Southport and Formby
Clinical Commissioning Group

Board Meeting
Agenda

To be held on Wednesday, 27 March 2013 at 1.00pm
The Family Life Centre, Ash Street, Southport

Key		
Dr Niall Leonard	Chair	(NL)
Helen Nichols	Vice Chair, Lay Member	(HN)
Dr Robert Caudwell	Clinical Vice-Chairman	(RC)
Dr Graeme Allan	GP Board Member	(GA)
Ann Bisbrown-Lee	Patient LINks Representative (Co-opted Member)	(ABL)
Roy Boardman	Practice Manager Board Member	(RB)
Gill Burke	Nurse Board Member	(GB)
Margaret Carney	Chief Executive, Sefton MBC (Co-opted Member)	(MC)
Fiona Clark	Chief Officer (Designate)	(FLC)
Dr Martin Evans	GP Board Member	(ME)
Debbie Fagan	Chief Nurse	(DF)
Sharon Forrester	Nurse Board Member	(SF)
Dr Liam Grant	GP Board Member	(LG)
Karen Leverett	Practice Manager Board Member	(KL)
Martin McDowell	Chief Finance Officer (Designate)	(MMcD)
Dr Hilal Mulla	GP Board Member	(HM)
Roger Pontefract	Lay Member	(RP)
Dr Jeff Simmonds	Secondary Care Doctor, Board Member	(JS)

The meeting will be preceded by a presentation from Karen Groves on the Care Home Audit

No	Item	Lead	Verbal or Report	Action
13/29	Apologies for absence	Chair	Verbal	To note
13/30	Minutes of Previous Meeting	Chair	Report	To approve
13/31	Action Points from Previous Meeting	Chair	Report	To note
13/32	Business Update	Chair	Verbal	To note
13/33	Chief Officer Update	FLC	Report	To note
13/34	Portfolio Leads Update	All	Verbal	To note
Performance				
13/35	Performance Reports			
	(a) Finance Update	MMcD	Report	To note

No	Item	Lead	Verbal or Report	Action
	(b) Prescribing Update	BP	Report	To note
	(c) Performance and Quality Report	MC	Report	To note
Policy/Strategy/Health Improvement				
13/36	Strategic Plan	MMcD	Verbal	To ratify
13/37	2013/14 Financial Outlook Report	MMcD	Report	To approve
13/38	Everyone Counts	TJ	Report	To approve
13/39	Plans for Healthwatch in Sefton	Sam Tunney	Report	To note
13/40	Low Utilisation of Summary Care Record	Paul Shillcock	Report	To approve
13/41	Quality Premium	FLC	Report	To note
13/42	Francis II – Update	DF	Verbal	To note
13/43	Southport and Ormskirk NHS Trust Patient Administration System (PAS) and Information Technology (IT) Update	RC / MMcD	Verbal	To note
13/44	Quarter 3 Update on 2012/13 Local CQUINS at Southport and Ormskirk NHS Trust	BD	Verbal	To note
Governance				
13/45	Prioritisation Framework	MC	Verbal	To note
13/46	Board Committees – Terms of Reference	TJ	Report	To approve
For Information				
13/47	Register of Interests	Chair	Report	To note
13/48	Hospitality Register	Chair	N/A	To note
13/49	Minutes of Committees (a) Audit Committee (b) Finance & Resource Committee (c) Quality Committee (d) Merseyside CCG Network	Various	Reports	To note

No	Item	Lead	Verbal or Report	Action
	(e) Health & Wellbeing Board (f) Medicines Management Operational Group (g) Strategic Integrated Commissioning Group (h) Engagement and Patient Experience Group (i) Locality Meetings – Formby Locality Central Locality North Locality South Locality (j) Southport & Ormskirk Strategic Partnership Board (k) Remuneration Committee			
13/50	Any Other Business			
13/51	Date, Time and Venue of Next Board Meeting Wednesday, 29 May 2013 at 1.00pm.			

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 of be transacted, publicity on which would be prejudicial to the public interest, (Section 1{2} Public Bodies (Admissions to Meetings), Act 1960).

Southport and Formby Clinical Commissioning Group

Board Meeting Minutes

Wednesday, 30 January 2013 at 1.00pm
The Family Life Centre, Ash Street, Southport

Board Members		
Dr Niall Leonard	Chair	(NL)
Dr Robert Caudwell	Deputy Clinical Chair	(RC)
Helen Nichols	Vice Chair, Lay Member	(HN)
Roger Pontefract	Lay Member	(RP)
Dr Graeme Allan	GP Board Member	(GA)
Dr Hilal Mulla	GP Board Member	(HM)
Dr Martin Evans	GP Board Member	(ME)
Dr Liam Grant	GP Board Member	(LG)
Sharon Forrester	Nurse Board Member	(SF)
Karen Leverett	Practice Manager Board Member	(KL)
Roy Boardman	Practice Manager Board Member	(RB)
Fiona Clark	Chief Officer	(FLC)
Martin McDowell	Chief Finance Officer	(MMcD)
In attendance		
Ann Bisbrown-Lee	Patient LINks Representative (Co-opted Member)	(ABL)
Fiona Doherty	Transformational Change Manager	(FD)
Peter Morgan	Deputy Chief Executive, Sefton Council (Co-opted Member)	(PM)
Tracy Jeffes	Head of Planning and Delivery	(TJ)
Malcolm Cunningham	Head of Performance & Health Outcomes	(Malcolm Cunningham)
Brendan Prescott	CCG Lead, Medicines Management	(BP)
John Garrett	Liverpool & Sefton Health Partnership	(JG)
Dr Bal Duper	GP	(BD)
Apologies		
Dr Jeff Simmonds	Secondary Care Doctor, Board Member	(JS)
Debbie Fagan	Chief Nurse	(DF)
Gill Burke	Nurse Board Member	(GB)
Minutes		
Melanie Wright	Business Manager	

No	Item	Action
13/1	**Apologies for Absence** were noted.	
13/2	**Minutes of Previous Meeting** *Sefton Council* now need to make savings of £51m. A summary of proposed cuts that will affect health services will be produced. *Phoenix House* - Ann Bisbrown-Lee asked whether any information was available. PM confirmed this has been referred to the Safeguarding Board, who were dealing with it and an independent chair has been appointed. Fiona Clark advised that the process is ongoing re Phoenix House.	PM

No	Item		Action
	End of Life Review - Fiona Clark confirmed that the PCTMS practices are subject to review by the Office of Fair Trading, the status quo remains at the current time at Jospice in relation to GP cover. Subject to the amendments above, the Minutes were agreed as an accurate record of the meeting.		
13/3	**Action Points from Previous Meeting** All actions were closed out, save for the following notes.		
	12/199	**Minutes of Previous Meeting** Clinical engagement with S&O clinicians regarding CQUINs is proving difficult. Billie Dodd to escalate and a letter to be sent withholding payment pending set up of the meeting. *Carried forward.*	BD
	12/211	**Choose & Book** Ann Bisbrown-Lee raised an issue around patients choosing Wigan and Wrightington NHS Foundation Trust. Advancing quality outcomes in relation to hips and knees are actually better at S&O and this should be communicated to patients Fiona Clark also updated the Board around the issue with Renacres and the challenge of the referral by Dr Allen and noted the Board is supportive of Dr Allen's manner of referral. A letter has been sent.	
13/4	**Business Update** Dr Leonard advised that the CCG was authorised on 22 January with four conditions. The Board have received the correspondence. There have been ongoing discussions around primary care development with Dr Bal Duper, who is leading on the development of a strategy, along with Angie Parkinson. A robust and resilient strategy is required, to be in place by June. Discussion with practices in relation to investments is ongoing via locality meetings. Drs Caudwell and Leonard met with 38 Degrees (a lobby group), following the acceptance of a petition the week previously requesting that the CCG do not engage private healthcare providers. A further meeting will take place in April. Roger Pontefract expressed caution around the parameters of engagement with such groups and misinterpretation around reporting of same. Dr Leonard also reported in relation to a recent positive Cardiology meeting around Peer Support at S&O. The MSK relaunch is on 1 April. There is a new Medical Director at S&O, Dr Rob Gillies, from June when Dr Geraldine Boocock retires.		

No	Item	Action
	Dr Leonard also updated the Board as to developing relationships with NCB Merseyside. The NCB Cheshire, Warrington and Wirral Area Team are the local team who will be dealing with specialised commissioning and the Merseyside CCG Network has a meeting scheduled with the Director in this regard.	
13/5	**Chief Officer Update** Fiona Clark provided highlights of her report. *CSU*: Debbie Fairclough is Head of Client Operations for the interface team at the CSU for Sefton. Communications lead is Lyn Cooke. Lesley McKinnell will be the local contact for Contracting. Luke Garner and Maria Dorpman are providing Intelligence. Other roles to be confirmed. *Planning*: Helen Nichols expressed concern at the submission of any planning documentation without an opportunity for the Board to comment. Tracy Jeffes advised as to the draft status of the planning documentation and the Board development session in February will consider this further. The final submission is due in March. The timetable is with a view to creating a prospectus for the public arena in June. When the Area Team have commented on the first draft planning document, it will be circulated to the Board. It is different to the planning process at the PCT, as lead managers already engage with lead clinicians in their portfolio areas and this has shaped the development of these plans. The Business Plan will be driven by the Commissioning Intentions, with which the Board have been engaged. Helen Nichols added that this document should drive future Board meetings. FLC agreed to send HN a copy. Ann Bisbrown-Lee raised the importance of considering young patients' views in relation to the choice agenda. *Authorisation*: further information in relation to the detail around the authorisation conditions will be provided by Johanna Reilly at a meeting with Fiona Clark tomorrow. A rectification plan with required further evidence will be submitted on 8 February 2013. Noted.	HN FLC
13/6	**Portfolio Leads Update** *Dr Grant* - there is now an Acute Respiratory Team based in South Sefton, meaning acute exacerbation of COPD can be treated at home. *Dr Mulla* - all practices in Sefton now have a relationship manager for the interface with Merseycare, although there had been some initial difficulties with setting up this service. CQUIN: Merseycare are seeking a reduction in the thresholds. Fiona Clark advised that a robust letter has been sent to Merseycare in this regard and a copy will be circulated to the Board. For IAPT, the waiting list is now below four weeks, which represented a considerable improvement.	MC

No	Item	Action
	Medicines Management – the MMOG visits to all surgeries are continuing and 75% practices have been visited. The Joint Medicines Organisation and APC are now operational. Dr Mulla referenced the Community Pain Clinic which has historically been paid for by NHS Sefton, but it has transpired that West Lancs patients attend; Dr Mulla queried whether costs could be reclaimed from West Lancs. Malcolm Cunningham agreed this was possible and that this difficulty had been encountered previously. Fiona Clark agreed to investigate. *Dr Caudwell - Paediatrics* – Dr Caudwell reiterated Ann Bisbrown-Lee's previous comments around patient choice, which should include children. *IT* - S&O are behind on CQUINs and are now unlikely to meet their targets. Dr Caudwell also indicated that the Lorenzo system was not fit for purpose. Fiona Clark suggested to the Board that a presentation from S&O as to their strategic direction in relation to IT was necessary, which the Board agreed. The EMIS web ipad trial comes to an end today, whch was felt to be hugely successful. *Dr Evans - Alternative Quality Contract* – it is being proposed that the CQUIN proportion be higher to include the community section, with a view to moving activity away from the acute area. In contractual terms, partial PbR is being discussed. There is an expectation of formal sign-off of contracts by 15 March. Martin McDowell added that the Trust was seeking an all PbR contract. They have overperformed on the contract this year on non-electives and outpatient follow ups. An opening offer in terms of activity will go to the Trust towards the end of this week/early next. A hybrid contract, amongst others, may be open for discussion. *Sharon Forrester – Cardiology* – Sharon also referred to the meeting with Liverpool Community Health and two other local CCGs to improve diagnostics. On behalf of the Board, Dr Leonard recognised the work Sharon had undertaken in relation thereto. *Roy Boardman* - blood samples are going missing on a large scale, which is being investigated. Practices are considering continuation of flu clinics later in the year. Fiona Clark referred to queries that were arising in relation to the GP contract, which were going to be raised with Tony Leo at NCB Merseyside. *Karen Leverett* – referred to discharge summaries and cancelled appointments, mixed sex breaches which were being reported. Fiona Clark referred to the dashboard contained within S&O board papers and indicated that this should be reviewed by the Quality Committee.	FLC/MC FLC DF
13/7	**Performance Reports** **(a) Finance Update** The financial position against the operational budget at the end of month 9 is £335k under spent prior to the application of reserves. This is a favourable movement of £155k when comparing to the month 8 financial position, which is largely attributable to an under spent position within Prescribing budget.	

No	Item	Action
	Martin McDowell drew the Board's attention to Appendix B; S&O are over performing by £2m, with key issues on-elective and outpatient follow ups. Non PbR areas of the contract are also overspent. High cost drugs represent a pressure and an over performance is expected. For month 8, there is a £3m overspend in relation to the contract, but there will be some challenge to this before negotiations begin on the 2013/14 contract. Dr Grant queried an overseas patient at the Walton Centre and whether the CCG are liable for the costs in relation thereto. Martin McDowell confirmed this was correct as part of the PCT legacy, with NHS Sefton as the lead commissioner for the Walton Centre. This would not be the case from April 2013. *Finance & Resources Committee* - the second meeting was well-attended and there was good contribution around business cases. Helen Nichols asked for another clinician to attend to ensure quoracy. Much of the conversation is clinical and only Dr Mulla was able to attend. Fiona Clark advised that a Prioritisation Framework is being put together for 1 April, which will need discussion and sign-off. Martin McDowell advised that the following Business Cases had been put forward which the F&R Committee had considered, with the results stated below: i) End of Life Care Home Facilitator - agreed 12 months in the first instance ii) Hospice at Home Funding - agreed 12 months iii) Evidence into practice - agreed iv) Rheumatology biologics – additional commissioned indications - agreed v) Introduction of an Alcohol Specialist Nursing (ASN) Service to operate out of the Accident & Emergency Ward at Southport & Ormskirk Hospital - commit to one year in first instance vi) Improving access to Psychological Therapies - Approved Option C with a view to receiving a further paper. Noted.	
	(b) Prescribing Update The South and Formby CCG position for month 7 (October 2012) was a forecast under spend of £1,286,150 or -6.3 %. This is marginally less than the forecast underspend at month 6. This has been a unique year in relation to relatively high cost and high volume drugs coming off patent. Fiona Clark sought clarification as to the practices and HM's alluding to two practices, whereas this report contains one practice; this is simply a matter of data timing of data and reports. The latest data shows two practices Noted.	
	(c) Performance and Quality Report Malcolm Cunningham reported that regarding 62 day cancer waits and mixed sex, although showing red, assurance has been provided that targets will be achieved.	

No	Item	Action
	A&E Performance at S&O - Karen Campion is undertaking a piece of work which has produced data showing S&O has the highest number of attendances in the North West, together with the highest number of breaches. The Trust are reporting that their attendances increased by 38%. Ambulance attendances were up by 22% and non-elective admissions have increased by 9%. Further investigations are ongoing. Ann Bisbrown-Lee queried why continuing care (or step down) beds were not being used. FLC explained that this was due to limited numbers and the fact that it has been difficult to get GP cover. Practices do not feel that they have capacity to support. Dr Paddy McDonald will now be supporting this cover. Fiona Clark advised that the whole system needs resolution and a co-ordinated effort/dialogue is required, which is a complex piece of work Dr McDonald is undertaking and board members are aware of the work being undertaken – Care Closer to Home. From April 2013, a Southport & Formby CCG performance report will be produced. Noted.	
13/8	**Financial Plan 2013/14** High level plans for CCGs have been drafted and will be shared later this week. Over the next month, a fuller version will be presented to the Board for discussion at the February Board Development session, for formal sign-off in March. Noted.	
13/9	**Health Inequalities Group for People with a Learning Disability** The paper was ratified.	
13/10	**PCT Transfer Schemes** This paper describes the work taking place and and the CCG's resposibilities from 1 April. Fiona Clark confirmed that she is comfortable with the content of this report. Noted.	
13/11	**Protected Learning Time** Roy Boardman confirmed that practices wish for Protected Learning Time to continue from 1 April 2013. There was a discussion around how practices use the time within use the time, when the sessions are not venued. It was felt that Colette Page and Pippa Rose could lead the liaison role instead of Dr Raj Patel from 1 April. Dr Leonard will continue as clinical lead on the PLT Steering Group. The recomendations contained within the report were approved.	
13/12	**Ophthalmic Service Plans** Dr Bal Duper had considered the background of commissioning ophthalmology and the immediate and medium term commissioning for these services and move some out into the community. A PCT review some years ago suggested that ophthalmic services be commissioned in a different way, but this was not progressed at that time.	

No	Item	Action
	Audits on local clinics have taken place and Dr Duper referred to some clinical examples and how some relatively minor opthalmic conditions have been referred. Dr Duper went on to describe possible solutions in the current econonic climate and the need to ensure sustainability of any service. He also discussed the engagement that has taken place, including with CCG Chairs. Dr Duper also confirmed that these propoals had been considered in terms of patient safety. A sequential scheme is proposed with an intitial glaucoma LES. There is an intention to remove, in the first year, 10% of the service into the community, increasing in years thereafter. Dr Duper then invited comments by the Board. Dr Leonard confirmed that a meeting with the Local Optometry Committee had taken place and felt that the proposed scheme was positive, but there was also a need to ensure the Emergency Eye Clinic was retained at S&O. Patient choice is important, but it is important to retain the local acute service. Formal arrangements for referrals to opticians should be encouraged. Dr Caudwell felt the glaucoma proposal was eminently sensible and asked whether the three parameters would be included; Dr Duper confirmed it would and that quality and safety will be of utmost importance. Some work will need to be undertaken on pathways. Helen Nichols queried the basis for the costings in the community – rates are based on services being provided in existing clinics, so the opticians hourly rate is £110, compared to £165 at the hospital. HN also queried whether this was an area of priority, given current pressures both financially and administratively. BD advised that this was one of the areas in which the local Trust was failing on 18 week RTT and therefore needed review. The Board <u>approved</u> the recommendations contained within the report. Dr Duper asked if any clinicians would be interested in supporting this piece of work. It was felt that Steve Nicholson may be interested. Dr Duper to approach.	Bal Duper
13/13	**Approval of CCG Network NOAC Position** NICE recommended Dabigatran or Rivaroxaban as a treatment option in AF for the prevention of stroke and systemic embolism. The CCG Network statement was approved at Board in July 2012. However, some clarification on the statement was requested from the AF task group of the Cheshire & Merseyside Cardiac Network. This was discussed at Network in November 2012. The statement was presented to the Pan Mersey (APC) in January 2013 who recommended a consistent adoption and approval of the statement across Merseyside. This statement is now presented to the Board.	

No	Item	Action
	Dr Leonard advised that these are effective NICE-recommended drugs. However, they do not present a significant advantage by comparison to existing drugs, except by way of convenience. If implemented across Mersey, there would be a significant cost implication. In CCGs where there are good quality anti-coag services, it is about patient preferences and convenience. These drugs are NICE approved and there may be some concern among GPs regarding patients who do not wish to take Warfarin. BP felt it was a matter of how explicit the statement was. It is hoped that all Boards within the Network will come to the same conclusion, but ensuring that clinicial liability is also covered. Dr Leonard supports the original statement and invited views from the Board. Dr Caudwell enquired as to what happens when consultants prescribe; this leaves GPs in a difficult position. Fiona Clark advised that a clinical discussion may be required with the consultant and this could then be addressed via contractual levers. Examples where this occurs need to be reported to the Quality Committee and this needs to be communicated to localties to ensure an evidence base is compiled. Sharon Forrester raised the circumstances where a patient is advised as to the benefits of Warfarin and chooses to decline. The Board was being asked to approve the contents contained within the report, which had been considered across the CCG Network. (The recommendation should be reading Southport and Formby CCG, not South Sefton CCG.) Ann Bisbrown-Lee asked if there was a paper available that GPs could give to patients; there is not, but the statement could be made available. Once a decision is made, Brendan Prescott advised that some material will be produced and this can be produced in formats such as Easyread etc. The Board approved the recommendations contained within the report.	
13/14	**NHS Merseyside – A New Approach to Estates Management** John Garrett outlined the contents of the report. Ann Bisbrown-Lee asked that the new company engages meaningfully with Merseytravel so that patients can access services. John Garrett agreed to take this point forward. Fiona Clark advised that there can be a formal communication with Graham Pink to this effect. The Board approved the recommendations contained within this report.	JG FLC
13/15	**Memorandum of Understanding – Dispute Resolution** This paper follows on from an issue raised during the authorisation site visit. The Board approved the policy.	

No	Item	Action
13/16	**Appointment of Registered Nurses to the Governing Body** The significant work undertaken by Gill Burke and Sharon Forrester was acknowledged. The Board approved the recommendations contained within the report and thanked Gll Burke and Sharon Forrester for their contributions. The recruitment/election of a further nurse will be considered.	DF
13/17	**Register of Interests** Dr Leonard: remove medial society and work at S&O. Note Dr Grant's practice. Include Fiona Clark's dual role. Dr Allen – remove Triangle. Note that Sharon Forrester and Gill Burke work for providers. Note that Karen Leverett is Practice Manager at the Village Surgery. Debbie Fagan to be added.	MW
13/18	**Hospitality Register** was noted.	
13/19	**Minutes of Committees** (a) Audit Committee (b) Finance & Resource Committee (c) Quality Committee (d) Merseyside CCG Network (e) Health & Wellbeing Board (f) Medicines Management Operational Group (g) Strategic Integrated Commissioning Group (h) Engagement and Patient Experience Group A training session was held at the last meeting and further sessions are planned. (i) Locality Meetings – Formby Locality Central Locality North Locality South Locality (j) Southport & Ormskirk Strategic Partnership Board The Minutes of Sub-Committees were noted.	

No	Item	Action
13/20	**Any Other Business** There is a Locality Leads development session next Wednesday afternoon, to which Board members are welcome. The Southport Postgrad Centre is looking for an additional board member. The meetings take place once a year. Interest to be communicated to Dr Leonard. Dr Allen has signed the contract on behalf of the CCG with the builder for the work on the Macmillan Centre. Noted.	
13/21	**Date, Time and Venue of Next Board Meeting** Wednesday, 27 March 2013 at 1.00pm.	

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 of be transacted, publicity on which would be prejudicial to the public interest, (Section 1{2} Public Bodies (Admissions to Meetings), Act 1960).

Southport and Formby
Clinical Commissioning Group

Board Meeting
Action Points

Wednesday, 30 January 2013 at 1.00pm
The Family Life Centre, Ash Street, Southport

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13/3	**Action Points from Previous Meeting** 12/199 **Minutes of Previous Meeting** Clinical engagement regarding CQUINs is proving difficult. Billie Dodd to escalate and a letter to be sent withholding payment pending set up of the meeting. *Carried forward.*	BD
13/1	**Chief Officer Update** When the Area Team have commented on the planning document, it will be circulated to the Board. Helen Nichols added that this document should drive future Board meetings. FLC agreed to send HN a copy.	HN
13/2	**Portfolio Leads Update** Merseycare are seeking a reduction in the thresholds. Fiona Clark advised that a robust letter has been sent to Merseycare in this regard and a copy will be circulated to the Board.	MC
	Medicines Management –Dr Mulla referenced the Community Pain Clinic which has historically been paid for by NHS Sefton, but it has transpired that West Lancs patients attend; Dr Mulla queried whether costs could be reclaimed from West Lancs. Malcolm Cunningham agreed this was possible and that this difficulty had been encountered previously. Fiona Clark agreed to investigate.	FLC/MC
	IT - S&O are behind on CQUINs and are now unlikely to meet their targets. Dr Caudwell also indicated that the Lorenzo system was not fit for purpose and Fiona Clark agreed to discuss with Sheilah Finnegan at S&O.	FLC
	Fiona Clark suggested to the Board that a presentation from S&O as to their strategic direction in relation to IT was necessary, which the Board agreed.	FLC
	Karen Leverett – referred to discharge summaries and cancelled appointments, mixed sex breaches which were being reported. Fiona Clark referred to the dashboard contained within S&O board papers and indicated that this should be reviewed by the Quality Committee.	DF

No	Item	Action
13/12	**Ophthalmic Service Plans** Dr Duper asked if any clinicians would be interested in supporting this piece of work. It was felt that Steve Nicholson may be interested. Dr Duper to approach.	Bal Duper
13/14	**NHS Merseyside – A New Approach to Estates Management** Anne Bisbrown-Lee asked that the new company engages meaningfully with Merseytravel so that patients can access services. John Garrett agreed to take this point forward. Fiona Clark advised that there can be a formal communicaton with Graham Pink to this effect.	JG FLC
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Southport and Formby
Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/33	**Author of the Paper:** Fiona Clark Chief Officer Fiona.clark@sefton.nhs.uk

Title:

Chief Officer's Report

Summary of the Paper/Key Issues:

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

Action/Decision Required:

1 The Governing Body is asked to note the contents of this report.

2 The Governing Body is asked to give delegated authority for the sign off of the Transfer schemes to the Chair, Chief Officer and Chief Finance Officer- Senior Leadership Team.

Date of Report:

20 March 2013

Southport and Formby
Clinical Commissioning Group

Report to Board

March 2013

1. Authorisation - Rectification Plan

The final Rectification Plan including evidence was uploaded to KMS on 28 February 2013 and a copy is attached hereto.

A copy of the evidence referred to therein is available upon request.

A final response is expected by the end of March as to whether any conditions are to be imposed on the CCG from the 1 April 2013.

2. Local Enhanced Schemes (LES) Update

Angela Parkinson, Locality Lead who has responsibility for Primary Care across Sefton, has been working since October 2012 to map and understand both the PCT and the CCG LESs. This work has taken much longer than anticipated, but we are now in a clearer position where we can give due consideration to all the LESs and the payments made to practices.

There is still work to be done in transferring these to the NHS standard contracts with accompanying clear service level agreements and I have agreed an approach with Tony Leo- Director of Commissioning at NCB Merseyside. This has been communicated to all practices.

In line with the changes to the NHS the LESs will stay with the CCG, with payments being made via the NCB Merseyside because of the shift of contractual responsibilities to the NHSNCB.

Future consideration will need to be given by the CCG in relation to investment in primary care, in conjunction with NCB Merseyside and involving the Local Medical Committee. To this end the work that Dr Bal Duper is leading to develop with the membership of the CCG a Primary Care strategy, will help to inform and drive future development in this area. There will need to be a separate group convened comprising of the Chief Officer, Chief Finance Officer, Lay members and Secondary Care Doctor in order to clearly and transparently manage the potential conflict of interests this area exposes.

3. Southport & Ormskirk NHS Trust (S&ONHST)

Work is progressing with the Care Closer to Home Network energising the work which has been developing across NHS Southport & Formby CCG and West Lancashire CCG in conjunction with other partners to develop a whole health & social care system approach to the demands being experienced as a result of our demographic changes. To date the work of Dr Paddy McDonald who is on secondment with the CCG and Dr Niall Leonard - CCG Urgent Care Lead has helped to

crystallise and shape some of the on-going thinking which has been shared and further refined with our CCG wider membership. There remain a number of challenges in relation to the enablers in making this project successful, including IT and the wider system support.

The Quality Committee undertook a 'walk about' on the 11th March 2013 and I have had a conversation with the CCG Chair and Vice Chair in relation to the potential for a further quality risk review in conjunction with NCB Merseyside, the National Trust Development Agency (NTDA) and the Care Quality Commission (CQC) which I have also discussed with Jonathan Parry-Chief Executive.

Work has also been undertaken to support S&O NHS Trust as a result of the dialogue at the Strategic Partnership Board in relation to A&E performance, capacity and discharge processes following the surge in demand. This work has been undertaken for the CCG by Karen Campion and Sue Ramprogus from NHS North of England. It is intended that this work will inform current delivery and future commissioning. Links have been made with Tina Wilkins in Sefton MBC.

I have also been in receipt of a letter from Jonathan Parry which covers 'twenty changes that would improves patients experiences in periods of high demand'. I have met with and responded to this letter and many of the areas have been captured already in the work of the Strategic Partnership Board.

4. 111 Update

The CCG have now signed off the Directory of Services (DOS). The DOS testing is complete. There is on-going work to refine the DOS but it is ready for the 'go live' date. The joint Sefton Local Clinical Advisory Group (LCAG) has met chaired by Dr Andy Mimnagh (111 lead for South Sefton CCG and the necessary additional Clinical Governance evidence was submitted, it is assumed currently that this is satisfactory, as no comments have been received by the overall Merseyside Clinical lead Dr Fiona Lemmens (GP in Liverpool CCG).

The LCAGs do not have delegated decision making authority from the CCG Governing Body. The LCAGs are accountable to the CCG Governing Body, to this end minutes from the LCAG will be received and any recommendations from this group considered and appropriately actioned.

The service readiness testing at NHSD has been completed both locally and in Milton Keynes and has been passed by DOH. There is further work on-going, but it appears that we are in a healthy position.

5. Procurement

Following the public consultation carried out in August 2012, the Government has now laid regulations in relation to procurement. These being known as The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013. They cover:

- general issues,
- requirements to procurement, patient choice and competition
- Investigations, declarations, directions and undertakings.

These regulations will guide the CCG in this area.

6. Authorisation of Transfer Schemes

The Transfer Scheme process continues to progress at pace and although we were expecting the Schemes to be ready for receiving at the Governing Body today, due to delays with the Department of Health drafting of the legal provisions, that has not been possible . Whilst the DH had previously issued guidance that CCGs are not expected to carry out formal sign off of the schemes before the 31st March 2013, further guidance was issued on Friday 15th March setting out the DH expectations in terms of "receiver assurance".

This guidance requires Boards of receiving organisations are now asked to provide assurance to the Secretary of State that:

The organisation has to the best of its ability:

- Carried out due diligence on sender transfer scheme instructions;
- Understands and agrees the property, assets, and liabilities transferring according to function, to the organisation as the most appropriate permitted receiver in the new system architecture.

As this due diligence process has not yet concluded the Governing Body is asked to delegate authority to the Chief Officer, Fiona Clark and Chair (Niall Leonard) to sign off the assurance process. This sign off must take place before the 25th March and the Chief Officer will ensure there is an independent assessment of the process prior to sign off.

7. Bulletin for proposed CCGs

These are produced monthly by the NHS National Commissioning Board (NHS NCB). They provide all members of the CCG with useful information and updates and I attach an electronic link to the March 2013 Bulletin. (http://www.commissioningboard.nhs.uk/blog/2013/03/07/ccg-bulletin-issue-30/). If anyone would like a copy via any other method please speak to Mel Wright-Business Manager.

8. Progress to Transition

As from the 1st April 2013 we will be officially an NHS statutory body. There are still a few vacancies which we are actively recruiting, with Becky Williams joining us in the role of CCG Analyst and we have the welcomed return from maternity leave of Jan Leonard Joint Head of CCG Development.

I just wanted to reflect on the last 12 months. Firstly, to thank all the Governing Body members and the wider CCG members for the support. I would also like to acknowledge the CCG support team for which I am privileged to lead. There have been some extremely tight time scales, rapid pace and at times incredible demands; all of which have taken place against a backdrop of personal uncertainty and immense change. They have behaved in a professional manner and I am confident that we have a team that can support the CCG members, to deliver the ambitious plans to improve patient care and reduce health inequalities in the CCG.

Southport and Formby
Clinical Commissioning Group

9. Recommendation

1. The Governing Body is asked to note the contents of this report.

2. The Governing Body is asked to give delegated authority for the sign off of the Transfer Schemes to the Chair, Chief Officer and Chief Finance Officer- Senior Leadership Team.

Appendices

Appendix 1 - Rectification Plan

Fiona Clark
Chief Officer
20 March 2013

Rectification Plan

Version 2: 11 February 2013

Southport and Formby Clinical Commissioning Group

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
4.2.1E	E	Provide evidence that CCG has arrangements in place to proactively identify early warnings of a failing service	• Quality dashboard – Has this been submitted as evidence? Is there a clear line of sight from the different provider groups? Is there evidence that this dashboard and early warnings are discussed and shared with all provider groups? (practices)	II	Performance and Quality dashboards presented to both the Governing Body in January 2013 and Quality Committee in January 2013. Previous report considered at Quality Committee in November 2012. Please refer to page 23 of the report attached hereto. Please note information on HCAI can be found in the Performance section of the report. Dr Doug Callow is the GP Lead for Quality and member of the Quality Committee, whose role it is to lead the quality contract meetings and to act as liaison point between practices and the Quality Committee. Plans are in place for the GP Quality Lead to report back on quality to the Wider Constituent meeting at regular intervals. Please also refer to the attached minutes of the Quality Committee regarding utilisation of the dashboard, together with patient and clinician experience, as a demonstration of the early warning system in place within the CCG and subsequent escalation to the Governing Body, minute 13/4.	1 Performance Report Jan 2013 2 Quality Committee Minutes of Jan 2013	Completed

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
			• You have confirmed that there is a quality committee in place but are there any further minutes, actions etc.… that you can submit as further evidence?. Do you have a surveillance group that captures all provider group issues that reports to the quality committee? If not what process do you have to capture issues, concerns etc.…Have there been any discussions on preparatory work for Mid Staffs and the Francis return, Winterbourne etc? if so this will aide your submission. Do you have a diagram or description of how incidents are collated and rated, reported and acted upon? Are you using Datix or is all this done with the CSU if so can you articulate this?		Minutes from the November and January Quality Committees included herein. A SUI Review Group has been established and details of the membership, dates of meetings and feedback are included herein. The Chief Nurse will represent the CCG at the Mersey Quality Surveillance Group. A letter detailing the Chief Nurse's invitation is attached, together with Guidance Outline. The pending publication of the Mid Staffs Inquiry Report (Francis 2) was discussed at the Quality Committee in January 2013 (minutes attached). It is an agenda item for the meeting in February where a report and action plan will be presented. This will then be presented to the Governing Body in March 2013. The CCG Chief Nurse is going to a Kings Fund seminar on 27 February 2013. The Chief Nurse has met with the Relationship Manager from the CSU on 7 February 2013 to discuss the Francis Report and support that will be required from CSU and the potential impact on the service they provide.	3 Quality Committee Minutes of Nov 2012 2 Quality Committee Minutes of Jan 2013 4 SUI Review Group 5 Mersey Quality Surv Let 6 Quality Surv Groups	

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
					The Chief Nurse, in collaboration with other Mersey CCG Chief Nurses to develop CQUIN and quality indicators relating to Compassion in Practice (National Nursing and Care Strategy) and the Francis Recommendations. This has been supported by CSU and the CQUIN and Quality Workshop on 10 January 2013 and at the CQUIN event with providers on 30 January 2013. Francis was also discussed at the Audit Committee on 6 February 2013, copy minutes included herein, please refer to 13/6, which is also referenced in the attached Action Tracker. *Winterbourne* A database has been developed to identify adults with LD/Mental Health and Autism in independent treatment and assessment units out of area. This information was sent to the NCB Area Team on 1 February 2013. A CCG GP Clinical Lead has been identified for LD/Mental Health. By 28 February 2013, a joint CCG/Local Authority database will be completed of children who are in out of area treatment centres. A joint CCG/local authority action plan is in the process of being completed re Winterbourne recommendations and was discussed at the Quality Committee in January 2013. A full report will go to the Quality Committee in February 2013, together with the Strategic Integrated Commissioning Group meeting on 11 March 2013 and the Governing Body on 27 March 2013.	7 Mins Audit Feb 8 Action Tracker Audit Ctee	

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
			• How are the system and processes for early warnings presented to your governing body then shared with member practices? • Are you holding any educational sessions if so this should support your submission.		Support regarding incident reporting is from the CSU. The names of the Chief Nurse and Business Manager have been provided by way of access to Datix/Steis. The CCG's Chief Nurse is attending the SUI Training Day organised by the Cluster/Area Team on 13 February 2013. The Chief Nurse has completed and returned the SUI Checklist along with the CCG SUI policy to Peter Groggins and Christine Griffiths-Evans at on Friday 1 and Monday, 4 February 2013 respectively. A copy of the Quality Early Warning and Reporting system is attached which includes governance arrangements. This will be covered within Governing Body Development sessions and Protected Learning Time with Constituent Member Practices. A further example of how locality meetings will be utilised as part of learning can be evidenced by the attached document which gives an example of lessons learned from SUIs will be fed down to the localities.	9 Early Warning 4 SUI Review Group	
4.2.1F	E	Provide evidence that arrangements are in place to deal with and learn from serious untoward incidents and never events	• Recognise that plans where in transition can you now demonstrate the implementation of policies and plans? • How the CCG receives the information and acts upon it there is plans to do but you now need to evidence what you have done.	II	The Quality Committee formally approved adoption of the SUI Policy on 23 January (copy minutes herein) at minute 13/10. A copy of the Quality Early Warning and Reporting system is attached which includes governance arrangements.	2 Quality Committee Minutes of Jan 2013 9 Early Warning	Completed

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
			• Can you mention anything re the network and co commissioning arrangements, any additional support i.e. MIAA, AQUA, regular meetings with CQC anything that will support your submission. • Do you have a Local management group, led by GP members with practice staff as well as CCG staff? Suggest you could refer to the evidence from 4.2.1E		The Chief Nurse will represent the CCG at the Mersey Quality Surveillance Group. A letter detailing the Chief Nurse's invitation is attached, together with Guidance Outline. The Chief Nurse will also represent the CCG at the Mersey Cluster SUI meetings (date of next meeting 18 February 2013). Please refer to the Minutes contained at 13/6 attached hereto for confirmation of MIAA support provided to the CCG together with 13/6 in the attached Action Tracker. The CCG has confirmed that they will continue their membership of AQuA. This membership contribution will also mean that the CCG receives support from the Academic Health Science Network. The Chief Nurse has also attended a Webex on 28 February 2013 with AQuA to identify the support required to the CCG generally. *CQC* Dates have been confirmed for the Chief Nurse to meet with the CQC Compliance Inspectors. The meeting is arranged for 6th March 2013 10am with Christine Penlington and Robert Taylor (CP covers Aintree, Liverpool CH and Merseycare, RP covers Sefton). The Serious Untoward Incidents Management Group of which Terms of Reference are attached.	5 Mersey Quality Surv Let 6 Quality Surv Groups 7 Mins Audit Feb 8 Action Tracker Audit Ctee 10 SUI Group ToR	

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
4.2.1H	A, E	Provide evidence that clear governance structures and programme management capacity and capabilities are in place to support the delivery of QIPP	• Cannot see the line of sight from the different sources of evidence.	II	Oversight for planning and monitoring of QIPP performance has been assigned to the Finance & Resource Committee. The Finance & Resource Committee has established a separate sub-group in order to perform the task. Meeting dates have been confirmed for the 2013 Calendar year. The Terms of Reference for the sub-group are attached and will be ratified at the F&R Committee meeting on 20 February 2013.	11 QIPP Group Schedule 12 QIPP Group ToR	20 February 2013
			• Is there not a clear description to show the governance arrangements? Is there a diagram, a plan? It is difficult to know what document is best to look at.		The diagram attached describes the QIPP governance arrangements and links to the Governing Body and Strategic Plans	13 QIPP Diagram	
			• Who has accountability and where is the structure? It may be there but it is not obvious?		The Chief Finance Officer holds accountability for leading, developing and assuring the QIPP plans delivery on behalf of the governing body.	14 CFO Role Spec	
			• Has the QIPP plan been approved at the governing body? If so can this be added as evidence?		The CCG's QIPP plan is currently in development and will be presented to the March Finance & Resource Committee for adoption.		20 March 2013
			• Do all plans feed into your 5 year strategy or is this in the planning stages; if so are you consulting? Again, if so are there dates of meetings, agendas, etc.		The QIPP plans will form an integral part of the CCG's strategic plans which are being refreshed. The Strategic Planning group meets on an informal basis. It is expected that the CCG's strategic plans will be presented to the Wider Constituent Group Meeting in March.		
			General comments – no clear line of sight, accountability and assurance re QIPP				
			• Suggest minutes & ToR of Finance & Resource committee be submitted as evidence. (Question: is QIPP a standing		• ToR (reference section 5.1) and draft minutes of F&R committee (minutes 13/6 and 13/11) . QIPP is a standing item.	18 ToR F&R	20 March

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
			agenda item? And what is the frequency of this meeting and membership?)		F&R Committee meets at least 9 times per year. • The month 9 financial position can be seen at section 2.7 of the Finance Report for January 2013.	19 Mins F&R Jan 2013 20 Finance Report Jan 2013 21 - 23 App's	2013
			• If QIPP subcommittee only meets quarterly how can the CCG keep a grip? Can the frequency not be increased in year 1 then reviewed?		• Agreed – Meetings now held on monthly basis apart from August & December – main meeting will be quarterly to inform group of performance ahead of any reporting requirements to AT / NHSNoE.	24 Revised QIPP Mtg Schedule	
			• Is there any evidence of the key risks to QIPP delivery? If so submit as evidence		• 12/13 Programme has been rated green throughout the year – no risks identified. The bulk of CCG related schemes focus on secondary care contracts (delivered through efficiency) and prescribing which has been on course to deliver throughout the year.		
			• Have any papers describing the approach taken by South Sefton CCG been presented at the governing body or the finance and resource committee? If so submit as evidence		• Not at this stage – paper planned for March F&R and GB as part of strategic financial plans.		
			• Please elaborate on comments in actions being taken to address the issue (your submission) "Discussions in place with NHS S&O CCG regarding identifying adequate resources to cover financial risk in 13/14" as you describe the risk pool in the subsequent bullet point?		• Yes – informal discussion took place this morning (11th Feb) between 2 chairs and CFO as to how we would create and manage a risk reserve across the 2 CCG's to deal with issues such as strategic investment / specific pressures that carry greater risk to one CCG than the other etc. This reserve would be controlled through agreement by the AO, CFO and 2 Chairs and would potentially		

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
					be up to 1% of resource allocation although this is yet to be confirmed. • It was agreed that the concept would be explored in greater detail in the February Board Development Sessions to ask the Board members how this reserve could be managed and what areas they thought it could cover. • It is planned to take a formal paper to the Board in March outlining options and a proposed recommendation.		
			• In the finance update and the QIPP update at the Board minutes neither items describe the governance or risks to delivery. • concerning that the CFO or a finance representative is not a formal requirement at this meeting (Quorate ??)		• F&R Committee minutes reflect progress and will receive the QIPP sub-group ToR in February. • Have extended quoracy to include CFO and Lay Member in attendance. Reference section 6 of ToR.	19 Mins F&R Jan 2013 18 ToR F&R 25 QIPP Group ToR	20 February 2013
4.2.3D	E	Provide evidence that the CCG has established appropriate systems for safeguarding	• Our only comment would be that as your policy was only endorsed by the quality committee and not fully approved, endorsed or signed off by your governing body you remain with this condition. • No clear governance or line of sight from subcommittee to governing body	II	The Governing Body approved the adoption of the Safeguarding Policy on 28 November 2012, please see 12/223A in the attached minutes. The CCG Safeguarding Assurance Framework demonstrates lines of accountability and governance arrangements. Further reference is made to the slides presented at the Site Visit on 31 October 2012, included herein, the Safeguarding Accountability and Governance Framework.	15 Board Mins Jan 2013 16 Safeg'g Framework 17 Auth Slides	Completed

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
			• In support of this are there any training plans, CRB checks, evidence that an escalation system is in place to keep the governing body aware of incidents and how do you feedback to your member practices and co commissioners?		An example of escalation of concern to the Governing Body can be seen in 12/202 in the aforementioned minutes.		

Southport and Formby
Clinical Commissioning Group

Board Meeting
March 2013

Agenda Item: 13/35 (a)	**Author of the Paper:** Clare Shelley Head of Financial Management and Planning NHS Southport and Formby Clinical Commissioning Group Clare.Shelley@sefton.nhs.uk

Title:

Finance Update

Summary of the Paper/Key Issues:

This paper presents the Governing Body with an overview of the Financial Performance for NHS Southport and Formby Clinical Commissioning Group. It details the performance against budget to date and risks in relation to the end of year financial position.

Action/Decision Required:

The Governing Body is requested to note the contents of this report.

Date of Report:

11 March 2013

13/35(a)

Southport and Formby
Clinical Commissioning Group

Report to Board

March 2013

1. Introduction and Background

This paper provides the Governing Body with an overview of the Financial Performance for NHS Southport & Formby Clinical Commissioning Group as at the end of February 2013.

This report will provide information regarding:

- The financial position at the end of month 11 including forecast outturn; and
- Financial Risks.

2. Healthcare Financial Position

2.1 Month 11 Financial Position

The financial position against the operational budget at the end of month 11 is £439k under spent prior to the application of reserves. This is a favourable movement of £175k when comparing to the month 10 financial position.

The 2012/13 indicative budgets delegated to Southport & Formby CCG equate to £159.7million.

The table below provides a summary of financial position as at the 28th February 2013 and forecast outturn prior to the application of further contingency reserves.

Detail	Annual Plan	Year to Date			Forecast Outturn
		Plan	Actual	Difference	
	£	£	£	£	£
Secondary Care Total	85,633,795	78,684,454	78,871,918	187,464	267,585
Block Contract Total	25,898,123	23,739,936	23,744,855	4,919	5,000
Prescribing Total	21,548,356	19,746,529	18,342,407	(1,404,122)	(1,354,600)
Other Healthcare Total	12,165,923	11,185,985	11,426,571	240,585	350,431
Risk Share Total	11,814,517	11,035,321	11,490,042	513,721	697,755
Miscellaneous Total	1,786,324	1,373,557	1,391,723	18,167	0
Sub Total	**158,847,038**	**145,765,782**	**145,326,516**	**(439,266)**	**(33,829)**
Reserves	862,197	(100,000)	(100,000)	0	(122,535)
Grand Total	**159,709,235**	**145,665,782**	**145,226,516**	**(439,266)**	**(156,364)**

Please note figures in brackets represent an under spent position. Positive figures represent an over spend.

A further breakdown is available in Appendix A.

2.2 Forecast Outturn

The forecast year end out turn position for Southport and Formby CCG prior to the application of CCG contingency reserves is £34k under spent. This represents a -0.02% under spend of the CCG annual budget. The projected financial position following the application of reserves is £156k under spent.

Additional costs have been built into the forecast for expenditure expected later in the financial year for Pharmacy high cost drugs, over performance on PbR contracts within the Independent Sector Treatment Centres and also Non Contracted Activity.

2.3 Financial Risk

The following risks have been identified as part of this financial year.

Restitution Claims

A provision has been placed into the accounts for the sum of £1.879m across Southport and Formby CCG and South Sefton CCG in relation to outstanding restitution claims. There is a risk if the number of successful claims are higher than anticipated. This will be monitored between now and the end of the financial year.

Ambulance Services

The contract continues to overspend due to an increase in ambulance calls. The forecast to date shows £141k over the budget for 2012-13. There is sufficient contingency to offset this pressure at this level of over spend. The activity continues to be monitored each month and forecast amended accordingly.

Pharmacy

The pharmacy over spend is a result of increased volume and drug costs and has continued throughout the year. There are sufficient funds within CCG contingency reserves however costs continue to be monitored each month. There is further risk if the overspend continues to rise above recent trends.

Independent Sector Treatment Centres

Activity levels have risen sharply during month 10 for Renacres & Spire Healthcare and were higher than anticipated. There is a risk if the activity continues at this level through to the end of the financial year. This however is being monitored by the finance team.

Continuing Healthcare & Free Nursing Care

The system is still in the process of being updated. The forecasted out turn position has been arrived by comparing historical spend across a number of years and has been reviewed with the CHC team.

Prescribing

The Prescribing Pricing Authority has now provided the year to date expenditure and year end forecasted figures based on month 9 actual data. This has been factored into the financial position and year end forecasts. There is an element of risk if the level of under spend estimated reduces.

