NHS
Southport and Formby
Clinical Commissioning Group

Board Meeting in Public
Agenda

To be held on Wednesday, 29 May 2013 at 1.00pm to 4.00pm
The Family Life Centre, Ash Street, Southport PR8 6JH

Please note: the formal Board meeting will commence following a brief period when members of the public will be able to highlight any particular areas of concern / interest and address questions to Board members.

Attendees

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

No	Item	Lead	Verbal/ Report	Action
13/58	Apologies for Absence	Chair	Verbal	To note
13/59	Minutes of Previous Meeting	Chair	Report	To approve
13/60	Action Points from Previous Meeting	Chair	Report	To discuss
13/61	Business Update	Chair	Verbal	To note
13/62	Chief Officer Report	FLC	Paper	To note
13/63	Portfolio Leads Update	All	Verbal	To note
Performance				
13/64	Performance Reports			
	(a) Finance Update	MMcD	Report	To note
	(b) Prescribing Update	BP	Report	To note
	(c) Activity and Quality Report	MC	Report	To note
Policy/Strategy/Health Improvement				
13/65	Draft Strategic Plan	MMcD	Report	To note
13/66	Draft CCG Prospectus	JL	Report	To approve

No	Item	Lead	Verbal/ Report	Action
13/67	Cancer Services Update	Sarah McGrath	Report	To note
13/68	Managing Conflicts of Interest Policy	Tracy Jeffes	Report	To approve
13/69	End of Life Care Services	Moira McGuinness	Report	To approve
Governance				
13/70	Board Assurance Framework	TJ	Report	To note
13/71	Update of Terms of Reference – Board Committees	TJ	Report	To note
For Information				
13/72	Register of Interests	FLC	Report	To note
13/73	Hospitality Register	FLC	Report	To note
13/74	Minutes of Committees a) Audit Committee b) Quality Committee c) Finance & Resource Committee d) Merseyside CCG Network e) Health and Wellbeing Board f) Medicines Management Operational Group g) Strategic Integrated Commissioning Group h) Engagement and Patient Experience Group i) Locality Meetings - Ainsdale & Birkdale Locality Formby Locality Central Locality North Locality	Various h) Not yet available i) Not yet available	Reports	To note
13/75	Any Other Business			
13/76	Date, Time and Venue of Next Board Meeting Wednesday, 31 July 2013 at 1.00pm at the Family Life Centre			

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).

NHS
Southport and Formby
Clinical Commissioning Group

Draft

Board Meeting Minutes

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

In attendance

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)
Dr Martin Evans	GP Board Member	(ME)
Dr Jeff Simmonds	Secondary Care Doctor, Board Member	(JS)
Debbie Fagan	Chief Nurse	(DF)
Roy Boardman	Practice Manager Board Member	(RB)
Sharon Forrester	Nurse Board Member	(SF)
Gill Burke*	Nurse Board Member	(GB)
Fiona Clark	Chief Officer (Designate)	(FLC)
Martin McDowell	Chief Finance Officer (Designate)	(MMcD)

In attendance

Billie Dodd	Head of CCG Development	(BD)
Jan Leonard	Head of CCG Development	(JL)
Malcolm Cunningham	Head of Performance & Health Outcomes	(MC)
Paul Shillcock**	Informatics Manager, Merseyside & Cheshire CSU	(PS)

Apologies

Dr Liam Grant	GP Board Member	(LG)
Karen Leverett	Practice Manager Board Member	(KL)
Dr Hilal Mulla	GP Board Member	(HM)
Roger Pontefract	Lay Member	(RP)
Peter Morgan	Deputy Chief Executive, Sefton MBC on behalf of Margaret Carney (Co-opted Member)	(PM)

*left the meeting at 13.43
**left the meeting at 15.30
***joined the meeting at 15.36

Minutes
Melanie Wright — Business Manager

The meeting was preceded by a presentation from Karen Groves on the Care Home Audit.

Care Homes Audit 2012 update 2013.pp

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No	Item	Action
13/29	**Apologies for absence** The Chair thanked both Gill Burke and Sharon Forrester for their considerable contribution to the CCG, which had been both effective and timely. The Chair also thanked Ann Bisbrown-Lee for her contribution on behalf of LINKs. The Governing Body noted that S&F CCG is now authorised without conditions.	
13/30	**Minutes of Previous Meeting** Subject to minor amendment re Helen Nichols entry on the Register of Interests, **approved** as an accurate record of the previous meeting.	
13/31	**Action Points from Previous Meeting** All actions have been closed down.	
13/32	**Business Update** The Chair referred to a meeting on 26 March with the Local Area Team at which closer working was agreed. Commissioning of primary care services was also discussed. *Strategic Partnership Board* – Dr Paddy McDonald's suggestions were received and approved. A public engagement event with the Local Authority also took place this month. *GP Operational Forum* – clinical attendance being sought from the ICO; Jonathan Parry attended the last meeting. The plan is to take forward some of the operational difficulties at the ICO. At this meeting the conversations GPs have with patients upon referring for suspected cancer was discussed as there would appear to be some miscommunication with patients not understanding they are being referred for suspected cancer. BD indicated that this would be communicated via localities. The Chair also attended the Practice Managers meeting on 7 March, which was positive. A CCG-wide intranet has been suggested that all practices can use and personalise. The next meeting in May will be a meeting in public. Six new working groups have been established in relation to: Diabetes, Dementia, End of Life, Frail Elderly, Respiratory and Cardiology, with a view to redefining pathways in these areas with cross-organisational input. Noted.	
13/33	**Chief Officer Update** FLC referred to a meeting which had just taken place in relation to ensuring a joined up approach in relation to social care.	

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No	Item		Action
	FLC also referred to the difficulties experienced in relation to the recent 111 pilot and reiterated that the difficulties had arisen due to the timescales and delivery on a national basis. Individuals who had particular issues were invited to communicate this to FLC directly. FLC withdrew the section on procurement regulation which has been superseded since writing. It was noted that the PCT transfer scheme has now been extended by twelve months in order to ensure any further matters arising are captured. FLC also thanked the wider team and colleagues for their work and resilience over the last twelve months in a challenging and developing environment. HN suggested a explicit agreement was required from the National Commissioning Board in relation to the Prescribing Quality Scheme to ensure transparency in relation to potential conflict of interests. HN also requested the proposals around Care Closer to Home be circulated. Dr Paddy McDonald is due to attend a Board meeting to present on this. The Governing Body <u>delegated authority</u> to the Chief Officer in relation to the PCT Transfer Scheme. *111* It was noted that the Local Clinical Advisory Groups are accountable to CCG boards. <u>Noted.</u>		BP BP
13/34	**Portfolio Leads Update**		
	SF	Cardiac – 976 bed days have been saved and admission/readmission rates are down. The Cardiology Peer Review will take place in April.	
	RC	Paediatrics are working well.	
	GA	The draft cancer strategy will be going out to stakeholders. The refurbishment of the Macmillan Centre is almost complete. New cancer profiles with offers of visits to practices will be sent out shortly. From 1 April, Dr Allen will be leading on 111 and Urgent Care.	
13/35	**Performance Reports** **(a) Finance Update** 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.		

Draft

No	Item	Action
	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. The CCG is on target to meet its biggest CCG risk in relation to restitution claims. Steps are being taken to ensure the CCG's future position is protected. Debbie Fagan added that by way of support from the CSU, patients claiming restitution will be re-assessed against national criteria to determine their eligibility. Noted.	
	(b) Prescribing Update 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. MMcD reiterated that the benefits of using generic drugs in some areas was still being felt this year and this reduce next year. Noted.	
	(c) Performance and Quality Report Sefton is on amber with two areas in relation to CDiff and 62-day cancer waits remaining on red and amber at Southport. For A&E, Southport is on target for A&E this year, although not for type 1. The Walk-in Centre has brought up figures markedly. Medical admissions via A&E have increased by 19% in February, ambulance arrivals have increased by 16.1%. Non-elective admissions up by 7.8%. Cancer performance has improved. There are no 52-week waiters, although 18 weeks remains of concern. Debbie Fagan referred to a recent incident reported in the press regarding chemotherapy patients not being cared for in the MDU environment/clinical area, which has bee addressed with the Director of Nursing & Quality at S&O. The second press article related to an issue that occurred when the Director of Nursing & Quality was off and is being investigated. A site visit occurred in January to considered these issues. Debbie Fagan wished to offer the Board assurance in relation to the actions that had been taken. Following a meeting with Gaynor Hales and Clare Duggan of the NCB, Fiona Clark also referred to a Quality Risk review now being undertaken with S&O, the CQC and NDTA, along with West Lancashire in relation to S&O. Noted.	

Southport and Formby
Clinical Commissioning Group

Draft

No	Item	Action
13/36	**Strategic Plan** Work is ongoing and a version should be available for review at the Wider Constituent membership next week, requesting comments by the end of April. The final document will be considered at the April development session, with a view to Governing Body sign-off at the May meeting. Noted.	
13/37	**2013/14 Financial Outlook Report** As a Governing Body, the CCG is required to set out its financial budgets for the next financial year. Martin McDowell advised that the population number of 119,000 was typically based on anticipated new housing developments and expected population flow. The PbR tariff has been set nationally. It is expected that 2% non-recurrent funding must be maintained. 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. Martin McDowell also described how last year's performance including over-performance is used as a starting point in terms of methodology. Current schemes identified where there are outliers will be discussed with public health around, for example, children's services. Martin went on to discuss the available options in relation to closing the gap in funding and his recommendations to the Governing Body were to defer the planned investment schemes and reduce the contingency. He then provided an update in relation to contractual negotiations, highlighting the risks and opportunities. Dr Leonard discussed the implications for practices on a PbR contract and the close examination in relation to financial risk that would follow. Conversations will be required with membership practices. Dr Leonard outlined the current issues for the Governing Body in terms of complete engagement with member practices, but acknowledged the available levers to assist with this, together with the CCG's viability in light of these issues. Dr Evans felt that a significant leap had been made in relation to PbR contracts, to which MMcD responded that member practices would need to consider referrals. Dr Evans felt that this was a large task, given the timescale. Regarding IT, this needs to be reviewed on a health economy basis. Dr Caudwell expressed concern as to whether the current IT system was strong enough to deliver for a PbR contract. Dr Leonard considered that the issue was getting some practices to take responsibility for their budgets.	

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No	Item	Action
	Dr Evans reiterated that data must be correct. Jan Leonard responded that this would necessitate challenging Providers to ensure that data was correct and ensuring a system is set up in relation to managing deadlines in relation thereto. Helen Nichols expressed concern regarding data quality and the associated risks to deliver a PbR contract across the health economy, referencing historic experiences at the PCT. Helen offered an alternative approach with a fixed term contract would offer less risk. Martin McDowell advised a block in relation to non-elective activity was possible, but there were a number of issues with this option. Dr Leonard advised that he had considered the figures, which he felt were compelling. However, he also felt a PbR contract represented an opportunity for informed patient choice. Helen Nichols also felt that PbR was the best way to encourage positive behaviour with providers and again urged consideration of a block contract: going PbR was felt to be the right choice, but noting the associated risks. Ms Clark expressed confidence that the appropriate detail will be available, with support from the CSU. Mr McDowell then referred to section 12 and the proposal to ask CCGs to delegate authority in relation to the set up of a risk pool. The Governing Body : - approved the opening budgets - approved a review of the deferred investment schemes - approved a reduction of the contingency reserve from 1% to 0.5%. - approved the risk share agreement. The Governing Body agreed that a PbR contract be pursued with S&O, with delegated responsibility to the Chief Finance Officer and Chief Officer to sign the contract.	
13/38	**Everyone Counts** Jan Leonard discussed the three local priorities for the Quality Premium within the document and the changes made following a discussion with the National Commissioning Board. On the alcohol priority, the wording to be updated to exclude new patients, as these are already incentivised under an existing DES. **Approved**. The suggested alterations by the National Commissioning Board were also **approved**.	
13/39	**Plans for Healthwatch in Sefton** Noted.	

Draft

No	Item	Action
13/40	**Low Utilisation of Summary Care Record** Paul Shillcock felt that this is likely to be become an area of pressure for CCGs, following reactivation of this project nationally. Barriers around systems and patient consent have been removed, with emergency care records only being shared. Practices are being approached on an individual basis. No direct refusals have been encountered. Roy Boardman agreed to take this to the Practice Managers' Forum. Dr Caudwell indicated that he would be happy to support this and liaise with practices on a clinical level. Ann Bisbrown-Lee added that it was beneficial from a patient perspective, but did need to be handled sensitively. It was agreed that Dr Caudwell would also come to locality meetings to progress this. Billie Dodd to facilitate.	BD
	Paul Shillcock agreed to provide a quarterly update. Noted.	PS
13/41	**Quality Premium** Fiona Clark asked the Governing Body to note that the figure quoted per practice, is not money that will be received by the practice, but a representation of the funding that would be received by the CCG. Noted.	
13/42	**Francis II – Update** Debbie Fagan outlined the work being undertaken in response to the Francis II report. Due to the number of recommendations, these have been split into themes. Amongst their recommendations, an Inspector of Hospitals is to be appointed, revalidation for nurses to be introduced, a code of conduct and minimum standards for healthcare assistants and the NHS Confederation is going to consider reducing bureaucracy. The Quality Committee will receive a report containing recommendations in response to the Francis II Report. Helen Nichols also advised that the CCG's response will be considered at length at the next Quality Committee, with a view to presenting the recommendations to the Board. Noted.	
13/43	**Southport and Ormskirk NHS Trust Patient Administration System (PAS) and Information Technology (IT) Update** Dr Caudwell advised that the issue with the PAS system is 23 years old and expires in April. S&O have been discussing the options available with S&F CCG and West Lancs CCG. There are two options available – Lorenzo or McKesson.	

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No	Item	Action
	Ann Bisbrown-Lee asked the Governing Body to keep the patient central to the discussions.	
	Dr Allan raised an issue around district nurses performing blood tests. BD/JL to pick this up with Dr Allan.	BD/JL
	Helen Nichols felt that it would be necessary at some point to refuse further funding to S&O, taking into account protection against adverse impacts upon patients. This requires the CCG to be a smarter commissioning organisation.	
	Fiona Clark questioned whether the ICO's baseline was correct and a piece of work was required to address this during the first quarter of the next financial year.	FLC
	The Governing Body **approved** a direction of travel to support a phased approach to providing the funding, based on demonstrable milestones.	
13/44	**Quarter 3 Update on 2012/13 Local CQUINS at Southport and Ormskirk NHS Trust** Billie Dodd updated the Governing Body with the discussions held at the Quality Committee on 20 March and asked for approval. The Governing Body approved the recommendations contained within the report. Martin McDowell asked the Governing Body to delegate authority to the Chief Officer and Chief Officer in relation to discharging CQUIN payments and withholding same in the event targets are not met.	
13/45	**Prioritisation Framework** The Prioritisation Framework was taken to the Finance & Resource Committee, which now requires further testing with more business cases. Noted.	
13/46	**Board Committees – Terms of Reference** Approved.	
13/47	**Register of Interests** Helen Nichols requires amendment to her entry on the register. Helen has also received a letter from the Chair of the Merseyside Audit Committee, expressing concern that the interests of GPs who are not on the Board, but who are in the wider constituent membership who may have interests and are inputting to CCG workstreams. It was decided that any individuals associated with CCG work would be requested to complete a Register of Interests Declaration. Noted.	MW
13/48	**Hospitality Register** Fiona Clark attended the Sefton Annual LMC Dinner. Noted.	
13/49	**Minutes of Committees** **(a) Audit Committee** noted.	

Draft

No	Item	Action
	(b) Finance & Resource Committee noted. **(c) Quality Committee** noted. **(d) Merseyside CCG Network** noted. **(e) Health & Wellbeing Board** noted. **(f) Medicines Management Operational Group** noted. **(g) Strategic Integrated Commissioning Group** noted. **(h) Engagement and Patient Experience Group** noted. **(i) Locality Meetings –** **Formby Locality** noted. **Central Locality** noted. **North Locality** noted. **South Locality** noted. **(j) Southport & Ormskirk Strategic Partnership Board** Noted. **(k) Remuneration Committee** To be discussed below.	
13/50	**Any Other Business** *Remuneration Committee* The levels of remuneration were commensurate with the National Guidance in recognition of the hard work undertaken Helen Nichols reiterated that there was strong unanimous support for the recommendations at the meeting. The Governing Body approved the recommendations made by the Remuneration Committee. Note correction to version of Minutes of Remuneration Committee within papers. *S&O A&E Performance* Jonathan Parry, CEO, has contacted Fiona Clark, to advise he has informed NTDA of the A&E performance projection for Quarter 1. Jonathan has stated that Quarter 1 performance will not be achieved unless current escalation beds are maintained. *IG Agenda* The Board confirmed its support to the Information Governance Agenda as specified in the recent communication to Boards.	
13/51	**Date, Time and Venue of Next Board Meeting** Wednesday, 29 May 2013 at 1.00pm.	

Southport and Formby
Clinical Commissioning Group

Board Meeting
Action Points

Wednesday, 27 March 2013 at 1.00pm

No	Item	Action
13/33	**Chief Officer Update** HN suggested a explicit agreement was required from the National Commissioning Board in relation to the Prescribing Quality Scheme to ensure transparency in relation to potential conflict of interests. HN also requested the proposals around Care Closer to Home be circulated. Dr Paddy McDonald is due to attend a Board meeting to present on this.	BP BP
13/29	**Low Utilisation of Summary Care Record** It was agreed that Dr Caudwell would also come to locality meetings to progress this. Billie Dodd to facilitate.	BD
	Paul Shillcock agreed to provide a quarterly update. Noted.	PS
13/43	**Southport and Ormskirk NHS Trust Patient Administration System (PAS) and Information Technology (IT) Update** Dr Allan raised an issue around district nurses performing blood tests. BD/JL to pick this up with Dr Allan. Fiona Clark questioned whether the ICO's baseline was correct and a piece of work was required to address this during the first quarter of the next financial year.	BD/JL FLC
13/47	**Register of Interests** Helen has also received a letter from the Chair of the Merseyside Audit Committee, expressing concern that the interests of GPs who are not on the Board, but who are in the wider constituent membership who may have interests and are inputting to CCG workstreams. It was decided that any individuals associated with CCG work would be requested to complete a Register of Interests Declaration. Noted.	MW

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MEETING OF THE GOVERNING BODY
May 2013

Agenda Item: 13/62

Report date: 20 May 2013

Author of the Paper:

Fiona Clark
Chief Officer
fiona.clark@southseftonccg.nhs.uk
Tel: 0151 247 7061

Title: Chief Officer's Report

Summary/Key Issues:

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

Recommendation

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

Note	x
Approve	
Ratify	

	Links to Corporate Objectives *(x those that apply)*
	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
x	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement			x	

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

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

NHS
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Report to Governing Body
May 2013

1. Military Health

Under the new commissioning arrangements, commissioning of services for Armed Forces Veterans, Reservists (when not mobilised) and Armed Forces Families (serving, reservist or veteran) are the responsibility of CCGs. CCGs will also be responsible for the commissioning of emergency care services for veterans and family members in their respective area.

Regional Support

- Military veteran IAPT Service: An IAPT based Psychological Service adapted for ex and current Service Personnel and their families.
- The Live at Ease Project – This project supports ex-service men/women adapt to civilian life and provide practical support including support with housing, employment, training, debt advice and drug and alcohol dependency issues.

Local Commitment to the Military Health Agenda

Sefton CVS has worked in partnership NHS Sefton, Sefton MBC and other Public, Voluntary, Community and Faith (VCF), and Private Sector partners have now developed, and signed off, a local Community Covenant which sets out commitments to supporting the Sefton Armed Forces Community

To support the future military health agenda, there is an agreement to use CCG resources to fund an existing staff member on a part time basis, for a period of 12 months. The aim of the post is to research the needs of the Sefton Armed Forces Community, map existing relevant services and structures across Sefton, and to enhance the co-ordination of a multi-agency approach to meeting this need. The employee would act as a link person to the Clinical Commissioning Group (CCG) lead on military health. The project aims to achieve a clearer understanding of the needs of veterans which will inform future commissioning decision making.

2. Regulations on Procurement, Patient Choice and Competition

Following the public consultation carried out in August 2012, the Government has now laid regulations to help ensure that commissioners' decisions on buying clinical services are transparent and fair and that they improve the quality and efficiency of health care services for patients.

A copy of the regulations can be viewed at
https://www.gov.uk/government/publications/regulations-on-procurement-patient-choice-and-competition

3. Safeguarding Update

3.1. **Safeguarding Hosted Service -** a meeting took place on 8 May 2013 between the Chief Nurses to discuss and review the Safeguarding Hosted Service. All safeguarding children posts have now been recruited to within the structure for the children's team and the Chief Nurse from Halton CCG will advertising shortly to fill the remaining safeguarding adult post within the structure.

Discussions are taking place following publication of 'Working Together to Safeguard Children' (Department for Education 2013) and the 'Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework' (NHS England 2013) with NHS England (Merseyside) regarding the role of the Named GP for Safeguarding Children and where this function will be undertaken in the future.

3.2. **CCG Section 11 Audit Action Plan -** the Safeguarding Hosted Service is working with the CCG to progress the actions highlighted in the Section 11 Audit as reported previously.

3.3. **Safeguarding Annual Report –** the Chief Nurse has liaised with the Safeguarding Hosted Service regarding timelines for the presentation to the Quality Committee and Governing Body of the Safeguarding Annual Report. Providers should have submitted their reports to the Safeguarding Leads by the end of June 2013 which will enable the hosted service to present to the CCG in September 2013.

3.4. **Safeguarding Key Performance Indicators (KPIs)/Safeguarding Standards –** the Safeguarding Hosted Service are working collaboratively with the CCGs and the CSU to address final queries that have been raised by the providers regarding the safeguarding KPIs and the safeguarding standards. It is envisaged that these discussions will be concluded by the end of May 2013.

3.5. **Safeguarding Serious Untoward Incidents (SUIs) –** the Safeguarding Hosted Service are working in partnership with the CMCSU to support the Chief Nurse specifically with safeguarding SUIs. There is one on-going SUI relating to children which the Designated Nurse is liaising with the Designated Doctor to progress to closure by the CCG. There are two on-going SUIs relating to safeguarding adults both of which require further information from the provider following consideration of the Root Cause Analysis Reports/action plans before commissioners are happy to close.

3.6. **Safeguarding Reports to the Quality Committee –** from the June 2013 meeting of the Quality Committee, a separate written report regarding safeguarding will be produced by the Safeguarding Hosted Service for consideration.

4. Provider Quality Accounts

The NHS England (Merseyside) Area Team facilitated a Mersey-wide meeting for CCGs and the Area Teams (including Cheshire, Warrington & Wirral who lead on Specialist Commissioning) on 9 May 2013 in order for Providers to present their Quality Accounts. The Sefton Area were represented by the Chief Nurse on behalf of the CCGs, Head of Vulnerable Adults for the Local Authority and Sefton HealthWatch. The CCGs are in the process of collaborating on their responses/statements back to the providers. The providers have also been asked to present to the

respective Overview and Scrutiny Committees (OSC). The Chief Nurse has been asked to meet with the Chair of Sefton Health & Social Care OSC in order to support them with this process.

Working Together to Safeguard Children has been revised and republished in March 2013. It came into effect from 15 April 2013. The revised guidance clarifies the core legal requirements, giving more lucidity with regard to what individuals and organisations are obliged to do to keep children safe and promote their welfare. The NHS Commissioning Board also published its accountability and assurance framework for safeguarding at the same time, this framework complements the revised statutory Working Together guidance.

The Safeguarding Service will be working with the CCG's to better understand the implication this guidance has for them and to ensure that systems and processes within the CCG take account of all recent national directives to enable the Governing Body to effectively discharge their safeguarding responsibilities. Two briefs have been provided to the Chief Nurse and these will provide a sound basis and focus for further discussion and exploration at the Quality Board. Key highlights for the CCG include :

- Responsibility for safeguarding quality assurance through contractual arrangements with all provider organisations.
- Greater emphasis on the role of the named GP and the vital role it plays within the quality and performance management of GP Practices as providers
- Places a duty on retaining the expertise of a designated and named professional for safeguarding children locally.
- CCGs are statutory members of the Local safeguarding children Boards (LSCB) and subject to Section 11 duties of the Children Act 2004.

5. CCG Assurance Framework

The publication of the CCG Assurance Framework is a statutory requirement on NHS England. Consultation and discussions are under way to determine the final approach, but the framework will act as an interim measure to cover the first six months of 2013/14.

The document clearly differentiates between:

- the on-going assessment of performance and delivery which it is proposed involves quarterly checkpoint meetings where NHS England will review information which the CCGs will publish for the local population; and
- an annual health check which will consider both the CCG's track record and its organisational health as a predictor of its future success.

The core elements of assurance include:

- Delivery – ensuring that the CCG is delivering for its population the full range of outcomes and standards (both national and local) agreed in its plan;

- Capability – ensuring the CCG is set up to serve patients and communities effectively, both now and for future generations with the required skills and knowledge and is exhibiting the appropriate behaviours;

- Support – determining the nature and level of support a CCG needs to be a great commissioner.

All these areas are to be tied into a balanced scorecard approach and there will be quarterly formal checkpoint meetings around the following domains:

- are local people getting good quality care?
- are patient rights under the NHS Constitution being promoted?
- are health outcomes improving for local people?
- are CCGs commissioning services within their financial allocations?
- are conditions of CCG authorisation being addressed and removed (where relevant)?

CCGs will be expected to publish the data no more than six weeks after the end of the quarter on the CCG website, as a record of progress. Any support conversation will also be published alongside the scorecard.

NHS England intends to establish a programme oversight group, co-chaired by a CCG leader and an NHS England Team Director. This will also involve other members of the CCGs, local authorities and patient representatives.

The Governing Body will receive more details as the CCG Assurance Framework is coproduced in conjunction with NHS England (Merseyside).

http://www.england.nhs.uk/wp-content/uploads/2013/05/ccg-af.pdf

6. A&E Performance

NHS England (Merseyside) has been asked by Dame Barbara Hakin to oversee the facilitation of a local partnership approach to improve A&E performance. The CCG is co-operating fully with this request to produce the local recovery and improvement plan.

7. Recommendation

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

Fiona Clark
Chief Officer
20 May 2013

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2013

Agenda Item: 13/64(a)	**Author of the Paper:** Clare Shelley Head of Financial Management and Planning NHS Southport and Formby Clinical Commissioning Group clare.shelley@southportandformbyccg.nhs.uk Tel: 0151 247 7035
Report date: May 2013	

Title: 2012/13 End of year financial position of NHS Southport and Formby Clinical Commissioning Group.

Summary/Key Issues:

This paper presents the F & R Committee with an overview of the financial performance for NHS Southport and Formby Clinical Commissioning Group. It details the performance against annual budget and shows the end of year 2012/13 financial position.

Recommendation

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

Note	x
Approve	
Ratify	

	Links to Corporate Objectives *(x those that apply)*
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
x	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Southport and Formby
Clinical Commissioning Group

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	x			Presented to Lay Members at Finance and Resource Committee May 2013
Clinical Engagement	x			Presented to GP Board Members at Finance and Resource Committee May 2013
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered	x			Ensure CCG meets its financial targets and spends its resources effectively.
Locality Engagement	x			Presented to Head of CCG Development at Finance and resource Committee May 2013
Presented to other Committees	x			Will be presented as part of Finance and Resource Committee in Minutes sent to Audit Committee

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to Governing Body
May 2013

1. Introduction and Background

This paper provides the F & R Committee with an overview of the Financial Performance for NHS Southport & Formby Clinical Commissioning Group for the financial year 2012/13.

2. Healthcare Financial Position

2.1 The Year End Financial Position for 2012/13.

The financial position against the operational budget at the end of the financial year is £90k under spent prior to the application of reserves. This is an adverse movement of £349k when comparing to the month 11 financial position.

The 2012/13 indicative budgets delegated to Southport & Formby CCG equate to £160.38million.

The table below provides a summary of financial position as at the 31st March 2013.

Detail	Annual	Year to Date	
	Plan	Actual YE Outturn	Variance
	£	£	£
Secondary Care Total	86,663,025	86,940,415	277,390
Block Contract Total	25,945,823	25,944,421	(1,402)
Prescribing Total	21,548,356	20,185,617	(1,362,739)
Other Healthcare Total	12,375,471	12,476,977	101,506
Risk Share Total	11,815,542	12,703,228	887,686
Miscellaneous Total	1,960,745	1,968,001	7,256
Sub Total	**160,308,962**	**160,218,659**	**(90,303)**
Reserves	70,303	(100,000)	(170,303)
Grand Total	**160,379,265**	**160,118,659**	**(260,606)**

Please note figures in brackets within the variance column represent an under spent position. Positive figures represent an over spend.

A further breakdown is available in Appendix A.

The year end out turn position for Southport and Formby CCG prior to the application of CCG contingency reserves is £90k under spent. The outturn financial position following the application of reserves is £261k under spent. An explanation of the key variances are as follows:

NHS
Southport and Formby
Clinical Commissioning Group

Secondary Care

The year end position on secondary care is £277k overspent. Of this over spend, £87k relates to Wrightington, Wigan and Leigh NHS Foundation Trust due to an increase in activity within Trauma and Orthopaedics for reconstruction procedures.

Non Contracted Activity also overspent this year and relates to a number of high cost patients including:

- Belfast HSC Trust a total of £75,098 across the 2 CCGs – Patient spent 23 days in Intensive Care Unit and 8 days in High Dependency Unit

- Oxford University Hospitals NHS Trust total of £37,352 across the 2 CCGs of which £16,353 relates to Trauma & Orthopaedics (multiple trauma diagnostic) and £16,560 relating to Critical care (3 Organs supported 13/01/13 – 20/01/13)

- Kingston Hospital NHS Trust a total of £37,086 across the 2 CCGs of which £30,082 relates to Critical care (3 Organs supported 20/06/12 – 06/07/12).

Other overspends have taken place within Lancashire Teaching Hospitals NHS FT caused by activity within elective skin procedures and non elective trauma and orthopaedics for major hip procedures.

Prescribing

The year end position within the prescribing budget was £1.36m underspent. The under spend has continued throughout the year and has been caused by reduced activity as well as a number of drugs coming off patent during the year.

Other Healthcare

The Other Healthcare position was £102k overspent. Of the over spend, £220k relates to the Independent Sector Treatment Centre as a result of over performance at Ramsay Healthcare and Spire Liverpool.

Risk Share

The Risk Share position was £888k overspent. Of this, £625k relates to an over spend within Pharmacy spend within secondary care which has been cause by high cost drugs. High cost drugs are charged via an invoice of which 30% have been raised by Southport and Ormskirk NHS Trust. Other charges have been received by Independent organisations such as BUPA.

Continuing care also ended the year end with an overspend of £287k. The year end provision for CHC restitution cases across the 2 CCGs was £2.109m of which £941k relates to Southport and Formby. This provision is based on the activity assumptions provided by the CHC team.

3. Recommendations

The F & R Committee is asked to note the year end financial position of the CCG.

Appendices

NHS
Southport and Formby
Clinical Commissioning Group

Appendix A Summary of the Financial Position as at month 12

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

APPENDIX A

Summary Financial Position as at Month 12 (March) 2012/2013

Consortium: North

Southport and Formby
Clinical Commissioning Group

Detail		Annual Plan	Actual Outturn	Variance
		£	£	£
Secondary Care	Southport And Ormskirk Hospital NHS Trust	63,880,424	63,880,423	(0)
	Wrightington, Wigan And Leigh NHS Foundation Trust	1,048,279	1,134,885	86,606
	Non Contract Activity	964,374	1,030,409	66,035
	Lancashire Teaching Hospitals NHS Foundation Trust	336,050	393,466	57,416
	University Hospital Of South Manchester NHS Foundation Trust	71,883	99,910	28,027
	Aintree University Hospitals NHS Foundations Trust	5,648,592	5,648,592	(0)
	The Christie NHS Foundation Trust	27,790	54,511	26,721
	Warrington And Halton Hospitals NHS Foundation Trust	52,831	71,315	18,484
	Royal Liverpool And Broadgreen University Hospitals NHS Trust	4,085,599	4,085,600	1
	Clatterbridge Centre For Oncology NHS Foundation Trust	5,353,762	5,366,586	12,824
	Alder Hey Children's NHS Foundation Trust	2,364,859	2,364,851	(7)
	St Helens And Knowsley Hospitals NHS Trust	966,058	966,108	49
	Liverpool Women's NHS Foundation Trust	910,240	910,240	0
	Liverpool H&C NHS FT CCG	583,550	583,551	1
	Countess Of Chester Hospital NHS Foundation Trust	46,724	46,024	(700)
	Central Manchester University Hospitals NHS Foundation Trust	197,289	191,911	(5,378)
	Wirral University Teaching Hospital NHS Foundation Trust	124,722	112,034	(12,688)
Secondary Care Total		**86,663,025**	**86,940,415**	**277,390**
Block Contract	Cheshire And Wirral NHS FT	26,799	39,177	12,378
	Lancashire Care NHS FT	86,079	88,054	1,975
	Southport & Ormskirk Community Services	5,419,012	5,419,012	0
	Merseycare NHS Trust	10,801,301	10,801,301	(0)
	Liverpool Community Health NHS Trust	9,612,632	9,596,878	(15,753)
Block Contract Total		**25,945,823**	**25,944,421**	**(1,401)**
Prescribing	Prescribing	21,548,356	20,185,617	(1,362,739)
Prescribing Total		**21,548,356**	**20,185,617**	**(1,362,739)**
Other Healthcare	Independent Sector Treatment Centres	1,975,838	2,195,679	219,841
	North West Ambulance NHS Trust	4,104,832	4,238,866	134,034
	Anticoagulation	570,230	653,319	83,089
	The Walton Centre NHS FT	279,553	279,776	224
	Patient Transport Services North West Ambulance NHS Trust	8,197	8,357	160
	PbR Reserve	1,094,260	1,087,340	(6,920)
	Children's Services	1,018,611	953,298	(65,313)
	Glaucoma Tests	89,310	3,495	(85,815)
	Dermatology Assura	387,958	300,814	(87,144)
	Other Commissioned Healthcare	2,846,683	2,756,035	(90,648)
Other Healthcare Total		**12,375,471**	**12,476,977**	**101,506**
Risk Share	Pharmacy	669,470	1,294,567	625,097
	Continuing Care	10,919,635	11,206,580	286,945
	Oxygen	226,437	202,081	(24,356)
Risk Share Total		**11,815,542**	**12,703,228**	**887,686**
Miscellaneous	Prior Year SLA's	0	34,296	34,296
	Primary Care	299,200	299,200	0
	GP Consortia	1,661,545	1,634,505	(27,040)
Miscellaneous Total		**1,960,745**	**1,968,001**	**7,256**
Sub Total		**160,308,962**	**160,218,659**	**(90,303)**
Reserves	Allocations	70,303	(100,000)	(170,303)
Reserves Total		**70,303**	**(100,000)**	**(170,303)**
Grand Total		**160,379,265**	**160,118,659**	**(260,606)**

Prepared by Chloe Rachelle
Management Accounts Assistant
22/05/2013

NHS
Southport and Formby Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2013

Agenda Item: 13/64(b)	**Author of the Paper:** Brendan Prescott CCG Lead, Medicines Management Brendan.prescott@southportandformbyccg.nhs.uk 01704 387010 / 0151 247 7093
Report date: 14 May 2013	

Title: Prescribing Update

Summary/Key Issues:

This paper presents the Governing Body with an update on the prescribing budget position based upon month 11 (February 2013) prescribing data.

