South Sefton Clinical Commissioning Group

Integrated Performance Report
May 2019

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Summary Performance Dashboard

Metric	Reporting Level		2019-20												
			Q1			Q2			Q3			Q4			YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
E-Referrals															
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
		Actual	66%	62.8%											64%
		Target	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Diagnostics & Referral to Treatment (RTT)															
% of patients waiting 6 weeks or more for a diagnostic test The % of patients waiting 6 weeks or more for a diagnostic test	South Sefton CCG	RAG	G	R											G
		Actual	0.765%	1.055%											0.91%
		Target	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
% of all Incomplete RTT pathways within 18 weeks Percentage of Incomplete RTT pathways within 18 weeks of referral	South Sefton CCG	RAG	R	R											R
		Actual	89.486%	89.64%											89.546%
		Target	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%
Referral to Treatment RTT - No of Incomplete Pathways Waiting >52 weeks The number of patients waiting at period end for incomplete pathways >52 weeks	South Sefton CCG	RAG	R	G											R
		Actual	1	0											1
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
Cancelled Operations															
% of Cancellations for non clinical reasons who are treated within 28 days Patients who have ops cancelled, on or after the day of admission (Inc. day of surgery), for non-clinical reasons to be offered a binding date within 28 days, or treatment to be funded at the time and hospital of patient's choice.	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RAG	G	G											G
		Actual	0												
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
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
		Actual	0												
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0

Cancer Waiting Times															
% 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 with suspected cancer	South Sefton CCG	RAG	R	G											R
		Actual	86.142%	94.578%											90.454%
		Target	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
% 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	R	R											R
		Actual	50.00%	86.842%											72.222%
		Target	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
% 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
		Actual	96.296%	98.718%											97.484%%
		Target	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
% 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	G	G											G
		Actual	100.00%	100.00%											100.00%
		Target	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
% 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
		Actual	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%	98.00%	98.00%	98.00%
% 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
		Actual	96.667%	100.00%											98.413%
		Target	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
% 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 of GP or dentist urgent referral for suspected cancer	South Sefton CCG	RAG	R	R											R
		Actual	75.00%	77.273%											76.316%
		Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
% 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	n/a	R											R
		Actual	-	85.714%											85.714%
		Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
% of patients receiving treatment for cancer within 62 days upgrade their priority (MONTHLY) % of patients treated for cancer who were not originally referred via an urgent GP/GDP referral for suspected cancer, but have been seen by a clinician who suspects cancer, who has upgraded their priority.	South Sefton CCG	RAG	R	R											R
		Actual	60.00%	70.00%											64.00%
		Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%

Metric	Reporting Level		2019-20												
			Q1			Q2			Q3			Q4			YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Accident & Emergency															
4-Hour A&E Waiting Time Target (Monthly Aggregate based on HES 17/18 ratio) % of patients who spent less than four hours in A&E (HES 17/18 ratio Acute position via NHSE HES DataFile)	South Sefton CCG	RAG	R	R											R
		Actual	78.178%	78.324%											78.251%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
EMSA															
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
		Actual	0	0											0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
Mixed Sex Accommodation - MSA Breach Rate MSA Breach Rate (MSA Breaches per 1,000 FCE's)	South Sefton CCG	RAG	G	G											G
		Actual	0.00	0.00											0.00
		Target	0	0											
HCAI															
Number of MRSA Bacteraemias Incidence of MRSA bacteraemia (Commissioner)	South Sefton CCG	RAG	G	G											G
		YTD	0	0											-
		Target	-	-	-	-	-	-	-	-	-	-	-	-	0
Number of C.Difficile infections Incidence of Clostridium Difficile (Commissioner) cumulative	South Sefton CCG	RAG	R	R											G
		YTD	7	7											11
		Target	6	11	15	20	24	28	34	40	46	51	55	60	60
Number of E.Coli infections Incidence of E.Coli (Commissioner) cumulative	South Sefton CCG	RAG	R	R											R
		YTD	15	33											33
		Target	11	21	32	42	53	63	75	85	96	108	125	128	128

Metric	Reporting Level		2019-20												
			Q1			Q2			Q3			Q4			YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Mental Health															
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													
		Status													-
		Actual													
		Target		95.00%			95.00%			95.00%			95.00%		
Episode of Psychosis															
First episode of psychosis within two weeks of referral The percentage of people experiencing a first episode of psychosis with a NICE approved care package within two weeks of referral. The access and waiting time standard requires that more than 50% of people do so within two weeks of referral.	South Sefton CCG	RAG	R	G											R
		Actual	50.00%	60.00%											54.545%
		Target	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	
IAPT (Improving Access to Psychological Therapies)															
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	G											R
		Actual	38.00%	52.90%											44.40%
		Target	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	
IAPT Access 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
		Actual	1.23%	1.03%											2.26%
		Target	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.83%	1.83%	1.83%	
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
		Actual	99.60%	97.70%											99.0%
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	
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
		Actual	100%	100%											100.00%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	
Dementia															
Estimated diagnosis rate for people with dementia Estimated diagnosis rate for people with dementia	South Sefton CCG	RAG	R	R											R
		Actual	64.169%	64.37%											64.27%
		Target	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%

Metric	Reporting Level		2019-20												
			Q1			Q2			Q3			Q4			YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Children and Young People with Eating Disorders															
The number of completed CYP ED routine referrals within four weeks The number of routine referrals for CYP ED care pathways (routine cases) within four weeks (QUARTERLY)	South Sefton CCG	RAG													
		Actual													
		Target		95.00%			95.00%			95.00%			95.00%		95.00%
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													
		Actual													

Metric	Reporting Level		Q1	Q2	Q3	Q4	YTD
Wheelchairs							
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					
		Actual					
		Target					

1. Executive Summary

This report provides summary information on the activity and quality performance of South Sefton Clinical Commissioning Group at Month 2 (note: time periods of data are different for each source).

Planned Care
Month 2 referrals are -6.3% down on 2018/19 due to a -13.2% reduction in GP referrals. In contrast, consultant-to-consultant referrals during month one were 4.1% higher than in May 2018.

At provider level, Aintree saw a 11% decrease in total referrals in month 2 when comparing to 2018/19. Royal Liverpool and Liverpool Women's have also reported a reduction of 13%.

For Diagnostics the CCG are achieving the improvement plan for May (1.07%) reporting 1.05% but are failing the National Standard of under 1%.

For patients on an incomplete non-emergency pathway waiting no more than 18 weeks the CCG has remained just over 89% for the past several months and have achieved the improvement plan of 88.7% in May reporting 89.6%. In May the incomplete waiting list for the CCG was 11727 against a plan of 10934 a difference of 793 patients. A 418/4% increase in May Incomplete Pathways compared to April.

The CCG are failing 5 of the 9 cancer measures year to date. Aintree are also failing 5 of the 9 cancer measures.

Aintree Friends and Family Inpatient test response rate is still below the England average of 24.9% in May at 18% in May 2019. The percentage of patients who would recommend the service increased to 95% below the England average of 96% and the percentage who would not recommend has decreased to 3% above the England average of 2%.

Unplanned Care
In relation to A&E 4-Hour waits, Aintree revised their trajectory for 2019/20. The Trust has failed their improvement plan target of 88% in May reaching 82.92%.

The NWAS Ambulance Response Programme (ARP) made progress during 2018/19 but failed to achieve the range of standards required. Baaased on this the 2019/20 contract has been negotiated and agreed with recurrent investment to deliver additional capacity and transformation of the service delivery model. Additional non recurrent capacity investment of £1m is conditional upon NWAS delivering the ARP standards in full (with the exception of the C1 mean) from quarter 4 2019/20. The C1 mean target is to be delivered from quarter 2 2020/21. A trajectory has been agreed with the Trust for progress towards delivery of the standards and if these are not met as per the trajectory, the payment will not be made.

Performance against the National Quality Stroke metric 90% stay standard was 76.10% for April 2019 so below the 80% plan for Aintree but improving.

Aintree have reported a case of MRSA in May so have failed the zero tolerance threshold for 2019/20.

The CCG had no new cases of C.Difficile in May, against a year to date plan of 11 so are under plan currently at 7 (2 apportioned to acute trust and 5 apportioned to community).

NHS Improvement and NHS England have set CCG targets for reductions in E.coli for 2019/20 NHS South Sefton CCG's year-end target is 128). In May there were 18 cases (33 YTD). Aintree reported 31 cases in May (63 YTD). There are no targets set for Trusts at present.

Mental Health
For Improving Access to Psychological Therapies (IAPT), Cheshire and Wirral Partnership reported the monthly target for M2 19/20 is approximately 1.58%. Month 2 performance was 1.03% so failed to achieve the target standard. The percentage of people moved to recovery was 52.9% in month 2 of 2019/20 and have achieved the target (target 50%).

The latest data shows South Sefton CCG are recording a dementia diagnosis rate in May of 64.37%, which is under the national dementia diagnosis ambition of 66.7% this is very similar to last month when 64.17% was reported.

Community Health Services
CCG and Mersey Care leads continue to work on a collaborative basis to progress the outcomes and recommendations from the service reviews undertaken of all South Sefton community services. A transformation plan has been developed and will provide the focus for service improvements over the coming year. It has been agreed that reporting requirements and activity baselines will be reviewed alongside service specifications and transformation work.

Children's Services
Children's services have experienced a reduction in performance across a number of metrics linked to mental health and community services. Long waits in Paediatric speech and language remains an issue. Alder Hey has provided a Recovery Plan to bring waiting times down by February 2020 and as part of this South Sefton and Southport & Formby CCGs have provided additional investment.

Better Care Fund
A quarter 4 2018/19 BCF performance monitoring return was submitted on behalf of the Sefton Health and Wellbeing Board in May 2019. This reported that all national BCF conditions were met in regard to assessment against the High Impact Change Model; but with on-going work required against national metric targets for non-elective hospital admissions, admissions to residential care, reablement and Delayed Transfers of Care. Narrative is provided of progress to date. Work is now ongoing in regard to collaborative work between health and social care which will evidence the 2019/20 BCF returns.

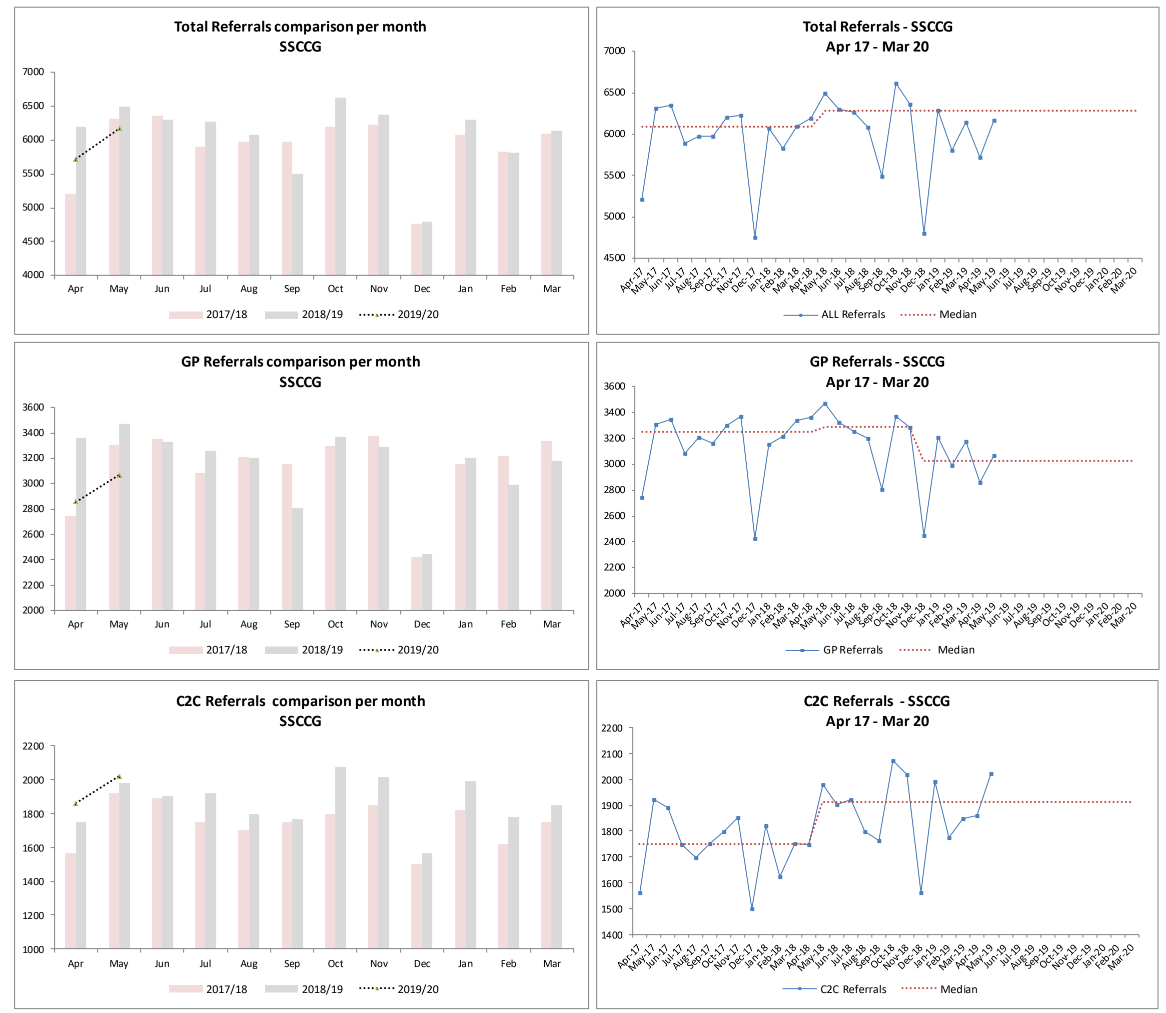
CCG Improvement & Assessment Framework
The 2018/19 annual assessment has been published for all CCGs, ranking South Sefton CCG as 'requires improvement'. However, some areas of positive performance have been highlighted; cancer was rated 'Good' and diabetes was rated 'Outstanding'.

2. Planned Care

2.1 Referrals by source

Indicator	GP Referrals				Consultant to Consultant				All Outpatient Referrals			
Month	Previous Financial Yr Comparison				Previous Financial Yr Comparison				Previous Financial Yr Comparison			
	2018/19 Previous Financial Year	2019/20 Actuals	+/-	%	2018/19 Previous Financial Year	2019/20 Actuals	+/-	%	2018/19 Previous Financial Year	2019/20 Actuals	+/-	%
April	3361	2858	-503	-15.0%	1748	1860	112	6.4%	6193	5721	-472	-7.6%
May	3469	3069	-400	-11.5%	1981	2021	40	2.0%	6498	6169	-329	-5.1%
June	3327				1902				6305			
July	3256				1920				6273			
August	3202				1798				6081			
September	2806				1765				5497			
October	3370				2074				6623			
November	3289				2018				6369			
December	2449				1563				4801			
January	3207				1990				6296			
February	2992				1776				5814			
March	3177				1849				6145			
Monthly Average	**3159**	**2964**	**-195**	**-6.2%**	**1865**	**1941**	**75**	**4.0%**	**6075**	**5945**	**-130**	**-2.1%**
YTD Total Month 2	**6830**	**5927**	**-903**	**-13.2%**	**3729**	**3881**	**152**	**4.1%**	**12691**	**11890**	**-801**	**-6.3%**
Annual/FOT	**37905**	**35562**	**-2343**	**-6.2%**	**22384**	**23286**	**902**	**4.0%**	**72895**	**71340**	**-1555**	**-2.1%**

Figure 1 - Referrals by Source across all providers for 2017/18, 2018/19 & 2019/20



Data quality note:

Liverpool Heart & Chest data has been unavailable from month 9 of 2018/19 onwards. Therefore, to allow for consistency, Liverpool Heart & Chest referrals have been removed from 2017/18 data onwards.

Royal Liverpool Hospital data for month 2 of 2019/20 is currently unavailable. As a result, monthly averages have been applied.

Month 2 Summary:

- Trends show that the baseline median for total South Sefton CCG referrals has remained flat since May 2018. However, a recent downward trend has been evident.
- Year to date referrals at May-19 are -6.3% down on 2018/19 due to a -13.2% reduction in GP referrals.
- In contrast, consultant-to-consultant referrals are 4.1% higher when compared to 2018/19 and a recent trend of three consecutive monthly increases has been apparent.
- Southport & Ormskirk and Alder Hey Hospitals are responsible for the majority of consultant-to-consultant increases. The former has reported increases within Gynaecology, Paediatrics and Trauma & Orthopaedics.
- Aintree has reported a -11% decrease in total referrals at month 2 when comparing to 2018/19. Liverpool Women's have also reported a reduction of -13%.
- St Helens & Knowsley (Plastic Surgery), Renacres (ENT/Gastroenterology) and Southport & Ormskirk (Gynaecology/Clinical Physiology) are seeing a notable increase in referrals when comparing to the previous year.
- GP referrals were below average from Dec-18, which triggered a decrease in the baseline median. This can largely be attributed to reduced referrals to Aintree Hospital.
- Taking into account working days, further analysis has established there have been approximately 24 fewer GP referrals per day in 2019/20 when comparing to the previous year.
- Trauma & Orthopaedics was the highest referred to specialty for South Sefton CCG in 2018/19. Referrals to this speciality are currently -1% lower than in 2018/19.
- Other notable reductions include ENT (-11%), Gastroenterology (-9%) and Cardiology (-8%).

2.2 E-Referral Utilisation Rates

<table>
<tr><th colspan="2">Indicator</th><th colspan="4">Performance Summary</th><th>IAF</th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2">NHS e-Referral Service (e-RS): Utilisation Coverage</td><td colspan="4">Latest and previous 3 months</td><td rowspan="4">IAF - 144a (linked)</td><td rowspan="4">e-RS national reporting has been escalated to NHSD via NHSE/I. Data provided potentially inaccurate therefore making it difficult for the CCG to understand practice utilisation. Potential for non e-RS referrals that are rejected to be missed by the practice.</td></tr>
<tr><td>RED</td><td>TREND</td><td>Feb-19</td><td>Mar-19</td><td>Apr-19</td><td>Latest</td></tr>
<tr><td rowspan="2"></td><td rowspan="2"></td><td>66%</td><td>65%</td><td>66%</td><td>62.8%</td></tr>
<tr><td colspan="4">Plan: 100% by end of Q2 2018/19</td></tr>
</table>

Performance Overview/Issues:

The national ambition is that E-referral utilisation coverage should be 100% by the end of Q2 2018/19 this wasn't achieved. Latest published e-referral utilisation data for South Sefton CCG is for April 2019 and reports performance to be 62.8%. Performance has declined this month and remains significantly below the national position. The above data however is based upon NHS Digital reports that utilises MAR (Monthly Activity Reports) data and initial booking of an E-Rs referral, excluding re-bookings. MAR data is nationally recognised for not providing an accurate picture of total referrals received, and as such NHS Digital will, in the near future, use an alternative data source (SUS) for calculating the demonitator by which utilisation is ascertained.

In light of the issues in the national reporting of E-Rs utilisation, a local data set derived from SUS has been used. The referrals information above is sourced from a local referrals flow submitted by the CCGs main hospital providers. This has been used locally to enable a GP practice breakdown. May data shows an overall performance of 79.4% for South Sefton CCG, an improvement on last month (72.2%). A meeting to validate inclusion criteria will be arranged imminently following escalation via Planned Care and Information Sub Group Meetings.

Actions to Address/Assurances:

A review of referral data was undertaken to get a greater understanding of the underlying issues relating to the underperformance. The data indicates that there is no uniform way that trusts code receipt of electronic referral and the e-RS data at trust level is of poor quality. This has therefore provided difficulties in identifying the root causes of the underperformance.

A meeting with relevant Trust and CCG staff was organised for the 17th June to discuss issues relating to Advice & Guidance and performance reporting for eRs. This unfortunately was cancelled due to forces outside our control. A new meeting will be reconvened as soon as conveniently possible. A series of actions will been formulated,with agreed actions and timescales for implementation. This will form the basis for a more robust contract management of e-RS with acutes, and the non-payment of activity not referred through e-RS.

When is performance expected to recover:

A recovery trajectory will be formulated after discussions with providers.

Quality:

An incident has been reviewed relating to Alder Hey with subsequent actions agreed with NHSE and Liverpool CCG relating to mitigating risks of non e-RS patients being missed, the following actions were agreed:
- A review of Trust SOPs to be fit for 'business as usual' (requests for updated SOPs to be made via Planned Care Group and Contract Review Meetings with a view to present a paper to the relevant Quality Committee).
- NHSE to escalate to NHSE/I concerns regarding e-RS National Reporting (response requested from NHSE on the 22nd July, however due to leave a response has yet to be received).