This will be closely monitored each month as updated reports are submitted from the PPA. There are sufficient contingency reserves to manage the risks as described above. Each risk is reviewed every month and forecasted out turn positions amended to reflect the most up to date information.

There are sufficient contingency reserves to manage the risks as described above. The estimation risk reduces during the year as more actual information is received.

3. Recommendations

The Governing Body is asked to note the content of this report.

Appendices

Appendix A Summary of the Financial Position as at month 11.

Clare Shelley
Head of Financial Management and Planning
NHS Southport and Formby Clinical Commissioning Group
March 2013

Summary Financial Position as at Month 11 (February) 2012/2013

Consortium: North

NHS
Southport and Formby
Clinical Commissioning Group

Detail		Annual Plan	Year to Date			
			Plan	Actual	Difference	Year End Forecast
		£	£	£	£	£
Secondary Care	Wrightington, Wigan and Leigh NHS Foundation Trust	1,048,279	960,905	1,040,502	79,597	86,000
	Non Contract Activity	964,374	884,006	939,878	55,872	66,404
	Lancashire Teaching Hospitals NHS Foundation Trust	336,050	308,044	360,443	52,399	57,000
	University Hospital of South Manchester NHS Foundation Trust	71,883	65,890	91,415	25,525	28,000
	The Christie NHS Foundation Trust	27,790	25,494	45,723	20,229	22,000
	Warrington and Halton Hospitals NHS Foundation Trust	52,831	48,433	64,076	15,643	21,000
	Central Manchester University Hospitals NHS Foundation Trust	197,289	180,834	194,344	13,510	15,000
	Aintree University Hospitals NHS Foundation Trust	5,583,905	5,121,454	5,121,454	0	0
	Alder Hey Children's NHS Foundation Trust	2,364,859	2,167,798	2,167,798	0	0
	Liverpool H&C NHS FT North CCG	583,550	545,644	545,644	0	0
	Liverpool Women's NHS Foundation Trust	910,240	833,674	833,674	0	0
	Royal Liverpool and Broadgreen University Hospitals NHS Trust	4,085,599	3,745,131	3,745,131	0	0
	Southport and Ormskirk Hospital NHS Trust	63,471,975	58,343,921	58,343,921	0	0
	St Helens and Knowsley Hospitals NHS Trust	966,058	898,205	898,205	0	0
	Countess of Chester Hospital NHS Foundation Trust	46,724	42,833	39,892	(2,941)	(3,000)
	Wirral University Teaching Hospital NHS Foundation Trust	124,722	114,332	106,442	(7,890)	(10,000)
	Clatterbridge Centre for Oncology NHS Foundation Trust	4,797,668	4,397,856	4,333,376	(64,481)	(14,819)
Secondary Care		**85,633,795**	**78,684,454**	**78,871,918**	**187,464**	**267,585**
Block Contract	Cheshire and Wirral NHS FT	15,341	14,069	18,988	4,919	5,000
	Lancashire Care NHS FT	86,079	78,913	78,913	0	0
	Liverpool Community Health NHS Trust	9,583,768	8,785,112	8,785,112	0	0
	Merseycare NHS Trust	10,793,923	9,894,419	9,894,419	0	0
	Southport & Ormskirk Community Services	5,419,012	4,967,423	4,967,423	0	0
Block Contract Total		**25,898,123**	**23,739,936**	**23,744,855**	**4,919**	**5,000**
Prescribing	Prescribing	21,548,356	19,746,529	18,342,407	(1,404,122)	(1,354,600)
Prescribing Total		**21,548,356**	**19,746,529**	**18,342,407**	**(1,404,122)**	**(1,354,600)**
Other Healthcare	Independent Sector Treatment Centres	1,975,838	1,823,300	2,113,031	289,731	332,956
	North West Ambulance NHS Trust	4,104,832	3,762,758	3,890,393	127,635	140,875
	Anticoagulation	570,230	522,710	573,896	51,186	61,000
	PbR Reserve	992,921	891,993	891,993	0	0
	The Walton Centre NHS FT	208,260	207,202	207,202	0	0
	Patient Transport Services North West Ambulance NHS Trust	8,197	7,511	7,099	(412)	(495)
	Dermatology Assura	981,694	933,627	921,574	(12,053)	(10,042)
	Children's Services	387,958	355,629	305,629	(50,000)	0
	Glaucoma Tests	89,310	81,862	3,862	(78,000)	(85,000)
	Other Commissioned Healthcare	2,846,683	2,599,393	2,511,891	(87,502)	(88,863)
Other Healthcare Total		**12,165,923**	**11,185,985**	**11,426,571**	**240,585**	**350,431**
Risk Share	Pharmacy	669,470	613,678	1,216,595	602,917	607,016
	Oxygen	226,437	207,570	183,522	(24,048)	(24,048)
	Continuing Care	10,918,610	10,214,073	10,148,924	(65,148)	114,787
Risk Share Total		**11,814,517**	**11,035,321**	**11,549,042**	**513,721**	**697,755**
Miscellaneous	Clinical Commissioning Group	1,487,124	1,099,294	1,116,411	17,117	0
	Prior Year SLA's	0	0	1,050	1,050	0
	PCT Allocations	862,197	(100,000)	(100,000)	0	(122,535)
	Primary Care	299,200	274,263	274,263	0	0
Miscellaneous Total		**2,648,521**	**1,273,557**	**1,291,723**	**18,167**	**(122,535)**
Grand Total		**159,709,235**	**145,665,782**	**145,226,516**	**(439,266)**	**(156,364)**

Prepared by Chloe Rachelle
Management Accounts Assistant
NHS Southport and Formby Clinical Commissioning Group
20/03/2013

Southport and Formby
Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/35(b)	**Author of the Paper:** Brendan Prescott CCG Lead, Medicines Management Brendan.prescott@sefton.nhs.uk

Title:

Prescribing Update

Summary of the Paper/Key Issues:

This paper presents the Governing Body with an update on the prescribing budget position based upon month 9 (December 2012) prescribing data.

Action/Decision Required:

The Governing Body is asked to note the contents of this report.

Date of Report:

14 March 2013

13/35(b)

Southport and Formby
Clinical Commissioning Group

Report to Board

March 2013

1. Executive Summary

The South and Formby CCG position for month 9 (December 2012) was a forecast under spend of £1,251,945 or -6.1 %. This is £6,000 less than the forecast underspend at month 8.

2. Introduction and Background

This is a regular monthly update on the management of the Southport and Formby CCG prescribing budget.

As we enter the last quarter of the year 2012-13, the forecast is likely to become more reliable

3. Content

Work at practice level continues balancing practice requirements and the CCG commissioning intentions for medicines.

MMOG visits to all practices began in December and will continue into April to outline prescribing intentions.

Further work on the impact of one off patent expiry for 2012-13 has been carried out with an estimated saving of £283,786 in 2012-13.

4. Recommendations

The Governing Body is asked to note the contents of this report.

Appendices

Appendix 1 : Performance table of budget versus spend (month 9, December data)

Brendan Prescott
CCG Lead, Medicines Management
14 March 2013

Southport and Formby
Clinical Commissioning Group

Appendix 1

Prescriber Code	Prescriber Name	Total YTD Spend	Total Budget	Total FOT	Variance £	Variance (%)
N84005	CUMBERLAND HOUSE SURGERY	£939,055	£1,292,506	£1,238,696	-£53,810	-4.2
N84006	CHAPEL LANE SURGERY	£917,358	£1,249,392	£1,210,076	-£39,316	-3.1
N84008	NORWOOD SURGERY	£967,916	£1,435,654	£1,276,765	-£158,889	-11.1
N84012	AINSDALE MEDICAL CENTRE	£1,469,769	£2,062,473	£1,938,754	-£123,718	-6.0
N84013	CURZON ROAD MEDICAL PRACTICE	£399,685	£549,161	£527,219	-£21,942	-4.0
N84014	AINSDALE VILLAGE SURGERY	£426,641	£595,315	£562,777	-£32,538	-5.5
N84017	CHURCHTOWN MEDICAL CENTRE	£1,504,219	£2,057,160	£1,984,195	-£72,965	-3.5
N84018	THE VILLAGE SURGERY FORMBY	£1,190,196	£1,579,355	£1,569,972	-£9,383	-0.6
N84021	ST MARKS MEDICAL CENTRE	£1,827,738	£2,472,450	£2,410,946	-£61,504	-2.5
N84024	GRANGE SURGERY	£1,273,044	£1,920,685	£1,679,256	-£241,429	-12.6
N84032	SUSSEX ROAD SURGERY	£246,965	£337,470	£325,768	-£11,702	-3.5
N84036	FRESHFIELD SURGERY	£434,368	£565,504	£572,969	£7,465	1.3
N84037	LINCOLN HOUSE SURGERY	£312,420	£466,499	£412,109	-£54,390	-11.7
N84611	ROE LANE SURGERY	£315,339	£417,214	£415,959	-£1,255	-0.3
N84613	THE CORNER SURGERY (DR MULLA)	£427,587	£626,699	£564,025	-£62,674	-10.0
N84614	THE MARSHSIDE SURGERY (DR WAINWRIGHT)	£303,618	£404,606	£400,498	-£4,108	-1.0
N84617	KEW SURGERY	£374,963	£510,411	£494,609	-£15,802	-3.1
N84618	THE HOLLIES	£519,310	£688,954	£685,015	-£3,939	-0.6
N84625	THE FAMILY SURGERY	£322,858	£441,530	£425,877	-£15,653	-3.5
Y02610	TRINITY PRACTICE	£470,733	£895,332	£620,938	-£274,394	-30.6
Total		**£14,643,781**	**£20,568,369**	**£19,316,424**	**-£1,251,945**	**-6.1**

Southport and Formby
Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/35(c)	**Author of the Paper:** Malcolm Cunningham Head of Performance and Health Outcomes malcolm.cunnigham@sefton.nhs.uk
Title: Performance and Quality Report	
Summary of the Paper/Key Issues: This paper presents the Governing Body with an update in relation to Performance and Quality.	
Action/Decision Required: The Governing Body is asked to note the contents of this report.	
Date of Report: 14 March 2013	

13/35(c)

Contents

Introduction and Background

This performance report provides a monthly performance update for Southport and Formby CCG. Information is available for CCGs on a PCT footprint, provider and cluster level to enable analysis and action for recovery for areas of underperformance.

This report includes the following:

- Underperforming KPI Trends
- Operating Framework Performance Measures 2012/13 for PCTs and Provider trusts
- Performance Recovery Action Plans
- General and Acute Activity Monitoring table comparing 2010/11 with 2011/12 activity
- A&E Attendances and Emergency Admissions in acute trusts (year to date 2012 to 2013)

Performance Reporting at CCG level

There has been good progress in developing a Mersey wide view on contracts at CCG level and there has also been significant work done on a range of other intelligence work streams that will add value to CCGs performance monitoring via the new Merseyside Intelligence Portal.

A range of intelligence products are in development and will be made available via the Mersey Portal including:

- Monthly Budget Statements at CCG and GP Practice level (subject to local information governance agreements) - These reports give an overall monthly position across a range of budget lines for all practices (Pbr, Non Pbr, block contracts and prescribing etc.) and can be made available at patient level where the data allows.
- Monthly Contract Reconciliation Reports - To enable GP Practices to validate Secondary care data returns and raise challenges on specific hospital attendances and spells.
- Practice level Prescribing Indicator Reports and Budgets developed in partnership with the Mersey Medicine Management leads.
- High Impact User Report at CCG and Practice level showing patients who have had multiple contacts with Secondary care in the past twelve months.

- First draft Clinical Dashboards - These are initially based on existing Clinical Indicator sets defined by the 'old' PCTs with local practices and combine local indicators from all of the localities. Once these indicators are capable of being delivered at a Mersey footprint level, a 'pick list of indicators' and local dashboards can then be created to enable individual CCGs to focus on the indicators that relate to their own areas of local interest.

- First draft practice level Risk Stratification report providing risk scores on the possibility of readmission to hospital within 12 months. First draft will be based on secondary care data only with GP data and other data sources added over the coming months. GP data is being piloted in a small selection of practices in Liverpool and will be rolled out once the outcomes are validated and assessed.

Work undertaken to enable the technical links that allow users to log on to the portal from their desktops has taken longer than expected, however, these issues are being resolved and full rollout for all CCGs / GPs is now commencing. There are a range of additional products in development which are expected to be delivered. These include:

- CCG / Practice level reports on Merseycare and 5 Boroughs Mental Health activity and referrals
- First draft Community Activity data at CCG / Practice level from the initial flows of the Community Minimum data sets.
- Further development and localisation of all of the phase 1 reports
- Contract Quality Indicator / CQUIN Dashboard covering all Mersey hosted contracts
- Mersey QIPP Programme Monitoring Dashboard
- Practice Level Referral reporting
- Practice Level Waiting List Reporting

It is important to note that all of the initial reports being presented are open to further development in response to user engagement and requirements. It has been requested that the Merseyside CCG Network support the setting up of a 'Mersey Intelligence Development working group'. CCG Boards are requested to put forward volunteers from each CCG area who have an interest in developing intelligence to engage in the specification of new data collections and reports for CCGs.

Executive Summary on Performance Trends

KPI	Underperforming Trusts	Underperforming PCTs
MRSA Bacteraemia	Aintree ⇔	
C-Difficile Infections	Aintree ⇩	NHS Sefton ⇧
Referral to Treatment (RTT)	**% Admitted Within 18 Weeks** Southport & Ormskirk ⇩ **RTT Incomplete Pathways 18 Weeks** Southport & Ormskirk ⇩	**Numbers Waiting on an Incomplete Pathway** NHS Sefton ⇩ **% Admitted Within 18 Weeks** NHS Sefton ⇩
Cancer Waits	**All Cancer 2 Month Urgent Referral to Treatment** Southport & Ormskirk ⇧ **62 Day Cancer Screening** Aintree ⇧ **62 Day Consultant Upgrade** Southport & Ormskirk ⇧ **All Cancer 2 Week Wait** Southport & Ormskirk ⇔	**All Cancer 2 Month Urgent Referral to Treatment** NHS Sefton ⇧ **62 Day Consultant Upgrade** NHS Sefton ⇧
Mental Health		**Early Intervention in Psychosis** NHS Sefton ⇧
Proportion of GP Referrals using Choose & Book		NHS Sefton ⇧
A&E 4 Hour Wait	Aintree ⇩ Southport & Ormskirk ⇧	
Ambulance Cat A response within 19 minutes	NWAS ⇩	

Key

⇧ **Performance Improving**
⇩ **Performance Worsening**
⇔ **Performance Remaining the Same**

NHS Merseyside Performance Overview - January 2013 Report

PCT	Overall	RTT admitted 90% Oct 2012	62 Day Cancer Q2 2012/13	C Diff Nov 2012 YTD	A&E 4 Hour Wait QTD 30/12/12	Mixed Sex Accommodation Nov 2012	Ambulance Cat A Nov 2012	Health Checks Q2 2012/13	Health Visitors October 2012
Merseyside									
NHS Halton & St Helens									
NHS Knowsley									
Liverpool PCT									
NHS Sefton									

PLEASE NOTE: This performance overview was presented last month. There have been no updates since.

The 'North SHA Performance Overview' provides a performance summary at PCT commissioner level of eight key indicators which help to give a reflection of performance overall. The indicators have been chosen either because of their priority as set out in the NHS Operating Framework for England 2012/13 or because there are particular challenges in the North of England. They should not be viewed as an exclusive set of indicators and the detailed performance table included in this report highlights performance against a much larger range of indicators. The key indicators used are subject to change from time to time to reflect areas of continued focus.

DATA THRESHOLDS AND TIME PERIODS

Indicator	Data Period	Upper Threshold (Green)	Lower Threshold (Amber)
RTT Admitted Patients Seen within 18 weeks	October 2012	90%	
62 Day Cancer Waiting Times	Quarter 2 2012/13	85%	
C- Difficile Infections	Year to Date November 2012	0 Z-Score	1 Z-Score
Mixed Sex Accommodation	November 2012	0 Breaches	Breach rate <1 per 1000 FCEs
A&E 4 Hour Wait	Q3 to date at 30th December 2012	0 Main Provider Trusts breaching the 95% threshold	
Ambulance Cat A (8 Mins)	November 2012	75%	71%
Health Checks - Eligible patients offered an NHS Health Check	Q2 2012/13	Meets plan	80% of plan level
Health Visitors - number of WTE on ESR	October 2012	Meets PCT Cluster target	Within 2% of PCT Cluster target

NHS Merseyside Performance Overview - January 2013 Report

Provider	Overall	RTT admitted 90% Nov 2012	62 Day Cancer Q2 2012/13	C Diff YTD Nov 2012	A&E 4 Hour Wait Q3 YTD 30/12/12	Mixed Sex Accommodation Nov 2012	VTE Assessments Nov - 12	6 Week Diagnostic Wait Nov 2012
Aintree Hospital Trust								
Alder Hey Childrens Trust								
Liverpool Heart & Chest								
Liverpool Womens Trust								
Royal Liverpool & Broadgreen								
Southport & Ormskirk Hospitals								
St Helens & Knowsley Hospitals								
The Walton Centre								
Warrington & Halton Hospitals								

PLEASE NOTE: This performance overview was presented last month. There have been no updates since.

The 'North SHA Performance Overview' provides a performance summary at Provider level of seven key indicators which help to give a reflection of performance overall. As with the commissioner overview the indicators have been chosen either because of their priority as set out in the NHS Operating Framework for England 2012/13 or because there are particular challenges in the North of England. They should not be viewed as an exclusive set of indicators and the detailed performance table included in this report highlights performance against a much larger range of indicators.

DATA THRESHOLDS AND TIME PERIODS

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RTT Admitted Patients seen within 18 weeks	October 2012	90%	
62 Day Cancer Waiting Times	Quarter 2 2012/13	85%	
C- Difficile Infections	Year to Date November 2012	0 Z-Score	1 Z-Score
Mixed Sex Accommodation	November 2012	0 Breaches	Breach rate <1 per 1000 FCEs
A&E 4 Hour Wait	Q3 to date at 30th December 2012	95%	
Proportion of Adult Admissions Risk Assessed for VTE	November 2012	90%	85%
Diagnostic 6 Week Waiting Times	November 2012	99%	97%

CLUSTER CORPORATE PERFORMANCE DASHBOARD – COMMISSIONER LEVEL

Performance Indicators		Halton & St Helens	Knowsley	Liverpool	Sefton	Mersey Cluster
Headline Measures						
Quality (Safety, Effectiveness & Patient Experience)						
PHQ27: HCAI measure (MRSA) (Cumulative)	12/13 - January	12	3	11	5	31
PHQ28: HCAI measure (Cdif) (Cumulative)	12/13 - January	76	34	130	105	345
Resources (Finance, Capacity & Activity)						
PHS16: Numbers Waiting on an Incomplete Referral to Treatment Pathway	12/13 - December	16,299	8,576	22,029	14,497	61,401
Supporting Measures						
Quality (Safety, Effectiveness & Patient Experience)						
PHQ03: All Cancer Two Month Urgent Referral to Treatment Wait (Cumulative)	12/13 - December	88.38	86.76	88.84	84.21	87.19
PHQ03-05: Cancer 62 Day Waits (aggregate measure) (Cumulative)	12/13 - December	89.53	88.55	90.16	85.71	88.61
PHQ04: 62-Day Wait for First Treatment Following Referral from an NHS Cancer Screening Service (Cumulative)	12/13 - December	96.39	96.77	96.49	95.18	96.14
PHQ05: 62-Day Wait for First Treatment For Cancer Following a Consultants Decision to Upgrade The Patient's Priority (Cumulative)	12/13 - December	89.66	96.55	91.73	86.30	90.44
PHQ06: Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat') (Cumulative)	12/13 - December	99.33	99.19	97.82	97.83	98.39
PHQ07: 31-Day Standard for Subsequent Cancer Treatments-Surgery (Cumulative)	12/13 - December	99.42	100.00	99.69	97.67	99.07
PHQ08: 31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens (Cumulative)	12/13 - December	98.89	100.00	99.33	98.91	99.20
PHQ09: 31-Day Standard for Subsequent Cancer Treatments-Radiotherapy (Cumulative)	12/13 - December	95.97	94.61	96.03	98.07	96.35
PHQ10: Early Intervention in Psychosis (Cumulative)	12/13 Q3 Oct - Dec	46	27	90	32	195
PHQ11: Crisis Resolution Home Treatment (Cumulative)	12/13 Q3 Oct - Dec	341	269	1,389	675	2,674
PHQ16: Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	12/13 - December	21.96	17.30	13.14	17.41	16.97
PHQ19: RTT - % of admitted pathways within 18 weeks	12/13 - December	93.55	94.68	93.81	89.97	93.02
PHQ20: RTT - % of non-admitted pathways within 18 weeks	12/13 - December	98.15	97.60	97.98	97.51	97.87
PHQ22: % of patients waiting 6 weeks or more for a Diagnostic Test	12/13 - December	0.0	0.2	0.6	0.4	0.3
PHQ24: All Cancer Two Week Wait (Cumulative)	12/13 - December	95.21	95.09	95.51	94.20	95.02
PHQ24-25: Cancer 2 Week Waits (aggregate measure) (Cumulative)	12/13 - December	95.16	95.34	95.52	94.38	95.11

Performance Indicators		Halton & St Helens	Knowsley	Liverpool	Sefton	Mersey Cluster
PHQ25: Two Week Wait for Breast Symptoms (where cancer was not initially suspected) (Cumulative)	12/13 - December	94.88	97.07	95.63	95.93	95.68
PHQ31: % who have been offered an NHS Health check (Cumulative)	12/13 Q3 Oct - Dec	12.9	15.9	36.3	19.1	22.6
PHQ31: % who have received NHS Health check (Cumulative)	12/13 Q3 Oct - Dec	5.2	4.6	12.6	8.6	8.4
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	12/13 Q3 Oct - Dec	85.1	90.0	90.4	83.0	86.9
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	12/13 Q3 Oct - Dec	57.1	100.0	98.7	80.0	89.8
SQU12 - % women who have seen a midwife by 12 weeks & 6 days of pregnancy	12/13 Q3 Oct - Dec	94.8	105.4	86.7	92.2	92.3
SQU19_05 - % Prevalence of breastfeeding at 6-8 wks after birth	12/13 Q3 Oct - Dec	22.40	16.20	27.30	26.60	24.85
SQU19_06 - % Coverage of breastfeeding at 6-8 wks after birth	12/13 Q3 Oct - Dec	99.80	95.80	95.80	99.10	97.50
SQU22 - Results of cervical screening test within 2 weeks	12/13 - January	99.23	98.18	98.45	98.17	98.57
SQU23 - % Diabetic Retinal Screening	12/13 Q3 Oct - Dec	97.89	98.62	104.17	N/A	N/A
Reform (Commissioner, Provider & building capability and						
PHF07: Bookings to services where named consultant led team was available (even if not selected) (Cumulative)	12/13 - December	91.36	91.38	84.94	90.68	88.15
PHF08: Proportion of GP referrals to first outpatient appointments booked using Choose and Book (Cumulative)	12/13 - December	52.36	36.55	63.79	36.92	50.67

Achieving Plan
Variance from Plan
Significant variation from plan

PROVIDER CORPORATE PERFORMANCE DASHBOARD

Performance Indicators		Aintree University Hospitals NHS Foundation Trust	Alder Hey Children's NHS Foundation Trust	Liverpool Heart & Chest NHS Foundation Trust	Liverpool Womens NHS Foundation Trust	Royal Liverpool & Broadgreen University Hospitals NHS Trust	Southport & Ormskirk Hospital NHS Trust	St Helens & Knowsley Teaching NHS Trust	The Walton Centre NHS Foundation Trust	Warrington & Halton Hospitals NHS Foundation Trust
Headline Measures										
Quality (Safety, Effectiveness & Patient Experience)										
PHQ27: HCAI measure (MRSA) (Cumulative)	12/13 - Jan	5	0	0	0	2	0	8	0	1
PHQ28: HCAI measure (Cdif) (Cumulative)	12/13 - Jan	64	0	8	0	48	16	30	7	15
Supporting Measures										
Quality (Safety, Effectiveness & Patient Experience)										
PHQ03: All Cancer Two Month Urgent Referral to Treatment Wait (Cumulative)	12/13 - Dec	87.41		79.06	87.66	92.72	85.36	91.70		91.19
PHQ03-05: Cancer 62 Day Waits (aggregate measure) (Cumulative)	12/13 - Dec	89.00		78.29	89.22	95.93	85.41	92.45		92.00
PHQ04: 62-Day Wait for First Treatment Following Referral from an NHS Cancer Screening Service (Cumulative)	12/13 - Dec	85.25			92.31	99.01	100.00	100.00		98.17
PHQ05: 62-Day Wait for First Treatment For Cancer Following a Consultants Decision to Upgrade The Patient's Priority (Cumulative)	12/13 - Dec	93.22		70.37	95.56	98.84	75.00	77.78		86.96
PHQ06: Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat') (Cumulative)	12/13 - Dec	97.80	100.00	98.24	97.17	98.95	98.89	99.68	100.00	100.00
PHQ07: 31-Day Standard for Subsequent Cancer Treatments-Surgery (Cumulative)	12/13 - Dec	98.61	100.00	100.00	98.70	99.25	96.35	99.73	100.00	100.00
PHQ08: 31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens (Cumulative)	12/13 - Dec	100.00	100.00			98.94	100.00	100.00	100.00	100.00
PHQ09: 31-Day Standard for Subsequent Cancer Treatments-Radiotherapy (Cumulative)	12/13 - Dec	94.44				100.00	100.00	100.00		
PHQ19: RTT - % of admitted pathways within 18 weeks	12/13 - Dec	90.92	80.94	87.00	95.83	94.38	85.56	96.47	94.12	93.75
PHQ20: RTT - % of non-admitted pathways within 18 weeks	12/13 - Dec	97.54	96.22	97.60	95.51	98.52	96.69	98.34	98.20	98.50
PHQ21: RTT - % of incomplete pathways within 18 weeks	12/13 - Dec	96.62	93.88	93.93	92.78	95.22	91.92	97.58	98.12	91.71
PHQ22: % of patients waiting 6 weeks or more for a Diagnostic Test	12/13 - Dec	0.54	0.00	0.00	0.52	0.00	0.39	0.00	0.00	0.00
PHQ24: All Cancer Two Week Wait (Cumulative)	12/13 - Dec	96.42		99.56	97.48	94.57	92.96	94.66	100.00	95.74
PHQ24-25: Cancer 2 Week Waits (aggregate measure) (Cumulative)	12/13 - Dec	96.32		99.56	97.48	94.79	93.39	94.92	100.00	95.32
PHQ25: Two Week Wait for Breast Symptoms (where cancer was not initially suspected) (Cumulative)	12/13 - Dec	95.52				95.86	96.49	96.39		93.67
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	12/13 Q3 Oct-Dec	80.9				92.93	85.86	87.41		80.70
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	12/13 Q3 Oct-Dec	100.0				98.46	75.86	91.67		21.05
Resources (Finance, Capacity & Activity)										
A&E % Patients waiting <4 Hours	Q4 YTD 10th Feb	93.7%	96.8%		99.9%	94.6%	93.2%	93.0%		94.7%

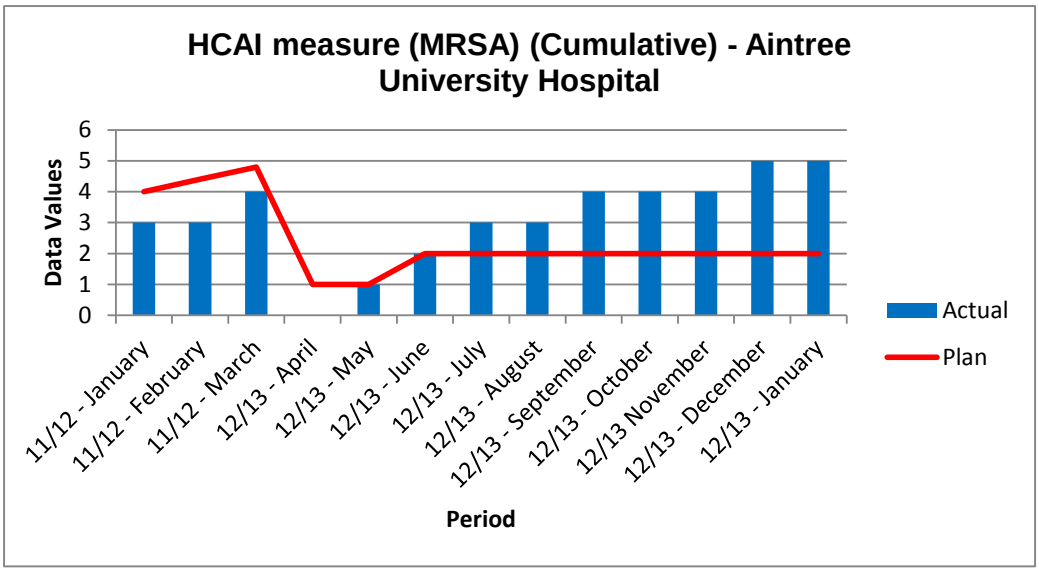
North West Ambulance Service	2012/13	April	May	June	July	August	Sept	October	November	December
Cat A response within 8 mins % R1	75%	77.1%	76.1%	75.7%	76.9%	75.2%	75.1%	73.6%	72.0%	70.8%
Cat A response within 8 mins % R2	75%			79.4%	79.8%	78.7%	76.6%	76.8%	76.1%	72.9%
Cat A response within 19 mins	95%	94.8%	94.2%	95.6%	95.9%	95.8%	94.6%	94.6%	95.1%	94.2%

Achieving Plan
Not Applicable
Variance from Plan
Not Available
Significant variation from plan

Performance Recovery Action Plans

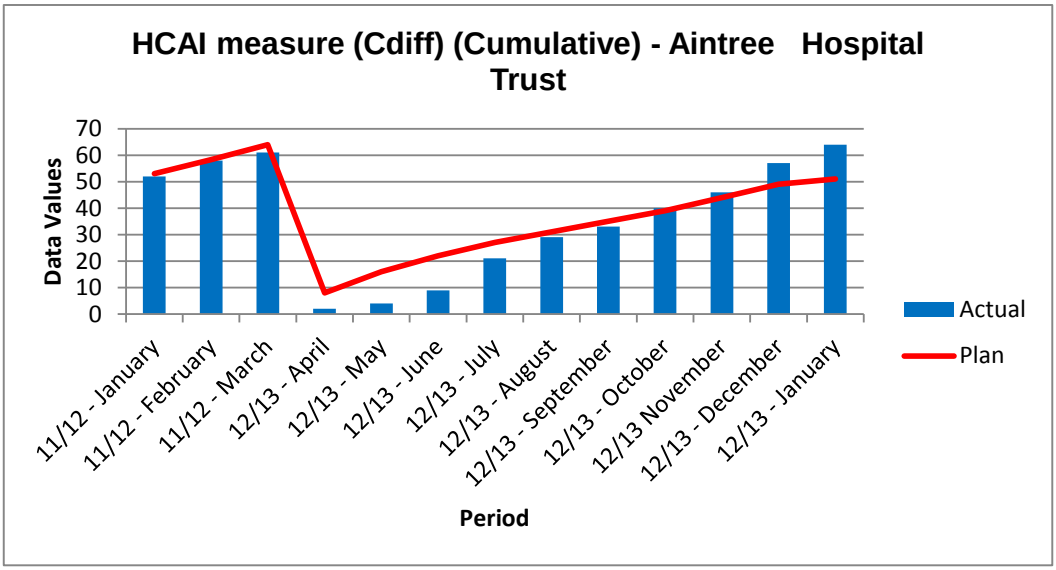
1. MRSA

In Aintree Hospital Trust, there were five cases of MRSA cumulatively at January 2013 against the tolerance of two cases. Each case has been thoroughly investigated. The issues have been discussed at contract meetings and quality meetings. A Health Care Acquired Infection Group (HCAI) has been set up and is chaired by the Trust Chief Executive with CCG quality leads as members. Action plans are continually reviewed and updated to minimise the risk of more cases.



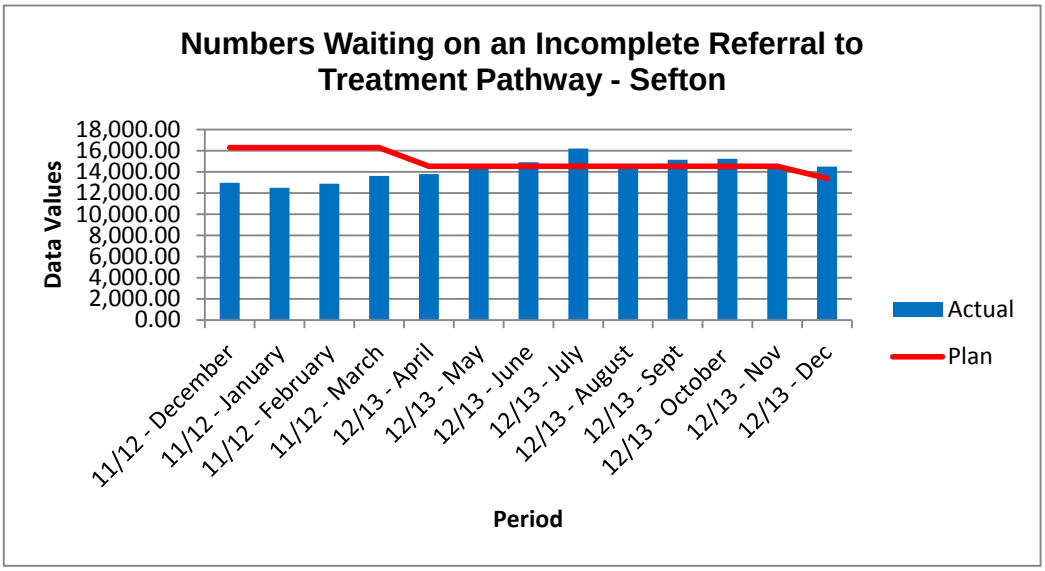
2. Cdifficile Infections

In Aintree Hospital Trust, there were 64 cases of Cdifficile cumulatively at January 2013 against the tolerance of 51 cases. Each case has been thoroughly investigated. The issues have been discussed at contract meetings and quality meetings. Action plans are continually reviewed and updated to minimise the risk of more cases.



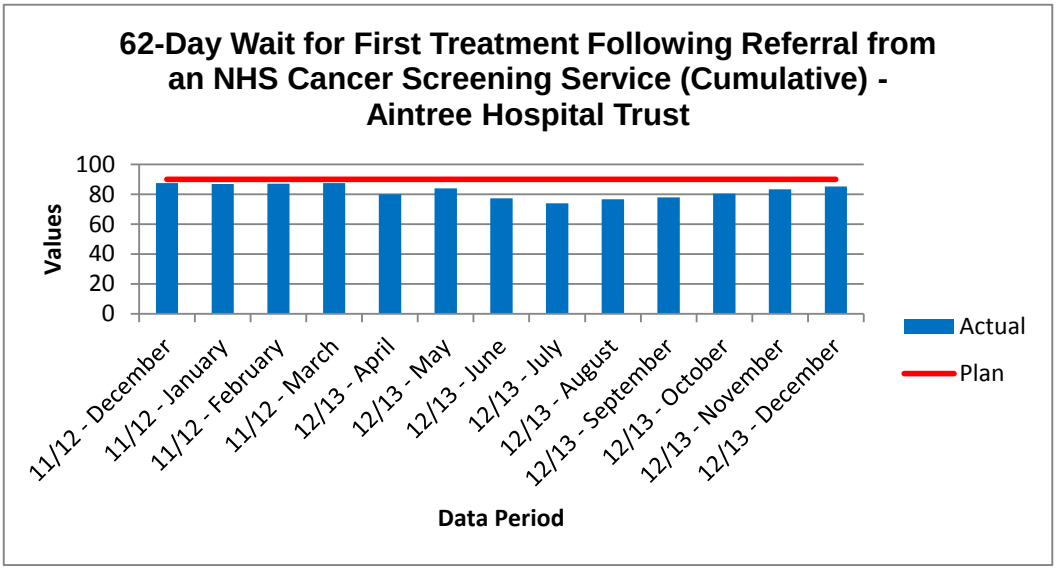
3. Number waiting on an incomplete RTT pathway

The numbers on the incomplete pathway should be used in conjunction with the delivery of the RTT for incomplete to assess if the system is working appropriately. Unfortunately whilst still delivering the incomplete target (92% with 18 weeks) a number of trusts are seeing a rise in the number of patients on an incomplete pathway – this in itself does not indicate a problem but contract and performance managers will need to work with providers to examine the numbers of long waiters and to ensure that trusts are not developing waiting list problems.

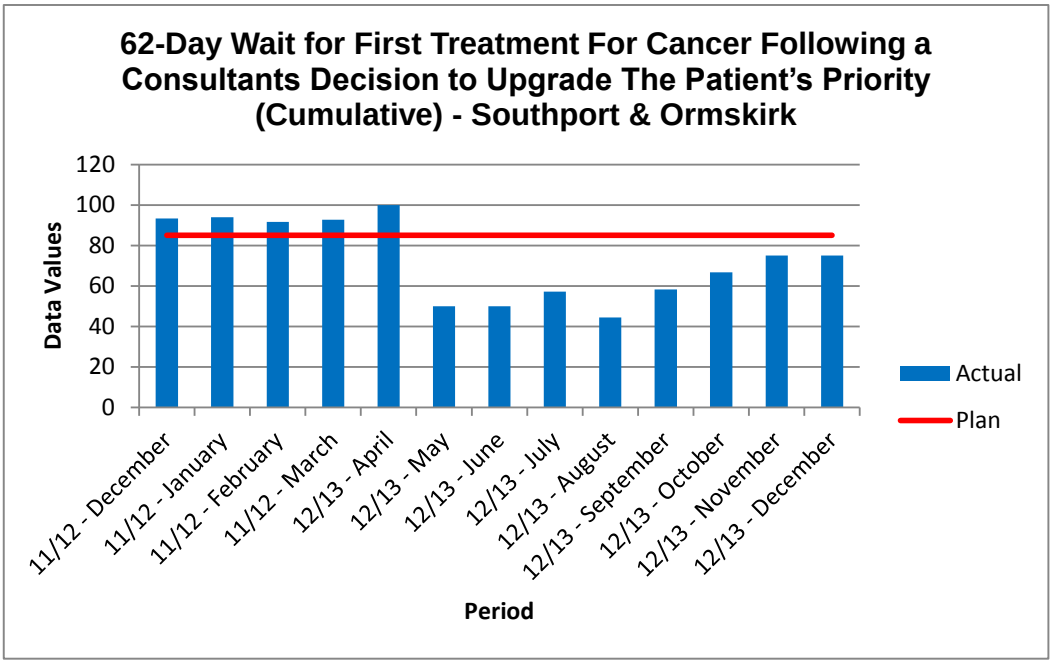


4. Cancer Waits

At Aintree Hospital Trust the 62 day wait for first treatment following referral from an NHS Cancer Screening Service at December 2013 was 85.25% against the 90% target. This continues to be a challenge due to the very small numbers treated each month with the majority of delays being due to patient choice and clinically complex pathways. The Trust cancer management team continue to work with Intensive Support Team in order to progress in all aspects of pathway management. The Trust is focusing on achieving the target for Q4.



For the 62 days wait for first treatment for cancer following a consultant's decision to upgrade the patient's priority in December 2012, Southport and Ormskirk Hospitals Trust are reporting 75% year to date against the 85% target. This is an underperformance of 10%. This year to date underperformance is carried forward from previous months; there were no patient breaches for consultant upgrade during the month of December.



5. Referral to Treatment (RTT) - % of admitted pathways within 18 weeks

At December Southport and Ormskirk Hospitals Trust were showing 85.56% against the 90% target. The backlog of patients waiting over 18 weeks has not made it possible to carry out additional activity to clear the longer waiters and still meet RTT targets. Lower performance trajectories have been agreed with the SHA and commissioners between December and February. The Trust is on plan to have no patients waiting over 52 weeks by April 2013. With regards to the percentage of incomplete pathways within 18 weeks, the Trust achieved 91.92% against the target of 92%, just slightly below.

6. A&E <4 Hour Wait

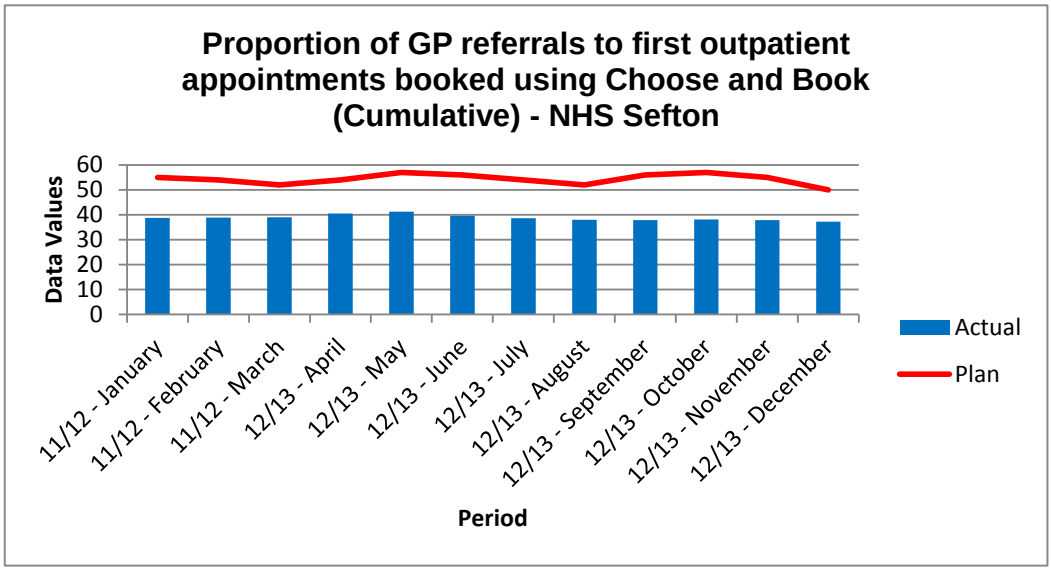
For A&E <4 hour wait at Aintree Hospital Trust, for the above reporting period stood at 93.7% against the 95% target. Aintree face many challenges as with other trusts. It is the high numbers of frail elderly and complex patients attending who require admission and require a longer stay which affects available beds for new patients. All escalation beds have been opened and where necessary some elective work has been cancelled to provider non elective beds. The Division of Medicine is working with local CCGs to review opportunities for improving non elective pathways. The Trust is focusing on achieving the target for Q4.

For the above indicator, Southport and Ormskirk Hospitals Trust achieved 93% against the 95% target. The significant increase in both the non-elective admissions and ambulance attendances alongside the acuity increase seen across the region has led to reduced performance. An A&E Performance

Action Plan is in place to tackle issues and implement alternative pathways. Internal daily stretch targets have been established to set out expectations for delivery in February and March to provide assurance for Q4 compliance.

7. Choose and Book

After a December position of 36.92%, Choose and Book performance at Sefton increased considerably and averaged 40% in January 2013 but performance has slightly dipped to an average of 39% throughout February 2013 to date. The national NHS average is currently 53%. Work is on-going to increase the use of Integrated Choose & Book.



8. Ambulance Response

The number of incidents in December was more than modelled, adversely impacting upon the in-month and cumulative positions. High levels of red call demand have continued, with an overall cumulative increase over plan of 10.2% in December. Of particular interest is the variable increase in demand seen across the region, with Merseyside however showing the lowest increases and hence the adverse impact upon performance.

During December the average daily 'tipping point' in call volume of 980 was exceeded every day by a significant average increase of 198 incidents each day, illustrating the high call volumes experienced. Hospital turnaround delays remain a significant cause for concern and have a significant adverse impact upon daily emergency capacity availability. Locally Southport & Ormskirk Hospitals Trust showed some of the longest turnaround times in excess of an average overall arrival to clear time for all attendances of 39 minutes. In addition their compliance in using the HAS screen system to 'stop the clock' remains very poor.

Efforts continue across Merseyside to reduce the reliance upon the emergency ambulance service and where possible provide patients with an alternative to hospital attendance. However the growth in red calls for those with the most immediate life threatening or serious needs inevitably means that the impact of these and other initiatives is reduced.

CCGs continue to be provided with access to the new comprehensive turnaround performance reports and are encouraged to use this more 'granular' information to then seek to intervene locally with Trusts where performance gives rise to concern. A Merseyside workshop with providers and NWAS was held on the 1st February to further develop understanding and stimulate local action to resolve difficulties and practical bottlenecks and improve turnaround performance. Unfortunately not all Trusts were in attendance and local follow up action on a 1:1 basis is planned.

NWAS overall trajectories are in place to deliver the red (Cat A) 8 and 19 minute targets by year end, despite the slight reductions in performance during December. Delivery of the red 1 80% target for 2012/13 only remains a significant challenge, with the majority of ambulance services nationally experiencing significant difficulties. The NWAS cumulative position for red 1 calls at the end of December has fallen slightly to 74.8%.

December	**North West (%)**	**Merseyside (%)**
Red (Cat A) 8 mins 75% target	72.72%	77% (Mersey)
Red 1 (Cat A) 8 mins 80% target, end March 2013 (revised to 75% for 2013/14)	70.84%	72.42% (Cheshire & Mersey)
Red 2 (Cat A) 8 mins 75% target	72.91%	73.91% (Cheshire & Mersey)
Red (Cat A) 19 mins 95% target	94.1%	94.9% (Cheshire & Mersey)

NHS Merseyside - Actual activity compared to planned activity - Cumulative to January 2012 & January 2013 for General & Acute Specialties

PHS07	GP G&A Referrals for First Outpatient Appointment									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	61091	53643	-7448	-12%	54511	57337	2826	**5.2%**	3694	7%
Knowsley	38726	38605	-121	0%	39837	40920	1083	**2.7%**	2315	6%
Liverpool	98173	97835	-338	0%	100535	97871	-2664	**-2.6%**	36	0%
Sefton	55255	56979	1724	3%	56460	57699	1239	**2.2%**	720	1%

PHS08	Other Referrals for First G&A Outpatient Appointment									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	24491	30577	6086	25%	30514	32823	2309	**7.6%**	2246	7%
Knowsley	21204	20864	-340	-2%	20394	21378	984	**4.8%**	514	2%
Liverpool	83434	83631	197	0%	85485	77825	-7660	**-9.0%**	-5806	-7%
Sefton	34386	34718	332	1%	35056	35013	-43	**-0.1%**	295	1%

	All referrals for first G&A outpatient appointment									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	85582	84220	-1362	-2%	85025	90160	5135	**6.0%**	5940	7%
Knowsley	59930	59469	-461	-1%	60231	62298	2067	**3.4%**	2829	5%
Liverpool	181607	181466	-141	0%	186020	175696	-10324	**-5.5%**	-5770	-3%
Sefton	89641	91697	2056	2%	91516	92712	1196	**1.3%**	1015	1%

PHS10	All first G&A outpatient attendances									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	77626	78611	985	1%	78177	81167	2990	**3.8%**	2556	3%
Knowsley	55135	51263	-3872	-7%	51409	53747	2338	**4.5%**	2484	5%
Liverpool	169257	168154	-1103	-1%	170499	165054	-5445	**-3.2%**	-3100	-2%
Sefton	82254	79984	-2270	-3%	80146	82402	2256	**2.8%**	2418	3%

	Elective Ordinary G&A Admissions									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	7446	8534	1088	15%	8338	8723	385	**4.6%**	189	2%
Knowsley	4649	4333	-316	-7%	4252	4196	-56	**-1.3%**	-137	-3%
Liverpool	10952	11576	624	6%	11768	11153	-615	**-5.2%**	-423	-4%
Sefton	7452	7445	-7	0%	7361	7313	-48	**-0.7%**	-132	-2%

	Elective Daycase G&A Admissions									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	26132	28676	2544	10%	27755	31689	3934	**14.2%**	3013	11%
Knowsley	15918	15907	-11	0%	15551	17163	1612	**10.4%**	1256	8%
Liverpool	40609	43435	2826	7%	43232	46058	2826	**6.5%**	2623	6%
Sefton	29480	30883	1403	5%	30099	31944	1845	**6.1%**	1061	3%

	All Elective G&A Admissions									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	33578	37210	3632	11%	36093	40412	4319	**12.0%**	3202	9%
Knowsley	20567	20240	-327	-2%	19803	21359	1556	**7.9%**	1119	6%
Liverpool	51561	55011	3450	7%	55000	57211	2211	**4.0%**	2200	4%
Sefton	36932	38328	1396	4%	37460	39257	1797	**4.8%**	929	2%

	Non-Elective G&A Admissions									
PHS06	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	34042	34880	838	2%	34,537	36,103	1566	**4.5%**	1223	4%
Knowsley	19595	18229	-1366	-7%	18,463	18,937	474	**2.6%**	708	4%
Liverpool	48307	47900	-407	-1%	47,221	46,945	-276	**-0.6%**	-955	-2%
Sefton	28332	27955	-377	-1%	28,076	29,446	1370	**4.9%**	1491	5%

Data Sources

Plans - Vital Signs/IPM Submissions

Actuals - Monthly Activity Return

General & Acute - All specialties excluding well babies, obstetrics & psychiatry

General and Acute Activity Monitoring

These figures refer to the period April to January 2012

The period April to January contains no more working days in 2012/13 than it did in 2011/12.

