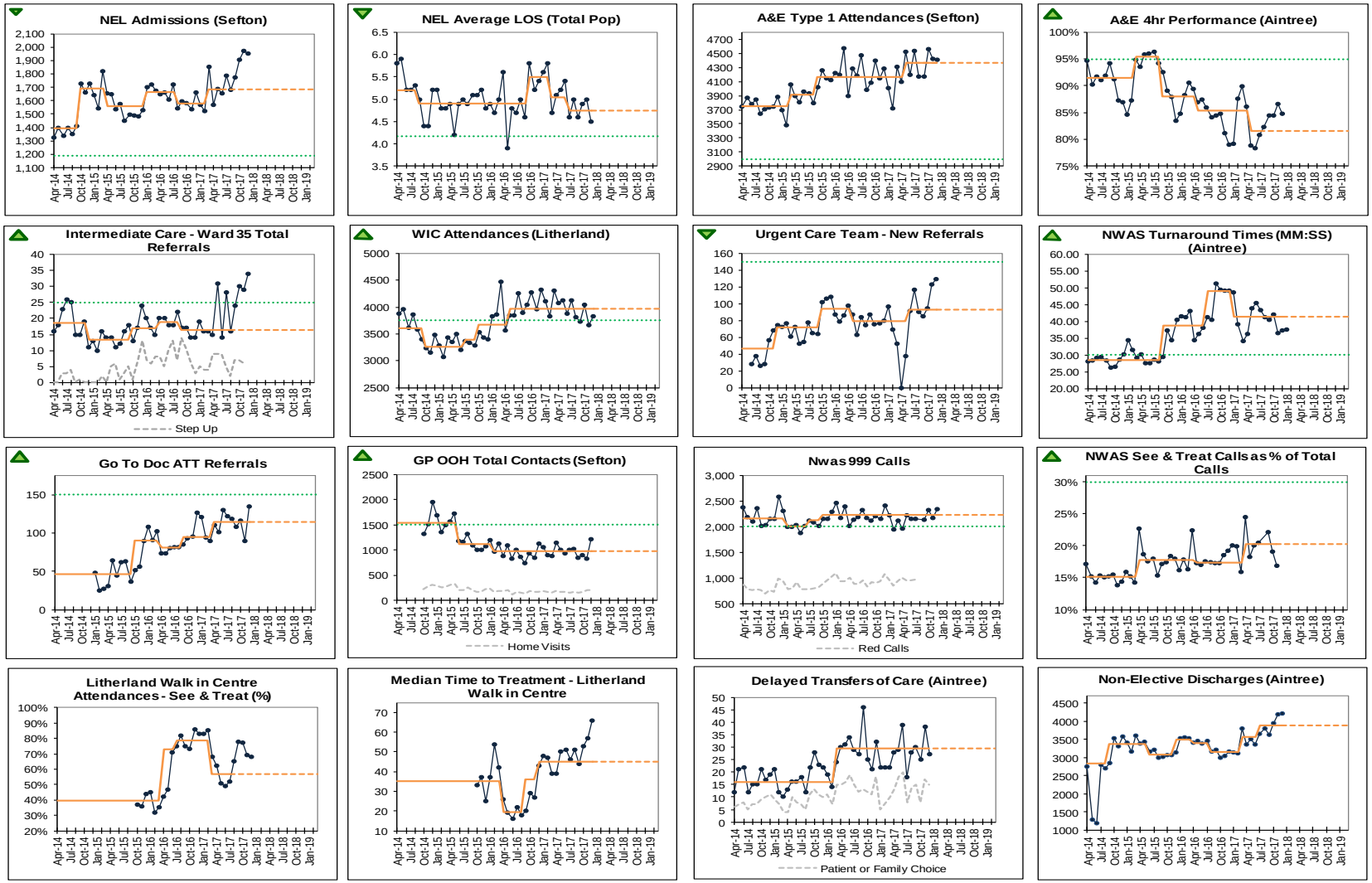
- % Response Rate
- % Recommended
- % Not Recommended

The percentage of people that would recommend A&E is above the England average (85%) reporting 87% in December the same as November. The not recommended percentage is at 9% in December which again is the same as the previous month, England average 8%.

4.9 South Sefton Urgent Care Dashboard

An urgent care system dashboard has been developed by Dr Pete Chamberlain incorporating 16 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

NHS
South Sefton
Clinical Commissioning Group



NHS
South Sefton
Clinical Commissioning Group

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.

NHS
South Sefton
Clinical Commissioning Group

4.10 Unplanned Care Activity & Finance, All Providers

4.10.1 All Providers

Performance at Month 9 of financial year 2017/18, against unplanned care elements of the contracts held by NHS South Sefton CCG shows an over performance of circa £1.5m/4.1%. However, applying a neutral cost variance for those Trusts within the Acting as One block contract arrangement results in there being a total under spend of approximately -£180k/-0.5%.

Aintree and Royal Liverpool represent the highest over performing providers for unplanned care at month 9 with a year to date variance of £1.6m/6% and £389k/26% respectively. In contrast, Southport & Ormskirk is currently underperforming by -£365k/-16%.

Figure 47 - Month 9 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	Acting as One Adjustment	Total Price Var (following AAO Adjust)	Total Price Var %
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	71,453	80,353	8,900	12%	£26,779	£28,449	£1,671	6%	-£1,671	£0	0.0%
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	7,467	7,053	-414	-6%	£1,612	£1,446	-£166	-10%	£166	£0	0.0%
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	186	116	-70	-38%	£307	£275	-£32	-10%	£32	£0	0.0%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2,591	2,388	-203	-8%	£3,137	£2,952	-£186	-6%	£186	£0	0.0%
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	4,057	4,236	179	4%	£1,485	£1,874	£389	26%	-£389	£0	0.0%
WALTON CENTRE NHS FOUNDATION TRUST	8	6	-2	-21%	£42	£47	£5	12%	-£5	£0	0.0%
ACTING AS ONE PROVIDERS TOTAL	85,761	94,152	8,391	10%	£33,362	£35,043	£1,682	5%	-£1,682	£0	0%
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	50	90	40	79%	£12	£26	£13	110%	£0	£13	110%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	0	69	69	0%	£0	£15	£15	0%	£0	£15	#DIV/0!
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST*	6,152	5,826	-326	-5%	£2,328	£1,963	-£365	-16%	£0	-£365	-16%
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	666	809	143	21%	£297	£326	£28	10%	£0	£28	10%
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	50	104	54	106%	£135	£195	£61	45%	£0	£61	45%
UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	31	33	2	7%	£10	£16	£5	49%	£0	£5	49%
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	0	94	94	0%	£0	£13	£13	0%	£0	£13	#DIV/0!
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	183	214	31	17%	£67	£114	£47	71%	£0	£47	71%
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	46	53	7	16%	£29	£31	£3	10%	£0	£3	10%
ALL REMAINING PROVIDERS TOTAL	7,179	7,292	113	2%	£2,878	£2,698	-£180	-6%	£0	-£180	-6%
GRAND TOTAL	**92,940**	**101,444**	**8,504**	**9%**	**£36,240**	**£37,742**	**£1,502**	**4.1%**	**-£1,682**	**-£180**	**-0.5%**

*PbR Only

4.10.2 Aintree University Hospital NHS Foundation Trust

Figure 48 - Month 9 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	30,800	35,316	4,516	15%	£730	£730	£0	0%
A&E - *Accident & Emergency*	22,827	24,799	1,972	9%	£3,078	£3,400	£322	10%
NEL - *Non Elective*	11,041	11,178	137	1%	£20,568	£21,352	£784	4%
NELNE - *Non Elective Non-Emergency*	36	29	-7	-20%	£130	£99	-£31	-24%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	15	78	63	412%	£4	£20	£15	359%
NELST - *Non Elective Short Stay*	1,506	1,623	117	8%	£1,012	£1,119	£107	11%
NELXBD - *Non Elective Excess Bed Day*	5,227	7,330	2,103	40%	£1,256	£1,730	£474	38%
Grand Total	**71,453**	**80,353**	**8,900**	**12%**	**£26,779**	**£28,449**	**£1,671**	**6.2%**

4.10.3 Aintree Hospital Key Issues

The Urgent Care over spend of £1.6m/6.2% is driven by an over performance within Non Electives and Non Elective Excess Bed Days as well as within Accident & Emergency. The key specialties over performing within unplanned care include Acute Internal Medicine, Gastroenterology, Diabetic Medicine and Cardiology. In contrast, there is currently a significant under spend within the Geriatric Medicine, Accident & Emergency, Trauma & Orthopaedic and Colorectal Surgery specialties.

Despite the overall indicative overspend for unplanned care PODs at Aintree, there is no financial impact of this to South Sefton CCG due to the Acting As One block contract arrangement.

4.10.4 Royal Liverpool University Hospital

Figure 49 - Month 9 Unplanned Care – Royal Liverpool University Hospital Trust by POD

The Royal Liverpool Hospital Urgent Care PODS	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
A&E - *Accident & Emergency*	3,351	3,318	-33	-1%	£349	£372	£24	7%
AMAU - *Acute Medical unit*	16	46	30	183%	£2	£4	£3	183%
NEL - *Non Elective*	506	512	6	1%	£1,004	£1,279	£275	27%
NELNE - *Non Elective Non-Emergency*	11	18	7	65%	£63	£95	£31	50%
NELST - *Non Elective Short Stay*	67	100	33	48%	£43	£67	£24	55%
NELXBD - *Non Elective Excess Bed Day*	106	242	136	129%	£25	£57	£33	134%
Grand Total	**4,057**	**4,236**	**179**	**4%**	**£1,485**	**£1,874**	**£389**	**26%**

NHS South Sefton Clinical Commissioning Group

4.10.5 Royal Liverpool University Hospital Key Issues

The overall Urgent Care over spend of £389k/26% is largely driven by a £297k/33% over performance in Non-Elective costs. Vascular Surgery is the top over performing specialty within this POD with a variance of £164k/153% against plan.

As with Aintree Hospital, despite the overall indicative overspend for unplanned care PODs at Royal Liverpool, there is no financial impact of this to South Sefton CCG due to the Acting As One block contract arrangement.

5. Mental Health

5.1 Mersey Care NHS Trust Contract

Figure 50 - NHS South Sefton CCG – Shadow PbR Cluster Activity

PBR Cluster	NHS South Sefton CCG			
	Caseload as at 31/12/2017	2017/18 Plan	Variance from Plan	Variance on 31/12/2016
1 Common Mental Health Problems (Low Severity)	11	43	-32	-34
2 Common Mental Health Problems (Low Severity with greater need)	7	25	-18	-19
3 Non-Psychotic (Moderate Severity)	71	150	-79	-72
4 Non-Psychotic (Severe)	278	270	8	-4
5 Non-psychotic Disorders (Very Severe)	87	67	20	16
6 Non-Psychotic Disorder of Over-Valued Ideas	36	46	-10	-9
7 Enduring Non-Psychotic Disorders (High Disability)	307	251	56	49
8 Non-Psychotic Chaotic and Challenging Disorders	133	122	11	6
10 First Episode Psychosis	147	144	3	4
11 On-going Recurrent Psychosis (Low Symptoms)	317	399	-82	-69
12 On-going or Recurrent Psychosis (High Disability)	398	354	44	41
13 On-going or Recurrent Psychosis (High Symptom & Disability)	101	101	-	-1
14 Psychotic Crisis	31	27	4	1
15 Severe Psychotic Depression	8	6	2	2
16 Psychosis & Affective Disorder (High Substance Misuse & Engagement)	41	38	3	2
17 Psychosis and Affective Disorder – Difficult to Engage	40	50	-10	-9
18 Cognitive Impairment (Low Need)	244	224	20	27
19 Cognitive Impairment or Dementia Complicated (Moderate Need)	432	446	-14	-9
20 Cognitive Impairment or Dementia Complicated (High Need)	448	398	50	46
21 Cognitive Impairment or Dementia (High Physical or Engagement)	123	140	-17	-18
Cluster 99	277	558	-281	-302
Total	3,537	3,859	-305	-352

NHS
South Sefton
Clinical Commissioning Group

5.1.1 Key Mental Health Performance Indicators

Figure 51 - CPA – Percentage of People under CPA followed up within 7 days of discharge

	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
The % of people under mental illness specialities who were followed up within 7 days of discharge from psychiatric inpatient care	95%	100%	95%	97%	100%	92.6%	92.3%	96%	89.3%	100%
Rolling Quarter				97%	100%	96.0%	95.2%	96%	92.6%	94.2%

Figure 52 - CPA Follow up 2 days (48 hours) for higher risk groups

	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-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%	No Patients	100%	No Patients	100%	100%	100%	66.7%	66.7%	100%
Rolling Quarter				100%	100%	100%	100%	66.7%	66.7%	77.8%

Figure 53 - EIP 2 week waits

	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-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%	No Patients	100%	67%	100%	50%	100%	67%	40.0%	100%
Rolling Quarter				80%	100%	81.8%	84.6%	67%	50%	64%

5.1.2 Out of Area Placements (OAP's)

Figure 54 - OAP Days

Period	Period Covered	Total number of OAP days over the period
	Feb 17 to Apr 17	128
	Mar 17 to May 17	160
Q1 2017/18	**Apr 17 to June 17**	**96**
	May 17 to Jul 17	51
	June 17 to Aug 17	28
Q2 2017/18	**Jul 17 to Sep 17**	**23**
	Aug 17 to Oct 17	20
	Sep 17 to Nov 17	10
Q3 2017/18	**Oct 17 to Dec 17**	**15**

The CCG has a target to reduce OAP's by 33% based on quarter 4 2016/17 activity. In quarter 4 2016/17, 104 OAP's were reported, and therefore the target for 2017/18 is 70. The latest reporting period is October to December 2017 where 15 OAP's were reported, an increase on the last reporting period of 10. The CCG is therefore currently in line with the target.

5.1.3 Mental Health Contract Quality Overview

From April 2017 Liverpool CCG became the lead commissioner for the Mersey Care NHS Trust Foundation contract and as such joint contract and quality monitoring arrangements have been put in place to provide oversight and scrutiny to the contract.

The Trust, in response to the recent Crisis Resolution Home Treatment Team (CRHTT) core fidelity review findings has established an urgent pathway work-stream to establish a Single Point of Access to enable a more responsive access point for urgent referrals. The first phase of this work will involve assessment based staff being within a single team with the Trust's footprint with agreed triage and assessment process. This work also includes the identification of staff who undertake CRHT team functions with the aim of establishing a one stop integrated referral and response across the Trust's footprint. The Trust has appointed a manager who will manage the integrated team and the bed management function so as to optimise appropriate admissions and discharges. It is expected that the new CRHTT staffing structure and arrangements will be in place by March 2018.

In conjunction with the urgent pathway redesign and recognising the need to improve collaborative working, the Trust has developed plans to enhance GP liaison building upon the primary care mental health practitioners which have been in place since 2013/14. As from 1st December 2017 consultant psychiatrists will be aligned to primary care localities and respective Primary Care Mental Health Liaison Practitioners so as to increase the mental health support available for GPs. Contact will soon be established to arrange consultant visits to practices and within these meetings it will be possible to discuss GP patients open to mental health services, and those patients not open but for whom the GP may wish to take advice on to either avoid the need for a referral or for support with signposting to an appropriate alternative service e.g. The Life Rooms. A tripartite meeting involving the Sefton LMC has been arranged for 21st March 2018 to discuss the Trust's proposals to change the outpatient model of care.

Eighteen week referral to treatment wait times (95% threshold) for psychotherapy and eating disorders have been sub-optimal throughout 2017/18 and following concerns raised by commissioners the Trust is working to improve performance Patients numbers within Psychotherapy and Eating Disorders within both CCGs are small and therefore the KPIs are sensitive to small fluctuation. The Trust has reported that vacancies are being filled and group work has been implemented in both services and the expectation is that performance will improve in the last quarter of the year.

Communication related KPIs within the contract continue to be a focus of concern. Commissioners are not satisfied that sufficient progress is being made and this issue will be raised at the next CQPG in February 2018.

The Trust is in the process of implementing a new clinical information system (RiO), expected to go live across all services in June 2018. The Trust has advised that there is likely to be a period of at least 6 months where activity and performance monitoring information will be reduced or unavailable. Risk is that KPI may be not able to be captured and this could impede the quality assurance controls currently in place through the contract. This will impact the CCGs' ability to effectively manage the contract and is also likely to add further delays to the development and implementation of mental health currencies.

At a meeting held with the Trust on 7th December 2017, it was agreed to work with the prioritise quality KPIs for reporting (e.g. national ones). At the subsequent commissioner meeting held on 6th February 2018 it was agreed to discontinue two KPIs and move monthly reporting for some

KPIs to quarterly so as to reduce administrative burden whilst RiO is being embedded. Trust has yet to respond to the commissioner proposals.
There are already data quality issues for the small services that have already gone "live" with RiO and it is likely that more issues will be identified with the transition of the major services, making planning and monitoring of contract activity and demand difficult

Activity and data quality discussions currently take place at the Currency Development Group and the Trust has action plans in place for the Data Quality issues identified within the existing system. RiO is also a standing agenda item for the contract review meeting.

The Trust was issued with a Performance Notice on 11th May 2017 following deterioration in Safeguarding related performance between Quarter 2 and Quarter 3 in 2016/17. This had previously been raised via CRM and CQPG meetings. The Trust has provided a remedial action plan against which progress will be monitored via CQPG. Good progress continues to be reported against the remedial action plan however the performance notice remains open until the CCG Safeguarding Team is assured that all concerns have been addressed.

The Adult ADHD service provided by the Trust continues to operate at over capacity. Six of the seven sessions per week became vacant on 1st October 2017 and these are being recruited to and the trust has reported that the vacant sessions will be filled in January 2018. The recently Sefton LMC approved shared care protocol for adult ADHD drugs has been approved by the Trust and transfers of patients back to primary care are expected to commence in January 2018.

In response to commissioner and provider concerns about the memory pathway and throughput of patients there have been initial discussions about undertaking a pilot involving two South Sefton general practices and Churchtown practices in Southport to forming part of a multi-disciplinary/multi –agency approach to the management of people living well with Alzheimer's disease. Initial work will focus on gathering baseline evidence from general practices involved and community nursing teams involved. The target cohort are patients who are prescribed Acetyl-Cholinesterase or Memantine. Cross referencing GP and community data will help understand demand /capacity issues.

5.1.4 Patient Experience of Mental Health Services

Figure 55 - Merseycare Friends and Family Test performance

Friends and Family Response Rates and Scores
Mersey Care NHS Foundation Trust
Latest Month: **Dec-17**

Clinical Area	Response Rate (Eng. Average)	RR Actual	RR Trend Line	% Recommended (Eng. Average)	% Recommended	PR Trend Line	% Not Recommended (Eng. Average)	% Not Recommended	PNR Trend Line
Mental Health	2.5%	3.0%		88%	86%		4%	4%	

Merseycare recorded 86% of respondents as recommending, this is now below the England average of 88% a decline from the previous month when 90% was recorded. The rate of those not recommending is 4% the same at the England average.

NHS
South Sefton
Clinical Commissioning Group

5.2 Improving Access to Psychological Therapies

Figure 56 - 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	2016/17	282	294	294	272	246	269	269	254	198	307	284	315
	2017/18	223	320	331	315	269	289	294	358	232			
Access % ACTUAL - *Monthly target 1.25% for Q1 to Q3* - *Quarter 4 only 1.4% is required*	2016/17	1.16%	1.21%	1.21%	1.12%	1.01%	1.11%	1.11%	1.05%	0.81%	1.26%	1.17%	1.30%
	2017/18	0.92%	1.32%	1.36%	1.30%	1.11%	1.19%	1.21%	1.47%	0.95%			
Recovery % ACTUAL - *50% target*	2016/17	41.1%	37.9%	30.7%	38.9%	34.5%	42.0%	39.0%	41.1%	36.7%	40.6%	50.3%	52.3%
	2017/18	35.4%	46.3%	41.9%	43.9%	47.4%	49.5%	43.0%	46.8%	42.1%			
ACTUAL % 6 weeks waits - *75% target*	2016/17	93.5%	98.5%	96.4%	97.4%	97.7%	95.5%	98.0%	99.5%	98.0%	98.8%	99.4%	99.5%
	2017/18	98.8%	98.90%	97.9%	100.0%	99.5%	98.4%	99.5%	99.5%	99.3%			
ACTUAL % 18 weeks waits - *95% target*	2016/17	100.0%	100.0%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	99.3%	100.0%	100.0%	100.0%
	2017/18	100.0%	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
National definition of those who have completed treatment (KPI5)	2016/17	166	162	156	164	148	171	162	212	153	167	173	189
	2017/18	169	181	196	184	199	186	192	198	150			
National definition of those who have entered Below Caseness (KPI6b)	2016/17	3	9	3	7	6	9	8	10	6	12	10	13
	2017/18	8	4	5	4	9	2	6	8	5			
National definition of those who have moved to recovery (KPI6)	2016/17	67	58	47	61	49	68	60	83	54	63	82	92
	2017/18	57	82	80	79	90	91	80	89	61			
Referral opt in rate (%)	2016/17	87.9%	89.4%	91.4%	84.2%	85.7%	84.2%	88.2%	83.2%	81.4%	84.1%	83.7%	80.4%
	2017/18	84.5%	89.0%	90.3%	84.7%	88.6%	88.9%	91.8%	89.3%	82.7%			

Cheshire & Wirral Partnership reported 232 South Sefton patients entering treatment in Month 9, which is a 35.2% decrease from the previous month when 358 were reported. Confirmation from NHS England has outlined that Commissioners are advised that for 2017/18 the access standard of 4.2% per quarter (16.8% annually) should apply to quarter 4 only.

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 therefore set for Quarter 3 at 3.75% which equates to 1.25% per month. The access rate for Month 9 was 0.95% and therefore failed to meet the standard.

There were 283 Referrals in Month 9, which was a 33.9% decrease compared to the previous month when there were 428. Of these, 60.4% were Self-referrals which is a decrease from the previous month (63.6%). GP Referrals were lower than the previous month with 58 compared to 87 for Month 8. 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 42.1% in Month 9, which is a decrease from 46.8% for the previous month and failing to meet the target of 50%.

Cancelled appointments by the provider saw an increase in Month 9 with 81 compared to 59 in Month 8.

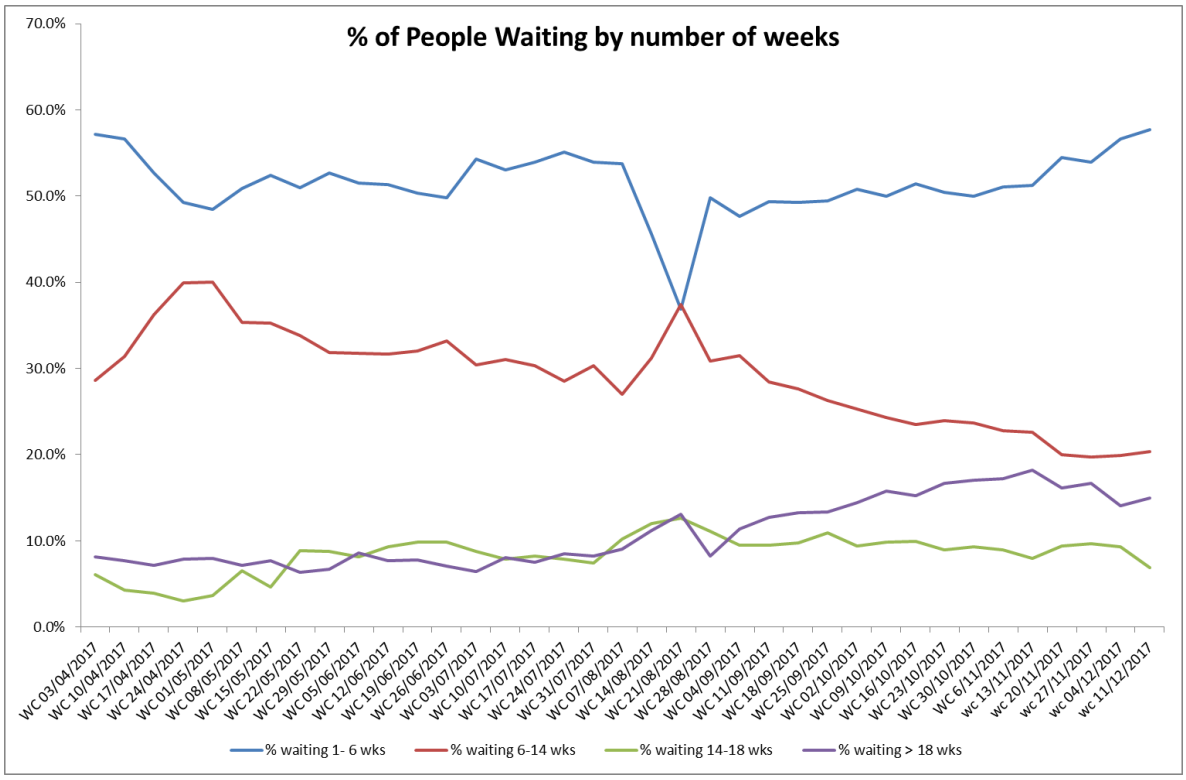
There was a decrease in DNAs in Month 9 (from 198 in Month 8 to 112 in Month 9); the provider has commented that the DNA policy has been tightened with all clients made aware at the outset. Cancelled slots are being made available for any assessments/entering therapy appointments.