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Rob Caudwell	Terry Hill

2.3 Diagnostic Test Waiting Times

Indicator		Performance Summary					IAF	Potential organisational or patient risk factors
Diagnostics - % of patients waiting 6 weeks or more for a diagnostic test		Latest and previous 3 months					133a	The risk that the CCG is unable to meet statutory duty to provide patients with timely access to treatment. Patients risks from delayed diagnostic access inevitably impact on RTT times leading to a range of issues from potential progression of illness to an increase in symptoms or increase in medication or treatment required.
GREEN	TREND		Feb-19	Mar-19	Apr-19	Latest		
		CCG	1.64%	1.75%	0.73%	1.05%		
		Aintree	3.90%	0.38%	0.09%	0.21%		
		Plan: less than 1% May's CCG improvement plan: 1.07% Yellow denotes achieving 19/20 improvement plan but not national standard of leass than 1%						

Performance Overview/Issues:

The CCG are achieving the improvement plan for May (1.07%) reporting 1.05%, out of 2750 patients waiting only 29 waited over 6 weeks including 1 patient waiting over 13 weeks. Of the 29 there were 12 for MRI, the 13+ week waiter was for cystoscopy. The issues affecting performance are mainly with Liverpool Heart and Chest and Southport Trust. Southport Trust is experiencing stafing and workforce problems, no immediate assurance on recovery for both Trusts likely.

Aintree are achieving in May reporting 0.09%.

Actions to Address/Assurances:

CCG performance currently in line with trajectory. Although issues being experienced with LHCH and S&O Trust are affecting the CCG, only approximately 6% of diagnostic activity flows to these providers and as such performance in the coming months is not likely to be impacted much in this area.

A close eye is being kept on performance at Aintree as waiting list initiatives are in the process of ceasing due to tax and pension implications. This is regularly being monitored via the Planned Care Group but latest information suggests performance to remain on trajectory for the near future.

When is performance expected to recover:

Recovery is expected in August, however, depending on Aintree's decision to extend insourcing of scopes this may affect performance in July onwards.

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	John Wray	Terry Hill

2.4 Referral to Treatment Performance

Indicator		Performance Summary					IAF	Potential organisational or patient risk factors
Referral to Treatment Incomplete pathway (18 weeks)		Latest and previous 3 months					129a	The CCG is unable to meet statutory duty to provide patients with timely access to treatment. Potential quality/safety risks from delayed treatment ranging from progression of illness to increase in symptoms/medication or treatment required. Risk that patients could frequently present as emergency cases.
RED	TREND		Feb-19	Mar-19	Apr-19	Latest		
		CCG	89.09%	89.04%	89.48%	89.64%		
		Aintree	90.45%	88.98%	89.67%	90.08%		
		Plan: 92% May's improvement plan: CCG -88.7% and Aintree - 89.4% Yellow denotes achieving 19/20 improvement plan but not national standard of 92%						

Performance Overview/Issues:

The CCG's Performance has remained just over 89% for the past several months and has achieved the the improvement plan of 88.7% in May reporting 89.6%. The CCG's main provider Aintree are also under the 92% target reporting 90.1% but achieving to local trajectory of 89.4% for May. Gastroentrology is the specialty most underperforming with achievement of 73.9%. This equates to 502 patients waiting over 18 weeks and equlivalent to 4.78% of their overall demoninator. The CCG is working closely with the main provider, Aintree, via the Planned Care Group to ensure performance remains on trajectory. Updates provided by a highlight report and suggests that capacity shortfalls are being met by outsourcing of scopes and delivery of waiting list initiatives whilst recruitment to posts ongoing. Delivery of waiting list initiatives have been challenging due to HMRC Pensions and Tax issues.Latest indications suggest performance to remain on trajectory, however, outsourcing of scopeswas expected to cease on the 23rd June and may provide a risk to performance if not extended.
Referral rates comparing YTD positions in 19/20 and 18/19 indicate a reduction in GP initiated activity, this is monitored on an on-going basis internally by the CCG with a view to see if demand is increasing and therefore possible pressures on RTT.

In May the incomplete waiting list for the CCG was 11727 against a plan of 10934 a difference of 793 patients. A 418/4% increase in May Incomplete Pathways compared to the previous month. Aintree make up 79% of the CCG increase with a Provider variance of 330.5/4%. Compared to the same period of the previous financial year 2018/19, current incomplete waiting list is 656/3% higher than last year. In terms of the NHSE submitted plans, 2019/20 Incomplete Pathways is currently 921/8% above plan.

Actions to Address/Assurances:

CCG Actions:

• The CCG has recruited 3 interim project managers whose focus is on redesigning services that will support the system in terms of of financial and acute sustainability.
• Issues relating to gastroentrology have been escalated via the Aintree Planned Care Group Meeting (APCG). An updated highlight report was circulated on the 25th July by Aintree to APCG members articulating issues and actions being undertaken.
• A further request will be made to Aintree to initate a Task & Finish Group with Clinical and Managerial leads from both CCGs and Trusts to formulate a System Recovery Plan organised for the 9th September.

Trust Actions Overall:

• Improve theatre utilisation at speciality level.
• Regularly review all long waiting patients within the clinical business units to address capacity issues and undertake waiting list initiatives (WLI's) where available in conjunction with weekly performance meetings with Planning and performance / Business Intelligence leads.
• Continued weekly monitoring of diagnostics waiting times to ensure delivery of the 6 week standard as a milestone measure for RTT performance. This to include horizon scanning and capacity / demand planning with Head of Planning and Performance
• Continue to meet with clinical business managers (CBMs) on a weekly basis to focus on data quality, capacity & demand and pathway validation.
• Continue to support the clinical business units (CBUs) with their RTT validation processes and Standard Operating procedures with a special focus on inter Provider Transfers and data recording/entry.
• Conduct a review of current processes, operating procedures and training revalidation at business unit level to ensure compliance with best practice and national guidance.

Trust Actions Gastro:

• Continue to support the reduction in Endoscopy waits by supporting WLI scope lists using dropped sessions in the week and additional sessions at weekends along with Insourcing extra capacity.
• Endoscopy capacity and demand modelling has been implemented.
• Insourced workforce via independent provider Medinet providing additional endoscopy activity (December 2018 to 23rd June 2019).
• Recruitment to posts ongoing however locum consultants recruited until permanent posts are filled.
• Virtual consultant led clinics scheduled (30 patients per clinic) with an expected 80% discharge rate.
• Telephone confirmation of endoscopy appointments implemented reducing DNA rates from 14% to 9% (in line with national average).

When is performance expected to recover:

The CCG have an improvement plan trajectory which shows the performance plans to improve by by Quarter 4, 2019/20. CCG will request the Trust to provide an improvement trajectory along with action plan.

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	John Wray	Terry Hill

Figure 2 – RTT Performance & Activity Trend

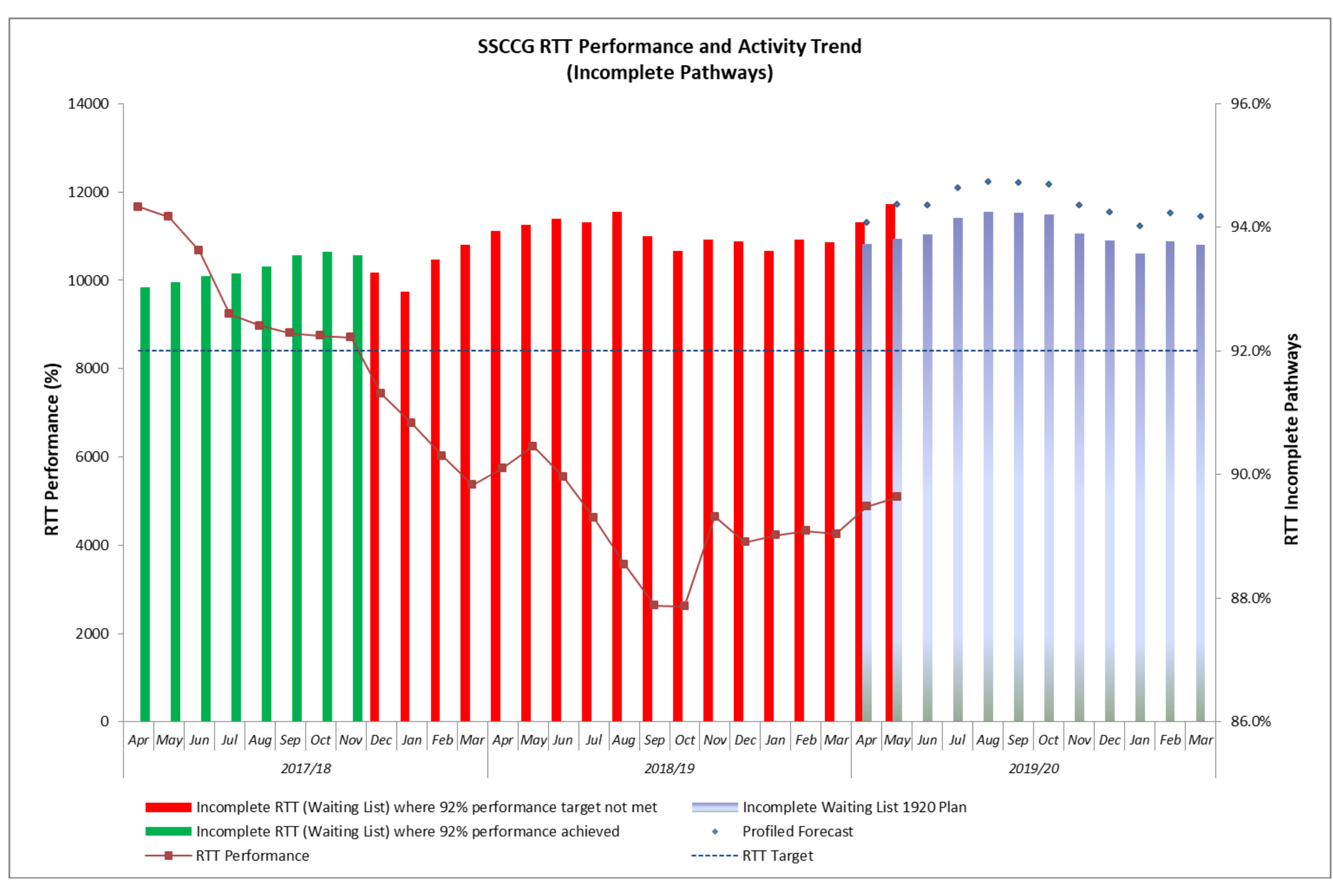


Figure 3 – South Sefton CCG Total Incomplete Pathways

Total Incomplete Pathways	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Plan v Latest
Plan	10,833	10,934	11,046	11,422	11,561	11,541	11,498	11,052	10,910	10,608	10,893	10,805	10,833
2019/20	11,309	11,727											11,727
Difference	476	793											894

South Sefton CCG has seen a 418/4% increase for May-19 Incomplete Pathways compared to April-19. Aintree make up 79% of the CCG increase with a Provider monthly increase of 330/5%.

Compared to the same period of the previous financial year 2018/19, current incomplete waiting list is 656/3% higher than last year. In terms of the NHSE submitted plans, 2019/20 Incomplete Pathways is currently 921/8% above plan.

2.4.1 Referral to Treatment Incomplete pathway – 52+ week waiters

Indicator		Performance Summary						Potential organisational or patient risk factors
Referral to Treatment Incomplete pathway (52+ weeks)		Latest and previous 3 months						The CCG is unable to meet statutory duty to provide patients with timely access to treatment. Potential quality/safety risks from delayed treatment ranging from progression of illness to increase in symptoms/medication or treatment required. Risk that patients could frequently present as emergency cases.
GREEN	TREND		Feb-19	Mar-19	Apr-19	Latest		
		CCG	1	1	1	0		
		Aintree	0	0	0	0		
		Plan: Zero						

Performance Overview/Issues:

No over 52 week waiters in May.

Actions to Address/Assurances:

For the breach (covering November to April), the Trust purchased the relevant equipment, staff training took place and the patient has now had their booked appointment.

The above 52 week breach occurred in the last financial year and as such clarification has been sought from NHSE as to whether this breach should be excluded from 2019/20 performance reporting (response requested from NHSE on the 22nd July, however due to leave a response has yet to be received).

When is performance expected to recover:

A decision from NHSE is expected shortly regarding this breach.

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	John Wray	Terry Hill

2.4.2 Provider assurance for long waiters

Figure 4 - South Sefton CCG Provider Assurance for Long Waiters

CCG	Trust	Specialty	Wait band (Weeks)	Details
South Sefton CCG	Liverpool Womens	Gynaecology	49 weeks	Confirmed June breach - awaiting details from CSU
South Sefton CCG	Liverpool Womens	Gynaecology	36 to 46 weeks	**31 patients**; Focus continues on managing long waiting patients and ASI lists, however, unprecedented levels of Consultant sickness in February & March have affected the position. This was further impacted upon by one locum being on leave for all of April. Long-term capacity issues persist in Uro-Gynaecology with 2 Consultants successfully recruited in March 2019 to address this shortfall. This is anticipated to improve as new Consultants started in post in May with a phased increase in activity as they become familiar with Trust pathways/processes.
South Sefton CCG	Alder Hey	Other	37 to 49 weeks	**16 patients**; 2 treated, 8 TCI dates, 5 sent to service for a date, 1 DNA and discharged) Alder Hey Trust has provided the following information in relation to their capacity issues: • The Trust has recruited prescribing pharmacist who has been in post since beginning of May and has commenced their own clinics from July. • Two additional nurse prescribers have completed their course through Edge Hill University and are awaiting results from this. They continue to spend a number of hours/clinics prescribing under direct supervision and it is hoped that they will be able to work independently from September/October 2019. A further two more are expected to start their training in September with Liverpool University and they will follow the same path, with course finishing January 2020. • Due to 4 members of staff being on long term sick leave and two on staff training the Trust has been hampered in ability to provide additional capacity since December. Two members of staff have now returned from long term sick leave which should see an increase in capacity.
South Sefton CCG	Royal	Dermatology	36 to 44 weeks	**6 patients**; 3 TCI 3 pathway stopped due to capacity.
South Sefton CCG	Royal	General Surgery	42 weeks	Pathway stopped due to capacity
South Sefton CCG	Royal	T&O	45 and 47 weeks	**2 patients**; 1 treated and 1 pathway stopped
South Sefton CCG	Manchester University	Gynacology	40 weeks	No provider update
South Sefton CCG	St Helens & Knowsley	Other	37 weeks	No provider update
South Sefton CCG	Wirral Teaching	Gynaecology	37 weeks	No provider update
South Sefton CCG	North Midlands	General Surgery	36 and 37 weeks	As at 7th July the Trust's latest weekly snapshot indicates 1 Upper Gastrointestinal Surgery waiting 41 weeks without a TCI date. Therefore one of the 36 plus week waiters has been treated

The CCG had a total of 90 patients waiting 36 weeks and over. Of the 90, 27 patients have been treated, 16 have a TCI date, 5 patients sent to service for dates, 5 patients had pathway stopped 4 no TCI or awaiting trust update, 1 DNA'd and discharged and 32 patients at the Liverpool Womens, see update above 1 which is a confirmed breach in June.

2.5 Cancer Indicators Performance

2.5.1 Two Week Urgent GP Referral for Suspected Cancer

Indicator		Performance Summary						IAF	Potential organisational or patient risk factors
2 week urgenty GP Referral for suspected cancer		Previous 3 months, latest and YTD						122a (linked)	Risk that CCG is unable to meet statutory duty to provide patients with timely access to treatment. Delayed dianosis can potentially impact significantly on patient outcomes. Delays also add to patient anxiety, affecting wellbeing.
GREEN	TREND		Feb-19	Mar-19	Apr-19	Latest	YTD		
		CCG	91.06%	86.14%	86.14%	94.58%	90.45%		
		Aintree	83.47%	85.92%	76.97%	93.88%	85.35%		
		Plan	93%	93%	93%	93%	93%		
		Aintree April Trajectory: 84.1% (National 93%)							

Performance Overview/Issues:

South Sefton CCG achieved the target for May with 94.58% but is still failing to achieve YTD target with 90.45%, due to performance in previous months. YTD there have been 124 breaches from a total of 1,299 patients seen.

Aintree also achieved the 93% target reporting 93.88% in May but also failing YTD due to poor performance in April.

Actions to Address/Assurances:

Breast services have dominated any previous underperformance against this standard.
There has been a significant improvement for month 2 brought about by workforce design and waiting list initiatives within breast services.
Aintree has confirmed that the 93% operating standard will be continue to be met in June 2019.

When is performance expected to recover:

Continued recovery expected.

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Debbie Harvey	Sarah McGrath

2.5.2 Two Week Wait for Breast Symptoms

Indicator		Performance Summary						IAF	Potential organisational or patient risk factors
2 week wait for breast symptoms (where cancer was no initially suspected)		Previous 3 months, latest and YTD							Risk that CCG is unable to meet statutory duty to provide patients with timely access to treatment. Delayed dianosis can potentially impact significantly on patient outcomes. Delays also add to patient anxiety, affecting wellbeing.
RED	TREND		Feb-19	Mar-19	Apr-19	Latest	YTD		
		CCG	57.58%	68.00%	50.00%	86.84%	72.22%		
		Aintree	40.97%	64.83%	39.10%	85.42%	64.66%		
		Plan	93%	93%	93%	93%	93%		
		Aintree May Trajectory: 93.3% (National 93%)							

Performance Overview/Issues:

The CCG failed the target for May with 86.84% and is also below YTD target with 72.22%. In May there were 10 breaches from a total of 76 patients seen. 9 breaches were at Aintree with 1 at Royal Liverpool. 5 delays were due to patient choice and 5 due to inadequate out-patient capacity. The maximum wait was 38 days.

Aintree reported 85.42% and are also failing the planned trajectory of 93.3% having 28 breaches out of a total of 192 patients.

Actions to Address/Assurances:

As a health economy we have developed some revised referral forms and educational resources for primary care aimed at better risk stratification of referrals into suspected cancer and symptomatic pathways and increased management of benign breast disease in primary care.
There has been a significant improvement for month 2 brought about by workforce design and waiting list initiatives.
Aintree has confirmed that the 93% operating standard will be met in June 2019.

When is performance expected to recover:

June 2019.

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Debbie Harvey	Sarah McGrath

2.5.3 62 Day Cancer Urgent Referral to Treatment Wait

Indicator		Performance Summary						IAF	Potential organisational or patient risk factors
All cancer two month urgent referral to treatment wait		**Previous 3 months, latest and YTD**						122b	Risk that CCG is unable to meet statutory duty to provide patients with timely access to treatment. Delayed dianosis can potentially impact significantly on patient outcomes. Delays also add to patient anxiety, affecting wellbeing.
RED	**TREND**		Feb-19	Mar-19	Apr-19	Latest	YTD		
		CCG	68.18%	78.79%	75.00%	77.27%	76.32%		
		Aintree	74.44%	81.58%	69.06%	70.20%	69.66%		
		Plan	85%	85%	85%	85%	85%		
		Aintree May Trajectory: 71.9% (National 85%)							

Performance Overview/Issues:

The CCG failed the target for May reporting 77.27%. In May there were 10 breaches from a total of 44 patients seen, breach reasons include delays due to complex diagnostic pathways, delay due to inadequate out-patient capacity and other reasons not stated.

Aintree also failed the target and planned trajectory of 71.9% in May reporting 70.20%.

Actions to Address/Assurances:

CCGs have received recovery plans from Aintree which will be reviewed monthly at the Aintree Planned Care Group. Key areas of focus include:
- Leadership and internal management processes
- Capacity and demand review
- Radiology workforce solutions
- Work with Liverpool Clinical Laboratories on improvement of pathology turnaround times
- Work with CCG clinicians around referral quality and interface issues, shared understanding of issues, meeting of Cancer Improvement Group 22nd August
- There will be discussion around issue of a contract performance notice for this standard at August Collaborative Commisioning Forum

When is performance expected to recovery:

Trajectory submitted by Aintree does not indicate recovery within this financial year.

Quality:

Root cause analyses should be undertaken on any tumour pathway which is failing 62 days. Themes should populate the provider's cancer improvement plan.

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Debbie Harvey	Sarah McGrath

2.5.4 62 day wait for first treatment following referral from an NHS Cancer Screening Service

Indicator		Performance Summary						IAF	Potential organisational or patient risk factors
62 day wait for first treatment following referral from an NHS Cancer Screening Service		Previous 3 months, latest and YTD							Risk that CCG is unable to meet statutory duty to provide patients with timely access to treatment. Delayed dianosis can potentially impact significantly on patient outcomes. Delays also add to patient anxiety, affecting wellbeing.
RED	TREND		Feb-19	Mar-19	Apr-19	Latest	YTD		
		CCG	50.00%	100%	No patients	85.71%	85.71%		
		Aintree	66.67%	91%	92.86%	86.96%	89.19%		
		Plan	90%	90%	90%	90%	90%		

Performance Overview/Issues:

The CCG are failing the 62 day wait for first treatment following referral from the screening service reporting 85.71% in May. This equates to 1 patient not seen out of a total of 7 patients. This lower gastro patient delay was due to complex diagnostic pathway, first seen trust being Aintree, first treatment trust Clatterbridge, 95 days waited.

