NHS
Southport and Formby
Clinical Commissioning Group

Agenda

Governing Body Meeting in Public
Agenda

Date: **Wednesday 25th January 2017, 13:00 hrs to 15:15 hrs**
Venue: **Family Life Centre, Southport, PR8 6JH**

PLEASE NOTE: we are committed to using our resources effectively, with as much as possible spent on patient care so sandwiches will no longer be provided at CCG meetings.

13:00 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.

13:15 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 & Clinical Director	RC
Helen Nichols	Vice Chair & Lay Member for Governance	HN
Dr Niall Leonard	Clinical Vice Chair & Clinical Director	NL
Matthew Ashton	Director of Public Health, Sefton MBC *(co-opted member)*	MA
Dr Emily Ball	GP Clinical Director and Governing Body Member	EB
Gill Brown	Lay Member for Patient & Public Engagement	GB
Dr Doug Callow	GP Clinical Director & Governing Body Member	DC
Debbie Fagan	Chief Nurse & Head of Quality & Safety	DCF
Dwayne Johnson	Director of Social Services & Health, Sefton MBC *(co-opted member)*	DJ
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Martin McDowell	Chief Finance Officer	MMcD
Dr Hilal Mulla	GP Clinical Director & Governing Body Member	HM
Colette Riley	Practice Manager & Governing Body Member	CR
Dr Kati Scholtz	GP Clinical Director & Governing Body Member	KS
Dr Jeff Simmonds	Secondary Care Doctor & Governing Body Member	JS
Fiona Taylor	Chief Officer	FLT

In Attendance

Charlotte Bailey	Executive Director, Sefton MBC	CB
Tracy Jeffes	Chief Delivery & Integration Officer	TJ
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Alison Ormrod	Deputy Director of Finance	AO
Judy Graves	*(Minute taker)*	JG

"Partnership Locality Model"
presentation by Charlotte Bailey, Executive Director, Sefton MBC

Quorum: 65% of the Governing Body membership and no business to be transacted unless 5 members present including (a) at least one lay member (b) either Chief Officer/Chief Finance Officer (c) at least three clinicians (3.7 Southport & Formby CCG Constitution).

No	Item	Lead	Report/ Verbal	Receive/ Approve / Ratify	Time
General					**13:30hrs**
GB17/1	Apologies for Absence	Chair	Verbal	R	3 mins
GB17/2	Declarations of Interest	Chair	Verbal	R	2 mins

No	Item	Lead	Report/ Verbal	Receive/ Approve / Ratify	Time
GB17/3	Minutes of Previous Meeting	Chair	Report	A	5 mins
GB17/4	Action Points from Previous Meeting	Chair	Report	A	5 mins
GB17/5	Business Update	Chair	Verbal	R	5 mins
GB17/6	Chief Officer Report	FLT	Report	R	10 mins
Finance and Quality Performance					
GB17/7	Quality, Innovation, Productivity and Prevention (QIPP) Plan and Progress Report	MMcD	Report	R	10 mins
GB17/8	Integrated Performance Report	KMcC/ MMcD/DCF	Report	R	30 mins
Governance					
GB17/9	Corporate Risk Register & Governing Body Assurance Framework Update	DFair	Report	A	5 mins
Service Improvement/Strategic Delivery					
GB17/10	Making Integration Happen Strategy	TJ	Report	R	5 mins
GB17/11	Two Year Operational Plan	KMcC	Report	A	10 mins
For Information					
GB17/12	Key Issues reports: a) Finance & Resource (F&R) Committee: October 2016 b) Quality Committee: October 2016 c) Audit Committee: July & Oct 2016 d) Joint Commissioning Committee: December 2016 e) Locality Meetings: Key issues October to December 2016	Chair	Report	R	5 mins
GB17/13	F&R Committee Approved Minutes - October 2016		Report	R	5 mins
GB17/14	Quality Committee Approved Minutes - October 2016		Report	R	
GB17/15	Audit Committee Approved Minutes - July and October 2016		Report	R	
GB17/16	Joint Commissioning Committee - October 2016		Report	R	
GB17/17	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting*				5 mins

No	Item	Lead	Report/ Verbal	Receive/ Approve / Ratify	Time
GB17/18	Date of Next Meeting **Wednesday 29th March 2017, Family Life Centre, Southport, PR8 6JH** <u>Future Meetings:</u> From 1st April 2017, the Governing Body meetings will be held on the first Wednesday of the month rather than the last. Dates for 2017/18 are as follows: Wednesday 7th June 2017 Wednesday 2nd August 2017 Wednesday 4th October 2017 Wednesday 6th December 2017 Wednesday 7th February 2018 Wednesday 4th April 2018 Wednesday 6th June 2018 All meetings will commence at 13:00hrs and be held in the Family Life Centre, Southport PR8 6JH.				-
Estimated meeting close					**15:15hrs**

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 30th November 2016, 13:00 hrs to 15:35 hrs
Venue: Family Life Centre, Southport, PR8 6JH

The Governing Body		
Dr Rob Caudwell	Chair & Clinical Director	RC
Helen Nichols	Vice Chair & Lay Member for Governance	HN
Dr Niall Leonard	Clinical Vice Chair & Clinical Director	NL
Paul Ashby	Practice Manager & Governing Body Member	PA
Matthew Ashton	Director of Public Health, Sefton MBC *(co-opted member)*	MA
Dr Emily Ball	GP Clinical Director and Governing Body Member	EB
Gill Brown	Lay Member for Patient & Public Engagement	GB
Dr Doug Callow	GP Clinical Director & Governing Body Member	DC
Debbie Fagan	Chief Nurse & Head of Quality & Safety	DCF
Dwayne Johnson	Director of Social Services & Health, Sefton MBC *(co-opted member)*	DJ
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Martin McDowell	Chief Finance Officer	MMcD
Dr Hilal Mulla	GP Clinical Director & Governing Body Member	HM
Colette Riley	Practice Manager & Governing Body Member	CR
Dr Kati Scholtz	GP Clinical Director & Governing Body Member	KS
Dr Jeff Simmonds	Secondary Care Doctor & Governing Body Member	JS
Fiona Taylor	Chief Officer	FLT
In Attendance		
Anne Dunne	Head of Safeguarding Children	AD
Debbie Fairclough	Chief Operating Officer	DFair
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Rebecca McCullough	Head of Strategic Financial Planning	RMcC
Helen Smith	Head of Safeguarding Adults	HS
Judy Graves	*(Minute taker)*	JG

No	Item	Action
Public	**Questions were given from the public:** **1. FLT explained that she had a call from a resident, Mrs Inglis, who was unable to attend the Governing Body meeting but had a number of concerns that she wanted to raise:** **(i) She was concerned that a private company, Virgin Medical, were taking over Southport & Ormskirk Hospital, and the process for doing so had been closed. Mrs Inglis considered it should be a more open and public process.** FLT clarified that Virgin Medical would be taking over community services for West Lancs CCG only. The community services contract for Southport & Formby CCG, as per agenda item GB16/187, had been awarded to NHS Lancashire Care. FLT had explained that the CCG had complied with policy and procurement law and tendered out the contract as per the required five year timeframe. The procurement process had taken into consideration both clinical and financial aspects, and had involved patient representation. The CCG would now work closely with NHS Lancashire Care and Southport & Ormskirk Hospital to ensure a seemless transition and ensure that the services delivered are right for the local population.	

No	Item	Action
	(ii) Does the National Insurance (NI) stamp go directly to healthcare? FLT confirmed that the NI payments are paid into general taxation. **2. Michèle Martin: Are the contracts going to be signed by 23rd December and are they of the same value as those they replace?** FLT explained that there was a timetable in place for the signing of the contracts, this of which included a negotiation process and was dependent on a number of factors including available resource. Further discussion was due to be had by the Governing Body in the closed PTII private Governing Body meeting. **3. Mrs Sue Lloyd: MHRA allowed for Co-Proxamol to be prescribed on a named patient basis they say nothing has changed, so why is the CCG now instructing GPs to stop prescribing it? Australia has now re-instated Co-Proxamol and banned Tramadol. Why can't Co-Proxamol be prescribed just for specific patients for whom it really does relieve suffering?** RC clarified that Co-Proxamol was a pain killer, the licence for which had been removed some years previous. RC explained that, even though the licence had been removed, the drug could still be prescribed by GPs. However, the risk sits with the prescriber if anything goes wrong. Furthermore, there was new evidence that it could cause cardiac arrest. Pan-Mersey Area Prescribing Committee have reviewed the drug and categorised it as Black, guidance for which stipulates "not for recommended use". HM agreed. The item had been removed from use some time ago. HM wasn't aware of whether the item was still stocked.as was considered a dangerous drug. HM explained that it was a combination drug and an opiate. GPs tended to not prescribe combination drugs as they are difficult to control; GPs consider it better to prescribe each part of the drug as this provides more control over dosage and any possible side affects. HM considered that a GP might consider prescribing for specific patients. However, that would be down to the individual GP, especially given the risks connected with the drug and the implications on the prescriber. **4. Mr Terry Durrane: Considered that the biggest curse in society was loneliness. It reflected on a persons physical and mental wellbeing. People accept that it is a big problem however, there doesn't seem to be much done about it. The gaps seem to be picked up by only the voluntary sector rather that the professional sector. TD advised that he had spoken to Southport & Ormskirk Hospital regarding the same and had suggested it should be included within the discharge papers so as to ensure that the persons home situation is taken into account. Of the gap that is picked up there seems little co-ordination between the professionals. TD suggested that GPs should refer and direct patients to the appropriate activities, as should social services. TD suggested the CCG organise a meeting of all involved and interested parties in order try and bring together.** RC agreed with TD and recognised that it was a big issue, and there were a lot of good organisations in the area that provided support, this was supported by the good work of Sefton CVS. GPs do receive information for signposting however it was sometimes difficult to know which service to best signpost to. Given the duration of appointments, it wasn't possible to do a proper referral. EB updated on the project that she and another colleague were working on to try and connect the services. EB reiterated that it was difficult to match the	

No	Item	Action
	person to the right service in a 10 minute appointment. The project was looking at devising a referral form to signposting service, this service would then have time to do an appropriate referral. TD further highlighted that it was difficult to sometimes identify those that need help. For example those living on their own that don't venture out. TD considered that the GPs, via home visits, would be aware of those living in those circumstances and that the GPs should then be able to provide the resident with appropriate information. TD considered that the Fire Brigade were also a good resource. Especially when visiting people's homes to fit smoke and fire alarms, they become aware of the circumstances that the person is living in. TD considered the information they hold a valuable resource but understood that Data Protection stopped them from providing any information. BD highlighted to TD that the work that EB was doing also involved work with the Fire Brigade. DJ thanked TD for raising this issue. DJ recognised what TD was saying from personal experience. Despite reductions, DJ considered that there was a lot that could be done and agreed that health and social care should get together to discuss. DJ informed the members and public of the pilot scheme being run by Cllr Paul Cummins; a pilot group being run in Churchward, Crosby a key component being social isolation. DJ offered to have a conversation with TD outside of the meeting and to talk with Sefton CVS to take forward and look at the possibility of TD becoming involved. **5. Dr Dave Neary: When will the CCG publish the financial appendices to the STP? The STP was published on November 16th but there are scant financial details in the publication and we have a right to know the financial implications of the STP.** FLT confirmed that she had not yet been informed when the financial aspect of the STP would be released. FLT offered to try and obtain a release date.	DJ FLT
Presentation	**Sustainability and Transformation Plans** FLT gave a presentation on the Sustainability and Transformation Plans (STP) which updated the members and public on the national and local intentions and provided an update on progress. FLT highlighted the following: There were 44 areas ("footprints") established across England. The collective look at ways in which money can be saved and transforming the delivery of care, and take the opportunity to look at the work of Shaping Sefton which shapes the STP. The NHS is facing increased challenges and pressures, both service demand and finance driven. FLT emphasised that the local authority were due to loose 50% of their total budget by 2019. The area covered by the Cheshire and Merseyside STP is the second largest in England, with a population of 2.5 million, 12 CCGs, 20 providers and 9 local authorities. FLT highlighted the need to change the way we operate. The STP enables a more collaborative way of working which will assist in the reduction of duplication and unnecessary waste. With the priority being to ensure continued access to safe, good quality and sustainable services, and making the best use of the funding received. FLT briefed the members and public on the four priorities:	

No	Item	Action
	• Support for people to live better quality lives • Designing hospital services to meet modern clinical standards and reducing variation in quality • Working together with partners in social care and the voluntary sector • Being more efficient by reducing duplication and suing the latest technology: reducing costs in managerial and administrative areas FLT further explained the variances between those proposals that can be delivered across the whole of Cheshire and Merseyside, and because of the diversity of the region, some will need to be more localised. There are three Local Delivery Systems (LDS) that have been established to assist this process – North Mersey, the Alliance and Cheshire and Wirral. Each of which will work to the same STP priorities but may need to tailor the way they are delivered for their area. FLT provided an update on the current position of each LDS and highlighted the progress for North Mersey. FLT referred to the community centred health and care five year vision and emphasised the patient being at the centre. Investment had increased for community services and hospitals. FLT briefed on the vision for integrated community centred healthcare. FLT advised all that the information was available on the CCG website.	
GB16/177	**Apologies for Absence** Apologies were received from Dr Jeff Simmonds and Martin McDowell. Debbie Fairclough and Rebecca McCullough attended on behalf of Martin McDowell. Margaret Jones, Consultant in Public Health, attended for an on behalf of Mathew Ashton.	
GB16/178	**Declarations of Interest** Those holding dual roles across both South Sefton CCG and Southport & Formby CCG declared their interest; Fiona Taylor, Debbie Fagan and Martin McDowell. It was noted that these interests did not constitute any material conflict of interest with items on the agenda.	
GB16/179	**Minutes of Previous Meeting** The minutes of the previous meeting held 28th September 2016, were accepted as a true and accurate record.	
GB16/180	**Action Points from Previous Meeting: 28th September 2016** ***Presentation: Independent Inquiry into Child Sexual Abuses (IICSA)*** DCF briefed the members and public on the IICSA inquiry as per the presentation with the intention of ensuring the Governing Body were aware of the expectations on the CCG and to highlight actions undertaken to date. Clarification was requested on the 13 incidents and whether (a) any local to Merseyside and (b) what areas the investigations were taking place. Update to be provided within the Chief Officer report for March 2017. *Update* A discussion was had with the NHSE National Lead regarding the 13 incidents. DCF was informed that no individual case information will be shared due to matters of confidentiality. It was therefore not possible to identify if any cases	Closed

No	Item	Action
	were specific to local CCGs. The interviews would identify themes. Any information or learning will be fed back to the Governing Body accordingly, as per the scheduled update planned for March 2017 or sooner if required. Update added to planner for March 2017. ***GB16/137 Minutes of Previous Meeting: July 2016*** Wording change: GB16/104: Discussions with Edge Hill regarding the Kings Fund. *Update* Pack updated. ***GB16/138: Action Points from Previous Meeting: July 2016*** **Presentation: Liverpool Women's Hospital and Neonatal Review** *Engagement Process: Planned Activities* Scheduled dates and activities had been organised as part of the engagement process for the Liverpool Women's Hospital and Neonatal Review. Scheduled information on events to be circulated to the Governing Body as available. Updated information had been received from Liverpool CCG. Was currently being reviewed before being put on website. *Update* Information had been added to the website and was in relation to the pre-consultation engagement exercise held in August 2016. *Video Presentation* YouTube video presented to the Governing Body is to be placed on the CCG website. *Update:* Link is available via the Governing Body minutes. A link had also been added to the Liverpool Women's website. **GB 16/108: Integrated Performance Report** *Cost Improvement Plans* The CCG have queried through contracting the cost improvement plans and highlighted the importance of greater understanding. HM confirmed that the question had been raised, as well as how it impacts on community services. CCG were awaiting a report from the Nursing Director and Medical Director of Southport and Ormskirk Trust. As of September the CCG were still awaiting the report. More meetings were planned. Further information would be available once these meetings had been held. *Update* Meeting had been rescheduled for December 2016.	Closed Closed Closed Closed DCF

No	Item	Action
	Southport and Ormskirk Hospital NHS Trust: Key Issues DC highlighted 'Elective Bedding' (page 49) and the discussion held at the Information Sub Group. DC was awaiting confirmation on the issues. Members agreed that the conversation needed to be structured in with the Board. FLT confirmed action was in relation to elective activity and the need to structure to the Quality Committee. FLT offered to take forward. *Update* Taken to Quality Committee. *Serious Incidents* DCF referred to the number of incidents currently open and relating to pressure ulcers. A comprehensive report had been compiled and a decision taken by the CCG not to close the incidents. This being due to the high number and to ensure they were being collectively monitored. DCF emphasised the need to be assured that the systems and processes for reporting were fit for purpose. Following the confirmation that the discrepancy was in relation to years, an Action Plan had been put in place and was being discussed at contract meetings. *Update* A formal letter had now been sent to the trusts Chief Executive Officer in relation to the open contract queries and pressure ulcers. Receipt of the letter has been acknowledged by the Interim Chief Executive Officer who has committed to ensure appropriate action will be taken. CCG will continue to monitor closely. ***GB16/140 Chief Officer Report*** *QIPP: Estate Implementation Officer* The GB ratified the decision to jointly fund an Estate Implementation Officer and asked that it be reported to the next meeting of the Joint QIPP Committee, as the lead in this piece of work. *Update* Joint QIPP updated on decision of the Governing Body. Conflicts of Interest Was requested that it be noted that Southport & Formby CCG should, in this instance, refer to South Sefton CCG. The CCGs constitution to be updated to reflect the agreement of the Governing Body to seek support from the South Sefton CCG Audit Committee Chair as needed, rather than an additional Lay Member serve on the Governing Body. This also be notified to NHSE following confirmation of that approach by the CCG. *Update* Wording changed. Constitution updated. Will also be shared with the wider group for ratification.	Closed Closed Closed Closed

No	Item	Action
	<u>Primary Care Development</u> Work has been undertaken in the new ways of working group and is now being translated into potential new models of care. Further discussion with the membership will be shortly underway regarding the second year of the Local Quality Contract, including its affordability. *Update* Will be part of on-going discussions. <u>Integration Agenda</u> Work continues with SMBC to develop the integration agenda with the next deadline for a 2020 blueprint 30th October 2016. Paper would be presented to the Governing Body at a later date. *Update* Scheduled for January 2017. <u>Operational Plan</u> FLT provided and additional update in relation to the Operational Plan NHS Operational Planning and Contract Guidance had now been received. Document was being reviewed by KMcC and would be scheduled for discussion at the October Development Session. *Update* October Development Session. **<u>GB16/141 CCG Annual Assurance Assessment 2015/16</u>** Following the Governing Body receiving the report and noting the directions applied by NHSE, it was agreed to be clearly posted on the CCGs website. *Update* Posted on website. **<u>GB16/143 Quality, Innovation, Productivity and Prevention (QIPP) Plan and Progress Report</u>** A general discussion was held in relation to QIPP and the need for the wider forum to understand. An example was given as the consultant to consultant referrals and whether the localities understood the issues and impact. RC stressed the need for a discussion on such at the Wider Group. *Update* Is being discussed with the wider group and will form part of regular discussions. **<u>GB16/144 Integrated Performance Report (IPR)</u>** DCF highlighted a duplication on the figures that needs to be removed: Oxfordshire University Hospital (page 89 of the report). *Update*	 Closed Closed Closed Closed Closed Closed

No	Item	Action
	Duplication removed. **GB16/145 Corporate Risk Register & Governing Body Assurance Framework Update** Reference was made to risk 1.1: ▪ Page 125 and whether it needed reviewing, both in score and wording. For example "….ability to identify schemes that can realistically be delivered". ▪ Page 127, 4th bullet, wording to be reviewed. *Update* Risk comments have been taken into consideration in the new version of the report. **GB16/147 Joint Children & Young People's Emotional Health and Wellbeing Strategy 2016-2021** The Governing Body received the report and agreed to feedback direct to PW with any comments as soon as possible and no later than 14th October 2016. *Updates* Updates were to be fed direct to PW. **GB16/148 Safeguarding Annual Report 2015/16** (1) Item 4: progress against last year's priorities, especially in relation to Female Genital Mutilation (FGM) and Harmful Practices, Child Exploitation and Looked After Children (LAC). DCF confirmed that a separate Annual Report for LAC will be presented to the Governing Body. (2) Section 6: Learning and Development. The members discussed in relation to the figures provided for the percentage take up of Governing Body training and were made aware that it was a total Sefton figure. FLT explained that the GPs and Practice Managers undertake practice training. As such it was expected that the figures would be transferred accordingly. FLT requested the figures be checked and detail of what, if anything, is due. Additional training is scheduled for the Governing Body including October (LAC) and Safeguarding in January 2017. *Update* (1) Looked After Children (LAC) on PTI Public November 2016 Governing Body agenda. (2) Safeguarding figures were reviewed: - There is specific safeguarding training for Governing Body members, the last training for which was held in January 2014. The training figures within the Safeguarding Annual Report relate to 2015/16 and those that were members for 2015/16. The low percentage of Governing Body Safeguarding training is as a result of (1) the apologies given at the time of the training; but more so (2) some members in 2015/2016 were not members in 2014/15 when the training was undertaken. Safeguarding training is scheduled for January 2017 and valid for three years. It has been suggested that the training is held annually so as to ensure that (i) those that give apologies are captured the following year and (ii) new Governing Body members are captured each year.	Closed Closed Closed Closed

No	Item	Action
	- Training carried out by Governing Body GPs and Practice Managers is not fed through to the CCG learning system. Sometimes multiple systems depending on the training undertaken, is the same for CCG staff. CCG looking at pulling all system information to a central point for all staff and Governing Body members, this includes the process for feeding the data through. (3) FLT congratulated the team on the "green" rated risks however requested clarification on the position of those that were "amber" rated. Progress report to be presented to the Quality Committee *Update* Safeguarding Service will incorporate into future routine assurance report. (4) Protected Learning Time (PLT) events regularly held and normally well attended. DCF offered to ensure that any attendance by Governing Body members were recorded and mentioned accordingly. *Update* JG has requested agenda and signing in sheet from each PLT event so as to monitor training carried out by GB members. FLT suggested that it would be useful to get a working group together to review the PLT events and see how effective they had been. In relation to QIPP, the organisation needed to review to ensure effective and value for money. **<u>GB16/150 Key Issues Reports:</u>** a) <u>Finance & Resource (F&R) Committee</u> HN highlighted that, as a collective, the CCG were not doing well in relation to Mandatory and Statutory training. To be looked at. *Update* Training data is kept in a number of different formats, lists and learning systems. A piece of work will be done that reconciles all the data back to one document with one definitive staff list. Once that has been pulled together the gaps can then be reviewed. For instance: - When apologies are given for training sessions, we then need to look at how that training can be covered; not always an option to do on-line as sometimes audience specific. - When classroom style training is delivered and not everyone receives a pass; all needs recording on the appropriate systems and how is information fed through to individuals who have passed/not passed, refresher training? - The information held within the learning system is not always correct or up to date - GP and Practice Manager training is not fed through the learning system	Closed Closed TJ Closed
GB16/181	**Business Update** RC advised that the main areas of work continue to focus on STP and QIPP. RC updated the members and public on the organisation achieving a 4% QIPP reduction. In normal circumstances this would be a high achievement. However, because if the CCGs financial position this was not the case. RC emphasised the difficulties of GP time, of dealing with areas that GPs want to deal with i.e.	

No	Item	Action
	primary care strategy and loneliness, when time is being signposted and pressured elsewhere.	
GB16/182	**Chief Officer Report** FLT presented the Chief Officer Report and highlighted: <u>QIPP</u> The CCG continues to focus on QIPP which continues to be underpinned by focused sessions at the Leadership Team, Senior Management Team and Operational Team. This is in addition to the Joint QIPP Committee and a meeting of the 12 local CCGs who are working together to share ideas. Progress is being made however the CCGs financial position remains challenging. FLT emphasised that the CCG was doing all it could. <u>Recovery Plan</u> NHS England has signed off the CCGs Recovery Plan: paper being presented to the PTII Governing Body meeting. <u>STP</u> Following the presentation, FLT emphasised the need for the CCG to use its resources and deliver services more cost effectively. <u>IAPT</u> Concerns had been raised with the Governing Body regarding the poor performance of the IAPT service. An action plan was now in place and was being closely monitored. <u>Contract Agreement 2017/19</u> The normal signoff for contracts is in March however, the national deadline had been brought forward to 23rd December 2016. A robust detailed timetable was in place to ensure a sign-off with the major providers is achieved. <u>Stroke Services</u> The commissioning of stroke services at S&O has been discussed at recent PTII Governing Body meetings due to concerns over performance, with a the Interim Chief Executive of the Trust attending Part II of the October 2016 Governing Body to provide an update for the purposes of assurance. The Governing Body made a decision not to de-commission stroke services at this time and mandated that the CCG Chief Strategy & Outcomes Officer pursue discussions with the necessary pace regarding stroke services as part of the STP / LDS developments. <u>CQC</u> The CQC had published a recent inspection report on the quality of care at Southport & Ormskirk NHS Trust. Overall the trust had been rated as 'requires improvement' with significant concern for safety identified in the A&E and the surgical services at the Southport & Formby District General Hospital site. However there was improvement noted in both the maternity services and the NW Regional Spinal Injuries Centre which both received 'inadequate' in the last inspection. FLT highlighted the 'good' received for caring and added that this was a testament to the staff.	

No	Item	Action
	<u>GP Five Year Forward View (GPFYFW)</u> FLT highlighted possible risks in relation to GP demand and workforce. Risk to be added to the risk register. <u>Integration of Health & Social Care</u> FLT highlighted the progress being made in relation to integrating key areas of work with Sefton Council including the development of an overarching strategy and clear priorities for integrated working. EB highlighted a prior discussion regarding Hyper Acute Stroke services. Members were updated on the work being carried out by KMcC and the recent LDS Stroke Review meeting, chaired by Debbie Lowe. Draft schedule pulled together. Is to be presented to the Stroke Steering Group in December 2016. Schedule was a significant piece of work and included information on population figures and flows, travel times, consultant and stroke numbers. Would be monitored through the monthly Performance Reports. Discussion was had in relation to the prior concerns regarding access to IAPT services. FLT confirmed that GP referrals had dropped as a result of introducing self referrals. EB confirmed she was referring as many patients but is also providing the self referral information. EB considered self referral would be an easier process for the patient. FLT updated on the recent data received on the service; services now has extra capacity, significant increase has been seen in recovery, now need to see improvements in the access data. **RESOLUTION** **The Governing Body received the report.**	DL
GB16/183	**Quality, Innovation, Productivity and Prevention (QIPP) Plan and Progress Report** RMcC and DFair presented members and the public with the QIPP plan and progress report which provided an update on the progress being made in implementing the QIPP plan schemes and activities. RMcC and DFair highlighted the following: The QIPP comprises five strategic domains: planned care, medicines optimisation, CHC/FNC, discretionary spend and urgent care. With discretionary spend and continuing health care being the main areas of current savings. With a current year to date actual of £3.8m against a year to date plan of £5.3m. The Joint QIPP Committee continue to monitor performance against the QIPP plan objectives and is supported by the Clinical QIPP Advisory Group that reviews all cases for change and clinical schemes ensuring robust clinical input at every level. The CCG continue to report to NHSE on progress. NHSE recognise the efforts being made. The CCG will continue to seek every efficiency possible. DCF highlighted the Quality Impact Assessment process which all schemes are subject to. The process has both a GP Clinical Lead and managerial lead so as to ensure quality and risk assessment. HN highlighted that there had been a range of QIPP schemes that were carried out earlier in the year that the CCG were now hoping to see the impact on. RC reminded the members and the pubic of the CCGs deteriorated financial	

No	Item	Action
	position from £4m to £7m. This being due to a number of unforeseen pressures including Nursing Funded Care which has had an impact of £1.2m. **RESOLUTION** **The Governing Body received the report.**	
GB16/184	**Integrated Performance Report** KMcC presented the Integrated Performance Report which updated on aspects of finance, quality and performance against key strategic targets. KMcC highlighted the following: <u>Planned Care</u> Across Cheshire and Merseyside seeing an increase in the number of referrals. A referral management scheme commenced October 2017. CCG achieved the target of 93% for 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms in September with a performance of 95.83% but are failing YTD with a performance of 91.89% due to previous month breaches which were as a result of patients being unavailable. KMcC highlighted the failing 2 month (62 day) measure for a number of specialities including GP referral to a first definitive treatment for cancer and for Southport and Ormskirk urology, colorectal, gynaecology, haematology, head and neck. The dominant theme remains lack of radiology capacity for interventional procedures and reporting. The Trust currently has 2 radiologist vacancies and are considering a business case for a further 4 posts. However, recruitment to the posts remains a difficulty. The Governing Body raised concern on the failed targets and the difficulty in recruiting to the posts. Members were briefed on the work that was underway across the Local Delivery System (LDS) of the STP to look at improved utilisation of radiology resources. 18 week target continues to be achieved. However, the margin by which it's achieving is reducing. <u>Unplanned Care</u> Southport & Formby CCG failed to achieve all 3 ambulance indicators year to date, this being a national issue. September saw an average handover time of 21 minutes across the month. The Trust continues to make sustainable improvements in handover performance. The approval to increase the A&E nursing will contribute significantly towards this as some of the additional resources will support triage and ambulance arrival processes. Exit blocks out of the hospital continue to cause operational difficulties, resulting in bottlenecks in the ED and delays in timely release of cubicle capacity. As highlighted in the Chief Officer Report, Southport and Ormskirk stroke performance for September showed some improvement with 64.5% of stroke patients discharged during the month of September having spent 90% of their time on the stroke ward (60% in August). As presented at the last Governing Body, a Stroke action plan has been devised reviewing potential to reconfigure a bay on the unit into 4 side rooms which would minimise the impact of male/female demand as patients could be appropriately managed in side rooms. There has also been a change in pathway, with patients now going direct to the Acute Stroke unit up to 8pm in the evening from the Emergency Department with the support of the Specialist Stroke Nurse. FLT referred to the stroke data detailed on page 71 of the report (4.3) and	KMcC

No	Item	Action
	suggested a trend line be added to show month on month performance. FLT highlighted the work of the Emergency Care Improvement Programme (ECIP) which is helping to bring in improvement type planned skills. ECIP report will highlight areas that the Governing Body, as system leaders, will need to be aware of. To be presented to a future Governing Body meeting as soon as it becomes available. <u>Mental Health</u> Early Intervention and Psychosis (EIP) are areas of prior agreed investment (April 2016). It is anticipated that performance will improve following the appointment of additional staff, in place by the end of January 2017. Reference was made to Liverpool Community Health Quality Overview and the issues outlined in 6.2.3 in relation to deteriorating waiting times for Physiotherapy, Podiatry, Nutrition & Dietetics and Paediatric SALT. FLT emphasised the need for a review of the risk register in light of the lack of improvement by LCH. The members and public were reminded of the new providers, Merseycare, and the current NHS transaction process. Meetings would be held with the new providers on the areas of concern. Attention was drawn to the recent CQC inspection visits carried out at a number of Southport & Formby practices (page 85 to 87). Two surgeries received a rating of good (The Village and Marshside), with one receiving a rating of inadequate (Kew surgery). Members discussed the ratings awarded for each of the inspection areas. Kew Surgery would be provided support, JL would be providing support. NL highlighted that he was aware that the surgery had experienced difficulty in replacing GP workforce and that the surgery were looking at a number of options which may provide a solution for 2017. <u>Quality</u> DCF referred to the discussion regarding the CQC visit to Kew Surgery and confirmed that the Quality Committee would also be providing support. DCF referred the members and public to 3.3 and 4.6, Patient Experience in relation to Planned Care and Unplanned Care. DCF updated on the presentation to be given to the Joint Clinical Quality Committee if the Trusts new Patient Experience Strategy. The Trust had implemented a number changes including a new Director of Nursing who had commenced at the Trust in November and whom DCF would be meeting in January 2017. Part of the new Director or Nursing's role will be to lead on Patient Experience and Scrutiny. The members and the public were updated on the current position of serious incidents (4.4), specifically those still open for Southport and Ormskirk NHS Trust. DCF explained that the incidents had deliberately been kept open as DCF was not assured that the action plans were comprehensive. DCF also provided an update on the letter that had been written to the Trust and the number of pressure ulcers being reported. The transparency of the incidents being reported was noted however but there was a need to ensure that there were lessons learnt. Chief Officer has taken a personal interest in the matter and was now a regular agenda item at contract meetings. DCF further referred to the prior conversation regarding LCH. DCF advised that LCH had also been subject to a CQC Action plan. Item was not in pack but it highlighted issues in relation to Safeguarding and Looked After Children. There were concerns regarding the ability to support systems in relation to meeting he timeframe of health assessments for looked after children. Weekly meetings were being held, item had been included on the risk register, processes were in place	FLT/JG JL

No	Item	Action
	and were being monitored. <u>Finance</u> RMcC updated the members and the public on the current position for month 7 being a £7m against a planned deficit of £4m. The financial position on operational budgets as at month 7 is an overspend of £1.720m, with a forecast for the year of £2.487m. The majority of the cost pressures relation to over performance within the acute provider contracts, independent sector and prescribing as well as the cost increases for Funded Nursing Care and Continuing Healthcare. The value of QIPP saving delivered at the end of month 7 is £3.812m. There is a significant risk of delivery on the remaining plan with a high proportion of schemes rated red or amber. These now need reviewing in order to look at what can be done to turn them around. HN assured the Governing Body that robust discussions were had at the F&R Committee regarding the realism of delivering the current forecast Reference was made to the risk rated financial position provided in figure 7 (page 56) with the most likely projected deficit being £8.347m. HN highlighted potential further risks in relation to secondary care which had been raised with NHSE. HN also raised concern that there was no formal arrangement in place for the end of year cash. FLT would look into. Further discussion was had in relation to the further potential risk from secondary care in relation to over performance. FLT explained that a legal directive had been given, therefore any additional expenditure required would not be from the CCG as would constitute a breach. FLT offered to raise formally with NHSE. **RESOLUTION** **The Governing Body received the report. FLT requested a timeslot of 30 minutes is allocated to the report.**	FLT FLT JG
GB16/185	**Looked After Children: Annual Report 2015/16** AD and HS presented the members and the public with the Looked After Children (LAC) Annual Report. Purpose being to assure the Governing Body and members of the public that the CCG is fulfilling its statutory duties in relation to safeguarding and LAC. The report also takes into account the national changes and influences and local developments, activity, governance arrangement sand the challenges for 2016/17. The CCG makes a significant contribution to embedding the principles, quality and requirements of national frameworks by its partnership work with Sefton local authority and the commissioned health providers. The following areas were highlighted: The report had also been presented to a prior Quality Committee so as to ensure compliance. The review of Health Assessments is improving and now running at 86%. As outlined on page 111 and 112, the assessments are a statutory requirement for all LAC and are required to be completed every six months for children under the age of 5 years and annually for children over this age. When a placement for a child is given, it is done so because it is deemed the best place for the child. This can quite often mean out of area placements (item 11). This then causes difficulties in relation to Health Assessments and records. Nationally work is being done however the process is complex and has an impact	

No	Item	Action
	on services. DCF confirmed that the report had been submitted to the Quality Committee. Report would now be presented to the LAC Board. **RESOLUTION** **The Governing Body approved the report. The Safeguarding team were thanked for their work.**	
GB16/186	**Mental Capacity Act: Annual Report 2015/16** HS presented the members and the public with the first annual Mental Capacity Act/ Deprivation of Liberty Safeguards (MCA/DoLS) report. The purpose being to assure the Governing Body and members of the public that the CCG is fulfilling its statutory duties in relation to people requiring care and treatment in the Borough who lack capacity to make best interest decisions. The following areas were highlighted: The CCG makes a significant contribution to embedding the principles of the Mental Capacity Act and DoLS by its partnership work with the National Forum, Sefton local authority and the commissioned health providers. The Annual Report provides the Governing Body with an update of the developing and emerging MCA/DoLS agenda, which the CCG has supported throughout the 2015-16 reporting period. This includes updates on the National Context (The Deprivation of Liberty Safeguards, Article 5 of the Human Rights Act 1998, Supreme Court ruling P v Cheshire West and Chester and P and Q v Surrey Council, CQC Document "The State of Health Care and Adult Social care in England 2015/16", The Chief Coroners Guidance No 16 in December 2014, Birmingham City Council v D & Another [2016] EWCOP 8 and requirements under the Court of protection) and the Local Context (NHSE North region MCA/DoLS Network, NHSE Designated Professionals Network, Partnership working and Training) and activity for commissioned health providers in relation to DoLS. It also outlines the future implications, challenges and key work streams for 2016/17. HS highlighted the importance of compliance with DoLs, which forms part of the Quality Contract Schedule. Support was being provided to Sefton LA who where struggling with capacity, highlighted through the DoLs incidents. Has been recognised as a national problem. Sefton LA had reconfigured their services and it is hoped that this will provide better support. DJ referred to page 131 item 2.5, Chief Coroner Guidance. DJ explained that on original judgement the local authority were dealing with approximately 100 DoLs per year. This had now increased to 100 per month. Additional staff have had to be identified which has been at the cost of the LA. There are currently four LA's challenging the Government through the courts. However, the High Court keep moving the item back. It was hoped that once the LA's are given the opportunity to challenge, more funding will be forth coming. **RESOLUTION** **The Governing Body approved the report.**	

No	Item	Action
GB16/187	**Community Services Procurement: Notification of Contract Award** The purpose of this paper is to note the formal award of the Community Services Contract for Southport and Formby CCG. A paper was taken to the private session of the Southport and Formby Governing Body on 26 October 2016 with a full description of the procurement process. The purpose of the report was to update the members of the procurement process that had been used and seek a recommendation to award the contract. In order to re-enforce the integrity of the procurement process used, the bidder's identities were anonymised in the report. A recommendation was made to award to Bidder A. Lancashire Care NHS Foundation Trust was the successful bidder. The members and public were informed that most of the staff would move to the new provider. Information was available on the CCG. Members discussed in relation to the appointment of the successful bidder and the need to ensure a wrap around and integrated service is delivered. **RESOLUTION** **The Governing Body received the update and noted the contract award to Lancashire Care NHS Foundation Trust and noted that service mobilisation had commenced.**	
GB16/188	**Corporate Risk Register & Governing Body Assurance Framework Update** The Governing Body is presented with the updated CRR and the GBAF as at November 2016. The CRR and GBAF have both been reviewed and updated by members of the leadership team. The Governing Body reviewed and scrutinised the report and highlighted the following areas: • QIPP remains a significant challenge and risk. Review of all potential areas of efficiency will continue. • Some risks had reduced • 6.1 and SF040: was considered that there was an inconsistency in scoring. To be reviewed. • SF006: would expect to see financial duties as a high risk. Is due to be looked at in more detail with the Governing Body in December. The members had a wide discussion in relation to the financial risks and how rated. • HN highlighted Nursing Homes as a potential new risk and asked it to be considered. To be discussed at Leadership Team. • SF034: consideration to be given to listing resulting consequences of risk. To be discussed at Leadership Team. **RESOLUTION** **The Governing Body reviewed, scrutinised and approved the report and updates.**	DFair DFair DFair

No	Item	Action
GB16/189	**Appointment of External Auditor 2017/8: Update** Members were reminded that in July 2016 six CCGs (St. Helens, Halton, Southport and Formby, South Sefton, Wirral and Knowsley) approached the market through the Crown Commercial Service's Framework in order to identify an appropriate external audit provider from April 2017. The procurement was required as per guidance from the Department of Health, which required all CCGs to make an appointment for an external auditor by no later than 31 December 2016. The audit chairs from each CCG acted as the evaluation panel for the procurement scoring each element of each bid. Presentations and interviews took place on 12 September 2016. Based on these presentations and interviews, the panel recommended that the contract for the service is awarded to Grant Thornton. The decision of the panel was then to be taken back to each respective CCGs Governing Body. The decision was presented to the Southport & Formby CCG Governing Body on 28th September 2016 who approved the decision of the panel to appoint Grant Thornton. It was confirmed that the decision had now been taken back to each respective Governing Body who where in agreement of the decision made to award Grant Thornton. Information would now be made available on the CCGs website. **RESOLUTION** **Governing Body received the update on the appointment of Grant Thornton as External Auditor for 2017/18.**	LC
GB16/190	**Disinvestment Policy and Procedure (Cessation and significant reduction of services) and prioritisation principles.** DFair presented the NHS Southport and Formby Clinical Commissioning Group's Disinvestment Policy. She advised that the policy will supersede all previous policies and procedures in respect of the approach to disinvestment and to connect all key programmes within the CCG, including QIPP, that generate proposals for disinvestment or service reduction with one single process and oversight procedure. This will ensure the CCG's decision making process operates within legal requirements. Members noted that the policy included roles and responsibilities, decision making requirements, stages of disinvestment and prioritisation principles. The main aims of the policy are to ensure that the disinvestment procedure is robust, lawful, open, and transparent and focussed on enabling the CCG to make the necessary efficiencies across the whole system. The policy also provides a framework for making sure the CCG continues to allocate its resources on the provision services for the highest priority areas whilst sustaining its focus on the quality and safety of those services. DFair highlighted the need to ensure that any decision made on the allocation of resources was done so lawfully, hence for the need for the framework, which had been developed by Andrew Woods, the CCG E&D Lead, with support from key officers. Members considered it critical that the organisation lawfully complies with any decision made and therefore the need of a framework was crucial. However members considered that it needed further work, in relation to presentation, wording and diagrams.	DFair

No	Item	Action
	RESOLUTION **The Governing Body approved the framework and policy, with further work needed on the presentation, wording and diagrams but to ensure that any changes in such does not affect its content.**	
GB16/191	**North Mersey LDS Plan** FLT presented the members and the public with the North Mersey Local Delivery System Plan (NM LDS Plan). The purpose being to update on the content of the plan which is a component part of the Cheshire & Merseyside Sustainability & Transformation Plan (C&M STP). The C&M STP was submitted to NHS England on 21st October 2016. It is currently being reviewed and until that process has been completed and feedback NHS organisations have been instructed that they should not publish the NM LDS Plan. However, it is possible to share the three local delivery system plans which represent the majority of the content of the STP. FLT highlighted page 218, Primary Care Transformation. Use of the word "adoption" has been changed to "consideration". This is following discussions with localities, it was felt as presumptuous **RESOLUTION** **The Governing Body received the report.**	
GB16/192	**Key Issues Reports:** a) Finance & Resource (F&R) Committee (July and September 2016) HN highlighted the utilisation review being carried out, intention being to get better use of buildings. FLT commented that within the STP there might be some money identified for capital funding. Would be something to look out for once the plan was made public. b) Quality Committee (September 2016) Received. c) Joint Commissioning Committee (October 2016) Received. d) Audit Committee (July 2016) HN highlighted the Internal Audit report received by Audit Committee which gives a rating of "significant assurance" on Risk Management arrangements. **RESOLUTION** **The Governing Body received the key issues reports**	
GB16/193	**F&R Committee Approved Minutes:** - July 2016 - September 2016 **RESOLUTION** **The Governing Body received the approved minutes.**	

No	Item	Action
GB16/194	**Quality Committee Approved Minutes:** - July 2016 - September 2016 **RESOLUTION** **The Governing Body received the approved minutes.**	
GB16/195	**Audit Committee Approved Minutes** None.	
GB16/196	**Any Other Business** 196.1 HSJ Awards: Quality Team had been nominated in the Workforce Category section in relation to the work with the youth and apprentices. 196.2 Sefton Youth: Sefton youth had made an impressive input in their involvement with the Emotional Health and Wellbeing Strategy. They showed role modelling and value set. Was important to consider what the CCG can give and offer. Currently two apprentices within the CCG; Reception and Business Intelligence.	
GB16/197	**Date of Next Meeting** Wednesday 25th January 2017 13:00 hrs, Family Life Centre, Southport, PR8 6JH	
Meeting concluded		**15:35hrs**

NHS
Southport and Formby
Clinical Commissioning Group

Governing Body Meeting in Public GB 17/04
Actions from meeting held 30th November 2016

No	Item	Action
Questions	***5. Financial appendices to the STP*** FLT offered to try and obtain a release date for the financial appendices to the STP	FLT
GB16/180	***Action Points from Previous Meeting: 28th September 2016*** **GB 16/108: Integrated Performance Report** *Cost Improvement Plans* The CCG have queried through contracting the cost improvement plans and highlighted the importance of greater understanding. HM confirmed that the question had been raised, as well as how it impacts on community services. CCG were awaiting a report from the Nursing Director and Medical Director of Southport and Ormskirk Trust. As of September the CCG were still awaiting the report. More meetings were planned. Further information would be available once these meetings had been held. Meeting had been rescheduled for December 2016. **GB16/148 Safeguarding Annual Report 2015/16** Following discussion regarding Safeguarding and LAC training members had been reminded of the Protected Learning Time (PLT) events regularly held and normally well attended. DCF offered to ensure that any attendance by Governing Body members were recorded and mentioned accordingly. JG had requested the agenda and signing in sheet is forwarded to order in order to ensure any Governing Body training is captured. FLT then suggested it would be useful to get a working group together to review the PLT events and see how effective they had been.	DCF TJ
GB16/182	***Chief Officer Report*** FLT had highlighted possible risks in relation to GP demand and workforce. Risk to be added to the risk register.	DL

GB16/184	***Integrated Performance Report*** **Stroke** Trend line to be added to the stroke data table in order to show month on month performance (as detailed on page 71 of the Governing Body report, item 4.3). **ECIP** Emergency Care Improvement Programme (ECIP) report to be presented to a future Governing Body meeting as soon as available; to be added to planner. **LCH: Quality Overview** Discussion was had in relation to Liverpool Community Health Quality Overview and the issues outlined in 6.2.3 in relation to deteriorating waiting times for Physiotherapy, Podiatry, Nutrition & Dietetics and Paediatric SALT. FLT emphasised the need for a review of the risk register in light of the lack of improvement by LCH. **Finance** Although confirmation had been given on the end of year cash, no formal arrangement was ye in place. FLT officered to look into. Further discussion was had in relation to the further potential risk from secondary care in relation to over performance. FLT explained that a legal directive had been given, therefore any additional expenditure required would not be from the CCG as would constitute a breach. FLT offered to raise formally with NHSE.	KMcC JG JL FLT FLT
GB16/188	***Corporate Risk Register & Governing Body Assurance Framework Update*** The Governing Body reviewed and scrutinised the report and highlighted the following areas: • 6.1 and SF040: was considered that there was an inconsistency in scoring. To be reviewed. • HN highlighted Nursing Homes as a potential new risk and asked it to be considered. To be discussed at Leadership Team. • SF034: consideration to be given to listing resulting consequences of risk. To be discussed at Leadership Team.	DL DL DL
GB16/189	***Appointment of External Auditor 2017/8: Update*** Information to be made available on the website on the appointment of the external auditor.	LC
GB16/190	***Disinvestment Policy and Procedure (Cessation and significant reduction of services) and prioritisation principles.*** Further work needed on the presentation, wording and diagrams within the policy but to ensure that any changes in such does not affect its content.	DFair/AW

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2017

Agenda Item: 17/06	**Author of the Paper:** Fiona Taylor Chief Officer Email: fiona.taylor@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: January 2017	

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 focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.
x	To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the "Forward View", underpinned by transformation through the agreed strategic blueprints and programmes.
x	To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.
x	To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
x	To advance integration of in-hospital and community services in support of the CCG locality model of care.
x	To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

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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
Clinical Commissioning Group

Report to Governing Body
January 2017

To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.

1. QIPP Update

During December the CCG has continued to make good progress implementing its QIPP priorities and staff and clinical leads continue to focus on these. The Clinical QIPP Advisory Group and Joint QIPP Committee continue work well together ensuring there is robust and thorough scrutiny of all QIPP related activity as well as the evaluation of clinical schemes. The assessment of those schemes enables the CCG to test whether or not the schemes are achieving the anticipated objectives and provides a framework for identifying any risks to scheme delivery at an early stage. Leads are continuing to look across all areas of spend to ensure that every opportunity to make efficiencies is being explored.

During January 2017 each scheme is being subject to a "deep dive" assessment in addition to the routine scrutiny of schemes to ensure that as we progress through the last quarter of the financial year, the CCG is very clear about any risks to delivery and what the mitigating actions are. The outcome of this work will be reported to both the leadership team and the Joint QIPP Committee in February.

To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the 'Forward View', underpinned by transformation through the agreed strategic blueprints and programmes.

2. Connecting the Clinicians Event – 11th January 2017

A further Connecting the Clinicians event was held in the Family Life Centre on Wednesday 11th January 2017.

3. Executives Meeting – 13th January 2017

Katherine Sheerin and Fiona Taylor met with Ged Fitzgerald – Chief Executive of Liverpool City Council and Margaret Carney – Chief Executive of Sefton Metropolitan Borough Council on Friday 13th January 2017 to discuss our work across the North Mersey footprint and opportunities for broader collaboration building on the Shaping Sefton and Healthy Liverpool transformation programmes. Going forward our Knowsley colleagues will be involved in our continued discussions.

