NHS
Southport and Formby
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

Date: Wednesday, 28 May 2014 at 1.00pm to 4.00pm

Venue: The Family Life Centre, Ash Street, Southport PR8 6JH

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

The Governing Body

Dr Rob Caudwell	Chair and GP	(RC)
Dr Niall Leonard	Clinical Vice Chair and GP	(NL)
Helen Nichols	Vice Chair and Lay Member, Financial Management & Audit	(HN)
Roger Pontefract	Lay Member, Engagement and Patient Experience	(RP)
Dr Doug Callow	GP	(DC)
Dr Martin Evans	GP	(ME)
Dr Hilal Mulla	GP	(HM)
Dr Kati Scholtz	GP	(KS)
Dr Jeff Simmonds	Secondary Care Doctor	(JS)
Colette Riley	Practice Manager	(CR)
Paul Ashby	Practice Manager	(PA)
Fiona Clark	Chief Officer	(FLC)
Martin McDowell	Chief Finance Officer	(MMcD)
Debbie Fagan	Chief Nurse	(DF)
Peter Morgan	Deputy Chief Executive, Sefton MBC (co-opted member on behalf of Margaret Carney)	(PM)

Also in attendance

Jan Leonard	Chief Redesign and Commissioning Officer	(JL)
Karl McCluskey	Chief Strategy and Outcomes Officer	(KMcC)
Billie Dodd	Head of CCG Development	(BD)
Brendan Prescott	Deputy Head of Quality and Safety	(BP)
Suzanne Lynch	Head of Medicines Management	(SL)
Bal Duper	Primary Care Quality Lead	(BDup)
Hannah Chellaswamy	Deputy Director of Public Health, Sefton MBC	(HC)
Janice Horrocks	Programme Sponsor Care Closer to Home, Southport & Ormskirk NHS Trust / Southport and Formby CCG / West Lancs CCG	(JH)
Sam Tunney	Head of Business Intelligence and Performance, Sefton MBC	(ST)

The meeting will be preceded by a presentation by Nanette Mellor, Neurosupport
On the Sefton Research Report

No	Item	Lead	Report	Receive/ Approve	Time
Governance					
GB14/60	Apologies for Absence	Chair		R	13.30
GB14/61	Declarations of Interest regarding agenda items	All		R	
GB14/62	Register of Interests	-	✓	R	
GB14/63	Hospitality Register	-	✓	R	
GB14/64	Minutes of Previous Meeting	Chair	✓	R	13.35
GB14/65	Action Points from Previous Meeting	Chair	✓	R	
GB14/66	Business Update	Chair		R	13.40
GB14/67	Chief Officer Report	FLC	✓	R	13.45
Finance and Performance					
GB14/68	Corporate Performance Report	KMcC	✓	R	13.50
GB14/69	Quality Performance Report	DF	✓	R	14.00
GB14/70	Financial Performance Report Month 12 – 2013/14	MMcD	✓	R	14.10
GB14/71	2014/2015 Revised Financial Budgets	MMcD	✓	A	14.20
GB14/72	(a) Five Year Strategic Plan (b) Five Year Financial Plan	KMcC MMcD	✓	R	14.30
GB14/73	Prescribing Performance Report	SL	✓	R	14.40
GB14/74	Annual Report and Accounts	MMcD	✓	R	14.50
GB14/75	Audit Committee Annual Report 2014	HN	✓	R	15.00
Quality and Safety					
GB14/76	Francis Report and Action Plan	DF	✓	A	15.10
Service Improvement / Strategic Delivery					
GB14/77	Sefton Strategy for Older Citizens 2014 - 2019	KT	✓	A	15.20
GB14/78	Primary Care Update	JL	✓	R	15.30
GB14/79	Revised Governance Structures 2014	TJ	✓	R	15.40
GB14/80	Care Closer to Home – Update	JH	✓	R	15.50
GB14/81	Transforming the Mental Health Commissioning Landscape in Southport and Formby CCG	GJ	✓	R	16.00
GB14/82	Out of Hours Pharmacy Services Review	BP	✓	R	16.10
For information					
GB14/83	Key issues reports from committees of Governing Body:- - Audit Committee	MMcD	✓	R	16.20
GB14/84	Audit Committee Minutes	-	✓	R	16.25
GB14/85	Quality Committee Minutes	-	✓	R	

No	Item	Lead	Report	Receive/ Approve	Time
GB14/86	Finance & Resource Committee Minutes	-	✓	R	
GB14/87	Merseyside CCG Network Minutes	-	✓	R	
GB14/88	Health and Wellbeing Board Minutes	-	✓	R	
GB14/89	Medicines Management Operational Group Minutes	-	✓	R	
GB14/90	Locality Meetings - (i) Ainsdale & Birkdale Locality (ii) Formby Locality (iii) Central Locality (iv) North Locality	-	✓	R	
Closing Business					
GB14/91	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting.*				16.30
GB14/92	Date, Time and Venue of Next Meeting of the Governing Body to be held in Public *Wednesday, 30 July 2014 at 1.00pm at the Family Life Centre*				-
Estimated meeting close					16.35

Motion to Exclude the Public:

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

Hospitality Register
May 2014

NHS
Southport and Formby
Clinical Commissioning Group

Recipient:	Nature of Gift / Hospitality:	Date Received	Approximate Value	Donated by:
Dr Hilal Mulla	Day at Aintree Racecourse	4 April 2014	£300	Renacres Hall Hospital

NHS
Southport and Formby
Clinical Commissioning Group

Governing Body Meeting in Public
Minutes

Wednesday, 26 March 2014 at 1.00pm to 4.00pm

The Family Life Centre, Ash Street, Southport PR8 6JH

Present

Dr Niall Leonard	Chair and GP	(NL)
Helen Nichols	Vice Chair and Lay Member, Financial Management & Audit	(HN)
Dr Robert Caudwell	Clinical Vice-Chair and GP	(RC)
Dr Martin Evans	GP	(ME)
Dr Hilal Mulla	GP	(HM)
Dr Jeff Simmonds	Secondary Care Doctor	(JS)
Roy Boardman	Practice Manager	(RB)
Fiona Clark	Chief Officer	(FLC)
Martin McDowell	Chief Finance Officer	(MMcD)
Debbie Fagan	Chief Nurse	(DF)
Peter Morgan	Deputy Chief Executive, Sefton MBC (co-opted member on behalf of Margaret Carney)	(PM)

Also in attendance

Jan Leonard	Joint Head of CCG Development	(JL)
Karl McCluskey	Head of Strategic Planning	(KMcC)
Lyn Cooke	CSU Lead for Communications	(LC)
Brendan Prescott	Deputy Head of Quality and Safety	(BP)
Tracy Jeffes	Head of Delivery and Integration	(TJ)

Apologies

Roger Pontefract	Lay Member, Engagement and Patient Experience	(RP)
Dr Liam Grant	GP	(LG)
Dr Graeme Allan	GP	(GA)

Minutes

Melanie Wright	Business Manager

Christina Chrislett, Affordable Warm Co-ordinator, Sefton Council –

Cold homes are a considerable risk to health for those in fuel poverty who may contract cold-related illnesses. Is the CCG considering fuel poverty as part of our preventative care?

Dr Leonard referenced discussions with senior colleagues at Sefton Council and matching of data has been considered to better target those at risk. Dr Leonard acknowledged more needs to be done for those who have attended hospital. GPs now operate a risk stratification tool to identify those who may be at risk of hospital admittance.

Roy Boardman responded that the Central Locality were piloting a Safer Communities Partnership, to link and facilitate referral for patients at risk. Shirley King is the lead at Sefton CVS.

Peter Morgan, the Deputy Chief Executive of Sefton Council was also at the meeting and Ms Clark referenced the ongoing strategic work between the Council and the CCG.

Mr Morgan advised that there has been considerable work on this and a dedicated session on fuel poverty has taken place.

The Wider Determinants Group also consider this.

NHS
Southport and Formby
Clinical Commissioning Group

Attendance Tracker

✓ Present
A Apologies
L Late or left early

Governing Body Member	Designation	Jan 2013	Mar 2013	May 2013	July 2013	Sept 2013	Nov 2013	Jan 2014	Mar 2014			
Dr Niall Leonard	Chair, and GP	✓	✓	✓	✓	✓	✓	✓	✓			
Helen Nichols	Vice Chair & Lay Member, Financial Management & Audit	✓	✓	✓	A	✓	✓	✓	✓			
Dr Robert Caudwell	Clinical Vice-Chair and GP	✓	✓	✓	✓	✓	L	A	✓			
Dr Martin Evans	GP	✓	✓	A	✓	✓	✓	✓	✓			
Dr Liam Grant	GP	✓	A	✓	A	✓	L	✓	A			
Dr Hilal Mulla	GP	✓	A	✓	✓	✓	✓	✓	✓			
Dr Graeme Allan	GP	L	L	A	A	A	A	A	A			
Roy Boardman	Practice Manager	✓	✓	✓	✓	✓	✓	✓	✓			
Karen Leverett	Practice Manager	✓	A	✓	✓	✓	✓	✓	Resigned			
Roger Pontefract	Lay Member, Engagement and Patient Experience	✓	A	✓	✓	✓	✓	✓	A			
Dr Jeff Simmonds	Secondary Care Doctor	A	✓	A	✓	✓	A	✓	✓			
Fiona Clark	Chief Officer	✓	✓	✓	✓	✓	A	✓	✓			
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓			
Debbie Fagan	Chief Nurse	A	✓	✓	✓	✓	✓	✓	✓			
Peter Morgan	Strategic Director, Sefton MBC	N/A			✓	✓	A	A	✓			
Hannah Chellaswamy	Deputy Director of Public Health, Sefton MBC					A	✓	✓	A			
Maureen Kelly	Healthwatch Sefton					A	A	A	A			

