AGENDA

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting (Part I)
Agenda

Date: **Thursday 4th November 2021, 13:00hrs to 15:00hrs**
Venue: **Virtual Meeting: Teams**
To help the CCG respond to the coronavirus we are moving all meetings that we hold in public to virtual meetings for the foreseeable future. This also applies to our regular operational internal meetings in line with national guidance to ensure our staff are supported to work remotely. We will continue to publish papers as normal.

13:00 hrs Formal meeting of the Governing Body (Part I) commences.

The Governing Body Members

Dr Peter Chamberlain	Chair & Clinical Director	PC
Alan Sharples	Deputy Chair & Lay Member - Governance	AS
Steven Cox	Lay Member - PPI	SC
Dr Gina Halstead	GP Clinical Director	GH
Jane Lunt	Interim Chief Nurse	JLu
Martin McDowell	Chief Finance Officer	MMcD
Dr Alison Rowlands	GP Clinical Director	AR
Dr Sunil Sapre	GP Clinical Director	SS
Dr Jeff Simmonds	Secondary Care Doctor	JS
Fiona Taylor	Chief Officer	FLT
Dr John Wray	GP Clinical Director	JW

Co-opted Members

Director *or Deputy*	Director of Public Health, Sefton MBC	
Director *or Deputy*	Director of Social Services and Health, Sefton MBC	
Bill Bruce	Chair, HealthWatch	BB

No	Item	Lead	Report/ Verbal	Receive/ Approve/ Ratify	Time
General					**13:00hrs**
GB21/142	Apologies for Absence	Chair	Verbal	Receive	25 mins
GB21/143	Declarations of Interest	Chair	Verbal	Receive	
GB21/144	Minutes of previous meeting – 2nd September 2021	Chair	Report	Approve	
GB21/145	Action Points from previous meeting – 2nd September 2021	Chair	Report	Approve	
GB21/146	Business Update	Chair	Verbal	Receive	
GB21/147	Chief Officer Report	FLT	Report	Receive	
Quality					**13:25hrs**
GB21/148	Chief Nurse update	JL	Report	Receive	10 mins
GB21/149	COVID-19 Equality Briefing Version 15	Jo Roberts	Report	Receive	10 mins

No	Item	Lead	Report/ Verbal	Receive/ Approve/ Ratify	Time
Finance and Quality Performance					**13.45hrs**
GB21/150	Chief Finance Officer update	MMcD	Report	Approve	30 mins
GB21/151	Integrated Performance Report	MMcD	Report	Receive	
GB21/152	Auditors Annual Report / Letter	MMcD	Report	Receive	
Governance					**14.15hrs**
GB21/153	ICS and ICB update	FLT	Verbal	Receive	10 mins
GB21/154	Closedown and Transfer progress update	DFair	Report	Receive	10 mins
GB21/155	EPRR Assurance	Niall Pemberton / DFair	Report	Recieve	10 mins
Key Issues Reports to be received for "review, comment and scrutiny":					**14.45hrs**
GB21/156	Key Issues Reports: a) Finance & Resource Committee b) Quality & Performance Committee c) Audit Committee d) Primary Care Commissioning Committee PTI	Chair	Report	Receive	10 mins
GB21/157	Approved Minutes: a) Finance & Resource Committee b) Quality & Performance Committee c) Audit Committee d) Primary Care Commissioning Committee PTI	Chair	Report	Receive	
Closing Business					**15:00hrs**
GB21/158	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting*				5 mins
GB21/159	Date of Next Meeting **Thursday 3rd February 2022, 13:00hrs.** **Venue/Format: Teams** All PTI public meetings will commence 13:00hrs.				
Estimated meeting close					**15:00hrs**

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

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Draft Minutes

Date: **Thursday 2nd September 2021, 13:00hrs to 15:00hrs**
Format: To help the CCG respond to the coronavirus meetings are being held virtually, as per the published notice on the CCG website.

The Governing Body Members in Attendance

Dr Peter Chamberlain	Chair & GP Clinical Director	PC
Alan Sharples	Deputy Chair & Lay Member for Governance	AS
Helen Armitage	Consultant in Public Health	HA
Chrissie Cooke	Interim Chief Nurse	CC
Dr Gina Halstead	GP Clinical Director	GH
Martin McDowell	Chief Finance Officer	MMcD
Alison Rowlands	GP Clinical Director	AR
Dr Sunil Sapre	GP Clinical Director	SS
Fiona Taylor	Chief Officer	FLT

In Attendance

Terry Stapley	*Minute Taker*	TS
Debbie Fairclough	Interim Programme Lead – Corporate Services	DF
Helen Armitage	Sefton Council	HA
Tracey Forshaw	Deputy Chief Nurse	TF
Tracy Jeffes	Director – Place (South)	TJ
Helen Armitage	Public Health, Sefton MBC (*co-opted member)*	HA

Apologies

Jeff Simmonds	Secondary Care Doctor	JS
Deborah Butcher	Director for Adult Social Care (Sefton Council)	DB
Steven Cox	Lay Member for Patient & Public Engagement	SC
Bill Bruce	Health Watch Chair	BB
Dr John Wray	GP Clinical Director	JW

Name	Governing Body Membership	Nov 20	Feb 21	Apr 21	Jun 21	Sept 21
Dr Craig Gillespie	Chair & GP Clinical Director	✓	✓			
Alan Sharples	Deputy Chair & Lay Member - Governance	✓	✓	✓	✓	✓
Director or *Deputy*	Director of Public Health, Sefton MBC (*co-opted member)*	✓	✓	A	✓	✓
Director or *Deputy*	Director of Social Service & Health, Sefton MBC	✓	✓	A	A	A
Graham Bayliss	Lay Member for Patient & Public Engagement	✓	✓			
Dr Peter Chamberlain	GP Clinical Director	A	✓	✓	✓	✓
Gina Halstead	GP Clinical Director	✓	A	✓	✓	✓
Maureen Kelly	Chair, HealthWatch *(co-opted Member)*	A				

Name	Governing Body Membership	Nov 20	Feb 21	Apr 21	Jun 21	Sept 21
Bill Bruce	Chair, HealthWatch *(co-opted Member)*		✓	A	✓	A
Steven Cox	Lay Member for Patient & Public Engagement				✓	A
Jane Lunt	Interim Chief Nurse	✓				
Chrissie Cooke	Interim Chief Nurse		✓	A	A	✓
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓
Alison Rowlands	GP Clinical Director					✓
Dr Sunil Sapre	GP Clinical Director	✓	✓	✓	✓	✓
Dr Jeff Simmonds	Secondary Care Doctor	✓	✓	A	A	A
Fiona Taylor	Chief Officer	✓	✓	✓	✓	✓
*Dr John Wray	GP Clinical Director	✓	✓	✓	✓	A

*Standing meeting clash

Quorum: Majority of voting members.

No	Item	Action
GB21/100	**Apologies for Absence** Apologies were received from Bill Bruce, Jeff Simmonds, Steven Cox, Dr John Wray and Deborah Butcher. The Chair informed the members that the information on the governing body meetings had been updated on the CCG website to provide the public with an opportunity to continue to present questions to the members. No questions had been received for the meeting.	
GB21/101	**Declarations of Interest** The members were reminded of their obligation to declare any interests they may have in relation to any items on the agenda and any issues arising at governing body meetings which might conflict with the business of NHS South Sefton CCG. Those holding dual roles across both South Sefton CCG and Southport & Formby CCG declared their interest; Fiona Taylor, Martin McDowell, Chrissie Cooke, Tracy Jeffes and Tracey Forshaw. GP members declared their interest in item 21/113. It was noted that the interests raised did not constitute any material conflict of interest with items on the agenda. Declarations made are listed in the CCGs Register of Interests which is available on the website http://www.southseftonccg.nhs.uk/about-us/our-constitution/	

GB21/102	**Minutes of Previous Meeting 3rd June 2021** The members approved the minutes of 3rd June 2021 as a true and accurate record.	
GB21/103	**Action Points from Previous Meeting** **GB21/68(i) Integrated Performance Report** • Members requested a Deep dive into the Mental Health services at the next Governing Body Development Session. **Resolution:** Close *Update:* Discussed at Development Session as part of the mental health investment discussion. **GB21/68(ii) Integrated Performance Report** • The Chair asked that the urgent care dashboard is updated to re-establish unplanned care measures (community parameters, Stoddart House and walk-in centre pressures). Take to Governing Body Development Session and IPR going forward. **Resolution:** Close *Update:* Included in Integrated Performance Report **GB21/75 Joint Committee of the Cheshire & Merseyside Clinical Commissioning Groups (Overview & Terms of Reference)** • FLT to clarify the voting members noted with table 6.3. If AOs/CFOs (9 voting members) its ok, but the table needs to be amended to show who has voting rights. If it's all members two CCGs will be more represented than others and this will need further review. **Resolution:** Close *Update:* Action complete, FLT clarified the information, and this has now been modified in the Terms of Reference.	
GB21/104	**Business Update** PC provided an update to the Governing Body on the 2020-21 CCG Self-assessment. Noting there were particular areas of good practice for the CCG including - - Robust approach to continuing engagement and eliciting patient experience in a COVID-19 context - Managerial and organisational development support to facilitate PCN development PC noted the AGM CCG Big Chat is taking place next week which summarises the year with a particular focus on GP services. **Resolution:** The members received the update.	

GB21/105	**Chief Officer Report** FLT presented the Chief Officer report which focussed on those items not covered on today's agenda. In relation to the mass vaccination programme FLT thanked colleagues from both general practice and community pharmacy. The CCG have made a decision this week to sign post members of the public to the "Grab a Jab" campaign as opposed to adding all the details of pharmacists in the area to the website, this is due to the fluid nature of the timings of pharmacies opening and closing. During July and August the programme focused on younger age groups and those hesitant to getting vaccinated. An increase in walk-in vaccination centres and their consistent promotion has greatly increased access for residents, as have a number of pop-up programmes. Peel Ports and Waterloo Festival have hosted pop ups, whilst Asda in Bootle and Netherton Activity Centre have welcomed a vaccination bus to deliver jabs. Member's attention was brought to section 2 which advised the CCG's Audit Committee has received and reviewed the Information Governance Annual Report for 2020/21 including the CCG's submission for the Data Security Protection Toolkit. The CCG was able to provide positive assertions relating to 87 of the 88 mandatory evidence enquiry lines. The one outstanding issue related to network security as the CCG had not arranged for a specialist penetration test to take place during the DPST timeframe. A revised date for the test to take place has been set for October 2021. The CCG subsequently reported that it had not met all standards and had an action plan in place to address outstanding issues, this will be reported back to the Governing Body once complete. In relation to section 3 the EPRR assurance process for 2020/21 will be taking place throughout September. The full submission will be presented to the Governing Body at the meeting in November 2021. Members attention was brought to section 5 and the relocation of the CCGs' to Magdalen House. The Interim Programme Lead for Corporate Services is continuing to work with CCG colleagues, iMersey and Sefton Borough Council to conclude the relocation of the CCG's headquarters to Magdalene House in Bootle. Floor plans have now been approved and shared with the landlord who will now make arrangements for the plans to be implemented. At this stage, there are continued delays with the media provider and we are currently in the process of finalising timelines. The Shaping Care Together programme continues and is overseen by the Joint Committee of NHS Southport and Formby CCG and NHS West Lancashire CCG. A summary of the key highlights was included within the report. In relation to section 8, A copy of the letter from the Regional Director of Performance and Improvement – North West was included within the report with regards to the 2020-21 CCG Self-Assessment. FLT noted that the findings where positive and there were several areas of good practice. Section 13, the three PCNs in Sefton are continuing to progress with plans against the additional roles reimbursement scheme (ARRS). This will see the introduction of a range of new roles within PCNs and practices supporting service delivery and integrated working with partners.	

	In relation to section 14 and 15, FLT briefed members on the current stage of transition, noting the new legislation which will establish an NHS body to be known as the NHS Integrated Care Board (ICB). ICBs will bring partner organisations together in a new collaborative way with common purpose. They will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place. Statutory functions, like those currently exercised by CCGs, will be conferred on ICBs from 1 April 2022, along with the transfer of all CCG staff, assets and liabilities (including commissioning responsibilities and contracts). FLT advised members of the CQC inspection at Liverpool University Hospitals Foundation Trust which took place in June and July 2021. As a result, CQC did not feel assured actions were being taking by the trust, thus issued a Section 31 notice on the 19th August 2021. **Resolution:** The members received the report.	
GB21/106	**Chief Nurse update** TF provided the Governing Body with an overview of the current key issues in terms of quality within the CCG commissioned services and the wider aspects of the Chief Nurse portfolio. CC noted the current pressures within Primary Care and advised that the local system continues to experience pressure in terms of elective waiting and urgent care. Notwithstanding the pressures there have been quality improvements during the past year, which providers have reported via their Quality Accounts. Member's attention was brought to the death of a 12-year-old girl with autism which has been reviewed by the Local Safeguarding Children Board (LSCB) practice review group as meeting the criteria for a learning review. The national team have been informed. The CCGs remain under scrutiny by NHS EI C&M in relation to the management and performance of CHC services. There is an improvement plan in place to meet the 80% threshold for 28-day assessment (from referral to decision) by Q4. The CCGs CHC Programme Lead and Programme Manager for Quality and Safety are leading the development work with key partners and the matter has been reported via Finance and Resources Committee and the Joint Quality and Performance Committee. A detailed report is being presented the Governing Body part 2 meeting in private to discuss the options to the CCG. In relation to Special Education Needs and Disability (SEND), the Department of Education (DfE) re-visit took place on 29 June 2021. Confirmation was received from the Under Secretary of State for Children and Families that the improvement notice has been lifted. Both the Local Authority and the CCGs have given the commitment for SEND governance arrangements with remain place across Sefton. On a final note CC advised members of the CQC inspection at Liverpool University Hospitals Foundation Trust which took place in June and July 2021. The trust was asked to take action on certain aspects of the report and further assurance was asked for by CQC in August 2021. As a result, CQC did not feel assured actions were being taking by the trust, thus issued a	

	Section 31 notice on the 19th August 2021. CC advised the concerns were in relation to senior management oversight of managing clinical risk and patient flow through the emergency departments. This is being managed and reviewed via Liverpool CCG lead contractor arrangements. FLT noted that the Local Authority have had a recent improvement notice issues in relation to children's services. FLT and CC are working through the CCGs accountabilities in relation to healthcare aspects of the notice. Governing Body members noted this was CC last meeting and thanked CC for professional work during her time at the CCG. CC advised that transition arrangements will be discussed at the next Joint Quality and Performance Development Session. **Resolution:** The members received the report.	
GB21/107	**Annual LeDeR Report** TF provided the Governing Body with an overview of the second Learning Disability Mortality Review (LeDeR) annual report which was produced by NHS South Sefton CCG and NHS Southport and Formby CCG. The annual report provided members with an update; on LeDeR performance, governance arrangements, priorities and developments covering the period from 1st April 2020 to 31st March 2021. TF noted that an action plan has been developed and will be monitored by Joint Quality and Performance Committee on a quarterly basis. This will then be reported as an exception report via the Chief Nurses report to the Governing Body. Member's attention was brought to the key issues within the report: • There has been significant improvement to the CCGs LeDeR performance is in line with NHS EI contractual compliance in year. The CCG has also reported complaint with LeDeR governance arrangements in year. • LeDeR governance arrangements have been strengthened in year with the introduction of the LeDeR task and Finish Group and the North Mersey Multi-Agency LeDeR Panel. • Backlog cases dating back to 2018, where completed and closed by the end of Quarter 4 2020/21. • The additional resource of the LeDeR Co-ordinator has been withdrawn by Mersey Care due to staffing issues. Recruitment to the 6month fixed term contract is in progress. • Learning and recommendations from LeDeR reviews have been included in the NHS EI C&M 4-year LeDeR strategy. • Changes to the current LeDeR programme are expected, with the publication of the national LeDeR strategy in March 2021. An action plan is in place to manage the changes to the system. • LeDeR management will transfer across to the Integrated care System as of the 1 April 2022. • Lack of LeDeR reviewers across all CCGs. **Resolution:** The Governing Body thanked TF for the report and approve the 2020/21 LeDeR annual report.	

GB21/108	**Complaints Report** CC presented the Governing Body with the complaints report which aims to provide a summary of complaints and concerns reported by our commissioned providers. Where possible, this will also include any improvement work carried out by providers. The report covered complaints, concerns, dispute queries, access requests and PALS received by the CCG open from 2020/21 and all those received during April – June 2021. The report details that there have been 75 contacts in the first quarter of 2021/22 all were acknowledged or resolved and closed within a short timeframe. During April and May 2021, out of the 75 contacts received for the CCG, 46 have since been closed and 29 are ongoing (14 recorded as complaints). FLT advised that Niche will be returning to review the CCG's progress on the action plan following the Niche Complaints and Governance review. Noting her thanks to CC and DFair for their work in getting clarity on the systems and processes following the original Niche visit. Members noted issues in relation to timescales of complaints being resolved. CC advised that although the CCG has its own expectations of when a complaint should be resolved by (6–12-week period). However, the providers have different timescales. Thus, the timescales must be negotiated, whilst keeping the complainant updated constantly throughout the process. **Action** – CC to provide information on the total number of complaints received to AS. Governing Body members noted this was CC last meeting and thanked CC for professional work during her time at the CCG. CC advised that transition arrangements will be discussed at the next Joint Quality and Performance Development Session. **Resolution:** Members received the report	**CC**
GB21/109	**Chief Finance Officer update** MMcD presented the Governing Body with an overview of the Month 4 financial position for NHS South Sefton Clinical Commissioning Group as at 31st July 2021. The standard business rules set out by NHS England require a 1% surplus in each financial year, however the usual financial framework has been replaced with temporary financial arrangements in response to the COVID-19 pandemic. It has been confirmed that the temporary arrangements remain in place for the first six months of 2021/22. The temporary arrangements include additional funding for COVID related costs including a continuation of the Hospital Discharge programme. NHS Planning Guidance has been published for April – September 2021 (H1) only and the CCG has agreed a financial plan for this period which is break-even in line with its statutory duty. The QIPP requirement to deliver the revised plan is £1.600m and the CCG remains on track to deliver this position although it is dependent upon non-recurring solutions to meet this expectation.	

	The Month 4 financial position reports an overspend of £0.488m which reflects costs for the Hospital Discharge Programme and the Elective Recovery Programme which are yet to be reimbursed. There are emerging cost pressures in other areas which will need to be addressed and the CCG should progress QIPP schemes and other mitigating actions to manage expenditure within the available resource. The forecast position to September 2021 is an overspend of £1.176m which is the forecast for costs related to the Hospital Discharge Programme Elective Recovery Programme up to September 2021. The CCG is expecting these costs to be reimbursed and on this basis, the CCG is forecast to achieve a break-even position. FLT advised members of the impact around IAPT funding with the CCG being expected to fund an increase in numbers of trainers to support the service, which is a significant increase than what was expected. The CCG is compliant with the mental health investment standard but will continue to work on the mental health programme. In relation to H2, MMcD advised that a provisional budget will be drafted as it is unlikely that full information will be available to sign off the next 6 months of the year. A provisional budget will be produced and will require sign off by the Governing Body before the end of September 2021. **Resolution:** The Governing Body approve the proposed budgets for H1 2021/22, noting the following key points: • Temporary financial arrangements implemented in response to the COVID pandemic remain in place for the first six months of the 2021-22 financial year. • Additional funding is available for COVID related costs and recovery of Elective and Mental Health services. • The CCG financial plan for April – September 2021 (H1) is break even in line with its statutory duty. • Delivery of the break-even position requires QIPP efficiency savings of £1.600m • The Month 4 financial position is an overspend of £0.547m and the forecast to 30th September 2021 is an overspend of £1.259m. Other cost pressures will need to be addressed if the CCG is to manage within the available resource. • Following reimbursement of costs for the Hospital Discharge Programme and the Elective Recovery Programme, the CCG is forecast to achieve a break-even position.	
GB21/110	**Integrated Performance Report** MMcD led the discussions advising, that the report provides summary information regarding the activity and quality performance on the key constitutional targets of South Sefton Clinical Commissioning Group. MMcD noted that on page 92 of the pack (Summary Performance	

	Dashboard) the table shows some improvement has taken place around RTT and the number of patients waiting at period end for incomplete pathways >52 weeks. The CCG has failed the target of less than 1% of patients waiting 6 weeks or more for their diagnostic test with 14.14% in June - this being a decline in performance from last month (12.71%). Despite failing the target, the CCG is measuring well below the national level of 22.4%. Liverpool University Hospital Foundation Trust (LUHFT) performance was 8.24% in June, a small decline in performance from last month when 7.49% was reported. There were a total of 2,307 South Sefton CCG patients waiting over 36+ weeks, the majority at LUHFT. Of the total long waiters, 912 patients were waiting over 52 weeks, a decrease of 66 on last month when 978 breaches were reported. The 912 52+ week wait breaches reported for the CCG represent 5.50% of the total waiting list in June 2021 which is just below the national level of 5.59%. For Cancer 62 Day standard the CCG is measuring above the national level of 73.27% recording 75% in June but now below the national standard of 85%. In relation to A&E 4-Hour waits for all types, the CCG and LUHFT have failed the 95% target in June 2021, reporting 71.29% and 69.62% respectively. This shows a decline from the previous month and the CCG and Trust performance is now lower than the nationally reported level of 81.71%. In relation to the COVID-19 vaccination programme 80.2% of the full adult population within South Sefton CCG have had their first dose, and 73.2% their second dose as of 18 August 2021. With the expansion of the programme to including 16 and over, 78.9% have had their first dose and 71.5% their second dose. This compares favourably with the national statistics on the vaccine uptake. PC asked could there be a breakdown of the diagnostics data? Due to LUHFT stating they achieving 1% on diagnostics not including endoscopy. Thus, what is causing the elevated figures for the CCG. **Action** - PC asked whether it is it possible to breakdown the diagnostics data into speciality. MMcD to check and bring back to the next GB. GH raised concerns in relation to IAPT recovery, due to the data showing there has been a decrease in recovery rate. **Action** - IAPT recovery deep dive to be carried out and brought back to the next development session. The chair noted that in General Practice anxiety and depression has doubled during the pandemic, with IAPT being a key service as this is where patients would be referred on to. **Resolution:** The Governing Body received the report.	**MMcD** **MMcD/GJ**
GB21/111	**ICS and ICP update** FLT presented the members with an update via a presentation on ICS/ICB. The ICS/ICB Chair is currently at the interview stage, the Chief Officer role of the ICB is being advertised this week. The two processes are running parallel	

	to allow for the Chair to be on the interview panel for the Chief Officer role. FLT noted that in Sefton we are currently working on the governance arrangements and working with the Local Authority to see what we can keep in the place. PC asked how will members be appointed to the roles within the ICB? FLT advised that there is no current guidance in relation to this. **Resolution:** The members received the update.	
GB21/112	**Staff Survey** TJ briefed members on the report which informs the Governing Body of the outcomes of the Sounding Board Staff Survey from June 2021. The report describes the analysis and result of the survey and includes the subsequent action plan. Key themes from the survey illustrated how respondents are feeling about their working arrangements, the organisation, their health and wellbeing and proposals for integration. Highlights include – • Strong case for agile working • CCGs have a lot to be proud of • Feeling supported by line manager is important to wellbeing • Mixed feelings about integration, but not unsupportive of change The next stage of the survey is to develop the results and information into recommendations that would feed into, influence, and support the model for how the CCG workforce will operate as pandemic restrictions begin to be lifted and also feeds into the CCGs Organisational Development plan. TJ noted that DFair is leading on the results from the survey and how we will adjust to a hybrid model of working. **Resolution:** The Governing Body noted the report, results, and action plan.	
GB21/113	**Primary Care Committee in Common Terms of Reference** The members were presented with the Primary Care Commissioning Committee Terms of Reference for approval. GPs from the Governing Body noted that would be unable to vote on the approval on the Terms of Refence but are able to contribute to the discussion. The Primary Care Commissioning Committees in Common met on 17 June 2021 and undertook annual review of the Terms of Reference. The proposed changes are minor and seek to strengthen the complaints management framework in place across the CCG. AS suggested reinstating the Vice Chair as part the quorum (Page 184) as the deletion of this could cause problems with quoracy at the meeting. **Action** - In relation to the PCCiC TOR, AS suggested reinstating the Vice Chair as part the quorum (Page 184). **Resolution:** The Governing Body approved the Terms of Reference with the above amendment.	**MMcD**

GB21/114	**Intermediate care strategy** MMcD presented members with the Integrated Intermediate Care Strategy. The report and Sefton Joint Intermediate Care Strategy 2021-24 is due to be presented to the HWBB for approval and may be subject to amends. The overall aim of this strategy is to reduce hospital admission, reduce the burden on acute hospital trusts, support more people to remain in their own homes during and following an episode of health and/or social decompensation and to reduce long term placements. MMcD noted that the strategy is aligned directly to the Aging Well Programme, the Sefton2gether strategy and Care Home strategy. It will also allow for an integrated approach to commissioning for health and social care and pooled budget arrangements utilising the Better Care Fund. This will ensure that resource is invested where it is most needed. **Resolution:** The Governing Body received the strategy and the governance arrangements and noted the ongoing process.	
GB21/115	**Key Issues Reports:** a) Finance & Resource Committee b) Quality & Performance Committee – Members noted the issues in relation to lost GP records (GP to GP) following digitisation which could expose patients to risk. c) Audit Committee d) Primary Care Commissioning Committee PTI e) Leadership Team **Action -** PC, MMcD, LMC to write a letter regarding concerns in relation to lost records due to digitisation to NHS digital. **Resolution:** The Governing Body received the key issues reports	**PC / MMcD**
GB21/116	**Approved Minutes:** a) Finance & Resource Committee b) Audit Committee c) Joint Quality & Performance Committee d) Primary Care Commissioning Committee PTI: **Resolution:** The Governing Body received the approved minutes.	
GB21/117	**Any Other Business** **<u>Blood Bottle Shortage</u>** GH noted the issues in relation to blood bottle shortage and the volume of work which is adding further pressure onto general practice. Noting there are review mechanisms in place for doctors to review whether blood tests can be safely left until the crisis has passed.	
GB21/118	**Date and Time of Next Meeting** <u>Future Meetings:</u> The Governing Body meetings are held on the first Wednesday of the month.	

	Dates for 2020/21 are as follows: 4th November 2021 All PTI public meetings will commence at 13:00hrs, format to be confirmed.	
Meeting concluded PTI meeting concluded using the Teams platform.		**15:10hrs**
Motion to exclude the public: Due to the format of the meeting the motion to exclude the public was not required.		

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Action Points

Date: **Thursday 2nd September 2021**

Item	Item and action	Lead	Update
GB21/108	**Complaints Report** CC to provide information on the total number of complaints received to AS.	CC	
GB21/110(I)	**Integrated Performance Report** PC asked whether it is it possible to breakdown the diagnostics data into speciality. MMcD to check and bring back to the next GB.	MMcD	
GB21/110(II)	**Integrated Performance Report** IAPT recovery deep dive to be carried out and brought back to the next development session.	MMcD / GJ	
GB21/113	**Primary Care Committee in Common Terms of Reference** In relation to the PCCiC TOR, AS suggested reinstating the Vice Chair as part the quorum (Page 184).	MMcD / DFair	
GB21/115	**Key Issues Reports** PC ,MMcD, LMC to write a letter regarding concerns in relation to lost records due to digitisation to NHS digital.	PC / MMcD	

NHS
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MEETING OF THE GOVERNING BODY
NOVEMBER 2021

Agenda Item: 21/147	**Author of the Paper:** Fiona Taylor Chief Officer fiona.taylor@Southseftonccg.nhs.uk 0151 317 8366	**Clinical Lead:** N/A
Report date: November 2021		

Title: Chief Officer Report

Summary/Key Issues:

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

Recommendation

Receive	X
Approve	
Ratify	

The Governing Body is asked to

- *Receive the update*
- *Approve the approach outlined at section 3 in respect of the DPST submission.*

Links to Corporate Objectives 2021/22 ***(x those that apply)***	
X	To implement Sefton2gether and realise the vision and ambition of the refreshed Health and Wellbeing Strategy.
X	To drive quality improvement, performance and assurance across the CCG's portfolio.
X	To ensure delivery of the CCG's financial plan and align it with Sefton2gether and the work plan of transformation programmes
X	To support primary care development ensuring robust and resilient general practice services and the development of Primary Care Networks (PCNs).
X	To progress the changes for an effective borough model of place planning and delivery and support the ICS development.

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

South Sefton
Clinical Commissioning Group

Report to the Governing Body
November 2021

COVID19 updates

1. COVID19 Vaccination Programme

The CCG continues to work closely with Sefton Council and other partners to increase uptake of the COVID-19 vaccine. We continue to encourage and support all vaccination sites in promoting real time availability on the national 'Grab a jab' website. Wide ranging communications and engagement activities continue to support the programme, including joint work with and information toolkits for partners. An overview of some of this work has been presented to the council's outbreak management board.

The most recent initiative has included targeted pilots in wards where rates are lower than other areas. This has seen us secure clear opening times and availability of community pharmacy vaccine clinics for this targeted work, including flyer production and leaflet drops around key postcodes. We have also ensured set opening times for PCN vaccination sites.

How and when can individuals get their COVID-19 booster vaccine?

Those eligible will be offered a booster dose at least 6 months, or 26 weeks after their 2nd dose. The NHS will contact them when it's their turn to have a booster dose. People are being advised not to contact the NHS for one before then. Most people will be invited to book an appointment at a larger vaccination centre, pharmacy, or local NHS service. Frontline health or social care workers can book a booster dose appointment online. They do not need to wait to be contacted by the NHS. People who work for an NHS trust or a care home will usually get their booster dose through their employer.

Individuals can book their COVID-19 booster vaccine dose online if you are a frontline health or social care worker. They can also book a booster dose online if they have been contacted by the NHS and they are either aged 50 and over or aged 16 and over with a health condition that puts you at high risk from COVID-19

General local and national updates

2. Headquarters – returning to on-site working

The CCG's Interim Programme Lead for Corporate Services is continuing to work with CCG colleagues, iMersey and Sefton Borough Council to conclude the relocation of the CCG's. Floor plans have now been approved and shared with the landlord who will now make arrangements for the plans to be implemented.

At this stage, there are continued delays some of which relate to the shortage of building supplies required to complete the office refurbishments. We are currently in the process of finalising timelines.

3. DPST Decision

NHS Digital hosted a webinar for CCGs and ICBs to clarify where responsibilities will lie in relation to the 2021-2022 Data Security and Protection Toolkit (DSPT) submission given the forthcoming transition. They confirmed responsibility to complete a DSPT submission for 2021-2022 lies with the ICB, should the ICB be established on 1st April 2022.

If for any reason the ICB is not established on this date, the responsibility to submit a 21-22 DSPT will be with the individual CCGs. It is understood that the ICBs that submit between April – 30th June 2022 can submit with standards not met and have improvement plans in place as they are new organisations.

Therefore, the 2021-2022 DSPT submission and the Internal Audit of the DSPT will be voluntary for all CCGs. If a CCG chooses to submit a DSPT, the ICB will still be required to submit before 30th June 2022.

This has been discussed with other CCGs across Cheshire and Merseyside that have decided that a formal submission will not be made, however, leads have also agreed to continue to collate relevant evidence in the event that the responsibility for submission returns to the CCGs. It is recommended that the CCG adopt the same approach. The governing body is asked to approve that approach.

4. Establishing the new Integrated Care Board (ICB) for Cheshire and Merseyside

On the 22nd October the Cheshire & Merseyside Heath Care Partnerships (HCP) Interim Chair David Flory and Interim Chief Officer Sheena Cumiskey wrote to the CCG confirmed the launch of the engagement process regarding the constitution of the new Integrated Care Board for Cheshire and Merseyside.

The letter set out the proposals for the composition of the Board and invites feedback from organisations **by Friday 5th November** to enable the HCP to meet rapidly moving national timescales. A copy of the letter can be found here The letter.

There will be a second stage to this process relating to the ICB constitution and the HCP will write out again to the system under separate cover.

To implement Sefton2gether and realise the vision and ambition of the refreshed Health and Wellbeing Strategy.

5. Shaping Care Together

The Shaping Care Together programme continues to progress. An update on key highlights is provided below.

Engagement and Communication: Challenges and Opportunities Paper is now complete and ready for circulation. An easy read version of the SCT questionnaire has also been approved. First draft of EIA and HIIA completed. There has been a moderate delay in the communications launch and public stakeholder events for options appraisal process to enable a programme refresh accommodating strategic partners input. Alignment made with S&F primary care engagement.

Clinical and care engagement and leadership: Clinical Senate visit planned. Detailed models of care to accompany graphics and summary have been produced. Clinical leadership and engagement framework developed.

Business Case: Demographic profiling narrative complete. **I**ssues around finalising the activity/demand baseline and financial baseline. Contract review meetings held with MLCSU and exception report raised describing the cause, impact and options for consideration. Estates, workforce, travel and digital progressing with option modelling.

Strategic Partnership: Engagement with colleagues in St Helen & Knowsley and Specialist Commissioners with invites extended to the programme board.

To drive quality improvement, performance and assurance across the CCG's portfolio.

6. Blood tube supply

Following the update provided in September in relation to blood tube disruption the current position is summarised below:

- Capacity has continued to recover in September and October
- Nationally, supply has stabilised but is not yet back at normal levels
- Locally, the CCGs are continuing to work with our local laboratory partners and community providers, to avoid a surge and continue to monitor local supplies
- The laboratory has confirmed that blood tube orders are being filled although demand has increased
- Mersey Care had reduced clinic capacity to meet the restricted blood tube supply and was offering 60% of clinic capacity across south Sefton and Liverpool community clinics. This has been increased and week commencing (w/c) 18 October 2021 saw an increase to 80% capacity
- Mersey Care and Liverpool LCL Laboratories have confirmed their trajectory to return to 100% capacity for w/c 25 October 2021 for south Sefton and Liverpool community clinics.
- Southport and Formby are less constrained due to reduced numbers in this area and returned to 100% capacity from w/c 27 September 2021. This has continued into October.
- All urgent blood testing continues to be delivered across Sefton
- Across Sefton, GP practices continue to be encouraged to do as much testing in-house as their capacity and blood tube supply allows
- Mersey Care are offering domiciliary blood tests to all patients who require these and will continue to monitor services as they return to 100% from w/c 25 October 2021.
- Testing activity in acute trusts, community hospitals and mental health trusts, in line with best practice guidance, can, local stocks permitting, resume
- GP teams should continue to follow the best practice guidance available at https://www.england.nhs.uk/wp-content/uploads/2021/09/B0960-optimising-blood-testing-primary-care.pdf

7. Cancer trial

Cheshire and Merseyside has been confirmed as the first pilot site in Europe to test the ground-breaking Galleri blood test as part of the national NHS England-GRAIL Screening Study Partnership. This research aims to help deliver the NHS Long Term Plan goal of increasing the proportion of cancers detected early and dramatically reducing deaths from cancer in the future. If this trial of Galleri is successful, then it could become routinely available. Galleri is a simple blood test that can identify over 50 different types of cancer such as head and neck, ovarian, pancreatic, oesophageal and some blood cancers. The trial will investigate the clinical use of the Galleri blood test in an asymptomatic population aged 50-77 with no current or recent cancer diagnosis or treatment.

Cheshire & Merseyside Cancer Alliance is aiming to recruit around 20,000 participants from across the region over the coming months.

This will contribute to the overall goal of 140,000 participants across eight Alliance sites by March 2022. Participants will be identified and written to by NHS DigiTrials based on postcode and their eligibility for the trial, which will include Sefton residents. Interested participants will book an appointment to attend a local mobile health unit to consent, give blood and fill in necessary forms. Up to two further blood samples will be taken at 12 and 24 months.

8. GP practice survey

A survey to gain Sefton patients experiences of using GP practice services during the pandemic has started to be rolled out across the borough. The survey is being launched in different areas of Sefton at different times over the coming weeks. Practices will send their patients details of how to take part when the survey launches in their area of Sefton. Patients registered with Southport and Formby practices are the first to receive their invitations via a text or a letter.

The exercise will help practices respond to the requirements of this year's Local Quality Contract focused on understanding and improving patient access. Flexibility has been built into the survey's design. This means that patients registered at a small number of practices where there have been site changes as a result of the pandemic, or where there are longer term changes will be asked additional questions. Practice level results will be discussed with patient participation groups to explore how access can be improved. Additionally, the overarching themes will help the CCGs to understand if any wider measures can be put in place to support practices and their patients

To ensure delivery of the CCG's financial plan and align it with Sefton2gether and the work plan of transformation programmes.

9. Finance update

The standard business rules set out by NHS England require a 1% surplus in each financial year, however the usual financial framework has been replaced with temporary financial arrangements in response to the COVID-19 pandemic.

The temporary arrangements include additional funding for COVID related costs including a continuation of the Hospital Discharge programme. Additional funding has also been provided for Mental Health investments and recovery in Elective Care and Mental Health services.

The report from the CCG's Deputy Chief Officer and Chief Finance Officer that is on the agenda today provides further information.

To support primary care development ensuring robust and resilient general practice services and the development of Primary Care Networks (PCNs).

10. Hightown Village Surgery update

NHS South Sefton Clinical Commissioning Group has received interest from a number of different providers to take on the running of Hightown Village Surgery. It follows the CCG's approval of the request to release the current provider, Chapel Lane Surgery in Formby, who has held the contract for Hightown since 2018, from running the practice. Local practices will be invited to express their interest in managing Hightown to provide continuous care for its small community of under 2,000 patients on a

temporary basis whilst a long term provider can be found. In July 2021 the Care Quality Commission rated Hightown Village Surgery as 'good' across all areas that the inspection looks at, finding it safe, effective, caring, responsive and well-led. Once temporary management arrangements are in place, an exercise will begin to identify a longer term provider to run Hightown Village Surgery. All NHS contracts are awarded for a set period of time. Before they reach their full term, a process begins to ensure there are no gaps for patients between the old contract ending and the new one beginning. This is particularly important where contracts are awarded to new providers. These re-procurement exercises are carried out to meet strict legal rules. A re-procurement exercise such as one for Hightown Village Surgery would expect to take around six to nine months.

To progress the changes for an effective borough model of place planning and delivery and support the ICS development.

11. Sefton Integrated Care Partnership

Work on the development of the Sefton Integrated Care Partnership has continued apace. A check-point meeting was held with the ICS Interim Chair and Chief Officer in September, who acknowledged the progress that has been made and set out a commitment to working together to ensure the governance arrangements, as they develop, will result in a strong and enduring partnership between the ICS and Sefton. Programmes of work are fully mobilised with the CCGs Leadership team active members across all programmes. Work with Hill Dickinson to develop a memorandum of understanding for Sefton partners is nearing completion and will underpin the future governance arrangements.

October's Health & Wellbeing Board meeting saw a focus on two of the borough's key priorities, obesity and mental health, with the next steps being to more closely align the two pieces of work in support of an integrated approach to physical and mental health. The Programme Delivery Group – as the borough's key delivery forum – held a workshop with the newly established Mental Health & Community Provider Collaborative in October, with further dialogue planned in support of understanding how NHS providers, who are operating across more than one borough, can best support delivery in Sefton.

12. Recommendation

The Governing Body is asked to

- *Receive this report.*
- *Approve the approach to the DPST submission as set out in section 3.*

Fiona Taylor
Chief Officer
November 2021

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
NOVEMBER 2021

Agenda Item:21/148	**Author of the Paper:** Jane Lunt Chief Nurse Jane.Lunt@liverpoolccg.nhs.uk	**Clinical Lead:** Dr Gina Halstead GP Governing Body Member and Clinical Quality Lead South Sefton CCG
Report date: November 2021		

Title: Chief Nurse report

Summary/Key Issues:

The Chief Nurse Report highlights the key quality issues related to commissioned services and also any other issues associated with the Chief Nurse Portfolio.

Keys risks to draw to members attention are:

- The local system continues to experience pressure in terms of elective waiting and urgent care. In particular since the lifting of some Covid restrictions in July, the community infection rates have increased resulting in an increased number of covid positive patients in the Trusts. Bed occupancy in trusts has been greater than 90% at times and there is persistent increased demand on services including primary care, community services and Maternity services.

- Delivery of Continuing Health Care for the people of Sefton continues to be non-compliant with the National CHC Framework.

- A single CQPG has been established for Mersey Care NHS Foundation Trust with Liverpool CCG as the lead commissioner. There has been agreement for the service to be placed on a period of enhanced surveillance as a supportive measure due to potential risks to the quality and safety of delivery of services. This will include patient and staff experience metrics to identify any areas of deterioration. Separate CCG contract meetings will remain in place.

- Update on the Liverpool University Hospitals NHS Foundation Trust (LUHFT) Section 31 Notice and follow up single item quality surveillance meeting (SIQSG). The trust have responded to the conditions within the notice which were shared at the SIQSG. There was agreement for a System Improvement Board to be put in place to monitor progress via a single improvement plan. The first meeting is scheduled to take place in November 2021.

- There have been changes to the LUHFT executive team with interim Chief Executive, Medical Director and Chief Nurse posts whilst recruitment to the substantive posts takes place.

Recommendation

The Governing Body is asked to receive this report.

Receive	X
Approve	
Ratify	

Links to Corporate Objectives 2021/22 *(x those that apply)*	
	To implement Sefton2gether and realise the vision and ambition of the refreshed Health and Wellbeing Strategy.
X	To drive quality improvement, performance and assurance across the CCG's portfolio.
	To ensure delivery of the CCG's financial plan and align it with Sefton2gether and the work plan of transformation programmes
	To support primary care development ensuring robust and resilient general practice services and the development of Primary Care Networks (PCNs).
	To progress the changes for an effective borough model of place planning and delivery and support the ICS development.

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

South Sefton
Clinical Commissioning Group

Report to the Governing Body
November 2021

1. Key Issues

This paper presents the Governing Body with an update regarding key issues that have occurred since the last report which was presented in June 2021.

The key risks to draw the members attention to are:

- The local system continues to experience pressure in terms of elective waiting and urgent care. In particular since the lifting of some Covid restrictions in July, the community infection rates have increased resulting in an increased number of covid positive patients in the Trusts. Bed occupancy in trusts has been greater than 90% at times and there is persistent increased demand on services including primary care, community services and Maternity services.

- Delivery of Continuing Health Care for the people of Sefton continues to be non-compliant with the National CHC Framework.

- A single CQPG has been established for Mersey Care NHS Foundation Trust with Liverpool CCG as the lead commissioner. There has been agreement for the service to be placed on a period of enhanced surveillance as a supportive measure due to potential risks to the quality and safety of delivery of services. This will include patient and staff experience metrics to identify any areas of deterioration. Separate CCG contract meetings will remain in place.

- Update on the Liverpool University Hospitals NHS Foundation Trust (LUHFT) Section 31 Notice and follow up single item quality surveillance meeting (SIQSG). The trust have responded to the conditions within the notice which were shared at the SIQSG. There was agreement for a System Improvement Board to be put in place to monitor progress via a single improvement plan. The first meeting is scheduled to take place in November 2021.

- There have been changes to the LUHFT executive team with interim Chief Executive, Medical Director and Chief Nurse posts whilst recruitment to the substantive posts takes place.

2. System report

The local system continues to experience pressure in terms of elective waiting and urgent care. This is covered in more detail in the Integrated Performance Report. Particularly the system has seen pressures resulting in diverts from maternity units. The system protocol for mutual aid has been enacted with good effect. This is under daily review by the local system.

2.1 Infection and Prevention Control:

The CCG are in attendance at C&M AMR (Antimicrobial Resistance) Programmes, including Gram Negative Blood Stream Infection (GNBSI) Oversight & Improvement Board. The CCG has presented the current position across North Mersey. This includes the reinstatement of the North Mersey GNBSI plan following the COVID pandemic. The CCG will be reporting quarterly to this group to provide assurance regarding plans and progress against them. The North Mersey GNBSI is intended to gain

assurance that all providers, local authorities and CCGs across the area can develop systems and processes to reduce preventable infections. The first meeting took place on 28th September 2021.

The NHS Standard Contract 2021/22: Minimising Clostridioides difficile and Gram-negative Bloodstream Infections (GNBSI) guidance has been published on 12th July 2021. This document has been shared with all providers and all reporting templates have been updated to reflect the new trajectories for the September reporting schedule.

2.2 Review of the Joint Performance and Quality Committee: The Committee held a development session on 2 September 2021. During this session Committee members received;

- ICS update
- An overview of the work needed- to get ready for 1st April and work to do April 2022 - March 2023
- An update on the current model/structure for Quality at place
- A plan for developing this further during October 21 – April 22

The Committee are aware the Chief Nurse is working on the development of a shared quality function with Liverpool. This will see one Chief Nurse/Director of Quality across both Sefton CCGs and Liverpool CCG, with deputies facing into local place/borough. To support this, it is intended that the quality teams for all three CCGs will operate as a shared resource. Jane Lunt the Chief Nurse for Liverpool CCG from October 2021 is providing the Chief Nurse role and function across the CCG.

2.3 Sefton Safeguarding Children Partnership Update: Governing Body will recall that Sefton Council received an improvement notice in June 2021 following an Ofsted focused visit to Sefton children's services in March 2021. The report highlighted that too many children are left in unassessed or high-risk situations for too long. Two areas of priority action included:

- Timely application of the pre-proceedings stage of the Public Law Outline where risks for children are not reducing through child protection planning.
- The effectiveness of case supervision and the monitoring of children who are subject to child protection planning, including those children in the pre-proceedings process, to prevent drift and delay.

As part of the improvement journey a number of interim leadership roles have been established within the council to support driving the agenda.

- To support the improvements, diagnostic reviews of the safeguarding system and recent multi agency audits have been undertaken around multi agency safeguarding hub (MASH), child exploitation and thresholds. This has highlighted areas of practice that will need to be further reviewed and strengthened to ensure statutory compliance and appropriate assessment of risk and interventions to support and improve outcomes for children, young people and their families.
- The CCGs and safeguarding professionals will be supporting these changes and are engaged in workstreams to review MASH pathways, multi-agency child exploitation (MACE) pathways, Model of Practice development, review of Level of Need Document and review of CP processes.
- Alongside these practice changes, the Safeguarding Partners have reviewed and strengthened the Multi Agency Safeguarding Arrangements introduced from the Children & Social Work Act (2017). The current Local Safeguarding Children Board (LSCB) will be replaced by a new Sefton Safeguarding Children Partnership and sub-groups. The new arrangements have been shared with the LSCB and feedback has been requested. The CCGs have scheduled a meeting with safeguarding leaders within the local health providers to consider how their leadership roles can support the new structure and sub-groups.

2.4 Liberty Protection Safeguards (LPS) National Baseline Audit: The CCG completed a base line readiness audit in preparation for LPS to the national team The Designated Safeguarding Adult Manager will use the information within the return to support a Sefton LPS implementation action plan.

2.5 Joint Targeted Area Inspection (JTAI) Action Plan Update: Four actions remain open on the action plan. One is rated red, which relates to Children and Adolescent Mental Health (CAMHs) waiting times. The CAMHs waiting times are also cited in the Special Educational Needs and Disability (SEND) action plan. The remaining three are amber. The action plan continues to be monitored and updated at the SEND health improvement group.