To ensure that the CCG maintains and manages performance and quality across the mandated constitutional measures.

4. NHSE/CCG Q2 Improvement and Assessment Framework Meeting – 4th January 2017

A full review of progress to date was undertaken with particular focus on areas of performance – RTT, stroke, signing of contracts and the state of play of the CCG IAF dashboard. The CCG's contribution to the broader STP was recognised through our key leadership roles.

5. Migration to the Health and Social Care Network (HSCN)

NHS Digital is planning to replace the current N3 data network for the health sector with a new HSCN when the N3 contract ends in March 2017. This will provide a relative, efficient and flexible way for health and social care organisations to access and share information by being more cost effective; reducing complexity by standardising networks; enabling service sharing and extending the parameters of collaborative working.

We have confirmed to iMerseyside that as we currently have COIN (Community of Interest Network) in place and operate collaboratively across the LDR footprint, we plan to procure through local organisations in a collaborative procurement deal. It is anticipated that migrations to the new network will begin late May or June 2017.

6. Information Governance

The CCG's Information Governance (IG) Policy and IG Handbook were ratified by the Finance and Resource Committees in November 2016.

The Corporate Governance Support Group, on behalf of the Joint Quality Committee and the Senior Information Risk Owner, continually monitors the CCG's compliance with IG protocols and statutory compliance. The Corporate Governance Support Group has scrutinised the CCG's IG strategy 16/17, which forms a large part of the IG toolkit submission and this work is on track for submission of the IG Toolkit in March 2017.

To support the IG Policy and Handbook, staff are required to annually undertake Mandatory Information Governance refresher training, this training can be done virtually or face to face and sessions have also been facilitated for staff. Confidentiality Audits and Information Security Audits have been undertaken by the CSU IG Lead on behalf of the CCG, the actions from which are being progressed and continually monitored. The CCG also continues to raise awareness of the requirement for Privacy Impact Assessments to be undertaken for any new programmes which require the use of personal data.

The Corporate Governance Group will continue to report on all IG related matters to the Joint Quality Committee as part of the key issues reporting.

7. Joint Local Area Special Educational Needs and Disability (SEND) inspection in Sefton

The inspection outcome letter was published on 13th January 2017. It contains areas of both strength and development along with some areas of significant weakness. The areas identified as being of significant weakness are as follows:

- The poor progress made from starting points by pupils with a statement of special educational needs and/or disabilities and their families;
- The poor operational oversight of the Designated Clinical Officer (DCO) across health services in supporting children and young people who have special educational needs and/or disabilities and their families;
- The lack of awareness and understanding of health professionals in terms of their responsibilities and contribution to Education Health Care Plans (EHCPs);
- The weakness of co-production with parents, and more generally in communications with parents;

- The weakness of joint commissioning in ensuring that there are adequate services to meet local demand.

The Chief Nurse is co-ordinating a meeting across the local system to discuss the future model for the DCO / DMO function and where this is best placed as a result of the inspection outcome and the recently published guidance from September 2016. Contact has also been made with the CCGs' GP Clinical Lead for Children & Young People to support this discussion.

The local area is required to produce and submit a Written Statement of Action to Ofsted that explains how the local area will tackle the areas of weakness.

8. Quality Risk Profile Tool – Liverpool Community Health NHS Trust

The Quality Risk Profile Tool for LCH has been jointly reviewed and updated by the Quality Teams from Southport & Formby CCG, South Sefton CCG and Liverpool CCG. This has been submitted to NHS England (Cheshire & Merseyside).

To support Primary Care development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.

9. GP Five Year Forward View (GP5YFV)

The CCG sent its submission for the GP5YFW to NHS England on 23rd December 2016. Feedback is awaited.

10. Guidance to primary care providers on supporting whistleblowing in the NHS

NHS England circulated a document last November entitled "Freedom to Speak Up in Primary Care" aimed at providing guidance to primary care providers on supporting whistleblowing in the NHS. A link to the document can be found here: https://www.england.nhs.uk/wp-content/uploads/2016/11/whistleblowing-guidance.pdf

To advance integration of in-hospital and community services in support of the CCG locality model of care.

11. Community Services – Mobilisation Update

Lancashire Care NHS Foundation Trust has been identified as the preferred bidder of the CCG's services from Southport & Omskirk Hospital NHS Trust. Work is underway to mobilise services from 1st May 2017. Regular meetings are taking place between the CCG and Lancashire Care NHS Foundation Trust to ensure a smooth transition. The Lancashire Care team attended the Southport & Formby CCG Wider Forum meeting on 11th January 2017.

NHS
Southport and Formby
Clinical Commissioning Group

To advance the integration of Health & Social Care through collaborative working with Sefton Metropolitan Council, supported by the Health & Wellbeing Board.

12. Making Integration Happen

Work continues on the integration agenda through the Integrated Commissioning Group and the paper on today's agenda, "Making Integration Happen", outlines the type of work being undertaken.

13. Social Services Visit – 5th January 2017

I was able to spend some time with the Sefton Metropolitan Borough Council's Hospital Social Work team on 5th January 2017. I took the opportunity to understand their working context. I will be taking some of the discussion into our ongoing work on CHC/FNC in supporting the improvement of the unplanned care system.

14. Sefton Metropolitan Borough Council Budget – 2017/2020

The Council has published the proposed budget for 2017/18 and the medium term financial plan 2018/19 – 2019/20.

The report provided to Cabinet reflects the current financial challenges facing the Council during the period, the proposed approach to meeting these challenges and how they reflect the Council's statutory requirement to remain financially sustainable and the desire to deliver Sefton 2030 Vision and the Council's core purpose.

15. Governing Body Elections

The Governing Body's three year term comes to an end on 31st March 2017. Sefton Local Medical Committee (LMC) has offered to run the independent nomination and election process which will commence in early February. The LMC will seek nominations from member practices for all six GP Governing Body member and two Practice Manager roles, in line with the CCG constitution. The outcome of the process will be announced by the LMC in mid-March, in time for the re-elected body to commence in April 2017.

16. Recommendation

The Governing Body is asked to formally receive this report.

Fiona Taylor
Chief Officer
January 2017

NHS
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Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2017

Agenda Item: 17/07	**Author of the Paper:** Martin McDowell Chief Finance Officer Email: martin.mcdowell@southseftonccg.nhs.uk Tel: 0151 247 7071
Report date: January 2017	

Title: Quality, Innovation, Productivity and Prevention (QIPP) Plan and Progress Report

Summary/Key Issues:
The report provides the Governing Body with an update on the progress being made in implementing the QIPP plan schemes and activities. The Joint QIPP Committee continues to monitor performance against the plan and receives updates across the five domains: planned care, medicines optimisation, CHC/FNC, discretionary spend and urgent care.

Attached with this report are the QIPP performance dashboard (Appendix 1)

Recommendation

The Governing Body is asked to receive the report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
X	To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.
	To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the "Forward View", underpinned by transformation through the agreed strategic blueprints and programmes.
X	To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.
	To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
	To advance integration of in-hospital and community services in support of the CCG locality model of care.
	To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

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Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	Y			Relevant QIPP schemes have been developed following engagement with the public.
Clinical Engagement	Y			The Clinical QIPP Advisory Group and the Joint QIPP Committee provide forums for clinical engagement and scrutiny. Key schemes have identified clinical leads
Equality Impact Assessment	Y			All relevant schemes in the QIPP plans have been subject to EIA
Legal Advice Sought				
Resource Implications Considered	Y			The Joint QIPP Committee considers the resource implications of all schemes
Locality Engagement	Y			The Chief Integration Officer is working with localities to ensure that key existing and new QIPP schemes are aligned to locality work programmes.
Presented to other Committees	Y			The performance dashboard was presented to the Joint QIPP Committee at its meeting on 12th September 2016.

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
January 2017

1. Executive Summary

The Joint QIPP Committee continues to monitor performance against the QIPP plan objectives and is supported by the Clinical QIPP Advisory Group that reviews all cases for change and clinical schemes ensuring robust clinical input at every level.

2. Key Issues

The QIPP plan comprises five strategic domains: planned care, medicines optimisation, CHC/FNC, discretionary spend and urgent care and within each domain there are number of schemes or actions that all have savings identified against them.

The QIPP plan is under regular review and as new opportunities are identified they are reflected in the plan. The plan was reviewed at the beginning of November and some changes were made, these are summarised below in the report.

The QIPP dashboard and the QIPP plan were received at a meeting of the Joint QIPP Committee on 10th January 2017.

3. Recommendations

The Governing Body is asked to receive the report and note the update.

Appendices

Appendix 1 – NHS Southport & Formby CCG Month 9 QIPP Performance Dashboard

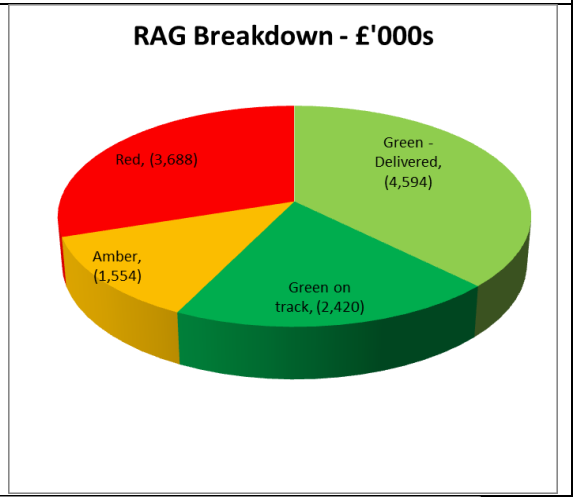
Martin McDowell
Chief Finance Officer
January 2017

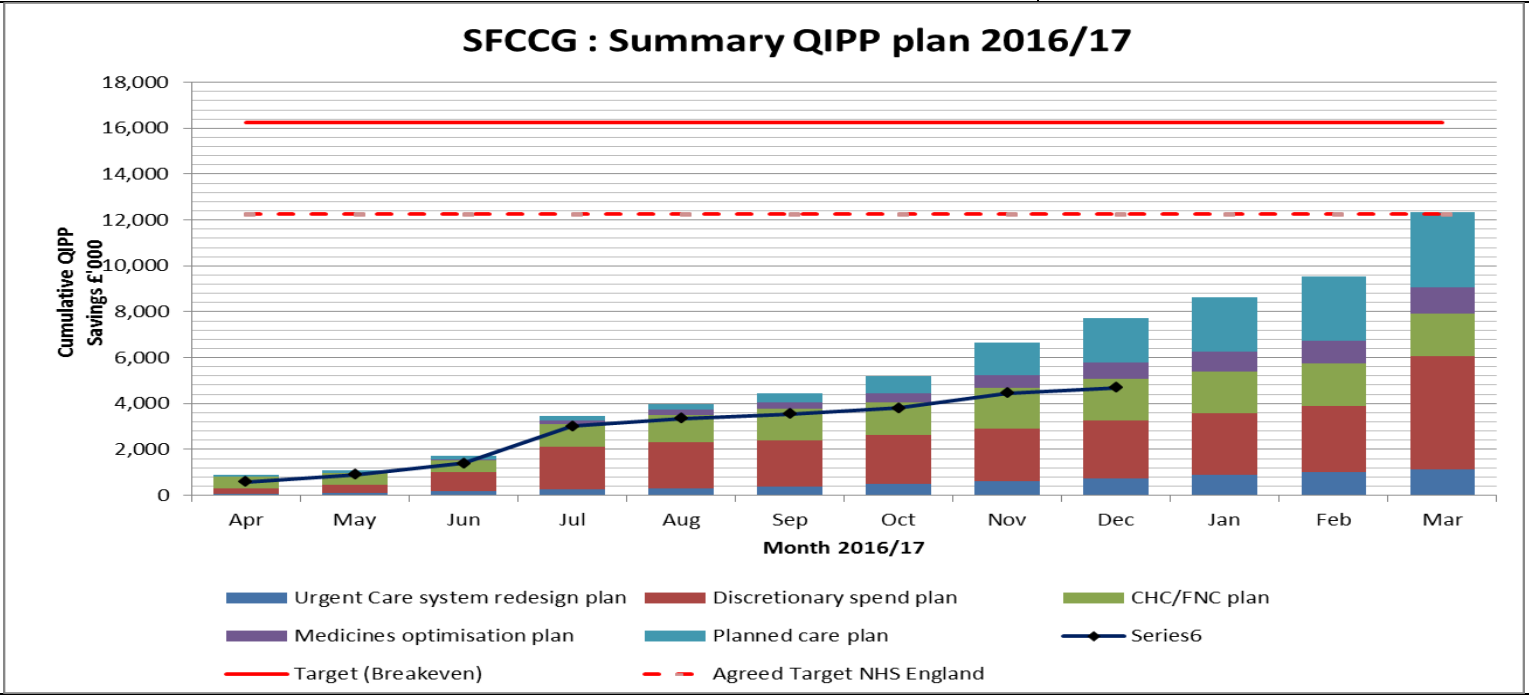
QIPP DASHBOARD – SUMMARY SFCCG AT MONTH 9

Southport and Formby CCG

£'000s

Scheme	Annual Plan	YTD Plan	YTD Actual	Variance
Planned care plan	3.264	1,938	194	(1,744)
Medicines optimisation plan	1,153	711	321	(390)
CHC/FNC Plan	1,839	1,797	1,795	(2)
Discretionary spend plan	4,863	2,509	2,384	(121)
Urgent Care system redesign	1,137	751	0	(751)
Total	12,256	7,705	4,694	(3,007)





QIPP DASHBOARD SFCCG – Detail by scheme – Themes 1 & 2

Theme 1: Planned care	Phasing	In month plan	In month actual	Variance		YTD Plan	YTD Actual	Variance			Annual Plan	Forecast out-turn savings	Forecast Variance	
Total PLCP procedures (allowed for 10% activity to go through)	M6-M12	58	0	(58)		115	0	(115)			288	288	0	
MCAS / T&O 15% reduction in activity with Gain share (1st oct start date)	M6-M12	93	0	(93)		280	144	(136)			560	560	0	
MCAS / T&O - 6 week delay	M1-M12	110	0	(110)		330	0	(330)			330	330	0	
Cataracts Policy	M1-M12	13	0	(13)		26	0	(26)			64	64	0	
Review of OPP T&O Coding	M6-M12	38	0	(38)		338	0	(338)			450	225	(225)	
Dermatology - reduce block	M1	0	0	0		50	50	0			50	50	0	
Contract Challenges MRET	M12	0	0	0		0	0	0			52	52	0	
Contract Challenges (Phase 1)	M7-12	0	0	0		128	0	(128)			128	64	(64)	
Contract Challenges (Phase 2)	M7-M12	165	0	(165)		495	0	(495)			990	0	(990)	
CQUIN - C2C reduction S&O	M7-M12	11	0	(11)		32	0	(32)			63	63	0	
CQUIN - 1st:Fup ratio S&O	M7-M12	48	0	(48)		145	0	(145)			289	289	0	
Total		**535**	**0**	**(535)**		**1,938**	**194**	**(1,744)**			**3,264**	**1,985**	**(1,279)**	

Theme 2: Medicines optimisation	Phasing	In month plan	In month actual	Variance		YTD Plan	YTD Actual	Variance			Annual Plan	Forecast out-turn savings	Forecast Variance	
Focus on reduced waste (repeat prescribing)	M6-M12	77	100	23		232	100	(132)			464	464	0	
Individual patient reviews (Generics / Optomise / Quick Wins)	M2-M12	34	0	(34)		233	165	(68)			335	335	0	
Additional rebate schemes	M3-M12	18	0	(18)		125	0	(125)			180	180	0	
Blood Glucose Monitoring strips	M7-M12	13	0	(13)		38	0	(38)			75	75	0	
Apixiban Price Reduction	M1-M4	0	0	0		56	56	0			56	56	0	
High Cost Drugs and Biosimilars	M4-M12	5	0	(5)		27	0	(27)			43	0	(43)	
Review other expenditure - Care at the chemist	N/A	0	0	0		0	0	0			0	0	0	
Total		**147**	**100**	**(47)**		**711**	**321**	**(390)**			**1,153**	**1,110**	**(43)**	

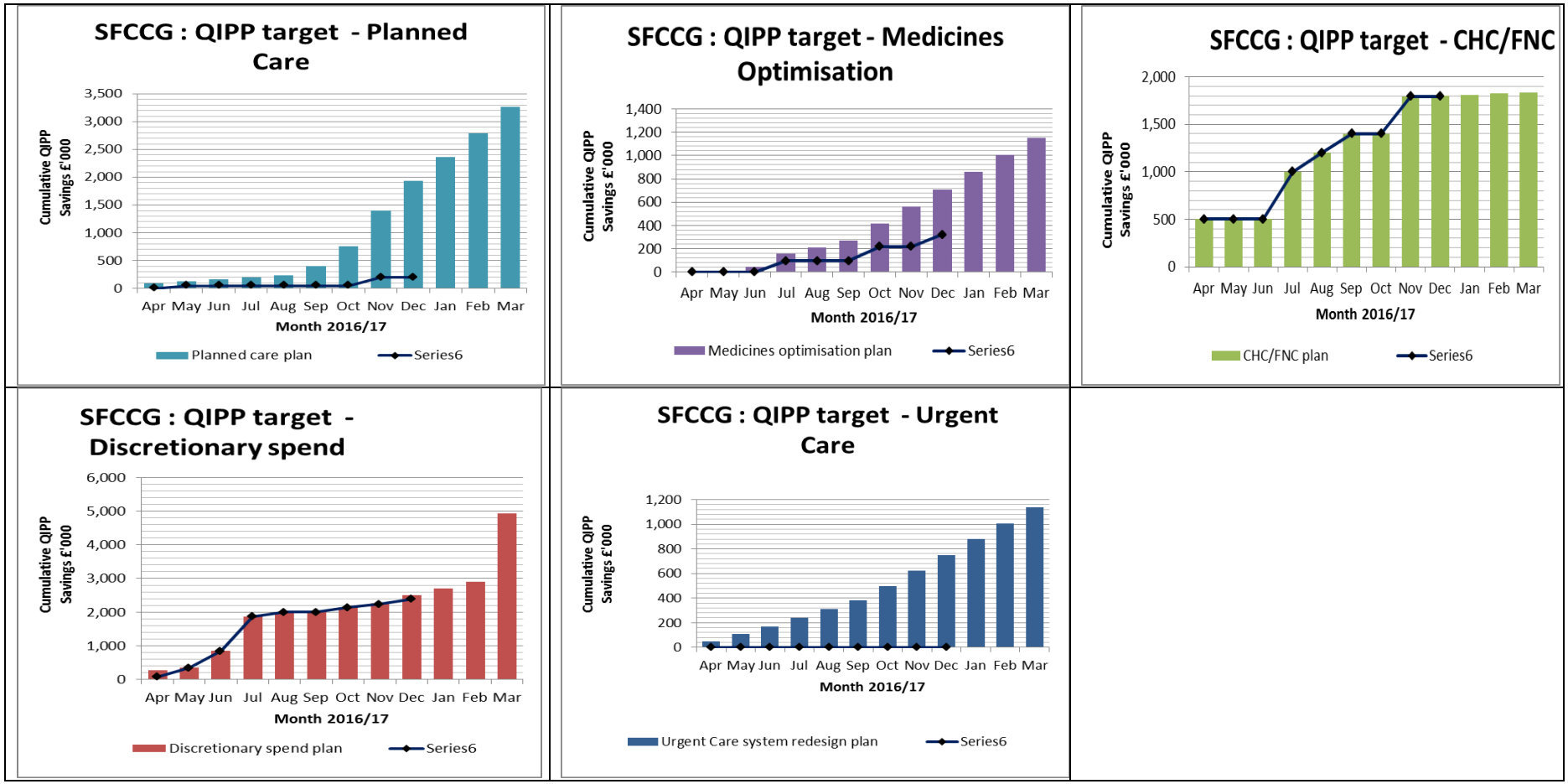
QIPP DASHBOARD SFCCG – Detail by scheme – Themes 3 & 4

Theme 3: Individual packages of care	Phasing	In month plan	In month actual	Variance		YTD Plan	YTD Actual	Variance			Annual Plan	Forecast out-turn savings	Forecast Variance	
CHC reduction -Q4 savings into 16/17	M1	0	0	0		900	900	0			900	900	0	
CHC reduction - No growth	M1-M3	0	0	0		895	895	0			895	895	0	
Outcome of CSU review work (net savings)	M7-M12	2	0	(2)		2	0	(2)			9	0	(9)	
Implementation of ADAM procurement system (net savings)	Q4	0	0	0		0	0	0			35	0	(35)	
Total		**2**	**0**	**(2)**		**1,797**	**1,795**	**(2)**			**1,839**	**1,795**	**(44)**	

Theme 4: Discretionary spend	Phasing	In month plan	In month actual	Variance		YTD Plan	YTD Actual	Variance			Annual Plan	Forecast out-turn savings	Forecast Variance	
Suspend CVS Investment	M1	0	0	0		180	180	0			180	180	0	
Contract Legacy review (Sexual Health/CHIS)	M2	0	0	0		392	392	0			392	392	0	
Review other Expenditure - 3rd Sector	Quarter 4	0	0	0		121	0	(121)			26	13	(13)	
Review other Expenditure - Remaining schemes 50% reduction	N/A	0	0	0		0	0	0			0	0	0	
Reduction in iLinks investment	M7	0	0	0		20	20	0			20	20	0	
GPIT - Reduction on IM SLA	M7	0	0	0		40	40	0			40	40	0	
Primary Care Collaborative Fees budget correction	M7	0	0	0		45	45	0			45	45	0	
1% Non-recurrent not required 17/18	Q4	0	0	0		0	0	0			1,805	0	(1,805)	
Provider CQUIN delivery 2016/17 (S&O) (20% of national)	M12	0	0	0		0	0	0			187	94	(94)	
Additional Provider CQUIN delivery 2015/16 (S&O)	M1-12	0	0	0		320	320	0			320	320	0	
Provider Sanctions - Aintree	M1-M12	0	0	0		0	0	0			2	2	0	
Provider Sanctions - S&O	M1-M4	0	0	0		0	0	0			30	15	(15)	
Blue Badge Legacy review 16/17	M1-M12	0	0	0		74	74	0			74	74	0	
LQC under-performance in 16/17	M1-M12	0	0	0		0	0	0			400	200	(200)	
Slippage in Transformation Fund / SRG Funding (In year slippage)	M7-M12	0	0	0		954	954	0			954	954	0	
Review other expenditure - Transformation Fund / SRG Funding (Recurrent reduction)	M6 - M12	0	0	0		0	0	0			0	21	21	
Prior Year adjustments	M6 - M13	243	145	(98)		243	243	0			243	243	0	
Running Cost Contingency	M1-12	0	0	0		80	80	0			80	80	0	
Move to bi monthly locality meetings	M7-12	0	0	0		25	25	0			25	25	0	
Reduction of fast transport contract	M7	0	0	0		15	11	(4)			40	40	0	
Total		**243**	**145**	**(98)**		**2,509**	**2,384**	**(121)**			**4,863**	**2,758**	**(2,106)**	

QIPP DASHBOARD SFCCG – Detail by scheme – Theme 5

Theme 5: Urgent care system redesign	Phasing	In month plan	In month actual	Variance		YTD Plan	YTD Actual	Variance			Annual Plan	Forecast out-turn savings	Forecast Variance	
Respiratory Primary Care Scheme	M1-M12	40	0	(40)		360	0	(360)			480	0	(480)	
Telehealth	M1-M12	41	0	(41)		248	0	(248)			370	0	(370)	
CQUIN - Zero LoS - S&O	M7-M12	48	0	(48)		144	0	(144)			287	144	(144)	
Total All Schemes		**129**	**0**	**(129)**		**751**	**0**	**(751)**			**1,137**	**144**	**(994)**	



NHS
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MEETING OF THE GOVERNING BODY
JANUARY 2017

Agenda Item: 17/8	**Author of the Paper:** Name Karl McCluskey Position Chief Strategy and Outcomes Officer Email: Karl.Mccluskey@southportandformbyccg.nhs.uk Tel: 0151 247 7000
Report date: January 2017	

Title: Southport and Formby Clinical Commissioning Group Integrated Performance Report

Summary/Key Issues:

This report provides summary information on the activity and quality performance of Southport and Formby Clinical Commissioning Group (note time periods of data are different for each source)

Recommendation

The Governing Body is asked to receive this report by way of assurance.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
	To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.
	To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the "Forward View", underpinned by transformation through the agreed strategic blueprints and programmes.
X	To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.
	To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
	To advance integration of in-hospital and community services in support of the CCG locality model of care.
	To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

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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

NHS
Southport and Formby
Clinical Commissioning Group

Southport & Formby Clinical Commissioning Group

Integrated Performance Report

Contents

List of Tables and Graphs

NHS
Southport and Formby
Clinical Commissioning Group

1. Executive Summary

This report provides summary information on the activity and quality performance of Southport & Formby Clinical Commissioning Group at Month 8 (note: time periods of data are different for each source).

CCG Key Performance Indicators

NHS Constitution Indicators	CCG	Main Provider
A&E 4 Hour Waits (All Types)		SORM
Ambulance Category A Calls (Red 1)		NWAS
Cancer 2 Week GP Referral		SORM
RTT 18 Week Incomplete Pathway		SORM
Other Key Targets	**CCG**	**Main Provider**
A&E 4 Hour Waits (Type 1)		SORM
Ambulance Category A Calls (Red 2)		NWAS
Ambulance Category 19 transportation		NWAS
Cancer 14 Day Breast Symptom		
Cancer 31 Day First Treatment		SORM
Cancer 31 Day Subsequent - Drug		SORM
Cancer 31 Day Subsequent - Surgery		SORM
Cancer 31 Day Subsequent - Radiotherapy		SORM
Cancer 62 Day Standard		SORM
Cancer 62 Day Screening		SORM
Cancer 62 Day Consultant Upgrade		SORM
Diagnostic Test Waiting Time		SORM
HCAI - C.Diff		SORM
HCAI - MRSA		SORM
IAPT Access - Roll Out		
IAPT - Recovery Rate		
Mixed Sex Accommodation		SORM
RTT 18 Week Incomplete Pathway		SORM
RTT 52+ week waiters		SORM
Stroke 90% time on stroke unit		SORM
Stroke who experience TIA		SORM

Key information from this report

Financial position

The forecast outturn after the application of reserves is a deficit of £7.000m against a planned deficit of £4.000m. The revised forecast incorporates known risks and has been amended following agreement with NHS England. Achievement of this position is subject to delivery of the remaining risk adjusted QIPP programme plus delivery of further efficiencies. The financial position on operational budgets as at Month 9 is an overspend of £1.499m and the forecast for the year an overspend of £2.274m. The forecast position has deteriorated by £0.055m during the month. The majority of the cost pressure relates to over performance within the acute provider contracts and the independent sector as well as the national increase in costs for Funded Nursing Care.

The value of QIPP savings delivered at the end of Month 9 is £4.694m. At this stage the CCG needs to deliver a further £4.562m in year, in order to achieve the forecast position of £7.000m deficit. It should be noted that the CCG is forecasting delivery of a total £7.791m worth of QIPP savings (risk adjusted plan) compared with £8.782m reported in the opening plan. This would equate to 89% delivery of its QIPP plan in year. The CCG is undertaking an urgent and critical review of the remaining QIPP programme areas to provide assurance that the required level of savings can be achieved in the financial year.

The CCG's commissioning team must support member practices in reviewing their commissioning arrangements to identify areas where clinical variation exists, and address accordingly. High levels of engagement and support is required from member practices to enable the CCG to reduce levels of low value healthcare and improve Value for Money

Planned Care

Local referrals for the year to date at month 8 (November) are slightly above 2015/16 levels for the same period (+2.2%). Broken down by referral source, GP referrals are 2.2% above, consultant to consultant referrals are 3.5% above and Other referrals are 8.7% above 2015/16 levels. A referral management scheme started on 1st October in Southport & Formby CCG. A consultant to consultant referral policy for Southport & Ormskirk Hospital has been approved.

The CCG has achieved the target of 93% for 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms in November with a performance of 95.31% but are failing YTD with a performance of 92.37% partly due to previous month's breaches. Year to date of 380 patients there have been 29 breaches.

The CCG achieved the 85% target for the 2 month (62 day) wait from urgent GP Referral to first definitive treatment for cancer in November with a performance of 86.49% but are failing year to date hitting 83.51%. In November 37 patients were seen 5 breaching the 62 day standard. For the same measure Southport & Ormskirk failed the target of 85% in November recording 76.67%, the previous months are still impacting on the YTD position of 82.98%. In November, 10.5 breaches occurred out of a total of 45 patients. Tumour sites not reaching the 85% standard were colorectal, gynaecology, haematology, head and neck, lung and urology. The Trust has instigated a Rapid Improvement Plan for 62 days for all tumours aiming for achievement by quarter 4.

Southport & Ormskirk Hospital NHS Trust continues to experience difficulties in relation to inpatient Friends and Family Test scores. However, the trust has seen an increase in response rates for inpatients compared to the previous month. The percentage of patients that would recommend the inpatient service in the trust has also increased compared to the previous month and is still below

the England average. The percentage of people who would not recommend the inpatient service has decreased since previous month and is the same as the England average.

Performance at Month 8 of financial year 2016/17, against planned care elements of the contracts held by NHS Southport & Formby CCG shows an over-performance of circa £275k/1%. This is predominantly caused by Renacres Hospital and Wrightington Wigan and Leigh Hospital who are showing an over performance of £319k/11% and £260k/50% respectively. Over performance can also be seen at Aintree University Hospitals who are reporting a cost variance of £191k/7%. Over spend is offset somewhat with under performance at Southport & Ormskirk Hospital which is showing an under spend of £515k/-3%.Within Elective care at Renacres, the majority of the over performance is in Trauma & Orthopaedics. In terms of HRG performance in T&O, Major Hip and Major Knee Procedures are causing the over performance. There have been 89 Major Hip & Knee Procedures carried out in 2016/17. The year to date plan is 54 patients, resulting in a combined £204k over performance in the two major Hip/Knee HRGs.

Unplanned Care

Southport & Ormskirk's performance against the 4-hour target for November reached 93.7% which achieved the STF plan of 92.1%. Year to date they are under plan and are achieving 91.77%. A clinical services plan is being put in place, redesigning all pathways taking account of previous advice from NHSE's Emergency Care Intensive Support Team. Exception comments were not received from the Trust this month.

Southport & Formby CCG failed to achieve the three ambulance indicators year to date. In line with Trusts across the region, the Trust has continued to have periods of high demand, which has resulted in delays on handovers.

Southport & Ormskirk failed the stroke target in November with only 17 out of 30 patients spending 90% of their time on the stroke unit (56.67%). Exception comments were not received from the Trust however, the October Integrated performance Report included comments that the Stroke action plan (devised during October) reviews potential to reconfigure a bay on the Unit into 4 side rooms which would minimise the impact of male/ female demand as patients could be appropriately managed in side rooms. During the month of October, there had also been a change in pathway to allow patients to go direct to Acute Stroke Unit up until 8pm in the evening from Emergency Department with the support of the Specialist Stroke Nurses. This was only agreed during October therefore the full impact of this was not seen during October's performance; however it would appear there has been some impact in November as performance has improved slightly from 53.3% to 56.7%.

One new case of Clostridium Difficile was attributed to the CCG in November, reported by Southport & Ormskirk Hospital Trust (actual 23/ plan 29). Year to date the Trust has had 14 cases (7 upheld), against a plan of 24, so is under plan.

No new cases have been reported of MRSA in November there remains 1 case of MRSA was reported in August.

There are 232 serious incidents on StEIS where Southport and Formby CCG is either responsible or lead commissioner. 86 apply to Southport & Formby CCG patients with six reported in November; four occurring from Southport and Ormskirk Hospitals NHS Trust, one for Ramsay Health Care and one Cheshire and Wirral Partnership. Southport and Ormskirk Hospitals NHS Trust have 146 open serious incidents on StEIS, 60 involving Southport and Formby CCG patients, 73 involve West Lancashire CCG patients. One hundred relate to pressure ulcers with 36 occurring year to date, 34 apply to Southport and Formby CCG patients.

Delayed Transfers of Care (DTOC's) decreased to 8 during November 2016 from 13 in October a decrease of 37.5%. Of the 8 delays the majority was for patient or family choice (5). Analysis of delays in November 2016 compared to November 2015 also illustrates a decrease in the number of patients waiting (37.5%). In terms of actions taken by the CCG to reduce the number of Delayed Transfers of Care within the system the Commissioning lead for Urgent Care participates in a weekly meeting to review all patients who are medical fit for discharge and are delayed. This is in conjunction with acute trust, community providers and Local Authority.

In A&E the percentage of people who would recommend the service has increased from 54% last month to 87% in November and is higher than the England average. The percentage not recommending has decreased from 41% to 10% in November, which is above the England average. Friends and Family is a standing agenda item at the Clinical Quality Performance Group (CQPG) meetings. A recently appointed Director of Nursing is in post and accountable for the action plan to deal with these issues. This plan seeks to address the areas of poor performance. A trust presentation of their Patient Experience Strategy and FFT update is planned for January CQPG.

Performance at Month 8 of financial year 2016/17, against unplanned care elements of the contracts held by NHS Southport & Formby CCG shows an over-performance of circa £783k/4%.This over-performance is clearly driven by Southport & Ormskirk Hospital who are reporting a £433k overspend. This is mainly due to General Medicine with activity (7%) and spend (14%) above the same period last year. The main HRGs driving the NEL over performance are Respiratory and Pneumonia related disorders. Non-Elective excess bed days have also increased against the plan and last year's levels. This is due to major spikes in performance in both April and October 2016 which again is focused primarily in General Medicine. The levels of excess bed days have been queried with the Trust.

Mental Health

The three Key Mental Health Performance Indicators of Care Programme Approach and Early Intervention in Psychosis are achieving.

In terms of Improving Access to Psychological Therapies (IAPT), the provider reported slightly fewer Southport & Formby patients entering treatment in month 8 but remains above an average for the year. The access standard (access being the number of patients entering first treatment as a proportion of the number of people per CCG estimated to have common mental health issues) is currently forecasting 11.4% against the 15% standard at year end. Referrals increased in month 8 by 22% which is the highest monthly total in 2016/17. 67% of these were self-referrals, the highest proportion of the year. Marketing work has been carried out specifically in this area, targeting specific population groups. GP referrals remained low with 42 reported in month 8 (the lowest monthly total and against a monthly average of 102 in 2015/16). Initial meetings have been agreed with Hesketh Centre, to attend weekly MDT meetings to agree appropriateness of clients for service. The percentage of people moved to recovery decreased to 50.4%. However, this remains above the minimum standard of 50%. A forecast outturn at month 8 gives a year end position of 48.4% which would fail to meet the minimum standard.

Commissioners continue to be involved in Merseycare's review of the acute care pathway (including crisis). This initial scoping and gathering of evidence and intelligence is expected to be completed by February 2017. The review will consider system wide issues that impact on the effective delivery of the acute care pathway, functions in the pathway and specialist pathways. At the December 2016 Clinical Quality and Performance Group meeting the CCG raised concerns regarding the underperformance in relation to the 'timeliness of GP Communications / Discharge

Letters, since this KPI ceased to be a CQUIN the Trust has failed to meet the targets. The Trust confirmed that there are issues particularly from the Clock View site regarding timeliness of discharge summaries due to clinical staffing capacity. The Trust has added this to their Risk Register. The roll out of the RIO clinical IT system should have a positive impact on performance. However, the Trust confirmed in December 2016 that the RIO roll out has been put on hold due to 'technical issues'. The Trust has indicated that a formal communication relating RIO implementation will be sent to CCGs January 2017.

Latest guidance from Operations and Guidance Directorate NHS England has confirmed that following a review by NHS Digital a decision has been made to change the way the dementia diagnosis rate is calculated. The new methodology is based on GP registered population instead of ONS population estimates. Using registered population figures is more statistically robust than the previous mixed approach. Latest figures following the change in methodology calculates Southport and Formby CCG's Dementia Diagnosis Rates at 72.1% for November 2016, 5.4% above the ambition of 66.7%.

Community Health Services

Since Southport & Ormskirk ICO shifted IT systems from IPM to EMIS, reporting on referrals, contacts and waiting times have been affected. The Trust has advised of issues and is continuing to work through them service by service but all services have now gone live on the new system. At the latest Information Sub Group meeting the Trust presented a waiting times report which highlighted the extent of the current data quality issues since the system switch over. The Trust will continue to provide the waiting times report monthly and highlight the services where the data quality has been corrected for the CCG to monitor. The report highlights issues in Phlebotomy and Treatment Rooms with waiting times increasing over recent weeks. The Trust continues to monitor this and update the CCG.

Primary Care

The latest Southport & Formby practice to receive CQC inspection results was The Hollies Surgery with a "good" rating.

Work is now progressing with MLCSU to produce the indicators for a Primary Care Dashboard to be released on Aristotle with a first live version available in Aristotle at the end of January 2017. There will be various "views" of the data, for CCG users to view the indicators across the CCG area with the ability to drill to locality and practice level, plus practice level views allowing authorised practice users to drill to patient level. A core set of indicators allowing benchmarking across a number of areas will be produced first (practice demographics, GP survey patient satisfaction, secondary care utilisation rates, CQC inspection status), followed by further indicators and bespoke information (e.g. GP Spec).

Better Care Fund

A Better Care Fund Plan for 2016/17 has been agreed and submitted to the national Better Care Support Team and joint work has been undertaken to further develop these plans for implementation. In the meantime a Quarter 2 performance report has been prepared for NHSE for submission on 22nd November 2016. BCF 2017/18 guidance is delayed.

2. Financial Position

2.1 Summary

This report focuses on the Month 9 financial performance for Southport and Formby CCG as at 31 December 2016.

The forecast outturn after the application of reserves is a deficit of £7.000m against a planned deficit of £4.000m. The revised forecast incorporates known risks and has been amended following agreement with NHS England. Achievement of this position is subject to delivery of the remaining risk adjusted QIPP programme plus delivery of further efficiencies.

The financial position on operational budgets as at Month 9 is an overspend of £1.499m and the forecast for the year an overspend of £2.274m. The forecast position has deteriorated by £0.055m during the month. The majority of the cost pressure relates to over performance within the acute provider contracts and the independent sector as well as the national increase in costs for Funded Nursing Care

The value of QIPP savings delivered at the end of Month 9 is £4.694m. At this stage the CCG needs to deliver a further £4.562m in year, in order to achieve the forecast position of £7.000m deficit.

It should be noted that the CCG is forecasting delivery of a total £7.791m worth of QIPP savings (risk adjusted plan) compared with £8.782m reported in the opening plan. This would equate to 89% delivery of its QIPP plan in year.

The high level CCG financial indicators are listed below:

Figure 1 – Financial Dashboard

Key Performance Indicator		This Month	Prior Month
Business Rules	1% Surplus	✗	✗
	0.5% Contingency Reserve	✓	✓
	1% Non-Recurrent Reserve	✓	✓
Surplus	Financial Surplus / (Deficit)	**(£7.000m)**	**(£7.000m)**
QIPP	QIPP delivered to date *(Red reflects that the QIPP delivery is behind plan)*	**£4.694m**	**£4.449m**
Running Costs	CCG running costs < 2016/17 allocation	✓	✓

2.2 Resource Allocation

There were no additional allocations received in Month 9.

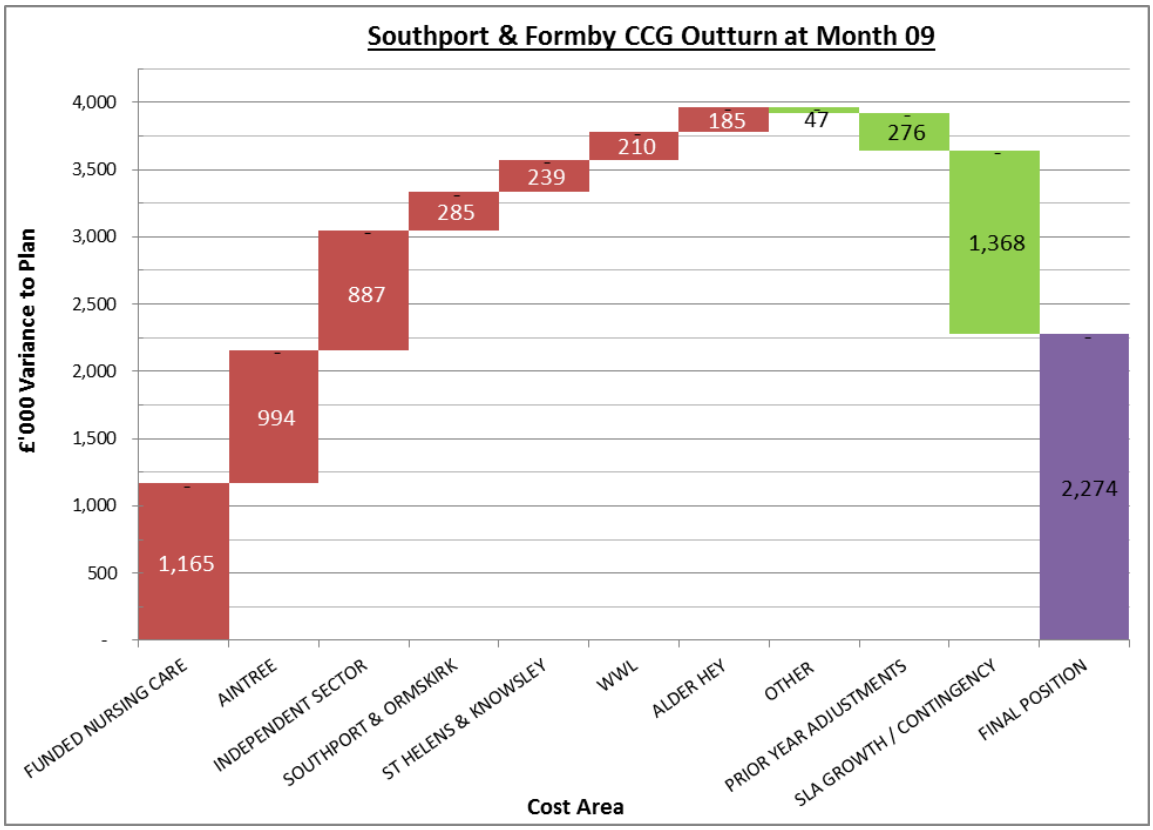
2.3 Financial Position and forecast

The main financial pressures included within the financial position are shown below in figure 2 which presents the CCGs forecast outturn position for the year.

The majority of the forecasted overspend is within acute commissioning contracts, funded nursing care, and pressure in independent sector budgets. A proportion of this overspend has been mitigated by the CCG contingency and growth reserves included in the original financial plan totalling £1.368m.

It should be noted that whilst the financial report is up to the end of December 2016, the CCG has based its reported position on the latest information received from Acute and Independent providers up to the end of November 2016 and extrapolated to December.

Figure 2 – Forecast Outturn



Prescribing

There is a year to date overspend of £0.165m with a year-end forecast of breakeven. The achievement of a breakeven position is dependent on delivery of in-year efficiencies in addition to the QIPP plan agreed. Cost reductions are being realised in the year to date expenditure and forecast, as QIPP efficiencies are achieved, the associated budget will be transferred to the QIPP plan.

Continuing Health Care and Funded Nursing Care

The month 9 position for the continuing care and Funded Nursing Care budget is a £0.594m overspend, this position reflects the current number of patients, average package costs and the uplift to providers of 1.1% until the end of the financial year. The full year forecast has been calculated at £0.986m, which includes the £1.205m Funded Nursing Care cost pressure due to price increases.

The position also incorporates the increased cost relating to the Continuing Health Care price increase agreed by the Governing Body in October. This is predicted to be a maximum of £0.125m for 2016/17.

Additional QIPP savings of £0.395m were identified in Month 8 due to introduction of the national spine to the Broadcare system, this integration identified a number of packages included in forecast costs which could be closed. Total year to date QIPP savings of £1.795m have now been actioned.

2.4 QIPP and Transformation Fund

The 2016/17 identified QIPP plan is £12.256m in total, the target has increased by £0.055m during the month due to the improved forecast outturn.

Figure 3 shows a summary of the current risk rated QIPP plan. This demonstrates that although recurrently there are a significant number of schemes in place, further work is required to move red and amber rated schemes to green rated schemes. The plan has been phased across the year on a scheme by scheme basis and full detail of progress at scheme level is monitored at the QIPP committee.

Figure 3 – RAG rated QIPP plan

2016/17 QIPP Plan	Rec	Non Rec	Total	Green	Amber	Red	Total
Planned care plan	(2,945)	(318)	(3,263)	(1,696)	(578)	(990)	(3,263)
Medicines optimisation plan	(1,153)	0	(1,153)	(1,110)	0	(43)	(1,153)
CHC/FNC plan	(1,439)	(400)	(1,839)	(1,795)	(44)	0	(1,839)
Discretionary spend plan	(711)	(4,152)	(4,863)	(2,413)	(645)	(1,805)	(4,863)
Urgent Care system redesign plan	(1,137)	0	(1,137)	0	(287)	(850)	(1,137)
Total QIPP Plan	**(7,386)**	**(4,870)**	**(12,256)**	**(7,014)**	**(1,554)**	**(3,688)**	**(12,256)**
Risk rated QIPP plan				**(7,014)**	**(777)**	**0**	**(7,791)**

As shown in Figure 4 and 5 below, below, £4.694m QIPP savings have already been actioned at Month 9 against a phased plan of £7.610m.

Figure 4 – Phased QIPP plan for the 2016/17 year

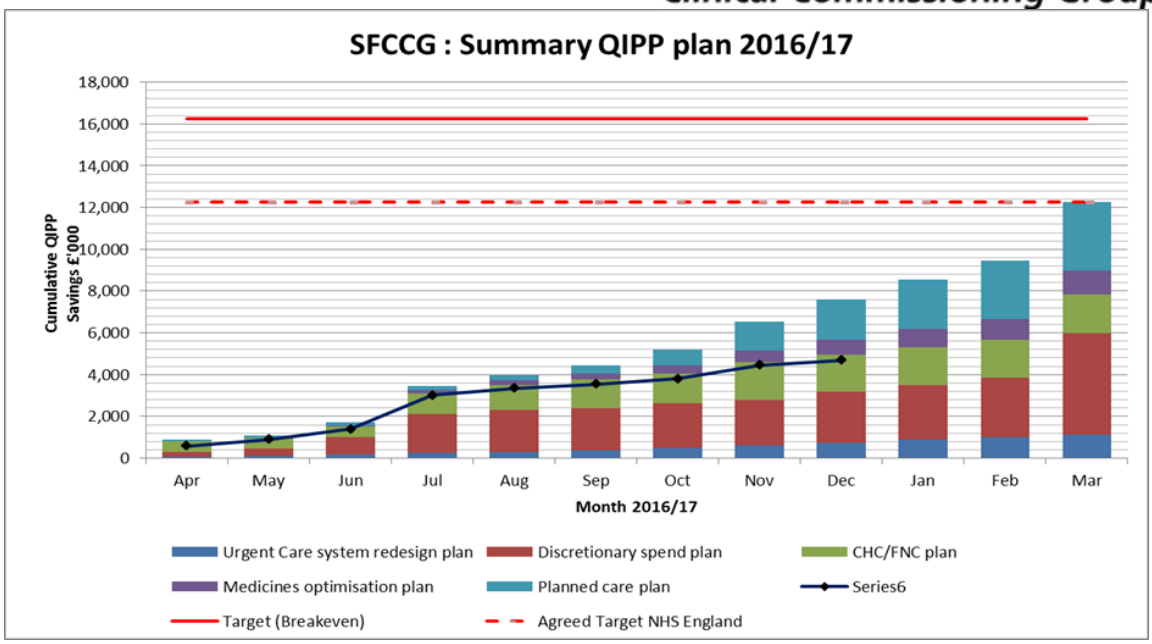


Figure 5 – QIPP performance at month 9

Scheme	Current month (M9)								
	In month plan	In month actual	Variance		YTD Plan	YTD Actual	Variance		
Planned care plan	535	0	(535)		1,938	194	(1,744)		
Medicines optimisation plan	147	100	(47)		711	321	(390)		
CHC/FNC Plan	2	0	(2)		1,797	1,795	(2)		
Discretionary spend plan	243	145	(98)		2,414	2,384	(26)		
Urgent Care system redesign	129	0	(129)		751	0	(751)		
Total	**1,056**	**245**	**(811)**		**7,610**	**4,694**	**(2,912)**		

QIPP delivery is £2.912m below plan at Month 9. There is a significant risk of delivery on the remaining plan with a high proportion of schemes rated red or amber and an increased target over the later months in the financial year.

Delivery of the agreed year end deficit of £7.000m requires a saving of £4.562m in the remaining three months of the financial year. An urgent and critical review of outstanding QIPP schemes is in progress and will be closely monitored. The CCG and scheme leads in particular must work to provide further assurance regarding the delivery of schemes.

2.5 CCG Running Costs

The running cost allocation for the CCG is £2.618m and the CCG must not exceed this allocation in the financial year.

The current year outturn position for the running cost budget is an underspend of £0.197m of which, the majority relates to prior year adjustments. There is a small contingency budget within running costs which has been actioned in year as part of the QIPP plan.