Aintree report 86.96% for screening in May, which equates to 1.5 patient breaches out of a total of 11.5 patients, the one above and another lower gastro patient whose delay was due to other reason, first seen trust Aintree, first treatment Trust Southport & Ormskirk, 83 days waited.

Actions to Address/Assurances:

Cancer Screening programmes are commissioned by Public Health England but CCGs are accountable for performance against the 62 day standard for any patients who receive a positive cancer diagnosis from screening and require treatment. There are some concerns around patient engagement following a postive screening result which exhibits as higher numbers of DNAs and patient -initiated cancellation for appointments and investigations in the pre-diagnostic phase of the pathway compared with a GP 2 week wait referral pathway.

A representative from the Operations & Delivery Directorate of NHSE will be attending the Bowel Cancer Screening Programme Board in September to discuss these issues and impact on performance.

When is performance expected to recovery:

Very small numbers in this patient cohort (typically 2-3 per month) make for volatile performance aginst this standard and difficult prediction of recovery.

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Debbie Harvey	Sarah McGrath

2.5.5 62 Day wait for first treatment for Cancer following a Consultants Decision to Upgrade

Indicator		Performance Summary						IAF	Potential organisational or patient risk factors
62 day wait for first treatment for Cancer following a Consultants Decision to Upgrade the Patient's Priority		Previous 3 months, latest and YTD							Risk that CCG is unable to meet statutory duty to provide patients with timely access to treatment. Delayed dianosis can potentially impact significantly on patient outcomes. Delays also add to patient anxiety, affecting wellbeing.
RED	TREND		Jan-19	Feb-19	Mar-19	Latest	YTD		
		CCG	85.71%	90.91%	60.00%	70.00%	64.00%		
		Aintree	79.07%	76.47%	70.00%	66.67%	68.29%		
		Plan	85%	85%	85%	85%	85%		
		Aintree May Trajectory: 82.4% (Local target 85%)							

Performance Overview/Issues:

The CCG failed the target for May with 70.00%. In May there were 3 breaches from a total of 10 patients seen, reasons were complex diagnostic pathways.

Aintree failed the monthly target for May with 66.67% also failing the trajectory of 82.4%. There were the equivalent of 7 breaches out of a total of 21 patients seen all but 1 due to complex diagnostic pathways of the 7, the treatment trust for 5 was the Liverpool Heart & Chest.

Actions to Address/Assurances:

Cancer Alliance are undertaking some work to promote consistent use of the 62 day upgrade pathway especially from emergency settings which should result in increased numbers of patients in this target cohort.

When is performance expected to recovery:

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Debbie Harvey	Sarah McGrath

2.5.6 104+ Day Breaches

Indicator		Performance Summary				IAF	Potential organisational or patient risk factors
Cancer waits over 104 days - Aintree		Latest and previous 3 months					Risk that CCG is unable to meet statutory duty to provide patients with timely access to treatment. Delayed dianosis can potentially impact significantly on patient outcomes. Delays also add to patient anxiety, affecting wellbeing.
RED	TREND	Feb-19	Mar-19	Apr-19	Latest		
		2	4	4	3		
		Plan: Zero					

Performance Overview/Issues:

In May there were 3 over 104 day breaches at Aintree the longest waiting 119 days,

Actions to Address/Assurances:

RCAs for very long waiting patients treated in April 2019 were reviewed at the Perfomance and Quality Investigation Review Panel (PQIRP) and thematic review undertaken . Key issues identified to date include:
- availability of chemicals for Transcatheter arterial chemoembolization (TACE)
- delays in accessing diagnostics at peripheral trusts (head and neck pathway)
- complex sequential diagnostic pathways and access to radiology investigation and reporting
- 3-4 week waits for CT colonography

When is performance expected to recovery:

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Jan Leonard	Debbie Harvey	Sarah McGrath

2.6 Patient Experience of Planned Care

Indicator		Performance Summary						Potential organisational or patient risk factors
Aintree Friends and Family Test Results: Inpatients		Previous 3 months and latest						
RED	TREND		Feb-19	Mar-19	Apr-19	Latest		
		RR	19.5%	20.8%	16.0%	18.0%		
		% Rec	94.0%	94.0%	92.0%	95.0%		
		% Not Rec	3.0%	4.0%	4.0%	3.0%		
		May 2019 England Averages Response Rates: 24.9% % Recommended: 96% % Not Recommended: 2%						

Performance Overview/Issues:

Aintree Trust has reported a response rate for inpatients of 18% in May 2019. This is significantly below the England average of 24.9%. The percentage of patients who would recommend the service increased to 95% below the England average of 96% and the percentage who would not recommend has decreased to 3% above the England average of 2%.

Actions to Address/Assurances:

On an annual basis the provider will submit a report to the CCG and present at the CQPG the outcome of their aggregated review of patient and carer experience. As a minimum this will include the following: the outcomes of the FFT responses and actions planned/taken as a result of these, how the provider listens to patients and carers and respond to their feedback, how the provider provides a safe environment for patients, how the provider meets the physical and comfort needs of patients, how the provider supports carers, how the provider recognises patients and carers individuality and involves them in decisions about their care, how the provider communicates effectively patients throughout their journey, how the provider used E&D data to drive patient and carer experience and service improvement.

When is performance expected to recover:

The above actions will continue with an ambition to improve performance during 2019/20.

Quality:

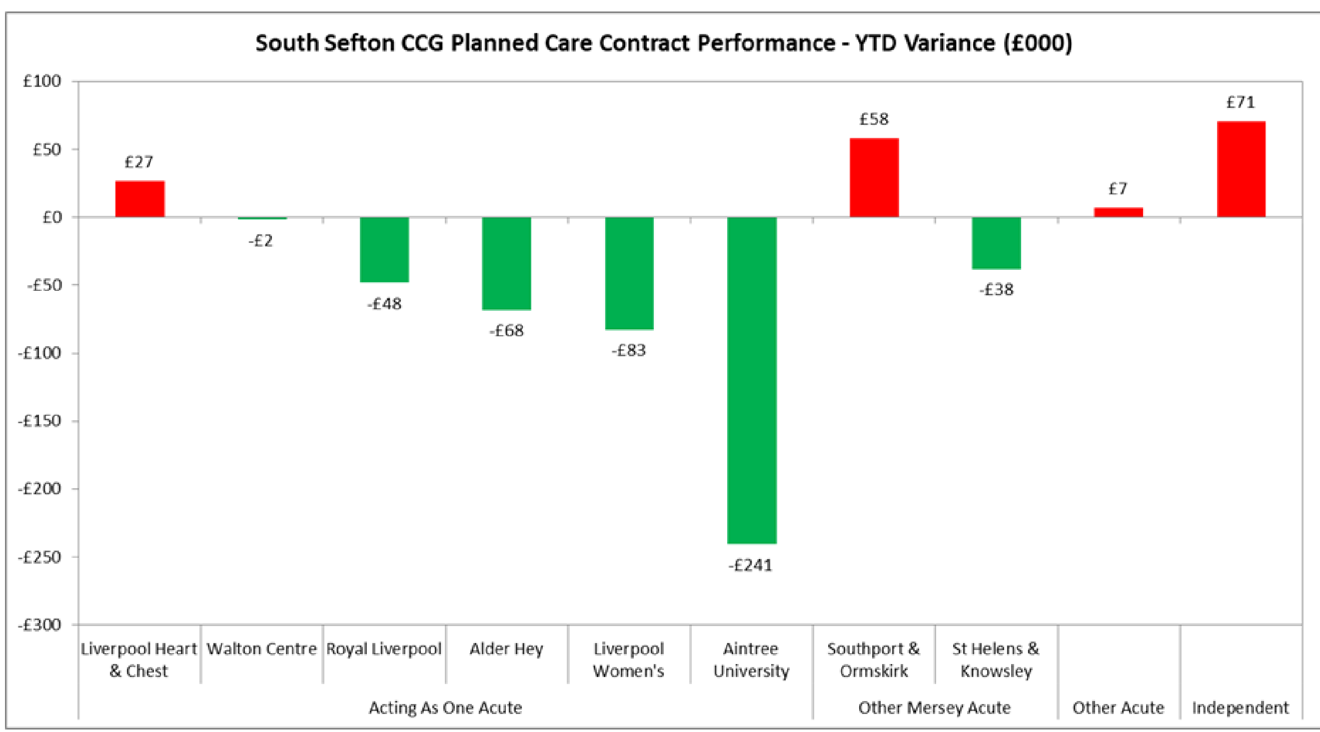
See actions.

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Brendan Prescott	N/A	Jennifer Piet

2.7 Planned Care Activity & Finance, All Providers

Figure 5 - Planned Care - All Providers



Performance at Month 2 of financial year 2019/20, against planned care elements of the contracts held by NHS South Sefton CCG shows an under performance of circa -£317k/-3.8%. However, applying a neutral cost variance for those Trusts within the Acting as One block contract arrangement results in an over spend of approximately £98k/1.2%.

At individual providers, Aintree Hospital is showing the largest under performance at month 2 with a variance of -£241k/-5%. In contrast, a notable over performance against contracts for Renacres and Southport & Ormskirk Hospital's has been evident.

At speciality level, Trauma & Orthopaedics represents the highest over performance for South Sefton CCG at month 2. The majority of this over performance is related to activity at Renacres Hospital. Market share for this particular provider has increased from 17% to 20% when comparing 2019/20 to the equivalent period of 2018/19.

NB. There is no financial impact to South Sefton CCG for contract performance at any Providers within the Acting as One block contract arrangement.

It should also be noted that the 2019/20 activity plan for Southport & Ormskirk Hospital is not yet available. Therefore, contract performance values included in the above chart will relate to variances against 2018/19 plan values.

2.7.1 Aintree University Hospital NHS Foundation Trust

Figure 5 - Planned Care – Aintree Hospital

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	2,054	2,135	81	4%	£1,325	£1,308	-£17	-1%
Elective	255	227	-28	-11%	£816	£805	-£11	-1%
Elective Excess BedDays	98	135	37	37%	£26	£36	£10	37%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	50	39	-11	-23%	£10	£8	-£2	-21%
OPFANFTF - *Outpatient first attendance non face to face*	311	184	-127	-41%	£9	£6	-£3	-37%
OPFASPCL - *Outpatient first attendance single professional consultant led*	5,500	5,079	-421	-8%	£913	£816	-£97	-11%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	135	116	-19	-14%	£14	£12	-£2	-17%
OPFUPNFTF - *Outpatient follow up non face to face*	1,100	926	-174	-16%	£28	£23	-£4	-16%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	12,296	11,301	-995	-8%	£906	£835	-£72	-8%
Outpatient Procedure	4,015	3,852	-163	-4%	£571	£540	-£31	-5%
Unbundled Diagnostics	2,493	2,405	-88	-4%	£210	£202	-£7	-4%
Wet AMD	277	271	-6	-2%	£218	£216	-£2	-1%
Grand Total	**28,584**	**26,670**	**-1,914**	**-7%**	**£5,047**	**£4,806**	**-£241**	**-5%**

Underperformance at Aintree Hospital is evident against the majority of planned care points of delivery. However, the overall under spend of -£241k/-5% is driven in the main by reduced outpatient activity, specifically first appointments. South Sefton CCG referrals to Aintree Hospital are currently below 2018/19 levels and further analysis has established a number of specialities are currently below planned levels for outpatient appointments at month 2. This includes Gastroenterology for outpatient first appointments and Ophthalmology for follow up appointments.

Day case activity is currently over performing against plan as a result of increased scopes being performed within Gastroenterology. Within Urology, activity related to 'Introduction of Therapeutic Substance into Bladder' is also 91% above plan at month 2. However, despite an overall increase in day case procedures, costs are currently below planned levels for this point of delivery with reduced activity in ENT and General Surgery attributed to the majority of this reduction.

Despite the indicative underspend at this Trust; there is no financial impact of this to South Sefton CCG due to the Acting as One block contract arrangement.

2.7.2 Renacres Hospital

Figure 5 - Planned Care – Renacres Hospital

Renacres Hospital Planned Care PODS	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	99	106	7	7%	£119	£149	£31	26%
Elective	23	29	6	24%	£130	£173	£44	34%
Elective Excess Bed Days	2	0	-2	-100%	£1	£0	-£1	-100%
OPFASPCL - *Outpatient first attendance single professional consultant led*	220	219	-1	-1%	£37	£36	-£1	-3%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	321	351	30	9%	£22	£24	£2	9%
Outpatient Procedure	171	126	-45	-26%	£21	£24	£3	14%
Unbundled Diagnostics	102	129	27	27%	£9	£13	£4	39%
Physio	247	275	28	11%	£8	£8	£1	12%
OPPREOP	0	99	99	0%	£0	£6	£6	0%
Grand Total	**1,186**	**1,334**	**148**	**12%**	**£347**	**£435**	**£88**	**25%**

Renacres over performance is evident across the majority of planned care points of delivery. Over performance is focussed largely within the Trauma & Orthopaedics speciality. Small numbers of high cost procedures account for the over performance within electives and day cases. An analysis of referrals has also shown increasing GP referrals to this provider in 2019/20, particularly Trauma & Orthopaedics and ENT.

Work is on-going looking into the potential shift in referral patterns in South Sefton from the main Acute Provider to other providers such as Renacres. Contributing factors to changes in referral flows could be due to long waiting times performance of RTT at Aintree and increased capacity in such specialties as ENT at Renacres. The CCG is currently undertaking a deep dive on ENT within the contract review meetings and planned care leads have been involved in respect of the procedures undertaken at Renacres.

3. Unplanned Care

3.1 Accident & Emergency Performance

3.1.1 A&E 4 Hour Performance: South Sefton CCG

Indicator		Performance Summary						IAF	Potential organisational or patient risk factors
CCG A&E Waits - % of patients who spend 4 hours or less in A&E (cumulative)		**Previous 2 months, latest and YTD**						127c	Risk that CCG is unable to meet statutory duty to provide patients with timely access to treatment. Quality of patient experience and poor patient journey. Risk of patients conditions worsening significantly before treatment can be given, increasing patient safety risk.
RED	**TREND**		Feb-19	Mar-19	Apr-19	Latest	YTD		
		All Types	80.14%	80.64%	78.17%	78.34%	78.26%		
		Type 1	76.42%	77.15%	74.01%	73.92%	73.97%		
		Plan: 95%							

Performance Overview/Issues:

The CCG is failing the national standard of 95% in May reporting 78.34%. Similar to last month. A trajectory has been agreed with NHSE/I that runs to 89% in March 2020 not the national target.

Actions to Address/Assurances:

A wide range of work is ongoing to support the Aintree system involving CCG and community provider, local authority:
• Action on A&E is supported by a system wide approach with significant involvement of the CCG Urgent Care lead, our community provider and local authority. Work has been refocused following the Newton Europe review with a wide range of work which focuses on improving patient flow within A&E and main hospital in regard to discharge planning that enables movement from A&E for appropriate admissions; as well as admission/attendance avoidance schemes to reduce A&E activity. This work will remain on-going in 2019/20.
• CCG have taken a lead role in facilitating the Newton Europe DTOC project with system wide action plans now developed to support patient flow and enhance quality of care in three specific areas – decision making, placements and home care. Work is being undertaken with all health and social care providers and commissioners across North Mersey. Within Aintree Hospital there is specific focus on the decision making element of this work.
• An escalation plan has been in place over the winter within North Mersey which outlines the expected roles and responsibilities of all providers with guidance as to when issues should be escalated outside of the Trust to commissioners. This was developed to ensure that resources are used appropriately and that there is a clear understanding of the mutual aid and partnership working that is expected at provider level prior to commissioner engagement. Aintree managed AED pressures over a challenging winter often providing support through ambulance diversions for other local Trusts. This support has continued in 2019.
• The weekly Multi Agency Discharge Events (MADE) which involve representatives from health and social care have being revised to provide a greater focus on areas requiring immediate action. Instead they have been operating as MDT Flying Squads from the start of December targeting front of house areas e.g. AED, Frailty, Observation ward. Working to maintain focus on patient flow from front door units has continued in 2019/20 with system work initiated to improve ambulatory care pathways within the Frailty Assessment Unit.
• On-going implementation of Mersey Care Alternative to Transfer scheme with system introduced to provide timely response to NWAS to support patients at home who do not require conveyance to A&E. Work underway to promote service further and increase referrals and range of pathways that can be supported. Work is being rolled out within Mersey Care to Liverpool and aim to share good practice and roll out to Southport & Formby to ensure consistent offer to NWAS.
• Collaborative work continues with Liverpool and Knowsley CCGs to review potential Urgent Treatment Centre provision within Aintree footprint again with focus of reducing A&E attendances.
• Weekly Aintree system calls are in place with NHSE and all partners to agree priority areas to progress each week reflecting local requirements. These are working well in maintaining operational and strategic communication across organisations.
In addition to above the three priority areas which the Trust have identified will make the greatest impact on A&E performance are:
- Optimising processes for See and Treat / Primary Care Streaming cohort of patients - **Review of process underway with opportunity to learn from Royal where higher uptake to primary care streaming**
- Ambulance turn around times and introduction of direct conveyancing to agreed front door units - **Awaiting Aintree revised ambulance turnaround plan**
- Integrated work with partners to address superstranded and support patient flow in and out of hospital - **On target for South Sefton patient cohort in regard to NHSI Long Length of Stay action plan and trajectory**

When is performance expected to recovery:

Aintree have an agreed trajectory with NHSE/I profiled from 88% in Month 1 to 89% in Month 12 not the national target of 95%.

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	John Wray	Janet Spallen

3.1.2 A&E 4 Hour Performance: Aintree

Indicator		Performance Summary							Potential organisational or patient risk factors
Aintree A&E Waits - % of patients who spend 4 hours or less in A&E (cumulative) 95%		Previous 2 months, latest and YTD							Risk that the Trust is unable to meet statutory duty to provide patients with timely access to treatment. Quality of patient experience and poor patient journey. Risk of patients conditions worsening significantly before treatment can be given, increasing patient safety risk.
RED	TREND		Feb-19	Mar-19	Apr-19	Latest	YTD		
		Improvement Plan	84.20%	95%	88%	88%			
		All Types	84.89%	85.12%	82.67%	82.92%	82.80%		
		Type 1	73.38%	73.36%	69.69%	69.29%	69.49%		
		Plan: 95% May's improvement plan: 88% Yellow denotes achieving 19/20 improvement plan but not national standard of 95%							

Performance Overview/Issues:

Whilst attendances for May were the highest ever recorded at 8119, the performance against the 4 hours care standard remaind fairly static at 82.92% for type 1 and 3, against April's performance of 82.67%. There was a 1% decline in T1 when comparing May 2018 against a 2.7% increase in attendance.

Actions to Address/Assurances:

Trust Actions:

• Performance against the 4 hour care standard for patients who are not admitted has declined. To address this additional medical seeing power has been increased (when available) during peak periods of demand with the aim of having up to 8 doctors assigned to See and Treat between the hours of 12:00 and 22:00 every day. The department is repeating the recruitment process of new medical staff utilising additional funding from April 2019. The presence of a senior doctor to support the medical workforce in decision making and oversee the overall safety of the area will also improve the throughput rate. An external review of PCS has been commissioned with the aim to increase the utilisation of the service. Whilst awaiting the output from this review the department has adopted a different approach at triage using the Luton and Dunstable model of streaming at the front door. The aim is to divert more demand away from A&E by increasing the use of available GP slots. This will also be supported by diverting more patients to a GP trained doctor in See & treat using the 'black numbers' facility, thus when PCS slots are not available, GP amenable patients will still be able to see a GP.
Outcome: Rapid improvement in non admitted performance and improved flow through See and Treat.

• The Clinical Director and CBM will reaffirm to all clinicians of FY3 and above the need to Pit Stop between the hours of 07:00 and midnight every day. The aim will be to formalise a Pit Stop roster encompassing the full set of staff required to successfully deliver the model during these hours including senior nurse, FY1's, staff nurse and HCA. **Outcome: Consistent coverage of the Pit Stop Model with improved WTTBS performance and improved Ambulance Turnaround Times.**

• Patients being conveyed directly to AEC and by-passing ED will reduce the demand to ED. Patients categorised as Amber pathway patients will following a call to AEC and following a pre-determined clinical criteria will travel straight to AEC via ambulance. The clinical protocol will support the correct and accurate redirection of patients and this will be supported by the ability for crews to call a senior clinician in AEC to discuss the safe conveyance of a patient to the department. **Outcome: patients with an amber category normally conveyed and treated in ED will be treated in AEC and by pass ED altogether.**

• The CBU structure will be realigned to improve role clarity and strengthened with the introduction of a Lead Nurse for Operational Management, Activity and Performance and a dedicated Lead Nurse for Quality & Safety. This will ensure that there is a continuous focus on the flow of patients across the CBU footprint supporting the timely egress of patients out of the Emergency and Urgent Portals of Entry.