2.6 Special Education Needs and Disability (SEND) Update: Waiting times for SEND: Therapy, CAMHs, Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactive Disorder (ADHD) continue to be monitored at the CCGs SEND health performance improvement group. Additional investment has been provided by the CCGs to support all areas of the waiting times to long term achievement the waiting times. Areas of particular challenge remain: CAMHs, ASD both children and young people, and ADHD for young people.

2.7 Continuing Health Care (CHC): The CCGs remain under scrutiny by NHS EI C&M in relation to the management and performance of CHC services. There is an improvement plan in place to meet the 80% threshold for 28-day assessment (from referral to decision) by Q4. The CCGs CHC Programme Lead and Programme Manager for Quality and Safety are leading the development work with key partners. This matter has been reported via Finance and Resources Committee and the Joint Quality and Performance Committee. A detailed report was being presented the Governing Body part 2 meeting in private in September.

In light of the slow progress in terms of improving the performance for CHC and compliance with the CHC Framework, The Chief Officer has established and chairs a CHC Strategic Board. The first meeting took place on 15th October and will meet every 2 weeks initially. There is a clear action plan which is being further reviewed to 'theme' the recommendations. The Strategic Board is clear about making improvements in the short term and that the future model will be determined via the ICS work led by the Directors of Quality/Chief Nurses. Most other Cheshire & Mersey CCGs have 'in-housed' their service, this means that there will be much work to do to implement the new model in 'Place'.

2.8 Integrated Care System (ICS) / Integrated Care Partnership (ICP) Quality Development:

The C&M Chief Nurses/Directors of Quality group continues to work on developing the new structure for the ICS and at Place. In recent weeks this has been focused on ensuring the correct links are made to the Transition work led by the Accountable Officers, particularly with the Quality and Governance work

2.9 Complaints Update: A complaints improvement plan has been developed, which is implemented by the Complaints Task and Finish Group. The action plan is monitored by the Complaints Oversight Group, on a monthly basis, with exception reporting to JQPC. The action plan now includes the collection and reporting of compliments. Staffs have been asked to forward any compliments to the complaints team for recording and inclusion in the monthly complaints report. Niche have returned to the CCG in October 2021, to follow up on the improvement work, the outcome of the re-visit is yet to be received.

2.10 Cheshire and Merseyside Maternity Escalation and Divert Policy: The policy was reviewed at the C&M Maternity Escalation & Divert Policy Task & Finish Group. With representation from NHSE/I Nursing & Quality, NHSE/I Emergency preparedness and resilience and response (EPRR), CCGs, Local Maternity System (LMS), Maternity Providers & NWAS. Agreement was achieved on the updated policy, which was published and took effect from 01 September 2021.

The policy supports improved communication across the system, to ensure the safe transfer of pregnant women between maternity providers. The CCGs serious incident policy has been updated to reflect the changes which was submitted to JQPC in September for approval.

2.11 National Patient Safety Alert (NPSA):

7 alerts have been received in month with dissemination as appropriate. Detail has been reported to Joint Quality and Performance Committee.

2.12 Mersey Care NHS Foundation Trust (MCFT)

Following the acquisition of Northwest Boroughs Healthcare (NWBH) on 1st June 2021 and to support the Trust in their reporting and assurance processes (reduce bureaucracy and duplication) it has been agreed to establish a single CQPG for the Trust that will oversee quality within all of the divisions of MCFT. The first single CQPG took place on 23rd September, led by Liverpool CCG (LCCG) and with support and in collaboration with other CCGs (Southport & Formby, South Sefton, Knowsley, Halton, St Helens). A follow up meeting took place on 19th October. NHS EI C&M have requested that the CCGs agree the level of surveillance for the Trust. For any trust that acquires new services, there are potential risks to the quality and safety of delivery of services. In light of this the Trust will be put in a period of enhanced surveillance with patient and staff experience metrics in place to elicit any deterioration.

The first single Commissioning Collaborative took place on 7th October, where principles of escalation to CQPG were established and agenda items discussed. A monthly quality catchup/agenda setting meeting has been established with CCGs and the Trust to improve communication and agree a structured process for papers and to work through actions outside of formal meetings. The aim is to also establish one Serious Incident Panel for MCFT from October 2021 as a precursor to what will be needed from April 2022. There will need to be reference to 'Place' as well as permitting an overall view of the Trusts Serious Incidents.

2.13 Liverpool University Hospitals NHS Foundation Trust (LUHFT)

- **IP&C Update:** The numbers of nosocomial nosocomial infections (COVID) across all providers has reduced. LUHFT reporting a total of 6; 1 in July, 5 in August. The trust has undertaken a full review to determine the original source, to reduce the risk of further spread. All persons infected were isolation and contacts identified. Action plans have been developed where appropriate. All outbreaks continue to be reported to NHSEI. IPC monitoring continues, to ensure all staff adhere to national guidance for PPE and visiting.

- **CQC Update:** In late August the Care Quality Commission (CQC) issued a Section 31 Notice to LUHFT imposing conditions on LUHFT's registration as a service provider in respect of regulated activities within the Emergency Departments (EDs) at LUHFT pertaining to the following:
  i. Ensure effective local oversight, timely provision of safe care and treatment and management of risk;
  ii. Ensure effective oversight from senior management of performance and risk management in the emergency departments;
  iii. iEnsure effective medical and surgical in-reach is monitored appropriately and audited weekly;
  iv. Ensure ICE referrals and times of service user review are monitored appropriately;
  v. Ensure there is a reduction in delays in assessment and treatment from initial triage so that service users receive timely and appropriate care and treatment based on both clinical need and national performance standards.
  vi. Proactively manage and respond to immediate risks in relation to patient access and flow through the emergency department including any audits and monitoring data.

The Trust were required to submit an action plan by the 14th September outlining their response to address the issues.

There have been changes to the Executive team. There are interim individuals in the Chief Executive, Medical Director and Chief Nurse posts whilst recruitment to the substantive posts takes place.

A follow up single item quality surveillance group (SIQSG) meeting took place on 21st September, with a pre-meet one week before. At this meeting, the Trust presented their response to the issues which the SIQSG had oversight of, which included the S31 Conditions letter. The interim Chief

Executive outlined a road map to improvement that would define how the Trust would become a high reliability organisation and ensure a strong safety culture. The roadmap would prioritise 5 domains:

- Governance
- Workforce and Training
- Integrated Clinical Services and Organisational Development
- Safety & Patient Flow
- Digital

The main outcome of this SIQSG was the agreement that the SIQSG would become a single improvement place to address concerns, monitored through a System Improvement Board. This process permits access to resources both financial and other to make improvements. The first meeting will take place in November.

- **Never Events:** On 14th October a Serious Incident Panel took place to review the 4 Never Events which took place in February, April and June to determine themes and trends and understand how they related to the themes and trends from the previous Review of the previous Never Events. There was a huge amount of congruence. The Panel elicited that there had been a lack of embedding of previous reforms and actions to identified issues from the previous plan and that there is much work to do to improve the safety culture in the Trust, including the psychological safety of staff. The outcomes from the Panel will be outlined to the Trust in a feedback letter, the new actions will be incorporated into the current action plan and progressed via the regular meeting s between the CCG and the Trust. Assurance will be provided to the monthly CQPG and the System Improvement Board once formally established.

- **Quality Performance:** A number of poor performance quality metrics were discussed at the August CQPG relating to: multi resistant staphylococcus aureus (MRSA), venous thrombo-embolism (VTE), malnutritional universal screening tool (MUST), falls and discharge communications. It was agreed that going forward the Trust will submit a recovery plan against these metrics which will be formally monitored on a monthly basis through CQPG until commissioners are assured.

- **Gastroenterology serious incident update:** Currently there are around 470 patients who have been deemed as needing an urgent face-to-face follow up. All of whom have now been seen with no further harms identified. To address capacity issues the executive team has approved additional insourcing of both clinics and endoscopy from an external company. Due to capacity issues within that company, this is scheduled to start first week of September 2021.

2.14 Liverpool Women's Hospital NHs Foundation Trust (Liverpool Women's)

- Significant recruitment is underway into consultant and midwifery posts. Assurance has been sought at the CQRM to ensure all staff have a robust induction programme, including preceptorship top support retention.

- The trust non-compliance with submission of the 52-week harm reviews as part of the cancer pathway has been raised at the CQRM. The trust has agreed that they would work with the CCG to review the process to enable this to happen going forward.

- As part of the new inspection arrangements with CQC, CQC have requested completion of a new proforma and evidence to be submitted by the 24th September 2021. Once reviewed a discussion will take place with the trust, following which they will receive a letter informing them of the outcome, and what will be required.

- The new pathway for the screening and administration of BCG vaccine for neonates within the first 5 -7 days of life, is anticipated to have a significant impact on the trust. The trust is currently working on a process to support adherence to the national programme, as several babies will need to be followed up at 4 weeks of age to enable vaccination. The trust will need to recruit to staff to support the national Public Health England (PHE) programme.

2.15 Alder Hey Children's Hospital NHS Foundation Trust (Alder Hey)

- **Never Events:** The final external report on the trust Never Event improvement work, is yet to be received by the trust from the external provider. The CCGs have requested an update at the October CCQRM on the improvement work irrespective of the external report being received.

- **Waiting Lists – Lost to Follow Up:** The root cause analysis (RCA) report has been reviewed at the Liverpool CCG serious incident (SI) panel and closed. There was one case of low harm and no serious harm having occurred for the whole cohort of patients. Liverpool CCG have stepped down from attending the trust meetings. No further meetings are planned to take place with Liverpool CCG, NHS E/I and the trust. An update on progress is scheduled to be presented at the November CCQRM.

- **AED Waiting Times:** As part of appropriate triage due and to reduce waiting times in AED, the trust is supporting additional measures. These include the presence of a health visitor, paediatrician and a pharmacist in the AED. Where appropriate appointments are allocated for review by a relevant health professional.

2.16 British Pregnancy Advisory Service (BPAS)

BPAS was served a Section 31 notice under the Health and Social Care Act on 6th August 2021. Notifying them of the decision to impose restrictions on the registration in respect of the activity that they provide including: Termination of pregnancy's, Family planning services, treatment of disease and disorder injury, surgical procedures, and diagnostic and screening procedures.

The notice applied to services across: Doncaster, Merseyside and Middlesbrough. The Deputy Director of Nursing at Halton and Warrington CCGs, is liaising across with all areas to discuss the best way to monitor the plan, seek assurance and to reduce any duplication.

Subsequently Halton and Warrington CCGs, as the lead commissioner have met with the provider. A CQC action plan has been developed, although there exist some concerns as to the limited evidence of the immediacy within the plan. This has been feedback to the provider.

Alongside the provider improvement, BPAS has a matron based in each of the settings to: support staff, review clinical practice, undertake daily audits of identified issues while the improvement work is underway.

2.17 Primary Care: The CCG has responded to complaints for two GP practices in relation to inadequate GP cover and clinical oversight. Meetings have taken place with the providers with the support of the Quality team. Reassurance was provided in terms of the actions being taken which includes recruitment to clinical posts. JQPC are fully sighted on the concerns and mitigation in place. Actions will be monitored by the CCG.

3. Recommendations

Governing Body members are asked to note the update as set out.

Jane Lunt
Chief Nurse
November 2021.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
NOVEMBER 2021

Agenda Item: 21/149	**Author of the Paper:** Jo Roberts Accountability Manager for Equality and Contract Administration jo.roberts10@nhs.net	**Clinical Lead:** N/A
Report date: November 2021		

Title: COVID-19 Equality Briefing Version 15

Summary/Key Issues:

The attached report is an updated version of the COVID-19 Equality Briefing; version 15.

As with previous communications the Equality Briefing is a live document which will continue to be updated. Changes since the last version evident by yellow highlight.

Recommendation

The Governing Body is asked to receive this report.

Receive	X
Approve	
Ratify	

Links to Corporate Objectives 2021/22 *(x those that apply)*	
X	To implement Sefton2gether and realise the vision and ambition of the refreshed Health and Wellbeing Strategy.
X	To drive quality improvement, performance and assurance across the CCG's portfolio.
	To ensure delivery of the CCG's financial plan and align it with Sefton2gether and the work plan of transformation programmes
	To support primary care development ensuring robust and resilient general practice services and the development of Primary Care Networks (PCNs).
	To progress the changes for an effective borough model of place planning and delivery and support the ICS development.

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

Merseyside CCG Equality and Inclusion Service

COVID-19 Equality Briefing

Briefing Date :	**Author of the Paper:**
Version (3): 30th March 2020 Version (4): 20th April 2020 Version (5): 14th May 2020 Version (6): 2nd June 2020 Version (7): 8th July 2020 Version (8): 10th August 2020 Version (9): 24th September 2020 Version (10): 6th November 2020 Version (11): 15th December 2020 Version (12): 5th February 2021 Version (13): 12th April 2021 Version (14): 22nd July 2021 **This Version (15):** 7th October 2021 *Changes since the last version in yellow highlight*	Andy Woods Senior Governance Manager Merseyside CCGs Equality and Inclusion Service Email: Andrew.Woods3@nhs.net Jo Roberts Merseyside CCGs Equality and Inclusion Service Manager Email: Jo.Roberts10@nhs.net
Title: COVID-19 Equality Briefing	

Background	The outbreak of COVID-19 in the UK has meant that the NHS has been operating under unprecedented emergency measures. As organisations try to recover care backlogs they are faced with increasing demand for urgent and emergency care and a rise in the number of infection rates of COVID-19. The NHS is operating with significant capacity constraints due to continuing infection, prevention and control measures and also staffing level pressures. COVID-19 booster vaccinations, alongside the routine annual influenza programme, a warning of a surge in respiratory virus affecting babies and toddlers, further variants and surges in COVID-19 cases and winter planning are all set to significantly challenge the NHS in coming months. Throughout the COVID-19 pandemic the Merseyside CCGs Equality and Inclusion Service has highlighted that all response, reset and recovery plans must consider the impact on people and develop mitigating actions, prior to making decisions to act or risk further disadvantage and poorer outcomes. The Equality Act 2010 is a statutory act. Public Sector Equality Duty (known as the 'equality duty' or 'PSED') remains active. This means all service changes, even in emergency circumstances such as responding to COVID-19 and recovery planning, must still be given 'due regard' to the objectives of: • Eliminating discrimination, harassment and victimisation • Advancing equality of opportunity • Fostering good relations between different protected characteristics. There continues to be a legal requirement for NHS organisations to publicly make available equality analysis reports on how 'due regard to PSED' was made when changing services.

	NHS Commissioners and Service Providers are still required to comply with legislation that covers: Equality, Human Rights, Duty of Care, Health and Safety and Employment. This document presents system-wide equality and health inequality considerations for Commissioners, Providers and other organisations that operate in collaboration with NHS organisations.
Barriers for People with Protected Characteristics and mitigations	The enclosed differential table provides NHS Commissioners and Service Providers with equality considerations to incorporate in their response and recovery and vaccination programme plans. Mitigations have been provided along with further recommended actions for NHS organisations. Further equality related publications are available in Appendix 1.
Key Issues	• Prompt decision making without fully considering equality impacts. • Disproportionate impact of COVID-19 on particular groups and health inequalities widening. • Changes to service provision. • Accessible Communications to meet information and communication needs for people with a disability or sensory loss on latest COVID-19 guidance, vaccine information and changes to services. • The need for local targeted campaigns and information giving; for those at risk (broader than the national highest risk groups) on key information across protected characteristic and other vulnerable groups.
Recommendations	1. Review this Equality specific brief alongside local and national guidance. 2. Distribute COVID-19 Equality Brief to all relevant teams across organisation and wider system partners where appropriate. 3. Providers and CCGs to ensure that when they are reviewing services they develop existing internal documentation to evidence Public Sector Equality Duty 'Due Regard'. PSED is still active. 4. CCGs, Providers and wider system partners to ensure that Organisation Boards are sighted on the latest version of the Equality Briefing and all associated appendices. 5. CCGs and Providers to continue to seek assurance of service provision from interpreter agencies (language and BSL). 6. Ensure communications are inclusive, timely and informative (in terms of appointment time, location, PPE requirements etc.). 7. Develop targeted campaigns, engagement and communications with vulnerable people and communities who are in high priority need e.g. Black, Asian and Minority Ethnic communities, and people living in deprived areas. 8. Ensure patient data of COVID-19 cases and deaths are recorded by protected characteristic e.g. ethnicity and disability in addition to the standard age and sex characteristics. Data should be monitored locally so that the intelligence can be used to inform targeted engagement. 9. Ensure workforce risk assessments are updated in line with National recommendations around Black, Asian and Minority Ethnic staff. 10. Commissioners and Providers to work collaboratively on Equality, Quality and health inequality considerations for response and recovery plans. Access advice and support from Provider Equality Leads and Merseyside CCGs Equality and Inclusion Service. 11. Commissioners and Providers to be cognisant of Human Resources (HR) implications in relation to Staff Risk Assessments, supporting staff, processes for raising concerns, use of Freedom to Speak Up

	Guardians etc. This also applies to the COVID-19 further waves and updated shielding guidance and the possibility that some staff may need to return to shielding. Link to latest guidance available in Appendix 1. 12. Ensure Commissioners and Providers continue to promote access to learning from emerging evidence and best practice. Continue to engage with local regional and national shared learning opportunities to identify best practice. Refer to Appendix 2. 13. Review internal Standard Operating Procedures for video consultations to ensure patients and staff enter and leave video consultations safely. Refer to Appendix 3. 14. Ensure equality considerations are incorporated into outbreak management plans.

Protected Characteristic	Issue	Remedy/ Mitigation	Recommended Actions
Age	**Over 65** Access to services and treatment. Human Rights Article 2 would relate to rationing of services and the ethical decision making in who receives recourses in life/death situations.	The challenge for local health commissioners and services during further waves of COVID-19 is to ***develop a consistent approach, based on an understanding and communication of risk on a case-by-case basis*** and to avoid a discriminatory approach. “In-Hospital” cell structure in place to review capacity. Escalation procedures in place. Mutual aid in place across the system. Refer to Publications approval reference: 001559 Maintaining standards and quality of care in pressurised circumstances https://www.england.nhs.uk/coronavirus/publication/maintaining-standards-pressurised-circumstances/ and BMA ethical issues guidance note: https://www.bma.org.uk/advice-and-support/covid-19/ethics/covid-19-ethical-issues and refer to NICE guidance: https://www.nice.org.uk/covid-19 and refer to NICE Guidance: COVID-19 rapid guideline: critical care in adults https://www.nice.org.uk/guidance/ng159 *Note this guidance was updated on 29th April 2020 to stating that the Clinical Frailty Scale should be used as part of a holistic*	Ensure processes are in place to communicate guidance with clinical staff and ensure methods auditable.

		assessment, but should not be used for younger people, people with stable long-term disabilities, learning disabilities or autism.	
	All Ages: Particular cohorts of people have been more significantly impacted on by COVID-19. A number of people may be hesitant to have the vaccine.	Every adult in UK has been offered COVID-19 vaccine.	Target specific groups where vaccine uptake is low. Resources available in appendix 1.
	All Ages: JCVI advises that for the 2021 COVID-19 booster vaccine programme individuals who received vaccination in Phase 1 of the COVID-19 vaccination programme (priority groups 1 to 9) should be offered a third dose COVID-19 booster vaccine.	This includes: • those living in residential care homes for older adults • all adults aged 50 years or over • frontline health and social care workers • all those aged 16 to 49 years with underlying health conditions that put them at higher risk of severe COVID-19 (as set out in the green book), and adult carers • adult household contacts of immunosuppressed individuals"	Ensure colleagues are sighted on NHS England Letter in Appendix A dated 15.09.2021 Ongoing follow up of staff and patients who have not had first or both doses.
	All Ages: media publications urging doctors to look for signs of stroke following AstraZeneca vaccines.		Ongoing monitoring of patient presentations following vaccine administration.
	All Ages Digital Inclusion – people who are digitally and socially excluded cannot access online services like health advice or services	Ensure people who do not have access to digital platforms are not disadvantaged by offering alternative communication or consultation methods.	
	All Ages New coronavirus variants have emerged sparking fears that		Ongoing monitoring of compliance with Infection, Prevention and Control (IPC).

	they may be more transmissible, more severe, or evade immunity acquired by prior infection or vaccines.		Continue to deliver IPC messages to workforce and public. Work with local Deaf organisations to ensure any BSL videos are shared through networks.
	All Ages: Vaccination programme planning; influenza and COVID-19 booster vaccinations	Public Health Guidance published on influenza vaccinations for 2021. Refer to appendix 1.	
	All Ages: People who have had two doses of COVID-19 vaccination may test positive for COVID-19. (NB also working age)	National data awaited. NHS Patients, staff and visitors must continue to wear face coverings in healthcare settings	Ongoing monitoring of workforce capacity.
	All Ages: While the majority of children and young people are not severely affected by COVID, ONS data has shown that 7.4% of children aged 2-11 and 8.2% of those aged 12-16 report continued symptoms. NHSE advise that estimates suggest that 340,000 people may need support for the condition including 68,000 who will need rehab or other specialist treatment.	Specialist long COVID services set up.	
	All Ages:	NHSE recommends that patients using	Clinicians to continue to remain vigilant for

	MHRA has detailed the factors affecting the accuracy of pulse oximeters, including skin colour, movement, nail polish, henna dye, and tattoos.	COVID Oximetry@home record a baseline oxygen saturation, and subsequent changes are compared with this baseline.	other signs of deterioration. Guidance available in Appendix 1.
	All Ages NICE reports that ongoing symptoms of COVID-19 may be more likely to be reported in older people. However, there seem to be different clusters of symptoms in people of different ages which means that there could be different presentations for children and younger people and adults compared with people aged over 65.	Funding is currently in place for the NHSE commissioned long COVID service until 31st March 2022. NHSE will continue to fund pulmonary rehabilitation and psychology for the pathway beyond this date.	Commissioners and providers to work collaboratively on developing and implementing local COVID-19 service.
	All Ages Regulations were approved by Parliament on 22 July 2021 to make vaccination a condition of deployment for staff working in CQC-regulated care homes in England, unless they have a medical exemption. There could be an implication on workforce resource in care homes if staff to not take up the vaccine.	A 16-week grace period was put in place to ensure staff who haven't been vaccinated could take up the vaccine before the regulations come into force on 11 November 2021. Care home workers who are exempt will need to sign the form attached to this letter and give this to their employer as proof of their temporary exemption status. This temporary self-certification process has been introduced for a short period prior to the launch of the new NHS COVID Pass system which will go live imminently. Once the NHS COVID Pass system is launched, care home workers will need to apply for a	Ongoing monitoring of resource implications by Care Home cell.

		formal medical exemption through that process.	
	Vulnerable People – All Ages Vulnerable people (broader than Government list) being made aware of specific services available to them via targeted campaigns.	Ensure Communications/ Engagement Teams access national and local information sources. https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19 https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people	CCGs and Providers to work collaboratively with networks e.g. Voluntary Organisations, Local Authority, Police, Fire Service, Healthwatch etc. to ensure communications are shared with communities. CCGs to ensure there is ongoing engagement and inclusive communication with communities.
	Vulnerable People – All Ages Potentially missed opportunities to identify Safeguarding issues as services move from face to face to virtual appointments.	Resources shared by local Safeguarding Boards.	Service Providers to review processes to support identification of safeguarding issues. Review internal standard operating procedures for video consultations. Example SOPs available in Appendix 3.
	People living in Care Homes/ Other Housing COVID-19 poses a higher risk to populations that live in close proximity to each other.	Commissioners to ensure that national and local information is shared with Care Home colleagues. All older residents in eligible care homes in England have been offered a COVID vaccine	Commissioners and Providers to ensure that collaborative work is ongoing with Local Authority, Care Quality Commission (CQC) and Care Home colleagues to monitor and review capacity and share information with relevant parties and continue to promote vaccine uptake.
	Working Age	NHS Employers has now provided	CCGs and Providers to review

	Groups disproportionally impacted upon by COVID-19	guidance and support to employers on creating proactive approaches to risk assessment for staff, including physical and mental health https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/risk-assessments-for-staff	organisational process which supports staff to raise concerns. CCGs and Providers to ensure communication is shared across staff networks. Review resources available in Appendix 1.
	Carers	NHSE & I: Resources and actions to support NHS employees with caring responsibilities. Refer to resources in appendix 1.	
	Worklessness; people who have been furloughed experiencing poor mental health	Ensure services are accessible.	Review resources available in Appendix 1.
	Working Age People who have been shielding may experience difficulty returning to work and may not feel supported.		Review support offer to staff who have been shielding and returning to work.
	Age 18-40 JCVI guidance states 'in addition to those aged under 30, unvaccinated adults aged 30 - 39 years who are not in a clinical priority group at higher risk of severe COVID-19 disease, should be preferentially offered an alternative to the AstraZeneca COVID-19 vaccine, where possible and only where no substantial delay or barrier in access to vaccination would	All those who have received a first dose of the AstraZeneca vaccine should continue to be offered a second dose of AstraZeneca vaccine, irrespective of age unless Patients who have experienced major venous and/or arterial thrombosis occurring with thrombocytopenia following vaccination with any COVID-19 vaccine should not receive a second dose of COVID-19 Vaccine AstraZeneca.	Monitor changes to green book as appropriate. https://www.gov.uk/government/publications/covid-19-the-green-book-chapter-14a

	arise.		
	Age within 3 months of 18th birthday Existing local COVID-19 vaccination delivery models can be used for the vaccination of children who are within three months of their 18th birthday	Refer to NHS England Letter dated 22.07.2021 in Appendix 1.	
	Age 16+ National monitoring of data on vaccine effectiveness and impact indicates lower protection in vaccinated adults who are immunosuppressed.	The Joint Committee on Vaccination and Immunisation (JCVI) has recently advised that adult (aged 16 years or over) household contacts of adults with severe immunosuppression should be offered the COVID-19 vaccination alongside priority group 6	Identify adult (aged 16 years or over) household contacts of adults with severe immunosuppression to offer them the COVID-19 vaccination alongside priority group 6.
	Age 16 and 17 JCVI advises that all 16–17-year olds should be offered a first dose of Pfizer-BNT162b2 vaccine.		Commissioners and providers to respond as appropriate when further information is received on whether second doses will be offered to this particular cohort.
	Age 16 to 18 The AstraZeneca (AZ) vaccine is not licensed for use in those under the age of 18.	This guidance is also in line with the 13 February 2021 letter which describes that Pfizer is the vaccine of choice for clinically extremely vulnerable young people aged 16-17 years old.	Should any young staff members or volunteers (aged 16-17) present to a vaccination centre for vaccination, they should be referred to their GP or local hospital hub where they can access the Pfizer vaccine which is authorised for this age group. If the Pfizer vaccine is unavailable, JCVI have recommended that the AZ vaccine can be used as an alternative in those aged 16-17 years. This is outside the license and must therefore be done under a PSD (by a medical prescriber) and cannot be done under a PGD or National Protocol.
	Age 12 to 15		Children and young people aged 12 years

	All children aged 12 to 15 will be offered a 1st dose of a COVID-19 vaccine.	Refer to NHS Letter dated 05.08.2021 and 22.07.2021 in Appendix 1.	and over with specific underlying health conditions that put them at risk of serious COVID-19 and Children and young people aged 12 years and over who are household contacts of persons (adults or children) who are immunosuppressed.
	Children and Young People Digital divide: not all have access to the internet or laptops to access health care advice/ other services online.	Resources available in Appendix 1.	Ensure services are accessible via telephone.
	Children and Young People Increase in the number of mental health admissions for people with Eating Disorders.		CCGs and Providers to ensure that service information is shared with Local Authorities for onward circulation to schools / wider community groups.
	Children and Young People Increase across some geographical areas in Merseyside of an increase in the number of referrals for ADHD and ASD.	Providers and Commissioners currently monitoring.	
	Children and Young People Negative impact on Children and Young People's mental and physical health		CCGs and Providers to continue to monitor activity and direct link to COVID-19; e.g. service reduction, isolation etc. Providers to review individual patient support needs for access to services. CCGs and Providers to communicate resources available.
	Children and Young People Concerns that parents and carers of children and young		Organisations to share Alder Hey Children's Hospital NHS FT press release: https://alderhey.nhs.uk/contact-

	people with 'red flag' symptoms may not seek appropriate care during the pandemic.		us/press-office/latest-news/alder-hey-warn-ignoring-red-flag-symptoms
	Babies and toddlers Government alert over surge in respiratory virus affecting babies and toddlers	Local providers already preparing.	
Disability	**All** Impact of COVID-19 on people with disabilities and access to services. Concerns that people with learning disabilities and children and young people with SEND will not get equal access to treatment. Human Rights Article 2 would relate to rationing of services and the ethical decision making in who receives recourses in life/death situations.	The challenge for local health commissioners and services during further waves of COVID-19 is to ***develop a consistent approach, based on an understanding and communication of risk on a case-by-case basis*** and to avoid a discriminatory approach. "In-Hospital" cell structure in place to review capacity. Escalation procedures in place. Mutual aid in place across the system. Refer to Publications approval reference: 001559 Maintaining standards and quality of care in pressurised circumstances https://www.england.nhs.uk/coronavirus/publication/maintaining-standards-pressurised-circumstances/ and BMA ethical issues guidance note: https://www.bma.org.uk/advice-and-support/covid-19/ethics/covid-19-ethical-issues and refer to NICE guidance: https://www.nice.org.uk/covid-19 and refer to NICE Guidance: COVID-19	Ensure processes are in place to communicate guidance with clinical staff and ensure methods auditable.

		rapid guideline: critical care in adults https://www.nice.org.uk/guidance/ng159 *Note this guidance was updated on 29th April 2020 to stating that the Clinical Frailty Scale should be used as part of a holistic assessment, but should not be used for younger people, people with stable long-term disabilities, learning disabilities or autism.*	
	All Digital Inclusion – people who are digitally and socially excluded cannot access online services like health advice or services.	Ensure people who do not have access to digital platforms are not disadvantaged by offering alternative communication or consultation methods.	
	Carers Impact on people who are Carers of people with dementia and/or learning disabilities and not being able to attend appointments or inpatient visiting.		Assess individual patient needs and support for Carers. Reasonable Adjustments. Refer to latest visiting guidance in Appendix 1.
	Learning Disabilities: People with learning disabilities had higher death rate from COVID-19		Organisations to consider the Public Health report: Deaths of people identified as having learning disabilities with COVID-19 in England in the spring of 2020 in Appendix 1. Organisations to review the reports and guidance specific to Learning Disabilities in Appendix 1.
	Sensory; D/deaf people		

	D/deaf, Deaf blind	Ensure there is access to British Sign Language for D/deaf people	
		Commissioners of BSL interpreter services (CCG and Provider organisations) to collate information on interpreter agency provision, capacity and Business Continuity Plans escalating any potential gaps as appropriate through organisation's internal escalation process.	Commissioners of interpreter services to review contract requirements to ensure any revisions include Quality Standards for Translation and Interpretation services. Commissioners of interpreter services to monitor usage and use intelligence / activity data to share with CCG Equality and Inclusion Service.
	D/deaf people may require additional support to understand national / local guidance on COVID-19 and changes to service and also support to access video consultations.	Consider use of Relay UK (previously Next Generation Text) to support communication with patients. https://www.relayuk.bt.com/	Explore access to video-conferencing facilities available free during COVID-19 to support non Face to Face healthcare appointments via Sign Health. https://www.bslhealthaccess.co.uk/ CCGs to work with IT system suppliers to review General Practice IT kit in the event they do not have access to e-consult. E.g. access to laptops for Skype etc.
		Sign Health continues to publish BSL videos on their website to update D/deaf people on the latest COVID-19 guidelines. https://www.signhealth.org.uk/coronavirus/	CCGs and Providers to work collaboratively with networks e.g. Voluntary Organisations, Deaf Charities, etc. to ensure communications are shared with communities.
		Sign Health has produced BSL videos providing patient information on the COVID-19 vaccination programme. https://signhealth.org.uk/resources/coronavi	CCGs and Providers to ensure they respond to any recommendations from Healthwatch surveys undertaken during COVID-19 on patient access/ experience

		rus/	etc. CCG Equality and Inclusion Service to work with Healthwatch colleagues to identify/ support any gaps in feedback from specific communities.
		Resources available in Appendix 1.	CCGs to ensure there is ongoing engagement and inclusive communication with communities.
	D/deaf; barriers experienced following the introduction of face masks/ coverings when D/deaf people use lip reading.	NHS National Team have advised that the national PPE team is undertaking a market assessment of transparent face masks and coverings and that there are a number of products that may in time demonstrate regulatory requirements of face masks. Supplier due diligence is being undertaken to review testing certification and to understand the manufacturing capabilities of those suppliers.	Liaise with Procurement colleagues with a view to sourcing approved transparent face coverings for use in appropriate setting. Providers to continue to liaise with their procurement colleagues and infection prevention and control team colleagues to mitigate the issue.
	Access to CE marked transparent face masks for use in clinical settings.	A number of local trusts are participating in a national pilot to test transparent face masks for use in healthcare settings.	
	Sensory; Visual Impairments People with visual impairments may require additional support to understand national / local guidance on COVID-19 and changes to service.	Ensure Communications/ Engagement Teams access national and local information sources: RNIB: https://www.rnib.org.uk/campaigning/priority-campaigns/accessible-health-information/coronavirus-and-accessible-online-information RNIB	CCGs and Providers to work collaboratively with networks e.g. Voluntary Organisations, Sight Charities, etc. to ensure communications are shared with communities. CCGs and Providers to ensure they respond to any recommendations from Healthwatch surveys undertaken during COVID-19 on patient access/ experience etc.

		https://www.rnib.org.uk/news/campaigning/accessible-covid-19-information Public Health England: (Audio, Large Print) https://campaignresources.phe.gov.uk/resources/campaigns/101-coronavirus-/resources Guidance is now available in easy read and in a range of community languages see https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance All NHS organisations to review accessibility tools on websites	CCG Equality and Inclusion Service to work with Healthwatch colleagues to identify/ support any gaps in feedback from specific communities.
	Disability: Workforce	NHS Employers has now provided guidance and support to employers on creating proactive approaches to risk assessment for staff, including physical and mental health https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/risk-assessments-for-staff	Providers to review progress against Workforce Equality Action Plans.
	Neurodiversity, Learning Disabilities, low levels of literacy People with neurodiversity or learning disabilities may require additional support to understand national / local guidance on COVID-19 and changes to service.	Ensure Communications/ Engagement Teams access national and local information sources: https://www.mencap.org.uk/advice-and-support/health/coronavirus-covid-19	Ensure monitoring arrangements in place for Care Plans and personalised care. CCGs and Providers to ensure compliance with Accessible Information Standard; e.g. information available in easy read. CCGs to ensure resources are shared with General Practice colleagues to share with families who may need additional support.

	Difficulty reported by people using NHS 111 online services. Anxiety amongst people with Learning Disabilities following the introduction of face masks/ coverings and the public not necessarily understanding that there are groups of people exempt from wearing them.	 A number of local trusts are participating in a national pilot to test transparent face masks for use in healthcare settings.	CCGs to seek assurance from NHS 111 service provider on mitigations in place to support people who have difficulty using the online function. CCGs and Providers to ensure exemptions are communicated.
	Disability: Children	Ensure parents/ carers/ guardians are involved in any changes to care plans.	Ensure monitoring arrangements in place for Care Plans and personalised care. CCGs and Providers to ensure compliance with Accessible Information Standard; e.g. information available in easy read. CCGs to ensure resources are shared with General Practice colleagues to share with families who may need additional support.
	Cancer People undergoing cancer treatment may need support to understand any changes to treatment plans.	https://www.macmillan.org.uk/coronavirus/cancer-and-coronavirus	Continue to keep patients informed of any changes to service delivery.
	Mental Health: All Redeployment of other care professionals to respond to coronavirus during further waves will help save lives. But it also risks leaving already vulnerable older people and	Organisations to link with Equality Leads, Organisation Development (OD) colleagues for access to local and national support agencies for both staff and patients. https://www.gov.uk/government/publications/covid-19-guidance-for-the-public-on-	Review and share resources available in Appendix 1.

	those living with mental health conditions exposed. The impact of COVID-19 is likely to increase demand for mental health services e.g. PTSD frontline staff, bereavement, Black, Asian and Minority Ethnic, domestic violence, isolation etc.	mental-health-and-wellbeing/guidance-for-the-public-on-the-mental-health-and-wellbeing-aspects-of-coronavirus-covid-19 https://www.mind.org.uk/information-support/coronavirus-and-your-wellbeing/ https://www.mentalhealth.org.uk/coronavirus	
*Race (in the context of Equality legislation)	**People whose first language is not English** may need support to understand national/ local guidance and service changes and support to access services.	Commissioners of language interpreter services (CCG and Provider organisations) to collate information on interpreter agency provision, capacity and Business Continuity Plans escalating any potential gaps as appropriate through organisation's internal escalation process. Commissioners of language interpreter services (CCG and Provider organisations) to identify if interpreter agencies provider Video provision. Ensure Communications/ Engagement Teams access national and local information sources: https://www.doctorsoftheworld.org.uk/coronavirus-information/# Guidance is now available in easy read and in a range of community languages see https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance	Commissioners of interpreter services to review contract requirements to ensure any revisions include Quality Standards for Translation and Interpretation services. Commissioners of interpreter services to monitor usage and use intelligence / activity data to share with CCG Equality and Inclusion Service. Explore access to video-conferencing facilities. CCGs and Providers to work collaboratively with networks e.g. Voluntary Organisations, Black, Asian and Minority Ethnic Community Development Projects, etc. to ensure communications are shared with communities. CCGs and Providers to ensure they respond to any recommendations from Healthwatch surveys undertaken during COVID-19 on patient access/ experience

		Ensure organisations connect with BME CDW Projects where appropriate to support any targeted communications. **Liverpool**: Liverpool Community Development Service (LCDS) http://psspeople.com/whats-happening/news/introducing-liverpool-community-development-services **Sefton**: Sefton CVS https://seftoncvs.org.uk/projects/bme/ **Halton, St Helens and Knowsley**: SHAP Ltd http://www.shap.org.uk/housing-support/knowsley/bme-community-development-service/ Ensure organisations can signpost people to Migrant Help. https://www.migranthelpuk.org/contact	etc. CCG Equality and Inclusion Service to work with Healthwatch colleagues to identify/ support any gaps in feedback from specific communities.
	Increase in the number of poor quality calls during virtual appointments using interpreter services.		CCGs and Providers to monitor relevant agencies against contract requirements.
	Gypsy and Romany Travellers Largely mobile populations and populations with lower literacy are more likely to miss	Further support is available through Irish Community Care http://iccm.org.uk/contact/	Organisations to ensure communication is effective and clear, through trusted organisations and individuals, in a culturally appropriate and sensitive way.

	accurate public health messages.		
	Black, Asian and Minority Ethnic: All Known conditions with poorer outcomes e.g.; Sickle cell anaemia, cardiovascular disease, hypertension, diabetes, maternal deaths, and infant deaths. Known historic barriers in relation to accessing medical services.	Refer to resources in Appendix 1.	Organisations to ensure communication is effective and clear, through trusted organisations and individuals. Organisations to ensure that services are accessible and support patients to navigate services and support from other agencies.
	Black, Asian and Minority Ethnic: All Scientific Advisory Group for Emergencies (Sage) have raised concerns over COVID-19 vaccine uptake among black, Asian and minority ethnic communities as research showed up to 72% of black people said they were unlikely to have the jab.		Develop targeted communications and offer health professional advice. Refer to resources in Appendix 1.
	Black, Asian and Minority Ethnic; Workforce Black, Asian and Minority Ethnic people disproportionally impacted upon by COVID-19. Refer to statistical reviews available in Appendix 1. Black, Asian and Minority Ethnic people are less likely to have career development opportunities, lack of progression, differential	NHS Employers has now provided guidance and support to employers on creating proactive approaches to risk assessment for Black, Asian and Minority Ethnic staff, including physical and mental health https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/risk-assessments-for-staff	CCG and Providers to amend staff risk assessment templates to include Black, Asian and Minority Ethnic and concerns on physical and mental health. CCGs and Providers to review organisational process which supports staff to raise concerns. CCGs and Providers to ensure communication is shared across staff networks.

	attainment, increased referrals to disciplinary processes and pay gap inequalities. **Black, Asian and Minority Ethnic; Patients** Black, Asian and Minority Ethnic people disproportionally impacted upon by COVID-19. Refer to statistical reviews available in Appendix 1. Prevalence of particular medical conditions in Black, Asian and Minority Ethnic population and perceived barriers in accessing healthcare services.		Commissioners and Providers to review progress updates on Workforce Equality Action Plans in response to Workforce Race Equality Standard, 6 inclusive recruitment actions and actions to reduce race disparity in career progression to below 1.5 CCGs and Providers to ensure their organisation is represented at the Regional Strategic Advisory Board. Ensure the organisation is represented at the Equality Collaborative Workforce Focused Group. Implement national recommendations to support Black, Asian and Minority Ethnic workforce and patients. Review how services are delivered to consider how to meet the needs of particular communities and to support particular groups to access services. E.g. Outreach services.
	South Asian / Indian: COVID-19 crisis in India has had a devastating impact on its people and health care service. This may have		Consider a well-being check with staff as they may be at higher risk of stress, anxiety psychological harm and burnout.

	impacted our South Asian/ Indian colleagues here in the UK. There may potentially be many reasons for this: • Many have friends and family in India who may be directly impacted • hearing harrowing accounts from friends and colleagues in India may impact their well-being • worrying/providing emotional support for friends and family • guilt at not being able to do more • increased risk of financial difficulty due to sending money to friends and family needing urgent medical attention abroad/donating money to hospital/charities • overhearing conversations regarding the crisis in India that may not be done in a sensitive way.		

Religion and Belief	A person's religion or belief may impact treatment options	Refer to information resources in Appendix 1.	Ensure access to religious and spiritual networks, Provider Lead Chaplain or Spiritual Teams.
	A person may have specific religious or spiritual need that they may need you to support them with during the End of Life phase or after death. Current Infection control issues may impact on achieving those needs. Inability for family/ friends to be with a dying person may breach Human Rights Articles 3 and 8.	Guidance relating to issues around death and burial for faith communities https://www.gov.uk/government/publications/covid-19-guidance-for-care-of-the-deceased	Ensure each patient is treated as an individual following local guidance and with support of local infection teams to ensure that where possible religious and spiritual needs are met and undertaken in the safest manner. Providers to work collaboratively with families/ friends.
Pregnancy and Maternity	Pregnant women are considered in the 'vulnerable' group of people at risk of coronavirus.	National Guidelines are available to support service providers in their response to COVID-19. https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/covid-19-virus-infection-and-pregnancy/ NHS Employers has now provided guidance and support to employers on creating proactive approaches to risk assessment for staff, including physical and mental health https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/risk-assessments-for-staff	Ensure pregnant staff and patients are aware of how to access support. Local resource to support pregnant people: https://www.improvingme.org.uk/ Organisations to respond as appropriate to NHSE letter dated 28th September 2021 (available in Appendix 1) regarding pulse oximetry for pregnant women.
	Media publications report that during the first wave of COVID-19 that three-quarters of NHS trusts did not allow	Guidance published for pregnant women. https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/pregnancy-and-coronavirus/	Maternity services to review local policy.

	birth partners to support mothers throughout their whole labour.		
	Media publications report that pregnant women attending scan appointments on their own are not allowed to film baby.		Maternity services to review local policy.
	Media publications report that the COVID-19 vaccine can impact on fertility.		Share Royal College information. Develop targeted communications and link in with local networks to support delivery of communications. Offer individual conversations to discuss fears.
	Fertility Services Storage limit for embryos and gametes Local Commissioning Policy Age criteria to commence cycle/s means that delays in access to services (either for existing or new patients) may impact on patients aged 40-42. NB refer to local policy	The Government has confirmed that the current 10-year storage limit for embryos and gametes will be extended by two years. Individual cases can be discussed between GP, CCG, Service Provider and Individual Funding Request leads.	Service Providers to ensure patients are informed of Government guidelines. Service Provider to consider Age when clinically triaging existing and new appointments.
Sex (M/F)	During periods of confinement domestic abuse (a crime mostly impacting women and girls) tends to increase, and that the health care that offers a way of identifying this issue will be under unprecedented pressure.	National programme and resources available https://www.gov.uk/government/publications/coronavirus-covid-19-and-domestic-abuse/coronavirus-covid-19-support-for-victims-of-domestic-abuse	Ensure any communications provide signposting to Voluntary Organisations and referrals to Safeguarding Team or Human Resources Team as appropriate.

