NHS
Southport and Formby
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

Date: Wednesday 29th July 2015, 1300 hrs to 14:54 hrs
Venue: Family Life Centre, Ash Street, Southport, Merseyside, PR8 6JH

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

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

The Governing Body		
Dr Rob Caudwell	Chair and Clinical Director	RC
Helen Nichols	Vice Chair and Lay Member for Governance	HN
Dr Niall Leonard	Clinical Vice Chair and Clinical Director	NL
Paul Ashby	Practice Manager and Governing Body Member	PA
Dr Doug Callow	GP Clinical Director and Governing Body Member	DC
Hannah Chellaswamy	Deputy Director of Public Health, SMBC	HC
Fiona Clark	Chief Officer	FLC
Dr Martin Evans	GP Clinical Director and Governing Body Member	ME
Debbie Fagan	Chief Nurse	DF
Dwayne Johnson	Director for Social Services & Health, SMBC *(co-opted member on behalf of Margaret Carney)*	DJ
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Anthony Leo	Director of Commissioning, NHSE – North *(co-opted on behalf of Claire Duggan)*	AL
Martin McDowell	Chief Finance Officer	MMcD
Dr Hilal Mulla	GP Clinical Director and Governing Body Member	HM
Roger Pontefract	Lay Member for Patient & Public Engagement	RP
Colette Riley	Practice Manager and Governing Body Member	CR
Dr Kati Scholtz	GP Clinical Director and Governing Body Member	KS
Dr Jeff Simmonds	Secondary Care Doctor and Governing Body Member	JS
In Attendance		
Tracy Jeffes	Chief Delivery & Integration Officer *(for items GB15/127 and GB15/129)*	TJ
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Karl McCluskey	Chief Strategy & Outcomes Officer *(for items GB15/129 and GB15/131)*	KMcC
Liz Williams	Sefton Carer Centre, Chief Executive *(presentation on 'Carers in Sefton')*	LW
Judy Graves	Business Manager (*Minute taker)*	

Presentation on "Carers in Sefton" (15 mins)

No	Item	Lead	Report	Receive/ Approve	Time
Governance					
GB15/120	Apologies for Absence	Chair	-	R	2 mins
GB15/121	Declarations of Interest	Chair	Verbal	R	1 mins
GB15/122	Minutes of Previous Meeting	Chair	✔	A	4 mins
GB15/123	Action Points from Previous Meeting	Chair	✔	A	5 mins
GB15/124	Business Update	Chair	Verbal	R	4 mins
GB15/125	Chief Officer Report	FLC	✔	R	7 mins
GB15/126	GP Pressures and Supporting Practices	All	Verbal	R	5 mins

No	Item	Lead	Report	Receive/ Approve	Time
GB15/127	Q1 2015/16 Corporate Risk Register and GB Assurance Framework	TJ	✔	A	10 mins
GB15/128	CCG Annual Audit Letter 2014/15	MMcD	✔	R	7 mins
GB15/129	QIPP/SIR Terms of Reference: Revised	KMcC/TJ	✔	A	7 mins
Service Improvement/Strategic Delivery					
GB15/130	ILinks Update	MMcD	✔	R	5 mins
GB15/131	Review of Case for Change	KMcC	✔	A	7 mins
GB15/132	Refresh of Dementia Strategy	DJ	✔	A	7 mins
Finance and Quality Performance					
GB15/133	Hosted Safeguarding Service Governing Report	DF	✔	R	7 mins
GB15/134	Integrated Performance Report	KMcC/ MMcD/ DF	✔	R	8 mins
For Information					
GB15/135	Emerging Issues				
GB15/136	Key Issues reports from committees of Governing Body: a) Finance & Resource Committee b) Audit Committee		 ✔ ✔	 R R	5 mins
GB15/137	Finance & Resource Committee Minutes: 20/5/15	-	✔	R	
GB15/138	Audit Committee Minutes: 22/4/15 and 20/05/15	-	✔	R	
GB15/139	Locality Meetings: a) Ainsdale & Birkdale (South) Locality: 23/4/15 and 28/5/15 b) Formby Locality: 7/5/15 and 4/6/15 c) Central Locality: 28/4/15 and 19/5/15	 - - -	 ✔ ✔ ✔	 R R R	5 mins
Closing Business					
GB15/140	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting*				5 mins
GB15/141	Date of Next Meeting Wednesday 23rd September 2015 at 15.00 hrs, Family Life Centre, Southport				
Estimated meeting close					14:54

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

NHS
Southport and Formby
Clinical Commissioning Group

Governing Body Meeting in Public
DRAFT Minutes

Date: Wednesday 27th May 2015, 1300 hrs to 1515 hrs
Venue: Family Life Centre, Ash Street, Southport, Merseyside, PR8 6JH

The Governing Body

Dr Rob Caudwell	Chair and Clinical Director	RC
Helen Nichols	Vice Chair and Lay Member for Governance	HN
Dr Niall Leonard	Clinical Vice Chair and Clinical Director	NL
Paul Ashby	Practice Manager and Governing Body Member	PA
Dr Doug Callow	GP Clinical Director and Governing Body Member	DC
Hannah Chellaswamy	Deputy Director of Public Health, SMBC	HC
Fiona Clark	Chief Officer	FLC
Dr Martin Evans	GP Clinical Director and Governing Body Member	ME
Debbie Fagan	Chief Nurse	DF
Dwayne Johnson	Director for Older People, SMBC *(co-opted member)*	DJ
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Anthony Leo	Director of Commissioning, NHSE – North (Cheshire & Merseyside)	AL
Martin McDowell	Chief Finance Officer	MMcD
Dr Hilal Mulla	GP Clinical Director and Governing Body Member	HM
Roger Pontefract	Lay Member for Patient & Public Engagement	RP
Colette Riley	Practice Manager and Governing Body Member	CR
Dr Kati Scholtz	GP Clinical Director and Governing Body Member	KS
Dr Jeff Simmonds	Secondary Care Doctor and Governing Body Member	JS

In Attendance

Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC

No	Item	Action
GB15/85	**Apologies for Absence** were received from Maureen Kelly, Helen Nichols and Dr Callow and Dr Mulla.	
GB15/86	**Declarations of Interest** Those holding dual roles across both Southport & Formby CCG and South Sefton CCG declared their interest.	
GB15/87	**Hospitality Register** FLC attended an LMC dinner on 13th March 2015 and received flowers amounting to £60.00. To be added to register.	JG
GB15/88	**Minutes of Previous Meeting** were accepted as a true and accurate record.	
GB15/89	**Action Points from Previous Meeting** *15/4 Review of Case for Change* – now included in QIPP plan and will be brought back to Governing Body for review. *15/49 – Southport & Formby CCG Constitution* – will go to next Wider Group meeting - can be removed from tracker.	KMc AL

No	Item	Action
	15/54 – Draft CCG Quality Strategy – Lyn Cooke to add to CCG website as a stand-alone document – can be removed from tracker. *15/56 - 2015/16 Planning Submissio*n – FLC to discuss in CO report - can be removed from tracker. *15/60 – Key Issues Reports – Service Improvement and Redesign Committee – Respiratory Support* – Dr Scholtz reported that nurse training and a pilot to employ respiratory nurse in nursing home and home care patients to be introduced – can be removed from tracker. *15/66 – Any Other Business – Section 75* – delegated authority to be given to Chief Officer – done - can be removed from tracker.	
GB15/90	**Business Update** Dr Caudwell reported that constructive Board to Board meetings have been held with Southport & Ormskirk Hospitals NHS Trust and West Lancashire CCG in relation to on-going areas of concern which has instigated work looking at solutions. Development work is underway on the primary care strategy.	
GB15/91	**Chief Officer Report** FLC gave highlights from her report. **Action: The Governing Body received the Chief Officer report.**	
GB15/92	**GP Pressures and Supporting Practices** The CCG has been informed that Southport & Formby GP practices are next on the list for a CQC inspection in the next couple of months which will put additional pressure on GP practices.	
GB15/93	**Annual Report and Audit Opinion 2014/15** The Annual Report needs to be submitted to Department of Health by midday on Friday 28th May. The Audit Committee and Audit Opinion were very positive. There were one or two minor items requiring some clarification which have now been completed satisfactorily. Roger Pontefract, Vice Chair of the Audit Committee, reiterated it was a very positive outcome and Miss Nichols had asked Dr Caudwell to express her thanks to the team for all the hard work team in relation to the clarity and quality of the report. The Annual Report will be uploaded to the CCG website by next Friday 5th June. **Action: The Governing Body received the report.**	LC
GB15/94	**Q4 Corporate Risk Register and GB Assurance Framework** MMcD provided members with an update on CCG's final Q4 position against the Governing Body Assurance Framework (GBAF), Corporate Risk Register (CRR) and the support provided. **GBAF** Southport & Formby CCG have a total of 14 risks recorded on the Governing Body Assurance Framework (GBAF) against the 7 corporate objectives for 2014/15: Risk Rating: • 1 has increased • 4 have decreased (improved) • 9 have remained static Of which • 0 are Extreme risks • 9 are High risks • 4 are Moderate risks • 1 is Low risk Assurance Rating: • 2 risks improved assurance ratings • 1 risk had a worsening assurance rating	

No	Item	Action

	CRR
	There are 22 operational risks recorded on the Southport & Formby CCG Corporate Risk Register (CRR) for quarter 4 (March) 2014/15:
	• 21 risks continue from February 2015:
	  ○ 1 has increased
	  ○ 18 have stayed the same
	  ○ 2 have reduced
	• 0 risks removed
	• 1 new risk
	Of which:
	• 3 are Extreme
	• 13 are High
	• 4 are Medium
	• 2 are Low
	Actions:
	• **The Governing Body received and noted the report and appendices presented;**
	• **The Governing Body noted the work undertaken and progress made on assurance and scrutiny, making comment for any further developments;**
	• **The Governing Body reviewed Q4 (March) 2015 GBAF positions, specifically the 'GIC' and 'GIA' and were assured where there were any incidences of an absence of 'Gaps in Control' and/or 'Gaps in Assurance';**
	• **The Governing Body considered/commented/approved accordingly;**
	• **Reviewed Q4 (Mar) 2015 CRR positions; and considered/commented/ approved accordingly.**	

GB15/95	**CCG Corporate Objectives 2015/16** The CCG has revisited its current Corporate Objectives and developed a proposal for 2015/16. The proposed Corporate Objectives were discussed at the CCG Senior Leadership Team and Operational Team meetings in May 2015. **Action: The Governing Body approved the Corporate Objectives 2015/16.**	
GB15/96	**Strategic Blueprints** The CCG has undertaken a review of its priorities, approach and direction of travel. While the priorities remain the same, the CCG has recognised the need for increased focus on delivery, with a much greater emphasis on locality working. The blueprints have been developed in conjunction with the respective clinical and managerial leads and include high level plans which are integrated with each other to progress the transformation of commission services that the CCG aspires to as part of its overall strategy. The CCG has affirmed its focus on the two strategic programmes of CVD and respiratory. It has now cemented blueprints (primary care, community support, intermediate care, mental health and unplanned care). These are all locality-facing and aimed at building services at a local level to support localities in providing the optimum care closer to home and avoiding unnecessary hospitalisation. Final versions of the Blueprint will be published on the CCG website. **Action: The Governing Body approved the commissioning strategy and endorsed the prioritisation of the blueprints.**	LC
GB15/97	**Shaping Sefton Update** FLC updated the meeting on the latest developments in regard to the Shaping Sefton initiative. Dr Caudwell believed the initiative was pivotal in providing good health and wellbeing for patients in the Sefton area. **Action: The Governing Body received the update.**	

No	Item	Action
GB15/98	**Integrated Performance Report** The financial position at the end of 14/15 was £4.583m overspent on operational budget areas before the application of reserves. The CCG has experienced significant financial pressures during the financial year, and a management action plan was agreed to achieve the planned £1.750m surplus. All of the actions identified have been delivered, and the CCG delivered the planned surplus and the business rules required by NHS England. However, there are risks in the reported financial position that may materialise in the new financial year (15/16). DF reported that a number of C-Diff Appeal sessions had been held which enabled Southport & Ormskirk Hospitals NHS Trust to evidence no patients had been put at risk during treatment. KMcC informed the meeting that a review of stroke services was being undertaken with Liverpool and West Lancashire CCGs with a view to looking at hyper-acute provision as well as looking at the number of strokes across Sefton and where they are occurring. DF drew the meeting's attention to the trends that were being identified in pressure ulcer reporting resulting in higher levels of harm, therefore a contract query had been issued to the Trust to understand the information DJ added that Sefton Council wanted to work with the CCG on Continuing Health Care by integrating their contractual framework resulting in savings across the local economy to ensure a higher level of quality working across health and social care. **Action: The Governing Body received the report.**	
GB15/99	**Overview, Quality and Performance – Southport & Ormskirk Hospitals NHS Trust** FLC updated the membership with a brief overview of areas of concern, together with an outline of the key actions that the CCG is undertaking. We are awaiting a formal response from the Trust following the Board to Board meeting to issues raised. KMcC added the areas identified were clear and it was reassuring the CCG had been able to raise those concerns in a formal way at the Board to Board **Action: The Governing Body noted that issues and the actions being taken.**	
GB15/100	**Revised Budgets for 2015/16 and Transformation Fund** The Governing Body was asked to approve the revised financial budgets (itemised in Table 2) for the financial year 2015/16 and note that unidentified shortfall of QIPP (Quality, Improvement Productivity and Prevention) target is valued at £6.151m (around 3.5% of turnover). The Governing Body was also asked to note: • That the revised budgets deliver the key metrics required by NHS England in terms of 1% surplus; • That the CCG planned running cost expenditure is within its running cost target. The CCG would be reviewing areas where savings could be made, prescription waste which was a national problem, unnecessary treatments, etc. NL believed this financial review was part of the Shaping Sefton initiative and in order to provide a sustainable health service for the future it was important to provide services that were attuned to the needs and demography of the population. **Action: The Governing Body was asked to approve the revised financial budgets for the financial year 2015/16 and note that unidentified QIPP is valued at £6.151m.**	
GB15/101	**Key Issues reports from committees of Governing Body:** a) Finance & Resource Committee b) Quality Committee c) Service Improvement Redesign Committee **Action: The key issues reports were received by the Governing Body**	
GB15/102	**Finance & Resource Committee Minutes** were received by the Governing Body. Governance note: FLC is an ex officio member and intends to attend F&R and Quality Committee meetings on quarterly basis.	

No	Item	Action
GB15/103	**Quality Committee Minutes** were received by the Governing Body. Governance note: FLC is an ex officio member and intends to attend F&R and Quality Committee meetings on quarterly basis.	
GB15/104	**Service Improvement & Redesign Committee Minutes** were received by the Governing Body.	
GB15/105	**Locality Meeting Minutes:** a) Ainsdale & Birkdale (South) Locality b) Formby Locality c) Central Locality d) North **Action: The key issues reports were received by the Governing Body**	
GB15/106	**Any Other Business** No items raised.	
GB15/107	**Date of Next Meeting** Wednesday 29th July 2015 at 13:00 hrs Family Life Centre, Ash Street, Southport, PR8 6JH	

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Governing Body Meeting in Public
Actions from meeting held in May 2015

No	Item	Action	
GB15/4 (GB14/125)	***Review of Case for Change*** – now included in QIPP plan and will be brought back to the Governing Body for review.	KMcC	Agenda item July 2015: GB15/131
GB15/93	***Annual Report and Audit Opinion 2014/15*** – the annual report will be uploaded to the CCG website by Friday 5th June.	LC	Complete
GB15/96	***Strategic Blueprints*** - Final versions of the Blueprint will be published on the CCG website.	LC	Complete

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MEETING OF THE GOVERNING BODY
July 2015

Agenda Item: 15/125	**Author of the Paper:** Fiona Clark Chief Officer Email: fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7061
Report date: July 2015	
Title: Chief Officer Report	
Summary/Key Issues: This paper presents the Governing Body with the Chief Officer's monthly update.	
Recommendation The Governing Body is asked to receive this report.	Receive [x] Approve [ ] Ratify [ ]

Links to Corporate Objectives *(x those that apply)*	
X	To place clinical leadership at the heart of localities to drive transformational change.
X	To develop the integration agenda across health and social care.
X	To consolidate the Estates Plan and develop one new project for March 2016.
X	To publish plans for community services and commission for March 2016.
X	To commission new care pathways for mental health.
X	To achieve Phase 1 of Primary Care transformation.
X	To achieve financial duties and commission high quality care.

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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

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Report to Governing Body
July 2015

1. Shaping Sefton Update

The second session of Shaping Sefton with the Kings Fund took place on 16th June 2015. The event focused on the first of our three strategic priorities Frail Elderly and Vulnerable people. It was led by Professor David Oliver. David is seconded to the King's Fund from the NHS for one day a week as a visiting fellow, alongside his clinical job as a consultant in geriatrics and acute general medicine at the Royal Berkshire NHS Foundation Trust. As well as holding a variety of honorary and teaching positions he is the current President of the British Geriatrics Society.

The day event generated lots of thinking and ideas from over 100 attendees, including providers, CCGs, CVS & Faith sector, Housing, Local Authority and GPs. David Oliver also took the opportunity to critique our 5 year strategy and blue prints and as critical friend offered some helpful amendments, additions and general advice. The event was captured beautifully by the artistic team.

This work is now being digested and Karl McCluskey will embed the changes into the working document. The ideas will continue to be tested with our public through our next Big Chat events in the Autumn.

At the same time that we have had the 2nd Shaping Sefton event, I have been working with Margaret Carney-CEO at Sefton MBC to think through our governance arrangements for the Shaping Sefton transformational programme and the interrelationship with the Health & Wellbeing Board. Each of the work streams below, has now or is in the process of establishing themselves and the recommended Governance will be presented at the next Health & Wellbeing Board:

- Primary Care;
- Mental Health;
- Community Services and Support;
- Intermediate Care;
- Urgent Care.

We are now in the planning stage with the Kings Fund for our next event on Primary Care (date to be confirmed) and will be working closely with Dr Niall Leonard-Primary Care lead for SFCCG who will be supported by Jan Leonard and Angela Parkinson.

2. iLinks 2015 Innovation Conference and Exhibition

As Chair of the IM Merseyside Partnership I was privileged to open and Chair the morning event of the annual iLINKS Innovations Conference and Exhibition which took place at Aintree Race course on 1st July 2015**.**

The afternoon session was addressed by Joe Anderson, Mayor of Liverpool. Other notable keynote speakers from across the local Merseyside health economy and beyond included:

Gideon Ben-Tovim, Chair of the North West Coast Academic Health Science Network

Dr Simon Bowers, GP and Clinical Vice Chair at Liverpool CCG

Dr Rob Caudwell, GP and Chair NHS Southport and Formby CCG

Anne Cooper, Lead Nurse for Informatics, NHS England

David Walliker, Director of IM&T at The Royal Liverpool and Broadgreen University Hospital Trust and Chief Information Officer at Liverpool Women's Hospital

Organised by NHS Informatics Merseyside, the iLINKS Innovations was a conference and exhibition dedicated to showcasing innovation and technology and exploring the benefits that this can deliver across health and social care ranging from improved outcomes for patients to key efficiency gains.

The theme for the 2015 event was the Information Sharing Framework which was launched by Dr Simon Bowers and Dr Rob Caudwell. There were exhibitors and sponsors including small business enterprises with the event attracting over 500 people. A great success, my thanks go to Gina Silvano and all the IMerseyside team.

3. Five Year Forward View

'Time to Deliver', a new publication from the NHS arms-length bodies, is primarily a tool for NHS managers. It looks at the progress made to date towards delivering the Five Year Forward View (FYFV), and sets out the next steps needed to achieve its ambitions in the immediate and longer-term future. The papers intends to kick start a period of engagement with the NHS, patients and other partners on how to respond to the long-term challenges and close the health and wellbeing gap, the care and quality gap, and the funding and efficiency gap.

4. Aintree University Hospital: New Urgent Care and Trauma Centre

The first phase of the new £35 million Urgent Care and Trauma Centre at Aintree University Hospital opened on Wednesday 10th June. All Emergency and Trauma services have transferred to the new centre (located next to the current Emergency Department).

The new Emergency Department provides major trauma and resuscitation, major and minor illness and injury services. It supports the hospital's role in the regional major trauma centre collaborative, treating critically-injured patients from across Merseyside and Cheshire.

5. NHSE Cheshire & Merseyside Co-commissioning Steering Group

An inaugural meeting of the newly established co-commissioning steering group was held on Monday 20th July. The group has been established across Cheshire & Merseyside to provide a forum for all CCGs to collectively consider the impact of issues locally and also to allow for consideration of any emerging national co-commissioning developments.

6. Home Oxygen Services – Air Liquide (Homecare) Ltd – Annual Operation Plan 2015/16

The North West Home Oxygen contractor, Air Liquide (Homecare) Limited, is contractually required to produce an annual Operation Plan, for approval and sign off by the Regional Lead organisation.

As a result, NHS Trafford CCG recently sought approval from Southport & Formby CCG to authorise them, as the lead commissioner, to sign off the annual plan, which was done on 26th June 2015. As Accountable Officer, within my delegated authority, I gave this approval.

7. NHS 111

As Accountable Officer I have received a letter on 3rd July from Dame Barbara Hakin at NHS England in connection with the 111 Procurement process.

The 111 procurement process in Merseyside is well advanced and confirmation has been received that the NHS 111 implementation will still be going ahead as the contract had already been awarded. Merseyside are in phase 1 of the implementation of the North West rollout with a go-live date of 1st October 2015.

8. Dermatology Service Procurement

The Bidder day was held on the 17th June, with interest from both NHS and private providers. Full open tender documents are going live on the 20th July with both Pre-Qualification Questionnaire (PQQ) and the Invitation to tender (ITT) going out at the same time. Bids will be required back by 3rd Sept. A Panel has been established and includes Dr Jonathan Berry from Salford CCG.

9. Merseyside CCG Network

The Merseyside CCG network is now hosted by NHS Halton CCG and over the past two months has focused its discussions on:

- NWCSU transition
- Safeguarding hosted service
- Stroke
- Neuro-Rehabilitation Service
- Public Health-Hypertension & Mental Health
- Feedback from NHS Clinical Commissioners
- Specialised Commissioning

In June the meeting was given over to a workshop led by Andrew Bibby & team from Specialised Commissioning NHS England North. The CCGs discussed:

- a proposal for Collaborative Commissioning of specialised services on a Cheshire and Mersey footprint;
- Capacity and capability of CCG staff resources;
- Financial Risks.

The Cheshire and Mersey CCGs agreed to continue the dialogue to explore how this could contribute to CCG visions and aims. Further exploratory work to be undertaken before any commitment is made.

10. NWCSU Update

Work continues led by Tracy Jeffes-Chief Delivery & Integration Officer to develop in collaboration with the Merseyside CCGs the required commissioning support. This has resulted in some services being considered for in-house provision through the required NHS England Business case process. The majority of services have had service specifications prepared by 27th July 2015 ready to be submitted to the Lead Provider Framework (LPF).

It is expected that we will collectively go out to tender by the end of July, award the contract in November and will fully mobilise the new service for January 2016. The CCG Senior Leadership Team (SLT) has been kept fully informed regarding key developments, including the proposal to in-house a further service line (contracting) in order to bring us in line will all other local CCGs. SLT will be asked to sign off the move to procurement at the end of this month, on behalf of the Governing Body, as agreed at the meeting in May 2015.

11. Continuing Health Care (CHC) Update

The CCG/CSU CHC Steering Group continues to meet on a fortnightly basis Chaired by a Lay member from SFCCG. Progress against the Improvement Plan is monitored via an exception report produced by NWCSU. Progress with regard to the number of CHC and Mental Health case reviews is monitored at this forum.

The CCG recently requested supporting documentation regarding Mental Health cases to review for the purposes of assurance from NWCSU. As a result of this review the Chief Officer has written to the Managing Director of the NWCSU raising concerns regarding the level of assurance in this area although improvements have been seen in the systems and processes for the management of CHC cases for physical disability.

Interim senior leadership has been secured by NWCSU from their stability partner for the Sefton locality which has been put in place with effective from the beginning of June 2015. CHC remains on the Corporate Risk Register.

Service specifications for CHC have been completed in preparation for re-tendering of the service through the Lead Provider Framework.

12. CHC Restitution Cases (Previously Unassessed Packages of Care - PUPoC) Update

The CCG continues to receive monthly performance reports from NWCSU. June 2015 has seen an increase on previous performance from the NWCSU. In order to expedite this process further, the CCG has agreed for a realistic measure to be put in place regarding the number of requests they make for records from third parties which is in line with what is deemed acceptable by the Public Health Service Ombudsman.

The CCG Leadership Team has recently reviewed the monthly trajectory for the CCG and this has been submitted to NHSE. The CCG are looking for all PUPoC cases to be closed no later than the end of August 2016. CHC Restitution (PUPoC) remains on the Corporate Risk Register.

13. Personal Health Budgets

NWCSU have approached the stability partner for support for the CCG in further developing systems and processes for Personal Health Budgets. The CCG are awaiting this response.

To date, one Southport & Formby CCG patient has a personal health budget and one patient has requested a personal health budget which is currently being processed.

14. CCG Safeguarding Annual Report

The CCG Safeguarding Annual Report for 2014/15 is currently being produced by the CCG Safeguarding Service. The Chief Nurse is expecting the report to be ready in time to be presented to the August 2015 meeting of the Quality Committee. It will then be presented to the September 2015 meeting of the Governing Body.

The Chief Nurse has discussed with the CCG Safeguarding Service the need for specific timelines to be met as a recommendation from the recent CCG MIAA Safeguarding Review related to improved timeliness in the production of this report in order to be received by the Governing Body.

15. Quality Surveillance Processes

Single Item Quality Surveillance Group / Quality Review Meeting (Southport & Ormskirk Hospitals NHS Trust) – Following on from the Chief Inspector of Hospitals Visit, the outcome of which has been previously reported to the Governing Body, a Single Item Quality Surveillance / Quality Review Meeting was chaired by NHSE on 15 June 2015. The Trust has now been placed on enhanced surveillance.

Single Item Quality Surveillance Group / Quality Review Meeting (Liverpool Community Health NHS Trust) – NHSE will chair a Quality Review Meeting for Liverpool Community Health NHS Trust (LCH) on 21 July 2015. This is a continuation of the Quality Surveillance process that is in place for this provider. The outcome of this meeting will be reported to the Quality Committee and Governing Body in due course.

Cheshire & Merseyside Quality Surveillance Group Meeting – Recent routine meetings of the Cheshire & Merseyside Quality Surveillance Group, chaired by NHSE, have focused on Maternity Services and Mental Health Services. In July 2015, the CCG presented information on Maternity Services at Southport & Ormskirk Hospitals NHS Trust following on from their recent Chief Inspector of Hospitals visit and delivered a joint presentation with Liverpool CCG regarding Mental Health Services.

16. Looked After Children Data Return (SSDA903)

The Local Authority are required to make an annual information return to the Department for Education regarding health reviews for Looked After Children. Information for this return is required from health providers who work in partnership with colleagues from Social Care to ensure health needs are met for this cohort of children and young people.

Some issues were identified with system and processes locally which have resulted in the Chief Nurse facilitating a 'lessons learnt' event across the local partnership which was held on 16 July 2015 and a pathway development session has been planned for 22 July 2015. There will be a

more detailed presentation of this at the next meetings of the Corporate Parenting Board and Local Safeguarding Children Board. This issue has been placed on the CCG Corporate Risk register.

17. Education and Health Care Plans (EHCP)

The production of Education & Health Care Plans (EHCP) replaced the statementing process for children and young people with Special Educational Needs and Disabilities in 2014. The CCG met all milestones for the introduction of this new system as a commissioner of health services in line with the new Code of Practice and this risk was removed from the Corporate Risk Register. Work has been on-going to further improve the local system since the introduction of this new system between the CCG, Local Authority (LA) and Liverpool Community Health NHS Trust (LCH).

A system and process issue was identified which identified a backlog of EHCPs requiring health outcome information to be produced. Discussions have taken place between the CCG, LA and LCH and a 3 phase remedial action plan has been put in place to mitigate the risk. This issue has been placed on the CCG Corporate Risk Register. Throughout this period there have been no delays in the CCG signing off the health component of the EHCP once completed and sent from the LA.

18. Cancer

MPs on the All Party Parliamentary Group on Cancer reported patients in Southport and Formby CCG and West Lancashire CCG showed the most improvement nationally in one-year cancer survival rates between 2011 and 2012.

In Southport and Formby, 72% of patients survived cancer for more than 12 months against 70% the previous year.

One year survival is usually considered a proxy measure for how early cancer was detected. Earlier detection is achieved through a combination of public and professional awareness of symptoms and the importance of cancer screening and quick access to diagnostics and treatment.

CCG Cancer commissioners supported by CRUK have worked with practices across Southport and Formby to undertake audits of the pathways leading up to a cancer diagnosis. This looks at the time taken between first presentation of symptoms in general practice (where made) and diagnosis of cancer. The audits serve to stimulate discussion, learning and improved safety netting within practices and highlight any gaps in commissioned services.

This autumn will see the third cancer-focused educational event for general practice across the Borough.

Plans for the future which will further impact on early detection include:

- Implementation of new NICE Guidelines for Suspected Cancer. This will also bring with it commissioning challenges in terms of increased demand for direct access diagnostics and lower referral thresholds;

- Direct GP access to tests such as abdominal/pelvic CT where cancer is suspected but its site of origin is uncertain.

The wealth of local information and support resources for individuals living with and beyond a cancer diagnosis now includes:

- Regular Macmillan Health and Wellbeing Events;
- Wellness and Activity Co-ordinator;
- Southport and Formby Recovery Package;

as well as the range of services provided by the Macmillan Cancer Information Centre based within the Living Well Centre, Southport.

19. Better Patient Experience Initiative

Following a rigorous interview process, the CCG has been successful in its application to become involved in a joint Macmillan and NHS England scheme to "commission for better patient experience." Led by Sarah McGrath, supported by Lyn Cooke and Jo Herndlhofer, the initiative will build on previous engagement work to help the CCG further develop innovative ways to make sure that patient experience is at the heart of our commissioning processes.

As a pilot site, we will gain support from experts in the field, have opportunities to learn from good practice around the country and by working with our Engagement and Patient Experience Group (EPEG) enable the lessons from this initiative to be systematically adopted across all our engagement work. The initiative will start in September, with a visit from the expert team to our Southport office.

20. Recommendation

The Governing Body is asked to formally receive this report.

Fiona Clark
Chief Officer
July 2015

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2015

Agenda Item: 15/127	**Author of the Paper:** Judy Graves Business Manager E: judy.graves@southseftonccg.nhs.uk T: 0151 247 7009
Report date: July 2015	

Title: Corporate Risk Register & Governing Body Assurance Framework Update

Summary/Key Issues:

To update members on the current Corporate Risk Register, Governing Body Assurance Framework position and assurance support for Quarter 1 (April - June) 2015-16.

Recommendation

Receive	
Approve	X
Ratify	

The Governing Body is asked to:

- Note the report presented;
- Note the support provided and the work completed making any suggestions for improvement or change;
- Review Q1 (June) 2015/16 CRR, specifically the highlights (section 4) and the decisions of the SMT and comment and approve accordingly; and
- Review the Q1 (June) 2015/16 GBAF, specifically the highlights (section 5) and the decisions of the SMT and comment and approve accordingly.

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Links to Corporate Objectives *(x those that apply)*	
x	To place clinical leadership at the heart of localities to drive transformational change.
x	To develop the integration agenda across health and social care.
x	To consolidate the Estates Plan and develop one new project for March 2016.
x	To publish plans for community services and commission for March 2016.
x	To commission new care pathways for mental health.
x	To achieve Phase 1 of Primary Care transformation.
x	To achieve financial duties and commission high quality care.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement				
Clinical Engagement				
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement				
Presented to other Committees	X			Discussed at SMT and Operational Team. Is due to be presented to the Quality Committee in August 2015 following cancellation of the July 2015 meeting.

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

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Report to the Governing Body
July 2015

1. Executive Summary

The CCG has a statutory responsibility and regulatory obligation to ensure that systems of control are in place to minimise the impact of all types of risk, which could affect the proper functioning of the CCG. Risk management and internal controls should be fully embedded at all levels of the organisation: effective risk management arrangements will, in addition to helping ensure goals and objectives are met, help ensure compliance with statutory, mandatory and 'best practice' requirements.

All committees of the CCG are responsible for ensuring that risks associated with their areas of responsibility are identified, analysed, evaluated and treated.

2. Introduction and Background

Governing Body Assurance Framework (GBAF)

The Governing Body Assurance Framework provides the Governing Body with assurances that risks to the achievement of the CCG's organisational objectives have been identified and that robust measures to mitigate those risks have been implemented and managed. It provides a list of the key pieces of evidence that the CCG Governing Body should use to gain this assurance. The Governing Body Assurance Framework is a key element of the CCG's system of internal control and its' primary purpose is to identify, evaluate, track and manage the impact of high-level strategic and operational risks. The GBAF also provides strong evidence and assurance of the effectiveness of the CCG's approach to risk management for the Annual Governance Statement, which is a requirement of the Annual Accounts.

The framework records the links between strategic objectives, key risks and key controls. It also indicates the sources of evidence or assurance, which support the controls, and identifies any gaps.

It is reviewed at business meetings of the Senior Management Team and Quality Committee on a quarterly basis and overseen by the Audit Committee. The Corporate Governance Group reviews and scrutinises it before submission to the Quality Committee to ensure the risk scores and assurances are accurate and robust.

The full document is reviewed twice a year by the Governing Body. Within that timeframe the Governing Body need to ensure that they:

- examine the previous year's final Q4 framework which will identify the final position on the risks for that year and provide the Governing Body with the information to ultimately determine whether the corporate objectives for that year have been met;
- examine the new financial year's Q1 framework which will outline the new organisational objectives and related risks, and identify any changes to the management of the risks; and
- ensure a robust process is in place for exception reporting.

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Corporate Risk Register (CRR)

The Corporate Risk Register (CRR) is a record of all the identified risks presented with details of assessment (the risk score) and actions taken to manage and mitigate the risk. The CRR supports the CCG's Assurance Framework by identifying operational risks which may impact on the ability to provide assurance against strategic risks.

All new and updated risks are recorded on the CRR on a monthly basis, where they are then reviewed by the Senior Management Team as a first line of assurance followed by the Corporate Governance Sub Group and Quality Committee as per the organisations Assurance Schedule.

3. Key Issues

- Work continues with the SMT and Corporate Governance Support Group to ensure robust assurance processes are in place, continued and reviewed
- 1:1 meetings held with risk leads to discuss updates
- Q1 (June) 2015/16 CRR and GBAF reports updated. Have included additional risk rating column to show position as at 0+2 (May) 2015.
- Assurance schedule continues to be updated as per availability of the risk leads and report submission deadlines.
- Paper was presented to the SMT for scrutiny.