GP G&A Written Referrals for a first outpatient appointment.

Overall, Merseyside saw a noticeable increase in referrals between September and November. This trend has continued into January, and has resulted in an increase in GP referrals between 2011/12 and 2012/13 of 2.7% (6,765 GP referrals); while in previous months there had been fewer than last year. This increase has also seen an over-performance against plan for 2012/13. Referrals for 2012/13 have increased in the past two months at 1% above plan (2,484 referrals), compared to around 2% below plan in previous months. This may warrant further investigation if it continues.

Sefton has seen an increase in year-to-date referrals in November, the organisation was below the 2012/13 plan in October. NHS Sefton are 2.2% (1,239 referrals) over plan, which shows an increase in over performance compared to November.

Other referrals for a first outpatient appointment

Other referrals are down on last year (1.6%, 2,751 referrals) across Merseyside. This figure has dropped steadily over the summer from the 0.79% increase shown at June, and a significant improvement from the May position which was 9% over the previous year's figures. The under-performance has shown a particular growth between October and November.

The Month 10 figures also show Merseyside is 2.6% under planned levels for 'Other' Referrals in the year to January.

It is worth noting that the increase seen in GP Referrals has not been reflected in Other Referrals which remain below plan.

When viewed in the context of total referrals ('GP' and 'Other' Referrals together) this equates to an overall increase of 1% (4,014 referrals) since last year, while referrals are below plan for 2012/13 by 0.5% (1,926 referrals). It is worth noting that this is the second month at which total referrals have fallen below last year's levels, and appears to be the result of falling referral levels during the year.

Sefton have previously shown a year-on-year increase in 'Other Referrals' (peaking at 13% in May), but have now fallen to 0.1% below plan after reducing consistently in previous months.

All first G&A outpatient attendances (G&A) Cumulative

In January, Merseyside shows a 1.2% (4,358) increase in attendances compared with same period in the previous year. There is also a 0.6% (2,139) over performance compared to plan.

The key drivers behind the over performance in these areas are:

- The additional COPD activity recorded for Liverpool Heart & Chest Hospital
- Additional activity associated with National Screening programmes
- Additional activity to support the achievement of 18 weeks in all Specialties

Elective Ordinary G&A Admissions

Elective ordinary G&A admissions for Merseyside are 1.1% (334 spells) under plan for the year and 1.6% down on the previous year. These are not a cause for concern, although have moved closer to plan since last month.

Elective Day Case Admissions

Elective Day Case Admissions for Merseyside are however, significantly over planned levels for 2012/13 by 8.8% (10,217 Day Cases) and 6.7% (7,953 Day Cases) on the same period of the previous year. Both comparisons are up noticeably on the reported positions from last month, although this represents a return to the trend seen in previous months, and the comparison with 11/12 continues its downward trajectory from April.

When combining day case and ordinary elective admissions, all PCTs show an over-performance against plan and all have shown an increase of between 1-2% since last month. Again, this is a return to the levels of performance seen in the August report.

In all cases there is evidence of an increase in the day case rate greater than that which was planned for.

The key drivers behind the over performance are:

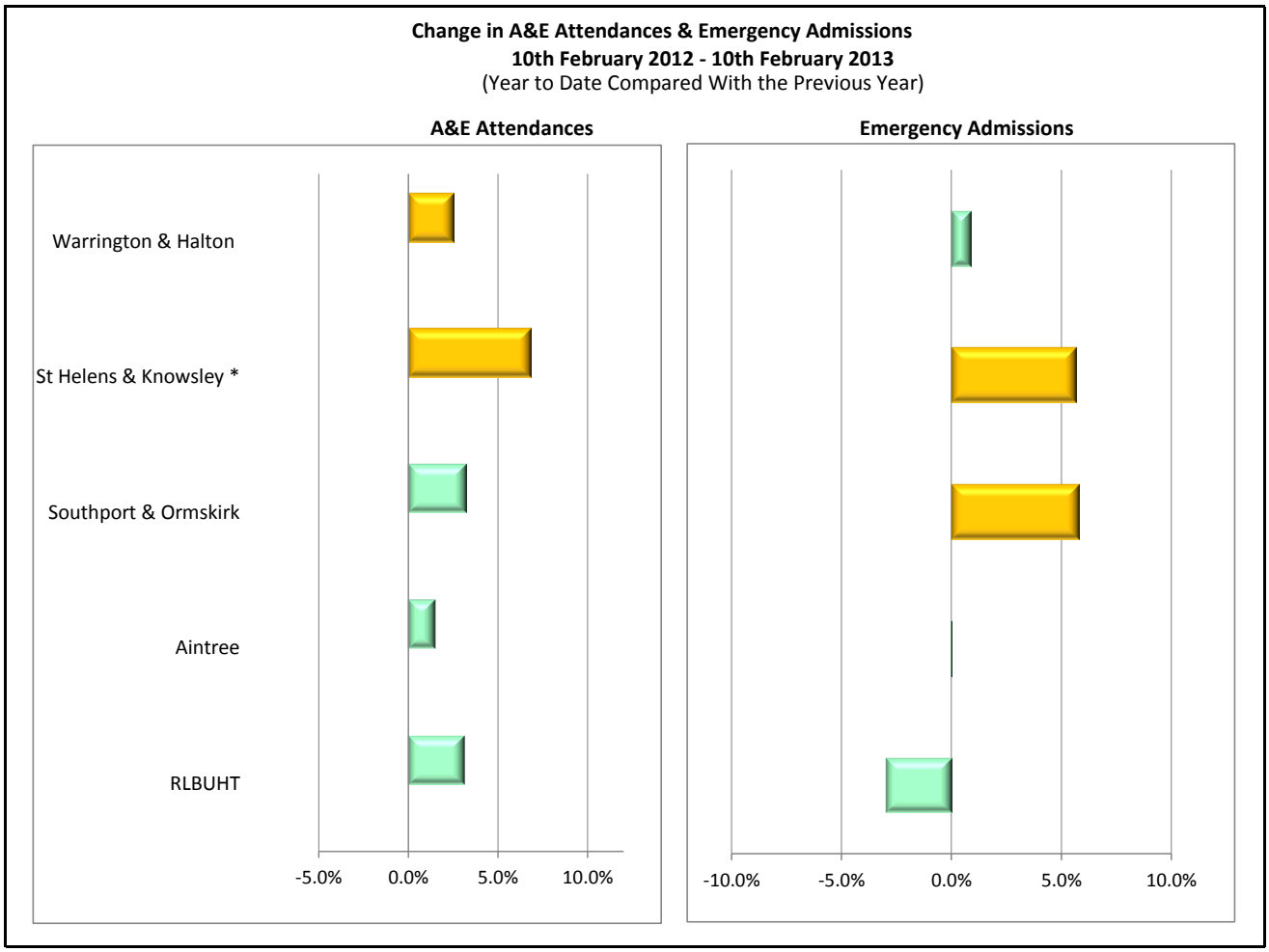
- Additional activity associated with National Screening programmes
- Additional activity to support the achievement of 18 weeks in all Specialties
- Appropriate shifts from Elective Admissions to Day Case procedures for specific surgical procedures. This is reflected in increasing Day Case rates for the BADs Basket of Procedures which is a positive improvement in service delivery.

Activity is levelling out as expected as the year progresses.

Non-Elective G&A Admissions

Merseyside is currently 1.7% over plan for the year to January and 1.3% over the activity levels for Non-Electives in the same period last year. Both comparisons show an increase compared to last month, and reflect a consistent trend this year.

This is being driven primarily by an increase in Non-Elective activity in the Sefton and Halton & St Helens localities. In Sefton, this relates primarily to activity at Southport & Ormskirk Hospital Trust where there is a 5.8% increase in spells, there was a particularly high number of spells in May. Work is on-going with the Trust to understand the Non-Elective/Urgent Care pressures currently being experienced, and the scale of the over-performance is diminishing.



	A&E Attendances						Emergency admissions (A&E and other)					
	Latest week	1 year previously	% change	YTD 2012/13	YTD 2011/12	% change	Latest week	1 year previously	% change	YTD 2012/13	YTD 2011/12	% change
RLBUHT	2092	1894	10.5%	89953	87269	3.1%	766	753	1.7%	32765	33779	-3.0%
Aintree	1686	1597	5.6%	73620	72552	1.5%	559	618	-9.5%	27409	27420	0.0%
Southport & Ormskirk	1859	1860	-0.1%	84699	82080	3.2%	586	549	6.7%	24615	23268	5.8%
St Helens & Knowsley *	1866	1721	8.4%	82768	77487	6.8%	865	838	3.2%	38725	36656	5.6%
Warrington & Halton	2021	1834	10.2%	87863	85702	2.5%	686	685	-0.1%	30904	30643	0.9%

Source: NHS Northwest

* Includes 'type' 3 attendances and is not directly comparable with the previous year

A&E Attendances & Emergency Admissions

This activity covers the period 1st April to 10th February:

All providers have had more A&E attendances in 2012/13 than they had in 2011/12 (to date).

Aintree, Royal Liverpool and Warrington have each seen a slight increase on 2011/12 (between 1.5% and 3.1%).

Southport & Ormskirk are 3.2% over last year; which represents a decrease compared to last month. Emergency admissions have grown over the same period.

St Helens & Knowsley however have had 5,281 (6.8%) more A&E attendances this year, this increase has fed a similar increase in emergency admissions (5.6%). The situations with both A&E attendances and emergency admissions have worsened in the past three months.

Southport and Formby
Clinical Commissioning Group

BOARD MEETING
March 2012

Agenda Item: 13/37	**Author of the Paper:** Martin McDowell Chief Finance Officer Martin.mcdowell@sefton.nhs.uk

Title:

2013/14 Financial Outlook Report

Summary of the Paper/Key Issues:

This paper presents the Governing Body with the CCG's opening financial position for 2013/14 to the Governing Body and advises upon risks still inherent in the baseline exercise and contract agreement process.

Action/Decision Required:

The Governing Body is asked to note/approve:

- Approve the opening revenue budget for the financial year 2013/14.
- Note that the opening budgets deliver the key metrics required by the NHS Commissioning Board in terms of 1% surplus.
- Note that this is reliant upon the delivery of £1.4m worth of QIPP schemes that are currently not identified.
- To review and comment upon the range of options provided to address the shortfall in QIPP savings described above.
- Note that the CCG has provided a 1% Contingency reserve which is in excess of the NHS Commissioning Board recommendation of 0.5%.
- Note that the CCG planned expenditure is within its running cost target.
- Note that the CCG has identified transformational schemes using 2% of non-recurrent expenditure.
- Approve the proposal to introduce a Sefton-wide "risk-share" agreement which allows up to 2% of baseline expenditure across the CCG's.

Date of Report:

19 March 2013

Southport and Formby
Clinical Commissioning Group

Report to Board

March 2013

1. Background

1.1 This paper provides details of the CCG's opening budgets for adoption in 2013/14, although this is subject to clarification of key issues.

1.2 The changes made to the structure of the NHS, which come into operation from 2013/14 are wide-ranging with a number of new bodies taking over the former responsibilities of Primary Care Trusts. This has led to increased complexity in terms of setting budgets for the new bodies. Some responsibilities have transferred across the new bodies since the exercise to identify baseline spending was undertaken in September 2012. A specific risk within the Sefton Health Economy was the creation of two separate CCG's and the requirement to split baseline expenditure across the new organisations using estimates in key areas (e.g. mental health, community contracts etc.). There are a number of other issues that remain unresolved and this paper will outline these risks.

1.3 A summary of the Financial Strategy using intelligence collected from a range of sources in relation to projected uplifts and reductions to expenditure plans is presented below:

Table 1: Financial Strategy Summary	**2013/14 £m**		
	Rec	**Non-R**	**Total**
Base Allocation	150.6	0.0	150.6
DH Growth Allocation	3.4	0.0	3.4
Running Cost Allowance	3.0	0.0	3.0
Lodgement B/F	0.0	0.8	0.8
Surplus B/F	0.0	0.8	0.8
Available Resources	**157.0**	**1.6**	**158.6**
Commissioning Budgets			
NHS Contracts	108.3	0.8	109.1
NCA's	1.2	0.0	1.2
Independent Sector	2.4	0.0	2.4
Other Secondary Care	2.1	0.0	2.1
CHC/FNC/Complex Care	12.6	0.0	12.6
Primary Care	1.6	0.0	1.6
Prescribing	21.6	0.0	21.6
Sub-Total	**149.8**	**0.8**	**150.6**
Reserves & Pressures			
Pay & Prices Cost Pressures	8.3	0.0	8.3
Other Cost Pressures	0.9	0.0	0.9

Southport and Formby
Clinical Commissioning Group

Table 1: Financial Strategy Summary	2013/14 £m Rec	Non-R	Total
Corporate Running Costs	2.8	0.0	2.8
Other Corporate costs	0.7	0.0	0.7
2% Non-Recurrent Reserve	0.0	3.1	3.1
Contingency Reserve	1.5	0.0	1.5
Other Reserves	0.3	0.8	1.1
Investment Plans	1.1	0.8	1.9
Lodgement C/Fwd	0.0	0.5	0.5
Anticipated Baseline Adjustments	(7.9)	0.3	(7.6)
Less Efficiency Target	(5.2)	(1.6)	(6.8)
Sub-Total	**2.5**	**3.9**	**6.4**
Anticipated Spend	**152.3**	**4.7**	**157.0**
Forecast Surplus / (Deficit)	**4.7**	**(3.1)**	**1.6**
Expressed as %	**3.0%**		**1.0%**

1.4. Detailed budgets showing expenditure information at cost centre level will be reported to the Governing Body in its May meeting.

2. National Context

2.1 The Department of Health (DH) issued its planning guidance for CCG's under the cover of *Everybody Counts : Planning for Patients 2013/14.* This publication sets out the DH's expectations for health service priorities for the forthcoming year. In the document, the DH outlines five specific offers to the public, notably,

- NHS Services – 7 Days a Week
- More Transparency, More Choice
- Listening to Patients and increasing their participation
- Better data, informed commissioning, driving health outcomes
- Higher Standards, safer care.

2.2 In addition to these offers, the DH also set out five domains aimed at improving services through the NHS Outcomes Framework:

- Preventing people from dying prematurely
- Enhancing the quality of life for people with Long-term conditions
- Helping people to recover from episodes of ill-health or injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

2.3 In setting out the Outcomes Framework and offers, the DH have been less prescriptive than previous years when key programme areas were identified and commissioners were advised to provide for a fixed level of investment within their financial plans. The CCG commissioning plan will incorporate all these areas although some of the financial consequences have yet to be determined (e.g. HFMA have been commissioned by Sir Bruce Keogh to undertake a costing exercise to quantify the costs associated with providing NHS Services for 7 days a week). This report is expected to be published towards the end of this calendar year and will inform 2014/15 financial plans. At this stage, the impact of national planning has not been explicitly included within these financial plans apart from notable exceptions (e.g. IAPT). The CCG plans to apply "Right Care" methodology across its key commissioning budgets to deliver the required improvements within its financial envelope.

2.4 The CCG's baseline commissioning allocation has been established at £150.6m through the exercise to split commissioning responsibilities across PCT successor bodies. In addition to this, all CCG's in England received uniform levels of growth of 2.3%, which equated to an uplift of £3.4m for the CCG. The CCG running cost allowance was set at £2.980m based on the Attribution Data Set (ADS) registered population adjusted to new ONS projections which estimated Southport and Formby's population at 119,080 (and equates to £25.03 per head). The 2012 ADS registered population for the CCG is 124,029 (which would equate to £24.03 per head).

2.5 In previous years, the DH published target allocations for PCT's to describe how actual allocations compared to "fair shares" targets and traditionally NHS Sefton faired well in terms of its actual allocation being above its expected fair shares allocation. The approach taken in 2013/14 by the DH is aimed at keeping the health system as stable as possible so it has attempted to use planned expenditure levels from 2012/13 as the starting points for 2013/14 allocations. A working group is still reviewing future allocation levels and it is possible that a move towards "fair shares" may be implemented in 2014/15 along with changes to key demographic weightings (e.g. age, deprivation etc.).

2.6 The DH's Quality, Innovation, Productivity and Prevention (QIPP) programme will enter its fourth year of a five year programme in 2013/14, with its aim to deliver £20 billion worth of savings and efficiencies in this period. Section 8 of this report will describe the impact of this on the CCG.

2.7 The DH set an annual level of planned efficiency within its publication of tariffs for providers. The target has been set at 4% for 2013/14 and is expected to continue at around this level in future years. The responsibility for setting the tariff in 2014/15 will transfer to Monitor and speculation suggests that the national average approach taken by the DH may not be the basis of tariff setting in future. Monitor may potentially favour the use of an average taken from selected providers who can provide that they deliver high quality, cost-efficient services. This may lead to differential impacts on providers in terms of ability to deliver savings in the future. The DH also takes expected levels of inflation into account when setting the tariff as described in the table below. The CCG financial plans have been constructed on the basis of applying a 1.1% contract reduction to its NHS expenditure baseline.

Table 2: 2013/14 net price adjustment (mandatory PbR tariff)	% adj.
Pay and price inflation	2.7
Total national efficiency requirement	-4.0
Net price adjustment	-1.3
Additional mandatory tariff increase for underlying cost pressures	0.2
Net uplift (prices in scope of mandatory tariff)	-1.1

Data Source : Table 1 : Payments by Results Guidance for 2013/14

2.8 In demonstrating sound financial planning, all CCG's are expected to ensure that 2% of recurrent funding is only committed to non-recurrent expenditure. The CCG's will have to submit business cases to the National Commissioning Board (NCB) Area Team for Merseyside for approval. These schemes are listed in section 5.

2.9 The DH has maintained the amount available for Trusts to earn via Commissioning for Quality and Innovation schemes (CQUIN) at 2.5%. This scheme is available for all services commissioned under standard NHS Contracts and whilst the guidance describes the funding as non-recurrent, CCG plans account for this funding on a recurrent basis. It is likely that the scheme will continue into the long-term future with the nature of the schemes changing on an annual basis. A proportion of the CQUIN funding 0.5% is retained to fund national schemes where appropriate to providers whilst the balance 2.0% is available to fund agreed local priorities.

2.10 The DH has also indicated its commitment to introduce PbR for Mental Health services in future years. In 2012/13 use of consistent currencies (clusters) for all patients in mainstream adult and older people's secondary mental health services was introduced. For this year contracts have been rebased using the clusters and mandating the use of some quality and outcome measures. The guidance also emphasises the need to improve the quality and completeness of clinical data that flows to the Mental Health Minimum Dataset. Commissioners will need to ensure that they are able to understand and interrogate the MHMDS to derive the information that they need to support effective service commissioning. It is not clear how this will impact on CCG budgets but introduction of PbR for Mental Health services should be considered as a medium-term risk.

3 PCT Surplus and Lodgements brought forward from 2012/13

3.1 NHS Sefton's expected surplus for 2012/13 is £2.624m and it also agreed a lodgement sum of £2.619m with the SHA at the start of the year. The CCG will inherit its proportion of these sums based upon its share of the PCT baseline. This equates to c.30.0% for the CCG.

3.2 Surpluses are returned to CCG's in the following year whereas "draw down" of lodgement figures are reviewed on an annual basis depending upon national policy. Final lodgement figures will be agreed with the NCB local area team and at this stage the CCG is planning upon drawing down £0.300m worth of its lodgement in 2013/14 and is expected to carry a reduced value (£0.486m) forward into 2014/15 financial plans.

4 2013/14 Opening Expenditure Budgets

4.1 The opening budgets for the CCG have been constructed using projected out-turn figures from 2012/13 financial year and will be subject to verification once the final outcome of 2012/13 has been assessed.

4.2 A general assumption of net 1.1% savings on NHS Contracts has been included in the opening budgets assessment. Work is continuing to understand the impact on individual providers, which may differ from the average national assessment.

4.3 The CCG Community prescribing budget has been uplifted by 5% before the application of a 4% efficiency saving leaving an overall net increase of 1% to the 2012/13 projected out-turn figures.

4.4 The opening budgets include the CCG's share of reablement funding (which is provided recurrently) and the CCG will need to agree plans for use across the health and social care system with Sefton MBC £0.792m is included within the expenditure plans for this purpose.

4.5 The opening budgets exclude DH support for social care funding that had been previously provided by PCT's. The Local Area Team of the NCB now hold the responsibility for providing this allocation to Local Authorities although the CCG will work closely with Sefton MBC in agreeing priorities for this expenditure through the Health and Wellbeing Board. Southport and Formby's estimated share of this funding is £2.237m.

4.6 Further work and analysis is still being undertaken by the CCG finance team to determine accuracy of budgets and the outcome of this review will be shared with the Governing Body in its May meeting.

5 Use of 2% Non-Recurrent Reserve

5.1 As mentioned in section 2.8, CCG's are required to spend at least 2% of their recurrent commissioning baselines on non-recurrent schemes. This equates to £3.081m for the CCG and the schemes described overleaf are proposed as priorities for the CCG in terms of deploying this funding.

Southport and Formby
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Use of 2% Non-Recurrent Reserve	2013/14 £m	2014/15 £m
Care Closer to Home Scheme	0.9	1.3
Mersey Rehabilitation Scheme	0.8	0.8
Primary Care Developments	0.3	0.3
CVS Schemes	0.3	0.3
Winter Pressures	0.3	0.3
Early Supported Discharge	0.2	0.0
Alcohol Nurse Liaison Service	0.1	0.0
Advancing Quality	0.1	0.1
IAPT Pump-Priming	0.1	0.0
Total	**3.1**	**3.1**

5.2 As can be seen from the proposal above, the CCG has outlined its commitments over the next two years. There are other schemes also being worked up and it is likely that the CCG will support other non-recurrent schemes over and above this value using recurrent funding. It should be noted that 2014/15 plans are provided for information at this stage and will be subject to confirmation in Q4 of the 2013/14 financial year. It should also be noted that should the schemes listed above be confirmed as recurrently funded, then the CCG's recurrent surplus will reduce.

5.3 Key schemes include the introduction of the Care Closer to Home scheme as previously agreed by the Governing Body and proposed support for the Mersey-wide rehab programme which is being supported for an initial 2 years pending review of evidence to support its longer-term introduction.

5.4 The CCG has also proposed holding a reserve to help support local winter pressure arrangements outside of any nationally agreed support.

5.5 The CCG is holding a further non-recurrent reserve outside of this budget to support potential investment of £0.800m into an Alternative Quality Contract with the local Trust.

6 Investment Plans

The CCG has identified reserves to support some local schemes and continuation of national priorities such as dementia and IAPT. Around £0.150m of these reserves has been committed and the CCG should undertake an additional review before making further commitments to invest.

7 Running Cost Allowance

7.1 As previously reported, the CCG's running cost allowance has been set at £2.980m. There remains a small unused level of contingency held against this reserve, but there are likely to be further pressures once key issues such as IT and Estates are resolved.

7.2 In addition to running costs, the CCG is likely to incur other costs supporting its commissioning programme (e.g. data facilitators etc.). These costs are excluded from the CCG's running cost calculations and will be reported separately. The CCG is expecting to receive an allocation from NCB with regard to support for primary care IT infrastructure. These figures have yet to be finalised and will be reported to the Governing Body once confirmed.

8 QIPP Plans

8.1 The CCG has inherited a share of NHS Sefton's QIPP target again based upon share of baseline expenditure. This figure has provisionally been established as £5.873m. Against this, the CCG has identified two clear QIPP schemes listed overleaf along with required targets to deliver both the shortfall in QIPP plan and financial targets,

Table 4: QIPP Schemes	**2013/14 £m**
Provider efficiencies through tariff	4.6
Prescribing schemes	0.8
Schemes required to meet QIPP target	0.5
Schemes required to deliver financial targets	0.9
Total	**6.8**

8.2 The CCG still has to find a further £0.5m to reach its QIPP target and also has to find an additional £0.9m to demonstrate that it can deliver its key financial targets. The options open to the CCG are discussed in section 9.

8.3 CCG's are expected to take a keen interest in savings delivered by providers through their efficiency plans. As part of agreeing contracts, clinical leaders in CCG's are asked to make their own assessment of cost improvements to satisfy themselves that services are safe for patients with no reduction in quality.

8.4 Progress against and required adjustments to the QIPP plans will be monitored separately via the CCG's QIPP sub-group.

9 Additional QIPP Schemes/Other Options

9.1 As identified above, the CCG has to find £1.4m worth of additional QIPP savings in order to deliver its financial targets. All of these savings are required on a non-recurrent (i.e. one-off basis) and will have to be cash-releasing in order to deliver the CCG's financial plans.

9.2 A range of options are open to the CCG in terms of addressing this gap and it may be that a mix of these options will present the best solution for the CCG. These include:

- identifying additional QIPP schemes. The CCG is targeting key areas to improve the effectiveness of deployed spend through the Programme Management Office and adoption of the Right Care methodology. Review of Ophthalmology services has begun and it is anticipated that use of this methodology will deliver additional savings;

- defer planned investment schemes for one year. This may raise up to £0.490m and the CCG is advised to review these schemes prior to the next budget update;

- defer the introduction of the alternative quality contract for one year. This would raise £0.800m towards addressing the gap;

- reduce the contingency reserve (see section 11) to 0.5% in line with national guidance. This would raise c. £0.750m but significantly reduce the CCG's ability to deal with pressures that may emerge during 2013/14;

- increase the use of its lodgement in 2013/14. This could raise up to £0.486m but would be subject to agreement by the local area team and potentially leave the CCG in a less resilient position as it enters 2014/15.

9.3 The Governing Body are asked to review these options and comment on proposals to potentially address this gap.

10 Key Financial Risks and Pressures

10.1 As mentioned in the introduction to this paper, the changes to financial arrangements to support the introduction of the new commissioning infrastructure within the NHS are complex and key issues still remain unresolved.

10.2 The key risk relates to agreement of contract splits between CCG's and NHS Commissioning Board in relation to Specialised Services and how this will be managed during the year. An agreement has been reached to manage through a co-commissioning arrangement which is likely to involve significant changes to opening budgeted position in terms of both income and expenditure and could also have an impact on overall financial position.

10.3 At the time of writing this paper, the CCG had not reached agreement with any providers in respect of agreeing 2013/14 contracts so commissioning budgets remain indicative at this stage and subject to changes arising from final agreements with providers.

10.4 The CCG plans have been prepared using 2012/13 Financial Year out-turn position so any growth in demand will need to be funded using CCG contingency reserves. It remains imperative that members of the Group continue to manage referrals into secondary care using appropriate thresholds, whilst also supporting improvements in the urgent care system.

10.5 The CCG's are inheriting a favourable position with regard to community prescribing after significant savings were delivered in 2012/13 through a range of schemes, including introduction of generic products replacing previously patented products. In setting budgets

for 2013/14, the CCG's have assumed a net 1% uplift in overall terms. It should be noted that aspects of prescribing remain volatile and this area could present risks to budgets in 2013/14 and will require continued support from community pharmacist teams and practices to deliver a balanced position.

10.6 The plans assume that the CCG will recoup 1.1% from all NHS Contracts under the planned tariff adjustment. There are a number of separate factors within the construct of the tariff that may mean that this sum is unable to be recouped in full. These include best practice tariffs, changes to maternity pathways and reporting of x-rays within tariff. These all add to the potential risks facing the CCG and more work is required before final agreements can be reached.

10.7 The PCT proposes to provide adequate cover for the impact of Continuing Healthcare (CHC) restitution payments for claims identified by September 2012 within its 2012/13 reported accounts. There is a further deadline for claims due at end of March 2013 and may lead to residual risk for the CCG as it takes over responsibility for commissioning these services. The Governing Body will be regularly updated on progress in this area during the 2013/14 financial year.

10.8 The local provider Trust has signified its intention to acquire a new PAS system for operation in 2014/15. They have made a request to commissioners to support part-funding of this system. The total request for support is estimated as £1.5m across all commissioners and discussions remain on going regarding the potential options available to all parties in respect of this issue.

11 Contingency Reserves

11.1 As a consequence of the heightened levels of financial risk described in section 9, it is recommended that the CCG plan for a 1% reserve as part of its contingency planning and this has been included within Table 1. This level of reserve exceeds the DH guidance which recommends a 0.5% contingency reserve within CCG plans.

11.2 As described in the February Board development session, the CCG is gathering better supporting information to review costs that had previously apportioned using estimated bases. The finance team supporting the two CCG's in the Sefton Health Economy are re-evaluating this information and it is likely to result in a number of baseline adjustments which should not impact on either CCG bottom-line position. These adjustments will be reported to both CCG Finance & Resource Committees when confirmed.

12 Proposed Baseline Transfer – "Sefton-wide" Risk Sharing Agreement

12.1 It is highly likely that a number of legacy issues will emerge during 2013/14 following confirmation of 2012/13 forecast out-turn figures for PCT's and review of the baseline exercise. Some of these issues may impact on the CCG's "bottom-line" position and will require a process to ensure that no unintended consequences arise and lead to potential de-stabilisation of services across the Sefton health economy.

Southport and Formby
Clinical Commissioning Group

12.2 To mitigate against this risk, both CCG's are asked to delegate the power to make a non-recurrent transfer of up to 2% of RRL to a sub-group comprising the Chairs and audit chair of both organisations, the Accountable Officer, and Chief Finance Officer. The outcome of these discussions will be reported through both CCG Finance & Resource Committees.

12. Conclusions & Recommendations

12.1 The CCG's Revenue Resource Limit (inclusive of running cost allowance) has been forecast at £158.6m for the financial year and anticipated expenditure is forecast at £157.0m which means that the CCG is projecting a surplus of £1.6m for the financial year, which equates to 1% of its forecast RRL. The CCG Governing Body is asked to approve the opening budgets for 2013/14 on this basis.

12.2 The CCG's underlying recurrent position has been assessed at 3% surplus which is additional to a 1% contingency reserve. The NHS Commissioning Board target contingency is 0.5% and the CCG plans exceed this at this stage.

12.3 The CCG remains on target to operate within its running costs target and further details will be provided to the May Governing Body.

12.4 The CCG has identified a range of transformational schemes for use of the 2% non-recurrent reserve.

12.5 The CCG still needs to identify QIPP schemes up to £1.4m in order to deliver its financial targets set by the national Commissioning Board. The Governing Body are asked to review and comment upon the range of options described in this report with a view to reducing the level of unidentified schemes.

12.6 The CCG Governing Body is asked to approve the adoption of a Sefton-wide risk sharing scheme which delegates the power to transfer up to 2% of baseline allocation to a sub group to ensure that services across Sefton are not de-stabilised during 2013/14.

20 March 2013

Martin McDowell
Chief Finance Officer
NHS Southport & Formby CCG

Southport and Formby
Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/38	**Author of the Paper:** Tracy Jeffes Head of Delivery tracy.jeffes@sefton.nhs.uk
Title: Everyone Counts	
Summary of the Paper/Key Issues: This paper presents the Governing Body with an update in relation to the planning document 'Everybody Counts', the content of which the Governing Body have developed during previous development sessions.	
Action/Decision Required: The Governing Body is asked to note the approve of this report.	
Date of Report: 14 March 2013	

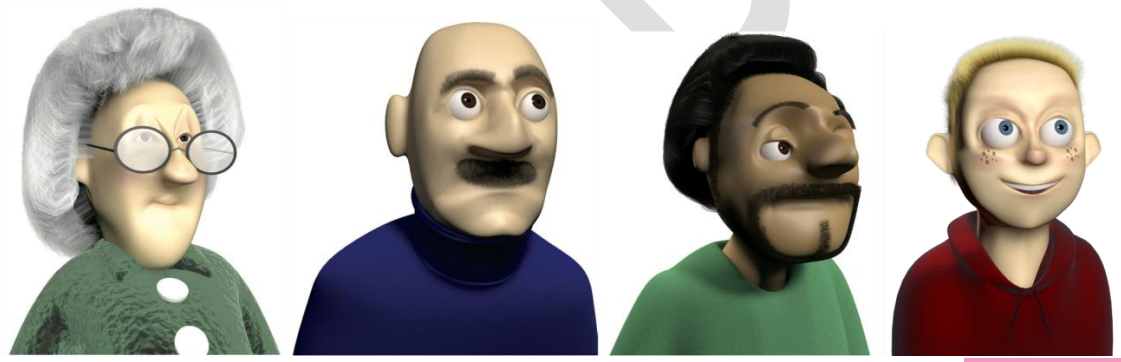
13/38

NHS

Southport and Formby
Clinical Commissioning Group

Everyone Counts

Planning for Patients in Southport and Formby 2013 - 2014



together with you

Contents

1.0 Introduction

NHS Southport and Formby Clinical Commissioning Group (SFCCG) bring together 20 doctors surgeries covering an area stretching from Ince Blundell in the south to Churchtown in the north. From April 2013, we are fully responsible for planning and buying or 'commissioning' the majority of local health services for our 122,000 patients. Our Governing Body is made up of local doctors, nurses, practice staff and lay people, who are well placed to know the health needs and views of people living in the area, and will lead and be accountable for the work we carry out.

This plan sets out an ambitious programme to ensure that health and health services in Southport and Formby continue to improve in the future, amidst an increasingly complex and challenging social and economic environment. SFCCG has a budget of £160 million in 2013-2014, and we will need to work innovatively and even closer with our partners if we are to make improvements. This plan also reflects the progress we have made in developing working relationships with our partners since coming into being - with organisations and groups including Sefton Council, hospitals, local people and voluntary and community organisations.

Over the past 18 months, we have played an active role in local commissioning and we have operated in shadow form from April 2012 to being awarded statutory body status effective from April 2013, as part of the changes to the NHS. Our work during this period has informed the priorities detailed in this operational plan for 2013-2014.

Our plans for the year ahead build on what we already know about health and wellbeing in Southport and Formby – identified through mapping, analysis, research and evidence, Sefton's joint strategic needs assessment, called the Sefton Strategic Needs Assessment (SSNA) and involving and informing the people who live in the area. It also responds to the goals set out in the following:

- Everyone counts – planning for patients 2013-2014
- NHS Outcomes Framework
- NHS Constitution
- The Quality, Innovation, Productivity and Prevention (QIPP) programme

1.1 Our vision and values

Our vision and values clearly set out what we want to achieve for everyone who lives in Southport and Formby. They embody our commitment to our local and statutory duties, and most importantly, local people.

Our vision

Southport and Formby; a sustainable, healthy community.

We will therefore:

- Guarantee that no community is left behind or disadvantaged
- Focus on reducing health inequalities and advancing equality to improve outcomes for all our patients
- Treat patients respectfully and put their interests first
- Transform NHS services to enable patients to take more control and make informed choices if they want to

1.2 How we have developed this plan

Our plans have been shaped around the effectiveness of current services, the views and experiences of the people living locally and the national standards that we aim to achieve. This section describes these considerations in more detail.

Health in Southport and Formby

Overall, life expectancy is similar to the national average - 78.4 years for men and 82.5 years for women. However, men and women living in the most deprived areas of Southport and Formby can expect to live over seven years less than their neighbours in more affluent communities. This gap in life expectancy is mainly caused by lifestyle related factors, such as smoking and poor diet, which account for greater rates of circulatory disease, Chronic Obstructive Pulmonary Disease (COPD), obesity, diabetes, poor mental health and alcohol related illness.

Sefton has the highest proportion of residents aged over 65 of any metropolitan borough. In Southport and Formby there are over 26,000 residents over 65 years of age (21%) and this could increase by 10% in the next five years.

Southport and Formby also has growing migrant worker population. Sources indicate there could be as many as 2,000 migrant workers, 300 school age children and 600 partners or other family members. The main communities are from Poland, Portugal and Latvia. In 2009 there were over 200 births to non-British mothers (13% of all births).

All these factors contribute to deciding what health services Southport and Formby residents' need. Because of this, SFCCG has continued working with partners to develop primary care based strategies that can promote health improvement and reduce health inequalities.

There is a strong history of commissioning against the priorities set out in Sefton's first two joint strategic needs assessments (JSNAs). The latest refresh of the JSNA in 2012, called the Sefton Strategic Needs Assessment (SSNA) was carried out by SFCCG and Sefton Council and the results have formed the basis of the Health and Wellbeing Strategy (HWBS) – which is in turn shaping priorities for both organisations.

The strategic objectives of the HWBS are:

- Ensure all children have a positive start in life
- Support people early to prevent and treat avoidable illnesses and reduce inequalities in health
- Support older people and those with long term conditions and disabilities to remain independent in their own homes
- Promote positive mental wellbeing
- Seek to address the wider social, environmental and economic issues that contribute to poor health and wellbeing
- Build capacity and resilience to empower and strengthen communities

Listening to local people

In all our discussions with Southport and Formby residents over the past few years, some clear and consistent themes have emerged about what they want for their health and from their health services. Our plans for 2013-2014 reflect these themes and priorities:

- For more services – like diabetes clinics, children's immunisations and physiotherapy - to be provided closer to home rather than in hospital, with better use made of existing community facilities like Ainsdale Centre for Health and Wellbeing
- Better integrated care – so, the many different health services to work better together, to make people's care and treatment easier
- More choice and involvement for people in their care and treatment
- Continued focus on programmes and services that prevent ill health, and that promote independent living
- Improve access to drug and mental health services
- Support for the most vulnerable and excluded people in our communities
- For people's views to be listened to, particularly those who find it difficult to voice their opinions

Priorities across the NHS

There is a clear mandate for NHS commissioners to achieve more. Our plans take account of this mandate and focus our work on the standards set out in the NHS Constitution and the NHS Outcomes Framework:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

In working towards achieving the goals set out in this plan, we will:

- Guarantee that no community is left behind or disadvantaged
- Focus on reducing health inequalities and advancing equality to improve outcomes for all our patients
- Treat patients respectfully and put their interests first
- Transform NHS services to enable patients to take more control and make informed choices if they want to

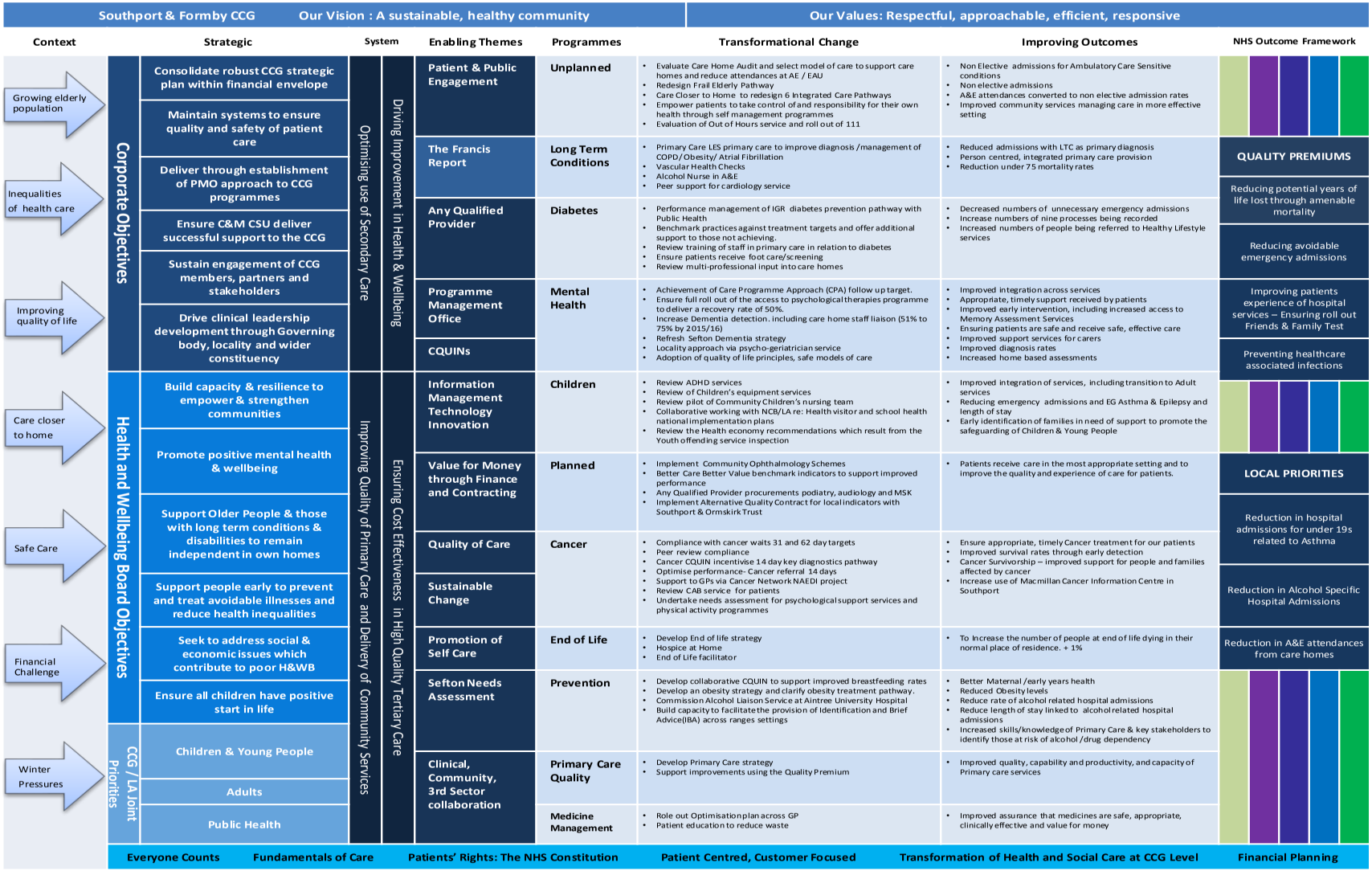
In order for us to deliver our priorities within the resources we have available we need to work with key partners to change the way in which care is delivered. One of the most significant programmes of work is delivering 'Care Closer to Home' which will shift the emphasis of care delivery from hospital based to community based services. Our main provider, Southport and Ormskirk Trust is an Integrated Care Organisation, which means they are ideally positioned to make such changes as part of the wider plans. Given the scale of these changes and in order to release the expected efficiencies the transformation plan is over a three year period and forms part of the CCG Strategic Plan. Our plans for 2013-14 reflect no growth, with some efficiencies released through the 'Care Closer to Home' implementation, however we are mindful of the demographic of our population and plans reflect that despite transformational change delivering a reduction in hospital based services, the requirements of the population will be increasing. The individual programmes of work to be delivered during 2013-14 that contribute to these plans can be found listed on page 12.

Appendix 2 sets out how we have involved and informed our partners in developing and setting this work plan for 2013-2014.

2.0 Improving Outcomes, Reducing Inequalities

2.1 Overview of our plans for 2013-2014 – Plan on a Page

Our 'Plan on a page' summarises key areas of delivery in 2013 – 2014 in the context of our vision, corporate aims, joint health and wellbeing strategic objectives and which shows the links to the achievement of progress against the NHS Outcomes Framework and delivery of the rights enshrined within the NHS Constitution.


Southport & Formby CCG
Our Vision : A sustainable, healthy community
Our Values: Respectful, approachable, efficient, responsive
Context
Strategic
System
Enabling Themes
Programmes
Transformational Change
Improving Outcomes
NHS Outcome Framework
Growing elderly population
Inequalities of health care
Improving quality of life
Care closer to home
Safe Care
Financial Challenge
Winter Pressures
Corporate Objectives
Consolidate robust CCG strategic plan within financial envelope
Maintain systems to ensure quality and safety of patient care
Deliver through establishment of PMO approach to CCG programmes
Ensure C&M CSU deliver successful support to the CCG
Sustain engagement of CCG members, partners and stakeholders
Drive clinical leadership development through Governing body, locality and wider constituency
Optimising use of Secondary Care
Driving Improvement in Health & Wellbeing
Patient & Public Engagement
Unplanned
Evaluate Care Home Audit and select model of care to support care homes and reduce attendances at AE / EAU
Redesign Frail Elderly Pathway
Care Closer to Home to redesign 6 Integrated Care Pathways
Empower patients to take control of and responsibility for their own health through self management programmes
Evaluation of Out of Hours service and roll out of 111
Non Elective admissions for Ambulatory Care Sensitive conditions
Non elective admissions
A&E attendances converted to non elective admission rates
Improved community services managing care in more effective setting
The Francis Report
Long Term Conditions
Primary Care LES primary care to improve diagnosis /management of COPD/Obesity/ Atrial Fibrillation
Vascular Health Checks
Alcohol Nurse in A&E
Peer support for cardiology service
Reduced admissions with LTC as primary diagnosis
Person centred, integrated primary care provision
Reduction under 75 mortality rates
QUALITY PREMIUMS
Reducing potential years of life lost through amenable mortality
Any Qualified Provider
Diabetes
Performance management of IGR diabetes prevention pathway with Public Health
Benchmark practices against treatment targets and offer additional support to those not achieving.
Review training of staff in primary care in relation to diabetes
Ensure patients receive foot care/screening
Review multi-professional input into care homes
Decreased numbers of unnecessary emergency admissions
Increase numbers of nine processes being recorded
Increased numbers of people being referred to Healthy Lifestyle services
Reducing avoidable emergency admissions
Programme Management Office
CQUINs
Mental Health
Achievement of Care Programme Approach (CPA) follow up target.
Ensure full roll out of the access to psychological therapies programme to deliver a recovery rate of 50%.
Increase Dementia detection. including care home staff liaison (51% to 75% by 2015/16)
Refresh Sefton Dementia strategy
Locality approach via psycho-geriatrician service
Adoption of quality of life principles, safe models of care
Improved integration across services
Appropriate, timely support received by patients
Improved early intervention, including increased access to Memory Assessment Services
Ensuring patients are safe and receive safe, effective care
Improved support services for carers
Improved diagnosis rates
Increased home based assessments
Improving patients experience of hospital services – Ensuring roll out Friends & Family Test
Preventing healthcare associated infections
Health and Wellbeing Board Objectives
Build capacity & resilience to empower & strengthen communities
Promote positive mental health & wellbeing
Support Older People & those with long term conditions & disabilities to remain independent in own homes
Support people early to prevent and treat avoidable illnesses and reduce health inequalities
Seek to address social & economic issues which contribute to poor H&WB
Ensure all children have positive start in life
Improving Quality of Primary Care and Delivery of Community Services
Ensuring Cost Effectiveness in High Quality Tertiary Care
Information Management Technology Innovation
Children
Review ADHD services
Review of Children's equipment services
Review pilot of Community Children's nursing team
Collaborative working with NCB/LA re: Health visitor and school health national implementation plans
Review the Health economy recommendations which result from the Youth offending service inspection
Improved integration of services, including transition to Adult services
Reducing emergency admissions and EG Asthma & Epilepsy and length of stay
Early identification of families in need of support to promote the safeguarding of Children & Young People
Value for Money through Finance and Contracting
Planned
Implement Community Ophthalmology Schemes
Better Care Better Value benchmark indicators to support improved performance
Any Qualified Provider procurements podiatry, audiology and MSK
Implement Alternative Quality Contract for local indicators with Southport & Ormskirk Trust
Patients receive care in the most appropriate setting and to improve the quality and experience of care for patients.
LOCAL PRIORITIES
Reduction in hospital admissions for under 19s related to Asthma
Quality of Care
Sustainable Change
Cancer
Compliance with cancer waits 31 and 62 day targets
Peer review compliance
Cancer CQUIN incentivise 14 day key diagnostics pathway
Optimise performance- Cancer referral 14 days
Support to GPs via Cancer Network NAEDI project
Review CAB service for patients
Undertake needs assessment for psychological support services and physical activity programmes
Ensure appropriate, timely Cancer treatment for our patients
Improved survival rates through early detection
Cancer Survivorship – improved support for people and families affected by cancer
Increase use of Macmillan Cancer Information Centre in Southport
Reduction in Alcohol Specific Hospital Admissions
Promotion of Self Care
End of Life
Develop End of life strategy
Hospice at Home
End of Life facilitator
To Increase the number of people at end of life dying in their normal place of residence. + 1%
Reduction in A&E attendances from care homes
Sefton Needs Assessment
Prevention
Develop collaborative CQUIN to support improved breastfeeding rates
Develop an obesity strategy and clarify obesity treatment pathway.
Commission Alcohol Liaison Service at Aintree University Hospital
Build capacity to facilitate the provision of Identification and Brief Advice(IBA) across ranges settings
Better Maternal /early years health
Reduced Obesity levels
Reduce rate of alcohol related hospital admissions
Reduce length of stay linked to alcohol related hospital admissions
Increased skills/knowledge of Primary Care & key stakeholders to identify those at risk of alcohol /drug dependency
Clinical, Community, 3rd Sector collaboration
Primary Care Quality
Develop Primary Care strategy
Support improvements using the Quality Premium
Improved quality, capability and productivity, and capacity of Primary care services
Medicine Management
Role out Optimisation plan across GP
Patient education to reduce waste
Improved assurance that medicines are safe, appropriate, clinically effective and value for money
CCG / LA Joint Priorities
Children & Young People
Adults
Public Health
Everyone Counts
Fundamentals of Care
Patients' Rights: The NHS Constitution
Patient Centred, Customer Focused
Transformation of Health and Social Care at CCG Level
Financial Planning

Key Programmes - Programme Management Approach

Our Plan on a Page also highlights key programmes of work. To enable us to achieve our longer term strategy, we have been able to identify actions to deliver required progress in 2013-14. We have developed an internal Programme Management capability, supported by a Programme Management Office function, which we commission from Cheshire and Merseyside Commissioning Support Unit (CMCSU) to drive this work forward.