	Privacy and safety issues if consultations are virtual or by video.		Providers to review letter templates to give patient options to rearrange telephone / video-consultation appointments. Review organisation standard operating procedure to ensure consultations start and end safely for staff and patients. E.g. recording devices such as Alexa and Siri types are switched off. Escalation procedures in place in the event a patient chooses to make a disclosure of domestic abuse. Example provider SOPs included in Appendix 3.
	Women are more likely to work in higher risk and low paid key worker roles. https://www.theguardian.com/world/2020/mar/29/low-paid-women-in-uk-at-high-risk-of-coronavirus-exposure	Ensure guidance on self-isolation is followed and Health and Safety procedures.	Ensure organisation response considers actions to improve protection and health and well-being of key workers. Ensure organisation monitors adherence with PPE, Infection Control and procedures to support staff to raise concerns.
	Patients and Staff: Working from home and caring responsibility		Ensure recovery/ reset plans include flexibility options for people working from home with caring responsibilities to support them to access services. Ensure communication lines open for staff, through one to ones, Freedom to Speak Up Guardians etc. to discuss/ address any issues.
	Access to Mental Health services		For Staff: Develop a clear mental health support system ensuring that there are continuous reminders of where support can be found, and this is done in a multifaceted way. Give

			information (form of an email) to each individual employee explaining the system and process and asking for a 'sign off/receipt' in order to show that the employee has received and understood the information. Seek feedback from staff if they are using such services (and if not why not) and what support they would like to see to help them. For Patients: Ensure that mental health resources are shared with staff and patients. – Resources available in Appendix 1.
	COVID-19 vaccination of patients who are HIV positive. It is expected that most patients will be invited for vaccination by their general practitioner, however, a small proportion have declined sharing their HIV status with their GP.		HIV clinics should continue to engage with individuals and encourage and support them to share their HIV status with their GP. If the patient declines, the HIV clinic should facilitate vaccination in accordance with Immunisation Against Infectious Diseases (the Green Book), likely via a local vaccination hospital hub.
Sexual Orientation	Access to key and supportive information Less likely to seek medical attention due to poor experience and discrimination and experience higher levels of health inequality. Privacy issues if virtual or	National information available to support LGB people to access healthcare services. Refer to resources in Appendix 1.	Ensure communications from local LGB community group are distributed. Organisations to link with Equality Leads for access to local and national support agencies for both staff and patients.

	video consultations directly linked to sexual orientation if patient living in home of multiple-occupancy/ shared accommodation.		Assess individual patient needs at the point of contact. Providers to review letter templates to give patient options to rearrange telephone / video-consultation appointments.
Gender Reassignment	Access to key and supportive information Less likely to seek medical attention due to poor experience and discrimination.	National information available to support people who are/ have transitioned to access healthcare services. https://www.stonewall.org.uk/about-us/news/covid-19-%E2%80%93-how-lgbt-inclusive-organisations-can-help	Ensure communications from local and regional Transgender community groups are distributed. Organisations to link with Equality Leads for access to local and national support agencies for both staff and patients.
Marriage and Civil Partnership	**Refer to Mental Health –All** **Refer to Religion and Belief** **Refer to Sex (M/F) Domestic Violence**	Resources available in Appendix 1.	Ensure family members are included in individual care planning as appropriate.
Other	**Health Inequalities and Poverty** Migrant workers who are vulnerable and unable to access public funds.	Resources available in Appendix 1.	Communications and Engagement Teams to ensure information is accessible to all staff with a view to signposting patients. From Migrant Help key info re access to
	People within the criminal justice service and prisons COVID-19 poses a higher risk to populations that live in close proximity to each other. (NHSE commissioned services)	National guidance available for responding to COVID-19 within prison services. Prisoners included in vaccine priority cohort.	Ensure organisation response includes information sharing with those delivering services within prisons. CCGs to liaise with General Practice to ensure people leaving prison are able to access General Practice services.
	Health Inequalities and Poverty E.g. Unhealthy behaviours; smoking, excessive	Resources available in Appendix 1.	CCGs and Providers to work with local communities to support Safeguarding people in poorer communities.

	consumption of alcohol, poor diet and low levels of physical activity. Difficulty reported by networks in engaging with certain communities. Poor diet children Poorer Northern areas more impacted by COVID-19 spikes. People feeling like they still have to go to work due to poverty.		Organisation recovery plans to include the continued communication of information to support people different communities. Review how services are delivered to consider how to meet the needs of particular communities and to support particular groups to access services. E.g. Outreach services. Ensure organisations share any information on local resources/ supplies with Local Authorities for onward communication to schools and community groups. Ensure any health messages on social distancing and risk messages are communicated widely. Communicate resources on local support available for people living in poverty who are experiencing COVID-19 symptoms and share resources on reporting workplace concerns (Appendix 1).
All	**Decision Making** The normal course of action, of writing and submitting Equality Analysis reports (EIAs) to committees, and then acting, may be too slow a process for rapidly changing environments. However, the Courts follow precedent and deviation from the precedent implies risk.	CCGs and Providers have established Governance arrangements in place.	Wherever possible current equality processes around meeting PSED must be maintained , however if this is deemed too impractical in an emergency situation then actions that need to be taken; Use a methodology to record decisions and acknowledge PSED responsibilities. The Courts will understand the 'time crunch/ delivering at pace' to respond quickly to COVID-19, but they will want to see how PSED has been incorporated into that process, even if that process has been temporarily abridged. Refusing to meet

			PSED is not an option. Commissioners and Providers must be cognisant that Equality Impact Assessments are public documents.
	Recovery Planning	Human Rights Any restrictions must be carefully thought through, so that restrictions are rights-respecting rather than breaching the very standards that we all need to maintain our safety and dignity	Review service change log. What dependencies are there to resume service, equality considerations and any mitigation needed. Engage with relevant stakeholders. Applicable to all NHS Organisations including CCGs for General Practice. Ensure staff are treated as an individual if returning to work ensuring local guidance is followed in relation to Health and Safety and local infection prevention and control measures. Continue to work with sub-contractors in relation to Response and Recovery plans. Share best practice across system, e.g. digital inclusion; use of telephone and video consultations between patients and clinicians. Ensure organisation representation at Community Advisory Group (Co-ordinated by Merseyside Police). Ensure ongoing Monitoring of Safeguarding referrals. Ensure Commissioners and Providers continue to promote access to learning from emerging evidence and best practice. Continue to engage with local

			regional and national shared learning opportunities to identify best practice.

Contact Details of a number of support agencies for people with Protected Characteristics or specific disabilities are available from Provider Equality Leads (via Best Practice Guidance for Reasonable Adjustments).

All advice to the public about what to do during the pandemic is issued by Public Health England (PHE) and published at https://www.gov.uk/coronavirus There is also supporting information on https://www.nhs.uk/conditions/coronavirus-covid-19/ This is the only official source of advice.

Local, Regional and National information sources is provided as follows:

200409 Accessible Information about CO

Appendix 1 COVID-19 Equality Related News Articles/ Statistical Reports/ Guidance/ Resources

COVID-19 Equality Specific documents.xl

Appendix 2 Provider Best Practice Examples

COVID-19 Equality Briefing Provider Best

Appendix 3 Provider Standard Operating Procedures for Video Consultations

Appendix 3 Video Consultations.docx

Version	Change Log
1	
2	Additions to barriers matrix
3	*Over 65's added to Age in relation to bed pressures and access to respiratory equipment. *Recommendations updated to include target audience for brief. *Provider Lead Chaplain or Spiritual Teams added to Religion or Belief. *Safeguarding and Human Resources added to mitigations on Sex (M/F) issue relating to domestic abuse. *End of Life Care needs added to Religion or Belief.
4	*Recommendations updated to include: Providers and CCGs to note that the Equality and Human Rights Commission has suspended reporting on specific equality duties for this year. The General Duty is still in force. *Guidance relating to issues around death and burial for faith communities added to Religion or Belief *easy read and community languages government information source added to Disability and Race *Web links added to Age: Vulnerable (All Ages) *Web links added to the end of the barriers matrix to include Public Health England official sources of advice *NHS England collated information sources list embedded at the end of the barriers matrix. *Reference to NICE guidance replaced with national guidance on maintaining quality on Age (Over 65 and disability). *BMA ethical guidance added to Age (Over 65 and disability).
5	*Dates added to Briefing Date to highlight version control. *Equality Legal Duty added to Background section *Reference to recovery, recommended actions and additional appendices added to Barriers Matrix section *key issue added: disproportionate impact of COVID-19 on particular groups. *key issue removed: translation and interpretation provision *key issue: wording added: "changes to services" to third bullet point. *key issue: wording added "the need to" to opening sentence of last bullet point. *recommendations: wording added "and CCGs" and "PSED is still active" to recommendation 3. *recommendation added: CCGs and Providers to ensure Governing Bodies and Organisation Boards respectively are sighted on Equality Duty and associated risks by sharing the latest version of the Equality Brief and PSED brief v3 (Appendix 2). *recommendation added: CCGs and Providers to continue to seek assurance of service provision from interpreter agencies (language and BSL). *recommendation removed: reporting requirements suspension. *recommendation added: Ensure patient data of COVID-19 cases and deaths are recorded by

	protected characteristic e.g. ethnicity and disability in addition to the standard gender, sex characteristics. *recommendation added: Ensure workforce risk assessments updated in line with National recommendations around Black, Asian and Minority Ethnic staff. *Structural/ formatting changes made to barriers matrix to include recommended actions column. Recommended actions added to each Protected Characteristic and Issue. *Disproportionate impact on Black, Asian and Minority Ethnic people added to Race protected characteristic. *Human Rights issue added to Religion and Belief protected characteristic. *Additional consideration added to barriers matrix: Health Inequalities and Poverty. *Additional consideration added to barriers matrix: Decision Making. *Additional consideration added to barriers matrix: Recovery. *Appendix 1 added: includes statistical reports, guidance, national letters, health journal articles and newspaper articles linked to relevant protected characteristics and patient / staff groups. *Appendix 2 added: PSED brief for CCG Governing Bodies and Provider Boards.
6	*background narrative updated to reference the need to consider equality issues in recovery planning. *recommendation 8: age added and reference to gender removed. *recommendation added: Commissioners and Providers to resume Workforce reporting; Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) in line with NHS England letter dated 19th May 2020. *recommendation added: Further to national advice that EDS2 reporting is for local determination; Commissioners and Providers should publish EDS2 summary reports on external websites. It is acceptable to re-publish existing summary reports if it has not been possible to update due to current organisational pressures. *recommendation added: Commissioners and Providers to work collaboratively on Quality and Equality considerations for recovery plans. Access advice and support from Provider Equality Leads and Merseyside CCGs Equality and Inclusion Service. *Disability: issue added to neuro-diversity of people reporting difficulty using NHS 111 online services. Recommended action also added. *Race: Black, Asian and Minority Ethnic: narrative amended to reflect that NHS Employers has now published guidance. *Pregnancy and Maternity: issue added to barriers matrix specific to fertility services; services resuming and storage limits. Mitigations and Recommended Actions added. *Other: Health Inequalities and Poverty: Narrative reworded in the issue section and now includes low level of physical activity and difficulty reported by networks in engaging with certain communities. *Appendix 1 updated with further publications. Publications added since the last issue of the Equality Briefing are highlighted in yellow for ease of reference.
7	*recommendation added: Commissioners and Providers to be cognisant of Human Resources (HR) implications in the return to “business as usual” in relation to Staff Risk Assessments, supporting staff, processes for raising concerns, use of Freedom to Speak Up Guardians etc. Link to NHS Employers publications available in Appendix 1. *recommendation added: Ensure Commissioners and Providers continue to promote access to learning from emerging evidence and best practice. Continue to engage with local regional and national shared learning opportunities to identify best practice. *recommendation added: Provide nominations from your organisation for the North West Region Black, Asian and Minority Ethnic Advisory Group further to the enclosed letter from Bill McCarthy, Executive Regional Director (North West) NHS England and Improvement 8th June 2020. *recommendation added: Respond to Black, Asian and Minority Ethnic assurance request from Regional Chief People Officer NHSE & I (North West) 20th June 2020. *recommendation added: Take actions in response to the letter dated 24th June 2020 from Dr Kanani, Medical Director for Primary Care NHSE &I, and Amanda Pritchard, Chief Operating Officer NHSE & I *recommendation added: Commissioners and Providers to use the recovery planning key equality considerations in Appendix 3. *Age Over 65: reference to disability removed. *Age Over 65: issue and mitigation added relating to digital inclusion *Age Over 65’s: link to NICE guidance added to mitigation. *Age: Vulnerable All Ages recommended action added for CCGs to ensure there is ongoing

	engagement and inclusive communication with communities. *Age: Working Age issues, mitigations and recommendations added relating to Groups disproportionally impacted upon by COVID-19**,** Carers and Worklessness. *Disability All: issue relating to prioritisation of patients in the response to COVID-19 and human rights duplicated from Age section; includes mitigations and further recommended action. *Disability All: issue and mitigation added relating to digital inclusion. *Disability Sensory; D/deaf; recommended action added to ensure there is ongoing engagement and inclusive communication with communities. *Disability Sensory; D/deaf: issue added in relation to barriers experienced following the introduction of face masks/ coverings when D/deaf people use lip reading. Resource including in Appendix 1 and recommended action added. *Disability: issue added in relation to workforce, mitigation and further recommended action included to resume Workforce Disability Equality Standard reporting. *Disability; neuro-diversity, learning disabilities; issue added in relation to Anxiety amongst people with Learning Disabilities following the introduction of face masks/ coverings and the public not necessarily understanding that there are groups of people exempt from wearing them. Recommended action added. *Race Black, Asian and Minority Ethnic: Workforce added to header. *Race Black, Asian and Minority Ethnic: recommendation added for Commissioners and Providers to resume Workforce Race Equality Standard reporting. *Race Black, Asian and Minority Ethnic patient issues and recommended action added relating to disproportionate impact of COVID-19 and prevalence of particular medical conditions in Black, Asian and Minority Ethnic population and perceived barriers in accessing healthcare services. *Pregnancy and Maternity: reference to NHS Employers guidance on risk assessments added to mitigations. *All Decision Making: additional sentence added to recommended action for Commissioners and Providers to be cognisant that Equality Impact Assessments are public documents. *All Recovery Planning: further recommended action added for Commissioners and Providers to continue to promote access to learning from emerging evidence and best practice. Continue to engage with local regional and national shared learning opportunities to identify best practice. *Appendix 1 updated with further publications. Publications added since the last issue of the Equality Briefing are highlighted in yellow for ease of reference. *Appendix 3 added; includes Recovery Planning Service Change Key Equality Considerations for recovery planning.
8	*BAME replaced with Black, Asian and Minority Ethnic throughout. *Background narrative: amended to reference evidence of COVID-19 on particular groups of people and to reference widening health inequalities. Information sources included. *Key Issues: ‘and health inequalities widening’ added to the sentence- Disproportionate impact of COVID-19 on particular groups. *Key issues: changes to service provision added. *Recommendations: new recommendation added: It is essential that the three NHS priorities as outlined in Simon Steven’s letter dated 31st July 2020; Third Phase of NHS Response to COVID-19 are unpinned by the findings and recommendations within this Equality Briefing. The NHS priorities noted as follows: a. Accelerating the return to near-normal levels of non-COVID health services, making full use of the capacity available in the ‘window of opportunity’ between now and winter. b. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable COVID spikes locally and possibly nationally. c. Doing the above in a way that takes account of lessons learned during the first COVID peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention. *Recommendations: Reference to specific staff groups removed from the sentence ‘Distribute COVID-19 Equality Brief to all relevant teams across organisation’. Added: ‘and wider system partners where appropriate’. *Recommendations: recommendation on ensuring Governing Bodies and Organisation Boards are sighted on legal duty and briefing reworded to: CCGs, Providers and wider system partners to ensure that Organisation Boards are sighted on the latest version of the Equality Briefing and all associated appendices.

	*Recommendations: additional narrative added regarding inclusive communications as follows: Ensure communications are inclusive, timely and informative (in terms of appointment time, location, PPE requirements etc.). *Recommendations: Narrative on targeted engagement amended to read: Develop targeted campaigns, engagement and communications with vulnerable people and communities who are in high priority need e.g. Black, Asian and Minority Ethnic communities, and people living in deprived areas. *Recommendations: narrative added to the collection of COVID-19 related deaths to include: monitored locally so that the intelligence can be used to inform targeted engagement. *Recommendations: Health inequalities added to the following: Commissioners and Providers to work collaboratively on Equality, Quality and health inequality considerations for recovery plans. Access advice and support from Provider Equality Leads and Merseyside CCGs Equality and Inclusion Service. *Age Over 65: reference to other countries guidelines removed. *Age Over 65: Access to services and treatment added as an issue. *Age Over 65: mitigation narrative amended from 'the challenge for local health commissioners and services if cases continue to rise on current projections is to develop a consistent approach, based on an understanding and communication of risk on a case-by-case basis and to avoid a blunt ageist approach to read 'the challenge for local health commissioners and services the event of a second wave of COVID-19 is to develop a consistent approach, based on an understanding and communication of risk on a case-by-case basis and to avoid a discriminatory approach'. *Age Over 65: note added to the NICE Guidance 159 to read Note this guidance was updated on 29th April 2020 to stating that the Clinical Frailty Scale should be used as part of a holistic assessment, but should not be used for younger people, people with stable long-term disabilities, learning disabilities or autism. *Age Vulnerable People-All Ages: link updated to reflect the latest shielding guidance. *Age Vulnerable People-All Ages: new issue, mitigation and further action added relating to potential missed opportunities to identify Safeguarding Issues as service recovery moves from face to face to virtual appointments. *Disability All: reference to other countries guidelines removed. *Disability All: new issue added: Impact of COVID-19 on people with disabilities and access to services. *Disability All: new issue added: Concerns that people with learning disabilities and children and young people with SEND will not get equal access to treatment. *Disability All: mitigation narrative amended from 'the challenge for local health commissioners and services if cases continue to rise on current projections is to develop a consistent approach, based on an understanding and communication of risk on a case-by-case basis and to avoid a blunt ageist approach to read 'the challenge for local health commissioners and services the event of a second wave of COVID-19 is to develop a consistent approach, based on an understanding and communication of risk on a case-by-case basis and to avoid a discriminatory approach'. *Disability All: reference to NICE Guideline 159 added to mitigation. *Disability D/deaf: support to access video consultations added to issue and mitigation narrative added for CCGs to work with IT service on General Practice IT Kit/ Equipment. *Disability Mental Health All: reference to a second wave added to the issues and reference to NHSEI letter dated 31st July 2020 added to the further actions column. *Race People whose first language is not English: support to access services narrative added to the issue. *Sex M/F: issue added for Patients and Staff: Working from home and caring responsibility. Further recommendation action added. *Sex M/F: issue added for Access to Mental Health services. Further recommendation added. *Appendix 1 updated with further publications. Publications added since the last issue of the Equality Briefing are highlighted in yellow for ease of reference.

9	*Throughout: BAME abbreviation removed throughout and replaced with Black, Asian and Minority Ethnic. *Background: opening narrative amended to reflect the current phase including winter planning and a second wave and emerging evidence of spikes in cases in particular groups. *Recommendations: sentence added to recommendation 14: This also applies to the event of a Second Wave of COVID-19 and the possibility that some staff may need to return to shielding. *Age: Working Age: issue and further recommended action added relating local spikes of COVID-19 cases in Working Age people and Women aged 20 to 40. *Age: Children and Young People: issue and further recommended action added relating to digital divide and not all have access to the internet or laptops to access health care advice/ other services online. *Age: Children and Young People: issue and further recommended action added relating to an increase in the number of mental health admissions for people with Eating Disorders. *Age: Children and Young People: issue and further recommended action added relating to the negative impact of COVID-19 on Children and Young People's Mental Health *Disability: All: issue and further recommended action added relating to the impact on people who are Carers of people with dementia and / or learning disabilities and not being able to attend appointments or inpatient visiting. *Race: asterix added to the protected characteristic to indicate the word race is used in the context of Equality legislation. *Race: Black, Asian and Minority Ethnic: All: specific reference to Sickle Cell Anaemia removed and replaced with the following issue; Known conditions with poorer outcomes e.g.; Sickle cell anaemia, cardiovascular disease, hypertension, diabetes, maternal deaths, infant deaths. Known historic barriers in relation to accessing medical services. Mitigation and further recommended action added. *Race: Black, Asian and Minority Ethnic: Workforce: issue added in relation to Black, Asian and Minority Ethnic people are less likely to have career development opportunities, lack of progression, differential attainment, increased referrals to disciplinary processes and pay gap inequalities. Further recommended action added to ensure the organisation has representation at the Equality Collaborative Workforce Focussed Forum. *Sex M/F issue and further recommended action added relating to domestic abuse and privacy and safety issues if consultations are virtual or by video. *Sexual Orientation: issue and further recommended action added Privacy issues if virtual or video consultations directly linked to sexual orientation if patient living in home of multiple-occupancy/ shared accommodation. *Other: Health Inequalities and Poverty: issue and further recommended action added relating to children and poor diet. * Other: Health Inequalities and Poverty: issue and further recommended action added relating to Poorer Northern areas more impacted by COVID-19 spikes. People feeling like they still have to go to work due to poverty. *Appendix 1 updated with further publications. Publications added since the last issue of the Equality Briefing are highlighted in yellow for ease of reference.
10	*Background: narrative amended to reflect the current second wave and lower age in the spike in women reduced to 18. *Recommendations: number 11 and 12 removed to reflect that the publication deadline for workforce reporting has now passed. Other recommendations renumbered. * Recommendation: narrative amended on the revised number 11 recommendation to reflect that Commissioners and Providers need to work collaboratively on Equality, Quality and health inequality considerations in their response plans in addition to recovery plans now that we are experiencing a second wave. *Recommendation: narrative amended on the revised number 12 recommendation to remove the reference to 'business as usual' and new shielding guidance. *Recommendation: Refer to Appendix 4 added to recommendation 13. *Recommendations: recommendations 14, 15 and 16 removed and the embedded documents have been transferred to the Race; Black, Asian and Minority Ethnic Workforce barrier to accompany the further recommended action narrative. *Age: over 65; mitigating narrative amended to reflect second wave. *Age: working age: lower age reduced from 20 to 18. *Age: children and young people: issue and further recommended action added in relation to Concerns that parents and carers of children and young people with 'red flag' symptoms may not seek appropriate care during the pandemic. *Disability: all: mitigating narrative amended to reflect second wave.

	*Disability: workforce: further action required amended to reflect that WDES reporting timeline has passed and organisations should refresh associated action plans. *Disability: mental health organisation: issue amended to reflect current second wave. *Race: Black, Asian and Minority Ethnic workforce: further recommended action narrative amended to reflect that the WRES publication deadline has now passed and organisations should refresh Workforce Equality Action Plans in response to Workforce Race Equality Standard reporting. *Pregnancy and Maternity: issue, mitigation and further recommended action added in relation to media publications reporting that during the first wave of COVID-19 that three-quarters of NHS trusts did not allow birth partners to support mothers throughout their whole labour. *Appendix 1 updated with further publications. Publications added since the last issue of the Equality Briefing are highlighted in yellow for ease of reference. *Appendix 4 added; includes best practice examples from providers.
11	*Background: narrative updated to reflect NHS organisations continue to experience a second wave whilst planning for winter pressures and preparing for local deployment of COVID-19 vaccinations. *Disability: issue and further recommended action added in relation to people with learning disabilities had higher death rate from COVID-19. *Disability: issue, mitigation and further recommended action added in relation to access to CE approved transparent face masks use in clinical settings. *Race: issue and further recommended action added in relation to an increase in the number of poor quality calls during virtual appointments using interpreter services. *Appendix 1 updated with further publications. Publications added since the last issue of the Equality Briefing are highlighted in yellow for ease of reference.
12	*Background: narrative amended to reflect that the NHS continues to experience unprecedented levels of pressure from the COVID-19 pandemic. At the same time the NHS is delivering a complex national COVID vaccination programme at scale whilst also continuing to provide non-COVID-19 care. *Barriers for people with protected characteristics: narrative updated to include vaccination programme plans. *Key Issues: narrative updated to include reference to vaccination plans. *Recommendation 11: reference to second wave removed and replaced with further wave. *Recommendation: removed; It is essential that the three NHS priorities as outlined in Simon Steven's letter dated 31st July 2020; Third Phase of NHS Response to COVID-19 are unpinned by the findings and recommendations within this Equality Briefing. The NHS priorities noted as follows: a. Accelerating the return to near-normal levels of non-COVID health services, making full use of the capacity available in the 'window of opportunity' between now and winter. b. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable COVID spikes locally and possibly nationally. c. Doing the above in a way that takes account of lessons learned during the first COVID peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention. *Recommendation removed: Commissioners and Providers to use the recovery planning key equality considerations provided in the Appendices. *Recommendation added: to review internal Standard Operating Procedures for video consultations to ensure patients and staff enter and leave video consultations safely. Refer to Appendix 3. *Age: Over 65: narrative added to mitigation to reflect that "In-Hospital" cell structure in place to review capacity. Escalation procedures in place. Mutual aid in place across the system. *Age: All ages: new issue, mitigation and further recommended action added to reflect that particular cohorts of people have been more significantly impacted on by COVID-19 *Age: All ages: new issue and further recommended actions added to reflect that the new coronavirus variants that have emerged are sparking fears that they may be more transmissible, more severe, or evade immunity acquired by prior infection or vaccines. *Age: vulnerable people – all ages: further recommended action added for organisations to review internal standard operating procedures for video consultations. Example SOPs available in Appendix 3. *Age: people living in care homes: further mitigation added to reflect that All older residents in eligible care homes in England have been offered a COVID vaccine.

	*Age: working age. Reference to spikes in Women aged 18 to 40 removed. *Disability: all: narrative added to mitigation to reflect that "In-Hospital" cell structure in place to review capacity. Escalation procedures in place. Mutual aid in place across the system. *Disability: workforce: further recommended action narrative amended to "review". *Disability: mental health: reference to Simon Stevens July 2020 letter removed in the further recommended action column and replaced with refer to resources in Appendix 1. * Race: Black, Asian and Minority Ethnic- all: issue and further recommended action added specific to Scientific Advisory Group for Emergencies (Sage) have raised concerns over COVID-19 vaccine uptake among black, Asian and minority ethnic communities (BAME) as research showed up to 72% of black people said they were unlikely to have the jab. *Race: Workforce: further recommended action narrative updated to reflect current position. *Pregnancy and Maternity: issue and further recommended action in relation to Media publications report that pregnant women attending scan appointments on their own are not allowed to film baby. *Pregnancy and Maternity: issue and further recommended action in relation to Media publications report that the COVID-19 vaccine can impact on fertility. *Sex M/F further recommended action added in relation to patient safety and reviewing standard operating procedures for video consultations. *Appendices renumbered *Appendix removed: COVID-19 Public Sector Equality Duty (PSED) Briefing to CCG Governing Bodies and Provider Boards *Appendix added: Video consultation standard operating procedures *Appendix removed: Recovery Planning; Service Change Key Equality Considerations
13	*Age: All: issue, mitigation and further recommended action added in relation to people who have previously had a stroke (including subarachnoid haemorrhage) and those who have had a TIA report being advised of differently eligibility criteria for the COVID vaccination. *Age: Working Age: Issue and further recommendation added in relation to people who have been shielding may experience difficulty returning to work and may not feel supported *Age: 18-29 Issue and further recommended action added to reflect that JCVI currently advises that it is preferable for adults aged under 30 without underlying health conditions that put them at a higher risk of severe COVID-19, to be offered an alternative vaccine to AstraZeneca (AZ) if available. * Age: 16+: issue, mitigation and further recommended action added to reflect that national monitoring of data on vaccine effectiveness and impact indicates lower protection in vaccinated adults who are immunosuppressed. *****Age: 16-18 issue, mitigation and further recommended action added to reflect that the AstraZeneca (AZ) vaccine is not licensed for use in those under the age of 18. * Disability: Learning Disabilities: further recommended action added for organisations to review the reports and guidance specific to Learning Disabilities in Appendix 1. * Race: Black, Asian and Minority Ethnic: All further recommended action added to review documents/ resources in Appendix 1 in relation to vaccine hesitancy. * Sex M/F issue relating to women not being disadvantage in their careers due to shielding removed. *Sex M/F reference to shielding removed from the mitigation column where women are more likely to work in higher risk and low paid key worker roles. *Sex M/F issue and further recommended action added to reflect that a small proportion of patients who are HIV positive have declined sharing their HIV status with their GP. *Other: people in criminal justice system: mitigation added to reflect that Prisoners included in vaccine priority cohort. *Appendix 1 updated with further publications. Publications added since the last issue of the Equality Briefing are highlighted in yellow for ease of reference.
14	*Background – narrative updated *Recommendations: recommendation added to ensure equality considerations are incorporated into outbreak management plans. *Age: All: Further narrative, mitigation and further recommended action added to reflect that particular cohorts of people have been more significantly impacted on by COVID-19 and there may be a number of people hesitant to get the vaccine. *Age: All Issue and further recommended action added to reflect that media publications urge doctors to look for signs of stroke following AstraZeneca vaccines. *Age: All removed that people who have previously had a stroke (including subarachnoid haemorrhage) and those who have had a TIA report being advised of differently eligibility

	criteria for the COVID vaccination as all UK adults have now been offered the vaccine. *Age:All: further recommendation added to Work with local Deaf organisations to ensure any BSL videos are shared through networks. *Age: All: issue added related to vaccination programme planning; influenza and COVID-19 booster vaccinations *Age: All: issue, mitigation and further recommended action added to reflect that People who have had two doses of COVID-19 vaccination may test positive for COVID-19. (NB also working age) *Age: All: issue and mitigation added for people experiencing long COVID-19. *Age: People living/ working in care homes: further narrative added to the recommended action to continue to promote vaccine uptake. *Age: working age: Review resources available in Appendix 1 added to further recommended action. *Age: worklessness: Review resources available in Appendix 1 added to further recommended action. *Age: 18-30: amended to 18-40 following the latest advice on the administration of the AstraZeneca vaccine in that age group. *Age: Issue and mitigation added to reflect that media publications report that children aged 12 to 15 with severe neurological conditions, Down's syndrome, immunosuppression or severe or multiple learning disabilities should be vaccinated. *Age: Children and Young People: new issue and mitigation added to reflect that there has been an **i**ncrease across some geographical areas in Merseyside of an increase in the number of referrals for ADHD and ASD. Commissioners and Providers monitoring. *Age: Children and Young People. Issue of negative impact on physical health added in addition to negative impact on mental health. *Age: new issue and mitigation added to reflect government alert over surge in respiratory virus affecting babies and toddlers. *Disability: carers: further recommended action added to review resources in appendix one in relation to visiting guidance. *Race: issue and further recommended action added to include the impact of the outbreak of COVID-19 in India particularly on NHS workforce. *Appendix 1 updated with further publications. Publications added since the last issue of the Equality Briefing are highlighted in yellow for ease of reference. *Appendix 2 updated with further best practice examples on providers' approach to staff and patient COVID-19 vaccinations.
15	*Age: all ages. issue, mitigation and further recommended action added to reflect that JCVI advises that for the 2021 COVID-19 booster vaccine programme individuals who received vaccination in Phase 1 of the COVID-19 vaccination programme (priority groups 1 to 9) should be offered a third dose COVID-19 booster vaccine. *Age: all ages. Vaccination programme planning; influenza and COVID-19 booster vaccinations - mitigation amended to reflect that national guidance has now been published. *Age: all ages. New issue, mitigation and further recommended action added to reflect that MHRA has detailed the factors affecting the accuracy of pulse oximeters, including skin colour, movement, nail polish, henna dye, and tattoos. *Age: all ages. issue, mitigation and further recommended action added in relation to NICE reporting that ongoing symptoms of COVID-19 may be more likely to be reported in older people. However, there seem to be different clusters of symptoms in people of different ages which means that there could be different presentations for children and younger people and adults compared with people aged over 65. *Age: all ages: issue, mitigation and further recommended action added to reflect that regulations were approved by Parliament on 22 July 2021 to make vaccination a condition of deployment for staff working in CQC-regulated care homes in England, unless they have a medical exemption. There could be an implication on workforce resource in care homes if staff to not take up the vaccine. *Age within 3 months of 18th birthday: issue and mitigation added to reflect that local COVID-19 vaccination delivery models can be used for the vaccination of children who are within three months of their 18th birthday. *Age 16 and 17; issue, mitigation and further recommended action added to reflect that JCVI advises that all 16–17-year olds should be offered a first dose of Pfizer-BNT162b2 vaccine. *Age 12 to 15: issue, mitigation and further recommended action amended to reflect that guidance has now been published. *Disability; Sensory; Deaf: mitigation added to issues in accessing CE approved masks to

	reflect that some local trusts are participating in a national pilot. *Disability: Neurodiversity, Learning Disabilities, low levels of literacy; mitigation added to reflect that some local trusts are participating in a national pilot. *Race: Black, Asian and other minority ethnic workforce: additional narrative to further recommended action for Commissioners and Providers to review progress updates on Workforce Equality Action Plans in response to Workforce Race Equality Standard, 6 inclusive recruitment actions and actions to reduce race disparity in career progression to below 1.5 *Pregnancy and Maternity: further recommended action added to pregnancy risk for Organisations to respond as appropriate to NHSE letter dated 28th September 2021 (available in Appendix 1) regarding pulse oximetry for pregnant women.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
NOVEMBER 2021

Agenda Item: 21/150	**Author of the Paper:** Martin McDowell Chief Finance Officer martin.mcdowell@southseftonccg.nhs.uk Rebecca McCullough Deputy Chief Finance Officer rebecca.mccullough@southseftonccg.nhs.uk	**Clinical Lead:** **N/A**
Report date: November 2021		

Title: Chief Finance Officer Update

Summary/Key Issues:

This paper presents the Governing Body with an overview of the Month 6 financial position for NHS South Sefton Clinical Commissioning Group as at 30th September 2021.

The standard business rules set out by NHS England require a 1% surplus in each financial year, however the usual financial framework has been replaced with temporary financial arrangements in response to the COVID-19 pandemic. The temporary arrangements include additional funding for COVID related costs including a continuation of the Hospital Discharge programme. Additional funding has also been provided for Mental Health investments and recovery in Elective Care and Mental Health services.

NHS Planning Guidance was published for April – September 2021 (H1) and the CCG agreed a financial plan for this period. The draft financial plan identified a deficit of £3.290m, following review with system partners, a revised distribution of system resources was agreed, and South Sefton CCG received a further allocation of £1.786m.

The revised financial Plan for April – September 2021 (H1) was break even. The QIPP requirement to deliver the revised plan was £1.600m and was agreed at 2.9%.

Planning guidance has been published for the remainder of the financial year (October – March 22 or H2). A funding settlement was announced, and CCG allocations have been issued for the period. Further work is required to agree the distribution of system funding allocations and to confirm the revised financial plans.

Detailed plans will be required for submission in November 2021. Additional funding will be available to support continuation of the Hospital Discharge Programme and the Elective Recovery Programme as well as supporting the current expenditure run rates and contracting arrangements to continue.

The reduced funding envelope for H2 compared to H1 results in an efficiency requirement across the NHS, the requirements for individual organisations will be confirmed when allocations and financial

plans are agreed.

The Month 6 financial position is an overspend of £0.945m which reflects costs for the Hospital Discharge Programme which are yet to be reimbursed, there are also cost pressures in other areas which will need to be addressed and the CCG should progress QIPP schemes and other mitigating actions to manage expenditure within the available resource for the remainder of the financial year.

Once the costs for the Hospital Discharge Programme are reimbursed, the CCG will achieve a break-even position for the period April – September 2021.

Recommendation

Receive	X
Approve	
Ratify	

The Governing Body is asked to receive this report noting that,

- Temporary financial arrangements implemented in response to the COVID pandemic remain in place for the 2021-22 financial year.
- Additional funding is available for COVID related costs and recovery of Elective and Mental Health services.
- The draft financial plan for H1 identified a deficit of £3.290m; this was revised to break even following revised distribution of system funding and agreement of CCG QIPP targets.
- Delivery of the break-even position required QIPP efficiency savings of £1.600m and this was achieved in H1.
- NHS Planning Guidance for October – March 2022 (H2) was published on 30th September. The CCG is working alongside other organisations within CM HCP to confirm the final plan prior to submission in mid-November
- The additional funding available to the NHS in H2 is less than in H1 and this will result in an efficiency requirement.
- The Month 6 financial position is an overspend of £0.945m. Following reimbursement of costs for the Hospital Discharge Programme, the CCG will achieve a break-even position.

Links to Corporate Objectives 2021/22	
X	To implement Sefton2gether and realise the vision and ambition of the refreshed Health and Wellbeing Strategy.
X	To drive quality improvement, performance, and assurance across the CCG's portfolio.
X	To ensure delivery of the CCG's financial plan and align it with Sefton2gether and the work plan of transformation programmes
X	To support primary care development ensuring robust and resilient general practice services and the development of Primary Care Networks (PCNs).
X	To progress the changes for an effective borough model of place planning and delivery and support the ICS development.

Process	Yes	No	N/A	Comments/Detail
Patient and Public Engagement	**X**			
Clinical Engagement	**X**			
Equality Impact Assessment	**X**			**As appropriate for Investment decisions**
Legal Advice Sought			**X**	
Quality Impact Assessment	**X**			**As appropriate for Investment decisions**
Resource Implications Considered	**X**			
Locality Engagement			**X**	
Presented to other Committees	**X**			**Finance & Resource Committee (October)**

NHS
South Sefton
Clinical Commissioning Group

Report to Governing Body
November 2021

1. Executive Summary

This report focuses on the financial performance of South Sefton CCG as at 30th September 2021.

Table 1 – CCG Financial Position

	Annual Budget	Budget To Date	Actual To Date	Variance To Date
	£000	£000	£000	£000
Acute Care	76,139	76,139	76,008	(131)
Mental Health	15,559	15,559	16,330	771
Continuing Care	7,987	7,987	8,743	755
Community Health	18,666	18,666	18,687	21
Prescribing	16,193	16,193	16,193	(0)
Primary Care	16,976	16,976	16,583	(393)
Corporate Costs & Services	1,575	1,424	1,231	(193)
Other CCG Budgets	5,130	5,130	5,245	115
Total Operating budgets	**158,225**	**158,074**	**159,020**	**945**
Reserves	0	0	0	(0)
In Year (Surplus)/Deficit	0	0	0	0
Grand Total (Surplus)/ Deficit	**158,226**	**158,074**	**159,020**	**945**
Retrospective Allocation - HDP	0	0	(945)	(945)
Retrospective Allocation - ERF	0	0	0	0
Revised (Surplus)/Deficit	**158,226**	**158,074**	**158,075**	**0**

Financial Arrangements April to September 2021

The CCG financial plan for April to September 2021/22 (H1) was agreed and the control total for the CCG was break even. The financial plan included a QIPP requirement of £1.600m to deliver the break-even position.

Month 6 Financial Position

The Month 6 initially reported financial position is an overspend of £0.945m which is related to costs that are yet to be reimbursed. The Mental Health budget is reporting an overspend due to an increase in s.117 packages of care and the Continuing Care and Community

budgets are overspent relating to costs for the Hospital Discharge Programme, which are expected to be reimbursed.

The overspending areas are supported by underspends in other areas. In Primary Care relating to funding for additional roles, and in Corporate and Support services due to vacancies.

The CCG has delivered its expected QIPP target of £1.600m via non-recurrent means.

Financial Arrangements October – March 2022

NHS Planning guidance for the remainder of the year was issued on 30th September. CCG allocations have been issued and detailed financial plans are required for approval in November.

Block contract arrangements for NHS providers will continue and a new PbR tariff will apply to non-NHS provider contracts. There is an increased efficiency requirement across the NHS and targets for individual organisations will be agreed during the planning process. Additional funding is available nationally for restoration and recovery of services as well as continuation of COVID related services including the hospital discharge programme.

Further work is required to agree system financial plans and final CCG funding envelopes.

2. Finance Dashboards

1. Finance Key Performance Indicators

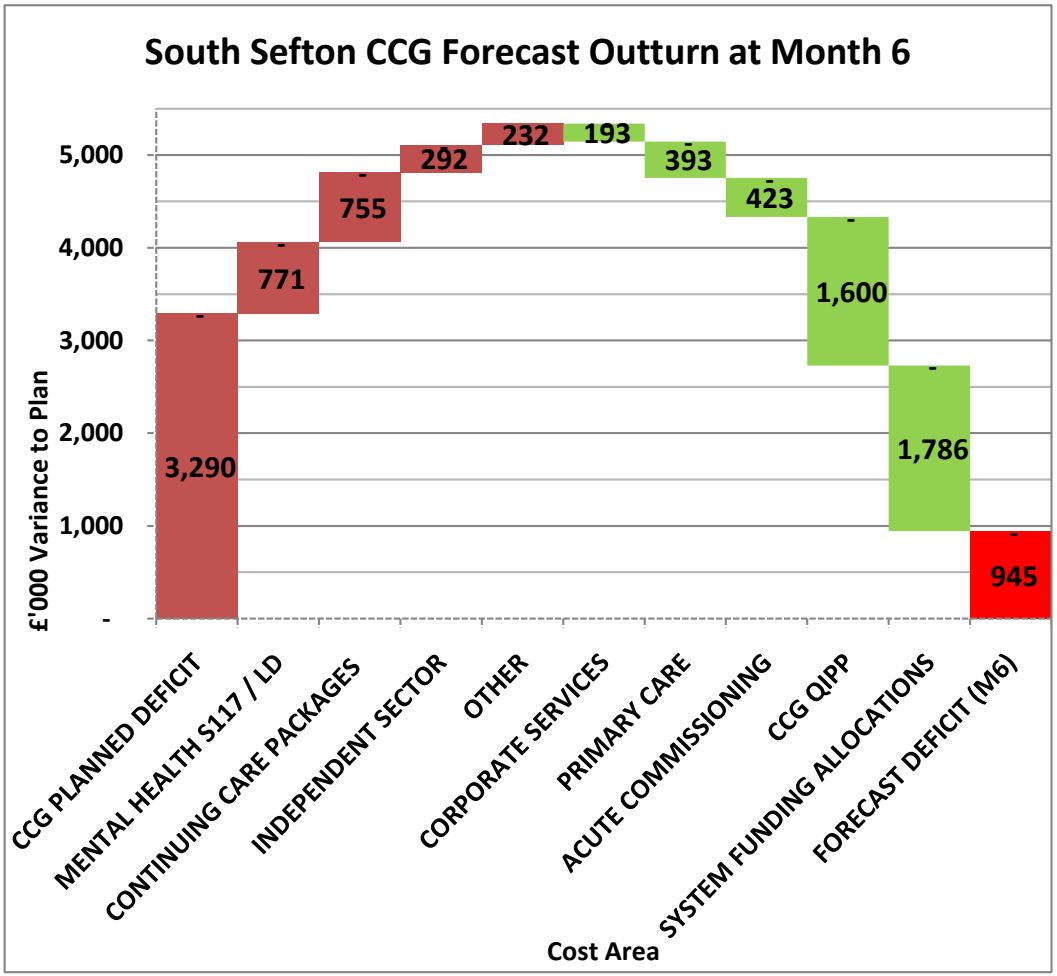
Report

Report Section	Key Performance Indicator		This Month
1	Business Rules	1% Surplus	n/a
		0.5% Contingency Reserve	n/a
		0.5% Non-Recurrent Reserve	n/a
		2020/21 Control Total (April-September)	✓
		2020/21 Control Total (October - March)	tbc
2	Breakeven	Financial Balance	✓
3	QIPP	QIPP delivered to date *(Red reflects that QIPP delivery is behind plan)*	✓
4	Running Costs	CCG running costs < 2021/22 allocation	✓
5	BPPC	NHS - Value YTD > 95%	99.97%
		NHS - Volume YTD > 95%	94.66%
		Non NHS - Value YTD > 95%	98.36%
		Non NHS - Volume YTD > 95%	95.77%

Commentary

- The standard business rules set out by NHS England require CCGs to deliver a 1% surplus.
- The 0.5% Contingency reserve and the 0.5% Non-Recurrent reserve were not required in H1 2021/22.
- The CCGs financial plan for April – September 2021 (H1) was breakeven.
- Financial plans for October – March (H2) are not yet confirmed.
- The QIPP target for H1 2021/22 is £1.600m and has been achieved.
- BPPC targets have been achieved with the exception of NHS by volume. Performance will continue to be closely monitored with the aim of achieving this target.

2. CCG Financial Position – Month 6 2021/22

Report	Commentary
	• The CCG Month 5 financial position is an overspend of £0.945m, this will reduce to a break-even position when costs are reimbursed. • The main financial pressures are as follows: ○ The CCG planned deficit for Months 1-6 ○ Section 117 Mental Health packages which have shown an increasing trend over recent financial years. ○ High-Cost LD packages ○ Continuing Care packages related to the Hospital Discharge Programme ○ Independent Sector related to the Elective Recovery Fund and other demand pressures The cost pressures are offset with the revised allocation of system funding, the CCG QIPP target, Acute Commissioning due to reduced costs of NCAs, high-cost drugs and AQP contracts and on Primary Care due to funding for additional roles. Further detail on the CCG financial position is provided in **Appendix 1**.

3. Risk Adjusted Position

Report

South Sefton CCG	Best Case £m	Likely Case £m	Worst Case £m
CCG Planned Deficit	(3.290)	(3.290)	(3.290)
Planned Surplus / (Deficit)	**(3.290)**	**(3.290)**	**(3.290)**
Further Risks			
S117 Mental Health Packages	(0.363)	(0.363)	(0.363)
High Cost Case	(0.500)	(0.500)	(0.500)
Pay Awards	(0.090)	(0.090)	(0.090)
Other Pressures	-	-	-
Sub Total	**(0.953)**	**(0.953)**	**(0.953)**
Mitigations			
Revised System Funding Allocation	1.786	1.786	1.786
CCG QIPP	1.600	1.600	1.600
Other Mitigations	0.857	0.857	0.857
Sub Total	**4.243**	**4.243**	**4.243**
Surplus / (Deficit)	-	-	-

Commentary

- The CCG draft financial plan for Months 1-6 identified a deficit of £3.290m.
- System funding has been distributed across the Cheshire & Merseyside CCGs and South Sefton CCG has received £1.786m
- The revised financial plan was break even.
- The CCG QIPP requirement to deliver the revised financial plan was £1.600m and this was achieved.
- Cost pressures in s.117 Mental Health packages will need to be addressed if the CCG is to manage costs within available resources for the remainder of the financial year.
- There is a risk relating to a high-cost package of care which is under review. The risk has been mitigated in H1 with efficiencies in other budget areas.

4. CCG Reserves Budget

Report

Reserves Budget	Opening Budget (Draft) £m	Additions £m	Transfer to QIPP £m	Deployed (to Operational budgets) £m	Closing Budget £m
QIPP Target	(1.600)				(1.600)
QIPP Achieved	0.000	1.600			1.600
System Funding Distribution	(2.200)	2.671		(0.471)	0.000
Reversal of planned system funding	0.579	0.232		(0.811)	0.000
Month 2 Budget adjustment - 6th May draft plan	0.502	0.142		(0.644)	0.000
Primary Care COVID support		0.334		(0.334)	0.000
Ageing Well Allocation		0.438		(0.438)	0.000
Long COVID allocation		0.199		(0.199)	0.000
Other allocations		0.059		(0.059)	0.000
Total Reserves	**(2.719)**	**5.675**	**0.000**	**(2.956)**	**0.000**

Commentary

- The CCG opening reserve budgets reflect the draft financial plan which was submitted on 6th May 2021
- The QIPP target is held as a negative budget and has been offset with budget transfers from operational budgets as schemes were achieved.
- The reserves budget includes the system funding adjustments.
- Other funding allocations have been deployed to operational budgets to support expenditure commitments.

5. Statement of Financial Position

Report

Summary working capital:

Working Capital and Aged Debt	Quarter 1	Quarter 2	Prior Year 2020/21
	M3 £'000	M6 £'000	M12 £'000
Non-Current Assets	26	17	36
Receivables	4,116	3,833	2,177
Cash	(454)	2,702	59
Payables & Provisions	(28,019)	(29,116)	(24,259)
Value of Debt> 180 days	106	473	95

Customer Name	Number of Invoices	Value of Invoices (£m)
NHS East Lancashire CCG	1	£0.072m
Sefton MBC	1	£0.338m

Commentary

- The non-current asset balance relates to assets funded by NHS England for capital projects. The movement in balance relates to depreciation charged during the financial year.
- The receivables balance includes invoices raised for services provided along with accrued income and prepayments.
- Outstanding debt more than 6 months old is currently £0.459m. There are 2 notable invoices more than £0.005m, with a combined total value of £0.410m. A breakdown of the invoices can be found in the table. Discussions are ongoing with the parties to resolve.
- At month 5, the CCG had drawn down £143.200m and made payments via NHS Business Services Authority of £15.242m, totalling £158.442m (100.3%) of its Annual Cash Drawdown Requirement (ACDR).
- The target cash balance at this point in the year is £157.991m (100.0%). The ACDR values currently only relate to H1, it has been confirmed by NHS England that any cash drawn down above the 100% ACDR will be rolled forward and deducted from H2 ACDR, the CCG is therefore still operating within its cash limits.