Recommendation

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

Note	x
Approve	
Ratify	

	Links to Corporate Objectives *(x those that apply)*
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
	To sustain engagement of CCG members and public partners and stakeholders.
	To drive clinical leadership development through Governing Body, locality and wider constituent development.

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

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Legal Advice Sought		x		
Resource Implications Considered		x		
Locality Engagement		x		
Presented to other Committees		x		

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
May 2013

1. Executive Summary

The Southport and Formby CCG position for month 11 (February 2013) was a forecast under spend of £1,252,606 or -6.1 %. This is £ 1k more than the forecast underspend at month 10.

2. Introduction and Background

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

3. Key Issues

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

There has been an issue with the wrong code being used at St Marks's Medical Centre which is being addressed.

The medicines optimisation plan for 2013-14 has been presented and approved at the Medicines Operational Group and Finance and Resource Committee.

4. Recommendations

The Governing Body is asked to note the prescribing update.

Appendices

Appendix 1 : Performance table of budget versus spend (month 11, February 2013 data).

Brendan Prescott
CCG Lead, Medicines Management
May 2013

Prescriber Code	Prescriber Name	Total YTD Spend	Total Budget	Total FOT	Variance £	Variance (%)
N84005	CUMBERLAND HOUSE SURGERY	£1,147,158	£1,292,506	£1,248,131	-£44,374	-3.4
N84006	CHAPEL LANE SURGERY	£1,109,056	£1,249,392	£1,206,676	-£42,716	-3.4
N84008	NORWOOD SURGERY	£1,170,029	£1,435,654	£1,273,016	-£162,638	-11.3
N84012	AINSDALE MEDICAL CENTRE	£1,797,575	£2,062,473	£1,955,799	-£106,673	-5.2
N84013	CURZON ROAD MEDICAL PRACTICE	£485,459	£549,161	£528,190	-£20,971	-3.8
N84014	AINSDALE VILLAGE SURGERY	£515,108	£595,315	£560,448	-£34,867	-5.9
N84017	CHURCHTOWN MEDICAL CENTRE	£1,815,126	£2,057,160	£1,974,895	-£82,265	-4.0
N84018	THE VILLAGE SURGERY FORMBY	£1,439,568	£1,579,355	£1,566,280	-£13,075	-0.8
N84021	ST MARKS MEDICAL CENTRE	£2,279,793	£2,472,450	£2,480,462	£8,012	0.3
N84024	GRANGE SURGERY	£1,543,439	£1,920,685	£1,679,294	-£241,391	-12.6
N84032	SUSSEX ROAD SURGERY	£301,986	£337,470	£328,567	-£8,903	-2.6
N84036	FRESHFIELD SURGERY	£527,667	£565,504	£574,113	£8,609	1.5
N84037	LINCOLN HOUSE SURGERY	£376,578	£466,499	£409,725	-£56,774	-12.2
N84611	ROE LANE SURGERY	£378,200	£417,214	£411,489	-£5,725	-1.4
N84613	THE CORNER SURGERY (DR MULLA)	£514,724	£626,699	£560,030	-£66,668	-10.6
N84614	THE MARSHSIDE SURGERY (DR WAINWRIGHT)	£368,723	£404,606	£401,178	-£3,428	-0.8
N84617	KEW SURGERY	£459,004	£510,411	£499,405	-£11,005	-2.2
N84618	THE HOLLIES	£623,836	£688,954	£678,747	-£10,207	-1.5
N84625	THE FAMILY SURGERY	£392,515	£441,530	£427,065	-£14,465	-3.3
Y02610	TRINITY PRACTICE	£507,575	£895,332	£552,252	-£343,080	-38.3
Total		**£17,753,118**	**£20,568,369**	**£19,315,763**	**-£1,252,606**	**-6.1**

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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.

Executive Summary on Performance Trends

KPI	Underperforming Trusts	Underperforming PCTs
MRSA Bacteraemia	Aintree ⇩	
C-Difficile Infections	Aintree ⇩	
Mixed Sex Accommodation	The Walton Centre ⇩	
Referral to Treatment (RTT)	**% Admitted Within 18 Weeks** Southport & Ormskirk ⇩	**Numbers Waiting on an Incomplete Pathway** Sefton ⇧ **% Admitted Within 18 Weeks** Sefton ⇩
Cancer Waits:		
All cancer two month urgent referral to treatment		Sefton ⇔
Cancer 62 day waits (aggregate measure)	Southport & Ormskirk ⇔ Hospitals Trust	
62 day wait for first treatment following referral from an NHS Cancer Screening Service	Aintree ⇔	
62 day wait for first treatment following a consultants decision to upgrade the patient's priority	Southport & Ormskirk ⇧	
% who had a stroke & spend at least 90% of their time on a stroke unit	Aintree ⇩	Sefton ⇩
A&E 4 Hour Wait W/E 14th April 2013	Aintree Southport & Ormskirk	
Ambulance Cat A response within 8 minutes	NWAS R1 ⇧ NWAS R2 ⇩	

Executive Summary on Performance Trends

Key

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

NHS Merseyside

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 - March	13.00	5.00	16.00	6.00	40.00
PHQ28: HCAI measure (Cdif) (Cumulative)	12/13 - March	89.00	45.00	145.00	126.00	405.00
Resources (Finance, Capacity & Activity)						
PHS16: Numbers Waiting on an Incomplete Referral to Treatment Pathway	12/13 - February	16,916	8,825	22,464	14,748	62,953
Supporting Measures						
Quality (Safety, Effectiveness & Patient Experience)						
PHQ03: All Cancer Two Month Urgent Referral to Treatment Wait (Cumulative)	12/13 - February	87.95	87.05	88.54	84.64	87.17
PHQ03-05: Cancer 62 Day Waits (aggregate measure) (Cumulative)	12/13 - February	89.32	89.13	89.95	86.06	88.68
PHQ04: 62-Day Wait for First Treatment Following Referral from an NHS Cancer Screening Service (Cumulative)	12/13 - February	96.81	97.73	97.04	95.74	96.73
PHQ05: 62-Day Wait for First Treatment For Cancer Following a Consultants Decision to Upgrade The Patient's Priority (Cumulative)	12/13 - February	91.18	97.37	91.77	86.21	90.88
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 - February	99.24	98.68	97.62	97.80	98.22
PHQ07: 31-Day Standard for Subsequent Cancer Treatments-Surgery (Cumulative)	12/13 - February	99.03	100.00	99.47	98.09	99.03
PHQ08: 31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens (Cumulative)	12/13 - February	98.75	100.00	99.47	98.79	99.20
PHQ09: 31-Day Standard for Subsequent Cancer Treatments-Radiotherapy (Cumulative)	12/13 - February	96.17	95.24	95.87	97.85	96.37
PHQ12: Mental health measures - CPA	12/13 - Q4 Jan - Mar	96.53	97.14	95.65	97.67	96.57
PHQ19: RTT - % of admitted pathways within 18 weeks	12/13 - March	92.62	93.28	93.35	92.75	93.00
PHQ20: RTT - % of non-admitted pathways within 18 weeks	12/13 - March	98.03	97.94	98.14	97.70	98.00
PHQ21: RTT - % of incomplete pathways within 18 weeks	12/13 - March	95.61	96.05	95.19	95.12	95.40
PHQ22: % of patients waiting 6 weeks or more for a Diagnostic Test	12/13 - March	0.11	0.50	0.96	0.31	0.50
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	12/13 - Q4 Jan - Mar	67.0	64.8	79.4	74.8	73.0
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	12/13 - Q4 Jan - Mar	50.0	100.0	100.0	80.7	88.5
PHQ24: All Cancer Two Week Wait (Cumulative)	12/13 - February	95.31	95.23	95.76	94.54	95.25
PHQ24-25: Cancer 2 Week Waits (aggregate measure) (Cumulative)	12/13 - February	95.36	95.45	95.77	94.61	95.33
PHQ25: Two Week Wait for Breast Symptoms (where cancer was not initially suspected) (Cumulative)	12/13 - February	95.61	96.96	95.87	95.23	95.81

Achieving Plan | Variance from Plan | Significant variation from plan

NHS Merseyside

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)										
PHQ26_01: MSA Breaches - No. of unjustified breaches	12/13 - Feb	0	0	0	0	0	0	0	2	0
PHQ27: HCAI measure (MRSA) (Cumulative)	12/13 - March	7.0	1.0	0.0	0.0	3.0	0.0	10.0	0.0	1.0
PHQ28: HCAI measure (Cdif) (Cumulative)	12/13 - March	72.0	0.0	8.0	0.0	53.0	22.0	31.0	7.0	19.0
Supporting Measures										
Quality (Safety, Effectiveness & Patient Experience)										
PHQ03: All Cancer Two Month Urgent Referral to Treatment Wait (Cumulative)	12/13 - Feb	87.4		81.4	87.9	92.0	85.7	91.1		91.3
PHQ03-05: Cancer 62 Day Waits (aggregate measure) (Cumulative)	12/13 - Feb	89.1		80.7	89.8	95.5	85.5	92.0		92.2
PHQ04: 62-Day Wait for First Treatment Following Referral from an NHS Cancer Screening Service (Cumulative)	12/13 - Feb	86.8			94.1	99.2	100.0	100.0		98.4
PHQ05: 62-Day Wait for First Treatment For Cancer Following a Consultants Decision to Upgrade The Patient's Priority (Cumulative)	12/13 - Feb	93.3		72.4	96.6	98.8	69.2	84.6		90.3
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 - Feb	98.0	100.0	98.4	97.3	98.8	99.0	99.5	100.0	100.0
PHQ07: 31-Day Standard for Subsequent Cancer Treatments-Surgery (Cumulative)	12/13 - Feb	98.8	100.0	100.0	98.7	99.3	96.0	99.3	100.0	100.0
PHQ08: 31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens (Cumulative)	12/13 - Feb	100.0	100.0			99.1	100.0	100.0	100.0	100.0
PHQ09: 31-Day Standard for Subsequent Cancer Treatments-Radiotherapy (Cumulative)	12/13 - Feb	94.4				100.0	100.0	100.0		
PHQ19: RTT - % of admitted pathways within 18 weeks	12/13 - Feb	90.2%	90.2%	92.8%	97.9%	95.1%	78.5%	94.2%	93.6%	90.5%
PHQ20: RTT - % of non-admitted pathways within 18 weeks	12/13 - Feb	97.4%	96.5%	95.2%	95.2%	98.5%	95.7%	98.6%	97.3%	97.4%
PHQ21: RTT - % of incomplete pathways within 18 weeks	12/13 - Feb	96.6%	93.1%	92.1%	93.1%	95.2%	94.1%	97.4%	97.0%	92.0%
PHQ22: % of patients waiting 6 weeks or more for a Diagnostic Test	12/13 - Feb	0.2%	0.0%	0.0%	0.9%	0.0%	0.1%	0.0%	0.0%	0.0%
PHQ24: All Cancer Two Week Wait (Cumulative)	12/13 - Jan	96.6		99.3	97.3	95.0	93.1	94.7	100.0	96.1
PHQ24-25: Cancer 2 Week Waits (aggregate measure) (Cumulative)	12/13 - Jan	96.5		99.3	97.3	95.1	93.4	95.0	100.0	95.7
PHQ25: Two Week Wait for Breast Symptoms (where cancer was not initially suspected) (Cumulative)	12/13 - Jan	95.3				96.0	95.6	97.0		94.2
PHQ29: VTE Risk Assessment	12/13 - Q3	92.60		96.30	95.20	90.40	93.60	90.00	92.00	94.0
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	12/13 - Q4 Jan - March	73.1				83.2	84.7	63.8		74.0
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	12/13 - Q4 Jan - March	100.0				100.0	64.3	78.3		23.8
Resources (Finance, Capacity & Activity)										
A&E % Patients waiting <4 Hours	W/E 14th April	80.4%	96.1%		100.0%	90.1%	87.7%	93.1%		94.0%

North West Ambulance Service

	2012/13	June	July	August	Sept	October	November	December	January	February
Cat A response within 8 mins % R1	75%	75.7%	76.9%	75.2%	75.1%	73.6%	72.0%	70.8%	73.1%	71.4%
Cat A response within 8 mins % R2	75%	79.4%	79.8%	78.7%	76.6%	76.8%	76.1%	72.9%	76.0%	74.4%
Cat A response within 19 mins	95%	95.6%	95.9%	95.8%	94.6%	94.6%	95.1%	94.2%	95.1%	94.5%

Achieving Plan

Variance from Plan

Significant variation from plan

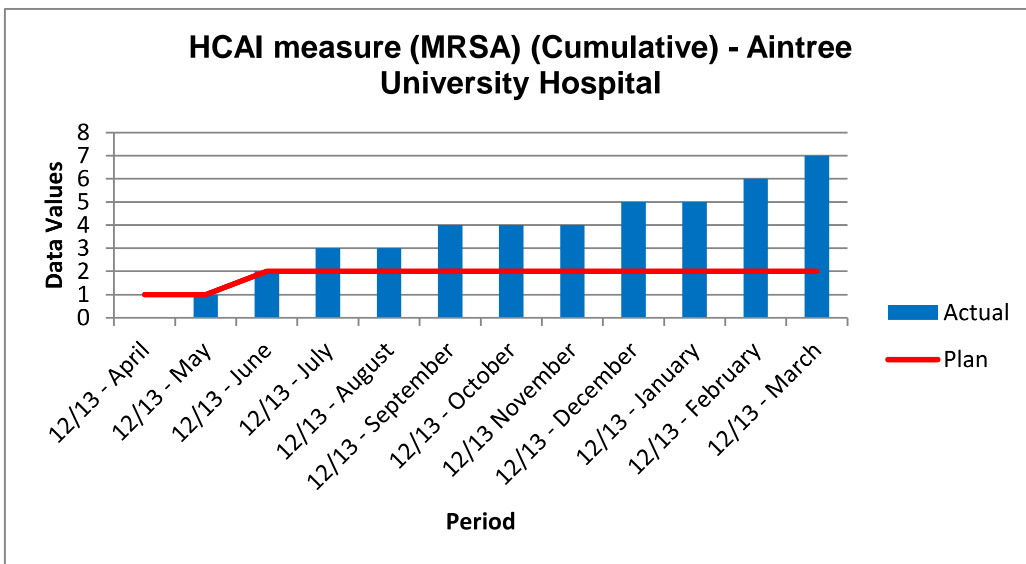
Not Applicable

Not Available

Performance Recovery Action Plans

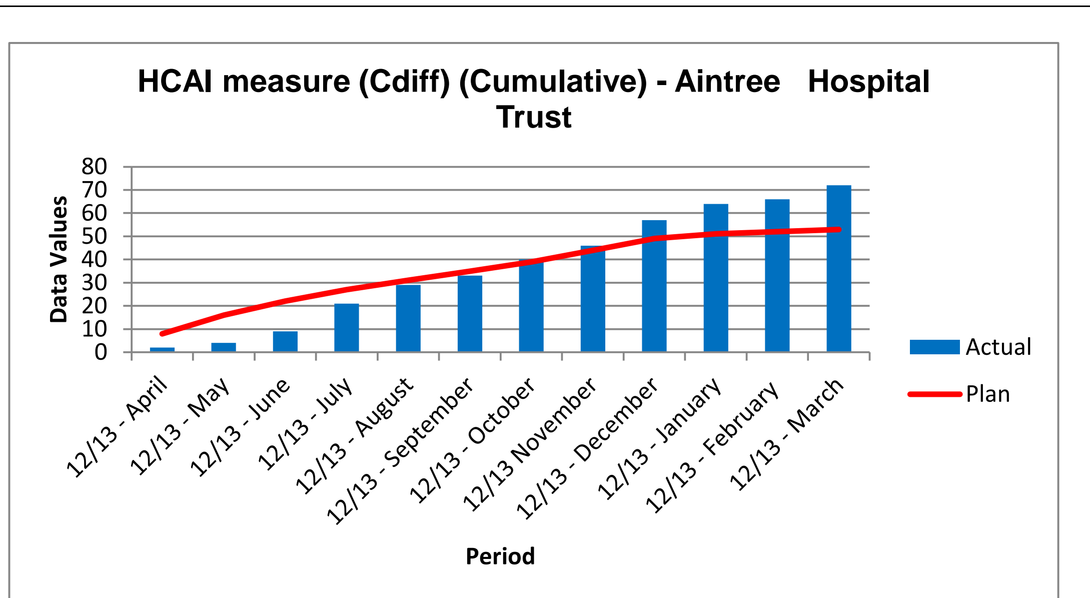
1. MRSA

For March 2013 Aintree Hospital Trust is reporting one further case of MRSA which brings the total for the year to seven against the tolerance of two. The Trust continue to reassess and update their plans which have been previously shared with CCGs for assurance Each case has been thoroughly investigated and discussed at contract meetings and was presented at the October quality meetings by the Lead Nurse. A Health Care Acquired Infection (HCAI) group is being set up and will be 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. The year-end target has been breached.



2. Cdifficile Infections

In March 2013 for Aintree Hospital Trust there were 72 cases of Cdifficile infections year to date against the tolerance of 53. The year-end target has been breached. The Trust is over testing compared to other providers and national guidance. The Trust will continue testing in the same way but will adjust their reporting which will show an improved position going forward into 2013/14. Plans in place for improved performance in 2013/14.

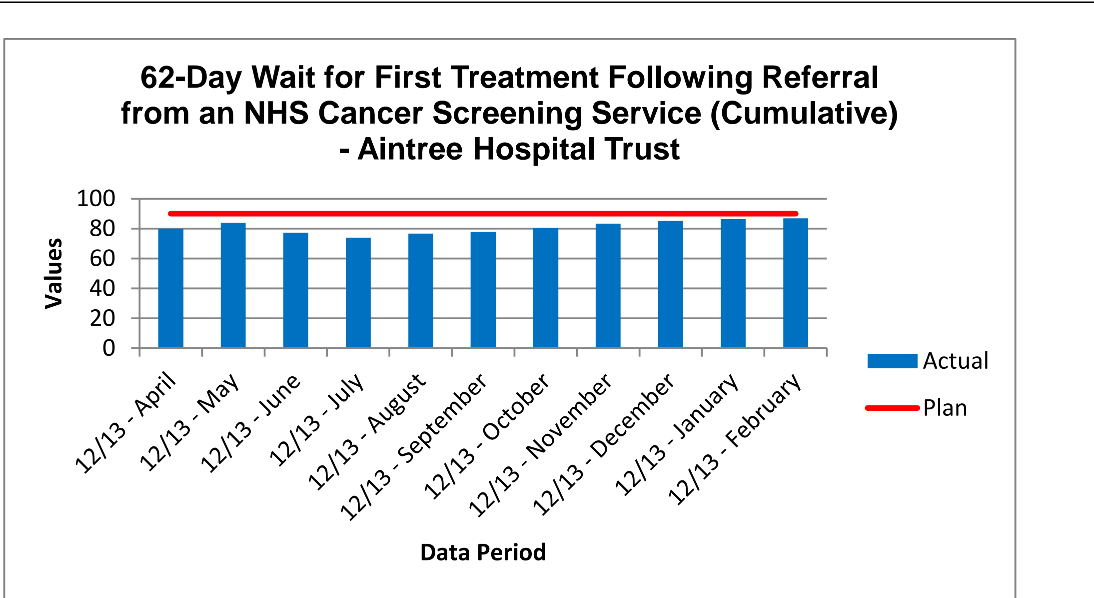


3. Mixed Sex Accommodation – MSA

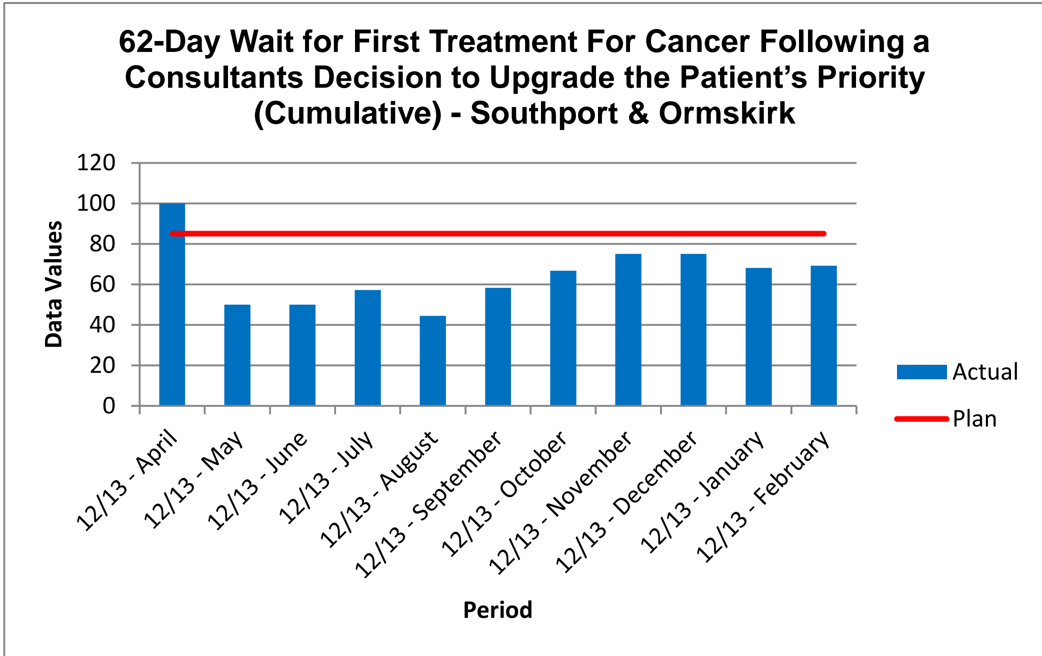
In February 2013 there were two Mixed Sex Accommodation (MSA) breaches in The Walton Centre. This was a one patient breach but this patient was in a bay with another patient so two are therefore recorded. The breach was in the high dependency unit and the patient was transferred back to the ward within 24 hours. The reason for the delay was a lack of ward beds. It was previously agreed with commissioners that due to the bed base and increased activity, patients would be returned to the ward within 48 hours, however it is always recorded when a patient exceeds 24 hours and this is the first time this has happened. This is the first occurrence of a breach and there have been none recorded since this. The Walton Centre is fully compliant in all inpatient areas with same sex accommodation.

4. Cancer Waits

At Aintree Hospital Trust, the 62 day wait for first treatment following referral from an NHS cancer screening service at February 2013 is 86.75%. The 90% target was also breached for March 2013 but the Q4 target was achieved. Monitor has agreed a target of 81.8% for screening for this provider, recognising the challenges facing it faces. The Trust is reviewing all pathways in order to tighten up processes and reduce time to 1st appointments and diagnostic tests which will impact on 62 day performance.



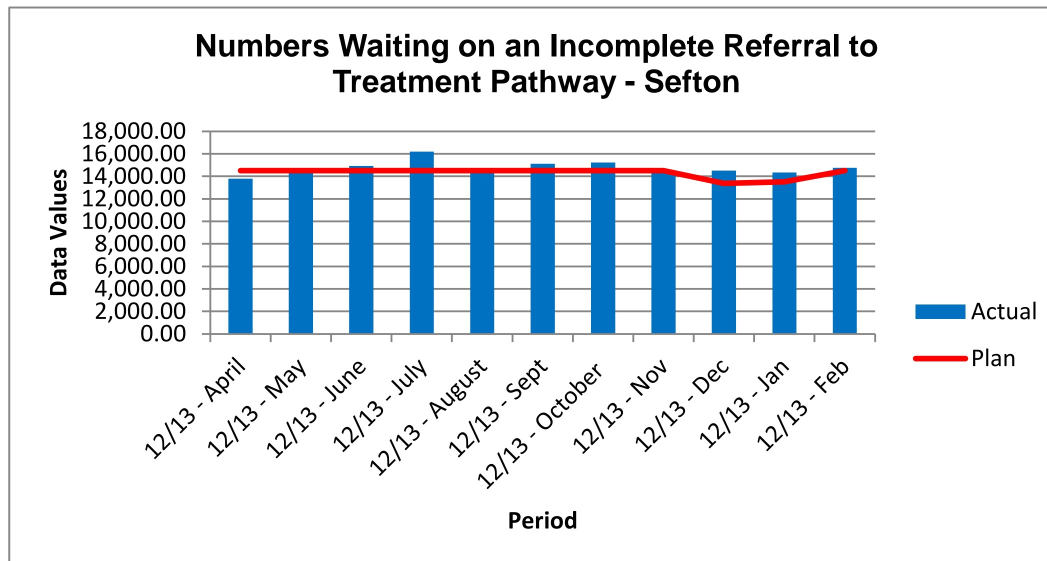
For the 62 days wait for first treatment for cancer following a consultant's decision to upgrade the patient's priority in February 2013, Southport and Ormskirk Hospitals Trust are reporting 69.23%. There is no current national standard/target set for 62 day upgrade for non-foundation trusts. The Sefton target was set for reporting purposes at 85% in line with the other 62 day categories. The Mersey and Cheshire Network wide target was never finalised. The numbers reported for the Trust are low for this indicator and as a consequence half a breach significantly affects performance. In addition the tumour sites being reported are lung and haematology which are the most complex pathways. There is a target for Foundation Trusts and as Southport and Ormskirk progress to FT status they will be working to achieve compliance of this target.



For Cancer 62 day waits (aggregate measure) for February 2013 Southport and Ormskirk are showing 85.50% against the 86% target which is lower than last month. The Trust breached for March 2013 but it is understood that Q4 2012/13 86% target has been achieved. There are small numbers involved with breach reasons being patient choice and/or complex pathways. The Trust have implemented the recommendations made by the Intensive Support Team including the development of the Trust Cancer Access Policy, pathway redesign and timed pathways for each tumour site, demand and capacity modelling, standardised breach analysis and dissemination and clear and robust escalation procedures.

5. RTT – Numbers waiting on an incomplete 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.



6. % Patients who had a stroke & spend at least 90% of their time on a stroke unit

Aintree Hospital Trust is reporting 73.1% in Q4 against a target of 80% for stroke (the percentage of stroke patients spending 90% of their stay on a stroke unit).

Commissioners are working with the Trusts to address performance issues

and ensure clinical pathways are being adhered to. Underperforming Trusts are being asked to provide exception reports and recovery plans where Q4 targets have not been achieved; these will be shared with commissioning CCGs by the end of May 2013.

7. RTT Admitted pathways within 18 weeks

For this indicator for Southport and Ormskirk Hospitals Trust, February performance was at 78.5%% against the 90% target. The clearing of the backlog of patients waiting over 18 weeks continues and it is not possible to carry out additional activity to clear the longer waiters and still meet RTT targets. There is agreement with local commissioners for the Trust to breach February 2013 as part of the plans to clear the backlog of long waiters.

8. A&E - % patients waiting <4 hours

The figure for A&E <4 hour wait at w/e 14th April 2013 for Aintree Hospital Trust is showing 80.4% against the 95% target. Previously reported challenges and pressures remain. The Trust is continuing to work on patient flow and direct entry for GP admitted patients should relieve some pressure on A&E going forward. Multiple actions have been listed by the Trust with the aim of improving performance. April and Q1 performance are at risk.

For Southport and Ormskirk Hospitals Trust, the w/e 14th April 2013 A&E <4 hour waiting figure was 87.7% against the 95% target. Again the challenges of the last few months remain. All available escalation beds are in use and additional staffing utilised for A&E to help meet demand. The acuity level of patients presenting has increased. The Trust continues to put in place additional measures to meet demand but as above, April and Q1 performance are at risk.

9. Ambulance Response

Overall regional performance in February against the Red 8 minute target was 74.1%, with cumulative Red 8 minute performance at the end of February falling slightly to 76.6% from 76.7% in January but this remains well ahead of the 75% target. National Ambulance Performance data for the twelve Ambulance Service Trusts is available to the end of January and shows that NWAS Red A8 cumulative performance is in the top three performing Trusts in the country for the seventh month running.

February performance for Merseyside against the overall 8 and 19 minute targets was 76.3% and 94.0% respectively. Cumulatively positive performance against these targets is shown at 79.9% and 95.5% at the end of February, with year-end delivery of the targets expected.

NWAS performance however against the trajectories to deliver Red 1

performance of 80% within 8 minutes by the year-end will not be achieved. At the end of February, NWAS cumulative performance against the revised clock start was 74.4% having dropped from 74.7% in January. Performance has remained below the expected trajectory, similar to many other services, since the clock start was implemented in mid-2012. Performance in February was 71.4%. The number of incidents in February was more than predicted which affects both the in-month and cumulative position. Achievement of the 80% Red 1 target has proved difficult for all Ambulance Trusts nationally. It should be noted that the NHS Commissioning Board's Everyone Counts 'Planning for patients 2013/14' introduces revised ambulance performance on Red 1 to be 75% from April 2013 onward.

NHS Merseyside - Actual activity compared to planned activity - Cumulative to March 2012 & March 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	73544	65394	-8150	-11%	65686	68999	3313	**5.0%**	3605	6%
Knowsley	46043	47276	1233	3%	48000	47939	-61	**-0.1%**	663	1%
Liverpool	119103	117672	-1431	-1%	120337	118846	-1491	**-1.2%**	1174	1%
Sefton	66794	68803	2009	3%	68739	68894	155	**0.2%**	91	0%

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	29804	37155	7351	25%	36796	39768	2972	**8.1%**	2613	7%
Knowsley	25550	25420	-130	-1%	24536	25538	1002	**4.1%**	118	0%
Liverpool	101223	100776	-447	0%	102323	90695	-11628	**-11.4%**	-10081	-10%
Sefton	41274	41836	562	1%	42086	42400	314	**0.7%**	564	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	103348	102549	-799	-1%	102482	108767	6285	**6.1%**	6218	6%
Knowsley	71593	72696	1103	2%	72536	73477	941	**1.3%**	781	1%
Liverpool	220326	218448	-1878	-1%	222660	209541	-13119	**-5.9%**	-8907	-4%
Sefton	108068	110639	2571	2%	110825	111294	469	**0.4%**	655	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	93370	95173	1803	2%	94080	97242	3162	**3.4%**	2069	2%
Knowsley	65865	62605	-3260	-5%	61822	63277	1455	**2.4%**	672	1%
Liverpool	205341	203321	-2020	-1%	204082	197226	-6856	**-3.4%**	-6095	-3%
Sefton	99325	96854	-2471	-2%	96004	98345	2341	**2.4%**	1491	2%

	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	8958	10457	1499	17%	10245	10370	125	**1.2%**	-87	-1%
Knowsley	5553	5275	-278	-5%	5116	5131	15	**0.3%**	-144	-3%
Liverpool	13287	14072	785	6%	14086	13612	-474	**-3.4%**	-460	-3%
Sefton	8989	9170	181	2%	8923	8906	-17	**-0.2%**	-264	-3%

	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	31578	35102	3524	11%	33790	37894	4104	**12.1%**	2792	8%
Knowsley	19016	19621	605	3%	18804	20759	1955	**10.4%**	1138	6%
Liverpool	49266	52787	3521	7%	51748	55388	3640	**7.0%**	2601	5%
Sefton	35897	38094	2197	6%	36408	38274	1866	**5.1%**	180	0%

	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	40536	45559	5023	12%	44035	48264	4229	**9.6%**	2705	6%
Knowsley	24569	24896	327	1%	23920	25890	1970	**8.2%**	994	4%
Liverpool	62553	66859	4306	7%	65834	69000	3166	**4.8%**	2141	3%
Sefton	44886	47264	2378	5%	45331	47180	1849	**4.1%**	-84	0%

	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	41092	42024	932	2%	41,300	43,492	2192	**5.3%**	1468	3%
Knowsley	23377	21838	-1539	-7%	21,951	23,056	1105	**5.0%**	1218	6%
Liverpool	57778	57430	-348	-1%	56,326	57,588	1262	**2.2%**	158	0%
Sefton	34068	33627	-441	-1%	33,430	35,104	1674	**5.0%**	1477	4%

Data Sources

Plans - Vital Signs/IPM Submissions

Actuals - Monthly Activity Return

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

General & Acute Activity Monitoring

These figures refer to the period **April to March 2013**

The period **April to March** contains two less 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 1.8% (5,533 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 three months at 0.6% above plan (1,916 referrals), compared to around 2% below plan in previous months. This may warrant further investigation if it continues at a more significant percentage.

Sefton has seen an increase in year-to-date referrals in November. The Trust was below the 2012/13 plan in October. Sefton are now 0.2% (155 referrals) over plan, which shows an increase in over performance compared to November.

In comparison with the same period last year, Sefton are 0.1% above.

Other referrals for a first outpatient appointment

Other referrals are down on last year with an under performance of -3.3% (-6,786 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 9.0% over the previous year's figures. The under-performance has shown a particular growth between October and November.

The Month 12 figures also show that Merseyside is -3.6% (-7,340) under planned levels for 'Other' Referrals in the year to February.