2.6 CCG Cash Position

In order to control cash expenditure within the NHS, limits are placed on the level of cash an organisation can utilise in each financial year.

The Maximum Cash Drawdown (MCD) is the maximum amount of cash available to a CCG each financial year and is made up of:

- Total Agreed Allocation,
- Opening Cash Balance (i.e. at 01 April 2016),
- Opening creditor balances less closing creditor balances.

Cash is held centrally at NHS England and is allocated monthly to CCGs following notification of cash requirements.

As well as managing the financial position, organisations must manage their cash position. The monthly cash requested should cover expenditure commitments as they fall due and the annual cash requested should not exceed the maximum cash drawdown limit.

The CCG is required to take part in a MCD submission to NHS England at month 6 and month 9 to incorporate any changes in the CCGs forecast cash position to ensure sufficient cash is available throughout the financial year.

Month 9 position

Following the month 6 submission, the MCD limit for Southport & Formby CCG for 2016/17 was increased from £185.119m to £192.109m. Up to Month 9, the actual cash received is £140.660m (73.2% of MCD) against a target of £144.081m (75.0% of MCD).

A full year cash flow forecast, based on information available at month 9. This shows the CCG will have sufficient cash to meet its liabilities as they fall due. At month 12, the CCG is required to meet a cash target of 1.75% of its monthly cash drawdown which is approximately £0.240m. This is excess cash above the threshold which will need to be returned to NHS England.

2.7 Evaluation of risks and opportunities

The primary financial risks for the CCG continue to be non-delivery of the QIPP target in the year and increased performance within acute care.

QIPP

QIPP delivery is below plan in Month 9 and savings of £4.562m are required to deliver the agreed financial position. There are still a significant number of QIPP programmes that are currently rated as ‘Red’ or ‘Amber’ and work is underway to provide the required levels of assurance to change these schemes to ‘Green’. In addition, a critical review of schemes rated ‘Green’ is required to ensure delivery is on target. Failure to do this will mean the CCG will not achieve the forecast deficit.

Overall management of the QIPP programme is being monitored by the QIPP committee.

Acute Contracts

The CCG has experienced significant growth in acute care year on year and if this continues the CCG will not achieve against the financial plan. The year to date performance is particularly high and further actions are required to mitigate further over performance and maintain the financial recovery trajectory for the financial year.

All members of the CCG have a role to play in managing this risk including GPs and other Health professionals to ensure individuals are treated in the most clinically appropriate and cost effective way, and the acute providers are charging correctly for the clinical activity that is undertaken.

Actions to mitigate the risk of further over performance are being implemented and include:

- Implementation of contract challenges for data validation and application of penalties for performance breaches.
- Scrutiny and challenge of all activity over performance and other areas of contested activity.
- Implementation of a robust referral management process, which will ensure adherence to the CCGs existing policies for procedures of limited clinical value.

Other risks that require ongoing monitoring and managing include:

- Prescribing - This is a volatile area of spend but represents one of the biggest opportunities for the CCG, and as such this makes up one of the biggest QIPP programmes for 2016/17. The monthly expenditure and forecast is monitored closely as QIPP schemes continue to be delivered.

2.8 Reserves budgets / Risk adjusted surplus

Reserve budgets are set aside as part of the Budget Setting exercise to reflect planned investments, known risks and an element for contingency. Each month, the reserves and risks are analysed against the forecast financial performance and QIPP delivery.

The assessment of the financial position is set out in figure 6. This demonstrates that the CCG needs to deliver a total management action plan of £9.053m in 2016/17 in order to achieve the revised forecast deficit of £7.000m.

Figure 6 – Forecast Outturn Position

NHS
Southport and Formby
Clinical Commissioning Group

	Recurrent £000	Non-Recurrent £000	Total £000
Planned Deficit	0.000	(4.000)	(4.000)
QIPP Target	(10.841)	0.859	(9.982)
Revised surplus / (deficit)	(10.841)	(3.141)	(13.982)
Forecast Outturn (against operational budgets)	0.236	(1.305)	(1.069)
FNC Cost Pressure	(1.205)	0.000	(1.205)
Reserve Budgets	(1.163)	1.366	0.203
Management action plan			
Actioned QIPP to date	2.860	1.834	4.694
Deliver on remaining QIPP plan	4.526	2.833	7.359
Total Management Action plan required	7.386	4.667	12.053
Revision to planned deficit	0.000	(3.000)	(3.000)
Forecast Surplus / (deficit)	(5.587)	(1.413)	(7.000)

Figure 7 outlines the Best, Most likely and Worst Case scenarios. The best case scenario assumes achievement of the remaining risk adjusted QIPP plan, plus mitigations of £1.000m and additional QIPP delivery of £0.465m. The most likely case assumes the additional QIPP of £0.465m is not achieved but at this stage, also assumes that the remaining risk adjusted QIPP plan will be achieved.

The worst case assumes only QIPP schemes rated Green in the current plan will be delivered for the remainder of the financial year and that the Acute Care position deteriorates over the remaining months of the year.

Figure 7 – Risk Rated Financial Position

Southport and Formby	Best Case £m	Most Likely £m	Worst Case £m
Management Action Plan required (to deliver planned deficit)	**(12.256)**	**(12.256)**	**(12.256)**
QIPP achieved to date	4.694	4.694	4.694
Remaining QIPP requirement	**(7.562)**	**(7.562)**	**(7.562)**
Predicted QIPP achievement (M10-12)	3.097	3.097	2.320
Planned Deficit	(4.000)	(4.000)	(4.000)
Forecast Surplus / (Deficit)	**(8.465)**	**(8.465)**	**(9.242)**
Further Risk - Acute Care			(0.500)
Management Action Plan			
Mitigation	1.000	1.000	-
Further QIPP delivery	0.465	-	-
Risk adjusted Surplus / (Deficit)	**(7.000)**	**(7.465)**	**(9.742)**

2.9 Recommendations

The Finance and Resource Committee is asked to receive the finance update, noting that:

- The CCG is currently forecasting a deficit of £7.000m against a planned deficit of £4.000m as its best case scenario. The likely case scenario indicates that the CCGs projected deficit will be £7.465m but this is dependent on delivery of the remaining risk adjusted QIPP plan and further mitigation.
- Despite remaining on target to deliver 89% of the original plan, additional pressures have emerged during the year, which require further QIPP savings for mitigation.
- Delivery of the agreed deficit of £7.000m requires further QIPP savings of £4.562m.
- The CCG is undertaking an urgent and critical review of the remaining QIPP programme areas to provide assurance that the required level of savings can be achieved in the financial year.
- The CCG's commissioning team must support member practices in reviewing their commissioning arrangements to identify areas where clinical variation exists, and address accordingly. High levels of engagement and support is required from member practices to enable the CCG to reduce levels of low value healthcare and improve Value for Money.

3. Planned Care

3.1 Referrals by Source

Figure 8 – Referrals by Source across all providers for 2015/16 & 2016/17

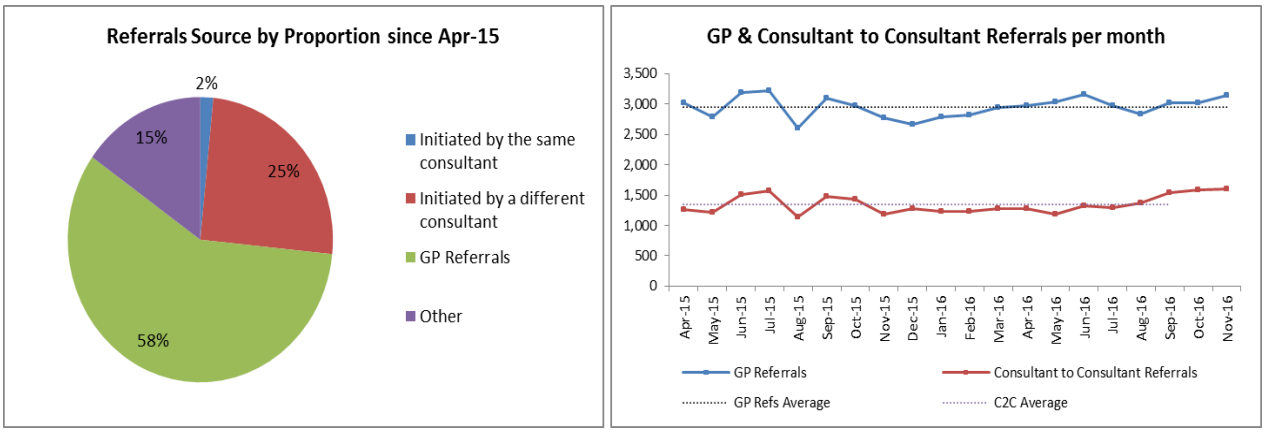


Figure 9 - GP and 'other' referrals for the CCG across all providers for 2015/16 & 2016/17

NHS
Southport and Formby
Clinical Commissioning Group

Referral Type	DD Code	Description	1516 YTD	1617 YTD	Variance	% Variance
GP	03	GP Ref	23,635	24,159	524	2.2%
GP Total			23,635	24,159	524	2.2%
Other	01	following an emergency admission	70	54	-16	-22.9%
	02	following a Domiciliary Consultation	27	5	-22	-81.5%
	04	An Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)	2,239	2,112	-127	-5.7%
	05	A CONSULTANT, other than in an Accident and Emergency Department	7,964	8,382	418	5.2%
	06	self-referral	1,172	1,131	-41	-3.5%
	07	A Prosthetist	5	3	-2	-40.0%
	08	Royal Liverpool Code (TBC)	268	316		0.0%
	10	following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)	132	180	48	36.4%
	11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	371	447	76	20.5%
	12	A General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)	6	8	2	33.3%
	13	A Specialist NURSE (Secondary Care)	45	33	-12	-26.7%
	14	An Allied Health Professional	1,199	1,171	-28	-2.3%
	15	An OPTOMETRIST	676	729	53	7.8%
	16	An Orthoptist	70	30	-40	-57.1%
	17	A National Screening Programme	459	500	41	8.9%
	92	A GENERAL DENTAL PRACTITIONER	233	311	78	33.5%
	93	A Community Dental Service	5	0	-5	-100.0%
	97	other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	1,661	2,071	410	24.7%
Other Total			16,602	17,483	881	5.3%
Unknow n			9	12	3	33.3%
Grand Total			**40,246**	**41,654**	**1,408**	**3.5%**

A referral management scheme started on 1st October in Southport & Formby CCG which is currently in Phase I (administrative phase). A consultant to consultant referral policy for Southport & Ormskirk Hospital has been approved.

Data quality note: Walton Neuro Centre & Renacres Hospitals have been excluded from the above analysis due to data quality issues. For info, Walton is recording approx. 80 referrals per month in 2016/17 and Renacres approx. 350 refs per month.

3.2 Diagnostic Test Waiting Times

Diagnostic test waiting times				
% of patients waiting 6 weeks or more for a Diagnostic Test **(CCG)**	16/17 - Nov	<1%	0.77%	↑
% of patients waiting 6 weeks or more for a Diagnostic Test **(Southport & Ormskirk)**	16/17 - Nov	<1%	0.58%	↑

3.3 Referral to Treatment Performance

Referral To Treatment waiting times for non-urgent consultant-led treatment				
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(CCG)**	16/17 - Nov	0	0	↔
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(Southport & Ormskirk)**	16/17 - Nov	0	0	↔
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(CCG)**	16/17 - Nov	92%	92.22%	↔
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(Southport & Ormskirk)**	16/17 - Nov	92%	92.71%	↔

3.3.1 Incomplete Pathway Waiting Times

Figure 10 - Southport & Formby CCG Patients waiting on an incomplete pathway by weeks waiting

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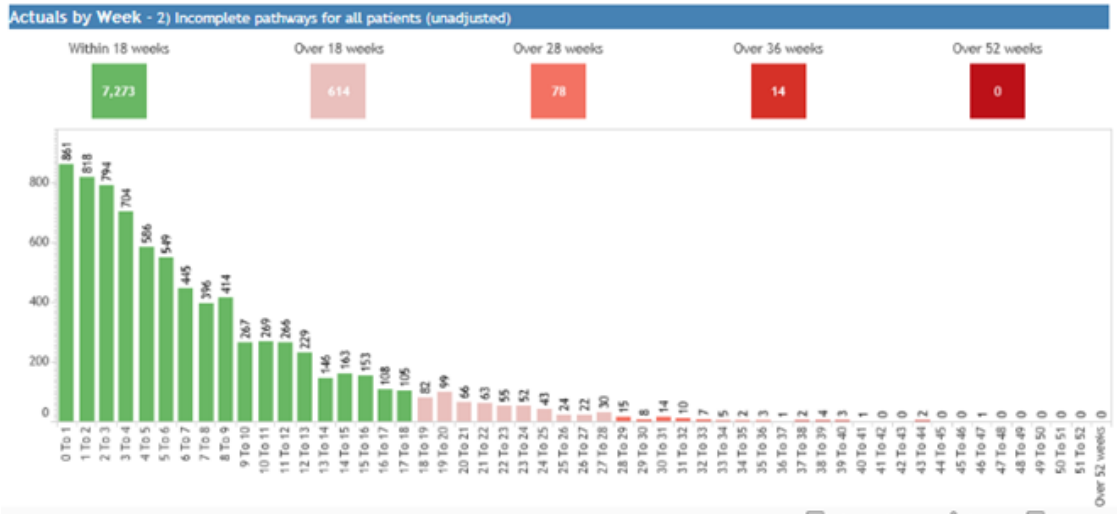
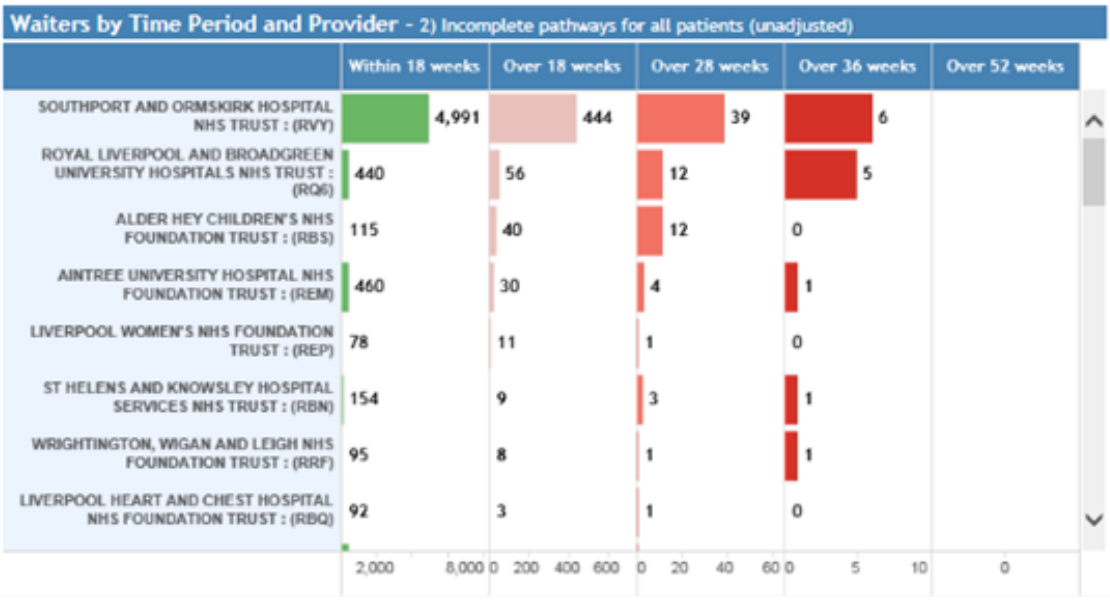
Clinical Commissioning Group



3.3.2 Long Waiters analysis: Top 5 Providers

Figure 11 - Patients waiting (in bands) on incomplete pathway for the top 5 Providers



3.3.3 Long waiters analysis: Top 2 Providers split by Specialty

Figure 12 - Patients waiting (in bands) on incomplete pathway for Southport & Ormskirk Hospital NHS Trust

NHS
Southport and Formby
Clinical Commissioning Group

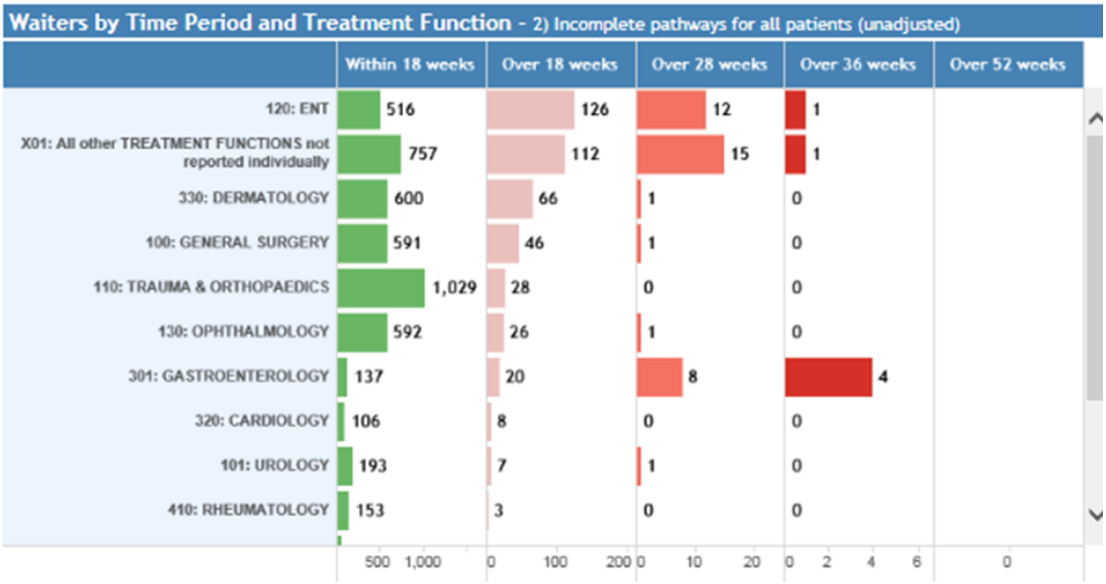
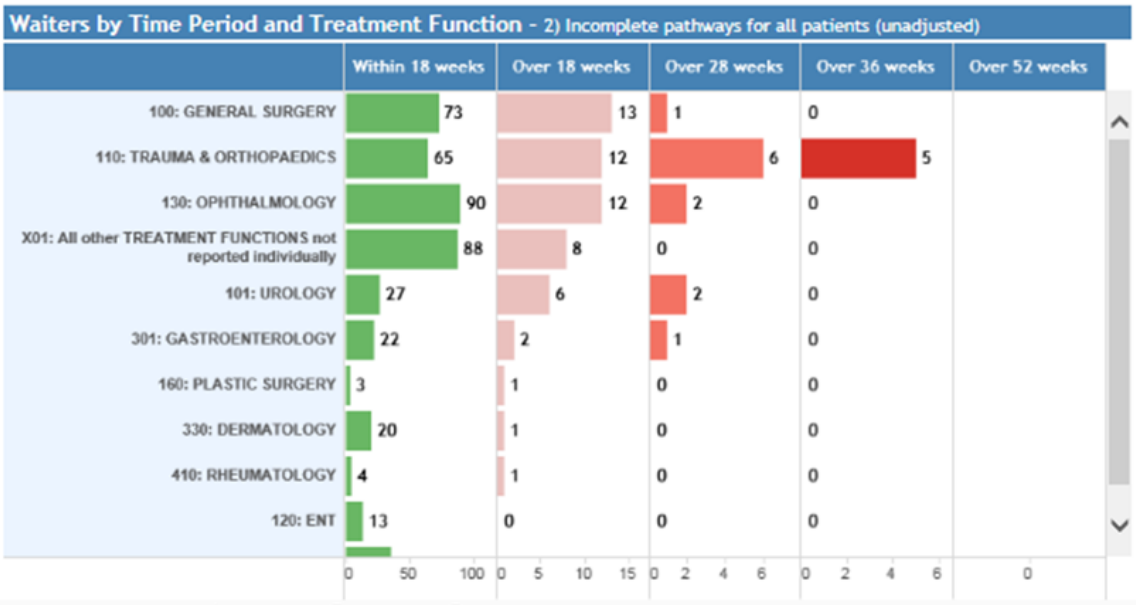


Figure 13 - Patients waiting (in bands) on incomplete pathway for Royal Liverpool and Broadgreen University Hospitals NHS Trust



3.3.4 Provider assurance for long waiters

CCG	Trust	Speciality	No of weeks waited	No of patients	Has patient been seen / has a TCI date?	Reason for the delay
Southport & Formby	ROYAL LIVERPOOL	T&O	40	1	Trust only provides updates for 42 plus week waiters	
Southport & Formby	ROYAL LIVERPOOL	T&O	43	1	TCI Date 10/01/2017	Capacity
Southport & Formby	ROYAL LIVERPOOL	T&O	46	1	Awaiting update from Directorate	
Southport & Formby	ST HELENS AND KNOWSLEY	Plastic Surgery	43	1	Awaiting update from Trust	

3.4 Cancelled Operations

3.4.1 All patients who have cancelled operations on or day after the day of admission for non-clinical reasons to be offered another binding date within 28 days

Cancelled Operations				
All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice - **Southport & Ormskirk**	16/17 - Nov	0	0	↔

3.4.2 No urgent operation to be cancelled for a 2nd time

Cancelled Operations				
No urgent operation should be cancelled for a second time - **Southport & Ormskirk**	16/17 - Nov	0	0	↔

3.5 Cancer Indicators Performance

3.5.1- Two Week Waiting Time Performance

Cancer waits – 2 week wait				
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(CCG)**	16/17 - Nov	93%	94.35%	↔
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Southport & Ormskirk)**	16/17 - Nov	93%	95.12%	↔
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(CCG)**	16/17 - Nov	93%	92.37%	↑
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(Southport & Ormskirk)**	16/17 - Nov	93%	N/A	↔

The CCG has achieved the target of 93% for 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms in November with a performance of 95.31% but are failing YTD with a performance of 92.37% partly due to previous month's breaches. Year to date out of 380 patients there have been 29 breaches.

3.5.2 - 31 Day Cancer Waiting Time Performance

Cancer waits – 31 days				
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(CCG)**	16/17 - Nov	96%	97.47%	↔
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Southport & Ormskirk)**	16/17 - Nov	96%	98.27%	↔
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	16/17 - Nov	94%	97.20%	↔
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Southport & Ormskirk)**	16/17 - Nov	94%	0 Patients	↔
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	16/17 - Nov	94%	100.00%	↔
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Southport & Ormskirk)**	16/17 - Nov	94%	96.88%	↔
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	16/17 - Nov	98%	99.37%	↔
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(Southport & Ormskirk)**	16/17 - Nov	98%	100.00%	↔

3.5.3 - 62 Day Cancer Waiting Time Performance

Cancer waits – 62 days				
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set (Cumulative) **(CCG)**	16/17 - Nov	85%	85.19%	↔
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set (Cumulative) **(Southport & Ormskirk)**	16/17 - Nov	85% (local target)	88.38%	↓
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(CCG)**	16/17 - Nov	90%	92.31%	↔
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(Southport & Ormskirk)**	16/17 - Nov	90%	95.00%	↔
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(CCG)**	16/17 - Nov	85%	83.51%	↔
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(Southport & Ormskirk)**	16/17 - Nov	85%	82.98%	↓

The CCG achieved the 85% target for the 2 month (62 day) wait from urgent GP Referral to first definitive treatment for cancer in November with a performance of 86.49% but are failing year to date hitting 83.51%. In November 37 patients were seen 5 breaching the 62 day standard.

For the same measure Southport & Ormskirk failed the target of 85% in November recording 76.67%, the previous months are still impacting on the YTD position of 82.98%. In November, 10.5 breaches occurred out of a total of 45 patients. Tumour sites not reaching the 85% standard were colorectal, gynaecology, haematology, head & neck, lung and urology. The Trust has instigated a Rapid Improvement Plan for 62 days for all tumours aiming for achievement by quarter 4.

3.6 Patient Experience of Planned Care

NHS
Southport and Formby
Clinical Commissioning Group

Friends and Family Response Rates and Scores
Southport & Ormskirk Hospitals NHS Trust
Latest Month: **Nov-16**

Clinical Area	Response Rate (RR) Target	RR Actual	RR Trend Line	% Recommended (Eng. Average)	% Recommended	PR Trend Line	% Not Recommended (Eng. Average)	% Not Recommended	PNR Trend Line
Inpatient	25%	17.9%		96%	95%		2%	2%	
Q1 - Antenatal Care	N/A	-		96%	57%		1%	14%	
Q2 - Birth	23.3%	31.8%		97%	91%		1%	4%	
Q3 - Postnatal Ward	N/A	-		94%	87%		2%	4%	
Q4 - Postnatal Community	N/A	-		97%	100%		1%	0%	

The Friends and Family Test (FFT) Indicator comprises of three parts:

- % Response rate
- % Recommended
- % Not Recommended

Southport & Ormskirk Hospital NHS Trust continues to experience difficulties in relation to the above. But the trust has seen an increase in response rates for inpatients compared to the previous month. The percentage of patients that would recommend the inpatient service in the trust has also increased compared to the previous month however this is still below the England average. The percentage of people who would not recommend the inpatient service has decreased since previous month and is the same as the England average.

The Engagement and Patient Experience Group (EPEG) have sight of the trusts friends and family data on a quarterly basis and seek assurance from the trust that areas of poor patient experience are being addressed. The Trust will present their Patient and Carer Experience Strategy and FFT update at the January CQPG and have been invited to the CCG EPEG meeting in February for the same.

The CCG Experience and Patient Engagement Group are currently creating a dashboard to incorporate information available from FFTs, complaints and compliments.

At the December EPEG meeting, it was noted that the Trust had shown reluctance engaging with Healthwatch recently when the organisation attempted to arrange an announced visit. The Trust will be encouraged to improve with this.

3.7 Planned Care Activity & Finance, All Providers

Performance at Month 8 of financial year 2016/17, against planned care elements of the contracts held by NHS Southport & Formby CCG shows an over-performance of circa £275k/1%. This is predominantly caused by Renacres Hospital and Wrightington Wigan and Leigh Hospital who are showing an over performance of £319k/11% and £260k/50% respectively. Combined over performance at the two Trusts equals £579k. Over performance can also be seen at Aintree University Hospitals who are reporting a cost variance of £191k/7%. Over spend is offset with under performance at Southport & Ormskirk Hospital which is showing an under spend of £515k/-3%.

Figure 14 - Planned Care - All Providers

ALL Providers	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	12,031	13,288	1,257	10%	£2,732	£2,923	£191	7%
Alder Hey Childrens NHS F/T *	678	772	94	14%	£357	£433	£76	21%
Central Manchester University Hospitals Nhs Foundation Trust	157	236	79	50%	£30	£87	£57	194%
Fairfield Hospital	53	94	41	77%	£8	£20	£12	146%
ISIGHT (SOUTHPORT)	2,590	2,481	-109	-4%	£593	£465	-£129	-22%
Liverpool Heart and Chest NHS F/T	1,458	1,594	136	9%	£672	£654	-£19	-3%
Liverpool Womens Hospital NHS F/T	1,636	1,729	93	6%	£470	£477	£7	1%
Renacres Hospital	8,998	10,545	1,547	17%	£2,835	£3,154	£319	11%
Royal Liverpool & Broadgreen Hospitals	10,625	10,750	125	1%	£2,312	£2,230	-£82	-4%
Southport & Ormskirk Hospital*	77,592	75,751	-1,841	-2%	£16,005	£15,490	-£515	-3%
SPIRE LIVERPOOL HOSPITAL	427	273	-154	-36%	£149	£88	-£61	-41%
ST Helens & Knowsley Hospitals	3,147	3,453	306	10%	£742	£859	£117	16%
University Hospital Of South Manchester Nhs Foundation Trust	135	160	25	19%	£24	£32	£8	31%
Walton Neuro	1,470	1,736	266	18%	£326	£372	£46	14%
Wirral University Hospital NHS F/T	210	186	-24	-11%	£69	£57	-£12	-17%
Wrightington, Wigan And Leigh Nhs Foundation Trust	1,442	2,197	755	52%	£517	£777	£260	50%
Grand Total	**122,648**	**125,245**	**2,597**	**2%**	**£27,843**	**£28,118**	**£275**	**1%**

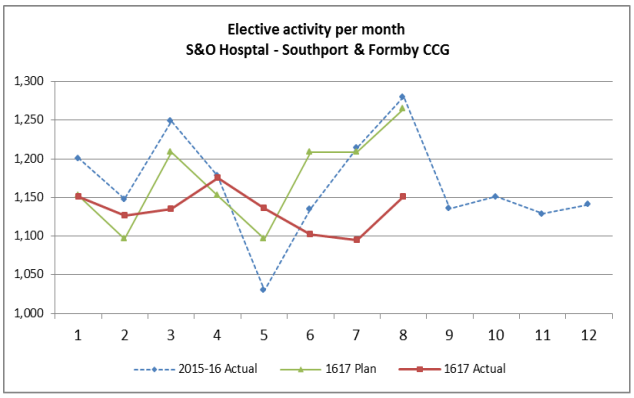
*PbR only

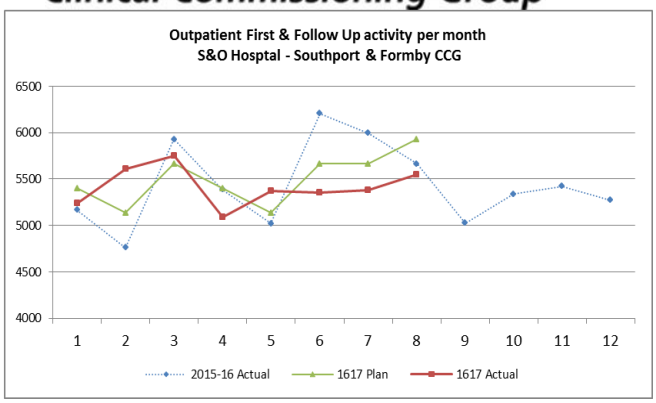
3.7.1 Planned Care Southport and Ormskirk NHS Trust

Figure 15 - Planned Care – Southport and Ormskirk NHS Trust by POD

S&O Hospital Planned Care*	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	8,277	7,953	-324	-4%	£4,629	£4,315	-£314	-7%
Elective	1,113	1,119	6	1%	£2,907	£2,995	£88	3%
Elective Excess BedDays	186	289	103	55%	£41	£65	£24	58%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	992	627	-365	-37%	£148	£103	-£45	-31%
OPFASPCL - *Outpatient first attendance single professional consultant led*	10,581	10,504	-77	-1%	£1,649	£1,617	-£32	-2%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	2,443	1,660	-783	-32%	£252	£187	-£65	-26%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	29,978	30,558	580	2%	£2,839	£2,858	£19	1%
Outpatient Procedure	16,306	16,372	66	0%	£2,893	£2,797	-£95	-3%
Unbundled Diagnostics	7,716	6,669	-1,047	-14%	£647	£553	-£95	-15%
Grand Total	**77,592**	**75,751**	**-1,841**	**-2%**	**£16,005**	**£15,490**	**-£515**	**-3%**

*PbR only





3.7.2 Southport & Ormskirk Hospital Key Issues

Planned Care at Southport & Ormskirk Hospital is reporting a year to date under performance of -£515k, which equates to a -3% variance. Under-Performance, in financial terms of the contract, is driven by Daycases which is showing a -£314k/-7% variance. Outpatient Procedures are showing a -£95k/-15 variance.

The Trust struggled all year with planned care elements of the contract citing the lack of theatre staff as one reason for the under-performance.

Elective procedures have picked up in the last two months with November now showing a slight over performance in both activity and cost. The main specialities influencing this shift are General Surgery and Trauma. Pain Management has seen a spike in activity which is not in line with the past 18 month's performance, this has been queried with the Trust in the last Information Sub Group and will form part of the month 8 challenges.

Outpatient activity has dropped in the past few months against plan with a number of specialties affecting the performance. First attendances have seen a drop in activity against General Surgery, ENT and Gynaecology while follow-up activity has dropped mainly in T&O, ENT, Ophthalmology and General Medicine.

3.7.3 Renacres Hospital

Figure 16 - Planned Care - Renacres Hospital by POD

Renacres Hospital Planned Care PODS	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	1,173	1,182	9	1%	£1,198	£1,263	£64	5%
Elective	166	219	53	32%	£743	£947	£204	27%
OPFASPCL - *Outpatient first attendance single professional consultant led*	2,630	2,224	-406	-15%	£387	£330	-£56	-15%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	2,593	4,932	2,339	90%	£223	£313	£90	41%
Outpatient Procedure	1,603	995	-608	-38%	£207	£193	-£14	-7%
Unbundled Diagnostics	831	993	162	19%	£77	£107	£30	39%
Grand Total	**8,998**	**10,545**	**1,547**	**17%**	**£2,835**	**£3,154**	**£319**	**11%**

Renacres over performance of £319k/11% is largely driven by a £204k over performance in Elective Care, which has been a constant theme in 2016/17. Daycase and Electives are over performing by £64k and £204k respectively.

In terms of HRG performance in T&O, Major Hip and Major Knee Procedures are causing the over performance. There have been 89 Major Hip & Knee Procedures carried out in 2016/17. The year to date plan is 54 patients, resulting in a combined £204k over performance in the two major Hip/Knee HRGs.

4. Unplanned Care

4.1 Accident & Emergency Performance

A&E waits					
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG) All Types**	16/17 - Nov	95.00%	90.77%	↔	Southport & Formby CCG failed the 95% target in November reaching 93.16% (year to date 90.77%). In November, 251 attendances out of 3669 were not admitted, transferred or discharged within 4 hours.
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG) Type 1**	16/17 - Nov	95.00%	84.07%	↑	Southport & Formby CCG failed the 95% target in November reaching 87.80% (year to date 84.07%). In November 250 attendances out of 2049 were not admitted, transferred or discharged within 4 hours.
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Southport & Ormskirk) All Types**	16/17 - Nov	STF Trajectory Target for Nov 92.1%	91.77%	↑	Southport & Ormskirk have achieved the STF trajectory target in November reaching 93.7% (but are failing it year to date recording 91.77%). In November 689 attendances out of 10991 were not admitted, transferred or discharged within 4 hours.
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Southport & Ormskirk) Type 1**	16/17 - Nov	95.00%	84.27%	↑	Southport & Ormskirk have failed the target in November reaching 88.89% (year to date 84.27%). In November, 685 attendances out of 6163 were not admitted, transferred or discharged within 4 hours.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
STP Trajectory S&O	87.50%	88.30%	88.80%	90%	90%	90.70%	91.40%	92.10%
S&O Actual	88.6%	89.8%	90.92%	88.0%	93.84%	91.49%	92.11%	93.73%

The CCG has updated the targets that are within STF accordingly. A clinical services plan is being put in place, redesigning all pathways taking account of previous advice from NHSE's Emergency Care Intensive Support Team.

Exception comments were not received from the Trust this month.

4.2 Ambulance Service Performance

Category A ambulance calls					
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	16/17 - Nov	75%	71.19%	↔	The CCG is under the 75% target year to date achieving 71.19%. In November out of 34 incidents there were 11 breaches (67.65%).
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	16/17 - Nov	75%	62.51%	↔	The CCG was under the 75% target year to date reaching 62.51%. In November out of 613 incidents there were 233 breaches (62.05%).
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	16/17 - Nov	95%	84.93%	↓	The CCG was under the 95% target year to date reaching 84.93%. In November out of 647 incidents there were 111 breaches (82.81%).
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	16/17 - Nov	75%	70.35%	↓	NWAS reported under the 75% target year to date reaching 70.35%. November reaching 62.80%.
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	16/17 - Nov	75%	64.07%	↔	NWAS failed to achieve the 75% target year to date reaching 64.07%. November reaching 60.35%.
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	16/17 - Nov	95%	89.95%	↓	NWAS failed to achieve the 95% target year to date reaching 89.95%. November reaching 86.79%.

Handover Times					
All handovers between ambulance and A & E must take place within 15 minutes (between 30 - 60 minute breaches) - **Southport & Ormskirk**	16/17 - Nov	0	77	↓	The Trust recorded 77 handovers between 30 and 60 minutes, this is an improvement on last month when 114 was reported.
All handovers between ambulance and A & E must take place within 15 minutes (>60 minute breaches) - **Southport & Ormskirk**	16/17 - Nov	0	57	↓	The Trust recorded 57 handovers over 60 minutes, this is also an improvement on last month when 60 was reported.

Southport & Formby CCG failed to achieve all 3 indicators year to date, (see above of number of incidents/breaches).

At both a regional and county level, NWAS failed to achieve any of the response time targets. Activity levels continue to be significantly higher than was planned for and this (together with the ongoing issues regarding turnaround times) continues to be reflected in the performance against the response time targets.

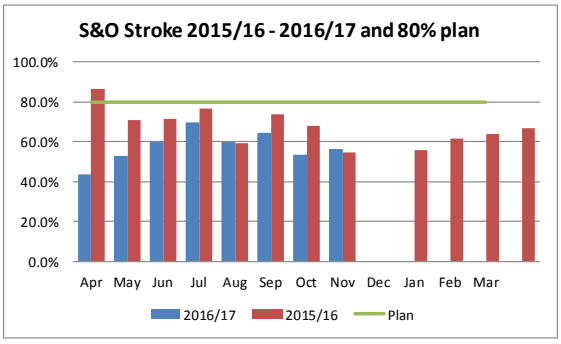
The Trust has signed up to the ambulance concordat across Cheshire and Mersey to deliver sustained improvement in handover performance across organisations.

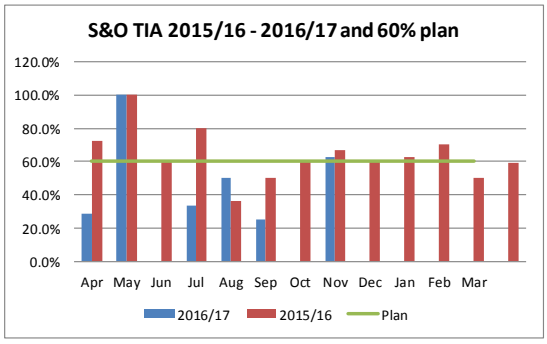
In line with Trusts across the region, the Trust has continued to have periods of high demand which has resulted in some delays on handovers. Across the month there was just under a 1% increase in ambulance arrivals brought to the Southport site.

4.3 Unplanned Care Quality Indicators

4.3.1 Stroke and TIA Performance

Stroke/TIA					
% who had a stroke & spend at least 90% of their time on a stroke unit **(Southport & Ormskirk)**	16/17 - Nov	80%	56.67%	↑	The Trust failed the 80% target in November with only 17 out of 30 patients spending 90% of their time on a stroke unit.
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(Southport & Ormskirk)**	16/17 - Nov	60%	62.50%	↑	





No exception comments received from the Trust. However the October Integrated performance Report included comments that the Stroke action plan (devised during October) reviews potential to reconfigure a bay on the Unit into 4 side rooms which would minimise the impact of male/ female demand as patients could be appropriately managed in side rooms. During the month of October, there had also been a change in pathway to allow patients to go direct to Acute Stroke Unit up until 8pm in the evening from Emergency Department with the support of the Specialist Stroke Nurses. This was only agreed during October therefore the full impact of this was not seen during October's performance; however it would appear there has been some impact in November as performance has improved slightly from 53.3% to 56.7%.

4.3.2 Mixed Sex Accommodation

Mixed Sex Accommodation Breaches				
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(CCG)**	16/17 - Nov	0.00	0.50	↑
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(Southport & Ormskirk)**	16/17 - Nov	0.00	0.90	↑

November saw the CCG and Southport & Ormskirk fail Mixed Sex Accommodation. In November the CCG had 2 mixed sex accommodation breaches (a rate of 0.5) and have therefore breached the zero tolerance threshold. The breaches were at Southport & Ormskirk.

In November Southport & Ormskirk had a total of 5 mixed sex accommodation breaches (a rate of 0.9) and have therefore breached the zero tolerance threshold, of the 5 breaches 2 were for Southport & Formby CCG and 3 for West Lancashire CCG. Year to date there have been 48

breaches. The Trust has been carrying out remedial building work in Critical Care ward to mitigate further breaches, this will continue to be closely monitored through normal surveillance routes.

4.3.3 Healthcare associated infections (HCAI)

HCAI					
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(CCG)**	16/17 - Nov	29	23	↑	There was 1 new cases reported in November 2016 , year to date 23 cases against a year to date plan of 29. Of the 23 cases all were reported at Southport & Ormskirk (10 apportioned to acute trust and 13 apportioned to community). Year-end plan 38.
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(Southport & Ormskirk)**	16/17 - Nov	24	14 (7 following appeal)	↑	There was 1 new trust apportioned case reported in November 2016 (YTD Actual 14 / YTD Plan 24), Year-end plan is 36.
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(CCG)**	16/17 - Nov	0	1	↔	There has been no new cases of MRSA reported in November for the CCG there has been 1 case in August year to date against a zero tolerance threshold.
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(Southport & Ormskirk)**	16/17 - Nov	0	1	↔	There has been no new cases of MRSA reported at the Trust in November (1 in August) against a zero tolerance threshold.

All C diff cases were reported by Southport & Ormskirk Hospital Trust. Please note: The CCG report on all cases of C.diff (Trust and Community) acquired, the Trust (S&O) only report on hospital apportioned cases. A local appeals panel met 9th December to review hospital acquired cases - of the 4 cases submitted, 3 were upheld and 1 rejected (that makes a total of 7 cases upheld year to date).

A case of MRSA was reported in August. A PIR has been held the conclusion of the meeting was to test the current PHS assignment process by assigning this as a third party incident due to the unique nature of the case.

4.3.4 Mortality

Mortality				
Hospital Standardised Mortality Ratio (HSMR)	16/17 - Nov	100	99.12	↔
Summary Hospital Level Mortality Indicator (SHMI)	16/17 - Q1	100	107.30	

HSMR is reported for July 2016 rolling 12 month figure. July 2016 HSMR = 90.89. Expected Deaths = 51.71, Observed Deaths = 47. Annual Rolling HSMR = 99.12.

The latest SHMI published (in June 2016) is for the period January - December 2015 and whilst it is above expected, it is not statistically significantly so and in the “as expected” range. No further update for Q2.

4.4 CCG Serious Incident Management

Serious incidents reporting within the integrated performance report is in line with the CCG reporting schedule for Month 8.

There are 232 serious incidents on StEIS where Southport and Formby CCG is either responsible or lead commissioner. 86 apply to Southport & Formby CCG patients with 6 reported in November; 4 occurring from Southport and Ormskirk Hospitals NHS Trust, 1 for Ramsay Health Care and 1 Cheshire and Wirral Partnership.

Southport and Ormskirk Hospitals NHS Trust have 146 open serious incidents on StEIS, 60 involving Southport and Formby CCG patients, 73 involve West Lancashire CCG patients. 100 relate to pressure ulcers with 36 occurring year to date, 34 apply to Southport and Formby CCG patients. The contract query remains open against this and a formal letter was submitted to the Trust in October. An updated thematic analysis has been requested as an interim arrangement until the composite pressure ulcer action plan has been agreed. 93 incidents remain open on StEIS >100 days, the majority of these are pressure ulcers.

Serious Incidents Open for Southport and Ormskirk Hospitals NHS Trust

Year	Provider	No of Open Incidents	
2014	GP Practice within Southport and Formby	2	5
	GP Practice within West Lancashire	3	
2015	GP Practice within Liverpool	1	63
	GP Practice within South Sefton	3	
	GP Practice within Southport and Formby	26	
	GP Practice within West Lancashire	33	
2016	GP Practice within Knowsley	1	78
	GP Practice within South Sefton	4	
	GP Practice within Southport and Formby	32	
	GP Practice within St Helens	1	
	GP Practice within West Lancashire	37	
	GP Practice within Wigan	1	
	GP Practice within Tameside & Glossop	1	
	GP Practice within Cumbria	1	

Merseycare NHS Foundation Trust – 18 open incidents on StEIS for Southport and Formby CCG patients with 14 open >100 days. No serious incidents were reported in November for S&F CCG patients making a total of 15 year to date. 1 incident reported in June relates to Secure Services which are managed by NHS England Specialist Commissioning.

4.5 Delayed Transfers of Care

Delayed transfers of care data is sourced from the NHS England website. The data is submitted by NHS providers (acute, community and mental health) monthly to the Unify2 system.

Delayed Transfers of Care (DTOC's) decreased to 8 during November 2016 from 13 in October a decrease of 37.5%. Of the 8 delays the majority was for patient or family choice (5).

Analysis of delays in November 2016 compared to November 2015 also illustrates an decrease in the number of patients waiting (37.5%).

Delayed Transfers of Care April 2015 – November 2016

	2015-16												2016-17							
Reason For Delay	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
A) COMPLETION ASSESSMENT	1	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1
B) PUBLIC FUNDING	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
C) WAITING FURTHER NHS NON-ACUTE CARE	0	0	0	0	1	1	1	1	0	1	1	1	1	0	0	0	2	0	1	1
DI) AWAITING RESIDENTIAL CARE HOME PLACEMENT	0	0	1	0	0	1	1	0	0	0	1	0	0	0	1	0	0	1	0	0
DII) AWAITING NURSING HOME PLACEMENT	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	1	1
E) AWAITING CARE PACKAGE IN OWN HOME	0	0	0	0	0	0	0	1	0	0	1	0	0	0	1	0	0	1	0	0
F) COMMUNITY EQUIPMENT/ADAPTIONS	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	3	0	1	1	0
G) PATIENT OR FAMILY CHOICE	1	1	0	0	0	7	2	2	1	1	4	4	3	3	4	4	1	1	7	5
H) DISPUTES	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
I) HOUSING	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	**2**	**1**	**1**	**1**	**1**	**9**	**4**	**5**	**1**	**2**	**7**	**5**	**4**	**5**	**7**	**7**	**3**	**4**	**13**	**8**

In terms of actions taken by the CCG to reduce the number of Delayed Transfers of Care within the system the Commissioning lead for Urgent Care participates in a weekly meeting to review all patients who are medical fit for discharge and are delayed. This is in conjunction with acute trust, community providers and Local Authority.

At times of severe pressure and high escalation the CCG Urgent Care lead participates in a system wide teleconference, which incorporates all acute trusts within the North Mersey AED delivery board, NWAS, local authorities, intermediate care providers, community care providers and NHSE to work collaboratively and restore patient flow. (this is SSCCG also)

Further plans to support the reduction of delayed transfers of care are being discussed within the CCG and include a comprehensive review of at least one DTOC each week with the aim of identifying key points of learning and improve future systems and processes.

The CCG is currently reviewing intermediate care services (ICB) to ensure sufficient capacity exists to expedite appropriate discharges at the earliest opportunity. Transitional beds are discussed between the acute provider, local authority and the CCG and agreed on an individual patient basis to facilitate early discharge to the most appropriate community setting.

4.6 Patient Experience of Unplanned Care

Friends and Family Response Rates and Scores
Southport & Ormskirk Hospitals NHS Trust
Latest Month: **Nov-16**

Clinical Area	Response Rate (RR) Target	RR Actual	RR Trend Line	% Recommended (Eng. Average)	% Recommended	PR Trend Line	% Not Recommended (Eng. Average)	% Not Recommended	PNR Trend Line
A&E	15%	2.2%		86%	87%		7%	10%	

The Friends and Family Test (FFT) Indicator now comprises of three parts:

- % Response Rate
- % Recommended
- % Not Recommended

Southport & Ormskirk Hospital NHS Trust continues to experience difficulties in relation to the above.

The Trust A&E department has seen an increase in the percentage of people who would recommend the service from 54% in October to 87% in November and is higher than the England average. The percentage not recommending has decreased from 41% to 10% in November, however, this remains above the England average.

Friends and Family is a standing agenda item at the Clinical Quality Performance Group (CQPG) meetings. A recently appointed Director of Nursing is in post and accountable for the action plan to deal with these issues. This plan seeks to address the areas of poor performance. A Trust presentation of their Patient and Carer Experience Strategy and FFT update is to be given at the January CQPG and invited to EPEG in February for the same.

The CCG Engagement and Patient Experience Group (EPEG) have sight of the Trusts friends and family data on a quarterly basis and seek assurance from the trust that areas of poor patient experience are being addressed.

EPEG are currently creating a dashboard to incorporate information available from FFTs, complaints and compliments with the aim to monitor patient experience from all acute and community providers.

4.7 Unplanned Care Activity & Finance, All Providers

4.7.1 All Providers

Performance at Month 8 of financial year 2016/17, against unplanned care elements of the contracts held by NHS Southport & Formby CCG shows an over-performance of circa £783k/4%.This over-performance is clearly driven by Southport & Ormskirk Hospital who are reporting a £433k overspend.