No	Item	Action
GB14/31	**Apologies for Absence** were noted.	
GB14/32	**Declarations of Interest** There were no declarations.	
GB14/33	The **Register of Interests** was received.	
GB14/34	The **Hospitality Register** was received.	
GB14/35	**Minutes of Previous Meeting** The Minutes of the previous meeting were approved as an accurate record thereof.	
GB14/36	**Action Points from Previous Meeting** All actions from the previous meeting have been closed down.	
GB14/37	**Business Update** The meeting is Dr Leonard's last as Chair. Roy Boardman has stepped down from the Governing Body and Dr Leonard took the opportunity to thank Roy for his hard work. Following the recent election, two new Practice Managers have been elected: Paul Ashby and Colette Riley. The following GPs were re-elected: Drs Evans, Mulla, Caudwell and Leonard. Drs Callow and Scholtz were elected as new members. Dr Caudwell is expected to succeed Dr Leonard as Chair of the CCG. Dr Leonard also thanked Drs Grant and Allen for their work on behalf of the CCG. *Primary Care Development*: a three month pause in developing primary care has been agreed to facilitate further engagement with practices. Dr Leonard described the CCG's desire to enable more services to be available within the community and which will necessitate engagement with the public and appropriate use of hospital services. Dr Leonard also referenced his recent visit to the Secretary of State for Health who was cognisant of the changes required in an area with a high elderly population, such as Southport and Formby.	
GB14/38	**Chief Officer Report** The CCG's Constitution requires that the Wider Constituent Membership elect the Chair and that this must be an individual who has gone through the National Assessment Scheme, of which there are only two eligible GPs: Drs Leonard and Caudwell. A communication is therefore pending to practices to facilitate the election of Dr Caudwell as Chair. The Governing Body also noted the importance of the section of the report dealing with Designating Commissioner Requested Services and noted the timescales in relation thereto.	

No	Item	Action
GB14/39	**Corporate Performance Report** Miss Fagan presented this item and item 14/40 at the same time.	
GB14/40	**Quality Performance Report** *Referral Time to Treatment* – Southport and Ormskirk Hospitals NHS Trust (S&O) failed to reach the 90% target in January 2014 in relation to RTT. This breach was negotiated and the Trust is on track to achieve target by year end. *Cancer:* Dr Evans acknowledged the challenges for the Trust in relation to patients who did not attend appointments for social reasons and the efforts made by the Trust in following up these patients. *A&E Element: Friends and Family Test* – acknowledging the national challenges in relation to this indicator, the Trust had recently attended the CCG's Engagement and Patient Experience Group to advise of the work undertaken in relation to the A&E component and improving care for patients, which was extremely helpful. *Mixed Sex Accommodation Breaches at S&O* – 35 breaches have taken place within the Critical Care Unit when the Trust experienced difficulties in patient flow. Remedial action planning is taking place at the Trust and assurance has been offered to the Trust's Board and Quality Committee. *CDifficile* – following a breach of the Trust's target, a remedial action plan is in place. The CCG have shared their own action plan with NHS England, who are assured by the CCG's actions from a commissioner/ provider perspective. *Aintree: MRSA* – this case was not a Sefton patient, but the CCG's Quality Programme Manager has attended the meeting to examine the action plan and lessons learned in relation to this occurrence in any event. *Pressure Ulcers at Liverpool Community Health Services NHS Trust* – this is not through to be Sefton patients, but the increased numbers reported are as a result of a change in the reporting mechanism. *Merseycare: Length of Stay* – length of stay appears to have increased and Dr Mulla will raise this as lead for Mental Health Services, but it will also be considered as part of the contract management process.	
	Action taken by the Governing Body	
	The report was received by the Governing Body by way of assurance.	
GB14/41	**Financial Performance Report** Continuing Healthcare claims remain the most significant issue for the CCG. The Chief Officer has requested a 'deep dive' to analyse the issues in more detail. Work will continue as part of the integration agenda with the Local Council. Mr McDowell advised that the CCG remains on target for the rest of the financial year.	
	Action taken by the Governing Body	
	The report was received by the Governing Body by way of assurance.	
GB14/42	**Prescribing Performance Report** Mr Prescott advised that forecast position for Month 9 is a forecast overspend of £173,071 or 0.88% on a budget of £19,587,637. Cost and number of items have increased from last year. The forecast is anticipated to improve towards the end of the financial year.	

No	Item	Action
	The CCG's Senior Leadership Team is now examining this data closely on a weekly basis as the end of the financial year approaches. This will complement the work of the Medicines Management Operational Group. Population shifts will be taken into account when considering prescribing budgets for the new financial year. A wider dashboard may be considered going forward to broaden the spectrum of associations around prescribing and this will be available by September 2014. The volatility of prescribing was recognised.	BP
	Action taken by the Governing Body	
	The report was received by the Governing Body by way of assurance.	
GB14/43	**The CCG 5 Year Strategic Plan and 2 year Operational Plan – Briefing on Progress – Update** Mr McCluskey referenced the first draft of the plans and timetable produced to the Governing Body in January 2014. By way of an update, national guidance continues to evolve and the CCG is working closely with colleagues at NHS England to review that guidance. Mr McCluskey described the evidence, tools and models that have been considered as part of the planning process, noting the 4 April deadline for the CCG to finalise its two-year Operational Plan. The five-year Strategic Plan is also under development and as part of this process, the national guidance produced in December, the Health and Wellbeing Strategy and existing strategic documents for CCGs have been considered, to produce some commonality in terms of vision and values. Ms Nichols referred to the Ambition Outcomes which she felt were sufficiently challenging and realistic in terms of achievement, although it was acknowledged that these may be further refined during the process. Ms Nichols expressed concern at the proposal to reduce admission by 15% in an environment where activity is increasing generally. Mr McCluskey responded that significant improvement had already been made and they key was to sustain this trend. Ms Clark referenced the alignment of plans that was necessary across the wider health economy.	
	Action taken by the Governing Body	
	The report was received by the Governing Body by way of assurance.	
GB14/44	**Strategic Financial Plan 2014/15 - 2018/19** Mr McDowell advised felt it was important to take stock at this stage to consider the financial planning process alongside the strategic process. A formal report will be brought back to the Governing Body in May, in advance of the submission date in June. Ms Nichols expressed her support for Finance Team's planning process.	
GB14/45	**Contracts for 2014/15** Formal sign-off of contracts with NHS providers must take place by 31 March 2014. An agreement has been reached with S&O and formal sign-off will take place later today.	

No	Item	Action
	A small number of Southport and Formby patients use services at Aintree University Hospitals NHS Foundation Trust and Liverpool Women's Hospital NHS Foundation Trust. These contracts have not yet been signed, but stability of services will be retained while the negotiation continues with lead CCGs. Ms Clark thanks Dr Evans for his clinical support in relation to the contracting process.	
	Action taken by the Governing Body	
	The report was received by the Governing Body by way of assurance.	
GB14/46	**Commissioning Intentions 2014/15** Care Closer to Home is vital terms of delivering the CCG's plans and the scheme will continue to be valued robustly. The Commissioning Policy Review and Policy for Procedures of Lower Clinical Priority are currently out to consultation and contributions are sought. Details are available on the CCG's website. Miss Fagan advised as to the recent presentation at the Quality Committee by the Community Paediatric Team which was receiving recognition nationally and demonstrated the excellent work by the Trust in this regard. Ms Clark advised that the CCG did not consider it necessary to produce a Business Plan at the current time, in the presence of the publication of the Commissioning Intentions and Strategic Plans. The document will be produced in July 2014.	
	Action taken by the Governing Body	
	The report was received by the Governing Body by way of assurance.	
GB14/47	**Clinical Directors Role** Ms Jeffes presented this paper and identified that the development of the portfolios will require further consideration and personal development of individuals. A parallel process needs to be developed for other members of the Governing Body. There will be opportunity to consider this further at the Development Session in May 2014. Dr Evans felt it was important to attract GP colleagues to work with the CCG and develop commissioning skills.	TJ/FLC
	Action taken by the Governing Body	
	The report was received by the Governing Body by way of assurance.	
GB14/48	**Key issues reports** were received. **Finance and Resource Committee** A correction is required at point 1. At point 4, the Committee reviewed the Operating Financial Review and agreed the content was appropriate. **Quality Committee** Ms Nichols raised the continuing issue of safeguarding assurance and the service hosted by Halton CCG. Gaining the appropriate level of assurance from providers is challenging, although improvement can be noted, albeit slowly. A deadline of the end of Quarter 4 has been agreed in order to see improvements at local providers. Evidence of risk mitigation has been sought. At the meeting last week, assurance as to the quality of services at Nursing Home was considered for the first time and this will be developed further.	