In month 9, 99.3% 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 confirmed that in response to primary care queries they are working to develop a prioritisation tool.

From the point of referral, the provider is able to routinely offer an appointment to clients within five days. Subsequent appointment times are dependent on the agreed appropriate clinical intervention and the client's own personal preference and internal waits continue to be monitored weekly.

Figure 57 - NHS South Sefton CCG – Access Sefton % Internal waiters



The chart above illustrates internal waits activity for April 2017 onwards over the 37-week reporting period. The proportion of people waiting 6 to 14 weeks for a second appointment has seen a slightly downward trend over the given time period with the exception of a peak in the week commencing 21/08/2017.

Some excessive waits remain, however the service reports that some patients request very specific days and appointment times for appointments.

5.3 Dementia

Figure 58 - Dementia casefinding

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
People Diagnosed with Dementia (Age 65+)	1219	1213	1224	1237	1247	1245	1259	1250	1216
Estimated Prevalence (Age 65+)	1845	1851.4	1855.3	1862	1860.5	1864.6	1864.6	1862.3	1870.5
NHS South Sefton CCG - Dementia Diagnosis Rate (Age 65+)	**66.07%**	**65.52%**	**65.97%**	**66.43%**	**67.02%**	**66.77%**	**67.52%**	**67.12%**	**65.01%**
Target	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%

The latest data on the HSCIC website shows that South Sefton CCG are recording a dementia diagnosis rate in December of 65.01% which is now under the national dementia diagnosis ambition of 66.7%.

The drop in diagnosis rates may be caused by seasonal variation; fewer older people being asked to attend GP practices due to other seasonal pressures. It is also worth noting that the numbers of people over 65 diagnosed with dementia dropped from 1250 in Nov to 1216 in Dec which is a significant drop. At the same time the estimated prevalence increased significantly for the December. Nationally the trend for diagnosis rates fell significantly during December. Nevertheless, we will continue to work with practices to improve uptake of diagnosis opportunities and continue to work with Primary Care Mental Health Facilitators (MCT) to minimise errors on practice registry / IT systems, which should help to recover the diagnosis rates for South Sefton.

5.4 Improve Access to Children & Young People's Mental Health Services (CYPMH)

Figure 59 - NHS South Sefton CCG – Improve Access Rate to CYPMH 17/18 (30% Target)

E.H.9	Q1 17/18		2017/18 Total	
	Plan	Actual	Plan	Actual
1a - The number of new children and young people aged 0-18 receiving treatment from NHS funded community services in the reporting period.	25	35	100	35
2a - Total number of individual children and young people aged 0-18 receiving treatment by NHS funded community services in the reporting period.	160	75	940	75
2b - Total number of individual children and young people aged 0-18 with a diagnosable mental health condition.	3,121	3,121	3,121	3,121
Percentage of children and young people aged 0-18 with a diagnosable mental health condition who are receiving treatment from NHS funded community services.	**5.1%**	**2.4%**	**30.1%**	**2.4%**

The data is published nationally by NHS Digital. Recent communications with the NHS Digital team have revealed that the data tables relating to this indicator have been removed from the publication. Discussions on the methods used to calculate these measures are ongoing between NHS England and NHS Digital. The CCG have been informed these tables have not been produced until those discussions have been completed therefore there is no Q2 update.

The CCG target is to achieve 30% by the end of the financial year. Quarter 1 performance showed 2.4% of children and young people receiving treatment (75* out of an estimated 3,121 with a diagnosable mental health condition), against a target of 5.1%. 85* more patients needed to have received treatment to achieve the quarter 1 target.

**For this data all values of less than 5 are suppressed by NHS Digital and replaced with a *, and all other values are rounded to the nearest 5.*

5.5 Waiting Times for Urgent and Routine Referrals to Children and Young People Eating Disorder Services

Figure 60 - South Sefton CCG – Waiting Times for Routine Referrals to CYP Eating Disorder Services (Within 4 Weeks) – 2017/18 Plans (95% Target)

	Q1 Plan	Q1 Actual	Q2 Plan	Q2 Actual	Q3 Plan	Q3 Actual	Q4 Plan	Q4 Actual
Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral	2	1	2	6	2	4	2	
Number of CYP with a suspected ED (routine cases) that start treatment	2	3	2	6	2	4	2	
%	100.00%	33.33%	100.00%	100.00%	100.00%	100.00%	100.00%	

Figure 61 - South Sefton CCG – Waiting Times for Urgent Referrals to CYP Eating Disorder Services (Within 1 Week) – 2017/18 Plans (95% Target)

	Q1 Plan	Q1 Actual	Q2 Plan	Q2 Actual	Q3 Plan	Q3 Actual	Q4 Plan	Q4 Actual
Number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within 1 week of referral	2	0	2	0	2	1	2	
Number of CYP with a suspected ED (urgent cases) that start treatment	2	0	2	0	2	1	2	
%	100.00%	N/A	100.00%	N/A	100.00%	100.00%	100.00%	

For Q3 South Sefton had 1 patient waiting for urgent (less than 1 week waiting), and had 4 patient waiting for a routine appointments. Of those 4 patients, 1 was seen between 0-1 weeks, 1 was seen at 1-2 weeks and 2 were seen at 2-3 weeks so performance against the 4 week target is 100% (against national standard of 95%).

The performance in this category is calculated against completed pathways only.

6. Community Health

6.1 Mersey Care Community Contract

The information leads from the CCG and the new community provider, Mersey Care, continue to meet on a monthly basis to discuss the current contract performance. Along with the performance review of each service, discussions regarding the targets set out in the service specifications such as waiting time targets are also being had.

Further work to understand the impact of ICRAS and the reporting mechanism for such schemes are on going. The Trust is currently undertaking a gap analysis of each measure stipulated in the contract, detailing what is currently available and what needs further work.

6.1.1 Quality

The CCG Quality Team and Mersey Care Community, frequently discuss the Quality Schedule KPIs, Compliance Measures and CQUIN development, this is to ensure that any issues are dealt with in a timely manner. The work programme continues to be reviewed, and is updated with specific areas requiring assurance, as well as focussing on areas highlighted in the QRP (Quality Risk Profile), Aintree CQC Inspection Action Plan (Community Services) and the enhanced surveillance from the transition handover document.

There is a review of all KPIs included in the Service Specifications, being undertaken by Mersey Care Community. This work will include LCH and Mersey Care Community BI Teams. KPIs focusing on Quality, Patient Safety, Clinical Effectiveness and Patient Experience will be prioritised.

6.1.2 Patient DNA's

A number of services have seen a high number of DNA's and Provider cancellations so far in 2017/18.

For patient DNAs, Sefton Physio Service reports a deterioration in cancelation rates with 14.3% in December compared to 8.2% reported last month. Adult Dietetics also continues to report high rates at 14.5% in December, a deterioration from 10.8% in November.

These high DNA rates have been discussed in the monthly contract meetings and the Trust is reviewing the appointments that are currently available to patients to ensure they are convenient, for example a potential need for out of hours or weekend appointments to accommodate those who work full time.

6.1.3 Waiting Times

Waiting times are reported a month in arrears. In November 2017, the following services reported above the 18 week waiting times target for the completed pathways (95th percentile).

Physiotherapy: In November, this service reported average waits of 26 weeks (red), a decline on last month when it was just over target at 21 weeks. Waiting times have gradually increased over the current financial year from 14 weeks in April. The average waiting times on the incomplete pathway are currently amber at 20 weeks, and have also been increasing over the year from 12 weeks in May.

Podiatry: In November, this service reported average waits of 20 weeks (amber), slightly less than last month when performance was at 22 weeks.

Nutrition & Dietetics: In November, the service reported average waits of 23 weeks which was higher than October when the waits were at 19 weeks and taking the performance into the red.

6.2 Any Qualified Provider Mersey Care Podiatry Contract

The AQP Podiatry contract for South Sefton CCG patients transferred over to Mersey Care on 1st June. Therefore the following information reports a year to date position from month 3 onwards.

At Month 9 2017/18 YTD the costs for the CCG for initial contacts was £21,907 with 324 contacts and for follow-ups costs were £150,041 with 4374 contacts.

6.2.1 Liverpool Community Health Quality Overview

Paediatric Therapy Services - From 1st May 2017, therapy services were transitioned across to Alder Hey; the CCG will continue close monitoring of performance and patient safety particularly in relation to waiting times.

6.3 Alder Hey Community Services

6.3.1 Services

The following services have been taken over by the Trust for South Sefton CCG patients;

- Paediatric Continence
- Paediatric Dietetics
- Paediatric OT
- Paediatric SALT

Liverpool Community Health is currently providing activity reports to the CCG for these services as per the 2016/17 information schedule.

6.3.2 Waiting Times

Paediatric SALT: The issue of long waiters with SALT has been raised with the Trust at recent CQPG and Contract meetings, it is understood that data cleansing exercise is being undertaken.

6.4 Percentage of Children Waiting More than 18 Weeks for a Wheelchair

Figure 62 - South Sefton CCG – Percentage of children waiting more than 18 weeks for a wheelchair - 2017/18 (92% Target)

	Q1 Plan	Q1 Actual	Q2 Plan	Q2 Actual	Q3 Plan	Q3 Actual	Q4 Plan	Q4 Actual
Number of Children whose episode of care was closed within the reporting period where equipment was delivered in 18 weeks or less being referred to the service	19	Nil return	19	Nil return	19	Nil return	19	
Total number of children whose episode of care was closed within the quarter where equipment was delivered or a modification was made	20	Nil return	20	Nil return	20	Nil return	20	
%	95.00%	0.00%	95.00%	0.00%	95.00%	0.00%	95.00%	

NHS England guidance states that CCGs should set out improvement plans to halve the number of children waiting 18 weeks by Q4 2017/18 and eliminate 18 week waits for wheelchairs by the end

of 2018/19. All children requiring a wheelchair will receive one within 18 weeks from referral in 92% of cases by Q4 2017/18 and in 100% of cases by Q4 2018/19.

South Sefton CCG commissioning arrangements have recently been clarified with NHS England commissioning this service and not South Sefton CCG, so a nil return for the CCG was recorded.

7. Third Sector Overview

Funding for 2018-19 has now been confirmed by the CCGs senior leadership team. Letters confirming commissioning intentions and funding arrangements have now been sent to providers. Reports detailing activity and outcomes during Q2 have now been finalised, a copy of this report has now been circulated amongst commissioners. Referrals to most services have increased during Q2 compared to the same period last year; the complexity of service user issues is also increasing, cases are now taking longer to resolve. Q3 reports are currently underway

Information reporting flows are now being received for Netherton Feelgood Factory, CHART & Parenting 2000. Work is ongoing with hospices to establish information schedules and reporting shortly.

A number of services providing support for service users applying for benefits have also informed Sefton CCGs in regard to the number of people presenting with anxiety and stress as a result of the new Universal Credit application process. The application is difficult and appears to be having a profound effect on a high volume of service users, in particular those suffering mental health. A number of agencies have informed that the majority of payments appear to be delayed and residents of Sefton are suffering severe hardship as a result.

Work is in progress to engage further with Third Sector providers and GP Practices in particular services for the elderly, Women's & Children's Aid (Domestic Violence), Stroke Association and dementia services.

Alzheimer's Society are currently piloting a project and have engaged with 9 GP practices across Sefton delivering 2 hourly dementia surgeries for patients and their carers. This model appears to have been very well received amongst GPs and practice staff, further plans have been put in place to role this out further across the borough.

A piece of work has been completed to capture the numbers of referrals during 2016-17 by electoral Ward for each of our providers. This is to be used going forward to identify hot-spots within the Sefton footprint.

8. Primary Care

8.1 Extended Access (evening and weekends) at GP services

Figure 63 - South Sefton CCG - Extended Access at GP services 2017/18 Plans

		E.D.14	Months 1-6	Months 7-12
Extended access (evening and weekends) at GP services	2017/18 Plan	Number of practices within a CCG which meet the definition of offering full extended access; that is where patients have the option of accessing pre-bookable appointments outside of standard working hours either through their practice or through their group. The criteria of 'Full extended access' are: • Provision of pre-bookable appointments on Saturdays through the group or practice AND • Provision of pre-bookable appointments on Sundays through the group or practice AND • Provision of pre-bookable appointments on weekday mornings or evenings through the group or practice	-	-
		Total number of practices within the CCG.	30	30
		%	**0.00%**	**0.00%**
	2018/19 Plan	Number of practices within a CCG which meet the definition of offering full extended access; that is where patients have the option of accessing pre-bookable appointments outside of standard working hours either through their practice or through their group. The criteria of 'Full extended access' are: • Provision of pre-bookable appointments on Saturdays through the group or practice AND • Provision of pre-bookable appointments on Sundays through the group or practice AND • Provision of pre-bookable appointments on weekday mornings or evenings through the group or practice	-	-
		Total number of practices within the CCG.	30	30
		%	**0.00%**	**0.00%**

This indicator is based on the percentage of practices within a CCG which meet the definition of offering extended access; that is where patients have the option of accessing routine (bookable) appointments outside of standard working hours Monday to Friday. The numerator in future will be calculated from the extended access to general practice survey, a new data collection from GP practices in the form of a bi-annual survey conducted through the Primary Care Web Tool (PCWT). Currently in South Sefton 15 out of 30 practices and in Southport and Formby 18 out of 19 practices are offering some extended hours, however the planning requirements include Saturday and Sunday and appointments outside core hours. No practices in either CCG are offering all three elements and there are no plans to do so at this stage.

The CCG are using 2017/18 to understand access and current workforce / skill mix including practice vacancies in order to produce a comprehensive workforce plan to develop a sustainable general practice model which is attractive to work in. Current initiatives through GPFV are being explored. A Primary Care Workforce plan will be developed in conjunction with other organisations including Mersey Deanery and Health Education England.

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. There have been no new inspections in South Sefton recently. All the results are listed below:

NHS South Sefton Clinical Commissioning Group

Figure 64 - 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 7 March 2017**					
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	24 July 2017	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
	129 Sefton Road (Branch Surgery)	08 August 2017	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
N84001	42 Kingsway	07 November 2016	Good	Good	Good	Good	Good	Good
N84007	Liverpool Rd Medical Practice	06 April 2017	Good	Good	Good	Good	Good	Good
N84011	Eastview Surgery	11 October 2017	Good	Good	Good	Good	Good	Good
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 Practice	19 February 2015	Good	Requires Improvement	Good	Good	Good	Good
N84627	Crossways Practice	06 August 2015	Good	Good	Good	Good	Good	Good
N84626	Hightown Village Surgery	18 February 2016	Good	Requires Improvement	Good	Good	Good	Good
N84003	High Pastures Surgery	09 June 2017	Good	Good	Good	Good	Good	Good
N84010	Maghull Family Surgery (Dr Sapre)	21 August 2017	Good	Requires Improvement	Good	Good	Good	Good
N84025	Westway Medical Center	23 September 2016	Good	Good	Good	Good	Good	Good
N84624	Maghull Health Center	05 February 2015	Good	Good	Good	Good	Good	Good
Y00446	Maghull Practice	19 March 2015	Requires Improvement	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
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
N84027	Orrell Park Medical Center	20 August 2015	Good	Good	Good	Good	Good	Good
N84029	Ford Medical Practice	31 March 2015	Good	Good	Good	Good	Good	Good
N84035	15 Sefton Road	22 March 2017	Good	Good	Good	Good	Good	Good
N84043	Seaforth Village Practice	29 October 2015	Good	Good	Good	Good	Good	Good
N84605	Litherland Town Hall Hth Ctr	26 November 2015	Good	Good	Good	Good	Good	Good
N84615	Rawson Road Medical Center	10 September 2015	Good	Good	Good	Good	Good	Good
N84630	Netherton Practice	24 September 2015	Good	Requires Improvement	Good	Good	Good	Good

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

9. Better Care Fund

Sefton Health and Wellbeing Board submitted a BCF plan in September 2017, and earlier in July, local areas were required to confirm draft Delayed Transfers of Care (DTOC) trajectories and Local Authorities completed a first quarterly monitoring return on the use of the improved BCF (iBCF) funding. The DTOC trajectory submitted is in line with the NHS England expectations that both South Sefton and Southport & Formby CCGs will maintain their current rates of delays per day, and this trajectory is adequately phased across the months from July 2017 – March 2018.

A quarter 3 performance monitoring return was submitted on behalf of the Sefton Health and Wellbeing Boards in January 2018. This reported that all national BCF conditions were met; progress against national metric targets for non-elective hospital admissions, admissions to residential care, reablement and Delayed Transfers of Care; assessment against the High Impact Change Model; and narrative of progress to date.

BCF planning guidance is awaited for 2018/19.

A summary of the Q3 BCF performance is as follows:

Figure 65 – BCF Metric performance

Metric	Definition	Assessment of progress against the planned target for the quarter
NEA	Reduction in non-elective admissions	Not on track to meet target
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	On track to meet target
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	Not on track to meet target

Figure 66 – BCF High Impact Change Model assessment

		Maturity assessment			
		Q2 17/18	Q3 17/18 (Current)	Q4 17/18 (Planned)	Q1 18/19 (Planned)
Chg 1	**Early discharge planning**	Plans in place	Plans in place	Plans in place	Established
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	Established
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established	Established	Established	Mature
Chg 4	**Home first/discharge to assess**	Mature	Mature	Mature	Mature
Chg 5	**Seven-day service**	Plans in place	Plans in place	Plans in place	Plans in place
Chg 6	**Trusted assessors**	Established	Established	Established	Mature
Chg 7	**Focus on choice**	Plans in place	Plans in place	Plans in place	Plans in place
Chg 8	**Enhancing health in care homes**	Plans in place	Plans in place	Plans in place	Plans in place

NHS
South Sefton
Clinical Commissioning Group

10. CCG Improvement & Assessment Framework (IAF)

10.1 Background

The CCG Improvement and Assessment Framework (IAF) draws together in one place 51 indicators including 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. The assessment also includes detailed assessments of six clinical priority areas of cancer, mental health, dementia, maternity, diabetes and learning disabilities (updated results for these will not be reported until later in the year). The framework is then used alongside other information to determine CCG ratings for the entire financial year.

A full exception report for each of the indicators citing performance in the worst quartile of CCG performance nationally or a trend of three deteriorating time periods is presented to Governing Body as a standalone report. This outlines reasons for underperformance, actions being taken to address the underperformance, more recent data where held locally, the clinical, managerial and SLT leads responsible, and expected date of improvement for the indicators.

11. NHS England Monthly Activity Monitoring

CCGs were required to submit two year (2017-19) activity plans to NHS England in December 2016. NHSE monitor actual activity against these planned activity levels, however NHSE use a different data source than CCGs to monitor the actual activity against plan. The variance between the plan and the NHS England generated actuals have highlighted significant variances for our CCGs. CCGs are required to submit the table below on a monthly basis providing exception commentary for any variances +/- 3%. The main variances are due to the data source used by NHSE; this assigns national activity data to CCGs by a different method. The end column of the table below describes the CCG calculated variances from plan and any actions being taken to address over/under performance which is of concern. A national issue has been identified regarding the application of Identification Rules to identify activity relating to Specialised Commissioning. This has had the (unquantifiable at this stage) effect of overinflating the % variance for each CCG.

NHS
South Sefton
Clinical Commissioning Group

Figure 67 - South Sefton CCG's Month 9 Submission to NHS England

December 2017 Month 09	*Month 09 Plan*	*Month 09 Actual*	*Month 09 Variance*	ACTIONS being Taken to Address Cumulative Variances GREATER than +/-3%
Referrals (MAR)				
GP	3422	2711	-20.8%	December has seen a large drop in GP and consultant referrals against previous months. This reduction is mainly focused in the CCGs main provider but nearly all providers are showing a drop. Work is on going with the CCGs planned care and Primary care leads to identify reasons for the drop. One factor being explored is the impact winter pressures has had on primary care and if this has dramatically affected referral levels in December.
Other	1903	2046	7.5%	
Total (in month)	5325	4757	-10.7%	
Variance against Plan YTD	50019	51829	3.6%	
Year on Year YTD Growth			4.6%	
Outpatient attendances (Specfic Acute) SUS (TNR)				
All 1st OP	4664	4115	-11.8%	December activity figures are following the trend in referrals and reduced in month. Winter pressures has had an effect system wide on planned care activity and is expected to continue into January. YTD the CCG is within planned levels and not exceeding the 3% threshold for either first or follow-up attendances.
Follow Up	10239	9219	-10.0%	
Total Outpatient attendances (in month)	14903	13334	-10.5%	
Variance against Plan YTD	143121	142361	-0.5%	
Year on Year YTD Growth			2.3%	
Admitted Patient Care (Specfic Acute) SUS (TNR)				
Elective Day case spells				
Elective Ordinary spells				
Total Elective spells (in month)	-	1735	-	Local monitoring suggests Elective and Day Case activity is below planned levels. In month the plan v actual variance is just outside the 3% threshold when examining the activity figures provided by NHSE. Winter pressures has had an effect system wide on planned care activity.
Variance against Plan YTD	-	-	-	
Year on Year YTD Growth			-5.8%	
Urgent & Emergency Care				
Type 1	-	4297	-	
Year on Year YTD			3.3%	Local monitoring of activity shows a slight increase in type 1 activity against previous years at 3.5% but overall A&E activity within the 3% threshold both in month and YTD. A&E plans detail and increase in the latter part of the year to accommodate any increases during the winter period. See below for Urgent Care leads plan to liaise with the local provider.
All types (in month)	9151	8503	-7.1%	
Variance against Plan YTD	81875	77511	-5.3%	
Year on Year YTD Growth			1.4%	
Total Non Elective spells (in month)	-	1982	-	Increased emergency admissions noted over the past three months compared with the previous activity levels. Pathway changes at the CCGs main provider Aintree has resulted in higher A&E to admission conversion rates. Increased number of short stay beds during winter period. CCG Urgent Care lead to liaise with Trust regarding pathway flow.
Variance against Plan YTD	-	-	-	
Year on Year YTD Growth			12.5%	

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MARCH 2018

Agenda Item: 18/48	**Author of the Paper:** **Name** Billie Dodd **Position** Deputy Director of Commissioning and Redesign **Email:** billie.dodd@southportandformbyccg .nhs.uk Tel: 01704 387034
Report date: February 2018	

Title: Mersey CCGs ambulance briefing paper

Summary/Key Issues:

NWAS implemented the national Ambulance Response Programme or ARP in August 2017, which marked a fundamental change in the way in which 999 calls are managed and responded to. At the time CCGs were advised that there would be at least a three month period before performance information under ARP became available, unfortunately it has taken longer than anticipated to make data available at a north west , county and CCG level. Since 'go live' LCCG have kept CCG officers up to date with progress and developments through the monthly commissioners meetings which Ian Davies at LCCG chairs.

Led by the Blackpool CCG central ambulance commissioning team, county leads have been working intensely with NWAS to support the implementation of ARP and understand the impact upon performance and service delivery. Earlier this month they were able for the first time to obtain national comparative data and can now set this alongside north west performance. NWAS have found the implementation of ARP significantly more challenging than expected and performance it is not where either the service or commissioners expected it to be, indeed performance against the most urgent standards is particularly disappointing, although some recent improvement has been noted.

Now that data is becoming available Ian has drafted the attached briefing paper which seeks to brief CCGs on the implementation of ARP, progress and performance to date and the remedial action underway to seek to improve performance and delivery of the ARP targets. It is intended that this briefing paper will be followed up by a resumption in flow of the monthly ambulance performance information going forward and Ian will advise of the contents and progress of the recovery plan and improvement trajectories expected from NWAS.

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

NHS
South Sefton
Clinical Commissioning Group

Links to Corporate Objectives *(x those that apply)*	
	To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.
	To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the "Forward View", underpinned by transformation through the agreed strategic blueprints and programmes and as part of the North Mersey LDS.
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			SFCCG GB and Joint CCGs Quality Committee

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

Merseyside CCGs NWAS Ambulance Performance Update – January 2018

Introduction.