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 decrease of -0.2% (-1,253 referrals) since last year, while referrals are below plan for 2012/13 by -1.1% (-5,424 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 0.7% (314) above plan after reducing consistently in previous months.

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

In March, Merseyside shows a -1.4% (1,863) decrease in attendances compared with same period in the previous year. There is also a 0.02% (102) over performance compared to plan.

Sefton is showing the second most significant growth from the previous year. They are 1.5% (1,491) up on 2011/12.

Elective Ordinary G&A Admissions

Elective ordinary G&A admissions for Merseyside are -0.9% (315 spells) under plan for the year and -2.5% (-955) 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 8.2% (11,565 Day Cases) and 4.6% (6,711 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 2011/12 continues its downward trajectory from April.

When combining day case and ordinary elective admissions, all CCGs show an over-performance against plan. When comparing against last year, Sefton is showing a slight decrease of -0.2%. Again, this is a return to the levels of performance seen in the August report.

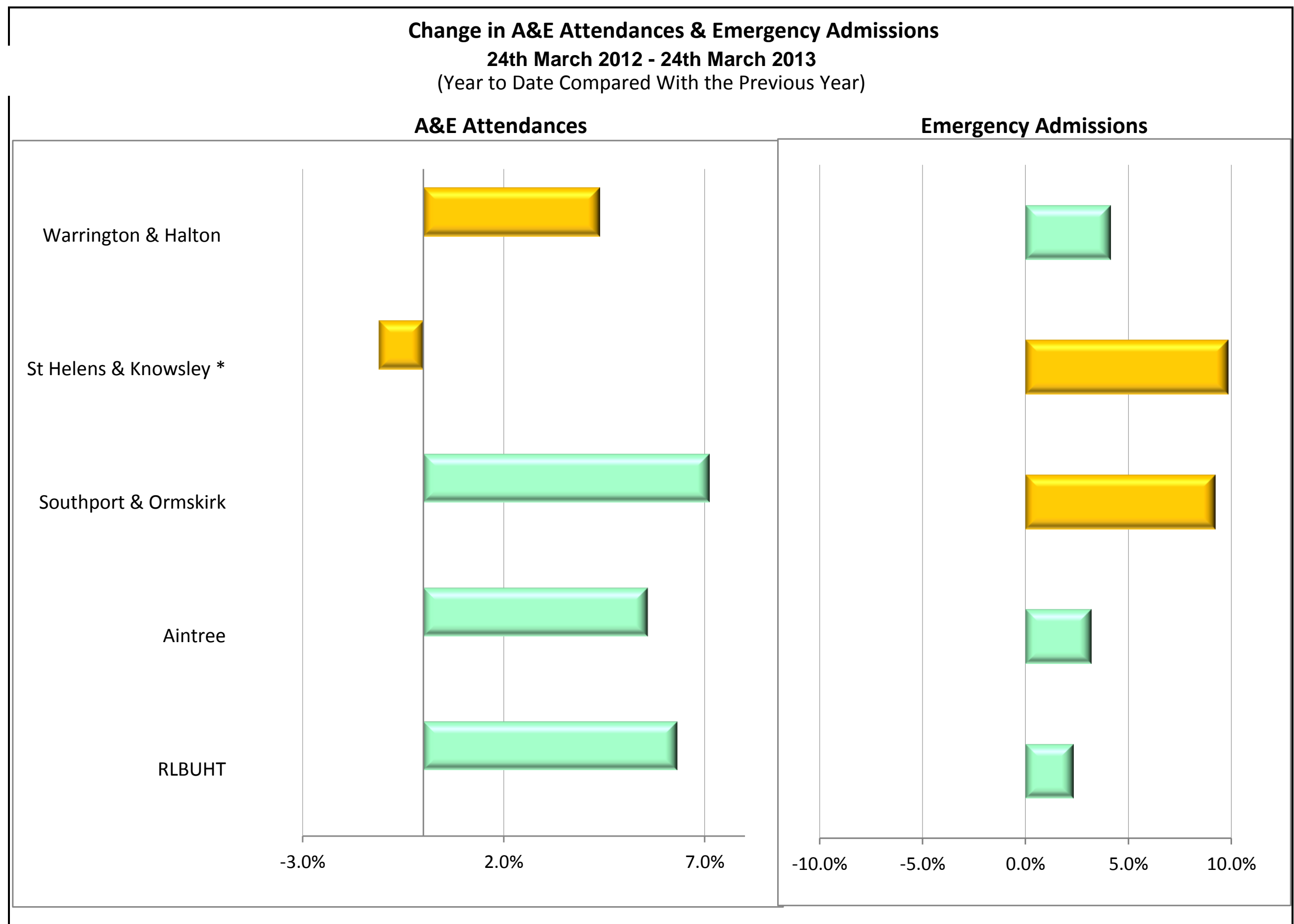
Non-Elective G&A Admissions

Merseyside is currently 4.1% over plan for the year to March and 2.8% over the activity levels for Non-Electives in the same period last year. There has been a slight drop compared to last month against plan and a slight drop compared to last year. Overall they 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 9.2% 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.

For Halton & St Helens, the main driver of over-performance appears to be St Helens & Knowsley, which is continuing to see increases in non-elective

admissions. The current position shows a 9.8% increase against last year. The increase is significantly greater when comparing current performance to the 2012/13 Plan – this shows a 5.3% over-performance against plan. This suggests that part of the explanation may lie in the calculation of the plan for 2012/13. Performance will continue to be monitored.



	A&E Attendances			Emergency Admissions		
	YTD 2012/13	YTD 2011/12	% change	YTD 2012/13	YTD 2011/12	% change
RLBUHT	218844	205890	6.3%	38294	37433	2.3%
Aintree	178148	168760	5.6%	31390	30424	3.2%
Southport & Ormskirk	207910	194130	7.1%	28500	26101	9.2%
St Helens & Knowsley *	229142	231714	-1.1%	45077	41046	9.8%
Warrington & Halton	214090	205116	4.4%	35627	34220	4.1%

Source: NHS Northwest

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

A&E Attendances & Emergency Admissions

A&E Attendances

This activity covers the period 24th March 2012 to 24th March 2013:

All providers have had a higher number of A&E attendances in 2012/13 than they had in 2011/12 (to date) apart from St Helen's & Knowsley. Overall, there has been an increase of 4.2% for A&E attendances and 5.7% for emergency admissions.

Southport & Ormskirk have had the largest increase of 7.1% (13,780) up on last year. Emergency admissions have also grown over the same period by 9.2% (2,399).

Royal Liverpool University Hospital has seen an increase on 2011/12 of 6.3% (12,954).

Aintree has seen an increase on 2011/12 of 5.6% (9,388).

Warrington has seen an increase on 2011/12 of 4.4% (8,974).

St Helens & Knowsley however have had 2,572 (-1.1%) less A&E attendances this year. This decrease is not reflected in a similar decrease in emergency admissions which has had an increase of 9.8% (4,031). The situations with both A&E attendances and emergency admissions have worsened in the past three months.

NHS

Cheshire and Merseyside
Commissioning Support Unit

Cheshire and Merseyside Commissioning Support Unit
Early Warning Quality Dashboard
May 2013 Update

This report highlights the current position for hospital providers of interest to Sefton CCG against a number of quality measures listed within the following domains;

- Patient Safety
- Clinical Effectiveness
- Patient Experience
- Organisational Quality Measures

Further analysis is available for each of the measures which you can view by clicking on 'Click Here' within the Data sheets column.

Click on the domain below to access dashboard

Domain 1 - Patient Safety
Domain 2 - Clincial Effectiveness
Domain 3 - Patient Experience

Performance Trend Key	Rag Rating Key:		Care Quality Commission Rag Ratings	
↑ Increase in performance compared to previous reporting	(green)	Performing against plan	✓	Compliant
↗ Slight increase in performance compared to previous reporting	(amber)	Work in progress/Average compared to other trusts	✖	Not Compliant (compliant actions requiring improvement
⇔ No change in performance compared to previous reporting	(red)	Underperforming against plan/Drop in performance	✖ (red)	Not Compliant (Enforcement action taken)
↙ Slight drop in performance compared to previous reporting	(grey)	Indicator not applicable to trust	● (amber)	CQC are currently conducting checks at this provider
↓ Drop in performance comprared to previous reporting	(blank)	Not applicable to rag rate indicator		

NHS

Cheshire and Merseyside Commissioning Support Unit

Patient Safety Quality Measures

Indicator	Data Sheets	Reporting Frequency	Detail	Aintree University Hospital	Royal Liverpool & Broadgreen	Southport & Ormskirk	Alder Hey Children's Hospital	Liverpool Women's Hospital	The Walton Centre	Liverpool Community Health	Mersey Care Trust
Hospital Care Aquired Infections		**Monthly**									
MRSA Cases Reported	Click Here	Mar-13	Actual/Plan	7/2	3/4	0/3	1/1	0/0	0/1	Data collection in development	
Cdiff Cases Reported	Click Here	Mar-13	Actual/Plan	72/53	53/73	22/30	0/3	0/0	7/8	Data collection in development	
Venous thromboembolism (VTE) risk assessment		**Monthly**		↑	↑	↙		↗	↑		
VTE Risk Assessments	Click Here	Mar 13 *Feb 13*	Actual/Plan	91.7%/90%	91.1%/90%	93.2%/90%		*95.5%/90%	95.1%/90%		
Local Incident Reporting		**Monthly**									
Never Events Reported	Click Here	Apr 13 *Feb 13	Actual (YTD)	1 (1)	*0 (0)	0 (0)	*1 (1)	*0 (0)	0 (0)	*0 (0)	*0 (0)
Never Events Currently Open		Apr 13 *Feb 13	Actual	1	*0	1	*1	*0	0	*0	*0
Serious Untoward Incidents Reported		Apr 13 *Feb 13	Actual (YTD)	1 (25)	*1 (3)	0 (24)	*1 (13)	*2 (12)	0 (3)	*1 (33)	*4 (42)
SUIs Currently Open		Apr 13 *Feb 13	Actual	21	*2	22	*4	*12	3	*23	*33
National Patient Safety Incident Reporting (*Per 100 admissions, **Per 1,000		**Bi-Annual**									
Total Incidents Reported	Click Here	April 12 - Sep 12	Actual	2692	1938	2102	792	1270	186	170	2082
Reporting Rates			Rate/Nat Median Rate	*7.2/6.7	4.5/6.8	6.9/6.7	4.7/5.8	8/5.8	*4.5/7.0	14.8/41.8	30.7/23.8
% Incidents reported resulting in Severe Harm			Actual (%)	0.20%	0.20%	0.30%	0.00%	1.30%	0.00%	0.60%	0.20%
% Incidents reported resulting in Death			Actual (%)	0.00%	0%	0.50%	0.00%	0.20%	1.10%	0.00%	0.10%
Mixed Sex Accomadation		**Monthly**		⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔
Mixed Sex Accommodation Breaches	Click Here	Mar-13	Actual (YTD)	0 (7)	0 (0)	0 (10)	0 (0)	0 (0)	0 (2)	0 (0)	0 (0)
National CQUIN - Safety Thermometer		**Quarterly**									
Timeleness submission of data harms data to Unify2	Click Here	Mar-13	Compliance								
National CQUIN - Dementia		**Quarterly**									
Screening for Dementia (Find)	Click Here	Mar-13	Compliance	Awaiting update from Unify2				Awaiting update from Unify2			
Risk Assessed (Assess and Investigate)		Mar-13	Compliance								
Patients Referred		Mar-13	Compliance								

Clinical Effectivness Quality Measures

Indicator	Data Sheets	Reporting Frequency	Detail	Aintree University Hospital	Royal Liverpool & Broadgreen	Southport & Ormskirk	Alder Hey Children's Hospital	Liverpool Women's Hospital	The Walton Centre	Liverpool Community Health	Mersey Care Trust
Mortality Indicators		**Monthly**		↙	↙	↗	↓	↑	↙	↑	↓
Hospital Standardised Mortality Ratio (HSMR)	Click Here	Apr 12-Nov 12	Relative Risk (Actual)	96.50%	91.00%	90.60%	162.00%	40.20%	80.5%	27.20%	89.60%
Summary Hospital-Level Mortality Indicator (SHMI)		Jul 11-June12	Relative Risk (Actual)	116.40%	106.40%	104.70%					
Patient Reported Outcome Measures		**Annual**									
Groin Hernia - Average increase in health gain	Click Here	2011/12	Actual/Nat Avg	7.5%/8.7%	3.6%/8.7%	7.1%/8.7%					
Hip Replacement - Average increase in health gain		2011/12	Actual/Nat Avg	38.1%/41.6%	29.5%/41.6%	32.6%/41.6%					
Knee Replacement - Average increase in health gain		2011/12	Actual/Nat Avg	30.1%/30.3%	32.5%/30.3%	29.7%/30.3%					
Varicose Vein - Average increase in health gain		2011/12	Actual/Nat Avg	Low Response Rate	Low Response 21 Rate	Low Response Rate					

Performance Trend Key	Rag Rating Key:		Care Quality Commission Rag Ratings	
↑ Increase in performance compared to previous reporting	(green)	Performing against plan	✔	Compliant
↗ Slight increase in performance compared to previous reporting	(amber)	Work in progress/Average compared to other trusts	✖	Not Compliant (compliant actions requiring improvement
↔ No change in performance compared to previous reporting	(red)	Underperforming against plan/Drop in performance	✖ (red)	Not Compliant (Enforcement action taken)
↙ Slight drop in performance compared to previous reporting	(grey)	Indicator not applicable to trust	● (amber)	CQC are currently conducting checks at this provider
↓ Drop in performance comprared to previous reporting		Not applicable to rag rate indicator		

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Patient Experience Quality Measures

Indicator	Data Sheets	Reporting Frequency	Detail	Aintree University Hospital	Royal Liverpool & Broadgreen	Southport & Ormskirk	Alder Hey Children's Hospital	Liverpool Women's Hospital	The Walton Centre	Liverpool Community Health	Mersey Care Trust
Regional CQUIN - Advancing Quality		**Quarterly**									
Acute myocardial infarction	Click Here	Apr 12-Oct12	Actual/Plan	100.03%/95%	99.42%/95%	99.50%/95%					
Hip and Knee		Apr 12-Oct12	Actual/Plan	97.12%/95%	97.12%/95%	97.28%/95%					
Heart Failure		Apr 12-Oct12	Actual/Plan	85.81%/86.36%	90.36%/95%	87.38%/95%					
Pneumonia		Apr 12-Oct12	Actual/Plan	74.9%/85.9%	93.80%/95%	89.33%/95%					
Stroke		Apr 12-Oct12	Actual/Plan	84.18%/90%	95.43%/90%	89.33%/90%					
Coronary Artery Bypass Graft		Apr 12-Oct12	Actual/Plan								
Dementia		Apr 12-Oct12	Actual/Plan								82.32%/71.3%
Psychosis		Apr 12-Oct12	Actual/Plan								85.49%/87.9%
National Community Mental Health Survey		**Annual**									
Overall Care	Click Here	2012	Trust score								7.7/10
			Compliance (Nat Avg)								About the same
Involving Family and Friends			Trust score								6.6/10
			Compliance (Nat Avg)								About the same
National Accident and Emergency Survey		**Annual**									
Overall view of A&E experience; for feeling their experience of being treated and cared for in the A&E had been good	Click Here	2012	Trust score	7.5/10	7.9/10	7.8/10					
			Compliance	Aout the same	Aout the same	Aout the same					
National Staff Survey		**Annual**		↑	↑	↑	↑	↑	↑	↑	↓
KF1 % Staff feeling satisfied with the quality of work and patient care they are able to deliver	Click Here	2012	Trust score/Nat Avg	82%/78%	81%/78%	81%78%	78%/82%	76%/82%	83%/82%	79%/76%	79%/78%
			Compliance (Nat Avg)	Above	Above	Above	Average	Below	Above	Above	Above
KF34 Staff recommendation of the trust as a place to work or receive treatment			Staff recommendation	3.68/3.57	3.65/3.57	3.39/3.57	3.49/4.06	3.41/4.06	3.92/4.06	3.52/3.58	3.59/3.54
			Compliance (Nat Avg)	Above	Above	Below (Worst 20%)	Below	Below	Average	Average	Above
National Inpatient Survey		**Annual**									
Q41: Involved satisfaction in decisions about care & Treatment	Click Here	2012	Trust score	71%/75.4%	79.1%/75.4%	68%/75.4%		78.4%/75.4%	75.4%/75.4%		
			Compliance (Nat Avg)	About the same	Better	About the same		About the same	About the same		
Q73: Overall level of respect & Dignity			Trust score	88.9%/90.4%	92%/90.4%	84.8%/90.4%		89.1%/90.4%	93%/90.4%		
			Compliance (Nat Avg)	About the same	About the same	About the same		About the same	Better		
National Outpatient Survey		**Annual**									
Satisfaction with visit	Click Here	2011	Trust score	8.8/10	8.8/10	8.7/10		8.8/10	8.2/10		
			Compliance (Nat Avg)	Aout the same	Aout the same	Aout the same		Aout the same	Aout the same		
Overall Care			Trust score	8.5/10	8.7/10	8.5/10		9.0/10	8.8/10		
			Compliance (Nat Avg)	Aout the same	Aout the same	Aout the same		Better	Aout the same		

Performance Trend Key	Rag Rating Key:		Care Quality Commission Rag Ratings	
↑ Increase in performance compared to previous reporting	(green)	Performing against plan	✓	Compliant
↗ Slight increase in performance compared to previous reporting	(amber)	Work in progress/Average compared to other trusts	✖	Not Compliant (compliant actions requiring improvement
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↓ Drop in performance comprared to previous reporting		Not applicable to rag rate indicator		

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Organisational Level Quality Measures

Indicator	Data Sheets	Reporting Frequency Latest Check	Detail	Aintree University Hospital	Royal Liverpool & Broadgreen	Southport & Ormskirk	Alder Hey Children's Hospital	Liverpool Women's Hospital	The Walton Centre	Liverpool Community Health	Mersey Care Trust
Care Quality Commission		**Monthly**		**18.01.2013**	**27.07.2012**	**24.11.2012**	**17.01.2013**	**03.04.2012**	**29.03.2013**	**31.08.2011**	
Compliance to CQC 5 standards following recent checks	Click Here	Apr-13	Compliance against 5 standards	✓ 3 Outcomes ✖ 2 Outcomes	✓ 5 Outcomes	✓ 5 Outcomes	✓ 5 Outcomes	✓ 5 Outcomes	✓ 5 Outcomes	✓ 5 Outcomes	✓ Compliant at initial assessment
Cental Alerts System		**Monthly**		↔	↔	↔	↓	↔	↔	↔	↔
Alerts reported as ongoing passed deadline date	Click Here	Feb-13	Actual/Plan	3/0	0/0	0/0	1/0	3/0	2/0	0/0	0/0
Quality Risk Profiles		**Monthly**		↓	↔	↔	↑	↔	↑	↑	↓
The Care Quality Commission's quality and risk profiles (QRPs) bring together information about a care provider and provide an estimate of risk of non compliance against each of the 16 essential standards of quality .	Click Here	Feb-13	Green	6	8	5	9	13	9	8	10
			Low Yellow	6	7	9	6	3	7	6	4
			High Yellow	3	1	2	1			1	1
			Low Amber	1						1 No data	1
			High Amber								
Monitor Risk and Financial Rating		**Quarterly**		↓			↔	↔	↔		
Monitor Risk Rating - *(Source Monitor)*	Click Here	Q3 12/13	Financial	3			4	4	3		
			Governance	Material Concerns			Limited Concern	No Concerns	No Concerns		
Sickness Rates		**Quarterly**		↑	↓	↑	↙	↓	↓	↙	↗
Sickness Absence Rates	Click Here	Q2 12/13	Actual/Plan	3.94%4.03%	5.38%/4.03%	4.13%/4.03%	4.80%/4.03%	4.50%/4.03%	3.91%/4.03%	5.33%/4.03%	5.72%/4.03%
Patient Enviroment Assessment Team (PEAT)		**Annual**									
Patient Environment Assessment Team (PEAT)	Click Here	2012	Compliance	Excellent	Excellent	Excellent	Excellent	Excellent	Excellent	Excellent	Excellent
NHS Litigation Authority		**Annual**									
NHS Litigation Authority Assessment - *Latest reports available*	Click Here	2012/13	Compliance	3	2	2	3	3	1	1	1
Quality Accounts		**Annual**									
Quality Accounts - *Accounts should include a number of specific measures*	Click Here	2011/12	Compliance								

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Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2013

Agenda Item: 13/65	**Author of the Paper:**
Report date: 2013	Martin McDowell Chief Finance Officer Martin.mcdowell@southportportand formbyccg.nhs.uk Tel: 0151 247 7071

Title: Strategic and Operational Commissioning Plan

Summary/Key Issues:

This plan sets out the CCG's 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 c.£160 million in 2013-2014, and we will need to work innovatively and link in with key partners to deliver 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.

Next Steps

	Southport and Formby CCG
Send out plan to Wider Group for comment	30th May 2013
Comments back for inclusion in revised draft	30th June 2013
Present final plan to Wider Group adoption	10th July 2013
Ratification of plan by Board	31st July 2013

Recommendation

The Governing Body is asked to note this report.

Note	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
x	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	x			Lay Member contribution at Governing Body Meeting in March 2013
Clinical Engagement	x			Clinical contribution at Governing Body meeting in March 2013
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered				
Locality Engagement	x			Contribution from Joint Heads of CCG Development.
Presented to other Committees				

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

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NHS Southport and Formby Clinical Commissioning Group

Strategic & Operational Commissioning Plan 2013 –2016

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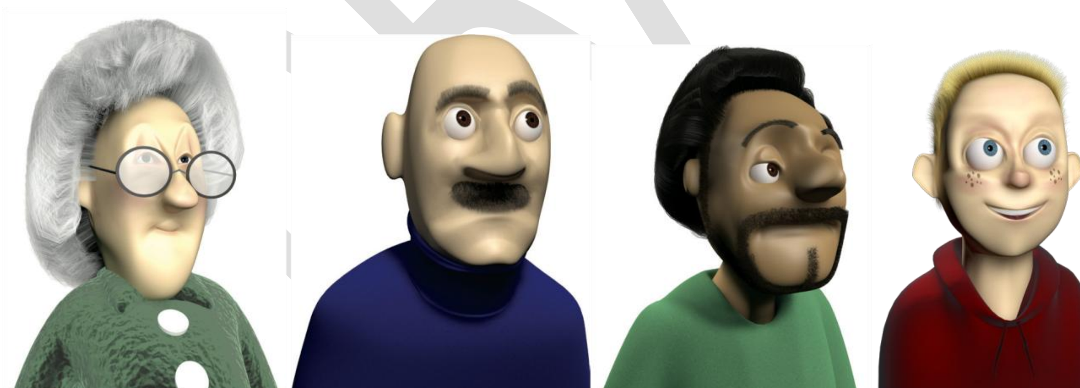

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Definitions

Acute Trust		Hospitals are managed by acute trusts. Acute trusts make sure that hospitals provide high-quality healthcare and that they spend their money efficiently. They also decide how a hospital will develop, so that services improve
Acute Service Review	ASR	Will consider the future configuration of services currently provided in a hospital setting. The aim is to improve healthcare services ensuring that they deliver higher quality, local services for the population which are also more cost effective.
Agenda For Change	A4C	NHS pay, terms and conditions for staff
Allied Health Professional	AHP	Allied health professions are clinical healthcare professions distinct from medicine, dentistry, and nursing, including audiology, midwifery, speech and language therapy
Ambulance Trust		There are 11ambulance services in England, providing emergency access to healthcare
Ambulatory Care		Ambulatory care is a type of medical care given to patients who do not need to be admitted to a hospital
Any Qualified Provider	AQP	When a service is opened up to choice of “Any Qualified Provider”, patients can choose from a range of providers all of whom meet NHS standards and price
Benchmarking		Benchmarking is the process of comparing the cost, cycle time, productivity, or quality of a specific process or method to another that is widely considered to be an industry standard or best practice.
Best Practice Tariff	BPT	Enables the NHS to improve quality by reducing unexplained variation and universalising best practice (best clinical care and most cost effective). The aim is to have tariffs that are structured and priced appropriately both to incentivise and adequately reimburse providers for the costs of high quality care.
British Medical Association	BMA	The professional medical association and trade union for doctors and medical students
British Medical Journal	BMJ	Open access medical journal; most influential and well read academic journals in the field of medicine.
Care Quality Commission	CQC	Regulate, inspect and review all adult social care services in the public, private and voluntary sectors in England
Community Elderly Care Service	CECS	Will prevent admission to hospital of some elderly patients by arranging their care at or near home

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Southport and Formby CCG – An Introduction

NHS Southport and Formby Clinical Commissioning Group (SFCCG) brings together 20 doctor's 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 20 months, S&FCCG has played an active role in local commissioning. It initially operated in shadow form until 1st April 2013 but now operates as a statutory body, as part of the changes to the NHS. Its work during this period has informed the priorities detailed in this operational plan for 2013-2014. Clinical commissioning groups are established under the Health and Social Care Act 2012 ("the 2012 Act"). They are statutory bodies which have the function of commissioning services for the purposes of the health service in England and are treated as NHS bodies for the purposes of the National Health Service Act 2006 ("the 2006 Act"). The duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act, and the regulations made under that provision. The constitution is:

a) published on the group's website at www.southportformbyccg.org.uk

b) or available in hard copy by writing to Melanie Wright at NHS SFCCG, 5 Curzon Rd, Southport, PR8 6PL

The CCGs plans for the years 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 National Quality, Innovation, Productivity and Prevention (QIPP) programme

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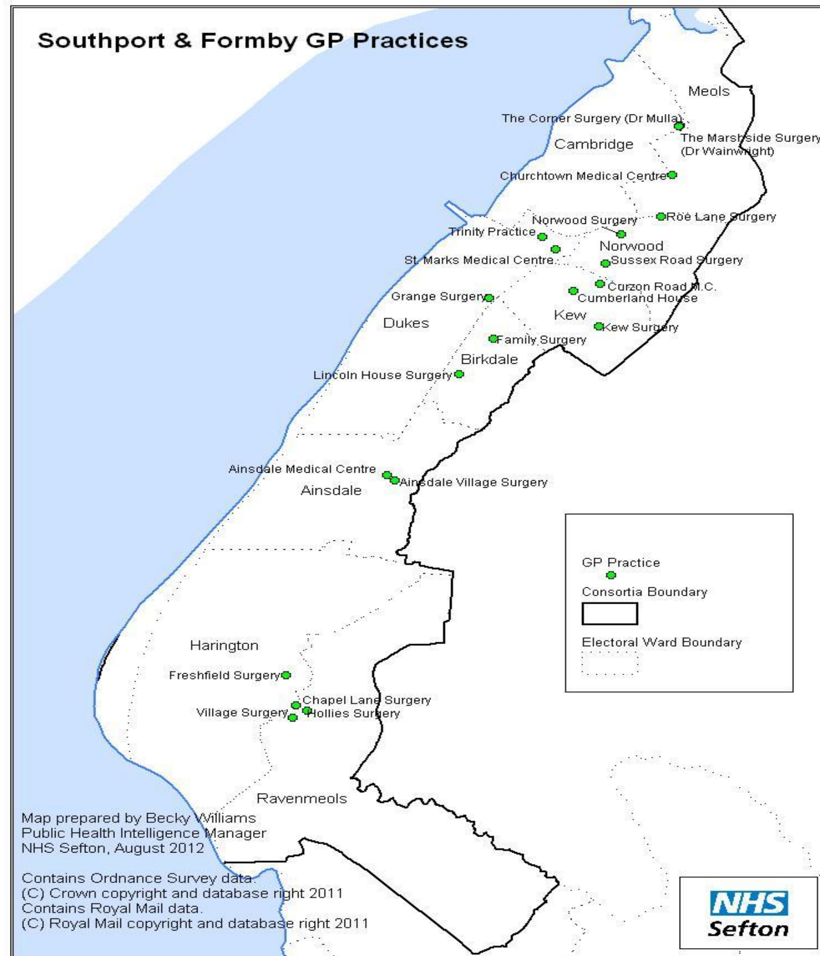
The geographical area covered by NHS Southport and Formby Clinical Commissioning Group is from Formby and Ince Blundell in the south to Crossens, Southport in the north of the borough of Sefton.



Our Vision, Values and Commitments

Vision:
"Southport and Formby; a sustainable health community".

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.

The importance of our work & our Values:

We understand that our work has a significant impact on people's lives.

In a complex health ecomomy we will remain clear that our core responsibility is to do the best we possibly can for the patients of Southport and Formby.

Our Core Values will support our culture to deliver the vision for Southport and Formby.

WE WILL	THROUGH
• Guarantee that no community is left behind or disadvantaged	Working closely with Public Health on Needs Assessments and planning delivery accordingly Increased Public and Patient Engagement (see Enabling Area 4)
• Focus on reducing health inequalities and advancing equality to improve outcomes for all our patients	
• Treat patients as respectfully and put their interests first	
• Transform NHS services to enable patients to take more control and make informed choices if they want to	
• Involve Southport and Formby residents in the decisions we make about their local healthcare	

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Local Needs Assessment & Priorities

Introduction

The CCG strives engage with key stakeholders and to evaluate all available and relevant data to ensure the best quality, evidence-based decision making. Critical to this is the Joint Strategic Needs Assessment which is developed with Sefton Council and input through to other engagement events (Big Chat, SSNA, Talking Health and Wellbeing – See Appendix 3)

Overview

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

Key findings and Conclusions

Southport and Formby has a higher than national average proportion of older residents and the population is aging faster than national rates; this will affect all localities. This will place increasing pressure on acute health services. The increase will also lead to more people living with a long term condition such as diabetes and dementia. It is therefore increasingly important to build close partnerships with the local authority and other strategic partners in order to tackle these significant challenges over the longer term. Finally, all localities have set as a priority the need for better long term condition management and the need to develop a comprehensive service model for frail older people.

For more Southport and Formby information (data and statistics) please see Appendix 1 (Health) and Appendix 2 (Non Health) below

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This plan distinguishes between a focus on Delivery and also on those areas that will facilitate and Enable delivery to take place:

Enabling Area 1 - The Approach

Innovation is about step change;
Innovation is doing something different – not just doing the same things better.

While cuts to public expenditure ramp up, demand for public services is forecast to increase. Pressure to deliver more for less will increase over the coming months and years and that will require innovation in the way that public services and the health economy are provided, supported and managed. Sefton and Formby CCG will accomplish innovative change through more effective products, processes, services, technologies, and ideas.

Information technology (IT)

Sefton and Formby's intention is to maximise the use of information technology to automate business processes, provide information for decision making, better connect clinicians with their patients, and to provide productivity tools to increase efficiency. We will make more use of informationbased technologies to design new models of care as well as improving the performance of existing services. We will integrate information around the patient, deliver relevant information at the right time to clinicians and use technology to drive efficiency for both patients and clinicians.

Programme Management

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 our 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 5. These leads have worked in conjunction with key stakeholders, across the NHS, Sefton Council, 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, but also with the four SSCCG localities, where discussions are led by Locality GP Chairs. 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.

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Diagram 1 – The Commissioning Cycle

Engagement: Joint Strategic Needs Assessment Commissioning Priorities & QIPP Plans; Public Patient Advisory Group; Public Health

(JSNA); Health & Wellbeing Strategy; CCG Consultation; Stakeholder Engagement; Expert Memorandum of Understanding

Information: Local commissioning intelligence; Quality Alliance (AQuA) and Academic Health Care Atlas, NHS CB Outcomes Framework,

NICE guidelines; comparator information; Advancing Science Network (AHSN) membership support; Right Merseyside Intelligence Portal.

Governance: GP Clinical Leads for Quality and Performance Groups and Contract Performance Warning System; Commissioning Support from the inspection; Peer Review; SUIs

Contracting; CCG Collaboratives; Clinical Quality & Meetings; CCG Quality Committee; CCG Early Commissioning Support Unit (CSU); External

Procurement and how it is managed is a key when incentives are structured to encourage

theme; systems lose all capacity for innovation people to focus on the bottom line

.

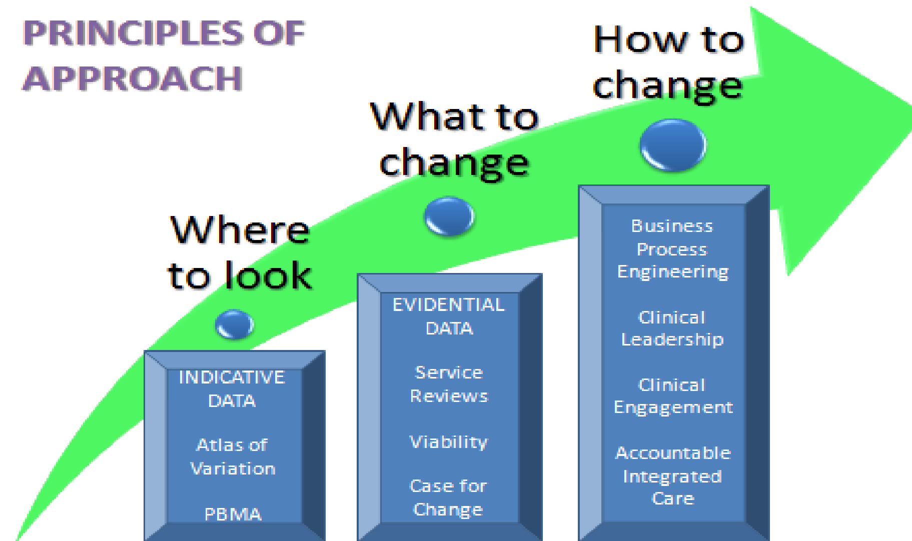
Any Qualified Provider (AQP)

The Any Qualified Provider (AQP) scheme means that, for some conditions, patients will be able to choose from a range of approved providers, such as hospitals or high street service providers. Patients and GPs can choose a service based on what's important to them – perhaps one that is closer to home, has a shorter waiting list or better outcomes.

This will require diligent management over the coming years to ensure an improved service to patients; all the principles associated with VFM will need to be applied in this process.