• The AEC Pathway will be the subject of a Rapid Improvement Event w/c 24th June with the aim of reducing the lead time for each patient and thus creating a productivity improvement opportunity and the ability to safely process more AEC amenable patients through the service. The event will focus on removing waste from the current process and streamlining the flow of information supporting the patient journey. The outcome will also support a much improved patient experience as they will wait less and not be subject to crowding in the AEC at peak times.

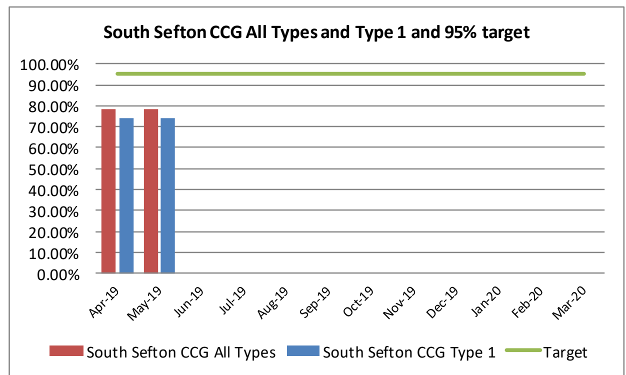
When is performance expected to recovery:

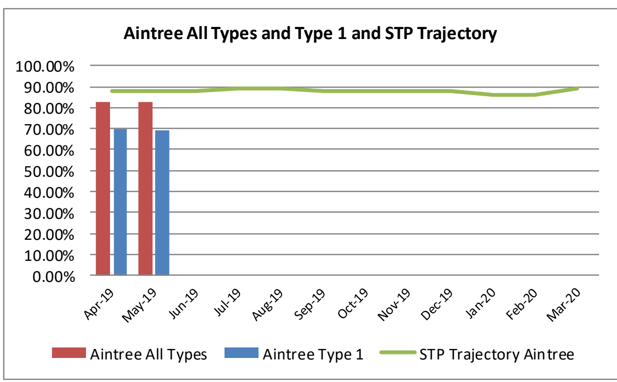
Quarter 4, 2019/20 trajectory is 89%.

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Jan Leonard	John Wray	Janet Spallen





3.2 Occupied Bed Days

The NHS has a new national ambition to lower bed occupancy by reducing the number of long stay patients (and long stay beds) in acute hospitals by 40% (25% being the 2018/19 ambition with an addition of 15% for 2019/20). Providers are being asked to work with their system partners to deliver this ambition.

Figure 6 – Occupied Bed Days, Aintree Hospital

Data Source: NHS Improvement – Long Stays Dashboard

The long stays dashboard has been updated for 2019 to report on a weekly basis. The Trust's revised target is a total bed reduction of 77 (41%) by March 2020; therefore the target is 111 or less. This target is yet to be achieved as the latest reporting as at 8th July 2019 (weekly average) shows 137 occupied beds. However recent reporting is encouraging as it shows a downward trend with a total reduction of 51 beds with 26 remaining in order to achieve the ambition in March 2020.

Actions to support improvement are identified within Newton work with a focus on initiatives which will support complex discharges with longer lengths of stay. There are a range of developments underway in regard to placement processes; discharge to assess pathways, the patient choice policy to facilitate flow, development of care home trusted assessor roles and community pathways to facilitate earlier discharge. Patient Flow Telecoms and focussed individual patient case work continue where stranded and super stranded patients reviewed with MDT involvement. Support provided where required with opportunity to identify specific themes requiring further action. Collaborative work by all Aintree partners is detailed in NHSI action plan and trajectory to address patients with long lengths of stay.

3.3 Ambulance Performance

<table>
<tr><th colspan="2">Indicator</th><th colspan="5">Performance Summary</th><th>Definitions</th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2">Category 1,2,3 & 4 performance</td><td colspan="5">Latest and previous 2 months</td><td rowspan="8">Category 1 -Time critical and life threatening events requiring immediate intervention
Category 2 -Potentially serious conditions that may require rapid assessment, urgent on-scene clinical intervention/treatment and / or urgent transport
Category 3 - Urgent problem (not immediately life-threatening) that requires treatment to relieve suffering
Category 4 / 4H / 4HCP- Non urgent problem (not life-threatening) that requires assessment (by face to face or telephone) and possibly transport</td><td rowspan="8">Longer than acceptable response times for emergency ambulances impacting on timely and effective treatment and risk of preventable harm to patient. Likelihood of undue stress, anxiety and poor care experience for patient as a result of extended waits. Impact on patient outcomes for those who require immediate lifesaving treatment.</td></tr>
<tr><td>RED</td><td>TREND</td><td>Cat</td><td>Target</td><td>Mar-19</td><td>Apr-19</td><td>Latest</td></tr>
<tr><td rowspan="6"></td><td rowspan="6"></td><td>1 mean</td><td><=7 mins</td><td>00:07:22</td><td>00:07:13</td><td>00:06:57</td></tr>
<tr><td>1 90</td><td><=15 mins</td><td>00:12:50</td><td>00:11:36</td><td>00:11:24</td></tr>
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<tr><td>4 90</td><td><=180 mins</td><td>02:50:09</td><td>03:00:37</td><td>03:14:38</td></tr>
</table>

Performance Overview/Issues:

In May 2019 there was an average response time in South Sefton of 6 minutes 57 seconds against a target of 7 minutes for Category 1 incidents. For Category 2 incidents the average response time was 25 minutes against a target of 18 minutes, the slowest response time in Merseyside. The CCG also failed the category 3 and category 4 90th percentile response. Performance is being addressed through a range of actions including increasing number of response vehicles available, reviewing call handling and timely dispatch of vehicles as well as ambulance handover times from A&E to release vehicles back into system.

Actions to Address/Assurances:

Through 2018/19 NWAS has made good and sustained progress in improving delivery against the national ARP standards. Significant progress has been made in re-profiling the fleet, improving call pick up in the EOCs, use of the Manchester Triage tool to support both hear & treat and see & treat and reduce conveyance to hospital. The joint independent modelling commissioned by the Trust and CCGs set out the future resource landscape that the Trust needs if they are to fully meet the national ARP standards, critical to this is a realignment of staffing resources to demand which will only be achieved by a root and branch re-rostering exercise. This exercise has commenced however due to the scale and complexity of the task, this will not be fully implemented until the end of Quarter 1 2020/21. To support the service to both maintain and continue to improve performance, the contract settlement from commissioners for 2019/20 provided the necessary funding to support additional response staffing and resources, including where required the use of VAS and overtime to provide interim additional capacity, prior to full implementation of the roster review.

When is performance expected to recovery:

The 2019/20 contract agreement with NWAS identifies that the ARP standards must be met in full (with the exception of the C1 mean) from quarter 4 2019/20. The C1 mean target is to be delivered from quarter 2 2020/21. A trajectory has been agreed with the Trust for progress towards delivery of the standards.

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	John Wray	Janet Spallen

3.4 Ambulance Handovers

Indicator		Performance Summary					Indicator a) and b)	Potential organisational or patient risk factors
Ambulance Handovers		Latest and previous 2 months					a) All handovers between ambulance and A&E must take place within 15 minutes with non waiting more than 30 minutes b) All handovers between ambulance and A&E must take place within 15 minutres with non waiting more than 60 minutes	Longer than acceptable response times for emergency ambulances impacting on timely and effective treatment and risk of preventable harm to patient. Likelihood of undue stress, anxiety and poor care experience for patient as a result of extended waits. Impact on patient outcomes for those who require immediate lifesaving treatment.
RED	TREND		Target	Mar-19	Apr-19	Latest		
		(a)	<=15 mins	159	183	151		
		(b)	<=15 mins	71	101	91		

Performance Overview/Issues:

Performance for the month of May saw a decline all over with 151 delays in excess of 30 minutes, which is 22 less than the April figure of 183, delays over 60 minutes also decreased to 91, 10 less than April. The average time from notification to handover for May was 14.47 minutes, (+1) . The median time to see 1st clinician saw an improvement in May to 82 minutes against April's 88 minutes (-6). There was also a slight improvement in the % of patients seen from registration within 15 minutes to 73.68% which is an improvement of (+1) from April. The clinical quality indicators for the number of patients who leave the department before being seen have increased to 461(+42). The number of patients re-attending in May saw an increase from 8.41% in April to 10.09% in May (1.68%).

Actions to Address/Assurances:

Aintree have been part of the Super Six working with NWAS to improve processes to support achievement of the handover targets. They have identified that the priority area which will have the greatest impact will be the introduction of direct conveyancing of appropriate patients to front door units e.g. Ambulatory Medical Unit, Frailty Assessment Unit, without being first triaged through AED. The Trust have been asked to update their Ambulance Handover Improvement Plan with details of implementation plans and timescales for the introduction of direct conveyancing.

When is performance expected to recovery:

This is a priority area for immediate improvement. We are awaiting an update Improvement Plan which will detail timescales for implementation of direct conveyancing.

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	John Wray	Janet Spallen

3.5 Unplanned Care Quality Indicators

3.5.1 Stroke and TIA Performance

Indicator		Performance Summary				Measures	Potential organisational or patient risk factors
Aintree Stroke & TIA		**Latest and previous 3 months**				a) % who had a stroke & spend at least 90% of their time on a stroke unit b) % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	Risk that CCG is unable to meet statutory duty to provide patients with timely access to Stroke treatment. Quality of patient experience and poor patient journey. Risk of patients conditions worsening significantly before treatment can be given, increasing patient safety risk.
RED	**TREND**	Feb-19	Mar-19	Apr-19	Latest		
		73.00%	70.60%	60.00%	76.10%		
		Stroke Plan: 90% TIA 60% (achieving in May)					

Performance Overview/Issues:

Performance against the National Quality Stroke metric 90% stay standard was 76.1 for May 2019 for Aintree. There were 46 patients with a primary diagnosis of stroke discharged from the Trust during the month. Of these, 35 patients spent 90% of their stay on the Stroke Unit. The standard was not achieved for 11 patients. All breaches of the standard are reviewed and reasons for underperformance identified:

- 8 patients required admission to the Stroke Unit with no bed availability
- 1 patient had no neurology on arrival to hospital
- 1 patient was a late referral to the Stroke Team
- 1 patient was referred after a MRI diagnosed Stroke

Actions to Address/Assurances:

Trust Actions:

• Work with Lead Nurse for workforce on a recruitment strategy for Registered Nursing vacancies:
- prepare recruitment briefing for Clinical Business Unit and Stroke.
– Recruit SALT to create a weekend service.
• Improve therapy scores SNAPP:
- Pilot change of working hours to create evening capacity.
– Recruit SALT to create a weekend service.
• Develop quarterly report from Stroke:
- Meet with Matt Roberts to agree content of the report.
– Monitor time to scan weekly with radiology.
• Improve data entry to SSNAP:
- Weekly data meetings with clinical leads and data clerks.
– Recruit to Data Quality Co-ordinators post.
• Develop SOP with timelines for escalate of PEG delays.

When is performance expected to recovery:

Quarter 3, 2019/20.

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	John Wray	Janet Spallen

3.5.2 Healthcare associated infections (HCAI): MRSA

Indicator		Performance Summary						Potential organisational or patient risk factors
Incidence of Healthcare Acquired Infections: MRSA		Latest and previous 3 months					Cases of MRSA carries a zero tolerance and is therefore not benchmarked.	
GREEN	TREND		Feb-19	Mar-19	Apr-19	Latest		
		CCG	0	0	0	0		
		Aintree	0	0	0	1		
		Plan: Zero						

Performance Overview/Issues:

Aintree have had a new case of MRSA in May so has failed the zero tolerance threshold for 2019/20. In May 19 there was one patient with a trust apportioned MRSA bacteraemia, blood culture taken on ward 28.

Actions to Address/Assurances:

Proposed Trust Actions:
- To undertake a post infection preview with the clinical team.
- To review the post infection review with CCG.
- To identify lessons learnt and actions.
- Draft action plan.
- Monitor action plan through DAG and IPC Operational Group.

When is performance expected to recovery:

Cases of MRSA carries a zero tolerance - recovery can therefore not be met.

Quality:

No further details as awaiting final report through the quality schedule with the IPC rep to attend and report to CQPG annually - expected Q4.

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Brendan Prescott	Gina Halstead	Jennifer Piet

3.5.3 Healthcare associated infections (HCAI): C Difficile

Indicator		Performance Summary						Potential organisational or patient risk factors
Incidence of Healthcare Acquired Infections: C Difficile		Latest and previous 3 months						
RED	TREND		Mar-19	Apr-19	Latest	YTD		
		CCG	4	7	0	7		
		Aintree	7	9	7	16		
		Plan: </=60 YTD for the CCG Plan: </=56 for Aintree						

Performance Overview/Issues:

The CCG had no new cases of C.Difficile in May, against a year to date plan of 11 (year end plan 60) so are under plan currently (2 apportioned to acute trust and 5 apportioned to community).

The national objective for C Difficile has changed. All acute trusts are now performance monitored on all cases of healthcare associated infections including those which are hospital onset health care associated (HOHA): cases detected in the hospital three or more days after admission and community onset healthcare associated (COHA): cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks. The Trusts national objective is to have no more than 56 healthcare associated cases in 2019/20. In May the Trust reports they had 4 cases of c diff in May (9 YTD). 1 community onset healthcare associated (COHA) and 3 hospital onset healthcare associated (HOHA). This is just under the monthly objective of no more than 4.66 cases per month. NB the national PHE data set does not currently reflect this change attribution and shows Aintree have had 7 cases in May (16 YTD) (6 apportioned to the trust and 10 community onset) this is the data reported above.

Actions to Address/Assurances:

Trust Actions:
- To undertake a post infection preview with the clinical team.
- To review the post infection review with CCG.
- To identify lessons learnt and actions.
- Draft action plan.
- Monitor action plan through DAG and IPC Operational Group.

When is performance expected to recovery:

Quarter 2, 2019/20

Quality:

No further details as awaiting final report through the quality schedule with the IPC rep to attend and report to CQPG annually - expected Q4.

Indicator responsibility:

Leadership Team Lead		Clinical Lead	Managerial Lead
Brendan Prescott		Gina Halstead	Jennifer Piet

3.5.4 Healthcare associated infections (HCAI): E Coli

Indicator		Performance Summary					RightCare Peer Group	Potential organisational or patient risk factors
Incidence of Healthcare Acquired Infections: E Coli (CCG)		Latest and previous 3 months						
RED	TREND	Feb-19	Mar-19	Apr-19	Latest	YTD		
		13	12	15	18	33		
		Plan: 128 YTD for the CCG						

Performance Overview/Issues:		
NHS Improvement and NHS England have set CCG targets for reductions in E.coli for 2019/20 NHS South Sefton CCG's year-end target is 128 the same as last year when the CCG failed reporting 170 cases. In May there were 18 cases (33 YTD) against a year to date plan of 21. Aintree reported 31 cases in May (63 YTD) there are no targets set for Trusts at present.		
Actions to Address/Assurances:		
The Gram Negative Bloodstream Infection Steering Group continues to meet on a bi-monthly basis with specific work stream areas on surveillance and reporting; continence and hydration to prevent symptoms of Urinary Tract Infection (UTI). The outputs of the work streams should impact on HCAI outcomes (inclusive of both C.difficile and E.Coli). Due to the failure of the C.difficile, the year-end target for 2019-20 has increased to 60 for the CCG. The target for E.coli remains the same for 2019-20 as it did in 2018/19, 128 cases.		
When is performance expected to recovery:		
Quarter 1, 2019/20		
Quality:		
North Mersey Gram Negative have oversight and progress against action plan will be reported through to JQPC.		
Indicator responsibility:		
Leadership Team Lead	**Clinical Lead**	**Managerial Lead**
Brendan Prescott	Gina Halstead	Jennifer Piet

3.5.5 Hospital Mortality

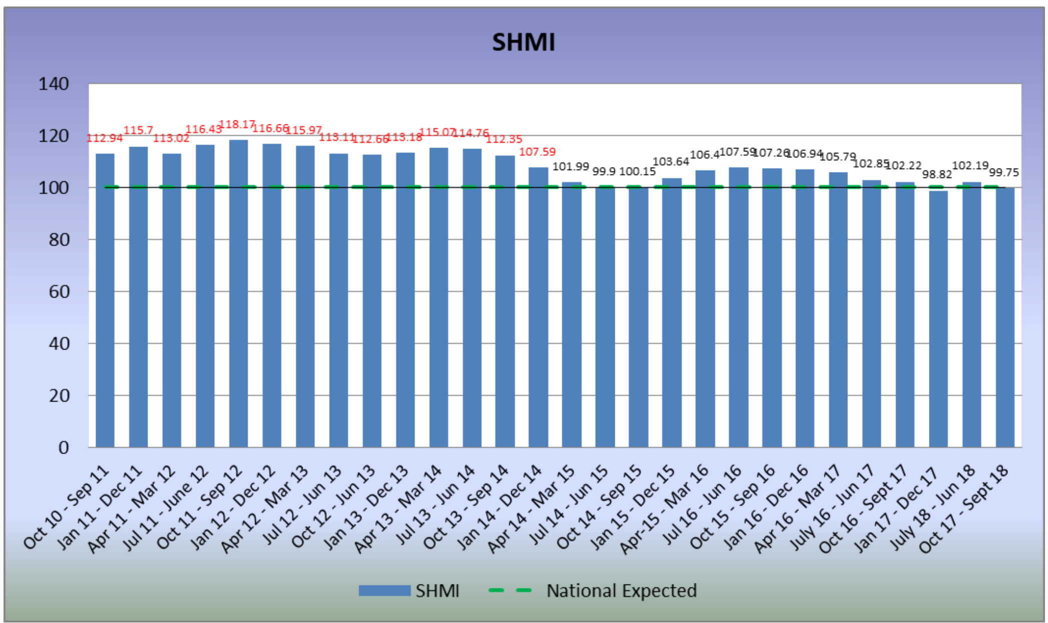
Figure 7 - Hospital Mortality

Mortality				
Hospital Standardised Mortality Ratio (HSMR)	19/20 - May	100	90.83	↓

HSMR is slightly lower than last month at 90.83 (Feb 18 – Jan 19) (93.11 was previously reported). Position remains better than expected. A ratio of greater than 100 means more deaths occurred than expected, while the ratio is fewer than 100 this suggest fewer deaths occurred than expected. Ratio is the number of observed deaths divided by predicted deaths. HSMR looks at diagnoses which most commonly result in death.

SHMI at 99.75 is lower than previous period and within tolerance levels. SHMI is risk adjusted mortality ratio based on number of expected deaths.

Figure 8 - Summary Hospital Mortality Indicator



3.6 CCG Serious Incident Management

CCG SI Improvement Action Plan 2019/20

The Quality Team have developed a CCG SI Improvement Plan for 2019/20 to further enhance the SI process and obtain the necessary assurances from our Providers. This will be monitored on a monthly basis via the Joint Quality and Performance Committee and includes the following key areas of improvement:

- Enhance the current CCG systems and processes to ensure appropriate assurances are gained from providers following the reporting and investigation of serious incidents
- Utilise Datix module to capture trends and themes following CCG assurance review of SI RCAs.
- Establish effective methods for capturing and distributing lessons learnt following SI investigations.
- Ensure all SIRG panel members and other appropriate CCG staff undertake RCA training.
- Enhance current CCG systems and processes to ensure provider compliance is maintained in relation to reporting an SI within the 48 hour timescale.
- Revise the current Terms of Reference for the CCGs Serious Incident Review Group (SIRG), to ensure appropriate quoracy is maintained and supported.

Figure 9 – Serious Incident for South Sefton Commissioned Services and South Sefton CCG patients

In May 2019 there are a total of 37 serious incidents (SIs) open on StEIS for South Sefton as the RASCI (Responsible, Accountable, Supporting, Consulted, Informed) commissioner or that involve a South Sefton CCG patient. This is a decrease from 43 in Month 1. Those where the CCG is not the RASCI responsible commissioner are highlighted in green in the table below.

Trust	SIs reported (M2)	SIs reported (YTD)	Closed SIs (M2)	Closed SIs (YTD)	Open SIs (M2)	SIs open >100days (YTD)
Aintree University Hospital	1	6	4	9	22	14
Mersey Care NHS Foundation NHS Trust (SSCS)	1	5	0	0	7	0
South Sefton CCG	0	0	0	1	1	0
Mersey Care NHS Foundation Trust (Mental Health)	1	1	1	2	3	1
Royal Liverpool and Broadgreen	0	0	0	1	1	0
The Walton Centre	0	0	0	0	1	1
Alder Hey Children's Hospital	0	0	0	0	1	0
UC24	0	0	0	0	1	1
North West Boroughs NHS Foundation Trust	1	1	0	0	1	0
TOTAL	**4**	**13**	**6**	**13**	**37**	**17**

Of the 14 SIs open > 100days for Aintree University Hospital (AUH), the following applies at the time of writing this report:

- 9 have been reviewed and are now closed
- 4 have been reviewed and closure agreed at South Sefton SIRG, however awaiting confirmation of closure from patients CCG.
- 1 have been reviewed at SIRG and further assurance has been requested from the provider.