We have identified a lead clinician / board member and a lead manager for each of our key programmes of work who are developing detailed implementation plans. A list of leads can be found in Appendix 3. These leads have worked in conjunction with key stakeholders, across the NHS, local authority, the voluntary sector and with local people, as appropriate to develop their plans. This includes an increasing emphasis on clinician to clinician discussion around the key priority areas, both across primary and secondary care and also with the CCG localities, where discussions are led by Locality GP Chairs. We have recently increased our clinical leadership and capacity in relation to our key areas of work – our Unplanned Care strategy, Care Closer to Home - through the secondment of a local secondary care doctor, working with a lead manager to work across the whole system. Each programme has a clear link to the transformation change required across the wider health system and to achieving the outcomes required for our population. Some programmes are more fully developed than others. Where there are gaps, leads are working on completing the detail over the next few weeks and months as part of our longer term strategic planning process.

The following pages provide more detailed on each of the key programme areas:

- Unplanned Care
- Long Term Conditions including, Chronic Obstructive Pulmonary Disorder (COPD), Cardiovascular Disease (CVD)
- Diabetes
- Mental Health, Dementia and Learning Disabilities (LD)
- Children
- Planned Care
- Cancer
- End of Life
- Prevention – Obesity, Alcohol and Maternal Health
- Primary Care Development
- Medicine's Management

NHS
Southport and Formby Clinical Commissioning Group

Programme: Unplanned Care Lead Clinician: Dr Niall Leonard

OBJECTIVE
To redesign community services to reduce hospital attendances and manage care more effectively in a community setting. (Domain 1,3,4,5)

WHY CHANGE IS NEEDED?
Despite a decreasing trend, non elective admissions remain higher than the national average (120/1000 pop versus 114/ 1000 pop). A&E attendance to admission conversion rates is in the 4th quintile. By redesigning community services (Care Closer to Home) we aim to deliver more care in a community setting which given the demographic of the local population will offer improved care for patients.

DESCRIPTION
Evaluate Care Home Audit and select model of care to support care homes and reduce attendances at AE / EAU Redesign Frail Elderly Pathway Retender of Out of Hours contract and roll out of 111 Care Closer to Home to redesign 6 Integrated Care Pathways Empower patients to take control of and responsibility for their own health through self management programmes *(improving quality in primary care and advanced care planning for patients in last year of life separate schemes)*

KEY MILESTONES	Q1	Q2	Q3	Q4
New out of hours contract				
New model of care for care homes				
Redesigned Frail Elderly Pathway launched				
New pathways of care for diabetes, cardiology, respiratory, dementia, End of Life, Frail Elderly.				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Non Elective admissions for Ambulatory Care Sensitive conditions				
Non elective admissions				
A&E attendances converted to non elective admission rates				

RISKS	MITIGATING ACTIONS
Care homes fail to adopt new model of care (financial risk as no reduction in admission rates)	Support and education during launch
Delay in implementing new pathways (financial risk as no reduction in admissions)	Recognise pace of change during 13/14 contract round and plan accordingly
Resistance to new ways of working	Project management, support to staff, regular briefings

WORKFORCE IMPLICATIONS
Training for staff in community settings to support new ways of working Closer working with other agencies (Local Authority and third sector) to deliver effective care

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

NHS
Southport and Formby Clinical Commissioning Group

Programme: Diabetes Lead Clinician: Dr Doug Callow

OBJECTIVE

Prevent or delay the onset of diabetes.
Improves the recording of the nine care processes for people with diabetes
Increase the number of people who access education for Type 1&2 diabetes (Domain 1,2,3,4,5)

WHY CHANGE IS NEEDED?

There is now an increasingly aging population in Sefton. Compared to ten years ago (1998), Sefton's population now has fewer under 45s and more people aged 45+ (particularly 45-64). This is important in relation to diabetes prevalence as Type 2 Diabetes tends to present in middle-aged and older age groups (although it is becoming more common in younger overweight people). Sefton's population is estimated to plateau to around 272,500 in the next 20 years with the number and percentage of over 65s continuing to increase. Older people account for the majority of both hospital admissions and long term conditions.
The number of people in Sefton likely to have Diabetes is about is 13,783, or 4.94% of the total population. Sefton's prevalence of diabetes has risen over the last 4 years by around 500-600 patients each year. The number of people with diabetes in Sefton is predicted to rise by 42% to nearly 20,000 in the next twenty years. This equates to around 300 new patients per year. In Sefton, 42,102 people are estimated to have IGR (borderline diabetes). 70% of diabetes is thought to be preventable and obesity is thee key modifiable risk factor.
Between April 2008 to March 2009, there were 23 day case or elective Hospital admissions with Diabetes as a Primary Diagnosis across the four hospital trusts. Between April 2008 to March 2009, there were 125 emergency admissions with a primary diagnosis of Diabetes .
The average length of hospital stay (days) for day case, elective and non-elective admissions with a primary diagnosis of Diabetes = 493.
HbA1c is a marker of long-term control of diabetes. Better control leads to fewer complications in both insulin-dependent and non-insulin dependent patients with diabetes

DESCRIPTION

- Performance management of IGR diabetes prevention pathway (activity to include annual review, patient education and weight management) – work with public health
- Explore the benefits of commissioning education for patients with established diabetes
- Improve recording of all nine care processes using the diabetes dashboard
- Benchmark practices against treatment targets (HbA1c, blood pressure, cholesterol) and offer additional support to those not achieving.
- Review training needs of staff in primary care in relation to diabetes
- Ensure patients receive foot care/screening as agreed within Nice Guidance the foot care pathway as agreed by North Mersey Network Group
- Review multi-professional input into care homes for residents with diabetes
- Explore the potential working with intermediate care to increase care closer to home.
- Work with secondary care to understand diabetic patients flow through improved coding of data
- Ensure that patients are discharged as appropriate from secondary care to be managed in a primary/community setting
- Encourage healthy lifestyles in particular to reducing obesity levels

KEY MILESTONES	Q1	Q2	Q3	Q4
Increase recording of the nine processes				
Review training needs				
Launch Merseyside IGR pathway, managing overweight / obese patients with high blood sugar				
Develop an integrated pathway and monitor impact on emergency attendances/admission				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Decreased numbers of unnecessary emergency admissions				
Increase numbers of nine processes being recorded				
Increased numbers of people being referred to Healthy Lifestyle services				

RISKS	MITIGATING ACTIONS
Funding	
Lack of capacity within GP practices	
Educational issues	

WORKFORCE IMPLICATIONS

None at this time

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Programme: Mental Health **Lead Clinician: Dr Hilal Mulla**

OBJECTIVE
Achievement of Care Programme Approach (CPA) follow up target. Ensure full roll out of the access to psychological therapies programme to deliver a recovery rate of 50%. Increase the proportion of people with depression/anxiety entering treatment (Domain 4)

WHY CHANGE IS NEEDED?
High incidence of mental health across the borough . The challenge of matching the mental health needs of an ageing population with reducing resources.

DESCRIPTION
Care Programme Approach (CPA): 95% of the proportion of people under adult mental health specialities of CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period. **IAPT:** The plan is to employ IAPT Wave 5 trainees, that are currently employed on temporary contracts as permanent staff post qualification, and to participate in Wave 6 of the roll out to achieve DH objectives of meeting 15% prevalence with recovery rates of 50% by 2014/15.

KEY MILESTONES	Q1	Q2	Q3	Q4
Increase in number of people who receive psychological therapies	418	424	438	440

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Mental Health Measure - CPA	95%			
Mental Health Measure - IAPT	9%			

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	181,431	
2014/15		
2015/16		
Total		

NHS
Southport and Formby Clinical Commissioning Group

Programme: Dementia Lead Clinician: Dr Hilal Mulla

OBJECTIVE
Refresh of the Sefton Dementia Strategy in line with recent policy changes including the targets in the Prime Ministers Dementia Challenge. Enhancing quality of life for people with dementia. (Domain 2)

WHY CHANGE IS NEEDED?
Increase in the numbers of people with dementia. Increase in Sefton's ageing population. Need to increase appropriate early referral to Memory Assessment Services. Need to improve access to support services for people with dementia and their carers / family.

DESCRIPTION
Case finding / diagnosis rates to increase from 51% to 75% by 2015/16 in line with GMS Contractual Changes 2013/14 – Enhanced service for Dementia Case Finding (6th December 2012). Facilitate further locality based approach of the psycho-geriatrician service. Improving public and professional awareness / understanding of dementia and impact on peoples lives. Facilitate appropriate support for patients, families and carers through co-ordination of VCF Sector.

KEY MILESTONES	Q1	Q2	Q3	Q4
Develop GP dementia screening tool				
Increased referrals to memory assessment service				
Increase in memory assessments in persons home				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Increase in diagnosis rates	75%	59%	67%	75%
Increase in prescribing of Cholinesterase Inhibitors				
Decrease in anti-psychotic prescriptions				

RISKS	MITIGATING ACTIONS
Lack of GP uptake in enhanced service for dementia case finding	Proactive clinical leadership and support
Capacity of psycho-geriatrician's may have resource implications	

WORKFORCE IMPLICATIONS
Enhance skill set of primary care workers in relation to dementia through appropriate training support.

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

NHS
Southport and Formby Clinical Commissioning Group

Programme: Learning Disabilities Lead Clinician: Dr Hillal Mulla

OBJECTIVE
Ensure effective and safe models of care for people with learning disabilities (Domain 2,4,5) Commission annual health checks Quality of Life principles should be adopted in all health and social care contracts to drive up standards. (Domain 1)

WHY CHANGE IS NEEDED?
Response to the Transforming Care: local response to Winterbourne View Hospital and Francis Report that ensures people with learning disabilities , autism, a mental health condition or challenging behaviour are safe and well looked after for NHS funded care.

DESCRIPTION
Joint working with Sefton Council to ensure any placements outside Sefton will be monitored to ensure good pathways for discharge. Contracts will be used to hold providers to account for the quality and safety of the services they provide. The NHSCB and ADASS will implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities .

KEY MILESTONES	Q1	Q2	Q3	Q4
Local register of people with challenging behaviour for NHS funded care.				
Contract monitoring and reviews to drive up standards of care.				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Learning Disability Health Self Assessment Framework	Yearly			
Winterbourne View local response	1st April 2013			
Annual Health Checks	Yearly			

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	£40,000 for Annual Health Checks	
2014/15	Possibly NCB investment	
2015/16		
Total		

Priority Area : Children's Lead Clinician: Dr Robert Caudwell

NHS
Southport and Formby Clinical Commissioning Group

OBJECTIVE
Children's Community Nursing Team Admission avoidance and facilitating early discharge for children and young people within North Sefton. Improve care pathways through joint working between primary and secondary care providers. Improve access to acute care which can be provided closer to home (Domains 1,2,3,4,5)

WHY CHANGE IS NEEDED?
Children's community nursing teams support the range of needs from complex needs, chronic ill health, long term conditions and also acute illness. This includes supporting discharge from hospital and early assessment and treatment of children to support families to stay at home where possible. Whilst North Sefton has a complex needs nursing team who support known children on a planned care basis, there is no equivalent service to support the acutely ill child within the community.

DESCRIPTION
Developing Children's Community Nursing Team for North Sefton with Southport & Ormskirk Paediatric Service. 18 month pilot to assess the benefits in increasing acute care available outside of hospital settings. Pilot will also • Review LCH complex needs (1 WTE Band 7) • Epilepsy development • EOL project • Secondment from LCH complex needs team to CCNT pilot (1 WTE Band 6) • Decommissioning LCH re Paediatric diabetes nursing service & commissioning S&O (TUPE transfer 1 WTE Band 7)

WORKFORCE IMPLICATIONS
Nursing team – 3.6 WTE – Funded via QIPP monies during pilot.

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Reduced emergency readmissions	No actual targets set for pilot, aim to see a reduction against expected activity levels CCNT activity aims to reduce PBR activity/income to meet service costs, therefore cost neutral			
Reduced A&E attendances at point of primary care				
Reduced length of stay				

RISKS	MITIGATING ACTIONS
CCG do not implement /fund service at end of pilot in 2013/14	Exit strategy agreed with providers.
No risk to diabetes specialist nurse	TUPE Transfer
On-going S&O service dependant on internal redesign of resources	Review of service redesign at S&O

KEY MILESTONES	Q1	Q2	Q3	Q4
Service fully established –Monthly activity review to support performance monitoring				
LCH complex needs review and LTC service redesigns completed.				
GP referral pathway developed with pilot practices				
Full service evaluation of S&O pilot in conjunction with LCH/Claire House work to inform model for future community nursing services.				

YEAR	INVESTMENT £	SAVINGS £
2013/14	160k – QIPP funding	
2014/15		
2015/16		
Total		

Priority Area : Children's Lead Clinician: Dr Robert Caudwell

OBJECTIVE
Improve outcomes for children through integrated commissioning and service delivery (Domain 1,2,3,4,5)

WHY CHANGE IS NEEDED?
1. Children's community nursing teams do not deliver equitable service across the borough 2. Service restructured to improve access and outcomes on previous poor performance 3. ADHD has no agreed multi-disciplinary pathway – works on historic practice 4. Demand for children's equipment has significantly increased

DESCRIPTION
Review community nursing support for children with complex needs Implementation of new T3 CAMHS specification Performance monitoring of ADHD services Review children's equipment arrangements

KEY MILESTONES	Q1	Q2	Q3	Q4
Implementation of new T3 CAMHS specification				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
TBC				
KPIs in service spec				
Implementation of agreed pathway and KPIs				

RISKS	MITIGATING ACTIONS
2. LA could withdraw CAMHS funding	New steering group in place with performance framework that currently has robust clinical involvement and LA support

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

NHS
Southport and Formby Clinical Commissioning Group

Priority Area : Planned Care Lead Clinician: Dr Martin Evans

OBJECTIVE
To ensure that patients receive care in the most appropriate setting and to improve the quality and experience of care for patients. (Domain 1,3,4,5)

WHY CHANGE IS NEEDED?
We know there are opportunities to change the way care is delivered for a number of clinical services, some of which will see care delivered in a community setting. This will improve the patients experience through offering more timely access and convenient locations.

DESCRIPTION
Review the orthopaedic / MSK pathway in Southport & Ormskirk Trust Implement Community Ophthalmology Schemes Ensure that key Better Care Better Value benchmark indicators are implemented where performance has declined Implement Alternative Quality Contract for local indicators with Southport & Ormskirk Trust. Any Qualified Provider procurements podiatry, audiology and MSK Community anticoagulation service re-procurement

WORKFORCE IMPLICATIONS
Training requirements for Community Optometrists wishing to participate in scheme. If significant shifts between providers for AQP / MSK may have workforce implications for current main provider.

KEY MILESTONES	Q1	Q2	Q3	Q4
Community Ophthalmology Scheme				
Orthopaedic / MSK				
Alternative Quality Contract				
Anticoagulation procurement				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Orthopaedic first outpatient referrals (all providers inc Independent)				
Referrals to MSK by GP Practice				
Ophthalmology first outpatient referrals (all providers inc Independent) and follow up rate				

RISKS	MITIGATING ACTIONS
MSK services not fully utilised – patients access secondary care services (financial risk)	Ownership of any changes by local GPs New model must demonstrate improved quality and experience for patients
Community Ophthalmology Scheme not fully utilised (financial risk)	Ownership of any changes by local GPs New model must demonstrate improved quality and experience for patients
Failure to deliver BCBV indicators (referral rates, follow ups and consultant to consultant) (Financial risk)	Performance management of rates, early discussion if performance slips with plan to bring performance back to trajectory

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	Ophthalmology 34k	
2014/15		
2015/16		
Total		

NHS
Southport and Formby Clinical Commissioning Group

Priority Area : Cancer Clinical Lead: Dr Graeme Allen

OBJECTIVE
Early detection (1) Improve cancer survival (Domain 1,4,5)

WHY CHANGE IS NEEDED?
Late detection is believed to be the key reason why cancer survival in the UK lags behind Europe. As a Cancer Network Merseyside and Cheshire needs to save 4000 lives a year to fall in line with European average survival rates. This equates to 1 life per GP practice. The ageing demographic will also result in higher rates of cancer diagnosis, so we cannot afford to stand still. Evidence shows that cancers detected via emergency presentations are likely to be later stage with correspondingly poorer prognosis than those detected via a managed ideally 2 week wait route

DESCRIPTION
• Ensure GPs receive timely information relating to their practice's cancer performance, eg 2week wait referral rates, diagnostic yield from 2 week wait referrals. presentation routes, staging data • Provide support (Cancer Network NAEDI project) to encourage reflective practice in relation to the management of potential cancer symptoms by general practitioners • Provide support (Cancer Network NAEDI project) to develop cancer early detection action plans at a practice level eg improving breast screening uptake or follow up of patients who decline bowel cancer screening

KEY MILESTONES	Q1	Q2	Q3	Q4
All practices have access to their cancer practice profiles				
Include cancer intelligence within Mersey intelligence portal				
Present findings of 2012/13 QP8 cancer pathway audits at a CCG level				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
NAEDI primary care project managers make contact with % of practices-	75%	75%	75%	75%

RISKS	MITIGATING ACTIONS
Lack of engagement by practices	
Delays in data provision	
Sustainability of NAEDI project manager roles	

WORKFORCE IMPLICATIONS
The Cancer Network's National Awareness and Early Detection Initiative (NAEDI) project team are instrumental in providing support to individual practices. The team are employed by CRUK and exclusivity to Cheshire and Merseyside cannot be guaranteed

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

NHS
Southport and Formby Clinical Commissioning Group

Priority Area : Cancer Clinical Lead: Dr Graeme Allen

OBJECTIVE
Early Detection (2) Improving cancer survival (Domains 1,4,5)

WHY CHANGE IS NEEDED?
Late detection is believed to be the key reason why cancer survival in the UK lags behind Europe. As a Cancer Network Merseyside and Cheshire needs to save 4000 lives a year to fall in line with European average survival rates. This equates to 1 life per GP practice. The ageing demographic will also result in higher rates of cancer diagnosis, so we cannot afford to stand still. Evidence shows that cancers detected via emergency presentations are likely to be later stage with correspondingly poorer prognosis than those detected via a managed ideally 2 week wait route

• DESCRIPTION
• Incentivise 14 day pathways to key diagnostics (rather than outpatient clinic) through CQUIN • Ensure optimum performance against 14 day referral to first seen target for suspected cancer patients • Consider introduction of direct access flexible sigmoidoscopy to improve early detection of colorectal cancers

KEY MILESTONES	Q1	Q2	Q3	Q4
Produce a leaflet to encourage attendance at 2 week wait clinics				
Introduce cancer waits CQUIN				
Make decision on implementation of direct access flexible sigmoidoscopy				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Cancer waits 2 week wait Aintree Hospital	93%	93%	93%	93%
Performance against cancer waits CQUIN requirements	Tbc			

RISKS	MITIGATING ACTIONS
Financial impact of direct access flexible sigmoidoscopy	

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

NHS
Southport and Formby Clinical Commissioning Group

Priority Area : Cancer Clinical Lead: Dr Graeme Allen

OBJECTIVE
Ensuring prompt access to high quality cancer treatments (Domain 1,4,5)

WHY CHANGE IS NEEDED?
Ensuring that all cancer patients receive the appropriate treatment, promptly and delivered to a high standard, is critical to improving cancer outcomes. Cancer Peer review has identified some areas of concern in the quality of service provision locally. Performance for the 62 days referral to treatment standard has slipped during 2012/13, average performance 84.2% year to date (Commissioner based –December 2012) against a standard of 85%

DESCRIPTION
• Identify the need for service improvements using the annual cancer peer review cycle holding providers to account through remedial action plans. • Ensure compliance with cancer waits 31 and 62 day targets

KEY MILESTONES	Q1	Q2	Q3	Q4
Peer review reporting				
Introduction of cancer waits CQUIN				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Peer review compliance with measures		100%	100%	100%
Performance against requirements of cancer waits CQUIN	tbc			
Cancer waits 31 days target		95%	95%	95%
Cancer Waits 62 day target (aggregate measure)		86%	86%	86%

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Priority Area : Cancer Clinical Lead: Dr Graeme Allen

OBJECTIVE
Cancer Survivorship – supporting people and families affected by cancer (Domain 2,3,4)

WHY CHANGE IS NEEDED?
There are now about 1.8 million people living in England who have had a cancer diagnosis. By 2030 it is anticipated that there will be 3 million people in England living with and beyond cancer. People living with and beyond cancer often have specific support needs which, if left unmet, can damage their long-term prognosis and ability to lead an active and healthy life. These needs can include information about treatment and care options, psychological support, access to advice on financial assistance and support in self-managing their condition Cancer patient experience surveys undertaken by Southport and Ormskirk Hospitals indicate that there are unmet information support needs especially in regard to financial and benefits advice.

DESCRIPTION
Continue to promote and evaluate the services of the Macmillan Cancer Information Centre in Southport Review the service provided by CAB for cancer patients in Sefton Undertake needs assessment for psychological support services for cancer patients in Sefton Undertake needs assessment for physical activity programmes for cancer survivors

KEY MILESTONES	Q1	Q2	Q3	Q4
2 year annual report Macmillan Cancer Information Centre				
Psychological support needs assessment				
Physical activity needs assessment				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Monthly contacts at Southport Macmillan Cancer Information Centre	120	100	115	120

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £'000
2013/14		
2014/15		
2015/16		
Total		

NHS
Southport and Formby Clinical Commissioning Group

Priority Area : End of Life Lead Clinician: To be confirmed

OBJECTIVE

To decrease the number of people at end of life dying in a hospital setting

To Increase the number of people at end of life dying in their normal place of residence. (Domain 3,4,5)

WHY CHANGE IS NEEDED?

Population forecasts published in 2012 suggest Sefton's resident population is set to grow by around 5% by 2035. The largest percentage increase across the population will be amongst older residents, aged 65 and over, with this age group expected to rise by more than 40% from 59,000 in 2012 to 83,000 by 2035. With 21% of residents in area aged over 65, Sefton already has one of the highest proportions of older residents nationally.
A survey commissioned by the National Audit Office and based on data from Sheffield in 2008 found that 40% of 200 patients who died in hospital were found to have had no medical need which required them to be in hospital at the point of admission, and could have been cared for and died elsewhere.

DESCRIPTION

- Hospice at Home

Consultant End of Life Care at Home Partnership, is an outreach service provided by a recognised Specialist Palliative Care Consultant led unit. It is able to provide a full range of hospice/specialist palliative care services and so give the patient and family the appropriate service at the appropriate time to meet their specialist needs. The aim of this service is to fill the gaps in the usual planned and currently funded community and sitting services, to ensure people can stay in their own homes. This is also in line with government policy to provide care to enable more patients to die at home.

- End of Life Care Home Facilitator

This End of Life Care Home Facilitator's role involves working within the framework of the North West End of Life Care Model, in ensuring best practice end of life care for all conditions.
The role plays a key part in enabling and empowering health and social care professionals to deliver best practice end of life care in their organisations.

KEY MILESTONES	Q1	Q2	Q3	Q4
Ensure staff capacity to deliver H@H service				
Increased number of care homes participating in education programme				
Encourage GP Practices to find their 1% of patients at end of life (QP Indicators)				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Increase of people dying in their normal place of residence				
Decrease in unnecessary hospital admissions				
GP Practices identifying and recording their 1% of patients at end of life				

RISKS	MITIGATING ACTIONS
Patients not being identified as being at end of life	
Care homes not participating in education programmes	

WORKFORCE IMPLICATIONS

None at this time

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14	H@H = £160,000 Care Home facilitator = £45,000	Not known at this time
2014/15	H@H = £160,000 Care Home facilitator = £45,000	Not known at this time
2015/16	H@H = £160,000 Care Home facilitator = £45,000	Not known at this time
Total	£615,000	Not known at this time

NHS
Southport and Formby Clinical Commissioning Group

Priority Area: Obesity Lead Clinician To be confirmed

OBJECTIVE
Develop an obesity strategy and clarify obesity treatment pathway.

WHY CHANGE IS NEEDED?
Nearly half of the adult population are overweight, obese or very obese (108,000 adults). A quarter of 5 year olds and more than a third of our 11 year olds are now overweight or obese.

DESCRIPTION
Develop an obesity strategy that links the current weight management programme with BMI screening, public health interventions and opportunities provided by Sefton Council and other voluntary sector organisations Work with public health to ensure that prevention based interventions/programmes are part of clinical interventions for patients (adults and children) who are overweight or obese Clarify the referral criteria and treatment pathway for bariatric surgery

KEY MILESTONES	Q1	Q2	Q3	Q4
Sefton wide obesity strategy agreed				
Every contact counts implemented				
Review bariatric surgery pathway				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16

RISKS	MITIGATING ACTIONS
Funding only ring fenced for 2 years	Value for money evidenced

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Priority Area : Alcohol Lead Clinician: To be confirmed

OBJECTIVE
To slow down the current rate of alcohol related hospital admissions To reduce current levels of binge drinking To increase the capacity and skills of hospital staff at S&O Hospital to provide screening and brief intervention support to increasing and higher risk drinkers (Domain 1,2,3,4)

WHY CHANGE IS NEEDED?
Alcohol related admissions is in the upper quintile in wards within this CCG. Approximately 1 in 4 men and over 1 in 7 women drink at increasing or higher risk levels. This is similar to regional average. Higher risk drinking is more common amongst males.

DESCRIPTION
In partnership with West Lancs CCG jointly commission and performance manage the Hospital Alcohol Liaison Service at Southport & Ormskirk NHS Hospital Build capacity and skills to facilitate the provision of Identification and Brief Advice(IBA) across all Southport & Ormskirk Hospital Sefton council is currently commissioning an integrated substance misuse service. We will work with them to ensure the service is responsive to the needs of residents and is integrated via appropriate pathways with CCG commissioned services.

KEY MILESTONES	Q1	Q2	Q3	Q4
To be agreed				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Achieve reductions in the projected rate of increasing AF1 alcohol specific admissions at Southport & Ormskirk Hospital	-5%	-5%	-5%	-5%
Achieve reductions in the length of stay as a result of alcohol specific admissions	-5%	-5%	-5%	-5%

RISKS	MITIGATING ACTIONS
Inability to recruit Alcohol Specialist Nurses	Provide in house alcohol specialist nurse training for existing S&O staff
Committing to 1 year funding only will not return savings on investment	Commit to a 3 year funding programme for the Alcohol Specialist Nurse Service
Reliant on partnership investment with West Lancs CCG	Negotiate with W Lancs CCG re investment intentions Years 2/3

WORKFORCE IMPLICATIONS
Alcohol Nurse Specialists 1 WTE Band 7, 3 WTE Band 6

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	108,700	61,000
2014/15	111,000	400
2015/16	111,000	86,000
Total	330,700	147,400

NHS
Southport and Formby Clinical Commissioning Group

Priority Area : Maternal Health Lead Clinician: to be confirmed

OBJECTIVE
Increase initiation and continuation rates for breastfeeding (Domain 1,2,3,4)

WHY CHANGE IS NEEDED?
Sefton rates, although the highest in North Mersey are below the regional and national average. Breastfeeding . Breastfeeding is the best form of nutrition for infants. Exclusive breastfeeding is recommended for the first 6 months of life. Available evidence suggests breastfeeding may have long term benefits such as reducing the risk of obesity and type 2 diabetes

DESCRIPTION
The CCG will work with partners to develop an environment that encourages and enables women to breastfeed. We will work to ensure that services provide individualised care and support, specifically we will Use commissioning levers to ensure maternity providers used by Sefton women are on target to achieve the UNICEF Baby Friendly Initiative Develop a CQUIN that rewards maternity and community providers who achieve improvements in initiation and continuation rates Work with public health to explore the possibility of a similar reward scheme for the community peer support scheme. Contribute to the Maternity Services Liaison Committee action plan objective of increasing breastfeeding, especially amongst younger women and those from the most socially and economically deprived areas. Support the Liverpool City Region Child Poverty and Life Chances Commission to implement their plan to increase Breastfeeding across Merseyside.

KEY MILESTONES	Q1	Q2	Q3	Q4
Liverpool Community Health to complete stage 3 BFI assessment				
Southport & Ormskirk Trust to receive Breastfeeding initiative assessment				
Agree collaborative approach to commissioning with NCB and LA				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
To be agreed				

RISKS	MITIGATING ACTIONS
Fragmented commissioning of key services which influence decisions to breastfeed and provision of breastfeeding support	CCG, NCB and LA to agree joint targets and performance monitoring, and service improvement systems.

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Priority Area : Primary Development Clinical Lead: Dr Bal Duper

NHS
Southport and Formby
Clinical Commissioning Group

OBJECTIVE
To devise a primary care medical strategy focusing on local priorities to support continuous primary care quality and development. The aim is to improve quality, capability and productivity further and to create capacity within primary care. (Domains 1,2,3,4)

WHY CHANGE IS NEEDED?
From April 2013 a statutory duty of the CCG will be to assist and support the NCB in discharging its duty in relation to securing continuous improvement in the quality of primary medical services. NHS restructures / changing policies especially in regard to NCB Primary care capacity and development to reflect NHS and population

DESCRIPTION
The process of developing the strategy will include key stakeholders and engagement of people directly involved in delivering primary care services. The strategy will consider • practice demographics • Workforce development • Clinical services particularly primary care through locality model • Premises / estate management • IT • Health outcomes of primary care activity

KEY MILESTONES	Q1	Q2	Q3	Q4
Draft Primary Care (Medical) Strategy				
Board Approval				
Implementation strategy				
Investment of areas in primary care strategy				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Quality premium – primary care areas				
Primary care strategy in place				
Investment of primary care development				

RISKS	MITIGATING ACTIONS
Variable engagement from stakeholders	Involvement with partners eg: LMC, Locality clinicians
Involvement in primary care development reflecting patient needs	Strategy will reflect recommendations of recent Francis report
Resources within CCG for substantial piece of work	Consider investment

WORKFORCE IMPLICATIONS
To be determined via primary care strategy

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	To be determined	
2014/15	To be determined	
2015/16	To be determined	
Total		

Priority Area : Medicines Management Lead Clinician: Dr Hilal Mulla / Dr Janice Eldridge

Southport and Formby Clinical Commissioning Group

OBJECTIVE
To optimise prescribing and outcomes for patients by ensuring medicines used are safe, appropriate and are both clinically effective and provide value for money. (Domain 1,2,3)

WHY CHANGE IS NEEDED?
Primary care prescribing accounts for one in every nine pounds spent in Southport and Formby CCG. The pressure on prescription item growth will continue at 6-7 % pa. There is a constant requirement to work towards the statutory duty of the CCG to remain in financial balance. There is a duty to ensure health outcomes for patients are improved by prescription of medicines rather than management of cost alone. This will require support in evidence based decision making, focussing on vulnerable patient groups and continued engagement with primary care prescribers.

DESCRIPTION
A clear and realistic medicines optimisation plan based upon a realistic prescribing budget will keep primary care prescribers engaged in safe and effective prescribing. A strong medicines management team support will support the delivery of the plan in addressing both therapeutic and disease areas in practice as well as supporting different systems of work in prescribing. Engage with over providers to direct accountability and responsibility for supply of medicines/ appliances to the most appropriate service. Medicines support to the older persons /long term conditions management project

KEY MILESTONES	Q1	Q2	Q3	Q4
Optimisation plan ratified				
Work stream plan developed				
All practices visited to ensure plan is actioned				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Evidence based decision making programme delivered				
Patient education campaign on medicines waste				

RISKS	MITIGATING ACTIONS
Financial balance is not achieved	Prescribing quality scheme to engage practice
Lack of capacity of medicines management team to deliver support at practice	Support of team members and investment in key area to ensure support is consistent

WORKFORCE IMPLICATIONS
Practice coverage plan in place. Locality leads for medicines management now in place. Review of functions in practice to maximise benefits of support to prescribers.

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		900,000
2014/15		
2015/16		
Total		

2.3 Additional information relating to the NHS Framework domains

Ensuring people have a positive experience of care

Currently 92% of patients have a good experience of primary care and 79% have a good experience of Out of Hours (OOH.)

We will work with practices to improve the quality of primary care - this is one of our strategic objectives. The OOH service is currently out to tender and we will work with the successful bidder to improve patient satisfaction for OOH services

Patient Experience of hospital care: Southport and Ormskirk Hospital Trust is on the national average, the other providers are above the national average, the data for the Ramsey Group is not available.

We will work with each provider to understand the patient's experience and together will implement the friends and family test and ensure that the results are clearly published on the Trust's and CCG's web page. A large proportion of practices now have a Patient Reference Group and our Engagement and Patient Experience Group (EPEG) is co-ordinating a range of relevant activities to gain feedback (see p55).

Providers (ordered by number of admissions) for this CCG	Number of Admissions / spells (Acute 2010/11)	4b Inpatient Overall Experience	4.1 Outpatient Overall Experience	4.2 Inpatient Responsiveness to needs	4.3 A&E Overall Experience
Southport & Ormskirk Hospital NHS Trust	24,674	76	79	64	79
Aintree Hospitals NHS FT	2,054	77	79	69	83
Ramsay Healthcare UK Operations Ltd	1,260	NA	NA	NA	NA
Alder Hey Children's NHS FT	1,013	NA	NA	NA	NA
Royal Liverpool & Broadgreen Hospitals NHS Trust	984	77	81	70	82
CCG weighted average		76	79	64	79
England average		Tbc	Tbc	Tbc	Tbc

Treating and caring for people in a safe environment and protecting them from avoidable harm

Current Health Care Associated Infection (HCAI) rates:

- MRSA (rate per 1000) = 3.91 Bottom Quintile (worse)
- C Diff (rate per 1000) = 37.9 Bottom Quintile (worse)

During 2013-2014, we plan to:

- Significantly reduce C Difficile in all providers in the local health economy
- Use the National Quality Dashboard to identify potential safety failures in providers
- Deliver zero tolerance to MRSA infection and conduct Post Infection Review

We have support from CMCSU to ensure that the indicators relating to HCAI (MRSA and C Diff) are in the provider contracts for 2013-14. Our Chief Nurse supports the CCG Clinical Quality Leads in this area. HCAIs will continue to be a focus of discussion at the appropriate contract / quality meetings with remedial action planning being put in place as appropriate. We are working in partnership with Liverpool CCG and providers to set up a Strategic HCAI forum to address these issues that will be led and driven at a strategic level – CCG representation includes the GP Clinical Lead for Quality, Chief Nurse and the Head of Medicine's Management. Current status regarding HCAI will be a standard agenda item at the Quality Committee with reporting also to the Governing Body Board Meeting. We also plan to link to the Quality Premium, part of which covers HCAI.

3.0 The 3 local priorities – Quality Premium

Ownership of the local priorities

The following local priority areas have been agreed by:

- The CCG Governing Body during informal and formal Board meetings in February and March 2013
- The CCG Wider Constituent membership – through the Wider Group meeting in March 2013
- The Health and Wellbeing Board – formally presented at March meeting and supported
- The CCG Experience and Patient Engagement Group (membership including Sefton LINKs, Sefton CVS, Sefton MBC and CCG Board Lay and Practice Manager members.) March session

The priorities have also been mapped to the Health and Wellbeing Strategic Objectives, the CCG Commissioning Intentions, and feedback from recent public consultation events to ensure that they fit strategically and respond to issues raised by local people. These are shown in Appendix 2.

Our 3 local priorities are:

1) **Reduction in A&E attendances from care homes**

Rationale - A recent local study highlighted that, with better support in care homes, a number of A&E attendances could have been avoided and the patient experience improved.

We plan to work with care homes to improve the identification of patients within primary care who are admitted to care homes and record this within GP clinical systems. This information will enable a more proactive approach to providing clinical support to patients within care homes.

Measures - 5% reduction in A&E attendances for patients within care homes

2) **Reduction in hospital admissions for patients under 19 related to asthma**

Rationale - The NCB outcomes benchmarking pack and the Atlas of Variation shows that Southport and Formby has more admissions than the national average in this area.

A new children's community nursing team will be established and will work with general practice to support children and families to prevent admissions.

Measures- 5% admissions for asthma <19 years

3) Reduction in Alcohol Specific Hospital Admissions

Rationale - In Sefton one in five residents drink at increasing or higher risk levels and one third of all hospital admissions are in some way alcohol related. Across Sefton the costs to the health service of alcohol related harm is estimated to be £14,755,000 *(Sefton Comprehensive Needs Assessment May 2012).* Alcohol specific admissions have increased by 18% per annum, for each of the last 5 years; clearly this is a significant driver for change. Three conditions account for over 95% of alcohol specific admissions and account for over 600 admissions each year.

We plan to implement a Hospital Alcohol Liaison Team within A&E at Southport and Ormskirk NHS Trust to manage the care of patients with alcohol specific admissions and working with colleagues in primary care reduce the number of admissions throughout the year.

Measures - 5% reduction in alcohol specific admissions (F10) (approximately 78 admissions) during the year

Delivering and monitoring progress through localities

Our four localities will play a key role in the planning and implementation of these local quality premium priorities and monitoring progress towards the national measures. Locality Managerial leads will work with clinical leaders within the localities to drive this process, supported by the GP lead for Quality and the Head of CCG Development.

The proposed process is:

Quarter 1: Consider benchmarks and agree plan of action within each locality.

Quarter 2: On-going implementation of plan and data review

Quarter 3: Review progress against quality measures

Quarter 4: Final data capture to demonstrate improvements.

Progress against the measures will also be included in the CCG Board performance dashboard.

4.0 The Basics of Care

We will drive quality improvement in the delivery of care from all providers and will seek on going assurance that provider cost improvement programmes, services are safe for patients with no reduction in quality and do not contravene NICE guidance.

We have plans in place to utilise suggested tools - Quality Dashboards and the Safety Thermometer - together with intelligence from staff and patient surveys. A Quality Dashboard, that includes staff survey information, is presented to both the Quality Committee and to our Governing Body. Our main providers voluntarily participate in the North West Transparency in Care Audit, which reports on a monthly basis in the public domain information on staff views regarding the organisation as a place to be cared for at when harm (e.g. pressure ulcer or fall) has occurred on a particular ward or department.

We have agreed the local quality indicators and CQUINs relating to patient safety and patient experience that it wishes to be negotiated into the contracts for 2013-14 alongside the national mandated indicators and CQUINs. We will be supported in this by CMCSU in this.

Our GP Quality Leads, supported by our senior management team and CMCSU, lead the Quality Contract meetings with providers, where performance in relation to quality is monitored. Finance representation at the Quality Committee is provided by our Chief Finance Officer and Quality representation at the Finance and Resource Committee is provided by our Chief Nurse, as part of our risk management processes.

'How to Guides' – such as the Quality Impact Assessment of Provider CIPs and Rapid Response Review - will be used as appropriate under the Governance arrangements set out within the CCG constitution.

In addition we are commissioning a governance review by Merseyside Internal Audit Authority (MIAA) to test committee functions in order to add extra assurance.

5.0 Patients' Rights: The NHS Constitution

We are developing a framework to performance manage the requirements of the NHS Constitution. The CCG Experience and Patient Engagement Group (EPEG) will have the responsibility within the governance structure to review this framework in order to reassure our governing body and our wider members that the rights and pledges from the NHS are adhered to across the system.

5.1 Eliminating Long Waiting Times

We have plans to ensure:

Referral to Treatment for waiting times for non-urgent consultant-led treatment:

- 90% of admitted patients to start treatment within a max of 18 weeks from referral
- 95% of non-admitted patients to start treatment within a max of 18 weeks from referral
- 92% of patients on an incomplete non-emergency pathway (yet to start treatment) should have been waiting no more than 18 weeks from referral

We will ensure that patients have access to high quality treatment in a timely manner. This means patients will be seen and treated within the 18 week pathway. We will work with Southport and Ormskirk Hospital Trust to maintain performance and ensure that we have early warning of any potential problem and offer patient alternative pathways.

We will also work with the Trust to ensure that there are no patients waiting over 52 weeks and that the Trust moves to a maximum waiting time of 40 weeks. SFCCG will use contractual levers where appropriate.

Diagnostic test waiting times

We plan to ensure:

- 99% of patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral

In order to help Southport and Ormskirk deliver the 18 week pathway, we will work with the Trust to enable patients to access diagnostic tests within 6 weeks.

5.2 More Responsive Care: Urgent & Emergency Care

A&E waits

We plan to ensure:

- 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department
- No patient to wait on a trolley for longer than 12 hours

We are working with Southport and Ormskirk Hospital Trust to deliver the A&E standard. Whilst the Trust has struggled to deliver the standard over the past two years, the health economy has made improvements in urgent care pathways, many of which are based on prevention of attendance / admission by managing people in the community. As an Integrated Care Organisation, Southport and Ormskirk Hospital Trust is well placed to implement these new pathways. In addition, we will work with the Trust to improve patient flow from admission to discharge.

Category A ambulance calls

We aim to ensure:

- 75% Category A calls resulting in an emergency response arrive within 8 minutes (met for red 1 and red 2 calls separately)
- 95% Category A calls resulting in an ambulance arriving at the scene within 19 minutes

Urgent and Emergency Care

- All handovers between an ambulance and an A&E department to take place within 15 minutes and crews ready to accept new calls within further 15 minutes
- Implement contractual fine for all delays over 30 minutes, further fine for delays of over an hour

Sefton saw a surge in Category A calls in the latter half of 2012. The CCG is looking at several data sources to understand this surge, however this target has been met by NWAS in the past, and the CCG has confidence that NWAS will deliver the target. We will apply the contract levers and fine the Trust for breaches of the 30 minute handover time

Cancer waits – 2 week wait

We plan to ensure:

- 93% max 2 week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP
- 93% max 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)

Actions to achieve this:

- Implement cancer waits CQUIN which incentivises delivery of first key diagnostic test (rather than outpatient appointment) by day 14 and reducing cancellations and DNAs of 2 week target appointments
- Modelling has shown that delivery of the first key diagnostic within 14 days has a strong positive impact on reducing 62 day breaches
- Produce a refreshed patient leaflet to be given by GP at the time of referral to help patients understand why they have been referred urgently and encourage attendance. DNAs and cancellations of 2 week wait target appointments have a significant impact on efficiency and performance, as well as delaying treatment

Cancer waits – 31 days

We plan to:

Maintain good Trust and CCG level performance against the standards set out below.

- 96% max one month (31-day) wait from diagnosis to treatment for all cancers
- 94% max 31 day wait for subsequent treatment where that treatment is surgery
- 98% 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen
- 94% max 31 day wait for subsequent treatment where that treatment is a course of radiotherapy

Surgical capacity is the most common issue accounting for breaches.

Cancer waits – 62 days

We aim to deliver:

- 85% max 2 month (62-day) wait from urgent GP referral for treatment for cancer
- 95% max 62 day wait from referral from an NHS Screening service for treatment for all cancers
- Max 62 day wait for FDT following a consultant's decision to upgrade the priority of the patient (all cancers) - no operational standard

We plan to:

- Implement cancer waits CQUIN which incentivises referral to treating trust by day 42 of the pathway
- Continue to monitor performance closely. A number of improvement areas have been identified – for example the use of timed diagnostic pathways for specified tumours especially those using specialist surgical centres where multiple trusts are likely to be involved
- Work with Southport and Ormskirk to use the Intensive Support Team to support this area of work

5.3 Keeping Our Promises: Eliminating mixed-sex accommodation

Mixed sex accommodation breaches

We will work in partnership with our commissioned providers to ensure there are minimal mixed sex accommodation breaches. This will be monitored through the appropriate contract and quality meetings supported by CMCSU and appropriate action taken – for example remedial action plan, or invoking of financial penalties. Performance and Quality Reports, which include mixed sex accommodation breaches, is a standing agenda item at our Quality Committee and the Governing Body meetings.

5.4 Keeping Our Promises: Reducing Cancellations

Cancelled Operations

- All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patients treatment to be funded at the time and hospital of the patients choice
- No patient to tolerate an urgent operation being cancelled for the second time

We will work with Trusts to ensure that cancelled operations are kept to a minimum and where an operation is cancelled patients are offered an alternative date within the 18 week pathway where possible.

5.5 Mental health

We plan to ensure:

- 95% of the proportion of people under adult mental health specialities of Care Programme Approach (CPA) who were followed up within 7 days of discharge from psychiatric in-patient care during the period. (Currently 97.25% is achieved)
- The full roll-out of the access to psychological therapies programme by 2014-15 and reach a 50% recovery rate

5.6 Keeping Our Promises: Choice and the information to exercise it

We are committed to ensuring the delivery of the 18 week Referral To Treatment standard for our population and we will continue to rigorously performance manage providers to ensure contract compliance with this national standard.

As set out in the NHS Constitution, we will ensure that in the unlikely event that a patient breaches this target, and they have not chosen to wait longer or it is not clinically appropriate they do so, there is an effective working process in place to offer a range of alternative providers using the 'Right to Redress' process adopted by our local providers.

We will work with all our providers to ensure outpatient letters provide patients with information on their right to treatment within maximum wait times and have a process in place for patients who are concerned or will likely to wait longer to formally redress the situation.