Appendices

Appendix 1 – Financial position - Month 6
Appendix 2 – Detailed breakdown of provider costs

Appendix 1 – Financial Position Month 6

01T NHS South Sefton Clinical Commissioning Group Month 6 Financial Position 2021/22						
Cost centre Number	Cost Centre Description	Annual Budget	Budget To Date	Actual To Date	YTD Variance	Month 6 Expenditure Outturn
		£000	£000	£000	£000	£000
	Acute					
598571	Acute Commissioning	66,660	66,660	66,406	(254)	66,406
598576	Acute Childrens Services	2,779	2,779	2,778	(0)	2,779
598586	Ambulance Services	3,665	3,665	3,665	(0)	3,665
598591	Clinical Assessment And Treatment Centres	2,405	2,405	2,697	292	2,697
598596	Collaborative Commissioning	333	333	332	(2)	332
598606	High Cost Drugs	172	172	92	(81)	92
598616	Ncas/Oats	125	125	38	(87)	38
Sub-Total: Acute		**76,139**	**76,139**	**76,008**	**(131)**	**76,008**
	Mental Health					
598501	Mental Health Contracts	172	172	167	(5)	167
598506	Child And Adolescent Mental Health	177	177	151	(26)	151
598511	Dementia	54	54	54	0	54
598521	Learning Difficulties	1,312	1,312	1,698	386	1,698
598531	Mental Health Services – Adults	8	8	9	1	9
598551	Mental Health Services - Older People	12	12	0	(12)	0
598556	Mental Health Services - SLA	12,274	12,274	12,291	17	12,291
598557	Mental Health Services - S117 Mental Health	1,551	1,551	1,961	410	1,961
Sub-Total: Mental Health		**15,559**	**15,559**	**16,330**	**771**	**16,330**
	Continuing Care					
598682	Chc Adult Fully Funded	4,781	4,781	4,583	(197)	4,584
598683	Chc Ad Full Fund Pers Hlth Bud	1,340	1,340	1,466	126	1,466
598684	Chc Adult Joint Funded	598	598	1,411	813	1,411
598685	Chc Ad Jnt Fund Pers Hlth Bud	150	150	150	1	150
598686	Chc Admin and Support	303	303	305	1	305
598687	Chc Children	(55)	(55)	(85)	(30)	(85)
598691	Funded Nursing Care	871	871	912	41	912
Sub-Total: Continuing Care		**7,987**	**7,987**	**8,743**	**755**	**8,743**
	Community Health					
598711	Community Services	18,165	18,165	18,154	(12)	18,154
598721	Hospices	184	184	193	9	193
598726	Intermediate Care	317	317	340	24	340
Sub-Total: Community Health		**18,666**	**18,666**	**18,687**	**21**	**18,687**
	PRIMARY CARE					
598646	Commissioning Schemes	491	491	437	(54)	437
598651	Local Enhanced Services	2,023	2,023	1,865	(158)	1,865
598656	Medicines Management - Clinical	555	555	514	(41)	514
598661	Out Of Hours	727	727	842	115	842
598662	GP Forward View	528	528	515	(13)	516
598666	Oxygen	274	274	273	(2)	273
598671	Prescribing	16,193	16,193	16,193	(0)	16,193
598676	Primary Care It	1,195	1,195	1,196	0	1,195
598678	PRC Delegated Co-Commissioning	11,182	11,182	10,942	(240)	10,942
Sub-Total: Primary Care		**33,169**	**33,169**	**32,776**	**(393)**	**32,776**
	Corporate Costs & Services					
600251	Administration & Business Support	302	151	116	(35)	268
600266	Business Informatics	187	187	166	(20)	166
600271	Ceo/ Board Office	214	214	253	39	253
600276	Chair And Non Execs	98	98	58	(41)	58
600292	Primary Care Support	84	84	100	16	100
600296	Commissioning	45	45	45	(0)	45
600301	Communications & PR	70	70	68	(1)	68
600311	Contract Management	75	75	58	(17)	58
600316	Corporate Costs & Services	139	139	115	(24)	115
600341	Equality & Diversity	10	10	6	(4)	6
600346	Estates And Facilities	81	81	74	(7)	74
600351	Finance	270	270	172	(98)	172
600426	Quality Assurance	0	0	0	0	0
600431	Recharges	0	0	(0)	(0)	0
Sub-Total: Corporate Costs & Services		**1,575**	**1,424**	**1,231**	**(193)**	**1,382**
	Other					
598756	Commissioning - Non Acute	3,451	3,451	3,552	100	3,552
598776	Non Recurrent Programmes	89	89	74	(15)	74
598791	Programme Projects	354	354	381	27	381
598796	Reablement	667	667	663	(4)	663
598801	Recharges NHS Property Services	126	126	129	3	129
598809	NHS 111	18	18	18	(1)	18
598810	Nursing And Quality Programme	268	268	279	11	279
		157	157	150	(7)	150
Sub-Total: Other		**5,130**	**5,130**	**5,245**	**115**	**5,245**
Sub-Total Operating Budgets pre Reserves		**158,225**	**158,074**	**159,020**	**945**	**159,171**
RESERVES						
598761	Commissioning Reserve	0	0	0	(0)	0
598781	Non Recurrent Reserve	0	0	0	0	0
Sub-Total: Reserves		**0**	**0**	**0**	**(0)**	**0**
Total I & E		**158,226**	**158,074**	**159,020**	**946**	**159,171**
099999	In Year Planned Surplus/Deficit	0	0	0	0	0
Grand Total (Surplus)/Deficit		**158,226**	**158,074**	**159,020**	**945**	**159,171**
099999	Historic (Surplus)/Deficit	(10,792)	(10,792)	0	10,792	0

Appendix 2 – Detailed Breakdown of Provider Costs

01T NHS South Sefton Clinical Commissioning Group Month 6 Contract Summary 2021/22						
Cost Centre Description	Area	Cost centre Number	Annual Budget	Budget To Date	Actual To Date	Variance Month 6
			£000	£000	£000	£000
ACUTE CHILDRENS SERVICES						
ALDER HEY CHILDRENS FT	SLA	598576	2,779	2,779	2,778	(0)
Sub-Total: Acute Childrens Services			**2,779**	**2,779**	**2,778**	**(0)**
ACUTE COMMISSIONING						
LIVERPOOL UNI HOSP NHS FT	SLA	598571	54,318	54,318	54,179	(138)
CLATTERBRIDGE NHS FT	SLA	598571	315	315	315	0
COUNTESS OF CHESTER FT	SLA	598571	0	0	0	0
LIVP HRT/CHST HOSP NHS FT	SLA	598571	417	417	417	0
LIVP WOMENS NHS FT	SLA	598571	5,404	5,404	5,402	(2)
MANC UNI NHS FT	SLA	598571	0	0	0	0
SOUTHPORT/ORMSKIRK NHST	SLA	598571	3,676	3,676	3,665	(12)
ST HEL/KNOWS TEACH NHST	SLA	598571	1,300	1,300	1,294	(6)
VIRGIN CARE PROVIDER SERVICES LTD	SLA	598571	164	164	60	(103)
WALTON CENTRE NHS FT	SLA	598571	794	794	794	(0)
WIRRAL UNIV TEACH HOSP NHS FT	SLA	598571	-	0	0	0
WRIGHT/WGN/LEIGH NHS FT	SLA	598571	-	0	0	0
SPECSAVERS HEARCARE LTD	SLA	598571	139	139	129	(10)
INJURY CARE CLINICS LTD	AQP	598571	-	0	0	0
SCRIVENS	AQP	598571	6	6	0	(6)
NORTH WEST BOROUGHS HEALTH NHS FT	AQP	598571	-	0	0	0
UNIVERSITY HOSPITALS OF NORTH MIDLAI	OTHER	598571	8	8	8	0
CALDERDALE/HUDD NHS FT	OTHER	598571	0	0	0	0
PHOENIX			118	118	141	23
GENERAL ACUTE	AQP	598571	0	0	0	(0)
NHS HALTON CCG	OTHER	598571	-	0	0	0
NHS KNOWSLEY CCG	OTHER	598571	-	0	0	0
NHS LIVERPOOL CCG	OTHER	598571	-	0	0	0
NHS SPORT AND FRMBY CCG	OTHER	598571	-	0	0	0
NHS ST HELENS CCG	OTHER	598571	-	0	0	0
Sub-Total: Acute Commissioning			**66,660**	**66,660**	**66,406**	**(254)**
COMMUNITY SERVICES						
LIVERPOOL UNIVERSITY HOSPITALS NHS FT	ANTI-COAG	598711	2,895	2,895	2,846	(49)
ALDER HEY CHILDRENS FT	COMMUNITY	598711	1,711	1,711	1,671	(40)
MERSEY CARE NHS FT	COMMUNITY	598711	12,087	12,087	12,183	96
LANCASHIRE CARE NHSFT	COMMUNITY	598711	57	57	71	14
SOUTHPORT/ORMSKIRK NHST	COMMUNITY	598711	0	0	0	0
			0	0	0	0
SEFTON METROPOLITAN BC	COMMUNITY	598711	779	779	747	(31)
CEDAS	COMMUNITY	598711	637	637	635	(1)
Sub-Total: Community Services			**18,165**	**18,165**	**18,154**	**(12)**
MENTAL HEALTH SERVICES						
MERSEY CARE NHS FT	Mental Health	598556	8,511	8,511	8,520	9
ALDER HEY CHILDRENS FT	Mental Health	598556	2,078	2,078	2,074	(4)
SLS DISH / PERINATAL	Mental Health	598556	674	674	674	(0)
NHS WARRINGTON CCG	Mental Health	598556	198	198	198	0
MENTAL HEALTH MATTERS	Mental Health	598557	812	812	812	0
EAST LANCS CCG	Mental Health	598559	0	0	0	0
GENERAL MENTAL HEALTH	Mental Health	598556	0	0	12	12
Sub-Total: Mental Health Services - Other			**12,274**	**12,274**	**12,291**	**17**
NHS 111						
NW AMBUL SVC NHST	NHS 111	598809	0	0	0	0
NHS LIVERPOOL CCG	NHS 111	598809	11	11	11	0
NHS BLACKPOOL CCG	NHS 111	598809	7	7	7	(1)
Sub-Total: NHS 111			**18**	**18**	**18**	**(1)**
AMBULANCE SERVICES						
NW AMBUL SVC NHST	SLA	598586	3,665	3,665	3,665	(0)
Sub-Total: Ambulance Services			**3,665**	**3,665**	**3,665**	**(0)**
Grand Total			**103,560**	**103,560**	**103,311**	**(249)**

01T NHS South Sefton Clinical Commissioning Group Month 6 ISTC Summary 2021/22					
Cost Centre Description	Area	Annual Budget	Budget To Date	Actual To Date	Variance Month 6
		£000	£000	£000	£000
Clinical Assessment And Treatment Centres					
RAMSAY HEALTHCARE UK	SLA	1,285	1,285	1,297	12
SPIRE HEALTHCARE LTD	SLA	484	484	454	(30)
FAIRFIELD INDEPENDENT HOSPITAL	SLA	43	43	29	(13)
ISIGHT LTD	SLA	132	132	166	35
BRITISH PREGNANCY ADVICE SERVICE	SLA	82	82	23	(59)
Sub-Total: ISTC Contracts		**2,025**	**2,025**	**1,969**	**(56)**
EUXTON HALL HOSPITAL	Non-Contract	11	11	11	(0)
SPIRE CHOICE	Non-Contract	13	13	27	14
SPAMEDICA LTD	Non-Contract	168	168	247	79
NUFFIELD HEALTH	Non-Contract	0	0	13	13
OAKLANDS HOSPITAL	Non-Contract	1	1	7	5
GENERAL ISTC	Non-Contract	187	187	424	237
Sub-Total: ISTC Non-Contracted		**380**	**380**	**728**	**348**
Grand Total: Clinical Assessment And Treatment Centres		**2,405**	**2,405**	**2,697**	**292**

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
NOVEMBER 2021

Agenda Item: 21/151	**Author of the Paper:** Martin McDowell Deputy Chief Officer Email: Martin.McDowell@southseftonccg.nhs.uk Tel: 0151 317 8350
Report date: November 2021	

Title: South Sefton Clinical Commissioning Group Integrated Performance Report

Summary/Key Issues:
This report provides summary information on the activity and quality performance of South Sefton Clinical Commissioning Group.

Please note the effects of COVID-19 are noticed in month 5 across a number of performance areas.

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives 2021/22 ***(x those that apply)***	
	To implement Sefton2gether and realise the vision and ambition of the refreshed Health and Wellbeing Strategy.
x	To drive quality improvement, performance and assurance across the CCG's portfolio.
	To ensure delivery of the CCG's financial plan and align it with Sefton2gether and the work plan of transformation programmes.
	To support primary care development ensuring robust and resilient general practice services and the development of Primary Care Networks (PCNs).
	To progress the changes for an effective borough model of place planning and delivery and support the ICS development.

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

NHS
South Sefton
Clinical Commissioning Group

South Sefton Clinical Commissioning Group

Integrated Performance Report Summary – August 2021

Summary Performance Dashboard

Metric	Reporting Level		2021-22												
			Q1			Q2			Q3			Q4			YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
E-Referrals - NB Reporting suspended on this metric currently															
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													
		Actual													
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
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	R	R	R	R	R								
		Actual	8.05%	12.71%	14.14%	15.02%	16.55%								
		Target	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%
% 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	R	R								
		Actual	63.70%	66.71%	66.29%	64.45%	63.16%								
		Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
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	R	R	R	R								
		Actual	1,422	978	912	1,017	1,082								
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
Cancelled Operations															
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.	Liverpool University Foundation Hospital Trust	RAG	R	R	R	R	R								R
		Actual	2	2	1	7	19								31
		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.	Liverpool University Foundation Hospital Trust	RAG	G	G	R	G	G								R
		Actual	0	0	1	0	0								1
		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 or dentist with suspected cancer	South Sefton CCG	RAG	G	R	R	G	R								R
		Actual	94.74%	91.88%	92.13%	93.89%	92.04%								92.95%
		Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
% 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	G	G	G								G
		Actual	90.91%	92.00%	97.78%	94.34%	95.00%								94.39%
		Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
% of patients receiving definitive treatment within 1 month of a cancer diagnosis (MONTHLY) The percentage of patients receiving their first definitive treatment within one month (31 days) of a decision to treat (as a proxy for diagnosis) for cancer	South Sefton CCG	RAG	G	G	G	G	G								G
		Actual	100%	96.92%	100%	97.33%	96.88%								99.36%
		Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
% 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	R	G	R	R								R
		Actual	100%	83.33%	100%	82.35%	92.31%								90.54%
		Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%
% 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	R	R	G	G	G								G
		Actual	95%	95.24%	100%	100%	100%								98.37%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
% of patients receiving subsequent treatment for cancer within 31 days (Radiotherapy Treatments) (MONTHLY) 31-Day Standard for Subsequent Cancer Treatments where the treatment function is (Radiotherapy)	South Sefton CCG	RAG	G	G	G	G	G								G
		Actual	95.24%	96.15%	100%	100%	100%								98.48%
		Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%
% of patients receiving 1st definitive treatment for cancer within 2 months (62 days) (MONTHLY) The % of patients receiving their first definitive treatment for cancer within two months (62 days) of GP or dentist urgent referral for suspected cancer	South Sefton CCG	RAG	R	G	R	R	R								R
		Actual	61.11%	85.71%	75%	76.09%	71.79%								74.04%
		Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
% 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	R	R	R	R	G								R
		Actual	75%	75%	40%	60%	100%								67.86%
		Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
% 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 but have been seen by a clinician who suspects cancer, who has upgraded their priority.	South Sefton CCG (local target 85%)	RAG	G				G								
		Actual	100%	71.43%	70.42%	80%	90%								67.86%
		Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Metric	Reporting Level		2021-22												
			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 % of patients who spent less than four hours in A&E	South Sefton CCG	RAG	R	R	R	R	R								R
		Actual	85.48%	73.86%	71.29%	66.63%	67.75%								72.95%
		Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
MSA															
Mixed sex accommodation breaches - All Providers No. of MSA breaches for the reporting month in question for all providers	South Sefton CCG	RAG													
		Actual	Not available	Not available	Not available	Not available	Not available								
		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													
		Actual	Not available	Not available	Not available	Not available	Not available								
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
HCAI															
Number of MRSA Bacteraemia Incidence of MRSA bacteraemia (Commissioner) cumulative	South Sefton CCG	RAG	G	G	R	R	R								R
		YTD	0	0	1	1	1								1
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of C. Difficile infections Incidence of Clostridium Difficile (Commissioner) cumulative	South Sefton CCG	RAG	R	R	R	R	R								R
		YTD	7	13	16	22	26								26
		Target	6	10	14	18	22	27	31	35	41	45	49	54	54
Number of E. Coli Incidence of E. Coli (Commissioner) cumulative	South Sefton CCG	RAG	G	G	G	G	G								G
		YTD	6	18	34	45	61								61
		Target	17	33	47	59	70	80	91	103	116	130	144	156	156

Metric	Reporting Level		2021-22												
			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	G	G	G	G	G								G
		Actual	100%	100%	100%	100%	100%								100%
		Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Episode of Psychosis															
First episode of psychosis within 2 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	G												G
		Actual	64.3%												64.3%
		Target	60%			60%			60%			60%			60%
Eating Disorders															
Eating Disorders Services (EDS) Treatment commencing within 18 weeks of referrals	South Sefton CCG	RAG	R	R	R	R	R								R
		Actual	34.38%	30.30%	36.10%	25.70%	11.40%								27.6%
		Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
IAPT (Improving Access to Psychological Therapies)															
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	R	R								R
		Actual	0.56%	0.54%	0.72%	0.90%	0.72%								3.43%
		Target	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	19%
IAPT Recovery Rate (Improving Access to Psychological Therapies) The percentage of people who finished treatment within the reporting period who were initially assessed as 'at caseness', have attended at least two treatment contacts and are coded as discharged, who are assessed as moving to recovery.	South Sefton CCG	RAG	R	R	R	R	R								R
		Actual	43.3%	41.4%	36.8%	42.3%	33.3%								41.50%
		Target	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
IAPT Waiting Times - 6 Week Waiters The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number who finish a course of treatment.	South Sefton CCG	RAG	G	G	G	G	G								G
		Actual	96%	100%	92%	88%	88%								93%
		Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
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	GG	GG	GG								G
		Actual	100%	100%	100%	100%	100%								100%
		Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Metric	Reporting Level		2021-22												
			Q1			Q2			Q3			Q4			YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Dementia															
Estimated diagnosis rate for people with dementia Estimated diagnosis rate for people with dementia	South Sefton CCG	RAG	R	R	R	R	R								R
		Actual	57.88%	57.74%	58.5%	59.3%	59.7%								58.60%
		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%
Learning Disability Health Checks															
No of people who have had their Annual LD Health Check	South Sefton CCG	RAG	R												R
		Actual	6.09%												6.09%
		Target	18%			35%			52%			70%			70%
Severe Mental Illness - Physical Health Check															
People with a Severe Mental Illness receiving a full Physical Annual Health Check and follow-up interventions (%) Percentage of people on General Practice Serious Mental Illness register who receive a physical health check and follow-up care in either a primary or secondary setting.	South Sefton CCG	RAG	R												R
		Actual	20.8%												20.8%
		Target	50%			50%			50%			50%			50%
Children & Young People Mental Health Services (CYPMH)															**Rolling 12 month**
Improve access rate to Children and Young People's Mental Health Services (CYPMH) Increase the % of CYP with a diagnosable MH condition to receive treatment from an NHS-funded community MH service	South Sefton CCG	RAG	G												G
		Actual	20.3%												40.4%
		Target	8.75%			8.75%			8.75%			8.75%			35.00% YTD
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	R												R
		Actual	69.6%												
		Target	95%			95%			95%			95%			95%
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	G												G
		Actual	100%												100%
		Target	95%			95%			95%			95%			95%

Metric	Reporting Level		2021-22												
			Q1			Q2			Q3			Q4			YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
SEND Measures															
Child and Adolescent Mental Health Services (CAMHS) - % Referral to choice within 6 weeks - Alder Hey	Sefton	RAG	R	R	R	R	R								R
		Actual	81.4%	62.5%	54.2%	56.5%	38.2%								58.6%
		Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Child and Adolescent Mental Health Services (CAMHS) - % referral to partnership within 18 weeks - Alder Hey	Sefton	RAG	R	R	R	R	R								R
		Actual	57.1%	42.3%	72.2%	45.5%	25.0%								48.4%
		Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Percentage of Autism Spectrum Disorder (ASD) assessments started in 12 weeks - Alder Hey	Sefton	RAG	G	G	G	G	G								G
		Actual	96%	98%	100%	100%	100%								98.80%
		Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Percentage of Autism Spectrum Disorder (ASD) assessments completed within 30 Weeks - Alder Hey	Sefton	RAG	R	R	R	R	R								R
		Actual	85%	83%	77%	72%	62%								75.8%
		Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Percentage of Attention Deficit Hyperactivity Disorder (ADHD) assessments started within 12 Weeks - Alder Hey	Sefton	RAG	G	G	G	G	G								G
		Actual	99%	98%	100%	100%	100%								99.4%
		Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Percentage of Attention Deficit Hyperactivity Disorder (ADHD) assessments completed within 30 Weeks - Alder Hey	Sefton	RAG	G	G	G	G	R								G
		Actual	98%	93%	91%	90%	88%								92.00%
		Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Average waiting times for Autism Spectrum Disorder (ASD) service in weeks (ages 16 - 25 years) - Mersey Care	Sefton	RAG													
		Actual	8.1	12.2	5.3	6.4	9.1								
		Target													
Average waiting times for Attention Deficit Hyperactivity Disorder (ADHD) service in weeks (ages 16 - 25 years) - Mersey Care	Sefton	RAG													
		Actual	90.5	77.0	78.4	63.8	62.9								
		Target													

Executive Summary

This report provides summary information on the activity and quality performance of South Sefton Clinical Commissioning Group at month 5 of 2021/22 (note: time periods of data are different for each source).

Constitutional Performance for August and Quarter 1 2021/22	CCG	LUHFT
Diagnostics (National Target <1%)	16.55%	10.62%
Referral to Treatment (RTT) (92% Target)	63.16%	61.84%
No of incomplete pathways waiting over 52 weeks	1,082	4,824
Cancer 62 Day Standard (Nat Target 85%)	71.79%	54.74%
A&E 4 Hour All Types (National Target 95%)	67.75%	66.03%
A&E 12 Hour Breaches (Zero Tolerance)	-	0
Ambulance Handovers 30-60 mins (Zero Tolerance)	-	670
Ambulance Handovers 60+ mins (Zero Tolerance)	-	234
Stroke (Target 80%)	-	see report
TIA Assess & Treat 24 Hrs (Target 60%)	-	Not Available
Mixed Sex Accommodation (Zero Tolerance)	Not Available	Not Available
CPA 7 Day Follow Up (95% Target) 2021/22 - Q1	100.0%	-
EIP 2 Weeks (60% Target) 2021/22 - Q1	64.3%	-
IAPT Access (1.59% target monthly - 19% YTD)	0.72%	-
IAPT Recovery (Target 50%)	33.3%	-
IAPT 6 Weeks (75% Target)	88.0%	-
IAPT 18 Weeks (95% Target)	100.0%	-

To Note:
Due to the COVID-19 pandemic and the need to release capacity across the NHS to support the response, the decision was made to pause the collection and publication of several official statistics. These include Mixed Sex Accommodation (MSA), Delayed Transfers of Care (DToC), cancelled operations, occupied bed days, Oversight Framework (OF), Better Care Fund (BCF) and NHS England monthly activity monitoring. These measures will be updated as soon as the data becomes available and incorporated back into the report.

Data quality issues due to the impact of COVID-19 remain within the data flows for referrals and contract monitoring.

COVID Vaccination Update
The South Sefton COVID-19 vaccination programme continues to offer dose 1 and dose 2 vaccinations to Sefton residents and has now successfully fully vaccinated the majority of patients in cohorts 1-9. The two vaccination sites at Maghull Town Hall and North Park Health Centre were brought to an end at the end of June having successfully administered dose 1 & 2 vaccinations to the majority of patients in cohorts 1-9, along with care home residents and staff and the local homeless population. Seaforth village Surgery has been introduced as a vaccination site and continues to offer dose 1 & 2 vaccinations to the local population. The vaccination programme continues to offer vaccinations to eligible patients in cohorts 1-12 through community pharmacies, hospitals and national vaccination sites. Patients between the ages of 16-17 are now also eligible for the vaccine and included in cohort 12. At the end of Aug 2021 there have been 102,507 (or 79.5%) first dose vaccinations and 93,047 (68.1%) second dose vaccinations in cohorts 1-12.

Planned Care

Local providers have continued to undertake urgent elective treatments during the COVID-19 pandemic period, and this has been clinically prioritised. There is a focus on delivering greater theatre capacity utilising on site theatres and that of the independent sector. This will include use of nationally agreed independent sector contracts following clinical assessment in terms of triage and prioritisation.

In the context of responding to the ongoing challenges presented by COVID-19, while also restoring services, meeting new care demands and tackling health inequalities, Elective Recovery Funds (ERF) have been made available to systems that achieve activity levels above set thresholds. In Cheshire & Mersey Hospital Cell (established to co-ordinate acute hospital planning resulting from the COVID-19 pandemic), the delivery of activity both at trust and system is being assessed against agreed trajectories for H1 (Half year 1).

Restrictions on outpatients and theatre capacity due to COVID is reflected in increased waiting list numbers and patients waiting longer than 52 weeks, which has led to considerable pressure on the waiting list position, despite targeting of patients in greatest need. Increased staff sickness/absence has also led to an increase in waiting list size. Cheshire and Merseyside Hospital Cell has set out principles for elective restoration with a proposed recovery approach. The approach is focused on development of system level waiting list management both in diagnostic and surgical waits to maximise the capacity available and to standardise waiting times where possible, with priority given to clinically urgent patients and long waiters (52 week plus). Outpatient validation is another expected area of focus to support elective recovery over the coming months. Elective recovery will continue to be supported by the independent sector facilitated by the procurement of service via the Increasing Capacity Framework (ICF).

Secondary care referrals were below historic levels across all referral sources for the majority of 2020/21. With a focus on elective restoration, referral numbers in 2021/22 have been significantly higher than in the equivalent period of the previous year. At provider level, Aintree Hospital saw the highest numbers of monthly referrals since October-19 in June-21. Referrals have then decreased in July-21 and August-21 but remain above an average for the last 12 months. However, year to date referrals remain below pre-pandemic (i.e., 2019/20) levels by -16.4%. GP referrals at Aintree Hospital are reporting a -21.9% decrease when comparing to the previous month. Also, considering working days, further analysis has established there have been approximately -20 fewer GP referrals per day in August-21 when comparing to the previous month. In terms of referral priority, all priority types have seen an increase at month 5 of 2021/22 when comparing to the equivalent period in the previous year. The largest variance has occurred within routine referrals with an increase of 29.9% (750).

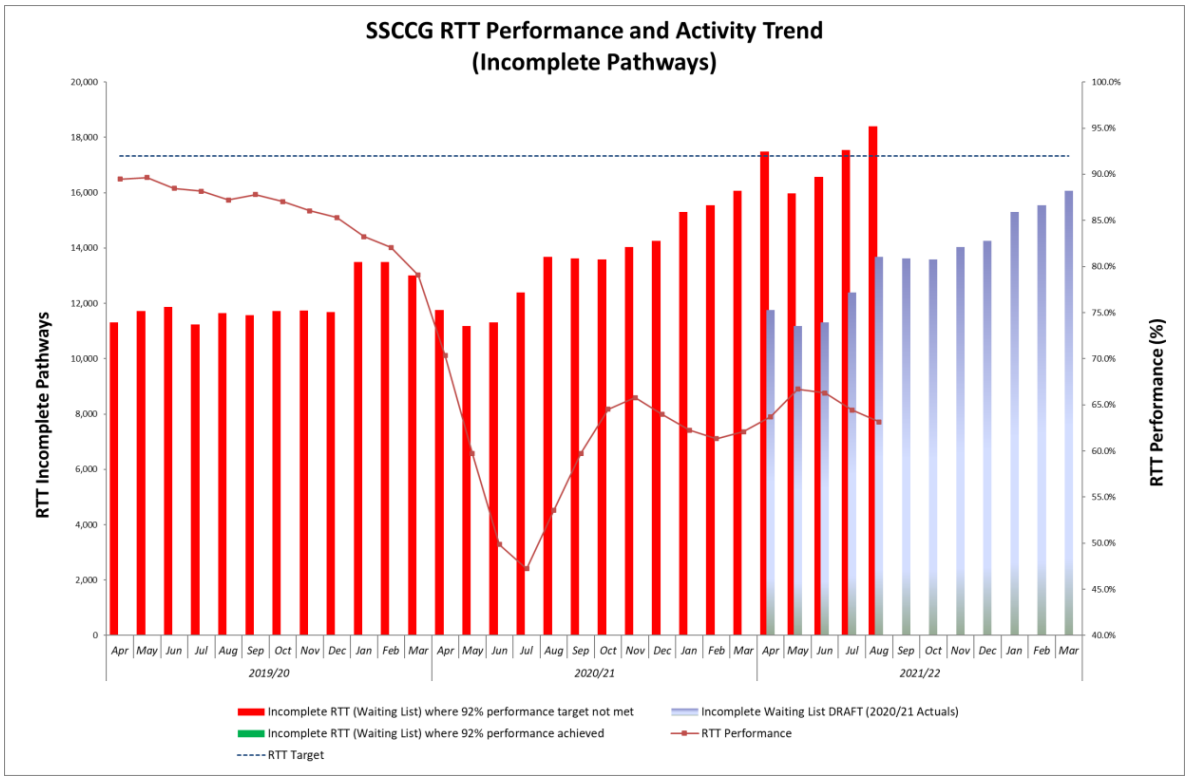
Reporting has been suspended on the e-Referral Service (e-RS) metric as e-RS capacity has been removed to ensure equity of provision. The current e-RS pathway is for all patients to be referred via the Appointment Slot Issue (ASI) functionality or via a Referral Assessment Service (RAS) for Trusts to manage the waiting lists fairly and according to clinical need. Therefore, reporting of e-RS utilisation will show a low conversion rate to bookings, as patients will be booked outside of e-RS. As system waiting lists reduce, there will need to be a transition plan to open capacity for direct booking via e-RS. However, until that point, e-RS reporting will be suspended.

The CCG has failed the target of less than 1% of patients waiting 6 weeks or more for their diagnostic test with 16.55% in August - this being a decline in performance from last month (15.02%). Despite failing the target, the CCG is measuring well below the national level of 27.1%. Liverpool University Hospital Foundation Trust (LUHFT) performance was 10.62% in August, a small decline in performance from last month when 7.94% was reported. But through the commissioning of delivery of additional diagnostic capacity, the Trust has made significant progress in reducing both the volume of patients waiting for outpatient diagnostics and the percentage waiting over 6 weeks.

For patients on an incomplete non-emergency pathway waiting no more than 18 weeks, the CCG's performance in August was 63.16%, a decline to last month's performance (64.45%). Unfortunately, the CCG is reporting below the national level of 67.63%. LUHFT reported 61.84% which is also a

decline on last month when 63.74% was reported. There is a continued focus on clinical prioritisation and access to additional capacity through mutual aid, independent sector and waiting list initiatives; specifically for Priority 2 patients waiting more than 4 weeks from decision to treat. Increases in the number of COVID positive patients and sickness absence has led LUHFT to request further mutual aid. This request is being facilitated by the lead commissioner, Liverpool CCG.

Figure 1 – CCG RTT Performance and Activity (Incomplete Pathways)



There were a total of 2,557 South Sefton CCG patients waiting over 36+ weeks, the majority at LUHFT. Of the total long waiters, 1,082 patients were waiting over 52 weeks, an increase of 65 on last month when 1,017 breaches were reported, the majority were at LUHFT (907) the remaining 175 breaches spanned across 14 other Trusts.

Included in the long waiters there were 16 patients waiting over 104 weeks. Liverpool CCG, as Lead Commissioner for LUHFT review Root Cause Analyses (RCAs) and harm reviews submitted by the provider for 104 days breaches and long waiters. Feedback has been provided to the Trust regarding those submitted and no serious harms have been identified. Additionally, the Deputy Chief Operating Officer has established a weekly review group to address patients waiting over 104 days (along with patients waiting on the 62-day cancer pathway).

The 1,082 52+ week wait breaches reported for the CCG represent 5.88% of the total waiting list in August 2021 which is just above the national level of 5.11%.

Overall waiters increased by 858 this month with a total 18,395 South Sefton patients now on the RTT waiting list in August 2021. This is compared to 13,682 patients waiting in the equivalent period of the previous year and 17,537 in July 2021. Monthly waiting list is increasing month on month at CCG and Trust.

LUHFT had a total of 4,824 52-week breaches in August 2021, showing an increase of around 7.7% (372) from previous month when the Trust reported 4,452.

Figure 2 – RTT Incomplete Pathways, 52 weeks waiters v Plan

South Sefton CCG

Total Incomplete Pathways	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Plan v Latest
Plan (last year's actuals)*	11,751	11,179	11,311	12,389	13,682	13,626	13,657	14,029	14,265	15,308	15,541	16,076	13,682
2021/22	17,491	15,977	16,576	17,537	18,395								18,395
Difference	**5,740**	**4,798**	**5,265**	**5,148**	**4,713**								**4,713**
52 week waiters - Plan (last year's actuals)*	8	46	106	171	198	247	349	503	647	1,025	1,374	1,548	
52 week waiters - Actual	1,422	978	912	1,017	1,082								
Difference	**1,414**	**932**	**806**	**846**	**884**								

LUHFT

Total Incomplete Pathways	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Plan v Latest
Plan (last year's actuals)*	41,822	39,838	39,096	41,292	42,299	40,417	42,570	43,605	44,536	46,052	47,414	49,055	42,299
2021/22	51,649	55,528	58,134	61,222	63,996								63,996
Difference	**9,827**	**15,690**	**19,038**	**19,930**	**21,697**								**21,697**

**NB. Plans were not required for 2021/22 Operational Planning. Therefore, previous year being used for comparative purposes.*

The Trust has reported 19 cancelled operations in August. No details given by the Trust. For all patients who have had their operation cancelled, on or after the day of admission for non-clinical reasons are to be offered a binding date within 28 days, or treatment to be funded at the time and hospital of patient's choice.

The CCG is achieving 4 of the 9 cancer measures year to date and 6 in August. LUHFT are achieving 3 year to date and 2 in month.

The Trust are still achieving both 2 week wait measures year to date. The 2 week wait measure is now reporting just under target the 93% in August for the CCG recording 92.04% after achieving last month and is now failing year to date.

For Cancer 62 Day standard the CCG is measuring slightly above the national level of 70.74% recording 71.79% in August but below the operational standard of 85%.

For patients waiting over 104 days, the CCG reported 1 patient who waited 124 days, the urological patient's delay was due to a complex diagnostic pathway, first seen and treatment Trust was LUHFT. Liverpool CCG as lead commissioner for the Trust has set up a harm review panel to discuss pathways and learning from 104-day breaches which South Sefton CCG attends when there are South Sefton CCG patients involved.

The 2021/22 Priorities and Operational Planning Guidance: October 2021 to March 2022 sets the following objectives:

1. Return the number of people waiting for longer than 62 days to the level we saw in February 2020 (based on the overall national average) by March 2022.
2. To meet the Faster Diagnosis Standard (FDS) from Q3, ensuring at least 75% of patients will have cancer ruled out or diagnosed within 28 days of referral for diagnostic testing.

In August, the CCG performed above the proposed target for the 2-week breast symptom FDS indicator. However, the two week and screening referral indicators performed below target.

Performance against recovery trajectories demonstrates that in August the CCG is exceeding plan for numbers of first outpatients seen following an urgent referral and for patients receiving a first cancer treatment within 31 days of a decision to treat.

LUHFT Friends and Family Inpatient test response rate is above the England average of 19.6% in July 2021 at 21.6% (latest data reported). The percentage of patients who would recommend the service has declined to 90%, which is below the England average of 94% and the percentage who would not recommend has increased to 6% and still above the England average of 3%. The Quality Team continue to monitor trends and request assurances from providers when exceptions are noted. Updates are provided via the CCG's Engagement & Patient Experience Group (EPEG) meetings and Clinical Quality Performance Group (CQPG) and discussed with rationale for dips in performance provided by the Trust. The Trust are due to present their bi-annual Patient Experience

update to EPEG in November 2021 and a wider EPEG Provider focussed Patient Experience workshop is planned for January 2022.

For planned care finance and activity, 2020/21 saw significant reductions in contracted performance levels across the majority of providers for South Sefton CCG. This was a direct consequence of the COVID-19 pandemic and subsequent response to postpone all non-urgent elective operations so that the maximum possible inpatient and critical care capacity would be available to support the system. For 2021/22 there is a focus on restoration of elective services as set out in the NHS Operational Planning Guidance. At month 5 of 2021/22, this has resulted in a considerable 34% increase in planned care activity (incorporating inpatients and outpatients) when compared to the equivalent period in the previous year. As part of the H1 Planning Guidance, CCGs were expected to plan for 85% of 2019/20 (pre-pandemic) activity levels being completed from July-21 and available contracting data suggests this has been achieved with activity in month 5 representing 97% of that in August-19. The majority of previous months have also seen activity exceed planned levels for South Sefton CCG.

Figure 3 – Planned Care All Providers - Contract Performance Compared to 2019/20

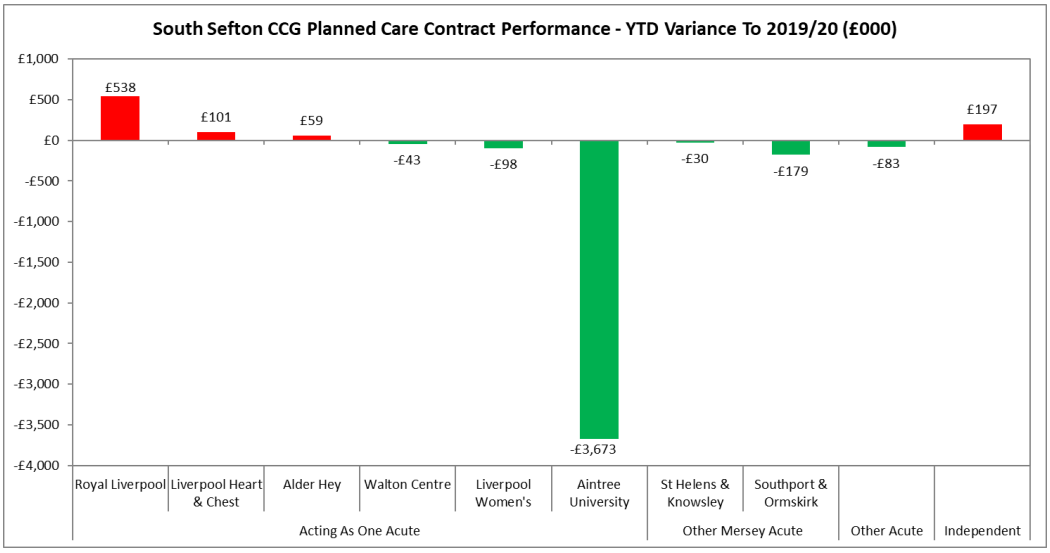


Figure 4 - Planned Care Activity Trends

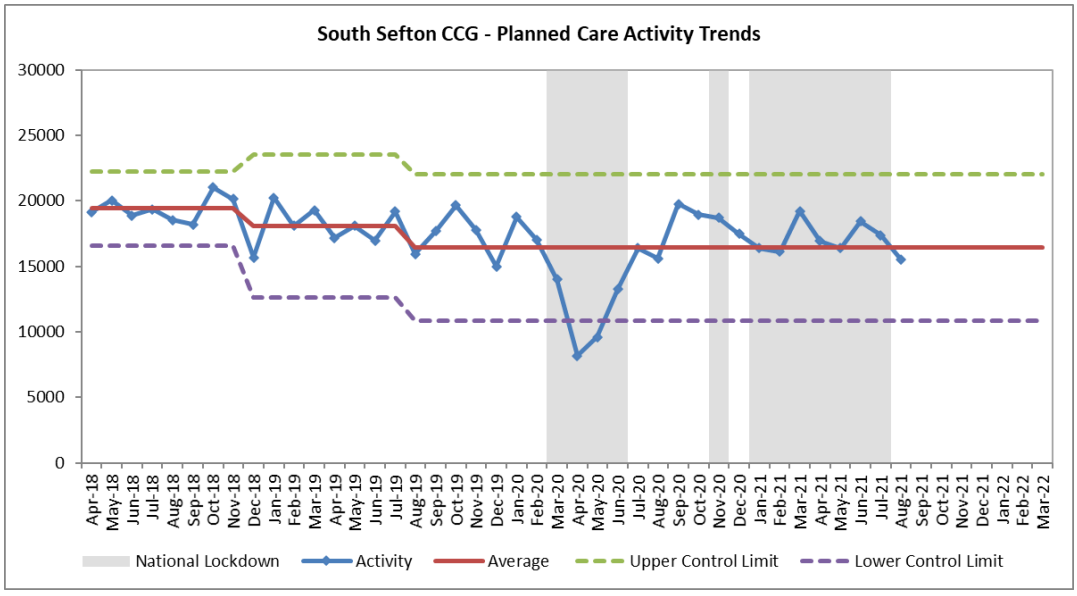


Figure 5 – Elective Inpatient Variance against Plan (Previous Year)

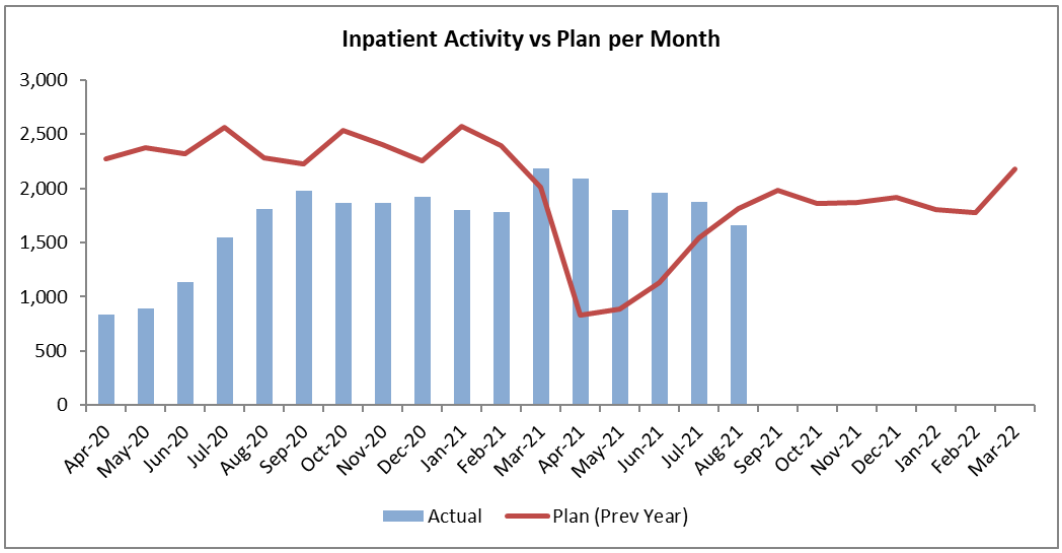
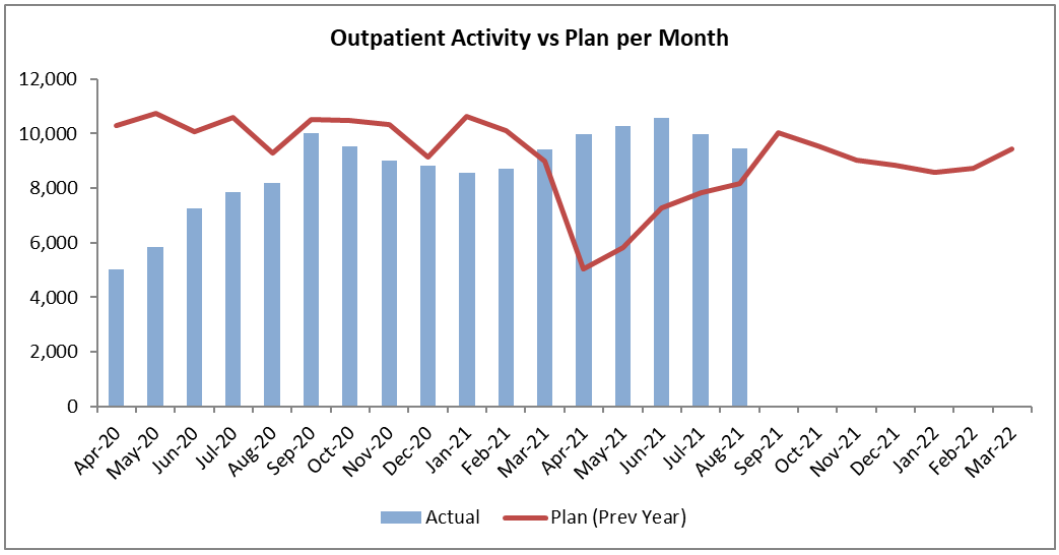


Figure 6 – Outpatient (First and Follow Up) Variance against Plan (Previous Year)



Unplanned Care

In relation to A&E 4-Hour waits for all types, the CCG and LUHFT have failed the 95% target in August 2021, reporting 67.75% and 66.03% respectively. This shows a very slight increase from the previous month and the CCG and Trust performance is lower than the nationally reported level of 77.01%. LUHFT's catchment position is showing a sustained historical peak which is impacting on performance. The Trust have reported no 12-hour breaches in August. Despite the unprecedented and prolonged surge in demand for unplanned care services, the CCG continue to work with system partners to redirect flow to appropriate non-AED services via the capacity and flow and NHS 111 First groups as well as progressing work streams to improve pathways into other urgent care services such as Walk-In Centres, the Clinical Assessment Service and 2-hour community response services. Fortunately, COVID admissions remain low. The CCG is still seeing a huge demand in general practice activity which is having a negative impact on AED due to increases in patient expectation to be seen the same day. However, more patients are being referred or redirected to community pharmacies, dentists and opticians from a variety of sources to direct patients to the most suitable service and relieve pressure on urgent care services. The CCG is also working with several AED's to implement the NHS Digital Emergency Department Streaming tool that will be launched

prior to winter in both LUHFT ED's to try and redirect lower acuity presentations into the community and provide a consistent offer to patients accessing urgent and emergency care services.

The original target to meet all of the ARP (Ambulance Response Programme) standards by Q1 2020/21 has not been met and was severely adversely impacted upon by COVID-19, which began to hit service delivery in Q4 2019/20 and has continued. The latest available data is for August 2021, when the average response time for South Sefton was 8 minutes 37 seconds, over the target of 7 minutes for category 1 incidents. Category 2 incidents had an average response time of 1 hour, 9 minutes against a target of 18 minutes. The CCG also failed the category 2, 3 and 4 90th percentile, these have shown the largest deterioration in recent months. 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. NWAS pathways into Litherland UTC is now live and pathways between NWAS and community services are being developed to increase see and treat and reduce conveyances to ED. The introduction of a Sefton Emergency Response Vehicle to support category 3 and 4 calls has been agreed to be implemented but is stalled due to a lack of additional resource with the current pressures.

For ambulance handovers, LUHFT reported an increase in ambulance handover times in August for handovers of 30 and 60 minutes which increased from 503 to 670, those above 60 minutes increased from 153 to 234. Work continues in collaboration with NWAS to improve processes to support achievement of the handover targets, which includes the adoption of the ED Checklist to support turnaround times within ED. There have been changes to processes since pandemic and a need for patients to enter A&E through revised estate reconfigurations due to COVID and Infection Prevention Control (IPC) restrictions. Performance regarding this target has varied in line with activity and pressures within A&E and patient flow. In addition to the ED Checklist, NWAS and LUHFT operational staff have been having open and transparent communication to understand each organisations viewpoint to find additional solutions to overcome ambulance delays.