For the remaining 3 SIs open > 100 days the following applies:

- _Mersey Care NHS Foundation Trust (Mental Health)_ – RCA reviewed at SIRG but further assurances requested from the provider via Liverpool CCG.
- _The Walton Centre NHS Foundation Trust_ - This RCA is being performance managed by NHSE Specialised Commissioning.
- _UC24_ – The RCA is awaited from the provider via Liverpool CCG.

Figure 10 – Timescale Performance for Aintree University Hospital

PROVIDER	SIs reported within 48 hours of identification (YTD)		72 hour report received (YTD)			RCAs Received (YTD)				
	Yes	No	Yes	No	N/A	Total RCAs due	Received within 60 days	Extension Granted	SI Downgraded	RCA 60+
Aintree	6	0	5	0	1*	4	1	2	1	0

* A 72 hour report was not submitted for this SI as a downgrade was agreed and the incident was closed.

Figure 11 – Timescale Performance for Mersey Care Foundation Trust (South Sefton Community Services (SSCS)

PROVIDER	SIs reported within 48 hours of identification (YTD)		72 hour report received (YTD)		RCAs Received (YTD)				
	Yes	No	Yes	No	Total RCAs Due	Received within 60 days	Extension Granted	SI Downgraded	RCA 60+
Mersey Care (Community)	5	0	0	5*	2	0	0	0	2*

*The trust performance against this target is monitored by Liverpool CCG, the Lead Commissioner for Mersey Care Trust. South Sefton CCG have escalated concerns in relation to compliance with the SI framework and the requirements of the Providers Quality Schedule 2019/20 to the Lead Commissioner which will be discussed at the Contract and Clinical Quality Review Meeting (CCQRM).

3.7 CCG Delayed Transfers of Care

The CCG Urgent Care lead works closely with Aintree and the wider MDT involving social care colleagues to review delayed transfers of care on a weekly basis. There is weekly telecom to review patients waiting over 7 and 21 days with the aim of ensuring movement against agreed discharge plans. There is opportunity within these interventions to identify key themes which need more specific action e.g. we are presently reviewing our discharge to assess pathway where we aim to ensure DSTs are undertaken outside of a hospital setting. We are also working with Mersey Care as our community provider to ensure that ward staff are educated on community pathways which are available to facilitate early discharge with particular focus on ICRAS. Collaborative action by all Aintree partners is detailed in NHSI action plan with trajectory for reductions on long lengths of stay.

Total delayed transfers of care (DTOC) reported in May 2019 was 1,062, an increase compared to May 2018 with 776. Delays due to Social Care have worsened, with those due to NHS improving. The majority of delay reasons in May 2019 were due to patient family choice, further non-acute NHS and care package in home.

See DTOC appendix for more information.

3.8 Unplanned Care Activity & Finance, All Providers

3.8.1 All Providers

Figure 12 - Month 2 Unplanned Care – All Providers

South Sefton CCG Unplanned Care Contract Performance - YTD Variance (£000)

£600
£500
£400
£300
£200
£100
£0
-£100

£487
£46
£26
-£12
-£28
-£30
-£51
£11
-£32

Aintree University
Liverpool Women's
Royal Liverpool
Walton Centre
Liverpool Heart & Chest
Alder Hey
Southport & Ormskirk
St Helens & Knowsley

Acting As One Acute
Other Mersey Acute
Other Acute

Performance at Month 2 of financial year 2019/20, against unplanned care elements of the contracts held by NHS South Sefton CCG shows an over performance of circa £417k/4.4%. However, applying a neutral cost variance for those Trusts within the Acting as One block contract arrangement results in an underperformance of approximately -£72k/-0.8%.

This over performance is clearly driven by Aintree Hospital, which has a variance of £487k/7% against plan at month 2.

NB. There is no financial impact to South Sefton CCG for contract performance at any Providers within the Acting as One block contract arrangement.

It should also be noted that the 2019/20 activity plan for Southport & Ormskirk Hospital is not yet available. Therefore, contract performance values included in the above chart will relate to variances against 2018/19 plan values.

3.8.2 Aintree University Hospital

Figure 5 - Unplanned Care – Aintree Hospital

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	7,067	6,619	-448	-6%	£168	£168	£0	0%
A&E - *Accident & Emergency*	5,956	6,202	246	4%	£962	£1,013	£52	5%
NEL - *Non Elective*	2,889	2,960	71	2%	£5,224	£5,773	£549	11%
NELNE - *Non Elective Non-Emergency*	8	9	1	10%	£30	£62	£32	106%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	46	0	-46	-100%	£12	£0	-£12	-100%
NELST - *Non Elective Short Stay*	553	601	48	9%	£384	£415	£31	8%
NELXBD - *Non Elective Excess Bed Day*	2,403	1,747	-656	-27%	£615	£451	-£164	-27%
Grand Total	**18,923**	**18,138**	**-785**	**-4%**	**£7,395**	**£7,883**	**£487**	**7%**

A&E type 1 attendances are 4% above plan for South Sefton CCG at Aintree Hospital with the Trust (catchment) reporting an historical peak for monthly attendances in May-19. Litherland walk-in centre continues to see decreased activity against plan as in 2018/19.

Non-elective admissions account for the majority of the total over spend at Aintree. Plans were rebased for 2019/20 to take into account a pathway change previously implemented by the Provider. Non-elective activity is currently 2% above plan but costs are exceeding planned values by 11%, which could suggest a change in case mix. Over performance has been recorded against various HRGs including those related to Pneumonia, COPD and Alzheimers Disease / Dementia.

Despite the indicative over spend at this Trust; there is no financial impact of this to South Sefton CCG due to the Acting as One block contract arrangement.

4. Mental Health

4.1 Mersey Care NHS Trust Contract (Adult)

4.1.1 Mental Health Contract Quality Overview

Mersey Care NHS RiO M2 update
Commissioners and the Trust have agreed a reporting format that ensures that the quality contract schedule KPIs are reflected in the Trust's board reports.

Performance which is dependent on the Trust's RiO system will is expected to be fully reported from Quarter 2 with performance backdated, however commissioners are expecting some improvements to take place in Quarter 1.

Any KPI that is rag rated Red the Trust will be submitting a narrative to how they expect to improve performance with a clear trajectory for expected time they will achieve the KPI.
The Commissioners at the next CQPG in August 2019 are seeking assurance that RiO will be fully able to capture data and KPIs. Communication and Eating Disorder KPIs will also be subject to further scrutiny at the August CQPG and contract performance notice(s) cannot be ruled out at this stage as a contractual lever to improve performance.

Safeguarding
The contract performance notice remains in place in respect of training compliance. Bi-monthly meetings continue to take place between the Trust and CCG Safeguarding teams to scrutinise progress against the agreed action plan and trajectory. The performance notice will remain open for a further 6 months to ensure sustainability.

4.1.2 Mental Health Contract Quality

KPI 125: Eating Disorder Service Treatment commencing within 18 weeks of referrals – Target 95%

Indicator		Performance Summary					Potential organisational or patient risk factors
Eating Disorder Service: Treatment commencing within 18 weeks of referrals		**Latest and previous 3 months**				KPI 125	
RED	**TREND**	Feb-19	Mar-19	Apr-19	Latest		
		23.5%	5.9%	0.0%	25.0%		
		Plan: 95% - May 2019/20 reported 25.0% and failed					

Performance Overview/Issues:

Out of a potential 16 Service Users, 4 started treatment within the 18 week target. Issues contributing to this poor performance are the high number of referrals to the service and there is also a vacant post that the provider is planning on recruiting for; in the meantime the possibility of internal or bank staff carrying out additional duties is being explored. In addition to this, two part time staff will be returning from maternity leave which will increase the therapy capacity.

Actions to Address/Assurances:

Demand for the service continues to increase and to exceed capacity.Commissioners have asked for the trust to present an action plan as part of a Deep Dive at August CQPG to include service transformation/ eligibility/primary care/capacity& modelling and managing risk of long waiters.

The provider has also developed a psychological skill/psycho- education group consisting of 4 two hour sessions a week. The first cohort of clients have completed this programme and the intervention is being evaluated; the intention being to deliver 4 to 5 groups in the coming months to assess how effective it is.

When is performance expected to recover:

Performance is linked to current service capacity which mitigates against significant recovery. The Deep Dive at August CQPG will better inform commissioner as to when performance is expected to recover.

Quality:

Linked to the above comments re: August CQPG Deep Dive.

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll	Sue Gough	Gordon Jones

KPI 19: Patients identified as at risk of falling to have a care plan in place across the trust – Target 98%

Indicator		Performance Summary					Potential organisational or patient risk factors
Falls Management & Prevention: Of the patients identified as at risk of falling to have a care plan in place		**Latest and previous 3 months**				KPI 19	
RED	**TREND**	Q1	Q2	Q3	Latest		
		66.7%	69.2%	28.6%	50.0%		
		Plan: 98% - 2018/19 YTD reported 55.2% and failed.					

Performance Overview/Issues:		
The Trust reported performance well below the 98% target in Q4, 50% but higher than quarter 3 when 28.6% was reported. In quarter 4 there were a total of 6 patients, 3 of which didn't have a care plan in place.		
Actions to Address/Assurances:		
Ward staff have been emailed and reminded to ensure that all patients identifiying as a falls risk have an appropriate care plan in place.		
When is performance expected to recover:		
From Q2 The Trust will submit a narrative to how they expect to improve performance with a clear trajectory for expected time they will achieve the KPIs.		
Quality:		
Narrative will include an impact of not achieving a KPI has on quality of care for the patient.		
Indicator responsibility:		
Leadership Team Lead	**Clinical Lead**	**Managerial Lead**
Geraldine O'Carroll	Sue Gough	Gordon Jones

KPI 25 (Keeping nourished) Patients with a score of 2 or more to receive an appropriate care plan – Target 100%

Indicator		Performance Summary					Potential organisational or patient risk factors
Patients with a score of 2 or more to receive an appropriate care plan		**Latest and previous 3 months**				KPI 25	
RED	**TREND**	Q1	Q2	Q3	Latest		
		60.0%	66.7%	50.0%	80.0%		
		Plan: 100% - 2018/19 YTD reported 63.6% and failed					

Performance Overview/Issues:		
The Trust reported performance well below the 98% target in Q4, with the above performance reported. Out of 5 patients there was 1 patient who didn't receive an appropriate care plan. The transition to Rio has impacted on MUST KPI's as templates in Rio are different to Epex forms therefore ward teams needed additional support.		
Actions to Address/Assurances:		
The indicator is number sensitive however to improve KPIs the Dietetic team and Physical Health Performance Nurse are offering a range of support and training to ward staff. MUST training will continue for staff induction.		
When is performance expected to recover:		
Quarter 1 2019/20. Commissioners are expecting RiO reporting issues to improve from Q1 onwards.		
Quality:		
Indicator responsibility:		
Leadership Team Lead	**Clinical Lead**	**Managerial Lead**
Geraldine O'Carroll	Sue Gough	Gordon Jones

4.2 Learning Disability Health Checks

Indicator		Performance Summary					Potential organisational or patient risk factors
Learning Disabilities Health Checks		**Latest and previous 3 quarters**				People with a learning disability often have poorer physical and mental health than other people. An annual health check can improve people's health by spotting problems earlier. Anyone over the age of 14 with a learning disability (as recorded on GP administration systems), can have an annual health check.	
RED	**TREND**	Q1	Q2	Q3	Latest		
		6.5%	11.7%	7.6%	13.8%		
		Plan: 18.7% 2018/19					

Performance Overview/Issues:

A national enhanced service is place with payment available for GPs providing annual health checks, and CCGs were required to submit plans for an increase in the number of health checks delivered in 2018/19 (target 504 for the year). Some of the data collection is automatic from practice systems however; practices are still required to manually enter their register size. Data quality issues are apparent with practices not submitting their register sizes manually, or incorrectly which is why the 'actual' data in the table above is significantly lower than expected. In quarter 3, the CCG reported a performance of 44.1%, above the plan of 18.7%. However, just 102 patients were registered compared to a plan of 675, with just 45 checked compared to a plan of 126. Quarter 4 data has yet to be published, in which we are expecting the total percentage checked to increase.

Actions to Address/Assurances:

The CCG Primary Care Leads are working with the Council to identify the cohort of patients with Learning Disabilities who are identified on the GP registers as part of the DES (Direct Enhanced Service). The CCG has also identified additional clinical leadership time to support the DES, along with looking at an initiative to work with People First (an advocacy organisation for people with learning disabilities) to raise the importance of people accessing their annual health check. To review reporting to mitigate data quality issues.

When is performance expected to recover:

Performance should improve from Quarter 2 2019/20 onwards.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll	Sue Gough	Gordon Jones

4.3 Improving Physical Health for people with Severe Mental Illness (SMI)

Indicator		Performance Summary					Potential organisational or patient risk factors
The percentage of the number of people on the General Practice SMI registers (on the last day of the reporting period) excluding patients recorded as 'in remission' that have had a comprehensive physical health check		**Latest and previous 3 quarters**				As part of the 'Mental Health Five Year Forward View' NHS England has set an objective that by 2020/21, 280,000 people should have their physical health needs met by increasing early detection and expanding access to evidence-based care assessment and intervention. It is expected that 50% of people on GP SMI registers receive a physical health check in a primary care setting.	
RED	**TREND**	Q1	Q2	Q3	Latest		
			14.5%	15.3%	17.2%		
		Plan: 50% - 2018/19 YTD reported 17.2% and failed					

Performance Overview/Issues:		
The most recent data period is January to March 2018/19. In the 12 month period to the end of quarter 4 2018/19, 17.2% of the number of people on the GP SMI register in South Sefton CCG received a comprehensive health check. Despite not yet achieving the 50% ambition this is an improvement from the previous quarter (15.3%).		
Actions to Address/Assurances:		
A Local Quality Contract (LQC) scheme for primary care to undertake SMI health checks has been developed and agreed by Sefton Local Medical Committee (LMC). EMIS screens to enable data capture are being validated on 3rd June 2019.		
When is performance expected to recover:		
Performance should improve from Quarter 2 2019/20 onwards.		
Quality impact assessment:		
Indicator responsibility:		
Leadership Team Lead	**Clinical Lead**	**Managerial Lead**
Geraldine O'Carroll	Sue Gough	Gordon Jones

4.4 Cheshire & Wirral Partnership (Adult)

4.4.1 Improving Access to Psychological Therapies: Access

Indicator		Performance Summary					Potential organisational or patient risk factors
IAPT Access - % of people who receive psychological therapies		Latest and previous 3 months					Risk that CCG is unable to achieve nationally mandated target.
RED	TREND	Feb-19	Mar-19	Apr-19	Latest		
		1.29%	1.28%	1.23%	1.03%		
		Access Plan: 19.0% - May 2019/20 reported 1.03% and failed.					

Performance Overview/Issues:

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) target for 2019/20 is to achieve 19% (4.75% per quarter) in the first 3 quarters and 22% Access (5.5% per quarter) in the last quarter. The monthly target for M2 19/20 is therefore approximately 1.58%. Month 2 performance was 1.03% and failing to achieve the target standard. Achieving the access KPI has been an ongoing issue for the provider but it should be acknowledged that other organisations in Sefton provide non IAPT interventions which people may take up as an alternative to IAPT. Waiting times from referral continue to be within national timescales.

Actions to Address/Assurances:

Access – Group work continues to be rolled out so as to complement the existing one to one service offer to increase capacity. In addition IAPT services aimed at diabetes and cardiac groups are planned with IAPT well-being assessments will be delivered as part of the routine standard pathway for these conditions. In addition those GP practices that have the largest number of elderly patients are being engaged with the aim of providing IAPT services to this cohort. The service has undertaken marketing exercises aimed at targeted groups(eg Colleges) to encourage uptake of the service. Additonal High Intensity Training staff are in training (with investment agreed by the CCG) and they will contribute to access rates whilst they are in training prior to qualifying in October 2019 when they will be able to offer more sessions within the service. Three staff returning from maternity leave and long term sickness will have a positive impact on the service capacity. Fortnightly teleconference is taking place monitor performance.

When is performance expected to recover:

The above actions will continue with an ambition to improve performance during 2019/20.

Quality:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll/Karl McCluskey	Sue Gough	Geraldine O'Carroll

4.4.2 Improving Access to Psychological Therapies: Recovery

<table>
<tr><th colspan="2">Indicator</th><th colspan="4">Performance Summary</th><th></th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2">IAPT Recovery - % of people moved to recovery</td><td colspan="4">Latest and previous 3 months</td><td rowspan="4"></td><td rowspan="4"></td></tr>
<tr><td>RED</td><td>TREND</td><td>Feb-19</td><td>Mar-19</td><td>Apr-19</td><td>Latest</td></tr>
<tr><td rowspan="2"></td><td rowspan="2"></td><td>47.9%</td><td>47.4%</td><td>38.0%</td><td>52.9%</td></tr>
<tr><td colspan="4">Recovery Plan: 50% - May 2019/20
52.9% and achieved</td></tr>
</table>

Performance Overview/Issues:		
The percentage of people moved to recovery was 52.9% in month 2 of 2019/20 and the target was achieved.		
Actions to Address/Assurances:		
Recovery – The newly appointed clinical lead for the service will be reviewing non- recovered cases and work with practitioners to improve recovery rates. Bi-monthly teleconferences/meetings have been set up with the provider to understand the progress around the recovery rate - ongoing despite achievement in Month 2.		
When is performance expected to recover:		
The above actions will continue with an ambition to improve performance during 2019/20.		
Quality:		
Indicator responsibility:		
Leadership Team Lead	**Clinical Lead**	**Managerial Lead**
Geraldine O'Carroll/Karl McCluskey	Sue Gough	Geraldine O'Carroll

4.5 Dementia

Indicator		Performance Summary				IAF	Potential organisational or patient risk factors
Dementia Diagnosis		Latest and previous 3 months				126a	Waiting times for assessment and diagnosis of dementia are currently 14+ weeks. NHS Mersey Care Trust have assured SS CCG that they are taking necessary steps to to reduce waiting times for the South Sefton Memory Service.
RED	TREND	Feb-19	Mar-19	Apr-19	Latest		
		64.08%	65.00%	64.17%	64.37%		
		Plan: 66.7%					

Performance Overview/Issues:
The latest data on NHS Digital shows South Sefton CCG are recording a dementia diagnosis rate in May of 64.37%, which is under the national dementia diagnosis ambition of 66.7% although a slight increase on last month when 64.17% was reported. CCG believes that coding issues in primary care may be impacting on performance. In addition there may be care home residents who may not have a diagnosis of dementia.
Actions to Address/Assurances:
The CCG has completed the Dementia Self-Assessment Tool requested by NHS England, which has full details of the planned actions being undertaken by the CCG. Work commenced March 2019 with Information Facilitator Team using updated search criteria with all South Sefton general practices. This work identified registry coding errors and patient letters from memory service with no coding yet identifying dementia diagnosis. This work identified approx. 24 new registrations to date. Informatics team will now run 3 monthly searches, however, this is still dependent on practices following up the “to do” list generated by this work. The CCG have been advised that the Care Home Liason Service (Mersey Care Trust) does not have the capacity to identify and assess care home patients in South Sefton. A further option is to develop a South Sefton CCG business case for one off funding to provide the necessary resource to achieve this. The CCG will consider this option, which may help recovery of the dementia diagnosis ambition.
When is performance expected to recover:
Plans are in place to achieve by the end of Q2, 2019/20.
Quality:
Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Jan Leonard	Susan Gough	Kevin Thorne

5. Community Health

5.1 Adult Community (Mersey Care)

The CCG and Mersey Care leads continue to meet on a monthly basis to discuss the current contract performance. Along with the performance review of each service, discussions regarding 2019/20 reporting requirements are being had. The service reviews are now complete and the Trust and CCG community contract leads have had a number of meetings to discuss outcomes and recommendations. A detailed action plan has been developed by the Trust to support this and regular meetings with the CCG have been arranged. It has been agreed that additional reporting requirements and activity baselines will be reviewed alongside service specifications and transformation. A discussion regarding ICRAS reporting took place at the April information sub group and amendments to the current report were agreed to meet CCG requirements.

5.1.1 Quality

The CCG Quality Team and Mersey Care NHS Foundation Trust (MCFT) are in the process aligning the Quality Schedule, KPIs, Compliance Measures and CQUIN for community services with Liverpool

CCG for 2019/20. In terms of improving the quality of reporting, providers are given quarterly feedback on Quality Compliance evidence which will feed through CQPG/ CCQRM. Providers are asked to provide trajectories for any unmet indicators and or measures.