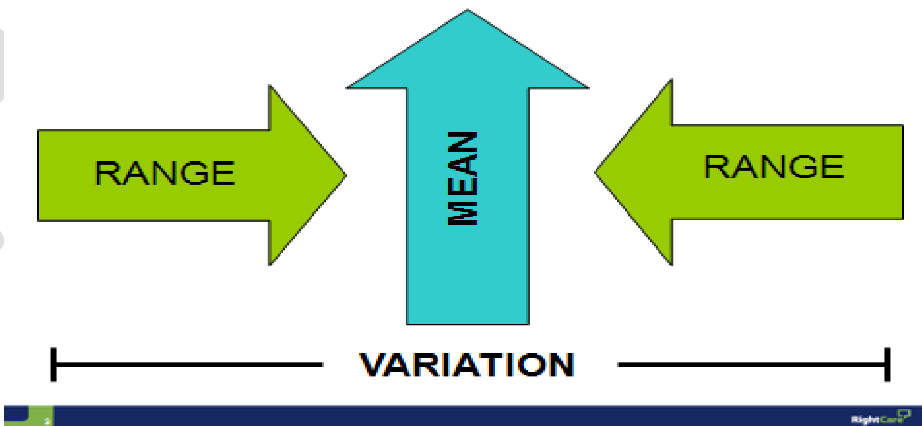
Project Management and the National Approach

The CCG's approach to identification, development and delivery of healthcare improvement, and thereby the achievement of the objectives and aims of this strategic plan, align with the thinking, tools and philosophy of the NHS RightCare programme (www.rightcare.nhs.uk). The RightCare programme, a part of the national QIPP architecture, advocates the principle of increasing system-wide value via a three step approach, underpinned by robust business processes within a programme management model. Adopting this principle supports the delivery of continuous improvement leading to a sustainable, high value health system for the population. The three step approach is summarised nationally as:



The CCG's programme approach, as described in the Establishment of a Programme Management Office document, builds on the RightCare approach for local implementation. The CCG works with NHS RightCare to ensure continuous improvement in the healthcare system and in the processes and approach used to increase value in it.

The approach focusses on the use of data on variation as its first phase. This is used to prioritise improvement effort that develops into the programmes and projects of reform that feed through the project management process. The ultimate measure of increasing value via this approach can be described as:



That is, if the range of unwarranted variation is reducing and the value measure is improving (increasing for quality, decreasing for spend), then the direction of travel of the health economy is correct.

National indicators of value have highlighted the need for the CCG to prioritise, or evidence that this is not required, the following areas for improvement:

Disease areas:

Cancer, Kidney Care, Child Health and GI (spend and quality);

Respiratory, including COPD (quality but with unplanned care spend opportunities), and;

Diabetes (quality).

System areas:

Unplanned Care – avoiding 'flow' into secondary care via ambulatory care, enhanced referrals protocols and emergency triage and the reduction in need for unplanned care, such as via;

Care planning/ Case management across all appropriate disease pathways, including those listed above, and;

Shared Decision Making – the use of the growing number of effective patient decision aids in primary and secondary care, including use of the new Android and iPhone Apps.

Improvement levers:

CQuINS – the insertion of Patient Decision Aid implementation, reform milestones and efficient ratios;

Contract management/ Service Specifications – the insertion of service specifications into contracts and subsequent management of pathways via the relevant contract clauses, and;

Local market management.

The latest Programme Budgeting national data is due to be published soon after the completion of the local strategic plan. As a consequence it will be necessary to review this and ensure that the CCG priorities remains robust where relative spend has been a criterion in the selection of projects. The need for review of the ongoing production of disease-specific Atlases of Variation also exists. This is in order to ensure that when opportunities for improvement come to light that ought to be prioritised, the CCG's approach to project management is able to flex for the best benefit to the population. The same is also true for locally generated improvement ideas that come to light outside of the annual planning round.

Programme Management and Engagement

The next phase of development from the RightCare approach provides a method that optimises the integration of the engagement programme with the reform and improvement programme. The technique is called Copy or Explain and it is planned for the CCG to use this model in year 1 of the strategic plan to develop the detail of Year 2 and 3's delivery. The local approach will be developed in the first quarter of year 1 and will follow the principles and process as described in the following flowchart:

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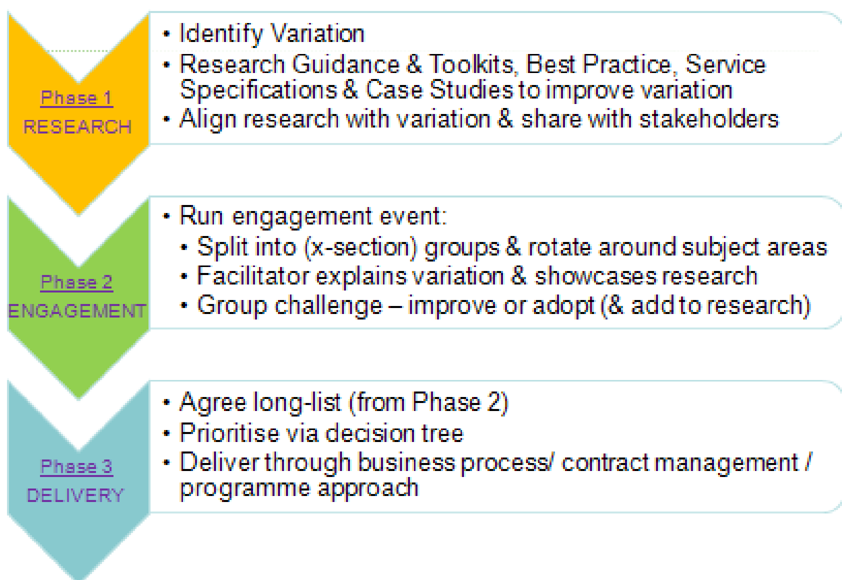

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Enabling Area 2 – (Build a stronger CCG Team)

Key Priorities, Objectives & Measures

Given the structural changes in the Health Economy , the demographic changes that Southport and Formby is facing and the generic financial pressures ahead for all NHS organisations, Southport and Formby CCG has a huge challenge ahead. The organistion will be best placed to meet this challenge when Managers and Clinicians work together as a cohesive team.

We are a member organisation that will only thrive if together we deliver on the promises we make to our patients and communities. Southport and Formby will strive to maximise clinical knowledge and experience to tackle the major health challenges that are faced in Southport and Formby's local communities In addition to a focus on improving teamwork and clinical input, Southport and Formby will also look to tackle the infrastructure barriers, (poor IT and information sharing) that will allow Southport and Formby to deliver against its objectives.

Together we will:

- Develop local healthcare services by pursuing innovative, high value solutions
- Develop relationships built on openness and honesty, with transparency in our decision making
- Support and develop all clinicians, managers and teams across the organisation – they represent our greatest resource
- Make best use of the resources entrusted to us and hold each other to account for the way we use public funds, ensuring we live within our means and commission or deliver safe and high quality services

The Organisational Development Plan is one of four core documents which the interim Southport and Formby CCG has produced to guide and shape its early development. These are: the Strategic Commissioning Plan; the Organisational Development Plan; the Structure of the organisation (both as structure and, as importantly, the rationale behind the structure); and the specification for the commissioning support the CCG will buy-in from the Commissioning Support Service. Each of these core documents links together.

The OD Plan is designed to show how the CCG will grow and develop as an organisation in order to deliver its key vision and objectives. Clearly the plan will change and evolve as the CCG develops and this early plan focuses on many of the issues any high performing organisation needs to have in place in order to deliver its business aims effectively. This is particularly relevant for a CCG which is in effect a new start up organisation from the 1st April 2013.

Southport and Formby CCGs aspirations are:

- To develop a more effective culture through the clinical commissioning structure
- Develop through innovation by harnessing the energy and expertise within the member practices
- Deliver a GP development programme to assist clinicians through the transition period.

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The Strategic Plan defines health priorities and outcomes that CCG will deliver, and includes:

•Pledges to stakeholders

•Measurable outcomes

•Initiatives and timelines

The specification defines the capabilities and services that the CCG requires to buy in to support delivery and includes:

•Key capabilities map – critical and enabling

•Do / share / buy decisions

•Specification, and / or capability descriptions (and implications)

•Operating manual (process and procedure definitions, internal governance & business management systems)

The structure defines the organisation form, structure, roles and headcount. Includes:

- •Narrative explanation
- •Structure
- •Roles
- •Headcount
- •Governance

The OD Plan is based on 5 key themes:

- Embedding the vision and culture of the CCG in everything we do
- Defining and consistently delivering our core business cycle and functions
- Establishing 'fit for purpose' governance
- Developing and delivering a truly effective membership organisation
- Improving our skills and learning in order to better deliver our vision and outcomes.

Our Organisational Development Priorities

Our organisational development (OD) plan has been instrumental in our journey towards authorisation. Our refreshed plan for 2013-14 has two key objectives:-

- To continue to develop an effective commissioning organisation capable of delivering its key objectives for 2013-14 and beyond.

- To develop an organisation with the ability to bring about positive changes in the whole health system, for the benefit of local people.

Our plan has six priorities, which build on the foundations laid in our shadow year, but will regularly reviewed as the organisation develops . These are:-

1. **Leadership, Workforce and Team Development**

- Defining future capability and capacity required to develop a truly effective membership organisation

- Individual and team development plans and performance management in place to achieve objectives

- Board, locality and clinical leadership plans implemented

- OD and training support commissioned including mandatory training.

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2. **Communications, Engagement and Collaboration**

- On-going implementation of Communications and Engagement strategy

- Collaborative working to fully embed our patient and public engagement model and structures and ensure they are working most effectively through EPEG, including monitoring of NHS constitution pledges.

- Proactive management and development of reputation and relationships with all stakeholders inc LA, VCF sector, providers

3. Strategy and performance management around outcomes

- Three year strategy developed with broad involvement and communicated effectively

- Delivered through annual plans and programme management approach linked to national and local outcomes and regular performance tracking.

- Development of GP Practice development planning, strengthening use of the intelligence portal and review of data facilitation.

4. Structure

- Full recruitment to CCG structure

- Effective development and performance management of CSU

- Planning for future procurement of CSU services

5. **Values, style and change management**

- Ensure CCG vision, values and culture is embedded across whole organisation and that the CSU operates on our behalf in this context through development of effective CSU locality team.

- Ensuring innovation and systematic approaches to transformation and change management.

6. Integrated Governance and Quality Improvement

- Full implementation of Quality strategy, dashboard and effective operation of and response to all feedback and early warning systems.

- Review effectiveness of committees, business cycle planning and further development of effective risk management systems.

- Full implementation of E&D strategy and IG toolkit.

- Development of collaborative arrangements / agreements for commissioning and joint working with key partners

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Enabling Area 3 – (Achieve Financial Balance)
Key Priorities, Objectives & Measures

Financial Planning

Financial Plan 2013/14:

It will be significant challenge to balance the books over the next three years. However, with a strong and dedicated team, and a robust financial management process in place, Southport and Formby believes that it is well positioned to meet the challenges ahead.

NHS Sefton has agreed that 100% of the relevant CCG budgets area delegated to the respective CCGs. In relation to Southport and Formby CCG, this equates to £161,816k

The 2003/14 financial plan for Southport and Formby CCG is set out in table 1

The medium term financial plan has been structured in line with key factors and best practice as set out by the Audit Commission to address the following:

- Leadership - Demonstrating strong leadership of finances and strategic direction
- Support Strategic Objectives - Using the MTFP to support the achievement of strategic objectives
- Establish lines of accountability - Establishing lines of accountability for producing and adhering to the MTFP
- Risk Management -Producing an MTFP that identifies and manages the financial implications of risk
- Understanding CCG cost drivers and achieve value for money- Through the collection and analysis of a wide range of data and planning over the medium term to improve value for money
- . Data Quality - Recognising the importance of good quality data
- Content of the MTFP - Producing an MTFP that is comprehensive, accurate and has content that is relevant and useful
- Scrutiny and Challenge - Providing internal and external stakeholders with an opportunity to scrutinise and challenge the MTFP
- Approval and Communication of the MTFP - Ensuring Board approval of the MTFP and that the MTFP is communicated to the right people
- Using, achieving, monitoring and updating the financial plan - Using the MTFP as the key financial document, from which the
- annual budget is developed and puts in place the systems for achieving, monitoring and continually refreshing the MTFP

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ADD Finance Tables

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 NCB 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 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 assessed growth in demand and have 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 Southport and Formby 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 the Council

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Enabling Area 3 - QIPP

The QIPP programme is a national Department of Health strategy which aims to improve the quality and delivery of NHS care while reducing costs to make £20bn efficiency savings by 2014/15.

As well as the financial targets attributed to QIPP, there are a range of Quality, Innovation, Productivity and Preventative merits and benefits that have been delivered via the QIPP programme implemented in Southport & Formby. For more information on historic QIPP performance, please see the report "QIPP Celebrating Success 2009/10 – 2012/13".

This strategic plan sets out the schemes where there is a future pipeline for delivery in 2013/14 and beyond.

Foundations for future delivery

There are a range of schemes where strong foundations have been set for delivery in 13/14 and beyond with continued focus and drive. These include:

Schemes	Next Phases	Financial Impact 13/14 £000's
Tailored Care	Continued implementation of personalised agenda in each locality	£2,400
Information Technology	Roll out of range of schemes and initiatives and further consideration of broader system opportunities	
Estates	Continuation and implementation of estates review and opportunities identified	
Children's and Young People	Continuation of listening exercises and patient and parent education	
Cancer	Continued development of new specialised cancer centre for Merseyside	
Rehabilitation	Continued implementation of rehabilitation strategy and provision of additional services and delivery model	
Cardiac Rehab		
Open Access Diagnostics		
Virtual Wards		
Opthalmology		
Out Of Hours		
IAPT		
111		£0
Prescribing		£898
Provider Contracts	Tariff Efficiency 4%	£4,564
Total		**£7,862**

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These initiatives will evolve to include detailed milestones and deliverables to ensure the delivery of wider service and financial sustainability. The CCG also understands the importance of past learnings so that improvements can be made for future initiatives. This is particularly important around the triangulation of activity, quality and cost data to drive QIPP planning and assurance.

Crucial for success with be clinical input at every step of each initiative in conjunction with local commissioning and public sector bodies to develop new ways of working through productivity and innovation.

The CCG will also look to a continued working relationship with the NCB Local Area Team to ensure that QIPP initiatives are mapped across the North West so that efficiencies and synergies.are utilised where possible.

The CCG has 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 – the CCG has made provision for 1% contingency reserve within the financial plans to deal with the costs of any unexpected growth in activity. The CCG will work with public health colleagues to review these assumptions over the coming weeks and months ahead; local metrics will be continually reviewed using key tools, such as 'Right Care', to help shape and influence our plans in respect of the needs of the local health economy

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Enabling Area 4 – (Enable Richer Public and Patient Engagement)
Key Priorities, Objectives & Measures

Engagement

In line with the Big Chat and Talking Health and Wellbeing events, the CCG are keen to make a quantum leap in the development of its engagement arrangements, and like quality, embed them at the heart of all the commissioning arrangements.

Southport and Formby CCG is keen to strengthen its engagement with patients and key stakeholders. It will build on engagement successes to date such as the 'Big Chat' and the partnership working with LiNKS which was an identified strength within the authorisation process. Our CCG Expert Patient Advisory Group (EPAG) is Chaired by our Lay Member who has a lead around patient and public involvement .

Clinicians in Southport and Formby have always set great store on engagement of patients in decision making and service re-design. For example, engagement of patients is at the heart of the diabetes pathway re-design, with a focus on patient education and co-production of the care plan.

There will also be programmed meetings with key stakeholders such as the Overview and Scrutiny Committee, emergent Health and Wellbeing Board, MPs, LMC and social care and local authority representatives. We will also actively seek patient views about how they can be more closely involved with decision-making on both individual and collective levels.

The outcome of the listening campaign will be an evaluation which will lead to a new and dynamic 'multi-channel' methodology for capturing and acting upon patient experience on an 'industrial scale'. This 'multi-channel' methodology will include:

- Near time, post treatment, out-bound telephone follow-up interviews.
- On-line opportunities to comment on-line with moderated feedback and publication.
- Structured attitudinal surveys.
- Patient experience sampling across service lines and provider geography.
- Proactive mobilisation of community and voluntary groups to monitor.
- Primary care satisfaction surveys.
- Comments and notes boxes in every GP surgery.
- Requirements of providers to carry out satisfaction surveys in situ.
- Deliberative patient groups in every locality.
- Feedback loops to patients to demonstrate how their experience has been taken into organisational and contractual learning to make service changes.

The CCG will commission these services from an external agency to provide a regular and systematic monitoring of patient experience. This data will be reviewed by clinicians at monthly locality and CCG executive boards as a core metric in the quality dashboard and for contract monitoring and service development

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We work with providers and partners to gather public insight into local health services, and our Quality Lead GP is working with Southport and Formby LINk and S&O Hospital 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:

HOW SEFTON PATIENT AND PUBLIC INSIGHT INFORMS COMMISSIONING

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 recognise the opportunity for developing ICT-based solutions and models that support the development of a participative society where 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).

SECURING PATIENT FEEDBACK

WHO

- Comprehensive Stakeholder Database – segmented, and targeted for areas of interest
- Lay Board Members with lead for Public and Patient engagement
- EPEG (Engagement and Patient Experience Group) – Scrutinise and advise commissioners using auditable guide – reports through to the Board via the Quality committee - Takes reports from LINks on Patient Experience data via community Champions Programme
- Patient Reference Groups in practices
- Targeted Patients and Carers – working with providers
- On-line two way feedback to and from the public via websites
- Partnership with VCS Networks to support hard to reach/relationships/trust
- Collaborative modelling with Council for Joint Commissioning insight plans (JSNA and JHWS)
- LINKS Community Champions Model at Locality level
- PALS Reports to the Quality committee
- Complaints & Compliments reporting to the Quality committee
- SUI Data Reports to the Quality Committee.

HOW

- Annual Big Chats / Joint events with the Local Authority regarding the Health and Wellbeing strategy.
- Quarterly "Meet the Commissioner Events"
- Virtual Lay Reader Group for information and communication sense checking
- Tender and Procurement Training Opportunities
- Every commissioning work stream has a Communications and Engagement Plan that includes:
  - Scoping of the engagement activity to support the project
  - Stakeholder mapping and clarification of the level of influence of the stakeholders to be engaged
  - The engagement methods to be used, including lay members on steering groups or committees, focus groups, surveys etc., and
- The methods of feeding back to stakeholders on how their views/comments have influenced commissioning decisions.

We recognise 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) to 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 encourages the local people of Southport and Formby 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, whose main focus is on the patient experience, 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 will utilise the Patient Access to Health Records as a functional mechanism in reporting the consequences of feedback from the FFT.

Informing patients

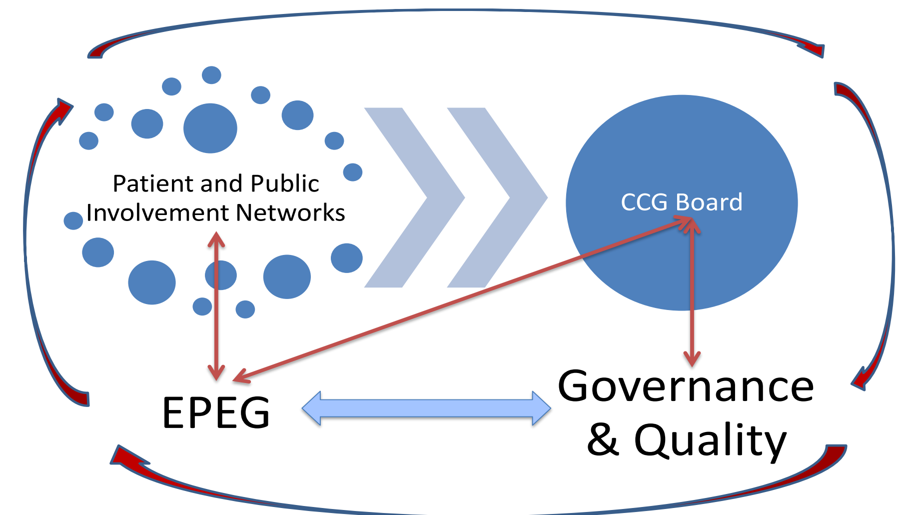
We will continue to:

- Work with the local Health and Wellbeing Board to assess population need

- Work with HealthWatch 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 Sefton Health and Wellbeing Board (HWBB). Our Chair has been a member of the shadow HWBB 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 Sefton Strategic Needs Assessment (SSNS). The results of SSNA 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 CCG commissioning intentions for 2013-14) the focus of five large public events across Sefton in December 2012 and January 2013 (see Appendix 3).



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A joint working group for both CCGs in Sefton, called the Engagement and Patient Experience Group (EPEG), has been established, which feeds directly into the Quality Committee of each CCG. This group has a broad membership and is chaired by both CCG Lay Board members and comprises Governing Body practice managers, CCG senior managers, Sefton Council engagement leads, Southport and Formby CVS and Southport and Formby LINk. In future it is hoped members and officers of HealthWatch will join the group. EPEG acts by co-ordinating engagement activities and considers patient information from all parts of the system, including practice level Patient Reference Groups, LINk Community Champions, who work in local community settings and feed into CCG localities, LINk local service provider experience reports, and CCG wide systems, such as trends from complaints.

Once in place, we will work with HealthWatch to ensure that public involvement plans match local expectations for engagement at all levels.

We are seeking to work with CMCSU in developing our 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 In Health Associates and Sally Williams of Frontline. We are seeking to use 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 also await the soon to be published 'individual' and 'collective' involvement guidance from the NCB

Equality & Inequality

The Cluster is reviewing EDS evidence with self assessment alongside providing training to enable grading of self assessment by wider Stakeholders. Equality Objectives will be drafted for verification by the Board leading to development of an Equality Strategy later in 2013. The Cluster and CCG will work together to develop performance measures to show how Equality Objectives will be met over the next 4 years.

There are a number of areas in this plan which will have a direct impact on reducing health inequalities, such as:

- Delivery of the Southport and Formby Cancer Strategy and the cancer access to treatment targets
- The new approach to long term conditions management
- The transformation of primary care programme

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Enabling Area 5 – (Build Stronger Partner Relations)
Key Priorities, Objectives & Measures

The Health Economy in Southport and Formby and surrounding areas faces significant challenges for the foreseeable future, with aging populations and financial pressures from the centre. The best way to ensure a first class service to the population of Southport and Formby is to ensure that all the key stakeholders within the Health Economy are working in harmony.

Our commitment to you – our partners: those we work with to commission services and those who provide the services we commission

- We will build relationships based on openness, honesty and trust – this is a two way process
- As clinical commissioners we will work with you to ensure local health care is led by clinicians
- We want to develop partnerships that reward real improvements in quality and outcomes and where we share both risks and gains

As commissioners we will work through the newly established network to specifically shape primary, community and secondary care services and focus on integration with social care, the Ambulance Trust and the third sector. This work will help to drive our 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 South Sefton CCG, Liverpool CCG and Knowsley CCG around the S&O NHS Trust 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.

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.

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CCG Integrated Strategic & Operational Plan: Plan on a Page

Southport & Formby CCG | **Our Vision : A sustainable, healthy community** | **Our Values: Respectful, approachable, efficient, responsive**

Context

- Growing elderly population
- Inequalities of health care
- Improving quality of life
- Care closer to home
- Safe Care
- Financial Challenge
- Winter Pressures

Strategic

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

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

CCG / LA Joint Priorities

- Children & Young People
- Adults
- Public Health

System

- Optimising use of Secondary Care
- Driving Improvement in Health & Wellbeing
- Improving Quality of Primary Care and Delivery of Community Services
- Ensuring Cost Effectiveness in High Quality Tertiary Care

Enabling Themes

- Patient & Public Engagement
- The Francis Report
- Any Qualified Provider
- Programme Management Office
- CQUINs
- Information Management Technology Innovation
- Value for Money through Finance and Contracting
- Quality of Care
- Sustainable Change
- Promotion of Self Care
- Sefton Needs Assessment
- Clinical, Community, 3rd Sector collaboration

Programmes, Transformational Change and Improving Outcomes

Programmes	Transformational Change	Improving Outcomes
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
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
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
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
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
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.
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
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%
Prevention	• Develop collaborative CQUIN to support improved breastfeeding rates • Develop an obesity strategy and clarify obesity treatment pathway. • Commission Alcohol Liaison Service at Southport & Ormskirk 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
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

NHS Outcome Framework

QUALITY PREMIUMS

- Reducing potential years of life lost through amenable mortality
- Reducing avoidable emergency admissions
- Improving patients experience of hospital services – Ensuring roll out Friends & Family Test
- Preventing healthcare associated infections

LOCAL PRIORITIES

- Reduction in hospital admissions for under 19s related to Asthma
- Reduction in the number of patients who have an emergency admission for dehydration
- Offer Interventions to Patients with Alcohol Related Admissions

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**

CCG Plan on a Page – Focus for Years 2 and 3

Programmes / Enablers	2014-2015 (Year 2)	2015-2016 (Year 3)
Medicines Management	To optimise prescribing and outcomes for patients by ensuring medicines used are safe, appropriate and are both clinically effective and provide value for money	To optimise prescribing and outcomes for patients by ensuring medicines used are safe, appropriate and are both clinically effective and provide value for money. (This is day to day activity, responding to the needs of practices across the organisation)
Medicines Management	To ensure medicines management support is tailored to the individual constituent practice to meet both clinical governance and quality needs. (building from the practice up to the organisation to support the unique requirements of practices and being able to respond with more clinical support if required)	To tailor medicines management support for care closer to home programme objectives in conjunction with providers.
Medicines Management	Where appropriate, assess and agree transfer of prescribing budget with providers to ensure both clinical governance and fiscal responsibility remain with the prescribing organisation.	
Organisational Development	Re-procurement of CSU provision for October 2014 to ensure effective on-going commissioning support.	Mature and fully empowered localities with significant increased budgetary and commissioning responsibilities and influence, underpinned by optimal use of the Intelligence Portal.
Organisational Development	Demonstrable broadening and strengthening of clinical leadership capacity and capability at Board, Locality and Practice level.	Demonstrable track record of significant transformational changes delivered within the system through the programme management approach
Organisational Development	Fully embedded engagement and patient experience systems (in conjunction with key partners LA, CVS, Healthwatch, Patient Reference Groups) which evidence a wealth of examples of changes made as a result of patient and public feedback	Reputation – the CCG continues to develop high levels of confidence, trust and respect amongst all stakeholders building on its first two years of operation, which has helped it to manage and plan for difficult decisions around healthcare affecting its patients, public and wider stakeholders
Care Closer to Home	Continuous review of the model. We would expect to see the impact and shift from acute to community based services delivery this year as staff and new ways of working are embedded. The CCG will continue to review demand as there is a risk that any potential to reduce acute beds (as a result of CCTH) will be off set against increased demand due to the demographic impacts within the population	
Dementia	Increase the detection rate and commission as a result of the	

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	dementia strategy	
Obesity	Review and commission services as a result of the Obesity strategy, in conjunction with strategic partners	
Hospital Alcohol Service	The CCG will expect to see the biggest impact of this team in this year as the team will be established and the repeat admissions should start to reduce	
Southport & Ormskirk FT Application	Support the Trust's application and commission as appropriate. In addition, the CCG will plan for back up scenarios in preparation should the FT application run into difficulties.	
Care Closer to Home		Review the model and impact versus growth (as per 14/15) it is likely that changes will be required to keep pace with demand based on the findings of previous year
Obesity & Dementia		Obesity and dementia will continue to be key themes for the CCG. The CCG will work with partners to commission services to minimise the impact of both on the health of the population
Long Term Conditions		Review pathways to ensure they are delivering the best outcomes for our patients, promote the self care model. Maximise use of telehealth being mindful of the risk of increased social isolation

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Delivery Area 1 – (Improve Quality & VFM through redesign)
Key Priorities, Objectives & Measures

Quality is at the heart of everything the CCG does. Quality in the CCG is driven by identified GP Clinical Leads with support from the Chief Nurse and other members of the CCG senior management and locality team. Our GP Clinical Leads for quality & contract performance together with the GP Clinical Pathway Leads work closely to ensure that quality is owned within the wider constituent membership and embedded into the CCG commissioning cycle

The CCG recognises the importance of ensuring quality and is developing its approach to quality, with a focus on clinical leadership and embedding quality in the commissioning and contracting process. The CCG wishes to ensure that its approach to contracting and quality concentrates on the following major areas:

1. **Patient experience** – both more effectively acting upon what patients tell us and strengthening their voice in service improvement and in targeting specific aspects of patients experience, such as personal dignity and communication
2. **Safety of clinical services**: targeting areas of concern raised by external intelligence
3. **Local intelligence** including proactive assurance of performance against national standards and ensuring that action from lessons learnt is taken effectively
4. **Good clinical practice**. Ensuring that clinicians and services are systematically working to accepted good practice guidelines, and that there are good systems of clinical communication that are timely, accurate, relevant and systematic
5. **Agreed pathways of care**, ensuring the effective adoption by primary, community and secondary care services of agreed care pathways in Southport and Formby, with care indicators that measure the quality of a whole pathway of care
6. **Commissioning intentions** and implementing new models of service delivery

In each area there will be a strong emphasis on integration of care between providers, primary, community and secondary, with the CCG recognising its responsibility as a partner to ensure that primary care works effectively as part of the health system. The CCG understands integration to mean the effective management of care for a patient between providers, requiring collaboration and communication. From the patients perspective we need to ensure that the service they receive is coherent and of high quality. That requires individual NHS providers to provide good quality care, but it also requires collaboration between organisations and clinicians to make sure that the patient is the focus of how care is provided. Promoting and supporting that collaboration will be a key feature of the contracts with providers.

This will centre on an approach that:

- Incorporates common indicators across individual Trusts, to support
- integrated working and improved communication
- Is actively led by clinicians
- Motivates staff and focuses on direct patient care, at team or ward level

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Value and Value For Money (VFM):

Value for money' (VFM) is a term used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it. Some elements may be subjective, difficult to measure, intangible and misunderstood. Judgement is therefore required when considering whether VFM has been satisfactorily achieved or not. It not only measures the cost of goods and services, but also takes account of the mix of quality, cost, resource use, fitness for purpose, timeliness, and convenience to judge whether or not, together, they constitute good value. (As described by HEFCE)

"Value in any field must be defined around the customer, not the supplier. Value must also be measured by outputs, not inputs. Hence it is patient health results that matter, not the volume of services delivered. But results are achieved at some cost. Therefore, the proper objective is… patient health outcomes relative to the total cost (inputs). Efficiency, then, is subsumed in the concept of value. "

Source: Porter ME. (2008). What is Value in Health Care? Harvard Business School

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Achieving VFM is also often described in terms of the 'three Es'.

- **Economy** - careful use of resources to save expense, time or effort.
- **Efficiency** - delivering the same level of service for less cost, time or effort.
- **Effectiveness** - delivering a better service or getting a better return for the same amount of expense, time or effort.

Southport and Formby will strive for Best practice and this will require a well-planned, thorough and clear approach to all activities which will be delivered through the Programme Management Office (PMO). However, procedures by themselves are not necessarily sufficient, since the achievement of VFM requires ***an attitude and culture that seeks continuous improvement***. The main benefits of promoting VFM principles are:

- **The clarification of objectives**. Rather than acting on assumptions about what is required, VFM principles will give managers a proper assessment of the objectives of an activity. This will maximise their chance of achieving the desired ends without unnecessary expenditure and effort.
- **Planning** is an essential part of all well managed processes. Good planning minimises the risk of an activity failing to deliver the intended outcome, at the right time and at the right price.
- **Openness and transparency of process**. Through properly documented planning and assessment, and the adoption of open processes involving all interested parties, organisations can publicly demonstrate a commitment to achieving propriety as well as VFM.
- **Compliance with statutes and regulations**. All organisations need to comply with legal and other associated requirements. By adopting good practice, the risk of failing to identify and comply with such requirements is significantly reduced.
- **Risk assessment**. All activities have risks attached. These include, for example, a reputational risk, control risk, financial risk (including financial health risk), health and safety risk, and a business risk. Risk assessment is an area that can often be improved. Although it is often not necessary to undertake a full risk assessment for every activity, an inadequate risk assessment, particularly for significant activities, can result in poor value for money.

A description of a value organisation is one that makes arrangements to secure continuous improvement in the way in which its functions are exercised. The objective of this continuous improvement in a CCG is to deliver optimally economic, efficient and effective healthcare services (systems).

The three areas of focus for an organisation seeking continuous improvement are:

1. Managerial processes and systems

2. The inputs and processes by which services are provided, by and/or for the Organisation

3. The achievement of outcomes in line with intent – that is, outcomes that meet the appropriate objectives of the service.

The CCG will endeavour, through its strategy, objectives and operations to give due focus to these areas and adopt best practice in delivering optimal internal business processes that drive continuous improvement in the local healthcare system.

Systems Review

Systems, or service review, is a key tool in driving continuous improvement towards optimal value. A systems review is an assessment of the inputs and processes to ensure they are economic and efficient. The key, when looking at a current service, is to identify the existence of waste:

- For inputs, waste constitutes an input that could be more cost effectively provided.

- For processes, waste constitutes an activity that adds nothing to the outcome or delivers an outcome that is not of value

With regard to the latter, value assessments – such as in workstreams that deliver clinical policies, referral thresholds and protocols – are built into the delivery of projects and programmes prioritised in this strategic plan.

The above description of value and continuous improvement towards value, alongside the tools and approaches described, is a foundation stone in the design of the CCG's overall reform business process and informs its workstreams, service reviews and reform project generation and prioritisation.

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The following pages provide more detail on each of the key programme areas.

D1 Programme 1 - Unplanned Care

A&E waits

The CCG will 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 will work with the Hospital Trust to deliver the A&E standard and support community based programmes which embrace technology with our providers to ensure:

- patients get the best possible outcomes,
- reduction in emergency admissions by better managing people in the community.

Category A ambulance calls – the CCG will 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, with a further fine for delays of over an hour

Southport and Formby has seen a surge in Category A calls in the later 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.

The 111 helpline will be made available in 13/14 and will provide support 24 hours a day, every day of the year. It is intended for 'urgent but not life-threatening' health issues and complements the long-established 999 emergency telephone number for more serious matters. The 111 operators are able to dispatch ambulances when appropriate.