For stroke, the CCG's lead provider LUHFT have not provided any further performance update this month. In terms of CCG actions, the extensive work of the Merseyside Stroke Board continues with recent presentations to local Oversight and Scrutiny Committees (OSCs) which to date have been received very positively. The programme has successfully passed NHSE stage 2 assurance subject to a number of caveats and an expectation that the proposal will proceed to public engagement.

The CCG and Trust reported no new cases of MRSA in August but have failed the zero-tolerance plan for 2021/22 due to 1 case reported in June. All incidents are reviewed as part of the Infection Prevention Control (IPC) meeting on a monthly basis, which the CCG attend.

For C difficile, the CCG reported 4 new cases of C difficile cases in August (26 year to date) against a year to date target of 22. The CCG now have the new objectives/plans for C. Difficile for 2021/22, year-end target is 54 cases. LUHFT reported 15 new cases in August (62 year to date) against a year to date target of 62 and are achieving. Post infection reviews (PIR) continue to be undertaken with 26 cases no lapses in care, 25 lapses in care which may not have contributed to the infection and 11 case were lapses may have contributed to the infection (stool monitoring, isolation and additional improvement required in IPC audits and environmental scores). It has been acknowledged nationally that this has in part due to the increased prescribing of antibiotics due to COVID and rates have risen in all acute Trusts.

NHS Improvement and NHS England (NHSE/I) originally set CCG targets for reductions in E. coli in 2018/19, the CCG have the new objectives/plans for E. coli for 2021/22 along with new Trust objectives to monitor. In August there were 16 new cases (61 year to date), against a year to date target of 70 so achieving the target currently, year-end target is 156. LUHFT reported 18 new cases in August (91 year to date) against their year to date plan of 97 so are also achieving.

LUHFT's Hospital Standardised Mortality Ratio (HSMR) was reported at 99.21 in August by the Trust, under the 100 threshold. The ratio is the number of observed deaths divided by predicted deaths. HSMR looks at diagnoses which most commonly result in death.

LUHFT Friends and Family A&E test response rate is above the England average of 9.7% in July 2021 at 20.9% (latest data available). The percentage of patients who would recommend the service has decreased to 58%, which is below the England average of 76%. The percentage who would not recommend has increased to 31% and above the England average of 16%. The Trust continue to work with the Care Quality Commission (CQC) and the CCG on the AED Improvement Plan. The improvements include increasing staff capacity and patient flow in AED which aims to have a positive impact on waiting times and therefore patient experience. Implementation of the plan and progress continues to be monitored by the CCG via monthly Clinical Quality Performance Group (CQPG) meetings and the Commissioning Collaborative Forum (CCF).

For unplanned care finance and activity, 2020/21 saw significant reductions in contracted performance levels across the majority of providers for South Sefton CCG. This is a direct consequence of the COVID-19 pandemic and subsequent national response whereby the public guidance was to 'stay at home'. Recent trends from March-21 have shown considerable increases in total unplanned care activity, which incorporates A&E attendances, non-elective admissions and attendances at Litherland walk-in centre (now operating on a pre-booked appointment basis). Total activity during May-21 was a historical high for South Sefton CCG and although the following months have seen a decrease, urgent care activity levels remain above average. Focussing specifically on A&E type 1 attendances, activity during August-21 was also 6% above that in August-19 with 2019/20 activity (pre-pandemic) being the applied baseline to operational planning levels for 2021/22. CCGs were expected to plan for 100% of 2019/20 activity levels being achieved during 2021/22.

Figure 7 – Unplanned Care All Providers - Contract Performance Compared to 2019/20

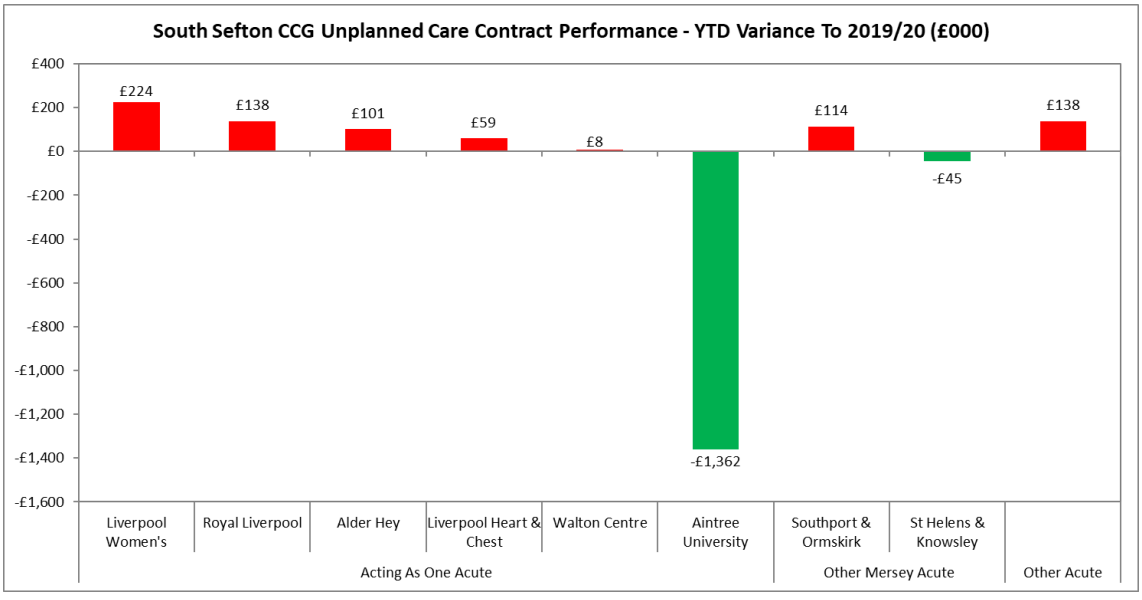


Figure 8 - Unplanned Care Activity Trends

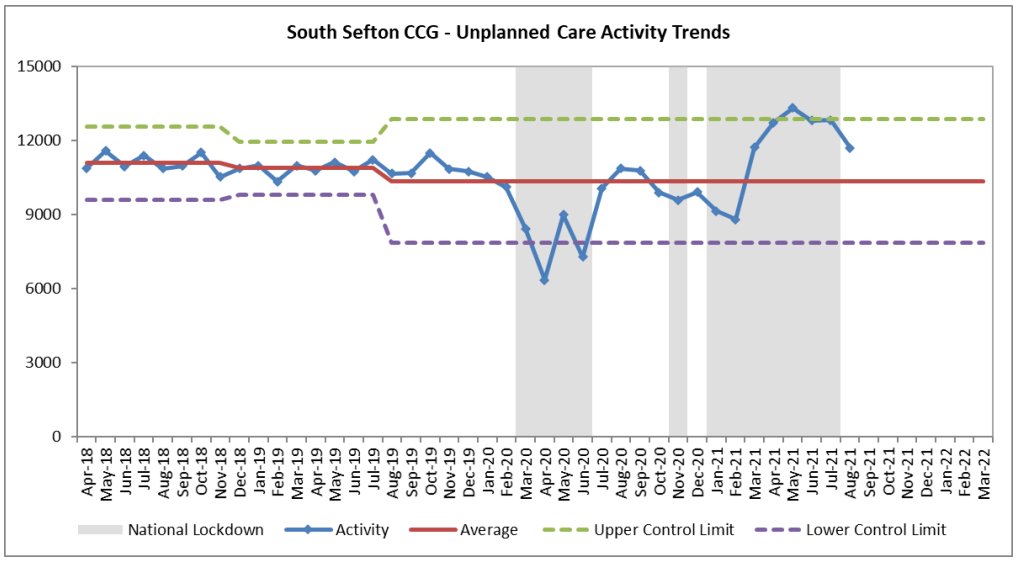


Figure 9 - A&E Type 1 against Plan (Previous Year)

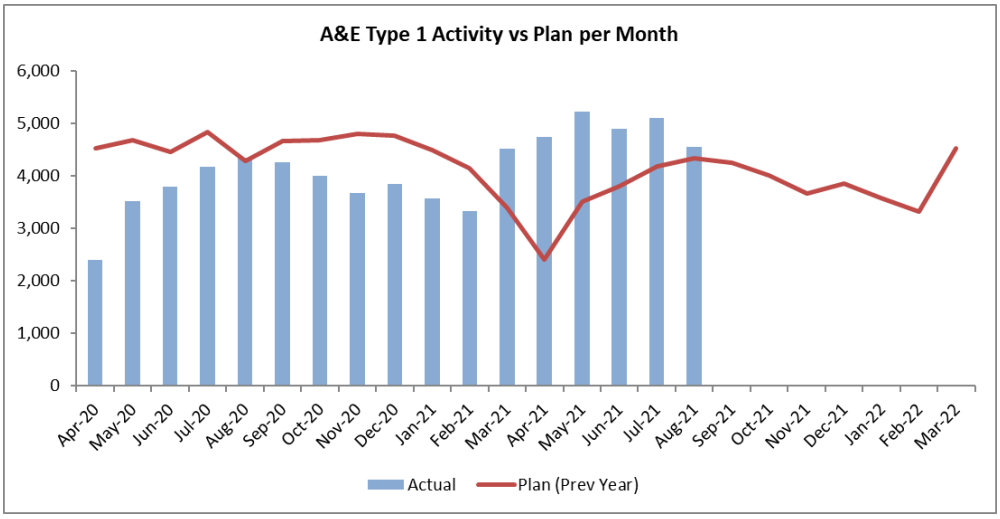
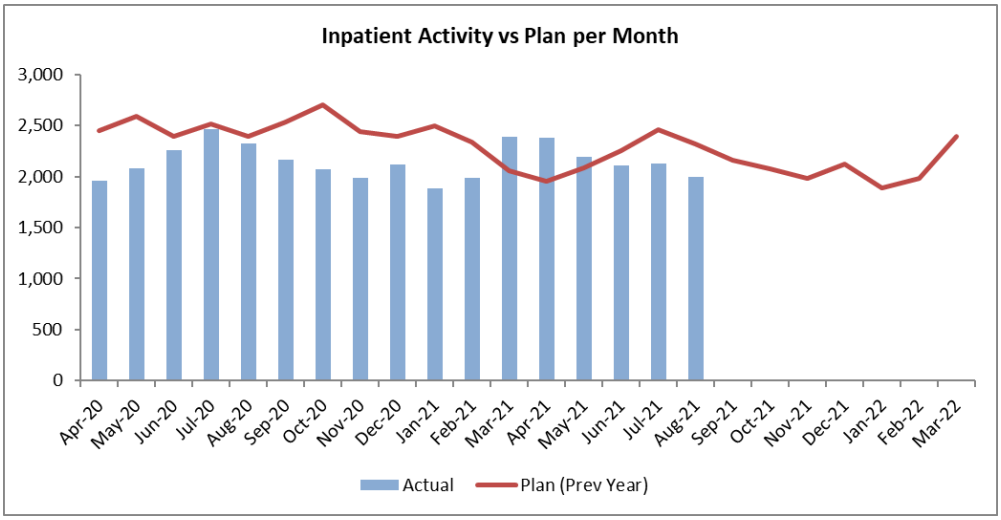


Figure 10 – Non-elective Inpatient Variance against Plan (Previous Year)



Mental Health
The Eating Disorder service has reported 11.4% of patients commencing treatment within 18 weeks of referral in August, compared to a 95% target. Just 4 patients out of 35 commenced treatment within 18 weeks, which shows another significant decline on last on month (25.7%). Demand for the services continues to increase and to exceed capacity. The CCG approved of £63k (£112k in total) of recurring investment within the Eating Disorder Service as part of its overall Mental Health Long Term Plan 2021 /22 investment plan. This investment is part of a 3-year phased approach (2021/22 – 2023/24 to developing a NICE compliant Eating Disorder Service. The service is planning to recruit for a dietician and psychology posts, however recruitment for a First episode Rapid Early Intervention (FREED) clinical Psychologist has been successful as a part of the Trust's Community Mental Health Transformation Programme.

For Improving Access to Psychological Therapies (IAPT), Mental Health Matters reported 0.72% in August, below the monthly target standard of 1.59%. Actions to address the underperformance include:

- 1 Trainee Psychological Wellbeing Practitioner (PWP) commenced in September and 3 trainee PWP's commenced in October 2021.
- 4 x High Intensity Therapists (HIT) recruited with 3 having commenced duties in June and 1 post due to commence in October 2021.
- Participation in Cheshire & Merseyside system level work to increase numbers of PWP and HIT trainees supported by a proposed Cheshire & Merseyside supervision hub and marketing of IAPT at local and planned regional level.

The percentage of people who moved to recovery was 33.3% in August against the target of 50%, which is a decline from last month when 42.3% was reported. Long internal waits within the IAPT service are a major contributing factor to recovery rates. The provider is planning to allocate the recently recruited HIT resource to address a ringfenced cohort of internal waiters.

South Sefton CCG is recording a dementia diagnosis rate in August of 59.7%, which is under the national dementia diagnosis ambition of 66.7%. This is similar to last month's performance of 59.3%. The CCG approved a scheme to go into 2021/22 Local Quality Contract with primary care across Sefton to improve performance going forward. Recovery is unlikely to take place until face-to-face assessments can resume. In line with Cheshire & Merseyside Health Care Partnership expectations the CCG as is working with Mersey Care Foundation Trust to ensure that £48k of non-recurring Spending Review monies is utilised to reduce Memory Assessment waits.

In November 2020 the CCGs agreed £100k non-recurring funding initially targeting those people with identified with SEND to be prioritised for diagnostic assessment. These individuals with SEND have had their diagnostic assessment undertaken and the residual funding is targeting the wider waiting list. The CCGs have acknowledged that long term investment in the ASD service is required and in July 2021 both CCGs agreed to fund £100k investment into the service and this will increase assessment capacity. The Trust have trained 5 staff across the service to undertake DISCO and AD-I-R / ADOS diagnostic assessment training and clarified that 2 of these staff face Sefton. These individuals commenced assessment duties in October 2021 and will add 90 assessments in addition to the 50 already commissioned. The service is also intending to remodel and the expectation is that this will generate additional assessment capacity. In addition, the service is recruiting an assistant psychologist to enhance existing post diagnostic support.

The Trust is developing a waiting list initiative aimed at reducing ADHD wait times which were reported as being 63 weeks in August 2021. The waiting list cleanse has been completed and the list is now 300 people having previously been recorded as being 547 people. All people on the waiting list have been contacted and have opted to remain on the list. The Trust is recruiting a nurse prescriber internally who will undertake reviews allowing the medical staff to undertake 12-14 new assessments per week. In addition, the Trust plans to outsource 100 assessments commencing in October 2021 by using some of the monies originally identified for agency staff. The Trust has been requested to

provide more detail of the sub-contract arrangement for assurance purposes and that it should be under the aegis of the NHS Standard Contract.

Adult Community Health Services – (Mersey Care NHS Foundation Trust)
Focus within the Trust remains on COVID-19 recovery/resilience planning and understanding service specific issues e.g., staffing, resources, waiting times. Assurance will be sought in regard to changes instigated in response to COVID-19 and an understanding of services that are not operating at pre-COVID levels. A single Clinical Quality Performance Group (CQPG) across the Mersey Care footprint of commissioned services including South Sefton, Southport and Formby and Liverpool CCGs has been introduced. The joint Sefton and Liverpool Information Sub-Group is supporting the ongoing development and performance monitoring with the Trust. The Trust in collaboration with CCG leads will be reviewing service specifications throughout 2021/22 to ensure they reflect required service delivery and improvement work that has taken place over past few years.

Month 5 assurance supplied by the Trust indicates that Allied Health Profession (AHP) waiting times have maintained improved positions within the 18-week standard with the exception of physiotherapy at 31 weeks as the longest wait and Speech and Language Therapy at 20 weeks. CCG continues to monitor waiting times with close monitoring of the Speech & Language Therapy (SALT) service and Physiotherapy which continues to see high demand. AHP services triage patients and prioritise on clinical need and the Trust has provided a performance improvement plan for physiotherapy. Consideration is being given to reduce the waiting times targets in 2021/22 in recognition of the sustained improved performance in line with agreed transformation work by the Trust.

Children's Services
In its ongoing response to the impact of the pandemic, Alder Hey continues to focus on sustaining and improving pre-COVID levels of activity for community therapy services and Child and Adolescent Mental Health Services (CAMHS).

In respect of community therapy services provision, this has enabled services to focus on reducing the numbers of children and young people who have been waiting the longest whilst managing increases in referrals. As previously reported, the SALT service has experienced a sustained increase in referrals following lockdown and the reopening of schools. Whilst referrals have reduced over the summer holiday period, the backlog of assessments and increased acuity and urgency of cases has meant that performance has continued to be challenged (August 18 weeks is at 39.1%). The position is being closely managed by the service and all referrals continue to be clinically triaged at the point of receipt and prioritised according to need. From mid-September, the service will be fully staffed and it is anticipated that if referral levels begin to return to pre-covid levels, improvements will be seen in subsequent months.

Physiotherapy and dietetics continue to perform better than the 92% KPI. There has been a slight deterioration in both Occupational Therapy (OT) and Continence in August (84.9% and 80% respectively), partially attributable to staff absences and delays in recruitment. The position of the continence service has since improved as more clinic appointments are being offered.

The Alder Hey CAMHS team continues to address the ongoing impact of the pandemic on the increase in demand for the service and the increasing number of high risk and complex cases, a position which is reflected regionally and nationally. Current modelling across Cheshire and Merseyside suggests that demand for mental health services could increase by 30% over the next two years, with the majority of this demand in crisis and urgent mental health support. Notably the 30% figure is twice the initial 15% estimate modelled at the outset of the pandemic.

Due to these ongoing issues, waiting times for assessment and treatment continue to be challenged locally and there was a further dip in performance in August as referrals continue to increase and the trust focuses on those children and young people who have been waiting the longest for assessment and treatment. To mitigate, two new staff commenced in post in August and further additional capacity is being provided where possible. Recruitment to utilise the 21/22 mental health investment

is progressing with multiple interview panels taking place in September and October. A detailed trajectory will be provided when staff are appointed to demonstrate when capacity and waiting times are expected to improve.

Sefton has also been successful in its joint bid with Liverpool CCG to be a pilot site for the mental health 4 week wait initiative which will also positively impact waiting times.

In the meantime, the CAMHS waiting time position continues to be closely monitored by the CCGs and the Trust, and the local CAMHS partnership and third sector providers continue to offer additional support and capacity.

As with CAMHS, the impact of COVID has led to an increase in demand for the Eating Disorders Young People's Service (EDYS) and a number of new and existing patients continue to present to the service at physical and mental health risk, a position that is reflected nationally. Consequently, during COVID-19 the service has seen the highest number of paediatric admissions for young people with an eating disorder since the service commenced.

Referral rates for ASD/ADHD services continue to increase at a rate significantly higher than what is currently commissioned. This is impacting on capacity within the diagnostic pathway and leading to delays in completion of assessment pathways within agreed timescales. ADHD waiting times are increasing and have fallen below target for completed assessments within 30 weeks reporting 88% against the 90% target. Also due to the increasing number of referrals and the pressure on service capacity, the ASD 30 week to completion of assessments was not achieved in August and fell to 62%. The Trust has a number of mitigating actions in place to manage this and is undertaking a deep dive of the drivers for the increase which will be concluded by the end of October 2021. The CCGs will review the outcomes from the deep dive alongside the Trust's paper which details the current position, mitigations and options for consideration.

CQC Inspections
Previously halted due to the COVID-19 pandemic. Practices in South Sefton CCG GP practices are visited by the Care Quality Commission and details of any inspection results are published on their website. The inspections have resumed, but no new inspections happened in August.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
NOVEMBER 2021

Agenda Item: 21/152	**Author of the Paper:** Document produced by Grant Thornton. To be presented by: Martin McDowell Chief Finance Officer martin.mcdowell@southportandformbyccg.nhs.uk	**Clinical Director Lead:** N/A
Report date: November 2021		

Title: Auditors Annual Report / Letter 2020/21

Summary/Key Issues:

The Annual Audit Letter summarises the key findings of the external audit of NHS South Sefton CCG for 2020/21. As this is a public document, the Auditors Annual Report has been displayed on the CCG website.

Recommendation

The Governing Body is asked to receive the Auditors Annual Report / Letter 2020/21.

Receive	X
Approve	
Ratify	

Links to Corporate Objectives 2021/22 *(x those that apply)*	
	To implement Sefton2gether and realise the vision and ambition of the refreshed Health and Wellbeing Strategy.
X	To drive quality improvement, performance and assurance across the CCG's portfolio.
	To ensure delivery of the CCG's financial plan and align it with Sefton2gether and the work plan of transformation programmes
	To support primary care development ensuring robust and resilient general practice services and the development of Primary Care Networks (PCNs).
	To progress the changes for an effective borough model of place planning and delivery and support the ICS development.

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

Grant Thornton

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Dear Martin,

NHS South Sefton CCG: Closure of the audit for 2020/21

Further to our letter dated 17 June 2021, we are pleased to be able to advise you that we have now completed our work on your arrangements for securing economy, efficiency and effectiveness in your use of resources for the year ended 31 March 2021.

We issued our Auditor's Annual Report to the CCG on 7 September 2021. Please ensure you publish this report on your website.

Our auditor's report, including our report on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources, and our certificate of completion of the audit for the year ended 31 March 2021 is attached. Please include this auditor's report and certificate in your Annual Report and Accounts alongside our auditor's report issued on 17 June 2021, which included our opinion on your financial statements, prior to publication of the Annual Report and Accounts on your website. Please ensure that you do not reproduce the signature of the auditor in any electronic format for any other purpose.

Please note that the Department of Health and Social Care Group Accounting Manual 2020-21 and the 'Financial accounting and reporting updates' issued by NHS England both clarify that your Annual Report and Accounts document is not complete until the audit report is accompanied by the audit certificate.

Please feel free to contact me if you would like clarification on any point.

Yours sincerely

Georgia Jones

Georgia Jones, Key Audit Partner

For Grant Thornton UK LLP

Independent auditor's report to the members of the Governing Body of NHS South Sefton CCG

In our auditor's report issued on 17th June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the CCG for the year ended 31 March 2021, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had:

- Completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 17th June 2021we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements - the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

The Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of NHS South Sefton Clinical Commissioning Group for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an audit certificate and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Georgia Jones

Georgia Jones, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Liverpool

7 September 2021

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
NOVEMBER 2021

Agenda Item: 21/154	**Author of the Paper:** Debbie Fairclough Interim Programme Lead – Corporate Services Debbie.fairclough@southseftonccg.nhs.uk	**Clinical Lead:** N/A
Report date: November 2021		

Title: CCG – Closedown and Transfer update

Summary/Key Issues:

In August 2021 NHSE/ published its document *ICS implementation guidance: Due diligence, transfer of people and property from CCGs to ICBs and CCG close down.*

This paper summarises the arrangements in place within the CCG to ensure compliance with mandated requirements and the safe and effective closedown and handover of relevant functions to the ICS.

Recommendation

The Governing Body is asked to *receive* the report.

Receive	X
Approve	
Ratify	

Links to Corporate Objectives 2021/22 *(x those that apply)*	
X	To implement Sefton2gether and realise the vision and ambition of the refreshed Health and Wellbeing Strategy.
X	To drive quality improvement, performance and assurance across the CCG's portfolio.
X	To ensure delivery of the CCG's financial plan and align it with Sefton2gether and the work plan of transformation programmes
X	To support primary care development ensuring robust and resilient general practice services and the development of Primary Care Networks (PCNs).
X	To progress the changes for an effective borough model of place planning and delivery and support the ICS development.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement				
Clinical Engagement				
Equality Impact Assessment				
Legal Advice Sought				
Quality Impact Assessment				
Resource Implications Considered				
Locality Engagement				
Presented to other Committees	x			Arrangements reviewed and approved by Leadership Team June 2021

South Sefton
Clinical Commissioning Group

Report to the Governing Body
November 2021

1. Introduction

The NHSE publication outlined the due diligence process required for the safe transfer of people (staff) and property (in its widest sense) from clinical commissioning groups (CCGs) to integrated care boards (ICBs), and the legal processes used for transfer, establishment and closedown.

2. Key points:

- Due diligence is necessary to enable safe and effective transfer from sending organisations to receiving organisations.
- The due diligence process is supported by a bespoke checklist specifically designed for the ICS implementation programme. This was published along with the guidance and is currently being updated.
- A staff and property transfer scheme will be the legal instrument used for the transfer. ICBs will be established by NHS England and CCGs concurrently abolished.
- ICBs will be responsible for any outstanding CCG close down activity.

The guidance required CCG accountable officers to ensure ensure that their teams plan for and undertake robust and proportionate due diligence, and recommended that the checklist provided is used for this purpose.

In March 2022, CCG accountable officers are expected to provide written assurance of due diligence to the relevant NHS England and NHS Improvement regional director and (if appropriate) the chief executive (designate) of the ICB.

3. The CCGs internal arrangements

The leadership team formally established a sub-group, the closedown and transfer group, that was given the responsibility for overseeing all closedown and transfer related activity. The group is responsible for ensuring that the due diligence checklist is completed and all relevant activities are transacted.

The close down and transfer group provides weekly progress updates to the leadership team and will update the governing body on progress at each future meeting. The governing body will be required to sign off the final due diligence list and schemes of transfer during Q4 and ahead of the implementation of the ICS legislation.

MIAA, the CCGs internal auditors, have been requested to undertake an internal audit of the checklist and transfer schemes so as to provide assurance that the content is accurate before being submitted to governing body for final sign off.

The CCG's Audit Committee has also received a report setting out the internal arrangements and confirmed it was assured that the arrangements are appropriate.

4. Cheshire and Merseyside arrangements

A transition programme has now been established as the ICS level and the accountable officer for NHS Knowsley CCG is the nominated executive lead. The transition programme also comprises the closedown and transfer programme and governance leads across Cheshire and Merseyside are required to submit assurance reports and exception reports on a regular basis. The first return was submitted on 28th September and the CCG was able to confirm that there were arrangements to oversee closedown and transfer and that progress was already being made by leads in terms of required actions.

5. Key area of progress to date

Due diligence KLOE	CCG or CSU lead	Comment
General	Chief Officer - SRO Interim Programme Lead – Corporate Service	Initial baseline submission sent to C&M transition team 28.9.21. New DD template will be published mid-October 2021. This has not yet been published. MIAA now represented on the Closedown and Transfer Group
Finance	Financial Accountant	**On track:** Finance team working through all requirements in the DD checklist.
Contracts	Senior Contracts Manager	**On track:** Repository of NHS standard contracts, corporate contracts, primary care and other non-clinical contracts now created. Information shared with C&M 15.10.21 further updates will be requested in due course.
HR	Interim Programme Lead – Corporate Service MLCSU HR Business Partner	**On track:** Full list of staff shared with C&M List of fixed term, secondments, contracts ***for*** services now shared with CCG. DF, TJ and MMcD to review initially and feedback required from managers as to what contracts will be required post transfer.
Estates	Estates Lead	**On track:** List of estates and assets being consolidated along with relevant rental/lease agreements.
Information Governance	Deputy Chief Officer/Chief Finance Officer and SIRO Interim Programme Lead – Corporate Services IG Lead - MLCSU	**On track:** IG adherence is reflected in all work programmes CCGs will not submit DPST this year but will collate relevant evidence – decision to be authorised by GBs on 2rd and 4th November
EPRR and COVID19 enquiry	Interim Programme Lead – Corporate Services	**On track:** All COVID19 files are held centrally and will transfer.

		Further work will be required ahead of and post transfer to ensure that all documentation and communications are accessible as part of the COVID19 public inquiry.
Corporate governance (risk, FOI, claims etc)	Interim Programme Lead – Corporate Services	**On track:** In progress. Consolidation of risk will take place over a period of time with focus on mitigating to an acceptable level, removing as no longer a risk or transfer to the ICS. CCG maintains comprehensive data bases of all corporate records that will be available to transfer.
Quality	Deputy Chief Nurse	**On track:** The CCG holds comprehensive records relating to complaints, SI, IFRs, LeDer, domestic homicide reviews, Safeguarding, SCRs etc. This will all be consolidated as part of a quality handover document.
Medicines management	Medicines Management Lead	**On track:** Work in progress to consolidate all MM related activities that will transfer.

6. Recommendations

The Governing Body is asked to receive the update.

Debbie Fairclough
Interim Programme Lead – Corporate Services
November 2021

Transfer and Closedown Group Terms of Reference

The group is established as sub group of the leadership team that comprises relevant leads to ensure the correct and effective closedown of the CCG and the transfer of staff and relevant functions and liabilities to the successor organisation.

The group as a collective does not have any decision making authority but can make recommendations to the Leadership Team or other committees as relevant in respect of matters that arise.

In addition to providing updates and assurances to the leadership team, the group will also work with the relevant wider Cheshire and Merseyside forum.

Terms of Reference

1. Roles and responsibilities

- To develop and implement a close down and transfer plan and provide assurances on progress to the leadership team
- To ensure that all HR roles and responsibilities are effectively discharged
- To oversee relevant staff consultation exercises and respective TUPE or COSOP transfers
- To ensure appropriate involvement of staffside and trade unions
- To ensure that all matters relating to quality are properly addressed and transferred as appropriate
- To ensure that all COVID19 pandemic response and emergency planning related activities and records are consolidated and transferred
- To ensure all legal liabilities are correctly identified and transferred
- To ensure that all assets disposed of or are transferred as appropriate
- To ensure that all information that is held by the CCG is archived, or transferred to the relevant parts of the new system and in accordance with relevant information governance requirements.
- To ensure that all financial closedown requirements are effectively discharged
- To ensure that all IM&T and digital related requirements are discharged and that related assets are transferred as appropriate
- To ensure that there are effective arrangements in place to notify providers of change in contract holder arrangements and arrange for the novation of relevant contracts
- To document terminated or expired contracts so that there is a clear record of such documents in the event of a claim made with the statutory limitation periods

- To ensure there are effective internal and external communications, involvement and engagement mechanisms in place to support the transition
- To create a corporate handover document for the successor body
- To create a quality handover document for the successor body
- To ensure that all risks associated with the transition are identified and relevant mitigations and controls put in place.
- To escalate risks that could adversely impact on the ability of the CCGs to achieve their strategic objectives and statutory duties are escalated to the leadership team.

2. Membership

- Interim programme lead corporate services – Debbie Fairclough
- Chief finance officer/Deputy chief officer – Martin McDowell
- Deputy chief nurse – Tracey Forshaw
- Head of communications and engagement – Lyn Cooke
- Corporate governance manager – Lisa Gilbert
- Senior contracts manager – Nadine Smith
- Information governance business partner – Pippa Joyce (MLCSU)
- Senior HR business partner, people services – Gillian Roberts (MLCSU)

3. Frequency and notice of meetings

- The group will meet fortnightly with effect from 22nd June 2021
- The frequency of meetings will increase or reduce as necessary to align with the transition programme

4. Review

Date: June 2021

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
NOVEMBER 2021

Agenda Item: 21/155	**Author of the Paper:** Debbie Fairclough Interim Programme Lead – Corporate Services Debbie.fairclough@southseftonccg.nhs.uk	**Clinical Lead** N/A
Report date: November 2021		

Title: EPRR assurance process 2020/21

Summary/Key Issues:

The EPRR assurance process for 2020/21 took place throughout September with a submission deadline of 1st October 2021. NHS England agreed that for this year's submission, and in recognition of the schedule of governing body meetings across the system, that it was acceptable for a member of the leadership team to sign off the submission to meet the deadline.

The CCG's Interim Programme Lead – Corporate Services, and the EPRR lead from MLCSU undertook the assessment against the relevant standards with an overall outcome of fully compliant.

The assessment was signed off the CCG's Chief Officer and submitt4ed to NHSE on 1st October.

The Governing Body are presented with a copy of the full submission.

Recommendation

The Governing Body is asked to

- *Receive the report.*

Receive	X
Approve	
Ratify	

Links to Corporate Objectives 2021/22 *(x those that apply)*	
	To implement Sefton2gether and realise the vision and ambition of the refreshed Health and Wellbeing Strategy.
X	To drive quality improvement, performance and assurance across the CCG's portfolio.
	To ensure delivery of the CCG's financial plan and align it with Sefton2gether and the work plan of transformation programmes
	To support primary care development ensuring robust and resilient general practice services and the development of Primary Care Networks (PCNs).

	To progress the changes for an effective borough model of place planning and delivery and support the ICS development.

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

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

South Sefton CCG has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, South Sefton CCG will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Full (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
29	0	0	29
Acute providers: **46** Specialist providers: **38** Community providers: **37** Mental health providers:**37** CCGs: **29**			

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

Fiona Taylor.

01/10/2021

Date signed

Date to be presented at public governing body meeting
4th November 2021

Date published in organisations Annual Report

Ref	Domain	Standard	Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England and NHS Improvement Region	NHS England and NHS Improvement National	Clinical Commissioning Group	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance																							
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• Name and role of appointed individual	Fiona Taylor - Accountable Officer is governing body level SRO Debbie Fairclough Interim Programme Lead Corporate Services (operational lead Leadership Team nominated lead) Alan Sharples South Sefton and Helen Nichols Southport and Formby identified as Lay Member	Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR Policy outlines the commitments and resourcing needs. CCG commissions MLCSU to undertake EPRR activities on its behalf (documentation, planning, BC activities and training and exercising).	Fully compliant				
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	EPRR Core standard outcome for 19/20 posted on website. IGG regular reporting for EPRR and BC issues chaired by Corporate services director, provided by MLCSU. Regular EPRR and BC reporting to GB reported on CCG website.	Fully compliant				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	EPRR Policy in place October 2020. Policy outlines resource and CCG commissions MLCSU to undertake EPRR activity on its behalf.	Fully compliant				
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Process explicitly described within the EPRR policy statement	Outlined in EPRR policy.	Fully compliant				
Domain 2 - Duty to risk assess																							
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	EPRR risk included in the Corporate Risk Register. Escalation of risk process described within the EPRR Policy. EPRR risks discussed at IGG regular meetings	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Risk Management Strategy in place for CCG (Jan 21). Corporate Risk Register includes process for capturing EPRR risks.	Fully compliant				
Domain 3 - Duty to maintain plans																							
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Critical Incident Management reponsibilities for CCG covered under Major Incident Plan and CCG Business Continuity Arrangements. Local risks linked to Community Risk Register and LHPR activities included in planning arrangements.	Fully compliant				
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	CCG has Major Incident Plan in place and EPRR policy. CCG role in Major Incident described and action cards included for risk specific incidents.	Fully compliant				
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Heatwave response included within Major Incident Plan. Arrangements reflect national Heatwave Plans. Action Cards highlight internal actions and expected system response to Heatwave management. Public Health England information hosted on CCG website. Severe weather plan in place.	Fully compliant				
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	CCG circulated and shared messages from NHS on website as part of the 'stay well campaign'. Public Health England information hosted on CCG website regarding cold weather. Severe weather plan in place. EPRR plan has action card in place for cold weather response.	Fully compliant				
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	CGG EPRR Plan describes process. CCG, through Business Continuity plan and EPRR plan has effective arrangements to manage Mass Casualty event. On Call Pack includes Mass casualty response and process across the region.	Fully compliant				
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Y												Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required						
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	CCG has effective arangements in place to evacuate office space. Fire Wardens trained and appointed to fulfill their role. Health and Safety Policy. Provider assurance given through Business Continuity Plans and adoption of NHS Shelter and Evacuation Plan principles.	Fully compliant				

21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Y	Y	Y			Y					Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required							
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals', Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Y	Y	Y			Y					Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required							
Domain 4 - Command and control																							
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	CCG part of the North Mersey On Call Group providing 24/7 on call response. Rota administration undertaken by MLCSU. Call Centre operating provided by Office Link. On Call Pack produced and updated quarterly by MLCSU. Escalation process listed as part of EPRR policy and on call pack circulation.	Fully compliant					
Domain 5 - Training and exercising																							
Domain 6 - Response																							
30	Response	Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		ICC idenfied within the Business Continuity Plan and alternative locations identified and listed within the plan. Roles and responsibilities of Crisis Management team listed within the Business Continuity Plan and Command and Control guidelines within the EPRR Plan. ICC scheduled for test as part of general building estates management	Fully compliant					
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business Continuity Response plans	Crisis Management Plan included as part of CCG Business Continuity Plan. Plans detail key processes and prioritisation of recovery, key risks and management of loss of electronic, people/skills, utilities	Fully compliant					
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented processes for completing, signing off and submitting SitReps	Process outlined within Business Continuity Plan and EPRR plan. On Call pack contains capture form.	Fully compliant					
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y													• Guidance is available to appropriate staff either electronically or hard copies							
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y													• Guidance is available to appropriate staff either electronically or hard copies							
Domain 7 - Warning and informing																							
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Emergency Communications Plan in place. Business Continuity Plan outlines Communications with partners and stakeholders in event of a disruption. Roles for Communication outlined as part of Crisis Management Plan. Communications Plan outlines systems to inform / warn staff and the public include websites and other channels (such as social media) in addition to sharing information across partner channels and mechanisms. CCG commissions MLCSU to attend LHPR. Planning arrangements are included on the CCG website where	Fully compliant					
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	CCG Communications Plan outlines principles of communication in an emergency. Business Continuity plan lists how and when communication should happen and how to escalate; Communications Plan gives overview of how public and partners can be warned and informed of incident. Website host messages regarding Heatwave and Cold weather. CCG social media regularly informs public regarding local risks and health campaigns. regular Covid communication undertaken through website publication and regular social media messaging	Fully compliant					
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	Emergency Communications arrangements outlined within the Business Continuity Plan and EPRR policy and Plan. CCG has identified Media Spokesperson and social media trained staff able to communicate effectively in emergency. Debrief, incident reports and exercising used to inform improvements to CCG response. Members of leadership team have been provided media training	Fully compliant					
Domain 8 - Cooperation																							
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Arrangements made between shared leadership team alongside Southport and Formby CCG. Mutual Aid arrngement with Liverpool CCG to utilise desk space in the event of a disruption. CCG operate as part of North Mersey On Call group alongside Southport and Formby CCG and Liverpool CCG.	Fully compliant					
43	Cooperation	Arrangements for multi-region response	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.			Y					Y	Y				Y	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs							
44	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.									Y					• Detailed documentation on the process for managing the national health aspects of an emergency							
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Information sharing protocols in place as part of contractual agreements. EPRR plan provides guidance on information sharing in the event of an emergency. Emergency Communications checklist provides guidance on sharing information in the event of an incident. Data sharing protocol included in On Call Pack and	Fully compliant					
Domain 9 - Business Continuity																							
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	BC policy outines the CCG commitment and intent regarding Business Continuity. Policy reviewed October 2020.	Fully compliant					

48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Business Continuity Policy October 2020. CCG statutory requirements described within Business Continuity Policy, Strategy and Plan. Staff Business Continuity roles outlined within Business Continuity Plan and Business Continuity Policy.						
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Statement of compliance	Statement updated August 2021. Plan in place to meet compliance.	Fully compliant				
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	CCG has Business Continuity Plan in place. Policy outlines commitment and resources, Strategy outlines the strategies the CCG employs, Plans outline prioritisation and response to loss of data/voice, people/skills, buildings, resources, supplies. Supply chain mapping included in BC strategy.	Fully compliant				
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	Business Continuity policy lists the process for audit. Business Continuity Plans updated October 2020.	Fully compliant				
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	Business Continuity Policy lists process for continuos inprovement. Undertaken through regualr review, debrief and lessons in the event of incident or organisational change, regualr review of risk and BC incidents at IGG meetings.	Fully compliant				
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	Y	Y	Y	Y	Y	Y	n	Y	Y	Y	Y	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Managed via Contracts meeting and Provider trust plans and submission to core standards.Supplier assurance reviewed as part of BIA refresh.	Fully compliant				
Domain 10: CBRN																							
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Y		Y			Y					Y		Staff are aware of the number / process to gain access to advice through appropriate planning arrangements						
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Y		Y			Y							Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies						
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste	Y	Y		Y			Y							• Impact assessment of CBRN decontamination on other key facilities						
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y													• Rotas of appropriately trained staff availability 24 /7						
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y		Y			Y							• Completed equipment inventories; including completion date						
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y													• Record of equipment checks, including date completed and by whom. • Report of any missing equipment						
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y													• Completed PPM, including date completed, and by whom						
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y													• Organisational policy						
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y													• Maintenance of CPD records						
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y													• Maintenance of CPD records						
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Y		Y			Y							• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique						
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	Y		Y			Y													

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
HART Domain: Capability										
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials • Chemical, Biological Radiological, Nuclear, Explosives (CBRNe) • Marauding Terrorist Firearms Attack • Safe Working at Height • Confined Space • Unstable Terrain • Water Operations • Support to Security Operations	Y						
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART.	Y						
H3	**HART**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART.	Y						
H5	**HART**	**Protected training hours**	Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week period.	Y						
H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include: • mandated training completed • date completed • any outstanding training or training due • indication of the individual's level of competence across the HART skill sets • any restrictions in practice and corresponding action plans.	Y						
H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered Paramedics.	Y						
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	Y						
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard.	Y						
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						

H11	HART	Returned to duty Physical Competency Assessment	Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						
H12	HART	Commander competence	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.	Y						
Domain: Administration										
H13	HART	Effective deployment policy	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y						
H14	HART	Identification appropriate incidents / patients	Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.	Y						
H15	HART	Notification of changes to capability delivery	In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence.	Y						
H16	HART	Recording resource levels	Organisations must record HART resource levels and deployments on the nationally specified system.	Y						
H17	HART	Record of compliance with response time standards	Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.	Y						
H18	HART	Local risk assessments	Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
H19	HART	Lessons identified reporting	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
H20	HART	Safety reporting	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
H21	HART	Receipt and confirmation of safety notifications	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.	Y						
H22	HART	Change Request Process	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y						
Domain: Response time standards										
H23	HART	Initial deployment requirement	Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.	Y						
H24	HART	Additional deployment requirement	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.	Y						

H25	**HART**	**Attendance at strategic sites of interest**	Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region.	Y						
H26	**HART**	**Mutual aid**	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the 'on duty' HART team is already deployed at a local incident requiring HART capabilities.	Y						
Domain: Logistics										
H27	**HART**	**Capital depreciation and revenue replacement schemes**	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment.	Y						
H28	**HART**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						
H29	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement.	Y						
H30	**HART**	**Fleet compliance with national specification**	Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification.	Y						
H31	**HART**	**Equipment maintenance**	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.	Y						
H32	**HART**	**Equipment asset register**	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
H33	**HART**	**Capital estate provision**	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.	Y						
MTFA										
Domain: Capability										
M1	**MTFA**	**Maintenance of national specified MTFA capability**	Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.	Y						
M2	**MTFA**	**Compliance with safe system of work**	Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work.	Y						
M3	**MTFA**	**Interoperability**	Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country.	Y						
M4	**MTFA**	**Compliance with Standard Operating Procedures**	Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
M5	**MTFA**	**Ten competent MTFA staff on duty**	Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified HART staff.	Y						
M6	**MTFA**	**Completion of a Physical Competency Assessment**	Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard.	Y						
M7	**MTFA**	**Staff competency**	Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA.	Y						

M8	**MTFA**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans	Y						
M9	**MTFA**	**Commander competence**	Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	Y						
M10	**MTFA**	**Provision of clinical training**	The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training.	Y						
M11	**MTFA**	**Staff training requirements**	Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff	Y						
Domain: Administration										
M12	**MTFA**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M13	**MTFA**	**Identification appropriate incidents / patients**	Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M14	**MTFA**	**Change Management Process**	Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.	Y						
M15	**MTFA**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).	Y						
M16	**MTFA**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners.	Y						
M17	**MTFA**	**Recording resource levels**	Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU.	Y						
M18	**MTFA**	**Local risk assessments**	Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
M19	**MTFA**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
M20	**MTFA**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
M21	**MTFA**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.	Y						
Domain: Response time standards										

M22	**MTFA**	**Readiness to deploy to Model Response Sites**	Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation.	Y						
M23	**MTFA**	**10minute response time**	Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.	Y						
Domain: Logistics										
M24	**MTFA**	**PPE availability**	Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets.	Y						
M25	**MTFA**	**Equipment procurement via national buying frameworks**	Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets.	Y						
M26	**MTFA**	**Equipment maintenance**	All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national standards.	Y						
M27	**MTFA**	**Revenue depreciation scheme**	Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.	Y						
M28	**MTFA**	**MTFA asset register**	Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
CBRN **Domain: Capability**										
B1	**CBRN**	**Tactical capabilities**	Organisations must maintain the following CBRN tactical capabilities: • Initial Operational Response (IOR) • Step 123+ • PRPS Protective Equipment • Wet decontamination of casualties via clinical decontamination units • Specialist Operational Response (HART) for inner cordon / hot zone operations • CBRN Countermeasures	Y						
B2	**CBRN**	**National Capability Matrices for CBRN.**	Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN.	Y						
B3	**CBRN**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments.	Y						
B4	**CBRN**	**Access to specialist scientific advice**	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7).	Y						
Domain: Human resources										
B5	**CBRN**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	Y						
B6	**CBRN**	**Arrangements to manage staff exposure and contamination**	Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated.	Y						
B7	**CBRN**	**Monitoring and recording responder deployment**	Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time committed).	Y						
B8	**CBRN**	**Adequate CBRN staff establishment**	Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times.	Y						

B9	**CBRN**	**CBRN Lead trainer**	Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation.	Y						
B10	**CBRN**	**CBRN trainers**	Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme.	Y						
B11	**CBRN**	**Training standard**	CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work.	Y						
B12	**CBRN**	**FFP3 access**	Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested.	Y						
B13	**CBRN**	**IOR training for operational staff**	Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).	Y						
Domain: administration										
B14	**CBRN**	**HAZMAT / CBRN plan**	Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans.	Y						
B15	**CBRN**	**Deployment process for CBRN staff**	Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident.	Y						
B16	**CBRN**	**Identification of locations to establish CBRN facilities**	Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces.	Y						
B17	**CBRN**	**CBRN arrangements alignment with guidance**	Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance.	Y						
B18	**CBRN**	**Communication management**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders.	Y						
B19	**CBRN**	**Access to national reserve stocks**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain).	Y						
B20	**CBRN**	**Management of hazardous waste**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste.	Y						
B21	**CBRN**	**Recovery arrangements**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality.	Y						
B22	**CBRN**	**CBRN local risk assessments**	Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work.	Y						
B23	**CBRN**	**Risk assessments for high risk areas**	Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area.	Y						
Domain: Response time standards										
B24	**CBRN**	**Model response locations - deployment**	Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.	Y						
Domain: logistics										
B25	**CBRN**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						
B26	**CBRN**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU.	Y						
B27	**CBRN**	**Equipment maintenance - British or EN standards**	Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations.	Y						
B28	**CBRN**	**Equipment maintenance - National Equipment Data Sheet**	Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item.	Y						