CCGs will recall that in August 2017 the NHSE directed that NWAS would be the next ambulance service in England to benefit from the roll out of the Ambulance Response Programme (ARP). NWAS went live across the north west with ARP on the 7th August 2017, which marked a fundamental change to the way in which 999 calls were responded to, vehicles dispatched and performance targets set.

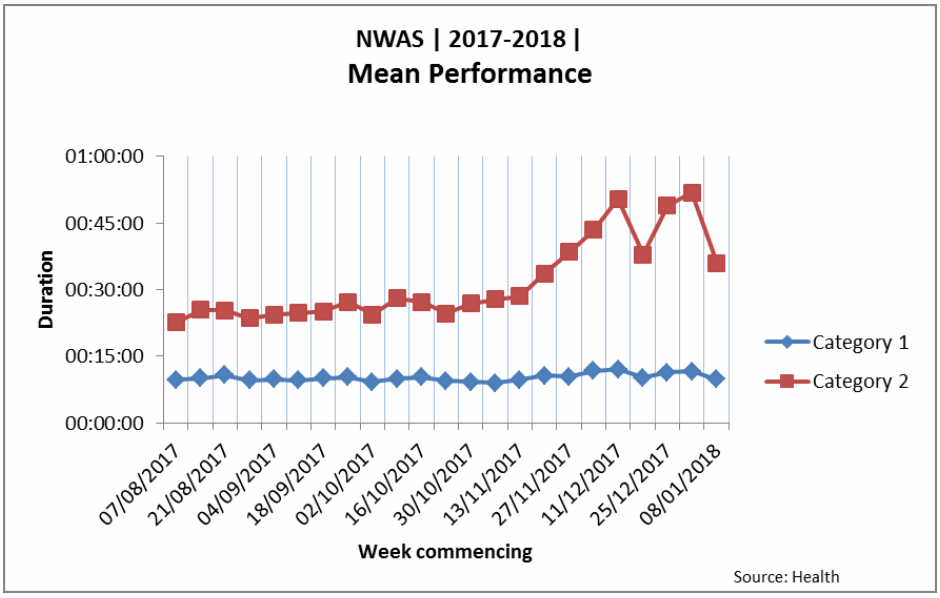
The operational changes to service delivery brought about by ARP are fundamental affecting call taking, dispatch, clinical call centre support and the operational resources deployed to incidents; necessitating wide ranging system change. ARP posed particular challenges on the Emergency Operation Centres, fleet resource and deployment, and in staffing mix and resource.

In light of the complexity of the changes required commissioners, in line with national guidance originally advised CCGs that ARP performance data under the new system would not be available for three months. Unfortunately the scale of changes required 'behind the scenes' to manage the transition from the former operational performance monitoring systems has been more significant than expected and it is only very recently that county and CCG level performance data has become available.

NWAS Performance.

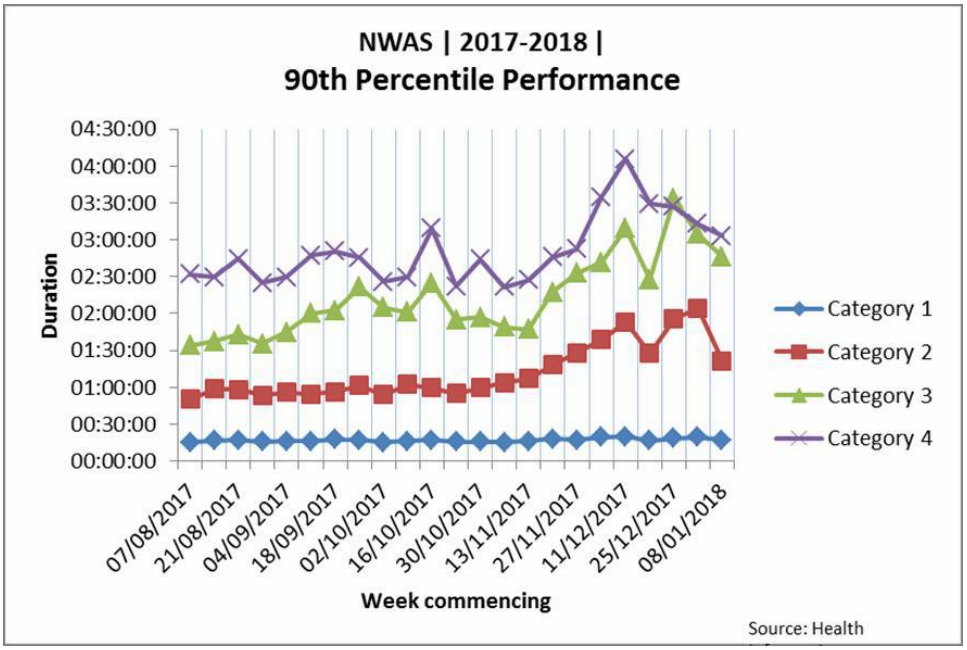
Performance under the new ARP regime has been significantly challenging for NWAS and overall their performance to date has been disappointing and below both their own and commissioners expectations.

The following graph illustrates the NWAS performance for life threatening Category 1 and emergency Category 2 calls to the week of the 8th January.



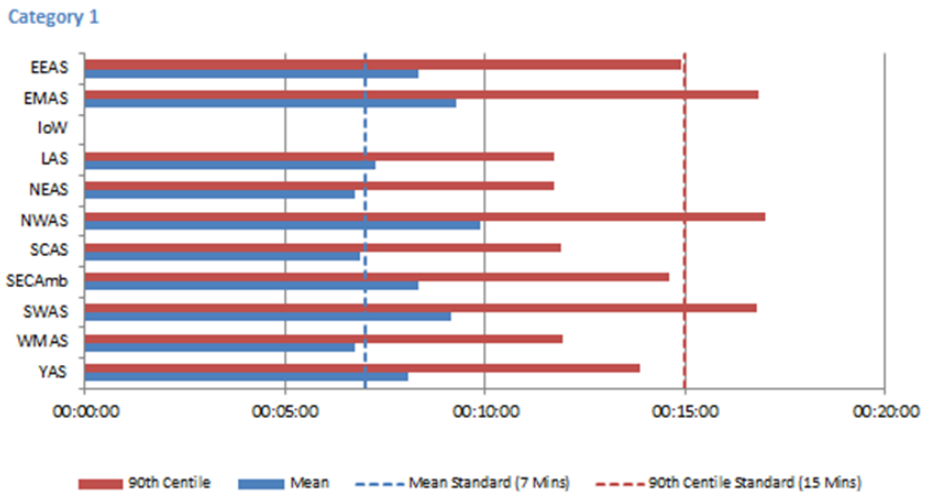
This performance is set against the target mean response for Category 1 incidents of 7 minutes and for Category 2 18 minutes. In both cases NWAS performance falls short of the required targets by some way, although most recently there have been some signs of improvement.

Turning to the requirement to attend 9 out of 10 calls against a variable set of Category specific standards, performance is more variable across the four targets, although performance against the two higher incident categories is of most concern.

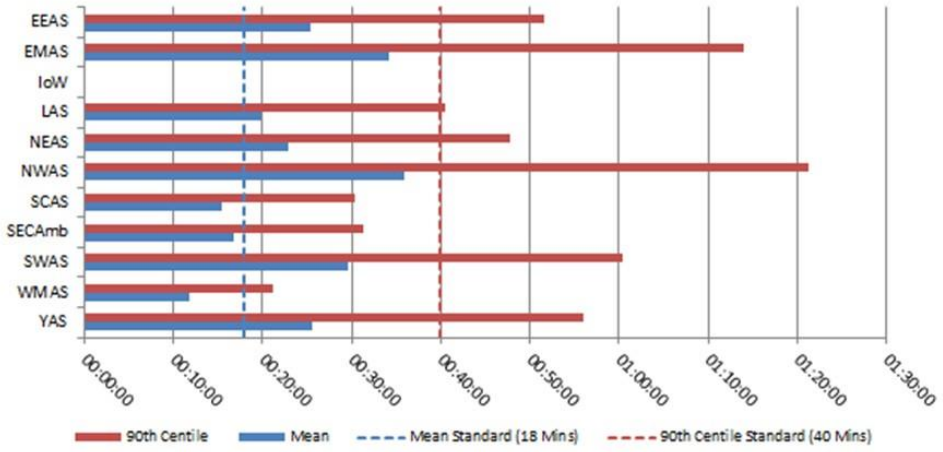


It should be noted that like many parts of the NHS NWAS experienced a significant rise in demand through December, with call volumes in NWAS + 12.1% above plan (Merseyside + 2.9%); although year to date their overall call volume is only around 1.4% above plan (Merseyside -3.1%) and overall incidents are actually below plan NWAS -1.2% (Merseyside -2.3%).

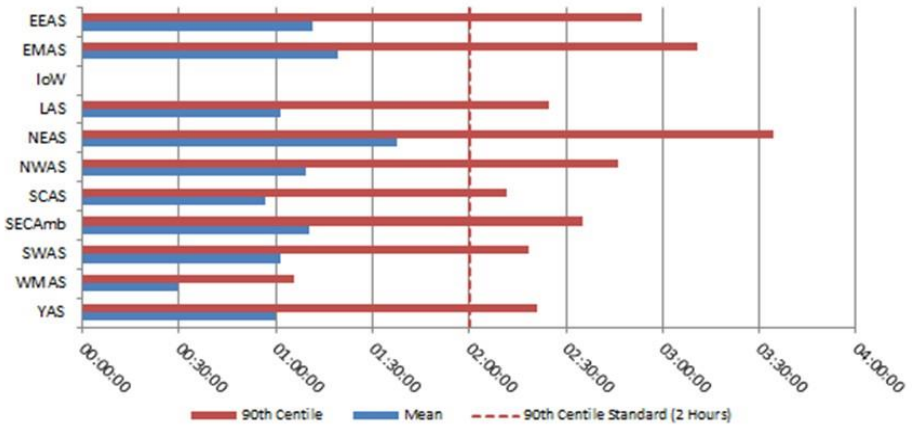
To set the performance of NWAS in context, recently released national comparative data shown in the following suite of graphs illustrates NWAS performance against that of the other ambulance services in England (other than the Isle of Wight):



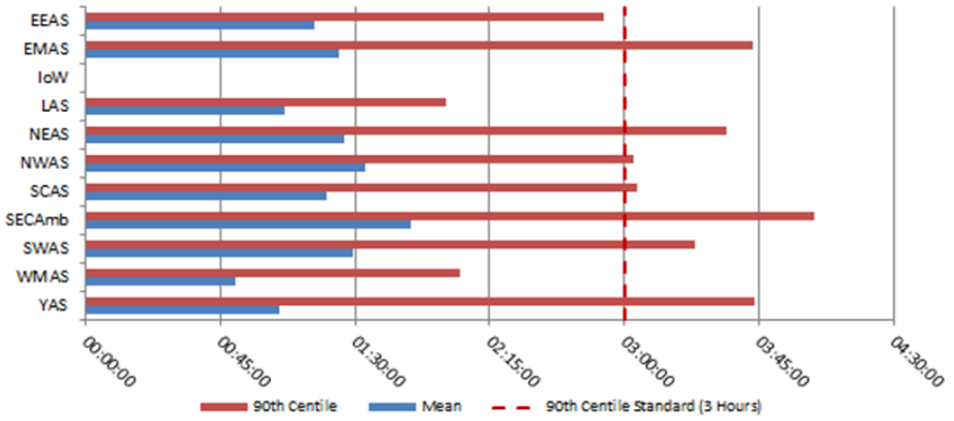
Category 2



Category 3



Category 4



These four category specific graphs illustrate the relative performance of NWAS and their distance from meeting the ARP targets, like many other services.

Draft local CCG performance from go live on the 7th August to the end of December 2017 is represented in the following table:

	Cat 1 Inc	Cat 1 Mean	Cat 1 90th %	Cat 2 Inc	Cat 2 Mean	Cat 2 90th %	Cat 3 Inc	Cat 3 90th %	Cat 4 Inc	Cat 4 90th %
Halton	614	00:09:58	00:16:55	4329	00:28:31	01:02:00	1990	01:53:31	847	02:55:36
Knowsley	845	00:10:18	00:14:59	5302	00:28:53	01:06:26	2456	02:07:04	1390	03:17:39
Liverpool	3335	00:09:16	00:15:01	18583	00:27:09	01:03:00	9989	02:00:16	4717	03:02:22
South Sefton	925	00:10:07	00:15:40	5370	00:31:36	01:15:32	2618	02:07:14	1266	02:52:54
Southport & Formby	574	00:12:06	00:24:02	3576	00:33:58	01:17:45	1986	02:05:01	1185	03:40:09
St Helens	935	00:09:41	00:15:57	5774	00:31:43	01:08:59	2750	02:13:25	1478	03:12:00
Merseyside	7228	00:09:50	00:17:06	42934	00:29:15	01:08:57	21789	02:04:25	10883	03:10:07
NWAS	39712	00:10:09	00:16:58	258420	00:30:53	01:09:59	132939	02:07:44	68471	02:50:06

Note:

RAG	Cat 1 Mean	Cat 1 90th %	Cat 2 Mean	Cat 2 90th %	Cat 3 90th %	Cat 4 90th %
Green (target)	< 7mins	< 15 mins	< 18 mins	< 40 mins	< 120 mins	< 180 mins
Amber	7-9 mins	15-20 mins	15-25 mins	n/a	n/a	n/a
Red	> 9 mins	> 20 mins	> 25 mins	> 40 mins	> 120 mins	> 180 mins

Performance Challenges.

As already outlined the performance of NWAS to date has fallen significantly below where it ought to be. The reasons for this poor performance are multifactural and include the following key areas:

- **Increase in activity:**

There has been overall an increase in the numbers of calls managed by the Emergency Operation Centres (EOCs), as already outlined with call volumes in NWAS + 12.1% above plan (Merseyside + 2.9%) in December, although overall incidents are actually below plan NWAS -1.2% (Merseyside -2.3%) cumulative to the end of December.

Any increase in activity above plan causes a service like NWAS difficulties, as whilst there is limited response flexibility through the likes of overtime and the use of third party providers e.g. St John / private providers, EOC capacity is more constrained. Increased activity also leads to increased hospital attendances and whilst NWAS have

conveyed fewer patients proportionately, the volume of patients conveyed has increased. However it has been found from audits of patients conveyed to AED, that the increase in volume is at the higher acuity spectrum of patients and these were clinically appropriate to be taken to AED. As more patients are conveyed to hospital, this leads to a higher risk of ambulances being delayed at AEDs and reduces the resource available to respond to incidents in the community.

- **Duplicate 999 calls:**

The time available before the allocation of resources under the ARP standards is deliberately longer than in the previous system in order to facilitate the selection of the correct resource, i.e. right response vehicle first time. To patients this change inevitably can result in a longer wait than they may have previously experienced. This is however a part of the design of ARP and in the interval between the call and the response resource arriving on scene the patients may call back several times increasing the call volume and therefore resources required to respond to a single patient. This is acknowledged as being experienced by other ambulance trusts. Another source of duplicate calls can be where healthcare professionals experience a delay to the likes of an urgent or emergency admission transport request and make further HCP or 999 calls.

- **Delayed call pickup**

The ambulance service standards are that 95% of calls are answered within 5 seconds of the call being passed from the BT operator. This is acknowledged as an exacting industry standard for call handling. Since September 2016 NWAS performance has been intermittent with various challenges to achieving this standard. These include: the technical infrastructure; the significant operational changes brought about by ARP to call handling protocols; staff turnover in the EOC's has increased unexpectedly; the time taken to recruit and train additional control room staff; and the increase already mentioned in call volume nationally and duplicate calls.

- **Hospital turnaround delays**

Protocols require that AEDs manage the handover of patients within 15 minutes of an ambulance arrival. Since November 2017 we have seen significant increases in these times, in a number of Trusts with ambulance crews regularly waiting more than an hour in some departments to handover their patients to hospital staff. To put this into perspective in December 2017 NWAS lost 10,026 hours of ambulance operational response time with this excessive waiting, significantly higher than the position of 8,588 hours lost in December 2016. Operationally this means less available frontline resources to respond to 999 calls and severely impacts on incident response times.

- **Acuity of calls**

NWAS originally forecast an acuity mix based on the previous red / green incidents with expected levels mapped onto the new ARP categories. However, the actual levels for C1 and C2 incidents, that require a vehicle response have increased above the planned levels and therefore increased pressure on vehicle resources and impacted upon response times.

ARP Responses

Standard	% of Activity Pre ARP	% of Activity Post ARP
Category 1	8%	11%
Category 2	56%	61.5%
Category 3	19%	20.6%
Category 4	17%	3.9%
C4H	N/A	1.2%
C4HCP	N/A	5.1%

Delivering the right care, at the right time, in the right place

Actions being taken to improve performance.

NWAS already had an implementation plan in place to manage the introduction of ARP and in light of the impact seen upon performance

post ‘go live’ it was clear that the scale, pace and delivery of this plan needed to be significantly enhanced. The release of national comparative data has further emphasised the need for rapid improvement in the service and the north west commissioning CCGs along with NHSE / NHSI have now required the Trust to draw up a comprehensive recovery plan and performance improvement trajectory. This plan is expected to be initially shared with commissioners and the regulators mid February.

Notwithstanding the requirement for an enhanced recovery plan and trajectory, NWAS have been implementing a series of actions to improve performance which include the following actions:

- **Call Taking:**

Changes have been made to the contents and sequencing of the initial questions the public will experience at the beginning of their call, with the aim of identifying and responding more quickly to the higher Category 1 & 2 calls. Alongside this additional staff have been recruited into the EOCs, to compensate for the increased call times and call volumes, with further changes being made to shift patterns and rotas. Measures have also been taken to understand and respond to the increased staff turnover. External consultancy has also been commissioned to examine call processes, efficiency and model future demand.

- **Dispatch:**

NWAS have begun a process to reconfigure internal processes to better understand demand (calls waiting for a vehicle to be dispatched) and supply (available staff and vehicles) to assist dispatchers in allocating the most appropriate resources to incident categories promptly and efficiently. A significant retraining of control staff is underway, supported by enhanced clinical supervision, shared learning from other ambulance services and the introduction of what is referred to as auto dispatch, all of which are designed to achieve the ARP aims of getting the most clinically appropriate resources to patients in a timely manner.

- **Operational response resources:**

The existing NWAS emergency and paramedic fleet is a mix of 25% rapid response vehicles (RRV cars) and 75% frontline emergency ambulances. Historically responding RRVs would ‘stop the clock’ in terms of the previous 8 minute responding standards, but could not convey the patient, leading to in effect unrecorded patient delays as a conveying vehicle was sought, something that ARP is designed to eliminate.

ARP now requires the service to send the most appropriate resource to an individual based upon their clinical needs and this is often not an RRV but a conveying ambulance. The reconfiguration of the fleet is a significant undertaking which requires planning and resourcing, although NWAS have taken steps in the meantime to optimise use of existing ambulances and are staffing them with two crew members.

The current initial planning assumptions show that the fleet mix ratio will need to change to a mix of approximately 15% RRVs and 85% ambulances over the next 2 years. NWAS are working toward this; however the practical availability of ambulance vehicles is slowing this process down. In the new financial year the fleet is to be expanded with 54 replacement ambulances and it is now planned to retain some of the outgoing fleet to boost the availability of ambulances. These ‘additional’ vehicles will be staffed from the planned reduction in the RRV fleet.

- **Future demand and capacity planning.**

NWAS and the commissioning north west CCGs jointly commissioned in the second half of last year a significant piece of external consultancy work to model the future shape of the emergency and paramedic ambulance service in light of the introduction of ARP and likely future demand. This work is examining all aspects of the services operations from initial call handling, through dispatch and response. Early results from the review and accompanying modelling work are already influencing processes, capacity and capability across the service and will play an important role in helping shape the future configuration and

organisation of the service, including call handling, staffing and vehicle mix .

Quality and Safety.

The current poor performance under ARP is a matter of significant concern to the commissioning CCGs and regulators, brought into sharp focus as comparative national data has latterly become available and as a number of serious incidents have come to light and are being investigated.

As part of implementation, NWAS with clinical commissioners are undertaking a full review of all aspects of quality and safety, including serious incidents and complaints, in order to understand any impact to individual patients and to embed the learning within the organisation. This will form part of the agreed recovery plan going forwards.

Conclusion.

It is disappointing to see that the benefits offered by ARP i.e. getting the right resources to patients in a timely and efficient manner first time have not yet been sustainably delivered or met across the north west. Commissioning CCGs, alongside the central Blackpool ambulance commissioning team will continue to work closely with and hold NWAS colleagues to account for the sustainable implementation of the Ambulance Response Programme. Regular north west, county and CCG level data will now be provided to CCGs on a monthly basis, supported by the monthly meeting of Merseyside CCG leads. Updates on the progress of the NWAS recovery plan and accompanying improvement trajectory will also be shared with commissioning CCGs in due course.

Ian Davies

Chief Operating Officer

Liverpool CCG

Merseyside Lead Commissioner for NWAS.

28th January 2018.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MARCH 2018

Agenda Item: 18/49	**Author of the Paper:** Lyn Cooke Head of Communications and engagement Lyn.cooke@southseftonccg.nhs.uk Tel: 0151 247 7051
Report date: February 2018	
Title: Revised communications and engagement strategy	

Summary/Key Issues:

This is the third refresh of Communicating health in south Sefton - the CCG's integrated communications and engagement strategy. It has been updated to reflect changes including revised national guidance.

Recommendation

The Governing Body is asked to approve this report.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
	To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.
	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 & 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.

South Sefton
Clinical Commissioning Group

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	X			Updates informed by survey results from staff, members practices and public
Clinical Engagement				
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement				
Presented to other Committees	X			Views sought from Engagement and Patient Experience Group members to inform refresh

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

NHS
South Sefton
Clinical Commissioning Group

Communicating health
in south Sefton…

A communications and engagement strategy for NHS South Sefton Clinical Commissioning Group (2018 - 2020)

Staying **local**
& together

Contents

On request this strategy can be provided in different formats including Braille, large print and different languages.

Forward

This is the third updated version of '*Communicating health in south Sefton*'. It sets out our approach to communicating, engaging and consulting – or 'involving' everyone we work with and for.

The strategy reflects our duties to involve our residents and partners in our work, as the body responsible for planning and buying, or 'commissioning' the majority of local health services.

A great deal has changed since we first developed *'Communicating health in south Sefton'* in 2012 prior to us becoming a statutory body. The NHS is now in the midst of one of the most testing periods in its history – facing unprecedented financial challenges and increasing demand for care, framed against a backdrop of ever tightening resources.

As a result, there have been a number of important developments in the NHS landscape that we must adapt and respond to. Most notably is NHS England's Five Year Forward View (5YFV)[1] that outlines a vision for more 'integrated' or joined up health and social care systems. Whilst our local Shaping Sefton programme continues to play an important role in achieving transformation described in the 5YFV, we will increasingly need to work with patients, public and partners beyond borough boundaries - across Cheshire and Merseyside – where system wide changes are proposed affecting our patients.

Additionally, our work is guided by the recommendations of important reviews into patient safety[2]. These have brought into sharp focus the importance of robust and rigorous monitoring and managing of the performance and quality of our services and the experience of patients and their families accessing these services.

Communicating health south Sefton 2018-2020 describes some of the systems we are putting in place to monitor patient experience, which is important in helping us to spot early any issues that may arise in the services we commission. It also underlines our continued commitment to involving our residents and partners in the decisions we make about their local NHS.

Graham Bayliss
Lay representative for patient and public involvement
NHS South Sefton CCG

[1] https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-exec-sum/
[2] Independent Kirkup review into LCH https://improvement.nhs.uk/news-alerts/independent-review-liverpool-community-health-nhs-trust-published/
Morecambe Bay Investigation Report, 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf
Patients First and Foremost: https://www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report and Transforming Care: A national response to Winterbourne View Hospital
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

Introduction

Why we communicate and engage

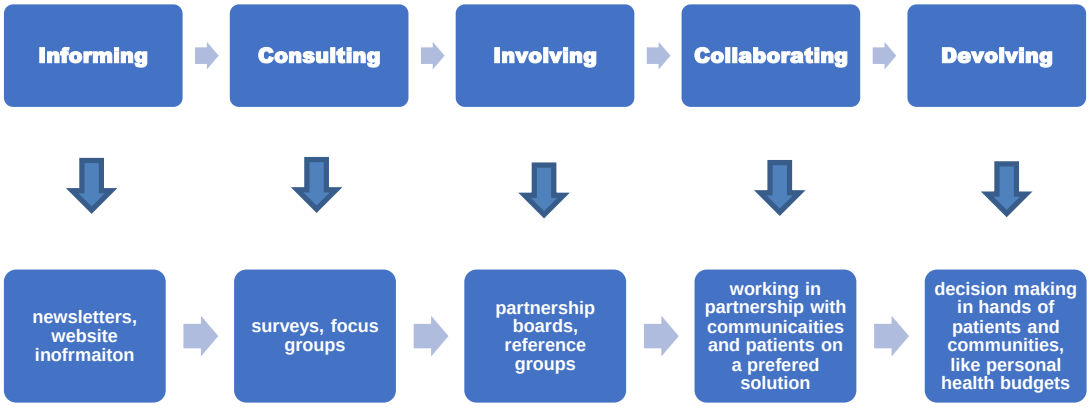
Communications and engagement is central to delivering our vision, values and aims. An effective, well devised strategy will support the delivery of and contribute to the success of our strategic plans and priorities.