5.1.2 Mersey Care Adult Community Services: Physiotherapy

Indicator		Performance Summary				RAG	Potential organisational or patient risk factors
Mersey Care Adult Community Services: Physiotherapy		**Previous 3 months and latest**				<=18 weeks: **Green** > 18 weeks: **Red**	
RED	**TREND**	Incomplete Pathways (92nd Percentile)					
		Jan-19	Feb-19	Mar-19	Latest		
		23 wks	23 wks	20.0%	20.0%		
		Target: 18 weeks *(reported a month in arrears)*					

Performance Overview/Issues:

April's incomplete pathways reported above the 18 week standard with 20 weeks, showing no improvement on last month. The longest waiter on the incomplete pathway was 2 patients at 25 weeks, an improvement on last month. Completed pathways reported a 95th percentile of 28 weeks, a slight increase on 27 reported last month. The Trust has reported that capacity issues due to staff sickness and vacancies have resulted in increased waiting times.

Actions to Address/Assurances:

Remedial actions have focussed on workforce and review of processes to manage referrals:
- Utilisation of agency physiotherapists whilst waiting for new starter to commence in post - commenced in February
- Implementation of single point of contact for all South Sefton OT & Physio referrals - commenced in April
- Recruited band 7 co-ordinator to support team with triage - awaiting start date
- Senior daily support from ICRAS Clinical Therapy Lead to allocate waiting list - commenced in May
- Senior Therapy Support reviewing caseload - commenced in May

When is performance expected to recover:

Trajectory identifies return to 18 weeks in July 2019 following implementation of all actions. The CCG are working closely with the Trust in regard to therapy waiting times and are assured that all action is being taken to address workforce issues. There has been a steady decrease in the number of patients waiting over 18 weeks with indications that this will resolve in line with the Trust trajectory of July 19.

Quality impact assessment:

The Trust has advised that all referrals are triaged by senior clinicians so that risks are identified and urgent referrals are seen appropriately.

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Sunil Sapre	Janet Spallen

5.1.3 Mersey Care Adult Community Services: Occupational Therapy

Indicator		Performance Summary				RAG	Potential organisational or patient risk factors
Mersey Care Adult Community Services: Occupational Therapy		**Previous 3 months and latest**				<=18 weeks: **Green** > 18 weeks: **Red**	
GREEN	**TREND**	Incomplete Pathways (92nd Percentile)					
		Jan-19	Feb-19	Mar-19	Latest		
		22 wks	22 wks	18 wks	18 wks		
		Target: 18 weeks *(reported a month in arrears)*					

Performance Overview/Issues:

April's incomplete pathways have shown the performance of 18 weeks has been maintained. The longest waiter on the incomplete pathway in April was at 21 weeks compared to 24 last month. Completed pathways reported a 95th percentile of 23 weeks, a further improvement on last month.

Actions to Address/Assurances:

When is performance expected to recover:

Month 1 data received for 2019/20 identifies that waiting times are back within target of 18 weeks. There are still further improvements to be made in line with above action plan which should improve throughput further. The CCG are working closely with the Trust in regard to therapy waiting times and are assured that all action is being taken to address workforce issues. Ongoing challenge will be to sustain workforce improvements.

Quality impact assessment:

The Trust has advised that all referrals are triaged by senior clinicians so that risks are identified and urgent referrals are seen appropriately.

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Sunil Sapre	Janet Spallen

6. Children's Services

6.1 Alder Hey Children's Mental Health Services

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

Indicator		Performance Summary					Potential organisational or patient risk factors
Percentage of children and young people aged 0-18 with a diagnosable mental health condition who are receiving treatment from NHS funded community services		**Latest and previous 3 quarters**					
RED	**TREND**	Q1	Q2	Q3	Latest		
		11.3%	5.5%	5.8%	6.8%		
		Access Plan: 32% - 2018/19 reported 29.4% and failed					

Performance Overview/Issues:

The CCG has now received data from a third sector organisation Venus. This Provider has not yet submitted data to the MHSDS although this is a work in progress. These additional figures have been included in the table above thus increasing the CYP Access performance and creating a variation in previous data.

The CCG still failed to achieve the target of 8% in Q4 with 6.8%; a total of 181 children and young people were receiving treatment out of a total 3,121 with a diagnosable mental health condition. This is an increase on the5.8% of children and young people receiving treatment in quarter 3. The CCG is narrowly failing to meet the year to date target of 32% (yearly performance being 29.4%).

Actions to Address/Assurances:

Additional activity has been commissioned and mainstreamed from the VCF in 19/20 which is South Sefton targeted. Figures for 18/19 are big improvement from previous years.

When is performance expected to recover:

Additional activity to be implemented for 19/20. Online counselling for Sefton is being jointly commissioned and will come online in 19/20. AHCH has submitted business cases to increase CYP Eating Disorder activity and Crisis/Out of Hours support during 19/20. These will make notable improvements to access rates in South Sefton.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll	Sue Gough	Peter Wong

6.1.2 Waiting times for Routine Referrals to Children and Young People's Eating Disorder Services

<table>
<tr><th colspan="2">Indicator</th><th colspan="4">Performance Summary</th><th></th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2">Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral</td><td colspan="4">Latest and previous 3 quarters</td><td rowspan="4">Performance in this category is calculated against completed pathways only.</td><td rowspan="4"></td></tr>
<tr><td>RED</td><td>TREND</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Latest</td></tr>
<tr><td rowspan="2"></td><td rowspan="2"></td><td>100.0%</td><td>100.0%</td><td>90.9%</td><td>92.3%</td></tr>
<tr><td colspan="4">Access Plan: 100% - 2018/19 reported 95.56% and failed</td></tr>
<tr><td colspan="8">Performance Overview/Issues:</td></tr>
<tr><td colspan="8">In quarter 4 the Trust fell under the 100% plan, out of 26 routine referrals to children and young people's eating disorder service, 24 were seen within 4 weeks recording 92.31% against the 100% target. Both breaches waited between 4 and 12 weeks. Reporting difficulties and the fact that demand for this service exceeds capacity are both contributing to under performance in this area.</td></tr>
<tr><td colspan="8">Actions to Address/Assurances:</td></tr>
<tr><td colspan="8">Work is being under taken by the Provider to reduce the number of DNAs. The Sevice works with small numbers and a single case can creat a breach for this KPI, which is understood nationally. Activity commissioned on nationally indicated levels. The last year has seen activity levels exceed these levels by over 100%. Risk is being managed and is part of national reporting. AHCH submitted business case for extra capacity which will be considered by SMT in June - further discussions about detailed cse being made at Clinical Advisory Group (CAG) and Quality, Innovaton, Productivity and Prevention Committee (QIPP).</td></tr>
<tr><td colspan="8">When is performance expected to recover:</td></tr>
<tr><td colspan="8">Improvement is dependent upon extra capacity being considered and agreed by the CCG in June.</td></tr>
<tr><td colspan="8">Quality impact assessment:</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="8">Indicator responsibility:</td></tr>
<tr><td colspan="3">Leadership Team Lead</td><td colspan="3">Clinical Lead</td><td colspan="2">Managerial Lead</td></tr>
<tr><td colspan="3">Geraldine O'Carroll</td><td colspan="3">Sue Gough</td><td colspan="2">Peter Wong</td></tr>
</table>

6.1.3 Waiting times for Urgent Referrals to Children and Young People's Eating Disorder Services

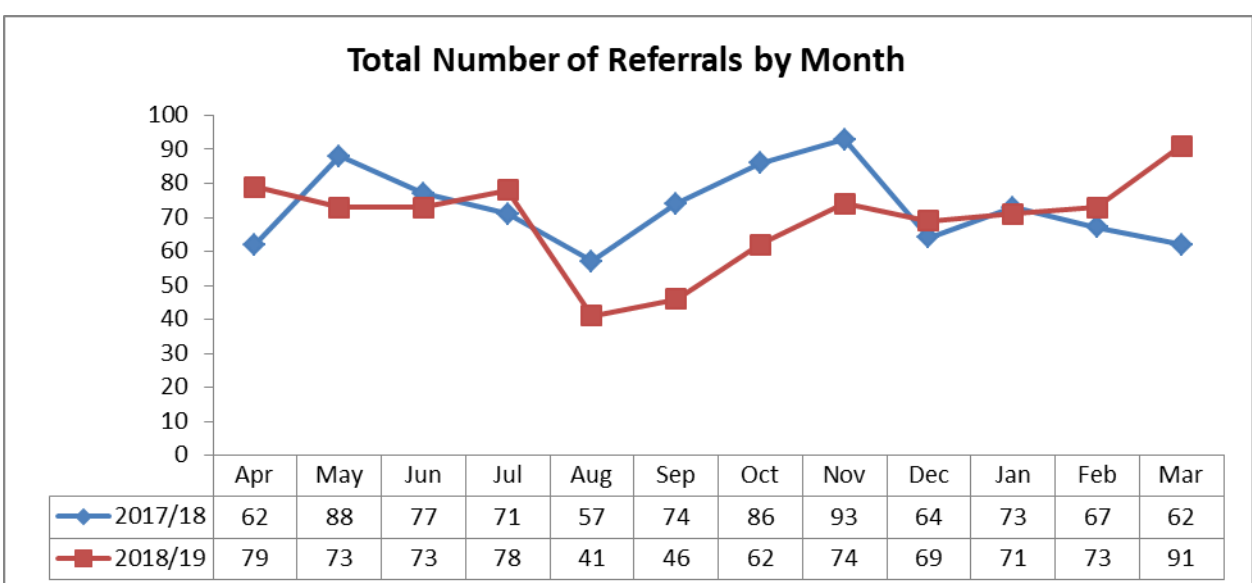
Indicator		Performance Summary					Potential organisational or patient risk factors
Number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within 1 week of referral		Latest and previous 3 quarters					
RED	TREND	Q1	Q2	Q3	Latest		
		100.0%	100.0%	80.0%	66.7%		
		Access Plan: 100% - 2018/19 reported 88.89% and failed					

Performance Overview/Issues:		
In quarter 4, the CCG had 3 patients under the urgent referral category, 2 of which met the target bringing the total performance to 66.67% against the 100% target. The patient who breached waited between 1 and 4 weeks. Reporting difficulties and the fact that demand for this service exceeds capacity are both contributing to under performance in this area.		
Actions to Address/Assurances:		
Work is being under taken by the Provider to reduce the number of DNAs. The Sevice works with small numbers and a single case can creat a breach for this KPI, which is understood nationally. Activity commissioned on nationally indicated levels. The last year has seen activity levels exceed these levels by over 100%. Risk is being managed and is part of national reporting. AHCH submitted business case for extra capacity which will be considered by SMT in June - further consideration of detailed case to be made in July at Clinical Advisory Group (CAG) and Quality, Innovation, Productivity and Prevention Committee (QIPP).		
When is performance expected to recover:		
Improvement is dependent upon extra capacity being considered and agreed by the CCG in June.		
Quality impact assessment:		
Indicator responsibility:		
Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll	Sue Gough	Peter Wong

6.2 Child and Adolescent Mental Health Services (CAMHS)

The following analysis derives from local data received on a quarterly basis from Alder Hey. The data source is cumulative and the time period is to Quarter 4 2018/19. The date period is based on the date of Referral so focuses on referrals made to the service during January to March 2018/19. Data includes both South Sefton CCG and Southport and Formby CCGs.
It is worth noting that the activity numbers highlighted in the report are based on a count of the Local Patient Identifier and there may be patients that have more than one referral during the given time period. The 'Activity' field within the tables therefore does not reflect the actual number of patients referred.

Figure 13 – CAMHS Referrals



Throughout quarter 4 2018/19 there were a total of 235 referrals made to CAMHS from South Sefton CCG patients. The monthly number of referrals remained stable between November and February then saw a subsequent increase in March 2019.

During the fourth quarter of 2018/19 there were no DNAs, which is an improvement from the last quarter.

The remaining tables within this section will focus on only the 78 Referrals that have been accepted and allocated.

Figure 14 – CAMHS Waiting Times Referral to Assessment

Waiting Time in Week Bands	Number of Referrals	% of Total
0-2 Weeks	30	38.5%
2-4 Weeks	33	42.3%
4- 6 Weeks	6	7.7%
6-8 weeks	0	0.0%
8- 10 weeks	5	6.4%
Over 10 weeks	4	5.1%
Total	**78**	**100%**

The biggest percentage (42.3%) of referrals where an assessment has taken place waited between 2 and 4 weeks from their referral to assessment. 94.5% of allocated referrals waited 10 weeks or less from point of referral to an assessment being made.

Of those referrals that waited over 10 weeks, there was one referral that waited 94 days (13.4 weeks) which was the longest wait during this quarter.

An assessment follows on from the Triage stage when the clinical risk is assessed and patients are prioritised accordingly. At the point of assessment the child/young person meets with a clinician to discuss their issues and it is possible to determine whether the CAMHS is appropriate. At this stage it may be that the child/young person is signposted to another service rather than continue to an intervention within the service.

Alder Hey has received some additional funding for staff for CAMHS services, and additional funding for neurodisability developmental pathways (ADHD, ASD). These should contribute to reducing CAMHS waiting times.

Figure 15 - CAMHS Waiting Times Assessment to Intervention

Waiting Time in Week Bands	Number of Referrals	% of Total	% of Total with intervention only
0-2 Weeks	10	12.8%	23.8%
2-4 Weeks	9	11.5%	21.4%
4- 6 Weeks	14	17.9%	33.3%
6-8 weeks	5	6.4%	11.9%
8- 10 weeks	0	0.0%	0.0%
10-12 Weeks	3	3.8%	7.1%
Over 12 Weeks	1	1.3%	2.4%
(blank)	36	46.2%	
Total	**78**	**100%**	**100%**

An intervention is the start of treatment. If the patient needs further intervention such as a more specific type of therapy then they would be referred onto the specific waiting list. These waiting times are routinely reviewed in local operational meetings.

46.2% (36) of all allocated referrals did not have a date of intervention. Of these, 10 have already been discharged without having had an intervention so are therefore not waiting for said intervention.

The assumption can be made that of the remaining 26 referrals where an assessment has taken place and no date of intervention reported, these are waiting for their intervention. Of the 26 waiting for an intervention, 17 were referred to the service within the month of March 2019 so have been waiting a maximum of four weeks from their referral date to their first intervention.

If the 36 referrals were discounted, 90.5% of the referrals made within Quarter 4 of 2018/19 waited 8 weeks or less from their referral to their first intervention taking place.

The one referral that waited over 12 weeks for an intervention waited for 94 days (13.4 weeks). This is an improvement on the previous quarter when there was 1 referral that waited over 14 weeks.

Performance Overview/Issues
Specialist CAMHS has had long waits, up to 20 weeks.

How are the issues being addressed?
NHSE non-recurrent funding secured and waits are reducing. CCG has jointly commissioned online counselling for 19/20 which will increase accessible support for those with needs but don’t meet CAMHS threshold, reducing necessity to refer to CAMHS. AHCH submitted business case for

extending crisis and out of hours support. Additional activity targeted at South Sefton to be brought online in 19/20.

When is the performance expected to recover by?
Impact of NHSE funding will be seen in the first quarter of 2019/20 and the impact of online counselling and additional South Sefton activity will be seen in quarters 2 and 3 of 19/20.

Who is responsible for this indicator?

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll	Vicky Killen	Peter Wong

6.3 Children's Community (Alder Hey)

6.3.1 Paediatric SALT

Indicator		Performance Summary				RAG	Potential organisational or patient risk factors
Alder Hey Children's Community Services: SALT		Previous 3 months and latest				<=18 weeks: Green > 18 weeks: Red	Potential quality/safety risks from delayed treatment ranging from progression of illness to increase in symptoms/medication or treatment required.
RED	TREND	Incomplete Pathways (92nd Percentile)					
		Jan-19	Feb-19	Mar-19	Latest		
		44 wks	45 wks	45 wks	43 wks		
		Target: 18 weeks					

Performance Overview/Issues:

In May the Trust reported a 92nd percentile of 43 weeks for Sefton patients waiting on an incomplete pathway. The longest waiting patient was 2 patients waiting at 54 weeks. Performance has steadily declined over the past two financial years, with referrals remaining static.

Actions to Address/Assurances:

Sefton SALT waiting times have been raised and discussed at contract review meetings. Alder Hey has developed a formal recovery plan to bring long waiting time to 18 weeks by 28-2-20. As part of this the CCGs have provifed additional funding. Discussions are on-going at a senior and also operational level on the reporting, including narrative on long waiters.

June 2019: Business case approved for some non-recurrent and recurrent therapists.

Currently Paediatric speech and language waiting times are reported as Sefton view; the Trust is working to supply CCG level information. This is a legacy issue from when Liverpool Community Health/ Mersey Care reported the waiting time information.

The CCG are working with provider to develop an improvement trajectory from Q2 onwards.

When is performance expected to recover:

Following investment, target is for reduction to 18 wk RTT by Feb 2020 and sustained thereafter.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Wendy Hewitt	Peter Wong

6.3.2 Paediatric Dietetics

<table>
<tr><th colspan="2">Indicator</th><th colspan="4">Performance Summary</th><th>RAG</th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2">Alder Hey Children's Community Services: Dietetics</td><td colspan="4">Previous 3 months and latest</td><td rowspan="7">DNAs
<= 8.5%: Green
> 8.5% and <= 10%: Amber
> 10%: Red

Provider Cancellations
<= 3.5%: Green
> 3.5% and <= 5%: Amber
> 5%: Red</td><td rowspan="7"></td></tr>
<tr><td rowspan="2">RED</td><td rowspan="2">TREND</td><td colspan="4">Outpatient Clinic DNA Rates</td></tr>
<tr><td>Feb-19</td><td>Mar-19</td><td>Apr-19</td><td>Latest</td></tr>
<tr><td rowspan="4"></td><td rowspan="4"></td><td>9.8%</td><td>17.2%</td><td>20.0%</td><td>22.6%</td></tr>
<tr><td colspan="4">Outpatient Clinic Provider Cancellations</td></tr>
<tr><td>Feb-19</td><td>Mar-19</td><td>Apr-19</td><td>Latest</td></tr>
<tr><td>0.0%</td><td>0.0%</td><td>7.1%</td><td>9.7%</td></tr>
<tr><td colspan="2"></td><td colspan="4">DNA threshold: 8.5%
Provider cancellation threshold: 3.5%</td><td></td><td></td></tr>
</table>

Performance Overview/Issues:

The paediatric dietetics service has seen high percentages of children not being brought to their appointment. In May 2019 this increased further with a rate of 22.6%. Provider cancellations also increased further in May with 9.7%.

Actions to Address/Assurances:

The CCG has invested in extra capacity into the service. The CCG is working with AHCH to understand the nature of the DNAs for this service. AHCH has implemented a text appointment reminder system.

In the contract review meeting in June is was agreed that operational issues relating to dietetics would be raised advance of the next contract meeting, so as to arrange attendance of the service or commissioning leads at the next contract review meeting.

When is performance expected to recover:

To be confirmed following the next contract review meeting and meeting with the leads.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Wendy Hewitt	Peter Wong

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

<table>
<tr><th colspan="2">Indicator</th><th colspan="4">Performance Summary</th><th></th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2">Percentage of children waiting less than 18 weeks for a wheelchair</td><td colspan="4">Previous 3 quarters and latest</td><td rowspan="5"></td><td rowspan="5"></td></tr>
<tr><td rowspan="2">N/A</td><td rowspan="2">TREND</td><td colspan="4">Waiting Times</td></tr>
<tr><td>Q1</td><td>Q2</td><td>Q3</td><td>Latest</td></tr>
<tr><td rowspan="2"></td><td rowspan="2"></td><td>Nil Return</td><td>Nil Return</td><td>Nil Return</td><td>Nil Return</td></tr>
<tr><td colspan="4">92% of children should receive equipment within 18 weeks</td></tr>
</table>

Performance Overview/Issues:

Commissioning arrangements are complex; services for South Sefton patients are commissioned by NHS England and services are provided by Aintree Hospital who then submit data to NHS England nationally. Quarter 4 was also a nil return. Quarterly plans have been submitted with the expectation the CCG is to achieve 100% of patients waiting less than 18 weeks.