B29	**CBRN**	**Equipment maintenance - assets register**	Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
B30	**CBRN**	**PRPS - minimum number of suits**	Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational.	Y						
B31	**CBRN**	**PRPS - replacement plan**	Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits.	Y						
B32	**CBRN**	**Individual / role responsible fore CBRN assets**	Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately.	Y						
Mass Casualty Vehicles Domain: Administration										
V1	**MassCas**	**MCV accommodation**	Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining.	Y						
V2	**MassCas**	**Maintenance and insurance**	Trusts must insure, maintain and regularly run the mass casualty vehicles.	Y						
V3	**MassCas**	**Mobilisation arrangements**	Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment.	Y						
V4	**MassCas**	**Mass oxygen delivery system**	Trusts must maintain the mass oxygen delivery system on the vehicles.	Y						
Domain: NHS England Mass Casualties Concept of Operations										
V6	**MassCas**	**Mass casualty response arrangements**	Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties* .	Y						
V7	**MassCas**	**Arrangements to work with NACC**	Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties.	Y						
V8	**MassCas**	**EOC arrangements**	Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident.	Y						
V9	**MassCas**	**Casualty management arrangements**	Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts.	Y						
V10	**MassCas**	**Casualty Clearing Station arrangements**	Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation.	Y						
V11	**MassCas**	**Management of non-NHS resource**	Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y						
V12	**MassCas**	**Management of secondary patient transfers**	Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements.	Y						
Command and control Domain: General										
C1	**C2**	**Consistency with NHS England EPRR Framework**	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.	Y						
C2	**C2**	**Consistency with Standards for NHS Ambulance Service Command and Control.**	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control.	Y						

C3	**C2**	**NARU notification process**	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y						
C4	**C2**	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y						
Domain: Human resource										
C5	**C2**	**Command role availability**	NHS Ambulance Service providers must ensure that the command roles defined as part of the 'chain of command' structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area.	Y						
C6	**C2**	**Support role availability**	NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times.	Y						
C7	**C2**	**Recruitment and selection criteria**	NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y						
C8	**C2**	**Contractual responsibilities of command functions**	Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment.	Y						
C9	**C2**	**Access to PPE**	The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function.	Y						
C10	**C2**	**Suitable communication systems**	The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y						
Domain: Decision making										
C11	**C2**	**Risk management**	NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU.	Y						
C12	**C2**	**Use of JESIP JDM**	NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y						
C13	**C2**	**Command decisions**	NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU.	Y						
Domain: Record keeping										
C14	**C2**	**Retaining records**	C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y						
C15	**C2**	**Decision logging**	C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice.	Y						

C16	**C2**	**Access to loggist**	C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.	Y						
Domain: Lessons identified										
C17	**C2**	**Lessons identified**	The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards.	Y						
Domain: Competence										
C18	**C2**	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C19	**C2**	**Strategic commander competence - nationally recognised course**	Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).	Y						
C20	**C2**	**Tactical commander competence - National Occupational Standards**	Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C21	**C2**	**Tactical commander competence - nationally recognised course**	Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C22	**C2**	**Operational commander competence - National Occupational Standards**	Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C23	**C2**	**Operational commander competence - nationally recognised course**	Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C24	**C2**	**Commanders - maintenance of CPD**	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	Y						
C25	**C2**	**Commanders - exercise attendance**	All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.	Y						

C26	**C2**	**Training and CDP - suspension of non-compliant commanders**	Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.	Y						
C27	**C2**	**Assessment of commander competence and CDP evidence**	Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.	Y						
C28	**C2**	**NILO / Tactical Advisor - training**	Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y						
C29	**C2**	**NILO / Tactical Advisor - CPD**	Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline.	Y						
C30	**C2**	**Loggist - training**	Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control Guidance.	Y						
C31	**C2**	**Loggist - CPD**	Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y						
C32	**C2**	**Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor**	The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).	Y						
C33	**C2**	**Medical Advisor of Forward Doctor - exercise attendance**	Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.	Y						
C34	**C2**	**Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures**	Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles.	Y						
C35	**C2**	**Control room familiarisation with capabilities**	Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.)	Y						
C36	**C2**	**Responders awareness of NARU major incident action cards**	Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.	Y						
JESIP Domain: Embedding doctrine										
J1	**JESIP**	**Incorporation of JESIP doctrine**	The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts.	Y						
J2	**JESIP**	**Operations procedures commensurate with Doctrine**	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y						

J3	JESIP	Five JESIP principles for joint working	All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working.	Y						
J4	JESIP	Use of METHANE	All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE.	Y						
J5	JESIP	Joint Decision Model - advocate use of	All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions.	Y						
J6	JESIP	Review process	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine.	Y						
J7	JESIP	Access to JESIP products, tools and guidance	All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance.	Y						
Domain: Training										
J8	JESIP	Awareness of JESIP - Responders	All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated annually.	Y						
J9	JESIP	Awareness of JESIP - control room staff	NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually.	Y						
J10	JESIP	Awareness of JESIP - Commanders and Control Room managers / supervisors	All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting.	Y						
J11	JESIP	Training records - staff requiring training	NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y						
J12	JESIP	Command function - interoperability command course	All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.	Y						
J13	JESIP	Training records - annual refresh	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y						
J14	JESIP	Commanders - interoperability command course	Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.	Y						
J15	JESIP	Participation in multiagency exercise	Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.	Y						
J16	JESIP	Induction training	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y						
J17	JESIP	Training - review process	All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine.	Y						
J18	JESIP	JESIP trainers	All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers.	Y						
Domain: Assurance										
J19	JESIP	JESIP self-assessment survey	All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP.	Y						

J20	**JESIP**	**Training records - 90% operational and control room staff are familiar with JESIP**	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.	Y						
J21	**JESIP**	**Exercise programme - multiagency exercises**	All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE tool.	Y						
J22	**JESIP**	**Competence assurance policy**	All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.	Y						
J23	**JESIP**	**Use of JESIP exercise objectives and Umpire templates**	All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.	Y						

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Mental Health Providers	Community Service Providers	Organisational Evidence	Self assessment RAG **Red (not compliant)** = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant)** = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant)** = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Oxygen Supply **Domain: Oxygen Suuply**													
DD1	**Oxygen Supply**	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	•□Committee meets annually as a minimum •□Committee has signed off terms of reference •□Minutes of Committee meetings are maintained •□Actions from the Committee are managed effectively •□Committee reports progress and any issues to the Chief Executive •□Committee develops and maintains organisational policies and procedures •□Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) •□Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate •□The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	Y	If applicable	If applicable						
DD2	**Oxygen Supply**	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	•□The organisation has reviewed and updated the plans and are they available for view •□The organisation has assessed its maximum anticipated flow rate using the national toolkit •□The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. •□The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site •□The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) •□Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies •□The organisation has breaching points available to support access for additional equipment as required •□The organisation has a developed plan for ward level education and training on good housekeeping practices •□The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	Y	If applicable	If applicable						
DD3	**Oxygen Supply**	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	•□The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries •□The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms •□The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes •□Organisation has utilised the checklist retrospectively as part of an assurance or audit process	Y	If applicable	If applicable						
DD4	**Oxygen Supply**	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	•□Job descriptions/person specifications are available to cover each identified role •□Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. •□Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements •□Medical gas training forms part of the induction package for all staff.	Y	If applicable	If applicable						
DD5	**Oxygen Supply**	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	•□SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds •□Staff are informed and aware of the requirements for increasing de-icing of vaporisers •□SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	Y	If applicable	If applicable						
DD6	**Oxygen Supply**	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	•□Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report	Y	If applicable	If applicable						
DD7	**Oxygen Supply**	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	•□Organisation has a risk assessment as per section 6.6 of the HTM 02-01 •□Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)	Y	If applicable	If applicable						

Ref	Domain	Standard	Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England and NHS Improvement Region	NHS England and NHS Improvement National	Clinical Commissioning Group	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Evidence - examples listed below	Organisational Evidence
Domain 1 - Governance																		
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a governing bodies level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive governing bodies member, or suitable alternative, should be identified to support them in this role.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• Name and role of appointed individual	Fiona Taylor - Accountable Officer is governing body level SRO Debbie Fairclough Interim Programme Lead Corporate Services (operational lead - Leadership Team nominated lead) Alan Sharples South Sefton and Helen Nichols Southport and Formby identified as Lay Member
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR Policy outlines the commitments and resourcing needs. CCG commissions MLCSU to undertake EPRR activities on its behalf (documentation, planning, business continuity activities and training and exercising). 2020-21 pandemic response meant that an exercise was not required as the organisation was operating in command and control as well as actually managing a live ongoing incident
3	Governance	EPRR governing bodies reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the governing bodies / Governing Body, no less frequently than annually. These reports should be taken to a public governing bodies, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• Public governing bodies meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public governing bodies	EPRR Core standard outcome for 19/20 posted on website. Corporate Services Support Group - regular reporting for EPRR and business continuity issues chaired by Interim Programme Lead Corporate Services, provided by MLCSU. Annual EPRR and business continuity reporting to GB reported on CCG website. This is particularly relevant for 2020-21 as EPRR relating to pandemic was routinely reported to the governing bodies
5	Governance	EPRR Resource	The governing bodies / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's govering body • Assessment of role / resources. • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	EPRR Policy in place October 2020. Policy outlines resource and CCG commissions MLCSU to undertake EPRR activity on its behalf.
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Process explicitly described within the EPRR policy statement	Outlined in EPRR policy.
Domain 2 - Duty to risk assess																		
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	EPRR risk included in the Corporate Risk Register. Escalation of risk process described within the EPRR Policy. EPRR risks discussed at IGG regular meetings and raised with Governing Body where appropriate. CCGs have in place a bespoke COVID19 risk register in addition
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Risk Management Strategy in place for CCG (Jan 21). Corporate Risk Register includes process for capturing EPRR risks. Bespoke COVID19 risk register in place
Domain 3 - Duty to maintain plans																		
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Critical Incident Management reponsibilities for CCG covered under Major Incident Plan and CCG Business Continuity Arrangements. Local risks linked to Community Risk Register and LHPR activities included in planning arrangements.
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	CCG has Major Incident Plan in place and EPRR policy. CCG role in Major Incident described and action cards included for risk specific incidents. CCGs have been operating within the command and control framework during 2020-21 pandemic as well as having internal incident management team.

13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Heatwave response included within Major Incident Plan. Arrangements reflect national Heatwave Plans. Action Cards highlight internal actions and expected system response to Heatwave management. Public Health England information hosted on CCG website. Severe weather plan in place. CCGs routinely issues weather warnings via GP practice and internal bulletins
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	CCG circulated and shared messages from NHS on website as part of the 'stay well campaign'. Public Health England information hosted on CCG website regarding cold weather. Severe weather plan in place. EPRR plan has action card in place for cold weather response.
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	CGG EPRR Plan describes process. CCG, through Business Continuity plan and EPRR plan has effective arrangements to manage Mass Casualty event. On Call Pack includes Mass casualty response and process across the region.
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Y												Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Not applicable to CCGs
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	CCG has effective arangements in place to evacuate office space. Fire Wardens trained and appointed to fulfill their role. Health and Safety Policy. Provider assurance given through Business Continuity Plans and adoption of NHS Shelter and Evacuation Plan principles. The CCGs commission health and safety advice and support from MLCSU
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Y	Y	Y			Y					Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Not applicable to CCGs
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Y	Y	Y			Y					Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Not applicable to CCGs
Domain 4 - Command and control																		
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	CCG part of the North Mersey On Call Group providing 24/7 on call response. Rota administration undertaken by MLCSU. Call Centre operating provided by Office Link. On Call Pack produced and updated quarterly by MLCSU. Escalation process listed as part of EPRR policy and on call pack circulation.
Domain 5 - Training and exercising																		
Domain 6 - Response																		
30	Response	Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		ICC idenfied within the Business Continuity Plan and alternative locations identified and listed within the plan. Roles and responsibilities of Crisis Management team listed within the Business Continuity Plan and Command and Control guidelines within the EPRR Plan. ICC scheduled for test as part of general building estates management.
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business Continuity Response plans	Crisis Management Plan included as part of CCG Business Continuity Plan. Plans detail key processes and prioritisation of recovery, key risks and management of loss of data/voice, people/skills, utilities, building.
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented processes for completing, signing off and submitting SitReps	Process outlined within Business Continuity Plan and EPRR plan. On Call pack contains capture form.
35	Response	Access to 'Clinical Guidelines for Major incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y													• Guidance is available to appropriate staff either electronically or hard copies	Not applicable to CCGs
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y													• Guidance is available to appropriate staff either electronically or hard copies	Not applicable to CCGs
Domain 7 - Warning and informing																		

37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Emergency Communications Plan in place. Business Continuity Plan outlines Communications with partners and stakeholders in event of a disruption. Roles for Communication outlined as part of Crisis Management Plan. Communications Plan outlines systems to inform / warm staff and the public include websites and other channels (such as social media) in addition to sharing informaiton across partner channels and mechanisms. CCG commissions MLCSU to attend LHPR. Planning arrangements are included on the CCG website where appropriate.
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	CCG Communications Plan outlines principles of communication in an emergency. Business Continuity plan lists how and when communication should happen and how to escalate; Communications Plan gives overview of how public and partners can be warned and informed of incident. Website host messages regarding Heatwave and Cold weather. CCG social media regualrly informs public regarding local risks and health campaigns. regular Covid communication undertaken through website publication and regular social media messaging.
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	Emergency Communications arrangements outlined within the Business Continuity Plan and EPRR policy and Plan. CCG has identified Media Spokesperson and social media trained staff able to communicate effectively in emergency. Debrief, incident reports and exercising used to inform improvements to CCG response. Members of leadership team have been provided media training
Domain 8 - Cooperation																		
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Arrangements made between shared leadership team between NHS South Sefton CCG and NHS Southport and Formby CCG. Mutual Aid arrngement with Liverpool CCG to utilise desk space in the event of a disruption. CCG operate as part of North Mersey On Call group alongside Southport and Formby CCG and Liverpool CCG.
43	Cooperation	Arrangements for multi-region response	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.			Y					Y	Y				Y	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs	Not applicable to CCGs
44	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.									Y					• Detailed documentation on the process for managing the national health aspects of an emergency	Not applicable to CCGs
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Information sharing protocols in place as part of contractual agreements. EPRR plan provides guidance on information sharing in the event of an emergency. Emergency Communications checklist provides guidance on sharing information in the event of an incident. Data sharing protocol included in On Call Pack and
Domain 9 - Business Continuity																		
47	Business Continuity	business continuity policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continutiy Management System (business continuityMS) in alignment to the ISO standard 22301.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Demonstrable a statement of intent outlining that they will undertake business continuity - Policy Statement	business continuity policy outines the CCG commitment and intent regarding Business Continuity. Policy reviewed October 2020.
48	Business Continuity	business continuityMS scope and objectives	The organisation has established the scope and objectives of the business continuityMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	business continuityMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake business continuity e.g. Statutory, Regulatory and contractual duties • Specific roles within the business continuityMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Business Continuity Policy October 2020. CCG statutory requirements described within Business Continuity Policy, Strategy and Plan. Staff Business Continuity roles outlined within Business Continuity Plan and Business Continuity Policy.
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Statement of compliance	Statement updated August 2021. Plan in place to meet compliance.
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented evidence that as a minimum the business continuityP checklist is covered by the various plans of the organisation	CCG has Business Continuity Plan in place. Policy outlines commitment and resources. Strategy outlines the strategies the CCG employs, Plans outline prioritisation and response to loss of data/voice, people/skills, buildings, resources, supplies. Supply chain mapping included in business continuity strategy.
53	Business Continuity	business continuity audit	The organisation has a process for internal audit, and outcomes are included in the report to the governing bodies.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR policy document or stand alone Business continuity policy • governing bodies papers • Audit reports	Business Continuity policy lists the process for audit. Business Continuity Plans updated October 2020.
54	Business Continuity	business continuityMS continuous improvement process	There is a process in place to assess the effectivness of the business continuityMS and take corrective action to ensure continual improvement to the business continuityMS.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR policy document or stand alone Business continuity policy • governing bodies papers • Action plans	Business Continuity Policy lists process for continuos inprovement. Undertaken through regualr review, debrief and lessons in the event of incident or organisational change, regualr review of risk and business continuity incidents at IGG meetings.
55	Business Continuity	Assurance of commissioned providers / suppliers business continuityPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	Y	Y	Y	Y	Y	Y	n	Y	Y	Y	Y	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Managed via Contracts meeting and Provider trust plans and submission to core standards.Supplier assurance reviewed as part of BIA refresh.
Domain 10: CBRN																		
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Y		Y			Y					Y		Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Not applicable to CCGs

57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Y		Y			Y							Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Not applicable to CCGs
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	Y		Y			Y							• Impact assessment of CBRN decontamination on other key facilities	Not applicable to CCGs
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y													• Rotas of appropriately trained staff availability 24 /7	Not applicable to CCGs
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y		Y			Y							• Completed equipment inventories; including completion date	Not applicable to CCGs
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y													• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	Not applicable to CCGs
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y													• Completed PPM, including date completed, and by whom	Not applicable to CCGs
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y													• Organisational policy	Not applicable to CCGs
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y													• Maintenance of CPD records	Not applicable to CCGs
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y													• Maintenance of CPD records	Not applicable to CCGs
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Y		Y			Y							• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	Not applicable to CCGs
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	Y		Y			Y								Not applicable to CCGs

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
HART Domain: Capability										
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials • Chemical, Biological Radiological, Nuclear, Explosives (CBRNe) • Marauding Terrorist Firearms Attack • Safe Working at Height • Confined Space • Unstable Terrain • Water Operations • Support to Security Operations	Y						
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART.	Y						
H3	**HART**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART.	Y						
H5	**HART**	**Protected training hours**	Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week period.	Y						
H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include: • mandated training completed • date completed • any outstanding training or training due • indication of the individual's level of competence across the HART skill sets • any restrictions in practice and corresponding action plans	Y						
H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered Paramedics.	Y						
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	Y						
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard.	Y						
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						

H12	**HART**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.	Y						
Domain: Administration										
H13	**HART**	**Effective deployment policy**	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y						
H14	**HART**	**Identification appropriate incidents / patients**	Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.	Y						
H15	**HART**	**Notification of changes to capability delivery**	In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence.	Y						
H16	**HART**	**Recording resource levels**	Organisations must record HART resource levels and deployments on the nationally specified system.	Y						
H17	**HART**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.	Y						
H18	**HART**	**Local risk assessments**	Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
H19	**HART**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
H20	**HART**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
H21	**HART**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.	Y						
H22	**HART**	**Change Request Process**	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y						
Domain: Response time standards										
H23	**HART**	**Initial deployment requirement**	Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.	Y						
H24	**HART**	**Additional deployment requirement**	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.	Y						
H25	**HART**	**Attendance at strategic sites of interest**	Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region.	Y						
H26	**HART**	**Mutual aid**	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the 'on duty' HART team is already deployed at a local incident requiring HART capabilities.	Y						
Domain: Logistics										

H27	**HART**	**Capital depreciation and revenue replacement schemes**	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment.	Y						
H28	**HART**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						
H29	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement.	Y						
H30	**HART**	**Fleet compliance with national specification**	Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification.	Y						
H31	**HART**	**Equipment maintenance**	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.	Y						
H32	**HART**	**Equipment asset register**	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
H33	**HART**	**Capital estate provision**	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.	Y						
MTFA Domain: Capability										
M1	**MTFA**	**Maintenance of national specified MTFA capability**	Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.	Y						
M2	**MTFA**	**Compliance with safe system of work**	Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work.	Y						
M3	**MTFA**	**Interoperability**	Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country.	Y						
M4	**MTFA**	**Compliance with Standard Operating Procedures**	Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
M5	**MTFA**	**Ten competent MTFA staff on duty**	Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified HART staff.	Y						
M6	**MTFA**	**Completion of a Physical Competency Assessment**	Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard.	Y						
M7	**MTFA**	**Staff competency**	Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA.	Y						
M8	**MTFA**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans	Y						
M9	**MTFA**	**Commander competence**	Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	Y						
M10	**MTFA**	**Provision of clinical training**	The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training.	Y						

M11	**MTFA**	**Staff training requirements**	Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff	Y						
Domain: Administration										
M12	**MTFA**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M13	**MTFA**	**Identification appropriate incidents / patients**	Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M14	**MTFA**	**Change Management Process**	Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.	Y						
M15	**MTFA**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).	Y						
M16	**MTFA**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners.	Y						
M17	**MTFA**	**Recording resource levels**	Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU.	Y						
M18	**MTFA**	**Local risk assessments**	Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
M19	**MTFA**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
M20	**MTFA**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
M21	**MTFA**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.	Y						
Domain: Response time standards										
M22	**MTFA**	**Readiness to deploy to Model Response Sites**	Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation.	Y						
M23	**MTFA**	**10minute response time**	Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.	Y						
Domain: Logistics										
M24	**MTFA**	**PPE availability**	Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets.	Y						
M25	**MTFA**	**Equipment procurement via national buying frameworks**	Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets.	Y						
M26	**MTFA**	**Equipment maintenance**	All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national standards.	Y						

M27	**MTFA**	**Revenue depreciation scheme**	Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.	Y						
M28	**MTFA**	**MTFA asset register**	Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment)	Y						
CBRN **Domain: Capability**										
B1	**CBRN**	**Tactical capabilities**	Organisations must maintain the following CBRN tactical capabilities: • Initial Operational Response (IOR) • Step 123+ • PRPS Protective Equipment • Wet decontamination of casualties via clinical decontamination units • Specialist Operational Response (HART) for inner cordon / hot zone operations • CBRN Countermeasures	Y						
B2	**CBRN**	**National Capability Matrices for CBRN.**	Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN.	Y						
B3	**CBRN**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments.	Y						
B4	**CBRN**	**Access to specialist scientific advice**	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7).	Y						
Domain: Human resources										
B5	**CBRN**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	Y						
B6	**CBRN**	**Arrangements to manage staff exposure and contamination**	Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated.	Y						
B7	**CBRN**	**Monitoring and recording responder deployment**	Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time committed)	Y						
B8	**CBRN**	**Adequate CBRN staff establishment**	Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times.	Y						
B9	**CBRN**	**CBRN Lead trainer**	Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation.	Y						
B10	**CBRN**	**CBRN trainers**	Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme.	Y						
B11	**CBRN**	**Training standard**	CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work.	Y						
B12	**CBRN**	**FFP3 access**	Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested.	Y						
B13	**CBRN**	**IOR training for operational staff**	Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).	Y						
Domain: administration										
B14	**CBRN**	**HAZMAT / CBRN plan**	Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans.	Y						
B15	**CBRN**	**Deployment process for CBRN staff**	Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident.	Y						

B16	CBRN	Identification of locations to establish CBRN facilities	Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces.	Y						
B17	CBRN	CBRN arrangements alignment with guidance	Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance.	Y						
B18	CBRN	Communication management	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders.	Y						
B19	CBRN	Access to national reserve stocks	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain).	Y						
B20	CBRN	Management of hazardous waste	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste.	Y						
B21	CBRN	Recovery arrangements	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality.	Y						
B22	CBRN	CBRN local risk assessments	Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work.	Y						
B23	CBRN	Risk assessments for high risk areas	Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area.	Y						
Domain: Response time standards										
B24	CBRN	Model response locations - deployment	Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.	Y						
Domain: logistics										
B25	CBRN	Interoperable equipment	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						
B26	CBRN	Equipment procurement via national buying frameworks	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU.	Y						
B27	CBRN	Equipment maintenance - British or EN standards	Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations.	Y						
B28	CBRN	Equipment maintenance - National Equipment Data Sheet	Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item.	Y						
B29	CBRN	Equipment maintenance - assets register	Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
B30	CBRN	PRPS - minimum number of suits	Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational.	Y						
B31	CBRN	PRPS - replacement plan	Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits.	Y						
B32	CBRN	Individual / role responsible fore CBRN assets	Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately.	Y						
Mass Casualty Vehicles Domain: Administration										
V1	MassCas	MCV accommodation	Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining.	Y						
V2	MassCas	Maintenance and insurance	Trusts must insure, maintain and regularly run the mass casualty vehicles.	Y						

V3	**MassCas**	**Mobilisation arrangements**	Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment.	Y						
V4	**MassCas**	**Mass oxygen delivery system**	Trusts must maintain the mass oxygen delivery system on the vehicles.	Y						
Domain: NHS England Mass Casualties Concept of Operations										
V6	**MassCas**	**Mass casualty response arrangements**	Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties*.	Y						
V7	**MassCas**	**Arrangements to work with NACC**	Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties.	Y						
V8	**MassCas**	**EOC arrangements**	Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident.	Y						
V9	**MassCas**	**Casualty management arrangements**	Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts.	Y						
V10	**MassCas**	**Casualty Clearing Station arrangements**	Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation.	Y						
V11	**MassCas**	**Management of non-NHS resource**	Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y						
V12	**MassCas**	**Management of secondary patient transfers**	Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements.	Y						
Command and control Domain: General										
C1	**C2**	**Consistency with NHS England EPRR Framework**	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.	Y						
C2	**C2**	**Consistency with Standards for NHS Ambulance Service Command and Control.**	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control.	Y						
C3	**C2**	**NARU notification process**	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y						
C4	**C2**	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y						
Domain: Human resource										
C5	**C2**	**Command role availability**	NHS Ambulance Service providers must ensure that the command roles defined as part of the 'chain of command' structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area.	Y						
C6	**C2**	**Support role availability**	NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times.	Y						

C7	**C2**	**Recruitment and selection criteria**	NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y						
C8	**C2**	**Contractual responsibilities of command functions**	Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment.	Y						
C9	**C2**	**Access to PPE**	The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function.	Y						
C10	**C2**	**Suitable communication systems**	The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y						
Domain: Decision making										
C11	**C2**	**Risk management**	NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU.	Y						
C12	**C2**	**Use of JESIP JDM**	NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y						
C13	**C2**	**Command decisions**	NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU.	Y						
Domain: Record keeping										
C14	**C2**	**Retaining records**	C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y						
C15	**C2**	**Decision logging**	C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice.	Y						
C16	**C2**	**Access to loggist**	C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.	Y						
Domain: Lessons identified										
C17	**C2**	**Lessons identified**	The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards.	Y						
Domain: Competence										
C18	**C2**	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C19	**C2**	**Strategic commander competence - nationally recognised course**	Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).	Y						
C20	**C2**	**Tactical commander competence - National Occupational Standards**	Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						

C21	**C2**	**Tactical commander competence - nationally recognised course**	Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C22	**C2**	**Operational commander competence - National Occupational Standards**	Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C23	**C2**	**Operational commander competence - nationally recognised course**	Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C24	**C2**	**Commanders - maintenance of CPD**	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	Y						
C25	**C2**	**Commanders - exercise attendance**	All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.	Y						
C26	**C2**	**Training and CDP - suspension of non-compliant commanders**	Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.	Y						
C27	**C2**	**Assessment of commander competence and CDP evidence**	Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.	Y						
C28	**C2**	**NILO / Tactical Advisor - training**	Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y						
C29	**C2**	**NILO / Tactical Advisor - CPD**	Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline.	Y						
C30	**C2**	**Loggist - training**	Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control Guidance.	Y						
C31	**C2**	**Loggist - CPD**	Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y						
C32	**C2**	**Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor**	The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).	Y						

C33	C2	Medical Advisor of Forward Doctor - exercise attendance	Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.	Y						
C34	C2	Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures	Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles.	Y						
C35	C2	Control room familiarisation with capabilities	Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.)	Y						
C36	C2	Responders awareness of NARU major incident action cards	Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.	Y						
JESIP										
Domain: Embedding doctrine										
J1	JESIP	Incorporation of JESIP doctrine	The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts.	Y						
J2	JESIP	Operations procedures commensurate with Doctrine	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y						
J3	JESIP	Five JESIP principles for joint working	All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working.	Y						
J4	JESIP	Use of METHANE	All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE.	Y						
J5	JESIP	Joint Decision Model - advocate use of	All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions.	Y						
J6	JESIP	Review process	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine.	Y						
J7	JESIP	Access to JESIP products, tools and guidance	All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance.	Y						
Domain: Training										
J8	JESIP	Awareness of JESIP - Responders	All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated annually.	Y						
J9	JESIP	Awareness of JESIP - control room staff	NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually.	Y						
J10	JESIP	Awareness of JESIP - Commanders and Control Room managers / supervisors	All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting.	Y						
J11	JESIP	Training records - staff requiring training	NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y						

J12	JESIP	Command function - interoperability command course	All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.	Y						
J13	JESIP	Training records - annual refresh	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y						
J14	JESIP	Commanders - interoperability command course	Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.	Y						
J15	JESIP	Participation in multiagency exercise	Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.	Y						
J16	JESIP	Induction training	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y						
J17	JESIP	Training - review process	All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine.	Y						
J18	JESIP	JESIP trainers	All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers.	Y						
Domain: Assurance										
J19	JESIP	JESIP self-assessment survey	All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP.	Y						
J20	JESIP	Training records - 90% operational and control room staff are familiar with JESIP	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.	Y						
J21	JESIP	Exercise programme - multiagency exercises	All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE tool.	Y						
J22	JESIP	Competence assurance policy	All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.	Y						
J23	JESIP	Use of JESIP exercise objectives and Umpire templates	All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.	Y						

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Mental Health Providers	Community Service Providers	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Oxygen Supply **Domain: Oxygen Suuply**													
DD1	**Oxygen Supply**	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	• Committee meets annually as a minimum • Committee has signed off terms of reference • Minutes of Committee meetings are maintained • Actions from the Committee are managed effectively • Committee reports progress and any issues to the Chief Executive • Committee develops and maintains organisational policies and procedures • Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) • Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate • The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	Y	If applicable	If applicable						
DD2	**Oxygen Supply**	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	• The organisation has reviewed and updated the plans and are they available for view • The organisation has assessed its maximum anticipated flow rate using the national toolkit • The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. • The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site • The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) • Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies • The organisation has breaching points available to support access for additional equipment as required • The organisation has a developed plan for ward level education and training on good housekeeping practices • The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	Y	If applicable	If applicable						
DD3	**Oxygen Supply**	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	• The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries • The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms • The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes • Organisation has utilised the checklist retrospectively as part of an assurance or audit process	Y	If applicable	If applicable						
DD4	**Oxygen Supply**	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	• Job descriptions/person specifications are available to cover each identified role • Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. • Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements • Medical gas training forms part of the induction package for all staff.	Y	If applicable	If applicable						
DD5	**Oxygen Supply**	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	• SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds • Staff are informed and aware of the requirements for increasing de-icing of vaporisers • SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	Y	If applicable	If applicable						
DD6	**Oxygen Supply**	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	• Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report	Y	If applicable	If applicable						
DD7	**Oxygen Supply**	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	• Organisation has a risk assessment as per section 6.6 of the HTM 02-01 • Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)	Y	If applicable	If applicable						

NHS
South Sefton
Clinical Commissioning Group

Key Issues Report to Governing Body

Finance and Resource Committee Meeting held on Thursday 29 July 2021	Chair: Alan Sharples

Key Issue	Risk Identified	Mitigating Actions
The CCG has developed a plan for H1 in conjunction with other CM CCG's which leaves a 2.9% QIPP target on influenceable spend. Reliance on national assumptions may create risks should local experience de different The CCG's underlying position remains challenged with an estimated deficit of c. £9m - £12m.	Potential overspending in key areas could mean that CCG does not deliver its statutory duty to break-even unless further mitigating actions are developed.	The CCG must continue to review all aspects of expenditure. The committee will receive monthly reports advising on risks and potential mitigations. The CCG must continue to work alongside local system partners to develop and implement QIPP and service improvement schemes to address financial sustainability of the CCG and wider system.

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

The Committee received a prescribing update noting that budgetary figures are provisional pending NHSBSA agreement. The report noted that costs incurred in April 2021 were lower than costs in April 2020. Susanne Lynch also noted that Cat M arrangements for the next quarter have been published and should provide a small benefit to the CCG's financial position.

The Committee approved the prescribing rebates for Fostair NEXThaler rebate and Freestyle Libre noting that the proposals were in line with the CCG's rebate policy.

The Committee noted the F&R report highlighting that key pressures exist due to increase in packages of care under s.117 arrangements. The CCG team will review this situation in detail and report back to the committee.

The Committee received an update relating to CHC, noting that all backlog cases relating to March 21 have been completed. Further work will now concentrate upon reaching the 28 day standard for eligibility decision following checklist assessment for BAU cases. The Committee was also asked to note that the CCG's regulator is still applying significant scrutiny in terms of how it is managing progress.

The Committee received an update on QIPP noting the work being undertaken with LUHFT and our partners in another CCG from the North West to evaluate schemes that have been introduced which could provide a benefit for the CCG.

A report detailing the High Costs Packages of Care agreed by the CCG during June was received and discussed by the Committee.

The IFR annual report for 2020/21 was received by the Committee.

The Committee noted the Terms of Reference and suggested that we remove the reference to the Director of Strategy and Outcomes role as the duties are now being undertaken by other team members.

The F&R risk register was discussed by the Committee and it was agreed that it needed to be reviewed and updated. An additional risk to be introduced relating to planning uncertainty for the second part of the year.

The F&R Committee approved the following policies subject to final review,

- Social Media Policy subject to confirmation that the policy had been reviewed by CCG Comms team
- Attendance Management Policy subject to confirmation that an EIA/QIA has been undertaken
- Mobile Device Policy

The proposal to award CCG Staff members an extra day holiday as a "well-being day" to recognise the outstanding contribution in responding to the COVID pandemic was agreed by the Committee, noting that members with a Conflict of Interest were excluded from the decision.

The Committee discussed whether it should meet in August and decided that it would not, that given the expectation that there was no guidance to be published for the second part of the financial year (H2) before the scheduled date. It was agreed that the Committee receive updated papers covering

- Month 4 Financial Update
- Report on QIPP progress
- Review of F&R Committee risk register

With papers being sent to members by Friday 20th August

Key Issues Report to Governing Body

NHS South Sefton Clinical Commissioning Group

Joint Quality and Performance Committee held on 29th July 2021	Chair: Dr Rob Caudwell

Key Issue	Risk Identified	Mitigating Actions
1. Patient Story presented by Gina Halstead with concerns raised regarding ADHD Service and response to specific patient needs (including communication methods). Also, the only KPIs currently in place measure waiting times only.	Concerns regarding ADHD service and potential quality of service provided to patients.	• A focussed ADHD deep dive paper to be produced and shared with the committee (Author of paper TBC). • CC to speak will discuss with Lisa Cooper about GH bringing the patient story to one of their forums. • SEND group to provide more detail regarding the pathway.
2. Review of the IPR highlighted concerns regarding level of data received from LUHFT particularly in relation to AED waiting times.		To be highlighted by the CCG at CQPG.
3. SI report presented with committee members highlighting concerns regarding number of Never Events reported by LUHFT despite improvement work following a number of NE reported in 20/21. It was queried whether human factors contributed largely to this and potentially culture issues.		LUHFT are currently re-reviewing improvement plan which is being led by Neal Jones who is a human factors expert, this will be presented at August CQPG following which an update will be provided back to this committee.

4. Neil Leonard produced good piece of work regarding gastrointestinal pathways. The pathways are for S&O and LUHFT and how they are integrated into GP processes.		Committee requested further information as to who has this been shared with and how will the committee obtain progress updates? GP Clinical leads to confirm.
5. Maternity Deep dive paper presented to JQPC. Providers are all part of the LMS and have provided a gap analysis directly to LMS however this report will be coming through contract meetings so will be fed into CN report when available. LWH confirmed that they have not done any diverts as no other organisation to facilitate full divert.	Maternity system is under significant pressure and several access incidents with diverts to other providers in place. This could potentially impact service access and the quality of care provided.	• LMS are sighted on all SIs reported by S&O including learning and themes. • Daily escalation meetings were taking place by LMS to manage group of mothers coming through. This has now gone to 3 times a week as they have more of a handle on activity. • CCGs Deputy Chief Nurse has asked for further clarity from LCCG and NHSE/I due to the variance with other organisations.
6. It was highlighted that Children in Care are not receiving timely care caused by a lack of capacity and resource (staffing) within the commissioned Children in Care Health Teams. There is also an increase in the number/complexity of children entering the care system. Staffing and increase in children is affecting the number of health assessments being carried out, however, there are no quality concerns of the assessments themselves.	Children in Care not receiving care appropriate to their needs.	• Mutual aid is being provided by means of the Designated Nurse CiC who is supporting the Community CiC Team • Recruitment process is to be undertaken in the Community CiC Team. • KPI data set has been reduced to prioritise assessments.

7. LEDER issues highlighted in terms of capacity and resource. The CCG currently share arrangements for managing LEDER with LCCG which is led by Tracey Forshaw. LEDER is now recorded onto new platform which was maintained using admin support. This is now not available.	Data quality issues and impact on reporting on performance.	• Admin support to be arranged – TBC • No resource was provided for LEDER reviewers but CCG been able to secure some external support form NHSE/I.
8. Children and Young People's NHS Continuing Care Protocol and associated Processes presented to the committee members and approved by JQPC.	N/A	N/A
9. Update provided and approval requested regarding the GP2GP and Destruction of Paper Patient Records Following Digitisation. Committee members raised concerns about destroying records and risks associated. It was highlighted that if you do not destroy records, increase workload on receiving practice. Also cost of deep storage is not factored into the budget.	• Risk of losing patient records. • Increased workloads on practice staff if they are not destroyed due to having to cross reference records. Deep storage costs are high and not factored into the budget.	• Louise Taylor will go back and look at guidance around destruction of records before this is agreed to. • Also Louise Taylor to identify failed records in the system which will be part of audits carried out. • JQPC approved the process of GP2GP, in terms of destruction, as long the guidance around destruction of records has been confirmed and that the LMC have been informed.
10. IAPT 18 week waiting times highlighted at EPEG.		Work ongoing with support from the CCG and oversight of the progress is being monitored.

Information Points for South Sefton CCG Governing Body (for noting)
None.

NHS South Sefton Clinical Commissioning Group

NHS Southport and Formby Clinical Commissioning Group

Key Issues Report to Governing Body

Audit Committees in Common: Wednesday 21 July 2021	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions

Information Points for South Sefton and Southport & Formby CCG Governing Body (for noting)

The Committee noted that whilst the SFCCG membership was appropriately constituted for decision making, SSCCG did not have the required number of members for decision making purposes and was not quorate. This meant that the minutes for SSCCG for April and June will need to be re-presented to the Committee at its next meeting.

The minutes for SFCCG April meeting will also need to be presented to the Committee at its next meeting having been omitted from the meeting pack.

The Committee received an update regarding the resolution of the outstanding GP pensions issues noting that the plan was for the CFO and his team to hold direct meetings with members affected by the issue along with their nominated professional advisors. The plan was to have reached agreement on outcomes for individuals by the end of September.

The Employee Privacy Notice was reviewed by the Committee and approved. It will be circulated to staff members via the Communications bulletin.

The Committee received an update regarding the Data Security and Protection Toolkit submission at the end of June. The CCGs' submitted a report noting that "standards not met, action plan in place." There was one standard not met in relation to testing the IT network within a required time period (9.2.1). The CCG plans to resolve this issue by undertaking a Penetration Test on its network during September 2021.

The Committee reviewed the Policy tracker and asked for further assurance regarding policies with review dates that are outstanding. The policies have been reviewed although there were outstanding actions to ensure that they are finalised.

The Committee received an update from Internal Audit noting compliance with the Internal audit charter which is important as evidence to assure the committee that it is delivering an appropriate internal audit function.

The Committee received an update from external audit which noted that further work to review the CCGs' value for money arrangements is being undertaken and that the final audit letter will be due for presentation to the October committee.

The Committee reviewed the Governing Body Assurance Framework (GBAF) and Corporate Risk Register (CRR). The papers were approved by SFCCG whilst SSCCG had to defer approval due to quorate issues.

The Audit Committee Risk register was also approved by SFCCG.

The Scheme of Reservation and Delegation was approved to reflect changes to personnel and inclusion of additional posts in the CCGs' structure.

Key Issues Report to Primary Care Commissioning Committee in Common

NHS South Sefton Clinical Commissioning Group

South Sefton Primary Care Commissioning Committee Part 1, Thursday 15th July 2021	Chair: Dil Daly

Key Issue	Risk Identified	Mitigating Actions

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

- Improvement grants bid have been submitted to NHSE
- Learning Disability Health Checks increase by 20% in both CCG's. The primary care team were invited to present how this was achieved, to other CCGs across the north west
- Out of hours provider PC24 have now completed 3 months of their contract. They are experiencing very high demands
- COVID Booster ES has now been released and PCN are in the process of reviewing the terms
- Quality team have produced a new process for dealing with complaints
- There have been several mergers of practices which has resulted in fewer GP contracts held in primary Care.
- The risk register was updated

NHS
South Sefton
Clinical Commissioning Group

Finance and Resource Committee
Draft Minutes

Thursday 29 July 2021, 1pm to 3pm
Microsoft Teams Meeting

Attendees (Membership)		
Alan Sharples	Lay Member (F&R Committee Chair), SS CCG	AS
Steven Cox	Lay Member (F&R Committee Vice Chair), SS CCG	SC
Chrissie Cooke	Interim Chief Nurse, SS CCG	CC
Tracy Jeffes	Director of Place – South, SS CCG	TJ
Susanne Lynch	Head of Medicines Management, SS CCG	SL
Martin McDowell	Chief Finance Officer, SS CCG	MMcD
Rebecca McCullough	Deputy Chief Finance Officer, SS CCG	RMcC
Dr Sunil Sapre	GP Governing Body Member, SS CCG	SS
Dr John Wray	GP Governing Body Member, SS CCG	JW
Dr Alison Rowlands	GP Governing Body Member, SS CCG	AR
Ex-officio Member*		
Fiona Taylor	Chief Officer, SS CCG	FLT
In attendance		
Jane Keenan	Interim CHC Programme Lead, SS CCG	JK
Paul Shillcock	Accounts/Training Manager – Informatics Merseyside	PS
Fiona Doherty	Head of Strategies and Outcomes	FD
Debbie Fairclough	Interim Programme Lead – Corporate Services	DF
Minutes		
Sandra Smith	PA to Finance Director	SSm

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

Name	Membership	April 2021	May 2021	June 2021	July 2021						
Alan Sharples	Lay Member (Chair)		Y	Y	Y						
Steven Cox	Lay Member (F&R Committee Vice Chair), SS CCG		Y	A	Y						
Dr Pete Chamberlain	SS Governing Body Chair		Y	A	A						
Chrissie Cooke	Interim Chief Nurse		Y	Y	Y						
Tracy Jeffes	Director of Place – South SS CCG		Y	A	Y						
Susanne Lynch	Head of Medicines Management		Y	Y	Y						
Martin McDowell	Chief Finance Officer		Y	Y	Y						
Rebecca McCullough	Deputy Chief Finance Officer				A						
Dr Sunil Sapre	GP Governing Body Member		Y	Y	Y						
Dr John Wray	GP Governing Body Member		A	A	Y						
Fiona Taylor	Chief Officer (Ex-officio member of F&R Committee*)		Y	A	A						
Alison Rowlands	GP Governing Body Member				Y						

No	Item	Action
General business		
FR21/106 **(a)** **(b)** **(c)**	**Apologies for absence** Apologies were received from: Jan Leonard Rebecca McCullough Due to the situation in relation to the Coronavirus (COVID-19) pandemic and the government guidance to limit social contact, the Finance & Resource (F&R) Committee meeting today was taking place via Microsoft Teams. Alison Rowlands (AR), GP was welcomed as a member to the Committee.	
FR21/107 **(a)** **(b)** **(c)**	**Declarations of interest regarding agenda items** Committee members were reminded of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NHS South Sefton Clinical Commissioning Group (CCG). Declarations made by members of the South Sefton Finance & Resource Committee are listed in the CCG's Register of Interests. The register is available on the CCG website via the following link: www.southseftonccg.nhs.uk/about-us/our-constitution. **Declarations of interest from today's meeting** • Declarations of interest were received from CCG officers who hold dual posts in both South Sefton CCG and Southport & Formby CCG. It was noted that these interests did not constitute any material conflict of interest with items on the agenda. It was noted there will be a conflict of interest for all CCG employed members of the Committee in respect of TJ's item on the proposed Wellbeing Day.	
FR21/108 **(a)** **(b)**	**Minutes of the previous meeting and key issues** The minutes of the previous meeting held on 17th June 2021 were approved as true and accurate records. The key issues log was approved as an accurate reflection of the main issues from the previous meeting on 17th June 2021.	
FR21/109 **(a)** **(b)** **(c)**	**Action points from the previous meeting – Wednesday 17th June** **FR21/89 (d) Out of hours/lone work procedure**: AS stated he had not yet received this procedure; SL confirmed there were some outstanding queries which need discussion with MMcD. The completed procedure will be sent to AS in due course; this item can now be closed. **FR21/91 (c) Prescribing report**: It was agreed that this session could take place at the September meeting which will be extended by 30 minutes to accommodate the presentation. SL will check Tom Roberts is available to attend to take part in the presentation and confirm to SS. **FR21/97 (b) CSU Service Report**: MMcD had not had an opportunity to review the HROD SLA for S&F and SS.	SL SL

No	Item	Action
(d) **(e)** **(f)** **(g)**	**FR21/98 (a) Sponsorship Register update**: This item is on the agenda for discussion today. **FR21/101 (b) 21/22 IM&T Investment Plan update**: a written report has been supplied and is on the agenda. **FR21/102 (e) Minutes of Steering/Sub-Groups:** It is noted this relates to a wider piece of work which is taking place across the CCG and been presented to LT. AS reminded the Committee this action was to gain assurance that sub-committees were quorate in the future. He asked for assurance to be fed back to the SS F&R Committee once the mapping work is finalised. **FR21/67 NHS People Plan Update:** The required action has been completed; this action is now closed. ***It was noted that all other actions on the action tracker following the May 2021 meeting had been completed; updates were provided on the action tracker which were taken as read. No queries were raised in relation to the updates provided.***	CC
Continuing Healthcare		
FR21/110 **(a)** **(b)** **(c)**	**Continuing Healthcare Update – July 2021** JK presented the CHC update, highlighting the progress made by Mersey Care in relation to South Sefton cases arising during 19/20 and 20/21. All South Sefton original backlog cases are now closed with reviews being undertaken; the next stage of the process will be to measure the financial impact. Mersey Care have developed a new backlog in quarter 1, which is a combination of assessments and reviews equating to 16. A contract performance notice is in place and work will need to be undertaken to ensure this number does not increase. MMcD noted this remains a risk to the CCG from a reputational perspective, the regulators are keeping a keen watch on the CCG and monitoring progress. AS agreed with this point, adding that there is a need for the Committee to be fully updated going forward. **JK left the meeting.**	
Prescribing		
FR21/111 **(a)** **(b)** **(c)** **(d)**	**Prescribing Spend Report** SL presented an update report on prescribing expenditure at month 1, noting that her paper alludes to a provisional budget, which has been added to give context. SL confirmed that the expenditure for South Sefton for April 21 is less than in April 20, with a reduction in both items and cost. SL confirmed that there will be a reduction in Category M from this month, which will provide a positive benefit from a financial perspective. The impact on the CCG will be reviewed and reported to a future committee meeting. AS referred to the Executive Summary and asked that the table previously included within the summary which notes both percentages and figures, could be reinstated. SL explained that Astro PU's was a measure that enables practice expenditure to be compared; Astro is based on age, sex, temporary residence status.	SL

No	Item	Action
(e)	MMcD estimated that a saving of approximately £120k per quarter may be available in relation to the Category M change, based on the information supplied. He then proceeded to give the background of Category M which is a mechanism to look at the 500 most popularly issued drugs, adjusting prices through that mechanism enables the agreed profit margin for community pharmacists to be delivered. The price of individual drugs can be altered during the year, sometimes without warning, and he noted that that the price can may increase or decrease.	
(f)	SC asked if the 2.3% reduction noted in the report is replicated in other CCG areas; it was confirmed that is not the case when comparing to another local CCG which has seen an increase in their month 1 expenditure.	
(g)	This report was received by the Committee.	
FR21/112	**Fostair NEXThaler rebate**	
(a)	SL provide a report on a proposed rebate, which is an inhaler device which equates to £2.5k per quarter. She confirmed that the proposal was consistent with the CCG's rebate policy.	
(b)	This rebate was approved by the Committee.	
FR21/113	**Freestyle Libre Rebate**	
(a)	SL reported this proposed rebate is more complex than normal arrangements as it is linked to market share and is retrospective in nature. The monitoring device had been introduced using NHSE funding which has since been withdrawn. The estimated saving to the CCG is £17.5k p.a. although demand projections suggest that this could rise to £39k p.a. SL recommended approval of the proposed rebate.	
(b)	AR asked if the CCG did not agree to sign up to this rebate, what would be the ramifications. SL explained if this was not approved, the CCG would not sign up for the rebate, meaning the rebate would not be received.	
(c)	AR followed with a further question, as to whether there are any negatives to signing up to the scheme. SL confirmed a strict protocol is in place, all assessments are undertaken prior to the proposal being brought to the F&R Committee for approval. SL reported that from a governance perspective these proposals are controlled via adoption of the policy and that other local CCGs have followed our lead to introduce the same policy.	
(d)	AS added that the use of Freestyle Libre was made separately some time ago and that decision was based on national guidance.	
(e)	SC asked if there was data on how many patients may fit the criteria to receive the devise. SL will review the data and share the outcome with the Committee.	SL
(f)	This rebate was approved by the Committee.	
Finance		
FR21/114	**Finance Report**	
(a)	MMcD provided an overview of the financial position; the Committee were reminded the CCG is in a block arrangement with providers for the financial year. The exception is the private sector and mitigating actions within the funding mechanism are available if the CCG should see any unexpected increases.	