Ambulatory care sensitive conditions (ACSC) are a group of 19 chronic or acute diseases for which hospital admission in adults may be avoidable by effective management in primary care. They fall into three groups – those preventable by vaccination; those avoidable through secondary prevention or better patient self-management; and those amenable to lifestyle interventions. The most frequent constituent conditions are angina, asthma, chronic obstructive pulmonary disease, cellulitis, complications of diabetes, heart failure, gastroenteritis and dehydration, epilepsy, iron deficiency and pyelonephritis. Productivity metrics identify potential savings from hospital admissions that could be made if CCGs s are able to reduce admission rates to that of the best 25% in the country.

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D1 Programme 1 - Unplanned Care – Plan on a Page

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		

D1 Programme 2 - Long Term Conditions

Southport and Formby has higher than average levels of long term conditions. Contributory lifestyle factors (Excess drinking, smoking, lack of exercise & poor diet) are improving but still vary across the borough. Asthma, kidney disease, CHD, dementia and diabetes are all areas of concern….

Dementia

We plan to continue improvements to dementia services for patients and carers in 2013-14 and actions include:

- Refresh of the Southport and Formby Dementia Strategy 2009-14 in line with recent policy changes, including the targets in the Prime Ministers Dementia Challenge. Both diagnosis and understanding of the condition are key to making a difference to people's lives
- Voluntary, community and faith sector services include awareness raising across Southport and Formby and support for carers
- Alzheimer's Society commissioned to lead on awareness raising and community support via Community Coordination workers. They also provide the following - Singing for the Brain®, Music and Wellbeing Therapy, Reading Aloud, Maintaining Skills Group, Carers Educational Course
- Continue to share good practice across Southport and Formby Dementia Action Alliance with statutory, voluntary, community and faith sector

The diagnosis rate we are aiming for in 2013-14 and 2014-15 is an increase from 51% to 75% by 2015-16 in line with GMS Contractual Changes 2013-14, through an enhanced service for Dementia Case Finding.

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 via CQUIN's with Liverpool Community Health Trust and Merseycare NHS Trust
- improved access to GP & 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

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- 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
- Asses 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

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D1 Programme 2 - Long Term Conditions – Plan on a Page

Southport and Formby
Clinical Commissioning Group

Priority Area : Long Term Conditions **Lead Clinician: Dr Liam Grant/Dr Niall Leonard**

OBJECTIVE
To provide person centred integrated care for people with long term conditions through improvements in primary care. To put patients in charge and have ownership of their care through personalised care plans and budgets whilst ensuring co-ordination and continuity of care. (Domain 1,2,3,4,5)

WHY CHANGE IS NEEDED?
The number of people diagnosed with long term conditions is higher than the England average and despite this there may be under diagnosis. Half of the population may be classed as overweight or obese. The Atlas of Variation indicates the following areas with potential for improvement: rates for bariatric surgery, closing the gap between the actual and expected prevalence of Coronary Heart Disease, reduce the number of admissions with COPD and the primary diagnosis.

DESCRIPTION
New integrated pathway for Respiratory disease, cardiology and frail elderly to be developed as part of the Care Closer to home scheme (*separate proforma)* Local Enhanced Service in primary care to improve diagnosis and management of COPD LES in primary care managing obesity LES primary care to diagnose and manage Atrial Fibrillation Vascular Health Checks Alcohol Nurse in A&E (See Priority Alcohol) Peer support for cardiology service in Southport and Ormskirk Trust

KEY MILESTONES	Q1	Q2	Q3	Q4
New integrated care pathways				
Peer Support for Cardiology				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Under 75 mortality rates for CVD and respiratory disease (longer term)				
CHD actual v predicted data				

RISKS	MITIGATING ACTIONS
Poor take up on Local enhanced service resulting in no changes	Monitor uptake, focus within locality groups, feedback on schemes for future developments

WORKFORCE IMPLICATIONS
Impact on primary care with multiple LES schemes Peer support may identify changes with workforce implications

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

D1 Programme 3 – Diabetes

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	Potential use of PC investment (£3/head)
Lack of capacity within GP practices	Primary Care Quality Strategy
Educational issues	Use of protected learning times

WORKFORCE IMPLICATIONS

None at this time

RESOURCE IMPLICATIONS

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

D1 Programme 4 – Mental Health

Southport and Formby
Clinical Commissioning Group

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	11%	11%	15%	

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

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

D1 Programme 4 - Mental Health (Dementia)

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		

D1 Programme 4 - Mental Health (Learning Disabilities)

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		

D1 Programme 5 - Mental Health (Military / Veteran Health)

Military Veteran health

The North West is the largest recruitment area for the British Armed Forces and accounts for 33% of the annual intake - in comparison to other regions. It is estimated that nearly 20% of all Military Veterans may suffer with anxiety and/or depression upon leaving the Services with a smaller percentage suffering from Post-Traumatic Stress Disorder and alcohol/substance misuse.

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 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 (see appendix 5) commissioning of services for Armed Forces Veterans, Reservists (when not mobilised) and Armed Forces Families (serving, reservist or veteran) are the responsibility of the CCG in each area. CCGs will also be responsible for the commissioning of emergency care services for veterans and family member in their area. It is also recommended that the hosting of the Armed Forces Network will be handed over to CCGs from the SHA.

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.

All CCGs across Merseyside were asked to consider continuation funding of 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. South Sefton and Southport & Formby CCGS (SS & S&F CCGs) have signed up to this for 2013-2014. The funding will be used for providing access to veterans to the MV IAPT Service which is Psychological therapies service based on the original IAPT model but adapted for ex and current Service Personnel and their families. This project is hosted by Pennine NHS Foundation Trust

The NHS is also supporting the Live at Ease Project – This project supports ex-service men/women to adapt to civilian life. The support includes help with housing, accommodation, employment, training, and debt advice and drug and alcohol dependency issues. The project will also support family members.

Liverpool Public Health Observatory is currently carrying out a health needs assessment for ex armed forces personnel and their families, on behalf of Merseyside and Cheshire Directors of Public Health. Initial findings have identified families:

- Have poor access to health and wellbeing advice
- Have depression, reliance on alcohol and anxiety as being common within service families
- Worry about a husband/wife/partner who is away on active service
- Struggle to cope alone and with children

DRAFT

- Live far away from their immediate family, lack of immediate support
- Have a limited social network, moving around prevents friendships and support networks forming
- Have financial insecurity, unable to work due to house moves and caring commitments.
- Suffer domestic abuse as both victims and perpetrators

There are no definitive figures on the total number of veterans in the UK at the present time. Estimates produced in 2007 by the Office of National Statistics in conjunction with the Royal British Legion (RBL). RBL extrapolated the findings of this survey to provide an estimate of 4.8 million veterans in the UK, with approximately 3.9 million in England. This equates to approximately 8% of the UK population aged over 16 years and over.

Local Authority	16-24yrs	25-34yrs	35-44yrs	45-54yrs	55-64yrs	65-74yrs	75+yrs	Total	Total Under 65yrs
*Sefton	516	797	1,996	2,282	2,400	6,569	9,567	24,128	7992
*Please note information currently not available at CCG level									

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.

SS & S&F CCGs 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.

DRAFT

D1 Programme 5 – Children's

Southport and Formby
Clinical Commissioning Group

Programme: Children **Lead Clinician: Dr Robert Caudwell**

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		

NHS
Southport and Formby
Clinical Commissioning Group

Programme: Children **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		

Southport and Formby Clinical Commissioning Group

Programme: 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		

D1 Programme 7 – Cancer

Southport and Formby Clinical Commissioning Group

Programme: 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	Work through localities and educational opportunities
Delays in data provision	Work with the data provider
Sustainability of NAEDI project manager roles	Review workload on regular basis

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

Programme: 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 Southport & Ormskirk 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

Programme: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		

NHS
Southport and Formby
Clinical Commissioning Group

Programme: 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		

D1 Programme 8 - End of Life Care

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

D1 Programme 9 - Prevention

For the NHS to be sustainable in the 21st century, it needs to focus on improving health as well as treating sickness.

This is not just the right thing to do for patients, but it is also a financial necessity. The benefit created by an NHS that promotes health, self-care and early intervention, and that integrates services around patients, is potentially sizeable, amounting to billions of pounds.

We will need to work more effectively with national and local partners, including local authorities and the third sector, to make a stronger contribution to promoting health and to ensure easier access to prevention services.

We will also need to think innovatively about how we can engage with other stakeholders, such as the life sciences industry, to achieve these aims.

Our prevention focus in this strategic plan is based around alcohol, obesity and maternal health.

DRAFT

D1 Programme 9 – Prevention (Alcohol Services and Addiction)

The summary of the Southport & 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"

DRAFT

NHS Southport and Formby Clinical Commissioning Group

Programme: 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

Southport and Formby
Clinical Commissioning Group

Programme: Obesity **Lead Clinician** ____________

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		

D1 Programme 9 - Prevention (Maternal Health)

Southport and Formby
Clinical Commissioning Group

Programme: 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		

D1 Programme 10 – Primary Care Quality

Southport and Formby
Clinical Commissioning Group

Programme: Primary Development **Clinical Lead: Dr Bal Duper**

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		

D1 Programme 11 – Medicines Management

Southport and Formby
Clinical Commissioning Group

Programme: Medicines Management **Lead Clinician: Dr Hilal Mulla / Dr Janice Eldridge**

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		

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.

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.

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D1 Local a) - A reduction in the number of patients who have an emergency admission for dehydration

Rationale - We are an outlier on the Better Care Better Value indicators for this and it reflects the age of our local population. We plan to take a more proactive approach with supporting our care homes and through this we expect to prevent admissions. We are also working with our local Acute Trust to develop an integrated care pathway for Frail Elderly patients and this will also contribute to reducing admissions.

Measures – Reducing emergency admissions (adults) for dehydration by 10 %.

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

D1 Local b) 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- 20% admissions for asthma <19 years

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)

D1 Local c) - Offer Interventions to Patients with Alcohol Related 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).

Measures – 20% of alcohol related admissions will receive an intervention.

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Delivery Area 2 – (Improve Quality and VFM through Contracting & CQINS)
Key Priorities, Objectives & Measures

During the next few years the CCG wishes to develop alternative approaches to contracting that better support integrated working between primary, community and secondary care and place quality at the heart of the contracting process. In agreeing contracts for 2013/14 the CCG wishes to anticipate those developments by laying foundations for this changed approach, by maximising the potential in existing contracting arrangements towards supporting its aims for quality.

The CCG regards contracting as a major lever, for both commissioners and providers, in driving attention to improved performance in the quality of health and health care in Southport & Formby. It wishes to see contracting used as an integrated part of its commissioning processes to support the focus on quality.

The CCG will utilise the following contract levers to ensure that we obtain the best VFM from the Trust. The following clauses from the National Contract 2013/14 will be of particular importance for the CCG going forward:

SC7.2 - "The provider may reject a referral on the grounds:
SC7.2.1 - Of any service limitations in the service specifications set out in Schedule 2 Part A; or...SC7.2.3 That a prior approval request made by the provider under the prior approval scheme has been rejected by the commissioner"

SC7.9 - "Unless a relevant Prior Approval Scheme applies, the Provider must not carry out, nor refer to another provider to carry out, any non-urgent or routine physical treatment and/or care that is unrelated to a Service User's original Referral or presentation without first consulting the Service User's GP"

SC10.1 - "The provider must share decision making...with the relevant service user, carer and legal guardian"

SC12.2 - Providers must demonstrate SDM to the commissioner on request.

SC29.4 - "The Provider must manage Activity in accordance with any caseloads, occupancy levels and clinical thresholds set out in the Service Specifications and Activity Planning Assumptions and/or published in Choose and Book. The Provider must:

SC29.4.1 - "comply with the reasonable requests of the Commissioners to assist the Commissioners in understanding and managing Referrals;

SC29.4.2 - "and require its agents, sub-contractors and employees to adhere to any Referral and treatment protocols that may be agreed between the Parties"

CQUIN will be agreed in 2013/14 and beyond as an incentive to improved performance. This may be performance beyond that nationally mandated or in areas of specific local concern. CQUIN will not be used to incentivise practice or performance which would normally be expected to be delivered as part of the national NHS contract. In line with national guidance, targets previously incorporated within local CQUIN schemes will be incorporated within the main contract, with CQUIN focussing on new areas of improvement or higher levels of performance in areas that remain a priority.

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

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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 2013-14 contracts and where possible have come to an agreement regarding common CQUINs – the Chief Nurses are leading on the development of specific portfolio related areas. The 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 is 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 our 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.

The CCG wishes to work supportively with its NHS Provider partners to ensure that we have a small number of highest priority areas that remain at the top of our agenda, and drive our overall approach to quality care. These will be:

1. **Service Reviews**. We will work with Southport & Ormskirk (S&O) to develop a shared understanding of Hospital Mortality data (SHMI) and the NHS Atlas of Variation. The reviews will be against NICE or best practice guidelines with the review scope jointly agreed with Commissioners. Improvement plans, where required, will be jointly agreed between commissioners and providers and progress monitored through the Quality- Contract Meetings
2. **Lessons Learnt**. S&O will be required to report regularly on the outcome of lessons learnt from complaints, serious incidents and external service reviews, providing evidence of the effective implementation of lessons learnt or agreed action plans
3. **The Clinical Senate**, will meet monthly to share and review clinical data to improve the quality of care and health outcomes
4. **Collaborative working**. The Trust will be invited to include within its contract a 'shared incentive' approach to two designated clinical areas, that through collaborative working across all providers will improve the quality of care for patients. Targets will be agreed that share the commissioning expenditure 'saved' in each area across the commissioner and participating providers.

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The CCG will:

- Not pay a Trust for care carried out that is a agreed locally or nationally as a 'never' event

- Reduce the total contract payment to a Trust should the Trust be in receipt of an improvement notice from the CQC.

Clear expectations for performance and quality are embedded in the CCG's relationship with its providers, with all quality and performance standards mapped against the NHS Outcome Framework, developed in collaboration with the CSU.

The CCG is developing its governance arrangements and its intelligence systems with clinical leadership, through forums such as Clinical Advisory Groups where clinical leaders from all Trusts address outcome, service quality and development issues in open discussion and work projects across Trusts.

The CCG's localities ensure clinician and patient feedback are as close to the patient as possible, with delegated authority to address local issues. This local intelligence, is brought together with information from a broad range of data sources (lessons learnt, public health mortality and trend data, etc) to proactively identify quality issues for action at local, or countywide level.

Quality contracting meetings will be appropriately supported at Director level with clear communication between and within organisations.

Each quality component of the contract, individual targets and major areas of focus, will have a named clinical lead from the CCG and from the NHS Provider Trust.- It is expected that this lead will be a Consultant, GP or Senior Clinical Professional at an equivalent level

The provider Quality and Contract Performance Meetings are lead by our CCG Clinical Leads with support from the senior management team and the Commissioning Support Unit. From 2013/14 onwards the recommendations from the Francis Inquiry, the vision set out within the national care strategy 'Compassion in Practice' (NCB 2012) and the Friends and Family Test feature strongly within the quality elements of our local provider contracts. Quality and Performance reporting is a standard agenda item at every Quality Committee and Governing Body Board Meeting.

During the next few years our CCG wishes to develop alternative approaches to contracting that supports integrated working and has quality at the heart of the process.

In 2013/14 our CCG will be working in collaboration with a neighbouring CCG to progress work regarding the introduction of an Alternative Quality Contract with a local NHS Integrated Care Organisation.

Contracting is an important part of commissioning for quality and improved outcomes and our CCG will agree local CQUIN schemes with providers who meet the nationally set pre-qualification criteria in order to focus on higher levels of performance that are a priority locally. If a provider fails to meet the expected level of performance as outlined within the contractual agreement for the CQUIN then it is likely that payment will not be made.

The CCG is in the process of further developing its commissioning support arrangements from the Commissioning Support Unit who will provide the necessary support to assist the CCG in delivering our commissioning responsibilities through the contracting processes.

Key performance indicators (KPIs)

We have a clinical lead for quality who, with our Lead Nurse, will develop our 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.

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Appendix 1 (Health related data for Southport and Formby)

- The population of Sefton (as a whole) 2010 is 272,900 and has declined each year since 1989
- The average life expectancy for Sefton males is 77 years and for females it is 82 years, both of which are below the England averages of 78.6 years
- Sefton's 65+ population is 56,300 accounting for 21% of the total
- Sefton's 0-15 years population is 47,340 (17%)
- Sefton children aged 4-Syears, 10.4% are classed as overweight or obese this rises to 21.3% at 10-llyears,and both figures are above the England average
- Sefton's C02 Emissions (tonnes) per head: total is 5.2t for 2009 an improvement of 5.5% on 2008, with this year's figure is better than the English average
- 85.4% of Sefton's older people have achieved independence through rehabilitation/intermediate care this is higher than the all England average and has improved by 3% since 2009/10
- Sefton scored 19.4 out of 24 for self-reported experience of social care users
- 1,110 of adults aged 65+ in Sefton are receiving home care service's this is lower than the England average
- Generally, health outcomes for Sefton's children and young people are improving, but some are still below the England average
- There are 900+ children on Sefton's voluntary disabled children register
- Over the past decade, there has been a shift in the patterns of birth locations, with a higher% choosing Southport and Ormskirk
- Sefton's breastfeeding initiation rates are rising but still comparatively low. Both initiation and duration are strongly linked to deprivation
- Childhood Immunisation rates are generally either close to or above national averages
- Whilst childhood smoking rates are average, alcohol consumption rates are higher than average
- Rates of teenage conceptions (u18) are amongst the lowest in the North West and the gap between Neighborhood Renewal and non-Neighbourhood Renewal areas is narrowing
- Most elective admissions for u18s are Ear, Nose and Throat (ENT) related; non elective admissions tend to be neonates, viral infections or respiratory
- Sefton has the highest proportion of residents aged 65+ and 75+ than both its neighboring and demographically similar CCGs- 21% are currently aged 65+- and Sefton's population is growing older
- An increasingly elderly population are likely to attend A&E and be admitted to hospital as a result of falls
- Deaths at home in Sefton are rising and Sefton's rate of deaths at home is better than comparable LAs and is similar to other north Mersey Las
- There are potentially 6,600 carers in Sefton aged over 65 -the numbers receiving a needs assessment or review is rising
- Top causes of elective hospital admissions for older people are knee and hip operations, diagnostic bladder procedures, hernia repairs and prostate operations- costing £3.6m per year
- Day Case operations are largely for diagnostic procedures and cataract operations at a cost of £4.6m
- Top causes of non-elective hospital admissions for older people are heart problems, respiratory problems, kidney or urinary infections and sprains
- Overall, whilst there is some progress on reducing health inequalities, inequalities persist

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- Life expectancy in Sefton is rising and is currently 77 for males and 82 for females. The gap between males and females is narrowing slowly
- CHD,lung cancer and chronic airways diseases, other cancers, liver cirrhosis and suicide (for men) are the main causes of excess deaths
- There a number of vulnerable groups in Sefton whose health outcomes are likely to be worse than the majority of Sefton residents
- Premature and avoidable mortality rates are falling
- Sefton has higher than average levels of long term conditions. Contributory lifestyle factors are improving but still vary across the borough
- Sefton generally has slightly higher levels of diagnosed long term conditions than average. Asthma, kidney disease, CHD, dementia diabetes
- In 5 years, Sefton's ageing population could mean 5,300 more people with hypertension and 2,200 with CHD
- Premature cancer mortality rates are higher than the national average but are falling at a similar rate to the average. A gap remains between rates in the most deprived areas compared to the rest of Sefton
- Whilst smoking and drinking rates in Sefton are lower than average, rates vary greatly within the borough. Whilst good progress has been made in reducing smoking prevalence, we need to ensure focus is maintained on our deprived areas and look at ways of preventing people from taking up smoking in the first place. Alcohol related hospital admissions continue to rise
- Whilst Sefton's rate of admissions is lower than other Merseyside LAs, it is higher than other comparable LAs
- Almost half of the population of Sefton may be classified as overweight or obese. Childhood obesity in Sefton is above average in Reception year but closer to average levels in year 6
- Most patients think their GP practices met or exceed the national benchmark for access and overall practices improved last year
- Chest & abdominal pain & delivery of new-barns cause most non-elective admissions for u65s costing around £6m. Heart problems, respiratory problems, kidney or urinary infections and sprains or strains account for most admissions for over 65s
- Increased non elective admissions over the next 5 years may mean extra costs in the region of £0.5m among over 65s
- Estimates of the use of, so called recreational drugs, such as cocaine, which are often linked to alcohol and socializing have increased significantly
- Every year approximately one in four people will suffer a mental health problem, with costs expected to double in the next twenty years. Mental health is apriority for the government for a focus on better outcomes for those affected by mental illness
- Dementia and depression are the most prevalent form of mental illness
- A recent review showed that between 12 and 18% of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing- between £8 billion and £13 billion in England each year. Moreover, by interacting with and exacerbating physical illness, the researchers calculated that total healthcare costs are raised by at least 45% for each person with a long-term condition and a comorbid health problem

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Appendix 2 (Other data and statistics for Southport and Formby)

- Sefton has the third lowest Local Authority rate of population growth across England & Wales and second worst within the North
- A further 169,200 (62%) of the population are aged 16-64,of which more than three quarters (131,200) are economically active, with 45,200 (27%) qualified to NVQ level 4 or above
- Sefton is ranked 92 out of 326 authorities in the 2010 Index of Deprivation (1is most deprived).
- The level of child poverty in Sefton has risen slightly from 21% to 21.8% in 2010 and is slightly worse than the English average
- 16% of school children in Sefton receive free school meals, higher than the England average of 14%
- The children achieving a good level of development at age 5 in Sefton is 59% (1,720) which is in line with the English average for 2011
- In 2010 the teenage pregnancy rate in Sefton is 29.1% this is lower than the England average of 32.84%.
- As of April 2012 8,848 (5.2%) are claiming Job Seekers Allowance
- 2640 of all Sefton JSA claimants are aged between 18-24,an increase of 58% over 5 years
- Sefton's job density figures for 2010 is 0.59 per 100,000 this shows a reduction from 2009 in the ratio of total jobs to population
- There are currently 10 JSA claimants in Sefton for every Job Centre Plus vacancy
- The number of older people receiving pension credits has increased from 16,740 in August 2009 to16,840 in 2010
- 38% of Sefton's land has been identified as previously developed land unused or available for redevelopment that is vacant or derelict. This is below the England average
- Sefton has approximately 400 green spaces and equates to 1.2 hectares per 1,000 population
- 82% of people of economically active age that have access within a reasonable time to more than 500 jobs by public transport, cycling and/or walking
- 81% of Sefton residents are satisfied with their local area as a place to live
- Across Sefton approximately 23% of residents surveyed say they have given voluntary help to a group or club in the last 12 months, and of these two thirds have volunteered for at 2 hours per week

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- 80% of Sefton's pupils achieved level4 or above in both English and Math's at Key Stage 2 this was higher than the England average of 74.66% and in the top 10% of all English authorities
- 59.5% of Sefton's pupils achieved 5 or more A * to C grades at GCSE or equivalent including English and Math's, this has risen from 55.8% in 2009/10
- Central government has estimated there are 650 Troubled Families within Sefton
- The under 20 population has fallen from 71,500 in 2000 to 62,200 in 2010
- The numbers of births to non-British born mothers is rising, particularly for Polish and Latvian born
- The areas of highest income deprivation affecting children are concentrated in the south, but there are pockets of deprivation around the Southport
- The areas of highest income deprivation affecting older people are concentrated in the south, and in central Southport. There are some pockets of income
- The Black and Minority Ethnic population of Sefton is growing, mainly in the 16-retirement age group
- Almost one quarter of Sefton is classed as belonging to the 20% most deprived area of England. There are wide variations in deprivation levels across Sefton that are masked when looking at deprivation levels for the whole area

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Appendix 3 – How we involved people in 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 Southport and Formby LINk (the forerunner to Southport and Formby HealthWatch, 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

Together with Sefton Council, we held nearly 50 public and partner events during 2012 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 Southport and Formby

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 SSCCG 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.

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Appendix 4 – Formal Leads

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 Boner
Communication	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	Karen Leverett	Jackie Robinson / Tracy Jeffes
Prevention and Public Health	To be confirmed	Margaret Jones
Primary Care Quality	*Bal Duper*	Angela Parkinson / Debbie Fagan
Unplanned Care / 111 Care	Dr Graeme Allen	Jane Uglow
Governance	Helen Nichols	Tracy Jeffes

**Italics* – not a Board member

Appendix 5 – NHS Outcomes Framework Measures

Annex A

NHS Outcomes Framework measures which the NHS Commissioning Board and Clinical Commissioning Groups will use to track progress (ie data can be generated at Clinical Commissioning Group level and a baseline can be determined against which progress can be considered).

1. Preventing people from dying prematurely

1.1 Potential years of life lost (PYLL) from causes considered amendable to healthcare

1.2 Under 75 mortality rate from cardiovascular disease

1.3 Under 75 mortality rate from respiratory disease

1.4 Under 75 mortality rate from liver disease

1.5 Under 75 mortality rate from cancer

2. Enhancing quality of life for people with long term conditions

2.1 Health-related quality of life for people with long-term conditions

2.2 Proportion of people feeling supported to manage their condition

2.3 Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)1

2.4 Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s1

2.5 Estimated diagnosis rate for people with dementia

3. Helping people to recover from episodes of ill health or following injury

3.1 Emergency admissions for acute conditions that should not usually require hospital admission1

3.2 Emergency readmissions within 30 days of discharge from hospital

3.3 Total health gain assessed by patients i) Hip replacement ii) Knee replacement iii) Groin hernia iv) Varicose veins

3.4 Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)1

4. Ensuring that people have a positive experience of care

4.1 Patient experience of primary care i) GP Services ii) GP Out of Hours services

4.2 Patient experience of hospital care

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4.3 Friends and family test

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

5.1 Incidence of healthcare associated infection (HCAI)
i) MRSA ii) *C.difficile*

1Will be used as part of a composite measure on emergency admissions

Annex B
Expected rights and pledges from the NHS Constitution 2013/14 (subject to current consultation) including the thresholds the NHS Commissioning Board will take when assessing organisational delivery.

6. Referral To Treatment waiting times for non-urgent consultant-led treatment

6.1 Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%

6.2 Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%

6.3 Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%

7. Diagnostic test waiting times

7.1 Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%

8. A&E waits

8.1 Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%

9. Cancer waits – 2 week wait

9.1 Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%

9.2 Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%

10. Cancer waits – 31 days

10.1 Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%

10.2 Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%

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10.3 Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%

10.4 Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%

11. Cancer waits – 62 days

11.1 Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%

11.2 Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%

11.3 Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set

12. Category A ambulance calls

12.1 Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately)

12.2 Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%

13. Mixed Sex Accommodation Breaches

13.1 Minimise breaches

14. Cancelled Operations

14.1 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 patient's treatment to be funded at the time and hospital of the patient's choice.

15. Mental health

15.1 Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on C

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NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2013

Agenda Item: 13/66	**Author of the Paper:** Jan Leonard / Tracy Jeffes / Lyn Cooke Head of CCG Development / Head of Delivery Jan.leonard@southportandformbyccg.nhs.uk Tracy.jeffes@southseftonccg.nhs.uk
Report date: 17 May 2013	

Title: Draft CCG Prospectus

Summary/Key Issues:

CCGs have a responsibility to publish a prospectus by 31 May 2013. The purpose of the prospectus is to market the organisation to a large audience, engage with partners and justify what we are spending public money on. The prospectus is in draft form pending approval from the Governing Body.

Recommendation

The Governing Body is asked to approve the Prospectus.

	x
Note	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
	To maintain systems to ensure quality and safety of patient care.
	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
X	To sustain engagement of CCG members and public partners and stakeholders.
	To drive clinical leadership development through Governing Body, locality and wider constituent development.

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

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

<logo>

NHS Southport and Formby Clinical Commissioning Group

A guide to who we are and what we do

We are a new kind of NHS, led by local doctors, nurses and other healthcare professionals. On 1 April 2013 we took over the majority of planning and buying or 'commissioning' of local health services. This guide tells you more about what this means for you, what we plan to do in our first year of full operation and how you can get involved. You will also find some useful contacts, if you want to know more about our work or if you have questions or comments about your local health services.

Why we are different

Because we see hundreds of Southport and Formby residents in our surgeries and clinics every day, we know what the main health problems are that affect the area. As medical professionals, we also have a better understanding of which treatments work best and how we can help people to stay as well as possible, for as long as possible.

Our patients are best placed to tell us what local health services are really like - how they can be improved, when they work well and what is needed in the future. Over the past year we have been collecting the views and comments of Southport and Formby residents, and these are already helping us to shape our plans. You can read about this on px.

We know we can achieve more by working together with our partners like Sefton Council, patient groups and other NHS organisations. We now have the chance to work even closer with these organisations than ever before as you will read about on px.

We are a membership organisation, bringing together all doctors' practices in Southport and Formby. Our members are actively involved in making health services better for you and you will read more about their work later in this guide.

Meet our Board

Our board members make decisions on behalf of our x member practices across Southport and Formby. They have been elected by practices to represent their views. You may even recognise some of the faces below from your doctor's practice.

- Dr Niall Leonard – Chair and GP
- Dr Rob Caudwell – Clinical Vice Chair and GP
- Helen Nichols – Vice Chair and Lay Member
- Fiona Clark – Chief Officer
- Martin McDowell – Chief Finance Officer and Deputy Chief Officer
- Dr Graeme Allan – GP
- Dr Hilal Mulla – GP
- Dr Martin Evans – GP
- Dr Liam Grant – GP
- Dr Rob Caudwell – GP
- Roy Boardman – Practice Manager
- Karen Leverett – Practice Manager
- Debbie Fagan – Board Nurse
- Dr Jeff Simmonds – Secondary Care Doctor
- Roger Pontefract – Lay Member

Our Board meets in public every two months and you can see a list of dates, times and papers by visiting www.southportandformbyccg.nhs.uk or by calling 0151 247 7000.

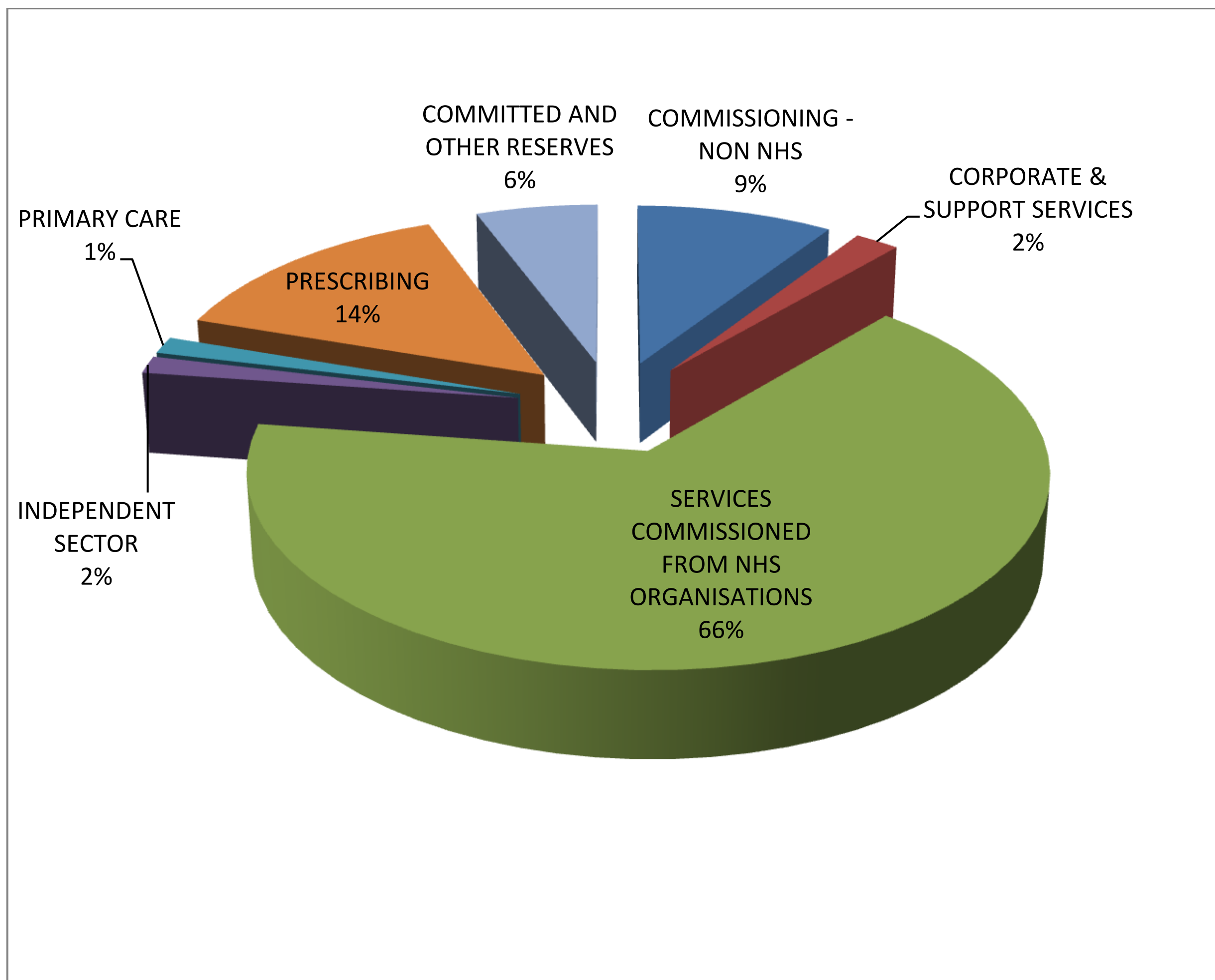
What we do

We are responsible for commissioning the following services and making sure they are safe and the highest possible quality.

- Most hospital services – including Accident and Emergency (A&E) care, maternity and mental health services, routine surgery and outpatient clinics
- Community healthcare – including blood testing, heart, diabetes and asthma clinics, rehabilitation, speech and language, podiatry, dermatology and district nursing
- Out of hours GPs – this service means you can still see a doctor outside normal practice opening hours if you need to. Simply call your practice phone number and follow the instructions

What we spend on your health services

We have a budget of over £160 million for 2013-2014 and we plan to spend it in the following ways….



Our plans for 2013-2014

We spent last year looking at our plans to improve health services and speaking to local people and our partners to make sure they were right.