No	Item	Action
	North Locality Group Mrs Leonard advised that monies would be spent at practice level, in the absence of agreeing a scheme across the locality, on the basis that outcomes commensurate with the National Outcomes Framework must be demonstrated. Ms Clark emphasised that all monies are subject to the utmost probity.	
	Action taken by the Governing Body	
	The report was received by the Governing Body by way of assurance.	
GB14/49	**NHS Constitution Statement of Assurance** The CCG is green in all areas and is fully compliant, save for access for patients of information in relation to patients travelling abroad. This will be rectified for the deadline of 31 March 2014.	TJ
	Action taken by the Governing Body	
	The report was received by the Governing Body by way of assurance.	
GB14/50	**2014/15 Opening Financial Budgets** The proposed budgets deliver the key metrics required by NHS England in terms of 1% surplus. This is reliant upon the delivery of £5.9m worth of QIPP schemes, for which schemes have been identified and delivery reflected in opening budgets. The CCG has provided a Contingency reserve of 0.5% of resource allocations in accordance with the national guideline. The CCG planned expenditure is within its running cost target. The CCG has identified Investment schemes using 2.5% of non-recurrent expenditure, in line with NHS England 2014/15 planning guidance. An update to this opening budget position will be presented to the Governing Body meeting in May, following confirmation of key issues which remain outstanding.	
	Action taken by the Governing Body	
	The Governing Body approved the opening budget for the 2014/15 financial year.	
GB14/51	Quality Committee Minutes were received.	
GB14/52	Finance & Resource Committee Minutes were received.	
GB14/53	Merseyside CCG Network Minutes were received.	
GB14/54	Health and Wellbeing Board Minutes were received.	
GB14/55	Medicines Management Operational Group Minutes were received.	
GB14/56	Health and Wellbeing Board Programme Group Minutes were received.	
GB14/57	Locality Meeting Minutes were received.	
GB14/58	**Any Other Business** Ms Clark expressed her formal thanks to Dr Leonard for his support, wisdom and challenge as Chair of the CCG, together with the other GPs who will be stepping down from the Board.	
	Action taken by the Governing Body	
	The report was received by the Governing Body by way of assurance.	
GB14/59	**Date, Time and Venue of Next Meeting of the Governing Body to be held in Public** Wednesday, 28 May 2014 at 1.00pm at the Family Life Centre	

NHS
Southport and Formby
Clinical Commissioning Group

Governing Body Meeting in Public Actions

Wednesday, 26 March 2014 at 1.00pm to 4.00pm

No	Item	Action
GB14/42	**Prescribing Performance Report** Population shifts will be taken into account when considering prescribing budgets for the new financial year. A wider dashboard may be considered going forward to broaden the spectrum of associations around prescribing and this will be available by September 2014.	BP
GB14/47	**Clinical Directors Role** Ms Jeffes presented this paper and identified that the development of the portfolios will require further consideration and personal development of individuals. A parallel process needs to be developed for other members of the Governing Body. There will be opportunity to consider this further at the Development Session in May 2014.	TJ/FLC
GB14/49	**NHS Constitution Statement of Assurance** The CCG is green in all areas and is fully compliant, save for access for patients of information in relation to patients travelling abroad. This will be rectified for the deadline of 31 March 2014.	TJ

NHS
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MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/67	**Author of the Paper:** Fiona Clark Chief Officer fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7061
Report date: May 2014	
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 by way of assurance.	Receive [x] Approve [ ] Ratify [ ]

Links to Corporate Objectives *(x those that apply)*	
	Improve quality of commissioned services, whilst achieving financial balance.
	Achieve a 1% reduction in non-elective admissions in 2014/15.
	Implementation of 2014/15 phase of Virtual Ward plan.
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
	Review the population health needs for all mental health services to inform enhanced delivery.

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

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

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

NHS
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Report to Governing Body
May 2014

1. Internal Audit and Service Auditor Reporting 2013/14 – Cheshire & Merseyside Commissioning Support Unit

1.1. Due to this being a transitional year following a period of significant changes, NHS England have advised on a national basis that where there have been findings from internal audit work commissioned by NHS England, there is no benefit in the same process being audited again by CCGs' internal auditors, as this would be duplication of effort and produce the same results.

1.2. CCGs should therefore not request to send their Internal Auditors into the CSU, if the process has already been audited by NHS England Internal Audit, as this request will be denied.

1.3. On a National basis, NHS England has advised that client side controls in CCGs should be considered as part of the assurance work undertaken by CCG Internal Auditors. These will provide a level of comfort where positive assurance is not possible for part of the year from the CSU due to this transitional year.

1.4. It is recognised that where there have been control weaknesses during the year, CCG External Auditors may wish to perform additional substantive testing for the periods where reliance cannot be placed on controls testing. Where this cannot be performed at CCG level NHS England will permit access to CSUs.

1.5. In a letter from Tim Andrews dated 3 February 2014, Cheshire & Merseyside CSU confirmed that such an audit by NHS England Internal Audit has taken place and, accordingly, the CCG will not be seeking to gain access into the CSU for audit purposes.

2. Hard Truths Commitments Regarding the Publishing of Staffing Data

2.1. The National Quality Board (NQB) issued guidance in November to optimise nursing, midwifery and care staffing capacity and capability. Research demonstrates that staffing levels are linked to the safety of care and that staff shortfalls increase the risks of patient harm and poor quality care. Patients and the public have a right to know how the hospitals they are paying for are being run, and so the Government has made a number of commitments in Hard Truths: The Journey to Putting Patients First to make this information more publically available.

2.2. There are two phases and, in the first phase, there are a number of milestones ahead which will focus on all inpatient areas; including acute, community, mental health, maternity and learning disability. The commitments from Trusts are to publish staffing data from April and, at the latest, by the end of June 2014 in the following ways:

- a Board report describing the staffing capacity and capability, following an establishment review, using evidence based tools where possible. To be presented to the Board every six months;

- information about the nurses, midwives and care staff deployed for each shift compared to what has been planned and this is to be displayed at ward level;

- a Board report containing details of planned and actual staffing on a shiftby- shift basis at ward level for the previous month. To be presented to the Board every month;

- the monthly report must also be published on the Trust's website and Trusts will expected to link or upload the report to the relevant hospital(s) webpage on NHS Choices.

NHS England/Care Quality Commission will be undertaking two stock-takes of progress, which will take place on the dates set out below and will be undertaken jointly with the NHS Trust Development Authority (TDA).

	Date Issued:	Date to be Returned:
Stock-take 1	23rd April 2014	30th April 2014
Stock-take 2	28th May 2014	6th June 2014.

2.3. Trust boards must, at any point in time, be able to demonstrate to their commissioners that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient to provide safe care. All NHS Trusts are accountable to the NHS TDA and, as stated in the Accountability Framework 2014-15, will be expected to provide the NHS TDA with assurance that they are implementing the NQB staffing guidance and that, where there are risks to quality of care due to staffing, actions are taken to minimise the risk. Monitor has worked with us in the development of this guidance and expects Foundation Trusts to have the right staff, in the right place at the right time. The Care Quality Commission will be looking for compliance with all the actions outlined in this letter as part of their inspection regime. Monitor will act where the CQC identifies any deficiencies in staffing levels in Foundation Trusts.

2.4. On 16 May 2014, NHS England sent a letter and guidance to all Trusts with inpatient beds on publishing staffing data on NHS Choices in June 2014. From a CCG assurance perspective, provider staffing is detailed within the quality element of the contract and will be monitored via the Clinical Performance and Quality Group meetings, reported as necessary to the Quality Committee.

3. Southport & Formby CCG Constitution

3.1. The deadline for the next opportunity for CCGs to update their constitutions closes on 1 June 2014.

3.2. Work has therefore been undertaken to update the Constitution generally and in accordance the national requirements for the Governing Body to include a Secondary Care Doctor, a Registered Nurse and Lay Members.

3.3. The changes also incorporate the creation of two new committees of the Governing Body – the Service Improvement and Redesign Committee and the Approvals Committee.

3.4. The changes have now been circulated to the Wider CCG Membership for discussion and are recommended for approval on 21 May 2014.

4. National CCG 360° Survey

4.1. The results of a national survey by Ipsos Mori calling for views about CCGs across the country have shown some positive results for Southport & Formby CCG. The CCG received its 360° feedback on the 9th May 2014, carried out on behalf of NHS England, the survey aimed at gauging perceptions and working relationships between CCGs and their key local partners.

4.2. As well as member GP practices, bodies like Sefton Health and Wellbeing Board, Sefton CVS and Healthwatch Sefton were also invited to complete the survey. Locally, the overall response rate was 60% for SSCCG.

4.3. A similar exercise was carried out in 2012 prior to the CCG becoming a statutory organisation and these latest findings compare favourably with the baseline results.

4.4. A more detailed analysis is currently being undertaken and this will link in to the CCG Organisational Development plan, overseen by Tracy Jeffes- Chief Delivery & Integration Officer.

4.5. The full and summary reports have been sent via the CCG newsletter to our member practices and are also available on our public website.
http://www.southportformbyccg.org.uk/?p=442

5. Progress on Strategic Plan

5.1. The CCG first draft strategic plan was submitted by the NHS England deadline on the 4th April 2014.

5.2. Following on from this submission further work has been undertaken through ‘mini chats’ with our public and recently developed work through the newly established Provider forum to gain feedback and input to the plans are they are evolving.

5.3. Recent feedback from NHS England (Merseyside) has been positive and encouraging, and a acknowledgement that this is the first iteration and part of our journey across our unit of planning-Sefton.

5.4. The areas of feedback and key lines of enquiry from NHS England are now being considered by Karl McCluskey- Chief Strategy & Outcomes Officer and will be incorporated into our submission for the 20th June 2014.

5.5. Work has also been finalised on the CCG structures and governance arrangements in order to drive the strategy effectively into its delivery phase.

6. Aintree University Hospital NHS Foundation Trust -CQC Quality report May 2014

6.1. The Care Quality Commission (CQC) has rated Aintree’s services as ‘good’ following an inspection in March. A team of 30 inspectors spent three days in the hospital and also conducted an unannounced visit.

6.2. Every specialty service has been rated as ‘good’, including:

- A&E
- Medical Care
- Critical Care
- End of Life Care
- Outpatients
- Surgery.

6.3. Areas highlighted in the report include:

- that all the patients who the inspectors spoke to were positive about their care and treatment at Aintree and felt that they were well cared for and treated with dignity and respect;

- all the wards and departments that were inspected were adequately staffed by staff who were "committed and enthusiastic about their work and worked hard to ensure that patients were given the best care and treatment possible";

- the hospital was clean throughout and there was good practice in the control and prevention of infection;

- Aintree's well-respected Volunteer department which makes a "positive contribution to the patient journey" and provides "development opportunities for the local population."

  http://www.cqc.org.uk/media/englands-chief-inspector-hospitals-has-published-his-first-report-quality-services-provided-ai

7. Co-commissioning of Primary Care Services

7.1 NHS England have written to the CCG to set out how CCGs can submit expressions of interest by the 20th June (see Appendix 1), to develop new arrangements for co-commissioning of primary care services, following Simon Stevens' announcement on 1 May. NHS England have also indicated that the NHS Commissioning Assembly will undertake a rapid piece of work to support CCGs.