During 2013-2014, we will explore the health market for service providers who have the capacity and capability to deliver the high quality, timely and cost effective services our population require and are able, within the competitive market, to demonstrate a willingness and ability to meet all national and local standards.

We will promote the use of Choose and Book with our GP colleagues, and will continue to work with our Local Hosted Trusts to reduce slot issues to the 'gold standard 0.04 slot issues per successful Choose and Book Booking'. This will be performance managed to ensure capacity is proactively managed and appointments made available to Choose and Book.

5.7 Keeping Our Promises: Dementia, IAPT, Military Veteran health, Offender health, Health visitors

Dementia

Aim to increase timely detection rates across Sefton to 75% by 2015-16:

Primary Care: Dementia: (NHS Outcome Framework Domain 1, Domain 2, Domain 4 and Domain5)

Current rate of detection for dementia is: NHS Southport and Formby CCG - 49%

‘ Care Closer to Home’ and ‘Virtual Ward’ approaches and via CQUIN’s with Liverpool Community Health Trust and Merseycare NHS Trust

Improved access to GP and health screening for Sefton residents over age 65

In the GMS – Contractual Changes 2013/14 (for consultation) the NHS Commissioning Board to develop a Dementia Case Finding Scheme with GP’s.

Extra support for GPs on dementia, the Department of Health is working on a dementia toolkit for surgeries. This is to better equip them to spot and diagnose dementia, and to help people with dementia and their carers to manage the condition.

GP support from Alzheimer’s’ Society (Sefton) for training and awareness raising

Increase in ‘appropriate’ patient flow from GP practices to Memory Assessment Units in Waterloo and Southport

Increase in locality based assessment of the psycho-geriatrician service e.g. in persons home, as appropriate

Increase in appropriate prescribing of anti-dementia drugs which can help to delay progression of disease

Secondary Care:

A National CQUIN has been developed that will have 3 main aims:

Identify people with dementia – members of staff in hospitals will ask members of the family or friends of a person admitted to hospital if the patient has suffered any problems with their memory in the last 12 months

Assess people with dementia – if there is evidence to suggest a problem with their memory, that person will be given a dementia risk assessment

Refer on for advice – a referral would be made for further support either to a liaison team, a memory clinic or a GP

Aim to enhance the quality of life for people with dementia:

Improve access to post diagnostic support through access to a full range of services including Alzheimer's Society Dementia Community Support Service, Peer Support Groups / Dementia Cafes following diagnosis

Working collaboratively with Sefton Council and other partners ensure each person has a personalised care plan post diagnosis

Ensure people with dementia have access to advocacy assistance if required through Sefton Pensioners Advocacy Centre, Sefton Carers Centre

Ensure people diagnosed with dementia and their carers have full benefits check post diagnosis

Increased carers assessments and individualised support for carers of people with a diagnosis of dementia

Improve access to appropriate community and social networks to maintain independence via voluntary community and faith sector support and sign up to Dementia Action Alliance

Aim: Achievement of the Care Programme Approach (CPA) follow up target: (NHS Outcome Framework Domain 2, Domain 3, Domain 4)

Ensure full roll out of the access to psychological therapies programme to deliver a recovery rate of 50%

Increase the proportion of people with depression/anxiety entering treatment

NHS outcomes framework 2013-14 Domain 4 - Ensuring that people have a positive experience of care. Patient experience of community mental health services (4.7)

Care Programme Approach (CPA): 95% of the proportion of people under adult mental health specialities of CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.

Aim: Improving Access to Psychological Therapies (IAPT): (NHS Outcome Framework Domain 2, Domain 3, Domain 4)

The plan is to employ IAPT Wave 5 trainees that are currently employed on temporary contracts as permanent staff post qualification. Funding for wave 5 investment been agreed by Financial Sub Committee of NHS Southport and Formby CCG and NHS South Sefton CCG to ensure success in achieving the 11% prevalence target for 2013-14

To participate in Wave 6 of the roll out to achieve DH objectives of meeting 15% prevalence with recovery rates of 50% by 2014-15.

Three IAPT CQUIN's have been developed to achieve the overall outcome on improving access to psychological therapies:

CQUIN 1:

Inclusion Matters (IM) will increase the delivery of psychological therapies through on-line, telephone, text and remote video interactions.

1. IM to develop an e-clinic model to improve online access to psychological therapies.
2. In the first year to train 10 staff in each area to deliver online therapy
3. By Q4 trained staff to deliver 15% of therapy online
4. IM to produce Quarterly progress report

CQUIN 2:

Inclusion Matters will establish on-line relapse prevention facilities.

1. IM to develop an on-line relapse prevention facility.
2. In the first year to train 5 staff in each area to act as online facilitators
3. To develop online relapse prevention facilities in relation to at least three different conditions
4. By Q4 online relapse prevention will be offered to all clients who have finished a course of therapy in relation to the specific conditions
5. IM to produce Quarterly progress report

CQUIN 3:

In conjunction with Inclusion Matters Merseyside, Mayden Health, and Health Care Gateway, Inclusion Matters will develop a system for sending GP letters electronically.

IM in conjunction with partners to develop an electronic GP letter system

2. By Q4 all IM staff trained to in using electronic GP letters
3. IM to produce Quarterly progress report

Military Veteran Health

- Under the new commissioning arrangements commissioning of services for Armed Forces Veterans, Reservists and Armed Forces Families (serving, reservist or veteran) are the responsibility of CCGs in the North West
- CCGs across Merseyside were asked to consider funding the MVIAPT service for a further 12 months. The request is that each CCG allocates £30k for the service for 2013-14. Southport and Formby CCG has signed up to this for 2013-2014
- Further work will need to be undertaken to understand patient flows and service uptake as current data suggest fluctuation in referral levels. Once this work has been completed, we will be better placed to understand future commitments
- We will undertake a mapping exercise of local services offering support to military veterans and their families to support and encourage partnership working
- MVIAPT will be encouraged to meet with CCG colleagues and seek to promote an increase in referrals
- We will ensure through workforce development strategies that Military Veterans and the issues they face are part of any continuing professional development programme

What is a Veteran?

The Ministry of Defence (MOD) defines a veteran as “anyone who has served in HM Armed Forces, at any time, irrespective of length of service (including National Servicemen and Reservists)”.

In 2011 a number of legislative initiatives were proposed that ensured continued support for current and ex-service personnel. They included:

Armed Forces Act 2011: Annual duty to report on progress against the Military Covenant to Parliament including Health & Social Care Bill 2011: Includes duty of the NHS Commissioning Board to commission services on behalf of the Armed Forces.
NHS Mental Health Strategy 2011: Includes a specific provision for veterans.

Under the new commissioning arrangements commissioning of services for Armed Forces Veterans, Reservists and Armed Forces Families (serving, reservist or veteran) are the responsibility of CCGs in the North West. CCGs will also be responsible for the commissioning of emergency care services for veterans and family member in their area.

Sefton Community Voluntary Services have led on the establishment and servicing or a Sefton Armed Forces Community Covenant Partnership to co-ordinate multi – agency activity. Sefton has now developed, and signed off, a Local Community Covenant which sets out commitments to supporting the Sefton armed forces community.

CCGs across Merseyside were asked to consider funding the Military Veteran IAPT service for a further 12 months. The request is that each CCG allocates £32k (circa) for the service for 13/14. Southport & Formby CCGS have signed up to this for 2013-2014. The funding will be used for providing access to veterans to:

An IAPT based Psychological Service adapted for ex and current Service Personnel and their families. This project is hosted by Pennine NHS Foundation Trust

The Live at Ease Project – To support ex-service men/women adapt to civilian life. Support including help with housing, accommodation, employment, training, debt advice and drug and alcohol dependency issues. The project will also support family members.

Liverpool Public Health Observatory is carrying out a health needs assessment for ex armed forces personnel and their families, on behalf of Merseyside and Cheshire Directors of Public Health. What do we already know about the needs of families? Initial findings have already identified the following:

Poor access to health and wellbeing advice

Depression, reliance on alcohol and anxiety as being common within service families

Worrying about a husband/wife/partner away on active service

Struggling to cope alone and with children

Living far away from their immediate family, lack of immediate support

Limited social network, moving around prevents friendships and support networks forming

Financial insecurity, unable to work due to house moves and caring commitments.

Domestic abuse as both victims and perpetrators

Most recent available data from Wirral NHS 2007, estimates that the following number of veterans resident in the north and south Sefton population.

PCT/ Age	16-24	25-34	35-44	45-54	55-64	<65's
Sefton	516	797	1996	2282	2400	7992

Currently all service personnel and families do not have an NHS number making it difficult to establish the level of spend on these groups. A project is on-going to map across Defence medical Service (DMS) number to the NHS number.

Further work will need to be undertaken to understand exact numbers, patient flows, and service uptake as current data suggest fluctuation in referral levels. Once this work has been completed CCGs will be better placed to understand future commitments, Consideration will need to be made for the recent military veterans redundancy scheme that will increase veterans returning to Sefton.

The Northwest armed forces Network held a commissioning handover event in March 2013, including handover arrangement for Clinical Commissioning Groups (CCGs). Each CCG identified a lead person to support and develop their local Military Health agenda

Southport & Formby CCG will continue to work with Sefton CVS to undertake a mapping exercise of local services offering support to military veterans and their families to support and encourage partnership working.

CCGs should ensure through workforce development strategies Military Veterans and the issues they face are part of any continuing professional development programme.

6.0 Patient Centred, Customer Focussed

6.1 NHS services, 7 days a week

We plan to respond to the Medical Director's report to ensure primary and community services deliver high quality, responsive service in out of hours and ensure better access to routine services 7 days a week in urgent and emergency care and diagnostic services.

We have dedicated project management support to the area of unplanned care. The demographics of our CCG are indicating a predicted use of our over 75 population from 11.4% in 2011 to 13.5% by 2020. It is the intention in 2013-14 to review and transfer this element of care through work with all our partners and to this end we have established a 'care close to home' (CCH) network. The network involves the following membership:

- Mental Health Services
- Social Services
- Hospital Services
- Ambulance Services
- Community Services
- Other CCGs

Our strategic planning refresh and business plan for 2013-14 will focus on the four CCG key strategic elements - namely driving improvement in the public health and wellbeing of Sefton residents, improving quality of primary care and delivery of community services, reducing the demand on secondary care and ensuring cost effectiveness of high quality tertiary care - which are intrinsically linked to the true use of NHS services through 7 days a week. As commissioners we will work through the CCH network to specifically shape primary, community and secondary care services and focus on integration, with social care, support from the Ambulance Trust and the third sector. This work will help to drive out service transformation.

Work needs to be undertaken with our main secondary care provider to scope and understand the diagnostic requirements of our population and the capacity needs. This will not only support unplanned care delivery but also our planned care delivery. This work should support the findings of the review launched on the 18th January 2013 by Sir Bruce Keogh – NCB Medical Director. We work closely with West Lancashire CCG and South Sefton CCG around the Southport and Ormskirk ICO footprint. However, work across all six Merseyside CCGs with the NCB's Local Area Team to firm up future arrangements to 'share and spread' learning, is currently underway. There is a specific focus on the impact of the major strategic service changes, such as the reconfiguration of trauma, vascular, cancer and rehabilitation services at this more regional as well as local level for each individual CCG Commissioner. The work plan of the Merseyside CCG network will be prioritised during 2013-14 to focus on and be cognisant of the Keogh review.

6.2 More transparency, more choice

In summer 2013, the Healthcare Quality Improvement Partnership (HQIP) will develop methodologies for case-mix comparison and publish activity, quality measures and national survival rates for every consultant in:

- Adult cardiac surgery
- Interventional cardiology
- Vascular surgery
- Upper gastro-intestinal surgery
- Colorectal surgery
- Orthopaedic surgery
- Bariatric surgery
- Urological surgery
- Head and neck surgery
- Thyroid and endocrine surgery

We expect each of our providers for the services they commission to publish their own information on these specialities on their website in the HQIP format in preparation for inclusion in the standard contract 2014-15.

We are currently developing a plan to detail how we intend to increase Choice in 2013-14 at all points of the pathway and how, where and in what services / pathways choice and competition will make the most difference.

6.3 Listening to Patients and Increasing Their Participation

We are working with providers to gather public insight into local health services and our Quality Lead GP is working to develop a CQUIN on patient experience. We have systems to ensure patient experience and insight is reported to our Quality Committee for scrutiny and action, as this section describes:

Acting on feedback

We are exploring a number of options presently and working with providers in the development of a patient feedback framework (via the CQUIN) which places the patient at the centre of the service. However, taking into account the national policy direction, we are considering utilising the Patient Access to Health Records programme as a key mechanism by which patients can leave feedback in real time. We will be working with CMCSU to fully realise the potential of developing technology and utilisation of social media tools and other programmes via an expanding digital eco system. We recognises the opportunity for developing ICT based solutions and models that support the development of a participative society in which patients, their families and carers respond and interact collaboratively for their own benefit and for the benefit of the wider community as a collective movement (Social Return on Investment).

We recognises that the Friends and Family Test is still in developmental form and understand that each provider will have chosen to develop its own systems and processes (as independent businesses) by which they capture and report patient feedback. With the potential for diverse fragmentation of systems across providers and possible manipulation of data, we are focussed on the development of technological based

systems - supported by a communication strategy and enhanced patient and public participation programme - which encourage Southport and Formby residents to become active citizens in their own health. Implementation of this programme fully supports the DH publications 'The Power of Information' (May 2012), articulating the NCB's commitment to improved customer service, through systematic patient and public involvement, intelligence based insight and positive patient outcomes.

We are of the opinion that the introduction of capturing real time feedback via Patient Access to Records (PATR) would generate significant savings (and supports the QIPP agenda) for providers who currently employ capacity and invest in systems and processes to support their own patient experience agenda and the newly introduced Friends and Family Test (FFT). In collaboration with our provider partners, we will seek to fully understand the potential for cost savings through development and implementation of comprehensive technological systems, which focus on patient experience and not based upon the commissioner/provider relationship. There is potential to capture all patient feedback in real-time via one source (PATR) linked to the NHS Information Centre for Health and Social Care (such a system could also be utilised by Social Care partners) providing a comprehensive data-set for patient consumption. The implementation of this process fits with the ideology and vision of the NCB National Director for Patients and Information, Tim Kelsey and supports the further role out of FFT into primary care by 2014-15.

We would welcome the opportunity to be a pathfinder in demonstrating how we would utilise the Patient Access to Health Records as a functional mechanism in reporting the consequences of feedback from the FFT.

Informing patients

We will continue to:

- Work with our local Health and Wellbeing Board to assess population need
- Work with Health Watch to ensure public involvement plans match local expectations for engagement at individual and collective level
- Develop metrics to evaluate socio economic return on investment and other impacts of patient and public involvement activities

We have played an integral role in the development of the Sefton Health and Wellbeing Board (HWBB). Our Chair has been a member of the shadow Board since its inception and has more recently been joined by our Accountable Officer. The HWBB, building on previous close working relationships in Sefton, has led an approach to assessing the population needs through a refresh of the JSNA. The results of this JSNA have formed the basis of the Joint Health Strategy, which is currently out for consultation and has been the subject of a very extensive consultation process and (along with our CCG commissioning intentions for 2013-14) the focus of five large public events across Sefton during December 2012 and January 2013 (see Appendix 2 for details).

We have established a joint working group for both CCGs in Sefton called the EPEG (Engagement and Patient Experience Group), which feeds directly into the Quality Committee of each CCG. This group has a broad membership is Chaired by the CCG Lay Board members and comprises of CCG Board Practice Manager members, CCG senior managers, Sefton Council engagement leads, Sefton CVS and Sefton LINk and in future, it is hoped, members and officers of Health watch. This group acts by co-ordinating engagement activities and considers patient information from all parts of the system including GP Practice Patient Reference Groups, LINk Community Champions (who work in local community settings and feed into CCG localities), and LINk patient experience reports of our local providers and CCG wide systems, such as trends from complaints. Once in place, we will work with Sefton Health Watch to ensure that public involvement plans match local expectations for engagement at all levels.

We are seeking to work with CMCSU in developing metrics to evaluate the socio economic return on investments (SEROI) and other impacts of our patient and public involvement activities. We are alerted to the work of the NHS Institute of Innovation and Improvement in collaboration with David Gilbert of InHealth Associates and Sally Williams of Frontline. We are seeking to utilise the learning from the number of case studies referenced in 'The economic case for patient and public involvement in commissioning', co-authored by David Gilbert and Sally Williams. In addition, we will underpin the development of metrics to evaluate the SEROI by utilising learning from implementing our programme supporting shared decision making and fully utilising the recently published 'Smart Guides to Engagement'. We are awaiting the soon to be published 'individual' and 'collective' involvement guidance from the NCB.

6.4 Better data, informed commissioning, driving improved outcomes

Key areas include:

- Universal adoption of the NHS number as the primary identifier by all providers in 2013-14
- We will use the contract to ensure that our local Trust uses the NHS number as the primary identifier. GP practices will have to use the NHS number as part of the implementation of 111
- By the end of December 2013, over 95% of GP practices in Sefton CCG's will be on the EMIS Web clinical system. EMIS Web will provide the opportunity to utilise its searches and reports module to collect clinical data. A Risk Stratification facility is already in place and currently being utilised to present analysed data back to GP practices for clinical care
- A dedicated team of Information Facilitators within Informatics Merseyside will support GP practices and Sefton CCG's to extract and report on clinical data as required
- We will use NHS Standard Contract sanctions in 2013-14 if not satisfied with completeness and quality of provider data on SUS
- We will ensure that secondary care providers will account for patient outcomes and they will ensure the adoption of safe, modern standards of electronic record keeping by 2014-15
- Based on our agreed Informatics Strategy of developing a local Electronic Patient Record (EPR) we are working with all partner Trusts to enable economy wide joined up patient care through systems integration, interoperability and information sharing, encouraging and developing integrated and electronic clinical pathways and communications across health care sectors
- We will ensure secondary care providers comply with data collections based on Information Standards Board and NCB advice by 30 September 2013
- We aim to move to a paperless referral system by 2015 to enable easy access to appointments in primary and secondary care
- We will work with GP practices to pro-actively increase uptake and utilisation of Choose and Book and support practices with training on the Advice and Guidance module to ensure paperless referral systems are utilised wherever possible
- Work is currently on going to utilise EMIS Web's internal referral system to enable electronic referrals across primary and community care. This will be rolled out to all EMIS users as the functionality becomes available
- Direct Commissioners will be responsible for the development of the primary care medical care record by Spring 2015

- An Informatics Strategy has been developed in conjunction with Informatics Merseyside. One of the key components of the strategy is patient empowerment. A key element of this component is the Patient Access to Medical Records project which is currently in progression with two pilot sites. The pilot will establish correct processes and protocols around Patient Access. The results of the pilot will be discussed by our Governing Body and the Local Medical Committee and from this point, future activity will be planned accordingly in response to the findings of the pilot
- The NCB is accountable for ensuring delivery of IT services is devolved to CCGs to manage GP IT services
- We have a Service Level Agreement in place with the CMCSU (and its strategic partnership with Informatics Merseyside) to commission appropriate GP information services to provide clinical assurance and safety

6.5 Higher standards, safer care

Along with the Health and Wellbeing Board, we will work with providers to ensure the recommendations in Transforming Care: A National response to Winterbourne View Hospital and Francis report are implemented, and ensure a dramatic reduction in hospital placements for people with learning disabilities or autism in NHS funded care that have a mental health condition or challenging behaviour.

Our Joint Commissioning Manager for adult services is leading across health and social care on the local response and planning to Winterbourne. We are receiving commissioning support from CMCSU regarding individual packages of care and complex cases but – with Sefton Council – we have retained a specific joint post that has a portfolio around Learning Disability and the commissioning of individual packages of care. Once the Francis Report is published, plans are in place to present the recommendations to the HWBB, Quality Committee and Governing Body.

Chief Nurses across Mersey are working collaboratively to ensure that Nursing Quality Indicators and necessary CQUINs are negotiated into the contracts for 2013-14 as appropriate.

We aim to ensure the Compassion in Practice standards and application of the 6 C's are implemented across all the services provided for our population. We are involved in the regional work regarding informing the implementation of the strategy. Chief Nurses across Merseyside are working in collaboration with the support of CMCSU to develop quality indicators and CQUINs for negotiation into the contract with providers from 2013-14. In particular, we will work in partnership with the NCB Local Area Team as part of their quality improvement role.

We have a lead for Primary Care Quality and Primary Care Quality is a standing agenda item at the Quality Committee.

Comply or Explain Procurement Rule:

CCGs will encourage trusts to (comply) purchase though framework agreements unless they can (explain) articulate a clear reason to take a different approach. This will be discussed with Trusts during contract negotiations and specified in the NHS Standard Contract.

The NHS will have to "Comply" with NICE guidance on new drugs and treatments or "Explain" why there is a delay. We will ensure that the latest NICE approved treatments are available in our area, and if not we will be responsible for explaining to patients why not. Through the NHS Constitution, patients have a right to NICE drugs and NHS organisations have a statutory duty to fund them. We will discuss with trusts during contract negotiations and specified in the NHS Standard Contract.

Innovation

We are committed to innovation and driving up standards across the system. All positive NICE Technology Appraisals (TAs) are considered for formal adoption via the Pan Mersey Area Prescribing Committee (APC). Recommendations on adoption of NICE TAs at this forum are passed to the respective Governing Bodies across Merseyside. We have representation at the APC. Both Formulary and Guidelines and New Medicines Subgroups are sub committees of the APC and we are represented at the sub committees. Sub committees provide the agenda to the APC on adoption of NICE TAs. APC recommendations are accepted at CCG Medicines Operational Groups and formally ratified at board.

Local formularies will cover all Merseyside CCGs. The local formulary will be published via the CCG website linking to the Pan Mersey formulary. This will obviously incorporate NICE TA adoption and will be tracked by medicines management support from CMCSU.

We are a member of the North West Cost Academic Health Science Network. By agreement with the Merseyside CCG Network, Dr Andy Davies Chair of Warrington CCG is our representative on the group. We will use a number of methodologies to ensure the adoption of innovation, including improving methodologies and spread.

We are working with the health economy to deliver 'Care Closer to Home' and will embrace technology with our providers to ensure patient get the best possible outcomes. For example community nurses using "iPads" to access patient's records in the patient's home, thus delivering real time record keeping and reducing duplicate inputting. We will also look at the use of telemedicine in order that patients can make better informed decisions about accessing health services - an example might be when a COPD patient exacerbates they have a better understanding of the type and severity of the exacerbation.

7.0 Transforming health and social care at CCG level

7.1 Joined up Local Planning

Organisations in the local health economy have worked together to identify the parents of children with special educational needs or disabilities who could benefit from a personal budget based on a single assessment across health, social care and education.

Our plans:

Following the Draft legislation on 'Reform of Provision for Children and Young people with Special Educational Needs (SEN)' published in September 2012 it is expected that this will be followed up in 2014 with the new SEN Code of Practice.

Sefton Council is already working towards its implementation of the National Funding Proposals (Schools funding reform: Next steps towards a fairer system) and its joint funding arrangements with health.

It is subsequently expected that the outcomes from this will be followed up in 2014 to comply with legislation around personal budgets in the new SEN Code of Practice.

Workforce Plans

We will work closely with providers to ensure they have robust workforce plans and there will be no compromising on quality improvements or any reduction in safety as a result of these plans.

7.2 Quality Innovation Productivity and Prevention (QIPP) 2013-14

CCGs' outline QIPP plans for 2013-14 should include the key milestones and outcomes to be delivered and detail on:

- Learning from 2012-13
- How they will ensure the delivery of wider service and financial sustainability
- Outline plans to ensure triangulation of activity, quality and cost data to drive QIPP planning and assurance
- Confirm that clinically led quality impact assessment of all cost improvement programmes (CIP) and detail how CIP will have medical director and nursing director sign off
- Activity plans and forecasts for the next 2 years
- Confirm that local metrics (such as staff and patient views and the Safety Thermometer) have been used to reflect needs of health economy in the planning

We remain on course to deliver our QIPP schemes in 2012-13, mainly drawn from three key areas - prescribing, efficiency delivered by local providers and transformational schemes - working in conjunction with local commissioning and public sector bodies to develop new ways of working through productivity and innovation.

We have reviewed plans from 2012-13 and provisionally identified areas where existing schemes will make a contribution to the delivery of QIPP in 2013-14. These plans will be worked up over the next few weeks and details will be included within our final submission. We are looking to work with the NCB Local Area Team to ensure that existing PCT QIPP targets are allocated to successor bodies and would be grateful for advice on how this will be achieved.

We have sought assurance from provider executive teams that known CIPs have been rigorously assessed in terms of from a service quality and patient safety perspective, and we awaiting response.

We have assumed steady state activity plans over the next 2 years based on a view that increased demand for services will be offset by productivity gains elsewhere in the system – we have made provision for 1% contingency reserve within our financial plans to deal with the costs of any unexpected growth in activity. We will work with public health colleagues to review these assumptions over the next few weeks and more details of specific assumptions will be provided in the final plans.

We continually review local metrics and are using key tools, such as 'Right Care', to help shape and influence our plans in respect of the needs of the local health economy.

QIPP PLANS 2013/14	Description	£'000	Total £'000
Transformational Schemes			**2,400**
Prescribing	ARB	14	
	Statins	74	
	ED	46	
	Other	764	
			898
Provider Contracts	Tariff efficiency - 4%		**4,564**
Total			**7,862**

8.0 Financial Planning

8.1 Financial Control

Surplus policy

We have planned to make a surplus of 1% of our revenue resource

Managing risk

We have set aside 2% of our recurrent resource allocation for investment on a non-recurrent basis in 2013-14. We will focus this investment in local schemes aimed at transforming pathways to deliver savings in later years and to redesign services to meet changing needs of our local population. There are some residual schemes left over from the PCT legacy which we have made provision for within our plans. We will work with other commissioners including the local area team to agree these schemes between now and final plan submission. We have established risk share arrangements with South Sefton CCG, which will include the review of the 2% non-recurrent investment and adjustments to baselines where additional analysis proves incorrect. We are also exploring wider risk-share agreements with other CCGs in Merseyside, particularly in respect of high cost Mental Health package of care. We have included contingency of 0.5% specifically to deal with growth areas in 2013-14 in our plans.

Planning assumptions

We have has assessed growth in demand and has included a contingency within our financial plans in 2013-14.

Tariff

Our plans have been constructed in line with tariff assumptions.

Integrated care plans

We will be working with local partners, notably Sefton Council, providers and the voluntary sector, to identify how the recurrent reablement funding (c. £1.8m across the Sefton area) can be best invested to deliver maximum benefit in terms of health outcomes and improving effectiveness of the local healthcare system. It is envisaged that this will be managed through a sub-group of the Strategic Integrated Commissioning Group established with Sefton Council.

8.2 Contracting for Quality

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CQUIN

CQUIN applies to 2.5% of the value of all services commissioned through the NHS Standard Contract. One-fifth is to be linked to national CQUIN goals and CCGs and direct commissioners should outline to plans to apply this to ensure delivery of improvements in:

- Friends and Family Test
- Improvement against the NHS safety Thermometer (excluding VTE)
- Improving dementia care (FAIR)
- Venous Thromboembolism – 95% patients being risk assessed and achieve locally agreed goal for no. of VTE admissions that are reviewed through RCA.

CQUINs will only be paid where providers meet the minimum requirements of high impact innovations. We are working collaboratively across Merseyside with the support of CMCSU to deliver a co-ordinated approach to CQUIN across the health economy. CCGs have identified CQUIN schemes for negotiation into the 2013-14 contract and where possible have come to an agreement regarding common CQUINs – the Chief Nurses are leading on the development of specific portfolio related areas. CQUINs have been identified in commissioner workshops that have taken place in November 2012 and January 2013. Providers were also asked, via CMCSU, to put some suggested CQUINs forward for commissioners to consider. A further meeting has been arranged whereby commissioners and providers will meet in order to start the negotiation process. CMCSU are liaising with Specialist Commissioning regarding any local CQUINs that have been developed that may be applicable for tertiary units in the area.

Local and Regional CQUIN plans

We will work with neighbouring CCGs and CMCSU to monitor the national CQUINs with our providers. We will also work collaboratively to develop and monitor the implementation of the Alternative quality contract which is being developed with local clinicians and in collaboration with West Lancashire CCG.

Our plans include CQUIN within applicable provider contracts at 2.5%. Alongside national measures, it is anticipated that a number of local measures will be applied consistently across Merseyside and will be agreed and reported within the final draft of commissioning plans.

Key Performance Indicators (KPIs)

We have a clinical lead for quality that, with our lead Nurse, will develop KPIs with providers and engage in performance management. In collaboration with the contract management team, this will also provide a direct link to our Governing Body. We will include appropriate penalty clauses in standard contracts and will apply them accordingly.

Continuity of Care

We will designate A&E as a commissioner required service in addition (as part of the designation), and we will require the following services to support A&E:

- Anaesthetics
- ICU/HDU
- Diagnostics
- Path labs

Appendix 1 - What the data shows us about morbidity and mortality in Southport and Formby

The information below compares Southport and Formby CCG against its neighbouring CCG and national figures. Consideration of the Sefton wide picture is relevant when working with the Health and Wellbeing Board and Local Authority colleagues, but increasingly we are able to look at much more local data, relevant to our four localities. As our plans develop we will increasingly work at a more local level, supported by member practices interrogating and acting on intelligence from the Merseyside Intelligence Portal.

Potential Years of Life Lost and Premature Mortality Rates

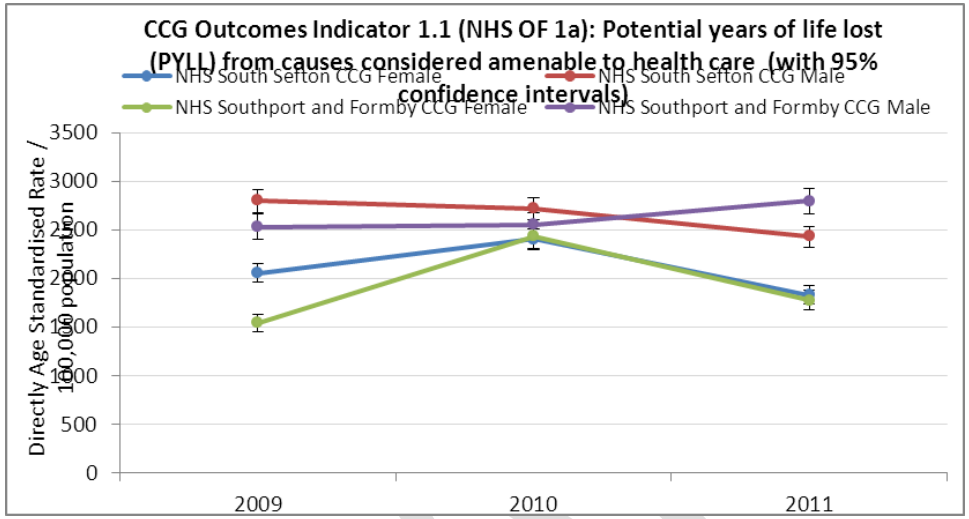
Deaths from causes considered 'amenable' to health care are premature deaths that should not occur in the presence of timely and effective health care. Potential years of life lost (PYLL) from causes considered amenable to health care in 2011 was significantly lower for females than males in Southport & Formby CCG. Rates were significantly higher among males in Southport & Formby CCG than males in South Sefton, and females in both CCGs. However, this has not been the case in previous years there were no significant differences between the CCGs, or between genders in 2010.

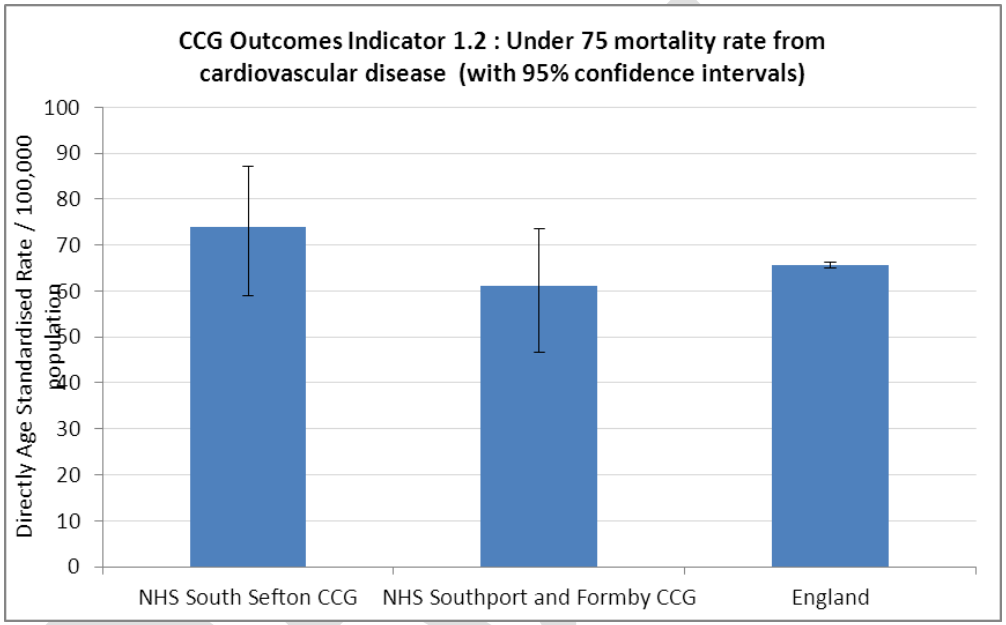
For premature mortality from cardiovascular disease there are no significant differences between the two Sefton CCGs or the England rate. Rates for CVD are higher than for premature mortality from respiratory diseases but lower than premature cancer mortality (also monitored in this indicator set).

Rates of premature mortality from respiratory disease are lower than those for CVD and cancer. Neither CCG differs significantly from the other, nor from the England rate.

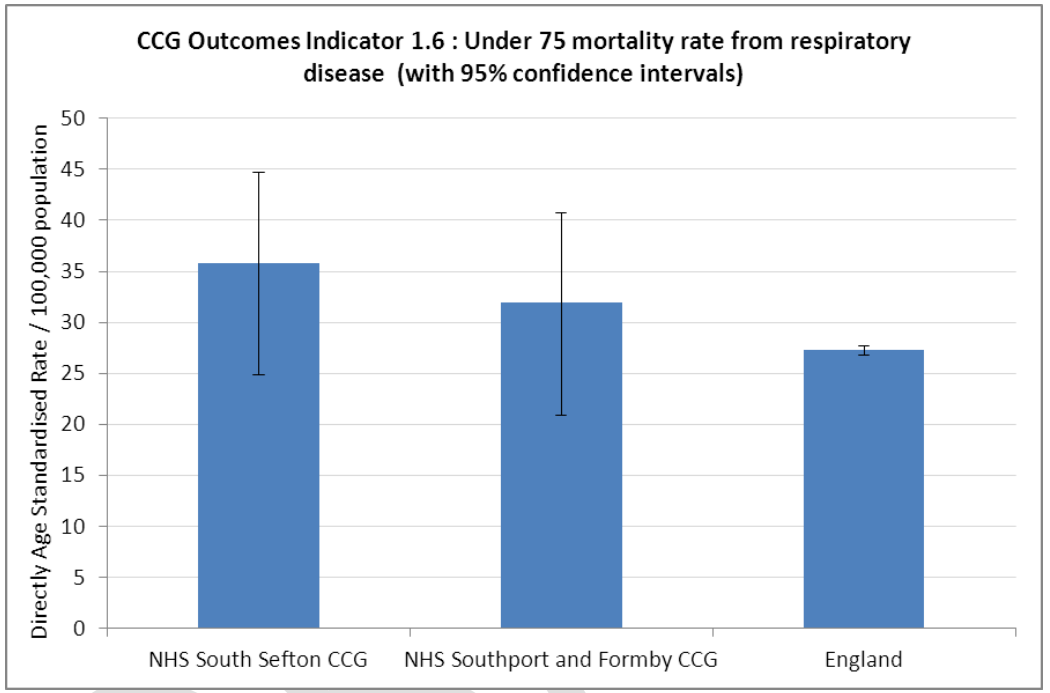
Premature mortality rates for cancer are higher than for premature mortality from respiratory diseases and cardiovascular mortality. There are no significant differences between the two Sefton CCGs and the England rate.

These indicators require careful interpretation and should not be viewed in isolation, but instead be considered alongside information from other indicators and alternative source such as patient feedback, staff surveys and similar material. Changes in the PYLL must be interpreted with care and may be due to changes in the number of lives lost, changes in life expectancy or a combination of these and other factors. Projected life expectancies have increased year on year so a downward trend in PYLL would reflect sustained improvement in healthcare and better outcomes for patients whereas a static PYLL figure should not be interpreted as showing no improvement. Other contributory factors outside of the control of the NHS, such as socio-economic factors also affect these outcomes. Direct comparison with previous year's mortality, prior to 2011, is not advisable. Differences in case-mix (beyond that accounted for by standardisation), comorbidities and other potential risk factors also contribute to any perceived variation. There may be variation in the prevalence of particular conditions due to differing levels of deprivation, for other geo-demographic reasons or between patients of different ethnic heritages.

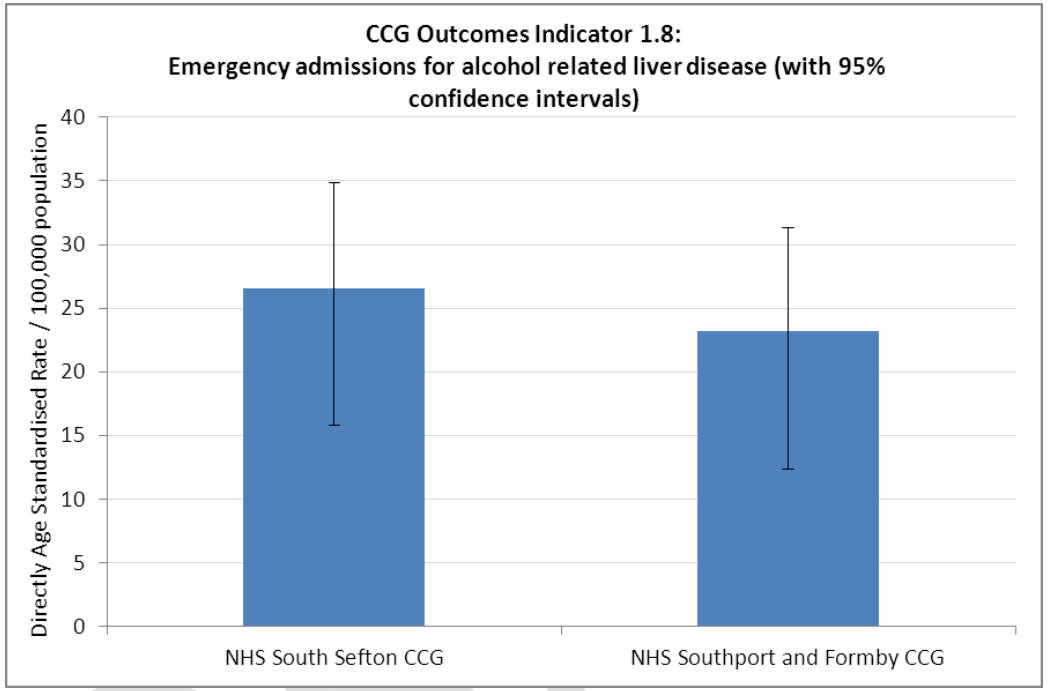

CCG Outcomes Indicator 1.1 (NHS OF 1a): Potential years of life lost (PYLL) from causes considered amenable to health care (with 95% confidence intervals)
NHS South Sefton CCG Female
NHS South Sefton CCG Male
NHS Southport and Formby CCG Female
NHS Southport and Formby CCG Male
Directly Age Standardised Rate / 100,000 population
3500
3000
2500
2000
1500
1000
500
0
2009
2010
2011



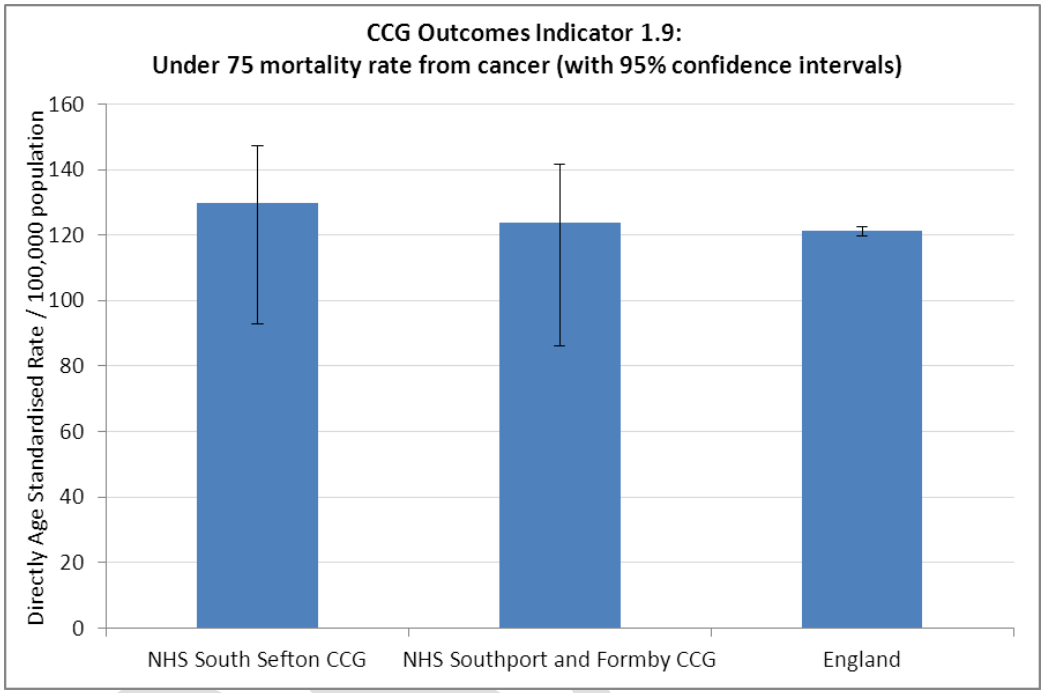
There are no significant differences between the two Sefton CCGs and the England rate. Rates for CVD are higher than for premature mortality from respiratory diseases but lower than premature cancer mortality (also monitored in this indicator set).



Rates of premature mortality from respiratory disease are lower than those for CVD and cancer. Neither CCG differs significantly from the other, nor from the England rate.



Rates between the two CCGs are not significantly different. A national average for this indicator was not available. This indicator forms part of domain 2: Enhancing Quality of Life for People with Long-Term Conditions and is intended to act as a proxy for the overall management of alcohol related liver disease. Some, but not all admissions for liver disease, may be potentially avoidable by high quality management in primary care. Excessive consumption of alcohol may be amenable to influence, and could result in a reduction in avoidable hospital admissions which are costly and expose patients to otherwise avoidable clinical risks such as health care acquired infections. The patterns of providing care may vary between organisations in terms of: extent of treatment in primary care settings; referral policies and practices; hospital outpatient facilities/walk-in clinics; and hospital inpatient admission policies and practices.



There are no significant differences between the two Sefton CCGs and the England rate. Premature mortality rates for cancer are higher than for premature mortality from respiratory diseases and cardiovascular mortality (also monitored in this indicator set). The desirable outcomes of this domain, specifically the prevention of premature deaths, are supported not only by the provision of health care, but also by public health and social care initiatives. Other contributory factors outside of the control of the NHS, such as socio-economic factors also affect these outcomes.

This indicator requires careful interpretation and should not be used in isolation. It should be taken in conjunction with other indicators and information from other sources (patient feedback, staff surveys and other such material) that together form a holistic view of CCG outcomes and a fuller overview of how CCG processes are impacting on outcomes. Direct comparison with previous year's mortality, prior to 2011, is not

advisable. There was a decrease in the number of deaths with an underlying cause coded to ‘Cardiovascular Disease’. However, a large proportion of this decrease is caused by a correction to the coding of vascular dementia, which was coded as underlying cause CVD (I67.9) until 2010 and is now coded as underlying cause in ‘Mental Health’ deaths (F01). Differences in case-mix (beyond that accounted for by standardisation), comorbidities and other potential risk factors also contribute to any perceived variation. There may be variation in the prevalence of particular conditions due to differing levels of deprivation, for other geo-demographic reasons or between patients of different ethnic heritages.

Appendix 2 - How we have involved people in developing our plans

We have worked with and consulted a wide range of partners to develop our plans for 2013-2014. Below are some of the ways we have done this:

Big Chat

We held our first public event in summer 2012, inviting local residents to give their views about how health and health services should develop in the future. Sefton Council and Sefton LINk (the forerunner to Sefton Health Watch, the patient's champion) joined forces with us at the event to gain feedback on the priorities identified in our joint strategic needs assessment, the Sefton Strategic Needs Assessment (SSNA).

SSNA involvement events

Nearly 50 public and partner events were held during 2012 by us and Sefton Council to gain wide ranging feedback on the priorities set out in the SSNA. These were organised to ensure as many people as possible could comment on the findings of the SSNA, from hard to reach communities to partners in different parts of the health and social care system.

Talking Health and Wellbeing in Sefton

All the feedback gained from the Big Chat and SSNA involvement events have been used to inform the overarching draft Health and Wellbeing Strategy for Sefton (HWBS). Our plans for 2013-2014, outlined in this document, also reflect these locally developed priorities and goals. In December 2012 and January 2013 we again worked with Sefton Council to hold five public Talking Health and Wellbeing sessions across Sefton to test out our specific CCG plans and the themes contained in the HWBS. There were also over 40 other events where people were invited to comment on the objectives and priorities in the draft HWBS.