3.1 Q1 (JUNE) 2015/16 CRR POSITION

Southport & Formby CCG (Appendix D):

CRR
There are 30 operational risks recorded on the Southport & Formby CCG Corporate Risk Register (CRR) for quarter 1 (June) 2015/16:

- 26 risks continue from May 2015:
  - 1 has increased: QUA011
  - 22 have stayed the same
  - 3 have reduced: QUA004, 6, 10.
- 0 risks removed
- 3 new risks: REP036, STA037, 38.

Of which:

- 8 rated 'Extreme': BUO001,FIN003, QUA011, 26, 33, 34, 37, 38
- 16 rated high level: BUO017, FIN006, 8, QUA002, 16, 20, 21, 23, 24, 25, 27, 28, 32, REP003, 035, 036.
- 3 rated as medium
- 2 rated low risk.

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3.2 HIGHLIGHTS

CRR Risk	Southport & Formby CCG
QUA011 **- Extreme rating** Risk that patients could be harmed or receive inadequate care due to failure to deliver against National Key Performance Indicator for IAPT (Improving Access to Psychological Therapies)	4x3 **(12) increased** to 4x4 **(16)** 'Transferred to new provider. Historic issues relate to data transfer and performance. Validation of waiting list and backlog completed. Backlog reduced from 1200 to 800. Acton plan in place. Full HR programme in place to address and tackle all identified HR issues with ongoing action plan. New system in place. Monthly reporting from July as part of internal performance report and weekly to SLT and SMT. To review position
QUA004 Impact of lab results on patient safety being sent to GP practices where they are not registered. Current IT system only allows GPs to reject results	3x3 **(9) reduced** to 1x3 **(3)** Meeting held with Rob Caldwell. Has been confirmed that appropriate training in place which supports mitigation of the risk. Risk reduced. Proposed for removal: in light of the assurance received and the reduction of the risk the lead has proposed removal. SMT agreed removal of risk.
QUA006 Providers RAG rating in relation to robust Safeguarding systems and processes presents lack of assurance for CCG based upon validation of information presented by the Trust.	2x3 **(6) reduced** to 1x3 **(3)** Systems in place between CSU and Safeguarding Services which is working well. Quality and performance function in-housed from 1st June which will enable tighter controls. Contract query remains in place with Southport & Ormskirk hospital due to limited assurance still being reported by CCG and Safeguarding Services. Is being closely monitored. SMT agreed position.

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CRR Risk	Southport & Formby CCG
QUA010 Risk that patients could receive inadequate care due to failure of implement local delivery of strategic blueprints and programmes (CVD and Respiratory)	3x3 **(9) reduced** to 2x3 **(6)** Indicated plan for disinvestment on current PMO function served by Informatics Merseyside. Development session held with wider membership strategy blue prints and priority programmes. SMT agreed position.
QUA026 **- Extreme rating** CCG's failure to meet NHS England's target for CHC restitution cases.	5x3 **(15) remained 5**x3 **(15)** Underperformance continues against monthly trajectory SMT reviewed risk. Members discussed in relation to risk REP036 and requested further review. Further review carried out by lead who has confirmed QUA026 can be removed: REP036 was considered to be more comprehensive. QUA026 will be removed from the CRR.
QUA033 **- Extreme rating**	5x4 **(20) remained** 5x4 **(20)** - Developed 'Facing the future together' document to clarify community model to be delivered and milestones for delivery - Strategic Transformational Board established - Board to Board meeting held on 29th April 2015, with formal letter written to ICO Board setting out quality and performance concerns SMT agreed position.
QUA034 **- Extreme rating** Risk to delivery of community services as a result of Southport & Ormskirk Community Services not performing as expected	5x3 **(15) remained 5**x3 **(15)** - Next Milestone meeting due: will be seeking a decision on whether or not to go to procurement. - Next Facing the Future Board meeting being held. Facing the Future document to be reviewed: needs to be more outward facing and to develop outcome measures. SMT agreed position.

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CRR Risk	Southport & Formby CCG
QUA039 **- New risk** **- Extreme risk**	3x5 (**15**) Provider unable to deliver key part of the service specification (Oxygen). Options on re-tendering being discussed with CSU. New risk following SMT discussion (end June 2015)
REP036 **- New risk**	4x3 **(12)** Non-delivery against national trajectory for CHC restitution cases (PUPoC - packages of care for Previously Unassessed Periods of Care) SMT reviewed risk. Members discussed in relation to risk QUA026 and requested further review. Further review carried out by lead who has confirmed QUA026 can be removed: REP036 was considered to be more comprehensive. QUA026 will be removed from the CRR.
STA037 **- Extreme rating** **- New risk**	5x3 **(15)** Risk that patients could be harmed or receive inadequate as a result of commissioned provider unable to deliver within statutory timeframes the health outcome information to be inserted into Education & Health Care Plans (EHCP) for children and young people with Special Educational Needs & Disability (SEND) SMT agreed position.
STA038 **- Extreme rating** **- New risk**	5x4 (20) Risk that patients could be harmed or receive inadequate care due to lack of commissioner assurance in current processes for Looked After Children Health Assessments and Reviews across the local system Lead has reviewed risk following discussion at SMT. No change.

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Clinical Commissioning Group

CRR Risk	Southport & Formby CCG
BUO001 **- Extreme rating** 18 week & cancer pathways may not be met due to non-delivery of target by provider	5x4 **(20) remained** 5x4 **(20)** All achieved apart from 2 week wait for referral from screening services (Breast). 18 Week: CCG failed to achieve 18 RTT target. Principally due to performance at Southport & Ormskirk. S&O issued contract query. RTT: backlog escalated to the Contract Meeting on 5/5/15. Action plan for recovery has been requested for the next meeting (June 2015). Performance not improved. To be discussed at next meeting on 1st July. Action Plans for (1) Maxillofacial, (2) Ophthalmology met and complete. Diagnostics Waiting Time Target: Target achieved in March and revised action plan in place with provider. Action Plan timelines review monthly. SMT agreed position.
FIN003 **- Extreme rating** Changes in patient flow causes financial issues, due to increases in activity overall and the financial implications on the 15/16 Financial performance of the CCG. Increased activity has resulted in a QIPP saving required of 6.1 million to be delivered for 15/16. Predominant risk areas are: CHC and Urgent Care which have both seen significant growth in demand. Significant QIPP scheme to be delivered during year totalling 6.1million.	5x4 **(20) remained** 5x4 **(20)** Monthly QIPP Working Group has robust interrogation from acute provider to identify any inaccuracies in coding. CHC Working Group with robust management of CHC finance team to ensure finances are actioned. Processes in place to eliminate financial waste. SMT agreed position.

3.3 Q1 (JUNE) 2015/16 GBAF HIGHLIGHTS

Against the new 7 objectives for Southport & Formby CCG there are a total of 13 risks that are being presented on the draft Q1 2015/16 GBAF:

- 2 'Extreme': 7.1 and 7.3
- 11 high
- 0 moderate
- 0 low

Please refer to the summary document for an overview of the risks and highlights.

4. Recommendations

The Governing Body is asked to:

- Note the report presented;
- Note the support provided and the work completed making any suggestions for improvement or change;
- Review Q1 (June) 2015/16 CRR, specifically the highlights (section 4) and the decisions of the SMT and comment and approve accordingly; and
- Review the Q1 (June) 2015/16 GBAF, specifically the highlights (section 5) and the decisions of the SMT and comment and approve accordingly.

Appendices

Appendix 1

Judy Graves
July 2015

NHS
Southport and Formby
Clinical Commissioning Group

Appendix 1

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
Low	1 - 3	
Moderate	4 - 6	
High	8 - 12	
Extreme	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 Corporate Risk Register.

Consequence Score for the CCG if the event happens		
Level	**Descriptor**	**Description**
1	Negligible	• None or very minor injury. • No financial loss or very minor loss up to £100,000. • Minimal or no service disruption. • No impact but current systems could be improved. • So close to achieving target that no impact or loss of external reputation.
2	Minor	• Minor injury or illness requiring first aid treatment e.g. cuts, bruises due to fault of CCG. • A financial pressure of £100,001 to £500,000. • Some delay in provision of services. • Some possibility of complaint or litigation. • CCG criticised, but minimum impact on organisation.
3	Moderate	• Moderate injury or illness, requiring medical treatment (e.g. fractures) due to CCG's fault. • Moderate financial pressure of £500,001 to £1m. • Some delay in provision of services. • Could result in legal action or prosecution. • Event leads to adverse local external attention e.g. HSE, media.
4	Major	• Individual death / permanent injury/disability due to fault of CCG. • Major financial pressure of £1m to £2m. • Major service disruption/closure in commissioned healthcare services CCG accountable for. • Potential litigation or negligence costs over £100,000 not covered by NHSLA. • Risk to CCG reputation in the short term with key stakeholders, public & media.
5	Catastrophic	• Multiple deaths due to fault of CCG. • Significant financial pressure of above £2m. • Extended service disruption/closure in commissioned healthcare services CCG accountable for. • Potential litigation or negligence costs over £1,000,000 not covered by NHSLA. • Long term serious risk to CCG's reputation with key stakeholders, public & media. • Fail key target(s) so that continuing CCG authorisation may be put at risk.
Likelihood Score for the CCG if the event happens		
Level	**Descriptor**	**Description**
1	Rare	• The event could occur only in exceptional circumstances. • No likelihood of missing target. • Project is on track.
2	Unlikely	• The event could occur at some time. • Small probability of missing target. • Key projects are on track but benefits delivery still uncertain. • Less important projects are significantly delayed by over 6 months or are expected to deliver only 50% of expected benefits.
3	Possible	• The event may occur at some time. • 40-60% chance of missing target. • Key project is behind schedule by between 3-6 months. • Less important projects fail to be delivered or fail to deliver expected benefits by significant degree.
4	Likely	• The event is more likely to occur in the next 12 months than not. • High probability of missing target. • Key project is significantly delayed in excess of 6 months or is only expected to deliver only 50% of expected benefits.
5	Almost Certain	• The event is expected to occur in most circumstances. • Missing the target is almost a certainty. • Key project will fail to be delivered or fail to deliver expected benefits by significant degree.

SOUTHPORT & FORMBY CCG

Corporate Risk Register

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

Q1: April - June 2015

Last Saved: 22/05/2015

ID	Date Added	2014/15 Reference	Principal Risk	2015/16 Corporate Objective	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	0+2 May	L	C	Current Risk Rating - April 15	Change Since Last Update
			Business Objective																
BUO001	Prior Q3 2013/14	BUO001	18 week & cancer pathways may not be met due to non delivery of target by provider	1	Business Objective and Statutory Duty	Chief Strategy & Outcomes Officer (Karl McCluskey) and Chief Redesign & Commissioning Officer (Jan Leonard)	1. Monthly contract meetings 2. Clinical Quality and performance meetings 3. Clinical lead for contracts and quality 4. Additional funding for RTT, worked closely with providers on cancer pathway. 5. Clinical meetings with Cancer Leads and Manager. 6. Managerial lead for cancer has action plan in place. 7. Weekly and monthly monitoring through SMT and contractual performance. 8. RCA for any 62 day breaches 9. RTT plans with Aintree and Southport & Ormskirk agreed and weekly review of performance is in place. 10. Reporting system developed that provides earlier notification of waiting time concerns. Is reviewed on a weekly basis and reported to SMT (Senior Management Team and SLT (Senior Leadership Team). 11. Integrated Performance Report developed and presented to Governing Body. 12. Action plans in place for failed areas: progress being monitored via SMT, contractual performance and continued reviews. Completed for Maxillofacial, Ophthalmology and Waiting Times.	3	3	9	RTT Recovery Action Plan requested.	Jun-15		Cancer 2 week: Systems in place are fit for purpose. All achieved apart from 2 week wait for referral from screening services (Breast). Cancer 31 day: Cancer 62 day: 18 Week: CCG filed to achieve 18 RTT target. Principally due to performance at Southport & Ormskirk. S&O issued contract query. RTT: backlog has been escalated to the Contract Meeting on 5/5/15. Action plan for recovery has been requested for the next meeting (June 2015) . Performance not improved. To be discussed at next meeting on 1st July. Action Plans: (1) Maxillofacial, (2) Ophthalmology: Targets met, all complete. Integrated Performance Reporting System: Diagnostics Waiting Time Target: Target achieved in March and revised action plan in place with provider. Action Plan timelines review monthly.	4x4	4	4	16	▶
BUO017	**Apr-15**	N/A	CCG Locality working does not lead to greater clinical engagement with CCG plans and objectives.	1	Business Objective	Chief Delivery and Integration Officer (Tracy Jeffes)	1. Roles of Locality Managers and Team Development Workers reviewed 2. Locality Plan in place 3. Managed by chief Delivery and Integration Officer and supported by Leadership Team 4. Progress reported to Governing Body 5. Wrap around support team identified to support localities	4	4	12	Regular local review meetings to be set-up. will including Governing Body members. Will focus on further developing the communications bulletin	Jun-15	Jul-15	Development meetings: being held. - Testing plans with localities - membership being reviewed - implementation from June Progress is dependant on Primary Care Transformation, and investment and improvements in community services.	3x4	3	4	12	▶
			Finance																
FIN003	Revised Q1 2015/16	FIN003	Changes in patient flow causes financial issues, due to increases in activity overall and the financial implications on the 15/16 Financial performance of the CCG. Increased activity has resulted in a QIPP saving required of 6.1 million to be delivered for 15/16. Predominant risk areas are: CHC and Urgent Care which have both seen significant growth in demand. Significant QIPP scheme to be delivered during year totalling 6.1million.	7	Finance	Chief Financial Officer (Martin McDowell)	1. Monthly contracting meetings with main acute providers 2. Information shared with GP leads 3. Practice level reporting of financial information 4. Monthly monitoring of financial position 5. QIPP Working Group established and meet monthly. 6. CHC Working Group established	4	3	12	QIPP working Group to identify savings totalling £6.1 million			Monthly QIPP Working Group have robust interrogation from acute provider to identify any inaccuracies in coding. CHC Working Group with robust management of CHC finance team to ensure finances are actioned. Processes in place to eliminate financial waste. Further increase in risk rating requested by Lead. Likelihood increased from 4 to 5. Rationale being that a fully worked up QIPP plan has still not been identified.	4x4	4 5	4	20	▲ (July 2015 - v3 change)
FIN006	July 2014 (Q1+1) revised May 2015	FIN006	Implementation of integration agenda to support Better Care Fund. If pace of integration set out in 15/16 Improvement Plan is not maintained and achieved there is a risk that the CCG will not have financial capacity to absorb a significant investment in the Better Care Fund pooled budget and also fund residual health care contracts.	7	Financial	Chief Financial Officer (Martin McDowell)	1. Ongoing review of Better Care Fund composition in conjunction with council colleagues.	3	3	9	Need to work through how BCF will be monitored and managed.	Aug-15		Government structures to be put in place. For further discussion at SMT.	3x3	3	3	9	▶
FIN008	Q3 Dec 2014	FIN008	Reductions in local authority expenditure may impact on NHS services and delivery of BCF schemes	7	Financial	Chief Financial Officer (Martin McDowell)	1. Monitoring progress of BCF schemes 2. Continued work with local authority	4	3	12	Need to understand the impact of the proposed budget reductions. Explore areas for effective joint commissioning to maximise use of the Sefton £1: ongoing.	~~May~~ Sept 2015 ~~April~~ Sept 2015	~~May~~ Sept 2015 ~~May~~ Sept 2015	Further cuts identified in public health on top of previous plans.	4x3	4	3	12	▶

SOUTHPORT & FORMBY CCG

Corporate Risk Register

▼ Risk reduced
► Risk unchanged
▲ Risk increased

Q1: April - June 2015

Last Saved: 22/05/2015

ID	Date Added	2014/15 Reference	Principal Risk	2015/16 Corporate Objective	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	0+2 May	L	C	Current Risk Rating - April 15	Change Since Last Update
Quality																			
QUA002	Prior Q3 2013/14	QUA002	Need for clarity of roles and responsibilities between Safeguarding Hosted Service, CSU CHC team and LCH Provider Safeguarding Team to enable CCG to discharge their safeguarding function. Need for further clarity between health and social care commissioning / safeguarding for vulnerable adults.	1	Quality	Chief Nurse (Debbie Fagan)	1. Regular 1:1 meetings between safeguarding adults lead in hosted service and CHC locality lead. 2. Identified a single point of contact system for Safeguarding Adults between the Safeguarding Service and hosted service. 3. ~~Draft~~ Standard Operating Procedure developed, includes recommendations as per review.	4	5	20	Awaiting feedback from Quality Committee on draft SOP Review required on the needs of the Sefton patch in order to determine commissioning responsibilities and necessary specification. To obtain the recommendations from Liverpool Community Health's internal Safeguarding review that explored the role of the Safeguarding Adults team. Part 1 received: Awaiting part II which looks at progress against ongoing recommendations.	April 2015 TBC March 2015	May 2015 TBC March 2015	~~SOP updated following recommendations from safeguarding 'CQC style' peer review. Deferred to January 2015 Quality Committee.~~ SOP in place. Meeting held with Safeguarding Service and CCG's Chief Nurse/Deputy Chief Nurse. Difference in response from provider services across Sefton patch regarding needs. Review now required in order to determine commissioning responsibility and necessary specification. LCH internal review requested by Chief Nurse. Discussed at Contract meeting. Part 1 previously received., still awaiting part 2: Chief Nurse has contacted the Deputy Director of Nursing - meeting was to be held with new Nursing Director when in post (expected January 2015). Contacted on 2/2/15 for confirmation of meeting and again 10/02/15 to confirm date with interim Nursing Director but no date set as yet. Plan for SOP review as part of meeting with LCH's review. Still waiting information from LCH in order to finalise SOP. CCG Network Steering Group updated at a meeting on 23rd February. Mitigating actions put in place. Still no meeting held or part 2 received despite efforts made by Chief Nurse. Chief Nurse to further raise. Role clarity exists between CCG safeguarding services and CHC/CSU team. Meeting held 10/6/15 to look at inequity of provider response into care homes identified. Need clarity on expectations of Local Authority and then CCG/LA commissioning responsibility. LCH Safeguarding Review to be utilised to inform discussion as appropriate. CCG has successfully appointed to role of Programme Manager of vulnerable people who will support this work going forward. Awaiting commencement into post.	2x4	2	4	8	►
QUA004	Prior Q3 2013/14	QUA004	Impact of lab results on patient safety being sent to GP practices where they are not registered. Current IT system only allows GPs to reject results	1	Quality	Chief Nurse (Debbie Fagan)	1. Raised as an issue at the Quality Committee and Contract meetings. 2. Steering Group established 3. Terms of Reference revised 4. Task and Finish Group established with the lead for Lab Services: progress reported to the Quality Committee	4	3	12	Discussed at LCL Incident Meeting on 3 July 2014. I-Merseyside team to send information to NHSE(M). NHSE(M) to liaise with HSCSC due to national issue and feedback. Note: not LCL issue	TBA: national issue	TBA: national issue	Confirmation received from Kate Warriner and Michelle Creed in February 2015 who have advised that it is associated to the rejection of pathology reports in GP clinical systems for patients not registered. E-mail received from NHS England on 1/5/15 stating HSCIC will link directly with I Merseyside to resolve issue. Chief Nurse spoke with Rob Caldwell in order to move forward on issue, who will raise at next I Links clinical Advisory Group meeting in May. Meeting held with Rob Caldwell. Has been confirmed that appropriate training in place which supports mitigation of the risk. ICE in 2 Southport & Formby practices. Southport & Formby issues have been acknowledged. Training will be delivered as per role out and introduction of system across other practices, with issues incorporated into the training . Completed. Proposed for removal: in light of the assurance received and the reduction of the risk the lead has proposed removal.	3x3	~~3~~ 1	3	3	▼
QUA006	Q3 2013/14	QUA006	Providers RAG rating in relation to robust Safeguarding systems and processes presents lack of assurance for CCG based upon validation of information presented by the Trust. ~~Risk increased due to interface issues with reporting system between CSU and Safeguarding Hosted Service.~~	1	Quality and Financial	Chief Nurse (Debbie Fagan)	1. Assurance process paper presented to LSCB on processes in place. 2. RAG rating monitored via Quality Contract meetings. Reported to Quality Committee and escalated to Governing Body as required. Chief Nurse informed NHS England (M) and safeguarding will be included in the quality review process with the Trust. 3. Monitored through quality contract meetings with CSU 4. Agenda item for discussion at provider Quality Contract meetings. 5. Safeguarding performance discussed at Quality Committee. 6. Process developed between CSU and Safeguarding service to further develop information flow across the two services. 7. Quality 'Walk Around' carried out with feedback and outcomes reported to Executive Nurse, contract meetings, Quality Committee. 8. Contract reviewed to ensure in line with KPI's 9. Quality Surveillance agenda item for February 2015.	4	4	16				- Formal processes now in place and reportedly working well between provider, CSU and Safeguarding Services. Systems in place between CSU and Safeguarding Services which is working well. Quality and performance function in-housed from 1st June which will enable tighter controls. - Increased level of assurance reported from CCG Safeguarding Service for the main commissioned providers. One contract query was issued in March 2015 and remains open. Although action plan has already been put in place in response to the contract query. Contract query remains in place with Southport & Ormskirk hospital due to limited assurance still being reported by CCG and Safeguarding Services. Is being closely monitored.	2x4	~~2~~ 1	~~4~~ 3	3	▼

SOUTHPORT & FORMBY CCG

Corporate Risk Register

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

Q1: April - June 2015

Last Saved: 22/05/2015

ID	Date Added	2014/15 Reference	Principal Risk	2015/16 Corporate Objective	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	0+2 May	L	C	Current Risk Rating - April 15	Change Since Last Update
QUA008	Q1 2014/15	QUA008	Lab results not being communicated to GP practices (from the Lab provider) due to IT system/technical issues that may have an impact on patient safety.	7	Quality	Chief Nurse (Debbie Fagan) and Deputy Head of Quality and Safety and Medicines Management Lead, (Brendan Prescott)	1. Raised as an issue at the Quality Committee and Contract meetings. Director of Public Health notified. CCG comms notified. 2. GP clinical lead identified within CCG 3. Steering group set-up with reps from lab provider, local CCGs, I-Merseyside, Aintree Hospitals, NHS England and St Helens and Knowsley Informatics. Remains agenda item for discussion at Aintree CQPG and Aintree Collaborative forum. 4. Task and Finish Group established and receive progress and lessons learnt are discussed.	**4**	**5**	**20**	Four issues previously identified. Technical aspect closed however clinical issues still remain: 1. Macroprolachin 2. Clinisys (NT-proBNP & other analyses) 3. EPOC/EMIS 4. Clinisys Corrupt Characters/EMIS Web Decision to commission external review in relation to lessons learnt ~~discussed and~~ agreed. ~~Full agreement received on the proposal for an external review to look at 'Lesson's Learnt'; yet to be undertaken.~~ Scope of review to be finalised.	July 15	July 15	Meeting to be held on 20th May to agree Terms of Reference for external review. Terms of Reference not agreed due to commissioning difference of opinion. Subsequent meeting with Liverpool and South Sefton CCG's. Agreed to commission a joint review with the possibility of Knowsley CCG commissioning a further review if required. Issues around the need for the review and the scope of the review discussed and agreed with provider on 13th May 2015: meeting on 20th May to finalise. Further meeting held 15/6. Now need to agree scope of review. Action log reviewed with further actions closed down at meeting. Another meeting planned for 14/7. External agency contacted. Further incident occurred that tested the system installed by LCL. System was proved 'fit for purpose': doesn't mitigate for human error but highlights when an error has occurred.	1x5	**1**	**5**	**5**	▶
QUA010	Split from original risk Q3 Dec 2014, reworded April 2015	QUA010 (newly numbered - split from QUO009)	Risk that patients could receive inadequate care due to failure of implement local delivery of strategic blueprints and programmes (CVD and Respiratory)	1	Quality, Finance and Performance	Chief Strategy & Outcomes Officer (Karl McCluskey)	1. Strategic blueprints 2. Strategic programmes 3. Primary Care Dashboard 4. Integrated performance report 5. Updates to SMT 6. Clinical and managerial leads identified for all blueprints and programmes.	**3**	**5**	**15**	Identified need for new performance improvement and supported processes for localities. Need to ensure locality development identified on dashboard	July 2015 June 2015		In the process of establishing new PMO to support implementation and delivery, including process for localities. Indicated plan for disinvestment on current PMO function served by Informatics Merseyside. Development session held with wider membership strategy blue prints and priority programmes.	3x3	~~3~~ 2	**3**	**6**	▼
QUA011	Q3+1 January 2015	QUA011	Risk that patients could be harmed or receive inadequate care due to failure to deliver against National Key Performance Indicator for IAPT (Improving Access to Psychological Therapies)	1	Quality	Chief Strategy & Outcomes Officer (Karl McCluskey) and Chief Redesign & Commissioning Officer (Jan Leonard)	1. Investigation completed: established that provider had made a local interpretation of target resulted in an over inflation of position. Situation has been notified to NHS England 2. Remedial action plan in place 3. Performance and contractual meetings and reporting process in place 4. paper presented to Governing Body November 2014 5. Contract awarded to another provider effective April 2015.	**4**	**3**	**12**	- Legacy issue from old provider, with a presentation of a previously un-identified backlog. - significant HR issue identified - need to clarify waiting list position on new IT system			'Transferred to new provider. Historic issues relate to data transfer and performance. Validation of writing list and backlog completed. Backlog reduced from 1200 to 800. Acton plan in place. Full HR programme in place to address and tackle all identified HR issues with ongoing action plan. New system in place. Monthly reporting from July as part of internal performance report and weekly to SLT and SMT.	4x3	**4**	**4**	**16**	▲
QUA016	Q3+2 February 2015	QUA016	High volume of over 60 minute AMB turnaround times result in patients not receiving appropriate care	1	Quality	Head of Primary Care & Contracting (Malcolm Cunningham)	1. Regular feedback to monthly contract meetings 2. Regular communication with Blackpool CCG (lead commissioner)	**3**	**3**	**9**	Contract sanctions to be applied (as mandated April 2015)			Review carried out to help identify where improvements could be made to turnaround times. systems and processes looked at. Review indicated issues were related to capacity.	3x3	**3**	**3**	**9**	▶

SOUTHPORT & FORMBY CCG

Corporate Risk Register

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Q1: April - June 2015

Last Saved: 22/05/2015

ID	Date Added	2014/15 Reference	Principal Risk	2015/16 Corporate Objective	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	0+2 May	L	C	Current Risk Rating - April 15	Change Since Last Update
QUA020	Q3 Dec 2014	REP004	The closure of Breast Surgery Service (for new patients) at Southport & Ormskirk poses a risk to the CCG and concerns for local residents.	1	Quality	Chief Redesign & Commissioning Officer (Jan Leonard)	1. pro-active engagement exercise with effective public and key stakeholders completed and report presented to Governing Body in March 2015. 2. Safe services have been put in place via Aintree Hospital Trust - Patient Safety maintained throughout 3. Equality Impact Assessment 4. External review commissioned with and action plan pulled together based on the outcome and recommendations.	4	4	16	Draft pathway redesign, incorporating the findings of the engagement, to be presented to the Governing Body Consideration to be given to a Governing Body development session	~~June~~ Sept 2015 July 15	~~June~~ Sept 2015 July 15	~~Engagement process now completed. Report presented to the Governing Body in March.~~ ~~Now in process of~~ Future planning and re-aligning pathways almost completed. Multi provider meeting held. Action plan expected by the end of May 2015, with a further meeting to be held June 2015 ~~in order to finalise the action plan: to be presented to the Governing Body by end of quarter 1 15/16~~. Meeting to be held with West Lancashire CCG to discuss new pathway (30/6). Multi provider meeting being held mid July 15, outcome to be presented to September 15 Governing Body. Discussions to include implications of pathway. Trust has commissioned external review and has formulated an action plan based on the recommendations. Note: is a lower risk to South Sefton patients.	4x3	4	3	12	▶
QUA021	Apr-15	N/A	Impact on ability to deliver as a result of not being able to maintain Commissioning Support Services, neither via sustainability of existing services from NWCSU nor suitability of locally responsive Commissioning Support Services through the LPF	7	Quality	Chief Delivery and Integration Officer (Tracy Jeffes)	1. Working collaboratively with Merseyside and Cheshire CCG's as part of Transformation Board to identify and look at any concerns regarding sustainability. 2. Collaborative working with neighbouring CCGs to secure best value for money from the LPF	4	3	12	To commence work with NHS England to look at the LPF process and will include workshops on the specification and procurement process.	Jul-15	Aug-15	Meeting held with neighbouring CCG's. Agreement reached on approach across all stakeholders.	4x3	4	3	12	▶
QUA023	Apr-15	N/A	Merseycare not delivering against supplementary 800K investment for 2015/16 will result in diminished quality of care and lack of contribution to strategic Mental Health priorities	5, 1, 7	All	Chief Strategy & Outcomes Officer (Karl McCluskey)		4	3	12	- Clinical Transformation Board to be established. - work plan to be developed: completed. - Clinical Schemes to be agreed.	June 15 July 15 July 15		- Members notionally identified. To be discussed at a further meeting being held in May. Meeting held. Reviewed list of services and identified long list of provider options. Monthly meetings and draft TOR to be discussed and agreed at the next meeting to be held 14/7. Work plan developed. Clinical Schemes have been listed however further review and clinical discussion is needed before being detailed and finalised. Clinical schemes identified. To further discuss and agree at next meeting on 19/6.	4x3	4	3	12	▶
QUA024	Apr-15	N/A	Risk of poor quality patient care as a result of not delivering against A&E target	2,7	Quality, Business Objective, Statutory Duty.	Chief Strategy & Outcomes Officer (Karl McCluskey)	1. Strategic Resilience Group (SRG) in place. Meetings held on a monthly basis and feed into Governing Body. 2. Operational Service level meetings held: currently weekly. 3. Monthly contractual performance meetings 4. Monthly Integrated Performance Report: reported to Governing Body. 5. Monthly Quality meeting: reported to Governing Body	3	3	9				Southport & Ormskirk target achieved at end of May year to date: 93.26% Revised the intra-organisational forums to support and improve integration and delivery between the Strategic Transformation Board (West Lancs ICO) and monthly Executive to Executive.	3x3	3	3	9	▶
QUA025	Apr-15	N/A	Failure to progress an integrated approach across providers s a result of not delivering against the CCG's strategic blueprint for Shaping Sefton.	1,2,4,5,6,7	Quality, Business, Finance	Chief Strategy & Outcomes Officer (Karl McCluskey)	1. Blueprints established and agreed 2. Kings Fund supporting progress and development	3	3	9	- Restructure in Local Authority leadership - Awaiting finalised Governance and reporting arrangements	Sept 15		Shaping Sefton event held 16/6. Restructure of LA continues to progress.	3x3	3	3	9	▶
QUA026	Apr-15	N/A	CCG's failure to meet NHS England's target for CHC restitution cases.		Quality, Reputation	Chief Nurse (Debbie Fagan) and Chief Financial Officer (Martin McDowell)	1. CCG/CSU Steering Group: review CSU performance on a monthly basis and report to SLT (Senior Leadership Team) and SMT (Senior Management Team) 2. Regular Agenda item for SLA (Service Level Agreement) meetings	5	3	15	- Further NHS England support at CCG Checkpoint Assurance Meeting - An 'All CCG' meeting of Merseyside and Cheshire to be held to discuss current and future service			Underperformance continues against monthly trajectory Further reivew of risk undertaken in light of discussion at SMT. Was considered that risk REP036 was more comprehensive. QUA026 to be removed from the CRR.	5x3	5	3	15	▶
QUA027	Apr-15	N/A	Lack of affective pathways of care for specialist CAMHS (Child and Adolescent Mental Health Services - all age model and task force) as a result of ineffective joint commissioning.	7, 5	Quality	Chief Nurse (Debbie Fagan) and Geraldine O'Carroll (Team Manager)	1. Joint funded post employed within the Sefton Council infrastructure	3	3	9	Joint post possibly being looked at as part of review.			Looking at 'all age' mental health service. Currently have sufficient resources and capacity to take forward. Joint post might be looked at as part of LA review and cost savings.	3x3	3	3	9	▶