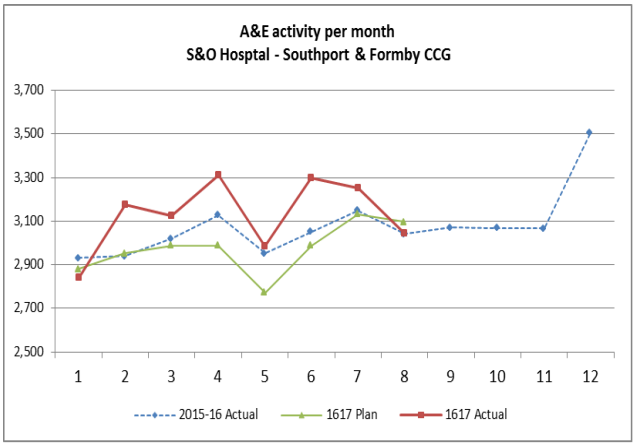
Figure 17 - Month 8 Unplanned Care – All Providers

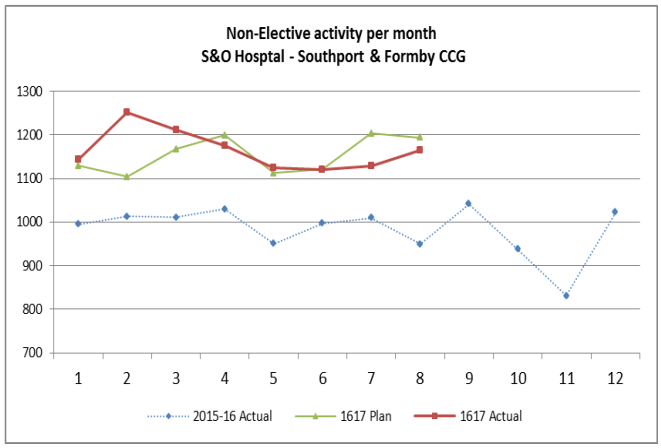
ALL Providers (PBR & Non PBR. PBR for S&O)	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	1,205	1,255	50	4%	£620	£813	£194	31%
Alder Hey Childrens NHS F/T	566	661	95	17%	£281	£309	£28	10%
Central Manchester University Hospitals Nhs Foundation Trust	59	65	6	11%	£20	£20	£0	1%
Countess of Chester Hospital NHS Foundation Trust	0	40	40	0%	£0	£17	£17	0%
Liverpool Heart and Chest NHS F/T	81	98	17	21%	£256	£282	£26	10%
Liverpool Womens Hospital NHS F/T	220	160	-60	-27%	£233	£197	-£37	-16%
Royal Liverpool & Broadgreen Hospitals	929	1,045	116	12%	£528	£574	£46	9%
Southport & Ormskirk Hospital	38,420	41,677	3,257	8%	£19,561	£19,994	£433	2%
ST Helens & Knowsley Hospitals	277	391	114	41%	£140	£183	£44	31%
Wirral University Hospital NHS F/T	74	60	-14	-19%	£30	£42	£12	41%
Wrightington, Wigan And Leigh Nhs Foundation Trust	41	68	27	65%	£35	£55	£20	57%
Grand Total	**41,872**	**45,520**	**3,648**	**9%**	**£21,702**	**£22,486**	**£783**	**4%**

4.7.2 Southport and Ormskirk Hospital NHS Trust

Figure 18 - Month 8 Unplanned Care – Southport and Ormskirk Hospital NHS Trust by POD

S&O Hospital Unplanned Care	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
A and E	24,338	25,899	1,561	6%	£3,238	£3,613	£375	12%
A and E Type 3	1,090	1,428	338	31%	£64	£81	£17	26%
NEL/NELSD - *Non Elective/Non Elective IP Same Day*	7,434	7,608	174	2%	£13,321	£13,362	£41	0%
NELNE - *Non Elective Non-Emergency*	736	1,026	290	39%	£1,391	£1,239	-£152	-11%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	118	124	6	5%	£38	£33	-£5	-13%
NELST - *Non Elective Short Stay*	1,060	1,030	-30	-3%	£744	£702	-£42	-6%
NELXBD - *Non Elective Excess Bed Day*	3,645	4,562	917	25%	£763	£963	£200	26%
Grand Total	**38,420**	**41,677**	**3,257**	**8%**	**£19,561**	**£19,994**	**£433**	**2%**





4.7.3 Southport & Ormskirk Hospital NHS Trust Key Issues

Urgent care is currently over spent by £433k across PbR and Non-PbR elements of the contract. The main driver behind the over performance is Non-Elective PbR admissions which is currently £428k over plan. This is mainly due to General Medicine with activity (7%) and spend (14%) above the same period last year. The main HRGs driving the NEL over performance are Respiratory and Pneumonia related disorders.

Non-Elective excess bed days have also increased against the plan and last year's levels. This is due to major spikes in performance in both April and October 2016 which again is focused primarily in General Medicine. The levels of excess bed days have been queried with the Trust.

Accident and Emergency at the Trust site remains above plan for the year with only April showing a reduction for the same period compared with 2015/16. Previous discussions with the Trust have highlighted the increase in patients over 65years attending A&E and admitted in an emergency setting which has caused higher costs and an increase in excess bed days.

NHS
Southport and Formby
Clinical Commissioning Group

5. Mental Health

5.1 Mersey Care NHS Trust Contract

Figure 19 - NHS Southport & Formby CCG – Shadow PbR Cluster Activity

	NHS Southport and Formby CCG			
PBR Cluster	Caseload as at 30/11/2016	2016/17 Plan	Variance from Plan	Variance on 30/11/2015
0 Variance	40	41	(1)	5
1 Common Mental Health Problems (Low Severity)	-	3	(3)	(6)
2 Common Mental Health Problems (Low Severity with greater need)	5	11	(6)	(9)
3 Non-Psychotic (Moderate Severity)	86	174	(88)	(82)
4 Non-Psychotic (Severe)	208	156	52	53
5 Non-psychotic Disorders (Very Severe)	40	29	11	12
6 Non-Psychotic Disorder of Over-Valued Ideas	27	22	5	4
7 Enduring Non-Psychotic Disorders (High Disability)	126	112	14	8
8 Non-Psychotic Chaotic and Challenging Disorders	77	65	12	11
10 First Episode Psychosis	72	65	7	8
11 On-going Recurrent Psychosis (Low Symptoms)	257	291	(34)	(26)
12 On-going or Recurrent Psychosis (High Disability)	182	153	29	29
13 On-going or Recurrent Psychosis (High Symptom & Disability)	97	100	(3)	(4)
14 Psychotic Crisis	18	11	7	5
15 Severe Psychotic Depression	4	6	(2)	(1)
16 Psychosis & Affective Disorder (High Substance Misuse & Engagement)	13	10	3	4
17 Psychosis and Affective Disorder – Difficult to Engage	28	26	2	2
18 Cognitive Impairment (Low Need)	214	244	(30)	(21)
19 Cognitive Impairment or Dementia Complicated (Moderate Need)	691	787	(96)	(55)
20 Cognitive Impairment or Dementia Complicated (High Need)	266	202	64	72
21 Cognitive Impairment or Dementia (High Physical or Engagement)	67	53	14	21
Cluser 99	167	123	44	31
Total	2,685	2,684	1	61
	-		0.04%	-

5.1.1 Key Mental Health Performance Indicators

Figure 20 - CPA – Percentage of People under CPA followed up within 7 days of discharge

		Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
E.B.S.3	The % of people under mental illness specialities who were followed up within 7 days of discharge from psychiatric inpatient care	95%	100%	100%	100%	100%	100%	100%	100%	100%

Figure 21 - CPA Follow up 2 days (48 hours) for higher risk groups

		Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
KPI_19	CPA follow up 2 days (48 hours) for higher risk groups are defined as individuals requiring follow up within 2 days (48 hours) by appropriate Teams	95%	100%	100%	100%	100%	100%	100%	100%	100%

Figure 22 - Figure 16 EIP 2 week waits

		Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
NR_08	Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral (in month)	50%	50%	50%	50%	0%	50%	50%	50%	67%
	Rolling Quarter				50%	0%	40%	43%	50%	60%

5.1.2

5.1.3 Mental Health Contract Quality Overview

Commissioners continue to be involved in the Trust's review of the acute care pathway (including crisis). This initial scoping and gathering of evidence and intelligence is expected to be completed by February 2017. The review will consider system wide issues that impact on the effective delivery of the acute care pathway, these will include pathways in and out of the Mersey Care services and the interfaces with other providers. Partners and will recommend models for each of the Mersey Care services (e.g. Access Service, A&E Liaison, Community Mental Health Teams), functions in the pathway (Stepped Up Care, Bed Management, Single Point of Access) and specialist pathways (e.g. personality disorder pathway, in-patient pathway)

The recommendations from the Review will be considered by both Mersey Care NHS Foundation Trust and the North Mersey Transformation Board. If accepted, the implementation of the recommendations will form a key area of work for both the Trust and the Transformation Board to begin from 2017/18 onwards.

At the December 2016 CQPG, the CCG raised concerns regarding the underperformance in relation to the 'timeliness of GP Communications / Discharge Letters, since this KPI stopped being a CQUIN, the Trust has failed to meet the targets. A meeting was held with the Trust in December 2016 to discuss the underperformance in relation to GP communication KPIs, in South Sefton and Southport & Formby CCGs. The Trust confirmed that there are issues particularly from the Clock View site regarding timeliness of discharge summaries due to clinical staffing capacity. The Trust have added this to their Risk Register. The roll out of RIO should have a positive impact on performance. However, the Trust confirmed in December 2016 that the RIO roll out has been put on hold due to 'technical issues'. Performance will continue to be monitored via the CQPG and a full report and action will be requested for submission at the February 2017 CQPG. The Trust has indicated that a formal communication relating RIO implementation will be sent to CCGs later in January 2017.

5.2 Improving Access to Psychological Therapies

Figure 23 - **Monthly Provider Summary including (National KPI s Recovery and Prevalence)**

NHS
Southport and Formby
Clinical Commissioning Group

Performance Indicator	Year	April	May	June	July	August	September	October	November	December	January	February	March
National defininiton of those who have entered into treatment	2015/16	103	96	130	164	104	123	128	165	191	216	186	176
	2016/17	201	195	180	167	162	150	201	188				
2016/17 approx. numbers required to enter treatment to meet monthly Access target of 1.3%	*Target*	*240*	*240*	*240*	*240*	*240*	*240*	*240*	*240*	*240*	*240*	*240*	*240*
	Variance	*-39*	*-45*	*-60*	*-73*	*-78*	*-90*	*-39*	*-52*				
	%	*-16.4%*	*-18.9%*	*-25.1%*	*-30.5%*	*-32.6%*	*-37.6%*	*-16.4%*	*-21.8%*				
Access % ACTUAL *- Monthly target of 1.3%* *- Year end 15% required*	2015/16	0.5%	0.5%	0.7%	0.9%	0.5%	0.6%	0.7%	0.9%	1.0%	1.1%	1.0%	0.9%
	2016/17	1.1%	1.0%	0.9%	0.9%	0.8%	0.8%	1.1%	1.0%				
Recovery % ACTUAL *- 50% target*	2015/16	44.3%	61.0%	48.6%	44.4%	58.7%	44.8%	38.2%	38.3%	55.4%	47.3%	51.1%	47.7%
	2016/17	42.9%	52.7%	48.0%	56.3%	53.7%	34.9%	53.3%	50.4%				
ACTUAL % 6 weeks waits *- 75% target*	2015/16	97.9%	98.8%	96.8%	91.3%	97.6%	95.2%	96.8%	98.3%	97.6%	97.0%	98.0%	97.8%
	2016/17	98.1%	99.0%	96.1%	94.8%	97.6%	98.4%	100.0%	100.0%				
ACTUAL % 18 weeks waits *- 95% target*	2015/16	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%
	2016/17	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	100.0%	100.0%				
National definition of those who have completed treatment (KPI5)	2015/16	95	85	78	99	83	93	79	115	86	101	98	95
	2016/17	112	103	101	98	84	130	123	131				
National definition of those who have entered Below Caseness (KPI6b)	2015/16	7	8	6	9	8	6	3	8	12	8	8	7
	2016/17	7	10	3	2	2	4	16	12				
National definition of those who have moved to recovery (KPI6)	2015/16	39	47	35	40	44	39	29	41	41	44	46	42
	2016/17	45	49	47	54	44	44	57	60				
Referral opt in rate (%)	2015/16	94.8%	90.1%	80.0%	70.6%	77.5%	70.1%	68.0%	67.0%	71.8%	82.0%	82.0%	82.0%
	2016/17	93.7%	86.5%	84.6%	52.1%	82.7%	76.2%	85.2%	82.3%				

The provider (Cheshire & Wirral Partnership) reported 188 Southport & Formby patients entering treatment in month 8. This is a decrease from the previous month (when the joint highest number of patients entering treatment was recorded) but remains above an average for the year. The access standard (access being the number of patients entering first treatment as a proportion of the number of people per CCG estimated to have common mental health issues) is currently set at 15% for 2016/17 year end. Current activity levels provide a forecast outturn of 11.4% against the 15% standard. This would represent an improvement to 2015/16 when Southport & Formby CCG reported a year end access rate of 9.3%.

Referrals increased in month 8 by 22% with a total of 271 reported (the highest monthly total in 2016/17). 67% of these were self-referrals, the highest proportion of the year. Marketing work has been carried out specifically in this area, targeting specific groups. The self-referral form has been adapted to make this far simpler to complete and is shared at appropriate meetings. GP referrals remained low with 42 reported in month 8 (the lowest monthly total and against a monthly average of 102 in 2015/16). Initial meetings have been agreed with Hesketh Centre, to attend weekly MDT meetings to agree appropriateness of clients for service.

The percentage of people moved to recovery decreased to 50.4%. However, this remains above the minimum standard of 50%. A forecast outturn at month 8 gives a year end position of 48.4% which would fail to meet the minimum standard although is higher than the year- end position of 2015/16 (47.9%).

Cancelled appointments by the provider remained low with 39 appointments being cancelled in month 8. The provider has previously stated that cancellations could be attributed to staff sickness. Staffing resources have been adjusted to provide an increased number of sessions at all steps in Southport & Formby.

The number of DNAs increased from 81 in month 7 to 103 in month 8, which is above average and is comparable to the number of DNAs reported at the beginning of the current year. The provider has commented that the DNA policy has been reviewed with all clients made aware at the outset. Cancelled slots are being made available for any assessments/entering therapy appointments.

To date in 2016/17, 97.7% of patients that finished a course of treatment waited less than 6 weeks from referral to entering a course of treatment. This is against a standard of 75%. 100% of patients have waited less than 18 weeks (against a standard of 95%). The provider has achieved the monthly RTT targets throughout 2015/16 and in the first eight months of 2016/17 for Southport & Formby CCG.

5.2.1 Improving Access to Psychological Therapies Contract Quality Overview

Internal waiting lists within the service are impacting on both recovery and access KPIs and the service continues to implement the actions identified in month 7 through additional staff/sessions, group work and changing working practices.

At the end of October 2016, a total of 512 patients were identified within the service as waiting for their second appointment with an average wait time of 39.1 days.

At the end of November 2016 a total of 489 patients were identified within the service as waiting for their second appointment with an average wait time of 37.9 days. Internal wait information is being submitted weekly by the provider.

Progress will continue to be monitored via the Quality and Contract meetings.

Efforts continue to receive a copy of the Intensive Support Team report following their visit on 21st October 2016.

5.3 Dementia

Summmary for NHS Southport and Formby dementia registers at 30-11-2016

People Diagnosed with Dementia (Age 65+)	1,555
Estimated Prevalence (Age 65+)	2,148
Gap - Number of addition people who could benefit from diagnosis (all ages)	634
NHS Southport and Formby - Dementia Diagnosis Rate (Age 65+)	72.4%
National estimated Dementia Diagnosis Rate	68.0%
Target	67.00%

Latest guidance from Operations and Guidance Directorate NHS England has confirmed that following a review by NHS Digital a decision has been made to change the way the dementia diagnosis rate is calculated. The new methodology is based on GP registered population instead of

ONS population estimates. Using registered population figures is more statistically robust than the previous mixed approach. The new methodology will implemented next year below being an example of the November figures.

Latest figures following the change in methodology calculates Southport and Formby CCG's Dementia Diagnosis Rates at 72.1% for November 2016, 5.4% above the ambition of 67%. The table above is the old methodology, hence the slight difference in the figures.

6. Community Health

6.1 Southport and Ormskirk Trust Community Services

EMIS Switch Over

The Trust continue to progress in moving over services from the old IPM clinical system to EMIS. As this continues potential data quality and reporting issues may arise. The CCG has requested a detailed report on the issues affecting each service and actions on how these are to be resolved.

Activity

Since the shift from IPM to EMIS reporting on referrals, contacts and waiting times have been affected. The CCG and Trust are working together to resolve the issues. The Trust has advised of the following issues and is continuing to work through them service by service;

- The Trust is unable to split out domiciliary and clinic activity from EMIS, activity is currently being reported as a combined figure for the time being.
- There are some duplicates in the referrals data as all open caseloads had to be migrated across.

All services have now gone live on the new system.

Waiting times

At the latest Information Sub Group meeting the Trust presented a waiting times report which highlighted the extent of the current data quality issues since the system switch over. The Trust will continue to provide the waiting times report monthly and highlight the services where the data quality has been corrected for the CCG to monitor.

The report highlights issues in Phlebotomy and Treatment Rooms with waiting times increasing over recent weeks. The Trust continues to monitor this and update the CCG.

This service will be discussed at the next contract meeting with the Trust and the CCG.

6.1.1 Any Qualified Provider

Southport & Ormskirk Hospital

Podiatry

There have been known issues in Southport & Ormskirk Trust with the recording of Podiatry activity on the new clinic system EMIS, which have been discussed at the information sub group

meeting. The issue was with the templates being used on EMIS not being fit for purpose. The Trust has stated that these templates have now been amended so that all required fields for AQP Podiatry can be completed, and this issue should have been rectified from October onwards. However, data cannot be corrected retrospectively for the early months of 16/17. An agreement will have to be made between the Trust and the CCG as to how the Trust will receive payment without this.

Adult Hearing

The Adult Hearing Audiology budget is £248,000.

At month 8 2016/17 the YTD costs are £310,533, compared to £303,035 at the same time last year. Comparisons of activity between the two time periods show that activity is slightly higher in 16/17 at 959 compared to 852 in 15/16.

The Trust carries out quality checks in the data before they submit. However, they have informed the CCG that due to the complexity of how they collate the dataset, some duplicates still appear, and continue to try to resolve the issue.

MSK

The budget for 2016/17 is £76,000. At month 8 16/17 YTD the costs are £49,949, compared to £40,070 at the same time last year. Comparing activity with last year shows that activity has increased in 16/17 at 329, compared to 262 in 15/16.

6.2 Liverpool Community Health Contract

There is currently a District Nursing systems review taking place across LCH. This is to review processes in relation to manual and electronic requirements. EMIS mobile is not yet available for DNs and so there is a requirement to duplicate information on paper and on EMIS. This is known to impact on the level of information added to the system. The current variance though is within agreed tolerance levels and the Trust is forecasting that activity levels will be higher than last year.

An EMIS mobile app was trialled in Adult Physio, so staff can enter information straight onto the system in the community rather than making paper records and then having to duplicate the information in EMIS. This programme was delivered by IM. There is a report that has been produced in relation to the pilot. The Trust is to send a copy for information.

6.2.1 Patient DNA's and Provider Cancellations

A number of services have seen a high number of DNA's and Provider cancellations so far in 2016/17.

For patient DNAs, Sefton Physio Service reported a high rate of 10.6% in Nov-16, however this is an improvement on last month. Adult Dietetics is also high this month at 23.8% compared to 20% last month, as well as Paediatric Dietetics at 14.8% compared to 10% last month. Total DNA rates at Sefton are green for this month at 6.5%.

Provider cancellation rates remain relatively static this month, with the exception of Adult Dietetics reporting 6.3% compared to 10.8% last month and Paediatric Dietetics reporting 13.2% compared

to 0% last month (7 cancellations this month). Total hospital cancellation rate for Sefton is green at 2% this month.

Treatment rooms, Podiatry, Physio, Adult Dietetics, and Paediatric Dietetics have all continued the trend of previous years showing high numbers of patient cancellations. All services are above 10% for November 2016. Total patient cancellations for Sefton have decreased in Nov-16 to 10.6%.

6.2.2 Liverpool Community Health Quality Overview

The Trust regularly revises their CQC Action Plan and shared with commissioners, the Trust will be supported with progressing actions up until services are transferred to the new providers. Therapies waiting times are being monitored through the CQC Action Plans at the Collaborative Forum (CF) and CQPGs. The Trust's Executives and the CQC have been invited to the January 2017 CF to review progress against the Action Plans.

The CCG has agreed a revised waiting time trajectory for Paediatric SALT with LCH to allow the Trust to develop a new service model, this will be reviewed at the end of the financial year. Patient experience and complaints / feedback are regularly monitored at CQPG meetings. At the end of November 2016, 96.7% of patients who responded to FFT positively recommended the Trust as a place to receive treatment and care.

6.2.3 Waiting Times

The following issues have arisen in November 2016;

Physiotherapy: Waiting times have steadily increased over the past 5 months, resulting in this service failing the 18 week target again in November – 20 weeks on the incomplete pathway and 28 weeks on the completed pathway. The longest waiter was 2 patients waiting at 26 weeks.

Occupational Therapy: Waiting times on the completed pathways (95th Percentile) have gradually increased over the past 3 months resulting in a breach of the 18 week target, an average of 23 weeks being reported in November. The longest waiter was at 21 weeks.

Podiatry: Waiting times on the completed pathways have steadily declined over the past 5 months, whilst the incomplete have remained relatively steady. The average wait (95th percentile) on the completed pathway was 19 weeks in November. The longest waiter was at 34 weeks.

Nutrition & Dietetics: Waiting times on the completed pathways have increased to 22 weeks from the 19 weeks reported in October, therefore this service is still reporting a breach of the 18 week target, whilst the incomplete pathway is still achieving. The longest waiter was at 34 weeks.

Paediatric SALT: A new reporting process has now been set up for this service, and the Trust has begun to report waiting times information from August. In November, on the incomplete pathway the average waiting time (92nd percentile) increased from 33 weeks to 36 weeks, with the longest waiting patient increasing to 3 patients at 42 weeks. This service has consistently breached the 18 week target since it began reporting in August, with waiting times steadily increasing.

6.3 Any Qualified Provider LCH Podiatry Contract

At month 8 2016/17 the YTD cost for the CCG remains the same as last month at £549 with 6 attendances and in 2015/16 the costs for the CCG were £306 with activity at 3. Low activity is due to the vast majority of podiatry AQP for this CCG occurring at the Southport and Ormskirk Trust.

7. Third Sector Contracts

It has been agreed that funding for all contracted Third Sector providers will continue to provide services at their current contract value until 31st March 2016. Letters have been sent to providers to inform of this decision and to propose reduced funding levels from 1st April 2017. Meetings and consultations with providers are underway to discuss the potential impact upon services as a result of these changes.

8. Primary Care

8.1 Primary Care Dashboard progress

The primary care dashboard that has been used in 2015/16 has been reviewed with a view to understanding the needs for reporting across the organisation from a quality, improvement, QIPP perspective. Work has been carried out with other CCGs to look at practice elsewhere, and the ability of Midlands and Lancashire Commissioning Support Unit's Business Intelligence tool, Aristotle to be able to report practice level primary care information across CCGs in Cheshire & Merseyside. Information would be made available to practices in a timely and consistent format to aid locality discussions. From this, localities can use this data to request further analysis, raise queries with providers, determine local priorities for action, understand demand, and monitor improvement.

Work is progressing with MLCSU to further define the indicators for the dashboard. A further meeting was held on 15th December, where it was agreed to begin to produce the dashboards with a first live version available in Aristotle at the end of January 2017. There will be various "views" of the data, for CCG users to view the indicators across the CCG area with the ability to drill to locality and practice level, plus practice level views allowing authorised practice users to drill to patient level. A core set of indicators allowing benchmarking across a number of areas will be produced first (practice demographics, GP survey patient satisfaction, secondary care utilisation rates, CQC inspection status), followed by further indicators and bespoke information (e.g. Liverpool CCG GP Spec).

8.1 CQC Inspections

All GP practices in Southport and Formby CCG are visited by the Care Quality Commission. The CQC publish all inspection reports on their website. Below is a table of all the results from practices in Southport & Formby CCG. The latest practice visited was The Hollies, it achieved a "Good" rating.

NHS
Southport and Formby
Clinical Commissioning Group

Figure 24– CQC Inspection Table

Southport & Formby CCG								
Practice Code	**Practice Name**	**Date of Last Visit**	**Overall Rating**	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-led**
N84005	Cumberland House Surgery	27th August 2015	Good	Good	Good	Good	Good	Good
N84006	Chapel Lane Surgery	26th September 2013	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
N84008	Norwood Surgery	n/a	Not yet inspected the service was registered by CQC on 1 April 2013					
N84012	Ainsdale Medical Centre	2nd December 2016	Good	Good	Good	Good	Good	Outstanding
N84013	Curzon Road Medical Practice	n/a	Not yet inspected the service was registered by CQC on 1 July 2016					
N84014	Ainsdale Village Surgery	10th December 2015	Good	Good	Outstanding	Good	Outstanding	Requires Improvement
N84017	Churchtown Medical Centre	17th August 2016	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
N84018	The Village Surgery Formby	10th November	Good	Good	Good	Good	Good	Good
N84021	St Marks Medical Centre	8th October 2015	Good	Requires Improvement	Good	Good	Good	Good
N84024	Grange Surgery	n/a	Not yet inspected the service was registered by CQC on 1 April 2013					
N84036	Freshfield Surgery	n/a	Not yet inspected the service was registered by CQC on 11 May 2016					
N84037	Lincoln House Surgery	n/a	Not yet inspected the service was registered by CQC on 24th June 2016					
N84611	Roe Lane Surgery	27th August 2015	Good	Good	Good	Good	Good	Good
N84613	The Corner Surgery (Dr Mulla)	15th April 2016	Good	Good	Good	Good	Good	Good
N84614	The Marshside Surgery (Dr Wainwright)	3rd November 2016	Good	Good	Good	Good	Good	Good
N84617	Kew Surgery	16th November 2016	Inadequate	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate
N84618	The Hollies	3rd January 2017	Good	Requires Improvement	Good	Good	Good	Good
N84625	The Family Surgery	n/a	Not yet inspected the service was registered by CQC on 30th September 2016					
Y02610	Trinity Practice	n/a	Not yet inspected the service was registered by CQC on 26th September 2016					

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

9. Better Care Fund

A Better Care Fund Plan for 2016/17 has been agreed and submitted to the national Better Care Support Team and joint work has been undertaken to further develop these plans for implementation. In the meantime a Quarter 2 performance report has been prepared for NHSE for submission on 22nd November 2016. BCF 2017/18 guidance is delayed.

10. CCG Improvement & Assessment Framework (IAF)

10.1 Background

A new NHS England improvement and assessment framework for CCGs became effective from the beginning of April 2016, replacing the existing CCG assurance framework and CCG performance dashboard. The new framework aligns key objectives and priorities, including the way NHS England assess and manage their day to day relationships with CCGs. In the Government's Mandate to NHS England, the framework takes an enhanced and more central place in the overall arrangements for public accountability of the NHS.

The framework draws together in one place NHS Constitution and other core performance and finance indicators, outcome goals and transformational challenges. These are located in the four domains of better health, better care, sustainability and leadership.

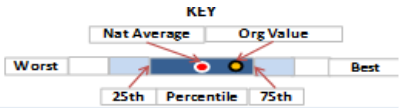
NHS
Southport and Formby
Clinical Commissioning Group

10.2 Q2 Improvement & Assessment Framework Dashboard

Please Note: If indicator is highlighted in GREY, this indicator will be available at a later date

If indicator is highlighted in BLUE, this value is in the lowest performance quartile nationally.

KEY
H = Higher
L = Lower
<> = N/A



	Improvement and Assessment Indicators	Latest Period	CCG	England	Trend	Better is...	Range
	Better Health						
▼	Maternal smoking at delivery	Q1 16/17	8.5%	10.2%		L	
◀▶	Percentage of children aged 10-11 classified as overweight or obese	2014-15	33.4%	33.2%		L	
▼	Diabetes patients that have achieved all the NICE recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	2014-15	46.8%	39.8%		H	
▼	People with diabetes diagnosed less than a year who attend a structured education course	2014-15	3.1%	5.7%		H	
◀▶	Injuries from falls in people aged 65 and over	Mar-16	2,303	2,014		L	
▲	Utilisation of the NHS e-referral service to enable choice at first routine elective referral	Jul-16	39.9%	52.0%		H	
◀▶	Personal health budgets	Q1 16/17	10.6	11.3		H	
▲	Percentage of deaths which take place in hospital	Q4 15/16	41.2%	47.0%		<>	
▼	People with a long-term condition feeling supported to manage their condition(s)	2016	62.2%	64.3%		H	
▼	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q4 15/16	853	929		L	
▼	Inequality in emergency admissions for urgent care sensitive conditions	Q4 15/16	2,547	2,168		L	
▼	Anti-microbial resistance: appropriate prescribing of antibiotics in primary care	Jul-16	1.2	1.1		<>	
▼	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	Jul-16	8.1%	9.3%		<>	
▼	Quality of life of carers	2016	75.6%	80.0%		H	
	Better Care						
◀▶	Cancers diagnosed at early stage	2014	49.5%	50.7%		H	
▼	People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Q1 16/17	80.8%	82.2%		H	
▲	One-year survival from all cancers	2013	72.8%	70.2%		H	
◀▶	Cancer patient experience	2015	8.7	#N/A		H	
▲	Improving Access to Psychological Therapies recovery rate	Jun-16	50.8%	48.9%		H	
◀▶	People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	Jul-16	50.0%	72.0%		H	

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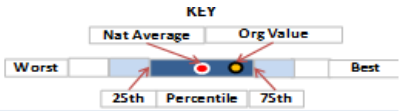
Please Note: If indicator is highlighted in GREY, this indicator will be available at a later date

If indicator is highlighted in BLUE, this value is in the lowest performance quartile nationally.

KEY
H = Higher
L = Lower
<> = N/A



	Improvement and Assessment Indicators	Latest Period	CCG	England	Trend	Better is...	Range
	Better Care						
◀▶	Reliance on specialist inpatient care for people with a learning disability and/or autism	Q1 16/17	64	SM/A		L	
◀▶	Proportion of people with a learning disability on the GP register receiving an annual health check	2014-15	No Data	47.0%		H	
◀▶	Neonatal mortality and stillbirths	2014-15	7.9	7.1		L	
◀▶	Women's experience of maternity services	2015	71.2	SM/A		H	
◀▶	Choices in maternity services	2015	60.5%	SM/A		H	
▲	Estimated diagnosis rate for people with dementia	Aug-16	71.9%	67.3%		H	
◀▶	Dementia care planning and post-diagnostic support	2014/15	76.7%	77.0%		H	
◀▶	Achievement of milestones in the delivery of an integrated urgent care service	August 2016	4			H	
▼	Emergency admissions for urgent care sensitive conditions	Q4 15/16	2,619	2,359		L	
▲	Percentage of patients admitted, transferred or discharged from A&E within 4 hours	Aug-16	93.4%	91.0%		H	
▼	Delayed transfers of care per 100,000 population	Aug-16	11.8	14.1		L	
▲	Population use of hospital beds following emergency admission	Q4 15/16	1.0	1.0		L	
▼	Management of long term conditions	Q4 15/16	820	795		L	
▲	Patient experience of GP services	H1 2016	90.4%	85.2%		H	
◀▶	Primary care workforce	H1 2016	0.9	1.0		H	
▼	Patients waiting 18 weeks or less from referral to hospital treatment	Aug-16	93.5%	91.0%		H	
▼	People eligible for standard NHS Continuing Healthcare	Q1 16/17	62.8	46.0		H	
	Sustainability						
◀▶	Financial plan	2016	Red	SM/A		H	
◀▶	In-year financial performance	Q1 16/17	Red			H	
◀▶	Outcomes in areas with identified scope for improvement	Q1 16/17	40.0%	58.3%		H	
▲	Digital interactions between primary and secondary care	Q2 16/17	70.5%			H	
◀▶	Local strategic estates plan (SEP) in place	2016-17	Yes	SM/A		H	
	Well Led						
◀▶	Staff engagement index	2015	3.8	3.8		H	
◀▶	Progress against workforce race equality standard	2015	0.0	0.2		L	
◀▶	Effectiveness of working relationships in the local system	2015-16	69.8	SM/A		H	
◀▶	Quality of CCG leadership	Q1 16/17	Amber	SM/A		H	

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Appendix – Summary Performance Dashboard

Aristotle Business Intelligence

Southport And Formby CCG - Performance Report 2016-17

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Metric	Reporting Level		2016-17												
			Q1			Q2			Q3			Q4			YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Preventing People from Dying Prematurely															
Cancer Waiting Times															
191: % Patients seen within two weeks for an urgent GP referral for suspected cancer (MONTHLY) The percentage of patients first seen by a specialist within two weeks when urgently referred by their GP or dentist with suspected cancer	Southport And Formby CCG	RAG	G	G	G	G	R	G	R	G					G
		Actual	97.273%	94.333%	94.561%	94.702%	92.077%	95.431%	92.347%	94.09%					94.352%
		Target	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
17: % of patients seen within 2 weeks for an urgent referral for breast symptoms (MONTHLY) Two week wait standard for patients referred with 'breast symptoms' not currently covered by two week waits for suspected breast cancer	Southport And Formby CCG	RAG	G	R	R	R	G	G	R	G					R
		Actual	100.00%	80.556%	80.00%	90.909%	98.214%	95.833%	91.228%	95.313%					92.368%
		Target	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
535: % of patients receiving definitive treatment within 1 month of a cancer diagnosis (MONTHLY) The percentage of patients receiving their first definitive treatment within one month (31days) of a decision to treat (as a proxy for diagnosis) for cancer	Southport And Formby CCG	RAG	G	G	G	G	G	G	R	G					G
		Actual	98.592%	96.053%	98.958%	97.297%	98.81%	96.552%	93.548%	98.611%					97.47%
		Target	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
26: % of patients receiving subsequent treatment for cancer within 31 days (Surgery) (MONTHLY) 31-Day Standard for Subsequent Cancer Treatments where the treatment function is (Surgery)	Southport And Formby CCG	RAG	G	G	G	G	G	G	G	G					G
		Actual	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					100.00%
		Target	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
1170: % of patients receiving subsequent treatment for cancer within 31 days (Drug Treatments) (MONTHLY) 31-Day Standard for Subsequent Cancer Treatments (Drug Treatments)	Southport And Formby CCG	RAG	G	G	G	G	G	G	R	G					G
		Actual	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.00%	100.00%					99.367%
		Target	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%

25: % of patients receiving subsequent treatment for cancer within 31 days (Radiotherapy Treatments) (MONTHLY) 31-Day Standard for Subsequent Cancer Treatments where the treatment function is (Radiotherapy)	Southport And Formby CCG	RAG	G	G	G	G	G	G	G	G					G
		Actual	100.00%	100.00%	100.00%	100.00%	95.00%	96.667%	95.833%	94.737%					97.203%
		Target	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
539: % of patients receiving 1st definitive treatment for cancer within 2 months (62 days) (MONTHLY) The % of patients receiving their first definitive treatment for cancer within two months (62 days) of GP or dentist urgent referral for suspected cancer	Southport And Formby CCG	RAG	G	R	R	G	G	R	R	G					R
		Actual	88.571%	70.732%	80.851%	94.118%	85.714%	83.333%	83.333%	86.842%					83.849%
		Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
540: % of patients receiving treatment for cancer within 62 days from an NHS Cancer Screening Service (MONTHLY) Percentage of patients receiving first definitive treatment following referral from an NHS Cancer Screening Service within 62 days.	Southport And Formby CCG	RAG	G	G	G	R	R	G	G	G					G
		Actual	100.00%	100.00%	100.00%	66.667%	85.714%	100.00%	100.00%	100.00%					92.308%
		Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
541: % of patients receiving treatment for cancer within 62 days upgrade their priority (MONTHLY) % of patients treated for cancer who were not originally referred via an urgent GP/GDP referral for suspected cancer, but have been seen by a clinician who suspects cancer, who has upgraded their priority.	Southport And Formby CCG	RAG													
		Status	P	P	P	P	P	P	P	P					-
		Actual	85.714%	88.889%	84.211%	80.952%	100.00%	77.778%	86.667%	81.818%					85.185%
		Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	

Ambulance

1887: Category A Calls Response Time (Red1) Number of Category A (Red 1) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes	Southport And Formby CCG	RAG	R	G	G	R	R	G	R	R					R
		Actual	55.56%	86.50%	76.90%	66.67%	67.50%	77.42%	71.74%	67.65%					71.191%
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%
	NORTH WEST AMBULANCE SERVICE NHS TRUST	RAG	G	R	R	R	R	R	R	R					R
		Actual	76.47%	74.28%	73.06%	70.45%	72.60%	69.49%	64.59%	62.80%					70.35%
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%
1889: Category A (Red 2) 8 Minute Response Time Number of Category A (Red 2) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes	Southport And Formby CCG	RAG	R	R	R	R	R	R	R	R					R
		Actual	65.29%	67.40%	61.70%	57.90%	61.87%	61.18%	63.13%	62.05%					62.509%
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%
	NORTH WEST AMBULANCE SERVICE NHS TRUST	RAG	R	R	R	R	R	R	R	R					R
		Actual	67.46%	66.26%	66.20%	62.69%	65.25%	61.75%	63.05%	60.35%					64.07%
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%

546: Category A calls responded to within 19 minutes Category A calls responded to within 19 minutes	NORTH WEST AMBULANCE SERVICE NHS TRUST	RAG	R	R	R	R	R	R	R	R					R
		Actual	92.01%	91.47%	91.49%	89.81%	91.09%	89.04%	88.23%	86.79%					89.946%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
	Southport And Formby CCG	RAG	R	R	R	R	R	R	R	R					R
		Actual	89.19%	87.40%	82.50%	80.67%	85.69%	84.01%	87.65%	82.81%					84.93%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
1932: Ambulance: 30 minute handover delays Number of ambulance handover delays over 30 minutes	SOUTHPORT & FORMBY DISTRICT GENERAL HOSPITAL	RAG													
		Actual	275	298	192	309	179	236	170	134	213				2,006
		Target													
1933: Ambulance: 60 minute handover delays Number of ambulance handover delays over 60 minutes	SOUTHPORT & FORMBY DISTRICT GENERAL HOSPITAL	RAG													
		Actual	173	134	71	172	65	107	60	57	69				908
		Target													

Enhancing Quality of Life for People with Long Term Conditions

Mental Health

138: Proportion of patients on (CPA) discharged from inpatient care who are followed up within 7 days The proportion of those patients on Care Programme Approach discharged from inpatient care who are followed up within 7 days	Southport And Formby CCG	RAG	G		G										G
		Actual	100.00%		100.00%										100.00%
		Target	95.00%		95.00%				95.00%			95.00%			95.00%

Episode of Psychosis

2099: First episode of psychosis within two weeks of referral The percentage of people experiencing a first episode of psychosis with a NICE approved care package within two weeks of referral. The access and waiting time standard requires that more than 50% of people do so within two weeks of referral.	Southport And Formby CCG	RAG	G	G	G	G	G	G	G	G					G
		Actual	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	66.667%					52.381%
		Target	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%

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Ensuring that People Have a Positive Experience of Care

EMSA

1067: Mixed sex accommodation breaches - All Providers No. of MSA breaches for the reporting month in question for all providers	Southport And Formby CCG	RAG	R	R	R	R	G	R	R	R					R
		Actual	11	5	2	5	0	2	1	2					28
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
1812: Mixed Sex Accommodation - MSA Breach Rate MSA Breach Rate (MSA Breaches per 1,000 FCE's)	Southport And Formby CCG	RAG	R	R	R	R	G	R	G	G					R
		Actual	2.88	151	0.60	148	-	0.60	0.00	0.00					28.00
		Target	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Referral to Treatment (RTT) & Diagnostics

1291: % of all Incomplete RTT pathways within 18 weeks Percentage of Incomplete RTT pathways within 18 weeks of referral	Southport And Formby CCG	RAG	G	G	G	G	G	G	G	G					G
		Actual	95.201%	94.882%	94.317%	94.51%	93.492%	92.619%	92.36%	92.215%					93.703%
		Target	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%
1839: Referral to Treatment RTT - No of Incomplete Pathways Waiting >52 weeks The number of patients waiting at period end for incomplete pathways >52 weeks	Southport And Formby CCG	RAG	G	G	G	G	G	G	G	G					G
		Actual	0	0	0	0	0	0	0	0					0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
1828: % of patients waiting 6 weeks or more for a diagnostic test The % of patients waiting 6 weeks or more for a diagnostic test	Southport And Formby CCG	RAG	G	G	R	R	R	G	G	G					R
		Actual	0.374%	0.68%	2.10%	1.916%	1.825%	0.305%	0.512%	0.768%					1.068%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Cancelled Operations

1983: Urgent Operations cancelled for a 2nd time Number of urgent operations that are cancelled by the trust for non-clinical reasons, which have already been previously cancelled once for non-clinical reasons.	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	RAG	G	G	G	G	G	G	G	G					G
		Actual	0	0	0	0	0	0	0	0					0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0

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Treating and Caring for People in a Safe Environment and Protect them from Avoidable Harm

HCAI

497: Number of MRSA Bacteraemias Incidence of MRSA bacteraemia (Commissioner)	Southport And Formby CCG	RAG	G	G	G	G	R	R	R	R					R
		YTD	0	0	0	0	1	1	1	1					1
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
24: Number of C.Difficile infections Incidence of Clostridium Difficile (Commissioner)	Southport And Formby CCG	RAG	G	R	R	G	G	G	G	G					G
		YTD	5	11	15	16	18	19	22	23					23
		Target	6	9	13	18	20	24	27	29	29	29	32	38	29

Accident & Emergency

2123: 4-Hour A&E Waiting Time Target (Monthly Aggregate based on HES 15/16 ratio) % of patients who spent less than four hours in A&E (HES 15/16 ratio Acute position from Unify Weekly/Monthly SitReps)	Southport And Formby CCG	RAG	R	R	R	R	R	R	R	R					R
		Actual	88.638%	89.65%	90.769%	87.891%	93.343%	91.165%	91.753%	93.159%					90.766%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
431: 4-Hour A&E Waiting Time Target (Monthly Aggregate for Total Provider) % of patients who spent less than four hours in A&E (Total Acute position from Unify Weekly/Monthly SitReps)	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	RAG	R	R	R	R	R	R	R	R					R
		Actual	88.596%	89.772%	90.923%	87.978%	93.838%	91.494%	92.109%	93.731%					91.022%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
1928: 12 Hour Trolley waits in A&E Total number of patients who have waited over 12 hours in A&E from decision to admit to admission	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	RAG	R	G	G	G	R	G	G	G					R
		Actual	1	0	0	0	1	0	0	0					2
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0

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MEETING OF THE GOVERNING BODY
January 2017

Agenda Item: 17/09	**Author of the Paper:** Danielle Love Programme Lead – Community Services Procurement Email: danielle.love@southportandformbyccg.nhs.uk Tel: 07917 551 806
Report date: January 2017	

Title: Corporate Risk Register and Governing Body Assurance Framework Update

Summary/Key Issues:

The Governing Body is presented with the updated CRR and the GBAF as at December 2016.

The CRR and GBAF have been fully reviewed, scrutinised and approved by the Audit Committee.

Recommendation
The Governing Body is asked to fully review, scrutinise and if satisfied, approve the updates.

Receive	
Approve	X
Ratify	

Links to Corporate Objectives *(X those that apply)*	
X	To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.
X	To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the "Forward View", underpinned by transformation through the agreed strategic blueprints and programmes.
X	To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.
X	To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
X	To advance integration of in-hospital and community services in support of the CCG locality model of care.
X	To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

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			Reviewed by Senior Management Team Approved by Audit Committee

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

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Report to the Governing Body
January 2017

1. Executive Summary

The Governing Body is presented with the updated CRR and the GBAF as at January 2017.

The CRR and GBAF have been fully reviewed, scrutinised and approved by the Audit Committee.