So, as well as providing a full range of hospital and community services we will also focus on the following during our first year:

Childhood mental health

- Improve the School Nurse Service, so it focuses on children's mental wellbeing as well as their physical health
- Ensure vulnerable children moving into the care of adult services are better supported
- Enable good and timely access to the Child and Adolescent Mental Health Service

Adult mental health

- Review mental health services, particularly psychological therapies (including psychological support for people with cancer)
- Better detecting dementia in our patients

Long term conditions

- Improve the identification of long term conditions like asthma, and support people to better manage their condition at home
- Ensure good access to services for people with diabetes
- Explore how care for the breathing illness, Chronic Obstructive Pulmonary Disorder (COPD), across hospitals and primary care can work better together to reduce the need for people being admitted to hospital
- Re-design heart or 'cardiology' services based on the results of a recent review
- Reduce the number of children with asthma admitted to hospital, which is currently higher than the national average

Obesity

- Better identify obese children in schools and in primary care, and provide support for their parents, families or carers
- Review bariatric surgery to make it more effective, and use any savings from this to fund more school obesity programmes

End of Life

- Support more people to die in the place of their choice

Sexual health

- Re-commission services to ensure they are the most effective and efficient for Southport and Formby residents

Prevention

- Develop our programme that identifies and supports people an alcohol dependency

- Better identify people at risk of developing diabetes
- Review breastfeeding services to find out how we can encourage more women to breastfeed
- Focus stop smoking support on women, young people and remind parents of the dangers of passive smoke
- Explore the potential of a ‘pre-falls’ programme or service for older people
- Design meaningful support programmes for carers based on a review of their health and wellbeing needs
- Review services provided by community, voluntary and faith organisations which target at risk and vulnerable people
- Review dental health services for children

You can find out more about our work programme for 2013-2014 on our website www.southportandformbyccg.nhs.uk

Working in your neighbourhood

We know that different parts of Southport and Formby often have differing health needs, so our four locality groups bring together doctors, nurses and staff from practices to design healthcare which tackles these differences. Below are some examples of the work being done by localities in 2013-2014.

<Map – linking to each locality photo>

Ainsdale and Birkdale <photo – Dr Rob Russell>

Central <photo – Dr Ob Obuchowicz >

Formby <photo – Dr Doug Callow>

North <photo – Dr Kati Scholtz>

- Developing a weight loss and management service for those at risk of diabetes
- Exploring ways to increase the number of appointments and the times they are offered in practices, to make it easier for people to get the care they need
- Reviewing musculoskeletal services to see how they can be improved
- Expanding Choose and Book to offer patients more choice about where they are treated
- Improving data systems so patients on existing disease registers are regularly reviewed, so they always receive the right care and support for their illness
- Making more treatment rooms available in practices, to help reduce the number of people going to A&E when they do not need to
- Improving data systems so patients on existing disease registers are regularly reviewed, so they always receive the right care and support for their illness
- Making more treatment rooms available in practices, to help reduce the number of people going to A&E when they do not need to

Who else is responsible for my healthcare?

These are some of the organisations we work closely with, and nearly all of them are new. They are all responsible for looking after different bits of your healthcare, although we often come together to make sure services and programmes are the best they can be.

Sefton Council

The council hosts the Health and Wellbeing Board (HWBB). This new committee brings together everyone with a responsibility for health and social care in Sefton. Whenever we can, we will join forces to make improvements. By working together we will be able to do and achieve more.

Sefton Council is now also responsible for promoting and protecting good health. It has taken on much of the Public Health work previously carried out by your local NHS, like commissioning Healthy Sefton - the telephone and internet support service that puts people in touch with free programmes to help them live healthier by stopping smoking, being more active, drinking and eating sensibly, or offering health checks to those most at risk of preventable conditions such as heart disease and diabetes. To do this, the council works in partnership with us, NHS England and another new national body – NHS Public Health England – which has a lead role in promoting and protecting health.

Other CCGs

Sometimes we commission services and treatments with neighbouring CCGs because it is more effective to so. We share a small management team with NHS South Sefton CCG, which means we can learn and benefit from each other's good work, avoid duplication and reduce costs, so as much of our money as possible is spent on your care.

NHS England

This new body leads the commissioning of primary care services. It oversees standards and holds the contracts for doctor's surgeries, dentists, pharmacists and opticians. NHS England is now the organisation to contact with queries or concerns about any of these, or for help to find your nearest. NHS England also commissions specialist healthcare, screening and immunisation programmes, and prison and armed forces healthcare.

HealthWatch Sefton

The new independent consumer's champion, that gathers and represents the views of people living in the borough. Because it is independent, Healthwatch can challenge those who provide services but it can also work in partnership with the CCG and others to improve frontline health and social care. One of the ways Healthwatch gains feedback is through its network of Community Champions but there are many other ways Healthwatch works on your behalf to ensure health and social care services are safe, effective and right for you.

Need to speak to someone about your health services?

Here's who to contact if you have a question, comment or concern about …

- Your doctor, dentist, pharmacist or optician – NHS England Customer Contact Centre **<add details>**
- Your treatment in hospital or by a community clinic / clinic – most hospitals and community health care providers have their own customer contact team, ask them for details, but because we commission most of these services, you can also call our Patient Advice and Liaison Service if you would prefer 0800 218 2333 pals@sefton.nhs.uk

Here are some other useful contacts

- Healthwatch – to find out more about the independent champion for patients or raise your comments **<add details>**
- Active Sefton – to find the right programme to support you to a healthier lifestyle call 0300 100 100
- Looking Local – our digital TV and intranet information service can be found on Sky px, or Virgin Media by **<add details>**

How you can get involved what we do

There are a number of ways you can get involved in our work and your local NHS:

- Come to our public events – last year we held two 'Big Chat' events and jointly hosted a number of 'Talking Health and Wellbeing in Sefton' sessions with the council, and the views we collected have informed our plans for 2013-2014
- Come to our Board meetings – we hold bi-monthly Board meetings in public, so you can hear us discussing our work and making decisions about local health services
- Sign up for our quarterly newsletter – it includes our latest news, dates of our Board meetings, and it tell you about our public events when they happen
- Join your practice's patient group – ask at reception for details of how you can get involved and have a say in services at your practice

How to contact us

Call us – 0151 247 7000

Email us – communications@sefton.nhs.uk

Visit our website – www.southportandformbyccg.nhs.uk

Write to us - NHS Southport & Formby CCG, 5 Curzon Road, Southport PR8 6PL

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2013

<table>
<tr><td>Agenda Item: 13/67</td><td rowspan="2">Author of the Paper:

Sarah McGrath
Locality Development Manager and Cancer Services lead
sarah.mcgrath@southportandformbyccg.nhs.uk
Tel: 01704 387008</td></tr>
<tr><td>Report date: 20 May 2013</td></tr>
<tr><td colspan="2">Title: Cancer Services Update</td></tr>
<tr><td colspan="2">Summary/Key Issues:

The paper presents the Governing Body with an update on local cancer services issues.</td></tr>
<tr><td colspan="2">Recommendation

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

Note [x]
Approve [ ]
Ratify [ ]</td></tr>
</table>

	Links to Corporate Objectives *(x those that apply)*
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement			x	

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Clinical Engagement	x			
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered		x		Business cases to be developed for several areas
Locality Engagement	x			Via Practice Cancer Profiles
Presented to other Committees		x		

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
May 2013

1. Context

In the region of 750 people are diagnosed with cancer each year in Southport and Formby and around 400 die from cancer. Approximately 2.3% of general practice lists are people who have received a cancer diagnosis at some time, meaning there are about 2,700 people who are living with and beyond cancer in Southport and Formby and this figure is predicted to grow by 3% year on year.

As a nation, our one year cancer survival falls short of European figures and late detection is considered to be the major explanation for this. The NHS Outcomes Framework indicators will measure 1 and 5 year survival for all cancers and for breast, lung and colorectal cancers specifically as well as premature mortality rates from cancer.

2. Southport and Formby CCG Cancer Strategy

Southport and Formby CCG are currently developing a CCG Cancer Strategy to cover the next five year period mirroring the local Health and Wellbeing Strategy.

The Strategy focuses on commissioning services which will detect cancers earlier, ensure timely access to optimum treatments and enhance survivorship following a cancer diagnosis. It is intended that the Strategy will be ready for presentation to the Board in the next quarter.

3. Cancer Waits Performance

3.1. **Cancer Waits targets for 14 day and 62 days.** Patient initiated cancellations and DNAs are a particular issue for Southport and Ormskirk Hospital affecting capacity to achieve the 14 day target. Both Sefton CCGs have produced leaflets to be given at referral, reinforcing the importance of attending appointments. The Intensive Support Team have worked with the Trust and are encouraging straight to test pathways and an ambition to see all target patients within 7 days thereby giving an extra week to meet treatment targets for the minority of patients (~13%) who do have a positive cancer diagnosis.

3.2. **3.2 Manchester Model.** Two and three trust pathways are very common in cancer due to the configuration of specialist surgical centres for several tumours and chemotherapy and radiotherapy being provided by the Clatterbridge Cancer Centre. The model aims to simplify and standardise allocation of breaches across trusts against the 62 day waiting times standard from referral to treatment.

4. National Awareness and Early Detection (NAEDI) Project

4.1. Cancer Research UK fund a project manager to work with general practices on encouraging earlier cancer detection. Examples of action plans include reflective practice by primary care staff on the pathway leading up to a cancer diagnosis and personalised letters to patients who do not take part in cancer screening programmes.

4.2. All practices now have access to their cancer profiles through the National Cancer Intelligence Network. These enable clinicians to benchmark practice referral rates for suspected cancers, yield rates and cancers detected through non-optimum pathways. In addition, we are working with local trusts to provide cancer staging data at a practice level.

5. Strategic Clinical Networks

The Merseyside and Cheshire Cancer Network has now become part of the Merseyside and Cheshire Strategic Clinical Networks resulting in a reduction in staffing dedicated to cancer. There are implications for management support to the tumour specific Clinical Network Groups (CNGs) which have a pivotal role in shaping and standardising clinical practice across its member Trusts. The level of input to cancer peer review internal validation processes in also likely to be reduced and increased commitment from commissioners may be sought to ensure balanced membership of peer review panels.

6. Service Developments

Initial discussions have taken place with Southport and Ormskirk Hospital regarding the following potential service changes.

6.1. Direct access to flexible sigmoidoscopy to facilitate better use of suspected cancer pathways in lower gastro-intestinal patients.

6.2. Development of breast surgical services to encompass local reconstruction and treatment of screen- detected breast cancers.

7. Survivorship

The National Cancer Survivorship Initiative published a document *Living With and Beyond Cancer: Taking Action to Improve Outcomes in* March 2013. The document focuses on five areas:

- Information and support
- Promoting recovery
- Sustaining recovery
- Managing the consequences of treatment
- Supporting people with active and advanced disease.

Locally our priorities are likely to be promoting self- management and physical activity, getting the best out of the cancer care review in primary care and addressing gaps in psychological support at all stages of the pathway.

8. Southport Macmillan Cancer Information and Support Service

Accommodation has recently been upgraded to provide increased space for browsing, a separate office and a private consultation room. The service produced its first annual report in January 2013. In the first year, more than one thousand contacts have been made by people affected by cancer, the majority at medium to high intervention levels. The team has been extended by a growing number of trained volunteers. The Centre offers a range of patient education and self-help programmes which have received excellent feedback. Aims for year two include further awareness raising of the Centre's role with public and professionals, an extended range of physical activity programmes and in-reach into the hospital's oncology clinics. St Mark's Medical Centre is piloting use of a personalised letter for newly diagnosed cancer patients promoting the benefits of the Centre.

9. Protected Learning Time Event

A cancer – themed protected learning time event is planned for September which will include items on CCG Cancer Strategy, using practice level cancer profiles including staging data, sharing good practice around quick diagnosis and models of support post treatment.

10. HPV Testing as Primary Triage

CCG cancer leads have successfully influenced the selection of Sefton as a national pilot study group in providing HPV testing as primary triage (TaPS) for cervical screening. The approach has been shown to improve the specificity and selectivity of cervical screening, leading to increased prevention of invasive cervical cancer and in the medium to long term should reduce the frequency of cervical screening required and demand for colposcopy.

Recommendations

The Governing Body is asked to note the contents of this update report and approve the direction of travel.

Sarah McGrath
Locality Development Manager- North Southport and Cancer Services Lead
14.05.13

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2013

Agenda Item: 13/68	**Author of the Paper:** Melanie Wright Business Manager melanie.wright@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: 14 May 2013	

Title: Managing Conflicts of Interest

Summary/Key Issues:

Managing conflicts of interest appropriately is essential for ensuring sound decision-making and that the CCG can demonstrate the highest levels of integrity in the way that it conducts business. The Governing Body is now presented with the CCG's Policy on Managing Conflicts of Interest.

Please note that the Register of Interests which is published in the May Board papers includes Governing Body members only. A full register to include all CCG members and employees is in development and will be brought to the next public Governing Body meeting.

Recommendation

The Governing Body is asked to approve the CCG Policy on Managing Conflicts of Interests.

Note	
Approve	x
Ratify	

	Links to Corporate Objectives *(x those that apply)*
	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Southport and Formby
Clinical Commissioning Group

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement			x	
Clinical Engagement	x			
Equality Impact Assessment			x	
Legal Advice Sought	x			Expert advice sought from CSU
Resource Implications Considered			x	
Locality Engagement	x			Locality engagement will be required as to roll out the policy at locality level
Presented to other Committees		x		

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to Board
May 2013

1. Introduction and Background

On 28 March 2013, NHS England published the document “Managing Conflicts of Interests: Guidance for Clinical Commissioning Groups” (http://www.england.nhs.uk/wp-content/uploads/2013/04/ccg-conflict-int-guide.pdf)

The Governing Body received a presentation on the new guidance and considered a range of scenarios based on managing conflicts of interest at the Joint Board Development session held on 18 April 2013.

2. Key Issues

As a commissioner, the CCG needs the highest levels of transparency so it can demonstrate that conflicts of interest (a definition of which can be found at Appendix 1, paragraph 3) are managed in a way that cannot undermine the probity and accountability of the organisation. This will be particularly important when decisions are taken by member practices.

The need for NHS bodies to identify and manage conflicts of interest is not new. Healthcare professionals have always had to manage competing interests, for example when having multiple roles on PCT Boards, professional executive committees and practice based commissioning groups, as well as separating their own provider and commissioning functions

It will not be possible to avoid conflicts of interest. They are inevitable in many aspects of public life, including the NHS. However, by recognising where and how they arise and dealing with them appropriately, the CCG can ensure proper governance, robust decision-making and appropriate decisions about the use of public money.

The Health and Social Care Act sets out clear requirements of CCGs to make arrangements for managing conflicts of interest and potential conflicts of interest, to ensure they do not affect or appear to affect the integrity of the CCG’s decision making processes.

3. Conclusions

Managing conflicts of interest appropriately is essential for protecting the integrity of the CCG from any perceptions of wrongdoing.

With this in mind, the Governing Body is now presented with the CCG’s Policy on Managing Conflicts of Interest.

4. Recommendations

The Governing Body is asked to (a) approve the Policy on Managing Conflicts of Interest and (b) formally endorse and adopt the Seven Principles of Public Life (Nolan Principles) as highlighted in Appendix 1.

Appendices

Appendix 1 Managing Conflicts of Interest Policy

Melanie Wright
Business Manager
14 May 2013

NHS
Southport and Formby
Clinical Commissioning Group

Policy on Managing Conflicts of Interest

Version 1
Date: 8 May 2013

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NHS
Southport and Formby
Clinical Commissioning Group

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1. Introduction

This policy sets out how NHS Southport & Formby Clinical Commissioning Group (CCG) will manage conflicts of interest and potential conflicts of interest.

2. Conflicts/Potential Conflicts covered by this Policy

2.1. The NHS Model Standing Orders, Reservation and Delegation Of Powers and Standing Financial Instructions, page 23 Department of Health (2006) defines relevant and material interests as:-

- Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
- Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;
- A position of authority in a charity or voluntary organisation in the field of health and social care;
- Any connection with a voluntary or other organisation contracting for NHS services;
- Research funding/grants that may be received by an individual or their department;
- Interests in pooled funds that are under separate management.
- Clause 7.15 of the Model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions states that such directorships should be included in the Trust's annual report.
- Interests *"...must not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less."*

2.2. The Royal College of General Practitioners in its Guidance on Ethical Commissioning (October 2011) stated that-:

"A conflict of interest can occur when an individual's ability to exercise judgement in one role is impaired by their obligation in another because of the existence of competing interest(s). For members of a CCG, a conflict of interest would exist when their duties as a commissioner could be, or could be perceived to be, influenced or impaired by their other concerns and obligations. It could arise because they are an owner, director or shareholder in an organisation doing business with the NHS, or because they are a professional or

member of a special interest group, or because of their relationship to a close family member.

Such concerns may be financial but could also relate to personal commitments (qualifications to friends, colleagues, peers), special interests (for example, in a particular treatment or condition due to an individual's own experience or that of a family member), other non-financial objectives (status or kudos), or professional loyalties or duties. There is nothing inherently wrong in having conflicts of interest and seeking to avoid or eliminate them entirely is unlikely to be possible or desirable for the CCG. But if they are not managed effectively, and GPs and their colleagues are seen or perceived to be misusing their new commissioning powers, the consequences will be serious. It could undermine providers and regulators' confidence in the probity and fairness of commissioning decisions, damage patients' confidence in the independence of healthcare professionals and ultimately destabilise public confidence in the system as a whole."

2.3. Code of Conduct: Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services (NHS Commissioning Board July 2012)

- This "Code of Conduct" sets out additional safeguards that CCGs are advised to use when commissioning services for which GP practices could be potential providers of services or where it is appropriate to commission community-based services through competitive tender or an Any Qualified Provider (AQP) approach and where through single tender. In general, commissioning through competitive tender or AQP will introduce greater transparency and help reduce the scope for conflicts.

- There may, however, be circumstances where CCGs could reasonably commission services from GP practices on a single tender basis, i.e. where they are the only capable providers or where the service is of minimal value.

- This Code sets out the following arrangements to preserving integrity of decision making process when all or most GPs have an interest in a decision:-

  - where certain members of a decision-making body (be it the Governing Body, its committees or sub-committees, or a committee or sub-committee of the CCG) have a material interest, they should either be excluded from relevant parts of meetings, or join in the discussion but not participate in the decision-making itself (ie not have a vote). In many cases, for example, where a limited number of GPs have an interest, it should be straightforward for relevant individuals to be excluded from decision-making;

  - Where all of the GPs or other practice representatives on a decision making body could have a material interest in a decision, particularly where the CCG is proposing to commission services on a single tender basis from all GP practices in the area, or where it is likely that all or most practices would wish to be qualified providers for a service under AQP the CCG will:-

    - refer the decision to the Governing Body and exclude all GPs or other practice representatives with an interest from the decision-making process (ie so that the decision is made only by the non-GP members of the Governing Body including the lay members and the registered nurse and secondary care doctor);

    - consider co-opting individuals from a Health and Wellbeing Board or from another CCG onto the Governing Body – or inviting the Health and Wellbeing Board or another CCG to review the proposal – to provide additional scrutiny, although such

individuals would only have authority to participate in decision-making if provided for in the CCG's constitution; and

- ensure that rules on forming a quorum (set out in the CCG's constitution) enable decisions to be made.

2.4. Depending on the nature of the conflict, GPs or other practice representatives could be permitted to join in the Governing Body's discussion about the proposed decision, but should not take part in any vote on the decision.

2.5. The Procurement Guide for Commissioners of NHS Funded Services Issued by the Department of Health (DH) in July 2010 contains the following paragraphs in respect of conflicts of interest:-

- *a conflict of interest is an issue that commonly arises during procurement activity and can occur when a commissioner is developing a service specification, when a commissioner is engaging incumbent or potential providers in preparing them to provide solutions to deliver that service, or during the procurement process itself. When conflicts of interest arise, it is the responsibility of the commissioner to manage them appropriately to ensure a robust and transparent procurement;*

- *in some circumstances, a bidder's involvement in previous or parallel projects, its participation in multiple bids, or its participation in the commissioner's activities (eg as a provider of commissioning or consultancy services) may give rise to a possible conflict of interest in bidding for certain contracts. Ideally, this should have been identified at the pre-procurement stage. The use of contractual mechanisms or ethical walls may be sufficient to mitigate such conflict of interest;*

- *in other cases, it may be appropriate to exclude the bidder and associated parties from the tender process to ensure equality of treatment between bidders if it is concerned about conflicts of interest. The bid documentation should clearly state the commissioner's policy on managing conflict issues, which should be applied consistently;*

- *a commissioner needs to strike an appropriate balance between working with providers to ensure innovative and deliverable service specifications, and working too closely to provide an unfair advantage. Therefore, transparency and equality of treatment are paramount.*

2.6. The Principles and Rules for Cooperation and Competition issued by the DH also in July 2010 states:

"The principles and rules are intended to apply to all commissioners and providers of NHS services irrespective of whether they are public, private or third sector organisations. The principles governing commissioning apply to PCTs, to specialist commissioners and to practice-based commissioning consortia, shadow GP commissioning consortia (now CCGs) or any other bodies with express delegated responsibility to commission or subcontract on behalf of the PCT.".

3. Definition of a Conflict of Interest

3.1. A conflict of interest occurs where an individual's ability to exercise judgement or act in one role is or could be impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise. A potential for competing interests and/or a perception of impaired judgement or undue influence can also be a conflict of interest.

3.2. Conflicts can arise from an indirect financial interest (eg, payment to a spouse) or a non-financial interest (eg, kudos or reputation). Conflicts of loyalty may arise (eg, in respect of an organisation of which the individual is a member or has an affiliation). Conflicts can also arise from personal or professional relationships with others (eg, where the role or interest of a family member, friend or acquaintance may influence an individual's judgement or actions or could be perceived to do so). These are all conflicts of interest.

3.3. For a GP or any other individual involved in commissioning, a conflict of interest may, therefore, arise when their own judgment as an NHS commissioner could be, or be perceived to be, influenced and impaired by their own concerns and obligations as a healthcare or related provider, as a member of a particular peer, professional or special interest group, or as a friend or family member.

"It is crucial that an interest and involvement in the local healthcare system does not also involve a vested interest in terms of financial or professional bias toward or against particular solutions or decisions. The fact that in their provider and gatekeeper roles GPs and their colleagues could potentially profit personally (financially or otherwise) from the decisions of a commissioning group of which they are also members, means that questions about their role in the governance of NHS commissioning bodies are legitimate. Failure to acknowledge, identify and address them could result in poor decision making, legal challenge and reputational damage."[1]

3.4. In summary, conflicts of interest can arise from a perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring. If in doubt, it is better to assume a conflict of interest and manage it appropriately rather than ignore it. For a conflict to exist, financial gain is not necessary.

4. Scope

4.1. This policy applies to all employees, appointed and elected individuals who are working for NHS South Sefton CCG, members of the CCG's Governing Body and committees of the Governing Body or any other committees or task groups, or individuals with a lead role within a particular clinical speciality (ie, diabetes), together with the wider membership of the CCG, given the CCG's status as a membership organisation.

4.2. The policy should be read in conjunction with the following documents, which also set out generic guidelines and responsibilities for NHS organisations and general practitioners (GPs) in relation to conflicts of interests:-

- the CCG's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions

[1] *RCGP and NHS Confederation's briefing paper on managing conflicts of interest September 2011*

- Managing Conflicts of Interests: Guidance for Clinical Commissioning Groups[2]
- Code of conduct for NHS Managers 2002[3]
- Appointments Commission: Code of Conduct and Code of Accountability[4]
- The Healthy NHS Board: Principles for Good Governance[5]
- General Medical Council: Good Medical Practice 2006[6]
- Towards Establishment: Creating Responsive and Accountable CCGs. (Technical Appendix 4)[7]
- Bribery Act 2010[8]
- The Nolan Principles (Appendix 1)
- The CCG's Constitution.

5. Aim

5.1. The aim of this policy is to support a culture of openness and transparency in business transactions. It is also to protect both the organisation and the individuals involved from any appearance of impropriety. All members and employees, appointed and elected individuals of the CCG referred to in section 4.1 of this policy are required to:-

- ensure that the interests of patients remain paramount at all times;
- be impartial and honest in the conduct of their official business;
- use public funds entrusted to them to the best advantage of the service, always ensuring value for money;
- ensure that they do not abuse their official position or confidential information acquired in the pursuit of their role for personal gain or to the benefit of their family or friends;
- ensure that they do not seek to advantage or further, private or other interests, in the course of their official duties.

5.2. The Governing Body of NHS South Sefton CCG has ultimate responsibility for all actions carried out by members, staff and committees throughout the CCG's activities. This responsibility includes the stewardship of significant public resources and the commissioning of healthcare services to the local community. The Governing Body is therefore determined to ensure the organisation inspires confidence and trust amongst its patients, staff, partners, funders and suppliers by demonstrating integrity and avoiding any potential or real situations of undue bias or influence in the decision-making of the CCG by holding in high regard the requirements set out above.

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[2] NHS Commissioning Board, March 2013
[3] Code of Conduct for NHS Managers, Department of Health, Oct 2002
[4] Code of Conduct in the NHS, page 2, Department of Health/Appointments Commission 2004
[5] The Healthy NHS Board: Principles for Good Governance, page 31, NHS/National Leadership Council 2010
[6] General Medical Council: Good Medical Practice 2006 Sec 73, 74, 75, 76
[7] NHS Commissioning Board 2011
[8] www.legislation.gov.uk/ukpga/2010/23/contents

5.3. This conflict of interest policy respects the seven principles of public life promulgated by the Nolan Committee (Appendix 1). The seven principles are:-

- selflessness
- integrity
- objectivity
- accountability
- openness
- honesty
- leadership.

6. Responsibilities

6.1. The Governing Body has a legal obligation to act in the best interests of NHS South Sefton CCG and in accordance with the CCG's Constitution and terms of establishment created by the NHS Commissioning Board and to avoid situations where there may be a potential conflict of interest. Conflicts of interest may arise where an individual's personal, or a connected persons interests and/or loyalties conflict with those of the CCG. Such conflicts may create problems such as inhibiting free discussion, which could:

- result in decisions or actions that are not in the interests of the CCG and the public it was established to serve;

- risk the impression that the CCG has acted improperly.

6.2. It is for each individual to decide whether to register any interests that may be construed as a conflict and to declare any gifts, hospitality or sponsorship offered and/or received. Gifts of low intrinsic value such as calendars, diaries, flowers or chocolates need not be regarded as subject to this rule. It is the responsibility of all staff employed, appointed or elected by the CCG and those serving in a formal capacity to ensure that they are not placed in a position which creates a potential conflict between their private interests and their CCG duties.

6.3. The CCG needs to be aware of all situations where an individual has interests outside of his/her NHS Contract of Employment or other involvement with the CCG, where that interest has potential to result in a conflict of interest between the individual's private interests and their CCG duties.

6.4. All individuals must therefore declare relevant and material interests to the CCG upon appointment, when a new conflict of interest arises, or upon becoming aware that the CCG has entered into or proposes entering into a contract in which they or any person connected with them has any financial interest, either direct or indirect.

6.5. CCG managers must ensure members of staff are aware of the policy and process to be followed.

6.6. It is the responsibility of all employees, appointees and those elected to familiarise themselves with this policy and comply with the provisions set out in it.

7. When to Declare an Interest

7.1. NHS South Sefton CCG Governing Body members and staff should declare an interest in the following circumstances:-

- direct financial interests: these arise when an individual involved in taking or influencing the decisions of an organisation could receive a direct financial benefit as a result of the decisions being taken. This may arise as a result of holding an office or shares in a private company or business, or a charity or voluntary organisation that may do business with the NHS;

- indirect financial interests - arise when a close relative of a director or other key person benefits from a decision of the organisation. As healthcare providers as well as commissioners, individual healthcare professionals sitting on the governing bodies of CCGs (and their family members or business partners) may have commercial interests in organisations that their commissioning group is already purchasing from or that could potentially bid/offer to provide services that the group might procure and fund;

- gifts, hospitality or sponsorship offered to you by external bodies and whether this was declined or accepted in the last twelve months;

- non-financial or personal interests;

- conflicts of loyalty;

- any other conflicts that are not covered by the above.

7.2. Where individuals are unsure whether a situation falling outside of the above categories may give potential for a conflict of interest they should seek advice from the Head of Corporate Delivery.

8. Declaration of Interests

8.1. Governing Body members and employees (as referred to under section 4.1 above) are required to declare any relevant and material interests (see above) together with any gifts, hospitality or sponsorship offered and/or received in connection with their role in the CCG.

8.2. A Declaration of Interests Form is provided for this purpose (see Appendix 2). To be effective, the Declaration of Interests Form must be completed prior to appointment, then updated at least annually and when any material changes occur. The CCG's Accountable Officer must be informed within 28 days of any changes to registered interests. If an individual is unsure what to declare, or whether/when the declaration needs to be updated, they should err on the side of caution and declare the interest.

8.3. Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the Group, in writing to the Accountable Officer, as soon as they are aware of it and, in any event, no later than 28 days after becoming aware.

8.4. Where an individual is unable to provide a declaration in writing, for example, if it becomes apparent in the course of a meeting, they will make an oral declaration before witnesses and provide a written declaration as soon as possible thereafter.

8.5. Interests, gifts, hospitality and sponsorship will be recorded on the CCG's Register of Interests and Hospitality Register, which will be maintained by the Business Manager on behalf of the Accountable Officer. The register will be accessible by the public by postal application (or for inspection on request) at the CCG Headquarters, 3rd floor, Merton House, Stanley Road, Bootle, Liverpool L20 3DL and at all Local Authority public libraries in Sefton.

An electronic version of the Register of Interests and Hospitality Register can be accessed at http://www.southseftonccg.org.uk/

9. Data Protection

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act 1998. Data will be processed only to ensure that the board members and employees act in the best interests of the CCG and the public and patients the group was established to serve. The information provided will not be used for any other purpose. Signing the declaration form will also signify that you consent to your data being processed for the purposes set out in this policy.

10. Action to take when faced with a Conflict of Interest

10.1. All Governing Body members, wider group members and CGG employees (as referred to in Section 4.1 above) in attendance taking part in discussion are required to declare their interests in relation to any items on the agenda at the start of each meeting. Where certain members have a material interest, they should either be excluded from relevant parts of meetings, or join in the discussion but not participate in the decision-making itself (ie not have a vote). The Chair of the meeting will decide if a member is to be excluded from the relevant part of the meeting. The conflict and the action will be recorded in the minutes of the meeting and the register of interests updated accordingly.

10.2. The Chair of the meeting, supported by the Lay Member with the lead role for overseeing governance, has the responsibility for deciding whether there is a conflict of interest and the course of action to take. All decisions will be recorded in the minutes of the meeting.

10.3. It is the responsibility of the Chair of the meeting to monitor quorum to ensure it is maintained throughout the discussion and decision of the agenda item. Should the withdrawal of the conflicted Governing Body member result in the loss of quorum, the item cannot be concluded at that meeting.

10.4. Once a conflict of interest is declared, the Accountable Officer should be notified, in writing, of any individual arrangements for managing the conflict of interests or potential conflicts of interests, within seven days of declaration. These arrangements should confirm the following:

- when an individual should withdraw from a specified activity, on a temporary or permanent basis;
- monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

11. Decisions taken where a Governing Body Member has an Interest

11.1. In the event of the Governing Body having to decide upon a question in which a member has an interest, all decisions will be made by vote, with a simple majority required. A quorum must be present for the discussion and decision; interested parties will not be counted when deciding whether the meeting meets quorum. Interested members must not vote on matters affecting their own interests. The Vice Chair will take the Chair's role for discussions and decisions involving a conflict of interest for the Chair.

11.2. All decisions under a conflict of interest will be recorded, at the meeting of the Governing Body, by the Chief Finance Officer and reported in the minutes of the meeting. The report will record:

- the nature and extent of the conflict;
- an outline of the discussion;
- the actions taken to manage the conflict;
- use of the waiver and reasons for its implementation.

11.3. Where a Governing Body member benefits from the decision, this will be reported in the annual report and accounts, as a matter of best practice. All payments or benefits in kind to Governing Body members will be reported in the CCG's accounts and annual report, with amounts for each member listed for the year in question. Independent external mediation will be used where conflicts cannot be resolved through the usual procedures.

12. Managing Contracts

If any person has a conflict of interest, they should not normally be involved in procuring, tendering, managing or monitoring a contract in which they have an interest. However, occasions may arise where the contribution of a professional with particular expertise or research knowledge in a field is desirable in support of the commissioning process. In such cases full disclosure should be made. Monitoring arrangements will include provisions for an independent challenge of bills and invoices, and termination of the contract if the relationship is unsatisfactory.

13. Breaches of the Policy

Breaches of the policy may result in the Governing Body or other member being removed from office in line with the CCG's constitution. A member of staff breaching the policy will be reported to the Accountable Officer and invoke the disciplinary procedure.

14. Monitoring Compliance and Effectiveness of the Policy

The policy will be reviewed annually by the CCG's Audit Committee. Staff and decision-makers will be reminded of the policy and register of interests at least annually. The Head of Delivery will review register entries on a monthly basis and take any action necessary as highlighted by the review.

Mandatory training and awareness sessions on this policy will be delivered annually for Governing Body Members, member practices and staff as detailed in the CCG's Organisational Development Plan. In this respect South Sefton CCG does not differentiate between permanent or temporary staff. Details of training programmes and attendance sheets will be retained centrally by South Sefton CCG for audit and compliance monitoring.

Appendices

Appendix 1 The Nolan Principles
Appendix 2 Declaration of Interests Form

Appendix 1

NHS
Southport and Formby
Clinical Commissioning Group

The Seven Principles of Public Life (the Nolan Principles)

Selflessness

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

Holders of public office should promote and support these principles by leadership and example.