7.2 Proposals may be submitted by an individual CCG or by a group of CCGs that wishes to propose co-commissioning arrangements to cover their combined localities.

7.3 Expressions of interest should set out how the proposals fit with the CCG five-year strategic plan, with some specific areas to consider; including what form the CCG would like co-commissioning to take and how they would like this to evolve, including the proposed relationship with any current or proposed joint commissioning with local authorities.

7.4 NHS England envisages that arrangements for managing the Performers List, revalidation and appraisal would fall outside the scope of any co-commissioning arrangements. NHS England cannot delegate responsibility for commissioning of community pharmacy services or dental services. CCGs will be expected to ensure that their proposals take advantage of synergies with existing areas of CCG activity and enable functions to be discharged within existing CCG running costs as far as possible. Expressions of interest will need to indicate where proposals would rely upon area team staff working under the supervision of CCGs.

7.5 Governance frameworks will need to be clear and specific reference made to how any additional proposed safeguards for managing conflicts of interest will be applied and clear timetables for applying any new arrangements detailed.

7.6 Expressions of interest should set out how CCGs have engaged their member practices in developing the proposals and any key issues raised by member practices, together with proposals for how they will further involve member practices. Expressions of interest should provide any initial views of local stakeholders, together with proposals for engaging stakeholders more fully in developing the proposed arrangements more fully. This should, for instance, cover:

• patient groups;
• local authorities and Health and Wellbeing Boards;
• other local provider organisations, e.g. community, mental health, acute trusts.

7.7 Finally, expressions of interest should set out initial proposals for how to monitor and evaluate the impact and effectiveness of the proposed co-commissioning arrangements, in order to ensure that CCGs and area teams can adapt.

7.8 Work is now underway to understand the perspectives of the member practices and other key stakeholders and public.

8. Corporate objectives 14/15

8.1 The following are the proposed CCG corporate objectives for 14/15.

- Improve quality of commissioned services, whilst achieving financial balance.
- Achieve a 1% reduction in non-elective admissions in 2014/15.
- Implementation of 2014-15 phase of Care Closer to Home / Virtual Ward plan.
- Review and Re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
- Implementation of 2014-15 phase of Primary Care quality strategy / transformation.
- Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy.
- Review the population health needs for all mental health services to inform enhanced delivery.

8.2 These will be underpinned by:

- Public and Stakeholder Engagement
- Clinical Leadership
- Locality Working
- Organisational and Workforce Development
- Information Management &Technology.

9. Recommendation

The Governing Body is asked to formally receive this report.

Appendices

Appendix 1 Letter from NHS England dated 9 May 2014.

Fiona Clark
Chief Officer
May 2014

Publications Gateway Ref. Number 01599

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9 May 2014

To: CCG Clinical Leads

Area Directors, NHS England

Copy: CCG Chief Officers

Co-commissioning of primary care services

We are writing to set out:

- how CCGs can submit expressions of interest to develop new arrangements for co-commissioning of primary care services, following Simon Stevens' announcement on 1 May (see annex A);
- the work proposed to be done through the NHS Commissioning Assembly to support CCGs and area teams in developing co-commissioning arrangements.

We are inviting CCGs to submit expressions of interest by 20 June. We would encourage CCGs to work with area teams in developing proposals.

Expressions of interest should include at least this information:

A. CCG(s) involved

Proposals may be submitted by an individual CCG or by a group of CCGs that wishes to propose co-commissioning arrangements to cover their combined localities.

B. Intended benefits and benefits realisation

Expressions of interest should set out how the proposals fit with five-year strategic plans and, in particular, how they will help:

- achieve greater integration of health and care services, in particular more cohesive systems of out-of-hospital care that bring together general practice,

community health services, mental health services and social care to provide more joined-up services and improve outcomes;

- raise standards of quality (clinical effectiveness, patient experience and patient safety) within general practice services, reduce unwarranted variations in quality, and, where appropriate, provide targeted improvement support for practices;
- enhance patient and public involvement in developing services, for instance through asset-based community development;
- tackle health inequalities, in particular by improving quality of primary care in more deprived areas and for groups such as people with mental health problems or learning disabilities.

C. Scope

Commissioning of primary care encompasses a wide spectrum of activity, including:

- working with patients and the public and with Health and Wellbeing Boards to assess needs and decide strategic priorities;
- designing and negotiating local contracts (e.g. PMS, APMS, any enhanced services commissioned by NHS England);
- approving 'discretionary' payments, e.g. for premises reimbursement;
- managing financial resources and ensuring that expenditure does not exceed the resources available;
- monitoring contractual performance;
- applying any contractual sanctions;
- deciding in what circumstances to bring in new providers and managing associated procurements and making decisions on practice mergers.

The expression of interest should indicate which aspects of commissioning fall within the scope of the proposed arrangements. CCGs may wish to propose that they take on delegated or joint responsibilities for some aspects, whilst NHS England continues to discharge other responsibilities directly.

We envisage that arrangements for managing the Performers List, revalidation and appraisal would fall outside the scope of any co-commissioning arrangements.

NHS England cannot delegate responsibility for commissioning of community pharmacy services or dental services. CCGs may wish to make proposals for how better to align decisions made by area teams in commissioning of community pharmacy services with CCGs' strategic objectives, provided that NHS England retains its statutory decision-making responsibilities and that there is appropriate involvement of local professional networks.

NHS England could in principle delegate responsibility for commissioning of primary eye care services, but the main services commissioned by NHS England (NHS sight tests) are essentially a demand-led service governed by national regulations.

D. Nature of co-commissioning

There is a spectrum of potential forms that co-commissioning could take, for instance:

- greater CCG involvement in influencing commissioning decisions made by NHS England area teams;
- joint commissioning arrangements, whereby CCGs and area teams make decisions together, potentially supported by pooled funding arrangements;
- delegated commissioning arrangements, whereby CCGs carry out defined functions on behalf of NHS England and area teams hold CCGs to account for how effectively they carry out these functions.

Expressions of interest will need to indicate the form that CCGs would like co-commissioning to take and how they would like this to evolve, including the proposed relationship with any current or proposed joint commissioning with local authorities.

CCGs will be expected to ensure that their proposals take advantage of synergies with existing areas of CCG activity and enable functions to be discharged within existing CCG running costs as far as possible. Expressions of interest will need to indicate where proposals would rely upon area team staff working under the supervision of CCGs.

E. Timescales

Expressions of interest will need to indicate the proposed timescales for applying the new arrangements, including any proposals for phasing (e.g. where some elements of co-commissioning are introduced during 2014/15, followed by a more developed form of co-commissioning during 2015/16).

Any proposals that rely upon setting primary care budgets at a locality level (below that of an area team) would have to be implemented from 2015/16 onwards.

F. Governance

CCGs already have powers to commission services from general practice (or from other primary care providers) in their own right. Where commissioning services from general practice, or from any organisation in which their members or offers have a

material interest, CCGs have a statutory duty to manage conflicts of interest and to have regard to the statutory guidance on managing conflicts of interest published by NHS England[1]. CCGs would need equally to meet these duties and follow the statutory guidance in relation to any functions that they were to carry out jointly with, or on behalf of, NHS England.

Expressions of interest should set out any additional proposed safeguards for managing conflicts of interest.

G. Engaging member practices and local stakeholders

Expressions of interest should set out how CCGs have engaged their member practices in developing the proposals and any key issues raised by member practices, together with proposals for how they will further involve member practices.

Expressions of interest should provide any initial views of local stakeholders, together with proposals for engaging stakeholders more fully in developing the proposed arrangements more fully. This should, for instance, cover:

- patient groups;
- local authorities and Health and Wellbeing Boards;
- other local provider organisations, e.g. community, mental health, acute trusts.

H. Monitoring and evaluation

Expressions of interest should set out initial proposals for how to monitor and evaluate the impact and effectiveness of the proposed co-commissioning arrangements, in order to ensure that CCGs and area teams can adapt

NHS Commissioning Assembly project

The primary care working group of the NHS Commissioning Assembly will undertake a rapid piece of work to identify the key issues that will need to be resolved to support successful co-commissioning, with the aim of supporting area teams and CCGs in working together to refine the proposals that come from expressions of interest and to help spread innovative thinking.

This will include:

- identifying likely success factors for effective co-commissioning;

[1] http://www.england.nhs.uk/wp-content/uploads/2013/03/manage-con-int.pdf

- identifying the different forms that co-commissioning could take – and its potential scope – and the considerations that would need to be applied locally in choosing between them;
- developing a checklist that could guide CCGs and area teams through the steps involved in setting up new arrangements.

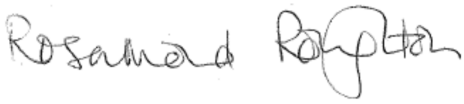
The project will also look, among other issues, at:

- how NHS England can assure itself that delegated functions are being discharged effectively and that any conflicts of interest are being managed appropriately;
- how associated financial resources would be allocated, managed and accounted for;
- any national decisions or approvals that would be needed in relation to information sharing;
- any implications for the public health offer to support primary care commissioning from Public Health England and local authorities.

Conclusion

CCGs are asked to submit expressions of interest, covering the factors set out above (paragraph 8), by 20 June. Please submit expressions of interest to england.co-commissioning@nhs.net.

The relevant Area Team will then discuss each proposal with the applicant CCG(s) and subsequently make a recommendation for approval through the Board governance of NHS England.