Appendix 3 – Clinical and Managerial Leads for each programme

Area	Southport & Formby CCG Lead	CCG Team Lead
Alcohol	To be confirmed	Tina Ewart
Cancer	Dr Graeme Allen	Sarah Reynolds
Children	Dr Robert Caudwell	Jane Uglow
Contracting	Dr Martin Evans	Stephen Astles / Jan Leonard
COPD	Dr Liam Grant	Sandra Boner / Jenny Kristiansen
CVD	Dr Niall Leonard	Stephen Astles / Sandra Bonner
Communication / Patient Engagement	Karen Leverett	Lyn Cooke / Tina Ewart
Dementia / Mental Health / Learning Disabilities	Dr Hilal Mulla	Geraldine O'Carroll / Kevin Thorne
Dermatology	To be confirmed	Billie Dodd
Diabetes	Doug Callow	Moira McGuiness
End of Life	Karen Groves	Moira McGuiness
Integrated Care	Dr Niall Leonard	Stephen Astles / Billie Dodd
IT	Dr Robert Caudwell	Alison Johnson
Medicines Management/Prescribing	Dr Hilal Mulla / Dr Janice Eldridge*	Brendan Prescott
Quality	Doug Callow	Debbie Fagan, Steve Astles, Billie Dodd
Patient and Public Involvement	Roger Pontefract / Karen Leverett	Jackie Robinson / Tracy Jeffes
Prevention and Public Health	To be confirmed	Helen Chelleswamy / Margaret Jones
Primary Care Quality	Bal Duper	Angela Parkinson / Debbie Fagan
Unplanned Care / 111 Care	Dr Niall Leonard / Dr Graeme Allen / Karen Leverett	Billie Dodd / Stephen Astles / Malcolm Cunningham
Governance	Helen Nichols	Tracy Jeffes

*Italics – not a Board member

Appendix 4 – Southport and Formby Local Priorities Mapping

Southport and Formby Local Priorities Mapping			
Reduction in hospital admissions for patients under 19 related to asthma			
Health and Wellbeing Strategy Priorities 2013 – 2018	Southport and Formby CCG Commissioning intentions	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
Strategic Objective **Ensure all children have a positive start in life.** **Ensuring that children and young people including those with complex needs and disabilities have the best opportunities in life to enable them to become healthy adults and make the best of their life chances**	**Long Term Conditions** Better identification of patients with long term conditions and support for them to better manage their conditions and avoid hospitalisation Reducing higher than average number of children with asthma admitted to hospital	"The flow of patients and treatment between primary and secondary care needs to be reviewed, with particular emphasis on the patient journey and level of care received." "How do we prepare for a retraction from acute providers to enable more preventive work?" "Longer-term, better treated young to prevent later problems." "Got to stop fire fighting, need to treat people before they get to the point where their treatment costs" "Support needs to be given to Carers (formal/informal). More needs to be done to identify carers, as they often prevent hospital admissions." "Services nearer to home - Children's services, diabetes, community matrons, people with long-term conditions." "Keeping people out of hospital may be seen as negative" "Use of technology, such a telehealth, to improve accessibility".	"Long term conditions – self management- education , commission different things, lifestyle management" (Southport) "Focus on young people – start now" (Southport)

Southport and Formby Local Priorities Mapping

Reduction in hospital admissions related to alcohol

Health and Wellbeing Strategy Priorities 2013 – 2018	Southport and Formby CCG Commissioning intentions	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
Strategic Objective **Support people early to prevent and treat avoidable illnesses and reduce inequalities of health** **Needs assessment identified:** **Whilst Sefton's rate of admissions is lower than other Merseyside Local Authorities, alcohol related admissions continue to rise.** **Consultation and engagement identified need to find different ways to support people early to avoid those needing acute services and surgical procedures**	System Wide Improvements We will work with public health to support prevention initiatives , provide training to health and social care staff to support their patients and clients and support those with long term illnesses to manage their conditions	"Self care needs to improve, not all bad backs need physiotherapy, people need to take some pain relief and see if it gets better on its own, the same for coughs and colds etc. We need to change people's mind about running to the hospital and GP with every niggle." "Look at prescriptions – issue of wasted repeats" "Understanding when to access services , ie: campaigns for coughs"	" Take control of own lives , manage sickness" (Bootle) " Stop pharmacy repeat prescriptions service" (Crosby) "Cost of medication not being used"

Reduction in unplanned admissions from nursing and care homes

Health and Wellbeing Strategy Priorities 2013 – 2018	Southport and Formby CCG Commissioning intentions	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
Strategic Objective **Support Older people and those with long term conditions and disabilities to remain independent in their own homes** **Needs assessment identified:** **By 2015 over 2,300 people are forecast to be living in a care or nursing home** **An increasing elderly population are more likely to attend A&E and to be admitted to hospital as a result of falls – estimated 28% more by 2030**	Long term Conditions Better identification of patients with long term conditions and support for them to better manage their conditions and avoid hospitalisation Prevention Explore potential for a pre- falls programme or service for older people	"The flow of patients and treatment between primary and secondary care needs to be reviewed, with particular emphasis on the patient journey and level of care received." "In terms of Care Homes, concerns that there has been no rise in financial support from Sefton Council for 3 years, despite residents receiving annual rises in pensions, with Social Services taking the rises." "Links between care facilities such as nursing homes and GP practices needs to be improved" "Service nearer to home - Could keep people out of care/hospitals and living more independent." "Use of technology, such a telehealth, to improve accessibility."	"To provide a good medical service to people despite their age "(Formby

Southport and Formby
Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/39	**Author of the Paper:** Samantha Tunney Head of Business Intelligence & Performance, Sefton Council Samantha.tunney@sefton.gov.uk

Title:

Plans for HealthWatch in Sefton

Summary of the Paper/Key Issues:

This paper presents the Governing Body with information on progress made in establishing HealthWatch Sefton.

Action/Decision Required:

The Governing Body is asked to note the contents of this report.

Date of Report:

14 March 2013

13/39

Southport and Formby
Clinical Commissioning Group

Report to Board

March 2013

1. Background

Further to previous reports significant progress has been made in establishing Healthwatch Sefton.

2. About Healthwatch

2.1. Healthwatch is the new consumer champion for the public, patients, health and care service users, and their carers and families. It has two forms: Healthwatch England, which was established on 1 October 2012; and local Healthwatch organisations which will start from 1 April 2013 based in upper-tier and unitary local authority areas in England2.

2.2. Healthwatch England will provide leadership, support and advice to the local Healthwatch network. It will use evidence based on experiences to highlight national issues and trends in order to influence national policy. Through the network and by receiving views directly, Healthwatch England will ensure that voices of people who use health and social care services are heard by the Secretary of State for Health, the Care Quality Commission, the NHS Commissioning Board, Monitor and local authorities in England.

2.3. A key role of local Healthwatch organisations will be to promote the local consumer voice to ensure that the views of patients, service users and the public are fed into improving local health and care services. The primary task of local Healthwatch organisations will be to gather evidence from the views and experiences of patients, service users and the public about their local health and care services and to provide feedback based on that evidence.

2.4. They will take this information and report the evidence to those in charge of arranging and funding services and making decisions – and those providing services – about the quality of care, including through statutory representation on the local health and wellbeing board. This should help to ensure that those who make decisions about health and care services can be aware of and act and respond quickly to concerns. Local Healthwatch organisations will also feed this evidence into Healthwatch England.

2.5. The Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012) sets out the requirements for arrangements for patient and public involvement activities through local Healthwatch organisations. Regulations laid in December 2012 make further provision about the criteria that bodies will need to meet in order to be contracted as local Healthwatch organisations, the duties on commissioners and providers, and the contractual arrangements between the local authority and local Healthwatch; and local Healthwatch and its contractors.

3. The role of Healthwatch

3.1. The legislation seeks to ensure that local Healthwatch organisations:

- act independently of political parties, think tanks and campaigns;
- keep any campaigning as secondary to their core purpose, and limited to and focused on improvement to local health and care services, based on evidence gathered and views heard from the local community, and;
- pursue their primary purpose as a consumer champion.

3.2. The legislation seeks to prevent a local Healthwatch from:

- aligning itself to a particular party or political body;
- being set up or run with a main purpose of achieving particular policy changes or changes to the law, and;
- making political activities its main activity.

3.3. The legislation does not stop a local Healthwatch from:

- using robust evidence and feedback from the community as basis for raising the concerns of local people with local councillors, council officers and health service managers who have responsibilities for commissioning, providing or managing particular local health and care services;
- speaking out based on evidence, at a local level about service improvements that affect the quality of care;
- advocating a change in the law or policy, provided it is based on evidence, is genuinely in connection with its community benefit activities; and that such campaigning or activities do not become the organisation's main focus or activity; and
- passing findings, concerns or views from the local community to Healthwatch England, which will have a role to speak out at the national level about service improvements and to provide evidence which will inform government policy.

4. Who can get involved with Healthwatch?

4.1. The legislation does not stop people with professional experience in health and social care settings being involved in local Healthwatch organisations and their activities, as lay persons and volunteers. "Lay person" and "volunteer" are defined as those people who wish to give their time to something they feel passionately about in order to influence change and service improvements. In this context, the definition of

"volunteer" could include someone with a health and social care background giving their time freely, whereas the definition of a "lay person" is aimed at those without a professional health or social care background contributing their time. If volunteers come with a professional health or social care background this does not necessarily create a conflict of interest – it can be complementary to the work of the local Healthwatch organisation. It is important that a local Healthwatch organisation is diverse and inclusive of its local people and community – be it through paid staff, lay people or unpaid volunteers. Local Healthwatch should ensure that a range of ways are available for people to get involved so that lay persons and volunteers can give their time in ways that suit their own needs and preferences.

4.2. With regard to elected members the legislation covering Local Healthwatch does not specifically disbar councillors from being involved in Local Healthwatch Organisations although the legislation does prevent local authorities from running Local Healthwatch Organisations.

5. Progress in establishing Healthwatch Sefton

5.1. On 13 December 2012 the Cabinet of the Council accepted the proposal from the "Commissioning Options for Healthwatch report" for Sefton Council for Voluntary Services (CVS) to set up an arm's length Company to Operate Healthwatch Sefton form 1 April 2013. This report had previously been considered by the Health and Wellbeing Board and the two Clinical Commissioning Groups for Sefton.

5.2. Implementation of Healthwatch Sefton has progressed since this decision was made, and the following actions have been taken:

- Sefton CVS Board have agreed to form the subsidiary company named Healthwatch Sefton and work is underway to resister the company with Companies House prior to the 1st April 2013. In order to avoid potential conflicts of interest the Memorandum of Understanding excludes elected members from the Local Healthwatch Organisations governance.

- The recruitment process for the appointment of the Chair of Healthwatch has now been concluded, subject to reference. Shortlisted candidates attended an interview comprising of the following panel: The Chair of the Health and Well-Being Board; Chair of South Sefton Clinical Commissioning Group, Chief Officer of both Clinical Commissioning Groups; Director of Adult Social Care and the Deputy Chief Executive of Sefton CVS.

- As previously reported Healthwatch will have a statutory seat on the Health and Well-Being Board. It is anticipated that the Chair will represent Healthwatch on the Health and Wellbeing Board.

- A workshop on patient and public voice was held in February to review the work of the landscape of patient and public involvement across Sefton and to identify the positive legacy that LinKs provides for Healthwatch Sefton moving forward. A further report on developing an approach to Public and Patient Engagement will be

presented to the Health and Wellbeing Board in April, Healthwatch Sefton being an important constituent part.

5.3. A further report will be brought back to the Board once Healthwatch Sefton is up and running has established it's the priorities for Healthwatch Sefton during 2013/14.

6. Independent Complaints Advocacy Service

6.1. Section 185 of the Health & Social Care Act transfers a duty to commission independent complaints advocacy services from the Secretary Of State to individual Local Authorities. This transfer will take place on 1st April 2013. Whilst the funding to be made available is not ring-fenced and Local Authorities have a duty to ensure that local complaints advocacy operates effectively providing value for money, lack of a sufficient level of funding could jeopardise the quality of the delivery of this service.

6.2. The Government's Localism agenda supports the shifting of the commissioning of NHS complaints independent advocacy services from central government to Local Authorities as it feels that Local Authorities are better placed to determine what services are appropriate to be arranged for their local area and giving them responsibility for arranging them.

6.3. Independent advocacy services are services assisting persons making or intending to make complaints in relation to the provision of NHS services or the exercise of certain NHS bodies. They cover complaints made under:

- Procedures operated by certain NHS bodies or providers of services;
- Section 113 and of the Health and Social (Community Health and Standards Act 2003).

6.4. NHS Complaints to the Health Service Commissioner in England or the Public Service Ombudsman in Wales are also covered.

14 March 2013

Samantha Tunney
Head of Business Intelligence & Performance
Sefton Council

Southport and Formby
Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/40	**Author of the Paper:** Paul Shillcock Primary Care Informatics Manager Paul.Shillcock@imerseyside.nhs.uk

Title:

Low Utilisation of Summary Care Record

Summary of the Paper/Key Issues:

This paper presents the Governing Body with a report on the low uptake of the Summary Care Record project across Southport and Formby CCG. Thus far within the project, only one GP practice in the CCG area has uploaded records, with a further two agreeing to upload.

A stated Government target is for every patient to have the opportunity to have their records uploaded by March 2013 and it is likely that CCGs will be performance managed on this target.

Action/Decision Required:

The Governing Body is asked to approve the recommendations contained within this report to increase utilisation of Summary Care Record uptake.

Date of Report:

14 March 2013

Southport and Formby
Clinical Commissioning Group

Report to Board

March 2013

1. Executive Summary

It is a key requirement for all GP Practices to make the Summary Care Record (SCR) available to all of its patients and it is a target that CCG's are likely to be measured against. The current target across the NHS is that all patients who want an SCR should have one created by March 2013. This target is set out in the SCR National Business Case and is also referenced in the 2012/13 NHS Operating Framework.

At present, utilisation of SCR in Southport and Formby is very low. The current breakdown is as follows:

Practices in Scope	15	Practices on EMIS Web, EMIS LV or INPS
Practices Live	1	
Practices Agreed to go Live	2	Awaiting Training
Practices Declined or no response	12	
Practices Out of Scope	*5*	*1 Practice on EMIS PCS, 4 migrating from ISOFT*

This equates to 3,543 patients in Sefton having their records uploaded, out of an approximate population of 277,826, representing 1.27% of the whole Sefton population.

Whilst National information is difficult to obtain, Southport and Formby is a low utiliser within the local North West Region and has a 'Red' RAG status on NHS North West's most recent quarterly report (see Appendix B)

It is recommended that a process of re-engagement occurs across the CCG and that a communique is issued from the board underlining the strategic importance of complying with the SCR achievement targets and ensuring all Sefton patients have the opportunity to have an SCR created.

2. Introduction and Background

The Summary Care Record was formerly part of the National Programme for IT (NPfIT) but, following a ministerial review in 2010, was maintained as a target for all NHS Organisations. The review found that it was "….reasonable for citizens to expect that when they arrive in an Accident and Emergency department or require treatment out of hours, clinicians have access to the essential medical information they need to support safe treatment and reduce the risk of inadvertent harm…."

Initial objections to Summary Care Record were that it relied on an 'opt out' consent model which both the local LMC and National GPC objected to. In 2010 however, the governance model was amended Nationally so that only an 'emergency care record' of Medications, Allergies and Adverse Reactions would be shared, with any detailed information over and above this requiring the explicit

consent of the patient. There are currently no plans in Sefton to extend the SCR beyond the 'emergency care record' scope.

As this report focusses on the low utilisation of Summary Care Record in Southport and Formby, it does not go into detail on the benefits and detailed background of the project although a summary is provided below.

3. Engagement

The SCR project has been actively project managed by Informatics Merseyside since November 2012, when Sefton LMC gave its approval to proceed and clinical systems became in scope.

Since commencing the project actively in Southport & Formby, all GP practices in scope have been written to, asking if they would like to participate in the project. These initial communications have been followed up and the following is a summary of project engagement thus far:

- Patient Information Programme (PIP) run across Sefton, informing all patients of the SCR and their right to opt out commenced in early 2010.
- Initial email invites to participate sent to all GP Practices in scope in June 2012.
- Letter written to all GP Practices (See Appendix A) in December 2012.
- On-going promotion and information via Co-ordinator practice visits.
- Inclusion of SCR information and promotion in 'CommunicateIT" newsletter.

4. Content

At present in Southport and Formby, the majority of GP practices are either unwilling to participate in SCR, or still have concerns with its use. The vast majority of practices in the CCG now have compliant systems as EMIS Web, EMIS LV and INPS Vision both have SCR capability. EMIS PCS is not compatible, and although CSC Synergy is compatible, all practices on that system are migrating to EMIS Web within the next few months so are not being approached to participate at this time.

During communications with the practices that are in scope, the following issues have arisen:

4.1. The following anecdotal reasons for not participating have been given by GP practices across the CCG:

- "We do not see SCR as a priority"
- "We thought it was already happening"
- "We thought this project had 'gone away.'"
- "We have concerns over security and privacy."
- "We do not want other people to be able to add to the record."
- "The patients do not want it."

The initial three areas above are around the perception of the project whilst the concerns over security and privacy have been addressed within the governance framework agreed nationally. No-one is able to add into the record.

4.2. Locally, there has also been a view that participation in the National Programme is less of a priority as Sefton has taken a pro-active approach to local data sharing, which shares more clinically rich data with local Trusts and this may have an impact on the importance practices attach to the National project. Whilst this may be true, local data sharing is obviously geographically restricted whereas SCR is a National project and has the capability of improving patient safety and clinical outcomes on a National basis.

4.3. Discussion with some GP practices indicates that awareness amongst practice managers is good, it may however be the reluctance or the concerns of GP's to participate that is preventing greater utilisation.

4.4. Some misconceptions still exist within the views expressed around SCR. The governance model however is nationally approved by the GPC and BMA and locally, by Sefton LMC.

Informatics Merseyside will continue to engage with all practices across the CCG in discussing these concerns and resolving queries and can provide regular reports on the outcome of these discussions but the intervention of the Board and localities will undoubtedly assist in the aim of increasing uptake of SCR across Southport and Formby and in helping to deal with any concerns.

5. Recommendations

A clear issue with utilisation of Summary Care Record is that practices either do not see it as a priority, or are not clear on various aspects of the project. It is recommended that the Governing Body approve the following steps:

- A communique from the CCG Board to be sent to Lead GP's underlining the strategic importance of the project.

- The SCR Project Manager from Informatics Merseyside to re-engage with sites via presentations at locality and practice manager meetings. Connecting for Health (CfH) has also offered to participate in any such events as we require. From this, practice objections to SCR to be escalated to localities and Board via reporting.

- Locality Managers to assist in the promotion and uptake of the project by forwarding any concerns to the Informatics Manager or CCG Lead and disseminating information.

- Consideration may possibly be given to including SCR uptake in any schemes or local enhanced services to GP practices from CCG.

6. Focus for Board

SCR is a key target for all NHS organisations and the project in its current format has full approval from the GPC, BMA and Sefton LMC. Southport & Formby currently has only 1.27% of its patient population uploaded into the Summary Care Record.

The current target within the NHS is that all patients who want an SCR should have one created by March 2013. This target is set out in the SCR National Business Case and is also referenced in the 2012/13 NHS Operating Framework. It is highly likely that CCG's will be performance managed against this National target so active consideration of how to increase utilisation across the CCG is highly recommended

Appendices

Appendix A - Letter Sent to all GP Practices in 2012:
Appendix B - North West Summary Care Record Summary as at December 2012.

March 2012

Paul Shillcock
Primary Care Informatics Manager
Merseyside & Cheshire CSU

Southport and Formby
Clinical Commissioning Group

Appendix A - Letter Sent to all GP Practices in 2012:

Dear Colleague

NHS National Summary Care Record (SCR) in NHS Sefton

We are pleased to advise you that local implementation of the Summary Care Record (SCR) for Sefton patients is now under way. This project offers a real chance to improve patient safety and clinical care while providing important safeguards about consent and confidentiality.

The SCR will contain essential health information about any medicines, allergies and adverse reactions derived from the patient GP record. Where a patient and their doctor wish to add additional information to the patient's Summary Care Record, this can only be added with the explicit consent of the patient. Once SCRs are created for all patients in Sefton, authorised NHS healthcare staff in urgent and emergency care settings that need access to the information will begin to view these records when delivering clinical care.

Following the 2010 review into the Summary Care Record, in which a number of patient and clinician bodies were involved, the BMA agreed to work with the programme. Also, Sefton LMC has approved of the rollout of the Summary Care Record locally. Some practices will choose not to upload SCRs at the time of roll-out and there is no obligation on practices to take part. These practices will be re-engaged on a regular basis to ensure they are given the opportunity to upload. At present, there is no national requirement or guidance for a practice currently not uploading and hence, there is no requirement for these practices to write to patients to inform them that their record has not been uploaded.

The first phase of the project, the Public Information Programme (PIP), was distributed in 2010. The purpose of the PIP was to inform patients of the benefits of the SCR and their choices. All patients in the Sefton area aged 16 and over were sent a SCR information pack. Following on from this, practices were asked to ensure that all new patients received a SCR information pack. The PIP lasted a minimum of 12 weeks, allowing patients sufficient time to make their choice. The SCR upload is the second phase of the project and over the coming months the SCR project manager will work with each practice to schedule their SCR upload.

What should a practice do now?

The next step for practices that wish to upload SCR's, is to nominate an SCR lead, this person will be responsible for cascading the guidance material within the practice, and ensuring relevant practice staff understand their responsibilities. The SCR project manager will use this lead as the main point of contact and will arrange SCR Concept training with them to ensure practice staff have the required information to deal with enquiries.

The SCR Project Manager will contact your practice within the next week to discuss any queries you may have and to request the name of the SCR lead within your practice.

Thank you in anticipation of your support, should you have any initial queries please email Michelle.Harvey@imerseyside.nhs.uk

Yours sincerely,

Michelle Harvey
IM&T Projects & Benefits Manager, Informatics Merseyside.

Appendix B - North West Summary Care Record Summary as at December 2012

PCT Cluster	% Patients with records created	PCT Name	Map Reference	GP Practices	Registered Population	Awareness & Engagement				Planning							Adoption		
						Project Manager In Post	Business Case Developed	Project Board Established	SCR Clinical Lead In Place	Potential GP Practices	Potential GP Practices (% of Total)	GP Practices that have Sent Patient PIP Letters	Total PIP Letters Sent (To Patients > 16 years)	Patient Opt-Outs	Patients Surveyed for Opt-Out	Patient Opt-Outs (% of Patients Surveyed)	GP Practices Uploaded	Patient Records Created	Potential GP Practices Planning to Upload Records
Cheshire	20%	Central & Eastern Cheshire	A	51	473,018	!	!	!	!	40	78%	50	386,646	6,347	473,014	1.3%	2	7,344	4
		Warrington	B	27	209,197	✓	✓	✓	✓	25	93%	27	167,770	1,945	209,197	0.9%	21	172,206	3
		Western Cheshire	C	39	263,114	✓	✓	✓	✓	36	92%	39	219,834	3,438	263,114	1.3%	11	62,221	0
		Wirral	D	60	331,144	✗	✓	✗	✗	40	67%	60	273,310	4,572	254,851	1.8%	12	62,883	0
Cumbria	0%	Cumbria	E	80	513,124	!	✓	!	!	45	56%	80	435,829	0	0		0	0	0
Lancashire	1%	Blackburn With Darwen	F	29	169,472	✓	!	✗	!	8	28%	28	130,750	724	168,507	0.4%	0	0	7
		Blackpool	G	21	153,593	✗	✗	✗	✗	12	57%	0	0	0	0		0	0	0
		Central Lancashire	H	85	473,261	✗	✗	✗	✗	47	55%	85	384,900	2,700	308,051	0.9%	0	0	0
		East Lancashire	I	64	388,747	✓	!	!	!	16	25%	64	314,295	1,980	388,747	0.5%	0	0	15
		North Lancashire	J	37	340,099	✗	✗	✗	✗	18	49%	37	286,258	1,904	139,798	1.4%	1	22,582	0
Manchester	33%	Ashton, Leigh & Wigan	K	65	320,960	✓	✓	✓	✓	56	86%	65	226,563	2,242	229,442	1.0%	44	211,149	5
		Bolton	L	51	297,621	✓	✓	✓	✓	49	96%	31	239,280	3,781	294,148	1.3%	29	188,187	1
		Bury	M	33	196,064	✓	✓	✓	✓	33	100%	33	158,868	1,977	179,359	1.1%	33	195,571	0
		Heywood, Middleton & Rochdale	N	39	224,377	✓	✓	✓	✓	26	67%	38	179,427	1,357	91,220	1.5%	21	95,029	3
		Manchester	O	99	574,481	✓	✓	✓	✓	32	32%	99	440,390	2,635	468,800	0.6%	10	68,106	22
		Oldham	P	47	240,943	✓	✓	✓	✓	19	40%	47	192,600	1,153	89,456	1.3%	19	96,157	2
		Salford	Q	50	250,261	✓	✓	✓	✓	48	96%	50	202,969	0	0		27	150,474	1
		Stockport	R	50	300,033	✓	✓	✓	✓	16	32%	50	246,203	289	26,031	1.1%	11	77,296	7
		Tameside & Glossop	S	42	241,328	✓	✓	✓	✓	16	38%	42	196,406	1,560	174,932	0.9%	8	48,673	13
		Trafford	T	37	235,731	✓	✓	✓	✓	24	65%	37	187,533	2,887	171,122	1.7%	10	52,228	0
Merseyside	10%	Halton & St Helens	U	54	322,072	✓	✓	✓	✓	23	43%	54	261,066	2,459	271,602	0.9%	1	2,355	0
		Knowsley	V	33	161,095	✓	✓	✓	✓	29	88%	26	128,771	1,448	94,676	1.5%	28	151,043	0
		Liverpool	W	95	496,318	✓	✓	✓	✓	38	40%	95	402,511	4,173	494,495	0.8%	3	17,806	0
		Sefton	X	54	277,826	✓	✓	✓	✓	12	22%	54	234,002	0	0		1	6,937	0
		North West Total		1242	7,453,879					708	57%	1191	5,896,181	49,571	4,790,562	1.0%	292	1,688,247	83

*We are still awaiting more up to date figures on SCR achievement but this is being hampered by the current organisational change within the NHS. Future reports will be categorised by CCG area.

Southport and Formby
Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/41	**Author of the Paper:** Fiona Clark Chief Officer fiona.clark@sefton.nhs.uk

Title:

Quality Premium

Summary of the Paper/Key Issues:

This paper is to update the Governing Body in relation to the payment of the Quality Premium for CCGs.

Action/Decision Required:

The Governing Body is asked to approve the recommendations contained within this report.

Date of Report:

March 2013

Report to Board

March 2013

1. Background

1.1. In December 2012, the National Commissioning Board published its draft guidance on Quality Premium 2013/14 payments for CCGs.

Link: http://www.commissioningboard.nhs.uk/wp-content/uploads/2013/02/qual-premium.pdf

1.2. The 'quality premium' is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

1.3. The quality premium paid to CCGs in 2014/15 – to reflect the quality of the health services commissioned by them in 2013/14 – will be based on four national measures and three local measures.

1.4. The national measures, all of which are based on measures in the NHS Outcomes Framework, will be:

- reducing potential years of lives lost through amenable mortality (12.5% of quality premium): the overarching objective for Domain 1 of the NHS Outcomes Framework;
- reducing avoidable emergency admissions (25% of quality premium): a composite measure drawn from four measures in Domains 2 and 3 of the NHS Outcomes Framework;
- ensuring roll-out of the Friends and Family Test and improving patient experience of hospital services (12.5% of quality premium), based on one of the overarching objectives for Domain 4 of the NHS Outcomes Framework;
- preventing healthcare associated infections (12.5% of quality premium), based on one of the objectives for Domain 5 of the NHS Outcomes Framework.

1.5. The three local measures, which should be based on local priorities identified in joint health and wellbeing strategies, will be agreed between individual CCGs and the area teams of the NHS Commissioning Board (NHS CB).

1.6. The NHS CB will reserve the right not to make any payment where there is a serious quality failure during 2013/14.

1.7. Subject to regulations due to be made and laid in Parliament early in the New Year:

- it will be a pre-qualifying criterion for any payment that a CCG manages within its total resources envelope for 2013/14 and does not exceed the agreed level of surplus drawdown

- the total payment for a CCG (based on its performance against the four national measures and three national measures) will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to (a) maximum 18-week waits from referral to treatment, (b) maximum four-hour waits in A&E departments, (c) maximum 62-day waits from urgent GP referral to first definitive treatment for cancer, and (d) maximum 8-minute responses for Category A red 1 ambulance calls.

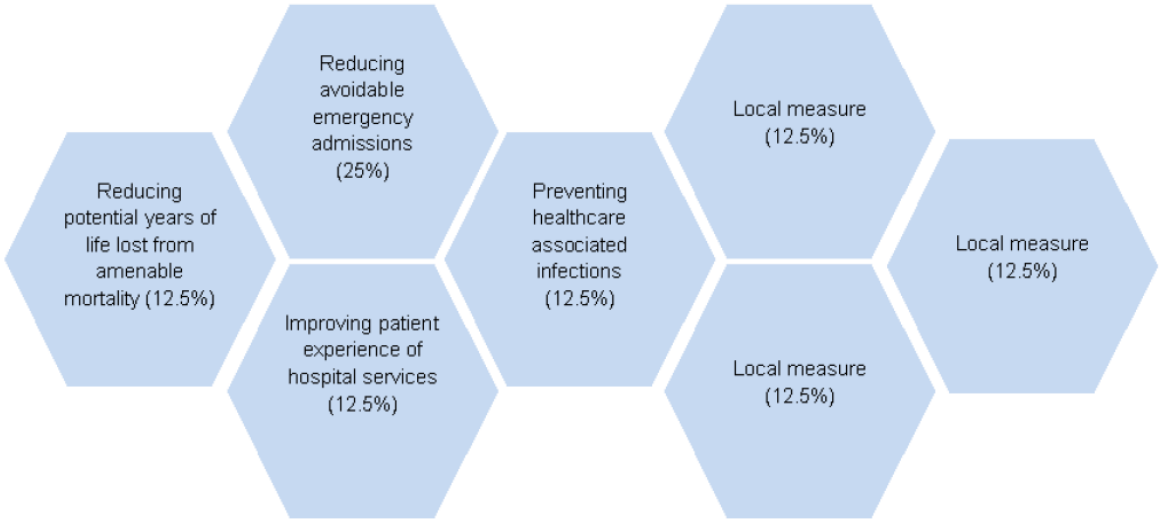
1.8. The total financial envelope for the quality premium will be announced in the New Year. This will be on top of a CCG's main financial allocation for 2014/15 and on top of its £25 per head running costs allowance.

1.9. The regulations will set out the purposes for which CCGs will be able to spend their payments.

1.10. This document has the status of draft guidance until it is revised to reflect the content of the regulations and published as final.

1.11. The likely payment is £5 per head, although this remains unconfirmed. For a population of 119,080, this would give a potential of £595,400 for Southport & Formby CCG, if all areas were achieved, which could equate to £29,770 per practice. A full breakdown of potential income can be found at Appendix 1.

1.12. The Quality Premium will be comprised of the following elements.



1.13. In addition, the CCG has to meet the four NHS Constitution measures and manage within its total resources for 2013/14.

1.14. Where a CCG does not deliver the identified patient rights and pledges on waiting times, a reduction of 25% for each relevant NHS Constitution measure will be made to the quality premium payment.

1.15. The quality premium payment will be made in the 2014/15 financial year.

2. Local Context

Southport & Formby CCG's Governing Body considered the options for the local priorities using data available in the Southport & Formby CCG Outcomes Pack provided and also the work that has been undertaken on Better Care, Better Value/Right Care over the past twelve months.

These deliberations and recommendations were then shared at the Wider Constituent Forum on 20 March 2013, led by Dr Bal Duper, Clinical Development Lead for Primary Care.

3. The Three Local Priorities

3.1. Reduction in A&E attendances from care homes.

3.2. Reduction in hospital admissions for patients under 19 related to asthma.

3.3. Reduction in Alcohol Specific Hospital Admissions.

Work has been undertaken on the activity schedules to ensure that these local priorities are stretching and reductions of health inequalities drive change for health improvement.

The Health and Wellbeing Board received these on 13 March 2013 and endorsed these local priorities as complimentary and aligned to the components of the newly emergent Health & Wellbeing Strategy.

4. Recommendations

The Governing Body is asked to:

4.1. approve the three local priorities; and

4.2. note the potential payment regime.

Appendices

Appendix 1 NHS Southport & Formby CCG Draft Quality Premium

19 March 2013

Fiona Clark
Chief Officer
NHS Southport & Formby CCG

Appendix 1 NHS Southport & Formby CCG Draft Quality Premium

CCG Population: 119,080 **Value of Quality Premium = £5 (estimated)**
CCG manages within its total resources for 13/14 – the QP will not be paid if financial balance not achieved

Measure	% of QP	Value for CCG	Achieved 12/13	Eligible QP Funding	Achieved 13/14	Eligible QP Funding
Domain 1 – preventing people from dying prematurely	12.5%	£74,425				
Domain 2&3 – enhancing quality of life for people with LTC and helping people to recover from episodes of ill health or following injury	25%	£148,850				
Domain 4 – ensuring that people have a positive experience of care	12.5%	£74,425				
Domain 5 – treating and caring for people in a safe environment and protecting them from avoidable harm	12.5%	£74,425				
LP1 – reduction in unplanned admissions from nursing and care homes	12.5%	£74,425				
LP2 – reduction in hospital admissions for patients under 19 related to asthma	12.5%	£74,425				
LP3 – reduction in hospital admissions related to alcohol	12.5%	£74,425				
Total	100%	£595,400				

NHS Constitution Rights & Pledges	Achieved 12/13	Adjustment to Funding (25%)	Quality Premium Funding	Achieved 13/14	Adjustment to Funding (25%)	Quality Premium Funding
Referral to Treatment Time (18 weeks)	If the CCG fails to meet any element of the NHS Constitution Rights and Pledges, a 25% deduction will be made to each area of non-achievement.					
A&E Waits						
Cancer Waits – 62 days						
Category A Ambulance Calls						

If all elements of both Measures and NHS Constitution Rights & Pledges are achieved, this could amount could be received by each member practice	**£29,770**

Southport and Formby
Clinical Commissioning Group

13/46

BOARD MEETING
March 2013

Agenda Item: 13.46	**Author of the Paper:** Tracy Jeffes Head of Corporate Delivery Tracy.Jeffes@sefton.nhs.uk

Title:

Board Committees – Terms of Reference

Summary of the Paper/Key Issues:

This paper presents the Governing Body with the revised Terms of Reference for the Audit Committee and Finance & Resource Committee.

A summary of the changes is given below:

Audit Committee

- Following a discussion in terms of reviewing and approving the annual accounts, it was agreed that the Governing Body should review and approve the annual accounts and report.
- Amend: Paragraph 3 refers to Annual Accounts "To review and make recommendations to the Governing Body with regard to the approval of (3) annual accounts (4) Annual report
- Add: Paragraph 4 refers to Annual Reports "To undertake annual review and assessment of the CCG's performance in respect of compliance with the requirements of the Information Governance Toolkit
- Add: To review any reports from external providers in relation to assurance regarding the function and operation of systems used to support the CCG's business".

Finance and Resource Committee

- It was agreed to amend the ToR to specify "either clinical or lay chair."
- Recommended that an attendance at the May meeting should be diarised for the CCG Chair
- Addition of Debbie Fagan – Chief Nurse and Brendan Prescott Head of Medicines Management to the Membership.
- QIPP Sub Group
- IRF Sub Group.

Action/Decision Required:

The Governing Body is asked to approve the Terms of Reference.

Date of Report:

14 March 2013

Southport and Formby
Clinical Commissioning Group

NHS Southport & Formby Clinical Commissioning Group

Audit Committee

Terms of Reference

1. Authority

The Audit Committee shall be established as a committee of the Governing Body to perform the following functions on behalf of the CCG Governing Body.

The principal functions of the Committee are as follows:

i) To support the establishment of an effective system of integrated governance, risk management and internal control, across the whole of the Group's activities to support the delivery of the Group's objectives.

ii) To review and approve the arrangements for discharging the Group's statutory financial duties.

2. Membership

The following will be members of the Committee:

- Lay Member (Governance) (Chair)
- Lay Member (Patient Experience & Engagement), (Vice-Chair)
- Practice Manager Board Member

Other officers required to be in attendance at the Committee are as follows;

- Internal Audit Representative
- External Audit Representative
- Counter Fraud Representative
- Chief Finance Officer
- Chief Nurse

The Chair of the CCG will not be a member of the Committee although he/she will be invited to attend one meeting each year in order to form a view on, and understanding of, the Committee's operations.

Other senior members of the Group may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Officer. Representatives from NHS Protect may be invited to attend meetings.

At least once a year the Committee should meet privately with the external and internal Auditors. Regardless of attendance, external audit, internal audit, local counter fraud and security management providers will have full and unrestricted rights of access to the Audit Committee.

Members are expected to personally attend a minimum of 75% of meetings held.

Relevant Officers from the CCG may be invited to attend dependent upon agenda items. Officers from other organisations including Cheshire & Merseyside Commissioning Support Unit (CMCSU) and from the Local Authority team may also be invited to attend dependent upon agenda items.

3. Responsibilities of the Committee

The Audit Committee is responsible for;

- Reviewing the underlying assurance processes that indicate the degree of achievement of the Group's objectives and its effectiveness in terms of the management of its principal risks.
- Ensuring that there is an effective internal audit function which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, the Chief Officer and the Group.
- Reviewing the work and findings of the external auditors and consideration of the implications of management responses to their work.
- Reviewing policies and procedures for all work relating to fraud and corruption as set out by the Secretary of State Directions and as required by the NHS Protect.
- Reviewing findings of other assurance functions (where appropriate) and consider the implications for governance arrangements of the Group (e.g. NHS litigation authority, Care Quality Commission etc.).
- Monitoring the integrity of the financial statements of the Group and to consider the implications of any formal announcements relating to the Group's financial performance.
- Responding on behalf of the Governing Body, to any formal requirements of the Group in relation to the audit process (e.g. the report from those charged with governance).
- Monitoring and review of the CCG Board Assurance Framework (BAF) to support the CCG's integrated governance agenda.

4. Duties of the Committee

The Committee is delegated by the Governing Body to undertake the following duties and any others appropriate to fulfilling the purpose of the Committee (other than duties which are reserved to the Governing Body or Membership alone):

- To review and recommend approval of the detailed financial policies that are underpinned by the Prime Financial Policies within the Group's Constitution to the Group's Governing Body.
- To review and approve the operation of a comprehensive system of internal control, including budgetary control, which underpin the effective, efficient and economic operation of the group.
- To review and recommend approval to the Governing Body of the Group's annual accounts.
- To review and approve the Group's annual report on behalf of the Governing Body
- To review and approve the arrangements for the appointment of both internal and external audit and their annual audit plans.
- To review and approve the arrangements for discharging the group's statutory financial duties.
- To review and approve the Group's Counter Fraud and Security Management arrangements.
- To review the circumstances relating to any suspensions to the Group's constitution (as set out in the Scheme of Delegation and Reservation) and to report to the Governing Body and Wider Membership Council on the appropriateness of such actions
- To undertake annual review of its effectiveness and provide an annual report to the Governing Body to describe how it discharged its functions during the year.

5. Administration

The Committee will be supported by an appropriate Secretary that will be responsible for supporting the Chair in the management of the Committee's business.

The agenda for the meetings will be agreed by the Chair of the Committee and papers will be distributed one week in advance of the meeting.

The Secretary will take minutes and produce action plans as required to be circulated to the members within 10 working days of the meeting.

6. Quorum

At least two members of the Audit Committee will be necessary for quorum purposes.

7. Frequency and notice of meetings.

The Audit Committee shall meet on at least four occasions during the financial year. Internal Audit and External Audit may request an additional meeting if they consider that one is necessary.

8. Reporting

The ratified minutes of Audit Committee will be submitted to the Governing Body. Exception reports will also be submitted at the request of the Governing Body. The ratified minutes will also be sent to the Quality Committee to support its role in monitoring the Group's integrated governance arrangements.

9. Conduct

All members are required to maintain accurate statements of their register of interest with the governing body. Members should notify the committee chair of any actual, potential or perceived conflicts in relation to the agenda, in advance of the meeting.

All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

10. Date and Review

These Terms of Reference were approved by the NHS Southport & Formby CCG Governing Body on [date to be inserted]

Version No.	3
Reviewed	February 2013
Review date	February 2014.

Southport and Formby
Clinical Commissioning Group

NHS Southport & Formby Clinical Commissioning Group

Finance & Resources Committee

Terms of Reference

1. Authority

The Finance & Resources Committee shall be established as a committee of the Governing Body to perform the following functions on behalf of the CCG Governing Body.

The principal functions of the Committee are as follows:

i) The Committee shall be authorised by the CCG Governing Body to undertake any activity within these terms of reference and act within the powers delegated to it in line with the Scheme of Reservation and Delegation.

ii) To provide assurance to the Governing Body that there are appropriate systems in place which operate in order to enable the Committee to fulfil its monitoring requirements.

iii) To provide regular reports to the Governing Body on a timely basis and to provide an annual report on the work carried out by the Committee including a self-assessment of how it has discharged its functions and responsibilities.

2. Membership

The following will be members of the Committee:

- Clinical Board Member (Chair)
- Clinical Board Member
- Lay Member (Governance) (Vice-Chair)
- Lay Member (Patient Experience & Engagement)
- Practice Manager Board Member
- Locality Clinical Representatives (x4)
- Chief Officer
- Chief Financial Officer
- Head of Performance & Health Outcomes
- Head of Corporate Delivery
- Head of CCG Development

The Chair of the CCG will not be a member of the Committee although he/she will be invited to attend one meeting each year in order to form a view on, and understanding of, the Committee's operations.

Members are expected to personally attend a minimum of 60% of meetings held and can send a deputy to attend in their absence as required.

Relevant Officers from the CCG will be invited to attend in line with agenda items. Officers from other organisations including Mersey Commissioning Support Unit (MCSU) and from the Local Authority Public Health team will also be invited to attend in line with agenda items.

3. Responsibilities of the Committee

The Finance and Resources Committee is responsible for;

- Advising the Governing Body on all financial matters and to provide assurance in relation to the discharge of statutory functions in line with the Standing Financial Instructions (SFI's).
- Reviewing the overall financial position of the CCG to ensure that the organisation meets its statutory financial duties.
- Overall financial management of the organisation including the delivery of investment plans, monitoring of reserves, and delivery of financial recovery plans and cost improvement plans.
- Ensuring that the performance of commissioned services is monitored in line with CCG expectations.
- Monitoring key performance indicators (e.g. any outlined in the NHS Operating Framework).
- Advising the Governing Body on the approval of annual financial plans.
- Monitoring and advising appropriate courses of action with regard to other key areas of CCG business (notably procurement, contracting and monitoring progress of Foundation Trust (FT) applications of local providers.
- Supporting the work of the Audit Committee through review of financial arrangements as required.

4. Duties of the Committee

The Committee is delegated by the Governing Body to undertake the following duties and any others appropriate to fulfilling the purpose of the Committee (other than duties which are reserved to the Governing Body or Membership alone):

- Oversee the development of the short and medium-term strategies for the CCG including assessment of the assumptions underpinning the financial models.
- To ensure the delivery of financial balance and that the organisation meets its statutory financial targets.
- Ensure that the Finance and Performance Plans are consistent with and complementary to the CCGs Annual Budget, Commissioning Plan ("One Plan") and Strategic Plan.
- To monitor implementation of the annual financial plan to ensure that the total resource available to CCG is invested in high quality services that support the achievement and delivery of specified priorities.
- Approving any variations to planned investment within the limits set out in the detailed financial policies of the CCG, ensuring that any amended plans remain within the overall CCG budget and do not adversely affect the strategic performance of the CCG.
- Monitoring Financial and Operational Performance across all commissioned services on an exception basis, assessing potential shortfalls and risk and recommending actions to address them.
- Monitoring Key Performance Indicators (KPIs) relating to CCG performance, for example as outlined in the NHS Operating Framework and One Plan.
- Monitoring delivery of the QIPP programme and agreeing corrective action if required.

- Monitor key risks facing the CCG, understand the financial consequences and make recommendations for inclusion on the CCG risk register accordingly.
- Oversee the development and delivery of capital investment plans including any schemes progressed through the LIFT or 3PD initiatives.
- Oversee the development and implementation of the Estates strategy.
- Oversee the development and implementation of Human Resource strategies, plans and corporate policies.
- Maintain an overview of recruitment, retention, turnover and sickness trends.
- To ensure that services provided by other organisations, notably Merseyside CSU, are being delivered as per the CCG's expectations and to advise on remedial action where necessary.
- To review, monitor and agree corrective action for all agreed financial performance indicators (KPIs to be determined based on CCG finance regime when published).
- To review the CCG procurement strategy and advise on an appropriate course of action regarding commissioning of new services / re-tendering arrangements for existing services
- To review and monitor progress regarding contracting arrangements with healthcare providers
- To monitor progress of local provider plans, particularly aspirant FT's, to advise the governing body in terms of key issues and any recommend decisions as appropriate.
- The Committee will review monthly reports detailing performance of commissioned services against core standards, national & local targets and the CCGs Strategic Plans, review may be on an exception basis.

5. Establishment of sub-groups of the Committee

The Committee will undertake regular review of its workload and will from time to time establish sub-groups to ensure that it conducts its business in an effective and appropriate manner. The Committee will establish 2 initial sub-groups as follows,

i). QIPP Sub-Group to undertake detailed review of all QIPP schemes, monitor progress and advise on corrective action as required.

ii). Individual Funding Request Sub-Group to receive recommendations from the local IFR panel, and approve as appropriate. Given that these requests may require urgent action, the Chair has the power to take action after consulting with whoever he/she deems appropriate.

6. Administration

The Committee will be supported by an appropriate Secretary that will be responsible for supporting the Chair in the management of the Committee's business.

The agenda for the meetings will be agreed by the Chair of the Committee and papers will be distributed one week in advance of the meeting.

The Secretary will take minutes and produce action plans as required to be circulated to the members within 10 working days of the meeting.

7. Quorum

Meetings with at least 50% of the committee membership, at least one Clinical Board Member, at least one Lay Person and either the Chief Officer or Chief Financial Officer in attendance shall be quorate for the purposes of the CCG's business.

8. Frequency and notice of meetings

The Committee shall meet at least 8 times a year. Members shall be notified at least 10 days in advance that a meeting is due to take place.

9. Reporting

The ratified minutes of the Finance and Resources Committee will be submitted to the Governing Body private meeting. Exception reports will also be submitted at the request of the Governing Body. The minutes and key issues arising from this meeting will be submitted to the Audit Committee.

10. Conduct

All members are required to maintain accurate statements of their register of interest with the governing body. Members should notify the committee chair of any actual, potential or perceived conflicts in relation to the agenda, in advance of the meeting.

All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

11. Date and Review

These Terms of Reference were approved by the NHS Southport & Formby CCG Governing Body on [date to be inserted]

Version No. [1]
Review dates [ ]

Register of Interests
March 2013

Southport and Formby
Clinical Commissioning Group

Board Member	Own Interest	Partner's Interest
Dr Niall Leonard	Director, Exacta Medico Legal GP Partner, Roe Lane Surgery Board Member, Southport Postgraduate Centre Undertakes Mental Health Assessments on ad hoc basis for a number of NHS Mental Health organisations (Section 12(2) approved)	GP, Cumberland House Surgery GPSI, Assura (Sefton Dermatology Service)
Dr Hilal Mulla	GP Partner, The Corner Surgery Out of Hours work, Integrated Care Sefton	None declared
Dr Liam Grant	GP Partner, Village Surgery, Formby	None declared
Dr Martin Evans	GP Partner, Grange Surgery	None declared
Dr Robert Caudwell	GP Partner, Marshside Surgery Owner/Director, Caudwell Medical Services Ltd	Director, Allbright Domestic Services
Dr Graeme Allan	Director, Trinity NHS Sefton, Primary Care Cancer Lead Colposcopist, Southport & Ormskirk Hospitals NHS Trust Partner, St Marks Medical Practice GP, Macmillan	None declared
Gillian Burke	None declared	None declared
Sharon Forrester	None declared	None declared
Karen Leverett	Practice Manager, Village Surgery, Formby	None declared
Roy Boardman	Business Manager, St Marks Medical Centre	None declared
Ann Bisbrown-Lee	Patient representative on QoF visits Member of governance and development group for British Association of Paediatric Nurses Patient Safety Champion Member of G.P.E.Z, General Practice Extraction Scheme Advisory Board	Son in law is a GP in South East England
Fiona Clark	Joint post held with South Sefton CCG	None declared
Martin McDowell	Joint post held with South Sefton CCG	Assistant Director of Finance with Liverpool Community Healthcare Trust
Roger Pontefract	Roger Pontefract & Associates Trustee, Formby Pool Trust Trustee, Formby Land Trust Chair, Sefton Partnership for Older Citizens	None declared

Board Member	Own Interest	Partner's Interest
Helen Nichols	Private medical work	Governor and vice chair, St Luke's Church of England Primary School
Jeff Simmonds	Non declared	None declared
Sharon Forrester	Employed by Liverpool Community Health Services NHS Trust	None declared
Gill Burke	Employed by Southport & Ormskirk Hospitals NHS Trust	None declared
Debbie Fagan	None declared	None declared

Hospitality Register
March 2013

Southport and Formby
Clinical Commissioning Group

Recipient:	Nature of Gift / Hospitality:	Date Received	Approximate Value	Donated by:
-	-	-	-	-

No hospitality received.