We also recognise that our communications and engagement activities are intrinsically linked, and therefore need to be fully integrated with each other to ensure they are as effective as possible in helping us to achieve our objectives.

We need to communicate and engage effectively with people so we can:

- Talk directly with people about their health, treatments and care
- Share information about our services and performance
- Work with our partners to transform health services and promote healthy living to better meet the health and care needs of our residents
- Ask people for their views and attitudes about current services and involve them in shaping them for the future
- Celebrate success
- Manage difficult situations

Below is an adaptation of the 'ladder of engagement and participation'[3]. This model is a helpful way of illustrating the continuum of involvement and the interdependencies between communications and engagement activities.



[3] https://www.england.nhs.uk/participation/resources/ladder-of-engagement-2/

What we need to consider

For communications and engagement to be effective, they need to be relevant, appropriate, timely and well informed by local knowledge and evidence. So, it is important that any planned activity considers the following questions:

1. Who are we communicating and engaging with?
2. What do we want our communications and engagement to achieve?
3. What will successful communications and engagement deliver?

What effective involvement can do for us

If we get our communications and engagement right and in line with our legal duties, we know they will help us to:

- Produce better health and care outcomes for local people
- Increase people's satisfaction and experience of services
- Gain a better understanding of the needs and priorities of our communities
- Help us to make better commissioning decisions and meet our legal duties
- Help us to design services that better reflect the needs of local people
- Provide services that are efficient, effective and more accessible
- Give better understanding of why and how local services need to change or be improved
- Give greater choice for patients
- Reduce health inequalities
- Give greater local ownership of health services
- Increase trust and confidence in the NHS
- Manage risks that may impact on our reputation

Our duty to involve

Engaging our public and statutory partners in an open and honest manner and consulting them at the right time, in a meaningful way is important to us. Our approach reflects the many legal and policy duties that demand us to effectively involve people. You will find a list of these duties in appendix 1. Here are some examples of how our duties shape our day to day work with patients, carers and other communities.

Individual involvement

Friends and Family Test – we monitor the results of this national patient experience survey to ensure the services we commission meet expected quality standards

Information for patients – we look at ways to offer targeted support so that patients can be more in control of their health

Personalised care planning – we will support those eligible to have the option of a personal health budget

Shared decision making – we will empower patients to have greater involvement in decisions about their care

Self-care and self-management – we look at ways we can provide support to patients to better manage their health and prevent illness

Collective involvement

Involving people in the development of our plans – we will ask people for their views about our commissioning plans and how we propose to spend our money. When we are reviewing the health needs of the area we will ask people what they think should be our priorities. When we are developing new services we will invite views to help shape them – ***co-producing***[4] where we can.

Involving people in plans to change services – sometimes we will need to make major changes to the services we commission. We will involve people, particularly those who may be affected by change, as early as possible in this process to ensure as many as possible have the chance to give their views.

Involving the right people – we carry out equality assessments to identify if any specific groups of people may be affected by our current work, when developing our plans and when proposing any changes to services, so no group is unfairly discriminated against.

[4] https://www.england.nhs.uk/participation/resources/co-production-resources/

Our vision and objectives

Our organisational vision and values[5] shape and define our communications and engagement activities and the key messages we need to communicate to our patients, public and partners.

Our **communications and engagement vision** provides greater focus:

"We want to be recognised as a people focused organisation, buying health services that represent the best patient outcomes and value, working with our public and partners to do this to improve the quality of our residents lives"

…as do our **communications and engagement objectives** in:

1. Encouraging participation of south Sefton residents' in their local NHS
2. Engaging and communicating effectively with member GP practices and our staff, to enable a shared understanding of our work and their role within it
3. Supporting the successful delivery of our priority programmes to transform health services so they can meet the changing health needs of our residents and so they are more effective and efficient, involving our partners to do this whenever we can
4. Working together with our NHS partners, Sefton Council, Healthwatch Sefton and the voluntary, community and faith sector around our shared aims for high quality local health and care services
5. Increasing awareness of health and care services amongst people in south Sefton, so they have the information to support them to make appropriate choices, self care or take steps to prevent ill, so encouraging them to take a greater role in maintaining their health and wellbeing
6. Increasing recognition of our work and raise our profile amongst all patients, members of the public and other partners
7. Managing and planning for difficult situations

[5] Our organisational vision, values and aims can be found on our website www.southseftonccg.nhs.uk

Our principles

We recognise the value of meaningful involvement and its integral role in helping us to provide the best possible services for the people we serve. Communicating and engaging effectively – at the right time and in the right way - will be central in helping us to do this.

Our overall approach to engaging and communicating reflects the good practice set out in the Sefton wide Public Engagement and Consultation Framework[6]. We will ensure our activities are:

1. **Relevant, planned and timely** – we will firstly establish the need to inform, engage or consult, so we are clear about our purpose. We will plan our approach, so that activities begin early, are timely throughout the process
2. **Proportionate and appropriate** – the scale of the activities we plan will be proportionate to the need to engage, consult or communicate with the different communities we need to reach
3. **Accessible and inclusive** – we will ensure our engagement and communications are appropriate and accessible by all
4. **Integrated and coordinated** – our communications and engagement activities will be integrated to get the best possible results, and we will work with our partners to organise and coordinate activities when possible to reduce duplication and resources
5. **Credible and informed** - our communications will be clinically led whenever possible and our messages will be consistent with our vision, values and objectives
6. **Open and two way** – we want people to be clear about how they can get involved in our work and how their views and experiences are being, or plan to be, used – coproducing[7] services when we can
7. **Effective and measured** – we strive to always demonstrate value for money and good outcomes from the activities we carry out, so we constantly learn from experience when we are devising future activities
8. **Systematic and responsive** - we will manage the insight and outcomes gained from our activities to ensure this knowledge is used effectively to inform our decision making
9. **Fed-back and well explained** – letting people know how we respond to their views, comments and experiences is important to us and we constantly strive to do this in an effective and timely way

[6] The framework was developed jointly and adopted by the local NHS, Sefton Council, and Sefton CVS in 2009 to set standards of good practice. Visit www.sefton.gov.uk

[7] https://www.england.nhs.uk/participation/resources/co-production-resources/

Our approach

The steps we take to involve

When we engage or consult with our patients and residents these are the steps we will generally take:

- Identify the relevant people we need to speak and work with – our 'stakeholders' - and understand their roles
- Develop information for our stakeholders that contains all the relevant and salient points they need to know
- Provide this information across a range of platforms, including our website
- Provide various ways to capture stakeholder feedback
- Analyse and consider this feedback for decision makers
- Publish a report of the results and how people's views have influenced our work and decisions

Carrying out the following activities helps us to plan and deliver our activities so they can be as effective as possible.

1. Knowing our audiences

Understanding who we need to communicate and engage with is crucial. It helps us to design the best methods for involving different partners and where to focus and prioritise our efforts. You can see a high level 'mapping' exercise of our priority partners in Appendix 1.

2. Understanding risks

We cannot know all the risks and issues that may affect our work all of the time. We can, however anticipate many and plan for those we do know about. We will consider and respond to any communications and engagement risks we identify. A high level analysis can be found in Appendix 2.

3. Feeding back

We understand the importance of feeding back how we have used people's views and experiences in a timely and appropriate way. We do this in a number of different ways but we know that we must constantly look at how we can improve the ways we do this.

Here are some examples of the mechanisms we use to feedback:

Meetings, events and forums

When it is relevant, we include a feedback section in our Big Chat and other events. We also go back to many of the groups and forums who have participated in our activities to update them on the results.

Reports, documents and materials

We produce feedback reports about all the specific programmes and activities we carry out, including our Big Chat events and as well as reporting them through our governance structures and systems we also publish them on our website.

Involvement information online

We have a dedicated section on our website where we publish information relating to all our current and previous involvement activities.

Annual involvement report

We include details of our activities to involve people in our main CCG Annual Report and Accounts in line with guidance[8] from NHS England around report requirements.

4. Other important considerations

There are a number of other organisational systems, committees and policies that this strategy complements and works together with. They can be found on our website[9] and include:

- Organisational Development Strategy
- Equality and Diversity Strategy
- Quality Strategy
- Complaints and Enquiries Policy
- Disinvestment Policy and Procedure
- Clinical Quality Innovation Productivity and Prevention Committee

[8] https://www.england.nhs.uk/participation/resources/ccg-reportingpublicpart/
[9] www.southseftonccg.nhs.uk

Our structures and systems

1. Our structures

Here we illustrate how we embed involvement into our daily business through our governance structures:

- We have a **lay representative** dedicated to patient and public involvement on our Governing Body, where our most important work is debated and approved
- We hold bi-monthly **Governing Body meetings in public**, where residents are invited to hear members discussing and making decisions about our work. Ahead of the start of these formal meeting, there is an opportunity for people to meet some of the doctors and other professionals who make up the committee. They are also welcome to ask any questions or queries they have during this session
- Our organisation works across four geographical **GP practice localities.** These are well established forums, chaired by doctors and where our member practices participate in and influence our work. Practices also use these forums to feedback service and patient experience issues for action. Quarterly **wider group meetings** provide a further forum for practices to get involved in CCG business
- We have a joint **Quality Committee** with NHS Southport and Formby CCG and overseeing patient experience is one of its main areas of responsibility. The committee provides our Governing Body with direct assurance of the experience our patients receive from the services we commission, taking action when this falls below what we expect
- Our **Engagement and Patient Experience Group (EPEG)** reports to our governing body via our Quality Committee. It is a Sefton wide group and is jointly chaired by our lay member for patient and public involvement and their counterpart from NHS Southport and Formby CCG. It includes representation from Healthwatch Sefton, Sefton Council, Sefton CVS - there to represent the borough's vibrant voluntary, community and faith sector - Sefton Carers Centre and Sefton Young Advisers
- By working together, **EPEG** helps us maximise the opportunities we have to engage across the different sectors in Sefton in a coordinated way. EPEG gives expert advice about how and where to go to engage and consult our residents. This includes tapping in to the forums and networks that our partners manage, run and have access to
- All the information we gather from our engagement and consultation activities is scrutinised by **EPEG**, in addition to the **patient experience data** that is reported to us by our providers, such as Friends and Family

Test results. All this data informs our work by helping us to gauge how effective the services we commission are and where we can improve them. It also helps us to spot early any emerging trends and issues, so we can take quicker action via the Quality Committee

- We design and carry out specific **involvement exercises** for different aspects of our work, particularly when we are planning changes to a service now or in the future, including pre and post equality impact assessments[10]. These exercises often use differing methods to encourage people to get involved, aiming to be as tailored and appropriate as possible for the different groups of residents we need to speak with. We design them with and report their results to **EPEG**
- Whenever appropriate, we invite patient, public or carer representatives to get directly involved in our day to day commissioning work, such as taking part in procurement processes or joining our working groups to enable services and programmes to be '**co-produced**'
- Our regular public **Big Chat** events where we bring people together to discuss our work, ask for their views about our plans and feedback how we have used their comments and experiences so far
- We hold 'Big Chat style' **annual general meetings** to make these sessions as meaningful and useful as possible for our residents
- Many GP practices in south Sefton have **patient groups[11]**. These enable patients to have greater participation in their local NHS
- Each year we report all our involvement activities in line with our legal duties in our **annual report and accounts**. However, there are many more ways we tell people about our work to involve them in our work, including a **dedicated website section** where people can find out about current and previous involvement activities
- Many of our organisation's **wider governance arrangements** play an important role in our ladder of assurance for patient and public involvement. Processes and systems are embedded in some of our most important committees such as our Corporate Governance and Clinical Quality, Innovation, Productivity and Prevention committees and the strategies, policies and protocols that underpin their work[12]

[10] See page 27
[11] These are sometimes known as Patient Participation Groups or Patient Reference Groups
[12] See page 10 for some of these other important considerations

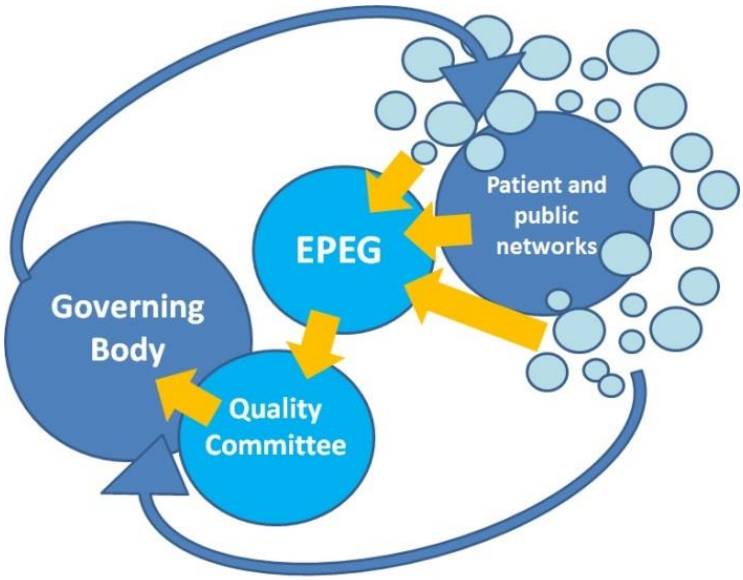
Wider involvement structures and networks

Whilst our organisational structures provide a firm foundation for involving people we know there is always more to do to ensure as many residents as possible have the chance to get involved in our work. So, we will constantly look for new opportunities to reach out to more people, particularly those who find it difficult to have their say about their health services.

Here are some examples:

- Working with Healthwatch Sefton's **Community Champions** to reach a much wider range of local residents, encouraging them to get involved in their NHS and to gain their experiences of using health services
- Working with **voluntary, community and faith groups** to gain their involvement and via Sefton CVS to also gather feedback and experiences from the networks it coordinates such as Ability, Every Child Matters and many others representing different **seldom heard groups**[13]
- Working with **Sefton Young Advisers** to better involve children and young people in our work and ensure their voices are heard
- Participating in Sefton Council's **Consultation and Engagement Standards Panel** to ensure we are working in line with best practice

The following diagram shows how our organisational structures and external systems work together:



[13] Guidance on working with seldom heard groups
https://www.england.nhs.uk/participation/resources/involveseldom-heard/

2. Our systems

Having a systematic approach to collecting all the views and experience we receive from the public and our other partners is vital, if we are to truly commission responsive services that reflect the needs of local people. Below are some examples of the systems we use to help us manage and act on information via our governance structures described earlier.

Patient experience and insight dashboard

We are continuing to develop a patient experience dashboard to improve reporting of this data to EPEG[14]. Part of EPEG's role is to scrutinise patient experience data, including Friends and Family Test results, reports of serious incidents and complaints from our service providers. This helps us to help spot trends and to act early on emerging issues, which are then escalated to the Quality Committee for action. Monitoring by EPEG also supports us to better understand which services work well and to share their best practice with other providers. A patient experience dashboard would provide a more systematic process for managing and overseeing data. Our early prototype uses a software system called 'Insight'.

Communications and engagement dashboard

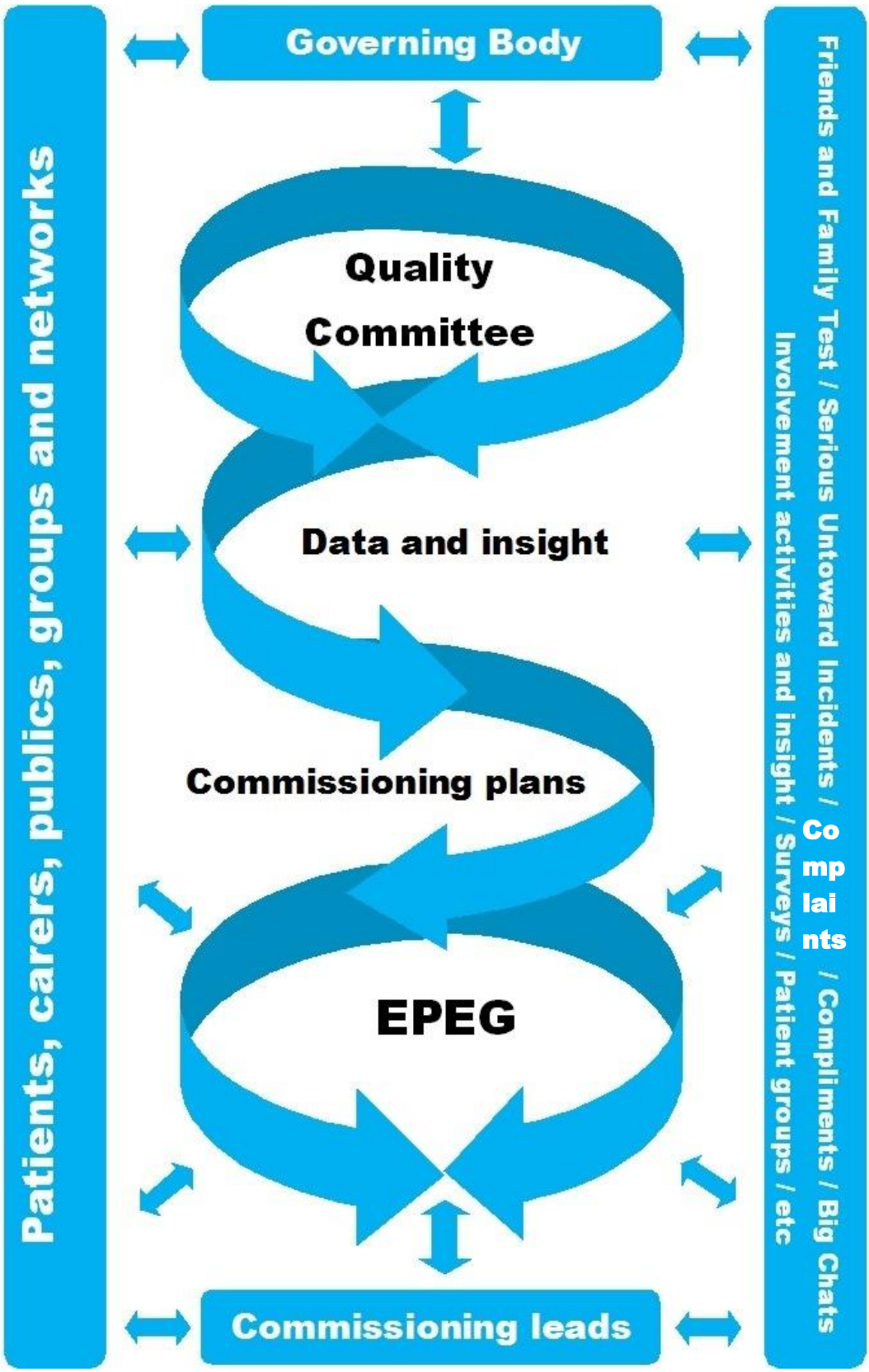
Our CCG communications and engagement activities are reported to our leadership team and EPEG in an easy to read one page monthly dashboard. Where possible we include data to show the outcomes of these activities, allowing monitoring and comparisons over time.

Customer relationship management

We use a secure database, called My NHS to store contact information for all the people who have asked to be kept updated about our work. When we are out and about we have been asking more people if they would like to join. This system keeps this data securely and it helps us to extend the number of people we are in contact with.

[14] See page 11 for information about EPEG

The following diagram shows our how our structures and systems work together with the aim of ensuring a systematic approach to managing all our data and insight.



Involvement in service planning

Planning and shaping our services

Our work revolves around an annual **'commissioning cycle'** that sees us regularly analysing and assessing the effectiveness of current services, exploring if there are any gaps and where we might need to make changes. Public and partner involvement is central to the process, taking place at every stage. The diagram below explains how this works.

Our strategy for local services

The NHS must change if it is to remain efficient and effective in this time of unprecedented challenge of dwindling finances and increasing demand on its services.

In response to these challenges, the national 5 Year Forward View (5YFV) suggests new models of care to transform and futureproof NHS services. Our strategic vision for **community centred health and care** - where services work better together, are more responsive to people's needs and are provided as close to people's homes as possible – is in line with the thinking set out in the 5YFV. This vision is central to our evolving **Shaping Sefton**[15] strategy and its three overarching areas of focus - primary care, urgent care and care for our older and vulnerable residents. Residents and partners views informed the development of our strategy.

[15] http://www.southseftonccg.nhs.uk/what-we-do/shaping-sefton/

Our strategy's place in the bigger picture

If we are to achieve our vision and the requirements of the 5YFV, as well as effectively tackle the challenges facing the NHS, we need to work even closer with our partners from across health and social care including Sefton Council.

Our three strategic priority areas of primary care, urgent care and care for our older and more vulnerable residents have been informed by our work with the council around the Joint Strategic Needs Assessment, Sefton Strategy for Health and Wellbeing and our joint strategy for integration, 'Making it Happen'.

Beyond Sefton, we are working even more closely and systematically with partners across Cheshire and Merseyside to better understand where bigger system changes might improve care for our local residents. New networks, forums and structures are beginning to emerge to support organisations across wider areas to work together more effectively, towards providing integrated efficient services where appropriate. Similar options for Cheshire and Merseyside are being explored through an emerging health and care partnership[16]. Guidance around patient and public participation for those teams developing and leading these system wide models was published by NHS England in 2016[17].

This new and emerging operating environment is likely to pose many further challenges for the local NHS. Importantly however, it means we have the potential to achieve more for local residents than we could do individually, as there is greater strength in working together.

The role of ongoing involvement

Embedding communications and engagement in our local and regional transformational projects, programmes and service developments will be crucial to their success.

Involvement will be built into overarching project plans from the start, so their feasibility and resourcing is accounted for from the outset. This will also help us to identify any issues, providing early support and good understanding of the challenges involved.

This work will see us working closely with partners in Cheshire and Merseyside when required to ensure the views and experiences of Sefton residents are represented in any proposed changes that may affect their health and services.

[16] https://www.england.nhs.uk/systemchange/

[17] https://www.england.nhs.uk/publication/engaging-local-people-a-guide-for-local-areas-developing-sustainability-and-transformation-plans/

Who we involve and how we do it

We use a range of 'channels' or methods to inform and encourage involvement with our priority audiences – **local residents, partners** and **member GP practices and staff**.

This section gives an overview of some of the key groups and individuals we communicate and engage with, and some of the methods we will use but these are not exhaustive.

It also sets out some of the **underpinning activities** that support our communications and engagement activities.

Our residents

We involve our residents in our work in a number of different ways. The list below highlights some of the core methods we use but it is by no means exhaustive. We continually look at how we can strengthen these further and supplement them with other activities and events, according to feedback from local people and based on our commissioning needs.

Big Chats

Our Big Chats provide a forum where we talk together with our residents about our work, ask for their views about our plans and feedback how we have used people's comments and experiences so far. We also hold Mini Chats to really focus on specific topics and where we can go out to talk to groups and individuals who often find it difficult to have their say about health services. We combined our Annual General Meeting with a Big Chat in 2015 and this approach was well received by attendees, so we have replicated this every year since. We are looking at how we can make Big Chats more accessible based on feedback, by shaping their content and format, the times they are held, as well as exploring more focused Big Chat style events for young people and other seldom heard groups for example.

Talking to patients and residents

It is essential that we gain 'first hand' experience from the patients of specific services and their carers when we are planning changes or improvements to them. We need to ensure we have a full understanding of any impact our changes may have on patients, so we can address issues and amend our plans when necessary. We design appropriate methods to do this including surveys, events, focus groups and sometimes inviting residents to join our working groups to directly input into our work.

Involving younger residents

We know there is always more we can do to involve children and young people to ensure their voices are heard. We are active members of a number of committees and groups with organisations from across Sefton, which are focused on children's care and services. Our partnerships with VCF groups and organisations are also important in helping us reach these seldom heard groups.

Sefton Young Advisers are represented at EPEG and we are committed to working more closely with the team to involve children and young people, adopting the Advisers' engagement toolkit for young people and co-producing whenever possible and appropriate.

Media relations

A number of distinct and well respected publications remain in Sefton, despite the national contraction in print media. The majority of newspapers are free sheets, delivered directly to a high proportion of homes in the area. These organisations are increasingly looking to boost their online presence, which presents us with new opportunities and challenges. Regional radio stations, such as BBC Radio Merseyside and Radio City command strong and loyal listenership, whilst national and trade publications present the opportunity to influence decision makers at a regional and national level. It is essential we manage our media effectively and to support members and staff in doing this we have a media protocol (Appendix 5).