No	Item	Action
(b)	He reported that it is likely that the breakeven target is expected be delivered for the first six months of the year. The main emerging risk for the CCG, and where future discussions will be needed, is around Section 117 joint funding packages which have increased over the past two years. The CCG needs to undertake a review of the factors influencing the increase to ensure only costs relevant to the CCG are being incurred.	
(c)	MMcD recommended that LT will undertake work on the above and an update will be brought back to the Committee on the factors contributing to the increase in costs.	
(d)	MMcD asked the Committee to note the best, likely and worse-case scenario for the CCG and reported that the range between best and worse-case was relatively narrow compared to other CCGs.	
(e)	This report was received by the Committee.	
FR21/115	**QIPP Update Report – July 2021**	
(a)	MMcD presented this report; the CCG's QIPP plans largely remain on pause due to the pandemic and the temporary financial arrangements in place. Fiona Doherty has met with members of S&O Trust to develop a joint workplan with the CCG.	
(b)	The CCG and wider system are looking to agree the QIPP plan by end of September. The supporting transformation work is focused upon fragile services at the Trust and key specialties have been identified.	
(c)	MMcD has met with the Director of Transformation from LUFT in the intervening period and several areas for joint work have been established. Further conversations with LUFT will take place over the next few months, with a view to implementing some of the saving plans during the latter part of the financial year.	
(d)	MMcD appraised the Committee of the work undertaken by Tameside and Glossop CCG (T&G CCG) who have been able to make savings within their plans; it was noted that peer review work will be undertaken between the CCG and T&G CCG.	
(e)	AS commented that it is unlikely that the projected QIPP savings will not be made this year, due to the current financial regime. However, he noted that it is good that the work is continuing behind the scenes.	
(f)	MMcD referred to the Meds Management QIPP and its current position. SL confirmed that South Sefton is currently £840k within the plan, however, more work needs to be undertaken. It was confirmed that £1.6m of savings in total is needed.	
(g)	This report was received by the Committee.	
FR21/116	**Improvement Grant Applications**	
(a)	MMcD verbally updated the Committee on this item, confirming expressions of interest were put forward for two South Sefton practices; Orrell Park Medical Centre and Sefton Road surgery. MMcD has approved both applications on behalf of the CCG and presenting this update to the Committee for information purposes. The outcome of assessment undertaken by the NHSE is now awaited and will be reported to the Committee in due course.	
(b)	AS understood that there was a need to act due to the deadline being moved, however, he asked if the applications could be shared with the Committee for information purposes.	MMcD

No	Item	Action
FR21/117	**High-Cost Packages of Care**	
(a)	TF brought this paper to the F&R Committee to provide a single report on the high-cost packages of care. She noted that all high-cost cases are approved by either FLT, MMcD or CC.	
(b)	MMcD commented that from his perspective, the report gives the F&R Committee an insight into some of the issues that are faced on a day-to-day basis.	
(c)	TF confirmed the packages are reviewed on regular basis, especially where 1:1 care is provided, to ensure the requirements are still needed.	
(d)	AR asked for a brief explanation on the CHC funding pathway, TJ confirmed it is continuing healthcare funding, where individuals have health needs above and beyond what core services can deliver. An assessment is undertaken to determine eligibility, this is then approved through the CHC panel meetings.	
(e)	This report was received by the Committee.	
FR21/118	**Individual Funding Request Service Annual Report 2020/21**	
(a)	MMcD introduced the report, taking the paper as read; it was noted activity is significantly reduced as a result of a slowdown in elective activity during the COVID pandemic.	
(b)	MMcD explained the Information Funding Requests (IFR) are requests for services which are not part of the CCGs portfolio. A panel is convened through the CSU to enable the case to be reviewed on an objective basis. These requests are usually supported by the specialist, consultant, or in some instances a GP.	
(c)	AS pointed out a table within page 98 of the report, which gives a comparison of the various CCGs, noting Sefton had comparatively high levels of referrals.	
FR21/119	**Finance & Resource Terms of Reference (ToR)**	
(a)	It was noted that there had not been a direct replacement for the Director of Strategy and Operation and that the post should be removed from the membership of the Committee.	
(b)	The Terms of Reference were approved with the above change.	SS
FR21/120	**Report on Mapping Exercise – Meeting membership and attendance**	
(a)	CC asked that this item be deferred as the work being undertaken will not be concluded until the end of July.	
(b)	It was agreed this item would be deferred to the next meeting.	
CCG Published Registers		
FR21/121	**Sponsorship register update**	
(a)	AS confirmed this update had been previously taken to the Audit Committee and has been brought to this Committee for information.	

No	Item	Action
(b)	The Committee receive this report for information.	
Risk		
FR21/22	**Finance & Resource Committee Risk Register**	
(a)	MMcD introduced the risk register, referring to Covid related risks, asking the Committee if they agreed they are valid in terms of risks that are pertinent to the CCG. It was noted that this question had been posed to S&F F&R Committee, who agreed they did.	
(b)	AS commented that most Covid risks have been mitigated down to less than red, adding that the one outstanding red risk is the QIPP as previously noted. He viewed this information as an accurate description of the current position given the financial regime.	
(c)	MMcD confirmed the CFOs across Cheshire & Merseyside are undertaking a collective high-level piece of work to try to anticipate the plan for the second part of the year.	
(d)	AS stated, he had recently reviewed risk registers of other organisations, adding one organisation had identified the financial uncertainty of the second half of the year as a risk itself. MMcD agreed with this view confirming that discussions would be taking place within LT.	
(e)	This report was received by the Committee	
Digital and Information Technology		
FR21/123	**IT Investment Plan 21/22**	
(a)	MMcD presented this report, noting that PS had given a verbal update at the last F&R Committee meeting and that this was the written report to consolidate the information.	
(b)	The Committee received this report.	
Policies for Approval		
FR21/124	**Social Media Policy/Attendance Management Policy/Mobile Device Policy**	
(a)	It was assumed that each policy had been read by Committee members.	
(b)	The Social Media Policy will be approved, once it is confirmed the Comms Team have had sight of the policy.	
(c)	The Equality Impact Assessment Policy will be approved once assurance has been given that the policy has been through the quality impact assessment process.	
(d)	The Mobile Device Policy was approved.	
(e)	It was agreed the Committee would approve the policies subject to confirmation they have been through the correct Committees. SS will liaise with the relevant departments and confirm relevant checks have been carried out.	SS
Minutes of Steering Groups to be formally received		
FR21/125	**Minutes of Steering / Sub-Groups to be formally received**	
(a)	The committee received the minutes of the following steering / sub-group meetings:	

No	Item	Action
	• Joint QIPP Delivery Group – June 21	
(b)	The minutes were taken as agreed and read.	
Closing business		
FR21/126	**Any Other Business**	
(a)	Wellbeing Day: AS apprised the Committee of the proposal to offer an extra day's annual leave to all CCG staff to be taken between 21/22.	
(b)	TJ has received confirmation that the Local Authority have agreed to award an extra day's leave to their staff.	
(c)	After discussion it was agreed that the proposal to offer a Wellbeing Day to all CCG staff is supported by the South Sefton F&R Committee.	
(d)	It was agreed that the August F&R Committee meeting would be cancelled. MMcD will arrange for the Committee to receive a Month 4 financial report, updated risk register and, potentially, receive a QIPP update in lieu of the August meeting. It was anticipated these papers would be shared on Friday 20 August.	MMcD
FR21/127	**Review of Meeting**	
(a)	Discussion took place on the use of acronyms included within the Committee papers and reports. It was agreed that in future best practice would be followed and all acronyms will have the wording in full, followed by the acronym.	
(b)	It was noted that an NHS Acronym list can be found via: **https://www.england.nhs.uk/get-involved/resources/involvejargon/** or, via the NHS Confederation website.	
(c)	CC asked if, in future, those preparing reports could look to user shorter sentences.	
(d)	MMcD commented that the reading of the papers beforehand gives a good introduction to the meeting and helps the meeting flow.	
FR21/128	**Key Issues Review**	
(a)	MMcD highlighted the key issues from the meeting, which will be presented as a Key Issues Report to Governing Body.	
	Date of next meetings: Next F&R Committee Meeting: Thursday 30th September 2021 1 pm to 3 pm Microsoft Teams	

NHS

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

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

Thursday 29th July 2021, 9am to 12noon
Microsoft Teams Meeting

Attendees (Membership)		
Dr Rob Caudwell	GP Governing Body Member, Chair, NHS Southport and Formby CCG	RC
Martin McDowell	Chief Finance Officer, NHS South Sefton CCG/NHS Southport and Formby CCG	MMcD
Dr Doug Callow	GP Quality Lead / GB Member, NHS Southport and Formby CCG	DC
Dr Gina Halstead	GP Clinical Quality Lead / GB Member, Deputy Chair, NHS South Sefton CCG	GH
Dr Jeffrey Simmonds	Secondary Care Doctor, NHS Southport and Formby CCG	JS
Tracey Forshaw	Deputy Chief Nurse and Head of Quality and Safety, NHS South Sefton CCG/NHS Southport and Formby CCG	TF
Chrissie Cooke	Interim Chief Nurse, NHS South Sefton CCG/NHS Southport and Formby CCG	CCooke
Steven Cox (for part of the meeting)	Lay Member, NHS South Sefton CCG	SC
Dil Daly	Lay Member, NHS Southport and Formby CCG	DD
Billie Dodd	Deputy Director of Delivery and Commissioning, NHS South Sefton CCG/NHS Southport and Formby CCG	BD
Ex Officio Member		
Fiona Taylor	Chief Officer, NHS South Sefton CCG/NHS Southport and Formby CCG	FLT
In attendance		
Mel Spelman	Programme Manager for Quality and Risk, NHS South Sefton CCG/NHS Southport and Formby CCG	MS
Chantelle Collins	Programme Manager for Quality and Performance, NHS South Sefton CCG/NHS Southport and Formby CCG	CCollins
Helen Roberts	Lead Pharmacist NHS South Sefton CCG/NHS Southport and Formby CCG	HR
Sue Jago (for agenda item 21/ 140 only)	Complaints and Corporate Services Officer, NHS South Sefton CCG/NHS Southport and Formby CCG	SJ
Peter Wong (for agenda item 21/148 only)	Children and Young People Commissioning Lead, NHS South Sefton CCG/NHS Southport and Formby CCG	PW LT
Louise Taylor (for agenda item 21/149 only)	Primary Care Business Change Manager, NHS Informatics, Merseyside	

Helen Case	Designated Nurse Children in Care, NHS South Sefton CCG/NHS Southport and Formby CCG	HC
Ally Dwyer (for agenda item 21/137 only)	Senior Business Intelligence Analyst, NHS South Sefton CCG/NHS Southport and Formby CCG	AD
Apologies		
Susanne Lynch	Head of Medicines Management, NHS South Sefton CCG/NHS Southport and Formby CCG	SL
Fiona Taylor	Chief Officer, NHS South Sefton CCG/NHS Southport and Formby CCG	FLT
Dr Jeff Simmonds	Secondary Care Doctor, NHS Southport and Formby CCG	JS
Minutes		
Michelle Diable	Personal Assistant to Chief and Deputy Chief Nurse, NHS South Sefton CCG/NHS Southport and Formby CCG	MD

For the Joint Quality and Performance Committee to be quorate, the following representatives must be present:

Chair of the Joint Quality and Performance Committee or Vice Chair.
Lay member (SF)
Lay member (SS)
CCG Officer (SF)
CCG Officer (SS)
A governing body clinician (SF)
A governing body clinician (SS)

Membership Attendance Tracker

Name	Membership	July 20	Aug 20	Sept 20	Oct 20	Nov 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21
Dr Rob Caudwell	GP Governing Body Member (Chair)	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
Dil Daly	Lay Member for Patient & Public Involvement	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Doug Callow	GP Governing Body Member /Clinical Quality Lead	✓	✓	A	✓	A	A	✓	✓	A	✓	✓	✓
Debbie Fagan	Chief Nurse & Quality Officer (on Secondment)												
Dr Gina Halstead	Chair and Clinical Lead for Quality (Deputy Chair)	✓	A	✓		✓	✓	✓	✓	✓	A	✓	✓
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Jeffrey Simmonds	Secondary Care Doctor	A	A	A	A	A	✓	✓	A	A	A	✓	A
Brendan Prescott	Deputy Chief Nurse and Head of Quality and Safety (on Secondment)	✓	✓	✓	A	✓	✓	✓					

Name	Membership	July 20	Aug 20	Sept 20	Oct 20	Nov 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21
Tracey Forshaw	Interim Deputy Chief Nurse								✓	✓	✓	A	✓
Fiona Taylor	Chief Officer Ex-officio member of JQPC Committee	✓	A	✓	✓	✓	A	✓	✓	A	✓	A	A
Billie Dodd	Deputy Director of Commissioning and Delivery						A	✓	✓	✓	A	✓	✓
Chrissie Cooke	Interim Chief Nurse						✓	✓	✓	✓	✓	✓	✓
Steven Cox	Lay Member for Patient & Public Involvement										A	✓	✓

✓ = Present A = Apologies

No	Item	Action
General		
21/132	**Welcome and Apologies for Absence** The meeting Chair, Dr Rob Caudwell welcomed all to the meeting. Apologies for absence were noted from Susanne Lynch, Dr Jeff Simmonds, Fiona Taylor and Jennie Piet. It was noted that Steven Cox had sent his apologies, however he joined part of the meeting to ensure quoracy for those agenda items requiring approval.	
21/133	**Declarations of Interest** Committee members were reminded of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NHS South Sefton Clinical Commissioning Group and NHS Southport and Formby Clinical Commissioning Group. Declarations made by members of the Joint Quality and Performance Committee are listed in the CCG's Register of Interests. The register is available on the CCG website. **Declarations of interest from today's meeting** • Declarations of interest were received from CCG officers who hold dual posts in both NHS South Sefton CCG and NHS Southport and Formby CCG. It was noted that these interests did not constitute any material conflict of interest with items on the agenda.	
21/134	**Minutes and Key Issues of the Previous Meeting** The minutes and key issues from the previous meeting held on Thursday 24th June 2021 were approved.	
21/135	**Matters Arising/Action Tracker** The Committee received the action tracker and the following updates were noted: - • **Agenda Item 19/201, Clinical Director Quality Update** Following issues raised regarding midwifes not having had EMIS training. Chrissie Cooke updated that it has been recognised by the Liverpool Women's Hospital NHS Trust that there are issues that need to be solved. She advised that she has asked IMersey to ensure that dialogue is maintained with the Trust in relation to the EMIS training for midwives. A further update to follow at the next meeting. Dr Gina Halstead thanked Chrissie Cooke for her work on this issue thus far. Action to remain on the tracker.	**CCooke**

No	Item	Action
	• **Agenda Item 21/50, Clinical Director Quality Update** (i) Billie Dodd to follow up the email sent by Dr Rob Caudwell to Jan Leonard and the LMC in relation to the MGUS patients at Southport and Ormskirk Hospital NHS Trust, being discharged from the haematology clinic and referred on to primary care. Dr Rob Caudwell had informed that there is a well ran nurse led haematology service at Whiston Hospital and that the suggestion of introducing similar for the haematology service at Southport and Ormskirk NHS Trust has been made. It had been noted that the issues whereby primary care services are being asked to monitor MGUS patients care are starting to re occur, this has been escalated. Billie Dodd to follow up the disconnection at the next Clinical Assurance Group to obtain clarity. Billie Dodd updated that there is a programme work on-going with St Helens in relation to a nurse led model. It is on their work plan and recruitment is to be undertaken. Billie Dodd to provide an update at the September JQPC meeting. Action deferred to the September meeting. • **Agenda Item 21/51 Commissioner Quarterly Controlled Drug Report to NHS England** Dr Doug Callow had made a plea on behalf of primary care colleagues in relation to 28 day repeat prescribing as it impacts on primary care workload. He suggested it be changed to 56 days for stable patients that are prescribed to take 4 or less drugs. Helen Roberts informed that she would take Dr Doug Callow's suggestion to her prescribing lead colleagues at the next JMOG meeting and report back. (i) Helen Roberts to take the suggestion of introducing 56 day prescribing for stable patients on 4 or less drugs to her prescribing lead colleagues at the next JMOG meeting and report back. Helen Roberts had previously informed that this had been discussed at JMOG where it was agreed for a separate meeting to be convened with GPs to obtain their input. The Committee had requested for the meeting to take place as soon as is possible. Helen Roberts had informed the Committee that she had expressed the urgency of this issue to Susanne Lynch. Following which, Helen advised that she had produced some supporting information for practices in relation to those patients that are not suitable for 56-day prescribing. In addition, she will be working with IMersey to undertake a pilot with local practices, to identify further opportunities to support the process. Work is ongoing. Helen Roberts informed that Susanne Lynch had raised the issue with Fiona Taylor who is considering it as part of the pressures on the primary care workforce.	**BD** **HR**

No	Item	Action
	Helen Roberts is meeting with the practice taking part in the trial, on 13th August 2021. Dr Rob Caudwell highlighted the urgency around this as the workload increasing. He informed that his practice is looking to recruit a pharmacy technician for support and that other practices are seeking solutions independently. Action to remain on the tracker. • **Agenda Item 21/60, Meeting Review** (iii) Development Session to be convened to better understand how strategic connections can be made to quality improvement and quality assurance. Chrissie Cooke had advised that a development session will be convened in due course. Chrissie Cooke updated that NICHE had suggested utilising the August JQPC meeting for a development session. Chrissie Cooke suggested that this would be discussed later in the meeting, under the meeting review agenda item. • **Agenda Item 21/87, Safeguarding Update Report** Tracey Forshaw to ensure discussions in relation to training non-compliance at Southport and Ormskirk hospital take place, highlighting the impact at the CF and CQRM meetings and to invite Karen Garside to those meetings. Tracey Forshaw had advised that safeguarding is on the agenda for the next Southport and Ormskirk Hospital NHS Trust CF meeting, tabled for 14th July 2021. A further update to be received from Tracey Forshaw. Action deferred to the next meeting. • **Agenda Item 21/96, Clinical Director Quality Update** (ii) Dr Rob Caudwell to discuss the issue of primary care being asked by radiology services to undertake further referrals at a meeting he is convening and provide an update. Dr Rob Caudwell updated that he has arranged a meeting in August 2021 regarding the issues being experienced in relation to the radiology service. He will provide an update following this at the next meeting. He noted that there are communication issues in terms of what the correct process is in relation to arranging x rays. Billie Dodd informed that the x ray referral process and the referral forms are to be discussed at the clinical reference group. Action deferred to the next meeting. • **Agenda Item 21/102, Engagement and Patient Experience Group (EPEG) Key Issues**	**TF** **RC**

No	Item	Action
	Chrissie Cooke/Tracey Forshaw to address the concern raised in relation the lack of a psychologist post in the Asperger service via the contract monitoring meeting. It was noted that clarification of the psychologist post in the Asperger's service is being taken through the Mersey Care CF meeting. The Trust has one full time psychologist in post for ASD, the other staff is currently on maternity leave. The Trust has been unsuccessful in filling this post for temporary cover and has recruited an additional assistant psychologist that will support psychological interventions and group work under the supervision of the psychologist, to ensure that individuals care is not unduly compromised. The Trust acknowledges the usual psychological offer has been compromised, which has also had impact due to the pandemic (the inability of psychological therapies and group work to be carried out face to face). The Trust is also working on a plan to resume face to face working and group delivery where appropriate. Action completed. • **Agenda Item 21/113, Chief Nurse Report** (i) Chrissie Cooke to amend the chief nurse report to state that the back log of assessments in the key issues section specifically relate to CHC. Action completed. (ii) Chrissie Cooke to ascertain the reasons for the CHC sickness absences and to advise how many staff members there are to provide context in relation to the percentage that are off sick. Chrissie Cooke explained that Mersey Care NHS Foundation Trust has advised that the sickness absences are sporadic and that there are no specific reasons. MLCSU had advised that there were no issues. However, sickness absence is being monitored. A performance notice and action plan are in place. Action completed. (iii) Chrissie Cooke to confirm the unit of measurement referenced in the June 2021 edition of the chief nurse report in relation to ADHD maximum waits. Chrissie Cooke advised that the figure is based on an average and that this information can be clarified later in the meeting under agenda item 21/137, where the integrated performance report is presented. • **Agenda Item 21/114, Complaints, PALS, MP Report – May 2021** (i) Dr Rob Caudwell to discuss with the Medical Director at Southport Hospital the issue whereby patients have no mechanism to contact care providers should their condition worsen and to suggest having a clear guidance from secondary care colleagues, in relation to what they will or will not expedite. To explore the possibility of writing to patients to sign post them should their symptoms/conditions worsen. In addition to raise	

No	Item	Action
	the issue at the next CQRM. Dr Rob Caudwell updated that he would be meeting with the Medical Director later that day where this will be discussed. Chrissie Cooke referred to the "Shaping Care Together" programme whereby patient initial follows ups are being built into their new models of care. This will include a mechanism for patients to escalate if they think that their conditions have worsened, instead of going via their GP. Dr Rob Caudwell informed that he has had sight of information via clinic letters from the Walton Centre which refer to a new patient initial follow up process, whereby the patient is to advise if a follow up is required. Dr Rob Caudwell explained that he has not received any information on how the process is being implemented and he is not aware if the process has been formally communicated. Billie Dodd advised that this is part of the long-term plan requirement and would provide further information at the next meeting. (ii) Chrissie Cooke to share the June 2021 Complaints and Oversight Group report with Committee members. Action completed. • **Agenda Item 21/115, Niche Corporate Governance Review 2020 Review JQPC and Complaints** (i) Jennie Piet and Mel Spelman to present a quality accounts summary report at the next meeting. It was noted that this was on the agenda. Action completed. (ii) Martin McDowell to review primary care data at a practice-by-practice level to ascertain gaps and how it can be reported. Martin McDowell to provide an update. Action deferred to the next meeting. (iii) Chrissie Cooke to arrange Joint Quality and Performance Committee Development Session to take place in July/August 2021. Chrissie Cooke had explained earlier in the meeting that this would be discussed later in the meeting. Action completed. • **Agenda Item 21/117, Quality in ICS** Chrissie Cooke to circulate the Quality and Safeguarding in Cheshire and Merseyside ICS presentation to the Committee. Action completed. • **Agenda Item 21/118, Implementing the recommendations of**	**BD** **McMD**

No	Item	Action
	Working Together Children (2018) regarding Local Safeguarding Children Board (LSCB) Safeguarding Children Board arrangements paper to be presented at future meeting. Action to remain on the tracker. • **Agenda Item 21/120, Clinical Director Quality Update** (i) Martin McDowell to take forward the concern raised in relation to GP records potentially being lost in history due to the transfer to an electronic platform and to recommend that an immediate halt in the destruction of paper records is put in place temporarily. It was noted that this will be discussed later under agenda item 21/149. Action completed. (ii) Martin McDowell to obtain an update from Leadership Team in relation to the issues that patients are experiencing when trying to access PC24 clinicians. To ask the commissioning team to undertake some research with a view to provide an update, if possible before the next meeting. Action deferred to the next meeting. (iii) Dr Rob Caudwell to send examples of the difficulties experienced in obtaining general neurology referrals to Martin McDowell. Action completed. (iv) Martin McDowell to escalate the issues in relation to the difficulties experienced by primary care in obtaining general neurology referrals. Action deferred to the next meeting. • **Agenda item 21/123, Serious Incident Review Group (SIRG) Minutes and Key Issues** Mel Spelman to confirm if there were any key issues arising from the SIRG meeting held on 5th May 2021 as the key issues template was blank. Mel Spelman confirmed that there were no key issues noted at the SIRG meeting held on 5th May 2201. Action completed.	**CCooke** **McMD** **McMD**
Quality and Performance		
21/136	**Patient Experience – ADHD Pathway** Dr Gina Halstead informed the Committee about one of her patients, a 15-year-old who is experiencing issues obtaining an assessment for ADHD. Dr Gina	

No	Item	Action
	Halstead declared an interest as she has a child with ADHD. It was noted that the child's mother has been removed from Dr Halstead's practice list for unacceptable behaviour. From the age of 12 the child had changed school multiple times and currently receives around 45 minutes of education a day which is not every day. The child was seen by CAMHS in 2019 and discharged, the mother was advised to self-refer to VENUS which did not happen. The child was seen after this but was discharged as she was presenting with ADHD symptoms and was on the ADHD pathway. The child was rereferred to CAMHS by the child's school in May 2021. The mother was invited by letter to attend a video meeting, however she did not attend and the child was discharged as a DNA. The mother said that she had not received the letter. It has recently come to light that the child's mother is functionally illiterate. The mother does have a mobile phone which is not a smart phone. The child has also been referred and re referred on to the ADHD pathway. She has been discharged through lack of communication, whereby letters have been sent to the child's mother which she says, she has not received. She is unable to read them and is self-conscious about her illiteracy. The GP practice recently contacted the ADHD team to make an appointment for the child, but they informed that this could not be done as a referral can only be made via education. There is no lead consultant to contact about it. It was noted that the only KPI in place for ADHD is in relation to waiting times. The Committee noted that there are many barriers which need to be addressed; Covid 19 has impacted as patients cannot be seen face to face, therefore video conferencing has been put in place, however this does not work for all. Not all patients have smart phones or mobile devices. Some have mobile phones but sometimes do not have enough credit on them to make calls. They can receive calls but if there is no caller ID, they do not know who has tried to contact them to be able to contact them. Some patients, parents or carers do not have land lines. Alternative methods and support is required as sign posting alone is insufficient. Chrissie Cooke suggested inviting Alder Hey NHS Foundation Trust to present their ADHD pathway to the Committee. She advised that she would contact Lisa Cooper, Director of Community & Mental Health Services at Alder Hey regarding the issues highlighted and ascertain how DNA's are monitored, followed up and their frequency. Dr Gina Halstead gave permission to share the presentation, which has been anonymised, with other appropriate forums. Chrissie Cooke also suggested asking the SEND Health and Performance Improvement Group to look in detail at the ADHD pathway, in particular the individual case DNA's and KPIs. ***Action: Chrissie Cooke to share the ADHD pathway patient experience presentation with Lisa Cooper.*** ***Action: Chrissie Cooke to ask the SEND HPIG to look at the ADHD pathway in detail,* in particular the individual case DNA's and KPIs.**	**CCooke** **CCooke**

No	Item	Action
21/137	**Integrated Performance Report** Ally Dwyer presented the draft integrated performance report for NHS South Sefton CCG and NHS Southport and Formby CCG for May 2021 pending approval from Martin McDowell. The report was taken as read and the following was noted: - <u>Planned Care</u> **Referrals** Secondary care referrals have remained below historical levels across all referral sources since the beginning of 2020/21. Referral numbers in April and May 2021 were significantly higher than in the previous year, mainly because of the effects of Covid 19 on 2020 data at the start of the pandemic. **E Referrals** These have been paused as previously reported. **Diagnostics** May 2021 has seen a small decline overall in performance for both CCGs and Southport and Ormskirk Hospital NHS Trust, very small improvement for Royal Liverpool University Hospitals NHS Foundation Trust. NHS South Sefton CCG 12.71%, Royal Liverpool University Hospitals NHS Foundation Trust 7.49%, NHS Southport and Formby CCG 18.41% and Southport and Ormskirk Hospital NHS Trust 17.53%). Comparing the CCGs against the national picture the CCGs are well below the national level being at 22.3%. As was seen last month both CCGs the 2 areas where performance is poor and waiting lists high is colonoscopy and gastroscopy. **RTT** May 2021 saw a similar performance for both CCGs and Trusts RTT compared to last month NHS South Sefton CCG 66.71%, Royal Liverpool University Hospitals NHS Foundation Trust 65.89%, NHS Southport and Formby CCG 79.17%, Southport and Ormskirk Hospital NHS Trust 83.74%. Measuring against the national level, NHS South Sefton CCG is reporting slightly but NHS Southport and Formby CCG is reporting well above, national level being at 67.41%. **RTT 52-week waiters** May 2021 has seen an improvement in the numbers of long waiters for NHS South Sefton CCG from 1,422 April 2021 to 978 in May 2021, along with NHS Southport and Formby CCG reporting 355 in May 2021 from 412 in April 2021. For NHS South Sefton CCG, the breaches represent 6.12% of the total waiting list in May 2021 and for NHS Southport and Formby CCG the breaches represent 3.09%, both CCGs being below the national level of 6.35%. Royal Liverpool University Hospitals NHS Trust also showed around just under an 8% decrease in their total 52-week waiters in May 2021 (from 4758 to 4404 in May 2021). **RTT waiting list** There are no waiting list plans required for 2021/22 operational planning, the previous year being is being used for comparative purposes, for incomplete pathways both CCGs are above levels of last year in May 2021.	

No	Item	Action
	Cancelled operations Both Trusts have reported cancelled operations in May 2021, 6 for Southport and Ormskirk Hospital NHS Trust and 2 for Royal Liverpool University Hospitals NHS Foundation Trust. For all patients who have had their operation cancelled, on or after the day of admission for non-clinical reasons are to be offered a binding date within 28 days, or treatment to be funded at the time and hospital of patient's choice. **Cancer Measures** Both CCGs are achieving 4 of the 9 cancer measures year to date. NHS South Sefton CCG is achieving 4 of the 9 cancer measures year to date and 3 measures in month 2. NHS Southport and Formby CCG is achieving 4 of the 9 cancer measures year to date and 4 measures in month 2. Also, after the improvement in recent months with both CCGs are now failing 93% target for all cancer 2 week waits NHS South Sefton CCG 91.88%, NHS Southport and Formby CCG 85.52%. 2-week breast also failing in May 2021. Access to breast services varies by hospital site for Royal Liverpool University Hospitals NHS Foundation Trust and plans are in place to assign patients to the site with the shorter wait and equalise waiting times, unless patient expresses a preference for given site. Both CCGs are now above the national level for 62 days of 69.75% with NHS South Sefton CCG over the 85% national target NHS South Sefton CCG is at 85.71% and S&F is at 76.60%. <u>Unplanned Care</u> **A&E 4 hour** This is still under the 95% target for both CCGs and Trusts ar showing a decline from last month, measuring against the national level of 83.72% both CCGs are at 73.86% for NHS South Sefton CCG and 80.16% below for NHS Southport and Formby CCG. Royal Liverpool University Hospitals NHS Foundation Trust's catchment position is showing a historical peak for activity in May 2021 so having an impact on performance, which was 72.83% in May, this is something that is being mirrored across the country currently. June 2021 data shows the Royal Liverpool University Hospitals NHS Foundation Trust at 69.62% a further decline - national level 81.31% in June 2021. This has been raised at CQPG recently and Royal Liverpool University Hospitals NHS Foundation Trust are going to present at the next CQPG around the governance they have in place internally, regarding their AED improvement plans and mitigating actions for the current performance, this should provide more assurance. **Trust 12-hour breaches** Southport and Ormskirk Hospital NHS Trust had 29 12-hour breaches in May 2021 (from none in April 2021). On review from quality team, they did not identify any harm in the ones they were able to review but noted that they are awaiting receipt of 1 mental health review for May 2021 and will be reviewing 4 mental health breaches for May 2021 at the August 2021 PQIRP meeting. **Mixed Sex Accommodation** Southport and Ormskirk Hospital NHS Trust reported 3 mixed sex accommodation breaches in May 2021 due to delays in transferring patients from critical care. **Handovers**	

No	Item	Action
	There have been further small increases in handover breaches for 15-30 and 15-60 minutes at Royal Liverpool University Hospitals NHS Foundation Trust and a slight rise at Southport and Ormskirk Hospital NHS Trust for 30-60 minutes, but numbers are much lower for that Trust compared to the previous year. **Stroke** For Southport and Ormskirk Hospital NHS Trust this indicator is 1 month in arrears. April 2021 being latest data 58.6% a decline of 14.7% from last month. At the end of April 2021, the stroke ward has moved and this has provided 3 additional cubicles, the stroke team are monitoring this and anticipate improvement in the following months**.** There is no update for stroke from Royal Liverpool University Hospitals NHS Foundation Trust, this has been requested and followed up several times. **HCAI** There were no new case of MRSAs for the CCGs and Trusts in May 2021 and 1 in June 2021. Clostridium difficile remains over plan at both CCGs and Trusts. No plans/objectives have been released nationally for Clostridium difficile so using previous plans in the interim. For E.coli, both CCGs are under plan again using last year's plans in the interim. <u>Mental Health</u> **Mental Health Eating Disorders** Both CCGs are still failing the measure. The CCG has approved of £63k, £112k in total of recurring investment within the eating disorder service as part of its overall mental health long term plan. This investment is part of a 3-year phased approach 2021/22 – 2023/24 to developing a NICE compliant eating disorder service. **IAPT Access** Both CCGs are still failing the measure. There are several actions to address underperformance within the main report. **IAPT Recovery** NHS South Sefton CCG are reporting 41.4% in May 2021 against the 50% target, But NHS Southport and Formby CCG are now achieving the target reporting 53.2%, an improvement from 42.4% last month. The difference in IAPT recovery rates can be explained by the fact that that NHS South Sefton CCG referrals tend to present with more entrenched mental health problems which can impact on recovery rates. In NHS Southport and Formby CCG, the presenting problems are not as severe and therefore optimum recovery rates are achieved. Demography/deprivation differences between the two areas are likely to play a part. Martin McDowell advised that Gordon Jones will have a discussion with the provider to respond to the different level of acuity. Dr Gina Halstead requested for the social prescribing team to be involved to enable patients on the waiting list to have a holistic assessment. ***Action: Martin McDowell to ask Gordon Jones to link in with other***	**McMD**

No	Item	Action
	commissioners in relation to involving the social prescribing team with IAPT recovery to enable patients on the waiting list to have a holistic assessment. **Dementia** This remains under plan for both CCGs. NHS South Sefton CCG 57.7%, NHS Southport and Formby CCG 64.5% - Target 66.7%. The CCG has approved a scheme to go into 2021/22 local quality contract with primary care across Sefton to improve performance going forward. <u>Children's Mental Health Services</u> **ASD** Alder Hey Hospital NHS Trust is on target in May 2021 reporting 98% for assessments within 12 weeks against the 90% target but are still under target reporting 83% completed assessments within 30 weeks (90%) target 90%. This is due to an increase in referrals, the Trust has several mitigating actions in place to manage this and discussions with local partners are underway to understand the drivers for this increase. **ADHD** Both measures were achieving in May 2021. **CAMHS** There has been a decline for both measures in May 2021. CAMHS has seen a decline in their position for referral to choice within 6 weeks to 62.5% from 81.4% in April 2021, plan 95%. A decline in percentage referral to partnership within 18 weeks 42.3% from 57.1% in April 2021, plan 75%. The CAMHS waiting time position continues to be closely monitored by the CCGs and the Trust, and the local CAMHS partnership and third sector providers continue to offer additional support and capacity. All community therapy service waiting times continue to achieve the SEND improvement plan average waiting time KPIs in May 2021. Notably SALT stood at 15.1 weeks against the 18-week KPI. **Gastrointestinal Pathways & GP Processes.** Dr Gina Halsted informed the Committee about a good piece of work produced by Neil Leonard regarding gastrointestinal pathways across Liverpool University Hospitals NHS Foundation Trust, Southport and Ormskirk Hospital NHS Trust and St Helens and Knowsley Hospitals NHS Trust. This work is in relation to how the pathways are integrated into GP processes, supporting the rationale discussions in relation to gastrointestinal problems. **Data Gaps – LUFT & A&E** Martin McDowell raised a concern in relation to the gaps in the data, especially in relation to Liverpool University Hospitals NHS Foundation Trust and how this is to be escalated. He advised that is team are working on that. He also noted that during the pandemic his team have been comparing the data to national averages. He recognises that this is not the norm, however it is a useful exercise. Another concern raised was in relation to the A&E figures in the south of the borough. **Stroke Unit Changes** Martin McDowell informed that he had attended a recent Overview and Scrutiny Committee where the proposed changes for the stroke unit were discussed. There was a lot of discussion regarding services such as ambulance times,	

No	Item	Action
	these will be reviewed by the team. The geography i.e travelling further for better services requires further explanation against the indicators that are in place. There is a joint Overview and Scrutiny Committee with NHS Liverpool CCG, Sefton CCGs, NHS West Lancashire CCG and NHS Knowsley CCG to consider the proposals to develop the Hyper Acute Stroke unit at Aintree. **Outcome: The Committee noted the integrated performance report.**	
21/138	**Chief Nurse Report** Chrissie Cooke presented the chief nurse report providing the Committee with an update on the key issues that have occurred since the last report presented in June 2021. The Committee noted the following highlights: - It was noted that Committee's terms of reference, work plan and priorities have been reviewed and approved. The following 3 gaps have been identified: - **Establishment of a quality performance dashboard** Work had commenced in this regard, however it has since been halted in the anticipation of the key quality indictors which will be released by the National Quality Board, to guide the development of ICS and place level dashboards. **QIA/EIA** A report to be provided at the next meeting **Primary medical service quality** A report is to be presented at the next meeting. Chrissie Cooke informed that a lot of progress has been made in relation to the young person with learning disabilities that had been in Aintree emergency department for 3 weeks. The SEND improvement notice for Sefton has been lifted. Chrissie Cooke wished to thank all those involved in making that happen. The SEND Health Performance Improvement Group will continue. Mersey Care NHS Foundation Trust has been served with a contract performance notice in relation to their performance against CHC. An action plan is in place. A contract procurement exercise has taken place for the CCGs PHB support service. A service provider has been confirmed and the contract term will be for 3 + 2 years. LeDeR resource has been lost, actions to mitigate this are in place. It was noted that there is a separate LeDeR update on the agenda. The uptake for Covid 19 vaccinations for Sefton patients with learning disabilities at the start of July 2021 was 94.5% for their 1st dose and 74.5% for their 2nd dose. There have been no SBARs noted for this month. The receipt of the ICS HR framework is expected imminently. The link between Clostridium difficile the Covid 19 vaccination is being investigated. It was noted that primary care prescribing has increased.	

No	Item	Action
	There have been 2 safeguarding issues; (i) death of a 12-year-old with autism. A safeguarding practice review is being undertaken. (ii) The death of a husband and wife in Birkdale. A patient in Warrington Hospital had died during a surgical procedure. The next of kin was notified and was unable to contact their parents, which were later found dead. A DHR is being undertaken. **Outcome: The Committee noted the chief nurse report.**	
21/139	**Maternity Services Deep Dive** Tracey Forshaw presented a deep dive report in relation to maternity services which is part of a suite of deep dive reports for this Committee. It was noted that several services are commissioned by Sefton Local Authority, therefore not all data is included in the report. Sefton CCGs are not the lead commissioner for all of the maternity services. The report was taken as read and the following key points were noted: - Data has not been included in the report in relation to support for pregnant women with mental health issues or in relation to the access to pre assessment from health visiting services or midwives. There is a separate report on the agenda in relation to the Ockenden report and the recommendations. However, it was highlighted that there is a clinical negligence scheme, Southport and Ormskirk Hospital NHS Trust and Liverpool Women's Hospital NHS Trust are part of the local maternity scheme (LMS). The Trusts have submitted their gap analysis to LMS. The CCG's do not have access to that information however biannual reports will be presented at the CQRM. Going forward the chief nurse report will include that information. The CCGs did not previously report on compliance. Additional funding has been secured in relation to the smoking cessation nurse role. Southport and Ormskirk Hospital NHS Trust has reported a number of serious incidents in relation to maternity and neonatal deaths to LMS, who are fully sighted on this and on the learning taken from it including themes and trends. LMS does not have access to StEis. There is an NHSEI maternity medicine network covering Cheshire and Merseyside. Tina Ewart is the commissioning manager for women's maternity and gynaecology, supporting the network from a commissioning perspective. There is an on-going issue in relation to providing EMIS training for midwives at Liverpool Women's Hospital NHS Trust, which was noted earlier in the meeting and it on the Committees action tracker. Chrissie Cooke advised that maternity services have been under significant pressure recently. This has resulted in diverting patients to other providers. Southport And Ormskirk Hospital NHS Trust could not support this due to capacity issues. Daily meetings were taking place in relation to the issues, however these meetings are now only required to take place 3 times per week. Generally maternity activity is predictable. Diverting patients impacts on continuity of care and can cause issues for families that are expecting to go to the Liverpool Women's Hospital but are then being diverted elsewhere. Complex	

No	Item	Action
	cases and routine cases are being monitored daily. Tracey Forshaw informed that it had been noted recently at the CQPG that Liverpool Women's Hospital NHS Trust reported that in the absence of a policy/process and because no one organisation is able to fully take on a divert, they have accessed mutual aid and have managed the situation internally. Tracey Forshaw advised that she has raised this issue and has requested clarity on the variants. Chrissie Cooke explained that the CCGs are requesting information on the diverts to understand the impact on patients and how the system is going to be managed going forward. She noted that declaring a divert can create work and therefore be perceived as being counterproductive, however it is important that this information is provided. This will be addressed outside of this meeting. It was noted that the number of pregnancies has increased during lockdown. 780 births were expected in July 2021 which is a large increase. Normally 8,000 births are anticipated each year, however this has risen to 9,000 births. Also noted is the significant increase in breast feeding rates during the pandemic. **Outcome: The Committee noted the maternity services deep dive report.**	
21/140	**Provider Summary Complaints Report & CCG Complaints Report** Mel Spelman presented the following 2 reports; provider summary complaints report for June 2021 and the CCG complaints report for Q1 2021/22. It was noted that the report titles are going to be renamed as they include contacts not solely complaints data. The reports were taken as read and the following points were highlighted: - <u>Provider Summary Complaints Report</u> Royal Liverpool University Hospitals NHS Foundation Trust has not reported against the quality schedule throughout the Covid 19 pandemic therefore there is no complaints data available for this report. NHS Liverpool CCG have confirmed that reporting will be stepped back up in Q2 2021/22. A drop in complaints was noted for Southport and Ormskirk Hospital NHS Foundation Trust, a lack of contact with patients during the pandemic has contributed. A request from EPEG was received asking for Mersey Care NHS Foundation Trust to drill down to provide data in relation to South Sefton patients. There had been issues in obtaining this information previously. However, this will be requested. Included will be the Southport and Formby community services data as those services now come under the auspices of Mersey Care NHS Foundation Trust. <u>CCG Complaints Report</u> The CCG complaints report provides a summary of legacy open complaints/contacts for 2020 and newly reported complaints and contacts for Q1 2021/22. Going forward the Committee will receive compliments as part of the report.	