SOUTHPORT & FORMBY CCG

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Q1: April - June 2015

Last Saved: 22/05/2015

ID	Date Added	2014/15 Reference	Principal Risk	2015/16 Corporate Objective	Domain Type	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Date	Progress against action Plan	0+2 May	L	C	Current Risk Rating - April 15	Change Since Last Update
QUA028	Apr-15	N/A	Unable to deliver Personal Health Budgets (PHB) to patients as a result of CCG not having a governance system nor process in place to develop the provision of personal health budget's (PHB) to eligible patients choosing the PHB option.		Quality, Reputation, Finance	Deputy Head of Quality and Safety and Medicines Management Lead, (Brendan Prescott)	1. CCG/CHC Steering Group: issue raised with CHC team leads and strategic leads 2. Specification developed for PHB support 3. Fixed term 1 year role Programme Manager Role agreed 4. Regular Local Authority meetings held	3	3	9	- Education for Deputy Chief Nurse on developing PHB process at regional level - need to agree with LA on shared use of direct pay - Programme Manager role to be appointed to: would be responsible for developing PHB.	June 15 June 15 July 15		Meeting to be held with Department of Health appointed facilitator and attendance at regular events. Meeting held. Linked into Learning Network on PHB's. Out to provider for response on costings and timings. Further meeting with LA to be arranged for July in order to discuss potential shared use of Direct Payment system. Position appointed to. Awaiting start date.	3x3	3	3	9	▶
QUA029	Apr-15	N/A	Lack of resource to reprocure and ensure robust, open and transparent procurement process and quality service (SSP)	6	Quality, Reputation	Chief Redesign & Commissioning Officer (Jan Leonard)	1. Regular meetings with NHS England: reported to Governing Body	3	4	12	- NHS England to write to provider - Procurement Plan - Public Consultation - Joint Commissioning Committee ~(Southport & Formby and NHS England) to be established. Will also require constituted ToR.	July 2015 Aug 2015 Oct 2015		- NHS England Evaluation matrix devised: looks at the risks for each practice. Is being presented to part 2 Governing Body in May 2015. Will be managed through Joint Commissioning Committee when established. Went to part 2 Governing Body in May 2015. CCG requested NHS England review 1 aspect of matrix. NHS England now ready to write to provider. Procurement Planning meetings ongoing with NHS England. Further discussion at Governing Body Development meeting on the configuration of practices in relation to contracts. Working with NHS England and provider to develop action plan.	2x3	2	3	6	▶
QUA032	Apr-15	N/A	Delay's in specialist review of referrals which may result in a potential risk to patients (Choose and Book)		Quality	Terry Hill	1. Escalation through a letter via CCF to the chief executive (Catherine Beardshaw). 2. Clinical risk of patient referral (ASI) not being triaged in a timely manner, added to Trust risk register. 3. Project plan developed to tackle key issues resulting in the large number of appointment slot issues (ASI's), including high risk area's. 4. Interim process established with high risk services to ensure timely review of referrals (Dummy clinics) 5. Trust monitoring of Clinical business units via reporting mechanism 6. Interim targets set to ensure timely review of referrals (Max. 2ww = 2 days, urgent = 1 weeks, Routine = 6 weeks) 7. Standard Operating Procedures in place with specialties that ensure the reviewed of 'daily ASI reports' to ensure patients are appointed in a timely manner a specialist review of referral. Based on agreed flags, referrals escalated to service for a decision on appointing (seek agreement for overbooking or additional clinics). 8. Monthly meetings with the trust with clinical representation from CCG 9. Bi-monthly RTT meeting with the trust – C&B standing agenda item 10. Identification of high risk areas and process of monitoring/reporting	4	3	12	- Review of other trusts to learn best practice. - Reset targets in order to meet national guidance (2ww = 1 day, urgent/routine = 5days). - Reporting mechanism to assure the CCG that patients are appointed and referrals reviewed within set timescales.	Aug 2015 Aug 2015		An outline plan has been articulated however no timescales provided. A capacity review with local improvement plans developed for each directorate/specialty in order ensure a reduction in the number of ASI's which will result in a timely review of referrals and reduced risk to patients. The plan includes: · Trust and commissioner added Risk to organisational risk register (trust completed) · Identification of high risk areas and process of monitoring/reporting (Completed) · Interim 'dummy clinics' implemented to allow timely review of referrals in high risk area's until a full capacity review has been implemented (Completed) · Standard operating procedure by division introduced in order that ASI are managed affectively. (Completed) · Service level demand and capacity modelling linked to capacity available on CAB (incomplete) · Trust visit to practice (Incomplete) · Work towards introduction of new NHS E-referrals (incomplete) CCG in the process of: - looking at how to work to national guidance - LTT - assurance reports to speciality	4x3	4	3	12	▶
QUA033	Apr-15	N/A	Sustainability of ICO	4, 2	Quality, Financial	Chief Strategy & Outcomes Officer (Karl McCluskey)	1. Jointly commissioned independent sustainability review being undertaken by Deloit in agreement with West Lancs CCG, Southport & Ormskirk Hospital and Southport Formby CCG 2. Strategic Transformational Board established	5	4	20	Waiting response on formal ICO letter	Jun-15	Jun-15	- Developed 'Facing the future together' document to clarify community model to be delivered and milestones for delivery - Strategic Transformational Board established - Board to Board meeting held on 29th April 2015, with formal letter written to ICO Board setting out quality and performance concerns	5x4	5	4	20	▶
QUA034	Apr-15	N/A	Risk to delivery of community services as a result of Southport & Ormskirk Community Services not performing as expected	4, 1, 2	Quality, Reputation	Head of CCG Development (Billie Dodd)	1. 'Facing the Future Together': combined programme with West Lancs (delivering and improving community services with milestones) 2. 'Facing the Future Together' Programme Board 3. Milestones meetings held 4. Managing process with trust to ensure cost implications are considered	4	4	16	- District Nurses carrying out additional duties: consideration to be given on how to capture activity data. Now have activity and performance data however need to develop a set of outcomes - Community Emergency Team seeing twice the amount in 14/15 than seen in 13/14: consideration to be given on how to capture and linkages with quality and performance. -Facing the Future document to be reviewed: needs to be more outward facing with outcome measures.			- Next Milestone meeting due: will be seeking a decision on whether or not to go to procurement. - Next Facing the Future Board meeting being held. Facing the Future document to be reviewed: needs to be more outward facing and to develop outcome measures.	4x4	4	4	16	▶

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Q1: April - June 2015

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QUA039 NEW RISK	Jul-15	N/A	Inequity of care to patients as a result of provider being unable to deliver key part/s of the service specification (Oxygen)	7	Quality	Jenny Kristiansen	1. Contract not in place 2. Temporary contract in place with alternative provider to ensure provision of service	3	5	15	Re-tendering of service needed Review of procurement process needed			Options on re-tendering being discussed with CSU. Procurement process being reviewed New risk following SMT discussion (end June 2015)	N/A	3	5	15	N/A
			Reputation/Adverse Publicity																
REP003	Oct 2014: originally split from REP001	REP003	Unable to effectively manage local demands due to inadequate local CHC processes.		Quality, Reputation Link risk to TJ LPC risk	Chief Nurse (Debbie Fagan)	1. CCG/CSU CHC Steering Group. Currently meet fortnightly. 2. Improvement plan in place: monitored at Steering Group 3. CHC backlog monitored on a monthly basis now that residual backlog has decreased 4. Regular meetings with CCG Chief Nurse/Deputy Chief Nurse with local CHC leadership. 5. MD of stability partner has met with Chief Officer 6. Regular monthly meetings with Locality Lead: now in place from stability partner.	4	3	12	Progress of stability partner to be reviewed after 3 months To go to LPF for new service provider.	Sept 15 July 2015	Oct 15	- No strategic support for CHC team based at Merton House. NWCSU requested for a stability partner. Stability partner identified for leadership of team for initially 3 months. Locality Lead now in place (commenced June 2015) - Discussions being had with Local Authority regarding a possible future integration model: ongoing. - high level plans presented to Leadership Team and SLT on 23/6 -Preparatory work plans in place and progressing on track. To go to LPF for new service provider (July 2015)	4x3	4	3	12	▶
REP035 (re-numbered from 032 as duplicate number)	Apr-15	N/A	Non delivery of BCF target reductions in non-elective activity will lead to fewer resources available for BCF and impact on partnership working with the Local Authority.			Chief Delivery and Integration Officer (Tracy Jeffes)	1. Clear reporting on BCF to Health and Wellbeing Board and Programme Integration Group (PIG). 2. Joint Leadership Team and Sefton Council Senior Leadership team meetings established 3. Terms of Reference for Programme Integration Group (PIG). 4. Terms of Reference for Health & Wellbeing Board 5. Ongoing implementation of three BCF schemes aimed at reducing non-elective activity.	4	3	12	- Review of all Health & Well Being governance arrangements	Sep-15		One meeting held and a series of dates for further meetings booked.	4x3	4	3	12	▶
REP036 (NEW)	Oct 2014: originally split from REP001	N/A	Non-delivery against national trajectory for CHC restitution cases (PUPoC - packages of care for Previously Unassessed Periods of Care)		Reputation, Quality	Chief Nurse (Debbie Fagan)	1. CCG/CSU Steering Group 2. Trajectory monitored on a monthly basis by steering group and via monthly reporting from CSU 3. Agenda item for discussion at CCG SLA meetings with CSU 4. CCG reports on performance to NHS England at Checkpoint meetings	4	3	12				- CCG attended Footprint meeting with CSU (June 2015) - CCG discussed issue with NHS England and asked for support as issue not just specific to CCG - 11 outcomes including: - CSU to work on plans to reduce backlog - Lessons Learnt to be identified from how another CSU operates Further reivew of risk undertaken in light of discussion at SMT. Was considered that risk REP036 was more comprehensive. QUA026 to be removed from the CRR.	N/A	4	3	12	N/A
			Statutory Duty																
STA037 (NEW)	Jun-15	N/A	Risk that patients could be harmed or receive inadequate as a result of commissioned provider unable to deliver within statutory timeframes the health outcome information to be inserted into Education & Health Care Plans (EHCP) for children and young people with Special Educational Needs & Disability (SEND)		Statutory Duty	Chief Nurse (Debbie Fagan)	1. CCG systems and processes in place 2. CCG members of SEND Steering Group 3. Children's Commissioning Manager in regular contact with LA and provider to support system and flow 4. Regular reporting of position to Leadership Team	5	4	20	- meeting needed with LA to discuss issues - Awaiting provider remedial action plan - Formal meeting needed with LCH: awaiting date	Jul 15 July 15 July 15		- CCG Children's Commissioning Manager has met with LCH to discuss LCH systems and processes and those of LA - Discussed at CCG Leadership Team - meet with LA planned for 2/7 to discuss issues - Lease with Director of Nursing and Operational Manager at LCH - Chief Nurse has requested as a regular agenda item at the contract meetings with the provider New system sat LA Teething problems expected however these masked actual issues.	N/A	5	3	15	N/A
STA038 (NEW)	Jun-15	N/A	Risk that patients could be harmed or receive inadequate care due to lack of commissioner assurance in current processes for Looked After Children Health Assessments and Reviews across the local system		Statutory Duty, Quality	Chief Nurse (Debbie Fagan)	1. Reporting position to Leadership Team 2. Monitor through Quality Committee 3. Agenda item for contract meeting 4. KPI's in contract for Looked After Children 5. Statutory 903 return will be presented to Corporate Parenting Board by LA: CPB chaired by an elective member	5	4	20	Data quality exercise to be carried out. Areas of assessment is on data to 31st March 2015 and will include: - whether or not assessed - if assessed, at what stage - whether assessments have been carried out but information not forwarded. Lessons Learnt event to be held	Jul 15 Jul 15		- Chief Nurse in conversations with Executive team of LCH and Head of Service in LA: discussions 25 and 26/6. - Remedial actions between LCH and LA with support from designated nurse for Looked After Children for CCG. Actions include data quality exercise on data to the end of March 2015 to determine whether or not assessed and at what stage of assessment. - Chief Nurse has sent an e-mail on 26/6 regarding a Lessons Learnt event to be held the beginning of July 15, with a Pathway meeting to be held within 2 weeks of event. - Designated Nurse for Looked After Children has requested provider do risk assessment for the children in order to prioritise any health assessment or review that might need to be undertaken.	N/A	5	4	20	N/A

VERSION: v1

Southport and Formby Clinical Commissioning Group

Southport & Formby CCG Assurance Framework – Quarter 1 2015-16: April - June 2015

Corporate Objective 1: To place clinical leadership at the heart of localities to drive transformational change				**Governing Body Reports**			
Lead Officer/Risk Owner: Jan Leonard							
Principal Risks	**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 Lack of capacity amongst clinical colleagues to deliver transformation ***(Carried forward from Q4 14/15: previously 5.1 - updated – new objective 1)***	**3 x 3**	Development of Local Quality Contract Primary Care Clinical Lead identified in new GB Documented and robust PDR process for Governing Body members and locality lead roles Locality and practice lead roles clarified Service Improvement and Redesign (SIR) Committee, established. Consultation complete. Contract finalised, all practices signed up.	Monitoring of uptake and performance of LQC, reported to SIR Committee and Governing Body. Regular updates to Senior Leadership Team on LQC Minutes of Locality Meetings received by Governing Body Governing Body oversight of PDR process for members/clinical and locality leads via exception reporting Primary Care Programme Lead appointed. Will have responsibility for focus on primary care development and transformation.	**Significant** **Reasonable** **Limited** Primary Care Programme Lead appointed: awaiting commencement.	(GIC) Review needed on 2014/15 delivery and outcomes. (GIC) Monitoring of 2015/16 uptake, delivery and performance needed.	To be undertaken by Programme Lead. To be undertaken by Programme Lead.	Sept 2015 Ongoing through year.
Progress Reports	**Q1**	**Primary Care Programme Lead appointed: awaiting commencement. Will have responsibility for focus on primary care development and transformation.**				**Assurance Rating**	**Limited**
	Q2						
	Q3						
	Q4						

Corporate Objective 1: To place clinical leadership at the heart of localities to drive transformational change				**Governing Body Reports**			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks	**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 Lack of clinical engagement in Primary Care and other providers limit level of clinical engagement in locality to drive transformational change ***(New)***	**4 x 3**	Organisational Development Plan in place. Local Development Plans	Support from Governing Body for the local development plans Reported to leadership team Regular Governing Body Development Sessions to help drive agenda.	**Significant** **Reasonable** **Limited** Roles and responsibilities of leads, locality support and reporting mechanisms being reviewed.	(GIC) Review to be undertaken on Organisation Development Plan. (GIC) Review to be undertaken on Local Development Plans (GIC) Clearer performance to deliver CCG Strategy (GIC) Capacity of clinicians to be release and engaged in CCG activity	Being developed further including the roles and responsibilities of leads, locality support and reporting mechanisms. Clinical leadership succession plan and commissioning training and development for emergent Clinical Commissioners.	Sept 2015 July 2015
Progress Reports	**Q1**	**Roles and responsibilities of leads, locality support and reporting mechanisms being reviewed.**				**Assurance Rating**	**Limited**
	Q2						
	Q3						
	Q4						

Corporate Objective 2: To develop the integration agenda across health and social care.				**Governing Body Reports**			
Lead Officer/Risk Owner: Tracy Jeffes							
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 Inability to carry out system wide change due to resource and structural re-organisation constraints ***(Carried forward from Q4 14/15: previously 6.1 - reworded and updated – new objective 2)***	**4x3**	Regular joint meetings with Sefton Council to develop Integration Plans. Key officers assigned from Sefton Council and CCG to develop intermediate care strategy Section 75 in place: BCF Cross sector shaping to stimulate whole system working: 2 held to date.	Documented Evidence of reports and minutes from meetings Regular joint reporting on BCF to NHS England	**Significant** **Reasonable** **Limited** Review of HWBB structure to ensure streamlined and effective however, awaiting completion of Local Authority restructure.	(GIC) Review of HWBB structure to ensure a streamlined and effective approach to commissioning.	Awaiting completion of Local Authority restructure.	August 2015
Progress Reports	**Q1**	**Review of HWBB structure to ensure streamlined and effective however, awaiting completion of Local Authority restructure.**				**Assurance Rating**	**Limited**
	Q2						
	Q3						
	Q4						

Corporate Objective 3: To consolidate the Estates Plan and develop one new project for March 2016.				**Governing Body Reports**			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks	**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 Securing adequate resources and expertise to deliver NHS Estates Strategy	**3x3**	CCG's requirement to deliver the Estates Strategy	Locality meetings Sefton Property Partnership established. Estates support secured 1 day per week	**Significant** **Reasonable** **Limited** Draft strategy being worked on. First draft due November 2015.	(GIC) Late notification from on responsiveness (GIA) Shared view at locality level regarding the outcome of the strategy	Draft strategy being worked on. First draft to November Governing Body. Expected to be finalised December 2015.	November 2015 December 2015

Progress Reports	**Q1**	**Draft strategy being worked on. First draft due November 2015.**	**Assurance Rating**	**Limited**
	Q2			
	Q3			
	Q4			

Corporate Objective 3: To consolidate the Estates Plan and develop one new project for March 2016.				**Governing Body Reports**			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks	**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 develop a coherent view in order to deliver an agreed project across part /full locality	3x3	Delivery of Estates Strategy by end of 2015	Locality meetings Sefton Property Partnership established. Estates support secured 1 day per week Ongoing dialogue with NHS England for capital project funding and finance	**Significant** **Reasonable** **Limited** Estates support secured. Ongoing dialogue with interested parties	(GIC) Lack of clarity around finance and availability. National guidance expected. (GIA) Need a clear response from GPs on Locality Estates Strategy		Q3 (Oct – Dec 2015) Sept 2015
Progress Reports	**Q1**	**Estates support secured. Ongoing dialogue with interested parties.**				**Assurance Rating**	**Limited**
	Q2						
	Q3						
	Q4						

Corporate Objective 4: To publish plans for community services and commission for March 2016.				Governing Body Reports			
Lead Officer/Risk Owner: Billie Dodd							
Principal Risks	**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 Review and re-specification of community services may not deliver ***(Carried forward from Q4 14/15: previously 3.1 and 4.1 merged, reworded and updated – new objective 4)***	3x4	Wider Constituent Group established. Lead GP focus from CCG chair and Vice Clinical chair 'Facing the future' work with West Lancs. 'Closer to Home' Strategy Monitoring activity rates via CSU portals and contract meetings.	Care closer to Home board Strategic Transformation Partnership Board Minutes of meetings feed into Strategic Transformation Partnership Board. Updates to the Governing Body via the Chief Officers report. Contract meeting via F&R committee. Care Closer to Home Programme Board Monthly minutes of F&R committee are reported to Governing Body and Chief Officers report is submitted to the Governing Body (standing agenda Items) Regular reporting to NHS E against performance. In particular quarterly assurance meetings.	**Significant** **Reasonable** **Limited** Event held in April 2015 which included a discussion regarding the Senior Medical Model in the community and involved local GP's and local Geriatricians. Outcome resulted in the commissioning of rapid access scheme. Wider Group meeting to be held 15/7. Process made by ICO in terms of community services and a recommendation will be sought for future direction	(GIC) Nursing Home Pilot to be rolled out across Southport & Formby. Is included as part of local Quality Contract.		Oct 2015
Progress Reports	**Q1**	**Final gateway meeting to be held 30/6/15 for milestones for Southport. Outcome and options to be presented to the 15/7/15 Facing the Future meeting. Outcome and options to then be presented to the Governing Body on 2/7/15. Implementation to commence 1/8/15.**				**Assurance Rating**	**Limited**
	Q2						
	Q3						
	Q4						

Corporate Objective 5: To commission new care pathways for mental health.				**Governing Body Reports**			
Lead Officer/Risk Owner: Karl McCluskey							
Principal Risks	**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 Failure to progress recommendations and priorities from Mental Health review ***(Is a continuation/ progression from Q4 14/15: re 7.1 – reworded and updated – new objective 5)***	**3 x 3**	Clinical lead appointed Blueprint agreed and signed off by Governing Body (June 2015). Clinical Group established. Project Group agreed and in place.	Regular progress reporting to Governing Body Progress management and assessment undertaken. Minutes of meetings PMO monitoring process in place.	**Significant** **Reasonable** **Limited** Enhanced resource position going out to advert. Detailed project plan being progressed.	(GIC) Enhanced resource required. (GIC) Detailed project plan required. (GIA) Project plan to be presented to the Service Improvement & Redesign Committee	Position to go out to advert. Currently being worked on. Will include: - Primary Care Mental Health - Dementia - CAMHS - Brain Injuries Plan scheduled for review by SIR committee.	July 2015 July 2015 Sept 2015
Progress Reports	**Q1**	**Enhanced resource position going out to advert. Detailed project plan being progressed.**				**Assurance Rating**	**Limited**
	Q2						
	Q3						
	Q4						

Corporate Objective 6: To achieve Phase 1 of Primary Care transformation.				**Governing Body Reports**			
Lead Officer/Risk Owner: Jan Leonard							
Principal Risks	**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**
6.1 Inability to deliver transformational change as a result of inappropriate estates ***(New)***	**4x3**			**Significant** **Reasonable** **Limited** Estates Group to be established and confirm position of estates review.	(GIC) Estates Group to be established. (GIC) Position of estates review to be confirmed by Estates Group.	Membership to include Finance, Clinicians, NHS England, Local Authority and Estates.	July 2015 Aug 2015
Progress Reports	**Q1**	Estates Group to be established and confirm position of estates review.				**Assurance Rating**	**Limited**
	Q2						
	Q3						
	Q4						

Corporate Objective 7: To achieve financial duties and commission high quality care.				Governing Body Reports			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks	**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**
7.1 Non Delivery of financial targets due to failure to control CCG expenditure budgets or failure to deliver required QIPP scheme ***(Carried forward from Q4 14/15: 1.1 reworded, merged and updated with 1.2 – new objective 7)***	4x4	Internal and External Audit Plan in place to review systems of internal control Robust financial management and control processes in place to ensure reserves and contingency are utilised in an appropriate manner Internal budgetary management process in place to support and challenge budget holder to deliver within agreed limit. Provider contracts agreed and signed with specified activity levels and associated costs	Financial Plan for 2015/16 signed off by Governing Body (May 2015). Agreed provider contracts signed for 2015/16. Robust contract management arrangements in place to review performance, activity and quality, including associated costs within agreed limits (including CQUIN) Monthly Finance performance reports presented to Finance & Resource Committee with reporting to Governing Body by exception report. Monthly reporting to NHS England as part of the collective NHS Financial position. Internal budgetary management process in place to support and challenge budget holder to delivery within agreed limit. Budget holder training held: ongoing rolling programme.	**Significant** **Reasonable** **Limited**	(GIC) Required QIPP schemes to be identified (GIA) Better information needed at practice level.	QIPP working group established. Group to identify required schemes Currently working through.	August 2015 August 2015

Corporate Objective 7: To achieve financial duties and commission high quality care.				**Governing Body Reports**			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks	**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**
			Working Group established to identify required QIPP scheme	Better information being provided at practice level however further improvements to be developed. QIPP working group established.			
Progress Reports	**Q1**	QIPP working group established. Group to identify required schemes. Further improvements to be developed for practice level information.				**Assurance Rating**	**Limited**
	Q2						
	Q3						
	Q4						

Corporate Objective 7: To achieve financial duties and commission high quality care.		Governing Body Reports					
Lead Officer/Risk Owner: Tracy Jeffes							
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**
7.2 Lack of sustainability of CSU services during transition and the effective procurement of CSU services via LPF ***(Carried forward from Q4 14/15: 1.5 updated – new objective 7)***	**3 x 4**	New SLA in place with CSU Contract/Performance Monitoring Group in place and meeting on monthly basis. Exception reporting on performance and delivery at SMT Pan Cheshire and Merseyside Collaborative approach to commissioning future services via LPF.	Monthly meeting of Performance Monitoring Group Reports to Finance & Resource Committee on six monthly basis Plan in place CHC. Project management support from NHS England. Additional capacity and support via secondment position Weekly meeting of Merseyside CCG's: work on procurement through LPF. Reported to Transition Board Stability partner identified.	**Significant** **Reasonable** **Limited** In-housing of some services continues. Stability partner identified. Robust specifications in development for the LPF.	(GIA) To complete r in-housing of identified services (GIA) Robust specifications needed for all areas.	Some additional services being brought in-house in order to secure local responsiveness and sustainability Specifications being development: to go out on LPF.	November 2015

Progress Reports	**Q1**	**In-housing of some services continues. Stability partner identified. Robust specifications in development for the LPF.**	**Assurance Rating**	**Limited**
	Q2			
	Q3			
	Q4			

Corporate Objective 7: To achieve financial duties and commission high quality care.						**Governing Body Reports**	
Lead Officer/Risk Owner: Karl McCluskey							
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**
7.3 Non-delivery of 2015/16 QIPP Plan which supports transformational change ***(Carried forward from Q4 14/15: 1.6 updated – new objective 7)***	4 x 4	Development Plan commenced. Initial focus will include Dermatology, Gynaecology and Development Plan commenced. Initial focus will include Dermatology, Gynaecology and Development Plan commenced. Initial focus will include Dermatology, Gynaecology and	QIPP financial savings targets and plans signed off by the Governing Body (April 2015) Monthly financial performance reports (including QIPP targets and associated savings) presented to Finance and Resource Committee and reviewed by the Governing Body. Revised Strategic Plan develop Joint QIPP Group established (Governing Body and Clinical Leadership)	**Significant** **Reasonable** **Limited** Development Plan commenced. Initial focus will include Dermatology, Gynaecology and Gastroenterology.	(GIC) Development plan required. Needs to include areas for financial cost reduction.	Being developed. Initial focus will include: 1. Dermatology 2. Gynaecology 3. Gastroenterology	July 2015
Progress Reports	**Q1**	Development Plan commenced. Initial focus will include Dermatology, Gynaecology and Gastroenterology.				**Assurance Rating**	**Limited**
	Q2						
	Q3						
	Q4						

Corporate Objective 7: To achieve financial duties and commission high quality care.				**Governing Body Reports**			
Lead Officer/Risk Owner: Karl McCluskey							
Principal Risks	**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**
7.4 Potential for any reduction in non-elective admissions may be offset by increased demand ***(Carried forward from Q4 14/15: 2.1 updated – new objective 7)***	**4x3**	Weekly and monthly non-elective performance reviewed by PMO / SMT Bi-monthly performance reports to Governing Body	Exception reporting to Governing Body bi-monthly Exception issues raised and alerted through SMT to be addressed via Head of CCG Development. Integrated Performance Report produced monthly for Governing Body. Minutes of meetings Revised 2015/16 activity plan developed with detailed rationale. Reviewed by Governing Body February 2015 with agreement and sign-off April 2015.	**Significant** **Reasonable** Performance being closely monitored with appropriate systems and procedures in place. Contract query issued to Southport & Ormskirk as a result of a performance issue being identified. **Limited**	(GIA) Awaiting response on contract query issued to Southport & Ormskirk	Reported RTT performance has been compromised by PAS information system (Patient Administration System).	July 2015
Progress Reports	**Q1**	**Performance being closely monitored with appropriate systems and procedures in place. Contract query issued to Southport & Ormskirk as a result of a performance issue being identified.**				**Assurance Rating**	**Reasonable**
	Q2						
	Q3						
	Q4						

Corporate Objective 7: To achieve financial duties and commission high quality care.				**Governing Body Reports**			
Lead Officer/Risk Owner: Debbie Fagan							
Principal Risks	**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**
7.5 Failure of provider to deliver high quality services for the delivery of CHC/Individual packages of care would result in patients not receiving appropriate level of care to meet their needs. ***(New)***	**4x3**	Steering Group established. Improvement Plan in place with NWCSU Weekly meetings between CCG Chief Nurse/Deputy Chief Nurse and operational leads within CSU	MIAA review of CCG internal processes: significant assurance. Closely monitor and review backlog for improvement in performance on a bi-monthly basis via Steering Group. Action plan in place. Regular reporting to Leadership Team and SLT. Regular reporting to F&R Committee. Regular review of Corporate Risk at Quality Committee. Continue to support CSU in local delivery of SOP and governance processes.	**Significant** **Reasonable** **Limited** Assurance level decrease following review of CSU information regarding Mental Health reviews.	(GIC) Discussion needed on the outcome of the CCG's review on NWCSU CHC systems, processes and evidence.	CCG requested information from NWCSU on the systems and processes in place for CHC, specifically Mental Health reviews and including: - Supervision policy - Templates used - Evidence of audit plan and outcome - 2 anonymised cases for independent review Evidence collated and reviewed. CCG consider 'Limited' assurance. Letter to be sent to MD of NWCSU.	July 2015
Progress Reports	**Q1**	**Assurance level decrease following review of CSU information regarding Mental Health reviews.**				**Assurance Rating**	**Limited**
	Q2						
	Q3						
	Q4						

GUIDANCE

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 needs 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 subcommittee or committee of the Governing Body which is tasked with monitoring the specific risk.

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

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 Governing Body information and not viewed as year-end exercises.

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 Governing Body 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 Governing Body, 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 Governing Body, 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 Governing Body 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 Governing Body, 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 Corporate Risk Register.

VERSION: v2

NHS
Southport and Formby
Clinical Commissioning Group

Southport & Formby CCG Assurance Framework – Quarter 1 2015-16: April - June 2015

SUMMARY

	Principal Risk	Owner	Risk Rating	Assurance Rating	Quarter update	Comments
1	**To place clinical leadership at the heart of localities to drive transformational change**					
1.1	Lack of capacity amongst clinical colleagues to deliver transformation	Jan Leonard	3x3	Limited	Primary Care Programme Lead appointed: awaiting commencement. Will have responsibility for focus on primary care development and transformation.	
1.2	Lack of clinical engagement in Primary Care and other providers limit level of clinical engagement in locality to drive transformational change	Tracy Jeffes	4x3	Limited	Roles and responsibilities of leads, locality support and reporting mechanisms being reviewed.	
2	**To develop the integration agenda across health and social care.**					
2.1	Inability to carry out system wide change due to resource and structural re-organisation constraints	Tracy Jeffes	4x3	Limited	Review of HWBB structure to ensure streamlined and effective however, awaiting completion of Local Authority restructure.	
3.	**To consolidate the Estates Plan and develop one new project for March 2016.**					
3.1	Securing adequate resources and expertise to deliver NHS Estates Strategy	Martin McDowell	3x3	Limited	Draft strategy being worked on. First draft due November 2015.	
3.2	Failure to develop a coherent view in order to deliver an agreed project across part /full locality	Martin McDowell	3x3	Limited	Estates support secured. Ongoing dialogue with interested parties.	
4.	**To publish plans for community services and commission for March 2016.**					
4.1	Review and re-specification of community services may not deliver	Billie Dodd	3x4	Reasonable	Final gateway meeting to be held 30/6/15 for milestones for Southport. Outcome and options to be presented to the 15/7/15 Facing the Future meeting. Outcome and options to then be presented to the Governing Body on 2/7/15. Implementation to commence 1/8/15.	

5.	**To commission new care pathways for mental health.**					
5.1	Failure to progress recommendations and priorities from Mental Health review	Karl McClusky	3x3	Limited	Enhanced resource position going out to advert. Detailed project plan being progressed.	
6.	**To achieve Phase 1 of Primary Care transformation.**					
6.1	Estates Group to be established and confirm position of estates review.	Jan Leonard	4x3	Limited	Estates Group to be established and confirm position of estates review.	
7.	**To achieve financial duties and commission high quality care.**					
7.1	Non Delivery of financial targets due to failure to control CCG expenditure budgets or failure to deliver required QIPP scheme	Martin McDowell	4x4	Limited	QIPP working group established. Group to identify required schemes. Further improvements to be developed for practice level information.	
7.2	Lack of sustainability of CSU services during transition and the effective procurement of CSU services via LPF	Tracy Jeffes	3x4	Limited	In-housing of some services continues. Stability partner identified. Robust specifications in development for the LPF.	
7.3	Non-delivery of 2015/16 QIPP Plan which supports transformational change	Karl McClusky	4x4	Limited	Development Plan commenced. Initial focus will include Dermatology, Gynaecology and Gastroenterology.	
7.4	Potential for any reduction in non-elective admissions may be offset by increased demand	Karl McClusky	4x3	Reasonable	Performance being closely monitored with appropriate systems and procedures in place. Contract query issued to Southport & Ormskirk as a result of a performance issue being identified.	
7.5	Failure of provider to deliver high quality services for the delivery of CHC/Individual packages of care would result in patients not receiving appropriate level of care to meet their needs.	Debbie Fagan	4x3	Limited	Assurance level decrease following review of CSU information regarding Mental Health reviews.	

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
JULY 2015

Agenda Item: 15/128	**Author of the Paper** PricewaterhouseCoopers LLP 8 Princes Parade St Nicholas Place Liverpool L3 1QJ Martin McDowell Chief Finance Officer martin.mcdowell@southportandformbyccg.nhs.uk Tel: 0151 247 7065
Report date: July 2015	

Title: CCG Annual Audit Letter 2014/15

Summary/Key Issues:

This report is provided by the CCG's External Auditors to confirm their findings from the Audit of the CCG's financial statements. The report concluded that the CCG's accounts were in line with approved Auditing Standards and issued an unqualified Audit Opinion. The report also concluded that the CCG had proper arrangements in place to secure economy, efficiency and effectiveness in the use of its resources. Based upon the findings of the work the CCG's external auditors issued an unqualified value for money conclusion.

Recommendation

The Governing Body is asked to receive this report.

Receive	X
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
X	To place clinical leadership at the heart of localities to drive transformational change.
	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	To publish plans for community services and commission for March 2016.
	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
X	To achieve financial duties and commission high quality care.

NHS
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	
Resource Implications Considered	X			
Locality Engagement			X	
Presented to other Committees	X			Audit Committee July 2015

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

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Annual Audit Letter to the Governing Body

NHS Southport and Formby Clinical Commissioning Group

Year ended 31 March 2015

1 July 2015

PricewaterhouseCoopers LLP
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The Governing Body
NHS Southport and Formby Clinical Commissioning Group
Family Life Centre
Southport
PR8 6JH

1 July 2015

Ladies and Gentlemen

We are pleased to present our Annual Audit Letter summarising the results of our audit for the year ended 31 March 2015.

This is our final year as auditors of NHS Southport and Formby Clinical Commissioning Group and we would like to thank members of the Governing Body, management and staff for their assistance during the course of our period as your external auditors. For your information we have met with your incoming auditors to share information relevant to the audit and ensure a smooth transition to the new external audit arrangements.

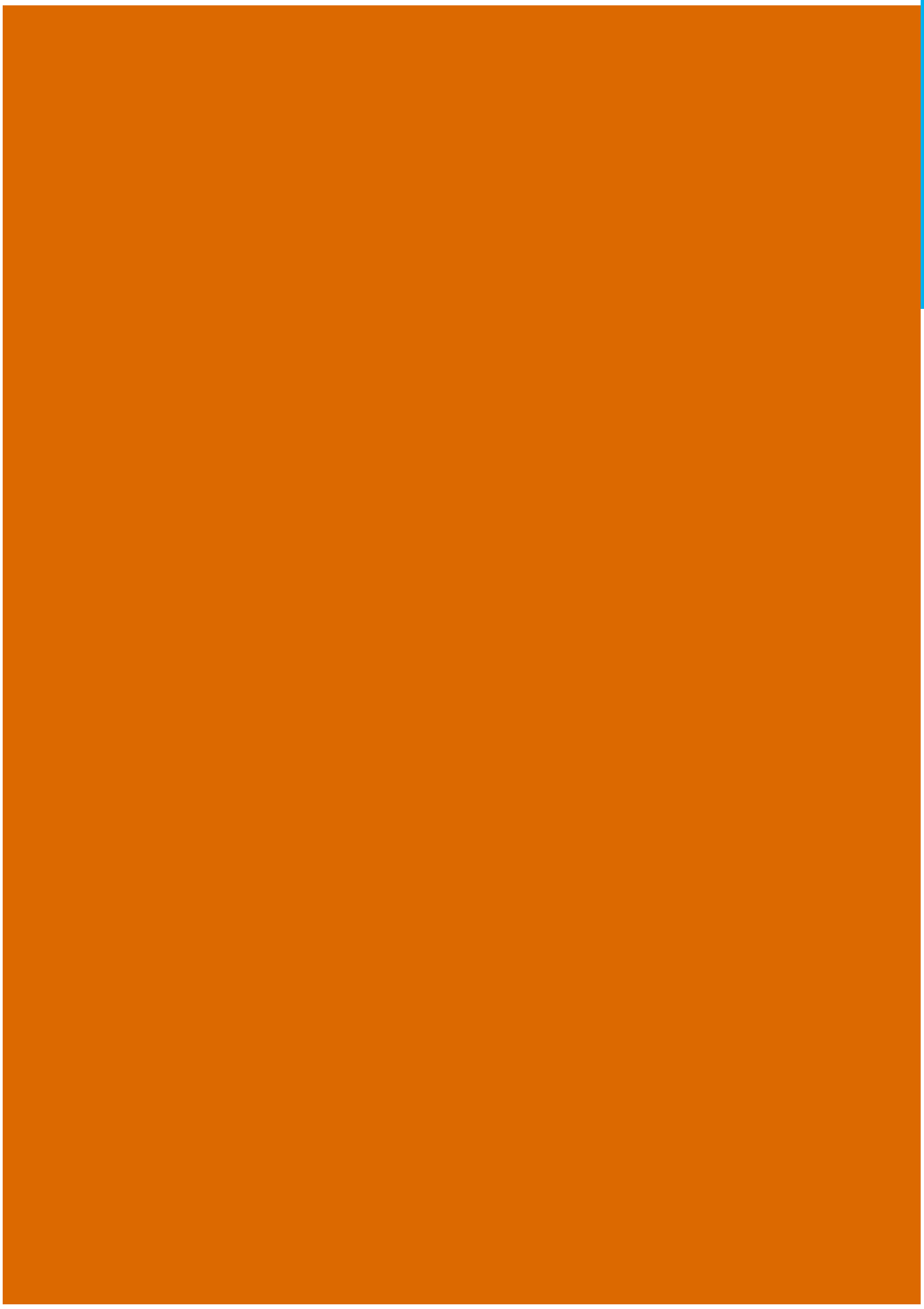
Yours faithfully

PricewaterhouseCoopers LLP

Code of Audit Practice and Statement of Responsibilities of Auditors and of Audited Bodies

In March 2014 the Audit Commission issued a revised version of the 'Statement of responsibilities of auditors and of audited bodies' (the 'Statement'). It is available from the Chief Officer of each audited body and on the Audit Commission's website. The purpose of the statement is to assist auditors and audited bodies by explaining where the responsibilities of auditors begin and end and what is to be expected of the audited body in certain areas. Our reports are prepared in the context of this Statement. Reports and letters prepared by appointed auditors and addressed to members of the governing body or officers are prepared for the sole use of the audited body and no responsibility is taken by auditors to any member of the governing body or officer in their individual capacity or to any third party.