Actions to Address/Assurances:

When is performance expected to recover:

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead

7. Primary Care

7.1 Extended Access Appointment Utilisation

<table>
<tr><th colspan="2">Indicator</th><th colspan="4">Performance Summary</th><th></th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2">Extended Access Appointment Utilisation</td><td colspan="4">Latest and previous 3 months</td><td rowspan="4">Extended access 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.</td><td rowspan="4"></td></tr>
<tr><td>GREEN</td><td>TREND</td><td>Feb-19</td><td>Mar-19</td><td>Apr-19</td><td>Latest</td></tr>
<tr><td rowspan="2"></td><td rowspan="2"></td><td>75.5%</td><td>73.5%</td><td>64.6%</td><td>72.7%</td></tr>
<tr><td colspan="4">The CCG should deliver at least 75% utilisation of extended access appointments by March 2020 (if the service went live in 2017/18).
May target 65.5%</td></tr>
<tr><td colspan="8">Performance Overview/Issues:</td></tr>
<tr><td colspan="8">A CCG working group developed a service specification for an extended hour’s hub model to provide extended access in line with the GP Five Year Forward View requirements. This service went live on the 1st October 2018 and now all GP practices are offering 7 day access to all registered patients. Therefore the CCG is 100% compliant.

In May South Sefton CCG practices reported a combined utilisation rate of 72.7%, exceeding the 65.5% target. Total available appointments was 1459, with 1172 being booked (80.33%) and 111 DNA's (7.61%). This shows an improvement in utilisation compared to April.</td></tr>
<tr><td colspan="8">Actions to Address/Assurances:</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="8">When is performance expected to recover:</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="8">Quality impact assessment:</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="8">Indicator responsibility:</td></tr>
<tr><th colspan="3">Leadership Team Lead</th><th colspan="3">Clinical Lead</th><th colspan="2">Managerial Lead</th></tr>
<tr><td colspan="3">Jan Leonard</td><td colspan="3">Craig Gillespie</td><td colspan="2">Angela Price</td></tr>
</table>

7.2 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 has been one recent inspection at Moore Street Medical Centre, this remains good in all areas. All results are listed below:

Figure 16 - 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 Centre	19 March 2018	Good	Good	Good	Good	Good	Good
N84015	Bootle Village Surgery	03 August 2016	Good	Good	Good	Good	Good	Good
N84016	Moore Street Medical Centre	30 April 2019	Good	Good	Good	Good	Good	Good
N84019	North Park Health Centre	27 March 2019	Good	Good	Good	Good	Good	Good
N84028	The Strand Medical Centre	04 April 2018	Good	Good	Good	Good	Good	Good
N84034	Park Street Surgery	17 June 2016	Good	Good	Good	Good	Good	Good
N84038	Concept House Surgery	30 April 2018	Good	Good	Good	Good	Good	Good
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	27 December 2018	Good	Good	Good	Good	Good	Good
N84041	Kingsway Surgery	07 November 2016	Good	Good	Good	Good	Good	Good
N84621	Thornton Practice	16 October 2018	Good	Good	Good	Good	Good	Good
N84627	Crossways Surgery	19 February 2019	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)	31 July 2018	Good	Good	Good	Good	Good	Good
N84025	Westway Medical Centre	23 September 2016	Good	Good	Good	Good	Good	Good
N84624	Maghull Health Centre	07 September 2018	Good	Good	Good	Good	Good	Good
Y00446	Maghull Practice PC24	30 October 2018	Good	Requires Improvement	Good	Good	Good	Good
N84004	Glovers Lane Surgery	27 March 2019	Good	Good	Good	Good	Good	Good
N84023	Bridge Road Medical Centre	15 June 2016	Good	Good	Good	Good	Good	Good
N84027	Orrell Park Medical Centre	14 August 2017	Good	Good	Good	Good	Good	Good
N84029	Ford Medical Practice	15 March 2019	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
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 Health Centre PC24	26 November 2015	Good	Good	Good	Good	Good	Good
N84615	Rawson Road Medical Centre	16 March 2018	Good	Good	Good	Good	Good	Good
N84630	Netherton Practice	19 February 2019	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement

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

8. CCG Improvement & Assessment Framework (IAF)

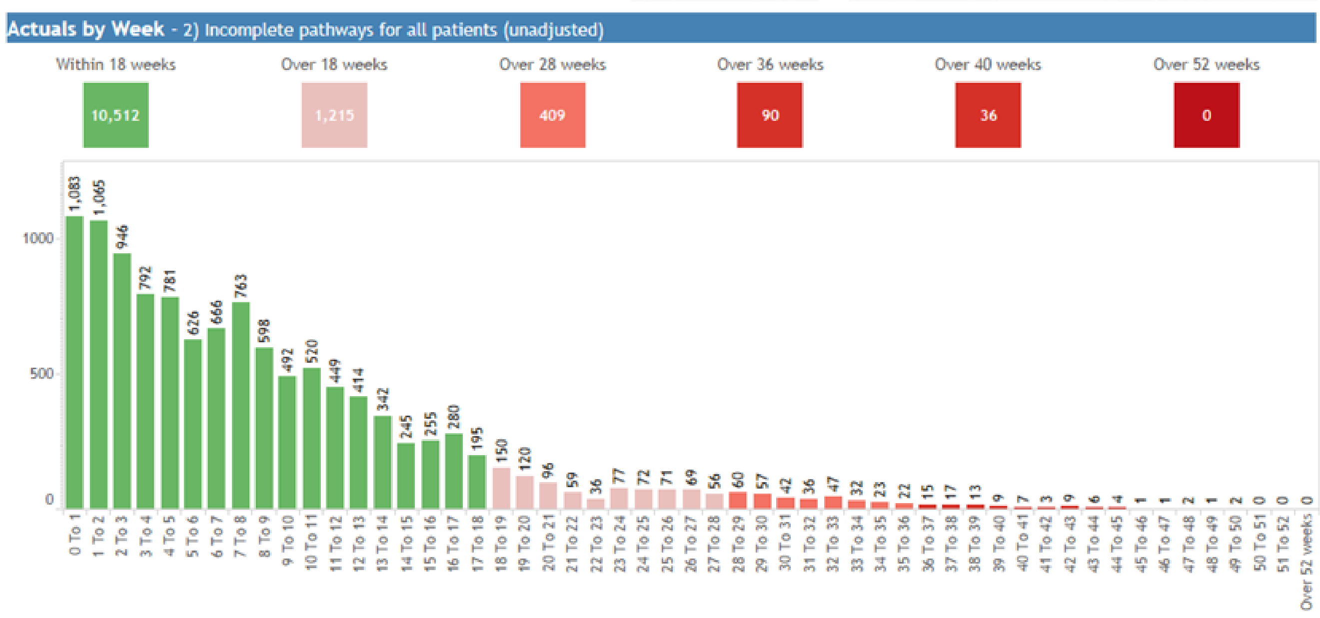
8.1 Background

The 2018/19 annual assessment has been published for all CCGs, ranking South Sefton CCG as ‘requires improvement’. However, some areas of positive performance have been highlighted; cancer was rated ‘Good’ and diabetes was rated ‘Outstanding’. 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 on a quarterly basis. 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.

9. Appendices

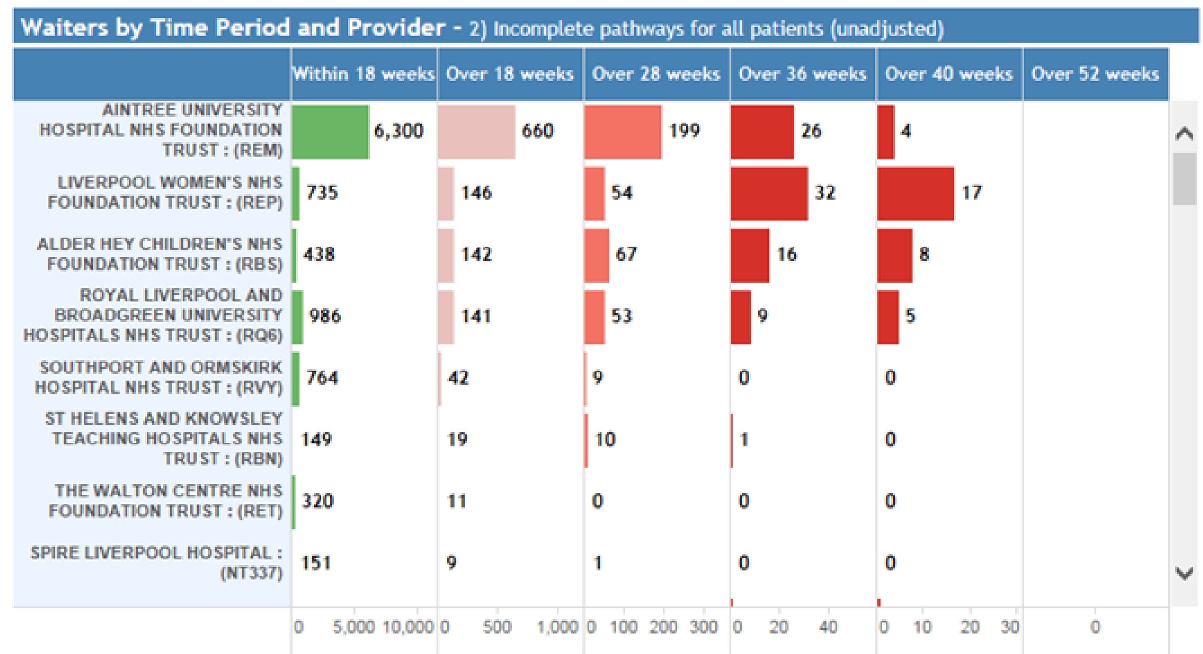
9.1.1 Incomplete Pathway Waiting Times

Figure 17 - South Sefton CCG Patients waiting on an incomplete pathway by weeks waiting



9.1.2 Long Waiters analysis: Top 5 Providers

Figure 18 - Patients waiting (in bands) on incomplete pathway for the top 5 Providers



9.1.3 Long Waiters Analysis: Top 2 Providers split by Specialty

Figure 19 - Patients waiting (in bands) on incomplete pathways by Speciality for Aintree University Hospitals NHS Foundation Trust

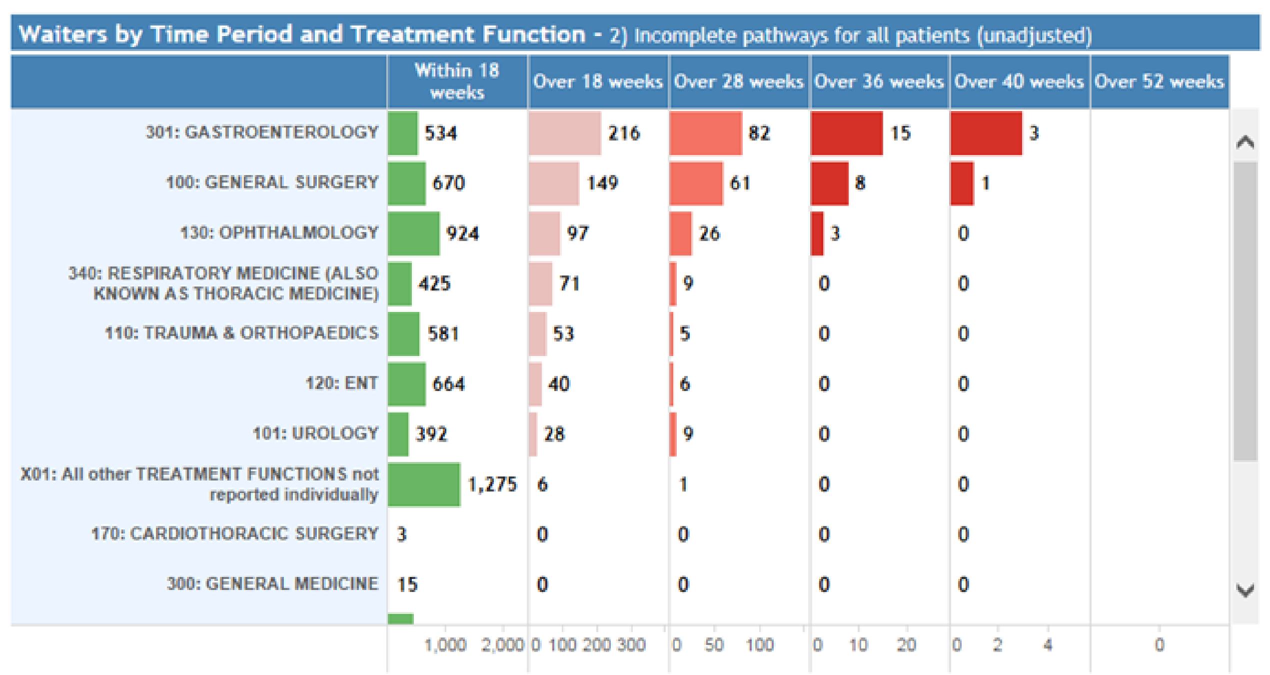
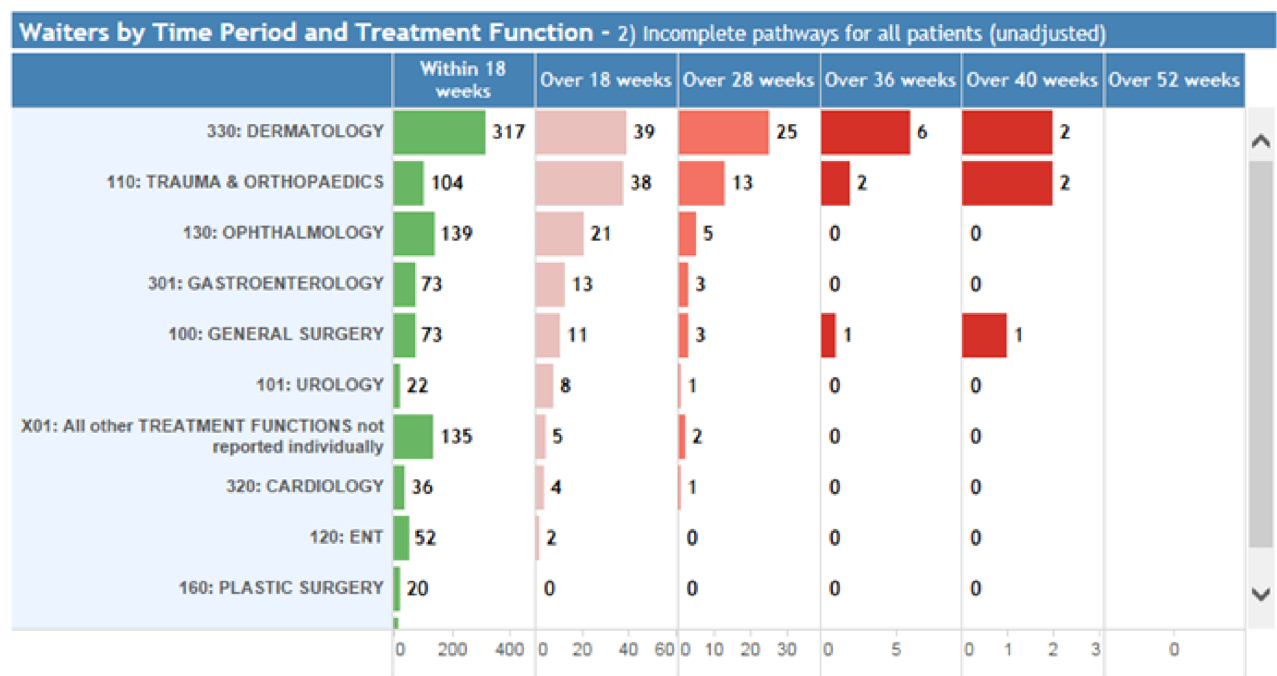
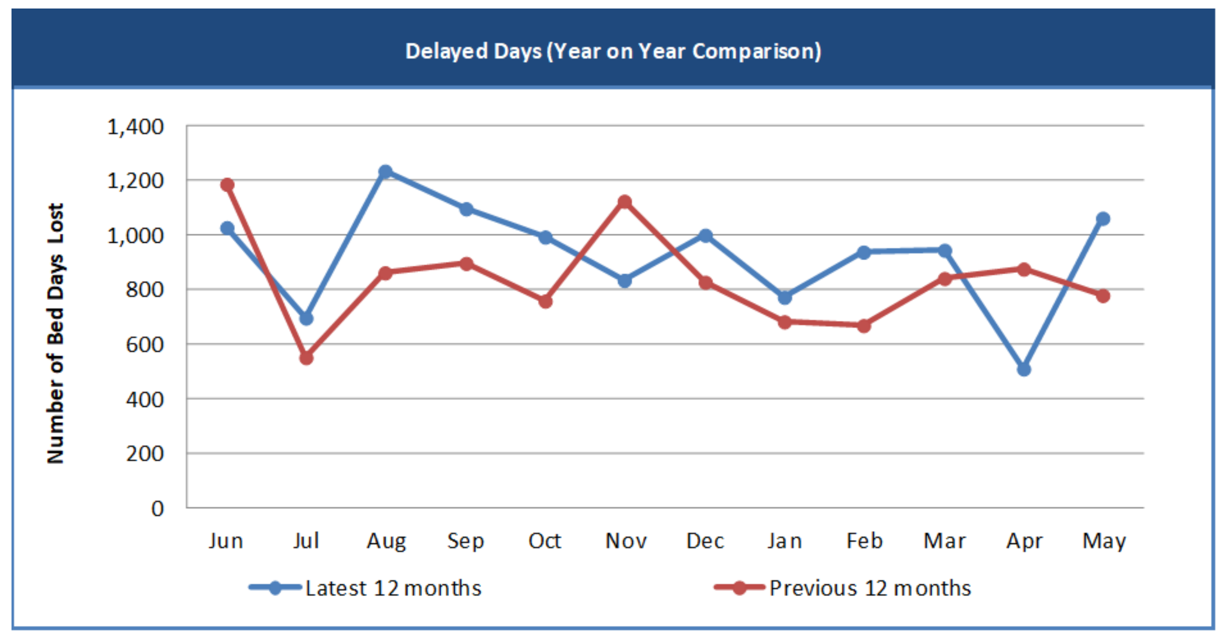


Figure 20 - Patient waiting (in bands) on incomplete pathway by Specialty for Royal Liverpool & Broadgreen University Hospital NHS Foundation Trust



9.2 Delayed Transfers of Care

Figure 21 – Aintree DTOC Monitoring

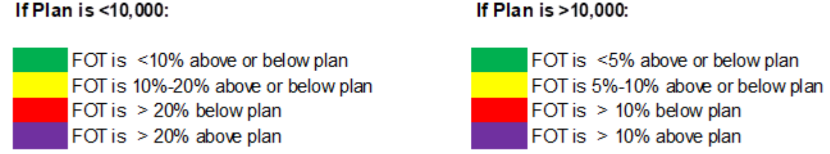


DTOC Key Stats	This month	Last month	Last year
Delayed Days	**May-19**	**Apr-19**	**May-18**
Total	1,062	506	776
NHS	89.5%	95.1%	81.6%
Social Care	10.5%	4.9%	18.4%
Both	0.0%	0.0%	0.0%
Acute	60.4%	50.0%	54.6%
Non-Acute	39.6%	50.0%	45.4%

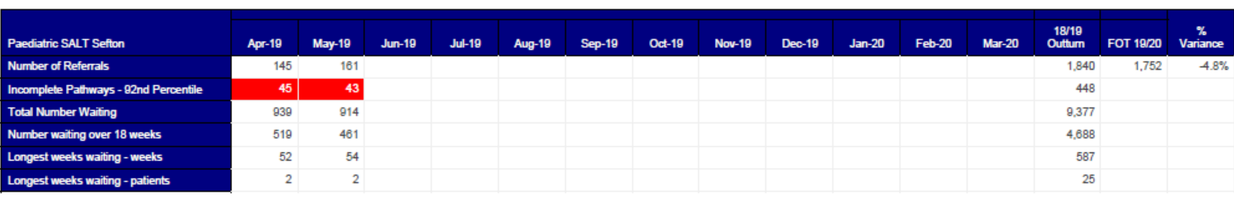
Reasons for Delayed Transfer % of Bed Day Delays (May-19)	
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	
Care Package in Home	9.0%
Community Equipment Adapt	0.0%
Completion Assesment	2.7%
Disputes	0.0%
Further Non-Acute NHS	52.3%
Housing	0.0%
Nursing Home	0.0%
Patient Family Choice	36.0%
Public Funding	0.0%
Residential Home	0.0%
Other	0.0%

9.3 Alder Hey Community Services Contract Statement

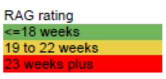
Commissioner Name	Service	Currency		Previous Year Outturn	Plan	FOT	Variance %	2019/20 Apr	YTD
NHS South Sefton CCG	Paediatric Continence	Caseload at Month End	264	264	273	3.41	267	279	273
		Total Contacts (Domiciliary)	1,740	1,740	1,590	-8.62	149	116	265
		Total New Referrals	174	174	162	-6.90	11	16	27
	Paediatric Dietetics	Referral to 1st contact (weeks average)							
		Total Contacts							
		Total Contacts (Domiciliary)							
		Total Contacts (Outpatients)							
		Total New Referrals							
	Paediatric Occupational Therapy	Caseload at Month End	201	201	146	-27.36	151	140	151
		Referral to 1st contact (weeks average)	15.9	15.9	14.2	-10.69	14.4	13.9	14.4
		Total Contacts (Domiciliary)	4,859	4,859	3,486	-28.26	298	283	581
		Total New Referrals	618	618	606	-1.94	41	60	101
	Paediatric Speech and Language Therapy	Caseload at Month End	34	34	0	-100.00	0	0	0
		Referral to 1st contact (weeks average)	24.8	24.8	35.3	42.34	35	35.5	35.3
		Total Contacts (Domiciliary)	12,788	12,788	13,656	6.79	1,042	1,234	2,276
		Total Contacts Complex Cochlear (N&S Sefton)	507	507	660	30.18	56	54	110
		Total New Referrals	1,094	1,094	1,080	-1.28	92	88	180
		Total New Referrals Complex Cochlear (N&S Sefton)	6	6	0	-100.00	0	0	0