Rosamond Roughton
National Director: Commissioning Development

Dame Barbara Hakin
Chief Operating Officer

Annex A

NHS ENGLAND PRESS NOTICE (1 May 2014)

LOCAL HEALTH PROFESSIONALS TO GET MORE POWER TO IMPROVE NHS PRIMARY CARE

Stevens announces new option for local Clinical Commissioning Groups to co-commission primary care in partnership with NHS England

England's 211 clinically-led local Clinical Commissioning Groups will get new powers to improve local health services under a new commissioning initiative announced today by NHS England Chief Executive Simon Stevens.

Speaking to GPs and other NHS health professionals at the Annual Conference of NHS Clinical Commissioners in London, Simon Stevens said:

"England has now taken the bold step – unique in the western world – of putting two thirds of its health service funding under the control of local family doctors and clinicians.

"If we want to better integrate care outside hospitals, and properly resource primary, community and mental health services - at a time when overall funding is inevitably constrained - we need to make it easier for patients, local communities and local clinicians to exercise more clout over how services are developed.

"That means giving local CCGs greater influence over the way NHS funding is being invested for their local populations. As well as new models for primary care, we will be taking a hard look at how CCGs can have more impact on NHS England's specialised commissioning activities.

"So today I am inviting those CCGs that are interested in an expanded role in primary care to come forward and show how new powers would enable them to drive up the quality of care, cut health inequalities in primary care, and help put their local NHS on a sustainable path for the next five years and beyond.

"CCGs are still young organisations at different stages of development, and with different local needs. So rather than specifying a one-size-fits all solution, and having listened carefully to what CCGs have been saying, I'm keen to hear from CCGs themselves about what next steps they would like to explore."

Mr Stevens announced that NHS England will be writing next week to all CCGs in England with details of how to submit expressions of interest in taking on enhanced powers and responsibilities to co-commission primary care.

Applications will need to describe the additional powers and responsibilities the CCG would like to assume. They will need to meet a number of tests, including showing

they will help advance care integration, raise standards and cut health inequalities in primary care.

They will also need to show how they will ensure transparent and fair governance - with a continuing oversight role for NHS England to safeguard against conflicts of interest - all in the context of the CCG's five-year plan for its local NHS services.

NHS England will work with the NHS Commissioning Assembly, NHS Clinical Commissioners and other stakeholders to advance this agenda.

CCG expressions of interest should be developed by June 20, the same date that CCGs will complete their initial five-year 'Forward Views' for local NHS services.

Each proposal will be discussed by the applicant CCG and the local Area Team of NHS England, which will subsequently make a recommendation for approval by the Board of NHS England.

NOTES TO EDITORS

England's 211 CCGs are statutory bodies led by local GPs, alongside hospital doctors, nurses and other health professionals, managers, and independent lay members of the public.

NHS Clinical Commissioning Groups (CCGs) now control £67 billion of NHS funding – about two thirds of NHS spending in England.

Giving CCGs the ability to better influence and shape primary care services requires no further structural reorganisation, and the necessary enabling powers are already included in current legislation.

In accordance with national legislation, NHS England (and its Area Teams) will in all parts of the country continue directly to discharge specific primary care responsibilities, including in respect of community pharmacy, primary dental and ophthalmic services, as well as certain responsibilities in respect of primary medical services.

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/68	**Author of the Paper:**
Report date: May 2014	Debbie Fagan debbie.fagan@southseftonccg.nhs.uk Karl McCluskey Karl.McCluskey@southseftonccg.nhs.uk Lisa Leckey Lisa.leckey@cmcsu.nhs.uk

Title: Corporate Performance Report

Summary/Key Issues:

This paper presents the Governing Body with the Performance Dashboard, Quality Report, Family and Friends Inpatient Summary, Friends and Family A&E Summary, Liverpool Community Health Quality Compliance Report for Month 12, Liverpool Community Health KPI Report.

Recommendation

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

Receive	X
Approve	
Ratify	

	Links to Corporate Objectives (x those that apply)
X	Improve quality of commissioned services, whilst achieving financial balance
X	Achieve a 2% reduction in non-elective admissions in 2014/15
X	Implementation of 2014-15 phase of Care Closer to Home / Virtual Ward plan
	Review and Re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public
	Implementation of 2014-15 phase of Primary Care quality strategy / transformation
	Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy
	Review the population health needs for all mental health services to inform enhanced delivery

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				
Locality Engagement			X	
Presented to other Committees	Yes			Quality Report has previously been submitted to Quality Committee

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
May 2014

1. Executive Summary

This report sets out the performance of the CCG's main acute providers and progress against the National Outcomes Framework at month 12 of the financial year

2. Introduction and Background

CCGs have a statutory duty to improve health outcomes and ensure that the NHS Constitution pledges are being delivered.

This report sets out the CCG's performance against the National Outcomes Framework and the NHS Constitution. It also shows provider performance for the CCG's 3 main providers, Aintree Hospitals NHS Foundation Trust, Southport and Ormskirk Hospital NHS Trust and The Walton Centre NHS Foundation Trust.

3. Key Issues

Health Care Acquired Infections (HCAI) – Cdifficile
Southport and Formby CCG reported a year to date figure of 45 cases against a target of 38 failing to hit the target failing the yearly tolerance by 7 cases. For March 2014 there were 5 cases in total apportioned to non-acute trust, reported at Southport and Ormskirk Hospital NHS Trust. Aintree Hospitals NHS Foundation Trust has reported 76 cases of Cdifficile year to date, 26 of these were South Sefton CCG patients. There was 1 case in March 2014 which will bring the year to date total to 33 cases above the 2013/14 year-end target of 43. The Walton Centre NHS Foundation Trust has reported 12 cases to date, 1 case was reported in March 2014. This was not a South Sefton CCG patient. This is 7 cases above the year to date tolerance of 5. Southport and Ormskirk Hospital NHS Trust has reported 34 cases year to date, 15 above the year to date plan of 19. 4 cases were reported in March 2014.
Health Care Acquired Infections (HCAI) – MRSA
Southport and Formby CCG reported zero cases of MRSA at March 2014. The Walton Centre NHS Foundation Trust has reported 1 case of MRSA year to date. Aintree Hospitals NHS Foundation Trust has reported 3 cases of MRSA; one of these cases was in March 2014. This was not a Southport and Formby CCG patient. This is above the zero tolerance. These were being reported through the Infection Prevention Committee to the CCGs. Root Cause Analysis (RCA) has been completed.

Emergency admissions for acute conditions that should not usually require hospital admission (cumulative)
As at March 2014 (cumulative) Southport and Formby CCG were over plan, (actual 1,765.09, plan 1,408.89). Looking at the emergency admissions figures this equates to 436 extra admissions compared to the same period last year.
% High risk of Stroke who experience a Transient Ischemic Attack (TIA) are assessed and treated within 24 hours
Southport and Formby CCG failed to achieve the 60% target for TIA hitting 50% for the month of March 2014, which equated to 1 out of 2 patients not being seen within the 24 hours.
% who had a stroke & spend at least 90% of their time on a stroke unit
Southport and Formby CCG failed to achieve the 80% target for Stroke with 77.8% for the month of March 2014; this is 14 out of a total of 18 patients. This is highlighted as an amber risk on the corporate performance dashboard. Southport and Ormskirk Hospitals NHS Trust did not achieve the target for the month of March 2014, achieving 69.2% which is 18 out of a total of 26 patients. There is no further breakdown of the stroke data. The Trust is in the process of improving the data flows for stroke. The national stroke database currently does not hold all of the data needed to perform more granular level analysis on the data and hope to have this rectified in the next couple of weeks. Aintree University Hospitals NHS Foundation Trust did not achieve the stroke indicator in March 2014, achieving 75.61%, a fall from the 96.88% achieved in February 2014. In March 2014 10 patients out of 31 admitted with a stroke did not spend 90% of their time on a stroke unit. The performance for the year is 74.25%. 61% of patients arrived on the Stroke Unit within 4 hours. A patient transferred to Aintree Stroke Unit (ASU) within 4 hours and discharged early resulting in failing the 90% stay target. Three patients had catastrophic bleeds and were transferred to other areas for palliative care/side rooms and died within 24 hours. There was no ASU female bed available on one occasion and late referrals to the Stoke team resulted in failure to achieve 90% target. A number of keys actions have taken place and these include: • consultant of the week rota commenced January 2014. The new rota releases stroke physicians from other commitments and allows for more rapid assessment and transfer of stroke patients. Four hour target has persistently been achieved since the changes took place. • stroke physician on-call every weekday and on site from 9am to 8pm to further facilitate timely assessment and transfer of stroke patients. Door to needle time achieved persistently between 26 and 33 minutes. • revised stroke team alert and bleep system now operational. The team comprises Consultant, Specialist Registrar or Senior House Officer and a Home Officer who will assess patients and if necessary clerk them on transfer to the Stroke Unit. This will enable more timely transfer to the Unit. • audit of every stroke admission continues to take place. The team has persistently achieved the 4hr target since the introduction of the new ways of working, 96% achieved against the 90% stay in February 2014 and there is an expectation that

going forward the team will achieve all standards. There is a risk that empty bed capacity will be occasionally utilised for medical admissions.

Rate of Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (Males and Females)

For males, Southport and Formby CCG achieved a rate of 2870.30. In 2012 this was slightly above over the planned tolerance of 2778.45. For females, Southport and Formby CCG achieved 2160.50 in 2012 which was again, above the planned tolerance of 2091.36. An update will be given as soon as possible as to what measures can be updated and when. This is highlighted as an amber risk on the corporate performance dashboard.