Contents



Introduction

The purpose of this letter

This letter provides the Governing Body of NHS Southport and Formby Clinical Commissioning Group ("the CCG") with a high level summary of the results of our audit for the year ended 31 March 2015, in a form that is accessible for you and other interested stakeholders.

We have already reported the detailed findings from our audit in the following reports:

- report on the results of our audit to the CCG's Audit Committee, as "those charged with governance" within the CCG, under the requirements of International Standards on Auditing (UK&I) 260, dated 19 May 2015;
- audit opinion on the financial statements for the year ended 31 March 2015, incorporating the value for money conclusion and the regularity opinion, dated 28 May 2015; and
- a letter to the Audit Committee dated 28 May 2015 to provide an update on any matters that were outstanding at the time we wrote our International Standards on Auditing (UK&I) 260 report referred to above.

We have included in this report our significant audit findings.

Scope of work

We carried out our audit work in accordance with the Audit Commission's Code of Audit Practice (NHS), International Standards on Auditing (UK and Ireland) and other relevant guidance issued by the Audit Commission.

You are responsible for preparing and publishing the CCG's financial statements, including the Annual Governance Statement. You are also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in your use of the CCG's resources.

As auditors we need to:

- form an opinion on the financial statements;
- form an opinion on the regularity of the CCG's transactions;
- form a conclusion on the arrangements that you have in place to secure economy, efficiency and effectiveness in your use of the CCG's resources;
- review the CCG's Annual Governance Statement; and
- carry out any other work specified by the Audit Commission or its successor bodies.

We have carried out our audit work in line with our 2014/15 Audit Plan that we presented to the CCG's Audit Committee in January 2015.

Audit Findings

Accounts

We audited the CCG's accounts in line with approved Auditing Standards and issued an unqualified audit opinion on 28 May 2015.

We reported to the CCG's Audit Committee on several areas where the CCG had applied judgement to the recognition and measurement of items in the financial statements to help the Committee to discharge its governance responsibilities with respect to the approval of the financial statements. In each case we were satisfied with the judgements and accounting estimates applied by the CCG when preparing its financial statements.

Our regularity opinion

We gave our opinion on whether, in all material respects, you have used the CCG's money as Parliament intended and whether you have done so in accordance with the various authorities governing the transactions. We issued an unqualified regularity opinion on 28 May 2015.

Our value for money conclusion

We carried out sufficient, relevant work, in line with the Audit Commission's guidance, so that we could conclude on whether you had in place, for the year ended 31 March 2015, proper arrangements to secure economy, efficiency and effectiveness in your use of the CCG's resources.

In line with Audit Commission requirements, our conclusion was based on two criteria:

- the organisation has proper arrangements in place for securing financial resilience; and
- the organisation has proper arrangements for challenging how it secures economy, efficiency and effectiveness.

To reach our conclusion, we carried out a programme of work that was based on our risk assessment as follows:

- we reviewed the CCG's monitoring processes for its Quality, Innovation, Productivity and Prevention (QIPP) programmes, performed a review of 2014/15 QIPP delivery and considered the robustness of 2015/16 QIPP plans;
- we reviewed the contractual arrangements with the CCG's main providers, focussing on the contracting process and a review of performance against contract; and
- we reviewed the CCG's risk management processes, in particular reviewing the risk register and assurance framework.

Based upon the findings of our work we issued an unqualified value for money conclusion on 28 May 2015.

Annual Governance Statement

The aim of the Annual Governance Statement is to give a sense of how successfully the CCG has coped with the challenges it faced, drawing on evidence on governance, risk management and controls.

We reviewed the Annual Governance Statement to see whether it complied with relevant guidance and whether it was misleading or was inconsistent with what we know about the CCG.

We found no areas of concern to report in this context.

Summary of recommendations

Management are responsible for developing and implementing systems of internal financial control and putting in place proper arrangements to monitor their adequacy and effectiveness in practice. As auditors, we review these arrangements for the purposes of our audit of the financial statements and our review of the Annual Governance Statement.

The only deficiency in the internal control system we identified during our audit is summarised below:

Deficiency	Recommendation	Management's response
Contract activity levels are not regularly reviewed (medium risk).	There are a number of contracts managed jointly by Southport and Formby CCG and South Sefton CCG. Allocations are sometimes made using management's best estimate without adequate support from the respective activity levels of the two CCGs. It is recommended that activity levels are reviewed on a more regular basis to ensure that apportionments are based on actual activity rather than best estimates.	Agreed, we are working closely with providers such as Mersey Care to continue to improve data quality and thus ensure contract apportionments are split accurately in line with patient data and activity wherever possible.

Our fees

We reported our audit fee proposals in our Audit Plan. Our actual fees will be as follows:

	2014/15 outturn (£)	2014/15 fee proposal (£)	2013/14 final outturn (£)
Total audit fee	60,000	60,000	66,000
Non-audit fees	0	0	0
Total fees	60,000	60,000	66,000

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2015

Agenda Item: 15/129	**Author of the Paper:** Karl McCluskey Chief Strategy and Planning Officer Email: karl.mccluskey@southportandformbyccg.nhs.uk Tel: 0151 247 7006
Report date: July 2015	
Title: QIPP / SIR Committee – Joint terms of Reference	
Summary: This paper provides the Terms of Reference for the new joint QIPP / SIR Committee.	
Recommendation The Governing Body is asked to approve QIPP / SIR Terms of Reference.	Receive [ ] Approve [x] Ratify [ ]

Links to Corporate Objectives *(x those that apply)*	
x	To place clinical leadership at the heart of localities to drive transformational change.
	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	To publish plans for community services and commission for March 2016.
	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
x	To achieve financial duties and commission high quality care.

NHS
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	
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 Southport and Formby CCG and NHS South Sefton CCG Joint Committee

QIPP/Service Improvement and Redesign (SIR) Committee

Terms of Reference

1. Authority

1.1. The Committee shall be established as a joint committee of NHS Southport and Formby CCG and NHS South Sefton CCG.

1.2. The committee is established in accordance with the Legislative Reform (Clinical Commissioning Group) Order 2014[1] and the associated enabling provisions of set out in Section 23.4 of NHS South Sefton CCG Constitution[2] and Section 6.6 of NHS Southport and Formby CCG Constitution[3].

1.3. The principal functions of the Committee are as follows:

- To enable thorough and open discussion about all service improvement and re-design priorities for both CCGs.
- To provide a forum for South Sefton CCG and Southport and Formby CCG localities, their practices clinical leads, Clinical Director, CCG locality leads and practice representatives to identify potential areas of improvement and support plans and proposals for implementation.
- The Committee shall be authorised by the CCG Governing Body of NHS Southport and Formby CCG and NHS South Sefton CCG – (the "Governing Bodies") 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.
- To provide assurance to the Governing Bodies that there are appropriate systems in place which operate in order to enable the Committee to fulfil its monitoring requirements
- To provide regular reports to the Governing Bodies 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.
- The Committee does ***not*** have power to authorise expenditure and any proposals in respect of the allocation of resources shall be submitted to the Finance and Resources Committee of each CCG for consideration of approval.

[1] Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292808/Legislative_Reform__Clinical_Commissioning_Groups__Order_2014-revised_dr....pdf
[2] At page 29
[3] At page 17

2. Membership

2.1. The following will be members of the Committee:

- Chair – Clinical
- Clinical Vice Chair(s) (SFCCG / SSCCG) (Rotational Chair of the Committee)
- Chief Officer (SF / SSCCG)
- Chief Finance Officer (SF / SSCCG)
- Chief Strategy & Outcomes Officer (SF / SSCCG)
- Lay Member for Governance & Audit (SFCCG)
- Lay Member for Governance & Audit (SSCCG)
- Chief Service & Redesign Officer (SF / SSCCG)
- Deputy Chief Financial Officer (SF / SSCCG)
- Chief Nurse or Deputy Chief Nurse (SF / SSCCG)
- Strategy & Outcomes Lead (SF / SSCCG)

2.2. A Vice Chair will be nominated at the inaugural meeting

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

2.4. Relevant Officers from the CCGs will be invited to attend in line with agenda items. Clinical and Programme leads of specific projects will be invited to attend the meeting via invitation, to update the Committee on progress. CCG Clinical Directors and locality leads will also be invite to attend meetings to provide subject matter expertise.

2.5. Officers from other organisations including the CCG's Commissioning Support Unit (CSU) 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 Committee is responsible for the following.

3.1. To recommend the adoption of the CCG's QIPP plan to the Governing Bodies

3.2. To approve the detailed QIPP performance plan against the summary programme approved by the CCG's Governing Bodies

3.3. To ensure plans and adjustments are effectively aligned to wider economy plans and transformation programmes

3.4. To ensure plans take quality and other statutory responsibilities into account

3.5. To advise on the management of QIPP related communication to wider stakeholders including the CCG's staff and its membership

3.6. Identifying, prioritising and supporting service improvement and re-design opportunities

3.7. Engaging and involving all relevant stakeholders on service improvement and re-design opportunities

3.8. Developing Business Cases for service improvement and re-design programmes

3.9. Monitoring and Evaluation of all service improvement and re-design programmes

4. Duties of the Committee

The Committee is delegated by the Governing Bodies 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 Bodies or Membership alone).

4.1. To oversee the development of the short and medium-term QIPP strategies for the CCG's

4.2. To identify areas for QIPP opportunities to create balanced contingency plans as required to deliver annual and longer-term financial sustainability

4.3. To monitor the QIPP performance against the plan on a monthly basis

4.4. To provide executive support to Clinical and Programme leads as required, to mitigate risks and remove barriers to the achievement of savings

4.5. To report the performance of the QIPP programme to the Governing Body on a monthly basis, including assessment of risk, quality assurance and to make recommendations for actions as required

4.6. To monitor provider efficiencies and liaise with other groups / committees to incorporate their impact on the CCG's service redesign plans as appropriate, reviewing quality impact assessments (QIA's) where required

4.7. To develop and recommend the production of a financial recovery plan to the Governing Bodies should the need arise

4.8. To identify potential areas of service improvement in all localities and provide recommendations to SMT and Governing Body

4.9. To support service improvements in Primary Care

4.10. Consider utilisation of various improvement models

4.11. To develop an annual service improvement and re-design plan that is prioritised in accordance with the CCGs Strategic Plan and QIPP plans

4.12. To support the development of the CCGs commissioning intentions and to make recommendations to the Governing Body

4.13. Engage with localities, their practices and clinical leads to ensure they are fully involved with the strategic planning of the CCG

4.14. To facilitate engagement with all stakeholders

4.15. To liaise with Engagement and Patient Experience Group to ensure "patient voice" is appropriately reflected in all proposals

4.16. To determine the rationale and evidence base supporting the need for improvement

4.17. To support the development of business cases

4.18. To recommend business cases for financial approval and implementation to the Finance and Resources Committee[4i]

4.19. To ensure that all service improvement proposals take account of national recommendations including, but not limited to the Francis report.

4.20. To ensure that the financial resources are available within an identified budget before making a recommendation to the Finance and Resources Committee

4.21. To assess business cases for service improvement or re-design and provide assurances that they contribute to the delivery of the CCGs Strategic Plan and QIPP plans

4.22. To ensure that all service reviews, business cases and the implementation of new services comply with all relevant laws and legislation including duties in respect of: Engagement, Consultation, Overview and Scrutiny, Equality and Diversity and Procurement

4.23. Ensure each programme of service improvement has an identified clinical lead and operational lead

4.24. To monitor the progress of all service reviews and ensure there are robust project management arrangements to assure successful delivery of service review programmes.

4.25. Ensure robust KPIs are in place for the monitoring of all schemes

4.26. To monitor and measure impact of improvements and ensure delivery of the anticipated clinical and financial benefits

4.27. To monitor programmes in line with the CCG's "Shaping Sefton" Transformation programme.

4.28. Ensure that work of the Cheshire and Merseyside Commissioning Support Unit is aligned to support successful delivery of programmes

4.29. Ensure there are appropriate arrangements for measuring and monitoring change.

4.30. The committee will have the full authority to commission any reports or surveys as deemed necessary to help it fulfil its obligations

5. Voting

5.1 Each substantive member shall have one vote on all general business items of the committee.

5.2 For decisions relating to business cases to be recommended to the Finance and Resources Committee for financial approval, the Lay Member for Governance of the respective CCG shall have the casting vote.

[4] The Finance and Resources Committee can approve business cases up to a value of £200K, subject to availability of budgetary resources. All other business cases will require sign off by the Governing Body following recommendation by the Finance and Resources Committee and subject to resources available.

6. Establishment of Sub-Groups of the Committee

6.1. 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 Committee and submit ratified notes of meetings to the Committee.

7. Administration

7.1. The Committee will be supported by an appropriate Secretary (PA to the Chief Finance Officer) that will be responsible for supporting the Chair in the management of the Committee's business.

7.2. 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.

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

8. Quorum

8.1. Meetings with at least 50% of the Committee membership, at least one Clinical Governing Body Member from each CCG, at least one Lay Person from each CCG and either the Chief Officer or Chief Finance Officer in attendance shall be quorate for the purposes of the Committee's business.

8.2. The quorum shall exclude any member affected by a Conflict of Interest. If this has the effect of rendering the meeting inquorate then the Chair shall decide whether to adjourn the meeting to permit the co-option of additional members.

9. Frequency and notice of meetings

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

10. Reporting

10.1 The ratified minutes of the Committee will be submitted to the respective Governing Body 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.

10.2 The Committee will work closely with Finance and Resource Committee

11. Conduct and Conflicts of Interest

11.1. 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.

11.2. 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 CCG Constitution and NHS South Sefton Constitution shall apply.

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

12. Review

Date:	7th July 2015
Version No.	**1**
Review dates	December 2015 June 2016 December 2016

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
JULY 2015

Agenda Item: 15/130	**Author of the Paper:** Martin McDowell Chief Finance Officer Email: martin.mcdowell@southportand formbyccg.nhs.uk Tel: 0151 247 7065
Report date: July 2015	

Title: North Mersey Information Sharing Framework

Summary/Key Issues:

The purpose of this report is to provide Southport and Formby CCG with the ILINKS Information Sharing Framework for the North Mersey Health and Social Economy

The document provides a clear set of safeguards and principles in relation to information sharing and describes a clinically led scaled information sharing model.

The framework will enable the economy to achieve a major step change in information sharing. Subject to consent, it will provide all local health and social care practitioners access to relevant information to care for individuals, regardless of the care setting or organisation where the information is held.

Recommendation

Receive	
Approve	X
Ratify	

The Governing Body is asked to:

- Sign up to the principles of the framework;
- Sign up to the direction of travel;
- Sign off the priority areas for implementation;
- Approve the delegation to the ILINKS Clinical Informatics Advisory Group and Programme Board to pursue the principles. Implementation plans will be agreed with each individual organisation.

NHS
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Clinical Commissioning Group

Links to Corporate Objectives *(x those that apply)*	
	To place clinical leadership at the heart of localities to drive transformational change.
	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	To publish plans for community services and commission for March 2016.
	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
	To achieve financial duties and commission high quality care.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement				
Clinical Engagement				
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement				
Presented to other Committees				Quality Committee – December 2014

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

North Mersey
Information Sharing Framework

Version – DRAFT 0v3

Contents

1. Executive Summary

1.1 Integrated Health and Social Care Records

The implementation of integrated health and social care records are a key priority for health and social care organisations both locally and nationally.

Locally, the Healthy Liverpool Programme and Shaping Sefton Programme both recognise integrated electronic health and social care records as a significant priority to transformation community and hospital based services. The North Mersey ILINKS Programme will enable this, providing all local health and social care practitioners to care for individuals with access to the information they need, over and above that held in their employing organisation.

As a local economy, we have extensive experience in joining up care sharing information safely and securely, with circa 6 million primary and community electronic records already shared to date. However, in order to achieve a major step change in the approach to information sharing at scale, a robust, economy wide information sharing framework, spanning all local health and social care organisations is crucial.

1.2 Information Sharing Framework Principles

Over the past 12 months, significant collaborative work spanning over 20 organisations has been undertaken to develop a scaled information sharing framework. The framework will drive and determine the implementation approach to delivery. From a risk and safeguarding perspective, the framework is based upon a number of key risk and safeguarding principles which are summarised below:

1. Role/Service Based Access: Levels of access to information will be based on roles or service profiles, for example a GP, hospital doctor or across an urgent care setting
2. Consent and Opt Out: Information shared is facilitated only when an individual has given consent to do. An individual holds the right to 'opt out' to all or parts of their personal information being shared
3. Proactive Audit: The framework will result in a significant increase in information being shared, therefore there is a significant safety and security need to assure that only those that require access to data, are able to access it
4. Exclusions: There are a number of exclusions which will not be included within the sharing model, unless explicitly stated due to legal/statutory requirements and sensitivity concerns
5. Mandatory Training: All staff will be expected to undertake mandatory training
6. Monitoring and Evaluation: Ongoing monitoring and evaluation of both the model and its effectiveness will be undertaken

7. Patient and Public Engagement: Patients and members of the public will be given an opportunity to consult, debate and inform the approach to sharing for the role purposes of providing care

1.3 Information Sharing Framework

With the principles in place, the framework is based on a number of segments, professional groups/roles and service areas. The segments are broken down into a number of tiers with information starting at lower levels of sharing and building upwards. The segments represent the following areas:

- **Summary Record** – Summary patient information to be shared across a wide range of health and social care practitioners
- **The Community** – Information held outside of hospitals, across Primary Care, Community, Mental Health and Social Care
- **Diagnostics** – Key diagnostic information including pathology, radiology and other tests available for North Mersey Patients
- **Hospitals** – Information held at secondary and tertiary care level across the many acute settings of the health economy

There are 5 professional groups and 2 service areas which would have access to specified segments and tiers as described through the framework:

- Medical
- Registered Health Care Professional
  Social Care Professional
- Unregistered Professional
- Admin
- Urgent Care
- Extended Primary Care Team

1.4 Implementation

The sharing framework purposely deals only with the principles, safeguards and model. There are a number of priority areas for implementation throughout 2015 and 2016 that are outlined within the framework. Implementation planning will include patient and public communications, financial discussions and Information Governance implementation requirements.

1.5 Summary

The ILINKS Information Sharing Framework is a substantial, collaborative piece of work that has been clinically led and developed by local health and social care professionals. It has been identified nationally as a pioneering approach that could be replicated elsewhere. The framework will enable us to put in place critical safeguards as key foundations to scaled information sharing for health and social care services.

2. Purpose

The purpose of this document is to provide an information sharing framework for the North Mersey Health and Social Care Economy. The document provides a clear set of safeguards and principles in relation to information sharing and describes a clinically led scaled information sharing model.

The model will enable the economy to achieve a major step change in information sharing, giving all local health and social care practitioners relevant information to care for individuals regardless of the care setting or organisation where the information is held.

The implementation of the framework is outlined briefly as part of this document, however detailed planning will be undertaken as part of the next stages of this work to drive priorities and plans for implementation. Organisations and local economy governance within the scope of the information sharing framework are:

- Clinical Commissioning Groups (CCG)
  - Liverpool CCG
  - South Sefton CCG
  - Southport and Formby CCG
- Health and Wellbeing Boards (HWB)
  - Liverpool HWB
  - Sefton HWB
- Liverpool Clinical Laboratories
- Local Authorities
  - Liverpool City Council
  - Sefton Council
- Local Medical Committees (LMC)
  - Liverpool LMC
  - Sefton LMC
- Provider Organisations
  - Alder Hey Children's NHS Foundation Trust
  - Go To Doc Healthcare
  - Liverpool Community Health NHS Trust
  - Liverpool and Sefton GP Practices
  - Liverpool Heart and Chest NHS Foundation Trust
  - Liverpool Womens NHS Foundation Trust
  - Merseycare NHS Trust
  - Royal Liverpool and Broadgreen University Hospitals NHS Trust
  - Southport and Ormskirk Hospital NHS Trust
  - The Clatterbridge Cancer Centre NHS Foundation Trust
  - The Walton Centre NHS Foundation Trust
  - University Hospital Aintree NHS Foundation Trust
  - Urgent Care 24

3. Background

The North Mersey Health and Social Care Economy must bring about the radical shift required to ensure not only services are sustainable, but also succeed in improving the health and well being of the population. North Mersey is brought together under the leadership of three Clinical Commissioning Groups (CCGs); Liverpool CCG, South Sefton CCG and Southport and Formby CCG, along with two overarching Health and Wellbeing Boards: Liverpool and Sefton.

Each organisation has set a clear strategy for the provision of Health and Social Care services across North Mersey through the Healthy Liverpool and Shaping Sefton Programmes. Integrated health and social care provision, is at the heart of each CCG Strategy; designing and developing services to ensure they are wrapped around patient need, truly harnessing collaborative working to maximise resources and improve the outcomes of the population across all settings of care.

North Mersey has strong relationships with Knowsley and West Lancs CCGs, both of whom have been active participants of the clinical discussions in the development of this framework.

4. Integrated Health and Social Care Records

The implementation of integrated health and social care records are a key priority to enable and transform care both from local and national perspectives.

4.1 National Context

Personalised Health and Care 2020: A Framework for Action notes that "better use of technology and data has the power to improve health, transforming the quality and reducing the cost of health and care services".

The NHS Five Year Forward View includes integration and interoperability of systems as key to not only enable but transform future care models.

4.2. Local Context

Each organisation has set a clear strategy for the provision of Health and Social Care services across North Mersey through the Healthy Liverpool and Shaping Sefton Programmes. Integrated health and social care provision, is at the heart of each CCG Strategy; designing and developing services to ensure they are wrapped around patient need, truly harnessing collaborative working to maximise resources and improve the outcomes of the population across all settings of care.

4.3 Integrated Health and Social Care Records

The Healthy Liverpool Digital Care and Innovation Programme and Shaping Sefton Programme recognise integrated health and social care records as a significant programme of work to not only enable but transform future models of care.

Through the North Mersey ILINKS Informatics Transformation Strategy, integrated health and social care records will enable all local health and social care practitioners to have access to the information they need, over and above that held in their employing organisation, to care for individuals.

In order to achieve this at scale, having in place a robust, economy wide information sharing framework is essential.

As a local economy, our health and social care organisations have a track record of sharing information safely and securely, enabling joined up care with circa 6 million primary and community electronic records already shared to date. The information sharing framework will enable us to achieve a **significant step change** in information sharing as a core foundation to transforming community and hospital based services, ensuring patients

receive high quality care through practitioners having access to the information they need, in the right care setting.

4.4 ILINKS Informatics Transformation Strategy

The ILINKS Informatics Transformation Strategy is the cross Health and Social Care Economy Informatics Strategy, providing a clear blueprint for the delivery of integrated health and social care records, which will enable the strategic objectives of the CCGs, local councils and NHS provider organisations across the local economy.

The ILINKS Informatics Transformation Strategy aims to enable patients to have better health outcomes through providing local health and social care professionals with the information they need to enable them to work and share collaboratively around the individual, allowing pathways of care to be designed around the patients and service users, with the confidence that the appropriate information will be available at the right time at all key touch points along a care pathway.

North Mersey has for many years reaped the benefits of informatics enabled clinical information sharing across many services and care settings. However, the current processes, governance and technical mechanisms supporting clinical information sharing have undergone a wholesale review in order to achieve the key objectives of the Programme, which is to define and implement a unified, scalable and fit-for-purpose process for information sharing which is compliant with all legal frameworks, enabling us to deliver the changes required across the Healthy Liverpool and Shaping Sefton Programmes.

5. ILINKS Information Sharing Framework

5.1 The Framework

The Information Sharing Framework is broadly a set of processes, principles and procedures that bring structure to the sharing of an individual's health and social care record for the purposes of care. This in turn enables the economy to significantly improve the delivery of health and social care services, through a safe, legal and consistent approach to collaboration.

Key clinical and informatics stakeholders across the Economy have worked collaboratively to debate and document a scaled information sharing framework which will meet the objectives of the economy transformational change strategies. The framework will drive and determine the implementation approach to delivery.

The ILINKS Information Sharing Framework provides a structured framework to facilitate information sharing, ranging from basic demographics and summary information sharing, through to access for practitioners to view full electronic health and social care records. The model is based upon roles and service profiles of practitioners, with specified roles and services having access to a defined set of information based on need and risk.

The ILINKS Information Sharing Framework takes into account the type of information that is being made available, along with the care setting in which it is being utilised. Patient Consent is a central component to the Framework, along with all information that is shared being deemed necessary, proportionate and relevant for the delivery of care.

- **Proportionate** – The information shared will be deemed of an appropriate level when assessed against why it is being shared
- **Relevant** – The amount of information shared will be no more than what is needed to cater for an individuals health and social care needs
- **Necessary** – The reason for sharing an individual's information will be what is required to support that particular contact with care professionals

The information shared through the framework is information over and above that which is held in individual employing organisations. It is explicitly aimed to give practitioners access to information about an individual they are caring for which is held by a different health or social care provider. Information within a practitioners employing organisation is subject to internal local organisational Information Governance policies and procedures. Viewing the shared record is not automatic, and will always be based on explicit patient consent which is discussed at the point of care.

The purpose of the ILINKS Information Sharing Framework is to support public service organisations and their partners in delivering holistic and responsive Health and Social Care Services. It concerns the sharing of personal data and seeks to lay the foundation for the safe and secure sharing of information in order to comply with the duties placed on organisations to

work together. As such, it is intended as a means of establishing a standard to which all North Mersey Health and Social Care Organisations will work towards in respect of the sharing of personal health and social care information for care purposes.

5.2 Information Governance and Legal Frameworks

The ILINKS Information Sharing Framework has a contribution to make towards fostering a culture in which all services work together to deliver better outcomes for residents and visitors across North Mersey. From an Information Governance and Legal perspective, the objective of the ILINKS Information Sharing Framework is:

- To assist staff in protecting the confidentiality of patients, customers, clients and employees where it is necessary to share personal data
- To enable the economy to quickly comply with new legislation through having a consistent approach to information sharing at an economy wide level
- To enable integrated and collaborative working by providing a secure and efficient way to exchange personal data where a power exists to do so, in accordance with the Data Protection Act 1998, the Human Rights Act 1998 and other relevant legislation
- To support joined up local Health and Social Care services
- To promote best practice in information sharing, with regard to general management, data quality and staff training and development needs

Each Organisation has its own local policies and procedures regarding information security and confidentiality. This Information Sharing Framework is not designed to supersede existing local policies, but to enhance them by facilitating cross-boundary dialogue and agreement, along with providing a context for Information Sharing between organisations across North Mersey.

External Information Governance (IG) and Legal expertise has been commissioned and utilised throughout the development of the ILINKS Information Sharing Framework, which concluded that sharing personal health and social care information which is relevant and proportionate, when necessary to do so with explicit consent of the individual has a sound legal base. And that not only does this model give an opportunity to increase information sharing across Health and Social Care Organisations to improve outcomes for patients, customers and services users, but will also provide a mechanism for uplifting professional practice in relation to when and how personal information is shared.

Throughout the implementation tranches of the Information Sharing Model with each Organisation, further discussions will be conducted to ensure a best practice approach is adopted in relation to IG and Legal requirements. It is envisaged that the number of data sharing agreements, privacy impact assessments and other associated requirements can be not only reduced, but also improved throughout the implementation processes at each Organisation.

6. Information Sharing Framework Principles

From a risk and safeguarding perspective, the framework is based upon a number of key risk and safeguarding principles:

6.1 Role / Service Based Access

Levels of access to information across the information sharing framework will be based on roles or service profiles, for example a GP, hospital doctor or across an urgent care setting.

A balance has been sought between identifying a minimum number of role / service profiles to maintain simplicity, whilst allowing for enough role / service profiles to ensure levels of access are proportionate, relevant and necessary to each health and social care role, or service area. Amending, removing or adding role or service profiles will be subject to appropriate governance processes.

6.2 Consent and Opt Out

The ILINKS Information Sharing Framework is based around the principle that the information shared across professional groups and organisational boundaries is facilitated only when an individual has given consent to do. An individual is at the heart of the information-sharing framework, and holds the right to 'opt out' to all or parts of their personal information being shared.

When consent is obtained, information may then be shared across health and social care organisations on a 'need to know' basis, at a level that is deemed proportionate, relevant and necessary for that particular health and social care setting and scenario. These levels of access are clearly defined within the Information Sharing Model, and its associated segments, tiers and role/service based profiles.

The Information Sharing Model does include the ability for any professional to override the need to obtain explicit consent if there is an urgent need to do so, for example to save a life where an individual is unable to give consent due to being unconscious or prevent significant harm or risk. Any instances of consent being overridden will be subsequently investigated, and professionals will be required to give an explanation of the decision they took and record this in the individual's record.

6.3 Proactive Audit

The ILINKS Information Sharing Framework aims to improve care delivery through enabling access to information required at the point of care, whilst

also improving the processes, mechanisms and practices associated with the sharing of personal information. The Information Sharing Framework will result in a significant increase in data being shared between services and organisations, therefore there is an ever-increasing requirement to provide assurance that data is being shared safely and securely, as well as provide evidence that only those that require access to data, are able to access it.

One method that will be used throughout the implementation approach is to improve system audit capability, and the associated processes. Through proactively monitoring audit logs of key systems across the Health and Social Care Economy, significant improvements will be made in identifying inappropriate access to personal records by proactively highlighting concerning system activity and allowing the appropriate bodies to investigate and deal with inappropriate access.

6.4 Exclusions

Whilst recognising the importance of sharing information to support the care provided to individuals, the Information Sharing Framework also identifies a series of exclusions which will not be included within the sharing model, unless explicitly stated. These exclusions have been identified due to legal/statutory requirements and sensitivity concerns and are included at Appendix 1.

6.5 Mandatory Training

All staff accessing information through the framework will be expected to undertake mandatory training for safeguarding information and the use of a shared record in practice.

6.6 Monitoring and Evaluation

In addition to the proactive audit systems, ongoing monitoring and evaluation of both the model and its effectiveness will be undertaken.

6.7 Patient and Public Engagement

Residents across North Mersey are at the heart of the Information Sharing Model, and therefore have an important voice in its development and implementation. Through a variety of approaches, patients and members of the public will be given an opportunity to consult, debate and inform the economy approach to sharing health and social care information, for the sole purposes of providing care.

These activities may include patient focus groups, public consultation, patient information sources, such as leaflets, posters and websites, which will ensure an open and transparent approach to further developing and implementing the information-sharing framework.

7. Information Sharing Model

With the framework principles in place, the Information Sharing Framework is based on 4 segments. Each segment is broken down into a number of tiers with information starting at lower levels of sharing and building upwards. The segments represent the following areas:

- **Summary Record** – Summary patient information to be shared across a wide range of health and social care practitioners
- **The Community** – Information held outside of hospitals, across Primary Care, Community, Mental Health and Social Care
- **Diagnostics** – Key diagnostic information including pathology, radiology and other tests available for North Mersey Patients
- **Hospitals** – Information held at secondary and tertiary care level across the many acute settings of the health economy

Diagram 1 below gives a visual representation of the ILINKS Information Sharing Model, showing all four segments and each tier of sharing within.

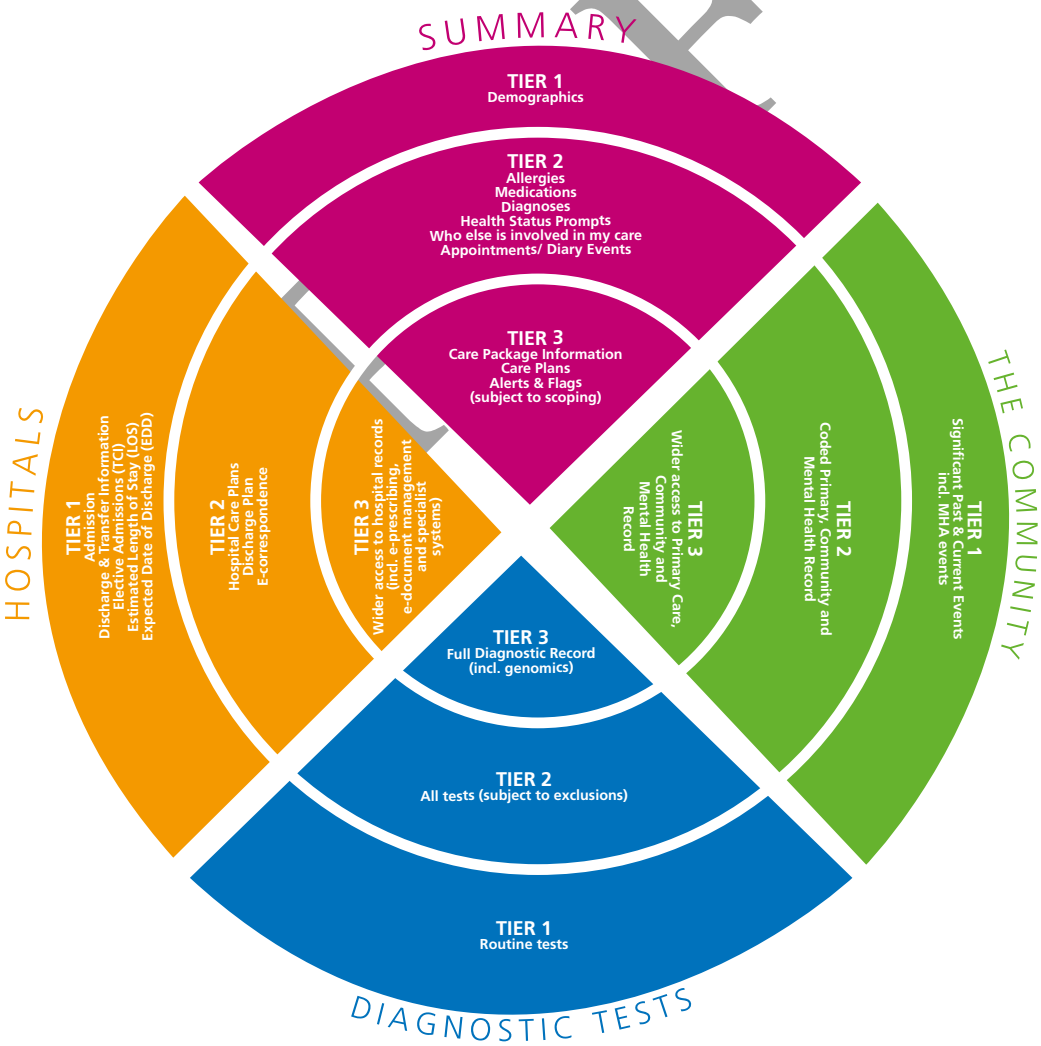


Diagram 1: ILINKS Information Sharing Model

The ILINKS Information Sharing model purposely represents health and social care information repositories as either type (summary and diagnostics) or as the care setting in which that information is held (community and hospital). It is important however, to consider that within each of these segments, multiple organisations exist. The implementation of each segment will be tackled from an organisational footprint perspective e.g. implementing the hospital segment will include sharing information across secondary care organisations as well as sharing that information into community organisations.