No	Item	Action
	Chrissie Cooke explained that in March 2021, it appeared as though there were a significant number of complaints outstanding. However, this is not the case. Work has taken place to breakdown the contacts received, providing a clearer picture. Chrissie Cooke advised that she is now confident that the CCGs have a handle on all complaints being received. Sue Jago advised that the CCGs had been experiencing difficulties in providing reports using the Ulysses database. She has been working with Insight who have adapted the system so that it matches up with reporting requirements. This will speed up the reporting process and will therefore make a positive and significant impact to the team. Also going forward the Committee will receive primary care complaints within the report. **Outcome: The Committee noted the provider summary complaints report & CCG complaints report.**	
21/141	**Quarter 1 2021/22 Serious Incident Report** Mel Spelman presented the Quarter 1 serious incident reports for both CCG's. The report was taken as read. The following key issues were noted: - <u>NHS Southport and Formby CCG</u> 12 incidents were reported in Q1, with no Never Events reported. There were 5 RCAs due for Q1 2021/22. All 5 were received within the 60-day timescale. Some issues in the May 2021 serious incident report were noted in relation to the provider not providing feedback following RCA reviews timely, however improvements have been made. <u>Southport and Formby Community Services</u> The community service as Southport and Formby has transferred to Mersey Care NHS Foundation Trust. Discussions are ongoing in terms of serious incident management arrangements with NHS Liverpool CCG. NHS Liverpool CCG have requested that the Sefton CCGs manage pressure ulcers at the Sefton CCG's SIRG panel. This request will be discussed at the next SIRG meeting. Mel Spelman advised that she has provided Mersey Care NHS Foundation Trust with a summary report including key issues in relation to reporting RCAs and themes and trends to assist them in their forward planning. <u>NHS South Sefton CCG</u> An update in relation to DMC was noted and is included in the chief nurse report noted by the Committee. Following a meeting on 28th July 2021, clinical validation has been completed in terms of gastroenterology serious incidents at Royal Liverpool University Hospitals NHS Foundation Trust. There were 7,517 patients identified. 3,444 patients were discharged. The remaining required an urgent review and have received one. Those requiring a routine appointment have been offered appointments within the agreed timescale. The Trust are sourcing extra resource including a consultant gastroenterologist and some administrative support. There were 34 patients that had come to harm, 3 were serious incidents and are under investigation. An external Get it right first time (GIRFT) review is to be	

No	Item	Action
	completed in September 2021 which will be presented at the October 2021 CQPG meeting. CORAL – are undertaking an external review in relation to the OD programme. The CCGs have been asked to provide a breakdown of the remaining patients to ascertain which CCG they relate. It was queried if patients with Barrett's Syndrome have been included in this review. It was confirmed that they have. **Never Events** The Royal Liverpool University Hospitals NHS Foundation Trust's improvement plan has been reviewed again. A further update will be provided at the August 2021 CQPG. The North Park vaccine incident is to be downgraded and therefore removed from StEis. Chrissie Cooke requested assurance in relation to what the Trust is putting in place to address the issues in respect of the reoccurrence of Never Events. Tracey Forshaw advised that NHS Liverpool CCG quality team are identifying the learning at a national and local level. A piece of work is to be undertaken, prioritising surgical Never Events as this is a common theme and to also review the impact Covid 19 has had on staff. Chrissie Cooke highlighted that the Never Events in relation surgical incidents whereby swabs had been left in patients, occur due to human factors, such as exhaustion, distractions, and psychological pressure to get things done quickly. She explained that she would like to ascertain what the Trust is doing to protect their staff from making mistakes as there are systems and processes in place to prevent Never Events. It was noted that Neal Jones is a human factors expert and is leading on the improvement plan review work. It was highlighted that there had been more engagement from staff based at the Royal site than at the Aintree site, which suggests cultural differences. It was noted that following a series of Never Events at Aintree several years ago, cultural differences had been highlighted. Providing evidence that change had taken place provided a challenge for Aintree. Dr Doug Callow queried if the Royal Liverpool University Hospitals NHS Foundation Trust GI lost to follow up issues were same as the ophthalmology issues experienced by Southport and Ormskirk Hospital NHS Trust. It was noted that was not the case. **Outcome: The Committee noted the quarter 1 2021/22 serious incident report.**	
21/142	**Provider Quality Account Summary 2020/21** Mel Spelman presented the provider quality account summary report which was taken as being read and the following key points were noted: - All providers have responded well to Covid 19. Liverpool Heart and Chest Hospital NHS Foundation Trust, Clatterbridge Cancer Centre NHS Foundation Trust, Walton Centre NHS Foundation Trust and Royal Liverpool University	

No	Item	Action
	Hospitals NHS Foundation Trust were commended on their response to mutual aid requests. Mersey Care NHS Foundation Trust was asked to resubmit their quality accounts summary as their initial submission was not fit for purpose. The Trust was asked to provide information in relation to patient engagement, complaints and wider learning, staff-wellbeing and support throughout the pandemic. In addition, further information was requested in relation to the Trust's objectives following its recent acquisition of Southport and Formby community services and Northwest Borough's community and mental health services. It was noted that the Trust's presentation was heavily focused on mental health services. The Trust was asked to provide a more balanced view of mental health services and community services for future quality accounts. Royal Liverpool University Hospitals NHS Foundation Trust has been asked to provide further information to demonstrate how it maintained business during the pandemic for example, complaints handling and patient experience. Feedback is awaited. A letter has been sent to all providers advising that they can finalise their quality accounts. **Outcome: The Committee noted the provider quality account summary 2020/21.**	
21/143	**Annual DCO Report** Helen Case presented the annual designated clinical officer report which is the second annual report for the Sefton CCGs. The report covers the period from 1st April 2020 to 31st March 2021 and includes the time period 1 April 2020 to 30 June 2020 which the first annual report also covered. This duplication of time period between the first and second annual reports has been made in order to bring this annual report, and future annual reports, in line with the agreed reporting period of 1st April to 31 March. It was noted that the improvement notice for Sefton has been rescinded following a DfE visit in June 2021. Helen Case explained that she covered the DCO role for part of the report period. Ingrid Bell is now post as DCO and the key priorities for the role this year have been agreed. Chrissie Cooke informed that she had met with the NHSEI lead for the SEND programme. The DCO role is going to be reviewed across the country and its duties are to be put on more of a statutory footing. The profile of the role is to be raised. A change in the role and its host is anticipated over the course of the next 12 months. Chrissie Cooke thanked Helen Case for covering the DCO role which she undertook whilst also doing her substantive job. **Outcome: The Committee noted the annual DCO report.**	
21/144	**Improve the Outcomes for Children and Young People in Care**	

No	Item	Action
	Helen Case presented this report which was requested by the Committee earlier in the year. The following highlights were noted: - Children in care are not receiving timely care caused by a lack of capacity and staffing resource within the commissioned Children in Care Health Teams. There is also an increase in the number/complexity of children entering the care system. Sefton is a net importer of children in care, which means that it receives more children from other local authorities than it places outside of Sefton. Staffing issues and the increase in children is affecting the number of health assessments being carried out, however the quality of assessments is good for Alder Hey Hospitals NHS Trust and Mersey Care NHS Foundation Trust. Issues relating to children in care being able to access dentistry services during the pandemic have been addressed and there is a new pathway in place. Chrissie Cooke informed that Sefton has been identified as one of areas not taking enough unaccompanied asylum- seeing children. Sefton is therefore on the rota for July and August 2021, to take on unaccompanied asylum-seeking children. Chrissie Cooke wished to raise this as a risk due the additional pressure anticipated on the system. Chrissie Cooke advised that in May 2021, the turnaround for IHAs in 20 days was 9%. All except one had received an assessment. A lot of assessments were undertaken the day after. In June 2021, it was 0. It is anticipated that issues in relation to sickness absences at Alder Hey Hospital NHS Foundation Trust are not likely to be rectified in the next few months as more children will come into the system. A review of the service specification is being undertaken by the Alder Hey team. Additional funding to appoint a nurse consultant is likely to be required. The KPI data set has been reduced to prioritise assessments. Dr Gina Halstead queried what is being done in relation to retention and recruitment and wished to understand the reasons why staff are leaving. Chrissie Cooke informed that this is being reviewed as part of the chief nurse approach to ICS. Covid 19 pressures have added to existing pressures being experienced in relation to the increase in demand and the type of cases being presented. Support for staff in dealing with the emotional and psychological demand is being explored, to make jobs worthwhile for people to do. Questions are being raised in relation to contract performance and KPI monitoring. Sefton's safeguarding team lost some supervision support as the person providing it had passed away. However, the gap is to be filled and some additional support has been secured. The named GP for safeguarding adults is contributing to the conversations and the work being undertaken in relation to the ICS development. Mutual aid is being provided by means of the Designated Nurse CiC supporting the Community CiC Team to streamline their reports. It was noted that some of the reasons for staff leaving their jobs include maternity leave cover, which is being recruited to. Staff member leaving to widen their experience. The recruitment process is more difficult during Covid 19. High calibre candidates are being sought.	

No	Item	Action
	A supervision audit being undertaken by Mersey Care NHS Foundation Trust. Helen Case was thanked for providing and presenting a comprehensive report. **Outcome: The Committee noted the improve the outcomes for children and young people in care report.**	
21/145	**Annual LeDeR Report** Tracey Forshaw explained that the annual LeDeR report for the period March 2020 to April 2021 has been delayed as per NHSEI requirements. A presentation was given to the Committee to provide assurance in the absence of the full report which will be presented at the next meeting. The following key points were noted: - There were 31 cases registered for Sefton, 25 were eligible for an LeDeR review (4 years and over with a learning disability diagnosis). The CCG's succeeded in clearing the backlog and ensuring CCG compliance. A total of 99 cases were managed in year. CCGs have not supported LeDeR resource since the programme's inception and have utilised external support provided by NHSEI Cheshire and also North England external panels. A bid has been submitted to NHSEI Cheshire and Merseyside for a Band 7 LeDeR Co-Ordinator across the North Mersey Area. Commitment to LeDeR resource has been confirmed by the CCG's Leadership Team. Chrissie Cooke highlighted that Tracey Forshaw manages the whole LeDeR programme. There was administrative support in place from Stephanie Manning who was on secondment from Mersey Care NHS Foundation Trust, however Stephanie has returned to her substantive role. Therefore, there is currently an administrative gap. It was noted that the annual LeDeR annual report will be presented at the next Committee meeting. An in-depth discussion will not be required because of the presentation provided today. **Outcome: The Committee noted the annual LeDeR presentation.**	
21/146	**Ockenden Report 2020 and Recommendations** Tracey Forshaw presented the report on behalf of Jennie Piet which seeks to provide the Committee with some background in to the Ockenden Review and the subsequent recommendations. NHSEI have requested that local maternity services monitor delivery. Additional money has been provided at a national level. Liverpool Women's' Hospital NHS Foundation Trust and Southport and Ormskirk Hospital NHS Foundation Trust are working closely with local maternity services. They have completed a gap analysis and have submitted their evidence. This Committee will receive biannual reports on this.	

No	Item	Action
	Outcome: The Committee noted Ockenden report 2020 and the recommendations.	
21/147	**Clinical Director Quality Update** It was noted that it is likely that Seaforth and Litherland primary care network will administer phase 3 of Covid 19 vaccination programme. Crosby, Bootle and Maghull will administer Covid 19 vaccinations to care homes, to house bound patients and to those with learning disabilities. The suggestion of the community nursing team undertaking blood pressure checks for patients who have been discharged from hospital or who are experiencing dizzy spells, is to be explored. Additional money from Mersey Care NHS Foundation Trust has been identified to support the reduction of GP visits. It was highlighted that Alder Hey NHS Foundation Trust has suggested streaming inappropriate A&E patients at their A&E department. Southport and Ormskirk Hospital NHS Trust are experiencing an increase in patient long waits at their A&E department and do not have the facility to stream patients. A system level approach is required. Southport and Formby primary care network has expressed a tentative interest in the phase 3 Covid 19 vaccination programme. **Outcome: The Committee noted the verbal clinical director update.**	
Policies/Protocols for Approval		
21/148	**Children and Young People's NHS Continuing Care Protocol and Associated Processes** Peter Wong presented this item on behalf of Michele Brookes. It was noted that the protocol was presented to the Committee in November 2020. However further work was required which has been undertaken and the Committee are requested to approve the protocol. It was noted that the protocol and policies will be amended in due course to align with ICS. Dil Daly enquired if parents and carers are directed to advocates before assessments are undertaken. Chantelle Collins confirmed that that is the case. **Outcome: The Committee approved the children and young people's NHS continuing care protocol and associated processes.**	
21/149	**GP2GP and Destruction of Paper Patient Records Following Digitisation** Louise Taylor presented this item which requires approval from the Committee. It was noted that there are 43 practices taking part in the digitalisation of patient	

No	Item	Action
	records. 25 practices have completed the scanning aspect of their records but have not destroyed the paper records. The results from an audit undertaken found that 20% of cases within the last 6 months using the electronic GP2GP transfer had failed. Concerns have been raised regarding the destruction of paper records following digitisation. If records have not transferred to GP2GP then they would need to be printed out. Another area of concern is in relation to a patient being deducted prior to registering with another practice. If a patient is registered in a practice that does not use smart cards, then the old style of file will not transfer across. If a patient moves abroad or joins the army for example, then their records will be destroyed and cannot be retrieved. Patients would need to be made aware of this should they leave the practice. A request has been made to halt the digitalisation programme because of the concerns raised. It was noted that if records are not destroyed then a solution needs to be found in relation to storage. Costings need to be considered in relation to this, including the cost of printing paper copies, the cost of them being returned to the practice and the work required to cross reference the records upon their return to the practice. Currently a timeframe cannot be provided in relation to how long the process takes to retrieve records from deep storage and return them to the practice. It was noted that scanned copies are produced in PDF and are therefore unsearchable. However, practices can be provided with an adobe redaction software which will enable them to remove documents if they are in the wrong file, remove blank pages and reorder them. A request was made for support for practices in relation to the implementation of the digitisation process. Martin McDowell noted that on behalf of the Sefton CCG's, he will provide support to practices in relation to any adverse outcomes due to the implementation of the digitisation process. He also noted that it is national programme and that this was the only solution available at the time. The process is the only one which is complete end to end which removes the records, scans them and uploads them on to EMIS seamlessly. Also noted is that the digitalisation programme is compulsory and is to be completed by 2023. A discussion was held in relation to the transfer of records without the need for paper copies. Louise Taylor advised that she will explore all the options, such as possibility of using encrypted USB sticks or encrypted compact discs, this would necessitate the provision of compact disc readers, however they are understood not to be costly. Louise Taylor advised that she will consider all the concerns issues raised by the Committee, address them and will check the guidance in relation to the destruction of records before this is agreed to. In addition, Louise Taylor will identify failed records in the system which will be part of an audit. A work package is to be implemented. The Committee approved the process of GP2GP in terms of destruction, with the caveat that the guidance around destruction of records has been confirmed and that further exploratory work is undertaken by IMersey to address the concerns raised.	

No	Item	Action
	It was suggested that the LMC should be made aware of the concerns raised by the Committee and its plan of action. ***Action: Louise Taylor to check the guidance in relation to the destruction of patient paper records before this can be agreed to and to identify failed records in the system which will be part of the audit to be undertaken.*** ***Action: LMC to be informed that the Committee has raised concerns in relation to GP2GP digitisation programme, that it has approved the GP2GP process in terms of the destruction of records with the caveat that the guidance around destruction of records is to be confirmed.*** **Outcome: The Committee approved the GP2GP process and destruction of paper patient records following digitisation with the caveat that the guidance around the destruction of records has been confirmed, that further work to be undertaken in relation to failed records and that the LMC are informed.**	**LT** **MMcD**
For Information		
21/150	**SEND Health Performance Improvement Group Minutes and Key Issues** The Committee noted the SEND Health Performance Improvement Group Minutes and Key Issues from the meeting held on 28th May 2021. No comments were made. **Outcome: The Committee received the SEND Health Performance Improvement Group Minutes and Key Issues.**	
21/151	**Serious Incident Review Group (SIRG) Minutes and Key Issues** The Committee noted the minutes and key issues from the NHS Southport and Formby on 2nd June 2021. No comments were made. The Committee noted the minutes and key issues from NHS South Sefton CCG SIRG meeting held on 2nd June 2021. No comments were made. **Outcome: The Committee received the Serious Incident Review Group (SIRG) Minutes and Key Issues.**	
21/152	**Individual Patient Activity Combined Quality and Performance Group (IPA CQPG) Minutes and Key Issues** The Committee noted the minutes and key issues from the Individual Patient Activity Combined Quality and Performance Group meeting held on 28th May 2021. No comments were made. **Outcome: The Committee received the Individual Patient Activity Group minutes and key issues.**	
21/153	**Complaints Oversight Subgroup Minutes and Key Issues** The Committee noted the Complaints Oversight Subgroup minutes and key issues from the meeting held on 21st June 2021. No comments were made.	

No	Item	Action
	Outcome: The Committee received Complaints the Oversight Subgroup Minutes and Key Issues.	
21/154	**North Mersey LeDeR Panel Minutes** The Committee noted the North Mersey LeDeR Panel Minutes from the meeting held on 15th June 2021. No comments were made. **Outcome: The Committee received North Mersey LeDeR Panel Minutes and Key Issues.**	
21/155	**Engagement and Patient Experience Group (EPEG) Key Issues** The Committee noted the Engagement and Patient Experience Group (EPEG) Key Issues from the meeting held on 14th July 2021. It was noted that the IAPT 18 week waiting times had been highlighted at EPEG. Work is ongoing with support from the CCG and oversight of the progress is being monitored. **Outcome: The Committee received the Engagement and Patient Experience Group (EPEG) Key Issues.**	
21/156	**Performance and Quality Investigation Review Panel (PQIRP) minutes and key issues** The Committee noted the Performance and Quality Investigation Review Panel (PQIRP) minutes and key issues from the meetings held on 10th May 2021 and 7th June 2021. No comments were made. **Outcome: The Committee received the Performance and Quality Investigation Review Panel (PQIRP) minutes and key issues.**	
21/157	**Corporate Governance Support Group Minutes** The Committee noted the Corporate Governance Support Group Minutes from the meeting held on 8th April 2021. No comments were made. **Outcome: The Committee received the Corporate Governance Support Group Minutes.**	
21/158	**JTAI Improvement Plan Meeting Minutes and Key Issues** The Committee noted JTAI Improvement Plan Meeting Minutes and Key Issues from the meeting held on 18th March 2021. No comments were made. **Outcome: The Committee received the JTAI Improvement Plan Meeting Minutes and Key Issues.**	
Closing Business		
21/159	**Any Other Business** No items noted.	

No	Item	Action
21/160	**Key issues arising from this meeting** Due to time constraints the key issues were not discussed but will be circulated to the Committee members before the next meeting. ***Action: Committee key issues to be circulated to members.***	**MD**
21/161	**Meeting Review** Due to time constraints this agenda item was not discussed, however Chrissie Cooke advised that she will email the Committee members in relation to the development session agenda. ***Action: Chrissie Cooke to email Committee members in relation to the development session agenda.***	**CCooke**
21/162	**Date of next meeting:-** Thursday 26th August 2021 at 9am to 12noon, Via MS Teams.	

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

Audit Committees in Common Minutes

Wednesday 21 July 2021, 1.30pm to 4pm
Microsoft Teams Meeting

Members – NHS Southport & Formby CCG Audit Committee		
Helen Nichols	Lay Member (S&F Audit Committee Chair)	HN
Dil Daly	Lay Member (S&F Audit Committee Vice Chair)	DD
Vikki Gilligan	Practice Manager Governing Body Member	VG
Dr Jeff Simmonds	Secondary Care Doctor and Governing Body Member	JS
Members – NHS South Sefton CCG Audit Committee		
Alan Sharples	Lay Member (SS Audit Committee Chair)	AS
Steven Cox	Lay Member (SS Audit Committee Vice Chair)	SC
Dr Jeff Simmonds	Secondary Care Doctor and Governing Body Member	JS
In attendance		
Martin McDowell	Chief Finance Officer, SFCCG and SSCCG	MMcD
Rebecca McCullough	Deputy Chief Finance Officer, SFCCG and SSCCG	RMcC
Clare Ingram	Interim Chief Accountant, SFCCG and SSCCG	CI
Andy Ayre	Manager - Audit, Grant Thornton	AA
Georgia Jones	Director, Grant Thornton	GJo
Michelle Moss	Anti-Fraud Specialist, MIAA	MM
Adrian Poll	Audit Manager, MIAA	AP
Chloe Howard	Information Governance Business Partner, MLCSU	CH
Pippa Joyce	Information Governance Business Partner, MLCSU	PJ
Terry Stapley	Corporate Business Manager, SFCCG and SSCCG	TS
Sandra Smith	PA to Chief Finance Officer, SFCCG and SSCCG	SS

*** Agenda items marked with an asterisk have a *separate* report for each CCG. All other report agenda items have a joint report covering both CCGs.**

No	Item	Action
A21/30	**Introductions and apologies for absence**	
(a)	Apologies were received from Chloe Howard Rebecca McCullough Vikki Gillan	
(b)	It was noted that due to the absence of Jeff Simmonds and Steven Cox, South Sefton CCG attendance is not quorate for the meeting	
(c)	Ying Li was in attendance from Grant Thornton.	
(d)	It was noted that Graham Bayliss should be removed from the membership of the Group and Steven Cox added.	

A21/31	**Declarations of interest**	
(a)	Committee members were reminded of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NHS Southport & Formby Clinical Commissioning Group.	
(b)	Declarations made by members of the Southport & Formby Audit Committee are listed in the CCG's Register of Interests. The register is available on the CCG website via the following link: www.southportandformbyccg.nhs.uk/about-us/our-constitution.	
(c)	HN explained she had made an executive decision after consultation with the Freedom to Speak Up guardians who wished their report to be given to members only. With this in mind HN agreed their presentation would be presented as the last item on the agenda with only members of the committee present, AS agreed to this decision.	
A21/32	**Minutes of Previous meetings and key issues** **Southport & Formby – 21 April 2021 and June 2021** **South Sefton – 22 April 2021 and June 2021**	
(a)	HN introduced to the items and clarified the situation in relation to the minutes of previous meetings.	
(b)	South Sefton Audit Committee Minutes – April 2021: These minutes were agreed as an accurate record.	
(c)	Southport & Formby Audit Committee Minutes – April 2021: As these minutes had only been shared with the Committee at late notice, it was agreed they can be signed off after this meeting by HN and DD.	
(d)	Southport & Formby Audit Committee Minutes – June 2021: These were agreed as a true and accurate record	
(e)	South Sefton Audit Committee Minutes – June 2021: AS agreed these were an accurate record, however, they cannot be ratified due to the quoracy issue for today's ACiC meeting previously noted in these minutes.	
(f)	It was agreed that the outstanding minutes from April, June and July will be brought to the October ACiC meeting for full ratification.	SSm
A21/33	**Action points from previous meetings**	
(a)	It was agreed that the action tracker will be constructed from the previous minutes and that all actions will be considered using that tracker. HN and AS will liaise with SSm on this matter and the updated tracker will be discussed at the October ACiC meeting.	SSm
A21/34	**Losses, Special Payments and Aged Debt**	
(a)		

(b)	CI introduced the paper which had been circulated to the Committee. It was noted the credit note for the LA invoice had not been raised after the last meeting, this was due to a changeover in staff. However, this is now in progress and will be cleared by the next ACiC meeting. This report was received.	
A21/35	**CCG Published Registers**	
(a)	TS confirmed these are the public registers for the first quarter of 21/22, which have been published on both CCG websites.	
(b)	The key update relates to sponsorship, and TS has worked with the finance team to check which payments are showing on the system and what are differing from ABPI system. He noted that each query is looked at individually on the ABPI system, and then the pharmacy company is approached to check payment details.	
(c)	HN referred to a number of payments which are old and asked for the reasons. TS confirmed that this is due to there being no sponsored events during the pandemic. HN wondered if it is a good use of resource, she asked MMcD for his views.	
(d)	MMcD confirmed that this work should be considered low priority. There is a degree of assurance from the work that has already been undertaken. He asked the Committee to recognise that a lot of work has been carried out and to give MMcD and DFair the latitude to determine whether any additional work needs to be done.	
(e)	HN referred to the recommendation to combine the registers; sponsorship, gifts and hospitality which has been held up due to this work not being completed. HN suggested they are combined and anything new should be dealt with at the time it arises.	
(f)	AS raised a related issue regarding registering of gifts and hospitality, noting that for SSCCG there are only two items reported for the whole of the year, and for S&FCCG there is only one item. He commented this is remarkably low in relation to the usual numbers. One of the items due for discussion is the need to validate whether people are registering or not. It is important to carry on this work as it suggests that people may be reluctant to register. Another explanation is that there has not been any information to register due to Covid.	
(g)	TS confirmed that staff are reminded on a monthly basis about the Gifts & Hospitality Policy.	
(h)	HN asked AP if he had any thoughts on this matter from an audit point of view. AP confirmed he is comfortable with the approach that has been discussed.	
(i)	To summarise, it is recognised that staff are being reminded of the need to report gifts and hospitality, but concern is noted that there is very limited activity being reported. The work that has been done on the sponsorship and hospitality registers should take a low priority in terms of completion. Any new items should be reported at the time so there is no ambiguity, and this should be on a combined register; this was agreed by the Committee.	
(j)		

	The Committee were reminded that compliance on conflict-of-interest training is at 83.3%, and that staff are being reminded to undertake the training.	
A21/36	**GP Pensions Update**	
(a)	MMcD provided an update on this item, confirming there are three courses of action. It was noted that there is no published national guidance on GP Pensions, and local arrangements are being sought.	
(b)	He reported that an in-depth meeting has been held with an affected clinical lead to review what had happened, what should have happened and to estimate the residual gap. This proved to be a successful approach and it has been agreed to undertake similar meetings with GP's and their representatives so that issues can be discussed at an individual basis.	
(c)	In response to questions posed by several GPs, liabilities which relate to the CCGs employer liabilities on payments which may need to be made; it is noted that an accrual for this liability had been included when the 20/21 final accounts reported.	
(d)	AS commented that he had been approached about this matter and the length of time it has been going on for. He asked for written reports identifying the current position in future meetings due to the importance of the issue.	
(e)	HN referred to a commitment made that people would be seen by end of July. MMcD confirmed this was an initial commitment, however, additional issues have emerged and a revised date of end of September has been set to conclude the initial meetings. HN shared AS concerns at the amount of time this process is taking, for something that is so personal and potentially financially significant.	
(f)	AS added that there has also been the added complication of the Remuneration Committee being cancelled, which is an added element which may impact on the pensions.	
(g)	MMcD commented that there is a responsibility from his perspective was to ensure the Remuneration Committee agreements through this period are enacted. He noted that this had been discussed in initial meetings.	
(h)	AS commented that there was a suggestion the amount paid, intended to include elements of payments that were not entitled and may lead to potential repayments to the CCG. He noted that this could add further complications to the issue. AS asked if it is the plan for the Remuneration Committee to review whether there has been an overpayment. CI confirmed that a Remuneration Committee meeting needs to take place, adding that due to this being such a complex area there could be a danger in undertaking the calculations, sharing the value, then having that value changed by the Remuneration Committee. CI stressed the process needs to take place in the correct order.	
(i)	CI agreed to liaise with Debbie Fairclough confirming that the Remuneration Committee needs to be arranged and confirmed she has met with affected clinical leads and that they had greater understanding of the process involved following the meetings.	
(j)		

	HN and AS agreed that this matter needs to be resolved and a Remuneration Committee should be agreed upon and arranged as soon as possible.	
A21/37	**Employee Privacy Notice**	
(a)	MMcD introduced this item noting that it had been provided by the CSU for information purposes.	
(b)	MMcD confirmed it has been reviewed and the relevant organisations and that it would be shared via normal staff communications if the Audit Committee was comfortable with process and content.	
(c)	This notice was received by the Committee.	
A21/38	**Information Governance Annual Report**	
(a)	It was noted that Pippa Joyce was not available to give the update at this time.	
(b)	HN commented on this report as being quite significantly out of date, in the sense that the DPST submission has been made at the end of June and that this report does not reflect the level of compliance at that stage.	
(c)	MMcD commented that the report covers wider issues than just the toolkit submission, picking up other IG related issues during the period in question.	
(d)	MMcD provided an update on progress with the DSPT and reported that at the time of submission, the CCGs had provided positive evidence to support 87 of the 88 assertions required. The outstanding issue related to whether a Penetration Test had been carried out on the CCGs' information security infrastructure. The last test had been undertaken in November 2019 which was outside the timeframe measured in the recent DSPT submission. The lack of a test has been influenced via COVID as more people are accessing the network remotely and it was unclear whether the tests were required under COVID arrangements.	
(e)	MMcD confirmed that funding had recently been received from NHS Digital to support the testing programme and that a revised date has been scheduled for the test to take place. The CCGs therefore reported that standards had not been met and that there was an action plan in place to address the outstanding issue.	
(f)	AP presented the internal audit report on the submission noting that the opinion was split into two parts, with one area being reported as substantial assurance and the other area being reported as moderate assurance. This meant that the final assurance level for the audit was classified as moderate.	
(g)	MMcD asked if there were any further questions on the Information Governance Annual Report.	
(h)	HN noted that three agenda items had been covered under this part of the meeting.	
(i)	AS asked for clarification regarding data breaches and asked for Pippa Joyce to contact him to outline the process as he was aware of an issue	

	that had taken place during the time period but had not been included within the report.	
(j)	The Committee received the above submissions.	
A21/39	**Policy Tracker**	
(a)	MMcD introduced the report and updated the Committee on progress.	
(b)	DD commented that the policies predating 20/21 were not finalised and that the Committee had been told that they needed prompt action. DD expressed his disappointment that they had not been finalised.	
(c)	MMcD explained that the personal health budget policy is active, and that no member of the public has been refused access to personal health budgets. The Lone Worker policy has taken longer than anticipated, however, he believed that the equipment required was now on order, it was also noted that the number of lone workers has decreased. MMcD will pick the issue up outside of the meeting to ascertain the current position. AS commented that this was brought to attention in February and that it needed an urgent Chairman's action to agree the finalised version once it had been decided on the nature of the equipment.	
(d)	On the Personal Health Budget, this has been dealt with previously, in March 19, and as the policy is in use this should be renewed and approved until the CSU has final agreement. The new agreement can then be brought to the Committee for approval. MMcD confirmed that a suitable operational PHB policy had been in place since the last review.	
(e)	HN raised concerns in respect of the Grievance and Disputes Policy, particularly as the CCG heads into the next 9 months and increased potential for HR changes during CCG closedown process. MMcD confirmed that this policy has been approved, noting that the last point to clarify was in relation to confirm where the reference to the Trade Union representation should take place.	
(f)	HN commented that there are several different points being raised in relation to Policies. HN agrees with AS, that if there is a policy currently being used then, from a Governance point of view, it should be reapproved until changes need to be made.	
(g)	HN referred to the Personal Health Budget and asked where this should go for approval. It would be useful for the policies to be finalised and if needs be they come back for substantive changes in the future.	
(h)	MMcD agreed he will review the current position regarding the policies.	MMcD
A21/40	**MIAA Data Security & Protection Toolkit – Sign Off Arrangements**	
(a)	Discussed under 21/38	
A21/41	**Information Governance (IG) Statements of Assurance:** **Midlands and Lancashire CSU** **Shared Business Services** **iMerseyside** **St Helens & Knowsley NHS Trust**	
(a)		

	CI presented these items, confirming that this outstanding information had been supplied by the various organisations.	
(b)	HN confirmed that the data on St. Helens and Knowsley showed that they have met their standards for IG. After discussion it was noted that the iMersey report was within the papers for the Committee's information.	
(c)	HN referred to the comment made in the papers that all three CCGs met the necessary standards for completion of the DSPT for 20/21 submission but does not confirm that iMersey met the standards. It was noted that the three CCGs referred to: South Sefton, Southport & Formby and Liverpool are confirmed to have met the necessary standards, HN commented it does not show that iMersey have met those standards.	
(d)	CI offered to go back to the supplier of the information and get clarification, it was also agreed that the Committee would like to see data in relation to Mersey Care.	CI
(e)	It was noted that the Shared Business Services or the Midlands and Lancashire CSU information yet. HN confirmed she was happy for that information to be brought to the next ACiC meeting.	CI
A21/42	**Freedom to Speak Up Reporting**	
(a)	Presentation given to ACiC members only.	
A21/43	**Data Protection and Security Toolkit 20/21 Update**	
(a)	Discussed under 21/38.	
A21/44	**Single Tender Action Form – MLCSU**	
(a)	MMcD provided a report on a Single Tender Action relating to the Shaping Care Together programme which is being undertaken jointly by West Lancashire CCG, Southport & Formby CCG and Southport & Ormskirk Trust. MMcD explained that SFCCG was the budget holder for the programme and that the proposal had been included within the agreed budget and approved through the Programme Board.	
(b)	HN confirmed she was aware of this information and asked for any comments from the Committee.	
(c)	This report was received by the Committee.	
A21/45	**Audit Committee Recommendations Tracker**	
(a)	CI provided an update on this item, commenting there was no information from the April or July meetings. CI explained that she reviews previous minutes to check if any issues need to be added.	
(b)	HN asked if there are any items which should come through the minutes, in terms of MIAA reports, etc.	
(c)	DD commented that the first two items are described as ongoing, and the third item is outstanding. CI responded by referring to a previous Committee agreement that the process would change from completed or	

	outstanding, to ongoing even if assurance had been provided as the committee wanted to demonstrate that assurance was being continually met.	
(d)	A discussion took place as to what colours are used under the rag rating for the register, particularly around Sponsorship, Gifts & Hospital. DD does understand the rationale for this approach and noted that it appears that there has been no reporting on sponsorship or gifts or follow up on non-declaration; he asked whether a clarifying narrative could be added. CI agreed an extra column could be added to the register to give clarification, this action was agreed by the Chair.	CI
(e)	HN referred to the point on the SIRO being regularly kept aware of regular updated key metrics. MMcD confirmed this was now managed in two ways, firstly via the IT steering group and secondly, through the Care Cert arrangements. He explained that the latter was how NHS organisations receive notification of impending threats and vulnerabilities. He further noted that updates are provided until remedial action is finalised.	
(f)	It was agreed MMcD, and CI would look to resolve this by the October meeting. There will by then have been a response to MIAA and should enable the issue to be reported as completed.	
(g)	GJo queried in terms of the tracker, asking would the external recommendations be included, reminding the Committee that there are some items from the AFR to be added on. HN commented that all audits of any description which take place within the CCG should be included so we are confident that everything is being addressed.	
(h)	CI referred to the previous rag rating discussion earlier, asking for clarification; green equates to completed, amber for outstanding/ongoing, would there was anything further the Committee would like added. DD responded that the agreement was that it would be useful to have a narrative which showed that a section may be outstanding whilst another section had been completed.	
(i)	AS asked if green completed and ongoing is amber, should this mean that outstanding should be red? CI agrees that should read ongoing rather than outstanding, as outstanding suggests it has not been picked up yet. AS agrees with DD is correct, probably need to divide the items and show different status.	
A21/46	**Internal Audit Progress Report**	
(a)	AP briefly apprised the Committee of the contents of the report. In particular, he noted the final Mandated Review around the Primary Care Commissioning Framework which needed to be completed following delegated responsibility. The draft report will be distributed this week, AP confirmed there is nothing of concern to be raised.	
(b)	AS asked HN if she received invitations to the Audit Committee Chairs Webinars; HN confirmed she does receive the invitations.	
A21/47	**Internal Audit Charter**	
(a)		

	AP confirmed this item is brought to the ACiC each year and that this is the framework which MIAA comply with in order to undertake their audits.	
A21/48	**Audit Progress Update Report**	
(a)	GJo introduced a brief report which covers both CCGs and summarised 20/21 Financial Year. She confirmed that they did issue unmodified opinions in terms of the financial statements for both CCGs. As previously reported the value for money work is ongoing, and they are in the process of finalising that work.	
(b)	A report will be submitted to MMcD for comment within the next few weeks and that this will be circulated ahead of the Committee meeting in October.	
(c)	GJo referred to the deliverables set out in the report and noted that formal report would be received in the ACiC meeting scheduled for October.	
A21/49	**Governing Body Assurance Framework Corporate Risk Register and Heat Map**	
(a)	Southport & Formby: TS introduced the GBAF noting that new corporate objectives had been agreed for the 21/22 Financial Year. Several objectives have been carried over from the previous year.	
(b)	The Risk register follows the same format, Q1 April to June has been reviewed by relevant Committees and risk leads. It will be discussed to SMT for further mitigation to reduce risks and to determine whether the risks need to stay on the register.	
(c)	HN commented in relation to Southport & Formby and confirmed there are two risks recommended for removal: JC 39 around the Covid mass vaccination programme and C12 around people not seeking care for serious eye condition.	
(d)	HN asked about the wording used within JC43 and QU95, querying that the risks appeared identical. MMcD added that one risk is owned by the Joint Committee whilst the Quality Committee owns 95. This ensures both Committees are sighted on the risks.	
(e)	HN continued to ask about five risks which had increased, although it was unclear as to why. It was agreed that in relation to risk 85, TS would clarify the position on this risk.	TS
(f)	DD had a similar question in relation to JC42, commenting that the wording mitigates the risk. Again, it was agreed that TS clarify the position with the relevant department.	TS
(g)	The GBAF and Risk registers were approved for SFCCG subject to final clarify on the issues identified above.	
(h)	South Sefton: AS commented on risk C9 which refers to a number of patients within Southport & Formby being lost to follow up due to Covid 19; he queried whether this is a South Sefton risk. MMcD stated there is	

(i)	an element of South Sefton patients who are likely to travel to Ormskirk for treatment. AS agreed, that they may have been delayed, but queried the word 'lost' used within the risk. It was noted that this report cannot be approved due to the South Sefton membership not being quorate.	
A21/50	**Audit Committee Risk Register**	
(a)	HN commented that most of the risks which are required to be on the risk register, even though are very low level, comply with the fraud standards.	
(b)	MMcD confirmed this adding that in terms of the last three risks, the counter fraud arrangements are in place, and are providing mitigation. We endeavour to be as proactive as possible, particularly around notification of new frauds they are alerted to. This includes fraud which effects the person i.e., telephone scams, this information is shared with staff members through appropriate bulletins.	
(c)	MMcD referred to the final risks, adding it is not envisaged that these are significant issues. CHC and PHB fraud due to lack of assessment and new ways of working and he noted that there are spot checks on PHBs and requests for explanations regarding unspent balances.	
(d)	In the case of Primary Care contractor fraud, the mitigations are all in place and that is judged to being relatively low risk.	
(e)	Southport & Formby Risk Register was approved; however, South Sefton Risk Register could not be approved due to not being quorate.	
A21/51	**Finance and Resource Committee** **Joint Quality & Performance Committee** **Primary Care Commissioning Committee**	
(a)	These minutes were received by the Committee, there were not comments raised.	
A21/52	**Any other business**	
(a)	CI referred to the Scheme of Delegation to be raised with the Committee. The document was shared on screen (attached) there are additional posts which have been requested and changes to users within posts, for noting by the Committee.	
(b)	CI asked for approval for the below:	
(c)	Senior Manager – Commissioning and Redesign – previously approved at £15,000, however this amount cannot be requested via Oracle. A revised request has been identified of £20,000.	
(d)	Programme Manager – Quality and Safety – this refers to a post which holds a title of Designated Nurse for Children in care. A request for £20,000 in relation to this has also been requested.	
(e)	DD (Deputy Chair) approved the above requests. CI appreciated that due to South Sefton not being quorate agreement could not be given. AS confirmed, he agreed with the proposals, and it was agreed that CI	CI

	would ascertain email confirmation from a South Sefton member giving their approval and share that information AS.	
A21/53	**Key Issues**	
(a)	MMcD highlighted the key issues from the meeting, and these will be circulated as a Key Issues report to Governing Body.	
A21/54	**Review of Meeting**	
(a) (b) (c)	HN suggested it would be useful for both CI and SSm liaise with the Chair of the ACiC prior to each meeting to check through the papers being submitted prior to distribution. The issue around the non-attendance of members of the ACiC was noted, it was agreed AS and HN will look at this issue outside of the meeting. AS asked if a check could be made as to why there was no representative from Information Governance Team at the meeting. HN thanked the group for attendance.	
	Date and time of next meeting **1.30 pm to 4.00 pm** **Wednesday 20 October 2021**	

Quorum for NHS Southport & Formby CCG Audit Committee: The Audit Committee Chair (or Vice Chair) and one other member will be necessary for quorum purposes. The quorum shall exclude any member affected by a Conflict of Interest under the NHS Southport and Formby CCG Constitution. If this has the effect of rendering the meeting inquorate then the Chair shall decide whether to adjourn the meeting to permit the co-option of additional members.

Quorum for NHS South Sefton CCG Audit Committee: The Audit Committee Chair (or Vice Chair) and one other member will be necessary for quorum purposes. The quorum shall exclude any member affected by a Conflict of Interest under the NHS South Sefton CCG Constitution. If this has the effect of rendering the meeting inquorate then the Chair shall decide whether to adjourn the meeting to permit the co-option of additional members.

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

NHS South Sefton CCG and NHS Southport & Formby CCG
Primary Care Commissioning Committee in Common – Part ONE
Minutes

Date: Thursday 15th July 2021

Venue: MS Teams due to Covid-19 Pandemic

Members		
Dil Daly	S&F CCG Lay Member (Co-Chair)	DD
Fiona Taylor	S&F SS CCG Chief Officer	FT
Martin McDowell	S&F SS CCG Chief Finance Officer	MMc
Alan Sharples	SS CCG Lay Member	AS
Helen Nichols	S&F CCG Lay Member	HN
Jan Leonard	S&F CCG Director of Place (North)	JL
Angela Price	S&F SS CCG Programme Lead Primary Care	AP
Alan Cummings	NHSE Senior Commissioning Manager	AC
Tracey Forshaw	SS S&F Deputy Chief Nurse Quality Team	TF
Non-Voting Attendees:		
Dr Kati Scholtz	GP Clinical Representative	KS
Richard Hampson	Primary Care Contract Manager SSCCG	RH
Jennifer Piet	Primary Care Quality Team	JP
Debbie Fairclough	Interim Programme Lead – SS SF CCG Corporate Services	DF
Joe Chattin	LMC Representative	JC
Diane Blair	Healthwatch	DB
Rob Smith	SS SF CCG Finance	RS
Jane Elliott	Commissioning Manager Localities	JE
Melanie Spelman	Programme Manager for Quality & Risk	MS
Chantelle Collins		
Minutes	Senior Administrator	AW
Anji Willey		

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

Name	Membership	Jan 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Sep 21	Nov 21	
Members:										
Dil Daly	SF CCG Lay Member (Co Chair)	✓	✓	✓	✓	✓	✓			
Fiona Taylor	S&F SS CCG Chief Officer	✓	N	N	A	N	✓			
Martin McDowell	S&F SS CCG Chief Finance Officer	✓	✓	✓	✓	✓	✓			
Alan Sharples	SS CCG Lay Member	✓	✓	✓	✓	A	A			
Helen Nichols	S&F CCG Lay Member	✓	✓	✓	A	✓	✓			
Jan Leonard	S&F CCG Director of Place (North)	✓	✓	✓	✓	✓	✓			
Angela Price	S&F SS CCG Programme Lead Primary Care	✓	✓	✓	✓	✓	✓			
Alan Cummings	NHSE Senior Commissioning Manager	✓	✓	N	✓	✓	N			
Tracy Forshaw	SS&SFCCG Deputy Chief Nurse and Quality Lead	N	A	N	A	A	N			
Non-Voting Members										
Dr Kati Scholtz	GP Clinical Representative SF	✓	✓	✓	A	✓	✓			
Dr Reehan Naweed	GP Clinical Representative SS	n/a	n/a	n/a	n/a	n/a	N			
Richard Hampson	Primary Care Contracts Manager	✓	✓	✓	✓	✓	✓			
Joe Chattin	LMC Representative	✓	N	N	N	✓	N			
Debbie Fairclough	SS SF CCG Corporate Services	N	N	N	D	D	N			

Diane Blair	Healthwatch	✓	N	A	✓	A	A			
Rob Smith	SS SF CCG Finance	N	✓	✓	N	✓	N			
Jennifer Piet	Programme manager – Quality & Performance	N	N	N	✓	N	N			
Melanie Spelman	Deputising for Tracy Forshaw	N	N	N	N	D	N			
Chantelle Collins		n/a	n/a	n/a	n/a	n/a	✓			

No	Item	Action
PCCiC 21/63.	**Introductions and apologies** Apologies were noted from Alan Sharples, Diane Blair and Steven Cox	
PCCiC 21/64.	**Declarations of interest** There were no Declarations of interest	
PCCiC 21/65.	**Minutes of the previous meeting** Date: Thursday 17 June 2021 agreed.	
PCCiC 21/66.	**Action points from the previous meeting** The action tracker was updated	
PCCiC 21/67.	**Feedback from JOG** JL gave an update as below: • CSU has been commission to undertake some public engagement with several practices across Sefton • Hightown has been rated as 'Good' by the Care Quality Commission • The Improvement Grant process has been started and is ongoing • LD health checks have increased by 20% across Sefton. The primary care team were asked to present innovative work at a webinar aimed at CCG's across the North West	
PCCiC 21/68.	**Estates** An opportunity has arisen for two practices to co-locate to Crosby Library. This is being discussed with Sefton Council at the moment. There is a potential for the PCNs too be involved.	
PCCiC 21/69.	**Healthwatch** DD gave an update in DB's absence. There is a new signposting and Information Officer. The council has been written to about housing development and the impact this will have on access to health care in Sefton. Enter and view visits will be restarting.There are concerns about e-consult being removed during OOH. We need to ensure practicesupdate their website to inform patients about why this has been done. Standard communications will be shared with Healthwatch to help support informing the general public. GP practices are under a lot of pressure and collaborative work will be done to understand the issue. The 'Big Chat' event will focus on the pressures in General Practice. JE told the group that the PPG are working with the CCG Comms team and Healthwatch, a working group has been set up across Sefton which will hopefully enhance public engagement.	
PCCiC 21/70.	**PCN Update** There is work being done with Merseycare on the new mental health roles. There is not a huge amount of roles so they are trying to maximise them. Each practice has to align their appointment slot to national appointment criteria under the IIF contract. The Covid booster is now aimed at PCNs. KS asked how we are going to move forward with phase 3 vaccinations. All practices don't want to be involved. As these are going to be done at the same time as the flu – if practices don't do them it will go to community pharmacies at a big loss to General Practice.	

PCCiC 21/71.	**OOH transition to PC24 Quarter 1** AP has done a brief paper regarding OOH across the seven CCGs in the last quarter. This had been delayed for 12 months due to Covid, but PC24 were the successful bidders. They have not covered Sefton before but come with experience. PC24 had introduced themselves and will meet quarterly with CCG representation also at 111 meetings quarterly too. The public should see no difference. Their start coincided with an unprecedented level of demand. There were four Bank Holidays, but they had allowed for this in the model. The definitive clinical activity was 50% higher than expected.111 Pathways have national changes. Patients who normally go to pharmacies and patients with long standing illnesses are going to OOH. The NHS Pathways review could have caused increased activity. Some of the things being looked at are: • Comfort calling • Addition workforce on Mondays • Reviewing needs • Analysis of top 10 practices –2 of which are in South Sefton There have been two contract meeting so far and these will continue monthly. The group discussed that there will be a bedding down period and we are ok to assist during this as long as it doesn't become the norm. We need to keep an eye on it. It was made clear that the report IS positive but we just need to tread cautiously as it is new. It was mentioned that a lot of the GPs are unhappy with the service and that the complaints are coming from practices, not patients. PC24 should be used for the more urgent cases. PC24 are aware of the issues and are open about them.	
PCCiC 21/72.	**DES sign up** RH has done a brief paper around enhanced services. They are: • Minor Surgery • Special allocation Scheme • Out of Area • Learning Disabilities Health check • Not included network as it sits on its own This year there were two new enhanced services: • Weight management • Long Covid • RH is currently collecting responses. He will present the full participation reviews at the next meeting.	
PCCiC 21/73.	**Quality** CC gave an update - Historical complaints are still open. The complaints report is more of a contact log It is broken down into CCGs and the plan is to go the Complaints Oversight Group. They are keen to find themes and trends and will do a root cause analysis. She made it clear that the new report is a work in progress and in the future we will see compliments too, not just complaints. CC was thanked for the quality of the report so far.	
PCCiC 21/74.	**Contract Changes** two practices in Maghull with the same provider have merged This means that there are now 29 practices instead of 30 in SS. There has been a non-renewal of APMS at Trinity and St Marks is now the sole provider. This means there are now 18 practices instead of 19 in SF. An options appraisal will be put together for Freshfield practice. The contract isn't due to expire until 2023. FT asked if the Committee would be happy to receive a list of GMS, PMS, AMPS practices and RH will provide this.	RH

PCCiC 21/75.	**Key Issues:** Updates regarding Improvement Grants and Learning Disabilities Estate updates OOH PCN COVID booster vaccinations New procedure for the complaints log Details of GP Contracts held in primary care Risk Register	
PCCiC 21/76.	**Risk Register** The risk register was updated.	
PCCiC 21/77.	**Any other Business** None	
PCCiC 21/78.	**Date and time of next meeting**	
Meeting Concluded.		
Date of Next Meeting: Thursday 16 September 2021 10.00am-11.00am. **Venue: MS Teams**		