2. Position Statements January 2017

2.1. Governing Body Assurance Framework (GBAF)

There are a total of 7 risks against the 6 strategic objectives for Southport & Formby CCG:

GBAF Risk Positions

Risk	Score	Number of Risks
Low	1-3	0
Moderate	4-6	2
High	8-12	4
Extreme	15 - 25	1

GBAF Highlights

Please see the following which highlights the risks that have either (a) changed in rating or (b) are extreme risks (c) new risks:

GBAF Highlights	Update
1.1 Insufficient governance and monitoring of the QIPP plan could result in a failure to deliver the objectives of identified schemes and adversely impact on the CCGs statutory financial duties.	Extreme Risk • Ongoing review of the impact of all clinical schemes by the Clinical QIPP Advisory Group
2.1 CCG QIPP position reduces the CCGs ability to progress planned transformational schemes	Risk Reduced • Revised outline for Shaping Sefton due to be drafted

2.2. Corporate Risk Register

There are 17 operational risks recorded on the Southport and Formby CCG CRR as at January 2017:

- 2 new risk has been recorded – SF041, SF042
- 1 risks has reduced in rating and has been de-escalated to the Quality Committees risk register – SF038

CRR Risk Positions

Risk	Score	Number of Risks
High	8-12	10
Extreme	15 - 25	7

CRR Highlights

Please see the following which updates on the extreme risks:

ID	Description of Risk	Update On Mitigating Action	Score Post Mitigation
SF006	Financial duties in 2016/17 will not be met due to significant unidentified QIPP 2016/17 and other emerging expenditure pressures resulting in statutory duties not met	• Management responses to PWC report compiled in an action plan - under leadership from DF • QIPP Committee is now operating well and receiving regular updates on QIPP progress • Leadership Team receives update on QIPP • Further measures to control expenditure are required to mitigate risk - awaiting first cut of Month 9 finances	**20**
SF011	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) resulting in poor patient care	• Early indications of reduced DNAs and heightened level of self-referral • Target remains challenging in terms of patient numbers • Requested expert team to support the CCG in improving performance • NHSI team have been formally engaged and awaiting report.	**16**
SF021	There is a risk to the sustainability of Southport and Ormskirk Hospital Trust caused by financial pressures and shortages in clinical staff resulting in poor patient care	• CCG now formally part of North Mersey LDS • CCG expects to conclude work on development of in-hospital model with recommendations through to GB by end Sept 16. Reports presented to GB in September 2016. • Model shared with GB in September. Engaging with local clinicians to develop a collaborative view of in-hospital services.	**16**

ID	Description of Risk	Update On Mitigating Action	Score Post Mitigation
SF026	There is a risk that stroke services fall below the required performance and quality standards resulting in poor patient care	• Action plan outlined at Oct Governing Body, service to remain under performance scrutiny, mitigated risk scoring to be maintained until performance improves • On-going performance monitoring	**16**
SF027	There is a risk that the Alliance Local Delivery System (LDS) as part of the Sustainability & Transformation Plan (STP) does not fully take account of the patient flows from S&F to Liverpool providers	• The mitigated risk has increased due to evolving provider federation views on patient flows, met with strategic lead and agreeing joint approach to ensure commissioner perspective remain at the forefront • The CCG is now part of the North Mersey LDS. • Revising North Mersey LDS activity and finance plans to reflect inclusion of S&F CCG. • LDS SROs and North Mersey AOs to meet and consider joint approach between the LDS and North Mersey	**16**
SF040	There is a risk that financial pressures across health and social care impacts negatively on local services and prevents implementation of integration plans	• Route map for integration finalised • Joint working with LA regarding CHC • Further joint development of intermediate care plans	**16**
SF041	Key local stakeholders involved in the APMS procurement have raised concerns about the consultation process being undertaken by NHSE and the CCG predominantly in SSCCG	New Risk	**16**

3. Appendices

Appendix A – Corporate Risk Register
Appendix B – Governing Body Assurance Framework

Danielle Love
January 2017

NHS
Southport and Formby
Clinical Commissioning Group

Corporate Risk Register

Current Version	v5		
Previous Version	v4	**Updated Date**	**Jan-17**
Document File Path	20170117 - SFCCG CRR - v5 - 17 Jan 17 Update.xlsx		

ID	Date Risk Added	Previous ID	Risk Owner	Responsible Function	Description of Risk (Description of the actual risk i.e. There is a risk that X risk caused by Y event resulting in Z effect)	Key controls and assurances in place (What controls/ systems are in place to prevent the risk from being realised)	Likelihood	Consequence	Current Score	Mitigating Action (What additional controls/ systems need to be put in place to reduce the risks rating)	Update On Mitigating Action (Update on the additional controls and progress)	Likelihood Post Mitigation	Consequence Post Mitigation	Score Post Mitigation	Date Reviewed	Trend
SF006	Revised Q3 2015/16	FIN009	Martin McDowell	Finance	Financial duties in 2016/17 will not be met due to significant unidentified QIPP 2016/17 and other emerging expenditure pressures resulting in statutory duties not met	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	4	5	20	QIPP Committee established and meet monthly. Review of discretionary spend to go to GB end July Monthly review with NHSE Revised control total agreed (£4m deficit) with NHSE	Management responses to PWC report compiled in an action plan - under leadership from DF QIPP Committee is now operating well and receiving regular updates on QIPP progress Leadership Team receives update on QIPP Further measures to control expenditure are required to mitigate risk - awaiting first cut of Month 9 finances	4	5	20	Dec-16	↔
SF011	Q3+1 January 2015	QUA011	Karl McCluskey	Redesign & Commissioning	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) resulting in poor patient care	2. Remedial action plan in place - which is reviewed monthly with provider 3. Performance and contractual meetings and reporting process in place 4. paper presented to Governing Body November 2014 5. Enhanced open access provision for patients to self refer	4	3	12	1. Additional focus on Did Not Attends 2. Re-advertising service with GP practice 3. Using CVS to advertise to general public	Early indications of reduced DNAs and heightened level of self-referral Target remains challenging in terms of patient numbers Requested expert team to support the CCG in improving performance NHSI team have been formally engaged and awaiting report.	4	4	16	Dec-16	↔
SF021	Apr-15	QUA033	Karl McCluskey	Redesign & Commissioning	There is a risk to the sustainability of Southport and Ormskirk Hospital Trust caused by financial pressures and shortages in clinical staff resulting in poor patient care	1. Jointly commissioned independent sustainability review being undertaken by Deloitte in agreement with West Lancs CCG, Southport & Ormskirk Hospital and Southport Formby CCG	5	4	20	Determine CCG requirements for in hospital services Enhance clinical engagement to inform clinical model	CCG now formally part of North Mersey LDS CCG expects to conclude work on development of in-hospital model with recommendations through to GB by end Sept 16. Reports presented to GB in September 2016. Model shared with GB in September. Engaging with local clinicians to develop a collaborative view of in-hospital services.	4	4	16	Dec-16	↔
SF026	Q1 2016/17	QUA043	Karl McCluskey	Redesign & Commissioning	There is a risk that stroke services fall below the required performance and quality standards resulting in poor patient care	1. Monthly review of stroke performance incl. SSNAP 2. Monthly review of constitutional targets and mortality	4	4	16	External review required	Action plan outlined at Oct Governing Body, service to remain under performance scrutiny, mitigated risk scoring to be maintained until performance improves On-going performance monitoring	4	4	16	Dec-16	↔
SF027	Q1 2016/18	QUA044	Karl McCluskey	Redesign & Commissioning	There is a risk that the Alliance Local Delivery System (LDS) as part of the Sustainability & Transformation Plan (STP) does not fully take account of the patient flows from S&F to Liverpool providers	1. CCG formal member of the Alliance LDS 2. Modelling work on patient flows has commenced	3	3	9	Identify gaps and Priorities Confirm CCG stance on LDS membership Agree approach with fellow commissioners to manage provider federation consequences Build a clinical model with S&O clinicians	The mitigated risk has increased due to evolving provider federation views on patient flows, met with strategic lead and agreeing joint approach to ensure commissioner perspective remain at the forefront The CCG is now part of the North Mersey LDS. Revising North Mersey LDS activity and finance plans to reflect inclusion of S&F CCG. LDS SROs and North Mersey AOs to meet and consider joint approach between the LDS and North Mersey	4	4	16	Dec-16	↔
SF040	Sep-16	N/A	Tracy Jeffes	Corporate	There is a risk that financial pressures across health and social care impacts negatively on local services and prevents implementation of integration plans	1. Health and wellbeing board executive in place 2. Review of current BCF and Section 75 arrangements 3. New integration role within the local authority to support further integration. 4. Number of key joint commissioning posts in place 5. New integrated commissioning group now established 6. Initial meeting held regarding development of multi-disciplinary teams	4	4	16	Establish a revised integrated commissioning group Agree joint commissioning priorities Development of a route map for integration Initial pooled budget arrangements within BCF agreed Further develop of pooled/aligned budgets Joint CCG and Public Health Plan	Route map for integration finalised Joint working with LA regarding CHC Further joint development of intermediate care plans	4	4	16	Dec-16	↔

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SF041	Dec-16	N/A	Jan Leonard	Redesign & Commissioning	Key local stakeholders involved in the APMS procurement have raised concerns about the consultation process being undertaken by NHSE and the CCG predominantly in SSCCG	Issue being addresses by joint commissioning committee Robust support from Comms and Engagement External comms support sourced by NHSE	4	4	16	Operational meeting of stakeholders Revised timetable agreed Revised comms agreed	New Risk	4	4	16	Dec-16	New
SF001	Prior Q3 2013/14	BUO001	Karl McCluskey	Redesign & Commissioning	There is a risk the CCG will not meet the constitutional 62 day target for cancer caused by patient choice and complex pathways between providers resulting in delayed cancer treatment for patients	1. Monthly contract meetings 2. Clinical Quality and performance meetings 3. Clinical lead for contracts and quality 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 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.	3	3	9	There are no additional systems or controls that can be put in place currently Performance of providers against constitutional target is monitored monthly with individual exceptions being addresses in turn	Consultant Radiology resourcing continues to hinder pathway performance for 62 days Trust is actively recruiting Locums being employed Linking with other Trusts for support	4	3	12	Dec-16	↔
SF002	Apr-15	BUO017	Tracy Jeffes	Corporate	CCG Locality working does not lead to greater clinical engagement with CCG plans and objectives resulting in disengaged membership	1. Roles of Locality Managers and Team reviewed 2. Locality Plan in place 3. Key issues reported to Governing Body 4. Wrap around support team identified to support localities 5. Key priority in Organisational Development plan	3	4	12	Clear focus for localities in relation to the QIPP agenda and influence over commissioning priorities Clear role out plan for use of Aristotle	Monthly Locality meetings reinstated, new locality manager appointed across all localities. GB Development session focusing on localities with clear areas for engagement identified.	3	4	12	Dec-16	↔
SF016	Apr-15	QUA024	Karl McCluskey	Redesign & Commissioning	Risk of poor quality patient care as a result of not delivering against A&E target due to patient flow in the trust	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	Recovery plan agreed STF trajectory agreed	ECIP review undertaken in Nov and draft report shared with CCG Enhanced recruitment of nursing staff to support ambulance turnaround times	3	4	12	Dec-16	↔
SF028	Q1 2016/17	QUA045	Jenny Kristiansen	Quality	Risk of infection/ hospital admission and harm to patients from poorly maintained nebuliser equipment	Identifying short term solution for patients currently prescribed a nebuliser to be reviewed, be given advice on cleaning equipment and have access to replacement filters and tubing. Long term liaising with respiratory teams, consultants, LCH and GP teams to ensure basics are right for the future. JK and HRo to raise at quality committee. HRo to add to corporate risk register.	4	5	20	• All providers informed of risk • LCH & Aintree have this on their risk registers • Pan Mersey Sub Group informed • All organisations to follow guidance from governance leads within their organisations • Regarding primary care prescribing – JK requested practice information facilitators to run a search on all patients prescribed nebules. This will identify the size of the problem and enable patients to receive a review & education. • An update to be presented at the August Quality Committee Meeting • A meeting will be held with all providers to work up a longer term solution.	Clinical Leads have received the data which is currently being reviewed to ascertain. Due to numbers of patients identified and capacity issues to conduct patient reviews, it has been agreed that the Respiratory Lead will work with Clinical Leads to put forward a business case with a number of options for agreement at the QIPP committee in February 2017.	4	3	12	Dec-16	↔

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SF034	Jun-16	N/A	Tracy Jeffes	Corporate	There is a risk that changes to services caused by current financial position results in inability to deliver on strategic objectives and the reputation of CCG	1. Clear plans are being created which are going through a rigorous governance and decision making 2. Plans to have full quality and equality impact assessments 3. Effective consultation and engagement with key stakeholder and the public 4. Clear communication of changes to any services	4	4	16	1. Clear QIPP plans being developed 2. Governance arrangements reviewed to strengthen effective decision making 3. Planning for future communications/ engagement activities if required 4. Clear plans for alternatives if required and clear communication of these	Proposed disinvestment within the VCF sector now communicated pending consultation and final decision Medicines waste pilot now live - on-going evaluation and engagement with key stakeholders Work continues on the QIPP plans and governance arrangements have been strengthened	4	3	12	Dec-16	↔
SF035	Jun-16		Tracy Jeffes	Corporate	There is a risk that gaps in workforce across the healthcare system caused by insufficient national workforce planning and funding pressures resulting in additional pressure on services	1. Participating in the Health Education North West workforce planning process. 2. Work with Sefton Council on wider strategies to promote Sefton as a 'great place to work'	4	3	12	1. Through STP process seek additional investment to fill identified gaps 2. Implementation of the 'blueprints ' to transform models of care to enable appropriate skill mix to support delivery	On-going work through STP	4	3	12	Dec-16	↔
SF036	Sep-16	N/A	Debbie Fagan	Quality	Risk of reputational damage to CCG as commissioner of LCH in light of media interest following Capsick's report and outcome of parliamentary adjournment debate.	Mersey QSG CCF CQPG Pro-active comms team	3	4	12	Discussed at QSG regarding plans for lessons learned in May & July 2016 Discussions at Quality Committee in May and July 2016 & GB July 2016 Meeting of MPs by Chief Officer July & Aug 2016 Chronology of CCG involvement in performance management of provider - on-going to provide assurance of CCG actions Chronology discussed at CCG GB development session Aug 2016 Consideration of joint MIAA review Sept 2016	Joint presentation to QSG made in October 2016 regarding recommendations and lessons learnt for Cheshire & Merseyside Commissioning colleagues. MIAA TOR for review to be agreed October 2016. Quality Risk Profile (QRP) meeting planned with providers to agree consistent approach to management of current risks with LCH. MIAA review on-going - reporting date likely to be spring 2017	3	4	12	Dec-16	↔
SF037	Sep-16	N/A	Debbie Fagan	Quality	Provider quality of care provision for some services (that are provided for SFCCG by LCH) negatively impacted by Transaction process	Transaction Board CQOG CCF CQPG LCH Improvement Plan QSG	3	4	12	Report through to CQPG and Chief Nurse having regular meetings with Director of Nursing on plans and issues	Quality Walkabouts now agreed with Deputy Director of Nursing at LCH and one team visited in October 2016 with highlight on safer working practices and management of staffing levels. Further quality walk rounds planned across localities over rest of the financial year Quality risks reported up to CQOG attended by CCG and risks managed by LCH Current operational risks managed through CQPG	3	4	12	Dec-16	↔
SF039	Sep-16	N/A	Jan Leonard	Redesign & Commissioning	There is a risk of a gap in service for paediatric audiology due to the current provider serving notice on the service.	Contract has a 6 month notice period	5	4	20	1. Contacted alternative provider 2. Paper on options to go to Leadership Team	Formal letter provided to Alder Hey next steps to mobilise and formalise contract	4	3	12	Dec-16	↔
SF042	Jan-17	N/A	Jan Leonard	Quality	Primary medical care services are under significant pressure due to increased workload, workforce issues.	GP Five Year Forward View Plan Local Quality Contract - increased investment	4	3	12	Reviewing LQC for 17-18 Working with LMC on options GP Five Year Forward View Implimentation on STP footprint	New risk	4	3	12	Jan-17	New Risk

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SF004	Revised Q1 2015/16	FIN003	Martin McDowell		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.	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	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. Savings totalling £1m have been identified to date with a further £5.124 to be realised recurrently for 2015/16. Financial recovery plan is being developed for submission to NHS England CHC working group has delivered £0.569m savings through pro active case management and additional leadership support. Have seen significant pressures emerging in the acute sector (including Independent Sector), along with unidentified QIPP has resulted in the CCG declaring a nil surplus against a target surplus of £1.8m. Note Q1: 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.	CLOSED Financial risks combined into SF006	5	4	20	Jun-16	
SF005	Q3 Dec 2014	FIN008	Martin McDowell		Reductions in local authority expenditure may impact on NHS services and delivery of BCF schemes	1. Monitoring progress of BCF schemes 2. Continued work with local authority	4	3	12	Further cuts identified in public health on top of previous plans. Joint working has commenced to understand scale of cuts across Sefton. P4P target is not being met at present (6% behind baseline as at July 2015)	CLOSED Financial risks combined into SF006	4	3	12	Jun-16	
SF014	Apr-15	QUA021	Tracy Jeffes		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	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	Transition to new CSU achieved, mobilisation complete and new CSU services fully operational Fully mitigated suggest risk closed	CLOSED CSU now transferred to Mids and Lancs CSU.	1	1	1	Jun-16	
SF003	Dec-15	BUO018	Mel Wright		Lack of available resource will lead to the inability to share budgets across health and social care impedes ability to realise benefits of health/social care integration within new Admission Avoidance and Transition from Hospital Scheme (Intermediate Care)	1. Risk identified and shared at BCF Review meetings as part of BCF Risk Register. 2. Full costing of scheme prepared. 3. Ongoing dialogue maintained with SMT and LA leads, appraisal of progress towards wider integration and pooled budget.	5	3	15	Feasibility test of scheme undertaken by SMT, the decision to not continue with this scheme was made	CLOSED Scheme no longer implemented	5	3	15	Jun-16	
SF007	Prior Q3 2013/14	QUA002	Debbie Fagan		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. 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. Standard Operating Procedure developed, includes recommendations as per review.	4	5	20	Awaiting feedback from Quality Committee on draft SOP - April 15 Review required on the needs of the Sefton patch in order to determine commissioning responsibilities and necessary specification. - TBC 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. - March 15	CLOSED delinieation of safeguading services is now clear from commissioning perspective. Oppoprtnity to raise any ongoing issues available via formal and informal meeting structure. Head of vuneralbel people in post fpr CCG who is able to identify any early signs ofoperationnal issues	1	5	5	Jun-16	

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SF008	Q3 2013/14	QUA006	Debbie Fagan		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.	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. Contract Query remains in place with S&O. Discussion of other provider performance where CCG is not the co-ordinating commissioner discussed at QC in September 2015 . Chief Nurse in contact with co-ordinating CCG to discuss concerns raised at the QC and for the purposes of assurance that all providers are being performance managed using a consistent approach. Awaiting formal Q1	CLOSED Contract governance mechanisims in place to monitor provider status fed through Quality Committee performance managed at CQPG and QSG	1	4	4	Jun-16	
SF009	Q1 2014/15	QUA008	Debbie Fagan/ Brendan Prescott		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.	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		CLOSED Duplication from SSCCG risk register any lessons learned in SSCCG will be fed through to SFCCG providers	1	5	5	Jun-16	
SF019	Apr-15	QUA028	Brendan Prescott		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.	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		CLOSED Policy now in place and approved by GB in March 16 regular contact at Northern Region level on national developments Proposed PHB in place	1	3	3	Jun-16	
SF032	Jun-15	STA037	Debbie Fagan		Risk that patients could be harmed or receive inadequate care 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)	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		CLOSED Provider now continuing to meet statutory timefrane Update to May 2016 GB Continued monitoring of process via Childrens commissioning manager as servicce transitions to alternative provider Any issues identified will be escallated and mitigated appropriatly	2	3	6	Jun-16	

ID	Date Risk Added	Previous ID	Risk Owner	Responsible Function	Description of Risk (Description of the actual risk i.e. There is a risk that X risk caused by Y event resulting in Z effect)	Key controls and assurances in place (What controls/ systems are in place to prevent the risk from being realised)	Likelihood	Consequence	Current Score	Mitigating Action (What additional controls/ systems need to be put in place to reduce the risks rating)	Update On Mitigating Action (Update on the additional controls and progress)	Likelihood Post Mitigation	Consequence Post Mitigation	Score Post Mitigation	Date Reviewed	Trend
	Q3+1 January 2015	QUA011	Jan Leonard		The closure of Breast Surgery Service (for new patients) at Southport & Ormskirk poses a risk to the CCG and concerns for local residents.	2. Remedial action plan in place - which is reviewed monthly with provider 3. Performance and contractual meetings and reporting process in place 4. paper presented to Governing Body November 2014 5. Enhanced open access provision for patients to self refer	4	3	12	1. Additional focus on Did Not Attends 2. Re-advertising service with GP practice 3. Using CVS to advertise to general public	CLOSED Meeting held with existing breast providers issues recognised and picked up by breast CNG assurances given by current provider that follow up service will continue.	1	3	3	Sep-16	↓
SF031	Q1 2016/17	REP037	Karl McCluskey		There is a risk that the Local Authority will not agree to a joint Better Care Fund (BCF) plan caused by failure to agree CCG to fund social care	1. Operating structure as part of HWB and BCF	5	5	25	CCG standalone BCF plan to be drafted	CLOSED BCF now agreed	5	5	25	Sep-16	↔

Risk 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	Q2

Risk Ratings

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

Significant Risks

Significant Risks

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.

Level	Descriptor	Description
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.

NHS
Southport and Formby
Clinical Commissioning Group

Southport and Formby CCG

Governing Body Assurance Framework

2016/2017

Update: January 2017

The Governing Body Assurance Framework (GBAF) aims to identify the principal or strategic risks to the delivery of the CCG's strategic objectives. It sets out the controls that are in place to manage the risks and the assurances that show if the controls are having the desired impact. It identifies the gaps in control and the key mitigating actions required to reduce the risks towards the appetite risk score. The GBAF also identifies any gaps in assurance and what actions can be taken to increase assurance to the CCG.

The table below sets out the strategic objectives lists the various principal risks that relate to them and highlights where gaps in control or assurance have been identified. Further details can be found on the supporting pages for each of the Principal Risks.

Strategic Objective	Principal Risk identified	Risk Owner	Risk Initial Score	Risk current Score	Key changes since last Review?
1. To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.	1.1 Insufficient governance and monitoring of the QIPP plan could result in a failure to identify schemes that can realistically be delivered and will impact on the delivery of the QIPP plan and the CCGs ability to deliver its statutory duties	Debbie Fairclough	20	16	• Ongoing review of the impact of all clinical schemes by the Clinical QIPP Advisory Group
2. To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the "Forward View", underpinned by transformation through the agreed strategic blueprints and programmes.	2.1 CCG QIPP position reduces the CCGs ability to progress planned transformational schemes	Karl McCluskey	15	9	• Revised outline for Shaping Sefton due to be drafted
3. To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.	3.1 There is a risk that identified areas of adverse performance are not managed effectively or initially identified	Karl McCluskey	16	8	• Continued monitoring of associated risks
	3.2 Failure to have in place robust emergency planning arrangements and associated business continuity plans could result in the CCG failing to meet its statutory duties as a Category 2 responder.	Tracy Jeffes	5	4	• Date for operational team discussion agreed to review Business Continuity Plans
4. To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.	4.1 Current work pressures reduce ability to engage on GP Five Year Forward View implementation.	Jan Leonard	9	9	• Further engagement session held by NHSE on GP 5YFV • NHSE return due 23 Dec on implementation plan presented to SLT • Concern that current LQC will not deliver, leaving practices less resilient.

Strategic Objective	Principal Risk identified	Risk Owner	Risk Initial Score	Risk current Score	Key changes since last Review?
					Approvals panel met to consider proposed changes. • Joint commissioning application being considered by NHSE, prospective start date 1 Jan 17 • LQC discussions advanced regarding 17-18 plan
5. To advance integration of in-hospital and community services in support of the CCG locality model of care.	5.1 Community Service currently going through procurement process which increasing risk of instability in services.	Jan Leonard	9	6	• LCFT to attend Steering Group for assurance
6. To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.	6.1 There is a risk that financial pressures across health and social care impacts negatively on local services and prevents implementation of integration plans	Tracy Jeffes	16	12	• Joint working with LA regarding CHC • Route map for integration finalised

Strategic Objective 1	**To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.**
Risk 1.1	**Insufficient governance and monitoring of the QIPP plan could result in a failure to identify schemes that can realistically be delivered and will impact on the delivery of the QIPP plan and the CCGs ability to deliver its statutory duties**

Risk Rating Initial Score **5x4=20** Current Score **4x4=16**	**Lead Director** Debbie Fairclough **Date Last Reviewed** December 2016

Controls (what are we currently doing about the risk?):	**Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):**		
• Secured senior dedicated support for designing and implementing a PMO approach to QIPP • Accountable leads have been identified for each contract and are responsible for ensuring that all QIPP schemes are supported by appropriate contracting mechanisms. • Clinical Advisory Group TOR has been updated to enable the group to identify additional areas of improvement and support the CCG in respect of its PSED and other statutory duties associated with any proposed service changes. • Schemes have been re-evaluated and risk assessed to allow focus of those that are deliverable in year, as well as looking at medium to long term plans • QIPP committee TOR have been revised and the relationship between QIPP and F&R has been formalised. • KPIs and monitoring criteria are being designed for every QIPP scheme so that any risks to delivery are identified and mitigated at the earliest possible opportunity. • PMO structure now in place and all schemes have supporting “plans on a page” • Highlight reports across strategic domains (planned care, CHC/FNC, medicines optimisation, discretionary spend and urgent care) are reviewed by QIPP Committee • Contracting team has been restructured and aligned to key business functions of BI, Finance and Quality	**Action**	**Responsible Officer**	**Due By**
	• Further work to take place to ensure QIPP embedded in localities	Debbie Fairclough/ Tracy Jeffes	Nov 16
	• Further work to ensure QIPP continues to have high profile in CCG	Debbie Fairclough	Nov 16
	• Continued focus on ensuring all contracting mechanisms are utilised	Jan Leonard	Ongoing
	• Ongoing review of all potential areas of efficiency	Debbie Fairclough	Ongoing
	• Ongoing review of the impact of all clinical schemes by the Clinical QIPP Advisory Group	Debbie Fairclough	Ongoing

Strategic Objective 1	**To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.**
Risk 1.1	**Insufficient governance and monitoring of the QIPP plan could result in a failure to identify schemes that can realistically be delivered and will impact on the delivery of the QIPP plan and the CCGs ability to deliver its statutory duties**

Assurances (how do we know if the things we are doing are having an impact?):	**Gaps in assurances (what additional assurances should we seek):**
• SMT and SLT will review progress on a weekly basis and QIPP Committee, with support from Finance and Resources will monitor all activity on a monthly basis. The QIPP dashboard will be the monitoring tool for all QIPP schemes and will provide assurances to the Governing Body on progress. A reduction in spend will demonstrate the impact of the implementation of the QIPP plan. • From November the data from providers will be available to demonstrate impact on activity levels as a result of RMS, MCAS, PCLP, prior approval and the new CQUIN. • From November the data showing the impact of the Medicines Management schemes will be available	Monthly run rate monitoring so that the CCG can mitigate early any risks to delivery of the schemes.
Additional Comments:	**Link to Risk Register:**
	SF006

Strategic Objective 2	**To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the "Forward View", underpinned by transformation through the agreed strategic blueprints and programmes.**		
Risk 2.1	**CCG QIPP position reduces the CCGs ability to progress planned transformational schemes**		
Risk Rating Initial Score **5 x 3 = 15** Current Score **3 x 3 = 9**		**Lead Director** Karl McCluskey **Date Last Reviewed** December 2016	
Controls (what are we currently doing about the risk?):		**Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):**	
• Current transformational schemes under rigorous review to ensure that those progress provide both Transformational change and contribute to QIPP • Secured senior dedicated support for designing and implementing a PMO approach - June 2016 • STP lead post recruited - to ensure dedicated resource ensures CCG has key role in local planning and transformational scheme development • Joining up QIPP and blueprint process, the transformational plans have been recast to align with QIPP plan • Strengthening links between transformational process and CCG contract management to ensure that all cases agreed link directly to provider contracts. • Reviewing transformational schemes in line with Cheshire and Merseyside STP plans • Joint work with Liverpool CCG to integrate plans across North Mersey	**Action**	**Responsible Officer**	**Due By**
	Revised outline for Shaping Sefton due to be drafted		End Jan 17
Assurances (how do we know if the things we are doing are having an impact?):		**Gaps in assurances (what additional assurances should we seek):**	
• Delivery of QIPP targets. • CCG vision for Shaping Sefton will be reflected in STP plans.			
Additional Comments:		**Link to Risk Register:**	

Strategic Objective 3	**To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.**		
Risk 3.1	**There is a risk that identified areas of adverse performance are not managed effectively or initially identified**		
Risk Rating Initial Score 4x4 = **16** Current Score 2x4 = **8**		**Lead Director** Karl McCluskey **Date Last Reviewed** December 2016	
Controls (what are we currently doing about the risk?):		**Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):**	
• Roll out of Aristotle Business Intelligence portal makes performance information available to all CCG staff at all times • Integrated Performance Report framework means all key constitutional and other performance is reported on, and actions agreed at monthly Integrated Performance meeting with leads allocated • Performance is standing agenda item at Leadership Team/Senior Leadership Team/Senior Management Team meetings each week. • New management structure put in place with clear lines of accountability and responsibility • Identified individuals update monthly through integrated performance meetings		**Action**	**Responsible Officer** / **Due By**
		Continued monitoring of associated risks	All / on-going
Assurances (how do we know if the things we are doing are having an impact?):		**Gaps in assurances (what additional assurances should we seek):**	
• Weekly discussions of performance issues at LT/SLT/SMT and progress on actions checked • Integrated Performance Report shows CCG understanding of issues and oversight of actions • Integrated Performance Reports may show improved performance as a result of robust management by CCG • Assurance from MIAA review of performance reporting			
Additional Comments:		**Link to Risk Register:**	

Strategic Objective 3	**To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.**		
Risk 3.2	**Failure to have in place robust emergency planning arrangements and associated business continuity plans could result in the CCG failing to meet its statutory duties as a Category 2 responder.**		
Risk Rating Initial Score **1 x 5 = 5** Current Score **1 x 4 = 4**		**Lead Director** **Tracey Jeffes** **Date Last Reviewed** December 2016	
Controls (what are we currently doing about the risk?):		**Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):**	
• CCG Commissions EPRR and Business Continuity support from MLCSU • CCG has in place business continuity plans • Emergency Planning training taken place in last12 months • Corporate Governance Group has responsibility for ensuring compliance • CCG Statutory Lead is Chief Delivery and Integration Officer		**Action**	**Responsible Officer** / **Due By**
		Self-assessment and action improvement developed	Tracy Jeffes / Sept 2016
		Refresh of the business continuity plans and business self-assessment	Tracy Jeffes/ CCG / Jan 2017
		Ongoing training for key staff	Tracy Jeffes / March 2017
		Date for operational team discussion agreed to review Business Continuity Plans	Tracy Jeffes / Dec 2016
Assurances (how do we know if the things we are doing are having an impact?):		**Gaps in assurances (what additional assurances should we seek):**	
• NHSE assurance through self-assessment and improvement plan			
Additional Comments:		**Link to Risk Register:**	

Strategic Objective 4	**To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.**
Risk 4.1	**Current work pressures reduce ability to engage on GP Five Year Forward View implementation.**

Risk Rating
Initial Score 3x3=**9**
Current Score 3x3=**9**

Lead Director
Jan Leonard
Date Last Reviewed
December 2016

Controls (what are we currently doing about the risk?):

- Shadow Joint Commissioning Committee
- LQC in place
- NHSE workshops for GP five year forward view.

Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):

Action	Responsible Officer	Due By
Supported emergent Federation.	Jan Leonard	Ongoing
Working Group on STP	Jan Leonard	Ongoing
Further engagement session held by NHSE on GP 5YFV	Jan Leonard	Nov 16
NHSE return due 23 Dec on implementation plan presented to SLT	Jan Leonard	Dec 16
Concern that current LQC will not deliver, leaving practices less resilient. Approvals panel met to consider proposed changes.	Jan Leonard	Jan 17
Joint commissioning application being considered by NHSE, prospective start date 1 Jan 17	Jan Leonard	Jan 17
LQC discussions advanced regarding 17-18 plan	Jan Leonard	Jan 17

Assurances (how do we know if the things we are doing are having an impact?):

- Developing quality reports for Primary Care with NHSE and other CCGs.
- Transformation agenda is continually monitored through Governing Body and Committee structure.

Gaps in assurances (what additional assurances should we seek):

Additional Comments:

Link to Risk Register:

Strategic Objective 5	**To advance integration of in-hospital and community services in support of the CCG locality model of care.**		
Risk 5.1	**Community Service currently going through procurement process which is increasing risk of instability in services.**		
Risk Rating **Initial Score** **3x3=9** **Current Score** **2x3=6**		**Lead Director** Jan Leonard **Date Last Reviewed** December 2016	
Controls (what are we currently doing about the risk?):		**Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):**	
• Community Services contract monitoring meetings • EPEG monitor feedback on services • Quality Committee monitoring of services • Community Services Steering Group		**Action**	**Responsible Officer** / **Due By**
		Mobilisation Plan being reviewed and managed through Steering Group	Jan Leonard / Ongoing
		LCFT to attend Steering Group for assurance	Jan Leonard / Ongoing
Assurances (how do we know if the things we are doing are having an impact?):		**Gaps in assurances (what additional assurances should we seek):**	

• Providers have expressed interest in acquiring services
  ○ Bids for Community Service procurement received from Providers
  ○ Preferred bidder to be announced by Tuesday 8 November2016
• No increase in complaints/comments on Community Services
• Procurement Awarded – Lancashire Care NHSFT now mobilising
		• During transaction process we are unable to progress integration.	

Additional Comments:		**Link to Risk Register:**	

Strategic Objective 6	**To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.**
Risk 6.1	**There is a risk that financial pressures across health and social care impacts negatively on local services and prevents implementation of integration plans**

Risk Rating **Initial Score** 4x4=16 **Current Score** 3x4=12	**Lead Director** Tracy Jeffes **Date Last Reviewed** December 2016

Controls (what are we currently doing about the risk?):	**Mitigating actions (What new controls are to be put in place to address Gaps in Control and by what date?):**		
1. Health and wellbeing board executive in place 2. Review of current BCF and Section 75 arrangements 3. New integration role within the local authority to support further integration. 4. Number of key joint commissioning posts in place 5. New integrated commissioning group now established 6. Initial meeting held regarding development of multi-disciplinary teams 7. Route map for integration finalised 8. Joint working with LA regarding CHC 9. Further joint development of intermediate care plans 10. Route map for integration finalised	**Action**	**Responsible Officer**	**Due By**
	Establish a revised integrated commissioning group	Tracy Jeffes	Sept 2016
	Agree joint commissioning priorities	Jan Leonard	Sept 2016
	Initial pooled budget arrangements within BCF agreed	Martin McDowell	Aug 2016
	Further develop of pooled/aligned budgets	Martin McDowell	March 2017
	Joint working with LA regarding CHC	Tracy Jeffes	Jan 2017

Assurances (how do we know if the things we are doing are having an impact?):	**Gaps in assurances (what additional assurances should we seek):**
1. Agreed route map for integration signed by all parties and assured by NHSE through BCF team.	

Additional Comments:	**Link to Risk Register:**
	SS040

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2017

Agenda Item: 17/10	**Author of the Paper:** Tracy Jeffes Chief Delivery and Integration Officer Email: Tracy.Jeffes@southseftonccg.nhs.uk Tel: 0151 247 7000
Report date: January 2017	

Title: Making Integration Happen Strategy

Summary/Key Issues:

This strategy has been produced jointly with Sefton Council to provide a strategic framework for integrated commissioning. It has been reviewed and recommended by the Integrated Commissioning Group and supports the implementation of the Better Care Fund.

The strategy was approved by the PTII Governing Body in December 2016 and is now being presented to the Public Governing Body meeting. Please note that this is a working document to steer the work on integration and therefore is informal in its presentation style and will evolve as the work develops.

Recommendation

The Governing Body is asked to receive the strategy.

Receive	X
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
	To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.
x	To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the “Forward View”, underpinned by transformation through the agreed strategic blueprints and programmes.
	To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.
	To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
	To advance integration of in-hospital and community services in support of the CCG locality model of care.

x	To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

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				

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

Sefton Council

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

Making Integration Happen
Sefton`s Health and Social Care Integration Strategy
2016-2020

Sefton Council

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

Contents

Sefton Council

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

1. Introduction

Health and social care integration has been a constant and dominant policy theme for a long time, and many places around the country are already demonstrating the potential to do things differently. Here in Sefton we are now keen to progress our Strategic Vision into operational reality as quickly as possible and to make integration "business as usual". We believe it is time to change gear. Doing the same is not option. We must work to transform the whole system at pace and scale.

The imperative to integrate and transform has never been greater. We will need to find ways to organise services around the demands of a population with more complex and chronic health and social needs whilst responding to the extremely challenging financial context for the NHS and Local Government.

Integration itself is not a panacea for the system's financial challenges. Its primary purpose is to shift the focus of health and care services to improving public health and meeting the needs of individuals by drawing together all services across a 'place' for greatest benefit, and of investing in services which maximise wellbeing throughout life.

We now restate our commitment to come together as a Health and Social care system to describe what a fully integrated, transformed care and support system should look like. This builds on our joint work over many years and reflects our recent call to work at an accelerated pace. This we hope will take integration to another level and on towards 2020 whereby integration is "business as usual".

To make this happen, we need everyone to develop and agree the principles and practices set out in this vision, to learn and to share, to challenge and to deliver. This will involve pushing ourselves and our partners to make sure we deliver the best outcomes for our communities.

We need to prepare, as we have much to do. It will mean making sure we understand the big issues that need to be addressed – at a local and national level – to make integration not only happen but to make sure it improves the health and wellbeing of our populations.

It will mean being clear why partners stand together, stepping outside institutional siloes and navigating multiple meanings of 'place'. It means redesigning the health and social care landscape together, decommissioning services as well as creating new ones, sharing risks and jointly being responsible for what may be difficult decisions within a complex, challenging and changing system. To really make a difference, it will be a demanding task.

2. Vision

Our vision for integration is to **deliver personalised coordinated care, health and wellbeing services with, and around, the person.**

> Together we are Sefton – a great place to be!
>
> We will work as one Sefton for the benefit of local people, businesses and visitors.

This was articulated in our original BCF submission in 2014 in the following way:

"By working together and aligning our resources, we aim by 2020 to:

- promote self-care, independence and help build personal and community resilience
- improve the care, health and wellbeing of all Sefton residents
- support people early to make the right choices to maintain or improve their own health and wellbeing deliver personalised, co-ordinated care around the person and their family and / or carer
- deliver integrated care at a locality level through a single point of access, a single integrated assessment and 7 day working
- narrow the gap between those communities with the best and worst health and wellbeing outcomes."

Our roadmap will move us towards the vision in the "Five Year Forward View" and the move towards full integrated health and social care services by 2020. Underpinning our Vision is the promise that in commissioning and delivering services the different partners, stakeholders and organisations in Sefton will work together to seek to improve the health and wellbeing of everyone, with the resources available.

By working together and aligning our resources, we aim by 2020 to improve the care, health and wellbeing of all Sefton residents and narrow the gap between those communities with the best and worst health and wellbeing outcomes. We will promote independence and help build personal and community resilience. We will work with parents and carers so that all children and young people have opportunities to become healthy and fulfilled adults and create a place where older people can live, work and enjoy life as valued members of the community. We will seek to improve opportunities and support residents to make choices so that people are able to live, work and spend their time in a safe and healthy environment and provide early support so that people can remain independent for longer.

3. Principles and A Framework for Action

In terms of working together it will be important to establish and agree the methodology of how we will work together and the principles that we will use to guide our joint work. This is important in all partnership working, whether across a wide geography for example a number of councils, across a number of Clinical Commissioning Groups or even on smaller scale in a locality or neighbourhood.

The following 10 stages will be the stages we use to describe our approach and to help identify our integrated work plan going forward.

3.1. Co-create a vision that is understood in which partners are united to a common outcome for an integrated system.

Success Factor
Ensure this is understood at all levels across all organisations.

3.2. Prepare a robust and comprehensive business case/s which identifies clear priorities between efficiencies, improved outcomes and increased customer experience. The business case must identify tangible intervention, be explicit about the delivery of timescales.

Success Factor
Targets set are achievable and with realistic trajectories for change.

3.3. Creating the environment and conditions for change by ensuring that the vision and business case ensures ownership and buy in from all partners. Building trust and engagement from all senior leaders will be essential at an early stage.

Success Factor
Ownership is evidenced.

3.4. Identify interventions and system enablers by creating high impact interventions based on evidence. Map the needs of the population and be clear about which interventions will provide the most significant efficiencies and delivering the same or better outcomes.

Success Factor
Population needs mapped and interventions based on these needs with outcomes and outputs agreed and delivered.

3.5. Co-design system and interventions which include the involvement of the community and are led by the workforce, which reinforce multi-disciplinary approaches.

Success Factor
Systems and interventions are owned by the community and the workforce.

3.6. Identify clear metrics to measure outcomes and performance. Ensure that these also include intangibles such as trust, and relationships across communities and organisations.

Success Factor
Metrics which are clear and are collectable and measurable.

3.7. Be clear about the evaluation, how the evidence will be collected and collated. Agree an evaluation framework and identify who will undertake the evaluation on either a live model/programme or at staging points.

Success Factor
Evaluation agreed at an early stage and who will undertake the evaluation.

3.8. Identify key Governance structures which are inclusive and adaptable which focus upon ownership and accountability.

Success Factor
Governance agreed at the beginning with clear terms of reference.

3.9. Consider internal and external organisations that can support and accelerate progress.

Success factor
Identification of organisations, with clear agreement on support.

3.10. Be clear about leadership both individually and system wide. Ensure involvement at the commencement of the programme.

Success Factor
Leadership is evident from the start.

4. The Case for Change

4.1. Our Population

The Sefton Strategic Needs Assessment (SSNA) shows there more than 18,000 residents over 65 living in single occupancy households, making up 16% of the total households.

Future projection predicts that by 2030 the number of over 65s in Sefton living alone will increase by 65% to in excess of 30,000. Sefton would appear to have more service users that struggle with everyday tasks than any of the comparator groups used and there has been an increase in the proportion of service users who find everyday tasks more difficult. This may be as a result of the age profile of Sefton's population and the increasing number of residents in the Borough over the age of 65, and with population projection estimating a 46% increase in residents over 65 by 2037 this may become more of an issue, with increased demand for services.

The Council`s Business and Intelligence and Performance Team and the Clinical Commissioning Group Strategy & Outcomes Lead are an integral part of the work to advance integration. As such reports have been prepared to assist and inform commissioning conversations and help identify the 1st Priorities.

4.2. Local Strategies

The development over the past three years of the Shaping Sefton vision to create a community-centred health and care delivery system has been very much aligned to the overarching Sefton Health and Wellbeing Strategy.

The Shaping Sefton vision describes our aspiration whereby we want all health and social care services to work together and to be more joined up – with as many as possible provided in our local communities, so it is easier (for you) to get the right support and treatment first time to help (you) live a healthy life and improve your wellbeing.

Community-centred health and care brings together eight priority health and transformation programmes, wrapped around our GP practices and their partners. These are

- Primary Care
- Community Care
- Urgent Care

- Mental Health
- Care for Elderly People with Frailty
- Intermediate Care
- Cardiovascular Disease
- Respiratory Disease.

The NHS and Local Government face many challenges ahead. Like all public sector organisations, we are working in tighter times. At the same time, demand on health and social care is increasing and locally, there are a number of reasons why this is the case.

- A growing number of older residents with more complex health conditions - this is much higher than the national average.
- Residents living in some parts of the borough can expect to live unacceptably shorter lives than their neighbours in more affluent areas of Sefton.

Together, these factors mean we need to prioritise the money we have, spending it on the most efficient treatments and services that offer the best outcomes.

The Shaping Sefton vision is the driver for the local implementation of the Five Year Forward View (FYFV) for our community. In recent months, NHSE guidance has required the local NHS to mobilise itself into working closely and collectively across organisations, instead of in individual silos to maximise its efforts.

Partners across Cheshire and Merseyside (C&M) have been working together to develop further the blueprint we set out in June 2016 to accelerate the implementation of the 5YFV for our Communities. We have come together to address head on the challenges we articulated then: that people are living longer, but not always healthier, lives; that care is not always joined up for patients in their local community, especially for the frail elderly and those with complex needs; that there is, as a result, an over-reliance on acute hospital services that often does not provide the best setting for patients; that there is a need to support children, young people and adults more effectively with their mental health challenges. At the same time, there is enormous pressure on health and social care budgets.

We are clear that these issues require us to think much more radically about how best to address the problems we face together; otherwise we will fail to support the needs of our Communities into the future. The C&M blueprint summarises the plans developed to-date to address these challenges across all the different communities in Cheshire and Merseyside and fall into four common themes:

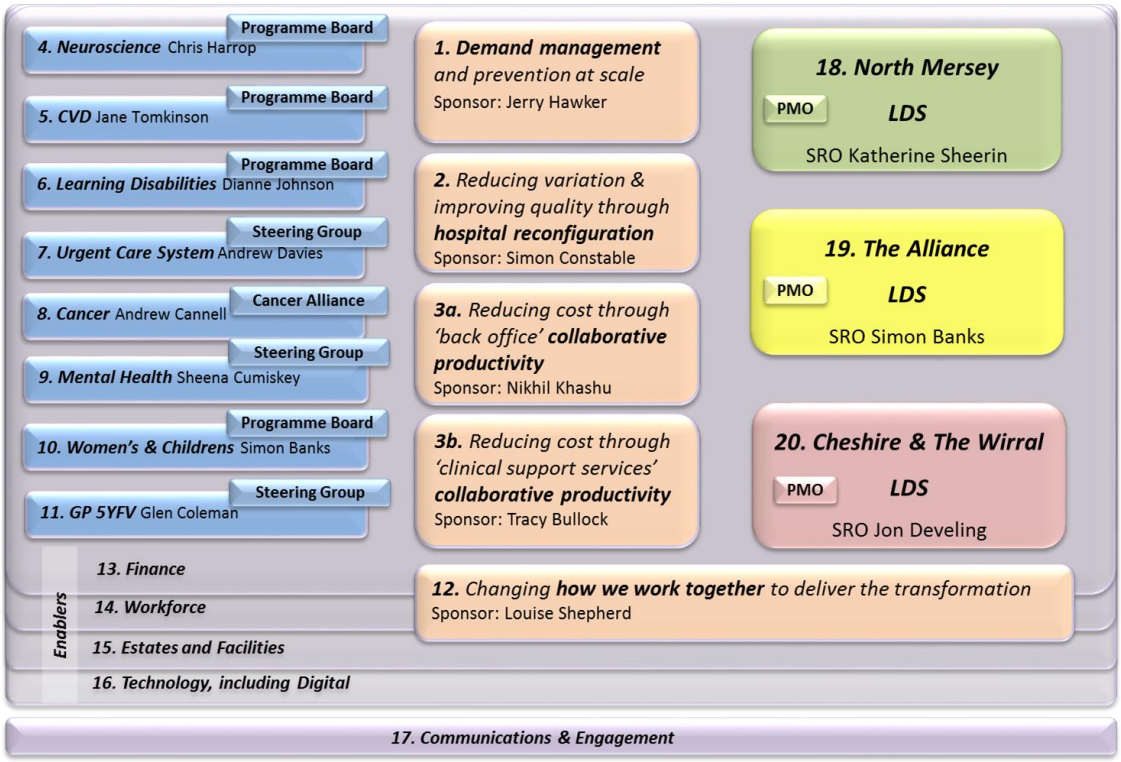
- Support for people to live better quality lives by actively promoting the things we know have a really positive effect on health and wellbeing.
- Working together with partners in local government and the voluntary sector to develop more joined up models of care, outside of traditional acute hospitals, to give people the support they really need in the most appropriate setting.
- Designing an acute care system for our communities that meets current modern standards and reduces variation in quality.
- Making ourselves more efficient by joining up non front-line functions and using the latest technology to support people in their own homes.

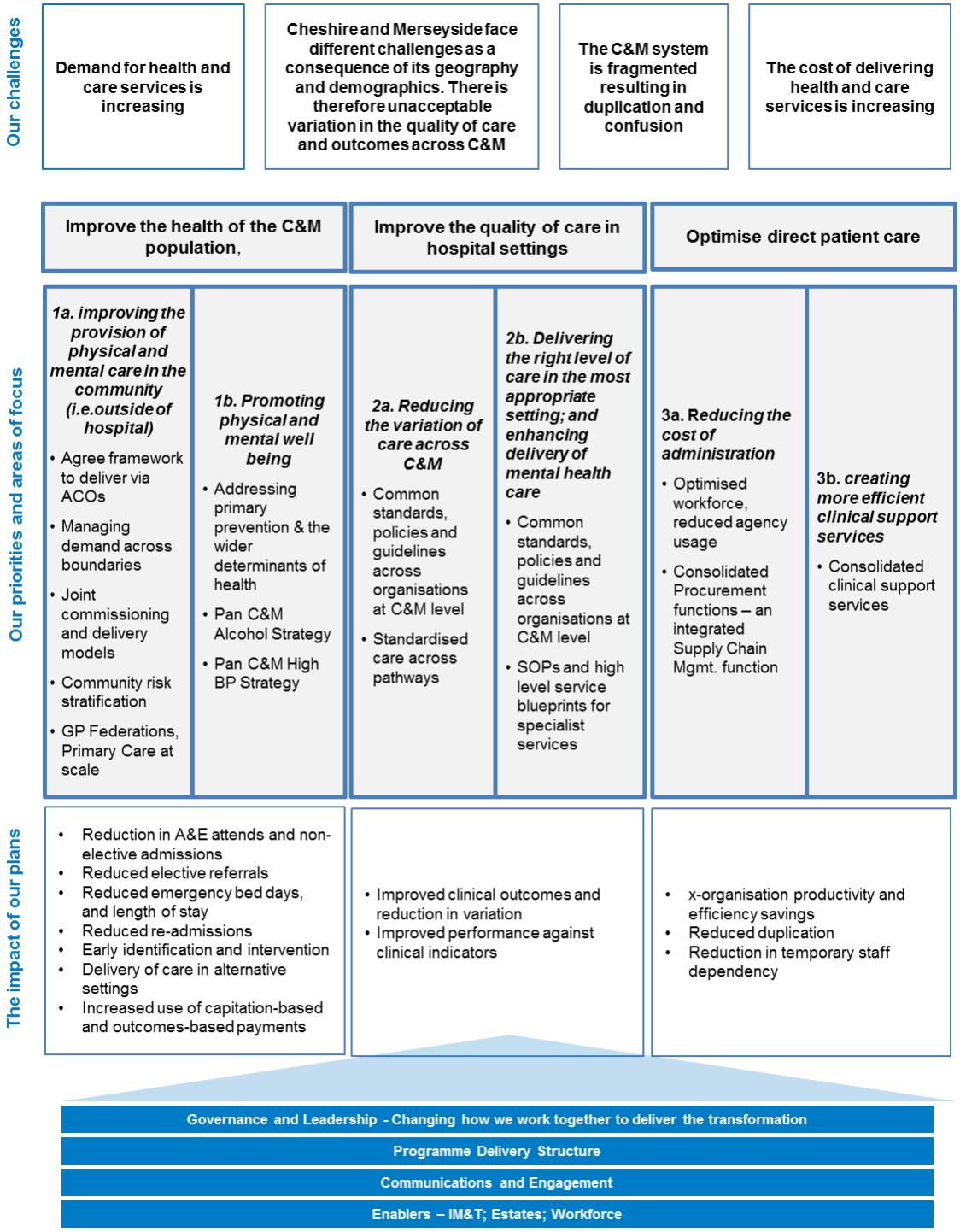
Much of this work is already underway at local level but there is also still much to do. The role of the Sustainability and Transformation Plan (STP) for C&M is to co-

ordinate our efforts, ensuring we promote the best ideas and expertise to provide for the needs of the whole region in the future.

The emergent STP is informed and shaped by local plans and Shaping Sefton.

This STP does not capture everything that we are doing as a health and care economy. Instead it focuses on the priority areas of focus that we believe will have the greatest impact on health, quality and finance.





The C&M STP is supported by three local delivery systems and the work in Sefton at level one is now captured in the North Mersey LDS at level 2.

Working across a larger footprint will bring economies of scale; however, we will need to ensure delivery at a local level to maximise resilience and create the transformational change required.

This will need leaders to work across the system to navigate differing, volatile, uncertain, complex, ambiguous and diverse environments, creating opportunity, working with partners, taking stakeholders with us on the journey and grounding its purpose back into the heart of the communities we serve in Sefton, to best meet its needs.

4.3. Citizen Experience

In 2013, the LGA, as part of the Integrated Care and Support Collaborative commissioned National Voices to develop a definition of integrated care:

"My care is planned with people who work together to understand me and my carer(s), put me in control, and to coordinate and deliver services to achieve my best outcomes."

It is recognised by key partners in health and social care that the current system does not do enough to meet these basic requirements. As well as offering poor user experience and outcomes, poor integration between health and social care is judged to result in services that are inefficient and offer poor value for money. Care that is better integrated is a priority for most health and care partners, driven by increasing demand, greater complexity.

4.3.1. Sefton's Citizen Experience

Consultation was conducted in 2012 Sefton. A report Our Lives Our Health summarised what was important to Citizens.

Messages from the consultation and engagement:

- People of all ages wanted choice and control over their lives
- Maintaining independence by supporting people to remain well, with care close to home, Combat social isolation through access to local services, accessible information and support networks
- Access to work, training and volunteering for all ages and abilities.

- Access to affordable, good quality housing.
- Services provided from children's centres which support vulnerable families and children, in particular those in the poorest neighbourhoods.
- Primary health services need to be local and accessible.
- Inequity in drug treatment and mental health services.
- Protect children and adults from harm.
- Accessible community information and support.