7.1 Summary Segment

The summary segment contains information regarding and individuals key health and social care information. This information will provide professionals with a clear overview of vital health care information, along with details on how to best care for individuals through the sharing of care plans, care package information and intelligence about who else is involved in a person's care.

Summary Segment		
Tier 1	• Demographics	• Primary Care
Tier 2	• Allergies • Medication • Diagnoses • Health Status Prompts • Who else is involved in my care • Appointments / Diary Events	• Primary Care • Primary Care • Primary Care (Subject to exclusions) • Primary Care • Multiple source systems • Multiple source systems
Tier 3	• Care Package Information • Care Plans (Inc. End of Life Care Plans, Enhanced Care Plans) • *Alerts & Flags	• Liquid Logic • Multiple source systems • TBC – Further scoping work required

Table 1: Summary Segment

Table 1 above gives an overview of the summary segment of the ILINKS Information Sharing Model, along with an outline of the content of each of the tiers and the likely source system(s) of that information.

Scenario 1

Joe is a 63 year old man, living with his wife in Southport. Joe is a diabetic and has COPD. Joe is taken into hospital one evening due to increased shortness of breath. He has recently been seen by his GP who has been treating Joe's chest infection.

Joe gives consent for AED staff at Southport and Ormskirk NHS Trust to see vital information contained within summary Tier 2 of his shared record, such as current medication, allergies and diagnosis. This enabled the care team to manage Joe's presenting symptoms in a timelier manner, whilst avoiding any possible clinical risks.

Once Joe's health improved the wider care team at the hospital were able to manage a safe and prompt discharge back home for Joe, through knowing the key professional involved in Joe's 'Care Closer to Home' package, whilst accessing and updating Joe's Shared Care Plans. This enabled a collaborative approach across all of Joe's care providers, improving coordination of care and communication across the care team and reducing the number of times information is repeated and duplicated.

Over time, the summary segment will contain information such as an alert or flag within a persons shared record, highlighting information of key importance. An alert or flag may inform professionals to potential hazards they should be aware of such as dangerous dogs. The inclusion of flags and alerts however, requires further discussion across the economy to clearly define the scope and governance associated with this type of information sharing, and therefore will be revisited before its implementation as part of Information Sharing Model.

7.2 Community Segment

The community segment refers to key health and social care information that is recorded and held within community provider organisations. Making this information available to a wider set of professional groups will enable professionals caring for an individual across a Community Neighbourhood or Ward environment with the information they require to work collaboratively, in order to deliver an improved and joined up approach to care.

Secondly, community segment information will be used to provide hospital-based professionals with a clear understanding of an individual's community based care. This will ensure continuity of care and improved assessment and discharge planning processes.

Community		
Tier 1	• Significant Past & Current Events (Inc. MHA events)	• Multiple source systems

Tier 2	• Coded Primary, Community and Mental Health record	• Multiple source systems
Tier 3	• Wider access to Primary Care, Community Health and Mental Health Record	• Multiple source systems

Table 2: Community Segment

Table 2 above gives an overview of the community segment of the ILINKS Information Sharing Model, along with an outline of the content of each tier and the likely source system(s) of that information.

Scenario 2

Joan is a 52-year-old lady living alone in a terraced house. Joan has a number of long-term conditions, and a history of regular hospitals admissions and poor self management of her health.

Joan's GP and Community Matron speak to Joan about how to better care for her needs in the community, reducing her time spent in hospital whilst increasing her quality of life. Joan is accepted as part of the Virtual Ward Programme and agrees to share relevant health and social care information across the extended primary care team.

Joan's Health Trainer visits her three times a week, to review and amend jointly set goals. These are shared across a wider Multi-disciplinary Team as part of Joan's shared care plan, along with key information such as Joan's planned appointments and key health status. Joan has equipment installed within her home that allows her to monitor and self manage her conditions much more proactively, and ensure any decline in health and well being is identified at the earliest opportunity, which is managed appropriately by her care team.

On a monthly basis the Community Multi-Disciplinary Team (MDT) carry out a full case review regarding Joan's progress and care needs. These discussions are facilitated through making the relevant sections of Joan's record available across the MDT, and key decisions and actions being recorded live as part of Joan's shared care plan.

Tier 3 of the Community Segment caters for wider access to community-based information, over and above that which is coded and included in tier 2. This level of access is unlikely to be utilised by a wide number of professional groups, however is included in the Information Sharing Model to cater for those scenarios where an increased level of information sharing is required such as in an extended primary care team.

The detail behind the term “wider access” will be defined on an individual case basis, subject to all relevant legal and information governance processes of the organisations concerned, along with patient consent.

7.3 Diagnostics Segment

The diagnostics segment contains information relating to diagnostics tests and procedures, not just limited to radiology and pathology. Diagnostic services are of great importance in the NHS, and when used correctly they support or rule out potential diagnoses, and underpin the effective and efficient management of patient pathways. Sharing this key information across relevant professionals (irrelevant of care setting or employing organisation) will improve rates of over-use of diagnostic tests, and significantly improve the timeliness and coordination of care pathways and outcomes for patients.

Diagnostics		
Tier 1	• Routine tests (FBC, U&E, LFT, TFT, Glucose, Cholesterol, B12/folate, INR, PT/APTT, Bone profile, drug level monitoring, Urine and Microbiology samples, ACR, ECGs, Echo, 24 Hour Tape, Pulmonary Function Tests, Endoscopy, Radiology)	• ICE • LIMS • Other Source Systems
Tier 2	• All tests (excluding sensitive information - GUM, HIV & AIDS)	• ICE • LIMS • PACS
Tier 3	• Wider Diagnostic Record – no exclusions (including genomics)	• ICE • LIMS • PACS

Table 3: Diagnostic Segment

Table 3 above gives an overview of the diagnostic segment of the ILINKS Information Sharing Model, along with an outline of the content of each of the tiers and the likely source system(s) of that information.

Tier 1 is aimed at health professionals who do not require a wider view of a patient’s diagnostic record, however access to routine tests and results will allow for increased quality and timeliness of care, along with reducing rates of re-testing.

Scenario 3

Brenda is a 44-year-old lady, living in a terraced house in suburban Liverpool with her parents. Brenda is a recovering alcoholic and has a history of Mental Health issues.

Brenda is in receipt of a number of health and social care services, supporting her on her road to recovery whilst also improving her management of schizophrenia. During a particularly challenging weekend for Brenda, she is seen by her community mental health team who decide to increase aspects of her medication regime.

Such a medication change requires a blood test to check Brenda's liver function profile, and often results in a delay to commencing the prescribed medication changes. However, Brenda's mental health team can see that her GP carried out a Liver Function Test very recently, during a routine health check within General Practice. Through the sharing of Diagnostics Tier 1 information, Brenda and her care team are able to commence the jointly agreed plans of care much sooner than would have previously been possible. This also results in Brenda not having to under go a repeat blood test.

Tier 2 gives access where necessary to all tests and results, however excludes information that is deemed sensitive, such as blood-borne disease status or an individual's genitourinary medicine (GUM) record. If access to such exclusions is required, then this is facilitated through access to tier 3.

Tier 3 however does not exclude any tests or results, and also may contain a patient's genomic record in the future (subject to further scoping at an appropriate time).

7.4 Hospital Segment

The hospital segment contains key health and social care information that will provide professionals caring for an individual across hospital settings with key information they require to work collaboratively.

This information will also be used by community based professionals, giving a clear understanding of an individual's stay in hospital, in order to better join up the care between hospital and community based health and social care services. This information will allow community based professionals access to information regarding planned admissions, along with important information such as expected date of discharge. This will enable great improvements in coordinating hospital discharges and cater for the required aftercare across the community setting.

Hospitals		
Tier 1	• Admissions, discharges and transfer information (Inc. Mental Health) • Elective admissions (TCI) • Estimated Length of stay (LOS) / Expected Date of Discharge (EDD)	• Through Trust Integration Engines (TIE) and HL7 Messaging
Tier 2	• Hospital Care Plans • Discharge Plan • E-Correspondence (Discharge summaries / OPD Letters)	• Trust EPR Systems
Tier 3	• Wider access to hospital records (Inc. E-Prescribing, E-Document Management Systems, Specialist Systems)	• Trust EPR Systems

Table 4: Hospital Segment

Table 4 above gives an overview the hospital segment of the ILINKS Information Sharing Model, along with an outline of the content of each of the tiers and the likely source system(s) of that information.

Scenario 4

David is a 69-year-old gentleman diagnosed with motor neurone disease. David has a care package in place to assist him to carry out most of his activities of daily living, requiring a care assistant to visit three times a day.

David is taken into hospital one evening suffering from chest pain and shortness of breath. David had suffered a pulmonary embolism.

The hospital clinicians are able to access a thorough summary of David's health and social care needs due to having access to Summary Tiers 1, 2 and 3 within the hospital environment. David's social worker was notified of his hospital admission (Hospital Tier 1), and was able to make appropriate adjustments and plans in relation to his community care package.

Increased information sharing enabled both the hospital and community health and social care teams to respond to David's condition in a safer and more timely manner, but also get David back home with the appropriate levels of care much quicker than what would have been previously possible.

Tier 3 of the Hospital Segment caters for wider access to hospital-based information, often contained in Electronic Document Management Systems (EDMS), or Electronic Prescribing and Medicines Administration (EPMA) systems. This level of access is unlikely to be utilised by a wide number of professional groups, however is included in the Information Sharing Model to cater for those scenarios where this level of access is required. For example, a hospital based consultant requiring access to an individual's scanned health records housed in another hospital trust, or a GP requiring access to a hospital prescribing system to give a detailed medicines management picture of a patients stay in hospital, over and above that contained within a discharge summary.

7.5 Exclusions

As a key principle of the framework, there are a series of exclusions which will not be included within the sharing model, unless explicitly stated. These exclusions have been identified due to legal/statutory requirements and sensitivity concerns.

Table 5 shows the heading areas along with some high level rational for excluding this information from the sharing model (unless explicitly stated). Further detail of each exclusion code associated with each of these categories can be found in appendix 1.

Data field	Reason
HIV and Aids	AIDS (Control) Act 1987
Sexually Transmitted Diseases	NHS (Venereal Diseases) Regulations 1974; NHS Act 1977; NHSTs & PCTs (STDs) Directions 2000
Termination of Pregnancy	Sensitive data
IVF treatment	Legal requirement - Human Fertilisation & Embryology (Disclosure of Information) Act 1992 imposes restrictions on the disclosure of information about individuals
Complaints	Could be perceived to prejudice care if known that patient was complaining about care
Convictions & imprisonment	Sensitive data
Abuse	Sensitive data
Gender Reassignment	Legal requirement
Adoption	Legal requirement

Table 5: Exclusion criteria

7.6 Role and Service based profiles

A core principle of the framework is role and service based profiles.

Table 6 below shows each of the role / service profiles that have been identified to date as part of the ILINKS Information Sharing Framework, along with the associated levels of access each profile will have across each segments of the Information Sharing Model.

Professional Group	Sub-Category	Levels of access
1. Medical	1a. Hospital Specialist	S3, C2, D3, H3
	1b. GP	S3, C3, D3, H2
	1c. Community Medical	S3, C2, D3, H2
2. Registered Health Care Professional	2a. Specialist (e.g. Matron)	S3, C2, D2, H2
	2b. Generalist (e.g. Allied Health Professional)	S3, C1, D1, H1
3. Social Care Professional	3a. Hospital	S3, C1, DX, H2
	3b. Community	S3, C2, DX, H1
4. Unregistered Professional	Nil (e.g. Support Worker, Health Trainer, Auxiliary Nurse)	S3, CX, DX, HX
5. Admin / Clerical	Nil	S1, CX, DX, HX
Service Area		
6. Urgent Care	E.g. AED, WIC, AMU etc	S3, C1, D3, H3
7. Extended Primary Care Team	E.g. GP, Community Matron, District Nurse, Practice Nurse	S3, C3, D2, H2

Table 6: Current Role and Service Based Profiles

8. Implementation

8.1 Governance and Implementation Approach

The Information sharing Framework development to date has been overseen by the ILINKS Programme Board, Clinical Informatics Advisory Group (CIAG) and the associated sub-groups. The framework will most certainly continue to evolve, particularly throughout its implementation phases through applying new scenarios and addressing changes in health and social care requirements.

It is therefore important that the governance and approach to implementation is of a dynamic nature. This approach must also ensure that areas that require further consultation and debate do not hold back the North Mersey Health and Social Care Economy in implementing areas that are deemed complete. For example, the economy could progress the implementation of the summary tiers across all organisations, whilst continuing to develop the detail behind other aspects of the information-sharing model.

8.2 Governance Structures and Processes

To support the on-going development and phased implementation, three levels of governance have been identified.

1. Level one will seek Chief Executive Officer sign up to the Information Sharing Framework from each Organisation. This involves agreement to the approach, standards and principles of the Information Sharing Framework, and a firm commitment to the future development and implementation of the Information Sharing Model. The template pledge for commitment (Appendix 2) will be used to capture the support from CEOs from across North Mersey Health and Social Care Organisations, providing a very strong platform for future developments and implementation.

2. Level two will cater for the on-going development of the Information Sharing Framework, including the formulation of implementation tranches. This will continue to be overseen by the well-established ILINKS Programme Board, Clinical Informatics Advisory Group (CIAG) and associated subgroups.

3. Level three will be triggered at specific points in the frameworks development and implementation. The ILINKS Programme Board will ask associated organisations to formally sign off the content of the Information Sharing Framework, along with agreeing to its next tranche of implementation. This sign off will follow existing Organisations governance structures, and involve the formulation of a very clear implementation approach for that particular tranche, for example data sharing agreements, privacy impact assessments and defining the relevant professional training.

Level three governance will be provided via well-established Information Governance forums within each Health and Social Care provider Organisation, along with the Local Medical Committees (LMC) across the patch.

The information sharing framework is not designed to supersede existing local governance structures, but to enhance them by facilitating a consistent approach at an economy level. The governance within each organisation is outlined at Appendix 3.

The information sharing framework will be endorsed by CCGs and care providers as best practice across the economy. The framework has been collectively led and developed at an economy level and will in the future form part of the provision of health and social care services.

8.2 Implementation Approach

Tranches of implementation will be recommended by the ILINKS Transformation Programme Board and formally agreed by the Organisations which it impacts. The implementation approach will not only recommend particular elements of the Information Sharing Model to be progressed, but also clearly describe the approach for each Organisation which it impacts.

The implementation of the information sharing model is broken into tranches, balancing further development of the model and adding value across care settings simultaneously. Below is a high level overview of priority areas for implementation:

Sharing Model Segment / Tier	Indicative dates
Summary Tiers 1, 2 & 3	2015 / 16
Community Tiers 1 & 2	2015 / 16
Hospital Tiers 1 & 2	2015 / 16
Diagnostics Tier 3	2015 / 16
Hospitals Tier 3	TBC
Community Tier 3	TBC
Diagnostics Tiers 1 & 2	TBC

Table 7: Indicative implementation Plan

Across the North Mersey Health and Social Care Economy, over 6 million records have been shared across traditional organisational boundaries, enabling a more integrated, safer and informed delivery of care. The Information Sharing Framework clearly outlines a structured and robust approach to increasing the sharing of personal information, when appropriate to do so for the purposes of care. This will ensure that the benefits associated with better access to information are achieved and consistent across all settings of care.

It is acknowledged that mobilising the sharing model will look different for each Organisation involved, due to varying degrees of digital maturity and technical ability across the North Mersey landscape. Therefore the

implementation teams will work jointly with organisations to ensure an appropriate approach to implementation is sought, clearly defining how the following will be undertaken:

- Workforce training and development
- Level of competency and technical capability of each Organisation
- Reporting and recording issues with shared records (breaches/errors)
- Information data flows
- Information Sharing Agreements
- Privacy Impact Assessments
- Approach to consent and Legitimate Relationship Controls
- Access controls and processes (including staff movements)
- Proactive audit requirements
- Technical enablement and interoperability of systems

8.3 Digital Interoperability Roadmap

The information sharing framework will be delivered through the technical interoperability of our strategic IT systems. This roadmap is deliberately driven by the information sharing framework and will be further influenced through the implementation phases at each organisation.

The approach to the interoperability roadmap can be categorised into the phases outlined below:

- Phase 0: Direct logon to systems for health and social care staff
- Phase 1A : Connect, using each organisations main strategic system, to an embedded view of data from another system held on a separate tab
- Phase 1B: A message sent from hospital to primary or community systems using HL7 message standards
- Phase 2: Connect, using each organisations main strategic system, to a single view of all other information held outside of your strategic system
- Phase 3: Access a fully integrated rendered record, via organisations Strategic Systems

9. Summary

The ILINKS Information Sharing Framework has been clinically led and developed by local health and social care professionals. It has been identified nationally as a pioneering approach to scaled information sharing that could be replicated elsewhere in the UK.

The framework will enable us to put in place critical safeguards from an Information Governance perspective as a key building block to scaled information sharing enabling transforming community and hospital services.

Appendices

Appendix 1 - Exclusion Codes

Category / Code	Description
HIV & Aids	
13N5.	HIV risk lifestyle
43C%	HTLV-3 antibody test
43WK.	Human immunodeficiency virus antibody level
43d5.	HIV antibody/antigen (Duo)
43h2.	HIV 1 PCR
43W7.	HIV1 antibody level
43W8.	HIV2 antibody level
4J34.	HIV viral load
62b..	Antenatal HIV screening
65P8.	AIDS contact
65QA.	AIDS carrier
65VE.	Notification of AIDS
67I2.	Advice about HIV prevention
6827.	AIDS (HTLV-III) screening
8CAE.	Patient advised about the risks of HIV
A788%	Acquired immune deficiency syndrome
A789%	Human immunodef virus resulting in other disease
AyuC4	HIV disease resulting in other infectious and parasitic diseases
Eu024	Dementia in human immunodef virus [HIV] disease
R109.	Laboratory evidence of human immunodeficiency virus
ZV018	Human immunodeficiency virus – negative
ZV019	Contact with and exposure to human immunodeficiency virus
ZV01A	Asymptomatic human immunodeficiency virus infection status
ZV19B	Family history of human immunodeficiency virus [HIV] disease
ZV6D4	Human immunodeficiency virus counselling
ZV737	Special screening examination for human immunodeficiency virus
Sexually Transmitted Diseases	
1415.	H/O: venereal disease
14OP	At risk of sexually transmitted infection
43U%	Chlamydia antigen test
65P7.	Venereal disease contact
65Q9.	Venereal disease carrier NOS
6832.	Venereal disease screening
A780.	Molluscum cantagiosum
A7812	Genital warts
A78A.	Chlamydial infection
A78A3	Chlamydial infection of pelviperitoneum and other genitourinary organs

A78AW	Chlamydial infection, unspecified
A78AX	Chlamydial infection of genitourinary tract, unspecified
A9%	Syphilis and other venereal diseases
EGTON34	Chlamydia infection
L172%	Other maternal venereal diseases during pregnancy, childbirth and the puerperium
ZV016	Contact with or exposure to venereal disease
ZV028	Other venereal disease carrier
ZV745	Screening for venereal disease
Termination of Pregnancy	
1543%	H/O: abortion
6776.	Preg. termination counselling
7E066	Hysterotomy and termination of pregnancy
7E070	Dilation of cervix uteri and curettage of products of conception from uterus
7E071	Curettage of products of conception from uterus NEC
7E084	Suction termination of pregnancy
7E085	Dilation of cervix and extraction termination of pregnancy
7E086	Termination of pregnancy NEC
8H7W.	Refer to TOP counselling
8M6..	Requests pregnancy termination
956%	HSA1-therap. abort. green form
9Ea%	Reason for termination of pregnancy
L05%	Legally induced abortion
L06%	Illegally induced abortion
IVF treatment	
ZV26%	Infertility management
8C8%	Treatment for infertility
7E0A%	Introduction of gamete into uterine cavity
7E1F2	Endoscopic intrafallopian transfer of gamete
Complaints	
9U%	Complaints about care
Convictions & imprisonment	
13H9.	Imprisonment record
13HN	Criminal Record
13HQ.	In prison
1317	Imprisonment of a family member
14X4	On sex offenders register
2JC	Medically fit adjudication young offenders
6992.	Prison medical examination
EMISNAC814	Accorn status: Young offenders institution
EMISNAC815	Accorn status: Bail/probation hostel
EMISNQSC1	Schedule 1 offender
EMISNQY03	Young Offender
EMISQAC759	Accorn location: Young offenders institution
T776.	Place of occurrence of accident or poisoning, prison
ZV4J4	Conviction in civil and criminal proceedings without imprisonment

ZV4J5	Problems related to release from prison
ZV625	Imprisonment
Abuse (physical, psychological or sexual, by others)	
14X..	History of abuse
1J3..	Suspected child abuse
SN55.	Child maltreatment syndrome
SN571	Sexual abuse
TL7..	Child battering and other maltreatment
TLx4.	Assault by criminal neglect
ZV19C	Family history of physical abuse to sibling
ZV19D	Family history of physical abuse to sibling by family member
ZV19E	Family history of sexual abuse to sibling
ZV19F	Family history of sexual abuse to sibling by family member
ZV19G	Family history of mental abuse to sibling
ZV19H	Family history of mental abuse to sibling by family member
ZV19J	Family history of sibling abuse NOS
ZV19K	Family history of sibling abuse by family member NOS
ZV4F9	Problems related to alleged sexual of abuse child by person outside primary support group
ZV4G4	Problems related to alleged sex abuse child by person within primary support group
ZV4G5	Problems related to alleged physical abuse of child
ZV612	Child abuse
TL01	Sexual Assault
ZV6D3	Counsel related/combined concern regard sex attitude/behaviour
Gender reassignment	
1K4	Gender reassignment
E225	Transexualism
EMISNQGE23	Gender reassignment
Adoption	
13I8	Adoption of child
6981	Adoption medical examination
8GE8	Adoption
9F5%	BAAF B1/2-adopt: birth history
9F6%	BAAF C/D-adopt: child report
EMISNQH120	Child legal status - freed for adoption
EMISNQH362	Child no longer for adoption
ZV703	Adoption medical

Appendix 2 - CEO Information Sharing Framework Commitment

iLINKS
informatics enabling connected care

Information Sharing Framework Commitment

<X Organisation> is in agreement with the fundamental vision of the ILINKS Informatics Transformation Strategy and its associated Information Sharing Framework, which will provide local health and social care professionals with the information they need to enable them to work and share collaboratively around the individual. Enabling pathways of care to be designed around the patients and service users, with the confidence that the appropriate information will be available at the right time at all key touch points along a care pathway.

<X Organisation> is committed to the ILINKS Information Sharing Principles, and recognises that there is a responsibility to work with partners to ensure personal information is collected, stored and shared within all appropriate statutory and legal codes.

This document should be read in conjunction with the ILINKS Information Sharing Framework. By signing this agreement I agree to the principles of the ILINKS Information Sharing Framework.

I <insert name> agree that as the Chief Executive for <insert ORG> we are committed to the key principles of this strategic Information Sharing commitment and its recommendations which are:

- Sign up to the principles of the framework
- Sign up to the direction of travel
- Sign off the priority areas for implementation
- Approve the delegation to the ILINKS Clinical Informatics Advisory Group and Programme Board to pursue the principles. Implementation plans will be agreed with each individual organisation

Date <insert date>

Appendix 3 – Organisational Governance

Organisation	Governance
Clinical Commissioning Groups	
Liverpool CCG	Healthy Liverpool Leads Governing Body
South Sefton CCG	Senior Leadership Team Finance and Resource Committee
Southport and Formby CCG	Senior Leadership Team Finance and Resource Committee
Health and Wellbeing Boards	
Liverpool	Liverpool Health and Wellbeing Board
Sefton	Sefton Health and Wellbeing Board
Liverpool Clinical Laboratories	
Liverpool Clinical Laboratories	Liverpool Clinical Laboratories Board
Local Authorities	
Liverpool City Council	Cabinet Briefing Management Team Select Committee Cabinet
Sefton Council	Audit and Governance Committee
Local Medical Committess	
Liverpool	Liverpool Local Medical Committee
Sefton	Sefton Local Medical Committee
Provider Organisations	
Alder Hey Children's NHS Foundation Trust	Information Governance Steering Group Electronic Patient Record Steering Group
Go To Doc Healthcare	TBC
Liverpool Community Health NHS Trust	Executive Team Information Governance Steering Group Technology Innovation and Information Sub-Committee Strategy and Performance Committee Trust Board
Liverpool and Sefton GP Practices	Local Medical Committees Liverpool GP Provider Organisation Individual GP Practices
Liverpool Heart and Chest NHS Foundation Trust	IM&T Board Clinical Systems Authority Risk Management & Corporate

	Governance Committee
Liverpool Womens NHS Foundation Trust	Information Governance Committee Governance and Clinical Assurance Committee
Merseycare NHS Trust	IM&T Board SIRO, Information Governance and Caldicott Committee Executive Committee
Royal Liverpool and Broadgreen University Hospitals NHS Trust	Information Governance Committee
Southport and Ormskirk Hospital NHS Trust	IM&T Board
The Clatterbridge Cancer Centre NHS Foundation Trust	Information Governance Group
The Walton Centre NHS Foundation Trust	Information Governance and Security Forum
University Hospital Aintree NHS Foundation Trust	Information Governance Group
Urgent Care 24	TBC

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2015

Agenda Item: 15/131	**Author of the Paper:** Fiona Doherty Strategy and Planning Officer Email: fiona.doherty@southportandformbyccg.nhs.uk Tel: 0151 247 7141
Report date: July 2015	

Title: Case for Change Prioritisation and Approval Process

Summary:

This paper outlines the new committee approval process for Cases for Change to reflect the new role of joint QIPP /SIR committees (see agenda item 15/129). It describes the CCGs criteria and prioritisation process which will be used to evaluate all future investments.

Recommendation
The Governing Body is asked to approve QIPP prioritisation and approval process.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	To place clinical leadership at the heart of localities to drive transformational change.
	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	To publish plans for community services and commission for March 2016.
	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
x	To achieve financial duties and commission high quality care.

NHS
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			Governing Body Development Session 25th June
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

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
July 2015

1. Executive Summary

The purpose of this document is to outline the new approval process for Cases for Change to reflect changes in CCG committee structure as outlined in 15/129. The QIPP /SIR committee intends to use the prioritisation process to help assess cases, to ensure all investments provide health outcomes, whilst contributing to QIPP. Southport & Formby CCG has set a minimum QIPP contribution of £3 return for every £1 invested.

2. Prioritisation process

The QIPP committee requested development of a prioritisation process to ensure that all cases progressed to QIPP committee by PMO meet the following key criteria:

- Links to our Strategic Blueprints;
- Links to our Strategic Programmes in CVD and Respiratory, supporting the clinical direction being set out in these programmes;
- Links with Localities and ensuring that the locality slant is tied into above criteria;
- Scheme has the ability to deliver a return on investment that is clearly evidenced and distinguishable (£3 for every £1 invested);
- Ability to identify benefit and impact in terms of reduced activity by point of delivery Eg: A&E Attendances, Non Elective Admissions, Outpatients New & Follow Up etc;
- Demonstrates links with current contracts to enable adjustment derived from criteria above to inform contract activity adjustments for future years.

The QIPP committee will then use prioritisation matrix (Appendix 1) to assess and score the evidence and information provided in each Case for Change. There are 5 categories, each scoring between 1 (very low evidence) to 5 (Very high evidence). Each category is weighted to reflect the CCG's priority level. For example, Patient Safety and Quality, and Finance categories have a joint weighting of 30%. The highest possible total score is 25, so the maximum weighted score is 5. Appendix 2 provides an overview of all the possible scores and weighted scores.

Cases are expected to score a 3 in each category, so the minimum weighted score for a case to be approved is 3.

3. Approval process

Appendix 3 outlines three steps each case for change must take in order to be approved.

The PMO must be engaged to initiate the case and will work with leads to understand their resource requirements in order to complete the Case, including any support from Finance and Business Intelligence teams.

The PMO will ensure that cases meet all key criteria (see section 2). Finance must sign off the financial aspects of the case and ensure that future contract changes are clearly described and meet the CCG's QIPP requirement. Once signed off by Finance, cases will be progressed to the next available QIPP Committee.

The QIPP committee will review cases, assessing clinical and financial evidence, and score against the prioritisation matrix. Cases scoring a weighted minimum of 3 can be recommended for approval at the next Finance and Resource Committee

4. Next Steps

A new Case for Change document will be developed to ensure that all categories in the prioritisation process are fully reflected.

The CCG is also looking to introduce a fixed number of gateways for case prioritisation and assessment in 2016/17.

Both proposals will be brought back the Governing Body in Quarter 3 for approval

Appendices

Appendix 1 – Prioritisation Matrix
Appendix 2 – Scoring Matrix
Appendix 3 - Approval Process

Fiona Doherty
July 2015

Prioritisation Matrix – Weighted Criteria

Scoring Criteria						
Category	%	Very Low - 1	Low - 2	Mid-scale - 3	High - 4	Top - 5
Contribution to achievement of CCG selected outcome aspirations	25	Scheme does not demonstrate link to achievement of CCG outcome aspirations	Scheme indicates a loose link to contribution to achievement of CCG outcome aspirations	Scheme demonstrates contribution to achievement of one CCG outcome aspiration	Scheme demonstrates a clear contribution to achievement of one or more CCG outcome aspirations	Scheme strongly demonstrates a significant contribution to achievement of more than one CCG outcome aspiration
Quality & Safety	30	Does not provide enough quality evidence.	Weak, but includes some quality evidence.	Adequate amount of quality evidence.	Reasonable amount of quality evidence.	Strong quality evidence base.
Finance & Performance	30	Scheme costing does not appear to be within budget and has not been scoped out correctly. No KPIs / Outcomes provides	Scheme calculations and estimated expenditure are weak and does not detail a breakdown and or forecast of the Scheme expenditure. KPIs & Outcomes provided weak and do not match aims of scheme	Scheme outline is viable, achievable and affordable. Includes a breakdown of all projected financial costs. KPIs provided demonstrate outcomes and can be collated.	Scheme calculations detailed with breakdown of quarterly expenditure, affordable, viable and achievable, with indication of projected savings. (£3 saved/£1 invested). KPIs clearly demonstrate outcomes and can be collated. It includes baselines, proposed changes in impact and target for future contract reduction	Scheme is cost effective and within budget detailed savings expected over Scheme delivery and beyond as a result of expected impact -spreadsheet costing, detailed Scheme expenditure and projected forecast provided attached as appendix. KPIs as previous however provider providing activity dashboard.
Risk Management	5	Scheme shows no consideration of risk, nor how risk would be managed in the event a risk should arise.	Scheme indicates consideration of risk and management reduction/ minimising risk	Scheme includes risks to the Scheme and includes a strategy, contingency plans for future risk.	Scheme Includes detailed risk register and interdependencies, including the issues that ,may arise as a result of delivery	Scheme clearly identifies the potential or real risk and proposes mitigating actions (including risks to the health economy)
Contracting & Procurement	10	Scheme does not clearly identify the implications for contracting, procurement or the implications for existing contractors or decommissioning strategy, nor timelines for procurement process as part of the application and delivery.	Scheme indicates how services will be impacted, what the current timeline and impact and what services and support would be required as part of the process for delivery.	Scheme indicates the implication for timelines and how this will be incorporated into the process for delivery. Supports future contracting discussions by addressing activity PODS for next financial year	Scheme clearly indicates the approach to and options considered as part of the delivery process. Details impact on contracts with clear financial plan based on clearly stated KPIs and outcomes and impact on activity PODS across LT plan	Scheme clearly identifies the implications for contracting, procurement and the implications for existing contractors and decommissioning strategy, outlining how the contract will achieve real objectives in the appropriate contractual schedules over 5 year plan.

Prioritisation Matrix – Weighted Scoring Chart

Category	Weighting %	Score	Weighted score	Total Weighted Score
Contribution to achievement of CCG Blueprint aims & outcomes	25%	5	1.25	
Quality & Safety	30%	5	1.5	
Finance & Performance	30%	5	1.5	
Risk Management	5%	5	0.25	
Contracting & Procurement	10%	5	0.5	5
Contribution to achievement of CCG Blueprint aims & outcomes	25%	4	1	
Quality & Safety	30%	4	1.2	
Finance & Performance	30%	4	1.2	
Risk Management	5%	4	0.2	
Contracting & Procurement	10%	4	0.4	4
Contribution to achievement of CCG Blueprint aims & outcomes	25%	3	0.75	
Quality & Safety	30%	3	0.9	
Finance & Performance	30%	3	0.9	
Risk Management	5%	3	0.15	
Contracting & Procurement	10%	3	0.3	3
Contribution to achievement of CCG Blueprint aims & outcomes	25%	2	0.5	
Quality & Safety	30%	2	0.6	
Finance & Performance	30%	2	0.6	
Risk Management	5%	2	0.1	
Contracting & Procurement	10%	2	0.2	2
Contribution to achievement of CCG Blueprint aims & outcomes	25%	1	0.25	
Quality & Safety	30%	1	0.3	
Finance & Performance	30%	1	0.3	
Risk Management	5%	1	0.05	
Contracting & Procurement	10%	1	0.1	1

APPROVAL PROCESS FOR CASES FOR CHANGE

ONGOING

MONTHLY

PMO – CONTACT TO INITIATE CASE FOR CHANGE. PMO WILL IDENTIFY SUPPORT NEEDS; EG BI, FINANCE INPUT.
CASE MUST MEET KEY CRITERIA BEFORE PROCEEDING TO QIPP COMMITTEE

QIPP COMMITTEE
REVIEW CASE AGAINST PRIORITISATION CRITERIA. IF AGREED MAKES RECOMMENDATION TO FINANCE & RESOURCE COMMITTEE

FINANCE & RESOURCE COMMITTEE
FINAL SIGN OFF

CASE FOR CHANGE TIMESCALES

IN ORDER TO ENSURE THAT SUPPORT REQUIREMENTS (BI, FINANCE, PMO ETC) ARE AVAILABLE TO SUPPORT CASES PLEASE ENSURE CASES ARE INITIATED AT LEAST FOUR WEEKS PRIOR TO QIPP COMMITTEE.