Southport and Formby
Clinical Commissioning Group

Audit Committee
Minutes

Wednesday 21 November 2012, 1.30pm to 3.00pm
Location Director of Finance Office, 3rd Floor, Merton House

Attendees
Helen Nichols (Chair), Lay Member
Roger Pontefract, Lay Member
Roy Boardman, Practice Manager

In Attendance
Martin McDowell, Chief Finance Officer (Designate)
Debbie Fagan, Chief Nurse (Designate)
Adrian Poll, Audit Manager (Mersey Internal Audit Agency)
Stuart Davison, Local Counter Fraud Specialist, (Mersey Internal Audit Agency)
Stuart Baron, Audit Manager, PriceWaterhouseCoopers

Apologies
Roy Boardman, Practice Manager
Peter Chambers, Audit Partner, PriceWaterhouseCoopers

Minutes

No	Item	Action
1.	**Welcome & Introductions**	
2	**Declaration/Register of Interests**	
3	**Constitution/Terms of Reference** The Constitution for S&F was accepted by the wider constitution meeting prior to authorisation including the terms of reference, presented to the Committee today for discussion. The Committee discussed the terms of reference and recommended the following changes to the Board Paragraph 2, page 2 insert “specialist” after fraud. take out (NHS Protect) Paragraph 1, page 2 add in “or Cheshire Merseyside Commissioning Support Service” after NHS Protect. Paragraph 4, page 2 insert “Cheshire Merseyside” instead of “Mersey”.	

No	Item	Action
	Section 3 – Add the monitoring review of the BAF to the Committee's Work Schedule for discussion at every meeting. The Committee agreed that one of its key functions would be to assure itself that the process underpinning the BAF was robust and thorough. Section 4. Duties of the Committee Following a discussion in terms of reviewing and approving the annual accounts, it was agreed that the Governing Body should review and approve the annual accounts and report. (Note: This requires a change in the Scheme of Delegation and reservation in sections 4.1 and 4.2 in that this matter should now be reserved to the Governing Body as opposed to being delegated to the Audit Committee). The Duties of the Audit Committee should be changed from "To review and approve the (3) annual accounts (4) annual reports on behalf of the Governing Body" To Paragraph 3 refers to Annual Accounts "To review and make recommendations to the Governing Body with regard to the approval of (3) annual accounts (4) Annual report Add in Paragraph 4 refers to Annual Reports "To undertake annual review and assessment of the CCG's performance in respect of compliance with the requirements of the Information Governance Toolkit" Add To review any reports from external providers in relation to assurance regarding the function and operation of systems used to support the CCG's business". A copy of the PCT's 20/11/12 Annual Governance Statement (AGs) to be provided to at the next meeting to help inform the Committee in terms of area covered. MMcD was asked to confirm arrangements regarding the provision of Security Management Services. Post meeting Note – This service will be provided by CMSCU as part of its core offer. Reporting – The ratified minutes will be sent to the Quality Committee to support its role in monitoring the Group's integrated governance arrangements. Constitution for SS was accepted by the wider constitution meeting prior to authorisation including the terms of reference. Presented to the Committee today for discussion.	
4	**Internal Audit Update** Discussions are on-going in relation to the internal audit plan with the CCG at present, which will include core assurance coverage in the plan. The plan will remain flexible, MMcD to agree plan with MIAA(AP) and report back to next Committee.	

No	Item	Action
	The CCG has 50 days allocated to it for 12/13 financial year. MMcD confirmed that MIAA had been confirmed as the CCG's Internal Audit provider. MMcD highlighted some risks around the Integrated Financial Single Environment (IFSE) project, notably the requirement that the CCG will be operating on a different ledger system to the PCT. MMcD updated on the working balance arrangements in relation to the closedown of the CCG. Where debtors/creditors are more than one year old, CCG's will inherit the outstanding transaction. Where debtors/creditors are less than one year old, NHS CB will inherit the outstanding transactions.	
5	**Local Counter Fraud Services Update** Plan to be pulled together following up from Locality Lead meetings.	
6	**External Audit Update** The practice arm of Audit Commission has been abolished. First Audit plan for the CCG will be received by Committee for Q4 2013/14 financial year. Roles & Responsibilities of Internal Audit, External Audit & LCFS to be discussed at next meeting. MMcD updated the Committee in respect of the appointment of external Auditors for the CCG. The NHS CB are required to instruct the Audit Committee to formally appoint auditors. This is expected to take place in December.	MIAA (AP) PWC (SB) MIAA(SD)
7	**Information Governance Toolkit** Based on Audit principles – Action plan to be brought to the next Audit Committee in February 2013.	MMcD
8	**Work Schedule** Receive minutes of other committees and review business inter-relationships Finance & Resource Committee and Quality Committee to be brought forward to Mtg 1 on work schedule. To be updated.	MMcD
9	**Meetings Schedule** 5th June 2013 this is a provisional meeting scheduled and may not be required at this stage.	
10	**Any Other Business** Register of interest – joint position with SS CCG. Hard copies of papers to be sent out where required – Members asked to notify PA.	
11	**Date and Time of Next Meeting** – Wednesday, 6th February 2013, 1.30pm to 3.00pm, venue – Family Life Centre, Ash Street, Southport, PR8 6JH	

Southport and Formby
Clinical Commissioning Group

Finance & Resource Committee Minutes

Wednesday 21st February 2013 at 1.30pm
Family Life Centre, Southport

Attendees		
Helen Nichols (Chair)	Lay Member	(HN)
Colette Riley	Practice Manager	(CR)
Hilal Mulla	GP Board Member	(HM)
Martin McDowell	Chief Finance Officer (Designate)	(MM)
Roger Pontefract	Lay Member	(RP)
Fiona Clark	Chief Officer	(FC)
Brendan Prescott	Head of Medicines Management	(BP)
In Attendance		
Paul Ashby	Practice Manager Lead Ainsdale and Birkdale	(PA)
Fiona Doherty	Transformational Change Manager	(FD)
Apologies		
Roy Boardman	Lay Member	(RB)
Billie Dodd	Head of CCG Development	(BD)
Tracy Jeffes	Head of CCG Development	(TJ)
Malcolm Cunningham	Head of Performance and Health Outcome	(MC)
Martin Evans	GP Board Member	(ME)
Debbie Fagan	Lead Nurse	(DF)
Minutes		
Karen Lloyd		

No	Item	Action
13.16	**Welcome, Introductions and apologies** The Chair welcomed everyone to the meeting and recorded the following apologies: Debbie Fagan Chief Nurse Billie Dodd Head of CCG Development Jan Leonard Head of CCG Development Malcolm Cunningham Head of Performance and Health Outcomes Roy Boardman Lay Member Dr Martin Evans GP Board Member Tracy Jeffes Head of Corporate Delivery RP noted that there may be an issue with the meeting being quorate on 20th March 2013 due to a number of committee members giving advance apologies. FC will liaise with Drs Evans and Grant to ensure that the meeting will be quorate in March 2013	**FC**

13.17	**Declarations of Interest** Fiona Clark Chief Officer, Martin McDowell Chief Finance Officer, Brendan Prescott Head of Medicines Management and Fiona Doherty Transformational Change Manager declared that they all have dual roles at both Southport and Formby CCG and South Sefton CCG.	
13.18	**Minutes of the previous meeting** The minutes were agreed as a true an accurate record of the previous meeting. The duplicated agreed action in item 13.7.i will be removed	
13.19	Action pointes of the previous meeting (not dealt with elsewhere on the agenda) • 13.4 – Brendan Prescott will be added to the membership as the representative from Medicines Management Team. • 13.4 – The BMI threshold for access to Bariatric Services was confirmed by DF. Does the patient have a BMI of 40kg/ m2 or between 35 kg/m2 and 40kg/m2 or greater in the presence of other significant disease. Other significant disease must include one major or two or more minor co-morbidities (see Appendix 1), and, have they been morbidly obese for 5 years or more? Has the patient attended and complied with Local Specialised Obesity Service (LSOS) for a minimum of 6 months? (see Appendix 2) Has the patient attended a minimum of two patient support group meetings for bariatric surgery patients (patient to provide dates and locations for meetings attended as evidence)? Is the patient aged 18 years or over, generally fit for anaesthesia/surgery, free from any specific clinical/psychological contraindications for this type of surgery? Is the patient prepared for the life-long commitment required for successful bariatric surgery? • 13.4 – The AQP report has been circulated to the committee members by MMD. This report is also to be circulated to Primary Care Services via GP Practices. • FC suggested that the Committee receive a 15 minute presentation from Peter Norman Head of Procurement and Contracting regarding the AQP program. • 13.7 – DF forwarded notice that following discussions with Locality Manager Moira McGuiness, it would not be possible to extend the services of the End of Life Care Home Facilitator to patients living at home. RP commented that in line with the end of Life Review currently underway this should continue to be a consideration. FC noted that whilst the answer was not positive in terms of this particular business case it could be possible in the future. FC is expecting the finding of the review in this area this week. • 13.7.iii – MMD reported that he has been working with GOC on improving access to psychological therapies. Additional funding from central government could make it possible to approve funding to recruit further trainees to achieve the DH target of 15% prevalence by March 2104. HM commented that the trainees would not contribute to increased capacity until they had completed 1 year of training. MMD noted that it was his understanding that trainees could undertake some clinical assessments at the beginning of the training program. HM noted that there was a significant financial difference between option C approved by the committee in January 2014 and Option D (Wave 6) MMD will confirm when clinical input will begin.	**MMD** **FC** **MMD**

13.20 **Month 10 Financial Report**

MMD presented this report which provided the F & R Committee with an overview of the Financial Performance for NHS Southport & Formby Clinical Commissioning Group as at the end of January 2013.

This report provides information regarding:

- The financial position at the end of month 10 including forecast outturn
- Financial Risks

Month 10 Financial Position

The financial position against the operational budget at the end of month 10 is £264k under spent prior to the application of reserves. This is an adverse movement of £91k when comparing to the month 9 financial position.

The 2012/13 indicative budgets delegated to Southport & Formby CCG equate to £159.8 million.

The table below provides a summary of financial position as at the 31st January 2013 and forecast outturn prior to the application of further contingency reserves.

Detail	Annual Plan	Year to Date			Forecast Outturn
		Plan	Actual	Difference	
	£	£	£	£	£
Secondary Care Total	86,020,560	72,042,893	72,203,556	160,663	197,235
Block Contract Total	25,898,123	21,581,761	21,581,761	0	0
Prescribing Total	21,548,356	17,959,748	16,725,670	(1,234,078)	(1,350,392)
Other Healthcare Total	12,214,478	10,260,384	10,505,840	245,456	208,656
Risk Share Total	11,126,090	9,567,751	10,100,963	533,212	728,415
Miscellaneous Total	1,594,228	1,111,047	1,141,971	30,924	0
Sub Total	**158,401,835**	**132,523,584**	**132,059,761**	**(263,823)**	**(216,086)**
Reserves	1,395,710	(100,000)	(100,000)	0	111,310
Grand Total	**159,797,546**	**132,423,584**	**132,159,761**	**(263,823)**	**(104,776)**

RP noted the forecast outturn position of £104,776 and requested confirmation that this would be achievable. MMD confirmed this to be the case although it was noted the prescribing position is reported two months in arrears so this figure is likely to change in the coming months. MMD gave assurance that the budget would finalise in a balance position.

HN requested further clarification surrounding restitution claims for continuing healthcare. Discussion took place surrounding final dates for claim submissions. FC and MMD assured the committee that as part of the risk sharing agreement there would be sufficient funding to satisfy all legitimate restitution claims and that going forward these would likely reduce due to the effective resourcing of the Continuing Health Care Assessment Team.

MMD will supply a fact sheet for the committee detailing issues surrounding restitution claims. **MMD**

CR requested clarification surrounding Any Qualified Provider Program (AQP), and

	suggested the possibility that this could lead to additional/duplication of referrals and the increased financial resource implications that could arise from this. MMD assured the committee that this issue was being monitored.	
13.20.i	**Financial Strategy Update** MMD presented this verbal update. The Committee were advised that MMD has had discussions with the Chair of Southport and Formby CCG and apprised him of the financial risks posed, in particular, by Specialised Commissioning. Whilst total funding initially appears to be adequate to support this area, there are some accounting anomalies to be addressed surrounding budget holding. In order to address this issue there may be some joint specialised commissioning during the coming year with corrections being made as appropriate. Work in this area is on going. Further detail on this issue will be presented by MMD at the Board Session later this month.	**MMD**
13.21	**Contract Performance Report** MMD presented the Contract Performance Report to the Committee which will be presented quarterly going forward. It detailed the financial performance against contract plan for 2012-13 with explanation of any key variances and highlights any key risks for the CCG. The paper also highlights non-financial performance targets and quality issues. The Committee noted that for 2012-13, contracts with providers based in Merseyside are operating under a "fixed price" arrangement for 2012-13, subject to certain agreed exclusions. This means that there will be no additional payment required by the CCG for any over performance in 2012/13. The converse applies, in that the CCG will not be reimbursed for under performance. This significantly reduces the level of financial risk due to activity shifts during the 2012/13 financial year. Southport & Ormskirk NHS Hospital is the largest contract for Southport & Formby CCG. As explained above for 2012-13 this is on a fixed price contract except for a small exclusion for high cost drugs which are paid for when the plan is exceeded. The month 9 report from the Trust shows what the financial position would have been if the contract was not on a fixed price agreement. The report shows significant over performance of £3.6M as at month 9 for the whole of Sefton. Southport & Formby's CCG share of this over spend is £3.3M when costs are apportioned on historic activity usage. RP requested clarification as to how this would be resolved. FC responded that this was part of the ongoing negotiations with the provider. The majority of the over spend is linked to outpatients. The over performance within first and follow up attendances is almost solely driven by Trauma and Orthopaedics. This is linked to changes made in relation to MSK activity. A full report is due from the Trust in February to understand this change. The outpatient procedure increase is focused within ENT, Ophthalmology and Dermatology. These specialities do not have any significant under performance within the other outpatient POD's which suggests a genuine increase in activity and not a shift from one POD to another. MMD drew attention to the issue of Direct Access Service in particular pathology. A change in NICE guidance has recommended B12 and folate testing for assessment of dementia patients which has created new activity levels. Brain Natriuretic Peptide (BNP) test activity for diagnosis and assessment of heart failure patients also accounts for the increased costs. There are also increased activity levels for bone profiling tests for patients. FC commented that further analysis was required to understand all issues related to this area. HM requested a full breakdown of what is included in direct access pathology. The Committee acknowledged that whilst over performance of contract was paid at 100% of tariff the providers would only receive 30% of this sum. The Committee further noted the CCG was overspent by £60k in the private sector. MMD assured the committee that in terms of performance the appropriate	**JW/ MC**

	monitoring was in place. Those patients waiting for 52 weeks at end of March 2013 have been given "To Come In" dates (TCI) prior to end March 2013. RP commented that a distinction should be made between over performing and overspending. **Agreed: The Committee noted the contents of the report.**	
13.22	**Prioritisation Report** FD presented the interim prioritisation framework. The Southport and Formby CCG Board has approved the establishment of a Programme Management Office (PMO). This paper sets out the process for submitting business cases for consideration, outlining the PMO role, using the PMO and approval from the F&R Committee. FD noted that this framework will form part of an overarching decision supporting system. RP requested clarification as to what constitutes a clinical priority. FC responded that this term is interchangeable with Health and Wellbeing. It was agreed that MC/FD/HN would trial the prioritisation framework using existing successful business cases to ascertain any issues. A revised prioritisation framework will be presented to the Finance and Resource Committee in March 2013 **Agreed: The Committee noted the interim prioritisation framework and the principles contained therein.**	**MC/ FD/HN** **MC/ FD**
13.23	**QIPP Sub Group - Review of Membership and Terms of Reference** MMD presented the Terms of Reference of the QIPP sub group. The QIPP Sub Group shall be established as a sub-group of the Governing Body to perform the following functions on behalf of the Finance and Resource Committee The principal functions of the Group are as follows: • to develop and monitor progress against QIPP plans • to support the development of and review the impact of short and medium term plans • to review service performance and quality in relation to QIPP The membership of the group was proposed as: • Lay Member (Chair) • GP QIPP Lead • The Chief Finance Officer • Head of Health Performance and Outcomes • Transformational Change Manager • Head of CCG Development • Chief Nurse **Agreed: The committee approved the draft terms of reference and membership for the QIPP Sub Group and recommended them to the Board for approval in March 2013**	**TJ**

13.24	**IFR (Individual Funding Requests)** MMD presented this report which gives an overview of the decisions made in respect of Individual Funding Requests for NHS Sefton during the period 1st -31st December. The expenditure for this period is £12,232. Total approved funding requests for the period 1st April 2012 – 31st December 2012 is £125,232. **Agreed: The Committee noted the contents of this report.**	
13.25	**Briefing updates – Commissioning NHS Operating Framework** MMD presented this verbal update and advised the Committee that the "Everyone Counts" publication has replaced the NHS Operating Framework**.** Strategy and Financial Planning sessions will take place at local and CCG level to meet the requirements of the framework. **Agreed: The Committee noted the update.**	
13.26	**Any other business** There was one item of other business MMD noted that there was an Information Governance for the CCG to appoint a SIRO and Caldicott Guardian. The Committee noted that Martin McDowell (CFO)would perform the role of the SIRO – responsible for the security management of information in the CCG and Debbie Fagan (CN) would perform the role of Caldicott Guardian – monitoring levels of access to patient related information. **Agreed: The Committee noted the appointments of the SIRO and Caldicott Guardian.**	
13.27	**Date and time of next meeting** The Committee noted the earlier start time for the next Finance and Resource Committee **1.00pm – 2.30pm Wednesday 20th March 2013 at the Family Life Centre.**	

Southport and Formby
Clinical Commissioning Group

Minutes of the Quality Committee

Wednesday, 23 January 2013, 3.30pm – 5.00pm
Family Life Centre, Ash Street, Southport

Attendees	
Helen Nicholl	Lay Member
Dr Rob Caudwell	Board Member, S&F CCG
Karen Leverett	Board Member, S&F CCG
Fiona Clark	Chief Officer, S&F CCG
Debbie Fagan	Chief Nurse, S&F CCG
Dr Doug Callow	GP, S&F CCG
Dr Katie Scholz	GP, S&F CCG
Roy Boardman	Board Member, S&F CCG
Billie Dodd	Head of CCG Development, S&F CCG

No	Item	Action
13/1	**Welcome and Introductions** HN welcomed everyone to the meeting and introductions were made.	
13/2	**Apologies for absence were received from:** Fiona Clark DF will check with Links re attendance of Ann Brisbrown-Lee	
13/3	**Declarations of interest** DF and MMD noted that they hold dual roles with both Southport and Formby and South Sefton CCG	
13/3.i	**Minutes of the previous meeting** The minutes of the previous meeting were circulated in advance but unfortunately omitted from the committee papers. In the interest of good governance they will be reviewed at the next meeting. **Agreed: The minutes of the previous meeting will be reviewed at the February meeting**	**DF**
13/4	**Quality Report** DF presented the CCG Quality Report and highlighted that due to the reporting timelines there was little significant change from the previous meeting. DF also went on to present the site visit report which was discussed in conjunction with the Quality Report. See next agenda item.	

No	Item	Action
	DC responded that although the information contained within it was accurate he did not feel that the Quality Report necessarily reflected some of the issues at S & O when considered alongside the qualitative information that was available. This was then discussed in the context of the Early Warning System that the CCG has in operation and the importance of both patient experience and clinician experience feedback as well as other intelligence being considered alongside the Quality and Performance Dashboards. DF assured the Committee that she had made a recent site visit to S&O Hospital with the NCB Mersey Area Team Director of Nursing and Quality following a Gold Command Winter Pressures teleconference. They discussed in detail issues surrounding quality of care including patient safety and patient experience. DF and Gaynor Hales (Area Team Director of Nursing & Quality) were shown around the Southport site by Liz Yates (S&O Director of Nursing and Quality). They received full verbal assurance from the Hospital and had sight of: • the major incident area in which the issues were being monitored and resolved. (CCG Head of Health Outcomes and Performance was present in the major incident room with the team), • A & E, • the Emergency assessment Unit and • other escalation areas that were open. Management have reported that patient safety has not been compromised although patient experience may not be to the standard that they would usually strive for due to the increased activity and acuity of patients. Although escalation beds were opened and staffed as per plan the increased pressures meant that further escalation areas had to be opened which resulted in the diluting of the staff establishment. DF further commented that whilst she and the NCB Area Team Director of Nursing & Quality had received verbal assurance, the Trust where asked for evidence that a risk assessment tool was in place. There was no such tool in use as described by the NCB Area Team Director of Nursing so one was going to be sent that was used at the Countess of Chester Hospital to Liz Yates for consideration. S & O have also been asked to produce an action plan which includes utilising the Ormskirk site in a more proactive way as long as patient safety can be maintained and the contingency plans that would be put in place for the treatment of oncology patients should the usual out-patient area be used as an escalation ward. At a subsequent telecom with Gold Command all CCG's had been asked to contact all acute providers to gain assurances that such a tool is in operation within their organisation. **Action: DF to confirm that risk assessment tool has been received by S&O and that the action plan is received by commissioners** **Action: The Committee instructed that the concerns as outlined above be escalated to the Governing Body for discussion at the next Board meeting. DF to arrange for this to be an agenda item. Board member to talk to this agenda item.**	**DF** **DF**

No	Item	Action
	DC asked for clarification regarding the decision not to use Ormskirk Hospital as a cold site. It was noted by the Committee that a lack of senior cover at Ormskirk was a patient safety issue if Senior Staff were not on site. A conversation resulted regarding the acuity of patients at the Ormskirk site and the level of medical cover required. DC noted his disappointment that Senior Staff had not been proactive in providing a more effective solution to the issues and noted a lack of urgency and robust problem solving. DC further commented that it was the opinion of a number of GP colleagues that the hospital had been sufficiently resourced. **Action: The CCG will arrange to conduct regular walkabouts at the hospital to include Clinical Directors/GPs.** HM suggested that CCG will contractually require consultants to engage effectively with GP colleagues. This may require a reorganisation of time for the consultants to allow meaningful dialogue. **Action: Effective Clinician to Clinician dialogue to be made specific in Quality contract.**	**DF** **DF**
13/5	**S&O Site Visit – CCG/NCB 10 Jan 13** See above	
13/6	**Quality Contract update** - **2012/13** DC gave an update on the 12/13 Quality Contract. The issue was raised that S & O need to ensure they involve the relevant clinicians at this meeting going forward. - **Preparation for 2013/14** DF informed the Committee of the preparation to date for the Quality elements of the contracts for 2013/14 which is being supported by CSU. Feedback was given on the commissioning workshop on 10 January 2013 and the planned event with Providers on 30 January 2013. DF informed the Committee of the collaborative work the Mersey Chief Nurses are undertaking regarding Quality Nursing Indicators which will encompass 'Compassion in Practice' (national nursing and care strategy) and reflect the recommendations from the Francis (2) Inquiry once published on 6 February 2012. Contract negotiations for 2013/14 are supporting the phased introduction of the Alternative Quality Contract - **Alternative Quality Contract** DC updated the committee on the developments between West Lancs CCG and S & O with regards to developing the Alternative Quality contract from April onwards.	
13/7	**Risk Register** Integrated Governance / Auditors - Integrated Governance / Auditors DF presented the corporate risk register to the Committee which will	

No	Item	Action
	be a regular agenda item going forward. The rationale for the risk registers being presented to the Quality Committee was discussed.	
13/8	**NHS Merseyside Quality Transition Status Report December 2012** The e-version of the Mersey report had been circulated with the meeting papers as previously requested. DF gave an update from quality legacy handover meeting with NHS Mersey on 10 Jan 13 but informed the Committee that she was unable to attend as she was asked to undertake the site visit that had previously been discussed with the NCB Area Team Director of Nursing & Quality. DF reported that the legacy handover meetings would continue until the end of March 2013	
13/9	**SUI update** **Feedback from handover meeting 18 Jan 13** The above meeting was cancelled; DF is now due to meet with Christine Griffith-Evans on 24 January 2013, to continue the SUI handover DF informed the Committee that there was a training event planned for February 2013 with the Mersey Cluster / NCB Area Team that she would be attending on behalf of the CCG as part of the SUI handover. DF reported that the CSU are identifying the staff who will be supporting the CCG going forward as part of the Core Offer. **SUI handover checklist** DF informed the Committee that the CCG have to complete a SUI checklist and send back to the Mersey Cluster / NCB Area Team along with the SUI policy **Feedback from NHS Mersey SUI group 21 Jan 13** DF gave verbal feedback from the meeting that took place this week. The Committee were informed that the next meeting scheduled for 18 February would be led by the CCGs with support from the CSU as part of the handover transition.	
13/10	**Policies** - **SUI policy for ratification** DF presented the CCG SUI policy for adoption by CCGs which is required as part of authorisation. With some agreed amendments re: terminology the Committee agreed to approve the policy in line with the Scheme of Reservation and Delegation. The policy will be reviewed on the publication of the Francis Inquiry recommendations and be brought back to the Committee as appropriate.	
13/11	**Safeguarding** - **Jimmy Saville Enquiry – Responses** DF informed the Committee that the DOH have issued a letter after a review was commissioned by the Government. The CCG have forwarded this letter to all their main providers. Providers have responded stating that they have actioned the points contained within the letter.	

No	Item	Action
	- **LSCB Section 11 Audit** DF informed the Committee of the Section 11 audit sent by the LSCB that requires completion. This shows evidence as to how we discharge duties regarding Safeguarding Children. This is difficult to complete as a purely commissioning organisation as some elements are provider focused. The audit will be completed and will be sent to the LSCB at the end of January 2013. It will be presented to the Committee at the next meeting. - **Residential Home update** The latest meeting to discuss the safeguarding concerns within a care home in the CCG area had been cancelled by the Local Authority and the CCG are awaiting a revised date. - **MOU update Safeguarding Hosted Service** DF reported that the MoU re: the hosted service has been circulated by Halton CCG. Some amendments have been made and these have been sent back to the Chief Nurse in Halton. Awaiting final MoU for sign-off. - **Serious Case Review / Management Review updates** AD stated that there was no further information to be reported at present. - **Winterbourne** Geraldine O'Carroll will present a joint CCG / LA response paper at the next Quality Committee giving an update of the local action being taken in response to Winterbourne. – it will give information regarding the collation of assurances for the relevant Committees and Governing Body to be certain that services are safe for patients.	
13/12	**Primary Care Quality update** Angela Parkinson reported on the work that she and Dr Bal Duper will be leading on in relation to Primary Care Quality and the Quality Premium. AP also reported that she and Debbie Fagan had met with Debbie Swantz to look at QP / Quality work across the CCGs. DF and AP have also discussed the links with the Practice Nurses Facilitators, Practice Nursing and Primary Care Quality. AP briefed the group on on-going pieces of work relating to Primary Care Quality and advised that a draft Quality Strategy will be available by May 2013. A Sefton wide primary care quality (PCQ) steering group was originally established in March 2012 comprising of CCG Chairs, GP Quality Leads, Practice Managers North and South, Medical Director of Mersey Cluster, members of PCT/CCG management team. With the appointment of the Chief Nurse and the introduction of the Quality Committee the PCQ steering group has now been superseded with the Quality Committee having oversight. AP described elements being used to identify / develop Sefton PCQ markers: - National Outcomes Framework 5 domains / Clinical Commissioning Group Outcomes Indicator Set (CCG OIS)(Appendix 1) - AQUA	

No	Item	Action
	- ATLAS - QOF /Calculating quality reporting suite (CQRS) - Merseyside Shared Intelligence Portal - Locality model for peer review, comparative referral data for QP indicators - Locality model Community Champion - Progress of Care Quality Commission (CQC) registrations - Locality knowledge **Quality improvement in primary care will be supported by:** - Maintaining relationship with NCB/LAT - Attending CCG Quality Network Meetings to enable peer review, learning environment - Supporting Dr Bal Duper to lead on PCQ across Sefton CCGs - Working closely with Practice Nurse Lead Educators - Discussion at locality meetings - Identifying a task and finish group - Supporting the Boards to fulfil its responsibilities for the proposed Quality Premium - Supported by primary care development plan **Action:** **The committee agreed that Primary Care Quality will now be a standing item on all future agendas.**	AP/BD
13/13	**Continuing Health Care update** DF and MMcD updated the Committee on progress to date from both a nursing and finance perspective. Next update from CSU expected February 2013. CHC has been recorded on the corporate risk register	
13/14	**National Care / Nursing Strategy update** DF informed the committee of the launch of 'Compassion in Practice' (national nursing and care strategy) in December 2012. DF will update the Committee regarding the implications for commissioning in future meetings and it's relationship to Francis (2) once published in February 2013. **Action:** **DF to provide an update with implications for commissioning and the relationship to Francis (2)**	DF
13/15	**Regional do not Resuscitate Policy** - **Regional do not Resuscitate Adult Policy** DF presented the North of England Adult DNAR policy that had been sent to her by a Chief Nurse from another CCG. DF explained that it was for information purposes only at this stage as we didn't know the status of the document and weren't aware that it had formally been sent to the CCG.	

No	Item	Action
	Action: **DF to contact Dr John Hussey, NCB Mersey Area Team Medical Director, to gain further information regarding the status of the policy**	DF
13/16	**Workplan** The draft work plan was tabled at the meeting for information purposes and DF asked all to have any comments back to her no later than **8 February 2013.** DF will then liaise with FLC/HC to update the work plan accordingly and present as a final document for sign-off at the next meeting. **Action:** **All to send comments on work plan to DF by 8 February 2013**.	ALL
13/17	**Research** DF asked the committee to note that to date she had received 3 x Research Governance requests from the Mersey Research Governance Group. These had been in relation to: • contacting GP practices regarding Paediatric Asthmas • contacting GP practices regarding GP Assessment • contacting a member of staff for follow-up research regarding Advancing Quality **CCG Responsibilities** DF informed the Committee that Debbie Fairclough from the CSU would be coming to a future meeting to discuss what the CCG responsibilities are going forward in relation to research and how the CSU can support this. **Action:** **DF to arrange for CSU to update the Quality Committee at a future meeting**	DF
13/18	**Any Other Business** **Francis Report** DF reported that the Frances Report will be available on the National Commissioning Board (NCB) website on 6 February 2013. DF/AM / GH will be travelling to London on 27 February 2013 to attend the kings Fund Frances Enquiry and will update at the subsequent Quality Committee meeting in March 2013. The Committee will receive a report in February re: Francis recommendations and an accompanying CCG action plan. **Action:** **DF to bring a report and action plan to the next Quality Committee meeting for consideration**	DF

No	Item	Action
13/19	**Date and Time of Next Meeting** Wednesday, 20 February 2013, 3.30pm – 5.00pm in Family Life Centre, Ash Street, Southport	

Knowsley Clinical Commissioning Group

Clinical Commissioning Groups Network meeting

Notes of Meeting Held on 6th February 2013

Part 2

Present:	*Name*	*Initials*	*Organisation*
	Dr Andrew Pryce	AP	Chair, Knowsley CCG
	Tom Fairclough	TF	Head of Commissioning, Knowsley CCG
	Dr Clive Shaw	CS	Chair, South Sefton CCG
	Fiona Clark	FC	Accountable Officer, Sefton CCG & Southport & Formby CCG
	Martin McDowell	MMc	Chief Finance Officer, Sefton CCG & Southport & Formby CCG
	Tom Jackson	TJ	Chief Finance Officer, Liverpool CCG
	Dr Steve Cox	SC	Clinical Accountable Officer, St Helens CCG
	Ian Davies	ID	Head of Operations & Corporate Performance, Liverpool CCG
	Paul Brickwood	PB	Chief Finance Officer, Knowsley, Halton & St Helens CCG's
	Simon Banks	SB	Accountable Officer, Halton CCG
	Dr Cliff Richards	CR	Chair, Halton CCG
	Dr Niall Leonard	NL	Chair, Southport & Formby CCG
	Nick Armstrong	NA	Chief Operating Officer, Warrington CCG
	Dr John Caine	JC	Chair, West Lancashire CCG
	Johanna Reilly	JR	Director of CCG Assurance, NCB Area Team
	Gaynor Hales	GH	Director of Nursing & Quality, NCB Area Team
	Leigh Thompson-Greatrex	LTG	Head of Assurance & Delivery, NCB Area Team
	Clare Duggan	CD	Area Team Director, Merseyside
	Tim Andrews	TA	Managing Director, C&M CSU
	Debbie Bywater	DB	Director of Client Services & Transformation, C&M CSU

Notes:	Andrea Kelly	AK	Secretary, Knowsley CCG

1. Apologies for Absence — **Action**

Apologies were received from:

- Katherine Sheerin (Accountable Officer, Liverpool CCG)
- Ray Guy (Liverpool CCG)
- Dianne Johnson (Accountable Officer, Knowsley CCG)

2. NCB Area Team Update

Gaynor Hales updated the group on the recently released Francis Report. This report looked at Boards, PCT's CQC's and the role of Monitor and doesn't feel that the current system focuses enough on quality.

There are 290 recommendations included in this report and the Area Team are currently going through these recommendations and prioritising accordingly.

Fiona updated the Area Team members on the suggestion in Part 1 that the Francis Report be included on the CCG/Area Team Time Out Day.

The report raised some concerns regarding nursing home regulation and how to link in with local councils. The Area team are looking at the support it can offer CCG's in this area.

Clare explained that Quality Surveillance Groups are being set up for the end of February 2013. The focus of this first meeting will be aims, purpose and membership. The second meeting will then focus on the Francis report – providers are not to be invited at this stage.

Clare updated the group on the planning submissions and confirmed that meetings are being held with individual CCG's.

Clare explained that next week's CCG/Area Team meeting will have a focus on strategic challenges. The Area Team will host meetings with individual CCG's and the local council then bring the group together.

Clare updated on staff levels; 90 day's notice has been issued to 99 staff and the number this now affects is down to 67. Questions and answer sessions are being held with these staff; Clare asked if the CSU & CCG could send some representation to the next meeting on 2.5 week's time

3. CSU Update

Tim updated the Network on three areas:

a) Business Development Unit (BDU)

C&M CSU have recently had visit for Checkpoint 3 which focused on the BDU – feedback from these visits have been very positive.
Feedback has also been positive on the merger of the two organisations and it was felt that C&M CSU is well advanced in the CSU market.

Point 4 is due diligence focused, interviews and sessions on these areas will take place next week.

b) Service Update

There are currently 73 vacancies which are to go through the clearing process. The Senior Management Team is almost complete with the most recent appointment being John Hayes as the Head of Quality & Performance.

Tim explained that each function is well staffed with the focus to switch staff to the new way of working. There are a lot of changes going on in IT, with Tim looking for a single CSU domain.

c) Transformation & Innovation

Tim explained that the CSU is keen to ensure capacity in this area, and have some processes which will be shared with the CCG Network when they are ready.

The CSU will use CCG plans as a target for this work and will look at different areas each quarter. This quarter the CSU is looking at: patient experience, commercial contracting & funding models and the frail elderly. Tim advised that capacity for this area has been built into the structure as a system called a 'flexible resource pool'.

Tim confirmed that the full service offer will be available from April 2013.

4. Provider CIP's

Leigh gave a presentation showing a look back at the process for obtaining provider cost improvement plans (CIP's)during 2012/13.

Dr Cox noted there were five providers that did not engage with this process and it will be difficult to seek assurances moving forward towards signing the new contracts.

Leigh explained that letters have been sent to providers informing of a review after 6 months, but providers can only give the information required after the fourth quarter. CCG's will be taking this process on and require a handover from Phil Wadeson. It has been agreed that Phil will pick up with CGG's regarding non-recurrent spend. It was agreed that a session will be held between NCB and CCG's.

Action – Area Team to arrange a session on Finance with CCG's	**NCB**
The Network discussed and agreed that if providers are not giving the assurances required then contracts should not be signed. It was agreed to add this discussion to the CCG/Area Team Time Out agenda for further discussion.	
Action – Add Provider CIP's to agenda for CCG/Area Team Time Out	**FC**
Date and Time of Next Meeting **Wednesday 6th March 2013 1pm in Boardroom 2 & 3, Regatta Place**	

SEFTON SHADOW HEALTH AND WELLBEING BOARD
MEETING 7th JANUARY 2013
AT THE BOOTLE TOWN HALL

Present - Councillors Ian Moncur and John Kelly, Robina Critchley, Clive Shaw, Fiona Clark, Peter Morgan.

Also in attendance – Councillor Paul Cummins and Sam Tunney (Sefton Council)

Apologies – Janet Atherton, Margaret Carney and Niall Leonard.

ITEM	TITLE	ACTION
1.	APOLOGIES Apologies for absence were received from Janet Atherton, Margaret Carney and Niall Leonard.	Noted
2.	NOTES OF THE LAST BOARD MEETING The notes of the meeting held on 3rd December 2013 were circulated and noted as a correct record.	Noted
3.	MATTERS ARISING Pursuant to minute 3, a copy of the bid for funding to build Health Partnerships, was circulated with the agenda for information. Pursuant to minute 5, the Board was asked to note that arrangments were in hand for the Stakeholder event to be held on 26th February. Pursuant to minute 8,, the Board was advised that it was proving difficult to re-arrange the next two Board meetings and to get an agreed programme of meetings.	Noted
4.	GOVERNANCE REVIEW/PREPAREDNESS The Board received a report on the governance review of the Board. The Board was advised that the government guidance on HWBB was still not out in its final form, and the review had been based on the draft guidance and the Governments response to the consultation. The report presented the issues contained within the draft guidance and consultation response and the	

	Board was asked to take a view in relation to each. Flexible Geographic Scope – in relation to boundaries, whilst the CCG boundaries are co-terminous with the local authority, some of the CCG patients would be living outside of the area, but may be registered in another CCG area. Fiona advised that the CCG networks across Lancashire and Merseyside provided the opportunity for big strategic issues to be dealt with. Some of the bigger issues such as mental health, learning disabilities, were already being picked up as wider than Sefton issues, through various existing arrangements. Some of the issues which would need to be addressed across boundaries, included children being placed out of borough, safeguarding issues, including childrens homes that are in borough, but are not registered, and there is no record of children from out of the borough who are in the homes. Core Statutory Membership – the report set out details of the current membership and the statutory minimum membership. It was suggested that the Board needed a criteria to determine whether there is any added value in adding people to the Board. It was suggested that if anyone made representations to join the Board, that they ought to be able to describe what added value they would bring. It was important to maintain an open mind, but be seen not to set a precedent. Robina explained that looking across Merseyside, there was a mixed picture as to what other Boards had done in terms of membership. Fiona suggested that as the connected partnerships were thought through, there was a need to map them all so that the Board could describe how they relate to each. A note on viral change had been circulated with the Board agenda, and it was felt that the principles set out in that paper were ones which could help the Board think through how best to make connections, and maintain links to other parts of the wider health and wellbeing system. Councillor Moncur, suggested that as the regulations had not yet been made, that the Board should defer consideration of membership and other governance matters until the next meeting. For the next meeting, it was suggested that a review of who has been asked to join the board be undertaken, and that a criteria for membership be explored which would allow the Board	That Fiona to keep the Board appraised of Lancashire and Merseyside wide issues which are pertinent to the Board That further work be undertaken to identify children placed in borough, which are not known about in order to ensure their health and wellbeing needs are being addressed That arrangements be made for a viral change workshop to be held as Board development Agreed to defer consideration of Board membership until the regulations had

	to consider the merits or otherwise of expanding membership. The Board was also advised of the need to consider how it progresses work outside of meetings, and it was proposed that the Board consider the role of the Operational Group at a future meeting, but in principle it be supported. Fiona advised that she would speak to Claire Duggan about nominating someone from the NCB to sit on the Board to enable them to discharge their responsibilities. Sub-Committees/Delegation – the draft guidance referred to the creation of sub structures. Reference was made to the Integrated Commissioning Group. It was suggested that the Group ought to submit reports and its minutes to the Board, but that it should not become a formal sub-committee. Councillor Moncur suggested that a similar approach be taken in the new financial year, to holding alternate informal briefings with formal meetings of the Board. There is a need to prepare an annual forward plan of issues for the Board, and it was suggested that this be brought to the first meeting of the Board in the new financial year. Items would include the CCG Commissioning Plans, CCG Annual Report (September), NCB Assessment of CCGs in relation to quality premium. The relationship with the Overview and Scrutiny Function would be important to work through. It was suggested that the Overview and Scrutiny Management Board should consider how best it perform its role. One of the issues which would need to be explored further was the level of delegation that the local authority would want to give the HWBB. For example would it have the same level of delegation as Cabinet Members. For foreseeable future, it was suggested that there should be minimal changes as possible, whilst the Board transitioned into its formal role and that the situation be reviewed during the next financial year.	been made That Fiona to contact Claire to request her to nominate a representative to sit on the Board That the Integrated Commissioning Group minutes be included on the agenda in the new financial year and if any issues need to be escalated, that these be submitted as a report to the Board That contact be made with the Overview and Scructiny Management Board with a request once the Regulations are made to consider O and S worked in relation to the Board
5.	<u>MAPPING OF PARTNERSHIPS</u> A report was submitted which offered the Board the results of the two exercises it undertook at its workshop on 3rd December looking at the range of partners/ships which, and through whom, it should	

	work in achieving the outcomes of the strategic objectives of the draft health and wellbeing strategy and adopton of a list of national outcomes frameworks, that have a direct influence on the strategic objectives of the draft health and wellbeing strategy, which will lead to the development of a performance management framework.. The Board was asked to note the work undertaken, some of the potential gaps in the information as outlined in the report, consider information on outcomes in light of recently emerged guidance from the NHS Commissioning Board and agree to the suggested timetable/next steps. It was suggested that an emphasis needed to be placed on individual responsibility for health and wellbeing, and there was a need to test out the health impacts of for example, the housing policy. The proposed stakeholder event was in the process of being organised and it was critical to get the right people at the event. Peter suggested that he, Fiona and Sam meet to develop the programme. The Board considered the work undertaken to date, and highlighted potential gaps and it was suggested that if there were meetings of the Childrens Trust and Local Safeguarding Board they be asked to assist in identifying local and national outcomes for children. The Board was asked to request the Operations Board to assist in identifiying, local and national outcomes from non health based partnerships for adoption within the agreed outcomes for the emergent strategy. The Operations Board met on 22nd January and they would be asked to further develop the outcomes framework and partnerships maps.	That the work undertaken to date be noted, the gaps identified be filled at the stakeholder event, and the Operations Board be requested to assist and support this process. Peter, Fiona and Sam to meet to develop the programme for the stakeholder event
6.	<u>ALCOHOL STRATEGY</u> Ian Canning attended the meeting and presented a report highlighting the isuses being consulted on in relation to the alcohol strategy; presenting recommendation responses, asking the Board to agree with the content of the responses, and asking each organisation on the Board to send invidual responses to the consultation. Ian advised that the Consultation ended on 6th February and this was the only opportunity the Board would have to consider making a response. Expert	That the Board agree the response, but in so doing it is noted that it could push

	groups had met in December, and there were 5 themes: 1. minimum unit price – Clive requested evidence that this would be successful; 2. multi-buy promotion – this would work more effectively when aligned with the minimum unit price; 3. licensing – mandatory – suggest no change, but may want to consider supporting not serving in bottles. 4. community impact policy – public health to have an input into licensing applications. Would like to be able to, as only the police could currently. Ian suggested that the approach required, was to denormalise drinking. 5. freeing up responsible business – such as champagne being served at house viewings, alcohol at the opening of say a florist. Ian asked the Board to consider 1. making a response and to which parts 2. requesting the CCG's and Council to do the same Clive expressed the view that the proposals were up against a very large industry and he felt that the best approach was to effect change by empowering people. He was concerned denormalising alcohol, would result in it gaining a mystique which was not beneficial. Councillor Moncur indicated that the Board was considering a response to a consultation, when what was needed was for the Board to have a wider discussion in relation to alcohol and drugs, and the type of service needed.	drinking under ground, but it was recognised there was a need to do something. That evidence on minimum pricing be circulated to the Board That the Alcholol and Drugs be included in the Forward Plan as a key policy discussion
7.	<u>Agnenda Items</u> The Board was asked to agree that the following items be deferred to a future meeting, namely: 1. Board Development Report; 2. Tobacco Controls/Plain Packaging.	That the items be included in the Forward Plan
8.	<u>Forward Plan</u> The Plan was noted. A copy of the Rospa paper was circulated at the meeting and the Board was asked to note that SEfton was the only local authority in the North West to achieve a Gold Award for its Childrens Play Areas.	Plan be updated to include the deferred items

9.	<u>Date of Next Meeting</u> It was agreed that the next meeting be rescheduled from 11th February in order to encourage full attendance by the Board.	Noted

Southport and Formby
Clinical Commissioning Group

Medicines Management Operational Group (MMOG) Minutes

Held on 18th January 10.30am-12.30pm
Library, 1st floor, Fylde Road Medical Centre, Southport

Attendees	Janice Eldridge, Susanne Lynch, Brendan Prescott, Jane Ayres, Hilal Mulla
Apologies:	Kay Walsh and Malcolm Cunningham
In attendance:	Dave Lawless, Informatics (Item 2 only)
Minute Taker:	Ruth Menzies

No	Item	Action
13/12	Minutes of meeting dated 4th January 2013 (agreed via email, sent to Melanie Wright for board minutes)	
13/13	Dave Lawless, Project Manager, Informatics Merseyside gave a presentation in relation to a website which he has put together and is widely used within Liverpool PCT. The aim of the website is a forum for clinicians and helps with the development of guidance and access to pathways. Currently there are 300 members and DL confirmed when new guidance is published an email is sent to the members informing them of this fact and giving them a month to comment. The introduction of this forum has resulted in greater clinical engagement in the development of guidance. Discussions took place as to how this could help in the future. It was agreed a link should be made with Helen Pearson (HP) the chair of the newly formed PAN Mersey APC. BP to email HP. DL felt there would be no extra cost to develop a Sefton website as felt it would come under the current SLA. HM to discuss with Rob Cauldwell re linking in with the CCG. DL will discuss with Steve Fraser for SSCCG.	**BP** **HM** **DL**

No	Item	Action
13/14	**Matters arising from minutes** <u>Information on sip feeds from Lucy Haworth for review and comments</u> HL stated he was impressed with the detail contained in the guidance. HM feels there is some sort of disparity as his dietician is prescribing sip feeds and as a result doesn't refer patients to a dietician. JE confirmed she likes the fact that you can add milk powder to juice and confirmed she would like to be able to hand to patients a leaflet in relation to the how the milk powder can be used. It was noted there had been a limited stock of Food First Leaflets that had been sent to practices. Further stocks are now available which will be sent out in due course. JA to feedback comments to Lucy Howarth and ask if she would be happy for us to adopt the guidance and would like reassurance all Dieticians would be following this guidance to ensure consistency. It was agreed awareness should be raised at locality meetings. <u>NOACs</u> Updated papers going to the Board at the end of the month. The papers had been clarified at CCG Networks and an SPU has been developed but have yet to be circulated. It was felt there would be very few patients but concerns were raised regarding the ethical situation eg if a patient was refused a NOAC and subsequently suffered a stroke. The APC recommended it should go to Board for full approval, however, concerns were raised at Knowsley. The aim is to get consistency across the CCGs. The committee agreed to remove this item from the agenda once been to the Board.	

No	Item	Action
	<u>Denosumab shared care</u> BP to ask GR to work out costings as no point in taking to the JMOG if there is no funding. Dr Siddique has confirmed he is happy to keep hold of patients until a resolution has been found. KW is going to draw up a draft share care. <u>RAG list (draft SPU attached)</u> Amendments have been made to the list following a meeting with the LMC. It is hoped the agreed SPU will be circulated next week. <u>Innovation Health and Wealth NICE TA</u> BP was hoping to speak with Margaret Geoghegan and other HOMMs to see if we could do a collective as opposed to going through all NICA TAs for the last 10 years. <u>GP Decisions Making</u> Business Proposals have been sent to F&R committees next week. Cost will be £6K per CCG if able to go to PLT sessions. If not there will be an increased cost due to locum cover etc required. Unique as not been done in this country before. BP to forward to Jenny Fox.	KW BP
	Standing items	

No	Item	Action
13/15	**Practice Updates/feedback** <u>Feedback from quarterly meetings/localities</u> JA confirmed she had nothing to report. SL – gave details of a patient who had been prescribed nitrofurantoin (as stated in the Antimicrobial Guidelines) for a UTI which had subsequently caused an horrendous eye condition. SL has brought the matter to Helen Stubbs's (HS) attention. HS will bring up at the review of the antimicrobial guidelines.	
13/16	**Scriptswitch** It was agreed that we need to publicise that scriptswitch will be closed and a few practices will be trialling the Eclipse system. Tom Roberts, the new analyst, will be the first port of call with any queries. Links need to be made with Doug Callow and Dave Mortimer. Item to be removed from future Agendas.	JA
13/17	**NS & WL Medicines Operational Forum** JE confirmed the above forum has been set up to retain links with the ICO and deal with local issues that have come out of the Pan Mersey APC.	