Local Authorities in England with responsibility for providing adult social care services are required to conduct an annual postal survey of their service users. The **Personal Social Services Adult Social Care Survey** asks questions about quality of life and the impact that the services they receive have on their quality of life.

Areas for Focus are identified:

- Social Isolation
- Access to Information
- Planning for the Future

In respect of our Citizens who are Carers. All Local Authorities with Adult Social Care responsibilities are required to undertake a **Biennial survey of people who are formal or informal carers** for any of the Local Authority's Social Care clients.

Whilst generally overall satisfaction has remained relatively high with services and support carers have received there are some potential gaps and concerns. The following summarises the themes from the survey.

Areas for Focus:

- Social isolation and provision of things to do.
- Lack of easy to access support and advice.
- Lack of control over day to day life.
- Possibly a lack in some areas of involvement in the decision making processes.

4.3.2. Sefton Patients' Experiences of Healthcare

The CCGs` Annual Engagement and Patient Experience Group report2 sets out how the CCGs` respond to the statutory requirements placed upon them by developing an annual work plan. The report also sets out the key areas of work undertaken during the previous financial year. As a result of our engagement exercises, the work plan for next 3 years 2015/16 included:

- Alignment of EPEG work streams to commissioning priorities and develop a programme management approach.
- Training and updates, to support understanding of the CCGs' statutory and technical requirements around consultation and Public Sector Equality duty, specifically in relation to transformational commissioning decisions.
- Development of the Patient Experience Dashboard to include Mersey Care NHS Trust and Liverpool Community Health NHS Trust.

- Further develop the SharePoint system to enable the triangulation of patient experience data and engagement feedback for the benefit of all partners.
- Develop more effective two way reporting and communication mechanisms between EPEG and the Quality Committee to ensure that key issues are captured, escalated and addressed.
- With providers and partners, continue to develop structures and processes to ensure that the Voice of the Child is captured and effectively embedded into all aspects of CCGs plans and activities.
- Further develop the 'You said. We did' feedback mechanism.
- Consider EPEG's role in supporting the cultural shift from the focus on clinical healthcare provision to community- based self-care and self- management.
- Develop an EPEG work plan which supports task and action focussed partnership working.
- Continue to develop a more coherent package of support for Patient Participation Groups and build on the engagement opportunities and intelligence that they offer.
- Continue to work in partnership to develop the locality/community model of engagement.

5. What do we mean by "Integration"

5.1. Definition

There is no one definition of what integration means. The notion of integrated care dates back to before the start of the NHS. The concern that care is fragmented and disconnected has focused on delivery that allows at times for individuals to fall through the gaps in care e.g. primary care/secondary care, health/social care, mental/physical health.

Approaches that seek to address fragmentation of care are common across many health systems, and the need to do so is increasing as more people live longer and live with complex health conditions impacted by social and social care needs.

There are many approaches to integration. Integration can be undertaken between organisations, or between different clinical or service departments within and between organisations. Integration may focus on joining up primary, community and hospital services or involve multi-disciplinary teamwork between health and social care professionals ('horizontal' integration). Integration may be 'real' (i.e. into a single new organisation) or 'virtual' (i.e. a network of separate providers, often linked contractually). Integration may involve providers collaborating, but it may also entail integration between commissioners, as when budgets are pooled. Integration can also bring together responsibility for commissioning and provision. When this happens, clinicians and managers are able to use budgets either to provide more services directly or to commission these services from others: so-called 'make or buy' decisions. (Curry and Ham 2010).

Key forms of integrated care:

- Integrated care between health services, social services and other care providers. (horizontal integration)
- Integrated care across primary, community, hospital and tertiary care services. (vertical integration)
- Integrated care within one sector. (e.g., within mental health services through multi-professional teams or networks)

- Integrated care between preventive and curative services.
- Integrated care between providers and patients to support shared decision-making and self-management.
- Integrated care between public health, population-based and patient-centred approaches to health care. This is integrated care at its most ambitious since it focuses on the multiple needs of whole populations, not just to care groups or diseases.

Source: adapted from International Journal of Integrated Care

5.2. National Policy and Integration

5.2.1. Five Year Forward View

The NHS Five Year Forward View[1] published in October 2014 considered the progress made in improving health and care services in recent years and the challenges that the NHS faces leading up to 2020/21. These challenges include:-

- the **quality of care** that people receive can be variable
- **preventable illness** is common
- growing demands on the NHS means that local health and care organisations are facing **financial pressure**
- the **needs and expectations of the public are changing**. New treatments options are emerging, and we rightly expect **better care closer to home**.

The way that health and care is provided has dramatically improved over the past fifteen years – thanks to the commitment of NHS staff and protected funding in recent years. But some challenges remain. The quality of care that people receive can be variable; preventable illness is common; and growing demands on the NHS means that local health and care organisations face financial pressure.

The Five Year Forward View highlights three areas where there are growing gaps between where we are now and where we need to be in 2020/21. These gaps are:-

- the **health and wellbeing** of the population;
- the **quality of care** that is provided; and
- **finance and efficiency** of NHS services.

The FYFV describes combining groups of "community health services…and social care services to create integrated out-of-hospital care" and describes the direction of travel for integrated health and social care which will support closing the gaps outlined above and as described in this document.

5.2.2. Care Act and "the duty" to Integrate

The **Care Act 2014** replaces nearly all the old legislation and supporting guidance covering the care needs and rights to support of both adults with social care needs and adult informal or family carers.

Most of it came into force in England from April 2015, but the planned new developments in paying for care will not now take effect until April 2020. The

original plan was for April 2016 implementation. In April 2015, the government decided to delay the implementation of the funding element of the reforms until the later date.

The act sets out some key responsibilities of Local Authorities, Clinical Commissioning Groups and specifically Health and Wellbeing Boards to:

1. Promoting individual well being
2. Preventing people's care and support needs from becoming more serious
3. Promoting integration of care and support with health services etc.
4. Providing information and advice
5. Promoting diversity and quality in provision of services
6. Co-operating generally with its relevant partners, such as other Local Councils, the NHS and Police
7. Co-operating in specific cases with other Local Authorities and their Relevant partners.

"Local Authorities must exercise its functions under this Part with a view to ensuring the integration of care and support provision with health provision and health-related provision…"

"Clinical Commissioning Groups must exercise its functions with a view to securing that health services are provided in an integrated way…"

"Health and Wellbeing Boards must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner."

5.2.3. Stepping up to the place

The Local Government Association, The NHS Confederation, ADASS, NHS Clinical Commissioners July 2016 published a resource guide "**Stepping up to the place - The key to successful health and care integration**" The guide includes a self-assessment tool designed to support local health and care leaders through Health and Wellbeing boards (HWBs) to critically assess ambitions, capabilities and capacities to integrate services to improve the health and wellbeing of local citizens and communities.

It focuses on "**10 key elements"** and the characteristics needed for successful integration. It offers insight to measure "where we are now" and helps steer the right way forward. The resource guide identifies ways to help;

- Local systems embed integration as 'business as usual'.
- Build a collective approach to achieving integration by 2020.
- Create a consensus and action on the barriers to making integration happen.

Along with, articulating some expectations on a national level to help create the right circumstances.

- Dialogue with national policy makers to ensure integration is effective.
- Ongoing testing and evaluation to develop the evidence base.
- National partner action to enable the minimum requirements to integrate effectively.

We propose that we use the **"The 10 Key Elements"** to frame our assessment of where we are, help us focus more on what we need to do.

6. What Integration means to us in Sefton – four key elements

Bringing health and social care together is a complex job and we have identified four distinct and interrelated elements.

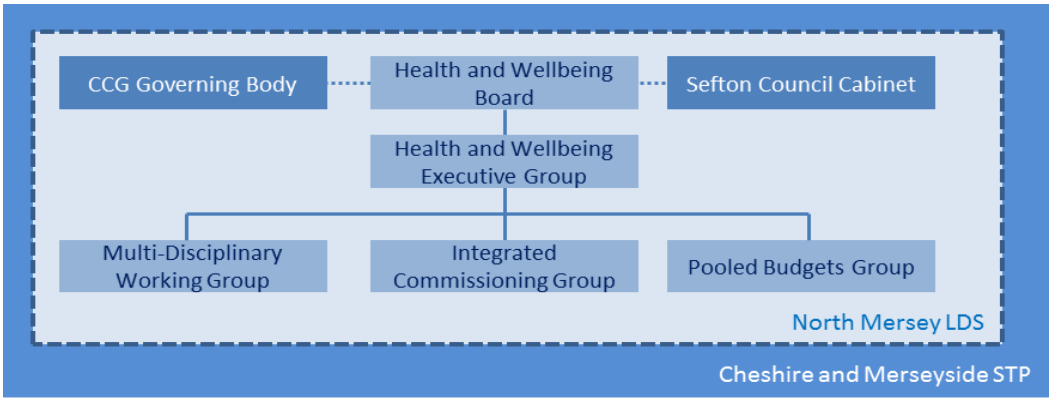
- Integrated Governance - Making decisions together
- Integrated Commissioning - Deciding what needs to be done
- Pooled Budgets - Using all of our resources in the best way
- Integrated Delivery - Working together to support our citizens.

6.1. Integrated Governance - Making decisions together

A review of the Health and Wellbeing Board's governance arrangements has recently been completed to reduce complexity and improve decision-making.

A new governance structure (figure 1 below) was agreed at the HWBB meeting in March 2016, which confirmed the establishment of a Health and Wellbeing Executive Group and Integrated Commissioning Group to oversee and drive integration in Sefton, together with delivery of the HWBB's action plan for the year.

The Health and Wellbeing Board gave support to the Executive to create any other groups and forums to enable the progression of integration. As such two further groups have been set up. A **Multi-Disciplinary Working Group** to progress help develop a model for multi-disciplinary working and the other, a **Pooled Budget Group** to accelerate the work on pooling budgets.



6.1.1. **The Health and Wellbeing Executive Group** will:
(Extract from Terms of Reference)

- determine and ensure delivery of a Strategy for Integrated Commissioning, to drive forward performance, own and manage risks relating to Integrated Commissioning and strategically lead the change programme towards full integration by 2020;
- hold organisations to account for the delivery of better outcomes for citizens and efficient use of combined/pooled resources;

- provide peer to peer leadership support in order to build resilient relationships between senior leaders and thus organisations;
- enable a consistent and collaborative leadership approach and a presence at local, regional and national NHS and Local Authority initiatives for betterment of the population of Sefton.

6.1.2. **Integrated Commissioning Group** will work to maximise combined resources across the commissioning function in both Health and Social Care and (extract from Terms of Reference):

- promote integrated working across all organisations in Sefton;
- encourage the use of flexibilities, including joint investment and pooled budgets;
- agree the strategy and planning processes for the development of areas of priority as detailed in all agreed joint strategies;
- develop the role of integrated commissioner;
- manage and co-ordinate commissioning under s75 agreements for Better Care Fund and any further agreements made;
- be accountable to the Health and Wellbeing Board for alignment of commissioning decision-making with the priorities of the Joint Health and Wellbeing Strategy;
- report progress and outcomes to the HWBB as part of the agreed performance reporting framework, operating within the schemes of delegation and accountability arrangements of Sefton Council and the CCGs;
- provide assurance that services commissioned by Sefton Council and the CCGs, including Independent Contractors services are safe, effective and provide the best possible experience for service users.
- advise on commissioning and monitoring services;
- oversee Joint Integrated Needs Assessments of the whole population;
- monitor the delivery and performance of the commissioned services and the performance of delegated functions;
- evaluate the way in which the services are delivered;
- ensure service users' and carers' views are represented through any integrated commissioning arrangements; ensure best value for money, that the parties' commissioning strategies and intentions are consistent with each other and agree jointly eligibility criteria where possible; and achieving combined organisational development programmes and joint human resources planning in relation to the services.

6.2. Integrated Commissioning - deciding what needs to be done

Underpinning our Vision is the promise that in commissioning and delivering services the different partners, stakeholders and organisations in Sefton will work together to seek to improve the health and wellbeing of everyone, with the resources available.

6.2.1. What is Commissioning?

"*Deciding how to use the total resource available in order to achieve desired outcomes in the most efficient, effective and sustainable way.*"

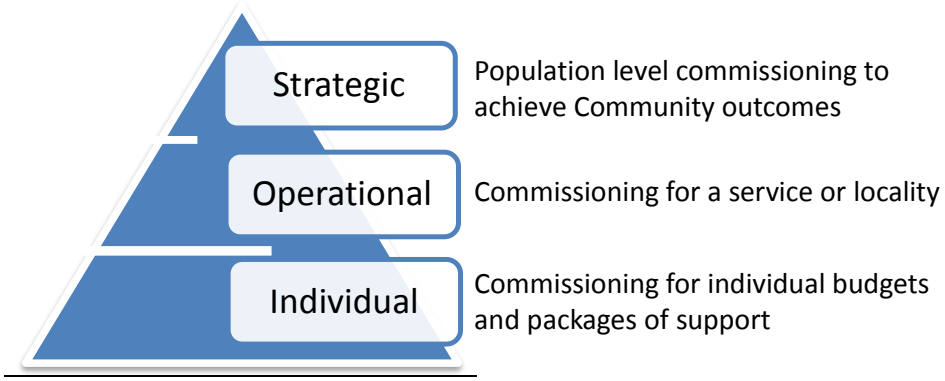
6.2.2. **What is required to commission effectively?**

Effective Commissioning processes:

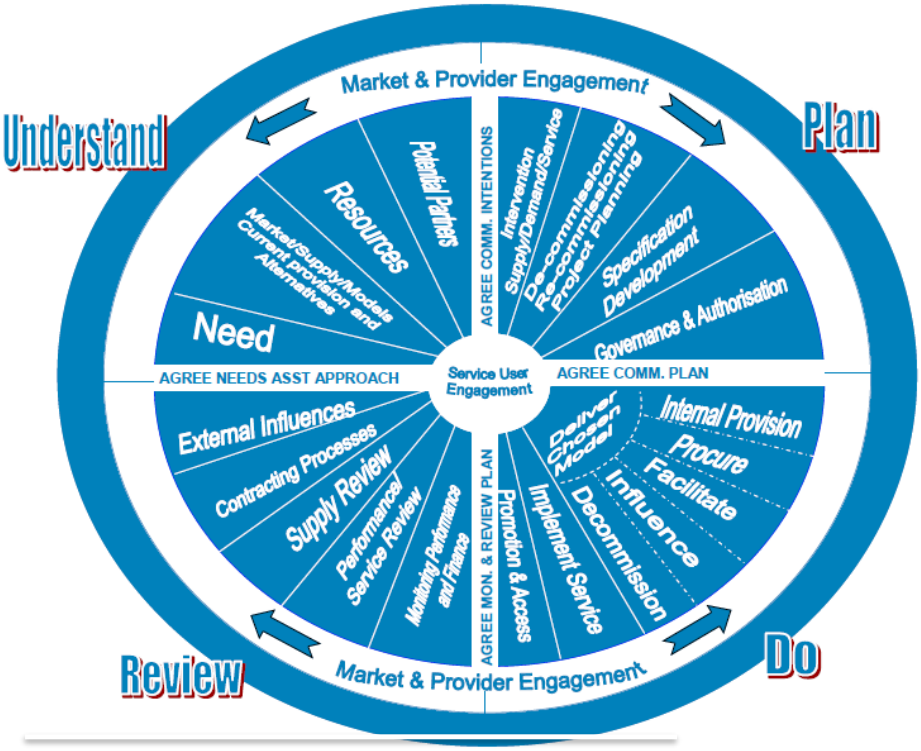
- sound understanding of what is needed in order to achieve desired outcomes
- a series of planned actions/activities intended to achieve those outcomes
- including, but not solely, the provision and procurement of services.

Commonly represented as a cyclical process of **Understand, Plan, Do** and **Review**.

6.2.3. **Levels of Commissioning**



6.2.4. **Sefton Commissioning Cycle**



6.2.5. **How we will Commission**

So we are clear, over the next 4 years we will commit to using potentially "6 commissioning arrangements". These are

1. **Lead Commissioning with Council as Lead Partner**. In this option the Council will be commissioning services in exercise of both CCG and Council Functions. The CCG will have delegated its Commissioning Function in respect of those services to the Council.

2. **Lead Commissioning with CCG as Lead Partner.** In this option the CCG will be commissioning services in exercise of both CCG and Council Functions. The Council will have delegated its Commissioning Function in respect of those services to the CCG.

3. **Aligned Commissioning with Council as Lead Partner**. Here the Council is commissioning the Services in exercise of Council Functions. There is no delegation of Functions from the CCG. However, the CCG and Council are co-operating in identifying and aligning services that need to be provided.

4. **Aligned Commissioning with CCG as Lead Partner**. Here the CCG is commissioning the Services in exercise of CCG Functions. There is no delegation of Functions from the Council to the CCG. However, the CCG and Council are co-operating in identifying and aligning services that need to be provided.

5. **Integrated Commissioning** – both the CCG and the Council enter into a contract for the commissioning of services in exercise of both CCG and Council Functions.

6. **Integrated Commissioning Unit** – this can be either Lead Commissioning (one Partner hosts the Unit as Lead and all functions are delegated to that Partner) or Joint Commissioning (the staff of each Partner work together but retain their separate roles) or using a s.113 Arrangement where the staff act as Council officers when undertaking Council roles and CCG officers when undertaking CCG roles.

The **"6 commissioning arrangements**" will also provide, in the next few years, a useful framework and the opportunity to evolve and mature our journey towards full integration by 2020, help partners to have a common language and terminology, reduce the potential for misunderstanding and help to mitigate the potential for disputes.

6.2.6. Our Commissioning Priorities

The Integrated Commissioning Group has recently been established. The outcome of the early meetings has led to six pathway areas as **1st priority areas** for reviewing the opportunity to develop joint commissioning arrangements.

- Obesity
- Falls
- COPD
- Mental Health and Learning Disabilities
- Stroke
- Hypertension.

These six priorities have been identified following an in depth analysis of the local joint strategic needs assessment, historical performance data, including trends and predictive analysis and a comprehensive review of existing policies and strategies. In terms of service delivery, the group has outlined the following areas for review and prioritisation, described as "System Enablers."

- Intermediate Care and Reablement
- Nursing /Residential Homes
- Domiciliary Care
- Continuing Health Care Funding.

These areas were identified because in some circumstances they provide the support necessary to prevent hospital admission; they avoid the requirement for longer term services and avoid delayed discharges. In addition some of these key services maintain and protect social care. The "system" recognises the fragility of the nursing, residential and domiciliary care market and the six pathways identified above are critical to focus on prevention and early intervention to avoid admission to hospital and subsequently the residential and nursing care system. It is recognised that there are significant difficulties within the care market. Whilst Sefton is not the largest in the Liverpool City Region, it does have more care homes than the other two larger Councils. Sefton has 7% of its care homes rated "Inadequate" by the Care Quality Commission and 34% that "Require Improvement". Over the last 2 years 3 Care Homes have closed in Sefton. Significant numbers of patients in Aintree Hospital currently reside in Hospital

wards because of patient choice into care homes – clearly there is a direct link between the number of inadequate care homes and the remaining beds we have available now in Sefton, which is now critically low. The majority of care homes now pay a 'top up' to their care fees ranging from £20 - £150 per week. Therefore these factors require significant investigation.

Intermediate Care and reablement continues to be another key area of joint development. Implementation of our joint strategy will show real examples of how our integrated work will bring about integrated delivery, with agreed plans for a multi- agency team approach to bring about more streamlined and co-ordinated care for local residents.

Whilst we have begun to determine a **1st list of priorities** for us to focus on and identified the enablers we have not sought at this point to shape our structures or move and align commissioning or commissioning support. In the future this may be an important step but for the time being we commit that form will follow.

6.3. Pooled Budgets - Using all of our resources in the best way

6.3.1. The Better Care Fund

The Better Care Fund has been established to help support integrated between the NHS and Local Authorities. It has been in place since April 2015. The 2015 Spending review set out a clear commitment around furthering health and social care integration across the country by 2020. In practical terms, CCG's and Local Authorities are required to develop a Plan to reach "full integration" for the financial year 2020/21. The Plan should be agreed in the form of a roadmap by March 2017. The creation of the pooled budget presents an opportunity to secure better value for money by avoiding duplication and streamlining contractual arrangements.

6.3.2. Section 75 Agreements and Pooled Budgets

A Pooled Budget is a shared budget between organisations supported by appropriate governance structures to enable shared decision making to take place. Arrangements between NHS and Local Authority bodies have been reflected as Pooled Budgets through a section 75 agreement (NHS 2006 Act), and will include specific directions to reflect appropriate contribution levels and any further adjustments required should the budget overspend or underspend. The agreement will also highlight the appropriate risk shares for each party. These risk sharing arrangements should be set up to confirm the further adjustments to the pool in the event of an over spend or underspend compared with the original pool contributions.

For the purposes of this paper, budgets that are subject to agreed joint working through integrated commissioning but not reflected in a section 75 agreement will be referred to as "aligned budgets". It is good practice to agree aligned budgets as a step towards establishing pooled budgets so that shadow monitoring can take place to understand the impact across the whole health and social care economy. Aligned budgets should be in operation for a minimum of six months prior to a pooled budget being established. The important point is that both parties should be in agreement before confirming pooled budget arrangements and appropriate risk shares.

6.3.3. **What we have already pooled**

See appendix C.

6.3.4. **Where exclusions currently apply**

It should be noted that section 75 is applicable only to prescribed health-related services and prescribed local authority services. It precludes CCGs from delegating any functions relating to family health services, the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services. These services will require changes in legislation before they could be considered for inclusion in pooled budgets.

For Local Authorities, the services that can be included within section 75 arrangements are broad in scope although detailed exclusions exist. It is therefore imperative to check that services considered for inclusion in the pooled budget can be incorporated legitimately and that no ultra vires spending is incurred.

6.3.5. **Pooling Budgets and Integrated Commissioning Priorities**

In respect of the "**1st Priority"** areas for reviewing existing NHS expenditure covering these pathway areas relates to providers from primary care across through to secondary acute care and in some cases specialised commissioning. There will be further work required to establish the financial flows across all commissioning budgets for the CCG Sefton`s Integrated Commissioning Group has recently highlighted six pathway.

In terms of service delivery, the group has outlined the following areas for review and prioritisation, described as system enablers

- Intermediate Care
- Reablement
- Nursing /Residential Homes
- Domiciliary Care

Expenditure in these areas is relatively easy to define and has been earmarked for inclusion within the pooled budget for 2017/18.

6.3.6. **What do we need to do next**

Further work is required to determine the extent that services could be included within a pooled budget during the timescale and this is reflected in Appendix B. The Appendix identifies the potential contribution and agreements are still to be confirmed in a number of cost centre areas.

Most of these services are delivered through secondary care arrangements and therefore will need further work to separate out what potentially could be included in a pooled budget as shown in Appendix B.

The scope of the CCG commissioning arrangements is expected to grow given that CCGs` will be responsible for additional delegated responsibilities including commissioning of both primary care, covering GP's and likely to extend to

pharmacies, dentists, etc. and also specialised commissioning (e.g. cancer services, neurology services and a range of low volume / high cost treatments.

Further work to understand the detail around elements of proposed pooled budgets will be progressed. A more granular review of key areas will need to be undertaken in key areas (e.g. to identify community services within the CCGs` main Mental Health contract).

The Pooled Budget Group should look to develop the rationale for entering into pooled budgets using appropriate criteria which builds upon the joint priorities of both parties.

6.4. **Integrated Delivery - Working together to support our Citizens**

Integrating care is a about ensuring that health and care services are planned and delivered around the needs and wishes of patients and service users and that they are well coordinated across the different organisations involved in providing these services.

Bringing health and social care together is a complex job and we propose our work plan in terms of integrated delivery is:

- **Giving people more information, support and tools to manage their own health** - A new Integrated Wellness Service will offer targeted holistic support and advice to people to help keep them healthy, independent and connected to their community.

- **Being proactive and getting better at preventing ill health** - Working with GPs and other health and social care staff to deliver community-centred health and care help to identify patients at highest risk of becoming ill so that the right care and support can be offered to keep patients independent and well.

- **Health and social care services working more closely together** - For many years, health and social care professionals have been working more closely together but this has often taken a piecemeal approach and has depended on where you live. We are committing to working in a more connected way across Sefton. As part of our programme for community-centred health and social care, we will now explore how we build on this to support more citizens to remain independent and in their own homes.

There is an increasingly challenging position around the financial sustainability of the Health and Social Care system. Doing nothing different is not an option.

Sefton Council is exploring opportunities to work differently in the future with two other Councils in particular. A potential work programme may be progressed subject to all of the appropriate approvals/decisions and governance routes. Although at very early stages this dynamic needs to be declared as a potential opportunity. The Case for Change at this point identifies an “Alliance of Councils” with three Councils with common characteristics. These characteristics being:

1. Ageing populations
2. High levels of deprivation
3. Common NHS providers
4. Similar aspirations in terms of multi-disciplinary working

Councils also share a similar vision with a focus upon improving the health and well-being of people living and working in their areas in order to prevent, reduce or delay the need for care. In addition the Councils wish to work towards an integrated health and social care system to ensure that people get the right choice to care closer to home and support people to return home safely reducing the pressure on social care and health services. These common aims are the basis for taking the conversation further and does not preclude the opportunity to work more locally and with as health partners.

Similarly, from a local NHS perspective and as part of the aforementioned work as part of both Shaping Sefton and the C&M STP, both healthcare providers and commissioners are also reviewing service provision with a view to improving quality and sustainability of services, while reducing variation.

This forms our 4th potential approach with two distinct strands one strand driven by local NHS and a second strand driven by an “Alliance of Councils”.

So to summarise our approach to integrated delivery will have four approaches.

- Giving people more information, support and tools to manage their own health
- Being proactive and getting better at preventing ill health
- Health and Social Care services working more closely
- On a footprint bigger than Sefton
  - Shaping Sefton and the C&M STP
  - “Alliance” with other Councils.

We have established a working group to explore “Multi-disciplinary” approaches as we recognise and confirm that joint working across agencies are a pre-requisite to delivering improved outcomes for citizens.

At this stage there are distinct differences in approaches because of health configurations and a mixed economy within the social care sector, with a fragile residential, nursing and home care market.

In addition whilst the aspiration is for neighbourhood\locality working the resources to deliver such models are finite and a review of models is required so a blueprint can be agreed. There is a desire to address multi-disciplinary working and a mapping exercise of key NHS community and social care services is required to identify opportunities for joint working. This is underway and agreement on future modelling is expected to be agrees by the end of the calendar year.

Building on the existing, well documented, Community Transformation programmes and Care Closer to Home programmes to deliver integrated care at a locality level - we have refreshed the approach to look at how we deliver greater coherence of processes, methods and tools used by all at a locality level with a model for community-centred health and care, supported by integrated teams. We have established a working group to explore “Integrated Delivery” in particular we have:

- Worked to understand the needs for our citizens in respect of prevention, early intervention and how this fits together with other community based services.
- Started to articulate what is our offer of access to advice information, support and services on a locality/neighbourhood basis.
- Linked to the Virtual Ward/Care Closer to Home schemes to those above and, in turn;

- Agreed implementation of our Intermediate care strategy by April 2017 in particular the scheme developed to improve access to reablement and our admission avoidance and transition from hospital scheme.

6.4.1. **New Models of Out-of-Hospital Care** - (Community Integrated Neighbourhood Teams Virtual Ward, Care Closer to Home)

An acquisition process and a formal procurement process haven taken place in both south Sefton and within Southport and Formby, with operational dates for new models of care scheduled for April/May 2017. Community teams will transition to this new way of working through robust mobilisation plans.

6.4.2. **Integrated Community Urgent Care** - (Admission Avoidance and Transition from Hospital Scheme)

Significant work has already taken place to redesign the range of services available in the community setting to support avoiding hospital admission. Following the collaborative development of the AATHS (intermediate care) scheme, implementation is scheduled for April 2017.

6.4.3. **Integrated/streamlined pathways for Long Term Conditions**

Again, pathways have been refreshed and the specifications for delivery of same have been revised. These are also subject to the procurement/acquisition processes that are underway and the larger schemes also form part of the C&M STP and LDS work.

6.4.4. **Care Home Improvement Project** (South Sefton)

- A comprehensive remote and local televideo urgent care network is now in place across the majority of care homes facilitated by Community Matron and Community Geriatrician both inreach and are supported by Rapid response teams (Urgent Care Team and Community Emergency Response Teams).
- This increased locality focus supports care homes and primary care to manage residents within their usual place of residence, reducing the risks associated with a hospital admission.
- Incentivised and standardised advanced care planning has been agreed via Local Quality Contract and is shared with Urgent Care providers (NWAS/GoToDoc etc.).
- Work is also under way regarding standardisation of care home protocols.

6.4.5. **Telemedicine** (Southport and Formby)

The Care Homes pilot is now under way in Southport and Formby and includes linking telehealth to five practices. Subject to positive evaluation and affordability there are plans to extend out to all practices/care homes.

7. The Challenges we will have to Overcome

Integrating is not a simple task. We will need to look beyond our own organisational issues, at times we will need to share risks, be open, be willing to challenge and be challenged. We will need to work with our citizens, communities, providers of care and support in a way which will harness the skills and assets to greater benefit. Some of our challenges are identified at this stage as:

- An ageing population with increased needs, particularly around Long Term Conditions.
- Unacceptably high health and wellbeing inequalities in a diverse borough with different challenges in different parts - deprivation in south Sefton (high levels of benefits reliance and social housing) compared with a popular seaside town in the north of the Borough attracting an older retirement age population.
- National and local growth in non-elective admissions.
- Continuing to meet ever increasing external standards and financial pressures across commissioners and providers over the next 5 years.
- The nursing, residential and domiciliary care market needs to be sustainable to avoid hospital admissions and delayed discharges and to maintain and protect social care.

These challenges are further compounded by a significantly reduced (and reducing) resource within the Local Authority as a result of the austerity measures and considerable pressures on the health system to make on-going efficiencies, while maintaining quality and reducing secondary care activity. This means Sefton's Health and Wellbeing Board's developing and on-going cohesive plan for the integration of Health and Wellbeing services in the Borough must be refocused and requires further efforts to stimulate change.

8. How will things be different for Citizens

Who is Mrs Sefton?
Mrs Sefton is 78 years old and lives alone. She has arthritis, chronic obstructive pulmonary disease, anxiety and high blood pressure. She gets out once a week, she is shaky walking and uses a stick. She wants to continue to living at home.

What does integration mean for Mrs Sefton?

Integrated commissioning in Sefton
We are making the best use of our scarce resources by sharing our budgets. Decisions are made jointly to avoid 'buck passing'. Working together means communication is much better.

Integrated delivery in Sefton
Services all accessed in one way, with care joined up care across health and social care. You'll be assessed once, with one care plan. Your care will be personalised and delivered as close to your home as possible. We will support you to live longer in your own home, reduce the number of times you are admitted to hospital and, if you are admitted, get you home quickly

Integrated delivery across North Mersey
No 'postcode lottery' – your care comes first, not which local authority provides your wheelie bin.

Health and social care services working more closely together

We will establish integrated working across Sefton to support patients and service users to remain independent and in their own homes. All of these services will be accessed via single point of contact/assessment, meaning residents will not be required to reiterate their story multiple times.

Investing in community based care

We will refocus Intermediate Care and reablement services to get people home sooner and to help avoid the need for going into hospital in the first place. Further changes will see more urgent assessments being offered to patients and service users to arrange support and care to avoid hospital stays and keep people at home. Home support and district nursing will be available 24 hours a day to help make this happen.

Being proactive and getting better at preventing ill-health

We will work with GPs and other health and social care staff to identify patients at highest so that the right care and support can be offered to keep patients independent and well.
We will also work to support patients and service users with very complex needs often related to drug or alcohol dependency and/or enduring mental health issues and whose needs extend beyond health and social care for example supporting with debt or housing issues.

Giving people more information, support and tools to manage their own health

We will offer targeted holistic support and advice to older people to help keep them healthy, independent and connected to their community.

Appendices

Appendix A	Our route map – work plan
Appendix B	Our route map (i) Pooled Budget – Sefton Council
	(ii) Pooled Budget – South Sefton and Southport and Formby CCGs
Appendix C	Our BCF Section 75 summary for 2016/17
Appendix D	Where we think we are against the 10 key elements

References

Stepping up to the place - The key to successful health and care integration http://www.local.gov.uk/web/guest/publications//journal_content/56/10180/7867709/PUBLICATION

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[2]The CCGs' Annual Engagement and Patient Experience Group report (http://www.southseftonccg.nhs.uk/media/1406/epeg-annual-report-2014-15-final.pdf)

Appendix A Our Route Map – Work Plan

2016 - 17 Actions
Embed the new Governance structure to help integration become business as usual and review before the end of 2017.
Move on integrated commissioning in Sefton the future approach by using any of the "6 commissioning approaches."
Pool budgets of circa 26 million.
Identify the areas of commissioning priority for the year and develop an Integrated Commissioning Strategy for the next 5 years.
Explore effective models of care to support the most vulnerable.
Complete the work to be ready to Pool X in the areas of Y.
2017 - 18 Actions
Following review at end of 2016, progress any actions identified to ensure Governance is fit for the purpose of supporting and developing integration (commissioning and delivery).
Implement the agreed approach in terms of Commissioning.
Review the areas of commissioning priority for the year and refresh intensions against the Commissioning Strategy in terms of commission, decommission, review and innovate.
Pool X in the areas of Y.
Complete the work to be ready to Pool X in the areas of Y.
Begin to prepare for the agreed future model to deliver the most efficient and effective way to support the most vulnerable.
2018 - 19 Actions
Pool X in the areas of Y.
Complete the work to be ready to Pool X in the areas of Y.
Review the areas of commissioning priority for the year and refresh intensions against the Commissioning Strategy in terms of commission, decommission, review and innovate.
Implement the agreed model to deliver the most efficient and effective way to support the most vulnerable.
2019 - 2020 Actions
Pool X in the areas of Y.
Complete the work to be ready to Pool X in the areas of Y beyond 2019- 2020.
Review the areas of commissioning priority for the year and refresh intensions against the Commissioning Strategy in terms of commission, decommission, review and innovate.
Roll out the model to deliver the most efficient and effective way to support the most vulnerable.
Complete any outstanding tasks around delivering an integrated commissioning function in Sefton.
2020 - 2021 Actions
Pool X in the areas of Y.
Review the areas of commissioning priority for the year and refresh intensions against the Commissioning Strategy in terms of commission, decommission, review and innovate.
Roll out the model to deliver the most efficient and effective way to support the most vulnerable.

Appendix B Our Route Map i) Pooled Budget – Sefton Council

SEFTON COUNCIL						
Service	**Budgets 16/17 Net £**	**Amounts Net in BCF £**	**17-18**	**18-19**	**19-20**	**20-21**
Adult Social Care						
Assessment	9,792,500	561,000	P			
Business Support	6,112,350	0	P			
Support to Carers	763,200	20,000	P			
Equipment & Adaptations	1,222,900	373,000	P			
Early Intervention & Information	824,450	50,000	P			
Community Care	67,055,550	7,348,000	P			
New Direction related including contract	9,710,550	1,127,000	P			
Central ILF grant, Local Reform & Community Voices, Prisons	-2,552,050		P			
BCF additional equipment, Care For You, Care Act, Manchester Rd	1,420,000	1,420,000	P			
Other Services (HRS,ELAS)	1,057,000	0	P			
BCF Income funding Council expenditure	-10,899,000	-10,899,000				
	84,507,450	**0**				
Commissioning, Business Intelligence & Strategic Support						
Commissioning and Central Procurement	853,700		P			
Business Intelligence	766,300		P			
Service Development - IT budget	118,000		P			
Corporate Communications	635,800		P			
Strategic Support	379,500		P			
	2,753,300					
Public Health						
Admin and Development	1,372,300		P			
Collaborative Working	105,100		P			
Health Protection	115,900		P			
Children's 0-19	5,560,700		P			
Substance Misuse	4,367,900		P			
Sexual Health	2,725,100		P			
Health Checks	300,000		P			
Integrated Wellness	2,270,850		P			
Funding Other Council Services	1,339,950		N			
	18,157,800					
Children's Social Care						
Admin and Management	3,879,650			P		
Community Adolescent Service	1,497,400			P		
Corporate Parenting	4,007,200			P		
Duty & Assessment	2,065,600			P		
Locality	2,080,350			P		
Placements & Care Packages	13,434,850			P		
Safeguarding	622,400			P		
	27,587,450					

Assumptions
Does not include any savings that will be required relating to contribution towards Council budget deficit of £64m over the next three years
Does not include any pay increases 17/18 and onwards
Does not include any uplift for NLW 17/18 onwards
Assumes £750k currently in MTFP will be allocated to ASC budget in 17/18

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Print date: 18 January 2017

Includes MTFP price inflation for PFI contracts for Sports and New Formby Pool Contract cost for 17/18
Education Services Grant is expected to reduce significantly over the next few years and mitigation will need to be identified in the budget for Schools and Families
Care Act increase not included
The above figures are budgets not actuals

Note - need clarification on the following which are currently included in the figures:
Specialist Transport Unit
Proportion of central admin costs and admin buildings
Capital Costs
Children's Social Care includes LSCB which is externally funded but with contribution from Children's Social Care.
Similar Position with adults
ASG centrally held grants included. PH grant isn't. Treatment clarification needed

Appendix B Our Route Map ii) Pooled Budget – South Sefton CCG and Southport and Formby CCG

SEFTON CCGS' COMBINED BUDGETS					
Service	**16/17 £**	**17-18**	**18-19**	**19-20**	**20-21**
Non NHS					
Mental Health Contracts	1,882	S/P	P	P	P
Child And Adolescent Mental Health	427	N	S	P	P
Dementia	211	N	S	P	P
Learning Difficulties	1,943	P	P	P	P
Mental Health - Collaborative Commissioning	400	P	P	P	P
Collaborative Commissioning	931	P	P	P	P
Out Of Hours	2,175	N	N	S	P
CHC Adult Fully Funded	12,250	S	P	P	P
CHC Ad Full Fund PHB	214	S	P	P	P
CHC Adult Joint Funded	3,346	P	P	P	P
CHC and Joint Fund PHB	23	S	P	P	P
CHC Children	893	S	P	P	P
Funded Nursing Care	5,106	S	P	P	P
Community Dermatology	818	TBC	TBC	TBC	TBC
Hospices	2,439	S	P	P	P
Intermediate Care	652	P	P	P	P
Reablement	2,224	P	P	P	P
	35,934				
Corporate & Support Services					
Running Cost Allowance	5,877	N	N	S	P
Commissioning Schemes	1,991	N	N	S	P
Medicines Management - Clinical	1,308	N	N	S	P
Primary Care IT	2,602	N	N	N	N
Nursing And Quality Programme	549	N	N	S	P
Corporate IM&T	0	N	N	S	P
	12,326				
NHS					
Acute Commissioning	212,051	TBC	TBC	TBC	TBC
Acute Children's Services	10,483	TBC	TBC	TBC	TBC
Non Acute	35,845	S	P	P	P
Mental Health SLA	29,130	TBC	TBC	TBC	TBC
NHS 111	621	TBC	TBC	TBC	TBC
Ambulance Services	11,316	TBC	TBC	TBC	TBC
NCA/OATS	3,193	TBC	TBC	TBC	TBC
Winter Resilience	1,423	TBC	TBC	TBC	TBC
	304,063				
Independent Sector					
Clinical Assessment & Treatment Centres	8,595	TBC	TBC	TBC	TBC
	8,595				
Primary Care					
Local Enhanced Services	6,045	N	N	S	P
Programme Projects	797	N	N	S	P
	6,843				
Prescribing					
High Cost Drugs	2,293	N	N	S	P
Oxygen	618	N	N	S	P

SEFTON CCGS' COMBINED BUDGETS					
Service	**16/17 £**	**17-18**	**18-19**	**19-20**	**20-21**
Prescribing	51,927	N	N	S	P
	54,838				
Sub-Total Operating Budgets pre Reserves	**422,598**				
Reserves					
Commissioning Reserve	1,432	N	N	S	P
Non Recurrent Reserve	1,810	N	N	S	P
	3,242				
TOTAL: CCG`s EXPENDITURE	**425,840**				
Place Based Expenditure					
Primary Care	35,910	N/S	N	S	P
Specialised Commissioning	82,290	N/S	N	S	P
	118,200				
TOTAL: NHS E and CCGs' EXPENDITURE	**544,040**				

Appendix C: Our BCF Section 75 Summary for 16/17

Theme	Scheme Name	Funded by	LA	SS CCG £	SF CCG £	Approach	Risk and benefit approach	
							Overs	Unders
Carers	Carers Grant	CCG		280,000	220,000	Lead Council	100% to Council	ICG and PBG to Exec
	Carers Card	CCG		12,000	8,000			
	Short Breaks and Respite	CCG		117,000	83,000			
	Total			**490,00**	**311,000**			
Equipment	Sensory Support	CCG		9,000	7,000	Joint	By utilisation Health to Health, Social Care to Social Care	ICG and PBG to Exec
	Care Line	CCG		58,000				
	Community Equipment	CCG		230,000	161,000			
	Community Equipment	CCG		427,000	350,000			
	Community Equipment	CCG		165,000	135,000			
	DFG	LA	3,349,000					
	Contribution to provision of care line				42,000			
	Contribution to provision of care line				42,000			
	Delivering integrated care and supporting discharge (equipment and telecare)	CCG			30,000			
	Total		**3,349,000**	**880,000**	**767,000**			
Children and Young People	Child and Adolescent Mental Health	CCG		702,000	188,000	Lead CCG	100% to CCGs	ICG and PBG to Exec
	Total			**702,000**	**188,000**			
Int` Care and Reablement	Care Services	CCG			7,000	Joint	Determined by who commissioner is and who provider is	ICG and PBG to Exec
	Sefton MBC Home from Hospital	CCG		96,000	76,000			
	End of Life Service	CCG		3,000	2,000			
	Community Beds and Medical Cover	CCG		235,000	165,000			
	Reablement	CCG		503,000	396,000			
	Early Discharge	CCG		95,000	121,000			
	Chase Heys	CCG			211,000			
	Care Worker	CCG			17,000			
	Ward 35	CCG		976,000				
	Int Care	CCG		688,000	500,000			

Theme	Scheme Name	Funded by	LA	SS CCG £	SF CCG £	Approach	Risk and benefit approach	
							Overs	Unders
	Services							
	Total			**295,600**	**1,495,500**			
Community Services Transform-ation	Virtual Ward/CC2H	CCG		1,632,000	888,000	Lead CCG	100% with CCGs	ICG and PBG to Exec
	Community Matrons	CCG		280,000	198,000			
	CCNOT	CCG		75,000	188,000			
	DN's twilight	CCG		895,000	1,000			
	DN's OOH	CCG		494,000				
	Alcohol Nurse	CCG		24,000				
	Community Treatment Rooms	CCG			280,000			
	GP Call handling	CCG			68,000			
	Discharge planning	CCG			135,000			
	DN's OOH	CCG			61,000			
	DN's OOH	CCG			162,000			
	Falls	CCG			67,000			
	HALS	CCG			82,000			
	Respiratory	CCG		587,000				
	Heart Failure	CCG		402,000				
	Community Nursing Children's	CCG		58,000				
	Community Paediatrics	CCG		229,000	61,000			
	Phlebotomy	CCG			110,000			
	Respiratory	CCG			273,000			
	Cardiac rehab	CCG			217,000			
	Community Dietetics	CCG			328,000			
	Community Nursing	CCG			15,000			
	Total			**4,676,000**	**3,134,000**			
Long Term Care and Adult Social Care	People First Advocacy	CCG		19,000	15,000	Lead Council	100% to Council	ICG and PBG to Exec
	Support to community care services	CCG		3,347,000	2,363,000			
	Performance money 2015.16 to support ASC	CCG		175,000	126,000			
	1.1% minimum uplift on social care min contribution	CCG		59,000	47,000			
	Social worker capacity and supporting	CCG		299,000	207,000			

Theme	Scheme Name	Funded by	LA	SS CCG £	SF CCG £	Approach	Risk and benefit approach	
							Overs	Unders
	discharge							
	Social worker capacity - mobile working	CCG		30,000	21,000			
	Reablement vouchers and telecare	CCG		53,000	42,000			
	Care Act	CCG		491,000	386,000			
	ASC Capital Funding 2015/16	LA	780,000					
	Total			**4,473,000**	**3,207,000**			
	TOTAL			**26,967,000**				

Appendix D: Where we think we are against the 10 key elements

Key Element
1. A shared commitment to improving local people's health and wellbeing using approaches which focus on what is the best outcome for citizens and communities.
What good looks like Moving away from a focus on episodic care and treating ill health towards an emphasis on independence, wellbeing and holistic care for everyone. Understanding the needs and wishes of citizens, including the resources they and those around them can contribute to their own health and wellbeing. Bringing together all the assets in a place to stimulate and support individuals, families and communities to be more able to lead happy, safe, independent and fulfilled lives.
Where we are
What we need to do

Key Element
2. Services and the system are designed around the individual and the outcomes important to them, and developed with people who use or provide services and their communities.
What good looks like Involving individuals and communities in decisions at all levels of the system, from jointly writing a care and support plan with service providers, to groups of community stakeholders playing a central role in designing, implementing and reviewing services. Ensuring services treat people with dignity and are personalised to their needs, and are based on a single system-wide assessment of the needs of the whole population. Giving citizens greater choice and control of services and support, including encouraging the use of a personal budget for health and social care.
Where we are
What we need to do

Key Element
Everyone – leaders, practitioners and citizens – is committed to making changes and taking responsibility for their own contribution to improving health and wellbeing
What good looks like Offering information, education, advice and support to enable everyone to understand how to make changes for a healthier lifestyle and support their care needs. Building capacity in the community to be able to support all citizens to make full use of community and social networks and activities. All system leaders and practitioners actively ensuring their actions support their shared vision and their contribution to improving health and wellbeing.

Where we are
What we need to do

A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens.
What good looks like Changing the perception of health and care from just treating ill health or substantial care needs to one which keeps people well and safe, leading happy and fulfilled lives. Redirecting investment to prioritise public health and community services, as well as wider issues affecting health such as education, housing and jobs for all citizens. Having open and trusting relationships with partners, stakeholders and the public from which to make effective, targeted and needs-based decisions about service provision.
Where we are
What we need to do

Shared Leadership and Accountability Locally accountable governance arrangements encompassing community, political, clinical and professional leadership which transcend organisational boundaries are collaborative, and where decisions are taken at the most appropriate local level.
What good looks like Leaders stepping beyond their organisation's walls to listen and understand each other, and to lead and make decisions collectively for the benefit of citizens. Local leaders being best placed to interpret and respond to community needs drawing in wider services and local resources where appropriate to improve health and wellbeing. Leaders being inclusive and collegiate, investing time and energy in relationships, ceding some control, and navigating complexity across multiple accountabilities.
Where we are
What we need to do

Locally appropriate governance arrangements which, by local agreement by all partners and through health and wellbeing boards, take account of other governance such as combined authorities, devolved arrangements or NHS planning requirements.
What good looks like Navigating across footprints and local identities which exist within any one place, ensuring that the focus remains on what most benefits local populations taking account of whole community need and multiple organisational governance.

It can mean health and wellbeing boards agreeing to sit within larger arrangements as well as establishing alternative partnerships to carry out business effectively.

It can mean multiple arrangements for different purposes – the key is ensuring decision-making is with the right people and in the right place.

Where we are

What we need to do

A clear vision, over the longer term, for achieving better health and wellbeing for all, alongside integrated activity, for which leadership can be held to account by citizens.

What does good look like

Working together to align priorities and responsibilities, including overcoming cultural and performance challenges to establish a common language and set of objectives.

Exploring the many ways to integrate health and care to find the models and approaches which best meet local needs and aspirations.

Developing a system which works cohesively, with individual services that are high-quality and safe, and is sustainable in terms of services, markets and workforce.

Where we are

What we need to do

Shared systems

Common information and technology at individual and population level shared between all relevant agencies and individuals, and use of digital technologies.

What does good look like

A common information basis and sharing for planning purposes and shared care records – both for individual care and population-based planning.

Service arrangements and plans involve enabling and empowering people through technology, and also meaning they tell their story only once.

Developing a shared risk stratification model to identify individuals most at risk

Where we are

What we need to do

Long-term payment and commissioning models – including jointly identifying and sharing risk, with a focus on independence and wellbeing for people and sector sustainability

What does good look like

Aligning commissioning across all budgets, whether pooled or not, focusing on outcomes and increasing investment in community services that build independence.