Governing Body meetings

We hold bi-monthly Governing Body meetings in public, where residents can hear members discussing and making decisions about our work. Ahead of the start of these formal meeting, there is an opportunity for people to meet some of the doctors and other professionals who make up the committee. They are also welcome to ask any questions or queries they have during this session.

Patient participation groups

Our member practices are now required to have a patient group, sometimes known as Patient Participation Groups or Patient Reference Groups. They provide a forum for people to get involved in their practice and the services it offers. They also provide us with an opportunity to inform and involve members in our wider CCG work. We will continue to explore ways we might more systematically enable the involvement of these networks in designing and shaping our plans and services.

Corporate documents

We are required to produce an Annual Report and Accounts. In addition to this we will publish a number of other corporate strategies and reports that will further illustrate our work and performance. We will only produce new printed materials when absolutely necessary in support of 'greener' working practices. So, whenever possible, corporate documents will be produced electronically, only offering alternative formats on request.

Digital communications

Digital and social media now permeate our daily lives and we are exploring opportunities where we can effectively use these channels of communication in support of our objectives (page 7). Mobiles and smartphones are increasingly becoming the gateway of choice to digital channels, particularly amongst our younger residents. So, we will continue to explore the benefits and opportunities of these channels for achieving a two way dialogue with our publics and partners. Better engagement through social media was one of the recommendations of the 2015 Sefton Youth Voice and Participation Strategy and we will look to work with Young Advisers to inform our approach when targeting this age group.

Website

We refreshed our website in 2016 to make it more engaging and relevant to our residents and our partners. It provides a further mechanism for people to contact us and give their views. In addition it contains more information and offers more user functionality helping to further build recognition, reputation and understanding of who we are and what we do.

e-bulletin

We will launch an e-bulletin in 2018 providing updates about our work to those members of the public and our partners who have signed up to our Customer Relationship Management System (page 14). We invite people to sign up to our database via our website and leave comments about the items it contains.

Social media

Our social media strategy looks at how we can implement, manage and monitor the use of these channels to support our objectives. We currently support Twitter and You Tube channels with the aim of engaging a much wider group of residents and key influencers. These provide an additional gateway to our website and we continue to explore employing other new channels that may support our communications objectives.

Video

This medium offers the potential for more immediate and engaging storytelling. Mobile devices give us the technology to do this and we have adopted an ‘think video’ approach to our activities to strengthen our messaging. This can be a time intensive activity and will need to be balanced against our core priorities.

Maximising our public waiting areas

We secured national funding in 2017 to install digital TV style information systems in a number of our practices' waiting rooms. Once fully operational, we will be able to tap into these systems to promote key overarching health messages, in addition to practice based information.

Working with partners to amplify our voice

Our partners use a range of channels to communicate with their staff, service users, members and patients and often include messages on our behalf. We will look at how we can further maximise these good, reciprocal partnerships that we have established, to both support their work and to maximise the impact of our messaging. This includes working jointly on campaigns and recent examples include promoting winter health, flu vaccinations and our Examine Your Options campaign encouraging people to choose the most appropriate service for their needs. Our partners also support the distribution of our key campaign materials to point of service delivery venues in their networks. All this is helping us to reach out more widely to communicate with our patients, the public and other partners.

Our partners

We know we cannot achieve the improvement that we are aiming for in isolation. Having strong partnerships is crucial in helping us to achieve the best possible results for local people. Here are some of the partners we work with and some of the ways we involve and inform them in our work.

Sefton Health and Wellbeing Board

As active and committed members of the board, we work collectively to involve our publics and other partners in our work – from developing our JSNA and Health and Wellbeing Strategy. Our shared vision of more joined up, integrated services mirrors our Shaping Sefton programme and together we have a strategy for integration called 'Making it Happen'. We aim to coordinate our activities, avoid duplication and maximise our resources and capacity whenever it is practical and appropriate.

Sefton Overview and Scrutiny Committee for Adult Social Care

We will continue to build good relationships with this committee. Our statutory duty to the committee is set out in appendix 1. Our Chief Officer attends every meeting to update councillors about our work. We will inform and involve the committee early about any relevant plans or changes to services. Other areas of specific work will be supported by members of the CCG's wider team.

Healthcare providers and partners

There are many NHS and non-NHS organisations that provide local health services on our behalf. So, we need to involve these partners early when we are developing our plans. This will be particularly important when considering transformational changes to local healthcare, which will require different and more effective ways of working in order to secure improvements to services that will benefit our local residents. We work together with a number of other NHS organisations to either provide services or monitor the quality and performance of the services and care we commission. We will look to carry out joint communications whenever appropriate with our NHS partners to ensure consistency and support. Partners include NHS England, NHS Improvement, other CCGs and the many hospitals and community services that provide care on our behalf.

Politicians and other key influencers

Members of Parliament (MPs) are uniquely positioned to provide us with views and perspectives about the services we commission based on the experiences of their constituents. It also means they are able to alert us early to problems, so we can begin to rectify them as soon as possible. Local councillors also provide similar insight into the care their electorate need and experience. We aim to hold regular meetings between our Chair and / or Chief Officer and local MPs to develop positive relationships, and we will respond quickly and effectively to requests in relation to parliamentary questions. We will work with Sefton Council to ensure its elected members are appropriately informed and involved in our work.

Healthwatch Sefton

We work with Healthwatch Sefton in a number of ways. The Chair of Healthwatch Sefton is a co-opted member of our Governing Body and the organisation is a member of the Health and Wellbeing Board and an active member of our EPEG group. These forums all present opportunities for Healthwatch to ensure the patients and publics it represents are kept up to date about our work, and for the organisation to feedback any comments directly to us, in its capacity as 'critical friend'. Healthwatch Sefton's network of Community Champions also presents us with greater opportunities to communicate with patients, local residents and voluntary, community and faith groups. We regularly attend these network meetings and have an agreed process for dealing with any queries or issues that so we can long, track and spot any trends over time. This working relationship helps us to engaging more widely with local people, particularly those who would not otherwise give their views about their local NHS, or whose voice is seldom heard. We continue to work together with Healthwatch Sefton to explore further opportunities for joint working.

Voluntary Community and Faith Sector

Our links with the voluntary community and faith sector (VCF) are extremely important to us. These links support us in providing information to, and gaining feedback from harder to reach groups via the VCF sector. Sefton CVS provides the link between the VCF sector and our EPEG group. This includes Sefton Equalities Partnership, Sefton Health and Social Care Forum and the Every Child Matters Forum. EPEG receives regular updates from the groups and networks that Sefton CVS coordinates. We will work together to explore how this can be further strengthened in the year ahead to ensure we are reaching the people who may be affected most by our work.

Our member GP practices and staff

We are one organisation bringing together many doctors and other professional who make up our membership. We are bound together by our CCG Constitution, which describes the individual responsibilities of our member practices and the systems in we have put in place to enable us to work effectively. We will support the effective delivery of our Organisational Development Strategy to keep our members and staff engaged and involved in our work. Here are more examples of how we **involve and inform** member GPs and our staff.

Training and development

We support regular Protected Learning Time events for the doctors, nurses and practice staff that make up our membership. These focus on different topics and subjects to support our membership in their day to day work. Alongside this we will strengthen our programme of development opportunities and support to our staff, clinical leads and Governing Body members.

Strengthening locality working

Locality working is central to how we want our organisation to operate and our commitment to this is set out in our founding Constitution[18]. Practices in each of our four locality areas come together each month to discuss commissioning issues. Each is led by a GP and supported by a locality manager from our operational team to devise schemes and initiatives to benefit their patients. We will continue to look at ways to further empower our localities through strengthened support in line with our Organisational Development Strategy.

Supporting our staff

We have a range of structured internal forums, including team and wider operational meetings, to ensure our staff have appropriate ongoing opportunities to be involved in shaping our day to day work and to be kept up to date with business across the organisation. In addition, we have a Sounding Board group, which includes a representative from each department. Sounding Board provides an important forum for airing workplace issues and for sharing ideas to improve the working environment.

[18] Our Constitution can be downloaded from our website

Digital and e-communications

We have a weekly e-bulletin and an intranet for our member practices and staff giving our members and employees access to a range of information that is useful in helping them to carry out their day to day work. We regularly review these channels and some of the improvements we have made so far based on feedback include launching a monthly staff bulletin in 2017 and redesigning our member GP practice and staff intranet to better meet our changing workloads that we expect to go live during 2018. We continue to look at ways to improve information channels with practices and staff. This includes streamlining email communications where possible. Our protocol encourages staff to use the intranet and e-bulletin as the main channels for non urgent operational communications to help reduce the circulation of often unnecessary global emails.

Underpinning activities

Brand management

There are high levels of trust and credibility in the NHS identity amongst our population. At the end of 2012 we created a visual identity, which incorporates NHS guidelines and which we use across our different channels of communication and corporate documents. We reviewed this visual identity in 2013, testing it with local people. Whilst the feedback was positive, the exercise highlighted areas for improvement and we revised our visual identity as a result. Effective management of our identity and corporate house style is an important element in promoting our reputation - the visual identity is designed to represent our vision and values clearly in all our communications. We must continue to ensure that our visual identity and corporate house style are consistently applied to ensure maximum recognition of our work. Alongside our CCG identity, the NHS issued revised identity guidelines in 2017 and we have been applying these changes to all new materials since the updates came into effect.

Content planning

We will develop a content plan that maximises our messaging across our different channels, mediums and other activities. Good content planning is essential if we are to ensure consistency and timeliness in our messaging, and this will further support us in building trust and awareness of our work in line with our objectives.

Crisis and issues management

In the event of a crisis or major incident, effective and timely communications are critical. We will horizon scan for potential negative or difficult issues and prepare appropriate responses for any emerging problems. This means adopting a whole system overview of the information we gain through complaints, freedom of information requests, MP letters, parliamentary questions, patient experience, engagement and campaign insight - ensuring communications is considered as part of our EPEG group.

Equality impact analysis

We carry out equality impact analyses (EIA) on all of our key work programmes in line with our duties under the Equality Act[19]. These inform option development and consultees at the beginning of a consultation. They also inform decision makers post consultation.

[19] See Appendix 1 – our duties: item 10, page 35

Delivering this strategy

1. Roles and responsibilities

Members of our Governing Body and staff, or Operational Team, will take a pro-active approach to carrying out their roles outlined below. They will do this in a timely way and be mindful of external deadlines in support of a positive reputation amongst our stakeholders.

Our Governing Body is responsible for:
Taking the lead and fronting media activity, both in relation to proactive and reactive issues
Lead on the delivery of high level communication to staff, constituent practices, partners and providers
Alerting the communications and engagement team to any emerging issues
Attendance and involvement in public events

Our Operational Team is responsible for:
Ensuring communications and engagement are represented in all workstreams and appropriate leads are alerted of any emerging issues
Informing and gaining the advice and involvement of the Communications and Engagement Team in all relevant activities
Supporting our e-bulletin and intranet first protocol for sharing appropriate information
Working pro-actively to provide updates to our Communication and Engagement Team for inclusion in briefings, press releases, bulletins, websites and newsletters etc

Communications and Engagement Team will be responsible for:
Developing and managing the operational delivery of the communications and engagement elements within this strategy providing an integrated, seamless service
Providing the Governing Body with timely progress reports and ensure that the Chair, Chief Officer and Senior Leadership Team are made aware of any significant issues or risks
Providing strategic communications and engagement input and advice to our work
Identifying, planning for and responding to emerging issues which may have a detrimental impact on reputation
Handling of all media activity – including social media and reactive media activity, ensuring appropriate response and timely escalation of issues and, where required, co-ordinate responses with communication leads from partner and provider organisations – to ensure a consistent approach
Oversight of all regulatory and non regulatory communications and engagement
Supporting the Operational Team with practical communication support
Acting as the first point of contact for our partners, including community and third sector groups in relation to public engagement and communications activity

2. Resourcing

We have many competing priorities and we must be realistic about what we can achieve. So, we must ensure our activities are focused on meeting our objectives, cost effective, make the best use of our capacity and regularly reviewed. This will be particularly important for any system wide transformational schemes, where we will need to consider resources from the outset, as part of the wider programme costs.

In recognition of the central and vital role of communications and engagement in our work, we strengthened our internal team in 2017 converting a successful two year Digital Communications and Engagement Internship scheme with John Moores University into a new full time role to concentrate on these quickly evolving communications channels.

Measuring and reviewing

We are mindful of the need for ongoing evaluation to measure and review the efficiency and effectiveness of our communications and engagement objectives. This section describes our approach for doing this.

Measuring

In 2017 new patient and public participation measures were added to the Improvement and Assessment Framework (IAF)[20] that sets wider expected performance requirements for all CCGs. An assessment of our performance against these new involvement indicators will appear for the first time in the IAF in the 2017-2018 publication of results. Our systems and structures for monitoring our involvement activities are described on pages 11 to 15. Some of the data, insight and outputs that feed into these systems and structures that we collect and analyse include:

- NHS England annual 360 degree survey of stakeholders and member practices
- Local and national patient experience feedback and surveys
- Insight about our work gained from partners including Healthwatch Sefton and Sefton CVS
- Independent audits of our internal processes for stakeholder engagement
- Public perceptions of local NHS services and people's ability to influence the future shape of these services
- Complaints and compliments, political and parliamentary queries, Freedom of Information requests
- Seeking views and gaining feedback from partners and provider organisations from a range of forums, using a range of mechanisms
- Seeking views and gaining feedback from staff through team meetings, staff briefings and other staff engagement events
- National and local surveys of staff and member practices
- Intranet / website usage
- Media content analysis
- Social media analysis

Reviewing

We have used data and insight gained from a number of activities described above to inform this refresh of our strategy. In particular this has included surveys of our member GP practices, staff and residents. Input has been invited from our Governing Body and from our partners via EPEG.

[20] https://www.england.nhs.uk/commissioning/ccg-assess/

Table of appendices

Appendix 1 – Our duties

The legal, statutory and regulatory requirements and guidance frameworks that steer our work around involvement and consultation are summarised in this section.

1.Health and Social Care Act 2012

The NHS has a legal duty to involve or consult patients and the public as outlined in Section 242 of the NHS Act 2006. The Health and Social Care Act 2012 (Section 14Z2) outlines how this legal duty applies to CCGs when authorised. The law requires CCGs to involve service users:
in the planning of its commissioning arrangements

- in developing and considering proposals for changes in the commissioning arrangements that would impact on the manner in which services are delivered or on the range of services available
- in decisions that affect how commissioning arrangements operate and which might have such impact

CCGs are also required to report annually on how they have met this duty to involve patients and the public (Section 14Z11).

CCG are required to adhere to Public Health, Health and Wellbeing Boards and Health Scrutiny Regulations 2013 where substantial development in services are planned and engagement with Health Overview and Scrutiny is required.

Duty as to Patient Choice (14v) - this sets the following legal requirement "Each CCG must in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided."

Duty as to the improvement in quality of services - Section 14R NHS Act 2006 "Each CCG must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness."

2.NHS 5 Year Forward View

Published in October 2014, this calls on the NHS to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services and that the NHS must:

- Do more to tackle the root causes of ill health
- Commit to giving patients more control of their own care
- Change to meet the needs of a population that lives
- Develop and deliver the new models of care, local flexibility and more investment in our workforce, technology and innovation

3.Equity and excellence: Liberating the NHS

This Department of Health document from 2010 highlights three mutually reinforcing parts:

- First, putting patients at the heart of the NHS: transforming the relationship between citizen and service through the principle of *no decision about me without me*
- Second, focusing on improving outcomes: orientating the NHS towards focusing on what matters most to patients – high quality care, not narrow processes
- Third, empowering local organisations and professionals, with a principle of assumed liberty rather than earned autonomy, and making NHS services more directly accountable

4. Gunning principles - (common law principles that govern lawful consultation)

There have been a number of legal decisions via Judicial review that we have to comply with, the most relevant being the 'Sedley principles' (often referred to as the Gunning principles) that consist of:

(i) consultation must take place when the proposal is still at a formative stage
(ii) sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response
(iii) adequate time must be given for consideration and response
(iv) the product of consultation must be conscientiously taken into account

5.Planning, assuring and delivering service change for patients

This guidance included was designed to build confidence with staff, patients and communities around major service change and reconfiguration. It includes four tests that commissioners proposals[21] must meet:

Test 1 – support from GP commissioners
Test 2 – strengthened public and patient engagement
Test 3 – clarity on the clinical evidence base
Test 4 – consistency with current and prospective patient choice

[21] Planning, assuring and delivering service change for patients 2015 https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf

6. NHS Constitution 2013

The Constitution[22] sets out the principles and values of the NHS in England. It brings together in one place the rights of patients, public and staff, as well as pledging what the NHS is committed to achieve. It also gives responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies, private and third sector providers supplying NHS services are required by law to take account of this constitution in their decisions and actions.

It states that people have the right to be involved in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services. The NHS Constitution states that the NHS will:

- Make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered
- Inform individuals about the healthcare services available, locally and nationally
- Engage staff in decisions that affect them and the services they provide

First published in 2012, the NHS Constitution is updated to reflect any changes to the NHS landscape.

7.Friends and Family Test

The Friends and Family Test (FFT) launched in April 2013, initially targeting the FTT test to all NHS inpatient and A&E departments across England. FTT is now a statutory requirement of all providers of NHS funded maternity services, GP practices and from April 2015, includes all NHS-funded mental health and community health services. FTT is being expanded to include NHS dental practices, ambulance services, patient transport services, acute hospital outpatients and day cases.

8.NHS Operating Framework 2015-2016

Domain 4 - Ensuring that people have a positive experience of care

[22] NHS Constitution: https://www.gov.uk/government/publications/the-nhs-constitution-for-england

9.Everyone Counts: Planning for Patients – 2013-14 to 2018-19

Citizen participation and empowerment - to focus on what patient choice their own health, and participating in shaping the development of health and care services. want and need. More information on how to stay well or manage their own health better through informed choices

Listening to patient views - commissioners to ensure patients and carers are able to participate in planning, managing and making decisions about their care and treatment through the services they commission.
Effective participation of the public in the commissioning process itself, so that services reflect the needs of local people.

The stronger role for user voice within services of Personal Health Budgets from April 2014-15.

10. Equality Act 2010

This is cross cutting legislative framework to protect the rights of individuals and advance equality of opportunity for all. It also updates, simplifies and strengthens previous legislation to deliver a simple, modern and accessible framework of discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

Public Sector Equality Duty

As part of the Equality Act, CCGs are required to pay due regard Public Sector Equality Duty (PSED) - across the following protected characteristics of age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, lack of belief, sexual orientation, marriage and civil partnership – to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it

We carry out equality analysis to inform option development and consultees at the beginning of a consultation, and to inform decision makers post-consultation.

Equality Delivery System

The Equality Delivery System (EDS) helps us to deliver our PSED. It describes how we should: “Improve accessibility and information, and deliver the right services that are targeted, useful and used in order to improve patient experience”. In summary, this means that in planning and delivering services we must ensure that:

- Measures are in place to identify and tackle any barriers to using services
- People have the necessary support and information they need to access services in a way that meets and takes account of their individual needs
- People are supported to make informed choices about their care and treatment and understand their rights
- Robust systems are in place to gather feedback and capture experiences from the people who use services and use this intelligence to improve services

11. HM Government Code of Practice on Consultation

Specifically in relation to work with Local Authority as joint commissioning arrangements and where Health Overview and Scrutiny are to be involved as described below:

Overview and scrutiny

CCGs are required to consult Sefton Council’s Overview and Scrutiny Committee for Adult Social Care (OSC) where we are planning a substantial change or variation in services[23]. A number of local councillors make up the committee and its purpose is to represent the views and safeguard the interests of local people by:

- Scrutinising NHS policy, service planning and operations
- Being consulted on all proposals for major changes to health services
- Calling commissioners to give information about services and decisions
- Reporting their findings and recommendations
- Referring matters to the Secretary of State where they have not been adequately consulted, or believe that the proposals are not in the best interests of the local health service

[23] Local Authority Regulations 2013 strengthen duties set out in the NHS Act 2006

12. Involving people in health and care guidance

In 2017, new statutory guidance was published for CCGs - patient and public participation in commissioning health and care and involving people in their own health and care[24]. These support us in improving individual and public participation and how we can better understand and respond to the needs of the people and communities we serve, in line with the statutory and legal duties described in this section.

13. Annual reporting on the legal duty to involve patients and the public in commissioning guidance

This guidance from 2016 sets out CCG requirements and good practice around the annual reporting of patient and public involvement.

14. Engaging local people – a guide for local areas developing Sustainability and Transformation Plans

This guidance[25] from 2016 is aimed at those developing STPs. It builds on the six principles for engaging people and communities Published by the People and Communities Board with support from National Voices, working in coproduction to improve access and outcomes. The six principles are:

- Care and support is person-centred: personalised, coordinated, and empowering
- Services are created in partnership with citizens and communities
- Focus is on equality and narrowing inequalities
- Carers are identified, supported and involved
- Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers
- Volunteering and social action are recognised as key enablers

[24] https://www.england.nhs.uk/participation/involvementguidance/
[25] https://www.england.nhs.uk/wp-content/uploads/2017/06/engaging-local-people-stps.pdf

15. Accessible Information Standard

The Accessible Information Standard ensures that people with a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. By law (section 250 of the Health and Social Care Act 2012), all organisations that provide NHS care or adult social care must follow the Standard in full from August 2016 onwards. Our service providers are monitored against this standard as it forms part of the equality reporting requirements in the quality compliance schedule of their contracts. A strategy is also being developed to support our primary care team with the implementation and compliance monitoring. We will continue to look at our internal systems and processes for supplying information requested by patients and publics to see how might be strengthened in line with best practice set out by how we supply information requested by patients and publics in line with this requirement.

16. Mental Capacity Act 2005

This Act sets out five core principles to ensure that individuals are empowered to make decisions where possible, and where this is not possible, that any decision made or action taken is made in their best interests.

17. Human Rights Act 1998

The Act outlines the fundamental rights and freedoms that individuals in the UK have access to and all public bodies must ensure they comply with these.

18. United Nations Convention on the Rights of the Child

This is a human rights treaty setting out the civil, political, economic, social, health and cultural rights of children. Article 12 states ‘parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child’.

Appendix 2 - Knowing who we need to communicate with

The table below categorises and summarises our overarching audiences. We know that relationships between different groups are complex and can sometimes shift from one category to another. So, we regularly revisit this mapping exercise to ensure appropriate relationships are maintained with different groups. When we consult, by law we must involve all interested parties. Who we consult with may change depending on the project. So, at the start of every consultation process we will carry out a specific stakeholder mapping exercise.

Keep engaged
CCG membership and staff
Patients, carers and patient groups (inc their reps, like Healthwatch Sefton etc)
Wider public
Seldom heard / diverse, potentially excluded and disadvantaged groups
Partners and providers (inc NHS, non-NHS and VCF organisations)
Keep informed
NHS England
Public Health England
Overview and Scrutiny Committee for Adult Social Care (OSC)
Sefton Council Cabinet
Ward councillors
MPs
Local Medical Committee (LMC)
Other medical committees (pharmaceutical , dental, optical etc)
Regulatory bodies (inc CQC, NHS Improvement)
Enablers
Commissioning Support Unit (CSU)
NHS England Cheshire and Merseyside Area Team
Service providers (inc Community, Acute and VCF)
Our Governing Body / locality groups / wider group / CCG staff
Neighbouring CCGs
Healthwatch Sefton
Sefton CVS
Sefton Health and Wellbeing Board (inc sub structure and task groups)
Sefton Public Health
Sefton Council Executive
MPs
Media
Clinical forums
Limiters
Groups with negative perceptions of the NHS or our work

Appendix 3 – Strengths and weaknesses

An analysis of the strengths, weaknesses, opportunities and threats which may impact on our work are set out below.

Strengths
Leadership demonstrating firm commitment to robust and meaningful engagement and communications
Good, collaborate relationships and working practices with key partners (statutory and VCF)
Experienced and skilled communications and engagement function provided with good local knowledge
Strong history of clinical engagement
Positive relationships with distinct traditional media outlets
Weaknesses
National perception tracking survey highlights fall in levels of satisfaction in NHS
Key partners reducing capacity and resource in engagement and communications due to wider economic challenges within the public sector
Continuously changing environment due to ongoing NHS and public sector reforms
Opportunities
Emerging new media channels to engage and communicate with members and stakeholders
Chance to enhance internal and external clinical engagement
Resolve to carry out joint communications and engagement activities between key partners to maximise impact, capacity and resource
Relatively high levels of public trust in clinicians continues, making us ideally placed to deliver key messages
Threats
Financial challenge of reduced healthcare budgets impacting on the level and quality of communications and engagement support we are able to provide
Ongoing political challenge associated with healthcare
Possible reduced levels of confidence amongst our publics and partners due to national or local factors
Maintaining continually high levels of clinical engagement amongst our members and wider clinical groups

Appendix 4 – Messages and objectives

The key messages below have been developed to support our objectives. When necessary, we will develop 'sub' messages in line with our vision and objectives.