Southport and Formby
Clinical Commissioning Group

Declaration of Financial and Other Interests for Members/Employees

Name	
Position or role within NHS South Sefton CCG	Member / Employee/ Governing Body Member / Committee or Sub-Committee Member (including Committees and Sub-Committees of the Governing Body) [*delete as appropriate*]
Date	

This form is required to be completed in accordance with the CCG's Constitution and Section 14O of *The National Health Service Act 2006.*

Before completing this form, please note:

- Each CCG must make arrangements to ensure that the persons mentioned above declare any interest which may lead to a conflict with the interests of the CCG and the public for whom they commission services in relation to a decision to be made by the CCG.
- A declaration must be made of any interest likely to lead to a conflict or potential conflict as soon as the individual becomes aware of it, and within 28 days.
- If any assistance is required in order to complete this form, then the individual should contact Tracy Jeffes (tracy.jeffes@southseftonccg.nhs.uk).
- The completed form should be sent by both email and signed hard copy to Melanie Wright (melanie.wright@southseftonccg.nhs.uk).
- Any changes to interests declared must also be registered within 28 days by completing and submitting a new declaration form.
- The register will be published as part of the CCG's Governing Body meeting papers and will be available on the website.
- Any individual – and in particular members and employees of the CCG - must provide sufficient detail of the interest, and the potential for conflict with the interests of the CCG and the public for whom they commission services, to enable a lay person to understand the implications and why the interest needs to be registered.
- If there is any doubt as to whether or not a conflict of interests could arise, a declaration of the interest must be made.

Interests that must be declared (whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual) include:

- roles and responsibilities
- held within member practices;
- directorships, including non-executive directorships, held in private companies or PLCs;
- ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG;
- shareholdings (more than 5%) of companies in the field of health and social care;
- a position of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care;
- any connection with a voluntary or other organisation contracting for NHS services;
- research funding/grants that may be received by the individual or any organisation in which they have an interest or role;
- any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the CCG.

If there is any doubt as to whether or not an interest is relevant, a declaration of the interest must be made.

In the event of no interests to be declared, the form should be completed below with 'nil return' and signed/dated.

Declaration

Type of Interest	Details	Personal interest or that of a family member, close friend or other acquaintance?
Roles and responsibilities held within member practices		
Directorships, including non-executive directorships, held in private companies or PLCs		
Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG		
Shareholdings (more than 5%) of companies in the field of health and social care		

Type of Interest	Details	Personal interest or that of a family member, close friend or other acquaintance?
Positions of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care		
Any connection with a voluntary or other organisation contracting for NHS services		
Research funding/grants that may be received by the individual or any organisation in which they have an interest or role		
Any other specific interests?		
Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the CCG		

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information provided and to review the accuracy of the information provided regularly and no longer than annually. I give my consent for the information to be used for the purposes described in the CCG's Constitution and published accordingly.

Signature	

Date	

Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2013

Agenda Item: 13/69	**Author of the Paper:** Tracy Jeffes Head of Delivery tracy.jeffes@southseftonccg.nhs.uk
Report date: 14 May 2013	

Title: Board Assurance Framework

Summary/Key Issues:

This paper presents the Governing Body with the Board Assurance Framework (BAF) which contains the strategic risks relating to the achievement of the CCG's corporate objectives, with the key purpose of providing assurance to the Governing Body that the risks have been identified and are being effectively managed.

This report closes down the 2012/13 with a Quarter 4 update and a new BAF will be presented to the Governing Body in July, reflecting on the new corporate objectives.

Recommendation

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

Note	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
x	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

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

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

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 1: Establish an authorised CCG without conditions				Board Reports			
Key Objective 1 Ensure all domains are for authorisation are met and CCG is established without conditions by April 2013							
Principal Risks ***Risk Owner***	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
1.1 Insufficient capacity of clinical leaders to maintain commitment due to pressure on time. ***Risk Owner: Head of Development*** ***Committee: Governing Body***	**3x4**	Regular meetings with clinical leaders to assess and update prioritising time. OD Plan developed	Documented presence of clinical leaders at all relevant meetings Ongoing development sessions with clinicians in place including time management and communication skills Full capacity currently maintained no gaps identified	Significant Reasonable Limited	**(GIC)** Review capacity issues during Q3	Examine options for backfill of clinical sessions	February 2013 Head of CCG Development

Progress Reports			Assurance Rating	
	Q1			**N/A**
	Q2			**N/A**
	Q3			**N/A**
	Q4	New time table for Governing body meetings and development sessions has meant that attendance has been good		**Reasonable**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 1: Establish an authorised CCG without conditions				Board Reports			
Key Objective 1 Ensure all domains are for authorisation are met and CCG is established without conditions by April 2013							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
1.2 That our plan is not considered clear and credible – that all plans do not coherently fit together and link to our vision, based on need. ***Risk Owner: Head of Development*** ***Committee: Governing Body***	3x3	Working Group Strategic Plan Locality Groups Commissioning Intentions based on JSNA Everyone counts plan Health and wellbeing strategy	Feedback from NHS North of England Working group/management team scrutiny and review of plans to ensure consistency Wider group meeting on Strategic Plan in March 2013. Monthly meetings of Locality Groups strategic plan is a standing item on the agenda Partnership meetings with Local Authority and Providers to ensure commissioning intentions are aligned with local Health & Wellbeing Strategy	Significant Reasonable Limited	**(GIA)** Communication of Strategy required **(GIC)** CCG Website needs further development	Hold a number of public meetings with patients/carers/public to engage in sharing CCG vision and strategic plan Further Develop website for CCG commissioning intentions and vision and values	February 2013 Head of Development End of December 2012

Progress Reports			Assurance Rating	
	Q1			**N/A**
	Q2			**N/A**
	Q3			**N/A**
	Q4	'Everyone Counts' plan completed and to go to public consultation. Strategic plan and Health and wellbeing plan continue to be refined. Strategic plan well received at wider group.		**Reasonable**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 1: Establish an authorised CCG without conditions				Board Reports			
Key Objective 1 Ensure all domains are for authorisation are met and CCG is established without conditions by April 2013							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
1.3 Insufficient capacity and capability within CSU to deliver sufficient support in a responsive manner within resource envelope. *Risk Owner: Head of Delivery* *Committee: Finance & Resource Committee*	3x4	Clear SLA agreed Regular discussions regarding support requirements .CCG monitoring group established and cross CCG working at network level	Evidence of support provided as appropriate. Regular performance reporting on activity Identified Lead Officer within CSU - Head of Client Operations to support CCG Board level monitoring and leadership on the monitoring group Reporting to Finance & Resource Committee on 6 monthly basis;	Significant Reasonable Limited	**(GIC)** KPIs require further development **(GIA)** Requirement to develop further workstream delivery from CSU	Meeting to be arranged with CSU lead to discuss further development KPIs Joint development work with leads across CCG and CSU to ensure effectively operationalise workstreams to take place	January 2013 Head of Delivery March 2013 Head of Delivery
Progress Reports	**Q1**					**Assurance Rating**	**N/A**
	Q2						**N/A**
	Q3						**N/A**
	Q4	KPIs now developed. Meetings between CCG leads and CSU leads for key operational areas have now taken place. Joint development session planned for June 2013.					**Reasonable**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 1: Establish an authorised CCG without conditions				Board Reports			
Key Objective 1 Ensure all domains are for authorisation are met and CCG is established without conditions by April 2013							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
1.4 Inability to gain / maintain active involvement of all constituents & stakeholders *Risk Owner: Head of Delivery* *Committee: Finance & Resource Committee*	3x4	Communications & Engagement Strategy Implementation of action plan Communications and Engagement Plan. Strengthening of Locality teams EPEG Group involving all major stakeholders has been established which is a sub- committee of the Quality Committee which co-ordinates public engagement activity	Documented evidence of involvement Community Champions through LINk identified for each locality Lead Locality GP, Practice Nurse & Practice Manager meeting on a monthly basis for each locality Quarterly wider constituent meetings with GP attendance.	Significant Reasonable Held a number of stakeholder events during summer 2012 . Through winter 2 public events run in conjunction with the local authority consulting on the health and wellbeing strategy and commissioning intentions. Southport & Formby website launched in December 2012 Chair of CCG has regular article in local press regarding CCG development and health messages Limited	**(GIA)** Further development of patient reference groups required **(GIA)** Further development of wider stakeholder events required	Identified lead officer to develop further meetings with patients in the local community Board development session on the voluntary sector to develop relationships further	March 2013 Head of Delivery February 2013 Head of Delivery

Progress Reports			Assurance Rating	
	Q1			N/A
	Q2			N/A
	Q3			N/A
	Q4	Ongoing implementation of Communications and Engagement Strategy. EPEG development sessions completed. Board development session held on CVF sector. Programme of public events regarding Health and Wellbeing Strategy and Commissioning Intentions completed.		**Reasonable**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 1: Establish an authorised CCG without conditions				Board Reports			
Key Objective 1 Ensure all domains are for authorisation are met and CCG is established without conditions by April 2013							
Principal Risks ***Risk Owner***	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
1.5 Inability to create sufficient time for team/ individual development ***Risk Owner: Head of Delivery*** ***Committee: Finance & Resource Committee***	**3x3**	OD plans / T&D scheduled to an achievable pace.	Records of development sessions Monthly Governing Body Development sessions Individual governing body's members undertaking development sessions Team coaching for the governing body	Significant Reasonable Individual governing body's members undertaking development sessions Team coaching for the governing body Completion of national governing body development framework Management team timeout sessions in November 2012 Secured funding for locality development work through the national CCG development programme. To be implemented from January to March 2013 Limited			

Progress Reports			Assurance Rating	
Progress Reports	**Q1**		**Assurance Rating**	**N/A**
	Q2			**N/A**
	Q3			**N/A**
	Q4	Board development sessions ongoing. Locality leadership development nearly completed. Management Team time outs delivered.		**Reasonable**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports			
Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes							
Principal Risks ***Risk Owner***	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
2.1 Long Term Conditions Increase in numbers and complexity of LTC in population could lead to increased pressure on services and resources ***Risk Owner: Joint Heads of CCG Development*** ***Committee: Governing body***	**4x4**	Education, AF, COPD, IGR LES's, Health Check. Development of North Mersey pathways Providers need to be aware as this will be a financial risk Local Implementation Team/Steering Group Developed + Education packs for Clinicians Sefton – wide Strategy group actions. Contract management Care Closer to home work Monitoring of CSU Business Information Portals (Q3-Q4)	Board reports Communications through strategy groups Reports to steering group (CCH/SPB) Performance reports	Significant Reasonable Limited Evidence of use of JSNA to inform CCG commissioning intentions	Increasing aging population – not necessarily a gap you can control **(GIC)** Coordinated approach to provision of Public Health intelligence data/advice to understand health needs for local communities		
Progress Reports	**Q1**					**Assurance Rating**	**N/A**
	Q2						**N/A**
	Q3						**N/A**
	Q4	It is unlikely that the risk score for this objective will improve in the near future. There is a great deal of work being done within the local health economy in particular around the management of patients with LTCs in the community. This is led by the care closer to home group and overseen by the local Strategic Partnership Board					**Limited**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports			
Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
2.2 Mental Health Introduction of new CAMHS service specification may not be successfully negotiated into the contract impacting upon ability to deliver improved health outcomes ***Risk Owner: Chief Nurse*** ***Committee: Quality Committee***	**3x3**	Quality Committee Sefton Integrated Commissioning Group Sefton CAMHS and Performance Group Wider Emotional Health and Wellbeing Stakeholder Group	Monthly Quality Committee meetings Performance reports to Quality Committee on progress from Strategic Commissioning Group Joint / Integrated commissioning approach with Sefton Council through the Sefton Integrated Commissioning Group – key work area 6 weekly meetings for Sefton CAMHS and Performance Group reporting into the Childrens Trust, CCG Governing Body and Childrens Services Overview and Scrutiny. Chaired by Sefton MBC Director of Childrens Services Emotional Health & Wellbeing Stakeholder Group inputted into specification and 6 monthly meetings in place	Significant Reasonable Limited	**(GIC)** Specification not agreed **(GIA)** Consultation on new specification required **(GIC)** Performance Framework required	Final draft specification for consultation required. Specification to be consulted upon and inserted into provider contract for 2013/14 Performance Framework in final draft format to be completed and to be included in specification	December 2012 Chief Nurse March 2013 Chief Nurse March 2013 Chief Nurse
Progress Reports	**Q1**					**Assurance Rating**	**N/A**
	Q2						**N/A**
	Q3						**N/A**
	Q4	Service specification not yet agreed. Chief Nurse has asked for it to be an agenda item on the CAMHS Partnership Board, the date of which has yet to be set. Once finalised, it will be negotiated in year into the contract. Chief Nurse discussed update with Director of Children's Service: remains a priority area within the workplan for the Integrated Commissioning Group (sign-off next meeting on 3 June 2013).					**Limited**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports			
Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
2.3 Dementia Lack of agreement for the Dementia Liaison Service pathway will prevent full implementation ***Risk Owner: Chief Nurse*** ***Committee: Quality Committee***	3x3	Provider Contract Quality Committee Merseyside QIPP Group	Monthly Contract meetings with Provider Monthly communication meeting with Provider and commissioners Monthly reports on progress to Quality Committee Bi-monthly meeting to discuss progress	Significant Reasonable Limited			Kevin Thorne

Progress Reports			Assurance Rating	
	Q1			N/A
	Q2			N/A
	Q3			N/A
	Q4	Discussions with Merseycare NHS Trust indicate that they have implemented part of the Contract Variation. The liaison service for Accident & Emergency Departments is in place and early evidence indicates a positive impact for people attending hospital with dementia. Further discussion and clarity is needed to identify a work plan with Sefton MBC and Merseycare NHS Trust to fully implement the Care Home Liaison Service.		Reasonable

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports			
Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
2.4 Children's Services Ensuring on-going joint commissioning with SMBC whilst developing CSU is robust and continues to commission for quality and within available resource during transition ***Risk Owner: Chief Nurse*** ***Committee: Quality Committee***	**3x3**	SLA with CSU Sefton Commissioning Panel Quality Committee Finance Committee	Meetings with CSU to begin January 2013. SLA monitoring Sefton Commissioning Panel decisions to report to Quality Committee & Finance and Resource Committee Monthly Quality Committee meetings and exception reporting on Performance of CSU team via contract monitoring. Intelligence on providers of individual packages of care via CSU staff and complaints process. Review of budget and management arrangements via integrated working with LA and SLA with CSU Joint Commissioning Team to inform and highlight any issues that may impact upon the transition regarding commissioning of individual packages of care to CSU locality team.	Significant Reasonable Limited	**(GIA)** Insufficient capacity in CSU service for Childrens Commissioning of individual packages of care **(GIC)** Operating Model for Childrens Commissioning of individual packages of care required	CSU leading on recruitment to posts created to increase capacity and capability within the service; CSU to develop Operating Model for Childrens Commissioning of Individual Packages of care to ensure integration with the local authority	January 2013 Chief Nurse Yvonne Lockhead February 2013

Progress Reports			Assurance Rating	
	Q1			N/A
	Q2			N/A
	Q3			N/A
	Q4	CSU structure now fully staffed, the last postholder started on 20 May 2013. The team are developing an operating model and will ensure integrated working with the Local Authority remains robust. (Lead: Yvonne Lockhead, CSU.)		**Reasonable**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports			
Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
2.5 Planned Care Increased referrals and not managing inappropriate follow ups effectively could have a negative financial impact ***Risk Owner: Joint Heads of CCG Development*** ***Committee; Governing Body, Finance and resource***	**3x4**	Close monitoring of activity at Practice, Locality and Board level using the Intelligence Portal. Locality meetings	Performance reports Monthly contract meetings with Trusts	Significant Reasonable Limited	Ability of portal to deliver required information	Meetings with CSU business intelligence re portal developments	June 2013

Progress Reports			Assurance Rating	
	Q1			
	Q2			
	Q3			
	Q4	The information provided on the portal has not been as good as it might have been during the transition of the PCT. Numerous discussions with CSU BI have resulted in some improvement. The next step is to achieve more timely data uploads. This year's contract (2013/14) has set targets for New to follow-up ratios.		**Limited**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports			
Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes							
Principal Risks ***Risk Owner***	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
2.6 Urgent Care Increase in avoidable admissions resulting in increased resource utilisation and poor outcomes ***Risk Owner: Joint Head of CCG Development*** ***Committee; Governing body***	**3x4**	Provider contracts in place Winter Plans Urgent Care Plans Care Closer to Home group Condition specific Integrated Care Pathway groups Ambulatory Emergency care pathway group/ virtual ward development	Performance Reports to Governing Body Daily performance updates for urgent care Weekly teleconferences with NCB LAT Monthly meeting of Care Closer to Home group by Strategic Partnership Group	Significant Reasonable Limited			

Progress Reports	Quarter		Assurance Rating	
	Q1			
	Q2			
	Q3			
	Q4	The local acute trust have suggested that the acuity of patients going into their emergency departments has increased and that in the main, admission is appropriate. There remain a number of admissions due to the fact there is no alternative for care in the community. The care closer to home group is working to develop such alternatives such as active case management, virtual ward for ambulatory emergency care conditions and intermediate (step up) beds which can manage care required.		**Reasonable**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports			
Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
2.7 Cancer Targets not met because of failure of providers to provide sufficient capacity in health system. ***Risk Owner: Head of Performance & Health Outcomes*** ***Committee: Name of responsible committee***	**3x4**	Cancers leads Plan in place Provider contracts in place Delivery Plans	Performance Reports to Governing Body Weekly performance updates from acute Trust Weekly teleconferences with NCB LAT Performance monitored.	Significant Reasonable Limited	GIC – refer to Q4 update on Cancer Strategy		

Progress Reports			Assurance Rating	
	Q1			
	Q2			
	Q3			
	Q4	The CCG are currently developing a Cancer Strategy to cover the next five year period mirroring the local Health and Wellbeing Strategy. The Strategy focuses on commissioning services which will detect cancers earlier, ensure timely access to optimum treatments and enhance survivorship following a cancer diagnosis. It is intended that the Strategy will be ready for presentation to the Board in the next quarter.		**Limited**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports			
Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
2.8 Prevention Programmes Insufficient scale of investment will prevent expected maximum impact for local population *Risk Owner: Head of Performance & Health Outcomes* *Committee: Name of responsible committee*	**4x3**	Joint strategy with LA as PH move to LA, based on JSNA	Agreed strategy	Significant Reasonable Limited			

Progress Reports			Assurance Rating	
	Q1			
	Q2			
	Q3			
	Q4	Health and Wellbeing Board formally established and meeting on a regular basis.		Limited

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 3: Ensure that our populations received best possible outcomes				Board Reports			
Key Objective 3 Develop the delivery of performance metrics which support the work of the CCG and track improvement in Health Outcomes							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
3.1 Current system-wide lack of focus on defining and measuring progress towards health outcomes resulting in an inability to adequately track progress against planned improvement *Risk Owner: Head of Performance & Health Outcomes* *Committee: Name of responsible committee*	3x3	Commissioning outcomes mapped to current performance Outcomes will be reported on annual basis Could use key controls such as clinical leads, partnership arrangements and competency/skills of staff	Performance reporting will move towards outcomes framework SMRs produced annually Joint framework being delivered with Local Authority	Significant Reasonable Limited			

Progress Reports			Assurance Rating	
	Q1			
	Q2			
	Q3			
	Q4	NHS England have published CCG outcomes benchmark pack.		Limited

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 3: Ensure that our populations received best possible outcomes				Board Reports			
Key Objective 3 Develop the delivery of performance metrics which support the work of the CCG and track improvement in Health Outcomes							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
3.2 Failure to recognise and manage the impact of key determinants on health on long term nature of health outcomes due to insufficient advice or information *Risk Owner: Head of Performance & Health Outcomes* *Committee: Name of responsible committee*	3x3	Head of Performance & Outcomes in place with lead responsibility	NHS Outcomes framework in development Support by CSU Joint framework being delivered with Local Authority	Significant Reasonable Limited			

Progress Reports			Assurance Rating	
	Q1			
	Q2			
	Q3			
	Q4	NHS England have published CCG outcomes benchmark pack.		Limited

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 3: Ensure that our populations received best possible outcomes				Board Reports			
Key Objective 3 Develop the delivery of performance metrics which support the work of the CCG and track improvement in Health Outcomes							
Principal Risks ***Risk Owner***	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
3.3 Knowledge / skills gap within CCG workforce in relation to setting and tracking health outcomes will prevent the CCG from delivering one of its key functions ***Risk Owner: Head of Performance & Health Outcomes*** ***Committee: Name of responsible committee***	**2x2**	Key action identified within OD plan	Update on progress to Board on OD plan Joint framework being delivered with Local Authority	Significant Reasonable Limited			

Progress Reports			Assurance Rating	
	Q1			
	Q2			
	Q3			
	Q4	NHS England have published CCG outcomes benchmark pack.		**Limited**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 4: Ensure that the services we commission deliver good value for money				Board Reports			
Key Objective 4 Ensure delivery of the CCG Quality, Finance, QIPP and Performance agenda in line with the agreed business plan							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
4.1 Quality Measures to improve productivity adversely affect quality of services in local providers ***Risk Owner: Chief Nurse*** ***Committee: Quality Committee***	**3x3**	CQUINs incentive scheme Quality Committee Provider Contract Governing Body	Monthly performance reports to Quality Committee Clinical reviews of plans to ensure no adverse effect. Governing Body Chief Nurse with lead on Quality to ensure that quality is maintained. Quality reporting standing agenda item for Governing Body Chief Nurse member of Finance Committee. Chief Finance member of the quality committee to ensure risk to quality is minimised. Chief Nurse in attendance at single provider quality meetings with provider since October 2012.	Significant Reasonable Quality Committee met for the first time in November 2012 reviewed Quality & Performance Dashboards. Feedback to Committee from GP Clinical Lead for Quality & CQUIN. Provider performance and data quality issues identified and discussed. Action planning to be pursued via clinical performance and quality group for each provider. Limited	**(GIA)** Attendance at all provider quality meetings	Chief Nurse for CCG to ensure attendance at all quality meetings in accordance with collaborative contracting arrangements	January 2013 Chief Nurse

Progress Reports			Assurance Rating	
	Q1			
	Q2			
	Q3			
	Q4	Achieved.		**Reasonable**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 4: Ensure that the services we commission deliver good value for money				Board Reports			
Key Objective 4 Ensure delivery of the CCG Quality, Finance, QIPP and Performance agenda in line with the agreed business plan							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
4.2 Finance Failure to maintain financial balance due to increased demand and over activity in providers or failure to manage budgets robustly internally. ***Risk Owner: Chief Finance Officer*** ***Committee: Finance & Resource Committee***	4x4	Robust financial planning identifying contingency reserves. Robust contracting with specified levels of activity and associated finances. Finance and Resource Committee and Governing Body reviews financial performance Signed contracts with provider are in place for 2013/14. External and Internal Audit in place to review systems of internal control and make recommendation where appropriate.	Financial Plan signed off by the F and R Committee / Governing body. Monthly Finance performance reports to F&R committee with exceptions reports to the Governing Body. Monthly finance reports for budget holders are produced. Monthly contract monitoring is in place to review and verify performance and activity on provider contracts including CQUIN. Budgets are monitored and corrective actions identified when necessary.	Significant Reasonable Finance report to F&R committee on a monthly basis demonstrating the CCG is on track to deliver the required financial outturn. Limited	Increased risks arising from u uncertainty in the baseline allocations, notably specialised commissioning but also in terms of allocation across the two CCGs.	Governing Body asked to defer all investments until risks mitigated. CFO to review financial position and determine. Refresh baseline exercise using 12/13 financial outturn information to identify gaps in funding for the CCG.	Further report to Governing Body in July 2013

Progress Reports			Assurance Rating
	Q1		
	Q2		
	Q3		
	Q4	See corrective actions above.	Reasonable

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DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 4: Ensure that the services we commission deliver good value for money				Board Reports			
Key Objective 4 Ensure delivery of the CCG Quality, Finance, QIPP and Performance agenda in line with the agreed business plan							
Principal Risks ***Risk Owner***	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
4.3 QIPP Inability to deliver a credible QIPP plan that leads transformational change ***Risk Owner: Chief Finance Officer*** ***Committee: Name of responsible committee***	**3x4**	QIPP plans are in place to deliver the required financial savings. QIPP targets are identified within the financial plan and signed off by the Governing Body. Finance and Resource Committee and Governing Body reviews financial performance including performance against QIPP targets and associated savings	Finance performance reports to F&R committee from QIPP sub group Board reports Last meeting held in May to discuss plans	Significant Reasonable Limited			
Progress Reports	**Q1**					**Assurance Rating**	
	Q2						
	Q3						
	Q4	Monthly Finance report to F&R committee demonstrating the CCG is on track to deliver its QIPP plans as part of delivering the required financial outturn position					**Reasonable**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 4: Ensure that the services we commission deliver good value for money				Board Reports			
Key Objective 4 Ensure delivery of the CCG Quality, Finance, QIPP and Performance agenda in line with the agreed business plan							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
4.4. Performance Lack of Effective performance monitoring systems across CCG and CSU could result in failure to recognise early a system or provider failure clinically or financially ***Risk Owner: Head of Performance & Health Outcomes*** ***Committee: Name of responsible committee***	**3x3**	SLA with CSU. CCG monitoring group established Steering group to develop performance monitoring systems	Performance Reports to Governing Body Weekly performance updates from acute Trust Weekly teleconferences with NCB LAT Performance monitored	Significant Reasonable Limited			

Progress Reports			Assurance Rating	
	Q1			
	Q2			
	Q3			
	Q4	Monthly contract meetings with providers in place.		**Reasonable**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 4: Ensure that the services we commission deliver good value for money				Board Reports			
Key Objective 4 Ensure delivery of the CCG Quality, Finance, QIPP and Performance agenda in line with the agreed business plan							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
4.5. Safeguarding Adults & Children Lack of clarity regarding roles and responsibilities during transition could impact on performance ***Risk Owner: Chief Nurse*** ***Committee: Quality Committee***	**3x3**	SLA with CSU. CCG monitoring group established Steering group to develop performance monitoring systems	Board reporting	Significant Reasonable CCG Safeguarding Policy approved by the Governing Body. Meeting arranged to look at roles and responsibilities between the CCG/CSU/Local Authority scheduled for 30 May 2013 Limited			

Progress Reports	Quarter		Assurance Rating	
Progress Reports	**Q1**		**Assurance Rating**	
	Q2			
	Q3			
	Q4	Meeting held on 8 May 2013 to discuss progress to date and future development of CCG Safeguarding Hosted Service following the publication of Working Together (2013) and Accountability Framework (2013).		**Reasonable**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 5: Consult with patients, clinicians and stakeholders about the care we commission on their behalf				Board Reports			
Key Objective 5 Ensure effective consultation and engagement with patients, clinicians and stakeholders to shape commissioned services							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
5.1 Inability to clearly and succinctly articulate our vision and key plans to all constituent practices and stakeholders could result in reduced/lack of engagement ***Risk Owner: Head of Development*** ***Committee: Governing Body***	**2x3**	Communications and Engagement strategy Strategic Plan Locality Groups Implementation Plan for Communications and Engagement Strategy Wider group engagement	Governing Body report regarding Communications and Engagement Strategy delivery Wider group meeting on Strategic Plan in March 2013. Monthly meetings of Locality Groups Achievement of Milestones and delivery KPIs reported Governing Body Quarterly meetings	Significant Reasonable Limited	**(GIA)** Communication of Strategy required **(GIC)** CCG Website required	Hold a number of public meetings with patients/carers/public to engage in sharing CCG vision and commissioning intentions for local populations Design and launch website containing Communication and Engagement Strategy	February 2013 Head of Development End of December 2012

Progress Reports			
	Q1		**Assurance Rating**
	Q2		
	Q3		
	Q4	Wider group meetings of the last 2 quarters have been extremely well attended suggesting improved engagement and a good understanding of the CCG's responsibilities and role. There remains work to be done around public engagement for strategic planning which is planned for early summer 2013	**Reasonable**

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Goal 5: Consult with patients, clinicians and stakeholders about the care we commission on their behalf				Board Reports			
Key Objective 5 Ensure effective consultation and engagement with patients, clinicians and stakeholders to shape commissioned services							
Principal Risks *Risk Owner*	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
5.2 Insufficient CSU capacity / localised support for communications and engagement could result in an inability to maintain and develop proactive and local internal and external communications *Risk Owner: Head of Delivery* *Committee: Finance & Resource Committee*	3x3	SLA in place with Provider Performance Monitoring Group SMT	Performance Mont Monthly meeting of Performance Monitoring Group Head of Client Operations – CSU to attend weekly SMT meetings to support Specific agreement reached with CSU to ensure continuation of locally based Communications and engagement capability.	Significant Reasonable Limited	(GIC) Monitoring of SLA agreement is required	Review at regular performance monitoring group meeting as an agenda item reporting to Finance and Resource Committee	December 2012 Head of Delivery

Progress Reports			Assurance Rating	
	Q1			
	Q2			
	Q3			
	Q4	Locally based team in place which ensures continuity of delivery.		Reasonable

Principal Risks: are what could prevent key objectives from being achieved. Key risks should be true risks (rather than consequences), and so cannot just be the converse of the objective.

Assurance Rating Section. This shows section seeks to help the Governing Body to 'weight' the assurance provided by Risk Owners. It directs the amount of attention it need to spend in reviewing entries on the Assurance Framework. The categories are 'Limited', 'Reasonable' and 'Significant'. The Governing Body should be expecting to see 'Reasonable' assurance for the entries in the document unless there is a specific reason for this not to happen. For example a new care pathway introduced in quarter 1 might only have been given limited assurance as the implementation plan for the pathway has only just begun. As the year progresses the assurance rating should increase with the embedding of the pathway.

Key Controls: are factors, systems or processes that are in place to mitigate the principal risk(s) and assist in securing delivery of the relevant key objective. Key controls should be robust and specific, and properly match the associated key objective(s). For example; a sub committee or committee of the Board which is tasked with monitoring the specific risk.

Assurance on Controls: are sources of evidence that the key controls are effective. Assurances should be matched with specific key control(s) wherever possible.

Key Positive Assurance: assessment seeks to measure the level of assurance with which it can be determined that the key controls are mitigating the principal risks identified. The assessment also specifies how/where the organisation has evidence showing that principal risks are being managed reasonably. Descriptions should provide sufficient details to identify specific documentary evidence, e.g. dates of meetings, publications, reviews etc. External or Independent assurances are generally given more weight than internal sources.

Gaps in Control: indicates where the organisation has failed to put key controls in place, or has failed to make key controls effective.

Gaps in Assurance: indicates where the organisation is failing to gain evidence that key controls are effective.

Corrective Action: shows what will or is being done to address the gap(s) in control or assurance.

Responsibility / Target Date: shows the Director (or senior manager) responsible for appropriate and timely implementation of corrective action(s) and the expected date by which actions should be completed.

Progress reports provide a quarterly update on achievement of action plans and identify where gaps in control or assurance have been addressed. They should also indicate where the risk grading has changed for any risks associated with that objective.

Generally, Assurance Frameworks should map key objectives to principal risks, key controls and assurances explicitly. Assurance frameworks should be embedded and dynamic, providing regular Board information and not viewed as year-end exercises.

DOMAIN: 4.2.1A - Southport & Formby CCG Assurance Framework – May 2013

Assurance Rating

Limited Rating – Insufficient Assurance Provided
A limited assurance rating will be applied where a risk owner has failed to record any evidence within the 'Key Positive Assurance' column during that quarter or where only minimal evidence is provided, all of which is deemed as providing 'limited assurance'.

Reasonable Rating – Adequate Assurance Provided
A reasonable assurance rating will be applied where a risk owner has recorded in the 'Key Positive Assurance' column at least one piece of evidence deemed 'reasonable' assurance together with a number of pieces of evidence deemed 'limited' assurance.

Significant Rating – Substantial Assurance Provided
A significant risk rating will be applied where a risk owner has recorded in the 'Key Positive Assurance' column a minimum of one piece of evidence deemed as providing 'significant' assurance **or** a number of pieces relating to different aspects of assurance deemed 'reasonable'

Examples of what constitutes differing levels of assurance:

Key Positive assurance (** External/Independent) EXAMPLES OF TYPES OF ASSURANCE
**SHA Audit of data quality indicating no significant concerns, reported to Trust Board January 2010, PCT commissioning committee February 2011. (significant assurance) **CQC indicators met for relevant targets as reported in periodic review, October 2011 (significant assurance) Performance Report received by the Trust Board, most recent September 2009, showing performance within tolerance for overall achievement of target for Q1 (reasonable assurance) Contract monitoring report to commissioning committee in September 2010 showing performance within tolerance for overall achievement of target for Q1 (reasonable assurance) Performance report to Trust Board, most recent September 2010, indicating current position against key targets (limited assurance)

Key Positive assurance EXAMPLE OF NEW LAYOUT
Significant Assurance
2010/11 prospectus published March 2009, included for information in Board papers May 2010 Uptake report on attendance at Health & Safety courses at Health & Safety working group November 2010 shows 60% of staff have attended relevant courses, compared with 40% last year
Reasonable Assurance
Update report to HR committee September 2010 demonstrating 80% of required courses now established
Limited Assurance
Performance report to Trust Board, most recent September 2010, indicating current position against key targets

Risk Grading Matrix

Consequence Likelihood	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

Risk	Score	Colour
Insignificant	1 - 3	
Low	4 - 6	
Moderate	8 - 12	
High	15 - 25	

Significant risk

Significant Risk

A risk which attracts a score of 8 or above on the risk grading matrix constitutes a significant risk and must be recorded on the Directorate Risk Register.

NHS
Southport and Formby
Clinical Commissioning Group

NHS Southport & Formby Clinical Commissioning Group

The Quality Committee

Terms of Reference

1. Principal Functions

The Quality Committee shall be established as a committee of the Governing Body in accordance with the CCG's Scheme of Delegation and will have key responsibilities to:

- Approve arrangements including supporting policies to minimise clinical risk, maximise patient safety and secure continuous improvement in quality and patient outcomes

- Approve the arrangements for handling complaints

- Approve the Group's arrangements for engaging patients and their carers in decisions concerning their healthcare

- Approve arrangements for supporting NHS England in discharging its responsibilities to secure continuous improvement in the quality of general medical services

The approval of arrangements for safeguarding children and adults remains a matter reserved for the Governing Body. However, monitoring of safeguarding arrangements and activity is part of the Quality Committee's principal functions and duties.