No	Item	Action
13/18	**Pan Mersey APC feedback** JE confirmed the inaugural meeting took place on 9th January and is entirely different to this format and other AMMCs she had attended. The committee has been set up to give final approval of items already looked at. Identifying what items will need to go to boards as opposed to CCG Network. It was noted 5 pathways were presented. These had previously been looked at as Individual Funding Requests but it was now felt it would be more appropriate to have as agreed Business Cases. There would be no great additional cost. BP to provide figures for JMOG and the F&R Committee The PAN Mersey APC will be producing a website. They will adopt the Mid Mersey website and newsletter which comes out monthly. Newsletter will continue for those who want to adopt it. JE tabled a copy. Agreed to publicise the website www.midmerseymmb.nhs.uk	**BP**
13/19	**QoF/PQS** Plan for 2013/2014 It was agreed the plans need to be made as to what areas will be addressed under next year's PQS. This will be covered at the next Senior Practice Pharmacist Meeting and possible options will be referred back to the MMOG. Also noted the MMOG needed to be mindful of what was already in the QoF. Discussions took place regarding specific practices and their approach to areas within the QoF.	

No	Item	Action
13/20	**Grey List** <u>Lasinoh lanolin cream</u> Rob Caldwell would like the above to be added to the Grey List as he has had lots of requests from the Breast Feeding Clinic (cost of item £10 per tube). JA will look at the evidence and report back. Dentinox for teething was also mentioned – JA will look at evidence.	**JA** **JA**
13/21	**Budget Update** S&F budget showing a forecasted underspend of 6.3% for October. BW has looked at 4 different models for budget setting. The Committee looked at JE's and HL's practice budgets and felt there was not much difference between the different models. However, when looking at a wider footprint it showed differences between each models can vary widely. BP to email details to all committee members with information regarding who will benefit from different models.	**BP**

	New Items	
13/22	**Medicines Management CQUINs 2013-2014** It is confirmed it is now too late to consider. BP had hoped to meet with Billie Dodd and Steve Astles. Discussions took place as to how we can control what happens in Medicines Management as a CQUIN. BP has emailed Doug Callow regarding NOACs and pregabalin CQUINS BP to also contact Margaret Geoghegan.	 BP BP
13/23	**Tredaptive** It was noted the above has been withdrawn however there is some prescribing in the CCG. JA to send prescribing data to the team.	 JA
13/24	**Degarelix and urology shared care** Draft shared care document attached. Treatment for patients who are at immediate risk of core retention and not just another add on. Discussions took place as how long patient will be in secondary care before rolling out and how patients will be managed. If adopting also need to clarify who needs to be notified. JE has emailed GR regarding bone density. JE to feedback to GR.	 JE
13/25	**Future website proposals** Nothing to report.	
13/26	**AOB** Paper on joint working – discussions took place regarding unneeded referrals. Principals going forward of working with trusts on shared care. JA to email documents to MMOG. Highlights communication issues. HM – gave details of a project undertaken in the Wirral whereby a respiratory nurse has taught all nurses inhaler techniques which has resulted in reduction in admissions by 400 patients.	
	Date, Time and Venue of Next MMOG – 15th February 10.30am Venue: Library, 1st floor, Fylde Road Medical Centre	

Sefton Strategic Integrated Commissioning Group (SSICG)

Minutes of the meeting held on 21st January 2013

Present :

Paul Acres	Chair of Sefton Strategic Integrated Commissioning Group	PA
Peter Morgan	Strategic Director People, Sefton Council	PSM
Fiona Clark	Interim Chief Officer – Sefton CCGs	FLC
Peter Moore	Head of Commissioning and Partnerships, Sefton Council	PM
Dr Clive Shaw	Chair of South Sefton CCG	CS
Martin McDowell	Chief Finance Officer	MMcD
Geraldine O'Carroll	Integration Commissioning Lead Sefton Partnership MCSS	GO'C
Dympna Edwards	Attending on behalf of Janet Atherton	DE
Carole White - (Minutes)	Senior Personal Assistant to Peter Morgan	CAW

In attendance for Item 3 only – Ian Canning, NHS Sefton

Apologies :

Tina Wilkins	Head of Vulnerable People, Sefton Council	TW
Robina Critchley	Director of Older People, Sefton Council	RC
Janet Atherton	Director of Public Health for NHS Sefton and Sefton Council	JA
Colin Pettigrew	Director of Young People & Families, Sefton Council	CP
Sam Tunney	Head of Business Intelligence & Performance, Sefton Council	ST
Dr Niall Leonard	Chair of Southport & Formby CCG	NL
Tracy Jeffes	Head of CCG Corporate Delivery – Sefton CCGs	TJ
Billie Dodd	Acting Head of CCG Development Southport & Formby CCG	BD
Steve Astles	Head of CCG Development South Sefton CCG	SA
Malcolm Cunningham	Head of Performance and Health Outcomes – Sefton CCGs	MC
Debbie Fagan	Chief Nurse for Sefton CCGs	DF

No.	Item	Minute	Action
1.	Minutes of the previous meeting	Agreed	
2.	Actions Arising / Update	Item 3 • Authorisation confirmation due on 22nd January 2013 Item 4 • Programme Management – On-going. Fiona Doherty recruited to post of Transformational Change Manager, reporting into MMcD. Programme Management to be	

No.	Item	Minute	Action
		an agenda item at the SSICG Meeting of 22nd April. <u>Item 5</u> • On-going <u>Item 10</u> • Sefton Carers Priorities – To be considered – agenda item for SSICG on 11th March. Phil Wadeson, Local Area Finance Director for the Merseyside Commissioning Board to become a Member of the H&WBB. phil.wadeson@liverpoolpct.nhs.uk ST to add to membership list.	ST
3.	Drug and Alcohol Needs Assessment Progress	• Ian Canning ran through with Members difference between the final and previous report and the outstanding challenges. • Deadline for completion - either w/c 28th January or w/c • 4th February. • Tender to be awarded after Easter. <u>Action</u> • Are we happy to share the care arrangements for Alcohol? • DE to feedback into FLC landmark dates, in order that FLC can raise at the relevant LMC Meetings. • FLC / CS / NL to come back to PM re a Member to join Procurement Process.	IC to circulate note to Members ALL DE / FLC FLC / CS / NL
4.	NHS Networks new content summary	• More monitoring being put in by NHS.	
5. / 6.	Funding Transfer from Health to support social services and reablement services 2013/14	<u>Background</u> In the 2011/12 Operating Framework for the NHS in England, the Department set out that PCTs would receive allocations totalling £648 million in 2011/12 and £622 million in 2012/13 to support adult social care. This funding was in addition to the funding for reablement services that was incorporated within recurrent PCT allocations of £150 million in 2011/12 rising to £300 million from 2012/13. From 2013/14, the funding transfer to local authorities will be carried out by the NHS Commissioning Board and the reablement funding will be carried out by the CCGs. In addition in January 2013 the DH allocated funding to support winter pressures and the PCT/CCGs will carry out this funding transfer. In each case the transfer will be made via a section 256.	

No.	Item	Minute	Action
	Winter Pressures Funding – Local Authority Allocation Reablement Funding	. • £468k Winter Pressures funding – PCT to via 256 agreement with the Council. PCT required to do a return in February to explain how funding has been spent. • 2013/14 allocation from NHSCB to support Social Care - £5,457,818 • Reablement – MMcD / TW / GO'C to meet shortly to agree investment of £1.8m to locally - via sec 256.	
7.	Any other Business	• GO'C now officially in her new joint role • Liz Johnson is soon to leave NHS / Sefton to take up a position at the CSU. • PM / GO'C to discuss way forward in light of Liz 'moving on'. • SSICG Draft Vision and Priorities – Action Plan – PM / DF as the leads to ensure document has been populated. This item to be an agenda item at the SSICG on 11th March. • PA asked if there was anything that Members wanted him to raise at the Merseyside Board Cluster Meeting – PA to reinforce the work that is being carried out by the SSICG.	PM / DF PA
		Date and time of the next meeting – 11th March 2013 at 3.30 p.m. – venue – Conference Room 3A, 3rd Floor, Merton House, Stanley Road, Bootle, Merseyside, L20 3JA	

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Engagement and Patient Experience Group
for South Sefton CCG and Southport and Formby CCG

07 November 2012, 15:00 – 17:00, Merton House

In attendance		
Kelly Jones	Engagement support CSU	(KJ)
Jackie Robinson	Head of Engagement CSU	(JR)
Lin Bennett	Practice Manager Board member SSCCG	(LB)
Sharon McGibbon	Practice Manager Board member SSCCG	(SM)
Wendy Anderson	Sefton LINk	(WA)
Roger Driver	Board Lay Member, South Sefton CCG (Chair)	(RD)
Helen Murphy	Sefton LINk	(HM)
Sarah Reynolds	Locality Lead, Southport & Formby CCG	(SR)
Diane Blair	Sefton LINk	(DB)
Libby Kitt	Sefton LINk member	(LK)
Lyn Cooke	Sefton Head of Communications, CSR	(LC)
Sam Tunney	Sefton MBC	(ST)
Jayne Vincent	Sefton MBC	(JV)
Ann Bisbrown-Lee	Sefton Link Chair	(ABL)
Roy Boardman	Practice Manager Board Member Southport & Formby CCG	(RB)
Jenny Kristiansen	Locality Lead, South Sefton CCG	(JK)
Tracy Jeffes	Head of CCG Corporate Delivery SSCCG, SFCCG	(TJ)
Rachel Bridge	Sefton CVS	(RB)
Apologies		
Roger Pontefract	Board Lay member, Southport & Formby CCG	(RP)
Billie Dodd	Head of CCG Development, Southport & Formby CCG	(BD)
Karen Leverett	Practice Manager, Southport & Formby CCG	(KL)
Steven Astles	Head of CCG Development, SSCCG	(SA)
Minutes		
Anne Lucy	Administrator, Southport & Formby CCG	

NO	ITEM	ACTION
12/30	**Apologies** were received and noted	
12/31	**Notes from the last meeting** The minutes were approved as an accurate record of the previous meeting	
12/32	**Matters arising not on the agenda** **12/23 Virtual Ward –** Steve Astles had met with LINk which now had sufficient detail of the Virtual Ward on which to develop a proposal to base/embed the patient voice. LK will bring the LINk proposal to the next meeting.	LK
12/33	**Authorisation update** TJ gave an update – The authorisation site visits for both Sefton CCGs went very well, with a large number of “reds turning to green.” Only a small number of criteria remained unmet; these would be systematically addressed in the coming weeks	

	and months. TJ thanked the group representatives for their valuable contribution towards the success of the two visits. The CCGs (particularly on the second visit) had been praised by the assessors for their strong patient engagement focus. The assessors had examined all levels of EPEG's work from practice level engagement through PRGs, through to the locality work/ liaison with the Community Champions and the EPEG's link into work at Board level. In response to a question from JV, TJ answered that any feedback from the visits in relation to patient and public engagement will come to EPEG and this is already part of the group's purpose. LK informed the group about an example of a piece work underway in conjunction with Terry Hill to support how patient choice influences commissioning. LK will feedback on this at future meetings.	LK
12/34	**Summary reports from the first Big Chat events** LC gave an update – a summary report has been produced to show interested parties an overview of the events and to outline what will happen as a result. The summary is now ready to be published. An interim website and e-bulletin will also be available from next month. Common themes identified in the summary are: • Care closer to home • Public involvement through two way dialogue **<u>Action</u> – LC to email group requesting any further comments by close of business on 15/11/2012** Once completed the final version, as well as other topical issues and events, will be publicised in local media (including the Crosby Herald, Midweek Visitor, Southport Visitor and Champion free papers). Additionally the CCG Chairs will be featured in radio / press articles in the North and South.	LC
12/35	**Proposal for Big Chat/JSNA and JHWBS Consultation Event (December)** TJ and ST had met to agree a joint approach to the next public events and presented a proposal for discussion by the group. ST noted that the proposal was recently approved by the Health and Wellbeing Board and the plan is to hold five events in the borough which will: • Feedback on SNA (JSNA) • Consult on the HWB strategy that is now in draft • Enable the documents to be shaped before sign off • Commence engagement before end November • Consult on commissioning intentions from CCGs • Make commissioning intentions clear and understandable for people In addition there the work will be taken to a range of other forums from the end of November. TJ noted that the first two events (due before Christmas) would be particularly important regarding consultation on commissioning intentions; the later events may be adapted based on feedback but would help people see the context of the strategy. The format would enable views to be fed in, but it was noted that both organisations would depend on networks for spreading the engagement future. RD noted that the two way flow was one benefit of the Big Chat events allowing groups to respond (whereas a forum was one way flow). The group discussed the format of the events, standardising communications and information to be recorded and disseminated, planning and resourcing for the future events. It was agreed that the small planning group reconvene as soon as possible to organise the events in detail. JR offered to co-ordinate the planning meeting. LA colleagues, Lay Board Members, CVS and LINk to be involved in this group.	JR
12/36	**Proposal from Carter Corson re EPEG development**	

	TJ gave an update - Carter Corson is the consultancy company that successfully bid to deliver our proposals for lots 2 and 4 in the national CCG development programme. A meeting in September began to shape the proposal further but it would be up to the EPEG to determine how best to shape, develop and increase the group's effectiveness based on the proposal. ST felt that it was important that a lasting legacy of self-development was built into the work once the consultancy came to an end. RB wished to ensure that the work did not go over old ground and the first session could be repetitive. JR noted that it had been discussed with Carter Corson that the programme should be building on earlier work to avoid repetition. TJ agreed to reinforce this message. JR felt that connectivity between this group and the Board would also need to be considered. RB suggested that the focus should be more on workshop two and three within the proposal – the connected committee and the influential committee. RD asked whether the group supported the premise behind the Relationship toolkit for GPs. The group discussed the toolkit and agreed that the proposal was not clear and discussion was needed to identify requirements. RB noted that the toolkit would need to be rolled out to GPs (protected learning time could be considered). LB felt that GPs might not use the toolkit as some areas were already covered by their own appraisal processes. GP/clinician involvement in public and patient engagement was however an area for further consideration and would be useful to focus on further. **<u>Action</u> – TJ asked for any further comments on the proposal to be emailed to her. She would liaise with Carter Corson to feedback views and agree the three half days for the new year.**	TJ
12/37	**Community Champions update** WA gave an update - Individuals are to be recruited to attend one pilot centre. Locality Leads are to be invited to the next Community Champions meetings (to tie in Locality Leads work and consult with focus groups). HM will be meeting Locality Leads in North Sefton, continuing the work she started in the South. She will be liaising with them to attend Locality meetings.	WA / HM and Locality leads.
12/38	**Patient Experience Report / Patient Choice Focus group** No reports were available for today's meeting but DB informed the group that discussions were taking place about the right the level of information to be shared with the group to form the basis of regular reports. TJ suggested that any available reports (regarding provider patient experience) could be shared with this group to see if it would be useful. This could also be provided to the quality committee and therefore directly influence commissioning when relevant. DB to send a report to the next meeting. TJ and JR offered support to the group to assist in streamlining the reports.	DB TJ/JR
12/39	**Reducing avoidable A&E attendances** SR provided an update regarding the work being done to identify / assess A&E attendances and asked the group if they could contribute ideas to reduce inappropriate attendances. Although previous work undertaken by other groups such as communications campaigns, QIPP projects, retrospective attendance follow up initiatives and other suggestions such as training, primary care access and triage were discussed further thought needed to be given to this area.. JR agreed to collaborate with SR re urgent care studies in other CCGs which have examined these issues. She noted that other CCGs shared the same problems with inappropriate A&E attendances.	SR/JR
12/40	**Patient Information Protocol** LC gave an overview and background to the protocol which dealt primarily with patient leaflets. She outlined the support that her department could offer the group.	

	The group discussed other media / publishing protocols and the setting up of a virtual reference group for patient information in order to test out messages. The group agreed that a standard template would be useful. **<u>Action</u> – Group to email comments to LC by close of business on 15/11/2012**	All
12/41	**PRG update** JR outlined that good progress had been reported in Sefton based on the work initiated by David Hammond, however some practices require further assistance and support – JR is providing this and will assist other practices on request. The next step is to set up quarterly meetings between PRGs in localities to help spare good practice, LB welcomed this and JR and LB/RB will liaise over involvement of the Practice Manager groups.	JR / LB/RB
12/42	**New CCG branding** Samples were shown to the group	
12/43	**AOB** None	
12/29	**Date and time of next meeting** 12 December 15:00 – 17:00, venue tbc Generally EPEG will meet every second Wednesday of each month from 10:00 – 12:00, however dates for the development sessions with Carter Corson in January, February and March would be required to be specifically agreed with Carter Corson and a longer session time made available (but could include business issues as well as development).	

PLEASE NOTE THAT SINCE THE MEETING IT HAS BEEN SUGGESTED THAT THE PROPOSED DATE OF 12TH DECEMBER BE CANCELLED DUE TO THE NUMBER OF PEOPLE UNAVAILABLE, THE PRXOIMITY TO THE LARGE PUBLIC EVENTS AND THE ADDITIONAL TIME REQUIRED FOR THE DEVELOPMENT SESSIONS IN JANUARY, FEBRUARY AND MARCH.

NEXT SESSION JANUARY 9TH 2013

Southport and Formby
Clinical Commissioning Group

Formby SFCCG Locality Meeting, 13 December 2012
Formby Village Surgery

Minutes

In Attendance

Moira McGuinness (Southport & Formby CCG Locality Lead)
Dr Doug Callow (Chair)
Dr Liam Grant
Dr Deborah Sumner
Colette Riley (Practice Manager)
Suzanne Lynch (Meds Management – NHS Mersey)
Dr Janice Eldridge
Pauline Needham (Practice Manager)
Colette Page (Practice Nurse Representative)

Dr Debbie Marsden - Merseycare
Alex Henderson - Merseycare
Barry Farrington - Merseycare

Apologies
Karen Leverett (Practice Manager)
Stuart Eden (Practice Manager)
Yvonne Sturdy
Jen hughes

No	Item	Action
12/80	**Apologies** were received and noted **Minutes of Previous Meeting** Minutes of previous meeting were discussed and agreed DC raised a query – would it be possible to identify North Sefton costs for A&E attendances?? MM will investigate.	MM
12/81	**Introductions** MM asked all in attendance to introduce themselves to our visitors	

No	Item	Action
12/82	**Mental Health** Dr Marsden and team attended to update the group on service developments, CQUINs and the positive impact anticipated, including improvement in communication between practices and service providers. There has also been the appointment of 'Relationship Managers' for each area, with the intent of a quarterly meeting to discuss issues, patient queries, waiting list information etc. It was mooted this could be combined with our Locality Meeting to reduce number of meetings clinicians are requested to attend. The team are also looking at assisting with the Annual Health Check, required for patients with certain diagnoses. Currently some patients miss this screening due to either multiple appointments or non-compliance; it is hoped greater communications and closer working will enable either team to perform the health screening and share outcome across both services. Other developments include a 'Duty' rota at Merseycare, for GP advice covering 3hr period each day this would be for advice only and not a Referral line. Audit is also planned, focussing on patients discharged at 1st appointment as this may indicate that patient could have been seen elsewhere. The service was reviewed, reminding the group that the Crisis Line is manned 24/7 by practitioners. DC raised query regarding sectioning of patients, and whilst Merseycare do have access to Section 12 GP's it is, in most cases, preferable for a GP who has met the patient, regardless of timescale, to be used if at all possible. In the NY it is anticipated to discharge stable patients, with an 'open-ended' option for review. This is to reduce waiting list and manage workload more effectively. This is anticipated to start mid-January 2013.	
12/83	**Risk Stratification** Although this is for discussion at the next meeting Practices were advised to advertise that we share data to ensure that patients are aware, and that data extraction is planned**.**	ALL

No	Item	Action
12/82	**Matters Arising** • **Winter Pressures Funds** • MM informed the group that some funds were likely reviewed our Locality Business Case and highlighted the pressure days identified ahead. • **Care Homes** • Care House situation in Formby was reviewed. MM notified the group that investigations into one particular Home were on-going. No Sefton CHC patients are resident in this particular home at present. • **Protected Learning Time** • The PLT provision is under review and on-going funding cannot be guaranteed. It was agreed that PLT is very helpful, allowing sharing of information, joint education and giving the CCG opportunity to inform the stakeholders as an assembled group. It was felt that funding for PLT needs to be sourced and ring fenced.	
12/85	• **GP Dashboard** • CR informed the group that the new GP Dashboard was on the MSIP – access details from Maria Dorpman	
12/86	• **Provider Services** • The S&ONHST FT application was discussed – the outcome from the recent wider meeting was reviewed and DC informed the group that support, with caveats was envisaged to be the way forward for all parties. DC also asked if any issues / concerns could be sent to him for use at either Senate or as part of caveat / CQUINs	
12/87	• **Development Sessions – Carter Corson–**f • MM outlined the sessions and dates – asking for as many to attend as possible – the idea being to attend 3 out of the 4 sessions if possible.	
12/88	**Prescribing** SL outlined the current budgetary position and congratulated all on their efforts, as we are currently under spent on the prescribing budget The replacement for **Epipen** was reviewed with guidance to continue to prescribe Epipen. Queries to Meds Management. GPs to be aware of new issues via AHCH who are switching brands from Epipen – **Fluticflur** – discussed – awaiting details but likely to be a blacklisted drug. **Epistasis** – new licensed PFS - strength needs awareness (5mg/1ml rather than 10mg/1ml) – watch Midazolam / Epistasis **Seretide** will be off patent in 2013 – further details awaited. JAE outlined guidance regarding **Clopidogrel for TIA** and rationale behind new advice. Ideally review on a patient by patient basis rather than wholesale change to patient medications.	

No	Item	Action
12/89	**AOB** **Procurement** PN reported that SSP Group had been successful in their bid for Freshfield Practice, together with the other 19 practices out for procurement. An open invitation will stand for representation from the Practice. **DN night Service** MM outlined issues and anticipated future pressures – a further meeting has been convened between MM and line managers involved – she will report back at the next opportunity. **Quorum** Quorum was discussed. If was agreed that a clinician from 3 of the 4 practices would be required **PN Representation** CP raised the lack of PN at the meeting. Usually either Jen Hughes or Yvonne Sturdy are in attendance, however Thursday is Yvonne's day off but she attends as often as possible, and Jen had a heavy workload that day which precluded her attendance. **Minutes** It was agreed to pass a copy of the meeting minutes to the PPG of each practice and also display a copy in the waiting room / reception for interested patients to access. **GSF** The ICO had asked for dates of Practice GSF meeting to be submitted, to allow for staff planning and attendance. It was felt this was not possible as most practices arrange their meeting dates at the close of a meeting to allow for holiday / pressures planning and in response to patient need rather than on a strictly rotational basis. **Local Authority** DC asked if Tina Wilkins can be invited to the next meeting, to inform about LA current services and potential effects to health and social services as a result of monetary savings have to be made. MM to inviter TW	MM
12/90	**Date, Time and Venue of Next Meeting** Thursday 10th January 2013 12.30 – 14.00, The Village Surgery Formby	

Southport and Formby
Clinical Commissioning Group

Central SFCCG Locality Meeting 29 January 2013
12:30pm to 2pm, Kew Surgery
Minutes

Attendees

Dawn Bradley-Jones	Practice Manager, Trinity
Mark Bond	GP, Curzon Road
Ian Hughes	GP, Cumberland House
Sandra Craggs	Senior Pharmacist, Sefton CCG
Halina Obuchowicz	GP, Kew (Chair)
Gillian Stubbens	GP, St Marks Medical Centre
Billie Dodd	Head of CCG Development, S&F
Roy Boardman	Business Manager, St Marks
Juliette Palmer	Practice Nurse, Curzon Road
Sue Critchlow	Business Manager, Cumberland House
Louise Campbell	GP, Trinity Practice
Pauline Kenny	Practice Manager, Kew

Apologies

Minutes
Anne Lucy

No	Item	Action
	Mersey Care gave an overview of the team and their work. The areas covered included: • Primary care improvement targets • Assistance with Mental Health checks for practices • Communication with practices via locality meetings • Capacity / demand assessment for practices • Improved management of mental healthcare issues • Identifying gaps in service	
13/01	**Apologies for Absence** – none were given. **Minutes of Previous Meeting** The group agreed to review the previous minutes at the February locality meeting.	
13/02	**Chair update:** • **Primary Care quality / development –** will be discussed in detail at the February meeting. A skill mix analysis is currently being undertaken at some other practices. The results will be discussed further to determine whether it would be useful to conduct the survey in this locality. • **Medicines Management –** will be part of the CCG by February. Extension of the role will be discussed at the next meeting	
13/03	**Practice Nurse update (Juliette Palmer)** • Two education sessions on child asthma and alcohol team audit had been delivered. BD noted that the business case to appoint an alcohol specialist nurse function in A&E in Southport had been approved. • A COPD nurse is available to review patients. Practice can refer patients to the nurse. • COPD training for nurses is required (to provide background of what the service delivers). RB suggested that PNs attend any future events	

No	Item	Action
	similar to those presented at the launch of the COPD LES last year.	
13/04	**Medicines Management Update** SC gave an update from Medicines Management: • SC reported that all practices in the locality were underspent. Only two practices in the CCG had overspent. • Scriptswitch licences will not be renewed after March. A new system (ECLIPSE) is to be used instead. This is being piloted in Dr Mulla's practice. • Shared care issues are highlighted in the recently distributed Sefton Prescriber update. Practices are advised to await guidance when starting new red drugs • Trials regarding the prescribing of drugs at Alder Hey are currently taking place. Feedback and further discussion is expected in the next few weeks. SC provide the following additional information: There is a pilot project running between Medicines Management teams across Merseyside and Alder Hey pharmacy regarding the prescribing and supply of paediatric special formulation (unlicensed) medicines. Currently, these medicines can be extremely expensive and there is no fixed price for many of them. The project is being co-ordinated by Clare Dutton at Knowsley with a pharmacist representative from each CCG and working with a senior pharmacist at Alder Hey. New patients requiring unlicensed special formulations are being identified prior to discharge and their GP is contacted by fax. The fax explains that the Consultant will continue to prescribe and accept clinical responsibility for the medicine and that Alder Hey pharmacy will supply the medicine (via a man & van) and the GP has to tick a box & complete the form to fax back agreement. The parents / carers are consulted about the supply / re-supply and then an email is sent to the CCG co-ordinator (Sandra Craggs for both Sefton CCGs) via NHSnet with the details. This enables me to contact out pharmacist / technician in the practice to ensure everything is running smoothly, that the fax has been completed & sent back & that the practice are aware that the medicine is NOT to be prescribed by them but they are aware that the child is taking it for clinical governance reasons in case of drug interactions etc. There is a feedback meeting on 4th Feb when we will look at the project, how it is running, costs etc & how we might take it forward to keep the costs of these unlicensed specials down to a reasonable level whilst ensuring the children get access to high quality and safe medicines. I will feed back on any progress in due course. The concept is that the costs will be top-sliced from the prescribing budget but that there will be considerable savings for the CCGs as well as GPs not having to accept clinical responsibility for unlicensed medicines for unusual conditions in children At this time, it is not possible to add in children already prescribed unlicensed specials in primary care but it is hoped that a mechanism can be developed to extend the project retrospectively as some stage.	 13 Jan Medicines_Man
13/05	**External Peer review of QP07 and QP10** This formed the main part of the meeting. The group discussed the cases they had reviewed, recommendations for possible solutions, and actions to be followed up.	
13/06	**AoB**	

No	Item	Action
	• **Winter Pressure money –** the use of this was clarified – each practice can choose any of the options for spending the winter pressure money as long as the allocation is not exceeded. • **Local Leadership development program** – HO had information about this program for any practices interested in participation	
13/07	**Date, Time and Venue of Meeting** Tuesday 26 February 2013 Kew Surgery. 13:00 – 14:00 (lunch from 12.30)	

Southport and Formby
Clinical Commissioning Group

North SFCCG Locality Meeting, 24th Jan 2013
Marshside / Corner Surgeries, Fylde Road

Minutes

Attendees

Lyn Roberts (LR)
Ann-Marie Woolley (AMW)
Sarah McGrath(SMc)
Hilal Mulla (HM)
Myles Moriarty (MM)
Lydia Hale (LH)
Mary McCormack (MMc)
Jane Ayres (JA)
Les Szczesniak (LS)
Helen Murphy (HM)
Stephanie Woodcock (SW)
Sharon Johnson (ST)
Carol Mackenzie (CM)
Jane Ayres (JA)
Kati Scholtz (KS, Chair)
Nicole Marshall (NM)
Rachel Pinedo (RP)
Janet McAlpine (JMcA)
Rob Caudwell (RC)
Tom Roberts (TR)
Abdul Zubairu (AZ)
Sam Muir (SM)
Pippa Rose (PR)

Apologies
Niall Leonard

No	Item	Action
13/01	**Apologies for Absence** were noted.	
13/02	**Updates from previous meeting** • **Risk Stratification Tool** Most practices within the North Locality have now signed the data sharing agreement which will enable inclusion of primary care data within the risk stratification tool. Please return the agreement asap if you have not already done so.	

No	Item	Action
13/02	• **Winter pressures funding** A menu of services which practices may be interested in providing had been circulated. Practices felt the list was restrictive and inappropriate for some practices eg small nursing home numbers or unable to secure additional pharmacist or nurse time. Practices were encouraged to tailor the models to suit what they could offer and all proposals would be considered on their merits. • **Quality** Real examples of areas where quality could be improved were required by Dr Doug Callow and all are encouraged to keep him informed of issues with service quality in both acute and community settings • **Clinical Availability Audit**. Returns are requested to Sarah by Friday 8th Feb. Some practices had started the audit and not encountered any difficulties. The audit had taken 1.5-2 hours to complete manually. • **OSKIS** An alternative to OSKIS search for COPD patients has been designed from EMIS. Results are being checked and the search criteria will be circulated when confirmed.	All All All SJ/JA
13/03	**QP indicators** In general the indicators (for outpatients, emergency admissions and AED) attendances are in three parts. The first part practices do internally, the second is a peer review done and submitted as a locality and the third part requires practices to document their individual contribution to action plans, use of new pathways etc. KS reminded the Group that the third part of the indicators was well rewarded in terms of the QOF points allocated QP8 11 points QP11 27.2 points QP14 15 points QP7 peer review. See attached document	
13/04	Medicines Management update See update attached Scriptswtich is approaching end of license and a replacement is being sought which is likely to be Eclipse. RC asked about prescribing for alcohol detox patients. Windsor Clinic were seeking approval from GP before prescribing which appeared to be part of a new shared care protocol.	

No	Item	Action
13/05	**Locality issues** KS asked about practices receiving support from PCT – employed pharmacists and information co-ordinators/data facilitators. Practices had perceived a reduction in information time available to them due to EMIS migration being a priority for the staff concerned. It was noted that some training was available for practice – employed staff to increase their knowledge of information systems. Action SJ to send link to available training. The future viability of the Rapid Response Team is being debated. Practices were asked to feed in any strong views on the service. HM raised an issue of psychiatrists requesting GP referral to cardiology where ECG has shown possible contraindication to certain medication. The Group felt this was not GP responsibility. Likewise MMc reported being asked by a consultant to make a referral to Wythenshawe for a heart MRI scan in a claustrophobic patient. Clarity re tertiary referral was needed	SJ All
13/06	**Any other business** **GSF** Practices are requested to ensure that District Nurse teams are aware of the planned dates for Gold Standard Framework meetings to maximise attendance. **Practice Nurse lead** Pippa Rose described her role as practice nurse lead within the CCGs and some of the clinical education events which are being organised for practice nurses and healthcare assistants. Pippa's contact details are Pippa.Rose@gp-n84026.nhs.uk	PMs
13/07	**Dates of Next Meetings** (to be held on Thursdays at 1300 – 14:30 at Marshside / Corner Surgeries) 14 February 28 March 18 April 16 May 13 June 11 July 15 August 19 September 17 October 21 November 19 December	

Southport and Formby
Clinical Commissioning Group

South SFCCG Locality Meeting, 24 January 2013
Ainsdale Village Surgery

Minutes

In Attendance

Dr Robert Russell (Chair)	Ainsdale Medical Centre
Jane Uglow	Locality Lead
Dr Paul Smith	Ainsdale Village Surgery
Carol Roberts	The Family Surgery
Dr Ian Kilshaw	The Grange Surgery
Dr K Naidoo	The Family Surgery
Paul Ashby	Ainsdale Medical Centre
Kay Walsh	Medicines Management
Dr Gladys Gana	Lincoln House Surgery
Penny Bailey	Community Matron
Nina Price	Grange Surgery
Karen Ridehalgh	Ainsdale Village Surgery
Gwen Clark	Ainsdale Medical Centre
Janice Lloyd	Lincoln House Surgery
Colette Page	Practice Nurse Facilitator

Apologies

Notes
Anne Lucy

No	Item	Action
13/01	**Apologies for Absence** None given. RR welcomed Carol Roberts (deputy Practice Manager) and Gwen Clark (Senior Practice Nurse) **Minutes of Previous Meeting** The minutes were agreed as an accurate record	
13/02	**Matters Arising** • **S&O FT Application** JU reported that a draft letter had been circulated for comment. The letter was principally one of support with conditions regarding leadership and targets / performance. RR noted that none of the GPs within the South Locality had seen the draft, but acknowledged that it would be unlikely to have been reviewed by a wide audience. • **Winter Planning** JU noted today was the deadline for suggested themes to be selected. Practices had been asked to send their preferences to JU. • **Respiratory Team Funding** JU had investigated the changes to the service (not instigated by Commissioning). The Health & Wellbeing clinic ran an all-day clinic on Tuesdays; Ainsdale held 2 clinics on Tuesday and Wednesday. Physiotherapy was available for home visits. PB noted that a new consultant-led, Sefton-wide service was available to provide care at home and will forward details to JU to circulate among localities. PB asked GPs to refer patients requiring respiratory physiotherapy (but not having the qualifying COPD or spirometry results) to her.	

No	Item	Action
	• **Update Capacity Skill Mix** PA commented on the audit template, noting that although it may be relevant to meet QP14, in practice they had not used the template as they found it to be too time consuming. It was also felt that it would be difficult to determine what a "good" or a "bad" week was. PA agreed to share the data that they are actually collecting with other practices. He felt that it provided a good benchmark of data for less effort. IK asked what such time consuming data collection would provide. RR noted that Niall Leonard had originally wanted to gain information for QP14. It was agreed to await the feedback from the north locality. • **Identification of a Locality Lead Practice Nurse** Rachel Ogden had agreed to undertake the role. Rachel is a practice nurse for Ainsdale Village and Lincoln House Practice • **AWP Specsavers – Advertising of services** JU had investigated advertising rules these are contained in the DOH marketing code of conduct it would appear Trust may advertise but they need to be mindful of the cost did not detract funding/resources away from patient care. PA noted that this had been discussed at the recent S&F Finance & Resource Committeee meeting. Malcolm Cunningham is undertaking an analysis of the uptake of the services offered by Specsavers to determine whether it had been influenced by advertising.	
13/03	**Update from Locality Chair (RR)** • The recent Locality Leads meeting had discussed: ○ The Rapid Response Team's cost and usage. RR reported that the service is not used as much as it used to be and some practices are not aware that it exists. Contract staff adds to the costs of £250K per annum. . PB noted that they were staffed by ICO. IK noted that RR had worked well for him during the Christmas period. In summary RR noted the locality thought the services was useful and would like to utilise the service more often and would support its retention. The current and future use of practice pharmacists. The group had agreed that this was a useful resource that could be developed further • There is to be an uplift in primary care in 2014/15 • Overspend on referrals is a continuing problem – it was noted only a small number of practices within S&F were overspending. • RR asked for feedback from the recent Wider Constituent Group meeting: ○ KN felt that the Risk Stratification model is excellent but clarification would be needed from the LMC prior to signing the data sharing agreement regarding the sharing of patient information to a 3rd party. KN would be happy to sign the agreement once it had the LMC approval It was also noted that his practice would not be able to use it until they had EMIS. ○ Unplanned care - the group generally agreed that education could help reduce the risk aversion believed to contribute to the number of 999 calls (and admissions) by care / nursing home staff	

No	Item	Action
13/04	**QPs** JU gave an update: • JU will provide information previously collected for QP7 & QP10 for internal review within practices before the peer review in February. • Practices will need to write up QP8 and QP11 before assessment by Mersey Internal Audit Agency (MIAA). MIAA would be using last year's model as the base for assessment. KN noted that the only additional work required for QP8 would be the cancer audit (as dermatology and MSK is on-going). JU to send cancer audit survey to practices • JU agreed to assist practices if required to identify QP work required / completed • KN noted that the Risk Stratification tool is not yet fully populated with the data that would be needed to identify patients at risk. The group discussed the data sharing agreements that are needed to allow patient data to be loaded. AL to send out the document and declaration (on page 4) to the practice managers. The group discussed the current situation regarding the requirement to supply confidential employee data to MIAA (for QP assessment). It was acknowledged that practices are awaiting advice from their LMC about the submission of QOF evidence to MIAA.	JU JU AL
13/05	**Medicines Management** KW provided an update. An electronic version will be supplied to the group (attached). In summary: • All practices have a green RAG status for prescribing spend • Scriptswitch is to be replaced by ECLIPSE at the end of March	
13/06	**Any other business** • **QP14** PA to forward guidance to KN re appropriate hospital attendance / high flyers. RR noted that considering contacting patients fulfilled the requirement. Consideration of monthly A&E attendance (albeit historic) and practice meeting notes/data to support findings, as well as contacting some patients would fulfil requirements. It was agreed that practices would prepare this for presentation and review at the February meeting • **NHS 111 (JU)** JU to send stakeholder bulletin to practices. NHS 111 will go-live on 21 March. The phased launch will allow the continued use of NHS Direct and the introduction of further areas during the year. Practice will receive communications requiring the preparation of detailed information to share with the new provider about services, telephony services, messaging, special patient notes etc. Managers will be required to prepare, respond and cascade as appropriate. • **Risk Stratification – data sharing** PA has asked the LMC for guidance on data sharing and opt out • **Practice Nurse Facilitator** Colette Page was introduced to the group and gave an outline of the role that she shares with Pippa Rose	PA All JU
12/30	**Date, Time and Venue of Next Meeting (lunch will be provided)** Thursday, 28 February 2013, 12:30 – 13:30, Ainsdale Village Surgery	

Southport and Formby
Clinical Commissioning Group

Southport & Ormskirk Strategic Partnership Board Meeting Minutes

Wednesday 09 January at 9.00am
Boardroom, Corporate Management Office, Southport & Ormskirk DGH

In attendance		
Jonathan Parry	Chief Executive, Southport & Ormskirk NHS Trust	(JP)
Dr John Caine	Chair of West Lancs CCG	(JC)
Dr Niall Leonard	Chair Southport & Formby CCG	(NL)
Fiona Clark	Chief Officer (Designate), Southport & Formby CCG	(FLC)
Mike Maguire	Chief Officer (Designate), West Lancs CCG	(MM)
Martin McDowell	Chief Finance Officer (Designate), Southport & Formby CCG	(MMcD)
Sharon Partington	Director of HR & Communication, S & O Hospital NHS Trust	(SP)
Damien Reid	Director of Finance / Deputy CEO, Southport & Ormskirk NHS Trust	(DR)
Malcolm Cunningham	Head of CCG Performance & Outcomes, Southport & Formby CCG	(MC)
Liz Yates	Director of Nursing ,Southport &Ormskirk Hospital NHS Trust	(LY)
Geraldine Boocock	Medical Director, S&O Hospital NHS Trust	(GB)
Apologies		
Sheilah Finnegan	Chief Operating Officer, Southport & Ormskirk Hospital NHS Trust	(SF)
Jane Higgs	Local Area Team Director, Lancashire	(JH)
Margaret Carney	Chief Executive, Metropolitan Borough of Sefton	(MC)
Minutes		
Anne Lucy	Administrator, Southport & Formby CCGs	

No	Item	Action
13/01	**Apologies** were received and noted.	
13/02	**Minutes of previous meeting** The Minutes were amended and approved as an accurate record of the previous meeting.	
13/03	**Action points from previous meeting** **12/19 Follow up to October Strategic session**. FLC had sent SF nominations for the forum. FLC will discuss with SF and timescales will be agreed at the next meeting **12/30 GP Operational Forum.** SP distributed an updated action report. It was agreed to make this the master list of issues and progress against them and to share it between this group and the GP Operational Forum. The group agreed that its profile should be raised, that it should be transparent and should be added as a standing item on this meeting's agenda. MM requested that dates of actions should be included. Updates and additions to be forwarded to SP for inclusion.	FLC GP Operational Forum Action Repor SP / MW

No	Item	Action
13/04	**Update on FT process** JP reported that the SHA authorisation process will be superseded by the National Trust Development Authority's (NTDA) process from April 2013. It had been therefore decided that the FT process would transfer to the NTDA. Whether any previous submissions would require resubmission will be determined by a Board to Board meeting after this date. Meanwhile the latest version of the IBP has been submitted and feedback is awaited (the plan may require further extension by a year to cover a five year period). FLC noted that the draft letter of support from the commissioners is still in progress and would contain conditions and caveats around strategic domains. JP anticipated that these could either be eliminated or begin to be addressed during the interval between shifting from the SHA to NTDA authorisation process. This was noted.	
13/05	**Update on Authorisation Process** MM reported that the 10 day window for submission of additional evidence for West Lancs CCG opens on 12 January 2013. The 8 red authorisation criteria are expected to reduce before April, although two major issues may not be reconsidered - QIPP. FLC reported that S&F CCG had updated their additional evidence by 24 December 2012 and the results will be known next week. It is expected that QIPP will remain outstanding. FLC noted that work on transition as an operational CCG was well underway. The budget allocation for S&F CCG was £156 million. This was noted.	
13/06	**Any Other Business** **Current Hospital status** LY gave an update on the pressures of the current high numbers of admissions, despite additional beds (56) and resources that had already been planned. There has been no flu pandemic yet – the admissions related mainly to COPD and were not initiated by GPs – most cases arriving by ambulance. Although the numbers of admissions had not increased greatly the case mix and severity had altered significantly. LY expressed concern that the quality of care received would be diluted as resources were stretched and that this surge would be unacknowledged. Ambulance diverts had not been possible although 9 step down beds on the Walton site had been offered. GB noted that elective procedures were being cancelled. The whole of Merseyside is under pressure. The group discussed various options to alleviate the current pressures: • Analyse case mix contributing to this surge and produce future plans / pathways, acknowledging that the demography of Southport was	FLC

No	Item	Action
13/06	atypical (25 years ahead of rest of UK in terms of age of population). FLC to nominate resource to lead • Release Paddy McDonald from secondment to provide additional resource • Examine what communication could be undertaken to advise patients to seek appropriate alternatives to hospital. • Fund appropriate GPs to assist in EAU (after initial triage) to support a reduction in admissions. • Liaise with Local Authority to up-skill or increase resource into social care (especially in period before Christmas). FLC to lead discussion at senior level, although routine winter planning this would normally be channelled through the Urgent Care Network. • Use care-home beds within Southport as step-down during peak admissions time. FLC agreed to liaise with Tina Wilkins at SMBC. • Consider NWAS support. A strategic meeting to be organised FLC asked whether primary care and GPs had influenced the recent surge. Anecdotal evidence of GP practices closing over the Christmas period, and signposting to A&E during OOH was given, although GP referrals had been appropriate. JC noted that number of OOH admissions had not significantly increased, but the reiterated that complexity of admissions had. JP noted that the ICO model remains appropriate, this was agreed. FLC noted that the on-going work regarding the community (the project being undertaken by Paddy McDonald) would be essential in understanding the resource requirements in these situations. The group noted LY's request that the ICO model and research project with UCLAN would require £60K of funding. This was noted. **Updates** • **Paddy McDonald** – FLC to ask Paddy McDonald and James Hester to present the scope of their project at the next meeting. GB requested specific details of their objectives and milestones (project plans) **Agenda items** • **ICO Business plan** – JP will have the ICO business plan ready for discussion at the next meeting • **Communication** – SP asked that this is included as a regular agenda item	JP FLC FLC FLC JP MW
Date of next meeting – Wednesday, 06 February, 09:00 am to 11:00, Boardroom, Corporate Management Office, S&O DGH.		

South Sefton Clinical Commissioning Group

Remuneration Committee

Wednesday 13 March 2013 at 9.00am
Boardroom, Merton House

Present
L Elezi (Chair)
Dr C Shaw
Dr R Sinha
S McGibbon

No	Item	Action
1.	**Chief Officer Remuneration** **CCG Level** / **Population size** / **Pay range for Chief Officer** Level 3 / at or over 500k / £120k – £130k Level 2 / between 150k - 499k / £105k - £120k Level 1 / at 149k or below / £90k - £105k. The Committee discussed the remuneration of the Chief Officer. As previously detailed in the paper, the population of Southport & Formby CCG is 119,080 and the population of South Sefton CCG is 147,366. The pay level is based on the largest CCG, not the combined total. The committee noted that based on the largest CCG, South Sefton, with a population of 147,366 the pay range level falls within level 1 (£90 - £105K). The Committee also identified that the population size at level 2 starts at 150K with a starting pay range of £105k and as the population for South Sefton CCG is only slightly below the level 2 bracket, it was agreed that the maximum pay range for level 1 should be applied.	
2.	**Chief Finance Officer Remuneration:** **CCG Level** / **Population size** / **Pay range for Chief Officer** Level 3 / at or over 500k / £95k – £110k Level 2 / between 150k - 499k / £85k - £95k Level 1 / at 149k or below / £75k - £85k. The Committee discussed the remuneration of the Chief Finance Officer. The committee followed the same rationale to agree the pay range for the Chief Finance Officer and that the maximum of Level 1 pay range (£75k - £85k) should be applied.	
3.	**Additional Payments Joint Management Arrangements**	

No	Item	Action
	In line with guidance, the Committee considered the guidance around Additional Premiums as detailed below: **JOINT MANAGEMENT ARRANGMENTS** - Where a CCG shares a Chief Officer/Chief Finance Officer with a neighbouring CCG, where each CCG has their own Governing Body, an additional premium of **up to 20%** of the appropriate pay range can be considered. This should be based on the population size of the largest CCG. The Committee discussed and agreed that as each CCG has their own governing body, this adds complexity to the role of Chief Officer/Chief Finance Officer. It was also identified that taking responsibility for two organisations should be recognised by awarding an additional 20% premium of salary as per guidance.	
4.	Development Pay, as per guidance, was not considered appropriate during this Committee meeting.	
5.	Recruitment and Retention, as per guidance, was not considered appropriate during this Committee meeting.	
6.	Additional Responsibility and/or Complexity Factors, was not considered appropriate during this Committee meeting.	
7.	**Recommendations** The Committee recommends that the **Chief Officer** remuneration as from 1st April 2013 should be approved as follows: Pay range Level 1 £105K Additional Premium re Joint Management Arrangement plus 20% Total remuneration £126K The Committee recommends that the **Chief Finance Officer** remuneration as from the 1st April 2013 be approved as follows: Pay range Level 1 £85K Additional Payment re Joint Management Arrangement Plus 20% Total Remuneration £102K	