COMPLETED CASES MUST BE SIGNED OFF BY BOTH FINANCE AND PMO IN ORDER TO PROCEED TO QIPP COMMITTEE

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2015

Agenda Item: 15/132	**Author of the Paper:** Dwayne Johnson Director of Social Services & Health Email: dwayne.johnson@sefton.gov.uk Tel: 0151 934 4900
Report date: July 2015	

Title: Refresh of the Dementia Strategy for Sefton

Summary/Key Issues:

Sefton's current strategy for Dementia, written following the publication of "Living Well with Dementia: A National Dementia Strategy" which was published in 2009, ran from 2009-2014. There is therefore a need to refresh this in order to reflect changes in national policy and guidelines and the changes in structure to health services in Sefton.

The Strategy has been refreshed and includes a draft collaborative action plan and is seeking the Governing Body's views and agreement to the draft Dementia Strategy for Sefton.

Recommendation

The Governing Body is asked to receive the draft strategy.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	To place clinical leadership at the heart of localities to drive transformational change.
	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	To publish plans for community services and commission for March 2016.
	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
	To achieve financial duties and commission high quality care.

NHS
Southport and Formby
Clinical Commissioning Group

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	X			Full consultation report attached as Appendix 2.
Clinical Engagement	X			Clinicians have been involved in developing the draft strategy as detailed in the Strategy document and the Consultation Report
Equality Impact Assessment	X			Draft EIA attached at Appendix 3.
Legal Advice Sought				
Resource Implications Considered	X			The Draft Strategy provides a framework to guide the Council and its partners in seeking to support people with dementia and their carers in the context of the current financial climate. Where actions will result in additional resources being required then this will be costed and referred to Elected Members and other partners to consider.
Locality Engagement				
Presented to other Committees	X			HWBB Programme and Integration Group 11th May 2015

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
	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
July 2015

1. Executive Summary

Sefton's current strategy for Dementia, written following the publication of "Living Well with Dementia: A National Dementia Strategy" which was published in 2009, ran from 2009-2014. There is therefore a need to refresh this in order to reflect changes in national policy and guidelines and the changes in structure to health services in Sefton

2. Introduction and Background

The draft 2014 – 2019 Dementia Strategy, attached at Appendix 1 to this report, provides an overarching framework within which the council and partners can provide positive, proactive approaches to service development providing individualised support to ensure that older citizens experiencing dementia can access appropriate, joined-up services that are provided safely and effectively to maximise independence, choice and quality of life.

The refreshed Dementia Strategy and consultation has been developed during the past 12 months by a multi-agency working group including officers from Sefton Council Business Intelligence and Performance Team, NHS South Sefton CCG, NHS Southport and Formby CCG, Sefton CVS, Mersey Care NHS Trust, Alzheimer's Society, Sefton Pensioners Advocacy Centre, Age Concern, Sefton Partnership for Older Citizens, One Vision Housing, Care Homes Association, Liverpool Community Health NHS Trust and Southport & Ormskirk Hospital NHS Trust. The group is chaired by the Cabinet Member for Adults and Health, Councillor Paul Cummins.

Through various consultation responses the communities of Sefton have identified the following thematic priorities:

- Most Vulnerable;
- Community Resilience;
- Economy;
- Environment;
- Health and Wellbeing.

The draft Strategy has been co-produced with people who have dementia, their carers and service providers. The draft Strategy has been developed within the context of the above thematic priorities and provides the Council and its partners with a refreshed approach to improving quality outcomes for people with dementia and their carers and families as they progress through the dementia care pathway. It has also been developed in the context of the current financial climate that the Council finds itself in.

Co-production of the Dementia Strategy

The multi-agency working group designed the consultation to be able to gather the views of people with dementia and their carers on the realities of living with dementia, to understand how their needs are being met, what gaps they have encountered and their views on improving services across Sefton. A range of methods were used to engage with people with dementia, their families and carers and providers. Care was taken in identifying the methods to be used to consult with people who have dementia and their carers. There is no "one size fits all" approach as each person is different, will interact differently and traditional approaches may not be suitable.

The process for developing the draft Strategy included a consultation and engagement process that included Open Space and Innovation Events to enable the sharing of views, thoughts, ideas and experiences about how together we can make a difference to the lives of people living with Dementia and their carers, meetings with Voluntary, Community and Faith Networks and hard to reach groups and taking on board the need to tailor consultation to specific groups, separate questionnaires were developed:

- A questionnaire specifically for people with dementia;
- A questionnaire for carers of people with dementia;
- A questionnaire for people who have recently lost somebody with dementia;
- A general questionnaire for members of the public;
- An easy read version of the general questionnaire which was used to engage with people with learning disabilities.

In total, in excess of 160 people engaged with the process. Regardless of whether people where old, young, disabled, living in the north or south of the Borough, there were some common themes that repeatedly emerged which resulted in the development of the five theme areas outlined within the Strategy as follows:

- Timely diagnosis, appropriate treatment and involvement in care plans;
- Support to live independently for as long as possible, and to make decisions for myself;
- Inclusive and dementia friendly communities;
- Information, advice and support for people with dementia and their carers;
- End of Life Services, ensuring a peaceful and pain free death in the place of choice.

Summary Feedback from the Consultation and Engagement Process

Attached to this report, at Appendix 2, is the full feedback report from the consultation and engagement process. The feedback from the consultation and engagement process found the following:

- Education is important. There is a need to increase awareness and understanding of dementia and to challenge stigma;

- Carers should be supported in their role as a carer but also as an individual, as to not lose their own identity;

- Early diagnosis is important and then once diagnosed, access to services quicker;

- People with dementia should be asked for their opinion, including their End of Life Plan;
- Services should be flexible and have a whole person approach. Activities available either in the day centre or in the community should be stimulating;
- There should be good quality, consistent information, advice and guidance for the person who has been diagnosed and for the carer.

With regard to the Prime Minister's Dementia Challenge to create dementia friendly communities, which was launched in 2012, people felt that dementia friendly communities will be places where:

- People with dementia are supported to remain active and included members of their communities;
- People will have increased understanding and awareness about dementia and how to support individuals with dementia;
- To support individuals living with dementia and their carers to maintain their independence for as long as possible;
- People with dementia being treated as valued members of society;
- People with dementia and their carers feel comfortable in their local environment (shops, leisure facilities, etc);
- People who work in the local community are trained to respond to the needs of people with dementia and do very simple and practical things that can make an enormous difference;
- Implementing simple steps to help people with dementia such as slow lanes in supermarkets and banks;
- Support from befriending groups to help people with dementia do the things that they want to.

Equality Analysis Report

In developing the draft Strategy, the Council has shown due regard to the Equality Act 2010, and attached at Appendix 3 is a draft copy of the Equality Analysis Report for views and agreement.

3. Key Issues

The draft Strategy is centred on improving quality outcomes for people with dementia and their carers and families as they progress through the dementia care pathway. The Partners to the Dementia Strategy will need to work together towards actions that promote early intervention and prevention in order to help to delay the onset of dementia and encourage healthy lifestyles, both physically and mentally, to help improve the wellbeing of Sefton's residents. A draft Action Plan is within the Strategy that will require resource allocation and the Governing Body is asked to consider the draft Action Plan, in particular the actions where the Clinical Commissioning Group is identified as the Lead.

4. Conclusions

Sefton has also recently consulted and refreshed its Carers and Older People's Strategies and this provides an opportunity to ensure that the Dementia Strategy is linked to both of these Strategies.

The Strategy provides a framework from which an overarching action plan will be developed for the delivery of the strategy in the context of the Strategic Objectives in the Sefton Health and Wellbeing Strategy and the priorities within the Sefton Carers Strategy 2014 – 2019 and Sefton Strategy for Older Citizens 2014 – 2019. These will be monitored through the Health and Wellbeing Board Adults Forum and reported from this forum to the Programme and Integration Group and the Health and Wellbeing Board.

The draft Strategy and associated documents will also be considered by the Sefton Council Strategic Leadership Team, before being considered at the Health and Wellbeing Board meeting in June, the Cabinet in July and by Full Council in September.

5. Recommendations

- That the content of the report and the feedback from the consultation and engagement process be noted, as described in the report;

- The Draft Equality Analysis Report and the actions therein are approved.

Appendices

Appendix 1: Draft Dementia Strategy – Living Well with Dementia 2014 – 2019
Author: Sefton Council Business Intelligence & Performance Team, May 2015

Appendix 2: Draft Dementia Strategy – Full Consultation Report
Author: Sefton Council Business Intelligence & Performance Team, May 2015

Appendix 3: Draft Dementia Strategy - Equality Impact Assessment
Author: Sefton Council Business Intelligence & Performance Team, May 2015

Dwayne Johnson
July 2015

Living Well with Dementia: A Strategy for Sefton 2014-2019

DRAFT

Prepared by Business Intelligence & Performance Department
7th floor, Merton House, Stanley Road, Bootle.
Version 12 12.05.15

Prepared by Business Intelligence & Performance Department
7th floor, Merton House, Stanley Road, Bootle.
Version 12 12.05.15

Table of Contents

Prepared by Business Intelligence & Performance Department
7th floor, Merton House, Stanley Road, Bootle.
Version 12 12.05.15

Foreword:

Councillor Paul Cummins, Cabinet Member for Older People and Health

Like most of the country, Sefton is experiencing a continuing rapid increase in the proportion of older people in its population. Older people in Sefton generally enjoy good physical and mental health, and they are a great asset to their communities through their many contributions to local organisations, neighbourhoods and their own families. Nevertheless, this increasing proportion of older people in the population will make increasing demands on health and social care services, including those with dementia.

Dementia can affect adults of any age, but is most common in older people. One person in 20 over 65 has a form of dementia, rising to 1 in five in those over 80. Dementia in people aged under 65 is relatively rare – less than 3% of all those with dementia.

Positive, proactive approaches to service development providing individualised support can help ensure that physical and mental health are sustained as long as possible, that people live at home for as long as possible and that crises and unnecessary use of intensive costly services are minimised. It remains our intention to ensure that older citizens experiencing dementia can access appropriate, joined-up services that are provided safely and effectively to maximise independence, choice and quality of life.

This draft strategy has been produced by a number of partners, together with input from people with dementia and their carers:-

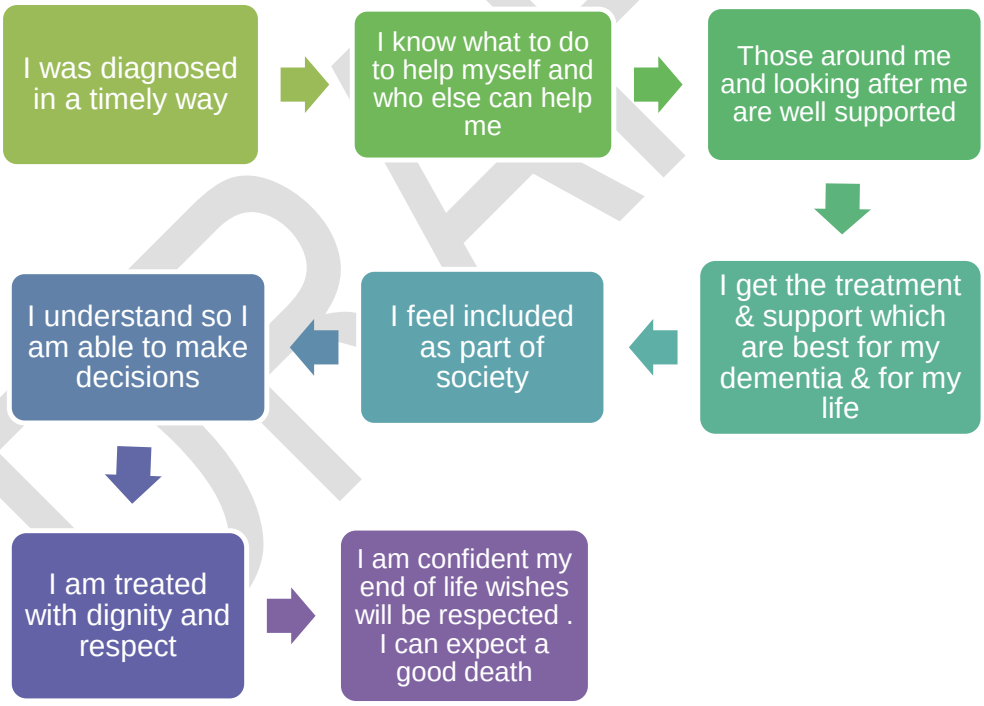
- Sefton Council
- South Sefton CCG
- Sefton CVS
- One Vision Housing
- University Hospital Aintree NHS Foundation Trust
- NHS Liverpool Community Health Trust
- Sefton Partnership for Older Citizens
- Southport & Formby CCG
- Sefton Carers Centre
- Alzheimer's Society
- Sefton & Liverpool Age Concern
- Mersey Care NHS Trust
- Southport & Ormskirk NHS Trust
- Sefton Pensioners' Advocacy Service

Vision for People with Dementia in Sefton

We want to ensure that people with dementia and their carers receive high quality, compassionate care whether they are at home, in hospital or in a care home. We want the person with dementia, and their family and carer, their wellbeing and quality of life to be first and foremost in the minds of those commissioning and providing services for them.

Aim for People with Dementia in Sefton

The following strategic priorities have been identified that will help people with dementia, and their carers, to live their lives in a positive way. They are based on what people with dementia and their carers have said nationally are important to them:-



Developing Sefton's Dementia Strategy

Living Well with Dementia has been developed in partnership with people with dementia and the people who care for them. We asked people with dementia and their carers what was important to them in order to make sure that this was reflected in the Strategy.

Conversations took place with providers of services, shops, businesses and offices around the themes of creating dementia friendly communities, promoting diagnosis and supporting people to live independently and information, advice, support for people with dementia.

Consultation also took place with the general public to test out people's thoughts and understanding about dementia, what they felt that people with dementia should be able to do (such as continue to live alone/being able to continue to work for as long as they are able/continue to drive for as long as they can/use technology to enable people to stay safe in their home) and their thoughts on the draft strategy and the priorities in it.

A full consultation and engagement report on has been prepared and is a separate document to this Strategy. In total 169 people engaged with the consultation and engagement process.

People with dementia and their carers told us that:-

- On the whole they found it easy to get a diagnosis, although some felt that the length of time from diagnosis to accessing the memory service was too long.

- Information and advice is available, although carers would like more information about long-term symptoms, how to choose residential homes and information about the costs involved. The work of the Alzheimer's Society and the support they offer was felt to be invaluable.

- In terms of healthcare it is important to see the same person each time so that they didn't have to repeat their story and over again to different people.

- People with dementia should be asked what they want, including their likes and dislikes, even if they find it difficult to answer
- It is important that the person with dementia should have a say in their end of life plan and this should be done at an early stage
- Where people with dementia have to stay in hospital, their experiences have been poor and that there needs to be more training and awareness raising for staff.

What is Dementia?

The term dementia describes a set of symptoms, including memory loss, mood changes and problems with communication and reasoning. Dementia is not a natural part of growing old. It is caused by diseases of the brain, the most common being Alzheimer's.

Although regarded and classified as a mental disorder, dementia is predominantly a physical, progressive condition; the symptoms becoming more severe over time and impacts on a person's functional ability and most noticeably their daily routines. Symptoms include:-

Impairment of memory

- Increasing difficulty in remembering recently acquired information
- Difficulty recognising friends and family
- Forgetting names of friends and common objects

Impairment of reasoning

- Difficulty in working things out
- Not being able to use a new design of kitchen appliance
- New-found difficulty handling money

Impairment of learning

- Inability to learn or remember names of people or objects
- Repetitive questioning due to inability to remember the answer
- Problems learning how to learn to use new objects

Increased stress levels

- Becoming distressed if you are in an unfamiliar environment
- Anxiety from not recognising people
- Inability to recognise, understand or adapt to what's going on around

Reduced capacity to deal with age-related changes

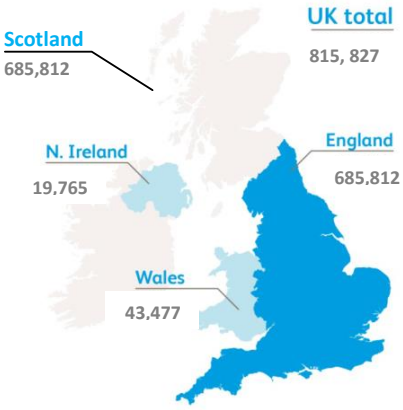
- Forgetting to use recently acquired prosthetics, e.g., glasses or hearing aids
- Neglecting to keep the house warm
- Forgetting to eat or drink enough fluids

Dementia often becomes more common with ageing, but can also be present in people of working age. People with dementia can present family, friends and carers with complex issues (especially in the later stages of the disease) which can include restlessness and wandering, mobility difficulties leading to falls and fractures, eating difficulties, recognition difficulties, memory and recollection difficulties, incontinence and, sometimes, a range of behaviours that can be challenging to carers, family and care home staff.

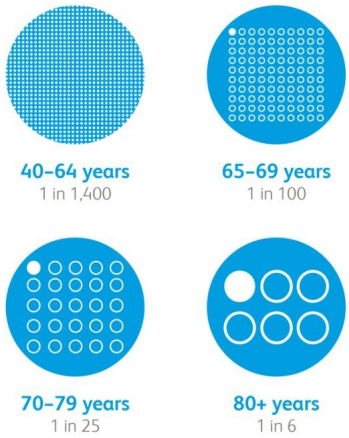
Dementia presents a huge challenge to society, both now and increasingly in the future. It is a common condition, which has a large impact on carers and society with an increasing cost attached to caring for people within the community.

Dementia: the National Context

In 2013 there were 815,827 people were suffering with dementia in the UK.



Dementia is most common in older people but younger in the can get it too

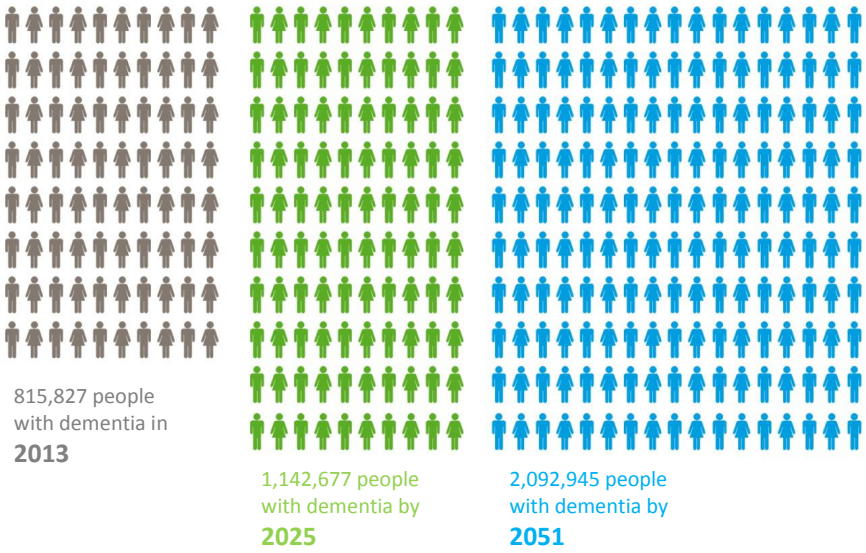


Two thirds of people with dementia are women

One in three people over 65 will develop dementia

One in twenty people with dementia are under the age of 65

If trends continue, the number of people with dementia will double in the next 40 years.

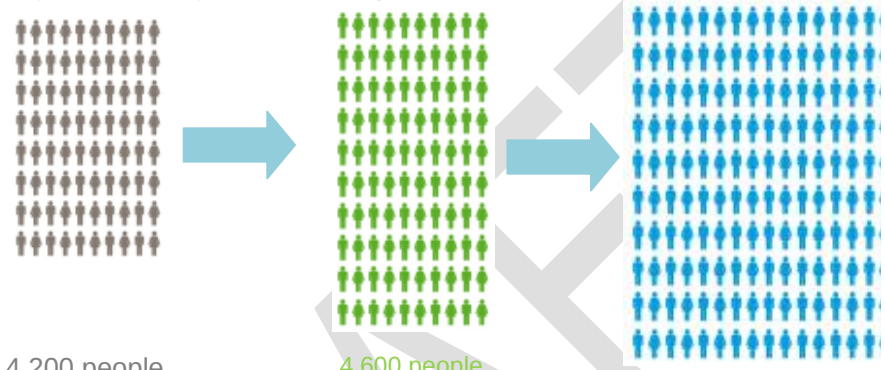


Dementia: the Sefton Context

Sefton has one of the highest percentages of adults with dementia in the UK.

According to figures recently released by the Alzheimer's Society, **Southport** has the highest number of people with a diagnosis of dementia in the North West and one of the highest rates in the UK – 1,765.

The number of people in Sefton over 65 with dementia is steadily increasing and this growth is expected to continue



4,200 people with dementia **2012**

4,600 people predicted with dementia **2015**

5013 people predicted with dementia **2020**

Of these numbers between 50% and 65% will **not** have a confirmed diagnosis

There will also be an increase in the number of people **under the age of 65** diagnosed with dementia

The numbers of people with dementia in Sefton is spread evenly across North and South of the Borough (based on statistics quoted in Dementia UK 2nd Edition). However there are differences in that the number of younger people (aged 40-64) with dementia is slightly higher in the South of the Borough, and the number of older people (aged 95 – 95+) with dementia is slightly higher in the North of the Borough.

The Economic Impact of Dementia

The overall economic impact of dementia in the UK is £26.3 billion, which works out at an annual cost of £32,250 per person (this excludes the costs of early onset dementia). Two-thirds (£17.4 billion) of the cost of dementia is paid by people with dementia and their families, either in unpaid care (£11.6 billion) or in paying for private social care. This is in contrast to other conditions, such as heart disease and cancer, where the NHS provides care that is free at the point of use. This is because, although dementia is a physical disease of the brain, most of the essential care required supports daily activities, such as washing and dressing, which is classified as 'social' rather than 'health' care.

£4.3 billion is spent on healthcare costs of which around £85 million is spent on diagnosis

£10.3 billion is spent on social care for people with dementia in the UK.

Social care is either publicly funded (£4.5 billion – 17.2% of the overall total cost of dementia) or privately funded (£5.8 billion – 22.9% of the total)

The cost of unpaid care for people with dementia in the UK is £11.6 million , working out as 44% of the total cost of dementia. The total number of unpaid hours of care provided to people with dementia in the UK is 1.34 billion

£111 million is spent on other dementia costs

Reducing the Risk of Dementia

While the causes of dementia remain unclear, it is known that a good diet, regular physical exercise and avoiding smoking and excessive alcohol consumption can reduce the risk of developing dementia. Interventions focusing on encouraging a healthier diet, regular exercise, reducing smoking and avoiding excessive alcohol consumption would therefore likely reduce future incidence of dementia.

While a lifelong approach to good cardiovascular health is recommended for some conditions (for example high blood pressure, blood cholesterol or BMI), a healthy lifestyle from midlife onwards is likely to be particularly effective at combating dementia. In addition to these vascular approaches, psychosocial factors such as educational attainment, complex work, and mental and social stimulation throughout life also reduce the risk of developing dementia. They are thought to do so by building up a cognitive reserve. Growing evidence also suggests that midlife depression is a probable risk factor for later dementia and its treatment should be encouraged.

There is no certain way to prevent all types of dementia. However, a healthy lifestyle can help lower the risk of developing dementia as people become older. It can also prevent cardiovascular diseases, such as strokes and heart attacks.

To reduce the risk of developing dementia and other serious health conditions, the following are recommended:

- Eating a healthy diet
- Maintaining a healthy weight
- exercising regularly
- Not drinking too much alcohol
- stopping smoking (if you smoke)
- keeping blood pressure at a healthy level

Helping People with Dementia and their Carers to Live Well

Housing and support for people with dementia

Two thirds of people with dementia live in the community and people with dementia and their carers place great importance on their homes. However, research undertaken nationally by the Alzheimer's Society shows that:-

- More needs to be done to link housing with health and social care services
- Many people with dementia and carers want to be supported in their current homes, but others prefer the option of housing with care where care is available on site.
- There are mixed experiences of accessing information and advice on housing and housing options, including access to funding and support to make adaptations to the home
- More needs to be done to ensure homes are designed and built with the needs of people with dementia in mind and older people in general
- The use of assistive technology to support people with dementia and their carers to be supported to stay in their own homes where possible. This includes things such as telecare, personal alarm systems, movement sensors, tracking devices and door opening detectors.

Current national and local planning policies do not require developers of elderly friendly homes to carry out an assessment of how dementia friendly their new developments are. However the National Planning Policy Framework (Paragraph 171) states that Planning and Health need to work together to consider health status and needs of local population both now and in the future. In Sefton's case this includes an increase in the older population and a need for environments that are supportive of those living with dementia.

The Town and Countryside Planning Association is working with Public Health England to identify ways in which Planning and Public Health can work together and contribute to outcomes for older people and those who are living with dementia. The Association has held two workshops in Sefton with the Council and other partners.

At a meeting of the full Council on 25th September 2014, Sefton Councillors considered the issue of dementia and housing and indicated that developers of homes should consider the issues associated with an ageing population, including how dementia-friendly their developments are at all stages of those developments.

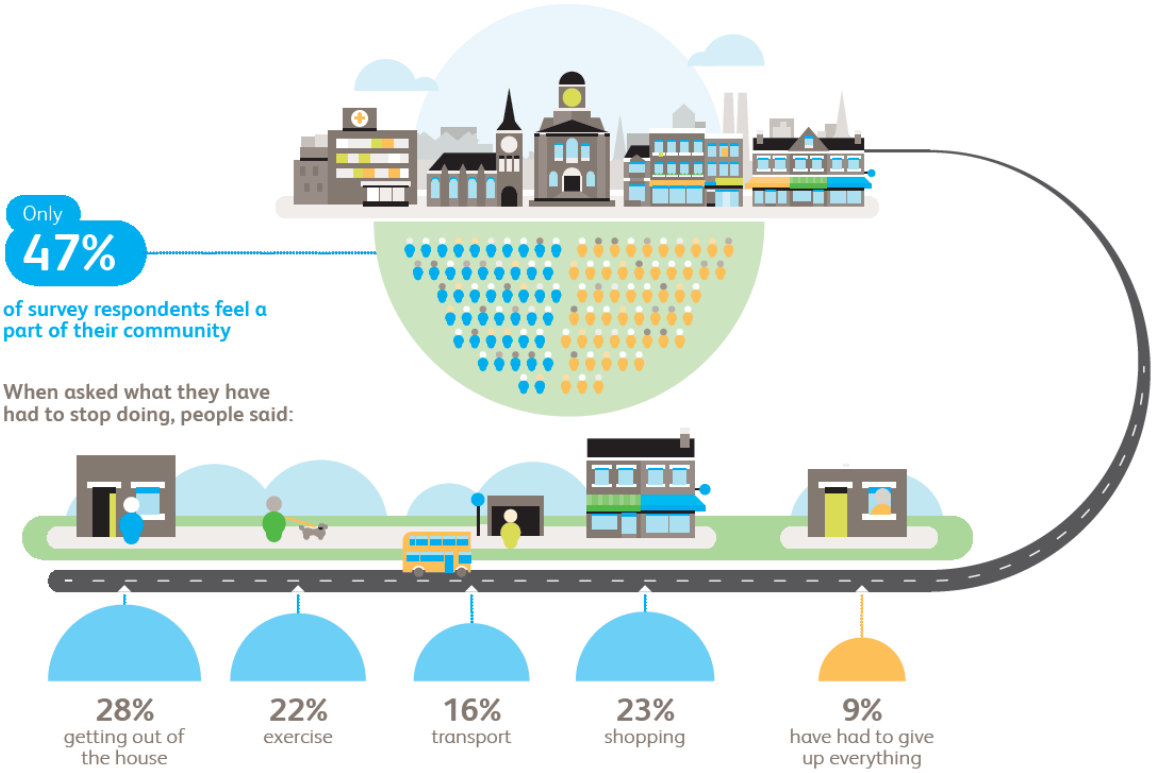
It passed a resolution that the Council will promote increased awareness of the needs of older people amongst those wishing to develop housing in the Borough, including the design and development of a dementia–friendly environment. The Council also resolved to consider, through the emerging Local Plan process, the making of a policy requiring developers to identify how best to address the housing needs of the ageing population.

With regard to **Social Housing** for people with dementia, the Council supports the provision of 'extra care housing schemes'. Extra Care Housing offers accommodation for older applicants who may need additional care and support services and there are specific assessment criteria to ensure an appropriate balance of residents with high/medium/low care needs.

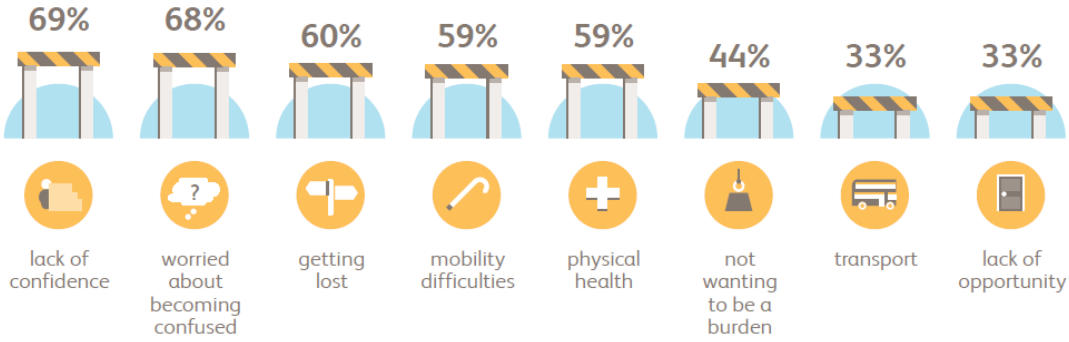
Creating Dementia Friendly Communities in Sefton

People with dementia and their carers can face many challenges going about their daily lives when shopping, using public transport, socialising and getting involved in their community. Having dementia does not mean someone has to stop carrying out everyday tasks or enjoying activities.

The Alzheimer's Society asked people with dementia for their views about living with dementia in their community:-



People with dementia feel their biggest barriers to participating in their local area are:



Whilst the main priorities for the Sefton dementia strategy are around prevention (e.g. tackling isolation, promoting wellbeing and healthy eating) and better treatment, by making Sefton more dementia friendly, it will make for a better quality of life for those who are already suffering from it.

At a meeting of the full Council held on 25th September 2014, Sefton Councillors resolved that the Sefton Dementia Action Alliance will seek dementia-friendly community status for the whole of the Borough.

In order for Sefton to become Dementia Friendly it will require strong commitment from everybody. This will be achieved by the Public Sector, the Private Sector, the Voluntary Sector, Church groups and individuals working together to enable people with dementia to live well. This might be making the bus into town or the library more accessible, or thinking about the support needed to go shopping. A little understanding about dementia and its effects is the only way to create dementia-friendly communities.

A dementia-friendly community is one in which people with dementia are empowered to have aspirations and feel confident, knowing they can contribute and participate in activities that are meaningful to them. Many villages, towns and cities are already taking steps towards becoming dementia-friendly, or have an ambition to do so

A group of shops on Fylde Road, Southport have recently received recognition from the Alzheimer's Society for being dementia friendly. The staff in the shops received Dementia Friends training and changed practices within their business to help people with dementia to use their services. Dementia-Friendly communities benefit everybody not just people with dementia.

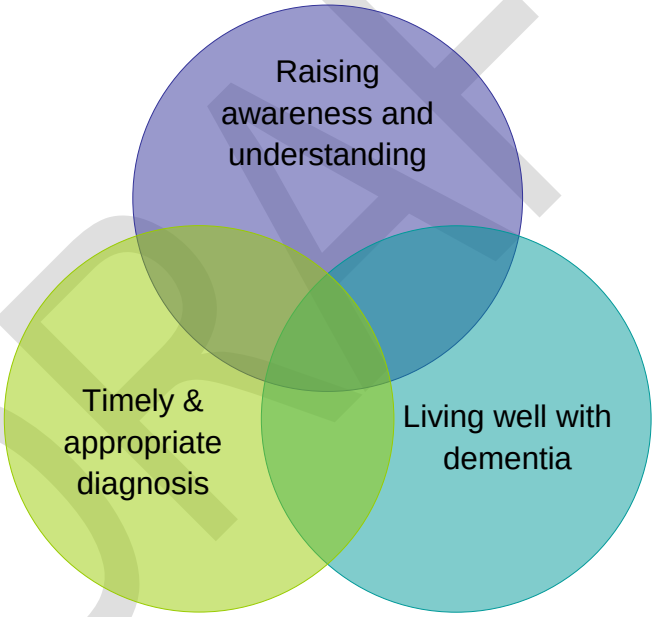
Links to National Strategies and Policies

This draft strategy is aligned with, a number of National Strategies and Policies:-

National Dementia Strategy 2009

In 2009 the Department of Health launched the first ever National Dementia Strategy for England. The Strategy is the Government's plan which explains what needs to happen to radically transform the quality of life for people with dementia and their carers.