Objective 1 - Encouraging participation of south Sefton residents in their local NHS	
We are committed to involving people in our work and we will feed back any changes or improvements we make to services, so people can see where they have influenced this process	**A**
Objective 2 - Engaging and communicating effectively with member GP practices and our staff, to enable a shared understanding of our work and their role within it	
We are one CCG, bringing together practices, doctors and other professionals in south Sefton, to plan and buy high quality services that represent the best value to support good health and wellbeing of our residents	**B**
Objective 3 - Supporting the successful delivery of our priority programmes to transform health services so they can meet the changing health needs of our residents and so they are more effective and efficient, involving our partners to do this whenever we can	
We are well placed to develop local health services because we are close to patients and know their healthcare needs	**C**
We want more services to be provided closer to people's homes, making them easier to access and so that hospitals can concentrate on more specialist care, and we want services across health and social care to be better joined up, working seamlessly together – in line with our *Shaping Sefton* vision for '*Community Centred Health and Care'*	**D**
We expect the services we plan and buy to be as effective as possible and to be of the highest possible quality, spending the money we are allocated for south Sefton wisely, so it represents best value. We will be transparent about the decisions we make	**E**
Objective 4 - Working together with our NHS partners, Sefton Council, Healthwatch Sefton and the voluntary, community and faith sector around our shared aims for high quality local health and care services	
We are committed to working even closer with our partners to improve services, reduce duplication and increase efficiency, with the aim of achieving more together for our residents to meet their changing needs	**F**
Objective 5 - Increasing awareness of health and care services amongst people in south Sefton, so they have the information to support them to make appropriate choices, self care or take steps to prevent ill, so encouraging them to take a greater role in maintaining their health and wellbeing	
We want people to have the confidence to choose the right care for their needs every time, using hospitals and other services like doctors surgeries and chemists appropriately	**G**
We want people to have the right support, so they can take control and better manage their conditions whenever possible to improve the quality of their lives	**H**
Objective 6 - Increasing recognition of our work and raise our profile amongst all patients, members of the public and other partners	
We will be pro-active in promoting our work, the achievements of our staff and members and the services residents can access to ensure a good understanding of the important role we carry out as the local lead organisation for the majority of local health care	**I**
Objective 7 - Manage and plan for difficult situations	
We will have to make tough decisions in this difficult financial climate, but we will involve south Sefton residents and our other partners in this process to ensure we make the best investments	**J**

Appendix 5 – Summary of activity

The table below is designed to give an overview of our work, and is supported by more detailed operational work plans. The messages and objectives below correspond with Appendix 4, and a list of 'audiences' can be seen in Appendix 2. Activity will be carried out during 2018 – 2020.

Objective	Audience	Messages	Methods
Encouraging participation of south Sefton residents in their local NHS, so it is the best it can be	All public audiences	A, D, E, G, H, J	Launch e-newsletter for engaged publics and partners and encourage further sign up via website
			Develop communications and engagement activities / campaigns to involve publics and partners in shaping services and to support their health and wellbeing, working jointly with our partners whenever possible
			Scoping opportunities to improve communications and engagement channels / mediums – including best use of public waiting areas, video storytelling etc
			Review programme of Big Chat events in line with commissioning requirements, incorporating Annual Review and working with Young Advisers and other bodies to target groups
			Encourage commissioning leads to adopt coproduction approaches where possible, based best practice frameworks and guidance
			Regular evaluation of our activities to determine their effectiveness and to ensure best use of capacity / resources
Engaging and communicating effectively with member practices and our staff, to enable a shared understanding of our work and their role within it	GP practices	A-J	Strengthening locality working, linking to and supporting delivery of Organisational Development Strategy (including support for practice learning time programme and other training opportunities)
	GP practices / staff		Refine internal communications channels (intranet / e-bulletin) based on feedback, to provide regular updates around locality and practice work, key corporate messaging and opportunities for member involvement
			Support key forums / meetings, including Sounding Board, practice manager, practice nurse and wider group meetings
			Explore potential for new communications channels and tactics with staff and practices

Supporting the successful delivery of our priority programmes to transform health services so they can meet the changing health needs of our residents and so they are more effective and efficient, involving our partners to do this whenever we can	Governing Body / staff	C-J	Ensure communications and engagement are tied into organisational planning – including development of overarching organisational strategy, annual commissioning cycle and development of business cases through project management office approaches
			Developing bespoke communications and engagement plans for priority work programmes – including Shaping Sefton and our Clinical Quality, Innovation, Productivity and Prevention (QIPP) programme
			Explore database system for more effective coordination of qualitative / quantitate engagement / consultation insight, with aim to better triangulate data and outcomes
			Regular review of communications and engagement capacity and resources in line with priorities / evaluation of activities against objectives
	Partners	C-J	Work with counterparts across Cheshire and Merseyside and as part of the Sefton Transformation Board to develop joint approaches and exercises
Working together with our NHS partners, Sefton Council, Healthwatch Sefton and the voluntary, community and faith sector around our shared aims for high quality local health and care services	Governing Body / staff / partners	F-J	Continue to develop and strengthen EPEG
	Partners	F-J	Work collectively through Health and Wellbeing Board, Sefton Transformation Board and Cheshire and Merseyside Care Partnership and other partnership forums
			Develop joint communications and engagement strategies / activities for specific programmes and projects where possible
	All public audiences	A, G-J	Use our public facing communications channels appropriately to promote active involvement in our services, and look to develop other opportunities to do this (including social media)
			Scoping opportunities to improve communications within public waiting areas including review of TV based systems
	Youth Voice	A, G-J	Work with Young Advisers to increase Youth Voice, promoting their service 'checklist' internally and with our providers
	All public audiences	A, G-J	Work with Healthwatch to promote greater public involvement in GP practice patient groups, and to explore how they can better provide a mechanism for involving people in CCG work
Increasing awareness of health and care services amongst people in south Sefton, so they have the	All public audiences	A, G-J	Further develop digital strategy to promote local health services and enable active involvement in our work
			Develop health campaigns in line with business objectives to support self care and choice of services etc

information to support them to make appropriate choices, self care or take steps to prevent ill, so encouraging them to take a greater role in maintaining their health and wellbeing	Public / partner	A, G-J	Provide communications for partner internal / external channels
			Joint working on campaigns / involvement activities
	Partner	A, G-J	Meet regularly with and use appropriate channels to pro actively inform key influencers – such as OSC, MPs, VCF forums, Healthwatch Sefton, LMC etc – and provide them with information when requested promptly
Increasing recognition of our work and raise our profile amongst all patients, members of the public and other partners	Staff	I	Continued consistent use of our visual identity and corporate style across all channels / materials / templates / reports / strategies etc
	All public audiences	A-J	Proactive identification of opportunities / requirements to involve and inform people about our work towards meeting our statutory duties and good practice commissioning
			Content planning to support key work programmes / celebrate success across all outlets / channels / media outlets
			Use our public facing communications channels appropriately to promote active involvement in our services, and look to develop other opportunities to do this (including social media)
Manage and plan for difficult situations	GP practices / Governing Body /Operational Team	I, J	Revised media protocol and social media guidelines in place and awareness raised amongst staff / members around responsibilities
	Governing Body /Operational Team		Ensure communications and engagement is considered in all corporate systems – including Governing Body, Quality Committee, Clinical QIPP and EPEG
			Ensure communications and engagement is considered in all key work programmes to ensure emerging issues are spotted and acted upon
			Deliver increased proactive media plan in line with objectives

Appendix 6

NHS
South Sefton
Clinical Commissioning Group

Media protocol

NHS South Sefton Clinical Commissioning Group

February 2018

Contents

About this media protocol

We aim to maximise opportunities to improve communications with local people and other partners through open, frank and effective media relations - initiating communications and responding to enquiries in a clear, timely and consistent way – to build a better understanding of our work and achievements.

Our central objective is to **ensure a positive media profile - maximise good publicity, minimise the effects of negative publicity and ensure a corporate approach to the media.**

To do this we will:

- Establish and maintain clear and regular channels of communication with the media and create a positive, informed and clear profile of who we are
- Develop and promote consistent key messages
- Respect the right of the media to represent all views
- Seek correction when media coverage is misleading or incorrect

Our media relations standards

1. **Telling our story** - proactive communication through press releases, briefings and opportunities is key to shaping our positive profile and ensuring our publics and partners understand our work and achievements. This requires our staff and member practices to inform the communications support service as soon as possible about the stories they have to tell about our work, new initiatives, successes that should be celebrated and difficult messages that must be communicated. Information must be timely and relevant to ensure media interest. Opportunities to attend events, interview key people and take photography will increase the appeal of our stories.
2. **Media enquiries** - a good relationship with the media is built on trust and responsiveness. We must ensure each issue is handled as well as possible and the media understand we are serious about openness and transparency. Our communications support service will respond to important media enquiries with a target turnaround of 4 hours whenever possible - this requires immediate attention and support from all our staff and members involved.
3. **Management of Information** – our Governing Body and Operational Team will consider communication issues at their regular meetings - discussing communication risks, opportunities and significant planned initiatives.
4. **Effective media communications**– our communications and engagement team can offer strategic advice and expertise, supported by analysis of media coverage of our activities and channels, through media monitoring.

Our media protocol

We will handle all media issues and enquiries in the following way:

A All media issues about our organisation are handled by our communications and engagement team…

- All direct approaches to staff by the media must be referred to the communications lead at the earliest possible opportunity
- The lead will prepare proactive press releases and provide briefings when appropriate, arrange opportunities for media interviews and provide briefings
- The lead will prepare reactive media statements and briefings, arrange media interviews and provide briefings
- The lead will quote the chair / accountable officer / other clinical members – who will also represent us as spokespeople for media interviews

B Our members and our staff should proactively inform our communications and engagement team about all plans that require or may lead to publicity…

- All plans that may lead to publicity - proactive or reactive - must be shared with the Team at the earliest stage to ensure communications opportunities and risks are identified and managed

C Our communications support will …

- Provide advice on issues and review reports that may lead to media interest
- Provide access to other appropriate communications opportunities
- Attend key internal meetings when required to discuss impending communications and engagement issues to identify opportunities and risks

D We will keep our partners informed by...

- Informing NHS England and other relevant partners – about media issues that may be of regional and national significance
- Liaising with our local partners – like Sefton Council, other CCGs and providers etc – on issues where we have joint responsibility or our media response may affect them
- Briefing key stakeholders about emerging issues or change - we will endeavour to ensure they hear news first from us

Social media guidance

Facebook, Twitter and You Tube are amongst some of the most well known examples of social media. Their power is growing and their application can therefore be useful for organisations to use appropriately to engage and inform their audiences. Whilst there are advantages to using social media, there can also be pitfalls which impact on reputation…

Our approach

…therefore, any engagement using these channels on behalf of the CCG should be managed by our central communications and engagement team. If you have a specific message you would like to cascade via social media, please contact communications who will provide advice and support.

Personal use

The following guidance provides a framework to help members protect themselves and our organisation, without sacrificing the benefits social media can bring to users.

1. Users are personally responsible for what they publish. Remember, anything posted will be published immediately and will be permanently available to a world wide audience and could be republished in other media
2. Internet postings must respect copyright, privacy, fair use, financial disclosure, and other applicable laws, such as libel and defamation
3. Internet postings should not disclose any information that is confidential or proprietary to the organisation or to any third party
4. If staff or members comment on our business they must clearly identify themselves with the disclaimer - "the views expressed are mine alone and do not necessarily reflect the views of the CCG." Individuals should neither claim or imply they speak on the organisation's behalf unless they have sought prior agreement via the communications and engagement team
5. Identify yourself – give your full name when you discuss work-related matters. Write in the first person. You must make it clear whether you are speaking for yourself or on behalf of the organisation with approval
6. Be aware of your personal profiles – you may wish to ensure your own personal profile and related content is consistent with how you wish to present yourself to colleagues and stakeholders
7. Be safe – never give out personal details or publish confidential information including that about patients, providers etc
8. Respect your audience - you should show proper consideration for others' privacy and for topics that may be considered objectionable or inflammatory
9. Add value – our brand is best represented by its people and what you publish may reflect on that
10. Social media should only be used in work time if it directly supports you in your employed position, and you have gained approval
11. Compliments and complaints – if you are made aware of any complaints/criticisms, or if you are made aware of a particularly satisfied service user, inform the communications team.
12. The organisation reserves the right to request the certain subjects are avoided, withdraw certain posts, and remove inappropriate comments

Our communications service

Press releases

We aim to achieve 100% take up of our press releases by the media, which means only producing releases on issues the media are likely to respond to and publish. Press release should be supported with arrangements for appropriate people to conduct follow up interviews and photo opportunities. Briefing notes will be prepared if appropriate. Our communications and engagement team will produce photography for distribution to the media if appropriate.

Media enquiries

We have highly skilled communications support in helping us to respond to media enquiries. The team relies on people throughout the organisation to respond to their referred enquiries as well and as quickly as possible. Each enquiry is logged and the results evaluated through our media monitoring.

Issue management

It is vital that we identify issues that may provide an opportunity for positive publicity or which may be contentious and plan for them as early as possible. Our communications and engagement team will prepare appropriate responses for any emerging problems, anticipating how the CCG will need to deal with criticism.

Nominated spokespeople

Agreeing a small pool of nominated, skilled spokespeople will ensure consistency of key messages. This will help build our reputation.

Rapid response

In cases where attacks on our organisation are made by media channels, our communications support will prepare a response with background notes, rebuttal statements and general advice.

Contacts

You can contact the communications and engagement team by:

Telephone - 0151 247 7055

Email - communications@southseftonccg.nhs.uk

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MARCH 2018

Agenda Item: 18/50	**Author of the Paper:** Phil Rule Interim Chief Accountant Email: phil.rule@southsefton.ccg.nhs.uk Tel: 0151 247 7070
Report date: March 2018	

Title: Annual Accounts Process 2017/18 - Governing Body Member's Declaration

Summary/Key Issues:

Governing Body Members are required to make an annual declaration as part of the annual audit process. The declaration confirms that Governing Body members know of no information which would be relevant to the auditors for the purposes of their audit.

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 and as part of the North Mersey LDS.
	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.

NHS
South Sefton
Clinical Commissioning Group

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement				
Clinical Engagement				
Equality Impact Assessment				
Legal Advice Sought				
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

South Sefton
Clinical Commissioning Group

Report to Governing Body
March 2018

1. Executive Summary

1.1 In support of the Corporate Governance Framework at the CCG, Governing Body Members are required to make an annual declaration as part of the annual audit process. The declaration confirms that Governing Body members know of no information which would be relevant to the auditors for the purposes of their audit.

1.2 The CCG Framework is summarised in the Introduction and Background in section 2 below and the declaration for consideration in Key Issues in section 3 below.

2. Introduction and Background

CCG Governance Framework

2.1 The CCG is a clinically led membership organisation made up of general practices. The member practices of the CCG are responsible for determining the governing arrangements for the organisation which are set out its Constitution.

2.2 The Constitution has been developed to reflect and support the objectives and values defined by the CCG and to ensure that all business functions discharged by the CCG are discharged in an open and transparent manner. It has been developed with the member practices and localities.

2.3 The Governing Body comprises a diverse range of skills from executive and lay members and there is a clear division of responsibility between running the Governing Body and running the operational elements of the CCG's business. The chair is responsible for the leadership of the Governing Body and ensures that directors have had access to relevant information to assist them in the delivery of their duties. The lay members have actively provided scrutiny and challenge at Governing Body and sub-committee level. Each committee comprises membership and representation from appropriate officers and lay members with sufficient experience and knowledge to support the committees in discharging their duties. The Governing Body is also assured of its effectiveness via the provider performance reports and compliance with constitutional standards.

2.4 The Audit Committee:

- Supports the establishment of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities to support the delivery of the CCG's objectives;
- Reviews and approve the arrangements for discharging the CCG's statutory financial duties;
- Reviews and approve arrangements for the CCG's standards of Business Conduct including conflicts of interest, the register of interests and codes of conduct;

- Ensures that the organisation has policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and to approve such policies, and
- Approves the annual accounts receives the letter of representation from external audit and receives other assurances from internal, external audit and third parties.

2.5 The CCG has a Risk Management Strategy and a Governing Body Assurance Framework in place and an annual review of the effectiveness of governance, risk management and internal control is carried out by the Accountable Officer and included in the Annual Governance Statement in the CCG's Annual Report and Accounts which is published on the CCG's website.

2.6 The Annual Governing Body Member's Declaration as part of the annual audit process is a further assurance in the Governance Framework. Previously this has consisted of a verbal declaration by Governing Body Members at the Governing Body meeting, with a confirmation reply to an e mail regarding the declaration sent by the CFO. The e mail responses are kept for audit evidence for the auditors.

3. Key Issues

3.1 The declaration to be confirmed by Governing Body Members is:

"I know of no information which would be relevant to the auditors for the purposes of their audit report, and which of the auditors are not aware, and (I have) taken all the steps that I ought to have taken to make myself aware of such information and to establish that the auditors are aware of any such information and to establish that the auditors are aware of it."

4. Conclusions

4.1 Governing Body Members to provide confirmation as part of the assurance process in the Governance Framework.

5. Recommendations

5.1 That Governing Body members:

- Verbal confirm their declaration at this Governing Body meeting, and
- Confirm their declaration by e mail to the CFO as audit evidence for the Auditors.

Phil Rule
Interim Chief Accountant
March 2018

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Key Issues Report to Governing Body

Joint Quality Committee Meeting held on 26th October 2017 Southport & Formby CCG and South Sefton CCG	Chair: Debbie Fagan

Information Points for Southport & Formby CCG Governing Body (for noting)
CQUIN Update – An update was received regarding 2017-18 CQUIN. Further contact to be made with NHSE to gain final clarification regarding ability to deviate from national CQUIN following provider request / information received from other commissioners and providers.
AQuA Quarterly Safety Report: Southport & Ormskirk Hospitals NHS Trust (S&O) – This report was received. Time lag in information noted but report was found to be valuable in re-inforcing information already known by commissioners. CCG BI team to be asked to provide more current information to be considered alongside the next quarterly AQuA report. AQuA to be contacted to facilitate a session at the next Joint Quality Committee Development Day.
Serious Incident Report Q2 2017-18 – This report was received. 3 x Ophthalmology incidents at Aintree University Hospital from September 2017 verbally reported at the September 2017 JQC now featured in this report.

Mersey Care Serious Incidents RCA Reports – Action plans not always submitted with the RCAs, this has been raised with Trust and Liverpool CCG. It was noted the constraints with 'Acting as One' in relation to contractual levers.
Standard Operating Procedure (SOP) Mersey Care Serious Incident Reporting: Community Contract – SOP was approved.
S&O Maternity Services – An update was received regarding challenges faced by the provider with the Middle Grade Rota and discussions across the health economy.
S&O CQC Section 65 Letters – The Trust have recently received 2 x Section 65 letters relating to RTT and a component of Maternity Services delivery. Responses have been sent from the Trust to the CQC. NHSE, NHSI, CQC and the CCGs are in regular contact with S&O for the purposes of assurance.
CCG Children in Care Annual Report 2016/17 – The annual report was received and approved. The Quality Committee recommended presentation to the Governing Body for the purposes of ratification.

Key Issues Report to SSCCG Governing Body

NHS
South Sefton
Clinical Commissioning Group

Joint Quality Committee Meeting held on 30th November 2017 Southport & Formby CCG and South Sefton CCG	Chaired by: Dr Rob Caudwell

Information Points for South Sefton CCG Governing Body (for noting)
Provider Performance Reports – these have been reviewed by the Joint Quality Committees
Mental Health Performance – a request has been made to the CCGs' Mental Health Commissioning Manager to undertake a 'deep-dive' of performance and report back to the March 2018 meeting of the Joint Quality Committee
Multi-Agency Discharge Event (MADE) – A MADE event has taken place at AUH which was supported by the CCG team. Recommendations from the event will form part of a system action plan
S&O CQC Inspection – the CCG has submitted information to the CQC to inform the forthcoming Chief Inspector of Hospitals Inspection Visit. The information submitted has been reviewed at the Joint Quality Committee
NHSE SEND CCG Self-Assessment – the CCG has completed and submitted this self-assessment which has been presented to the Joint Quality Committee for information.

NHS

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Joint Quality Committee Minutes
Part B – Southport & Formby CCG and South Sefton CCG

Date: Thursday 26th October 2017
Venue: Room 3A, 3rd Floor, Merton House, Stanley Road, Bootle L20 3DL

Membership		
Graham Bayliss	Lay Member (SSCCG)	GB
Lin Bennett	Practice Manager / Govn Body Member (SSCCG)	LB
Gill Brown	Lay Member (SFCCG)	GBr
Dr Doug Callow	GP Quality Lead (SFCCG)	DC
Dr Rob Caudwell	GP Governing Body Member (SFCCG)	RC
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation (SSCCG)	PC
Billie Dodd	Head of Commissioning (SFCCG / SSCCG)	BD
Debbie Fagan	Chief Nurse/Quality Officer(SFCCG/SSCCG)	DF
Dr Gina Halstead	GP Clinical Quality Lead (SSCCG)	GH
Dr Dan McDowell	Secondary Care Doctor (SSCCG)	DMcD
Martin McDowell	Chief Finance Officer (SFCCG / SSCCG)	MMcD
Dr Andy Mimnagh	Chair & Governing Body Member (SSCCG)	AM
Jeffrey Simmonds	Secondary Care Doctor (SFCCG)	JSi
Ex Officio Member		
Fiona Taylor	Chief Officer (SFCCG / SSCCG)	FLT
In attendance		
Emma Bracewell	Programme Manager – Quality & Performance	EB
Brendan Prescott	Deputy Chief Nurse / Head of Quality and Safety	BP
Helen Roberts	Senior Pharmacist	HR
Gail Winder	Designated Nurse Safeguarding Adults	GW
Apologies		
Dr Rob Caudwell	GP Governing Body Member (SFCCG)	RC
Karen Garside	Designated Nurse Safeguarding Children	KG
Lin Bennett	Practice Manager / Govn Body Member (SSCCG)	LB
Dr Pete Chamberlain	GP Clinical Lead Strategy & Innovation (SSCCG)	PC
Julie Cummins	Clinical Quality & Performance Co-ordinator	JC
Gill Brown	Lay Member (SFCCG)	DmcD
Jeffrey Simmonds	Secondary Care Doctor (SFCCG)	JSi
Dr Gina Halstead	GP Clinical Quality Lead (SSCCG)	GH
Dr Andy Mimnagh	Chair & Governing Body Member (SSCCG)	AM
Fiona Taylor	Chief Officer (SFCCG / SSCCG)	FLT
Dr John Wray	Governing Body Member (SSCCG)	JW
Dr Dan McDowell	Secondary Care Doctor (SSCCG)	DMcD
Minutes		
Debbie Fagan	Chief Nurse (SSCCG/SFCCG)	DF

Membership Attendance Tracker

Name	Membership	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18
Dr Rob Caudwell	GP Governing Body Member	√	A	A										
Graham Bayliss	Lay Member for Patient & Public Involvement	A	√	√										
Lin Bennett	Practice Manager, Ford	√	A	A										
Gill Brown	Lay Member for Patient & Public Involvement	√	A	A										
Dr Doug Callow	GP Governing Body Member /Clinical Quality Lead	A	√	√										
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	A	A	A										
Billie Dodd	Head of CCG Development	A	√	√										
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										
Martin McDowell	Chief Finance Officer	A	√	A										
Dr Andrew Mimnagh	Clinical Governing Body Member	A	A	A										
Dr Jeffrey Simmonds	Secondary Care Doctor	A	A	A										

✓ Present
A Apologies
L Late or left early

Part B

No	Item	Actions
17/186	**Welcome, Introductions & Apologies** Apologies received from LB, Dr RC, Dr PC, Dr DMcD, Dr AM, MMcD, BP, Dr JSi and FLT. SL in attendance for HR.	
17/187	**Declarations of Interest** None reported other than those staff holding dual roles across both CCGs.	
17/188	**Minutes & Key Issues from previous meeting** Minutes of the meeting and key issues log were agreed as an accurate reflection of the previous meeting.	
17/189	**Matters Arising / Action Tracker** **17/065(xx) Dr GH to contact Dr WH re: LWH regarding communication between Midwives and GPs re: prescribing requests.** **Update:** Dr GH stated that this issue has been addressed. **Outcome:** Action closed.	