9.4 Alder Hey SALT Waiting Times – Sefton

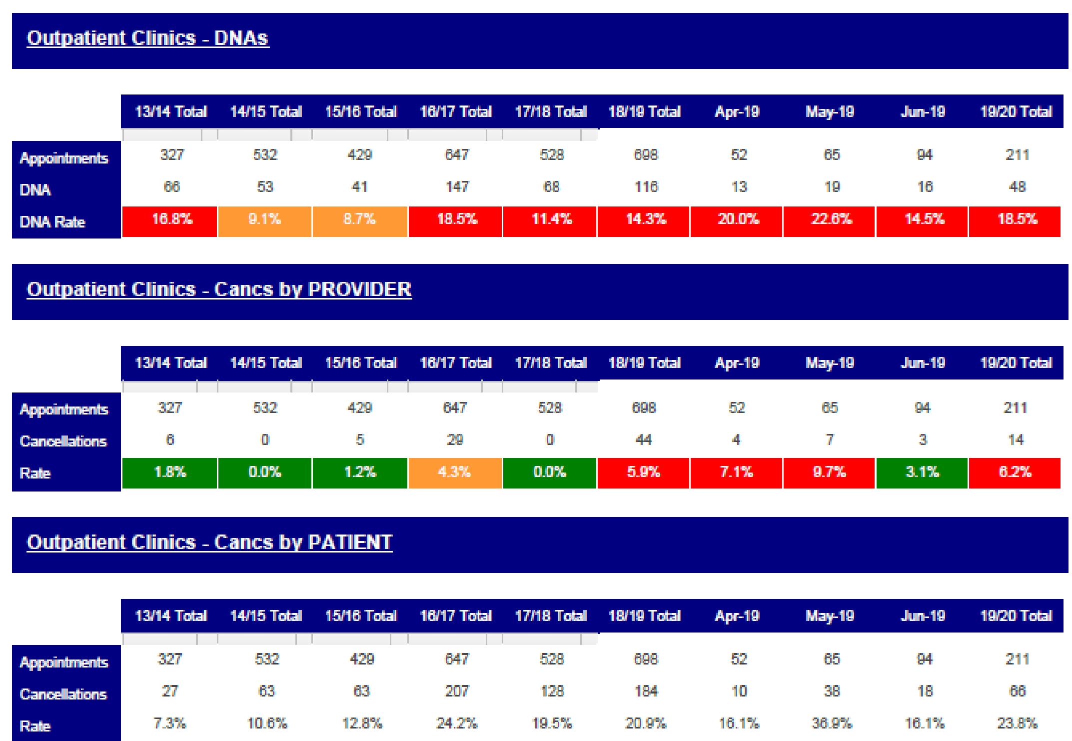


Paediatric SALT Sefton	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	18/19 Outturn	FOT 19/20	% Variance
Number of Referrals	145	161											1,840	1,752	-4.8%
Incomplete Pathways - 92nd Percentile	45	43											448		
Total Number Waiting	939	914											9,377		
Number waiting over 18 weeks	519	461											4,688		
Longest weeks waiting - weeks	52	54											587		
Longest weeks waiting - patients	2	2											25		



Currently Paediatric speech and language waiting times are reported as Sefton view; the Trust is working to supply CCG level information. This is a legacy issue from when Liverpool Community Health reported the waiting time information.

9.5 Alder Hey Dietetic Cancellations and DNA Figures – Sefton



Outpatient Clinics - DNAs

	13/14 Total	14/15 Total	15/16 Total	16/17 Total	17/18 Total	18/19 Total	Apr-19	May-19	Jun-19	19/20 Total
Appointments	327	532	429	647	528	698	52	65	94	211
DNA	66	53	41	147	68	116	13	19	16	48
DNA Rate	16.8%	9.1%	8.7%	18.5%	11.4%	14.3%	20.0%	22.6%	14.5%	18.5%

Outpatient Clinics - Cancs by PROVIDER

	13/14 Total	14/15 Total	15/16 Total	16/17 Total	17/18 Total	18/19 Total	Apr-19	May-19	Jun-19	19/20 Total
Appointments	327	532	429	647	528	698	52	65	94	211
Cancellations	6	0	5	29	0	44	4	7	3	14
Rate	1.8%	0.0%	1.2%	4.3%	0.0%	5.9%	7.1%	9.7%	3.1%	6.2%

Outpatient Clinics - Cancs by PATIENT

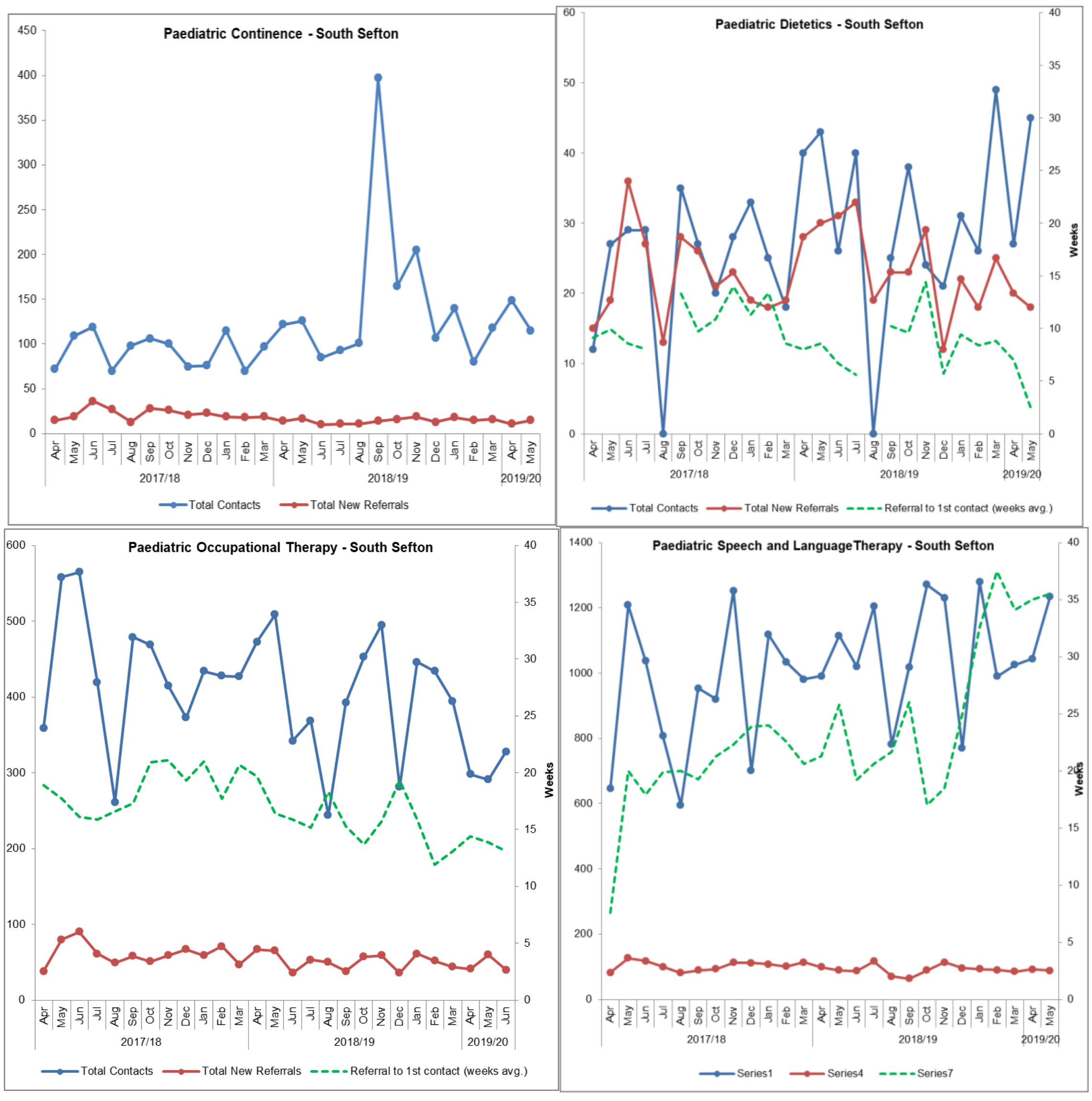
	13/14 Total	14/15 Total	15/16 Total	16/17 Total	17/18 Total	18/19 Total	Apr-19	May-19	Jun-19	19/20 Total
Appointments	327	532	429	647	528	698	52	65	94	211
Cancellations	27	63	63	207	128	184	10	38	18	66
Rate	7.3%	10.6%	12.8%	24.2%	19.5%	20.9%	16.1%	36.9%	16.1%	23.8%

Rag Ratings & Targets 19/20

DNAs Outpatients	
<= 8.47%	Green
> 8.47% and <= 10%	Amber
> 10%	Red

CANCs Outpatients - by Provider	
<= 3.5%	Green
> 3.5% and <= 5%	Amber
> 5%	Red

9.6 Alder Hey Activity & Performance Charts



9.7 Better Care Fund

A quarter 4 2018/19 BCF performance monitoring return was submitted on behalf of the Sefton Health and Wellbeing Board in May 2019. This reported that all national BCF conditions were met in regard to assessment against the High Impact Change Model; but with on-going work required against national metric targets for non-elective hospital admissions, admissions to residential care, reablement and Delayed Transfers of Care. Narrative is provided of progress to date.

A summary of the Q4 BCF performance is as follows:

Figure 22 – BCF Metric performance

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements
NEA	Reduction in non-elective admissions	Not on track to meet target	NHS England set an expectation nationally for growth within Non-Elective admissions, specifically of note is the requirement to increase zero length of stay activity by 5.6% and any admission with a longer length of stay by 0.9%. Despite these growth asks, the CCGs in the Sefton HWBB area have planned for 18/19 growth as follows: South Sefton CCG: 5.12% 0 day LOS, 0.82% 1+ day LOS. Southport & Formby CCG: 1.4% 0 day LOS, 0.4% 1 day LOS. Indicative Q3 YTD data shows a slight increase for the Sefton HWBB NEA position from 25% in Q2 to 27% in Q3 with 34,677 NEA compared to a plan of 27, 310. However, this is measured against BCF original 18/19 plans that were submitted back in 2017, not the latest CCG Ops Plan submissions for 18/19 which were made Apr 18.	There is a continued focus from our ICRAS services around both the S&O and Aintree systems to provide community interventions that support admission avoidance with activity monitored through A&E Delivery Board. SW posts have now also been implemented within localities as part of our place based developments to support early interventions that may avert emergency admission.
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	Sefton's aging in ill health demographics continue to place signifciant additional demand on social care services for older people. Work continues to provide a home first culture and maintain people at home where possible. This is a key aspect of our Newton Decision Making action plan in regard to hospital discharge. Reablement, rehabilitation and ICRAS services all help to support our care closer to home strategy.	Implementation of enabling beds within Chase Heys and James Dixon care homes is an example of model of care designed to increase independence and avoid permanent placements.
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Not on track to meet target	Review of reablement service ongoing but recruitment of workforce continues to be a challenge. Recruitment events underway to strengthen workforce. Plans to develop reablement 'offer' available to community cases - such as people in crisis and/or who are at risk of Hospital admission.	Agreement to conduct a Pilot Scheme around rapid response - meeting held with Providers, CCG and Lancashire Care to discuss approach and next steps.
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Not on track to meet target	Following Newton Europe Review of delayed transfers of care across system we have reviewed recommendations of report with action plans developed for the three key areas.	At an operational and strategic level there has been enhanced partnership working around the S&O and Aintree systems to address delayed transfers of care. There are weekly calls between partners, MDT flying squads to target patient areas, increased focus on 7 and 21 day + LOS and actions to progress discharge.

Figure 23 – BCF High Impact Change Model assessment

		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Current)	Narrative: If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Narrative: Milestones met during the quarter / Observed impact
Chg 1	Early discharge planning	Plans in place	Plans in place	Plans in place	Established		This Chg is in already established for SFCCG area and work continues to progress to move to maturity though implementation of MADE recommendations. Aim to move to one system for S&O across into W.Lancs. For SSCCG area this has been implemented through the ICRAS programme and the discharge lanes/SAFER system within Aintree.
Chg 2	Systems to monitor patient flow	Plans in place	Plans in place	Plans in place	Established		Currently established in Southport and Formby in S&O and system working well to monitor capacity and demand. In Aintree there has been a re-focus in Q4 on use of the Medworxx system in conjunction with the SAFER and discharge lanes approach. Band 4 discharge posts have been introduced attached to wards to support patient flow but also provide additional support to data capture. Ongoing work will aim to develop a mature system with peer support from the Royal Liverpool who also use Medworxx as part of planned merger work.
Chg 3	Multi-disciplinary/multi-agency discharge teams	Plans in place	Plans in place	Established	Mature	Assessment of mature is based on robust implementation of the ICRAS model (Integrated Community Reablement & Assessment Services) within Sefton but also across North Mersey. It is an example of collaboration designed to introduce consistency in approach and pathways across a larger geographical footprint. Further evidenced by linking our ongoing MDT development work to Newton Europe findings to improve Sefton service provision. Again work carried out locally but in conjunction with similar work underway across North Mersey. Shared learning and peer support has been an important part of our development.	Significant progress has been made in regard to multi-disciplinary / multi-agency discharge teams across Sefton. Our ICRAS model (Integrated Community Reablement & Assessment Services) has been key in facilitating joint working arrangements between health and social care and third sector partners with robust pathways in place to support step down from hospital and admission avoidance/step up if required from community. Areas developed in Q4 include our reablement bed based service pathway (Chase Heys & James Dixon Court) developed through collaborative working of all partners. The MDT approach has also been the focus of collaboration with primary care. Examples of this include the pilot work for Integrated Care Communities which is being implemented. During the last quarter activity in the South of the borough has included the identification of resource to support the work this includes two dedicated Primary Care Link Workers who will work across four health localities. This pilot work is being scoped further in terms of monitoring
Chg 4	Home first/discharge to assess	Established	Plans in place	Plans in place	Established		In Q4 we have achieved our plan to develop short stay enablement beds with model of care and pathway now in place. Work involved inputs from partners across acute, community and primary care (Chase Heys and James Dixon Court pathways referenced in Change 3). The newly introduced enablement bed provision complements our Home First service and our intermediate care beds and has helped to widen the range of support that we can provide for our Sefton population.

		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Current)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Milestones met during the quarter / Observed impact
Chg 5	Seven-day service	Plans in place	Plans in place	Plans in place	Established		Nurse led discharge and ICRAS services in place at the weekends to support patient flow. Review ongoing of impact alongside social work activity at weekend to move to more mature assesment.
Chg 6	Trusted assessors	Plans in place	Plans in place	Plans in place	Established		Model has been developed within S&O area in past year. For the Aintree catchment a 12 month pilot is being implemented through Mersey Care community trust with consistent approach being utilised which is in place in Knowsley and Liverpool. Domiciliary Care Trusted assessor established across Sefton footprint
Chg 7	Focus on choice	Not yet established	Plans in place	Plans in place	Established		The Choice Policy has been revisited with partners across North Mersey to ensure a consistent approach. In place within S&O and Aintree. The Newton Europe work will focus on strengthening and again ensuring consistency in processes e.g. best interest, capacity assessements. Process is established with opportunity to progress to mature over 19/20 as it is utilised and used positively to support patient flow and decision making.
Chg 8	Enhancing health in care homes	Plans in place	Plans in place	Plans in place	Established		Many key components in place such as Care Home Matrons, Acute Visiting Service (South Sefton) Red Bag scheme and work planned to move to mature such as on falls, pro-active management and therapy strategy. Focus for the Provider Alliance and further strategic development across the system. This work will continue to be progressed in 19/20.

9.8 NHS England Monthly Activity Monitoring

Two year plans set which started in 2017/18 have been rebased for 2018/19 due to changes in pathways and coding practices, as well as variations in trend throughout 2017/18. The updated plans also include national growth assumptions which CCGs were required to add. The CCG is required to monitor plans and comment against any area which varies above or below planned levels by 2%, this is a reduction against the usual +/-2% threshold. It must be noted CCGs are unable to replicate NHS England's data and as such variations against plan are in part due to this.

Month 2 performance and narrative detailed in the table below.

Figure 24 - South Sefton CCG's Month 2 Submission to NHS England

Month 02	*Month 02 Plan*	*Month 02 Actual*	*Month 02 Variance*	ACTIONS being Taken to Address Cumulative Variances GREATER than +/-2%
Referrals (MAR)				
GP	**3,330**	**3,315**	**-0.5%**	GP referrals have increased in month 2 following an expected seasonal trend. However, Other referrals remain high against plan. An increase in consultant-to-consultant referrals had been evident at the main hospital provider within various specialities including T&O and ENT. The CCG has recently queried the increase in C2C referrals to the aforementioned specialities via the information sub group and no changes in practice/coding were identified. Total referral numbers are also within the 2% threshold year to date for South Sefton CCG. Seasonal trends suggest referral increases in month 3 before reductions during the summer months. Discussions regarding referrals at the main hospital provider take place via information sub groups, contract review meetings and the planned care group.
Other	**2,550**	**2,725**	**6.9%**	
Total (in month)	**5,880**	**6,040**	**2.7%**	
Variance against Plan YTD	11,449	11,640	1.7%	
Year on Year YTD Growth			-5.7%	
Outpatient attendances (Specfic Acute) SUS (TNR)				
All 1st OP	**5,039**	**4,749**	**-5.8%**	First OP attendances increased in month 2 as expected but were below planned levels. Appointments at the main hospital provider increased but the overall position may have been impacted by a decrease in appointments at Royal Liverpool across a number of specialities. Decreases for OPFUP have been evident at a number of providers including the main hospital provider for South Sefton CCG. Rheumatology has shown a notable decrease for FUP appointments at the main provider as well Ophthalmology, Cardiology and Gastro. Both first and FUP appointments were below current averages at month 2 but are expected to come closer to averages as seasonal trends expect each to increase in month 3. A planned care group was established in 2018/19 with the main hospital provider to review elements of performance and activity. This group will continue to work throughout 2019/20.
Follow Up	**11,985**	**10,567**	**-11.8%**	
Total Outpatient attendances (in month)	**17,024**	**15,316**	**-10.0%**	
Variance against Plan YTD	32,765	29,982	-8.5%	
Year on Year YTD Growth			-5.4%	
Admitted Patient Care (Specfic Acute) SUS (TNR)				
Elective Day case spells	1,603	1,927	20.2%	CCG local monitoring of day case and elective spells have activity for month one much closer to planned levels, particularly for day cases where the variance against plan is closer to 4%. Electives are outside of the 2% threshold but activity variances are minimal. Activity trends are driven by the main hospital provider where there has been increased scopes performed within Gastro. A planned care group was established in 2018/19 with the main hospital provider to review elements of performance and activity. This group will continue to work throughout 2019/20.
Elective Ordinary spells	247	214	-13.4%	
Total Elective spells (in month)	**1,850**	**2,141**	**15.7%**	
Variance against Plan YTD	3,590	4,183	16.5%	
Year on Year YTD Growth			1.3%	
Urgent & Emergency Care				
Type 1	**4,649**	**4,655**	**0.1%**	Type 1 attendances are aligned to plan in month 2. However, attendances remain historically high and 4hr performance at the main hospital provider is consistent with the previous month at 82.9%. A trend of decreasing attendances at Litherland WIC has been evident in the last 12 months, which has contributed to a reduction in all types attendances. This appears to be part of North Mersey trend of decreased WIC attendances. CCG urgent care leads are continuing to work collaboratively with the provider and local commissioners to understand A&E attendances/performance and address issues relating to patient flow.
Year on Year YTD			4.8%	
All types (in month)	**9,447**	**8,622**	**-8.7%**	
Variance against Plan YTD	18,286	16,929	-7.4%	
Year on Year YTD Growth			-2.0%	
Total Non Elective spells (in month)	**2,218**	**2,288**	**3.2%**	Plans were rebased for 2019/20 and now take into account pathway changes at the CCG's main hospital provider. Admissions increased in month 2 following an increase in A&E attendances. However, YTD actviity remains within the 2% threshold.
Variance against Plan YTD	4,411	4,481	1.6%	
Year on Year YTD Growth			6.6%	