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

Southport and Formby CCG achieved 90.16% cumulatively to February 2014, which failed to hit the target of 93% target. Southport and Formby CCG failed the target year to date but the Trust achieved for the month of February 2014, seeing all 52 patients within 14 days. Failure to reach the target was due to previous months breaches. This is highlighted as an amber risk on the corporate performance dashboard.

For the maximum 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms, Southport and Ormskirk Hospital NHS Trust did not achieve the February 2014 cumulative target for breast symptomatic referrals with 91.06% year to date against the 93% target, although the target was achieved for the month of February 2014. The year to date failure was due the patient breaches from previous months.

Maximum two month wait from urgent GP referral to first definitive treatment for cancer – 85%

Southport and Formby CCG achieved 81.84%, cumulatively to February 2014 which failed to achieve the target of 85%. The CCG did achieve the target for the month of February 2014. In February 2014, there were 3 breaches out of a total of 21 patients. The reasons included delays due to late referrals between trusts in admitted and non-admitted care and cancellation due to other emergency. This is highlighted as an amber risk on the corporate performance dashboard.

Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (cumulative)

Southport and Formby CCG successfully achieved 96.21% for this indicator cumulatively to March 2014 against the 94% target.

For the maximum 31-day wait for subsequent treatment where that treatment is surgery, Southport and Ormskirk Hospitals NHS Trust did not achieve the target of 94% with a cumulative 93.9% to February 2014. The Trust also failed to achieve the target for the month of February 2014. There was 1 patient breach out of a total of 9 patients treated (tumour type breast). The delay was due to the patient having shingles and the days waited were 50.

Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%
Southport and Formby CCG successfully achieved 100% for this indicator cumulatively to March 2014 against the 90% target. Southport and Ormskirk Hospital NHS Trust are underperforming cumulatively to February 2014 on the NHS screening service target with 83.33% against the 90% target. The trust achieved the target for the month of February 2014. This underperformance is due to breaches during previous months. Year to date there have only been 12 patients with 2 patient breaches.
Mixed Sex Accommodation (MSA)
The Mixed Sex Accommodation (MSA) breach rate is the number of breaches of mixed-sex sleeping accommodation per 1,000 finished consultant episodes. Southport and Formby CCG reported 4.10% in March 2014 against a 0% target. Southport and Ormskirk Hospitals NHS Trust have reported a further 16 breaches in March 2014, 79 breaches reported year to date. Of the 16 breaches, 10 relate to bed pressures and patient safety being the primary goal. The remaining 6 related to the 'deep cleaning' of ward 14A. The Trust is currently reviewing the care pathways of patients out of critical care. The Trust is also addressing the root cause of bed pressures through a wide-range of actions under the urgent care action plan. Whilst there are bed pressures across the Trust there is a risk of delayed discharges from critical care which may cause further breaches in the future. The Trust is delivering against the urgent care action plan and progress to date is positive.
Admitted patients to start treatment within a maximum of 18 weeks from referral (RTT)
Southport and Formby CCG successfully achieved 94.29% for this indicator in March 2014 against the 90% target. Southport and Ormskirk Hospitals NHS Trust has failed to achieve the adjusted admitted target reaching 79.86% which reflects the Trusts overall position. For Southport and Formby CCG patients, the Trust failed to achieve the adjusted admitted target for the fifth consecutive month, reaching 88.56%. This equates to 50 out of 437 patients not being seen within 18 weeks. 47 patients were seen within 18-29 weeks and 3 patients were seen within 29-34 weeks. All breaches were in trauma and orthopaedics. *Please note these figures are specifically for Southport & Formby CCG patients and do not reflect the trusts overall position.*
Local measure - 20% reduction in emergency admissions for asthma <19 years. Baseline = 101 - 20% reduction = 81 (Cumulative)
Southport & Formby CCG has not achieved the target and is 9 above the plan (year to date plan 81), however compared to the baseline it is approximately 20 less admissions. The baseline being last year's actual.

Ambulance Clinical Quality

Southport and Formby CCG did not achieve the targets in all 3 Ambulance Clinical Quality indicators cumulatively at March 2014. For Category A (Red 1) 8 minute response time, performance was 68.50% and did not achieve the target of 75.00%. For Category A (Red 2) 8 minute response time, performance was 73.22% and did not achieve the target of 75.00%. For Category 19 transportation time, performance was at 92.64%, below the 95% target. The underachievement for the 3 indicators was due to low performance in previous months. This is highlighted as an amber risk on the corporate performance dashboard.

Please note: the CCG is measured on the North West Ambulance Service (NWAS) figures and NWAS are achieving all 3 indicators, (Category A Red 1, Red 2 and Category 19 Transportation time).

Friends and Family Test Score – Inpatients and Accident & Emergency (A&E)

The indicator comprises two elements: the test score and the % of respondents who would recommend the services to friends and family – for Inpatient Services and A&E. The national CQUIN requirement is for all providers to achieve a combined 15% response rate by April 2014, the test score is measured against the national average.

For Southport and Ormskirk Hospitals Trust, the overall combined (A&E and Inpatients) response rate was achieved in Q4 2013/14, 18.6% reported compared to a plan of 15% but is 4.8% lower than the England average. However, for A&E alone the provider failed to achieve the 15% plan reaching 11.4% making a very slight improvement compared to Q3 2013/14. Published monthly data shows for March 2014, the overall combined (A&E and Inpatients) response rate was achieved, with 19.1% reported compared to a plan of 15% but is 4.9% lower than the England average. A&E alone was below the 15% for March 2014 at 8.8%.

Patient Safety Incidents

The provider performance dashboard (Appendix 2) shows the number of patient safety incidents reported. Commentary on patient safety incidents is as follows:

Aintree Hospitals NHS Foundation Trust reported 1 Serious Incident (SI) in March 2014. Year to date, for all patients, there have been 27 SI's.

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Communicable Disease and Infection Issue		1											1
Delayed Diagnosis		1		1		2	1						5
Cdifficile and HAI									1				1
Drug Incident (general)				1					1				2
Failure to act upon test result						1				1			2

RSA Bacteraemia			1										1
Other						1							1
Outpatient Appointment Delay				1	1								2
Pressure Ulcer Grade 3	1		1				1			1			4
Pressure Ulcer Grade 4				1									1
Slips/Trips/Falls			1			2		1					4
Unexpected Death (general)								1				1	2
Sub-optimal care of the deteriorating patient											1		1
Grand Total	**1**	**2**	**3**	**4**	**1**	**6**	**2**	**2**	**2**	**2**	**1**	**1**	**27**

Southport and Ormskirk Hospitals NHS Trust reported 0 serious untoward incidents in March 2014, 14 serious untoward incidents reported year to date.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YT
Adverse media coverage of public concern about the organisation or the wider NHS				1		1							2
Failure to act upon test results							1						1
Confidential information leak				1				1			1		2
Communicable Disease and Infection Issue								1					1
Delayed diagnosis										1			1
Safeguarding vulnerable child								1					1
Surgical error				2									2
Maternity services – Intrapartum death									1				1

Maternity service											1		1
Pressure ulcer Grade 3											1		1
Grand Total	**0**	**0**	**0**	**4**	**0**	**1**	**1**	**3**	**1**	**1**	**3**	**0**	**14**

Details of actions taken and reports received as a result of the serious untoward incidents are discussed at the SI/Complaints Monthly Management Groups.

4. Recommendations

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

Appendices

Appendix 1 CCG Corporate Performance Dashboard – Southport and Formby CCG
Appendix 2 CCG Corporate Performance Dashboard – Provider Level.

Karl McCluskey
May 2014

CCG CORPORATE PERFORMANCE DASHBOARD - Southport & Formby CCG

Baseline as at 07/05/2014 15:41:49

		Current Period			
Performance Indicators	**Data Period**	**Target**	**Actual**	**RAG**	**Fore cast**
IPM					
Treating and caring for people in a safe environment and protecting them from avoidable harm					
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative)	13/14 - March	38	45		
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative)	13/14 - March	0	0		
Enhancing quality of life for people with long term conditions					
Patient experience of primary care i) GP Services	Jan-Mar 13 and Jul-Sept 13		88.83		
Patient experience of primary care ii) GP Out of Hours services	Jan-Mar 13 and Jul-Sept 13		66.27		
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s(Cumulative)	13/14 - March	587.78	504.02		
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	13/14 - March	1,204.93	1,086.40		
Emergency Admissions Composite Indicator(Cumulative)					
Helping people to recover from episodes of ill health or following injury					
Patient reported outcomes measures for elective procedures: Groin hernia	12/13	7.60%	8.50%		
Patient reported outcomes measures for elective procedures: Hip replacement	12/13	36.80%	42.30%		
Patient reported outcomes measures for elective procedures: Knee replacement	12/13	29.50%	31.20%		
Emergency readmissions within 30 days of discharge from hospital (Cumulative)	13/14 - March		15.75		
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	13/14 - March	425.93	388.69		
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	13/14 - March	1,408.89	1,765.09		
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	13/14 - March	60%	50.00%		
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	13/14 - March	80%	77.78%		
Mental health					
Mental Health Measure - Care Programme Approach (CPA) - 95% (Cumulative)	13/14 - March	95.00	98.78		
Preventing people from dying prematurely					
Under 75 mortality rate from cancer	2012		131.16		
Under 75 mortality rate from cardiovascular disease	2012		67.21		
Under 75 mortality rate from liver disease	2012		14.40		
Under 75 mortality rate from respiratory disease	2012		24.59		
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Males)	2012	2,778.45	2,870.30		
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Females)	2012	2,091.36	2,160.50		
NHS Outcome Measures					
Cancer waits – 2 week wait					
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative)	13/14 - February	93%	90.16%		

Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative)	13/14 - February	93%	93.74%		
Cancer waits – 31 days					
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative)	13/14 - February	96%	98.21%		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative)	13/14 - February	98%	98.88%		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)	13/14 - February	94%	96.21%		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative)	13/14 - February	94%	97.03%		
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)	13/14 - February		82.35%		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative)	13/14 - February	85%	81.84%		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative)	13/14 - February	90%	100%		
Mixed Sex Accommodation Breaches					
Mixed Sex Accomodation (MSA) Breaches per 1000 FCE	13/14 - March	0.00	4.10		
Referral To Treatment waiting times for non-urgent consultant-led treatment					
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted)	13/14 - March	0	0		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways	13/14 - March	0	0		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways	13/14 - March	0	0		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	13/14 - March	90%	94.29%		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	13/14 - March	95%	98.07%		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	13/14 - March	92%	97.39%		
A&E waits					
Percentage of patients who spent 4 hours or less in A&E (Cumulative)	13/14 - March	95%	96.56%		
Diagnostic test waiting times					
% of patients waiting 6 weeks or more for a Diagnostic Test	13/14 - March	1.00%	0.29%		
Category A ambulance calls					
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	13/14 - March	75%	68.50%		
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	13/14 - March	75%	73.22%		
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	13/14 - March	95%	92.64%		
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	13/14 - March	75%	75.83%		
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	13/14 - March	75%	77.42%		
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	13/14 - March	95%	95.79%		

Local Measures					
20% reduction in emergency admissions for asthma <19 years. Baseline = 101 - 20% reduction = 81 (Cumulative)	13/14 - March	81.00	90.00		
10% reduction in the number of patients who have an emergency admission for dehydration. Baseline = 193 10% reduction = 174 (Cumulative)	13/14 - March	175.00	3.00		

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/69	**Author of the Paper:**
Report date: May 2014	Brendan Prescott Deputy Chief Nurse / Head of Quality & Safety brendan.prescott@southportandformbyccg.nhs.uk Tel: 0151 247 7093 Debbie Fagan Chief Nurse & Quality Officer debbie.fagan@southportandformbyccg.nhs.uk Tel: 0151 247 7007

Title: Quality Performance Report

Summary/Key Issues

This report provides the Governing Body with an overview position of provider performance in relation to quality and safety since the last meeting of the Governing Body in March 2014. The detail contained within this Quality Report and dashboard has been considered at the last meeting of the Quality Committee which took place on 22 May 2014 as part of the CCG assurance process. The key issues are detailed within this report by exception. The Governing Body are asked to note:

- mixed Sex Accommodation Breaches at Southport & Ormskirk Hospitals NHS Trust reported for March 2014 and April 2014;
- provider and CCG 2013/14 performance relating to C-Difficile and the local health economy work that has commenced around the patient journey and root cause analysis to identify lessons learnt;
- pressure ulcer aggregated Serious Incident Review being undertaken by Liverpool Community Health and co-ordinated by Liverpool CCG;
- outcome of the March 2014 Care Quality Commission inspection of Aintree University Hospital NHS Foundation Trust which gave the provider an overall rating of 'good'.

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)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
	Achieve a 2% reduction in non-elective admissions in 2014/15.
	Implementation of 2014/15 phase of Care Closer to Home plan.
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
	Review the population health needs for all mental health services to inform enhanced delivery.

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

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
May 2014

1. Executive Summary

This report provides the Governing Body with an overview position of provider performance in relation to quality and safety since the last meeting of the Governing Body in March 2014. Performance has been discussed at the Quality Committee meeting in May 2014 in order to provide assurance to the Governing Body.

2. Introduction and Background

2.1 For the purposes of this report, the detail contained within is concentrated on the main CCG commissioned providers as follows:

- Southport & Ormskirk Hospitals NHS Trust (S&O);
- Liverpool Community Health NHS Trust (LCH);
- Aintree University Hospital NHS Foundation Trust (AUH);
- Mersey Care NHS Trust;

although the detail does cover other providers across the Merseyside area where the CCG may have smaller numbers in terms of patient flow.

2.2 The key issues are identified by exception and presented in accordance with the domains of the National Outcomes Framework.

3. Key Issues – Domain 4: Ensuring people have a positive experience of care

Mixed Sex Accommodation Breaches

3.1 Further Mixed Sex Accommodation Breaches (MSA) have occurred at S&O in addition to those reported at the last meeting of the Governing Body which occurred in January 2014 and February 2014. 16 breaches occurred in March 2014 and 24 breaches in April 2014. The Trust had reported that these occurred due to bed pressures and fogging of a ward as a result of C-Difficile infection and there was a need to breach in order to maintain patient safety. This was an agenda item for discussion at the last Quality and Contract Performance Meeting that was held in May 2014 whereby the CCG although acknowledging the patient safety rationale put forward by the Trust clearly stated that this was also a patient right as detailed in the NHS Constitution. In addition, the CCG were in attendance at the Trust Quality & Safety Committee (sub-committee of the Trust Board) at which this was discussed.

Friends & Family Test

3.2 Challenges remain around performance at S&O in relation to A&E. The CCG Programme Manager for Quality & Safety continues to meet regularly with the Trust team regarding progress with the Friends & Family Test and this remains a standing agenda item for discussion at the Clinical Performance and Quality Contract Meeting.

3.3 AUH performance in this area remains satisfactory and the Trust attended the CCG Engagement and Patient Experience Group (EPEG) in May 2014. Positive feedback regarding the Trust presentation has been communicated to the Trust from the CCG Chief Officer.

4. Key Issues – Domain 5: Treating and caring for people in a safe environment and protecting from harm

Healthcare Associated Infections (HCAI) – C-Difficile (C-Diff)

4.1 As previously reported to the Governing Body both S&O and AUH have breached their full year C-Diff objective for 2013/14. The CCG has also breached its full year objective for patients with C-Diff with 45 being reported against a year end plan of 38. Remedial action plans, together with details relating to commissioner assurance, have been fully discussed at provider Clinical Performance and Quality Meetings, the CCG Quality Committee and CCG Assurance Checkpoint Meeting with NHS England (Merseyside). C-Diff objectives have now been set nationally for both providers and the CCG and 2014/15 Q1 performance will be reported to the next meeting of the Governing Body in July 2014.

4.2 Despite having breached the full year C-Diff objective, the HCAI C-Diff workstream in place at AUH appears to be having a positive impact with the Trust performance showing signs of improvement throughout Q3 and Q4 of 2014/15. The CCG has now been able to indicate to the Trust that the contract query regarding HCAI performance will now be lifted. The CCG will continue to work collaboratively with other local CCGs and the provider to support this continued improvement.

4.3 A Sefton Health Economy Workshop was held on 28 April 2014 hosted by South Sefton CCG and Southport & Formby CCG. This was well attended and the programme was developed in partnership between the CCGs, Public Health, AUH, S&O and LCH. Partners are looking forward to continuing this work around the patient journey and the development of a local system Root Cause Analysis process in order to identify lessons learnt in order to reduce the numbers of Sefton patients who contract C-Diff.

Serious Incident Reporting

4.4 LCH reporting of Grade 3 and 4 pressure ulcers continues and the Trust are undertaking an aggregated review at the request of commissioners. The CCG are working closely with Liverpool CCG who are co-ordinating this review from a commissioning perspective. The CCG Programme Manager for Quality & Safety is liaising with Liverpool CCG regarding this and once completed will be brought to the CCG Internal Serious Incident Review Meeting for consideration in addition to being an agenda item for discussion at the Clinical Performance and Quality Group Meeting.

4.5 S&O have reported a serious incident regarding breast biopsies which resulted in a small number of patients having a managed re-call which resulted in some local media attention. This has been proactively managed by the Trust and the CCG have been present at all the internal Serious Incident Meetings held regarding this within the Trust in order to identify the root cause for the incident and identify any lessons learnt. The incident has been reported and discussed at the CCG Quality Committee.

4.6 Mersey Care have reported 1 serious incident for a Southport & Formby CCG patient which involved a person under the age of 18 being admitted onto an Adult Mental Health Ward. This review of the Root Cause Analysis Investigation Report will be managed as per the CCG routine process.

5. Other Provider Quality Performance

Although the CCG patient flow to the Royal Liverpool & Broadgreen University Hospitals NHS Trust is smaller in volume than to AUH, discussions have taken place between the CCG, Cheshire & Merseyside Commissioning Support Unit and Liverpool CCG as co-ordinating commissioner with regard to the performance of this provider specifically in the areas relating to HCAIs, Friends and Family Test, Venous Thrombus Embolism Risk Assessments, national dementia screening and Advancing Quality. This has been discussed at the May 2014 of the Quality Committee.

6. Provider Quality Surveillance

6.1 A Single Item Quality Surveillance Group Meeting regarding Alder Hey Children's NHS Foundation Trust was chaired by NHS England (Merseyside) on 24 April 2014 in accordance with the process which is set out nationally. The outcome was discussed at the CCG Quality Committee for the purposes of assurance and any further developments will be reported to the Governing Body as appropriate.

6.2 A Joint Care Quality Committee (CQC) Feedback Meeting and Quality Review Meeting was held at AUH on 12 May 2014. This followed on from the previous Risk Summit Meeting that had been held in December 2013 and the recent CQC new in-depth hospital inspection programme visit which took place in March 2014. The meeting had a positive outcome with the following able to be reported to the Governing Body:

- safety, effectiveness, caring and responsiveness of the acute services are rated as 'Good' by the CQC; however, some improvement is still required in relation to services being well-led. The CQC has given the Trust an overall rating for acute services as 'Good'. The report has been published in the public domain and is accessible on the CQC website;

- the CCG has indicated to the Trust that they will be lifting the contract queries that were in place due to the provider's performance in the identified areas, eg HCAI, A&E, Referral to Treatment but the query in relation to mortality still remains in place as further work is required due to the Trust's outlier status.