In the event of overlap or conflict between the roles or responsibilities of the Audit Committee and the Quality Committee of the CCG, the role of the Audit Committee and any decisions made by the Audit Committee shall have precedence over those of the Quality Committee. The main functions of the Quality Committee are:

- To monitor standards and provide assurance on the quality of commissioned services, by the CCG to ensure that local and national standards are met.

- To promote a culture of continuous improvement and innovation with respect to safely, clinical effectiveness and patient experience.

- to provide an assurance to the Governing Body that there are robust structures, processes and accountabilities in place for identifying and

managing significant risks facing the organisation (i.e. strategic, operational, clinical and organisational)

- To provide corporate focus, strategic direction and momentum for quality, and risk management within the CCG.

2. **Principal Duties**

The principal duties of the Committee are as follows:

Ensure effective management of governance areas (clinical governance, corporate governance, information governance, research governance, financial governance, risk management and health & safety) and corporate performance in relation to all commissioned services:

- to ensure the establishment and maintenance of an effective system of integrated governance, risk management and internal control in line with the Integrated Governance Handbook (DoH February 2006), across the organisation's activities (both clinical and non-clinical), that support the achievement of the organisation's objectives;

- to provide assurance to the Audit Committee, and the Governing Body, that there are robust structures, processes and accountabilities in place for the identification and management of significant risks facing the organisation;

- to ensure the CCG is able to submit risk and control related statements, in particular the Annual Governance Statement and declarations of compliance.

- to ensure that the organisation has policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and to approve such policies;

- to monitor the CCG's Quality Strategy and ensure improvement in standards across all commissioned services that reflect all elements of quality (patient experience, effectiveness and patient safety)

- to receive, scrutinise and monitor progress against reports from external agencies, including the Care Quality Commission, Monitor and Health and Safety Executive;

- receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans

- to have oversight of the process and compliance issues concerning serious incidents requiring investigation (SIRIs); being informed of Never Events and informing the CCG Governing Body of any escalation or sensitive issues in good time.

- to work collaboratively to identify and promote "best practice", the sharing of experience, expertise and success across the CCG and with key stakeholders;

- To monitor the CCG Performance Dashboard and drive year-on-year improvement in performance. The Committee will agree what information, reports, notes or minutes from other committees or Cheshire and Merseyside CSU colleagues that it needs to see on a regular or ad hoc basis and ensure they are scrutinised.

- to establish sub-groups or task and finish groups as and when appropriate to assist the Committee discharge its duties effectively. These groups will be required to report to the Quality Committee by submission of meeting notes and key issues reports as stipulated by the Quality Committee.

- the Quality Committee shall monitor the effectiveness of meeting the above duties by:

  - Reviewing progress against its own programme of business agreed by the Governing Body;
  - Producing an annual report for the CCG Governing Body.

- Support the Governing Body to meet its Public Sector Equality Duty

- Promote research and the use of research across the organisation

- Promote education and training across the organisation

- Support the improvement of primary medical services and primary care quality

- To review and approve plans for Emergency Planning and Business Continuity

- To review and approve arrangements for the proper safekeeping of records.

3. Membership

The following will be members of the Committee:

- Lay Advisor Governing Body Member (Chair)
- GP Governing Body Member
- Nurse Governing Body Member
- Practice Manager Governing Body Member
- Chief Officer
- Chief Finance Officer or nominated deputy
- Chief Nurse
- CCG Clinical Lead for Quality (non- Governing Body member)
- CCG Head of Corporate Performance & Outcomes
- Locality Manager with a lead for Quality
- A clinical lead from each locality (x 4)
- Patient Representative (HealthWatch)

The following leads have an open invitation for each meeting of the Quality Committee

- Designated Professional Safeguarding Children & Adults

All Members are required to nominate a deputy to attend in their absence.

All members are expected to attend a minimum of 50% of meetings held.

Minutes and papers shall also be sent for information to CCG Chair who shall have a standing invitation to attend committee meetings.

4. Chairing

A Lay Advisor Governing Body member nominated by the CCG Governing Body shall chair the committee. The Committee shall select a Vice Chair from its membership

5. Quorum

The quorum shall consist of the Chair of the Quality Committee or Vice Chair, one Member of the Governing Body that is also a member of the CCG Senior Management Team, a Governing Body Clinician and three other members from within the Quality Committee Membership.

6. Frequency of Meetings and Reporting Arrangements

The Committee will meet at least 8 times per year and submit the ratified minutes of its meeting to the next available Audit Committee and CCG Governing Body.

The Committee will submit an annual report to the CCG Governing Body.

7. 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 or at the beginning of each meeting. The Chair shall consider such notices in accordance with NHS Southport and Formby CCG procedure for the management of Conflicts of Interest as set out in the Constitution.

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

8. Secretarial Arrangements

PA to the Chief Officer shall provide secretarial support to the Committee.

The agenda for the meetings will be drawn up with the Chair of the Committee.

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

The minutes of the meeting will be produced in 10 working days.

Version No.	**Approving body**	**Date**	**Review Date**
Version 1	CCG Governing Body	June 2012	June 2013
Version 2	CCG Quality Committee CCG Governing Body		December 2013

NHS
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.
- **Determining banking arrangements**
- **Approving arrangements for exceptional/novel treatments**
- **To receive recommendations from the local Individual patient review (IFR) panel and approve as appropriate.**

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. **These sub groups will be required to provide key update reports as stipulated by the Finance and Resources Committee and submit ratified notes of meetings to the Finance and Resources Committee.**

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.

In the event that there is a Conflict of Interest declared before or during a meeting the procedure for dealing with Conflicts of Interest as set out in the NHS Southport and Formby Constitution shall apply.

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.	2
Review dates	November 2013 March 2014 September 2014 March 2015

NHS
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)
- 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 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 (NHS Protect) 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 Mersey Commissioning Support Unit (MCSU) and from the Local Authority Public Health 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 approve the Group's annual accounts on behalf of the Governing Body
- 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.

The Audit Committee Chair (or Vice Chair) and one other member will be necessary for quorum purposes.

6. 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.

7. 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.

8. 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. The Chair shall consider such notices in accordance with NHS Southport and Formby procedure for the management of Conflicts of Interest as set out in the Constitution.

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

9. Date and Review

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

Version Number: 2

Review dates	November 2013 March 2014 September 2014 March 2015

NHS
Southport and Formby
Clinical Commissioning Group

Hospitality Register
May 2013

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

No hospitality received.

Southport and Formby
Clinical Commissioning Group

Audit Committee
Agenda

Wednesday 6th February, 1.30pm to 3.00pm
Family Life Centre Southport

Attendees
Helen Nichols (Chair), Lay Member (HN)
Roger Pontefract , Lay Member (RP)

In Attendance
Debbie Fagan, Chief Nurse (DF)
Adrian Poll, Audit Manager (Mersey Internal Audit Agency) (AP)
Stuart Baron, Audit Manager, Price Waterhouse Coopers (SB)

For Minutes
Karen Lloyd PA to Chief Finance Officer (KL)

No	Item
13/1.	**Welcome & Introductions and Apologies for absence** The Chair welcomed the Committee members. The following apologies were received: Martin McDowell Chief Finance Officer Roy Boardman, Practice Manager Stuart Davison, Local Counter Fraud Specialist, (Mersey Internal Audit Agency) Peter Chambers, Audit Partner, Price Waterhouse Coopers RP noted that the Terms of Reference required attendance of the Chief Finance Office and Counter Fraud Representative both of whom had sent apologies. **Agreed: The Committee agreed to amend the wording of the Terms of reference to state: "Other officers who will usually be in attendance at the Committee include:"**
13/2.	**Declaration of Interest** DF declared that she has a dual role as Lead Nurse at both Southport and Formby CCG and South Sefton CCG.
13/3.	**Minutes of the meeting of 29th November 2012** The minutes of the meeting of 29th November were agreed as a true and accurate record of the meeting subject to the following amendments: HN commented that the minutes did not comprehensively reflect the amendments required to the Terms of Reference. The Committee agreed that the role of Audit Committee is to review the Annual Accounts and that these accounts will be approved by the Governing Body. **Agreed: The minutes will be amended to reflect the interpretation of the Terms of Reference by the Audit Committee.**

No	Item
13/4.	**Matters arising from the minutes not covered elsewhere on the agenda** The Annual Governance Statement was not presented. **Agreed: The Annual Governance Statement will be presented at the next meeting of the Audit Committee.**
13/5.	**Terms of Reference** The Terms of Reference will be amended subject to the agreed additions and retractions in Item 13/3. **Agreed: The Terms of Reference will be presented to the Governing Body for ratification in March 2013**.
13/6.	**Internal Audit Update** Adrian Poll of MIAA presented this update. The Committee were advised of work undertaken, key issues and progress against the Internal Audit Work Plan for 2012/2013. AP advised the Committee that MIAA will begin with a review of the Committee structures and Terms of Reference. In relation to Continuing Healthcare RP suggested that the term "funded solely by the NHS" could unnecessarily restrict any review of care that included partner providers and that a wider view may be more beneficial. The committee noted that in this case, the review relates to a specific area, however, AP noted these comments and will discuss with MMD the potential to widen the scope of this review. In relation to Payments to GP's RP requested clarification as to why the CCG was involved in this as it was his understanding the GP's were paid outside of the CCG budget. DF confirmed that this was the case. AP clarified that MMD had specifically requested support in this area. **Agreed: AP will undertake further discussion with MMD to agree the scope of the MIAA support**. MIAA Events – RP noted that the list of events appeared to be particularly useful and relevant. He requested clarification that all those, for whom the events were relevant, had been contacted. **Agreed: AP will feedback attendance rates of Southport and Formby GP's and providers at these events**.
13/7.	**External Audit Update** SB from PWC presented this report. SB gave an overview of the features and benefits of audit and responsibilities of both PWC and Southport and Formby CCG. HN noted that she had received correspondence regarding the appointment of PWC as the likely External Auditor and that attention had been drawn to a number of potential issues. In particular, HN requested confirmation from MMD as to how he could assure himself and the CCG that there would be no conflict of interest in PWC providing personal, financial and taxation advice to GP's and performing the role of External Auditor. SB noted that PWC examine any potential risks of conflict of interest prior to accepting a contract and mitigate these risks with separation of duties. **Agreed: MMD will be asked to provide assurance to HN as Chair of the Audit Committee regarding the possible conflict of interest for PWC**
13/8.	**Information Governance Toolkit** KL presented this report on behalf of MMD/TH. The Committee noted the plan to provide assurance of compliance with the IG Toolkit. RP commented that the majority of these processes and polices had previously been in place for the PCT and were being adapted for CCG purposes. **Agreed: The Committee delegated responsibility to MMD to oversee and sign of the final submission of the IG Toolkit**.

No	Item
13/9.	**Work Schedule** The Committee noted that all appropriate additions have been made to the work schedule. DF requested clarification surrounding the role of the Audit Committee in light of the Francis Report published today, 6th February 2013. AP noted that MIAA will be working with all provider organisations to ensure that they meet their obligations to publically evidence their response to this report. This will include identifying and publishing any gaps in compliance with recommendations and demonstrations of the implementation and review of effective early warning systems. RP noted that the recommendations made in this report are likely to be the priority focus of the Quality Committee in the coming year. HN requested that Quality Committee formulate an action plan surrounding the Francis Report and progress against this plan will be monitored by the Audit Committee. **Agreed: Quality Committee will draft an action plan in response to the Francis Report. Progress against the action plan will be monitored by Audit Committee**.
13/10.	**Meetings Schedule** The Committee reviewed the Meeting schedule. It was agreed that the meeting in June 2013 was no longer required as the final accounts will be presented to committees of the PCT. **Agreed: all committee members will be notified that the meeting of 5th June 2103 will not be required.**
13/11.	**Any Other Business** There was no other business
13/12.	**Date and Time of Next Meeting:** Wednesday, 1 May 2013 1.30pm – 3.00pm Family Life Centre

NHS

Southport and Formby
Clinical Commissioning Group

Minutes of the Quality Committee

Wednesday, 20 February 2013, 3.30pm – 5.00pm
Family Life Centre, Ash Street, Southport

Attended:

Fiona Clark	Chief Officer, S&F CCG	(FLC)
Helen Nicholl	Lay Member	(HN)
Dr Rob Caudwell	Board Member, S&F CCG	(RC)
Karen Leverett	Board Member, S&F CCG	(KL)
Martin McDowell	Chief Finance Officer, S&F CCG	(MMcD)

Guest Speakers:
Kevin Thorne – Item's 13/30 and 13/31
Integrated Commissioning Manager - Sefton Partnerships (KT)

Minutes:
Tracey Cubbin
SS & S&F CCG Administrator (TC)

DRAFT

No	Item	Action
13/20	**Welcome and Introductions** HN welcomed everyone to the meeting and introductions were made.	
13/21	**Apologies** Debbie Fagan (DF), Dr Katie Scholz (KS), Dr Doug Callow (DC), Billie Dodd (BD), Ann Dunne (AD), Geraldine O'Carroll (GO)	
13/22	**Declarations of Interest** None.	
13/23	**Sign of minutes – 28 November 2013** Minutes were agreed and signed off with the following change: FLC asked for attendee's initials to also be listed for clarity when using them as a reference throughout the minutes. TC has now updated and will list on all future minutes/agenda's etc.	
13/24	**Minutes of the last meeting – 23 January 2013** Minutes of the last meeting were agreed as an accurate record with the exception of the following points: **13/4 – Quality Report** FLC to inform DF of action's to be taken as a result of the Committee discussing the S & O action plan that the Provider have produced – this must include the utilisation of the Ormskirk site in a more proactive way as long as patient safety can be maintained.	DF

No	Item	Action
	A suggestion was made by HN that the CCG will contractually require consultants to engage effectively with GP Practices, the notes listed Helen's initial's as HM which have now been corrected to 'HN' **CCG will arrange to conduct regular walkabouts at the Hospital to include Clinical directors/GPs** This visit has now been arranged and will take place on Monday 11 March 2013 at 2:30 pm. **13/7 – Risk Register** - Integrated Governance /Auditors This line has been removed as was noted in error. The notes also stated that FLC went on to explain the purpose and relevance to the Committee going forward. FLC was not in attendance at this meeting and the notes have now been corrected to read that it was in fact 'DF and not 'FLC' who stated this. **13/10 Policies – SUI Policy for Ratification** An action was listed for any amendments to the SUI Policy to be sent to DF no later than 1 February 2013. The suggested amendments have now been incorporated and the policy has since been approved. **13/11 Safeguarding – Residential Home update from meeting held on 18 January 2013** The above meeting had to be re-arranged, DF to update at a future meeting.	DF
13/25	**Matters Arising** **13/2 - DF will check with Links re attendance of Ann Bisbrown-Lee** DF to write to LINKs to clarify the above.	
13/26	**Chief Nurse Report** - **Matters Arising** DF was unable to attend the meeting today as she was at a conference in London 'Commissioners Network Forum' to discuss a national piece of work relevant to CCGs. The committee discussed the Chief Nurse Report in detail and the following was noted: **5 – Quality Dashboard Development** FLC – noted for the record Bal Duper is supporting the CCGs in Primary Care Strategy & Quality and will meet in the future with the National Commissioning Board (NCB), Merseyside Head of Primary Care Tony Leo, an update regarding this meeting will be discussed at a future Quality Committee. **Support for GP Practices re: Safeguarding element for CQC Registration** DF has been in touch with Gaynor Hales, Merseyside National Commissioning Board (NCB) Director of Nursing and Quality, as an advert has been placed on NHS Jobs for a named Dr to work on this portfolio area within a neighbouring area team. DF to update in the next Chief Nurse Report. **9 – Merseyside Quality Surveillance Group** An invitation was sent to attend an inaugural meeting of the Merseyside Quality Surveillance Group scheduled for 27 February 2013. FLC confirmed that DF will be attending this and will update in the next Chief Nurse Report.	DF DF

No	Item	Action
	21 – Quality Contract Update for 2013/14 Amendment – The Chief Nurse report references South Sefton CCG in error when it should state Southport & Formby CCG. **Section 11 – Safeguarding Children Arrangements - Self Assessment Audit** Section 1.1 makes reference under the ‘action plan / timescales’ lists 2012 which should be 2013. **2.4 – whistleblowing and complaints** HN asked if this is available as induction training to new members of staff?. FLC advised that Tracy Jeffes, Head of CCG Corporate Delivery, will be implementing this through the induction process and that all should have a copy of the Whistleblowing Policy. All new employees and those currently employed by the CCG will have an induction in the near future.	
13/27	**Quality Dashboard** FLC confirmed that the Dashboard was received from Cheshire and Merseyside Commissioning Support Unit (CSU), the group discussed in detail but felt the report was not related to Southport & Ormskirk as all references etc. seem to be towards Aintree, the group also felt that the report was a ‘so what’ report and did not give clear information as to what changes had been made or what action was being taken to make relevant changes. The report gave plenty of data but did not give any intelligence within the detail. The group’s biggest concern was that a view cannot be taken as the report is not giving the information that is required. FLC advised that Debbie Fairclough and her team are working hard to get the reports changed so that exception report matches the dashboard. FLC agreed to discuss these concerns in more detail with Mike Maguire, Accountable Officer, West Lancs CCG. FLC to update at a future meeting.	FLC
13/28	**Progress towards the Alternative Quality Contract with Southport and Ormskirk NHS Trust** Paper was given as update, no action required for information only.	
13/29	**S&O Action Plan** Dr Doug Callow expressed some concerns via email to HN regarding the S&O Action Plan, FLC stated that she is happy to speak to Doug and address concerns if required. FLC noted that there was no risk assessment listed within the action plan, the group expressed concerns regarding the action plan in particular stating that the report does not give sufficient answers and that it references Aintree throughout and not Southport & Ormskirk. FLC advised that if there is to be risk assessment of patients, there must be a contingency plan which is put in place and followed. FLC suggested inviting Liz Yates from Southport & Ormksirk to the next Quality Committee to discuss the plan in more detail especially around clinician to clinician issues regarding quality of care, to relay any concerns that the Board have and to answer any questions the Committee may have. The committee all agreed that what is needed is a reasonable and robust relationship with CCGs and all of their providers.	FLC/LY
13/30	**Winterbourne – CCG/LA joint Paper**	

No	Item	Action
	Kevin Thorne, Integrated Commissioning Manager - Sefton Partnerships, attended the meeting in place of Geraldine O'Carroll, Integrated Commissioning Manager, who gave her apologies, In response to this investigation the Department of Health (DOH) have responded with a review and timetabled actions for Health and Local Authority Commissioners working together: There is a programme of local actions for Sefton which GO discussed in detail including developing a local register for all people with learning disabilities who have challenging behaviour in NHS funded care; there will also be a database to support this information. The National Commissioning Board (NCB) Local Area Team action plan was also discussed at the meeting which outlines key contacts for local areas across Merseyside. The committee agreed to look at this on a quarterly basis.	
13/31	**Learning Disabilities Health Self-Assessment and Performance Framework 2012/13** KT presented this single delivery system for PCTs/CCGs in partnership with the Local Authority to assure the Strategic Health Authorities (SHA) and the DOH on the following: - Key priorities in the operating framework 2012/13 that apply to people with learning disabilities - Key levers for the improvement of health services for people with learning disabilities within the operating framework for example: i. The equality delivery system ii. Safeguarding adults at risk iii. NHS outcomes framework - Progress report on six lives and the provision of public services for people with learning disabilities - Responding to the national review following the abuse uncovered in Winterbourne View and subsequent CQC inspection of assessment and treatment units.	
13/32	**Work Plan** DF has set up a work plan from November 2012 to March 2014; the plan gives information such as timescales for submitting of papers / sending out minutes etc. and agenda items for future meetings. TC to re-send meeting schedule dates as timescales for papers have been list as working days and not days, this means that the dates will in effect change. TC to update and send to Committee. HN had discussed the work plan with DF prior to today's meeting; Helen advised that there will be a number of standing items for the Committee which she will pick up with Debbie to ensure that all relevant issues are being covered.	TC
13/33	**Commissioner Assurance of Provider Cost Improvement Plans** The committee was asked to take into account the guidance provided and make recommendations to inform the decision-making /adopted by the Governing Body at the next Board meeting. The committee all agreed were happy to do as requested.	
13/34	**Any Other Business** - **IG Policies** The above item was withdrawn from the Quality Committee as it is to be discussed at a future Finance & Resource Committee. - **Change of time of next meeting** As a one off, the next meeting will take place from 4:00 pm – 5:30 pm	

No	Item	Action
	in order to accommodate a Wider Constituent Meeting.	
13/35	**Date and Time of Next Meeting** Wednesday, 20 March 2013, 4.00pm – 5.30pm in Family Life Centre, Ash Street, Southport	

NHS
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 points 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 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? 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**

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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	Year to Date			Forecast Outturn
	Plan	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.

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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 appraised 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 ongoing. 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 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.	**JW/ MC**

DRAFT

	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**

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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 requirement 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.**	

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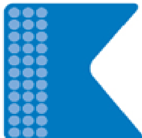

NHS

Knowsley Clinical Commissioning Group

NOTES OF THE MERSEYSIDE CCG NETWORK MEETING
held on Wednesday 3rd April 2013
Regatta Place
Part 2

ATTENDEES	
Dianne Johnson	Accountable Officer, Knowsley CCG (Network Chair)
Sarah Johnson	Head of Commissioning, St Helens CCG
Dr Steve Cox	Clinical Accountable Officer, St Helens CCG
Simon Banks	Accountable Officer, Halton CCG
Martin McDowell	Chief Finance Officer, South Sefton CCG & Southport & Formby CCG
Paul Brickwood	Chief Finance Officer, Knowsley, Halton & St Helens CCGs
Dr Nadim Fazlani	Chair, Liverpool CCG
Tom Jackson	Chief Finance Officer, Liverpool CCG
Katherine Sheerin	Accountable Officer, Liverpool CCG
Dr Niall Leonard	Chair, Southport & Formby CCG
Steve Corrigan	NHS England (Merseyside)
Dr John Hussey	NHS England (Merseyside)
Alison Tonge	Specialised Commissioning
Roger Booth	Senior Resilience Manager, C&M CSU

Present:
Andrea Kelly Secretary – Knowsley CCG

		Action:
1	**Welcome & Introductions:**	
	Dianne welcomed everyone to the meeting and explained that she would be chairing the Network in Dr Pryce's absence.	
2	**Apologies for Absence:**	
	Apologies for absence were received from: • Dr Andrew Pryce (Knowsley CCG) • Fiona Clark (South Sefton and Southport & Formby CCGs) • Dr Cliff Richards (Halton CCG) • John Caine (West Lancs CCG) • Dr Fiona Lemmens (Liverpool CCG) • Mike McGuire (West Lancs CCG) • Dr Clive Shaw (South Sefton CCG) • Tim Andrews (C&M CSU) • Debbie Bywater (C&M CSU) • Clare Duggan (NHS England Merseyside) • Jenny Scott (Specialised Commissioning)	

3	**Notes from meeting held on 6th March 2013:**	
	The notes of the meeting were read and agreed to be accurate.	
4	**Matters Arising:**	
	There were no matters arising.	
5	**EPRR Scenario Planning**	
	Steve Corrigan circulated a presentation to the Network. The CCG roles and responsibilities as identified in the guidance are: • A robust escalation process (24/7) for providers • Clear authorisation to act on behalf of other CCGs if they are to operate on each other's behalf • 24/7 business as usual contact arrangements are sufficient that should the NHS England (Merseyside) area team director need to contact out of hours. • Required to work with the area team in support of the wider NHS response to the incident through directing providers. The slides in the presentation indicate how this will look in the future. Workshops for scenario planning have been set for 29th April, 3rd May & 7th May. Steve Corrigan noted that further development was needed regarding the specialised commissioning aspect of the roles and responsibilities. There was some discussion about the definition of 'times of severe pressure' with CCG colleagues raising concern this may be too vague. The Network discussed the UCAT Stakeholder Board and the part it could play in this process in particular diverts. It was agreed that the purpose and terms of reference of this board should be reviewed by the Network to ensure it is fit for purpose. Katherine suggested re-establishing a Mersey wide Board, inviting providers, reviewing the terms of reference and identifying work programmes. Steve Corrigan noted there is a meeting planned in early May and suggested using this date. Sarah agreed to pick this up with Johanna Reilly. ***Action – Sarah to liaise with Johanna Reilly regarding Mersey wide board meeting.*** NHS England (Merseyside) will communicate further information regarding the workshops.	**SJ/JR**

6	NHS England (Merseyside) Update	
	Dr Hussey updated the Network regarding the change from NHS Commissioning Board to NHS England (Merseyside) and congratulated the CCGs on achieving authorisation. Dr Hussey confirmed that the six CCG's plans on a page priorities and commitments have been incorporated in the area team plan on a page developments. Dr Hussey updated on complaints, there are 30 outstanding from PCT and NHS England (Merseyside) needs named to link in with for each CCG until the CSU arrangements are in place. Dr Hussey asked that each CCG lets Jo Richardson aware of the named person. ***Action – CCGs to contact Jo Richardson with named person for complaints.*** There is information available on the NHS England (Merseyside) website regarding direct enhanced services the funding for these new DES's has been reduced, but can be linked to other areas and co-commission.	 **CCGs**
7	**Update on Specialised Commissioning**	
	Dianne fed back to Alison discussions that the CCG's have had under Part 1 of this meeting. Dianne explained that CCG's are keen to seek assurance that monthly meetings to have senior representatives from all organisations in attendance. Alison assured this would be the case. Dianne raised some concerns regarding patients in other areas and how CCG's would be aware of these individuals. Alison explained that national quality systems would pick up these patients experiences although the detail of this is TBC. Paul raised some concerns regarding the finance and activity schedule as CCGs have not received this information. Alison confirmed it is nearing completion and will be with CCG's very shortly. Alison advised that Specialised Commissioning are wanting to align plans and share their business plan with CCG colleagues.	
8	**Healthy Liverpool Programme**	
	Dr Fazlani introduced the Healthy Liverpool Programme and explained the aim is for a sustainable health service in Liverpool and the Healthy Liverpool Programme is an approach to achieve this aim. Katherine & Dr Fazlani will be presenting this programme to the	

	Mayor as well as at the Merseyside Wide Meeting on the 10th April 2013. This programme has been developed with consultation with Provider CE's. Vision is that by 2020 the population of Liverpool will have improved outcomes relative to the rest of England. Liverpool CCG have looked at care in 3 settings: • Outside of Hospital • General Hospital Services • Specialist Services in Hospital And for each setting have looked at 4 segments to be looked at for each setting: • Long Term Conditions • Episodic Care • Women & Children • Mental Health Katherine is proposing that the Healthy Liverpool Programme is a Committee of the Governing Body and that a Business Case for each segment will be required with reports coming back to the Governing Body,	
Details of the next meeting: Wednesday 1st May 2013 1pm in Regatta Place		

SEFTON SHADOW HEALTH AND WELLBEING BOARD
MEETING 17TH APRIL 2013
AT BOOTLE TOWN HALL

Present - Councillors Ian Moncur and John Kelly, Robina Critchley, Fiona Clark and Janet Atherton.

Also in attendance – Sam Tunney (Sefton Council).

ITEM	TITLE	ACTION
1.	**APOLOGIES** Councillor Paul Cummins, Niall Leonard, Clive Shaw, Colin Pettigrew, Maureen Kelly and Phil Wadeson.	Noted
2.	**NOTES OF THE LAST BOARD MEETING** The notes of the meeting held on 13th March 2013 were circulated and noted as a correct record, subject to a correction to minute 6, by deleting the word 'Everybody' and addition of the word 'Everyone'	Noted
3.	**MATTERS ARISING** Councillor Moncur reported that he, Peter Morgan and Sam Tunney had recently met with Maureen Kelly, Chair of Healthwatch Sefton as an introductory session, and to explore the role of Healthwatch, and its relationship to the Board. Pursuant to minute 6, Councillor Moncur reported he had received a letter from Fiona Clark advising that there had been small amendments to the three local quality premiums priorities for both CCG's which were agreed at the last meeting by the Board. Fiona advised that she had asked for copies of the revised documents to be brought to the meeting, but in essence the priorities were: South Sefton CCG: • To reduce the number of respiratory admissions through A&E at Aintree Hospital; • To reduce prescribing for three high risk antibiotics; • To reduce the number of GP referred patients (during normal working hours) who receive an AED assessment before being admitted into Aintree Hospital.	

Agenda Item 3

ITEM	TITLE	ACTION
	Southport and Formby CCG: • To bring about a reduction in the number of adults who have an emergency admission for dehydration (this is linked to the previous priority of improving care in care homes); • To reduce hospital admissions for patients under the age of 19 related to asthma; • To increase the number of patients who receive a healthcare intervention following an alcohol related admission to hospital. The Board was asked to agree to the amendments as reported verbally at the meeting on changes to priorities on South Sefton CCG and a change of emphasis/focus on Southport and Formby CCG quality premium priorities.	That the Board at its first formal meeting be requested to endorse the amendments submitted.
	Pursuant to minute 5, Councillor Moncur reported that the Health and Wellbeing Strategy had been approved by Cabinet and was due to be considered by Council the next day. He advised of the receipt, by the Leader of the Council, of a letter from the Police Commissioner requesting a position on the Board. He advised the Board that having considered the request that whilst the criteria for membership was quite tight, he was of the view that the Police Commissioner could meet that criteria.	That the Board agree to accept the request from the Police Commissioner to join the Board, and Councillor Moncur speak to her regarding membership
	Pursuant to minute 4, Sam Tunney reported that all members of the Board would be formally written to in order to advise them of the provisions within the Code of Conduct, and in particular declaration of interests. The letter would be sent by the Head of Governance and Civic Services, and would invite members to meet with her to discuss a potential 121 induction, particularly with the CCG Chairs to explain the differences between their code of conduct and the Councils. Additionally, the Board was asked did it require any other induction arrangements to be put in place.	That the arrangements for induction be noted

ITEM	TITLE	ACTION
4.	**PERFORMANCE FRAMEWORK FOR THE HEALTH AND WELLBEING STRATEGY** A draft report outlining the principles of a Performance Management Framework for the Health and Wellbeing Strategy, including agreement to a sub structure below the HWBB level, the development of a performance scorecard and ensuring that these remain at a level of satisfaction for HWBB to effectively manage performance, was submitted. The Board was asked to give a steer on the several matters presented in the draft report to enable it to be finalised for the formal meeting. Fiona reported that the CCGs had a performance dashboard. Robina asked how issues would be brought to the Board, which were outside of the dashboard, an example being how would the issue of measles be escalated. She indicated that the Board members networks' provided soft intelligence which may need a process for escalating matters. There was a need for soft intelligence to trigger consideration of an appropriate matter at the Board. Janet advised that the Board had a health protection role, and suggested that a Health Protection Forum could be established which could report into the Board so that it could give oversight of such issues. Janet further made reference to a group established across Merseyside, where soft intelligence issues could be raised, but her view was that there needed to be a wider range of representatives around the table. Fiona indicated that she had the Terms of Reference for the Group and agreed to circulate them to the Board. Councillor Moncur indicated there were networks and frameworks which the Board needed to link into and this wider view would need to be considered. Fiona reminded the members present that the Board had a role in relation to performance managing the CCGs.	That the steer given by the Board be taken account of in the final report to the Board

Agenda Item 3

ITEM	TITLE	ACTION
	A table showing the links between the themes in the strategy, potential lead Board Members, links to Cabinet Member portfolios, was tabled. Fiona asked for consideration to be given to joint CCG development and councillor development. Janet volunteered to meet with the Cabinet Members referred to in the report, along with Councillor Moncur.	That Councillor Moncur and Janet, brief other members of the Cabinet at the informal meeting on the linkages between the strategy and the cabinet member portfolios.
5.	**COMMUNICATIONS PLAN** A draft report outlining principles, methods, frequency, ownership and standards of a communications plan for the Board and its works was submitted and members were asked to give a steer. The draft plan was aimed at covering activity over the next 6 months, and the plan was to resource the activity by working collaboratively across Council and CCG Teams. Councillor Kelly asked whether the plan was too aspirational. The risks also needed to be included in the report.	That the steer given by the Board be taken account of in the final report to the Board
6.	**Public and Patient Engagement** A report outlining the importance of Public and Patient Voice and how to effectively engage with the system was submitted. Fiona indicated that the Panel was part of the CCG infrastructure, but she was happy for the remit and role of the board to be extended but it needed to keep to Integrated Commissioning. It would not be tasked by the Board but would be by default doing HWB activity. It was suggested that the role of Healthwatch needed to come across more strongly in the report.	That the steer given by the Board be taken account of in the final report to the Board

ITEM	TITLE	ACTION
7.	**Operational Group** A report was submitted which sought agreement to the migration of the existing Strategy Needs Assessment Planning Group into a form of an Operations Group to serve the Health and Wellbeing Board. It was suggested that rather than create a separate Group, that the role of the proposed Operational Group could be consumed within the existing Strategic Integrated Commissioning Group. The remit and membership of the Group would need to be refreshed in particular, membership to include representatives from the former Place Directorate on the Council.	That the steer given by the Board be taken account of in the final report to the Board
8.	**Viral Change Workshop** A report was submitted setting out the details of the viral change workshop. Fiona asked for it to be noted that the person running the workshop was her coach, and she had had no part in selecting who would run the workshop.	Noted
9.	**Board Development** Janet circulated a paper produced by the BI Team within the Council on large scale change, and suggested that the members present give some thought as to how the new membership of the Board skills, experiences, and talents could be tapped into. The Transition Alliance were now subsumed within the NWEO and it was suggested that they may have done some work on a skills audit for Boards. The presentation outlined and built on previous development activity. One simple activity was to understand each other's networks.	;

Agenda Item 3

ITEM	TITLE	ACTION
	Janet advised that the LGA had launched its Peer Review of Health and Wellbeing Boards, but that it may be too early in the process for the Board to request a review. It was suggested that the Board reconsider this in 6 months. Janet suggested that she contact the LGA to check out their 360 degree toolkit. Janet indicated that she would work up a development plan for the Board.	That at this stage, the Peer Review be not pursued That Janet prepare a development plan for the Board; That Sam contact the NWEO to seek to obtain, if possible, a skills audit for use with the Boar
10.	**Forward Plan** Fiona mentioned that she would need to bring their Strategic Plan to the Board before the end of May.	