The Dementia Strategy sets out 17 recommendations that the Government wants the NHS, local authorities and others to adopt to improve dementia care services. The recommendations are focused on three key themes of:



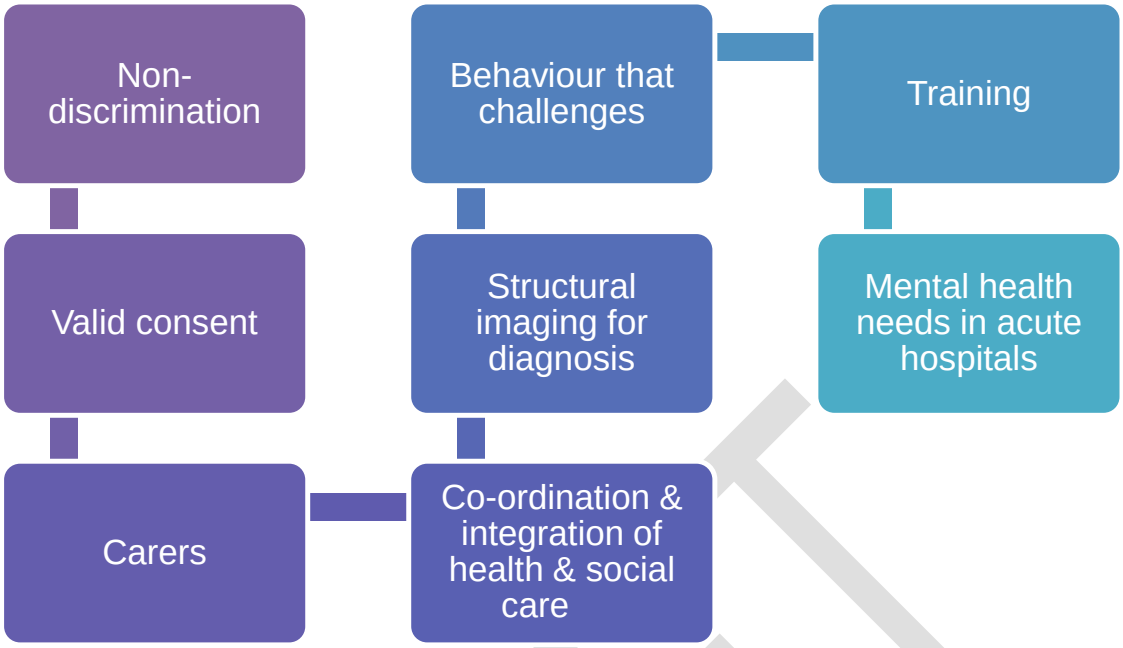
Following on from the publication of the Strategy, in 2010 the Government produced the document **Quality outcomes for people with dementia: building on the work of the National Dementia Strategy**. The document lists four priority areas for the Department of Health's policy development work to support local delivery of the Strategy. These areas provide a real focus on activities that are likely to have the greatest impact on improving quality outcomes for people with dementia and their carers:-

More generally the improvement of community personal support services is integral to and underpins each of the four priorities as it supports early intervention; prevents premature admission to care homes and impacts on inappropriate admission to hospital and length of stay.

National Institute for Health and Care Excellence /Social Care Institute for Excellence Guidance 42 2006 (updated March 2013)- Supporting People with Dementia and their Carers:

This guidance makes recommendations for the identification, treatment and care of people with dementia and the support of carers. Settings relevant to these processes include primary and secondary healthcare, and social care. It states that wherever possible and appropriate, agencies should work in an integrated way to maximise the benefit for people with dementia and their carers

The following recommendations have been identified as priorities for implementation:-



Prime Minister's Dementia Challenge 2012:

The dementia challenge was launched in March 2012 by Prime Minister David Cameron The Dementia Challenge is an ambitious programme of work designed to make a real difference to the lives of people with dementia and their families and carers, building on progress made through the National Dementia Strategy.

There are 3 dementia challenge champion groups, each focusing on 1 of the main areas for action:

National Dementia Declaration for England – Dementia Action Alliance

The Dementia Action Alliance is made up of over 900 organisations committed to transforming the quality of life of people living with dementia in the UK and the millions of people who care for them.

Members of Dementia Action Alliance have signed up to a National Dementia Declaration. Created in partnership with people with dementia and their carers, the Declaration explains the huge challenges presented to society by dementia and some of the outcomes it is seeking to achieve for people with dementia and their carers. Outcomes range from ensuring people with dementia have choice and control over decisions about their lives, to feeling a valued part of family, community and civic life.

These are the seven outcomes that people with dementia and their family carers said they would like to see in their lives.

Dementia and People with Learning Disabilities Charter, 2013:

Advances in medical and social care have led to a significant increase in the life expectancy of people with learning disabilities. Understanding the effects of ageing among this group − including the increased risk of developing dementia - has therefore become increasingly important. People with learning disabilities in general and people with Down's syndrome specifically, have a higher risk of developing dementia and at a younger age than people in the general population and:-

- often show different symptoms in the early stages of dementia
- are less likely to receive a correct or early diagnosis of dementia and may not be able to understand the diagnosis
- may experience a more rapid progression of dementia
- may already be in a supported living environment, where they are given help to allow them to live independently
- may have already learned different ways to communicate (e.g. more non-verbal communication if their disability affects speech)
- will require specific support to understand the changes they are experiencing, and to access appropriate services after diagnosis and as their dementia progresses

The Charter outlines 14 important outcomes for the individual person that organisations need to be aware of, and that are aimed at improving the persons experience of support, underpinned by comprehensive person centred planning based on their own wishes, their capacity (maximising their decision making, wherever possible), and their needs and history.

Links to Local Strategies

There are a number of local strategies that link to this draft strategy, but do not duplicate it. These include:

The Sefton Health & Wellbeing Strategy 2013 – 2018 which this draft strategy seeks to support in the delivery of the six strategic objectives for Health and Wellbeing:

The Sefton Carers Strategy 2014-2019

This Strategy has been co-produced with partners, providers and the carers themselves (including young carers) and identifies a set of draft strategic objectives for Carers in Sefton, together with the creation of a model for working with Carers, and a whole life course approach to defining carers. A draft model of working with carers in Sefton has

been created which shows that carers and those they care for are at the heart of the process and that those closest to them "their world" are also very important.

The model shows that all organisations should talk to each other and where ever possible share appropriate data in a secure way to ensure that services provided best meet the need.

Sefton Strategy for Older Citizens 2014 – 2019

Sefton Partnership for Older Citizens (SPOC), continues to work with partners to create a better place where older people can live, work and enjoy life as valued members of the community. The five year strategy for older citizens sets clear direction for our communities and strives to ensure that the needs of people are met. It also provides a framework of common outcomes that link directly to the ambition and vision within other strategies (Carers, Mental Health and End of Life) currently being developed and in this way helps to bring a shared focus and collaborative approach to service development in Sefton.

Sefton Mental Health and Wellbeing Strategic Plan

Work is also underway to develop a draft Sefton Mental Health and Wellbeing Strategic Plan based on feedback from service users as part of the consultation on the Health and Wellbeing Strategy.

End of Life / Palliative Care

A Sefton commissioning strategy is being developed that will enable patients, carers and families to access appropriate high quality care when facing the issues associated with life threatening illness. The strategy aims to ensure that all services involved in end of life care act in a compassionate way, that treats, comforts and supports people who are living with progressive, chronic or life threatening conditions. All care services need to acknowledge and have a plan for the cultural, personal and spiritual beliefs, values and practices that need to be considered as part of their role in giving support up to and including the period of bereavement

These draft strategies and plans will be further consulted upon to ensure that this strategy and other strategies and plans are aligned, but do not duplicate activities and deliver value for money.

Gaps identified from the Consultation & Engagement Process

Early Onset Dementia

There is currently very little information available about the numbers of younger people (under 65) in Sefton with dementia.

Getting an accurate diagnosis of dementia can take a very long time for people under 65, often due to lack of awareness that dementia can happen in this age group. Medical professionals often misdiagnose them as being depressed, experiencing relationship difficulties, suffering from the effects of stress or, for women, it may be put down to the onset of the menopause.

Younger people with dementia will face different issues, especially if they are still working when they receive a diagnosis. They may face discrimination at work and have to give up work earlier than they would like. As the population ages and the retirement age increases, it is more likely that more people will be diagnosed with dementia while they are still in work.

Dementia care services are usually designed for older people. Some dementia services have a minimum age criterion of 65 and even if services accept younger users the type of care they provide may not be appropriate. This means that younger people with dementia may have to travel considerable distances to access appropriate services or they may be left without the support they need.

It is essential that younger people with dementia have access to a range of specialised services that address their particular needs and enable them to live well with dementia. This should include not only health and social care services, but also wider services that promote their wellbeing such as financial advice and support to remain in work should they choose to do so. Many will have significant financial commitments such as a mortgage. They often have children to care for and dependent parents too.

Their lives tend to be more active and they have hopes, dreams and ambitions to fulfil, up to and beyond their retirement.

The contribution of family members and carers is often very important in helping to reach a correct diagnosis in this age group. Many people say the first sign that something was wrong was that the person 'didn't seem quite themselves' or they started to make mistakes at work that didn't fit with their usual performance

Dementia and Learning Disability

This was raised at the Open Space and Innovation events during discussions around the topic “Promoting Diagnosis”.

Dementia generally affects people with learning disabilities in similar ways to people without a learning disability, but there are some important differences. People with a learning disability are at greater risk of developing dementia at a younger age – particularly those with Down’s syndrome where one in three develop dementia in their 50s. People with learning disabilities:-

- often show different symptoms in the early stages of dementia
- are less likely to receive a correct or early diagnosis of dementia and may not be able to understand the diagnosis
- may experience a more rapid progression of dementia
- may already be in a supported living environment, where they are given help to allow them to live independently
- may have already learned different ways to communicate (e.g. more non-verbal communication if their disability affects speech)
- will require specific support to understand the changes they are experiencing, and to access appropriate services after diagnosis and as dementia progresses.

There is no evidence that dementia affects people with learning disabilities differently to how it affects other people. However, the early stages are more likely to be missed or misinterpreted - particularly if several professionals are involved in the person's care. The person may find it hard to express how they feel their abilities have deteriorated, and problems with communication may make it more difficult for others to assess change.

It is vital that people who understand the person's usual methods of communication are involved when a diagnosis is being explored

Studies have shown that the numbers of people with Down's syndrome who have Alzheimer's disease are approximately:

- 1 in 50 of those aged 30 to 39 years
- 1 in 10 of those aged 40 to 49 years
- 1 in 3 of those aged 50 to 59 years
- more than half of those who live to 60 or over.

With regard to those people with learning disabilities other than Down's syndrome studies suggest that approximately:-

- 1 in 10 of those aged 50 to 65
- 1 in 7 of those aged 65 to 75
- 1 in 4 of those aged 75 to 85
- nearly three-quarters of those aged 85 or over.

These numbers indicate a risk about three to four times higher than in the general population. At present we do not know why this is the case and further research is needed

Strategic Objectives

The following strategic objectives have been identified for the Sefton Dementia Strategy.

Timely diagnosis, appropriate treatment and involvement in care plans – people receive a timely diagnosis of their dementia, have their concerns listened to by healthcare professionals, and, together with their cares, are involved in developing care plans.

Support to live independently for as long as possible, and to make decisions for myself – people with dementia and their carers can live in their own homes for as long as they choose to do so, and can make decisions about choices that affect their lives.

Inclusive and dementia friendly communities – people with dementia and their carers will have support from local communities, will not suffer any stigma as a result of their condition and will be able to live as normal a life as possible for as long as they can.

Information, advice and support for people with dementia and their carers – people with dementia and their carers will have easy access to the information and advice they need to manage their condition, to stay as well and active as possible, and know where to go to find out what they need to know.

End of Life Services, ensuring a peaceful and pain free death in the place of choice – people with dementia and their carers will be helped to plan for their end of life, enabling them to die free from pain, fear and with dignity, cared for by people who are trained and supported in high quality palliative care, in the place of their choosing.

This table also shows how these local priorities relate to the national objectives in the National Dementia Strategy and the Dementia Declaration.

Sefton's Draft Strategic Objectives	Timely diagnosis, appropriate treatment and involvement in care plans	Support to live independently for as long as possible, and to make decisions for myself	Inclusive and dementia friendly communities	Information, advice and support for people with dementia and their carers	End of Life Services, ensuring a peaceful and pain free death in the place of choice
					
Objectives from National Dementia Strategy	• Good-quality early diagnosis and intervention for all • Easy access to care, support and advice following diagnosis	• Development of structured peer support and learning networks • housing support, housing-related services and telecare to support people with dementia and their carers	• Improved community personal support services • Living well with dementia in care homes	• Good-quality information for those with diagnosed dementia and their carers • An informed and effective workforce for people with dementia • Improving public and professional awareness and understanding of dementia	• Improved end of life care for people with dementia
Statements from Dementia Declaration	• I have received an early diagnosis • I can make decisions now about the care I want in my later life • If I work, I have an employer that understand my condition which means I can still work and stay connected to people in my life	• There are a range of services that support me with my daily living that enable me to stay at home and in my community, enjoying the best quality of life for as long as possible • It is easy for me to continue to live in my own home and I and my carer will both have the support needed for me to do this	• I live in an enabling and supportive environment where I feel valued and understood • I have a sense of belonging and of being a valued part of family, community and civic life • I feel safe and supported in my home and in my community, which includes shops and pubs, sporting and cultural opportunities	• I have the knowledge and know-how to get what I need • I have enough information and advice to make decisions about managing, now and in the future, as my dementia progresses • I have information and support and I can have fun with a network of others, including people in a similar position to me.	• I will die free from pain, fear and with dignity, cared for by people who are trained and supported in high quality palliative care

Next Steps

Dementia remains a national challenge in terms of its scale and impact. Research shows that in 2014 there are 835,000 people in the UK who have dementia. Over 40,000 younger people (65 years of age or below) live with the condition.

With an ageing population the numbers of people with dementia in the UK are increasing and as Sefton has an ageing population this will be an issue that will need to be dealt with.

The Partners to the Dementia Strategy will work towards actions that promote early intervention and prevention in order to help to delay the onset of dementia and encourage healthy lifestyles, both physically and mentally, to help improve the wellbeing of Sefton's residents.

Everybody will need to work together to make Sefton a Dementia-Friendly Borough and a place where people with Dementia and their carers can find the support they need to live well with dementia.

The Action Plan, attached as Appendix 1, gives a list of actions against each of the Objectives and partners will use this plan to achieve positive outcomes for people with dementia and their carers in Sefton.

Financial Implications

Delivery of the attached action plan will be contained within existing budgets.

However, where actions will result in additional resources being required then this will be costed and referred to Elected Members and other partners to consider.

For further information on the Dementia Strategy please contact Nicola Beattie on 934 4664

Copies of this document are available in large print and other formats on request. To request this service please call 0151 934 4664

Produced in collaboration with

Sefton Council
NHS South Sefton Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
Sefton CVS
OneVision Housing
Leading the fight against dementia Alzheimer's Society
Sefton Partnership For Older Citizens
SPAC Sefton Pensioners Advocacy Centre
Sefton Carers Centre
The Princess Royal Trust for Carers Network Member
Liverpool Community Health NHS
LCH Delivering quality health services in your community
AGE concern Liverpool & Sefton
NHS Mersey Care NHS Trust

Prepared by Sefton Council Business Intelligence and Performance Division, Bootle Town Hall, Oriel Road, L21 7AE, Tel. 0151 934 4664

Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead
Timely diagnosis, appropriate treatment and involvement in care plans	• People will receive a timely diagnosis of their dementia, have their concerns listened to by healthcare professionals, and, together with their cares, are involved in developing care plans.	• People with dementia and their carers will receive the support and care that they want and need, tailored to their individual needs	• Support people early to prevent & treat avoidable illnesses & reduce inequalities in health	South Sefton Clinical Commissioning Group and Southport & Formby Clinical Commissioning Group
	• Agencies will work together to improve the rate of diagnosis for people with early onset dementia and provide access at an early stage to a range of specialised services that address their particular needs and enable them to live well with dementia. To include not only health and social care services, but also wider services that promote their wellbeing such as financial advice and support to remain in work should they choose to do so	• Improved identification of those with early onset dementia and involvement in care plans helping them to live active lives and fulfilling their hopes, dreams and ambitions up to and beyond their retirement	• Support people early to prevent & treat avoidable illnesses & reduce inequalities in health	The Dementia Strategy Multi Agency Working Group

Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead
	• Agencies will work together to improve the rate of diagnosis of dementia in people with Downs Syndrome and learning disabilities ensuring that the people who understand the person's usual methods of communication are involved when a diagnosis is being explored and care plans are being put in place.	• Those with Downs Syndrome and learning disabilities and dementia will be identified earlier and the special challenges that they face will be recognised and the support they need put in place	• Support people early to prevent & treat avoidable illnesses & reduce inequalities in health	The Dementia Strategy Multi Agency Working Group
	• Partners to the Dementia Strategy will promote the early intervention and prevention of dementia including healthy lifestyles, healthy eating and keeping active	• The onset of dementia will be delayed and healthy lifestyles, both physically and mentally, will be developed in Sefton's communities.	• Support people early to prevent & treat avoidable illnesses & reduce inequalities in health	The Dementia Strategy Multi Agency Working Group
Support to live independently for as long as possible, and to make decisions for myself	• The Council will promote increased awareness of the needs of older people amongst those wishing to develop housing in the Borough, including the design and development of a dementia–friendly environment.	• There will be housing provision available that will support the needs of older people and people with dementia to live in their own homes for longer without the need for adaptations to be made.	• Support older people & those with long term conditions and disabilities to remain independent & in their own homes	Sefton Council – Head of Service Regeneration and Housing

Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead
	• The Council will consider, through the emerging Local Plan process, the making of a policy requiring developers to identify how best to address the housing needs of the ageing population.	• The future housing needs of Sefton's older population will be met, enabling them to stay in their own homes for longer, and living independent lives.	• Support older people & those with long term conditions and disabilities to remain independent & in their own homes	Sefton Council – Head of Regeneration and Housing

	• Partners will provide support and advice to people with dementia and their carers to enable them to keep as healthy and active for as long as possible and prevent further ill health including:-
	  • eating a healthy diet
	  • maintaining a healthy weight
	  • exercising regularly
	  • Not drinking too much alcohol
	  • Stopping smoking
	  • Keeping blood pressure at a healthy level
		• People with dementia and their carers will have improved health and wellbeing and be able to manage their condition themselves, with support, for as long as possible.	• Support people early to prevent & treat avoidable illnesses & reduce inequalities in health	The Dementia Strategy Multi Agency Working Group

Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead
	• All Agencies will develop Dementia Friendly Workplaces	• People with early onset dementia will be supported to remain in employment for as long as possible	• Promote positive mental health and wellbeing	The Dementia Strategy Multi Agency Working Group
Inclusive and dementia friendly communities	• Sefton Dementia Action Alliance will seek dementia-friendly community status for the whole of the Borough.	• People with dementia and their carers will have support from local communities, will not suffer any stigma as a result of their condition and will be able to live as normal a life as possible for as long as they can.	• Build capacity & resilience to empower & strengthen communities	Dementia Action Alliance
	• The Dementia Strategy Multi Agency Working Group will co-ordinate the development of an area based approach to "Dementia Friendly Sefton" by the creation of more dementia friendly areas across the whole of the Borough.	• People with dementia will feel safe and supported in their home and community, which includes shops and pubs, sporting and cultural opportunities.	• Build capacity & resilience to empower & strengthen communities	The Dementia Strategy Multi Agency Working Group

Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead
	• All partner agencies will sign up to the "Dementia Friends" programme by requiring staff to undertake dementia friends training resulting in more Dementia Friendly services, businesses, services and shops.	• There will be increased understanding of the needs and behaviours of people with dementia which means that they will be able to be as independent as possible for as long as possible	• Build capacity & resilience to empower & strengthen communities	The Dementia Strategy Multi Agency Working Group
	• Sefton Library Service will develop the "Sefton Lost Voices Project". The project will record the memories of people who are in the early stages of memory loss.	• People with dementia and their families will have an 'aide-memoire', as the person's memory begins to fade and as a keepsake once the person is lost to the family	• Promote positive mental health and wellbeing	Sefton Council – Head of Service Communities
	• Sefton Libraries will make available a series of memory boxes and reminiscence packs to all areas of Sefton. These will contain old photographs, newspaper cuttings and maps, oral histories, etc.	• The boxes will evoke memories and start conversations with People with dementia and their carers, maintaining relationships and memories.	• Promote positive mental health and wellbeing	Sefton Council – Head of Service Communities

Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead Officer
Information, advice and support for people with dementia and their carers	• Agencies will provide information about long-term symptoms, what will happen as dementia progresses and where to go for advice and support and this will be in a format that is easy to understand. .	• There will be enough information and advice for people with dementia and their carers to make decisions about managing, now and in the future, as their dementia progresses	• Support older people & those with long term conditions and disabilities to remain independent & in their own homes	The Dementia Strategy Multi Agency Working Group
	• All Partner agencies will take a co-ordinated approach to providing information and signposting people with dementia and their carers to the most appropriate agency to obtain information, support and guidance.	• People with dementia and their carers will know where to get the support and guidance they need and will not need to repeat their stories to different agencies	• Support older people & those with long term conditions and disabilities to remain independent & in their own homes	The Dementia Strategy Multi Agency Working Group

Appendix 1 – Action Plan

Objectives	Actions	Outcomes	Relates to Health & Wellbeing Strategy Objective	Lead
End of Life Services, ensuring a peaceful and pain free death in the place of choice	• The Sefton End of Life Strategy will include support for people with dementia and their carers	• People with dementia will be able to plan for their end of life, enabling them to die free from pain, fear and with dignity, cared for by people who are trained and supported in high quality palliative care, in the place of their choosing	• Promote positive mental health and wellbeing	South Sefton Clinical Commissioning Group and Southport & Formby Clinical Commissioning Group
	• Those agencies working with People with Dementia and their carers will ensure that their wishes with regard to their palliative and end of life care are carried recorded and carried out where this is practicable.	• Improved end of life care for people with dementia	• Promote positive mental health and wellbeing	South Sefton Clinical Commissioning Group and Southport & Formby Clinical Commissioning Group
Sefton Dementia Strategy Equality Analysis	• Gather further feedback or evidence on the gaps of our understanding as identified in the Equality Analysis Report	Improved understanding of the needs of the protected groups and how relevant evidence has been used to	• All	The Dementia Strategy Multi Agency Working Group

Appendix 1 – Action Plan

Report		understand the potential equality impacts Update Equality Analysis Report		

Sefton Council

Alzheimer's Society — Leading the fight against dementia

Sefton Carers Centre — carerstrust a Network Partner

Sefton CVS — Supporting Local Communities

Living Well with Dementia: A Strategy for Sefton 2014-2019

Consultation Report

G:\Policy\CSU\Public Engagement and Consultation\dementia strategy Author: June McGill
Version 0.3 – 12.05.15

Table of Contents

Summary Report

This report provides a summary of the findings from the consultation and engagement process undertaken on Living Well With Dementia: A Strategy for Sefton 2014-19. The consultation and engagement process took place over during the summer of 2014 and included:-

- Two Open Space and Innovation Events held in Southport (1st July 2014) and Bootle (3rd July 2014) for providers of services, voluntary community faith sector, shops, businesses and offices
- A questionnaire specifically for people with dementia
- A questionnaire for carers of people with dementia
- A questionnaire for people who have recently lost somebody with dementia
- A general questionnaire for members of the public
- An easy read version of the general questionnaire which was used to engage with people with learning disabilities

In total, 169 people engaged with the process. These are some of the common themes that people raised as part of the consultation process:-

Key findings from the Open Space and Innovation Events

Creating Dementia Friendly Communities

- Communities need to understand dementia and offer support and challenge stigma
- Education is important
- Help people to make changes to live well with dementia and as normal as possible for as long as possible.

- Support carers so that they don't lose their own identity.
- Ask people with dementia what they want
- Process for businesses becoming "dementia friendly" is too complicated and onerous and needs to be simplified
- Early diagnosis is essential
- Care homes should become community hubs and have more interaction with the public

Promoting diagnosis and supporting people to live independently

- Downes Syndrome: early screening for dementia for children/adults with Down's Syndrome as dementia statistically more prevalent in people with Down's Syndrome.
- There needs to be community based health services to maintain people in their homes for as long as possible
- There needs to be meaningful day services for people with dementia. People with dementia need activities that stimulate them.
- There needs to be a whole person approach – services need to be flexible to meet the needs of individuals.
- Need to promote the importance of getting early diagnosis. There are drug treatment and services available and early diagnosis needs to be viewed as positive.
- There needs to be easy access to Information, advice and guidance following diagnosis.
- There needs to be a structured pathway following diagnosis with other agencies involved in agreeing, developing and supporting it – information, advice, guidance, face to face, advocacy, networks and groups etc.

Information, advice, support for people with dementia

- Carers struggle on without support because they don't know what is available or they don't want people to know they aren't coping.

- Family members don't know what signs to look for when somebody is struggling.

- People need to know where to go for advice and support - Dementia agencies, pharmacists, Age UK, SAGA, etc
- More needs to be done when people are diagnosed. People are diagnosed and then just left to get on with it with no information about where to go for support.

- Need to give positive messages about dementia. It's not all over just because you have dementia – it's not all doom & gloom. Use people who are living well with dementia as champions to promote positive messages.

- Information needs to be available using language that everybody can understand. Avoid using jargon and medical terms that people can't understand.

Key findings from questionnaire for People with Dementia

- 7 people completed the questionnaire. This was facilitated by the Alzheimer's Society.

- On the whole people with dementia found it easy to get a diagnosis and that they had received enough information about their condition.

- Most people said that their GP noticed or that they noticed themselves that they were having problems.

- With regard to things that are working well for people with dementia one person felt that the time between being diagnosed and attending the memory clinic was too long, and another had found it difficult to adjust. Other respondents felt that the Alzheimer's Society was particularly helpful.

- One person had spent time in hospital and their experience was not good, with food being put out of reach, and not answering the bell during the night when they needed to use the commode.

- People that wanted to attend events and classes already do.

- Everybody that completed the questionnaire felt that everything that was important to them was covered.

Key Findings from Questionnaires for Carers of People with Dementia

- 20 people completed the questionnaire and this was facilitated by the Alzheimer's Society and the Carers Centre.

- On the whole carers noticed themselves that the person they care for were having problems with their memory. The majority felt that it was very easy to get a diagnosis for the person that they care for and that professionals listened. 80% also said that they had received enough information about dementia.

- With regard to specific information that carers would have liked to have received this included more information about the long-term symptoms; how to go about choosing residential care and the costs involved and more information about aftercare following diagnosis.

- When asked what had gone well in their role as a carer of a person with dementia, comments related to

    - ❖ problems getting reliable carers
    - ❖ having to making all decisions by themselves
    - ❖ Lack of help with transport.
    - ❖ Working through the minefield of financial support

- When asked about what was important to them as a carer of a person with dementia, carers felt that in terms of healthcare for the person they cared for it was important that they saw the same person so that they didn't have to repeat their story and over again to different people.

- With regard to the person with dementia being asked what they want, including their likes and dislikes, even if they find it difficult to answer, most felt this was important.

- All those who completed the questionnaire felt that it was important that the person with dementia should have a say in their end of life plan.

- With regard to the provider of care services, half of those who answered said that they had a choice of provider.

- Where the person with dementia had spent time in hospital comments about their experience included food just being put down and left which resulted in the person not getting anything to eat.

- Of those who indicated that they have opportunities to talk to other people in the same situation as themselves, comments included:-

    - For the person with dementia to attend a Day Centre for one day a week for him to mix with different people.

    - To be able to talk to carers in similar situations would be very useful as ideas, methods used, etc., could be swapped

    - Have had very good chats with the psychiatric nurse who gave us some good advice which stood me in good stead

- Carers were asked if there was anything else that they would like to do such as attending events and classes at local centres:-

    - If I want to go out for the day I would like him to be able to go until about 6.30 and then I could pick him up

    - I only go to events where you can both attend. I do not have time to attend classes.

- ❖ Would like to attend classes but not been possible until recently when I have managed to place my wife in day care

- The following additional comments were made by carers:-

  - ❖ Being able to come to the memory clinic to discuss any problems we may have

  - ❖ Although there are a lot of people waiting to help and a lot of information that is available, it can be a bit of hit and miss on whether you get all the support you need.

  - ❖ Perhaps when a person is first diagnosed with dementia somebody should identify who the carer is going to be and make sure they have a copy of something like the excellent "Dementia Guide" published by the Alzheimer's society.

Key findings from interviews with Carers of a person with dementia who has recently passed away

- A questionnaire was produced for use with a very small sample (3 people) to find out about end of life services for people with dementia. The interviews were undertaken by staff from the Carers Centre.

- The length of time that people had suffered from dementia prior to death ranged from 2years to 10 years. Of the three responses two people were in a care home and one was in hospital.

- End of Life Care Plans were in place for two of the three people, and in both cases the wishes of the person with dementia were carried out.

- When asked about support (including for the carer) in the final days, this was provided by care home staff, NHS staff, the Alzheimer's Society, GP, Mental Health Team, District Nurses and a Priest.

- With regard to general comments one person indicated that getting a diagnosis was very hard as letters from the GP were sent to the person they cared for so diagnosis was not made until they were in

hospital for another reason. They also found out about Alzheimer's Society far too late.

Key Findings from the General Public Questionnaire

The questionnaire was designed to test out people's thoughts and understanding about dementia and the draft Strategy, and was completed by 78 people.

The first section of the questionnaire was to get a picture of people's understanding of dementia and on the whole most people have a good knowledge of what dementia is, how it can be treated, and the standard of life that people with dementia can have.

It also asked about people's thoughts about what people with dementia should be able to do including:

- Continue to live alone
- being able to continue to work for as long as they are able
- continue to drive for as long as they can
- Use technology to enable people to stay safe in their home
- Have a single point of contact for their dementia care

Most people agreed with all of these statements. The only exception was that people with dementia should continue to live alone which had an equal split between agree, disagree and not sure.

People were then asked for their thoughts on the following statements:

- **People with dementia should be involved in activities in the community** – most people agreed with this statement

- **It is better for people with dementia and their families if they are cared for in a residential unit or a nursing home** – most people disagreed with this statement

- **There is little or no benefit to be gained from telling someone they have dementia** – the majority disagreed with the statement or were not sure about it.

- **People who have just been diagnosed with dementia are unable to make decisions about their own care** – most people disagreed with this statement

- **There is no point in trying to talk to people with dementia as they won't be able to understand** – most people disagreed with this statement

With regard to the Prime Minister's Dementia Challenge to create dementia friendly communities, which was launched in 2012, people felt that dementia friendly communities will be places where:-

- People with dementia are supported to remain active and included members of their communities

- People will have increased understanding and awareness about dementia and how to support individuals with dementia.

- To support individuals living with dementia and their carers to maintain their independence for as long as possible

- People with dementia being treated as valued members of society

- People with dementia and their carers feel comfortable in their local environment (shops, leisure facilities, etc.)

- People who work in the local community are trained to respond to the needs of people with dementia and do very simple and practical things that can make an enormous difference

- Implementing simple steps to help people with dementia such as slow lanes in supermarkets and banks

- Support from befriending groups to help people with dementia do the things that they want to

The final section asked about the Strategy itself. It listed the aims for people with dementia in Sefton and asked people to rank them 1-9.

The top five selections were:-

1. People with dementia should be diagnosed in a timely way
2. People with dementia are treated with dignity and respect
3. People with dementia get the treatment and support which is best for their dementia and their life
4. People with dementia will have help in planning for their future health and care needs through a co-ordinated health and social care service.
5. People with dementia's wishes with regard to end of life will be respected

Respondents were then asked to rank the Strategic Objectives in the Strategy from 1-5. These are the results:-

1. Timely diagnosis, appropriate treatment and involvement in care plans
2. Support to live independently for as long as possible, and to make decisions for myself
3. Inclusive and dementia friendly communities
4. Information, advice and support for people with dementia and their carers
5. End of Life Services, ensuring a peaceful and pain free death in the place of choice.

Gaps identified from the Consultation & Engagement Process

Early Onset Dementia

There is currently very little information available about the numbers of younger people (under 65) in Sefton with dementia.

Getting an accurate diagnosis of dementia can take a very long time for people under 65; often due to lack of awareness that dementia can happen in this age group. Medical professionals often misdiagnose them as being depressed, experiencing relationship difficulties, suffering from the effects of stress or, for women, it may be put down to the onset of the menopause.

Younger people with dementia will face different issues, especially if they are still working when they receive a diagnosis. They may face discrimination at work and have to give up work earlier than they would like. As the population ages and the retirement age increases, it is more likely that more people will be diagnosed with dementia while they are still in work.

Dementia care services are usually designed for older people. Some dementia services have a minimum age criterion of 65 and even if services accept younger users the type of care they provide may not be appropriate. This means that younger people with dementia may have to travel considerable distances to access appropriate services or they may be left without the support they need.

It is essential that younger people with dementia have access to a range of specialised services that address their particular needs and enable them to live well with dementia. This should include not only health and social care services, but also wider services that promote their wellbeing such as financial advice and support to remain in work should they choose to do so. Many will have significant financial commitments such as a mortgage. They often have children to care for and dependent parents too.

Their lives tend to be more active and they have hopes, dreams and

ambitions to fulfill, up to and beyond their retirement.

The contribution of family members and carers is often very important in helping to reach a correct diagnosis in this age group. Many people say the first sign that something was wrong was that the person 'didn't seem quite themselves' or they started to make mistakes at work that didn't fit with their usual performance

Dementia and Learning Disability

This was raised at the Open Space and Innovation events during discussions around the topic “Promoting Diagnosis”.

Dementia generally affects people with learning disabilities in similar ways to people without a learning disability, but there are some important differences. People with a learning disability are at greater risk of developing dementia at a younger age – particularly those with Down’s syndrome where one in three develop dementia in their 50s. People with learning disabilities:-

- often show different symptoms in the early stages of dementia
- are less likely to receive a correct or early diagnosis of dementia and may not be able to understand the diagnosis
- may experience a more rapid progression of dementia
- may already be in a supported living environment, where they are given help to allow them to live independently
- may have already learned different ways to communicate (e.g. more non-verbal communication if their disability affects speech)
- will require specific support to understand the changes they are experiencing, and to access appropriate services after diagnosis and as dementia progresses.

There is no evidence that dementia affects people with learning disabilities differently to how it affects other people. However, the early stages are more likely to be missed or misinterpreted - particularly if several professionals are involved in the person's care. The person may find it

hard to express how they feel their abilities have deteriorated, and problems with communication may make it more difficult for others to assess change.

It is vital that people who understand the person's usual methods of communication are involved when a diagnosis is being explored

Studies have shown that the numbers of people with Down's syndrome who have Alzheimer's disease are approximately:

- 1 in 50 of those aged 30 to 39 years
- 1 in 10 of those aged 40 to 49 years
- 1 in 3 of those aged 50 to 59 years
- More than half of those who live to 60 or over.

With regard to those people with learning disabilities other than Down's syndrome studies suggest that approximately:-

- 1 in 10 of those aged 50 to 65
- 1 in 7 of those aged 65 to 75
- 1 in 4 of those aged 75 to 85
- Nearly three-quarters of those aged 85 or over.

These numbers indicate a risk about three to four times higher than in the general population. At present we do not know why this is the case and further research is needed

Information and Background

The refreshed Dementia Strategy and consultation has been developed by a multi-agency working group including officers from Sefton Council Business Intelligence and Performance Team, NHS South Sefton CCG, NHS Southport and Formby CCG, Sefton CVS, Mersey Care NHS Trust, Alzheimer's Society, Sefton Pensioners Advocacy Centre, Age Concern, Sefton Partnership for Older Citizens, One Vision Housing, Care Homes Association, Liverpool Community Health NHS Trust and Southport & Ormskirk Hospital NHS Trust. The group is chaired by the Cabinet Member for Adults and Health, Councillor Paul Cummins.