No	Item	Actions
	17/158 Workplan - DF to review the JQC ToR and Work Plan with Debbie Fairclough from a quoracy and governance perspective. **Update:** DF stated that she had discussed the workplan and quoracy with DFair – this included how the JQC had been operating since auctioning the request from members to split into Part A, B and C due to the time available and growing agenda. It was noted that although the changes had many positives, there were some potential challenges to quoracy, efficiency and the rationale as to why the committee became joint following the PWC review. Members of the committee acknowledged that the CCG officers had attempted to meet the request of members and it had always been the intention to review. The decision was made to stop the Part A, B and C and to revert back to one whole meeting with the time frame remaining a 3 hour duration and alternating between an external and internal focus. DF stated that this discussion would now inform the workplan. DF stated that DFair would be adding HR to the ToR to show Medicines Management as a member of the committee going forward. **Outcome:** Action closed. **17/160 Modern Slavery & Human Trafficking Statement - KG to liaise with the CCGs' Communications Team to have the Modern Slavery & Human Trafficking Statement uploaded on to the websites.** **Update:** DF in the absence of KG stated that this action had been completed. **Outcome:** Action closed. **17/162 Revision of Standard Operating Procedure (SOP) for management of serious incidents.** HR to liaise with LG to suggest that more specific information is contained within section 5.5 ie. e-mail address. **Update:** HR has spoken to LG regarding the Datix form and she is going to ask the Insight Team to amend the form that CCG staff use (ie. not GP practice staff form). There will be an option (in addition to yes or no) under 'Is this a serious incident?' to refer to the Quality Team, a link to their generic e-mail and an information message that the reporter should contact the Quality Team to discuss in person asap. **Outcome:** Action closed. **17/163 Performance Report Trend Information** EB to look at report / data and discuss with the BI Team if trend analysis could be made more clearer in their reports. **Update:** EB stated that she had been liaising with the BI Team. DF stated that the Quality Team had had previous discussions with the BI Team to explore if future provider performance reports could be amended / consolidated as the Quality Committee isn't the CRM / CQPG. DF asked EB to ensure these conversations are included in the work she is doing with BI re: trend analysis. **Outcome:** Action closed. **17/165 CHC Disputes and Resolution Policy** DF to raise with LA colleagues at the Integrated Commissioning Group the concern raised re: potential conflict of interest with the LA suggested Chair raised by GB. **Update:** DF confirmed that she had raised this issue at the Integrated Commissioning Group meeting and LA colleagues although they felt there was no conflict of interest had agreed to take the issue back for further discussion internally. **Outcome:** Action closed.	

No	Item	Actions
17/190	**Chief Nurse Report** DF presented the Chief Nurse report. The Committee were asked to particularly note the following: • Progress in relation to the SEND Written Statement of Action • Usage of the ADAM DPS still remaining suspended for End of Life patients whilst the necessary assurances are gained from the provider by the CCG – liaison between the CCGs and CSU / ADAM continues • Q2 2017/18 performance regarding the number of DSTs undertaken within acute Trust environments – improving position reported for SSCCG but decline in position noted for SFCCG. The Committee were asked to note the small numbers involved and the attempts being made between the CCGs and CSU to improve data quality • Update since the completion by commissioners of the Quality Risk Profile Tool (QRPT) for AUH. A date is awaited to meet with the provider to review the QRPT and agree risk rating • Recent CQC Chief Inspector of Hospitals Visit to AUH – outcome is awaited • Feedback from NHSE on the CCGs' GNBSI reduction plan – updated plan requested to be submitted in December 2017 • Collaborative work with the support from the Cheshire & Merseyside Vanguard to address challenges with the Obstetric Middle Grade Rota at S&O. Communication planned and being developed for all stakeholders. • Outcome of the recent CQC Chief Inspector of Hospitals Visit to Alder Hey Children's NHS Foundation Trust which went into the public domain at the beginning of October - overall rating was 'Good' with 'Outstanding' for caring. Surgery and Out-patients (which includes CAMHS) were rated as 'Requires Improvement'. The Committee were also informed of the recent issuing of a Section 65 letter to S&O in relation to a component part of maternity services provision – the Trust response has been sent to the CQC. Updates will be received by the Quality Committee as appropriate.	

No	Item	Actions
17/191	**S&O CQC Regulation 10 / Section 65** DF presented the paper to the Committee which outlined the rationale for the issuing of the Section 65 letter relating to RTT by the CQC to the Trust. The required provider response has been submitted to the CQC by the Trust and meetings have taken place between NHSE, NHSI, CQC and the CCGs for the purpose of assurance – commissioners and regulators have set out what they expect the Trust to have in place to manage any risk and in order to provide assurance. Current level of assurance in relation to the provider discussed with GBr and GB raising the issue about Duty of Candour, transparency and messages to be given to patients, the public and local GPs. GBr and GB asked to see sight of the Communications plan for both Maternity Services and RTT. It was explained that the Trust were leading on the Communications but BD would ask the CCGs' Head of Communication to forward any plans and briefings to the CCG Lay Members. Discussion took place regarding quality concerns at the Trust and DF explained the Quality Surveillance and Assurance processes that were in place, including the involvement of commissioners and regulators. Dr DC raised concerns about challenges with medical rotas at the Trust and DF stated that this had been a specific agenda item at the last CRM / CQPG with the Deputy Medical Director presenting an initial overview of the current position – this is to be further updated by the Trust and NHSE had been made aware of the intention to have this discussion – update will be contained within the next QSG Exception Report. The importance of lessons learnt was discussed and Dr GH relayed some of the lessons learnt from the Liverpool Clinical Laboratories incident that had previously occurred and gave some reflections from Liverpool Community Health NHS Trust and subsequent involvement in the Kirkup Review. DF stated that she would escalate issues to the CCG Chief Officer for further discussion.	
	Action: **17/191/(i) S&O CQC Regulation 10 / Section 65 - S&O Communication Plans & Stakeholder Briefings Re; Maternity and RTT** BD to contact LN to ask for any provider Communication Plans and Stakeholder Briefings to be shared with the CCG Lay Members. **17/191(ii) S&O CQC Regulation 10 / Section 65 – Quality and Performance Issues** DF to escalate issues to the CCG Chief Officer for further discussion.	BD DF
17/192	**QIPP** **i. Issues from Clinical QIPP** DF stated there was nothing specific to report. **ii. QIA Activity** DF stated there was nothing specific to report.	

No	Item	Actions
17/193	**Cheshire & Merseyside Quality Surveillance Group – SFCCG / SSCCG Exception Report** DF presented the report which was received by the Committee.	
17/194	**Nursing Home Quality, Performance & Safeguarding Report** JC presented the report which was received by the Committee. GBr asked how the quality monitoring was undertaken and this was explained by JC. The Committee noted that exclusions remain regarding admissions to St. Joseph's Hospice following the recent CQC inspection.	
17/195	**Children in Care Annual Report 2016/17** CB presented the CCGs' Children in Care Annual Report 2016/17 to the Committee. Members of the committee thanked CB for the quality of the report. Dr GH stressed the importance of the CCGs taking their corporate parent responsibility seriously and stated that this report reflect why they need to do so. The elements regarding health assessments was highlighted and it was noted that this will be further discussed in agenda item 17/196 Sefton IHA Q1 Audit Commentary. The Committee approved the report and recommended presentation to the Governing Body for ratification.	
	Action: **17/195 Children in Care Annual Report 2016/17** CB to present the Children in Care Annual Report 2016/17 to the Governing Bodies.	CB
17/196	**Sefton Initial Health Assessment Q1 Audit Commentary** CB presented the report which covered the period Q1 2017/18. The previous revised pathway work that had been undertaken across the health economy to bring about improvement was discussed along with the outcome of this audit. The audit which was undertaken by the Designated Nurse Looked After Children and a representative from the LA, identified continued challenges with the part of the pathway, which at Q1, was provided by LCH. This service is now provided by Mersey Care under a sub-contracting arrangement with North West Boroughs – DF confirmed that this service and the issue with health assessments had already been placed on the CCGs' Corporate Risk Register. The audit results have been shared with both Mersey Care and North West Boroughs and a remedial action plan has been requested. The Designated Nurse for Looked After Children has also been liaising with the provider organisation to provide clarity re: outcome / recommendations and support. The CCGs' Chief Nurse and Designated Nurse for Looked After Children have recently presented the audit to the Corporate Parenting Board who have requested sight of the action plan and details of when a re-audit will take place at its December 2017 meeting. Updates to come to the Joint Quality Committee as required.	

No	Item	Actions
17/197	**Planned Review of SSCCG & SFCCG Safeguarding Children & Adults at Risk Policy.** DF presented the report which was received by the Committee. The Committee agreed to support an extension to the review period for the policy due to the new Working Together to Safeguard Children national guidance being awaited which will inform the policy update.	
17/198	**Commissioner Quarterly Controlled Drug Report** SL presented the report which was received by the Committee.	
17/199	**EPEG Key Issues** GBr and GB presented the key issues from the last meeting. The Quality Committee were asked to note the following: • The GP patient survey results for 2017 were positive and an improvement from 2016 • Concerns raised in relation to repeat prescribing, it was confirmed that SL was managing this • The contract for Sefton MBC Dom Care Service Providers had been completed with inclusion and support from medicines management for this element of the contract. • Good feedback was reported in relation to the service received provided by the Living Well Mentors, which is part of Well Sefton and the Virtual Ward. There was a recommendation for information about the Sefton CVS Living Well programme co-ordinated by Karen Nolan to be brought to the attention for GP's at locality meetings and via CCG bulletin.	
	Action **17/199 Living Well Mentors - TF to liaise with Angela McMahon and Louise Taylor to contact Karen Nolan for inclusion at locality meetings and CCG bulletin**	
17/200	**Corporate Governance Support Group Key Issues** DF presented the key issues log from the last meeting of the Corporate Governance Support Group which was held in June 2017. The Quality Committee received this information.	
17/201	**Any Other Business** None reported.	

No	Item	Actions
17/202	**Key Issues Log (identified in this part of the meeting)** The following key issues were identified from this meeting: • **S&O Maternity Services** – An update was received regarding challenges faced by the provider with the Middle Grade Rota and support being received from across the health economy. • **S&O CQC Section 65 Letters** – The Trust have recently received 2 x Section 65 letters relating to RTT and a component of Maternity Services delivery. Responses have been sent from the Trust to the CQC. NHSE, NHSI, CQC and the CCGs are in regular contact for the purposes of assurance. • **CCG Children in Care Annual Report 2016/17** – The annual report was received and approved. The Quality Committee recommended presentation to the Governing Body for the purposes of ratification.	
	Date & Time of Next Meeting **Thursday 30th November 2017 - 09.00 – 12.00** **Boardroom, 3rd Floor, Merton House, Bootle**	

NHS

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Joint Quality Committee Minutes
Part C – NHS South Sefton CCG

Date: Thursday 26th October 2017
Venue: Room 3A, 3rd Floor, Merton House, Stanley Road, Bootle L20 3DL

Membership		
Graham Bayliss	Lay Member (SSCCG)	GB
Lin Bennett	Practice Manager / Govn. Body Member (SSCCG)	LB
Gill Brown	Lay Member (SFCCG)	GBr
Dr Doug Callow	GP Quality Lead (SFCCG)	DC
Dr Rob Caudwell	(Chair) GP Governing Body Member (SFCCG)	RC
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation (SSCCG)	PC
Billie Dodd	Head of Commissioning (SFCCG / SSCCG)	BD
Debbie Fagan	Chief Nurse & Quality Officer (SFCCG / SSCCG)	DF
Dr Gina Halstead	GP Clinical Quality Lead (SSCCG)	GH
Dr Dan McDowell	Secondary Care Doctor (SSCCG)	DMcD
Martin McDowell	Chief Finance Officer (SFCCG / SSCCG)	MMcD
Dr Andy Mimnagh	Chair & Governing Body Member (SSCCG)	AM
Jeffrey Simmonds	Secondary Care Doctor (SFCCG)	JSi
Ex Officio Member		
Fiona Taylor	Chief Officer (SFCCG / SSCCG)	FT
In attendance		
Emma Bracewell	Programme Manager Quality & Performance	EB
Brendan Prescott	Deputy Chief Nurse / Head of Quality and Safety	BP
Helen Roberts	Senior Pharmacist (SFCCG / SSCCG)	HR
Apologies		
Dr Pete Chamberlain	GP Clinical Lead Strategy & Innovation (SSCCG)	PC
Julie Cummins	Clinical Quality & Performance Co-ordinator	JC
Lin Bennett	Practice Manager / Govn. Body Member (SSCCG)	LB
Dr Gina Halstead	GP Clinical Quality Lead (SSCCG)	GH
Dr Andy Mimnagh	Chair & Governing Body Member (SSCCG)	AM
Fiona Taylor	Chief Officer (SFCCG / SSCCG)	FT
Dr John Wray	Governing Body Member (SSCCG)	JR
Minutes		
Debbie Fagan	Chief Nurse	DF

Membership Attendance Tracker

Name	Membership	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18
Dr Rob Caudwell	GP Governing Body Member													
Graham Bayliss	Lay Member for Patient & Public Involvement	A	√	√										
Lin Bennett	Practice Manager, Ford	√	A	A										
Gill Brown	Lay Member for Patient & Public Involvement													
Dr Doug Callow	GP Governing Body Member /Clinical Quality Lead													
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	A	A	A										
Billie Dodd	Head of CCG Development	A	√	√										
Debbie Fagan	Chief Nurse & Quality Officer	√	√	√										
Dr Gina Halstead	Chair and Clinical Lead for Quality	A	A	√										
Dr Dan McDowell	Secondary Care Doctor	A	√	A										
Martin McDowell	Chief Finance Officer	A	√	A										
Dr Andrew Mimnagh	Clinical Governing Body Member	A	A	A										
Dr Jeffrey Simmonds	Secondary Care Doctor													

✓ Present
A Apologies
L Late or left early

Part C

No	Item	Actions
17/203	**Welcome, Introductions & Apologies** Apologies received from LB, Dr PC, EB, Dr DMcD, Dr AM, MMcD, BP and FLT. SL in attendance for HR.	
17/204	**Declarations of Interest** None reported other than those staff holding dual roles across both CCGs.	
17/205	**Minutes & Key Issues from previous meeting** Minutes of the meeting and key issues log agreed as an accurate reflection.	
17/206	**Matters Arising / Action Tracker** There were no actions open from the last meeting.	

No	Item	Actions
17/207	**CQUIN Update** DF provided an update on CQUIN progress on behalf of EB. It was reported that some providers are requesting deviations from parts of the national CQUINs. Advice has been received from NHSE stating that no deviations are allowed. However, there is a query regarding the consistency of this advice and information has been provided to EB from other commissioners and providers evidencing support for some deviation. DF stated she would asked EB to re-contact NHSE and share the evidence in order to obtain a definitive position to inform any change in the current stance of the CCG which is no deviation as these are nationally set. Dr GH stated that it is important that definitive advice is received from NHSE as the CCG has previous examples where NHSE had been clear about not deviating from national guidance.	
	Action: **17/207 CQUIN Update – Advise on local deviation of national CQUIN** EB to re-contact NHSE and share the information obtained from other commissioners and providers to obtain a definitive response to inform any change in the current CCG position.	EB
17/208	**AQuA Quarterly Safety Report – Aintree University Hospital NHS Foundation Trust** DF presented the report which provided information on incident reporting, re-admissions and the in-patient survey. The time-lag in the information provided was highlighted and it was acknowledged that this did support the information that commissioners were already aware of regarding the Trust and had incorporated into the recent Quality Risk Profile Tool. DF stated that the Quality Team would liaise with the CCG Business Intelligence Team to request that current information that the CCG holds in relation to the 3 areas in the report is presented alongside the next AQuA quarterly report. It was agreed that the AQuA reports be a focus of the Joint Quality Committee development session next year and AQuA be contacted in order to arrange.	
	Action: **17/208(i) AQuA Quarterly Safety Report – Aintree University Hospital NHS Foundation Trust (AUH)** EB to liaise with the CCG Business Intelligence Team to request that current information that the CCG holds in relation to the 3 areas in the report is presented alongside the next AQuA quarterly report. **17/208(ii) AQuA Quarterly Safety Report – Aintree University Hospital NHS Foundation Trust (AUH)** DF to contact AQuA to discuss them presenting at the next Joint Quality Committee Development Session.	

No	Item	Actions
17/209	**Serious Incident Report Q2 2017-18** TF presented the report. Issues of inconsistent inclusion of action plans submitted with RCA's has been raised with Mersey Care and Liverpool CCG as the co-ordinating commissioner for the SI process. DF was asked to raise at the next Mersey Care CQPG. The Quality Committee asked of the incomplete RCAs (those sent without an action plan) constituted a breach in contract. However, it was explained that due to 'Acting As One', certain financial sanctions could not be applied but this did not prevent other contract sanctions being utilised as appropriate. It was requested that the Governing Body be made aware of the constraints of 'Acting As One' and to be included on the Key Issues Log	
17/210	**Standard Operating Procedure for Mersey Care NHS Foundation Trust Serious Incidents – Community Contract** TF presented the Standard Operating Procedure (SOP) which was approved by the Committee. The Committee were asked to note that now that the community services in Liverpool had been awarded to Mersey Care NHS Foundation Trust this may mean going forward either amendments being made to the SOP or no need for this SOP going forward – this will be determined and appropriate action taken by the Quality Team.	
17/211	**Any Other Business** None reported.	
17/212	**Key Issues Log (identified in this part of the meeting)** **Key Issues Log (issues identified from this part of the meeting** The following key issues were identified from this meeting: • **CQUIN Update** – An update was received regarding 2017-18 CQUIN. Further contact to be made with NHSE to gain final clarification regarding ability to deviate from national CQUIN following provider request / information received from other commissioners and providers. • **AQuA Quarterly Safety Report: Southport & Ormskirk Hospitals NHS Trust (S&O)** – This report was received. Time lag in information noted. CCG BI team to be asked to provide more current information to be considered alongside the next quarterly AQuA report. AQuA to be contacted to facilitate a session at the next Joint Quality Committee Development Day. • **Serious Incident Report Q2 2017-18** – This report was received. 3 x Ophthalmology incidents from September 2017 verbally reported at the September 2017 JQC now featured in this report. • **Mersey Care Action Plans including in RCA's** – Action plans not always submitted with the RCA's, this has been raised with Trust and Liverpool CCG. It was noted the constraints with 'Action As One' in relation to contractile levers. • **Standard Operating Procedure (SOP) Mersey Care Serious Incident Reporting: Community Contract** – SOP was approved.	

No	Item	Actions
17/213	**Date & Time of Next Meeting** **Thursday 30th November 2017 - 09.00 – 12.00** **Boardroom, 3rd Floor, Merton House, Bootle**	

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Joint Quality Committee Minutes
NHS Southport and Formby CCG & NHS South Sefton CCG

Date: **Thursday 30th November 2017, 09:00 – 12:00**
Venue: **Room 3A, Merton House, Stanley Road, Bootle L20 3DL**

Membership		
Graham Bayliss	Lay Member (SSCCG)	GB
Lin Bennett	Practice Manager / Govn.Body Member (SSCCG)	LB
Gill Brown	Lay Member (SFCCG)	GBr
Dr Doug Callow	GP Quality Lead (SFCCG)	DC
Dr Rob Caudwell	(Chair) GP Governing Body Member (SFCCG)	RC
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation (SSCCG)	PC
Billie Dodd	Head of Commissioning (SFCCG / SSCCG)	BD
Debbie Fagan	Chief Nurse & Quality Officer (SFCCG / SSCCG)	DF
Dr Gina Halstead	GP Clinical Quality Lead (SSCCG)	GH
Dr Dan McDowell	Secondary Care Doctor (SSCCG)	DMcD
Martin McDowell	Chief Finance Officer (SFCCG / SSCCG)	MMcD
Dr Andy Mimnagh	Chair & Governing Body Member (SSCCG)	AM
Dr Jeffrey Simmonds	Secondary Care Doctor (SFCCG)	JSi
Ex Officio Member		
Fiona Taylor	Chief Officer (SFCCG / SSCCG)	FLT
In attendance		
Paul Shilcock	Account &Training Manager – iMerseyside	PS
Becky Williams	Strategy & Outcomes Officer (SSCCG/SFCCG)	BW
Apologies		
Lin Bennett	Practice Manager / Govn.Body Member (SSCCG)	LB
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation (SSCCG)	PC
Dr Gina Halstead	GP Clinical Quality Lead (SSCCG)	GH
Martin McDowell	Chief Finance Officer (SFCCG / SSCCG)	MMcD
Dr Andy Mimnagh	Chair & Governing Body Member (SSCCG)	AM
Dr Jeffrey Simmonds	Secondary Care Doctor (SFCCG)	JSi
Minutes		
Debbie Fagan	Chief Nurse (SFCCG / SSCCG)	DF

Membership Attendance Tracker

Name	Membership	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18
Dr Rob Caudwell	GP Governing Body Member	√	√	A	√									
Graham Bayliss	Lay Member for Patient & Public Involvement													
Lin Bennett	Practice Manager, Governing Body Member				A									
Gill Brown	Lay Member for Patient & Public Involvement	√	A	√	√									
Dr Doug Callow	GP Governing Body Member /Clinical Quality Lead	√	√	√	√									
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation				A									
Billie Dodd	Head of CCG Development	A	√	√	√									
Debbie Fagan	Chief Nurse & Quality Officer	√	√	√	√									
Dr Gina Halstead	Chair and Clinical Lead for Quality		A	√	A									
Dr Dan McDowell	Secondary Care Doctor			A	A									
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	A									

✓ Present
A Apologies
L Late or left early

No	Item	Actions
17/214	**Welcome, Introductions & Apologies** All were welcomed to the meeting. FLT was in attendance in her ex-officio member capacity. Paul Shilcock (PS) was in attendance to present agenda item 17/218. Becky Williams (BW) was in attendance to present agenda item 17/223. Apologies were received from LB, DrPC, DrGH, MMcD, DrAM and DrJS. The meeting was deemed quorate.	
17/215	**Declarations of Interest** None were reported other than those staff holding dual roles within the CCGs.	
17/216	**Minutes & Key issues log of the previous meeting** <u>Part A – SFCCG</u> Subject to the following amendments the minutes were deemed to be an accurate reflection: • Date of the meeting should state 26th October 2017 and not 28th September 2017 • Membership attendance tracker requires completion for October 2017	

No	Item	Actions
	Part B – SFCCG / SSCCG Subject to the following amendments the minutes were deemed to be an accurate reflection: • Date of the meeting should state 26th October 2017 and not 28th September 2017 • Membership attendance tracker requires completion for October 2017 Part C – SSCCG Subject to the following amendments the minutes were deemed to be an accurate reflection: • Date of the meeting should state 26th October 2017 and not 28th September 2017 • Membership attendance tracker requires completion for October 2017 The Key issues logs for both Governing Bodies were deemed to be an accurate reflection. 17/191(i) on the action tracker requires amending from 'BD to contact LN' to 'BD to contact 'LC'.	
	Action: DF to ask JW to make the necessary amendments to the minutes and action tracker.	DF
17/217	**Matters Arising / Action Tracker** **SFCCG 17/181; SSCCG 17/207 CQUIN Update – Advise on local deviation of national CQUIN** **Update:** EB confirmed that she had contacted NHSE and forwarded the information that providers had sent about agreements with other commissioners. Information from NHSE appeared to be inconsistent. It was confirmed that the stance taken back to providers within the CQPGs was that the CCGs would not be deviating from the national CQUIN unless authorised to do so by NHSE. **Outcome – To remain open and EB to feedback at the next meeting.** **SFCCG 17/182(i); SSCCG 17/208(i) AQuA Quarterly Safety Report – Southport & Ormskirk Hospitals NHS Trust (S&O) & Aintree University Hospital NHS Foundation Trust (AUH)**	EB

No	Item	Actions
	Update: EB confirmed that she had liaised with the CCG BI team to request that current information that the CCG holds in relation to the 3 areas in the report is in future presented alongside the AQuA information so a more up to date picture is obtained if possible. **Outcome – Action closed.** **SFCCG 17/182(ii); SSCCG 17/208(ii) AQuA Quarterly Safety Report – Southport & Ormskirk Hospitals NHS Trust (S&O) & Aintree University Hospital NHS Foundation Trust (AUH)** **Update:** DF has e-mailed BW and received contact details of AQuA colleague to be invited to the Quality Committee Development Session in 2018. **Outcome – Action closed.** **17/183(i) Serious Incident Report Q2 2017-18** **Update:** DF confirmed that she had raised the issue at the Mersey Care CQPG. **Outcome – Action closed.** **17/183(ii) Serious Incident Report Q2 2017-18** **Update:** Constraints and impact of 'Acting as One' was contained within the key issues log to the Governing Body. **Outcome – Action closed.** **17/191(i) S&O CQC Regulation 10 / Section 65 – S&O** **Communication Plans & Stakeholder Briefings Re; Maternity & RTT** **Update:** This has not yet been actioned. **Outcome:** Action to be carried forward to the next meeting **17/191(ii) S&O CQC Regulation 10 / Section 65 – Quality & Performance Issues** **Update:** DF confirmed that this had been discussed at the Governing Body. **Outcome – Action closed.**	BD

No	Item	Actions
	17/195 Children in Care Annual Report 2016/17 **Update:** DF confirmed that the presentation to the Governing Bodies had been actioned. **Outcome – Action closed.** **17/199 EPEG Key Issues** **Update:** This has not yet been actioned. **Outcome:** Action to be carried forward to the next meeting	
17/218	**EPaCCS Update** PS presented an update report on EPaCCS which gave an overview of progress. Issues were identified with the GP Out of Hours provider being able to access the necessary information to support End of Life care (reportedly have read only access) but there had been some recent progress on this. PS reported that meetings have been progressing but there had been some issues with engagement from the CCGs. The narrative within the report was discussed and FLT asked if the report could be amended to clearly state 'Southport & Formby CCG' and 'South Sefton CCG' as Sefton CCG did not exist. PS was also asked to amend the wording 'negligible' and 'hampered' to 'impacted'. PS stated he would make the necessary amendments following the discussion that had taken place at the Committee. PS asked if there was still a requirement for continued reporting into the Quality Committee. The Committee requested that high level dashboard reporting come to the Quality Committee on a bi-annual basis and that this should be built into the work plan.	
	Action 1: CCG representation at the EPaCCS Task & Finish Group BD to ask Moira Harrison to attend the Task & Finish Group to represent the CCGs. **Action2: EPaCCS to be added to the Quality Committee Work plan** DF to ask JW to put EPaCCS on the Quality Committee work plan bi-annually.	BD DF
17/219	**Transition of Community Services / Quality Assurance** BP confirmed that the transition KPIs were included in the new contracts and that providers will be reporting against these. A report has been received from AUH regarding the transition of the Diabetes Team from LCH to AUH. The surveillance questions demonstrated high confidence levels for incident reporting with the new employer and good satisfaction scores in relation to staff support and support to patients. **Action:** The Committee received the report.	