Agreeing how to assess and share risk between partners. Shared long-term planning, which charts an achievable course to transform services and improve health, wellbeing and financial sustainability.
Where we are
What we need to do

Integrated workforce planning and development, based on the needs and assets of the community, and supporting multi-disciplinary approaches.
What does good look like Developing a joint workforce strategy across the health and care system, involving formal and informal workforces, and based on the needs of the population. Investing in changing skills and behaviours towards ones which enable person-centred, coordinated care in order to promote people's independence and wellbeing. Practitioners across health and care disciplines working seamlessly together to plan and provide care which is proactive and holistic, and supports independence.
Where we are
What we need to do

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2017

Agenda Item: 17/11	**Author of the Paper:** Becky Williams Strategy & Outcomes Officer Email: Becky.Williams@southportandformbyccg.nhs.uk Tel: 01512477000
Report date: January 2017	

Title: Two Year Operational Plan

Summary/Key Issues:

This report presents to the Governing Body the Southport and Formby CCG Operational Plan 2017-19 in response to the requirements of NHS England and NHS Improvement jointly issued guidance. It further presents a chronological record of the work, assumptions, analysis and discussions undertaken to develop a two year CCG operational plan as required and the assurance activities NHS England have announced they will undertake when reviewing CCG plans.

Recommendation

The Governing Body is asked to approve this report.

Receive	
Approve	X
Ratify	

Links to Corporate Objectives *(x those that apply)*	
	To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.
X	To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the "Forward View", underpinned by transformation through the agreed strategic blueprints and programmes.
X	To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.
	To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
	To advance integration of in-hospital and community services in support of the CCG locality model of care.
	To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement		X		
Clinical Engagement	X			At Governing Body Development session 15/12/2016.
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
Clinical Commissioning Group

Report to Governing Body
JANUARY 2016

1. Executive Summary

This report presents to the Governing Body the Southport and Formby CCG Operational Plan 2017-19 in response to the requirements of NHS England and NHS Improvement jointly issued guidance. It further presents a chronological record of the work, assumptions, analysis and discussions undertaken to develop a two year CCG operational plan as required.

Following final submission of the Operational Planning templates on 23rd December 2016, NHS England has announced details of the assurance process plans will be tested against. The latest version of the ratings was shared with CCGs on 9th January 2017 and Southport and Formby CCG is adjudged Red/Amber for activity plans and a combination of Red and Green for Mental Health.

2. Introduction and Background

2.1 Planning Guidance

CCG Operational Planning guidance for 2017-19 was jointly published by NHS England and NHS Improvement 22nd September 2016 (see Appendix 1 for the link to the official planning guidance publication). This planning guidance describes to CCGs the expectations of the two regulatory organisations with respect to planning and also references support to Sustainability and Transformation Plans (STPs), and the NHS Five Year Forward View (NHS5YFV) and the 'NHS Reset'. It reaffirms national priorities and sets out the financial and business rules for both 2017/18 and 2018/19. CCGs were required to complete submission of plans in line with the published planning timetable (see Appendix 2 for a copy of the planning timetable).

There are direct links between CCG Operational Plans (which primarily focus on activity and meeting NHS Constitutional targets), CCG Financial Plans, and the negotiation and agreement of CCG and Provider contracts.

Significant differences should be noted in that final CCG Operational Plans and CCG Financial Plans were required to be submitted at a point three months' earlier in the year than previous years, concurrently with contract sign-off, and that plans should be derived for two financial years as opposed to one year. The rationale for this being to allow organisations to "provide certainty earlier" and "devote more of our energies towards getting on with the job of redesigning and delivering better, more efficient care".

3. Key Issues

3.1 Planning Template

The Operational Planning template required CCGs to review an NHS England pre-populated 2016/17 month 3 based Forecast Outturn activity. CCGs were permitted to make adjustments if necessary, to reflect local intelligence and knowledge of activity and forecasting, and then create monthly CCG level activity plans across several Points of Delivery (POD) for both 2017/18 and 2018/19. Plans should take into account non-recurrent activity changes, trend and demographic

growth, transformational change and policy changes. Unlike previous years, provider level plans were not required to be completed by CCGs for this planning round.

As described throughout the 2016/17 planning process, activity numbers were provided to CCGs and pre-populated in planning templates using the Temporary National Repository (TNR), and CCGs have struggled to replicate their local data to this data source for a number of detailed technical reasons which have been raised with Local Area Teams in the 2016/17 planning round.

Following the first draft submissions of CCG plans on 24th November 2016, NHS England issued six key lines of enquiry for CCGs to ensure they addressed in their final 23rd December submission. These are addressed in the following sections:

3.2 Affordability

A cost and volume Payment by Results (PbR) contract has been agreed between Southport and Formby CCG and Southport & Ormskirk Hospital for 2017/18 and 2018/19.

The activity figures are in line with contract values included within the CCG financial plan. It should be noted that delivery of the financial plan requires a QIPP saving of £11.5m in 2017/18 and £2.5m in 2018/19.

3.3 Adjustments (Forecast Outturn, Growth, Trend Analysis, Counting and Coding Changes)

The NHS England produced month 3 based Forecast Outturn was tested against a number of CCG internal forecasting methodologies. These were straightforward twelfths and a seasonally profiled forecast, both of which based on month 6 of 2016/17 as opposed to the month 3 based NHSE forecasts. These CCG generated methods resulted in forecast outturns on the whole lower than the NHSE generated FOTs which were felt to be too high, likely because the NHSE forecast was subject to high variation given that it only took 3 months of the year into account. The choice of profile for each measure was then based on the degree of variation from the NHSE produced forecast.

Code	Activity Line	17/18 Annual Plan	18/19 Annual Plan	Forecast Growth from CCG 16/17 FOT to 17/18	17/18 to 18/19 Forecast Growth
E.M.7	Total Referrals (General and Acute)	53,531	53,119	-5.8%	-0.8%
E.M.7a	Total GP Referrals (General and Acute	34,154	33,606	-5.5%	-1.6%
E.M.7b	Total Other Referrals (General and Acute)	19,377	19,513	-6.3%	0.7%
E.M.8	Consultant Led First Outpatient Attendances	43,075	42,586	-7.3%	-1.1%
E.M.9	Consultant Led Follow-Up Outpatient Attendances	97,201	97,882	-7.1%	0.7%
E.M.10	Total Elective Admissions	21,319	21,467	-0.7%	0.7%
E.M.11	Total Non-Elective Admissions	16,012	15,473	0.7%	-3.4%
E.M.12	Total A&E Attendances excluding Planned Follow Ups	44,962	44,684	0.6%	-0.6%
E.M.18	Number of Completed Admitted RTT Pathways	8,466	8,526	0.7%	0.7%
E.M.19	Number of Completed Non-Admitted RTT Pathways	39,021	39,295	0.7%	0.7%
E.M.20	Number of New RTT Pathways (Clockstarts)	50,040	49,632	-6.3%	-0.8%
E.J.3	Number of specific acute bed days relating to hospital provider spells	111,463	112,244	0.7%	0.7%

Growth calculations mirror those used in financial plans as follows:

Growth	2017/18	2018/19
Southport & Formby Total	0.67%	0.70%
- *Demographic*	*0.17%*	*0.20%*
- *Non Demographic*	*0.50%*	*0.50%*

The Southport & Formby CCG demographic growth is based on the projected population growth for 2017/18 (NHS England figures used to generate CCG allocations). This is in addition to non-demographic growth of 0.5%. This is an estimate based on the knowledge that activity may increase but will be countered by QIPP schemes and transactional efficiencies such as contract challenges. Historically this level of non demographic growth has been included and it is believed to be a suitable estimate.

Activity trends over the past three years have been analysed, however it was concluded that to take account of activity from 2013/14 and 2014/15 would skew activity projections as in most areas, activity has grown in the last 18 months. A three year average would generate activity figures that would look too low when compared to 2015/16 activity; therefore plans are based on activity from the last 18 months.

After consultation with CCG leads in planned and unplanned care, contracts and other commissioning leads, there are no significant counting, coding or policy changes to account for in CCG Operational Plans.

3.4 Transformation Schemes

A number of transformational schemes are planned for implementation in 2017/18 and 2018/19. Note that they do not include plans that have materialised in that activity and costs have been avoided, saved or diverted by schemes in previous years as these will already be reflected in the baseline forecast outturn.

Transformation schemes have been presented to and agreed at QIPP committee (a sub group of the CCG's Finance and Resource committee). All schemes are based on best practice, evidence from academic literature, and activity and financial impacts have been modelled. Draft activity plans have been presented to Governing bodies. Once these have been agreed, schemes are added to the CCG QIPP dashboards and monitored on a monthly basis to assess progress and measure impact.

Note that the impact of Non Elective schemes on A&E attendances was modelled through based on historic activity splits of method of admission, and the impact of referral management schemes on GP and other referrals was apportioned modelled on historic activity.

The transformational change via the STP from 2018/19 onwards focusing on Outpatient and Elective activity schemes are described below in more detail:

Musculoskeletal Clinical Assessment Service (MCAS)
Analysis from NHS Rightcare packs indicated that there a degree of over-hospitalisation of patients in Southport and Formby; particularly in inpatient areas such as MSK services and procedures of limited clinical value. Increasing levels of referrals to providers outside of Southport and Ormskirk NHS Hospital Trust, namely Wrightington, Wigan and Leigh and Ramsay Health have emerged. Southport and Formby CCG carried out full review of the existing MCAS and orthopaedic

pathways. A Case for change has been developed and agreed with Providers. Changes will be reflected in contracts with providers from November 2016. The CCGs have adopted the principles of solution focussed shared decision making (SFSDM) to inform the shape of the new service and to introduce patient self-referral for routine physiotherapy and Musculoskeletal Clinical Assessment Service (MCAS) scheme has been launched in Southport and Formby. This service includes a single point of triage, with assessment and onward referral if deemed necessary, diagnostics, treatment including physiotherapy, joint injection therapy and pain management.

Procedures of Limited Clinical Value (PLCV)
The Midlands and Lancashire Commissioning Support Unit (MLCSU) have been commissioned to deliver clinical commissioned policies that will prioritise procedures of limited clinical value against value and cost over a 3 year period. The Individual Funding Requests (IFR) team have also offered a prior approval service to implement a process and an IT system to enforce the eligibility of treatment with respect to the procedures of limited clinical value. MLCSU process and administer this service on behalf of the CCG from December 2016 onwards.

Referral Management Scheme (RMS)
In response to NHS England concerns regarding referrals, schemes have been explored. The referral management system for Southport and Formby CCG comprises three phases and 4 levels: With phase 1 (level 2 intervention) implemented in October 2016:
• A software system installed in GP practices
• A referral reception team and booking team
This service is supported by an IT platform which ensures all referrals are managed. To date there are 4 specialties being referred via the service.

The next phase of the programme is to introduce clinical triage to specialities with opportunities identified via benchmarking. This includes additional investment in extending triage for all dermatology referrals

Phase 2 (level 3 intervention)
• Clinical triage by GpwSI

Phase 3 (level 1 intervention)
• Peer review in practice incentivised by new LQC

Phase 4 (level 4 intervention)
• Develop more community services to refer to

Consultant to Consultant Referral Policy (C2C)
A consultant to consultant policy has been reviewed and updated and agreed with Providers for Southport and Formby CCG. Southport and Formby CCG has also agreed a CQUIN with Southport and Ormskirk to support implementation.

The transformational change for Non Electives via the STP originally stated a number of activity reductions in 2017/18. However in order to ensure plans are realistic and achievable STP activity changes are now reflected in 2018/19 onwards. The schemes are described below in more detail:

Cardiology
The implementation of a North Mersey-wide cardiology redesign initiative, one aim of which is to reduce emergency admissions. This is an opportunity identified from the Right Care programme.

Community

The development of integrated multi-disciplinary care teams, on a neighbourhood footprint, designed to meet the specific care needs of local populations has been specified for the forthcoming Community Services contract award for April 2017.

Digital
The Assistive Technology Programme will support not only the future development of community services but will also greatly impact of how services will be provided across primary and secondary care. The ability to access and deploy the latest technology to support diagnosis, monitoring and self-care coupled with enhanced patient relations through consumer devices offers a viable route to redesigning care pathways capable of meeting future demands. Published research from Liverpool shows a reduction of 22-32% in emergency admissions and secondary care costs for patients using telehealth technology in chronic condition pathways.

Primary Care
Implementation of a new GP specification supporting greater capacity and resilience within primary care with increased same day access to routine and urgent primary care seven days a week, enabling a single pathway for access. The spec will continue to provide direct incentives for localities and practices to reduce emergency admissions by providing regular review and proactive care to patients with Long Term Conditions. This is incentivised via the Local Quality Contract.

3.5 Alignment with other plans (CCG financial, activity, QIPP, STP, Providers)

The transformation schemes for 2017/18 described earlier are detailed in financial terms in the CCG financial plan with direct read-across to CCG QIPP plans. Note that they differ from the October 2016 submission of the North Mersey LDS STP. This is because the October 2016 submission has been reviewed and further refined, with growth and demographic changes updated and aligned with financial plans, while the initial STP was based on a 'Do Nothing' IHAM scenario. Another key difference is the starting points for the STP versus the CCG operational plans: STP uses Month 5 FOT, and the Operational plan uses various starting points.

The contribution to the STP submission from the two CCGs has been reviewed to ensure that transformational schemes are achievable and realistic. As stated in the original STP submission the modelling demonstrated sound ideas, however would require further analysis and challenge to convert them into more robust plans Following this review 2017/18 QIPP plans have been aligned with CCG financial plans, and reflected impacts of STP schemes that were submitted for 2017/18 against 2018/19 instead.

Whilst Providers have been fully engaged in the STP process and have agreed to the activity and finance plans submitted, there is likely to be divergence between separate organisational plans (CCG and Provider). This is because in contract negotiations, Provider organisations are cautious to agree activity and financial plans for CCG schemes that are yet to deliver. This means for example that Providers are unlikely to have accounted for the impact of Demand Management schemes in their plans. Provider organisations tend to prefer to build activity changes into plans the year following implementation once impacts have actually been observed. In terms of POD by POD alignment of plans, see below:

Consultant led First Outpatient attendances (Specific Acute)	Data error is clear in the table for Provider plans with approx. 25% less than baseline. Providers reticent to include demand management impacts so likely to be some degree of variance once error is rectified.
Consultant led Follow up Outpatient attendances	Broadly align but as described above, Providers reticent to include demand management impacts

(Specific Acute)	
Total elective admissions spells (Specific Acute)	Align
Total non-elective admissions (Specific Acute)	Align
Total A&E attendances (excluding planned follow up)	Data error is clear in the table for Provider plans with approx. 40% less than baseline. Providers reticent to include demand management impacts so likely to be some degree of variance once error is rectified.

3.6 NHS Constitution Measures

Activity is deemed to be both affordable and sufficient to meet the NHS constitutional standards. Confidence remains high that the transformation schemes described above will manage demand sufficiently to permit planned activity levels be manageable enough to meet the constitution targets. Following NHSE feedback from draft submission one, the RTT clock starts were reviewed alongside referrals. Colleagues at NSHE highlighted a disparity between the number of first outpatient attendances and Clock starts, noting they would not expect to see a higher number of Clock starts than first outpatient appointments. On review of local data, clock starts historically are higher than first Outpatient appointments but lower than referrals. It is believed that there are a number of legitimate reasons why clock starts may be higher than outpatient firsts which has been fed back to NHS England local DCO.

A further more detailed technical planning narrative document has been shared with the NHS England local area team to enable assessment and assurance of CCG Operational Plans. Each indicator within the planning template was assigned a managerial lead form the within the Commissioning team and a dedicated analyst from the CCG Business Intelligence team to review and then plan for those indicators aligned to their area of work (Appendix 3).

3.7 NHS England Assessment and Assurance of Plans

Following final submission of the Operational Planning templates on 23rd December 2016, NHS England has announced details of the assurance process plans will be tested against. Local NHS England area teams have been asked by NHS England North counterparts to form an initial assessment of CCG Operational Plans using a template to RAG rate two main aspects of the plans; overall credibility of activity pans (a single overall RAG rating on a scale of Red, Red/Amber, Amber/Green, Green), and compliance with the Mental Health Investment standard and achievement of Mental Health performance trajectories.

The assessment approach is to revisit the overall assurance RAG ratings that were undertaken on the first draft submissions made on 24th November 2016 where an assessment was made against four key questions described in section 3.1 of this report and the sections that follow it.

• Q1 – Is activity affordable and in line with financial plans?: Factors which move a CCG towards red are setting a deficit plan/being in recovery or directions/having a high % QIPP and the overall scale of these issues.
• Q2 – Sufficient activity to deliver NHS Constitution standards?: All CCGs rated Green where CCGs are planning to meet an NHS Constitution standard and red where they are not.

• Q3 – Credible plans to reduce demand?: Assessment is somewhat subjective, but the most robust plans clearly quantify the impact of specific transformational initiatives on each point of delivery within the narrative supplied, and include clear milestones for delivery as well as narrative around the evidence base/rationale that supports a sense that the initiatives are deliverable. Factors which drive ratings in a negative direction are either lack of information e.g. the narrative supplied doesn't support an analysis of how CCG plans will produce the activity reductions within the planning templates, or the information supplied indicates that the initiatives are high risk or at a very early stage of development such that limited benefit will be seen in 2017/18.
• Q4 – How does activity align to provider plans?: In the absence of provider activity data, overall CCG contract sign off status has been used as a proxy, so all contracts signed gives a Green, major contracts heading for arbitration is a Red, and issues still outstanding but unlikely to lead to arbitration is Amber/Green.

In terms of overall rating, any Red means that the overall rating is Amber/Red at best. Overall ratings of Red or Amber/Red are likely to entail further assurance questions in due course. The latest version of the ratings was shared with CCGs on 9th January 2017:

Activity plan assurance for Southport and Formby CCG:

Is activity affordable & in line with financial plans?	Sufficient activity to deliver the NHS constitution standards?	Are there credible plans in place to reduce demand?	How does activity align to provider plans?	Overall Activity Plan RAG
R/A	G	A/G	G	R/A

Mental Health plan assurance for Southport & Formby CCG:

Mental Health Investment Standard*	Performance Trajectories**	Comments
Not assured - both		For MHIS, CCG in deficit, in financial recovery and is not planning to meet business rules.

* DCO to highlight if not assured that the Mental Health Investment Standard will be met (specifying whether this is with reference to MHIS including or excluding LD & Dementia)

** DCO to highlight if not assured that the performance trajectories for the following standards are credible: Dementia Diagnosis Rate, IAPT Access, IAPT Recovery, IAPT 6ww, IAPT 18ww, EIP RTT, CYP Access, ED Routine, ED Urgent (please list as appropriate)

A comprehensive email has been sent to NHS England to query the reasons for the rating against the MH Investment Standard rating. A letter from national mental health lead, Anne Rainsberry suggests that a CCG will be flagged as an outlier where "one or more of the performance standards outlined in the table below are not planning to be met for three out of the four quarters (or monthly equivalent) for their respective year AND; the CCG does not plan on meeting the MH Investment Standard for 2017/18 and/or 2018/19 (for both plans including and excluding LD & Dementia)". Therefore the table above suggests that the CCG meets one of those criteria but not both. There is a section in the CCG financial plans for the Mental Health Investment standard and where a CCG is adjudged to have not met the investment standard, then the CCG has to provide a valid reason code. In the Southport and Formby CCG plan the following reason was submitted;

"Commissioners in deficit, not achieving 1% plan metric or with very low growth – in this case MH Parity of Esteem will be measured against increase in overall planned spend, recognising that growth will need to support the improvement in the financial position". Southport and Formby CCG is planning a deficit position, 2016/17 expenditure includes non-recurrent investments in transformation initiatives – across both years. A response from NHS England is awaited.

4. Conclusions

The Southport and Formby CCG Operational Plan details the key activity and performance metrics the CCG will aim to meet in order to meet the requirements of the NHS England and NHS Improvement CCG planning guidance 2017-19.

Following final submission of the Operational Planning templates on 23rd December 2016, NHS England has announced details of the assurance process plans will be tested against. The latest version of the ratings was shared with CCGs on 9th January 2017 and Southport and Formby CCG is adjudged Red/Amber for activity plans and a combination of Red and Green for Mental Health.

5. Recommendations

The Governing Body is asked to note the contents of this report and approve the Southport and Formby CCG 2017-19 Operational Plan.

Appendices

Appendix 1: Link to NHS England, NHS Improvement CCG Operational Planning Guidance 2017-19
https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

Appendix 2: NHS England, NHS Improvement CCG Operational Plan 2017-19 timetable

Timetable Item (applicable to all bodies unless specifically referenced)	Date
Planning Guidance published	**22 September 2016**
Technical Guidance issued	**22 September 2016**
Commissioner Finance templates issued (commissioners only)	22 September 2016
Draft NHS Standard Contract and national CQUIN scheme guidance published	22 September 2016
National Tariff draft prices issued	22 September 2016
Provider control totals and STF allocations published	30 September 2016
Commissioner allocations published	21 October 2016
NHS Standard Contract consultation closes	21 October 2016
Submission of STPs	**21 October 2016**
National Tariff section 118 consultation documents issued	31 October 2016[1]
Final CCG and specialised services CQUIN scheme guidance issued	4 November 2016[2]
Provider finance, workforce and activity templates issued with related Technical Guidance (providers only)	1 November 2016
Submission of summary level 2017/18 to 2018/19 operational financial plans (commissioners only)	1 November 2016 (noon)
Commissioners (CCGs and direct commissioners) to issue initial contract offers that form a reasonable basis for negotiations to providers	4 November 2016
Final NHS Standard Contract published	4 November 2016
National Tariff section 118 consultation opens	9 November 2016[3]
Providers to respond to initial offers from commissioners (CCGs and direct commissioners)	11 November 2016[4]
Submission of full draft 2017/18 to 2018/19 operational plans	**24 November 2016 (noon)**
Weekly contract tracker to be submitted by CCGs, direct commissioners and Providers	Weekly from: 21/22 November 2016 to 30/31 January 2017
Where CCG or direct commissioning contracts not signed and contract signature deadline of 23 December at risk, local decisions to enter mediation	5 December 2016
Contract mediation	5 – 23 December 2016
National Tariff section 118 consultation closes	6 December 2016[5]
National Tariff section 118 consultation results announced	w/c 12 December 2016
Publish National Tariff	20 December 2016[6]
National deadline for signing of contracts	**23 December 2016**
Final contract signature date for CCG and direct commissioners for avoiding arbitration	23 December 2016
Submission of final 2017/18 to 2018/19 operational plans, aligned with Contracts	**23 December 2016**
Final plans approved by Boards or governing bodies of providers and Commissioners	By 23 December 2016
Submission of joint arbitration paperwork by CCGs, direct commissioners and providers where contracts not signed	By 9 January 2017
Arbitration outcomes notified to CCGs, direct commissioners and providers	Within two working days after panel date
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 31 January 2017

[1] The first set of documents that make up the s 118 National Tariff consultation were published on the 31 October. The remaining documents were published on the 8 November, and the statutory consultation period commenced on the 9 November. The consultation period closes on the 6 December.
[2] The final CQUIN and Prescribed Specialised Services CQUIN guidance were published on 4 November rather than 31 October as included in the original timetable.
[3] See footnote 1 above.
[4] Row 16 footnote: The date 4 November for 'Providers to respond to initial offers from commissioners (CCGs and direct commissioners)' was incorrect. It has been corrected to 11 November.
[5] See footnote1 above.
[6] The National Tariff publication date is dependent upon the completion of a 28-day consultation period.

Appendix 3: CCG Internal Management Oversight and Planning for Constitution Indicators

	Indicator	Managerial Lead	BI Lead
Activity	Total Referrals (General and Acute)	Karl McCluskey	Luke Garner
	Consultant Led First Outpatient Attendances	Karl McCluskey	Luke Garner
	Consultant Led Follow-Up Outpatient Attendances	Karl McCluskey	Luke Garner
	Total Elective Admissions (Ordinary Electives + Daycase)	Karl McCluskey	Luke Garner
	Ordinary Elective Admissions	Karl McCluskey	Luke Garner
	Daycase Elective Admissions	Karl McCluskey	Luke Garner
	Total Non-Elective Admissions	Karl McCluskey	Luke Garner
	Total A&E Attendances excluding Planned Follow Ups	Karl McCluskey	Luke Garner
	Number of Completed Admitted RTT Pathways	Karl McCluskey	Luke Garner
	Number of Completed Non-Admitted RTT Pathways	Karl McCluskey	Luke Garner
	Number of New Incomplete RTT Pathways (Clock starts)	Karl McCluskey	Luke Garner
Constitution	RTT - Incomplete	Moira Harrison	Emily Golightly
	Diagnostics	Moira Harrison	Emily Golightly
	Cancer Waiting Times - 2 Week Wait	Moira Harrison	Ally Dwyer
	Cancer Waiting Times - 2 Week Wait (Breast Symptoms)	Moira Harrison	Ally Dwyer
	Cancer Waiting Times - 31 Day First Treatment	Moira Harrison	Ally Dwyer
	Cancer Waiting Times - 31 Day Surgery	Moira Harrison	Ally Dwyer
	Cancer Waiting Times - 31 Day Drugs	Moira Harrison	Ally Dwyer
	Cancer Waiting Times - 31 Day Radiotherapy	Moira Harrison	Ally Dwyer
	Cancer Waiting Times - 62 Day GP Referral	Moira Harrison	Ally Dwyer
	Cancer Waiting Times - 62 Day Screening	Moira Harrison	Ally Dwyer
	Cancer Waiting Times - 62 Day Upgrade	Moira Harrison	Ally Dwyer
	Ambulance Calls Closed by Telephone Advice	N/A	N/A
	Incidents Managed Without Need for Transport to A&E Departments	N/A	N/A
	A&E Performance Provider 1	Sharon Forrester	Becky Williams
	A&E Performance Provider 2	Sharon Forrester	Becky Williams
	A&E Performance Provider 3	Sharon Forrester	Becky Williams
Quality & Mental Health	Dementia	Kevin Thorne	Debbie Fahy
	IAPT roll-out	Geraldine O'Carroll	Debbie Fahy
	IAPT Recovery	Geraldine O'Carroll	Debbie Fahy
	IAPT Waiting Times - 6 Weeks	Geraldine O'Carroll	Debbie Fahy
	IAPT Waiting Times - 18 Weeks	Geraldine O'Carroll	Debbie Fahy
	EIP - Psychosis treated with a NICE approved package within two weeks	Gordon Jones	Debbie Fahy
	Improve access rate to CYPMH	Peter Wong	Becky Williams
	Waiting Times for Routine Referrals to CYP Eating Disorder Services - Within 4 Weeks	Peter Wong	Becky Williams
	Waiting Times for Urgent Referrals to CYP Eating Disorder Services - Within 1 Week	Peter Wong	Becky Williams

	Reliance on Inpatient Care for People with LD or Autism	N/A	N/A
Other Commitments	Total Bed Days	Karl McCluskey	Luke Garner
	E-Referral Coverage	Moira Harrison	Becky Williams
	Personal Health Budgets	Tracy Forshaw	Becky Williams
	Children Waiting more than 18 Weeks for a Wheelchair	Peter Wong	Becky Williams
	Extended access (evening and weekends) at GP services	Angela Price	Becky Williams

Becky Williams
Strategy & Outcomes Officer
January 2017

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Wednesday 19th October 2016	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions
• Changed forecast outturn to £7m deficit from £4m plan after discussions with NHSE.	• Missed financial plan / impact on CCG legal directions.	• Confirmed focus on reducing expenditure to deliver revised forecast outturn of £7m and to ensure that 17/18 plans are robust and deliverable.

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

- Non-delivery of QIPP is the biggest risk facing the CCG.
- ETTF Bids evaluated. The CCG has been given approval to proceed with four IM&T schemes in the year and to start business cases for key estates developments.
- Positive feedback reported from the Repeat Prescribing Ordering Service Pilot in terms of patient safety / reducing unnecessary prescriptions.
- The CCG agreed support for improvement grant bid received. Further discussion and information required before the bid is confirmed.
- Pooled budget report received. Governing Body discussion is scheduled for January / March regarding sign off.

NHS
Southport and Formby
Clinical Commissioning Group

Key Issues Report to Governing Body

Quality Committee Meeting held on 20th October 2016	Chair: Dr Rob Caudwell

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

- **High Court Judgement: CQC Inspections of GP Practice** – To request further information from NHSE regarding this judgement. Issue to be placed on the Risk Register.
- **Quality Team Risk Register** – Received by the Quality Committee.
- **Dermatology Update** – Strategic Review Group has been established by the CCGs. Terms of Reference are being finalised. Participation from Secondary Care colleagues and patients is to be secured.
- **Southern Health Report** – Report received by the Committee and recommendations for commissioners noted. Progress against the recommendations highlighted particularly in relation to Serious Incident Management and impact on the proposed CQUIN for 2017/18 due to recent planning guidance. Relationships between DoLS and the Coroner to be explored.
- **Quality Impact Assessment Policy** – Approved by the Committee.
- **IAPT** – National IAPT Support Team are working with Access Sefton to improve processes and performance. Concern remains regarding 'hidden waits' and the remedial action plan had been received. Concern regarding prioritisation remains. An update has been presented to the Overview & Scrutiny Committee and a Chief Officer to Chief Executive conversation has taken place.
- **Dementia** – Challenges evident with Dementia diagnosis. A discussion is to be had a Leadership Team.

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Audit Committee Meeting held on Thursday 14th July 2016	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions
Register of Interests to be taken to the Governing Body meeting in July and to the Audit Committee meeting in October.	GB not appraised of Conflicts of Interest.	To circulate in October.

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

- Internal Audit progress report received – significant assurance on "Risk management arrangements".
- Anti-Fraud Services report received on Conflicts of Interest:
  - No fraudulent activity identified in sample selected.
  - Small number of recommendations reviewed which officers are working through.
- Auditor presented Annual Audit letter 2015/16 which completes the external audit for the 2015/16 Financial Year.
- Managing Conflicts of Interest and Gifts and Hospitality Policy approved subject to minor amendments.
- Chair of Audit Committee and the Chief Finance Officer have been given delegated authority to approve the "Anti-Fraud, Bribery and Corruption Policy", following review/comments from committee members.

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Audit Committee Meeting held on Wednesday 12th October 2016	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions

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

- Internal audit plan on target.
- Proactive review postponed to enable resources to be diverted to the NHS Protect Assessment Report.
- NHS Protect Assessment Report received. Evidence of good practice in most areas.
- Risk register – risks and overall rating reviewed.
- Review of Conflict of Interest Register. A number of actions to follow. Governing Body members will receive an update in November.
- External Audit Technical Update received.
- Counter Fraud Progress Report received.

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

SF NHSE Joint Commissioning Committee, Wednesday 7th December, 2016	Chair: Gill Brown

Key Issue	Risk Identified	Mitigating Actions
APMS Procurements	Concern raised over engagement process.	A more formal process is required and actions to address
LQC Phase 2	Frailty Scheme- performance to date	Searches are being amended to ensure all appropriate activity picked up; practices have been contacted and assurances given by practices that plans are in place.
CQC Results- SFCCG practice placed into Special Measures	Quality of care. Local housing development will mean increase in patient numbers. Risk to practice resilience.	Task and Finish group to be set up to address this. Will explore offer of support through GP Resilience Fund. LMC already supporting practice to address concerns.
Care Home patients	Trinity has >10% of population as care home patients which is above CCG and national average.	Dr Kati Scholtz has successfully negotiated with local practices to take on a number of patients whose homes no longer fall within the Trinity boundary. Possibility of exploring reallocation of further patients as 2017 progresses.

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

Key Issues Report
Southport & Formby Localities

NHS
Southport and Formby
Clinical Commissioning Group

Oct –Dec 2016

Due to change in frequency the following meetings took place for this period:
Ainsdale & Birkdale: October only (December postponed to January)
Central: November only
Formby: November only
North: October and December

AINSDALE & BIRKDALE LOCALITY		
Key Issues	**Risks Identified**	**Mitigating Actions**
1. Ambulatory Care Unit	• Issues reported with the service as they often do not answer the phone or have answering service. GPs often have to speak to non-clinical bed manager which does give confidence for a clinical discussion/handover. Need clarity on the process for DVT patients.	• AJ escalated to Billie Dodd and the Clinical Director of Acute Care at S&O.
2. Electronic letter – duplication of electronic and paper copies	• Ongoing issues with duplication which impact on workload.	• AJ investigating this with Paul Shillcock, iMersey to resolve.
3. Optimise	• Issues with changing drugs when in workflow; you cannot edit this. Query raised whether block changes can be put on for items used regularly.	• SL is aware of this and is investigating. • KW investigating possibility of block changes.
4. Transgender Prescribing	• Issues around GPs doing the prescribing for transgender patients for their bridging hormones.	• AJ has confirmed with Jenny Kristiansen (CCG LGBT Lead) that she is working up the concept of having a GPSWI to do this prescribing. • Dr Leong at Arrowe Park will initiate these hormones.

Key Issues Report
Southport & Formby Localities

NHS
Southport and Formby
Clinical Commissioning Group

Oct –Dec 2016

CENTRAL LOCALITY		
Key Issues	**Risks Identified**	**Mitigating Actions**
1. Cardiology services	• Concerns raised at waiting times for S&O for cardiology referrals.	• Suggestion of giving patients other choices of hospital to refer to. • Community cardiology service is being worked up.
2. Inappropriate delegation to primary care.	• Concerns raised regarding non-commissioned work from secondary care to primary care. Increasing GP workload.	• To be sent back to secondary care using using BMA/LMC templates. • Quality team are also following this up. • To be followed up at January locality meeting.
3. LQC 17/18	• Discussions on the Liverpool GP Specification that was circulated for comments as to whether we should adopt something similar – concerns raised about access and KPI indicators at 100%, 50% and 25% (there should be 75% as well).	• Locality and individual Practice comments to be fed back to Angela Price; confirmed that if this spec was adopted it would be localised.

Key Issues Report
Southport & Formby Localities

Oct –Dec 2016

NHS
Southport and Formby
Clinical Commissioning Group

FORMBY LOCALITY		
Key Issues	**Risks Identified**	**Mitigating Actions**
1. Osteoporosis diagnosis	• Locality identified high number of fractures in comparison with osteoporosis diagnoses.	• AJ to look at activity on Aristotle and feedback. AJ to look at a process of identifying patients at risk, assessment, access to falls prevention etc.
2. Inappropriate delegation to primary care.	• As per Central locality. Concerns raised regarding non-commissioned work from secondary care to primary care and increasing GP workload.	• DC urged practices to send in examples of this work and not just complete it. LMC are following this up.

Key Issues Report
Southport & Formby Localities

Oct –Dec 2016

NHS
Southport and Formby
Clinical Commissioning Group

NORTH LOCALITY		
Key Issues	**Risks Identified**	**Mitigating Actions**
1. Care Homes allocation	• Concerns raised that issues around Care Home allocation have not been progressed.	• AJ to follow up with Jan Leonard and Tanya Mulvey for update on progress.
2. Workforce audit	• Key themes/concerns from this audit were discussed around the need to have the correct skill mix each day, signposting for patients could be utilised more effectively; having practice pharmacist/HCA/nurse practitioner available and triage of home visits.	• AJ feeding these themes back to New Ways of Working Group/GP Forward View Committee which will supplement the findings from the Heath Education North West workforce survey.
3. Ambulatory Care Unit	• Issues with service as per Ainsdale and Birkdale locality.	• Escalated to Billie Dodd and the Clinical Director of Acute Care at S&O.

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Minutes

Wednesday 19th October 2016, 9.30am to 11.30am

Family Life Centre, Southport

Attendees		
Helen Nichols	Lay Member (Chair)	HN
Gill Brown	Lay Member	GB
Dr Emily Ball	GP Governing Body Member	EB
Martin McDowell	Chief Finance Officer	MMcD
David Smith	Deputy Chief Finance Officer	DS
Susanne Lynch	CCG Lead for Medicines Management	SL
Debbie Fagan	Chief Nurse & Quality Officer	DF
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Ex-officio Member*		
Fiona Taylor	Chief Officer	FLT
Apologies		
Dr Hilal Mulla	GP Governing Body Member	HM
Colette Riley	Practice Manager	CR
Minutes		
Tahreen Kutub	PA to Chief Finance Officer	TK

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

Name	Membership	Jan 16	Feb 16	Mar 16	May 16	June 16	July 16	Sept 16	Oct 16	Nov 16	Jan 17
Helen Nichols	Lay Member (Chair)	A	✓	✓	✓	✓	✓	✓	✓		
Dr Martin Evans	GP Governing Body Member	✓	A	✓							
Dr Hilal Mulla	GP Governing Body Member	✓	A	✓	A	✓	A	✓	A		
Roger Pontefract	Lay Member	✓	✓								
Colette Riley	Practice Manager	A	✓	✓	✓	✓	✓	✓	A		
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓		
Debbie Fagan	Chief Nurse & Quality Officer	✓	✓	✓	✓	A	✓	✓	✓		
Jan Leonard	Chief Redesign & Commissioning Officer	✓	A	✓	✓	A	✓	✓	✓		
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A	✓	A	A	A	A	A			
Fiona Taylor	Chief Officer	*	*	*	*	*	*	*	*		
David Smith	Deputy Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓		
James Bradley	Head of Strategic Finance Planning	✓	N								
Susanne Lynch	CCG Lead for Medicines Management	✓	A	✓	✓	✓	✓	✓	✓		
Malcolm Cunningham	Head of Primary Care & Contracting	A	N	N	N	N	N				
Gill Brown	Lay Member				A	✓	✓	✓	✓		
Dr Emily Ball	GP Governing Body Member							✓	✓		

No	Item	Action
FR16/108	**Apologies for Absence** Apologies for absence were received from Dr Hilal Mulla and Colette Riley.	
FR16/109	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both Southport and Formby and South Sefton CCGs declared their potential conflict of interest. SL declared an interest in relation to the Repeat Prescribing Ordering Service Pilot to be discussed under item FR16/114, as her husband is a community pharmacy services contractor in Sefton.	
FR16/110	**Minutes of the previous meeting and key issues** The minutes of the previous meeting were approved as a true and accurate record **subject** to the following amendment under *FR16/95 Month 5 Finance Report:* the first three references to 'risk adjusted' should be taken out. The key issues log was approved as an accurate reflection of the main issues from the previous meeting.	
FR16/111	**Action points from the previous meeting** **FR16/80: Month 3 Finance Report** – DS confirmed the 17/18 forecast will be included in the Finance Report for next month. The run rate report has been included as an appendix in the report. Action closed. **FR16/87: Quality Premium Dashboard** – MMcD noted that the change in the CCG's financial forecast is likely to mean the CCG will not qualify for Quality Premium funding in 16/17. This effectively supercedes the outstanding query in the action. Action closed. **FR16/95: Month 5 Finance Report** - DS provided the following update: • *The year-to-date overspend at Alder Hey is £0.104m. The main area of overspend is related to Non- PbR Paediatric Rheumatology. DS to provide further information on this.* - Elective paediatric rheumatology - overspend was caused by a single high cost patient: behavioural disorders with long-term length of stay at a cost of £23k. - Day case diagnostic imaging £24k overspend – partly caused by two one-off patients in month 4. • *In reference to the Detailed Breakdown of Provider Costs in Appendix 2 of the report, DS to confirm what 'Other' is in relation to.* - This is related to smaller AQP providers including hearing care and chiropractor services. • *Provide clarity on the figures related to the independent sector.* - £390k YTD overspend is made up of: ▪ £121k cost pressures from 15/16. Due to increased costs greater than year-end accruals. ▪ £224k over-performance between MO1 and MO5. ▪ £45K predicted overspend for MO6. • *In the prescribing budget in the Finance report, GP prescribing is to be separated out for clarity.* - To be covered under item FR16/112. • *Re. the top paragraph on page 166 of the meeting pack which provides an overview of Table F (Risk Rated Financial Position), DS to correct the reference to 'achievement of the remaining QIPP requirement in full'. The correct reference should be to risk adjusted QIPP and not 'QIPP requirement in full'.*	

No	Item	Action
	- This has been corrected. Action closed. **FR16/95: Month 5 Finance Report** – re. the action for MMcD and SL to work on putting a statement together to ensure Directors of Finances are collectively clear with Trusts as to what is required re. QIPP and high cost drugs: - SL confirmed high cost drugs have been included in the CCG commissioning intentions letter including the expectation for Blueteq to be used. The letter has been shared with other CCGs so a consistent approach is taken by commissioners. CSU have written a proposal for the set up and ongoing update of the Blueteq software. The CCG is yet to see the proposal. MMcD is supporting the work by ensuring other Directors of Finance are aware of aspiration to use Blueteq and therefore support funding. Action closed. **FR16/97 and FR16/105** – actions completed and closed.	
FR16/112	**Month 6 Finance Report** DS provided an overview of the year-to-date Month 6 financial performance for Southport & Formby CCG as at 30th September 2016. The following was highlighted: • Forecast position at Month 6 is a deficit of £7.000m which was submitted after discussion with NHS England and includes known risks. • Financial position on operational budgets as at Month 6 - an overspend of £1.445m and the forecast for the year an overspend of £2.553m. • QIPP savings delivered at the end of Month 6 is £3.547m. • CCG Cash Position - if expenditure levels continue and the CCG does not achieve the planned QIPP targets to deliver the planned deficit of £7m, the CCG will need to develop plans to manage the additional cash requirement or this will require an additional cash allocation requested from NHS England which is not currently guaranteed. MMcD to ask Leah Robinson to liaise with NHSE to seek assurance that the CCG will receive sufficient cash during the year. • The main financial risks for the CCG continue to be non-delivery of the QIPP target in the year and increased levels of activity within acute care. The following comments were made: • HN queried how realistic the best and worst case figures were in *Table F – Risk Rated Financial Position*. MMcD will undertake further review with the finance team and report back next month. • HN commented that the prescribing budget in *Appendix 1 - Financial position to Month 6* does not reconcile with the budget in the prescribing report under item FR16/114. SL confirmed this is because the budget in the prescribing report refers solely to GP prescribing. It was requested that DS amend the budget layout in *Appendix 1 so* that it reconciles with the figures from the prescribing report. DS to action. • HN commented there needs to be an evaluation of risks and opportunities (in addition to commentary) in section 8 of the report, entitled *Evaluation of risks and opportunities*. DS to action. • GB commented about the importance of being realistic about QIPP. • MMcD referred to *Appendix 1 – Financial position to Month 6*. He said the Finance Outturn Variance is detailed as £1m but he thinks it should be £5m due to a presentational issue. DS to review for next month's report. ***The Committee received this report.***	MMcD MMcD DS DS DS
FR16/113	**Estates Working Group** MMcD provided an update on the outcome of the first stage of the Estates and	

No	Item	Action
	Technology Transformation Fund (ETTF), highlighting the following: • The ETTF has been oversubscribed. The value of bids received has exceeded the available resources allocated to deliver the programme. • MMcD provided a brief overview of Cohort 1, Cohort 2 and Cohort 3 schemes which are detailed in the report. • MMcD said four digital schemes have been assessed as Cohort 1: 1) Videoconferencing and telehealth solution 2) Mobile enabled kit purchase 3) Envisage and Patient Partner 4) CDA E-discharge summaries MMcD said the first three could be completed by the end of the financial year but E-discharge summaries could take longer. MMcD is meeting with Paul Shillcock, Primary Care Informatics Manager, next week to discuss the ETTF bids. ***The Committee received this report.***	
FR16/114	**Prescribing Performance Report** SL provided an overview of the prescribing report for Month 4 2016/17. She noted the position for month 4 (July 2016) is forecasting an underspend of £622k for the year. SL provided an update on the Repeat Prescribing Ordering Service Pilot. She said Epact data for September won't be available until mid-November. The Medicines Management team have run practice level searches on EMIS. The results have a number of caveats but currently show that on average pilot sites are showing a 6% higher reduction of repeat ordering / waste medicines compared to non-pilot sites. SL said she has also received positive feedback from individual contractors and pharmacists in regards to the pilot project. The Medicines Management team are currently collating further information and feedback on this. SL said will take this item to Clinical QIPP with a recommendation to roll out the project. ***The Committee received this report.***	
FR16/115	**IFR Update** JL provided an overview of this report which provides a summary of individual exceptional funding requests for quarter 1. JL noted the new design of the report as it is now provided by Midlands & Lancashire CSU. ***The Committee received this report.***	
FR16/116	**NHSE Improvement Grants** MMcD gave an overview of the paper on GP Practice Expressions of Interest for NHS England Improvement Grants. He said only one bid has been received, from Roe Lane Surgery. JL confirmed the email about the grants had been sent to all practices and therefore every practice was given the same opportunity. MMcD asked the committee for agreement in principle to the bid received with a view to further information being provided and further discussion. ***The Committee did not raise any objections to the bid received.*** ***The Committee received the report.***	
FR16/117	**Quality Premium Dashboard**	

No	Item	Action
	JL reported on the Quality Premium dashboard. MMcD noted that the change in the CCG's financial forecast is likely to mean the CCG will not qualify for Quality Premium funding in 16/17. ***The Committee received the report.***	
FR16/118	**Better Care Fund Update / Pooled Budgets** MMcD said that by the end of March 2017, the CCG and local authority need to identify the integration plan for health and social care for 2020-21. The report and outline financial plan submitted for this meeting is the first stage of this process. As detailed in the report, further work to determine the scope of integrated commissioning is ongoing and will inform the pace in terms of adoption of pooled budgets. MMcD said he has met with Dwayne Johnson, Director of Social Care and Health at Sefton Council, in regards to the Better Care Fund / pooled budgets to specifically identify what criteria should be used to determine whether budgets should be pooled or not. He highlighted two key things that came out of the discussion: • Avoidance of duplication of services • Clear focus on getting better outcomes GB commented that whilst she is aware this is a finance paper, it does not focus on the benefits to patients and she would be interested in knowing this aspect. MMcD said a Governing Body discussion is scheduled for January / March regarding sign off. ***The Committee received the report and would like to see further detail and criteria developed in due course.***	
FR16/119	**Any Other Business** <u>December F&R meeting</u> As a December F&R meeting has not been scheduled and given the financial position of the CCG, it was agreed to have a one hour finance session during the December Governing Body Development Session. MMcD to liaise with Judy Graves.	MMcD
FR16/120	**Key Issues Review** MMcD highlighted the key issues from the meeting and these will be presented as a Key Issues Report to Governing Body.	
	Date of Next Meeting Wednesday 16th November 2016 9.30am to 11.30am The Marshside Surgery, 117 Fylde Road, Southport, PR9 9XL	

NHS

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Joint Quality Committee Minutes

Date: **Thursday 20th October 2016, 1.00 pm – 3 pm**
Venue: **The Board Room, 3rd Floor, Merton House, Bootle L20 3DL**

Membership

Dr Rob Caudwell	Chair & GP Governing Body Member	RC
Paul Ashby	Practice Manager, Ainsdale Medical Centre	PA
Lin Bennett	Practice Manager, Ford	LB
Graham Bayliss	Lay Member	GB
Gill Brown	Lay Member	GBr
Dr Doug Callow	GP Quality Lead S&F	DC
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	PC
Billie Dodd	Head of CCG Development	BD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Dr Gina Halstead	Vice Chair & Clinical Lead for Quality	GH
Dr Dan McDowell	Secondary Care Doctor	DMcD
Martin McDowell	Chief Finance Officer	MMcD
Dr Jeffrey Simmonds	Secondary Care Doctor	JSi

Ex Officio Member

Fiona Taylor	Chief Officer	FT

In attendance

Tracey Forshaw	Head of Vulnerable People	TF
Gordon Jones	Mental Health Programme Manager	GJ
Brendan Prescott	Deputy Chief Nurse & Head of Quality and Safety	BP
Helen Roberts	Senior Pharmacist	HR

Apologies

Paul Ashby	Practice Manager, Ainsdale Medical Centre	PA
Gill Brown	Lay Member	GBr
Dr Doug Callow	GP Quality Lead S&F	DC
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	PC
Dr Gina Halstead	Vice Chair & Clinical Lead for Quality	GH
Dr Dan McDowell	Secondary Care Doctor	DMcD
Dr Jeffrey Simmonds	Secondary Care Doctor	JSi

Minutes

Vicky Taylor	Quality Team Business Support Officer	VT

Membership Attendance Tracker

Name	Membership	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Dr Rob Caudwell	GP Governing Body Member	√	√		√		L	L					
Paul Ashby	Practice Manager, Ainsdale Medical Centre	√	A		L		√	A					
Graham Bayliss	Lay Member for Patient & Public Involvement	A	√		A		√	√					
Lin Bennett	Practice Manager, Ford				√		A	√	A			A	
Gill Brown	Lay Member for Patient & Public Involvement	√	A		√		√	A					
Dr Doug Callow	GP Governing Body Member /Clinical Quality Lead	√	A		L		L	A					
Dr Peter Chamberlain	Clinical Lead Strategy & Innovation	A	√		√		A	A				A	
Billie Dodd	Head of CCG Development	√	√		√		√	L					
Debbie Fagan	Chief Nurse & Quality Officer	√	√		√		√	√					
Dr Gina Halstead	Chair and Clinical Lead for Quality	√	A		√		√	A					
Dr Dan McDowell	Secondary Care Doctor	A	√		A		A	A					
Martin McDowell	Chief Finance Officer	A	A		√		√	A					
Dr Andrew Mimnagh	Clinical Governing Body Member	√	√		A		A	√					
Dr Jeffrey Simmonds	Secondary Care Doctor						√	A					