Where we started from: Sefton Dementia Strategy 2009 – 2014

Following publication of "Living Well with Dementia: A National Dementia Strategy" which was published in 2009, a multi-agency group was formed to deliver a Sefton Dementia Strategy. This group comprised officers from NHS Sefton, Sefton Council, Mersey Care Trust, Sefton Carer's Centre, Sefton Pensioners Advocacy Centre and Sefton CVS and also included GP representation.

The National Dementia Strategy provided a strategic framework which local commissioners and service providers could use to deliver quality improvements to dementia services and address health inequalities relating to dementia; provide advice, guidance and support for health and social care commissioners and providers in the planning, development and monitoring of services; and provide a guide to the content of high quality dementia services.

It was recognised that the National Dementia Strategy would take up to 5 years to implement. The national strategy included 3 key themes, namely:-

- raising awareness
- early assessment and diagnosis and
- living well with dementia

17 objectives in support of the themes had been developed to ensure local access to services for people with dementia and their carers, and five key priorities for action in Sefton 2009-2012 were identified as follows:-.

- Improving Public and Professional Awareness
- Early intervention and diagnosis:
- Improved community support services;
- Improved quality of care for people with dementia in general hospitals:
- Living well with dementia in care homes

Work was undertaken to review services for people with dementia and develop priorities for future investment. A consultation exercise was undertaken in 2008 and a carers' survey undertaken in March 2009 formed part of the review process to assist Commissioners to determine future investment priorities and identify opportunities for service re-design.

The Strategy was monitored and reviewed by the Sefton Partnership for Older Citizens, which in turn reported to the Healthy Communities and Older People sub-group of the Sefton Borough Partnership.

Living Well with Dementia: A Strategy for Sefton 2014-2019

Sefton's current strategy for Dementia runs from 2009-2014 and there is therefore a need to refresh this in order to reflect changes in national policy and guidelines and the changes in structure to health services in Sefton.

Dementia has been identified as a Government priority and there was an additional marketing campaign, the launch of an online training tool and a dementia promise during April 2014.

Sefton is also currently refreshing its Carers and Older People's Strategies, the consultation on which has recently taken place, and this provides an opportunity to ensure that the Dementia Strategy is linked to both of these Strategies.

The Consultation and Engagement Process

This report brings together the feedback from the communities of Sefton and sets out the key points and recommendations that have emerged through our conversations with the public and stakeholders over the recent months.

A multi-agency working group including officers from the two CCGs for Sefton, Sefton Council Business Intelligence and Performance Team, Merseycare Trust, and the Voluntary and Community Sector developed and progressed the consultation and engagement process for the Strategy. The group is chaired by the Cabinet Member for Adults and Health, Councillor Paul Cummins.

What are the aims of the engagement process?

The aim of the consultation is to gather the views of people with dementia and their carers on the realities of living with dementia, to understand how their needs are being met, what gaps they have encountered and their views on improving services across Sefton.

The outcome of the process is the development of a final version of **Living Well with Dementia: A Strategy for Sefton 2014-2019** which will inform the future planning, commissioning and delivery of services for people with dementia and their carers in Sefton.

Engaging Sefton's communities; what we did and why

The Steering group developed the proposed methodology for consultation as the representatives from the groups that work with people with dementia have experience about what approaches would work best.

Care was taken in identifying the methods to be used to consult with people who have dementia and their carers. There is no "one size fits all" approach as each person is different, will interact differently and traditional approaches may not be suitable. Guidance from the Dementia Engagement and Empowerment Project (DEEP) suggests approaches including small group discussions using pictures to help people connect with the discussion topic, visual aids to help people remember questions i.e. noting them on a flipchart or post it note, and using creative approaches to reflect views such as making collective pictures.

Taking on board the need to tailor consultation to specific groups, separate questionnaires were developed:-

- A questionnaire for people with Dementia
- A questionnaire for people who care for a person with Dementia
- A questionnaire for carers who have recently lost a person with Dementia
- A general questionnaire to collect the public's perceptions and understanding of dementia

Two Open Space and Innovation Events for people, organisations, groups and providers of services were held. One in Southport on 1st July 2014 and one in Bootle on 3rd July 2014. The purpose of the events was to enable the sharing of views, thoughts, ideas and experiences about how together we can make a difference to the lives of people living with Dementia and their carers.

How did we engage?

Open Space Innovation Events

In order to find out about people's experience of dementia and living well in Sefton a wide range of people, organisations, groups and Providers of services were invited to come along to two Open Space and Innovation Events. The events were held on Tuesday 1st July 2014, at The Atkinson, Southport and on Thursday 3rd July 2014 at Bootle Town Hall. People could drop in and out of the sessions any time between 9.30 a.m. and 12.00 p.m. to share their views, thoughts, ideas and experiences about how we could work together to make a difference to the lives of people living with dementia and their carers.

61 people from a wide range of organisations attended the two events.

What is an Open Space Innovation Event?

Open Space – Innovation Events enable people to drop in, join a discussion, listen to others within an 'Open' agenda and the 'Space' to share ideas and create solutions.

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There is no preset agenda other than the topic previously agreed and the time allotted for the meeting. From the start of the event until the agreed end time people meet in groups to discuss and make recommendations for action which they consider are relevant to the specific issue – in this case improving the lives of people with dementia and their carers. A facilitator was available for each topic to guide the discussion and a scribe took notes of what was discussed.

Three discussion areas were agreed. These were:-

- Promoting diagnosis and supporting people to live independently
- Information advice and support for people with dementia and their carers
- Creating dementia friendly environments and communities across Sefton

In addition a Dementia Awareness/Dementia friend's area was available to give people the opportunity to find out more about dementia

People attending the sessions were free to move between the discussion areas to ensure that they were able to put forward their views on all the topics.

What did the consultation tell us?

Open Space and Innovation Events

Discussion took place across three topics and participants were able to move to different discussions as they wished:-

Three discussion topics were:-

- Promoting diagnosis and supporting people to live independently
- Information advice and support for people with dementia and their carers
- Creating dementia friendly environments and communities across Sefton

The following comments came out of the discussions on each of the topics:-

Promoting diagnosis and supporting people to live independently

Southport Event

- **Down's Syndrome**:-
  - Early screening for dementia for children/adults with Down's Syndrome – dementia is statistically prevalent in people with Down's Syndrome and is being diagnosed more.

- Barriers to diagnosis include lack of information, lack of awareness for professionals, carers and families and general Practitioners not engaging.

- Carers are more likely to spot early signs of dementia in people with Down's Syndrome and thus the relationship between the carer and the General Practitioner needs to be stronger and based upon mutual respect and trust.

- If diagnosed early treatment can slow down the condition.

- There have been no issues to date of people with Down's Syndrome who are cared for going missing from home as far as anyone in the discussion was aware.

- **Assisting people to live independently:-**

  - A decrease in funding of packages of care may impact on people being able to live independently.

  - Important that for people with dementia who are attending hospital for treatment there is no delay for their discharge as long stays often have a negative impact on the mental wellbeing (effects them cognitively).

  - Needs to be more community based health services to maintain people in their homes for longer

  - Currently no way of giving intravenous treatment for more than twice a day – more cost effective to invest that resource in the community rather than potentially blocking hospital beds.

  - Visits to people in the community need to be for at least 30minutes and although this is currently the practice in Sefton this needs to be monitored effectively through contracts and commissioning to ensure compliance.

  - Continuity of carers going to see people in their homes – this is generally provided by commissioned agencies and there can be a high turnover of staff which does not allow for service users to build up a relationship/connection with their carers and this can add to their confusion/distress.

- Meaningful day services for people with dementia - loss of day centre provision from the Local Authority. People with dementia need activities that stimulate them. Sefton is currently looking at how it provides day care.
- Services are still a postcode lottery based upon what different agencies/trusts provide. North/South divide in terms of services available.
- Need more home care support services, particularly out of hours/night-time.
- Wider impact of those with dementia on those around them; carers, friends, family etc.
- Better use of new drugs that becomes available on the market.
- Home adaptations and accommodation design are important. Currently One Vision Housing is working on a design brief as part of their community based accommodation update/refresh that is dementia friendly. Has to be non-intrusive.
- Need to build dementia friendly considerations in to our everyday capital schemes. Taps with cut off sensors to prevent sinks/baths over flowing.
- More co-operation and integration of services.
- Better signposting for all.
- Managing risk to help people live independently.
- Greater awareness amongst professionals around roles and responsibilities – Who does what?
- Whole person approach – services need to be flexible to meet the needs of individuals.
- Understanding the General Practitioner's referral process.

- How do we support the support networks? Mutual support services/networks based upon people's experience.

- **Promoting diagnosis**

  - People's reluctance to get help in the first place due to stigma associated with mental health. Also people and families can often be in denial about the condition and try and cope as best they can.

  - General Practitioners – difficult to diagnose due to memory loss being often a symptom of other physical problems being presented at surgeries. General Practitioners tend to deal with the physical diagnosis first so often the dementia diagnosis is either lost or delayed.

  - Need to promote the importance of getting early diagnosis – drug treatment and services available. Early diagnosis needs to be publicised as positive.

  - More needs to be done on awareness raising to improve the public's perception of dementia.

  - Negative media has had an impact on people not wanting to be diagnosed in case then end up in a home that turns out to be poorly managed with poor practice habits. – Needs more positive press.

  - General Practitioner training and awareness raising – some General Practitioners are reluctant to diagnose until the patient and family reach a tipping point.

  - General Practitioner diagnosis needs to be consistent in their approach – some are overzealous and others too cautious – training to help assist.

  - The physical impact on health of people suffering with dementia needs to be recognised.

  - Being taken out of routine environment tends to highlight the issue and it is then that professional's, carers, family can help to identify and seek an assessment for diagnosis.

- A significant amount of people remain un-diagnosed.
- Professionals need to be more aware of the signs to look out for. 'Every contact counts' approach. Part of staff core knowledge.
- Professionals need to have the confidence to identify and broach issues with the individual and families (training).
- Need to investigate how local businesses can help to identify those perhaps not yet diagnosed and who do they raise this with and where does it go to?
- Need a similar campaign as Cancer in terms of the number of people dementia affects and the nature of the illness. Current campaigns around dementia have portrayed a negative image of the services received.
- Need to raise awareness that it is not just an older person problem but is wider than that. Start to teach as part of a general life course awareness raising in schools around the topic.
- Posters in prominent areas such as super markets.

The following were discussed as possible actions to take some of the above forward:-

- One Vision Housing would like a link in to Adult Social Care Services to understand the access criteria and what is available.
- Need to identify where awareness raising training currently take place in the borough?
- What level of training do Police officers have and in terms of places of safety could they be made dementia friendly?

- **Services**

  - Memory Clinic – based in the North of the Borough and linked in to the Alzheimer's Society. Could the service perform dementia assessments as an outpatient /community based service to avoid delayed discharges in hospitals? Is there evidence that this is a successful service, with appropriate waiting times and easy access?

  - When someone is diagnosed they need to have a link with Alzheimer's Society to ensure someone available to be present at the diagnosis to help answer questions and to offer support.

  - All referrals come from General Practitioners.

  - Support with early memory loss, post diagnostic work, signposting, information giving.

  - Agencies advise that they struggle to get people with severe learning difficulties assessed by Memory Clinic.

  - Pharmacists – What do local Pharmacists do in terms of identification of dementia?

  - Walk In Centres – What do local Walk in Centres do in terms of identification of dementia?

The following action is proposed with regard to the above:-

- Mersey Care Learning Disabilities to feed in to Dementia Meetings

Bootle Event

- **Assisting people to live independently:-**

  - Need to consider the impact on the family and carer(s) around the individual as they offer the most support and their health is just as important to maintaining people in their own homes longer. Also need to consider their social isolation as they often lose touch with people around them when they become the main carer (issues such as lack of sleep, increased stress levels, becoming agitated).

  - Friends and family avoid people with dementia due to a lack of understanding of dementia.

  - Cross generational work – shift in culture – young people and older people working together.

  - More work around understanding changes in behaviour as a result of dementia.

  - Immerse the family in what is happening.

  - Easy access to Information, advice and guidance.

  - Information, advice and guidance following diagnosis.

  - The assessment process needs to be more holistic and should involve other agencies who provide services as well as the person, their family and carer.

  - There needs to be a structured pathway following diagnosis with other agencies involved in agreeing, developing and supporting that pathway – information, advice, guidance, face to face, advocacy, networks and groups etc.

  - More preparation work with families/carers around planning for the future.

  - Need to consider managing end of life treatment for those with dementia, for example managing pain medication.

- At what stage do we decide when a person can come and go as they please when suffering with dementia? Managing the risk. Awaiting judgement on deprivation of liberty.
- Use of dementia friends.
- Currently services are available based upon postcode and this is not equitable.
- What is available – community equipment? Helps people to manage longer.
- Opportunities for people to meet and talk with similar people who are experiencing dementia.
- A mobile night visiting service that also offers a sitting service during the week.
- Need to consider those with dementia who have no family or carer.
- Need to revise/review the virtual ward model.
- Need to consider how we wrap the care around the individual and their carer.
- Need a 24hour 7day a week contact service for health and social care.
- Difficult to get an emergency respite night.
- Keep the individual active and improve availability of low level interventions.
- Health and Social care fragmented - confusing to both the public and professionals.
- Need a key worker for continuity when dealing with family and those with dementia.

- Doing nothing is not an option – increasing elderly population with more complex needs in Sefton matched by decreasing resources.

- Transport is an issue for people being able to access day care provision.

- Diagnosis rates for dementia are around 50% of what is believed to be the actual figure.

- **Promoting diagnosis**

  - Difficulty of accessing services as some General Practitioners diagnose only the physical health problems and overlook the potential mental health issue of dementia.

  - A general awareness raising campaign like the one rolled out for Cancer that reaches most people and training as part of a core set of skills for all professionals with regards to dementia.

  - Families and carers more likely to spot signs earlier. They need to know who they can speak to i.e. the persons General Practitioner about their concerns.

  - Need to look for the signs of people putting in place strategies and coping mechanisms to mask their illness and prevent early diagnosis.

  - Dementia needs championing positively in terms of early diagnosis. Too much bad press.

  - Still perceived as a memory issue.

  - Specialist General Practitioners with a clear understanding of dementia being available to colleagues for advice and guidance?

  - Feedback from families is that they would have appreciated advice and guidance earlier.

- Early diagnosis can lead to years of improved quality of life.
- Need to remove the fear or stigma of going in to a care home for those most needy.
- Sharing information and improving communication.
- Improving the negative image/perception of social care i.e. all they do is put you in a home.

The following action is proposed with regard to the above:-

- Post-diagnostic support available in North of Borough but not the South (Alzheimer's Society)
- **Services**
  - Health and Wellbeing Trainers – work with community, operate out of Burlington House via Sefton CVS, work around social isolation, offer training, link with some General Practitioners (those willing to engage), part of the Virtual Ward.
  - Memory Clinic – How may people do they see?
  - Community Practice Nurses – need to be trained and made aware as to what is out there.

The following action is suggested with regard to the above:-

- There needs to be a mapping exercise of befriending services in Sefton. There are currently long waiting lists – anywhere from 12weeks to 6months..

Information advice and support for people with dementia and their carers

Southport Event

- **Support for People with Dementia and their Carers**

  - People are isolated – couples live on their own and say they are coping. Are people struggling because they don't want help or don't know where to go. People just muddle along until they are in a crisis situation

  - Husbands/wives tend to think it is their role to be carer, for better or worse and don't seek support - the Label "Carer" inhibits people to get help because they are a husband or a wife. People need to be a husband or wife and understand that other "SUPPORT" is available - it is ok to have support. People need to understand they won't be a good carer if they don't get support

  - Some people are private and don't want to show they are vulnerable

  - People say Social Care hasn't worked for me after a bad experience and aren't prepared to try anything else

  - Some family members are controlling and abusive, is this conscious or does it come after years of caring and you don't realise your behaviour has changed

  - The main carer often sees other family members as interfering and pushes them away. Other family members or friends trying to get help are kept away by the carer (husband or wife)

  - It often gets to the point where the carer can't look after themselves. If a carer becomes ill and there are no family members around they can become a crisis

- People need to get over the stigma of being a carer. Maybe we should say someone is not "THE" carer but "A" carer, part of a supporting care team. People don't like the word carer, they are a family member and we should use a whole family approach
- People sitting services are needed
- People miss out on the bigger picture; a little bit of help can make all the difference. How do you get a little bit of help? Where do you go?
- Money – Paying is an issue if you don't get the service you are paying for
- Professional carers get people up from 11- 5pm so care isn't tailored, people want to be up 6-10pm ish. Commissioned services are dictating delivery. Staff can't do later because of block contracts, so people don't want service as they can't deliver what is needed. There is an intensive time in the morning and evening when lots of staff are required but not available
- Respite is only every 6 months, there needs to be a shift, there needs to be financial proof that giving a carer £1000 to have respite will save money in the long term by keeping them well
- 2 main barriers – hard to reach holding onto role as carers and the service options available (home care or care home) are not suitable
- Couples protect or mask each other
- Family members don't know what signs to look for (no food in cupboard)
- Health professionals need to be harsh and tell people "you are not helping"
- GP's play a pivotal role

- Support need to produce an “at risk profile” from demographics – over 70, no children in the areas, possibly visit GP regularly because they are lonely or don’t visit at all. These should be on a high risk register and on GP’s radar

- Organisations such as affordable warmth go into people’s houses and see risks, they should pick up on these and be able to feed them back, anyone gaining access to someone’s home should look for risks

- We should see the person not the illness, people have a range of illnesses and they shouldn’t be labeled. Medical staff often don’t worry about other ailments such as heart conditions and just deal with the dementia, dementia often masks other conditions or it might not be dementia but similar symptom

- People don’t want to admit they have a problem - If they get help first it can be better

- People need support before diagnosis as this can take a long time

- Care home staff can see deterioration over time but families can’t see it and won’t accept – a lady took her mother to Spain against advice because she thought she was ok and she was very confused which shocked her daughter who then booked a cruise

- Gentle conversations need to be had with families to build confidence about stigma

- We need to build support around the family unit

- People are angry, confused and frustrated, the main carer also has their own medical needs but no time and no one to speak to

- We need to speak to people at the right time and have tougher conversations in a supportive way and this issue is not going to go away

- We need to recognise carers as this is how we society is going to cope
- There is bad press about paid care - and paid care is open to abuse
- We need to give skills to older men re cooking / washing etc as they will never have done them before, change cultures so they can offer support
- There should be behaviour risk management
- We need wrap support round people and maintain anyone already around then add to it
- We are all carers at different levels at different times in our lives we might need to make small adjustments to our lives but it's about loving someone, duty, responsibility, it shouldn't be because we have to but because we want to. Some people don't have this view due to expectation that it is the NHS responsibility, where has love gone? There needs to be conversations that it is your responsibility, there has been a culture shift of people becoming selfish, they ring an agency and their job is done, people need to take ownership and we assist no do for.
- We recruit by behaviour now and we should be assessing the behaviour of families, we need to understand people's attitudes before they are assessed, we need to separate those who feel care should be free and believe it

- **Information and Advice**
  - Where should people go for advice? Dementia agencies, pharmacists, road shows, Age UK, SAGA (over 50's, silver surfers, have DOB to mail shot you)
  - People who get lots of information in the post don't read it and just bin it

- Organisations need to say the same thing, they need to give a consistent message and advice

- Organisations and charities should work better together and not be in competition with each other (at the Southport road show 3 different organisations were recruiting befrienders and competing against each other). Organisations should, join up, not be competition. Commission differently, work better together, pool resources, work differently, pool befrienders and sitters etc

- Information should all be put in one place and be accessible. Someone can show you how to use the information as long as it's all in one place. There should be simple stuff on the web not just diagnosis stuff

- There needs to a process in place not just a directory, a flow chart of long term condition info and advice. The Sefton directory just confuses people. We need to lay out the process families will go through

- More needs to be done at diagnosis, don't just diagnose and leave, show pathway and where to go

- Use mosaic to see how people would like to receive information

- One Vision Housing has given a pack to 1000 residents. We need to learn from this process and experience

- One Vision Housing have used the house of memories approach and this should be replicated

- There should be core information for all, if you wait till the GP tells you, you won't get it All organisations should agree basic information, at the minute information is confused and people don't do anything until it's too late

- There is a mismatch between care services language and public language, language is important (service user / client – all misunderstood) (frail elderly, Elderly & mentally infirm – degrading) People don't want to be labeled

- There should be information on early signs and symptoms and how to get help
- We shouldn't use negative labels
- A key message must be early diagnosis, if you're worried about your memory see your GP. How do we raise awareness – early diagnosis
- People are swamped with information, advice and competition between charities
- Leaflets and shops etc should use assessable information and pictures, less info & easy read (this is important for low level adult literacy, EASL too)
- People are coming to use the shops as they have more confidence, time to pack, go slow isle, people wear a badge if you need help
- Information in shops rather than GP's is good
- We need to share information, but let the individual store info and share it with who they want so no data protection issues

- **Other issues**
  - We need to support people to share their experiences with the strategy development group so we can get under the skin of issues
  - We don't shout loudly enough about carers. Sefton is a very caring borough but we do not champion this, we should have pride in carers, value them
  - Lots of carers don't recognise they are carers yet they have bought into the situation
  - This is just about us living as we will all go through it at some point with a friend / relative or ourselves

- Organisations and commissioning work in boxes so it can never be person centered
- Society has unrealistic expectations – some people can't be bothered caring for family members, we should champion great families, self care, saving money for later life care, having the human touch and listening to people. We need to reset language as we are speaking 2 different languages
- We only work at the tipping point but need to move to prevention
- We could have a Sefton version of a time bank and celebrate skills and gifts
- People with dementia have gifts and skills to share in communities and just need support. We need to get people out into the community
- We should listen to individuals but encourage them to live well in their community
- Do neighbourhoods still support each other, if it's a stable area then yes but if not no, people don't know where this support is happening or how to replicate it
- Housing providers have a responsibility to design friendly communities with low fences, walking paths etc where community champions can be based
- A block of shops has done its dementia friends training but a stumbling block is getting them to write action plans (there needs to be a light version for small businesses) – there's pop up pubs, badges, training, GP lead, memory prompts
- Faith communities – how helpful are they? Churches are big but we don't know what they are doing we need to grow and join together
- Is it dementia friends or People friendly? Family friendly, respectful, elderly friendly (MH, LD) we should be a people friendly borough running a campaign on dementia / LD etc we

should be disease or condition friendly. Champion great families, communities, Sefton a great place to live

- We need to celebrate positive stories and messages like cancer, there needs to be positive marketing and mindset. We need to show its not all over just because you have dementia – there are lots of funny stories, it's not all doom & gloom

- Because of the pattern emerging in the UK, China have passed a law 20 years before its needed making it illegal to abandon an elderly relative

- Families are not making the best decisions because of money, they are protecting their inheritance, and there have been cases of people being locked in cellars. We need to talk honestly about money – people don't like to talk about it because it's embarrassing but people wouldn't demand a paid for taxi from M&S so why do they expect it from A&E? We need to set out the costs in plain English and have discussions

- We need a "right & wrong" is this the way to treat people campaign, like moral dilemma story lines / cartoons which one are you

- There was a couple he was in his 80's and her in her 60's they used all of their savings on his care, she had no money left after he died to look after herself, is this fair?

- Some people don't want relatives back after they've been in care or hospital and they do things so they can't move back, last week a man dumped his mums furniture so she couldn't move back to her home as he'd moved in and didn't want to share

- People dump relatives before they go on holiday, we need to start involving the police if this happens

- We need to speak the same language and not pass the buck from one organisation to the next deal with it, we need to get our ducks in a row as a whole team

- If the system falls over, start again, people play the system and its a cycle

- We need to assess how efficient people are being at managing their own health, find out who is inefficient and have conversation with them, private industry would know who they are and do something about it

- We need to keep people on track on a pathway with one care plan the we all feed into

Bootle Event

- **Support for People with Dementia and their Carers**

  - It has takes a long time to get a mental health assessment for a lady being aggressive – there was lots of red tape, her family were reluctant to do anything or admit there is a problem, 1 month on and still there has been no action, time scales around assessment need addressing. Once a risk has been identified I would expect the issue to be escalated, as would be the case with a safeguarding pathway referral.

  - Issues are that people live on their own and wait until they reach crisis point – they then call the GP who rings the rapid response team, often they have an infection (such as a water infection) this can make them more confused and increase the risk of falls. People get up to 4 care visits per day bu7t nothing at night making night falls a risk, they often get up a lot at night, these people don't need to be in hospital but are not safe to be at home alone, people are placed in nursing homes for a few weeks and then have a trial at home to see if they are ok.

  - If the main carer is ill and goes into care for safety, them a double placement is needed, the CERT provide 72 hours of emergency cover but sometime this has been known to last 2 weeks.

  - People often ring and say they are not coping but this is not medical it is social; social services are very slow, why? Is the system clogged up?

- The CERT do the following – refer to Chase Hays for 2 weeks rehab (there are never enough beds which causes a back log), advocacy, befriending and help with shopping, housing support if homeless, make phone calls for people or give numbers (e.g. Carers Centre), take people to the carers centre
- The CERT is a multi disciplinary team of Nurses, GP's, Physio, OT, Memory Clinic
- We shouldn't see someone with dementia in isolation of their support network
- Anyone with dementia needs support - It financially makes sense to support
- In the past people have lived for up to 40 years in care, but thresholds are increasing so better if people live longer at home, this is better because their surroundings are familiar.
- We should support people who care to do it for longer
- We should keep people at the lower end of the spectrum as long as possible
- Families need support for long term conditions
- Dementia "Friend" – they are not a carer or an expert just a friend, this language is very good

- **Information and Advice**
  - There is lots of information available

- The CERT (Community Emergency Response Team) –People don't know who we are, we need to raise the profile with professionals as they do the referrals, we need to work hand in hand with social workers / services to pick up the slack
- Self funders do not want to pay for care (they say why should I pay) so pull out after 2 weeks (not 72 hours) then they are in crisis again and it's just a spiral.
- The CERT signpost to luncheon clubs but there are not a lot around
- The CERT do not use a PC but use hard copy directories
- One vision are holding a focus group together looking at peoples experience
- Small changes to environment can make a difference (housing & communities)
- There is lots of information around – but how do you know? You only know what you know
- Information should be not all IT based as not all on PC
- Information should be at GP's, Post office – Places where people go, also we should inform the people who work there and educate them about what groups are available locally
- We do not need to invent anything it's all there it's just about getting hold of it
- Information shouldn't just be with GP's as people are anxious at Dc's and don't read notice boards, we need to target people
- We also need to target carers – the free press is good
- People can live well and extend life so not all negative
- We need champions who are living well to promote in the media
- People don't know what to say so don't ask in case they get it wrong, saying anything is the right thing saying nothing is wrong

Creating dementia friendly environments and communities across Sefton

Southport Event

- Sefton Careline offers assistive technology to help people stay at home – alarms, monitoring, pressure pads, fall monitoring based on individual needs.
- Changes in benefits are affecting people with dementia and their carers
- Wander alerts/alarms linked to central point to advise when people go out on their own
- There is CCTV monitoring in sheltered schemes – but only in public areas for security purposes.
- CCTV monitoring of people with dementia in their homes – has privacy and human rights issues. Fine line between wanting to check person is ok and spying.
- Telehealth/Telecare is helpful – uses system like SKYPE so that professionals can contact patients to take BP readings, consultation on-line and results are sent to a central point.
- Danger that technology is replacing the personal touch which is important for people with dementia.
- We need to encourage people to do more for themselves – so they can get out of the house, build and maintain capacity and avoid social isolation.
- Early Stage Dementia – people worried about perceptions of them and it puts them off doing things for themselves – deteriorate much more quickly.
- Befriending Services are good – but over-subscribed. Do we need to identify who is providing them and encourage them to work together, identify areas where they are duplicating provision to enable them to reach more people over a wider area – need to promote volunteering.

- Use existing resources to widen help for people with dementia by training people up to become Dementia Friends – use SPOC/SPAC/VCF sector and also encourage public sector partners to become more active e.g. refuse workers being able to signpost people etc.

- Need better data sharing protocols between agencies to identify people with dementias. At the moment there are problems sharing personal data.

- Older People in general aren't accessing food banks – missed opportunity to identify those who need help.

- How do people know if shops/businesses are dementia friendly? No plaque or branding available and process to get some recognition is overly bureaucratic and needs one person to co-ordinate – off putting for small businesses

- Need to get public transport/taxi services on board – Dementia Friends Training.

- Community Leaders need to take ownership – encourage more DF areas.

- Need to change culture in neighbourhoods – build trust and encourage neighbourliness

- Safeguarding issues – where informal help is in place may be problems where people have memory issues in accusations of things happening that haven't actually happened. May put people off.

- Should we develop "informal neighbourhoods" rather than formal volunteering routes?

- How do we identify and help the "unwilling carers" who start off doing a bit but then end up as full time carers.

- Nursing Homes are seen as somewhere were "people are put" and don't come out of rather than somewhere that people might choose to

go for respite or short term care. Need to change perception and use them more as community facilities.

- Community Centres could be used as a catalyst to bring communities and resources together and work more collaboratively
- Education and awareness needs to have a more positive approach
- How can society move on to help people with dementia live well
- Dementia Friendly is of benefit to the whole community
- Needs a more positive approach to dementia – to make it less frightening using a more informal approach
- Is better planning part of the solution? Things like end of life planning, better information about changes in journey, etc.
- Need to make people with dementia "feel like people" rather than just focusing on condition.
- Approaches such as memory boxes, pop up shops, pop up pubs, music therapy, etc. are working well but heavily oversubscribed. Can we extend this further?
- How do we build up networks/communities that have been lost?
- Don't see people with dementia in isolation – need to keep the whole "unit" well in order to keep people out of hospitals and institutions if carers fall ill. Build carers into pathways.
- There are degrees of caring – people don't identify themselves as carers – just looking after mum/dad/partner/siblings, etc.
- There is a GP pilot currently running in one practice in the North and one in the South to identify carers from their lists.
- Dementia is the poor relation of mental health – it is a disease of the brain but is still often seen as taboo.
- Need to promote positive messages about living well with dementia – using positive methods and approaches.

- Need to encourage people with dementia to keep their skills – use them as positive role models.
- How do we identify those who haven't been diagnosed?
- The "face of dementia" is very negative – how do we get a more positive approach to tell people that it is possible to live well with dementia.
- Banks/Taxi operators are important to dementia friendly societies.
- Building Communities: can churches do more to bring people together.
- Hospital provides packs for people with dementia and their relatives – information sheet giving details of useful numbers plus leaflets for things such as memory cafes, etc.
- Too much time spent in hospital awaiting tests away from home – testing should be done in the community.
- Dementia Friendly communities – more information needed so that communities/stakeholders understand dementia and remove stigma/barriers, but key stakeholders need to be involved to take it forward.
- Independent Living schemes give a sense of community (Fernley Grange) but need to find ways of opening this up to the outside so that people get involved.
- Encourage volunteering as a way of avoiding social isolation.
- Top down approach doesn't work – needs to be community led.
- People on the ground need to deliver on Dementia Friendly Communities: District Nurses/Health Visitors, etc.
- Need to share good practice – how do we cascade information if we don't know what is going on? How can we join up the dots?

- Awareness raising of Dementia Friends – use all areas of organisation to identify dementia early.

- Pilot Dementia Friendly row of shops in Fylde Road, Southport – but not many people know about it – it's not advertised. There is no recognition that businesses are dementia friendly so how do people know that they are?

- There are barriers to becoming Dementia Friendly accredited that rely on one person taking responsibility for preparing an action plan for the area and reporting on every 6 months.

- Pilot in Fylde Road is good – but how do we extend this model to the rest of Sefton and other areas such as Churchtown, Maghull, Ainsdale, Netherton. All of these places are based around GP surgeries – could we use the surgery as the central point and include all the shops in the locality?

- Dementia is seen as an older person's disease – part of getting old.

- Southport Football Club hold regular Tuesday afternoon sessions for people with early onset dementia in conjunction with Merseycare – including trips out to other venues such as Everton FC.

- Need to provide more education for young carers about dementia.

- Dementia Friendly is of benefit to the whole community as it provides a positive approach, is informal and less frightening.

- There is reticence about approaching people with dementia to offer help – how far does responsibility go? This needs a common sense approach.

- Pharmacies should be used more as an interface: medicine reviews, etc.

- Lack of diagnosis is a problem: earlier diagnosis would be helpful.

- GP's are reluctant to make a diagnosis or some are "over diagnosing". GP's need better understanding of dementia and the

services available to support people and their carers – memory clinics, memory cafes, memory boxes, etc.

Bootle Event

- People make Dementia Friendly communities
- Communities need to understand dementia and offer support and challenge stigma
- Talk to people with dementia and ask what they want.
- Businesses can get an award of the national symbol for dementia friends, the Forget Me Not, but the process is quite bureaucratic. The symbol is allocated to an area and one person leads on the process to become Dementia Friendly. Can be done within existing resources and has benefits for businesses and raises standards for everyone. Nationally Tesco, Argos, M&S and Lloyds Bank Group are committed to becoming Dementia Friends.
- Some services are driven by technology – but this precludes people who are not IT aware – not just people with dementia i.e. Barclays banks taking service counters out of branches and using just machines.
- Services are moving out of communities, leading to loss of personal touch, awareness of where problems are or if somebody hasn't been seen for a while i.e. banks, post offices, etc.
- Transport needs to be improved – ring and ride service for older/vulnerable people bit like a "big taxi" service where people are collected and dropped off and then picked up again.
- Do people know what services exist?
- If people are diagnosed earlier it is easier to identify long-term support.
- Education is important – start early in schools to change "modelled behaviour". This will help children to relate to family members and others who may have dementia.

- Need more inter-generational work to raise awareness.
- Could we become “Dementia Friendly Sefton” or “Bootle” or “Southport” or “Maghull”, etc. down to smaller localities such as “Birkdale Village” or “Ainsdale Village”.
- Could GP surgeries do more to co-ordinate communities to become Dementia Friendly?
- Use “pop up shop” in empty shop fronts to raise awareness.
- Families and Friends need support too.
- The Police/Fire Service can do more – help to identify where problems arise, particularly where people are isolated.
- Need more signposting so that people know where to get help and avoid hospital admissions.
- We need to be brave – fund smaller things to keep people out of crisis and the need for more expensive services.
- We need more “age friendly shops” including the “Take a Seat” project to provide somewhere for the old and vulnerable to sit in shops and businesses.
- Wigan Project (Hindley) for Dementia whereby £15,000 funding was provided and local businesses could pitch ideas (Dragons’ Den) for help for people with dementia such as swimming sessions, etc. Services had to be provided by local businesses. Staff in Morrisons supermarket set up a dementia café where people with dementia can come and pay £1.50 for coffee and cake and sit and have a chat and this has proved extremely popular. Can we extend to other local tea and coffee shops at times when things aren’t busy?
- Local Press needs to do more to highlight activities and events for people with dementia. This needs to be included in the Action Plan.
- Who get the ball rolling and take the lead on the Strategy. Need to get local people to want to take it forward.