No	Item	Actions
17/220	**Provider Performance Reports** EB presented the new style report and the Committee were asked for comments. The Committee welcomed this new style which clearly set out performance by exception and assurance. It was acknowledged that this report would require further development but was received well. Key areas discussed by exception were as follows: <u>S&O – Women & Children's</u> System work continues with the support of the Vanguard. The Trust is due to responded to a letter from the CCG Chief Officer confirming that they are in a position to continue to deliver their contractual responsibilities for Obstetrics and Gynaecology Services. The work undertaken by the Trust and the wider system was acknowledged. <u>S&O – Urgent Care</u> FLT informed the Committee of a half-day session she had facilitated with the Trust and wider system to support greater understanding and improvement across the system. GBr stated that she felt the session was insightful. RC stated that NHSI had agreed a trajectory with the Trust and queried where the Trust where up to with this. EB agreed to find this out and report back to RC.	
	Action 1: S&O Urgent Care Performance Against the NHSI Agreed Trajectory EB to find out what S&O performance is like in meeting the urgent care trajectory set by NHSI.	EB

No	Item	Actions
	S&O – Mortality Latest AQuA Mortality Report has been previously discussed with the Trust and a CCG / System workshop has been planned for the purposes of assurance. The Trust has established a Mortality Assurance Clinical Improvement Committee and the CCG has agreed to identify representation – this will be RC for SFCCG. S&O – Stroke Services The trust continues to be challenged in meeting the indicators regarding the % of stroke patients spending more than 90% of their Hospital Stay on a Stroke Unit and the % of TIA cases with a higher risk of stroke who are seen and treated within 24 hrs. A recent discussion has taken place with the interim Chief Executive who has acknowledged these challenges and has expressed eh intention to speak with the CEO at AUH regarding the pathway of care. S&O - Dermatology The Trust is currently only accepting a 2 week waiting list for Dermatology due to capacity issues. DC raised the issue of procedures of low clinical value possibly being referred / undertaken by DMC. BD has asked for case examples so the commissioning managers can address as appropriate. FLT reported that KMcC is visiting local CCGs as part of an engagement exercise regarding a possible joint case for change	
	Action 2: Dermatology Case Examples - LCV DC to send case examples of referrals / procedures of LCV being undertaken by DMC to BD for the commissioning managers to address as appropriate.	DC

No	Item	Actions
	Renacres Data quality in relation to diagnostics has been raised as an issue and the CCGs are awaiting a remedial action plan. Issues are apparent with coding for pain management and the CCG is awaiting feedback from a coding audit that has been commissioned by WLCCG. Lancashire Care Foundation Trust The data flow from the Trust for the purposes of assurance was discussed along with what softer intelligence is available – some data starting to flow through but as of yet it isn't comprehensive. The Committee noted that there had been a recent presentation from the Trust to SFCCG Governing Body regarding around intelligence they had which was supporting the Transformation process for the purposes of assurance. DF reported that it had been confirmed by NHSE C&M that reporting for the Trust as part of the NHSE Quality Surveillance Process would be by the Lancashire Commissioners to the Lancashire QSG and that the NHSE C&M team would feed back any issues to SFCCG. There was no requirement for the CCG Quality Team to report information about this provider into the C&M QSG. Mersey Care NHS Foundation Trust (Mental health Contract) – Psychotherapy Issues regarding performance against the Psychotherapy Treatment indicator was discussed and BP stated that this had been discussed at the recent contract meeting and a remedial action plan has been requested. FLT asked how the provider was performing against this indicator against peers and requested that the Mental Health Commissioning Manager look at the available benchmarking data and report back to the Committee at the next available meeting. Mersey Care NHS Foundation Trust (Mental health Contract) – Eating Disorder Service Treatment Commencing Within 18 Weeks of Referral RC stated he had raised this with DrHM as the CCG GP Clinical Lead for this area as there appears to be a gap in meeting the physical needs of such patients and this is then having an impact on GP workload in the community. FLT asked for the Mental Health Commissioning Manager to do a 'deep dive' into Mental Health performance.	
	Action 3: Mersey Care NHS Foundation Trust (Mental health Contract) – Psychotherapy & Eating Disorder Service Treatment Commencing Within 18 Weeks of Referral DF to ask GJ to undertake a deep dive into Mental Health performance, including benchmarking, and to report back to the next available meeting of the Joint Quality Committee.	DF

No	Item	Actions
	Mersey Care NHS Foundation Trust (Mental health Contract) – Adults on Care Programme Approach Receive a Review Within 12 Months It was noted that performance for SSCCG and SFCCG was lower than that for patients in other CCGs. BP reported that further detail was being asked for at the next CQPG. Mersey Care NHS Foundation Trust (Mental health Contract) – Appropriate Supply of Medication on Discharge BP reported that this drop in performance had been identified and was an agenda item for discussion at the Mersey Care Collaborative Commissioning Forum which was held on 29.11.17. Aintree University Hospital NHS Foundation The Committee noted the assurance currently being received from the Trust in relation to falls, completion of the MUST tool and delays in out-patient communication. The Quality Committee acknowledged previous in-depth reporting of quality and performance issues at the Trust. Mersey Care NHS Foundation Trust (Community Contract) Performance and quality data submitted remains lacking in details and this has been raised with the Trust. Pressure ulcer remedial action planning remains in progress. Transitional KPIs are reported in 17/219 are insitu.	
17/221	**Chief Nurse Report** DF presented the Chief Nurse Report. The Committee were asked to note the updates regarding: • The NHS Improvement Emergency Care Improvement Programme (ECIP) Multi-Agency Discharge Event (MADE) which was held at AUH on 7th & 8th November 2017. A planning meeting has since been held to take forward the recommendations from the event • The continuation of meetings and the Harm Review process following the issuing of a Section 65 letter to S&O from the CQC • The continuation of system-wide meetings, supported by the C&M Vanguard, to ensure delivery against the contract of Obstetrics and Gynaecology Services at S&O • Discussion at the CCG Governing Bodies regarding the quality of services at S&O.	

No	Item	Actions
	DF presented the NHSE CCG SEND Self-Assessment which had been submitted and which was attached as an appendix to the Chief Nurse Report. **Action:** The Committee received the report.	
17/222	**CCG Information to the CQC re: S&O** BP presented the report which contained information that had been jointly submitted by SFCCG, SSCCG and West Lancashire CCG (WLCCG) to the CQC to inform key lines of enquiry for the Chief Inspector of Hospitals Visit. The Committee reviewed the information and requested that a follow-up e-mail be sent to the CQC highlighting the CCGs' concern about the impact of the many leadership changes at the Trust to ensure that this was explicit.	
	Action: CCG Information to the CQC for S&O BP to e-mail the CQC to ensure the CCGs' concerns regarding the impact of the leadership changes were explicit and noted.	BP
17/223	**Primary Care / General Practice Quality** Following a recent CQC inspection, it was noted that the Christiana Hartley Medical Practice / Curzon Road Medical Practice had been rated as 'Outstanding'. BW provided an update on the development of the Primary Care Dashboard and the conversations that had been had with the LMC – it was stressed that the dashboard is a tool to support quality improvement and is not intended to be a performance management tool **Action:** The Committee received the updates.	
17/224	**CQUIN Update** The information for this agenda item was also discussed in 17/217 (Action tracker - SFCCG 17/181 SSCCG 17/207). EB reported that Q1 2017/18 data had been submitted from both AUH and Mersey Care. Lancashire Care as the new contract holders for SFCCG community services had submitted some data and conversations had been had with the provider regarding what information they were able to submit at this time. **Action:** The Committee received the updates.	

No	Item	Actions
17/225	**EPEG Key Issues** GB and GBr informed the Committee of the following key issues discussed at the last EPEG meeting: • AUH Patient Experience Presentation - Presentation described as impressive. • S&O - Presentation planned for the next meeting of EPEG. • EPEG Dashboard - Review of the dashboard to be undertaken. • Pharmacy 2 U - SL reviewing the advice that is being given to patients in the SFCCG area from this provider which may not be consistent with the messages from the CCG. FLT asked if EPEG looked at high level complaints information as although all CCG complaints were reviewed by the Chief Nurse / Deputy Chief Nurse and signed-off by herself before leaving the organisation, there was a need for such high level information to be considered at a committee or sub-committee. It was agreed that a high level complaints report needed to come through to the Quality Committee as this was not presented at EPEG. DF reported that discussions had already taken place between herself and LG to ensure this took place.	
	Action 1: CCG Complaints Report **DF to ask JW for CCG complaints to be built into the Quality Committee Work plan.** **Action 2: CCG Complaints Report to be Presented to the Next Meeting** **DF to ask LG to produce a report for the next meeting.**	DF DF
17/226	**Any other business** <u>Secondary Care Doctor</u> It was noted that this would be DMcD last meeting as he was due to leave his position within SSCCG as the Secondary Care Doctor. The Committee thanked him for his input and involvement. <u>Kirkup Review - LCH</u> FLT informed the Committee that the CCGs had made contact with the Kirkup Review Team requesting an update. The CCGs had been informed that warning letters would be sent to individuals / organisations within the next 2 weeks or so – not every individual interviewed would receive such a letter. The report was originally expected to be published before Christmas but this time line has been put back.	

No	Item	Actions
	Deputy Chief Nurse - Leadership FLT expressed her thanks to BP for his leadership whilst DF had been on annual leave – this demonstrated high quality distributed leadership that is evident within the CCGs. Quality Team Capacity DF gave an update on capacity and recruitment within the Quality Team. FLT asked if the capacity issues within the Quality Team to deal with the increasing demand was clearly articulated on the CCG Corporate Risk Register (CRR). DF responded that it was and that this would be seen when the CRR was presented to the Quality Committee at the next meeting. AUH – Section 29 Letter from the CQC BP informed the Committee that AUH had recently been issued with a Section 29 letter from the CQC regarding DNAR records and record keeping in relation to DoLS assessments. The Committee noted this along with the actions taken for the purposes of assurance. Covert Medication HR informed the Committee of recent discussions with the LMC regarding a letter about covert medication and inclusion in the LQC. St Joseph's Hospice Update FLT informed the Committee that a restriction to admissions remained in place currently with Jospice following the CQC inspection. CCG teams continue to work in partnership with both the provider and the regulator to support necessary improvements. The amount of support from the CCG Medicines Management Team was acknowledged. **Action:** The Committee received the updates.	
17/227	**Key Issues Log (from this meeting)** The following key issues were highlighted for reporting to the Governing Bodies: SSCCG: • **Provider Performance Reports** – these have been reviewed by the Joint Quality Committees	

No	Item	Actions
	• **Mental Health Performance –** a request has been made to the CCGs' Mental Health Commissioning Manager undertake a 'deep-dive' of performance and report back to the February 2018 meeting of the Joint Quality Committee • **Multi-Agency Discharge Event (MADE)** – A MADE event has taken place at AUH which was supported by the CCG team. Recommendations from the event will form part of a system action plan • **S&O CQC Inspection** – the CCG has submitted information to the CQC to inform the forthcoming Chief Inspector of Hospitals Inspection Visit. The information submitted has been reviewed at the Joint Quality Committee • **NHSE SEND CCG Self-Assessment** – the CCG has completed and submitted this self-assessment which has been presented to the Joint Quality Committee for information. <u>SFCCG</u> • **Provider Performance Reports** – these have been reviewed by the Joint Quality Committees • **Mental Health Performance –** a request has been made to the CCGs' Mental Health Commissioning Manager undertake a 'deep-dive' of performance and report back to the February 2018 meeting of the Joint Quality Committee • **S&O CQC Inspection** – the CCG has submitted information to the CQC to inform the forthcoming Chief Inspector of Hospitals Inspection Visit. The information submitted has been reviewed at the Joint Quality Committee • **NHSE SEND CCG Self-Assessment** – the CCG has completed and submitted this self-assessment which has been presented to the Joint Quality Committee for information. • **Christiana Hartley Medical Practice / Curzon Rd CQC Inspection Judgement** – this practice was rated 'Outstanding' following a recent CQC Inspection. • **S&O Harm Review Process** – the Harm Review process continues at the Trust following the issuing of the Section 65 letter from the CQC.	
17/228	**Date of Next Meeting and advance notice of apologies** Date: Thursday 25th January 2018 Time: 0900hrs-1200hrs Venue: The Marshside Surgery, 117 Fylde Road, Southport PR9 9XP No advance notice of apologies received at this time.	

HEALTHY LIVERPOOL PROGRAMME

HOSPITAL BASED SERVICES

COMMITTEE(S) IN COMMON

KNOWSLEY, LIVERPOOL, SOUTH SEFTON CCGS AND SOUTHPORT & FORMBY CCGS

MEETING ROOM 1 LIVERPOOL CCG

FRIDAY 17TH NOVEMBER 2017

PRESENT:

Simon Bowers (SB)	Chair (in the Chair)	NHS Liverpool CCG
Jan Ledward (JLe)	Interim Chief Officer	NHS Liverpool CCG
Mark Bakewell (MB)	Acting Chief Finance Officer	NHS Liverpool CCG
Fiona Lemmens (FL)	Clinical Vice Chair	NHS Liverpool CCG
Chris Grant (CG)	Hospital Services Programme Director	NHS Liverpool CCG
Carole Hill (CH)	Healthy Liverpool Integrated Programme Director	NHS Liverpool CCG
Graham Morris (GM)	Deputy Chair	NHS South Sefton CCG
Iain Stoddart (IS)	Chief Finance Officer	NHS Knowsley CCG
Andrew Bibby (AB)	Assistant Regional Director of Specialist Commissioning	NHS England
Paula Jones	Committee Secretary/minute taker	NHS Liverpool CCG

APOLOGIES:

Fiona Taylor (FT)	Chief Officer	NHS South Sefton CCG/ NHS Southport & Formby CCG
Ian Moncur	Councillor/Health & Wellbeing Board Chair	Sefton Council
Dyanne Aspinall (DAsp)	Interim Director of Adult Health & Social Care	Liverpool City Council
Rob Caudwell (RC)	Chair	NHS Southport & Formby CCG
Dianne Johnson (DJ)	Chief Officer	NHS Knowsley CCG
Donal O'Donoghue (DOD)	Secondary Care Clinician	NHS Liverpool CCG

1.0	**Welcome, Introductions and apologies:**
1.1	Chair welcomed all to the meeting and introductions were made. The meeting was not quorate as there was no representative from Southport & Formby CCG. The plan was to go to consultation next year from the Joint Committee and we knew that the process would be challenged – we needed to ensure that the governance/decision making behind the consultations was correctly done with the right people involved from all CCGs concerned.
2.0	**Declaration of Interest:**
2.1	There were no declarations of interest made specific to the agenda.
3.0	**Minutes & Actions of the previous meeting: 15TH SEPTEMBER 2017**
3.1	The minutes of the 15th September 2017 meeting were agreed as an accurate record of the meeting subject to the following amendments: ✓ There needed to be a correction to the spelling of Iain Stoddart's first name.
3.2	There were no outstanding actions from the Committees in Common meeting of the 15th September 2017.
4.0	**Establishing a North Mersey Joint Committee – Draft Terms of Reference – Report No: CIC 05-17 – Jan Ledward**
4.1	• DJ had reviewed the Terms of Reference which had in turn been reviewed by the Chief Officers of all the CCGs. A workshop was to be held to look at what the joint Committee was and was not, it would have delegated authority from the Governing Bodies to make decisions. LWH consultation process in full to be looked at and role of Joint Committee at workshop in December before potentially being on the agenda for a public meeting of the Joint Committee in January 2018. • The Terms of Reference needed to be taken to all Governing Bodies for approval. IS confirmed that Knowsley CCG Governing Body met on 7th December 2017 and then later in the month there was a clinical membership meeting. Indications were that the

Governing Body was supportive and had no major issues. For South Sefton CCG GM noted that the issue was around Sefton Metropolitan Council which saw it's role as scrutinising rather than proposing. The Committee discussed whether West Lancashire CCG would be an associate member (not included in the TOR).

- Individual CCG Governing Body membership on the Joint Committee to be decided by each CCG – however FT could not represent both South Sefton and Southport & Formby CCGs.

- JLe noted that this needed to reflect the STP footprint which could see West Lancs as a full member. . The Workplan for the Joint Committee needed to be attached to the Terms of Reference, CH had a first draft which she agreed to circulate . JLe agreed to write to Mike Maguire, Chief Officer at West Lancashire CCG, for his opinion.

- Re NHS England representation AB reminded the CIC that NHS England specialist commissioning was in the unusual position of being able to make commissioning decisions with groups of CCGs but could not make the same decision with each CCG. For this reason NHS England needed to be "in attendance" and would then need to convene their own internal committee to take the decision.
- FL referred to 6.1.1 of the draft terms of reference– it was agreed to remove the reference to each CFO either being a member or in attendance. JLe noted that if finance expertise was required a CFO could be co-opted.

- FL referred to the 6 month notice to withdraw clause section 13 – it was agreed to delete this reference as should anyone withdraw then the Joint Committee would no longer be valid.

Action Points:

- **Workshop on Joint Committee to be arranged in December 2017.**
- **CH to circulate the draft Workplan,**
- **JLe to contact West Lancashire CCG**
- **Remove reference to CFO of each CCG being a member**
- **Remove section 13 around withdrawal from Joint Committee.**
- **PJ to correct the numbering in the document.**

The Committees in Common:

- **Noted the amendments proposed to the Terms of Reference and proposed workshop to be held.**

5.0	**Orthopaedics Reconfiguration – post consultation update – Presentation – Chris Grant/Carole Hill**
5.1	• Recap on proposal: Unplanned/trauma surgery to be dealt with at Aintree Hospital , For ENT, all day case & elective activity would move from Broadgreen to Aintree, all planned surgery to be carried out at Broadgreen. High risk planned surgery to be done at Aintree. • Proposed changes were clinically driven. An Oversight Board had been set up and a feasibility study had been developed which had resulted in a clear proposal, based on apprisaing a number of options. There was a preferred option and the consultation had set out all options considered. • Format of consultation had been a mixture of face to face, Website and social media, Booklet, VCSE Engagement Partners, Public Events/ HealthWatch, Clinics and engagement with the workforce. The reach was 10,030 consultation booklets distributed, Aintree's volunteer team had given out 2160 surveys and directly supported 306 people to complete the survey. Volunteers at the Royal gave out 907 surveys and directly supported 58 people to complete the survey. Online - 3,870 visits to the website, Facebook - 57,860 reach, Twitter - 94,204 impressions, Community Partner Engagement – approx. 600, 20 community meetings, 32 sessions with BME communities, 22 community clinics and 2 Healthwatch events. • Consultation Findings: ✓ Overall, there were 2000 responses to the consultation ; 1757 received through a completed survey and 243 individuals involved in 19 focus groups. ✓ Do you think that the doctors have come up with the best plan (for orthopaedics)? 1,023 said yes, 207 said no and 489 did not know. ✓ Do you think that the doctors have come up with the best plan (for ENT)? 990 said yes, 162 said no and 559 did not know. There was more perception of impact on South Sefton & Knowsley patients re travel and access, less so in Liverpool. ✓ How might the changes affect you? 40% would have to travel further, 5% would have a shorter distance to travel, 48% would not be affected and 7% would be affected in another way. ✓ What would be the impact of travelling further to use services? The challenge was to mitigate any issues regarding access for

	surgery for people with disabilities, patients with Learning Disabilities and low income patients. Work was being done with Mersey Travel to triangulate travel between Aintree, Broadgreen and the Royal. Next Steps: • Approval by trust boards of the final feasibility study, incorporating consultation findings – November 2017. • Outcome of capital bids from both trusts awaited. • Further assurance on capacity and resilience of Aintree to manage all unplanned T&O. • Decision to be taken by Liverpool, South Sefton and Knowsley Public Governing Bodies – December 2017/January 2018. (Knowsley CCG 7th December, Liverpool CCG 12th December, South Sefton CCG 11th January 2018). • Joint OSC to consider consultation findings and mitigations – January 2018. IS requested the dates of the trust boards the consultation results were going to. It was noted that the timescales were extremely tight. **Action Points:** • **CH to send IS dates of trust boards consultation results were going to for approval.** **The Committees in Common:** ➢ **Noted the presentation.**
6.0 **6.1**	**Review of Liverpool Women's Services update on the path to consultation - Presentation – Chris Grant/Carole Hill** CG made a presentation to the Committees in Common: • To re-cap ; January 2017, a draft Pre-Consultation Business Case (PCBC) was published, setting out 4 potential solutions: **1.** Relocate women's and neonatal services to a new hospital building on the same site as the new Royal Liverpool Hospital *(the preferred option)* **2.** Relocate women's and neonatal services to a new hospital building on the same site as Alder Hey Children's Hospital **3.** Make major improvements to Liverpool Women's Hospital on the current Crown Street site **4.** Make smaller improvements to the current Crown Street site

	• Pause then required to have peer review carried out via the North East Clinical Senate. This lead to clear recommendation from the Clinical Senate that the future was co-location **Next Steps:** • Additional assurance evidence submitted to NHSE and NHSI. NHSE assurance response expected on 22nd November following review by NHSE North RMT. • Clinical view is that there is now only one viable option to consult on: services to be delivered from a new hospital on the Royal Liverpool Hospital campus • It is lawful to consult on implementing that single option. However, we will need to clearly explain the rationale and to enable people to suggest alternative options, which will be given genuine consideration. • North Mersey OSCs (Liverpool, Knowsley and Sefton) have agreed that the proposal presented represents a substantial variation • Planning for a comprehensive and authentic consultation, with opportunities for meaningful dialogue between individuals or groups, based on a genuine exchange of views, with the objective of influencing the final decision. • To be discussed at the Workshop in early December 2017 in respect of the role and responsibilities of a Joint Committee. FL updated that LWH had concerns about the consultation process being split by purdah. This would mean starting the consultation in June 2018 for 12 weeks therefore finishing in September 2018 with a decision announced in November 2018. **The Committees in Common:** • **Noted the presentation and timescales.**
7.0	**Any Other Business** None
8.0	**Date of next meeting** Friday 8th December 2017, 12pm to 2pm Boardroom, Liverpool CCG – it was agreed that this meeting would be used for the purposes of the Workshop mentioned to discuss the function of the Joint Committee and LWH subject to confirmation of required full attendance.

	Action Point: • **PJ to email out to ensure that senior representation was available for the workshop date o 8th December 2018.**