✓ Present
A Apologies
L Late or left early

No.	Item	Action
16/120	**Apologies for Absence** Apologies for absence were received from PA, GB, Dr DC, Dr PC, Dr GH, Dr DMcD and Dr JS. DF welcomed everyone to the meeting noting that there were a number of conflicting meetings being held today which prevented some Committee members from attending. LB gave advanced apologies that she would be unable to attend any JQCs held on Wednesdays due to existing commitments.	
16/121	**Declarations of interest regarding Agenda items** CCG Officers holding dual roles in both Southport & Formby and South Sefton CCGs declared their potential conflict of interest. RC declared an interest with regard to the Dermatology agenda item.	
16/122	**Minutes and Key Issue Logs from the previous meetings** The Minutes of the Joint Quality Committee were agreed as an accurate reflection of the previous meeting. The Key Issues for SFCCG and SSCCG were approved.	
16/123	**Matters Arising/Action Trackers** There were no matters arising. **<u>Action Tracker</u>** **16/054 Whistle Blowing Policy and Procedure (Raising Concerns at Work) - *Southport & Formby CCG & South Sefton CCG*** DF has not yet received a response from AB and will liaise with Tracy Jeffes to ensure this matter is resolved. **Outcome: The JQC agreed that this action could be reviewed in one month** **16/114 Improving access to Psychological Therapies (IAPT) Quality Performance Reports - *Southport & Formby CCG & South Sefton CCG*** DF confirmed a more comprehensive report was on today's agenda following a presentation given to the JQC last month. **Outcome: Action completed – remove from the tracker.** **16/115(i) Dementia Diagnosis Rates – Improvement Plan for South Sefton - *South Sefton CCG*** DF confirmed a more comprehensive report was on today's agenda following a presentation given to the JQC last month. **Outcome: Action completed – remove from the tracker.** **16/115(ii) Dementia Diagnosis Rates – Improvement Plan for South Sefton - *South Sefton CCG*** In the absence of MMcD, it was agreed that a response would be sought outside of the meeting. FLT added that she was aware of a number of non-commissioned pieces of work being undertaken by GPs and that discussions with the LMC and CCG will be undertaken to address and will bring an action back into Leadership Team as required. LB was aware that the CCGs Programme Manager for dementia has already asked practices for information. **ACTION: FLT agreed to ensure this will be discussed with the LMC and will add to the Leadership Team agenda.** **16/117 Key Issue Logs: EPEG - *Southport & Formby CCG & South Sefton***	

	CCG GBa confirmed he hadn't received any feedback regarding the Healthwatch website. DF confirmed that discussion regarding the site had been raised at the S&O so that the Trust were aware and could have a look at the site. Contracts meetings. GBa explained that as EPEG had been cancelled this month, no further updates were available. **Outcome: Action completed – remove from the tracker.** **16/118 Any Other Business - *Southport & Formby CCG & South Sefton CCG*** FLT confirmed that the issue relating to the requirement for Lay Members from both SF and SS CCGs to attend each meeting had been raised at GB with agreement that the JQC Terms of Reference could be amended to reflect the need for only one Lay Member to be present to achieve quoracy. **Outcome: Action completed – remove from the tracker.**	
16/135	**Chief Nurse Report** DF presented the Committee with a number of key issues which had occurred since the Chief Nurse report submitted in September 2016. <u>Court of Protection (Southport & Formby CCG)</u> The Head of Vulnerable People represented the CCG at the Court of Protection for a final hearing in relation to a patient who SFCCG had been identified as the responsible commissioner. DF added that Hill Dickinson has passed on positive feedback from the Judge in relation to commissioner support and co-operation. <u>MRSA Post Infection Review (PIR) Meeting (South Sefton CCG)</u> The CCG chaired a MRSA PIR meeting in relation to a SSCCG patient who was diagnosed during a recent admission to AUH. The case was assigned to the CCG. <u>Nursing Home Update</u> An update on the latest position relating to the previously agreed financial uplift for this sector was shared with the JQC who were advised that a report is scheduled for presentation to the next meeting of both Governing Bodies 2016. The Knight Frank Research Report which looks at the Care Home market was discussed and this report is to be circulated after the meeting. FLT informed the Committee that the CCGs would be jointly commissioning with the LA a care home market analysis exercise so we can all better understand the market position as part of our commitment to the integration agenda. **ACTION: The Knight Frank report is to be circulated to Committee members**. <u>Local Safeguarding Children Board/Safeguarding Adult Board</u> The Chief Nurse and Deputy Chief Nurse have met with the new Chair of the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adults Board (SAB) as part of her induction. The LSCB met on the 5th October 2016 and received/approved: • Private Fostering Annual Report 2015/16 and Forward Plan 2016-2018 • The Local Safeguarding Children Board Annual Report 2015/16 • Sefton LSCB Improvement Plan August 2016-2017 (To meet OFSTED recommendations) • Sefton Multi Agency Safeguarding Hub Annual Report 2015-2016 • Integrated Early Help Strategy • Multi-Agency Neglect Strategy 2016-2018 The CCGs Safeguarding Annual report is due to be presented to the LSCB and SAB following review of the training statistics.	**VT**

	Safeguarding performance at Southport & Ormskirk Hospital NHS Trust (S&O) was discussed at the LSCB due to concerns raised in relation to current oerformance. A joint presentation with NHS England (NHS E) to the LSCB will be undertaken to provide further information to this Board in relation to systems of assurance in place across the health sector.. S&O CQC Inspection Report S&O has now received its CQC report. The Trust is within the 10 days checking period for factual accuracy and a response is expected to be submitted to the CQC by mid-November 2016. An update is likely to be provided at the next meeting of the Southport & Ormskirk Hospital NHS Trust Executive Improvement Board. Sefton Emotional Health & Wellbeing Strategy The Committee were advised that the Child & Adolescent Mental Health Services (CAMHS) partnership were due to meet later in the day with a view to finalising the strategy. MIAA Review re CCG Systems and processes to quality assure LCH The Chief Nurses of SF and SS CCGs and LCCG recently met with MIAA to discuss the Terms of Reference (TOR) for this review. A draft TOR is currently with the CCGs for review and feedback is likely to take approximately 6 weeks. AM highlighted the recent High Court challenge to the CQC Inspection in Primary Care. The High Court ruled that the CQC must allow GP Providers to submit evidence against any challenge within the report that may affect the outcome. AM also highlighted the timeliness of CQC reports, which may include quality concerns. BP acknowledged that this would be included on the Risk Register. DF stated she would contact NHSE colleagues to find out if they had any further information on this. **ACTION: BP to ensure the timeliness of CQC reports which involve quality concerns are included on the Quality Risk Register.** **ACTION: DF to contact NHSE colleagues to find out if they had any further information on the High Court challenge with respect to the CQC and GP practice inspections.**	**BP** **DF**
	The Committee received the report	
16/124	**Quality Surveillance Report – October 2016** The JQC received an exception report on quality issues for providers which incorporated Healthwatch Sefton reports and Local Authority issues with regard to the quality of care. The purpose of the report is to highlight issues across the wider Merseyside and Cheshire footprint which may have a bearing regionally and to discuss any potential solutions with support from NHS E or colleagues across the system. DF stated that this was the first time the JQC had received this report and asked whether the Committee considered it would be of value to receive such an update when performance reports were not scheduled as part of the workplan. BP considered local intelligence of issues experienced by GPs could be fed up through this route. FLT agreed that whilst it was a very helpful and comprehensive report, the timing	

	of some of the content needed to be borne in mind. BP referred to the dental issues in Southport &Formby and understood a plan was in place to address. Short term and long term actions were discussed during the meeting. AM raised issues regarding patients requiring out of hours dental support. Whilst BP was unaware of out of hours issues with the Dental service, he agreed to look into this further. RC said he had been contacted by a nursing home on behalf of a patient requiring dental support but could only signpost the caller to the Out of Hours service whilst recognising that the patient could only be transferred to a dentist by ambulance. **ACTION: BP to look into issues with out of hours Dental services as raised by AM and RC and feed back to the JQC.**	**BP**
	The Committee noted and received the report	
16/125	**Quality Team Risk Registers** BP presented this report which provides a summary of the risks currently managed by the Quality Team (QT) on behalf of NHS South Sefton and NHS Southport & Formby CCGs. The Quality Risk Register is to be shared with the JQC for review prior to submission to the Audit Committee. BP clarified actions taken by the QT in relation to reviewing and updating items on the register with the comments from the latest review highlighted within the report. The Committee discussed the revised process for the Corporate Risk Register / Governing Body Assurance Framework and how the loop was closed within the organisations subject to the specific risk ratings. RC raised concerns over SF004 which was a finance related risk. BP explained this had been discussed at QT but as it was a Finance Risk it should not have been included in the pack however he offered to share RC's concerns with MMcD. **ACTION: BP will raise the cause for the deteriorating position with MMCD.**	**BP**
	The Committee received the report	
16/126	**Dermatology** BP presented the JQC with a verbal update on Dermatology services. The Dermatology Strategy Review Group led by Karl McCluskey, Chief Strategy & Outcomes Officer will include Dr Gina Halstead and Dr Chris Randall of S&FCCG who has dermatology expertise and who has also agreed to be part of group. Representation from West Lancashire CCG, patient representation and a secondary care clinician will also be sought. Terms of Reference for the group are to be drawn up with a proposal that the main group meet monthly with a working group held fortnightly with an agreed way forward recognised by April 2017. . The mapping of services and different models in operation across different CCGs using community services is to be undertaken utilising Better Care Better Value and reviewed for benchmarking purposes. BP confirmed that Dermatology is discussed regularly at the Aintree CQPG, following Dr Steve Evans' letter advising that the Trust is unable to accept new referrals. The Trust is due to review its position at the end of October 2016 with	

	discussion to take place at the November 2016 CQPG. The Trust Dermatology Action Plan was circulated at the October 2016 CQPG and shared with the working group. RC reminded the Committee of a previously declared conflict of interest regarding dermatology services working out of his practice which is recorded on the CCGs Declarations of Interest Register. BP confirmed to FLT that the Quality Team (QT) were not aware of any safety issues at present. FLT suggested the QT be made aware of any risks by BD's team who are reviewing dermatology services to enable assurance to be provided.	
	The Committee received the verbal update	
16/127	**TRANSFORM (Hospice at Home)** BD presented this report which comprised details of the success and good quality care delivered by the TRANSFORM service provided by Southport & Ormskirk Hospital NHS Trust (S&O) which supported end of life patients. RC recognised the merits of the service, however AM understood there was no similar service in the South Sefton area. RC recognised that whilst the TRANSFORM service is continuing, there is a separate piece of work underway relating to the Woodlands. AM considered the quality of the work provided as reported was excellent. BD and RC agreed to discuss the service further outside of the meeting in terms of quality and value for money.	
	The Committee received the report	
16/128	**Southern Health Report** BP presented the JQC with a summary of a review carried out by Southern Health following the preventable death of Connor Sparrowhawk in 2013. This led to a number of investigations and enquiries into practices at Southern Health NHS FT. Recommendations for Commissioners were included within the report and BP stated that whilst some actions had already been undertaken as detailed on page 64 of the report, issues around contracting required further work to be undertaken. RC recognised the increased focus by the Head of Vulnerable People in ensuring improvement in the timeliness of reporting and closing down of provider incidents on StEIS. Steps have also been taken to address the quality of reports to ensure appropriate levels of assurance are provided.. BP highlighted recent positive conversations with Mersey Care Foundation Trust (MC) who were very open and welcoming in relation to discussions with the CCG and they are keen to continue to work with commissioners in order to further improve the quality of reporting. AM thanked BP for sharing the comprehensive report but considered the impact of DoLs assessments was inadequately reflected within the report. AM therefore suggested that this should be identified as part of our mitigation. **ACTION: BP is to look into the conclusions listed within the report in light of the DoLs issue raised by AM.**	**BP**
	The Committee received the report and noted the recommendations	

16/129	**Quality Impact Assessment Policy to support commissioning decisions** BP presented this policy which has been developed to support CCG officers and clinicans in the completion of Quality Impact Assessments. The policy was developed alongside Liverpool CCG to enhance QIA systems with the more comprehensive reasons behind the work explained under key issues within the report. It was noted that there was an incomplete sentence on page 73 of the pack (page 5 of the policy). **ACTION: BP will provide the additional wording that is missing from page 5 of the policy.** DF thanked BP for the work undertaken with the QIA process which will be utilised across the SS, SF and LCCGs. FLT asked whether providers would be clear on what was required of them and whether it was any different to what had been requested before, now that a policy was in place. DF clarified this process was for the CCGs and not providers as they would have their own QIA process. FLT asked if this could be shared with providers so they were aware about what was in use within commissioning for the purposes of transparency. DF stated that this could be done and that the policy would also be put with others from the CCGs on the respective websites **ACTION: DF to discuss with LCCG whether they would be happy to share the policy and QIA with providers.**	**BP** **DF**
	The Committee received the report and approved the policy subject to the amendment to page 5	
16/130	**Access Sefton IAPT Performance** GO'C attended the meeting to present the report and summarised the content drawing particular attention to the major issues caused by 'hidden waits' and actions being taken to address. NHS E are working with the Access Sefton service to manage the 'hidden waits' with work underway to ensure patients are fully aware of what they can expect from the service. RC was concerned that he could not identify how 'hidden wait' patients were prioritised in order to demonstrate recognition of their different levels of need. AM suggested 5 levels which could be used to assess patients requiring help in order to identify their needs and how soon they should be seen. GO'C explained joint work was underway to try and address this issue between the local Mental Health provider and the provider of the IAPT service. GO'C advised that a KPI on 'hidden waits' was to be included in next year's contracts with a potential shadow sanction. FLT confirmed that conversations had taken place at Governing Body from which she had taken an action to provide an IAPT update and have a discussion with the CEO of the IAPT provider. The CCGs concerns are recognised and the Overview & Scrutiny Committee pleased to see actions are being undertaken. FLT anticipates a response shortly from the national team and is satisfied all is being done by the CCGs to deal with the issue. **ACTION: GO'C to ascertain whether a prioritisation service is in place for patients accessing the service and report back to RC/JQC.**	**GO'C**

	The Committee received the report	
16/131	**Dementia Diagnosis Rates – South Sefton** GO'C presented this report which outlines the efforts and actions South Sefton CCG has taken to support people with memory issues, cognitive impairment and dementia to enable them to access appropriate and timely diagnosis and post diagnostic support. As part of the 'SAFE' assessment, GO'C advised that Kevin Thorne, Integrated Commissioning Manager has contacted practices to ask that they use the '6CIT' tool for initial screening / follow up to identify deterioration in a patient's condition which enables a GP to refer on for a full dementia assessment by Mersey Care Foundation Trust, with the NHS E in receipt of` monthly updates. GO'C is confident that SS CCG will have achieved the planned trajectory submitted and reminded JQC members that the targets are from the Prime Ministers ambition. RC referred to the disparity in some practices receiving baseline support to undertake the reviews. FLT recognised SS colleagues had been requested to undertake a piece of work without remuneration which it was believed S&F colleagues had received funding to carry out. FLT undertook to speak to MMcD regarding where these funds have come from. (BD left the meeting 15.02) **ACTION: FLT will discuss the source of funding with Leadership Team and asked that DF update the JQC with the response.**	**FLT / DF**
	The Committee received the report	
16/132	**GP Quality Lead Update:** • **Locality** • **Provider** RC and LB spoke of the increasing number of additional work requests being made of GPs.	
	The Committee received the report	
16/133	**Any Other Business** 1. DF advised that following the CQC report on Aintree University Hospital Trust's A&E department, the CCG Quality Team and Operational Team had undertaken a walk around of the new department accompanied by Dr Gina Halstead and Dr John Wray. The opportunity was taken to look at the SEPSIS pathway, staff training and priority for training, lessons learnt from SIs (particularly in relation to Learning Disability and Mental Health) and MEWS / NEWS. Patient entry through AED by the three different routes were also reviewed. Patient feedback on experience of AED was positive on the visit. Further visits are planned 2. At the Aintree CQPG last week a presentation on Advancing Quality and fractured neck of femur was made highlighted challenges and successes. The CCGs team accepted an invite from the Orthopaedic Clinical Team at the Trust and visited the unit and spoke with the clinical team today. A member of the team will be visiting the unit again to support from a commissioning perspective the reduction in any delayed transfers of care.	
16/134	**Key Issues Log** The following key issues were raised to be informed to the Governing Bodies:	

	South Sefton CCG • **High Court Judgement: CQC Inspections of GP Practice** – To request further information from NHSE regarding this judgement. Issue to be placed on the Risk Register. • **Quality Team Risk Register** – Received by the Quality Committee. • **Dermatology Update** – Strategic Review Group has been established by the CCGs. Terms of Reference are being finalised. Participation from Secondary Care colleagues and patients is to be secured. • **Southern Health Report** – Report received by the Committee and recommendations for commissioners noted. Progress against the recommendations highlighted particularly in relation to Serious Incident Management and impact on the proposed CQUIN for 2017/18 due to recent planning guidance. Relationships between DoLS and the Coroner to be explored. • **Quality Impact Assessment Policy** – Approved by the Committee. • **IAPT** – National IAPT Support Team are working with Access Sefton to improve processes and performance. Concern remains regarding 'hidden waits' and the remedial action plan had been received. Concern regarding prioritisation remains. An update has been presented to the Overview & Scrutiny Committee and a Chief Officer to Chief Executive conversation has taken place. • **Dementia** – Challenges evident with Dementia diagnosis. A discussion is to be had at Leadership Team Southport & Formby CCG • **High Court Judgement: CQC Inspections of GP Practice** – To request further information from NHSE regarding this judgement. Issue to be placed on the Risk Register. • **Quality Team Risk Register** – Received by the Quality Committee. • **Dermatology Update** – Strategic Review Group has been established by the CCGs. Terms of Reference are being finalised. Participation from Secondary Care colleagues and patients is to be secured. • **Southern Health Report** – Report received by the Committee and recommendations for commissioners noted. Progress against the recommendations highlighted particularly in relation to Serious Incident Management and impact on the proposed CQUIN for 2017/18 due to recent planning guidance. Relationships between DoLS and the Coroner to be explored. • **Quality Impact Assessment Policy** – Approved by the Committee. • **IAPT** – National IAPT Support Team are working with Access Sefton to improve processes and performance. Concern remains regarding 'hidden waits' and the remedial action plan had been received. Concern regarding prioritisation remains. An update has been presented to the Overview & Scrutiny Committee and a Chief Officer to Chief Executive conversation has taken place.	
	Date of Next Meeting The next meeting will be held at 11.30 am – 1.30pm on Wednesday 16th November 2016 – venue TBC	

Chair : _____ _____

PRINT NAME **SIGNATURE**

Date : _____

NHS
Southport and Formby
Clinical Commissioning Group

Audit Committee Minutes

Wednesday 14th July 2016, 11.00am to 12.30pm
3rd Floor Boardroom, Merton House

Attendees		
Helen Nichols	Lay Member (Chair)	HN
Gill Brown	Lay Member	GB
Martin McDowell	Chief Finance Officer	MMcD
David Smith	Deputy Chief Finance Officer	DS
Leah Robinson	Chief Accountant	LR
Paul Ashby	Practice Manager	PA
Dr Jeff Simmonds	Lay Member and Governing Body Member	JS
Adrian Poll	Audit Manager, MIAA	AP
Jerri Lewis	Audit Manager, KPMG	JL
Apologies		
Michelle Moss	Audit Manager, KPMG	MM
Minutes		
Tahreen Kutub	Interim PA to Chief Finance Officer	TK

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

Name	Membership	Jan 16	April 16	May 16	July 16	Oct 16	Jan 17
Helen Nichols	Lay Member (Chair)	✓	✓	✓	✓		
Roger Pontefract	Lay Member	✓					
Paul Ashby	Practice Manager	✓	✓	✓	✓		
Jeff Simmonds	Lay Member and Governing Body Member	✓	✓	✓	✓		
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓		
Debbie Fagan	Chief Nurse & Quality Officer	N	N	N	N		
David Smith	Deputy Chief Finance Officer	✓	✓	✓	✓		
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A	N	N	N		
Leah Robinson	Chief Accountant	✓	✓	✓	✓		
Roger Causer	Senior Local Counter Fraud Specialist, MIAA	A	N	N	N		
Michelle Moss	Local Counter Fraud Specialist, MIAA	✓	✓	N	A		
Adrian Poll	Audit Manager, MIAA	A	✓	A	✓		
Ann Ellis	Audit Manager, MIAA	✓	N	N	N		
Amanda Latham	Audit Director, KPMG	✓	N				
Jillian Burrows	Audit Senior Manager, KPMG	A	✓				
Andrew Smith	Audit Director, KPMG		✓	✓	N		
Jerri Lewis	Audit Manager, KPMG		✓	✓	✓		
Gill Brown	Lay Member		✓	✓	✓		

No	Item	Action
A16/51	**Apologies for absence** Apologies for absence were received from Michelle Moss.	
A16/52	**Declarations of interest** Declarations of interest were received from CCG officers who hold dual posts in both Southport and Formby CCG and South Sefton CCG.	
A16/53	**Advance notice of items of other business** The Chair advised she had received two items of other business.	
A16/54	**Minutes of the previous meeting and key issues** The minutes of the previous meeting were approved as a true and accurate record and signed-off by the Chair. The key issues log was approved as an accurate reflection of the main issues from the previous meeting.	
A16/55	**Action points from previous meeting** ***A16/24, A16/25, A16/30 and A16/35***: On agenda ***A16/31 Anti-Fraud Services Annual Report 2015/16***: MMcD confirmed LR is working on a review of providers, where the CCG is a co-ordinating commissioner, for service contracts over £200k. This is to be a simplistic review. To be carried forward to next meeting. ***A16/34 – External Audit Technical Update***: DS said he is liaising with the Communications team on the communications statement re. the UK Modern Slavery Act. To be carried forward to next meeting. DS to ask Debbie Fagan to ensure safeguarding personnel are aware of the Act. ***A16/33 and A16/39***: Actions completed and closed.	LR DS DS
A16/56	**Losses and special payments** LR said a review of outstanding debt up to last period end (June 2016) has been carried out. The review showed five items greater than £5k and over six months old. LR provided the following update. 1) Southport & Ormskirk Hospital (value - £58,000) – This has now been paid. 2) National Licensed Trade Association (value - £20,375) – A letter will be issued to directors to chase payment. 3) NHS Greater Preston CCG (value - £17,874) – The debtor is disputing part of the charges. A credit note will be raised for £14,000. MMcD said he would prefer the CCG not to chase individual CCGs and instead would prefer for an adjustment to be made via the Prescription Pricing Authority. 4) Southport and Ormskirk Hospital (value - £49,770) – This is related to the first S&O item. As the first item has now been paid, LR is hopeful that this will also be settled. 5) NHS West Lancashire CCG (value - £6,170) – The debtor has confirmed all documentation sent from S&F CCG has been received and is currently being reviewed.	
A16/57	**Audit Committee Recommendations Tracker** LR reported on the audit recommendation tracker and highlighted the following: • HMRC Review: HMRC have apologised for the delay and are still reviewing. HMRC hope to have this resolved by August. • Proposed Anti-Bribery Strategy: MMcD asked LR to check whether the clear, joint statement from the Board Chair and AO/CFO had	

	been fully communicated again as per the update comment on the tracker. • Proposed Anti-Bribery Strategy: re. the risk for 'Review, amend and dovetail all related policies and procedures to reflect AB&C provisions' – LR confirmed she has sent the policies to MM who has confirmed she is happy with them. This risk item is to be closed. • QIPP Review (Jan 2016) – LR said she has left all the update comments as *Ongoing* due to the background work taking place on QIPP at the moment. GB referred to the Patient Engagement table in the report and to the identified risk of *Clarify responsibility of EPEG*. She confirmed the EPEG terms of reference have been reviewed and the workplan is being finalised and therefore this risk can be taken off. GB said she was unclear on what the other two risks in the table relate to. LR to send GB further information on this.	LR LR
A16/58	**Scheme of Delegation** LR provided an overview of the changes proposed to the Scheme of Delegation. She clarified that the invoice limit of £5k will still stand for the Corporate Support Officer for non-PO related invoices. The proposed increase in invoice limit to £25k for the Corporate Support Officer is only for PO related invoices - for the purposes of business continuity in the absence of the PA to the Chief Officer. MMcD confirmed he was happy with the proposed changes. **Action by the Committee** The Committee approved the proposed changes to the Scheme of Delegation.	
A16/59	**Liaison Accounts Payable Review** LR reported on the recoveries made as part of the Liaison Accounts Payable Review. She confirmed Liaison are the CCG's VAT advisors but also carry out Accounts Payable reviews for overpayment. A discussion followed, resulting in the following actions: • LR to look into why the recoveries that have been picked up by Liaison have not been picked up through the Counter Fraud process. • LR to look into why there are so many occurrences of Community Care Direct Ltd invoice overpayment. • MMcD to email Martin Whiteley regarding assurance around duplicate invoices being entered on SBS system.	LR LR MMcD
A16/60	**Internal Audit Progress Report 2015/16** AP provided an overview of the MIAA Internal Audit Progress Report. He noted a key point in this was to review the Corporate Risk Register and how this can be improved. Work is ongoing on this in the CCG. It was agreed for MMcD to ask NHSE to circulate the 'Capability and Capacity' PwC review report to the Governing Body when he and Fiona Taylor have the S&F CCG Recovery Checkpoint Meeting with NHSE in two weeks' time.	MMcD
A16/61	**MIAA Anti-Fraud Conflicts of Interest Report** MMcD confirmed the NHS Protect inspection of S&F will be taking place on 19th and 20th July. The focus will be on two standards: Strategic Governance and Inform & Involve. HN and MMcD will be interviewed as part of the inspection. JS declared a potential conflict of interest and will email MMcD the details. MMcD said MM had done a presentation on Anti-Fraud Conflicts of Interest at the Operational Team meeting last week.	JS

	HN had a query on page 6 of the report and questioned why details of four staff who had completed a declaration were not provided by the CCG. MMcD to query this with MM. HN referred to the text in the report that referred to Declaration of Interest forms being sent out to staff by the Governance Commissioning Support Team three times per year to complete. She said she does not think this happens three times per year with Governing Body members. MMcD to query this with the Governance Commissioning Support Team. HN said she was unclear what the following paragraph meant: "The AFS through review of Board papers found whilst minutes noted formal review of declarations of interests, interests were not explicitly stated in minutes to provide for continuous and live update of the conflicts of interest register." MMcD to seek clarity on this with MM.	MMcD MMcD MMcD
A16/62	**Receipt of External Audit letter** JL said the audit letter closes off the 2015/16 audit. JL thanked the committee for co-operation in getting sign off. HN thanked JL for her work on this.	
A16/63	**External Audit Technical Update** JS said this update highlights thought leadership work that may be of interest to the NHS. JS said there are links to further information in the update but she or AS can be contacted for any additional information if required. MMcD said the *New models of care – learning from New York State's Medicaid reforms* report has been circulated as part of the work around STP. HN asked TK to forward the information on the *Digital Health* report to Rob Caudwell.	 TK
A16/64	**Register of Interests 2015/16** It was noted that although a paper was included on the Register of Interests 2015/16, the actual register of interests was not included. HN asked for the Register to be included as a paper in the July S&F Governing Body meeting and the next Audit Committee meeting in October. A discussion took place about the strong recommendation (in the NHSE revised guidance on the management of conflicts of interest for CCGs) that CCGs are to have a minimum of three lay members on the Governing Body. GB said the committee needs to consider whether three lay members are needed as opposed to two in respect of the guidance from Primary Care Commissioning. MMcD will look further into this with Debbie Fairclough with a view to having a discussion in Part II of the Governing Body meeting.	TJ MMcD / DFair
A16/65	• **Finance and Resource Committee – Key Issues report** • **Quality Committee – Key Issues report** **Action by the Committee** The Committee received the key issues of the Finance and Resource Committee and the Quality Committee.	
A16/66	**Any other business** i) <u>Managing Conflicts of Interest and Gifts and Hospitality Policy</u> GB noted the following re. the policy: ○ Section 2.5 – the first sentence refers to 'If the CCG opts to engage in any Joint Commissioning activities with NHS England…' GB said that if this is referring to Primary Care, then the CCG is already engaging in Joint Commissioning activities and it is not a case of 'opting to.' This is to be reflected in the policy. ○ Section 3.1 – GB noted a few typos in the bullet points.	

	○ Section 4.1 – Scope of Policy. GB said it is unclear who has to declare what and that this needs to be made clearer in the policy. ○ Section 4.1 – Scope of Policy. GB asked for clarity on what 'other organisations' is referring to in the following sentence: "Any members of committees/groups from other organisations." TK to communicate the above to Debbie Fairclough. HN asked what the policy is based on and wanted assurance that it is fully compliant on the guidance that was released in June. DS to check with Debbie Fairclough as to what the policy is based on and ask for a statement to be provided that it is fully compliant with the guidance released in June.	TK DS
	Action by the Committee The Committee approved the Managing Conflicts of Interest and Gifts and Hospitality Policy subject to the changes and clarifications noted in the meeting.	
	ii) <u>Anti-Fraud, Bribery and Corruption Policy</u> LR provided a brief overview of this policy and said she would circulate the draft to the Committee for feedback to be received by Monday 18th July. The Committee agreed to this. LR to send to the Committee ASAP today.	LR
	Action by the Committee The Committee agreed to provide delegated authority to MMcD and HN to approve the Anti-Fraud, Bribery and Corruption Policy further to the feedback that is received on 18th July.	
	HN asked to have the internal audit and counter fraud meeting at the beginning of the next meeting in October – to be scheduled for half an hour.	
A16/67	**Key Issues Review** DS highlighted the key issues from the meeting and these will be circulated as a Key Issues Report to Governing Body.	
	Date and time of next meeting Wednesday 12th October 2016 10.00am to 11.30am Family Life Centre, Southport	

NHS
Southport and Formby
Clinical Commissioning Group

Audit Committee Minutes

Wednesday 12th October 2016, 10.00am to 11.30am
Family Life Centre, Southport

Attendees		
Helen Nichols	Lay Member (Chair)	HN
Gill Brown	Lay Member	GB
Martin McDowell	Chief Finance Officer	MMcD
David Smith	Deputy Chief Finance Officer	DS
Leah Robinson	Chief Accountant	LR
Dr Jeff Simmonds	Lay Member and Governing Body Member	JS
Michelle Moss	Local Counter Fraud Specialist, MIAA	MM
Jerri Lewis	Audit Manager, KPMG	JL
Apologies		
Paul Ashby	Practice Manager	PA
Adrian Poll	Audit Manager, MIAA	AP
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Minutes		
Tahreen Kutub	PA to Chief Finance Officer	TK

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

Name	Membership	Jan 16	April 16	May 16	July 16	Oct 16	Jan 17
Helen Nichols	Lay Member (Chair)	✓	✓	✓	✓	✓	
Roger Pontefract	Lay Member	✓					
Paul Ashby	Practice Manager	✓	✓	✓	✓	A	
Jeff Simmonds	Lay Member and Governing Body Member	✓	✓	✓	✓	✓	
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓	
Debbie Fagan	Chief Nurse & Quality Officer	N	N	N	N	N	
David Smith	Deputy Chief Finance Officer	✓	✓	✓	✓	✓	
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A	N	N	N	A	
Leah Robinson	Chief Accountant	✓	✓	✓	✓	✓	
Roger Causer	Senior Local Counter Fraud Specialist, MIAA	A	N	N	N	N	
Michelle Moss	Local Counter Fraud Specialist, MIAA	✓	✓	N	A	✓	
Adrian Poll	Audit Manager, MIAA	A	✓	A	✓	A	
Ann Ellis	Audit Manager, MIAA	✓	N	N	N	N	
Amanda Latham	Audit Director, KPMG	✓	N				
Jillian Burrows	Audit Senior Manager, KPMG	A	✓				
Andrew Smith	Audit Director, KPMG		✓	✓	N	N	
Jerri Lewis	Audit Manager, KPMG		✓	✓	✓	✓	
Gill Brown	Lay Member		✓	✓	✓	✓	

No	Item	Action
A16/68	**Apologies for absence** Apologies for absence were received from Paul Ashby, Adrian Poll and Tracy Jeffes.	
A16/69	**Declarations of interest** Declarations of interest were received from CCG officers who hold dual posts in both Southport and Formby CCG and South Sefton CCG.	
A16/70	**Advance notice of items of other business** None	
A16/71	**Minutes of the previous meeting and key issues** The minutes of the previous meeting were approved as a true and accurate record **subject** to the following amendment under *Action points from previous meeting*: The following sentence detailed in point 1) should be changed to the sentence detailed in point 2). ***1) A16/31 Anti-Fraud Services Annual Report 2015/16***: MMcD confirmed LR is working on a review of providers the CCG co-commissions for service contracts over £200k. ***2) A16/31 Anti-Fraud Services Annual Report 2015/16***: MMcD confirmed LR is working on a review of providers, where the CCG is a co-ordinating commissioner, for service contracts over £200k. The key issues log was approved as an accurate reflection of the main issues from the previous meeting.	
A16/72	**Action points from previous meeting** ***A16/31 Anti-Fraud Services Annual Report 2015/16****:* LR has performed a review of the co-ordinating commissioner contracts in excess of £200k. This was in conjunction with the NHS Protect review and a recommendation was raised as part of the review in relation to this. Action closed. ***A16/34 External Audit Technical Update*** *(DS to liaise with the Communications team on the communications statement re. the UK Modern Slavery Act)*: DS said a policy/statement has been finalised for the CCG and will be put up on the website. The Committee agreed for the policy to go on the website if the CCG Communications department is approved it. Action closed. ***A16/34 External Audit Technical Update*** *(DS to ask Debbie Fagan to ensure safeguarding personnel are aware of the UK Modern Slavery Act):* Safeguarding personnel are aware of the Act and a meeting will take place involving Debbie Fagan and the NHSE Deputy Director of Nursing/ Safeguarding Lead. Action closed. ***A16/57 Audit Committee Recommendations Tracker****:* LR said the CCG Communications department have confirmed that the clear, joint statement from the Board Chair and AO/CFO is on the CCG intranet and website. Action closed. ***A16/57 Audit Committee Recommendations Tracker****:* LR confirmed she has sent GB further information on what the second and third risks relate to in the Patient Engagement table. Action closed.	

	A16/59 Liaison Accounts Payable Review: Actions for LR and MMcD will to be covered in agenda item A16/75.	
	A16/60 Internal Audit Progress Report 2015/16: The Governing Body members in attendance confirmed they had not seen the 'Capability and Capacity' PwC review report. MMcD to ensure this is circulated to the Governing Body.	MMcD
	A16/61 MIAA Anti-Fraud Conflicts of Interest Report: JS has emailed MMcD the details of a potential conflict of interest. Action closed.	
	A16/61 MIAA Anti-Fraud Conflicts of Interest Report: LR confirmed that details of four staff who had completed a declaration were not provided by the CCG for the following reasons: • One staff member was on maternity leave • One staff member opted out as they were leaving the CCG • Two of the four staff members were leavers Action closed.	
	A16/61 MIAA Anti-Fraud Conflicts of Interest Report: Debbie Fairclough has confirmed that the Declaration of Interest forms have been sent out to staff (including Governing Body members) three times per year to complete and will now go out every quarter as per the new guidance. Action closed.	
	A16/61 MIAA Anti-Fraud Conflicts of Interest Report: Upon seeking clarity on what the below paragraph meant, MIAA confirmed that on further review of the evidence presented they have removed the reference in the report regarding formal declaration of interests in minutes and their explicit statement. The paragraph in question was: "The AFS through review of Board papers found whilst minutes noted formal review of declarations of interests, interests were not explicitly stated in minutes to provide for continuous and live update of the conflicts of interest register." Action closed.	
	A16/63 External Audit Technical Update: TK confirmed she has forwarded the information on the *Digital Health* report to Rob Caudwell. Action closed.	
	A16/64 Register of Interests 2015/16: The Register of Interests has been included as an item on the agenda for this meeting but it was not included in the July S&F Governing Body meeting. DL to ensure it is included in the November Governing Body meeting.	DL
	A16/64: Register of Interests 2015/16: re. NHSE recommendation for CCGs to have a minimum of three lay members on the Governing Body – having considered the options, the Chief Officer's report (in the Governing Body meeting on 28th September – item GB16/140), proposed that the CCG does not appoint a third lay member but will seek support from South Sefton CCG Audit Committee Chair in respect of conflicts of interest should the need arise. The Governing Body supported this proposal. Action closed.	
	A16/66 Any other business (*Managing Conflicts of Interest and Gifts and Hospitality Policy):* TK has sent Debbie Fairclough the changes to the Managing Conflicts of Interest and Gifts and Hospitality Policy. Action closed.	
	A16/66 Any other business (*Managing Conflicts of Interest and Gifts and Hospitality Policy):* Re. checking to ensure the policy is fully compliant	

	with the guidance released in June. Action closed. ***A16/66 Any other business (Anti-Fraud, Bribery and Corruption Policy):*** LR confirmed this action is complete.	
A16/73	**Losses and special payments** LR reported that the outstanding debt has been reviewed up to the last period end of September 2016. She said there are five items greater than £5k and over six months old. LR provided the following update on the five items: 1) National Licensed Trade Association (value £20,375) – A final reminder letter has been issued by the CCG. NHS Shared Business Services has provided the CCG with documentation for external debt recovery. 2) Southport & Ormskirk Hospital (value £49,770) – S&O has disputed the invoice. The CCG has provided S&O NHST with information in support of the changes, which they are reviewing. 3) NHS West Lancashire CCG (value £6,170) – This has now been recovered. Payment made in October. 4) Sefton Metropolitan Borough Council (value £78,000) – The council have disputed the charge, believing it is not valid. The integrated Commissioning team are negotiating payment of this invoice. 5) NHS West Lancashire CCG (value £7,245) – This has now been recovered. Payment made in October. ***The Committee received this report.***	
A16/74	**Audit Committee Recommendations Tracker** LR reported on the audit recommendation tracker and highlighted the following: • HMRC Review – LR is still awaiting a final figure for this. HMRC had said they were hoping to have this resolved by August but this has not happened. • Re. CCG Board Advisory Paper: Proposed Anti-Bribery Strategy – LR said the CCG Communications department have confirmed that the clear, joint statement from the Board Chair and AO/CFO is on the CCG intranet and website. In reference to the Patient Engagement table, LR said she had kept the following two risks as ongoing (and therefore in amber) as by their nature they would always be ongoing: • Continuation of collection of patient experience data to inform commissioning decisions. • Research & Development. GB said the first risk can be taken off as it will always be ongoing. She advised that the second risk should stay on as this needs to be monitored. LR to action. HN commented that risks in the External Audit 2015/16 table is up to May 2016 but that there have been further external audit recommendations since. LR is to add these and update the table. ***The Committee received this report.***	LR LR
A16/75	**Liaison Accounts Payable Review** Following review of all payments made by the CCG from its inception on 1st April 2013, 14 overpayments were identified. LR said £13,975.03 of the overpayments balance (which totalled £17,912.04) has been recovered. This leaves £3,937.01 to be recovered which is in progress.	

	Counter Fraud process did not pick up some duplicates which were highlighted by the Liaison review due to timing, whereby some duplicates were outside the date parameters for NFI process. Items that should have been picked up by NFI process have been raised with the cabinet office for further investigation. It was noted that a provider had submitted a number of duplicate invoices and the CCG raised this with SBS. This was a result of the supplier sending in multiple invoices with invoice numbers having an A or B added to the end. SBS confirmed that ultimately the responsibility for checking the description of the invoice rests with the CCG. ***The Committee received this report.***	
A16/76	**Review of Internal Audit Progress Reports** MM provided a brief overview of this report and highlighted that three pieces of work are in progress: primary care commissioning, conflicts of interest and assurance on quality of services commissioned. HN said she has not seen the Assurance Framework Benchmarking briefing note. MM to send to HN. MMcD drew the Committee's attention to the Upcoming Events section in the report and highlighted the *Health and Housing: A new Dimension* event on 20th October. Jenny Kristiansen, Programme Respiratory Lead at S&F CCG and SS CCG, will be presenting with the National Housing Federation and One Vision Housing. ***The Committee received this report.***	MM
A16/77	**Review of Counter Fraud Progress Report** MM provided an overview of the MIAA anti-fraud work undertaken during the period of April-September 2016. She spoke about the reporting dashboard and highlighted the *fraud proofing policy and procedure – policy tracker document.* She asked if the committee would like a policy tracker that would detail when policies are due to be reviewed, who the responsible officer is etc. The committee agreed to the tracker. DL to action with Judy Graves and Debbie Fairclough. MM referred to page 4 of the report and the following paragraph: *"Due to the NHS Protect Inspection of anti-fraud arrangements at the CCG the work involved in the preparation and inspection has resulted in additional resource being allocated to the work. This does mean to maintain the integrity of the plan within the existing days it is proposed that the proactive exercise on Private Provider Invoices is deferred to 2017/18 as a first priority against the workplan."* MM asked for the Committee's approval of the proposed change. ***The Committee approved this proposed change.*** ***The Committee received this report.***	DL
A16/78	**External Audit Technical Update** JL said this report is for the committee's info and has links to further information. She referred to page 6 of the report and highlighted the apprenticeship levy; from April 2017, all businesses with a wage bill of over £3m will pay an annual levy of 0.5% of their total wage bill. This will impact all NHS providers as well as some commissioners. MMcD said the CCG is working collaboratively across Merseyside with regards to what needs to be done re. apprenticeships.	

	HN queried the Sunshine Rule on page 23 of the report. JL confirmed the information was in relation to providers. ***The Committee received this report.***	
A16/79	**NHS Protect Assessment Report** MM provided an overview of this report, which shows the CCG's current rating against the standards following the NHS Protect Inspection. Two standards were assessed: Strategic Governance and Inform and Involve. MM referred to standard 1.8 on page 13 of the report: *The organisation reviews the anti-fraud, bribery and corruption arrangements in place within the providers it contracts to deliver NHS Services, to ensure they comply with the conditions set out in Service Condition 24 of the NHS Standard Contract.* MM noted this could have been assessed as green but as it had been reviewed and not evaluated, it was assessed as amber. HN referred to standard 1.5 on page 10 of the report: *The organisation reports annually on how it has met the standards set by NHS Protect in relation to anti-fraud, bribery and corruption work, and details corrective action where standards have not been met.* As this has been assessed as green in the report, HN commented that this means the Self-Review Tool (SRT) will not be on the action tracker. MM confirmed SRT will be included in Anti-Fraud Services Annual Reports. MMcD said S&F CCG was only the second CCG nationally to be inspected. MM thanked the CCG for all the help provided in regards to the inspection. MMcD and HN thanked MM for supporting the CCG through the process. ***The Committee received this report.***	
A16/80	**Risk Registers** DL presented the Corporate Risk Register and Governing Body Assurance Framework (GBAF). It was noted that the financial risk in SF006 should be rated as the highest risk and other risks should be re-evaluated where necessary to be lower than SF006. DL to action. HN said risk SF040 seems to be on both Corporate Risk Register and GBAF. She commented it does not need to be on both. DL will action so that it is included on only one of the documents. Some other queries and comments were raised in regards to individual risks; DL is to liaise with the relevant risk owners to address these. ***The Committee received this report and provided approval subject to the changes agreed at this meeting.***	DL DL DL
A16/81	**Conflict of Interest Register** DL presented the Conflict of Interest Register. She noted declarations for 4 individuals are outstanding; she is expecting these in by close of play today. HN suggested employees, Governing Body and member practices be separated out in the register. Everyone in attendance agreed with this. DL to action. In regards to conflict of interest forms being sent to GPs for completion, HN queried whether these should be sent to practice managers for consistency	DL

	and whether this should be noted in the constitution. MMcD to take this suggestion to the S&F CCG Chair. MMcD referred to page 142 of the pack and queried whether Rob Caudwell is a director. DL to look into this and amend if required. DL noted that the governance team is working on finalising a process whereby a COI template will be circulated with the agenda for each committee meeting and that any conflicts of interest in relation to agenda items will need to be declared at least two days prior to the meeting. ***The Committee received this report and provided approval subject to the changes agreed at this meeting.***	MMcD DL
A16/82	• **Finance and Resource Committee – Key Issues report** • **Quality Committee – Key Issues report** ***The Committee received the key issues of the Finance and Resource Committee and the Quality Committee.***	
A16/83	**Top 10 Reports of Fraud Bribery and Corruption** MM said this paper is for the committee's info. She said the information is specific to CCGs nationally. ***The Committee received this paper.***	
A16/84	**Any other business** MMcD noted that this meeting is DS's last Audit Committee meeting, as he will be leaving the CCG in November. MMcD and HN thanked DS for his support to the Committee and contribution to the CCG.	
A16/85	**Key Issues Review** MMcD highlighted the key issues from the meeting and these will be circulated as a Key Issues Report to Governing Body.	
	Date and time of next meeting Wednesday 11th January 2017 10.00am to 11.30am Family Life Centre, Southport	

NHS Southport and Formby Clinical Commissioning Group

NHS England

S&F NHSE Joint Commissioning Committee
Final Minutes – Part I

Date: Wednesday 5th October 2016, 9.30am – 11.00am
Venue: Salvation Army Southport Corps, 65 Shakespeare Street, Southport, PR8 5AJ

Members:		
Gill Brown	SFCCG Lay Board Member (Meeting Chair)	GB
Jan Leonard	Vice Chair, S&F CCG Chief Redesign and Commissioning Officer	JL
Glenn Coleman	Head of Primary Care (NHSE C&M sub-regional team)	GC
Susanne Lynch	S&F CCG Head of Medicines Management	SL
In Attendance		
	Louise Taylor, Primary Care Commissioning Support Officer, CCG	LT
	Alan Cummings , NHSE	AC
	Sharon Howard, Assistant Contracts Manager, NHSE	SH
Apologies	Debbie Fagan Brendan Prescott Dwayne Johnson Chicco Kandemiiri, Finance, CCG	
Minutes		
Louise Taylor	Primary Care Commissioning Support Officer	LT

No	Item	Key Issue?	Action
SFNHSE 16/92	**Introductions and apologies** Apologies were noted from Debbie Fagan, Brendan Prescott and Dwayne Johnson. A round of introductions was completed for the attendees.		
SFNHSE 16/93	**Actions and notes from the previous meeting** The members/attendees list was revised. Aside from this, the minutes were agreed. No items were listed on the action tracker. It was agreed that for future meetings, the operational group Key issues logs would be discussed in Part 1, with the full operational group minutes being discussed in Part 2.		LT
SFNHSE 16/94	**Declarations of interest regarding agenda items** SL declared an interest- her husband is in business with a pharmacy contractor in Southport and Formby area.		
SFNHSE 16/95	**Report from Operational Group – Report- action notes supplied** SH gave an update on the key issues report. No current list closures in SFCCG. JL gave an update on the item marked "LQC" and the funding method. SL informed the group that NICE have recently issued guidance on multi morbidity patients which has similarities to the LQC Frail Elderly scheme. A decision is still awaited regarding the ETTF bids although JL did report a positive recent meeting with Formby practices regarding potential future co-location.		
SFNHSE 16/96	**Decisions made by Operational Group** None were taken		

SFNHSE 16/97	**Performance Dashboard** A discussion took place regarding what a Primary Care Dashboard could look like, and the Primary Care Webtool report was circulated amongst the group to illustrate the types of information it could show however it was recognised that a flaw of this report is that it is difficult to easily ascertain how recent the data was that was contained within it. JL also discussed Aristotle software, and Public Health "Fingertips" reports. There was agreement that any dashboard should contain robust information that is as current as possible. GB requested a Board Development session to look at Aristotle.		JL
SFNHSE 16/98	**LQC** Nothing further was discussed than the issues discussed in item 16/95		
SFNHSE 16/99	**GP Forward View** Some funding has already been released (e.g. training for reception and clerical staff). There was an awareness of the need to publicise GPFV to all GP's, as there was a feeling that GP's who do not have CCG/Board involvement may not be fully aware of the GP Forward View funding. There is likely to be funding for transformation teams across LDS areas, ensuring they work closer with practices. The GPFV event on 6th October should give a more in depth update around GPFV. Clinical Pharmacists- planned that the ratio of pharmacists:patients would be 1:30,000 so scope for working on a locality footprint. SL said that the ideal would be for the pharmacist to be dual role (ie CCG/practice) in order to ensure support was available.		
SFNHSE 16/100	**ETTF Update** Nothing further was discussed than the issues discussed in item 16/95		
SFNHSE 16/101	**Delegation** Discussion deferred as no GP's present.		
SFNHSE 16/102	**PCS Update** The accompanying paper sets out the current position, which seems to be improving. NHSE taking a rigorous performance management approach now. Capita have installed a new management team. A root and branch analysis is being undertaken, results of which should be ready by end October/November and will be submitted to Governing Body.	Y	JL
SFNHSE 16/103	**Any Other Business** GC informed the group that AC would be representing NHS England regarding GPFV from now on.		
	Date of next meeting Wednesday 7th December, 2016, **10.00am - 11.30am** Venue: Salvation Army Southport Corps, 65 Shakespeare Street, Southport, PR8 5AJ		