7. Provider Quality Accounts

A collaborative event was held with local CCGs and HealthWatch Sefton on 2 May 2014 in order for relevant providers to present their Quality Accounts. The CCGs are working together to draft a joint response to be sent to providers for inclusion into their Quality Accounts.

8. Commissioner Assurance of Provider Cost Improvement Plans

The CCG has developed and shared its process for commissioner assurance of provider cost improvement plans (CIPs) with NHS England (Merseyside) by the required deadline of the end of March 2014. Working with the Cheshire & Merseyside Commissioning Support Unit, the CCG has requested provider CIPs in order to gain the required commissioner assurance that such CIPs will

not have a negative impact on quality of care for patients. The monitoring of possible impact on quality of care will be an on-going process throughout the year which will be reported for assurance purposes to the CCG Quality Committee.

9. Recommendations

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

Appendices

Appendix 1 – Southport & Formby CCG Quality Reporting May 2014 Update.

Brendan Prescott
Debbie Fagan
March 2014

Cheshire and Merseyside
Commissioning Support Unit

Southport and Formby CCG
Quality Reporting
May 2014 Update

Contents

CCG Summary of Key Concerns

Indicator: Infections

Indicator: Cdiff Cases

5 cases reported in March 2014 compared to a monthly plan of 3.17 cases, all cases apportioned to Non-acute (Community). Year to date there have been 45 cdiff cases reported relating to Southport and Formby patients compared to a year-end plan of 38 cases, 20 cases apportioned to acute providers and 25 cases apportioned to non-acute (Community).

Apportioned to Acute Providers

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Aintree University Hospitals NHS Foundation Trust	0	0	1	0	0	0	0	0	0	0	0	0	1
Royal Liverpool & Broadgreen Hospitals University NHS Trust	0	0	0	0	0	0	0	0	0	0	1	0	1
Southport & Ormskirk Hospital NHS Trust	1	0	1	1	0	2	2	5	0	1	5	0	18
Total	**1**	**0**	**2**	**1**	**0**	**2**	**2**	**5**	**0**	**1**	**6**	**0**	**20**

Apportioned to Non-Acute Community

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Southport & Ormskirk Hospital NHS Trust	2	0	1	5	2	4	3	0	1	1	1	5	25
Total	**2**	**0**	**1**	**5**	**2**	**4**	**3**	**0**	**1**	**1**	**1**	**5**	**25**

Indicator: Serious Incidents Reported

Indicator: SUIs and Never Events

2 Serious Untoward Incidents reported in April 2014 relating to Southport and Formby CCG patients, 1 incident reported at Mersey Care and 1 incident reported at Southport and Ormskirk Hospital.

Incident Type	Reported within 48 Hours	Provider
Admission of under 18s to adult mental health ward	No	Mersey Care NHS Trust
Radiology/Scanning incident	Yes	Southport and Ormksirk Hospital

All incidents reported throughout 2013/14 can be found within the attached annual SUI report.

S&Formby CCG SUI Report_March 2014.c

Indicator: Mixed Sex Accommodation

16 sleeping breaches reported against Southport and Formby CCG patients, all breaches apportioned to Southport and Ormskirk Hospital.

Southport and Ormskirk Hospital Comments: 10 relate to previously recorded issues with bed pressures and patient safety being the primary goal. The remaining 6 related to fogging ward 14A.

Indicator: Groin Hernia, Knee Replacement, Hip Replacement and Varicose Vein

The following table provides a high level summary of Appropriate Care Score (ACS) for Southport and Formby CCG Commissioned patients treated at any AQ Provider.

As at December 2013 (Latest data available) Southport and Formby CCG Cumulative ACS was reported above median/top quartile for CABG, Dementia, First-Episode of psychosis, Heart Failure and Pneumonia care. AMI (although performance reported above the NW region average), Hip and Knee and Stroke are all reported below median or within the bottom quartile.

Clinical Focus Area	AMI	CABG	Dementia	First-Episode Psychosis	Heart Failure	Hip and Knee (Combined)	Pneumonia	Stroke
CPS	96.3%	100.0%	92.4%	100.0%	88.8%	93.2%	91.1%	85.2%
ACS	92.9%	100.0%	75.0%	100.0%	73.8%	81.6%	73.7%	35.2%
Quartile (ACS)	Below Median	Top Quartile	Above Median	Top Quartile	Above Median	Bottom Quartile	Above Median	Bottom Quartile

The table above includes activity for Southport and Formby CCG patients treated at an AQ provider, below is a summary of providers failing to achieve ACS care bundle targets at trust level.

AMI	Hip and Knee	Stroke
SOUTHPORT & ORMSKIRK has achieved ACS target 1 out of 9 months in AMI and is below target YTD by 1.7%	SOUTHPORT & ORMSKIRK has achieved ACS target 3 out of 9 months in Hip and Knee (Combined) and is below target YTD by 2.8%	SOUTHPORT & ORMSKIRK has achieved ACS target 2 out of 9 months in Stroke and is below target YTD by 10.8% ROYAL LIVERPOOL has not achieved ACS target once during the 9 months and is below target YTD by 17.5%

A full summary has been included within the latest quality report.

Southport and Formby CCG Population Quality Dashboard

Patient Safety Quality Measures			
Indicator	**Reporting Frequency**	**National Average**	**Southport and Formby CCG**
Hospital Care Acquired Infections			**Actual**
MRSA Cases Reported	Mar-14	0	0
Cdiff Cases Reported	Mar-14	0	5
Incident and Complaints Reporting			**Actual**
Serious Untoward Incidents Reported	Apr-14	0	2
SUIs Reported as Never Events	Apr-14	0	0
Complaints Received to CMCSU	Apr-14	0	0
Mixed Sex Accommodation			**Actual**
Mixed Sex Accommodation Breaches	Mar-14	0	16
Rate per 1,000 FCEs	Mar-14	0	0

Clinical Effectiveness Quality Measures			
Indicator	**Reporting Frequency**	**National Average**	**Southport and Formby CCG**
Patient Reported Outcome Measures			**Actual**
Groin Hernia - Average increase in health gain	Apr 12-Mar 13	0.086	0.085
Hip Replacement - Average increase in health gain	Apr 12 -Mar 13	0.065	0.423
Knee Replacement - Average increase in health gain	Apr 12 -Mar 13	0.56	0.312
Varicose Vein - Average increase in health gain	Apr 12 -Mar 13	0.837	<5 Modelled Records

Patient Experience Quality Measures			
Indicator	**Reporting Frequency**	**NW Region Average**	**Southport and Formby CCG**
Regional CQUIN - Advancing Quality ACS			**Actual**
Acute myocardial infarction	Apr - Dec 13	85.60%	92.90%
CABG	Apr - Dec 13	76.60%	100.00%
Dementia	Apr - Dec 13	59.20%	75.00%
First-Episode Psychosis	Apr - Dec 13	81.20%	100.00%
Hip and Knee	Apr - Dec 13	88.10%	81.60%
Heart Failure	Apr - Dec 13	69.40%	73.80%
Pneumonia	Apr - Dec 13	74.20%	73.70%
Stroke	Apr - Dec 13	66.30%	35.20%

Section B – Level 2 Provider Catchment Quality Dashboard

Provider Level Key Concerns

NEW	*Indicates any changes that have been made from previous update. Not all indicators will be updated due to the reporting frequency of individual measures.*

Health Care Acquired Infections

NEW Indicator: MRSA Cases

Royal Liverpool and Broadgreen Hospital 1 MRSA case reported in March 2014 compared to a monthly threshold of 0 cases, the Trust stands at 8 cases year to date.

Provider Comments: Clinical measures in place in relation to MRSA include:

- Divisional Medical Directors to attend weekly Bacteraemia meetings
- Supervisor status of Ward Managers with Ward Manager responsible for Infection Prevention and Control KPIs
- Introduction of Divisional Practice Facilitator role with key responsibilities for:
  - Peer Review Process (IV access, Blood Cultures, cannulation)
  - On-going Training
  - Trouble shooting
  - Provide update to Divisional Governance
- Simulation ward based training being trialled with IPC and Skills team
- Trust wide point prevalence covert hand hygiene audit completed in February. This indicates compliance is low in some areas. Individual wards have been informed and required to improve. This audit will be repeated each quarter and results published on the Intranet**.**

Aintree University Hospital 1 MRSA case reported in March 2014 2 MRSA cases reported year to date. The Trust has reported 3 MRSA cases year to date.

Provider Comments: Due to issues related to the imminent lab move as part of the Mersey joint venture, there are now some new technical issues regarding the compiling of MRSA compliance**.**

NEW Indicator: Cdifficile Cases

Royal Liverpool and Broadgreen Hospital 4 cdiff cases reported in March 2014 compared to a monthly threshold of 2.92 cases, the Trust stands at 50 cases year to date compared to a yearend plan of 35 cases.

Provider Comments: Clinical measures in place in relation to Clostridium difficile include:

- Fidaxomicin is prescribed for all CDT toxin and GDH patients. Trials on this drug have indicated a reduction in CDT spores, its use is under the guidance if the Infectious Diseases Consultant.
- Daily Antimicrobial reports sent to Consultants and Clinical Directors in High Risk areas.
- Monthly Antimicrobial audits in high risk areas which are reported to DIPC.
- Nutritional/CDT risk assessment now completed on all patients admitted to the Trust.
- Weekly environmental audits in areas that have had CDT
- Trust Deep Clean programme continuing
- Immediate DIPC and IPC review with lead consultant following a positive CDI case

The Walton Centre – *Data currently being queried as the provider has stated 2 cdiff cases in March 2014 but published data reports only 1 case.*

According to the providers HCAI assurance framework 2 cdiff cases reported in March 2014 compared to a monthly trajectory plan of 0.42 cases, the provider has reported 13 cases year to date compared to a year-end plan of 5 cases.

Below is the published data table – currently being queried?

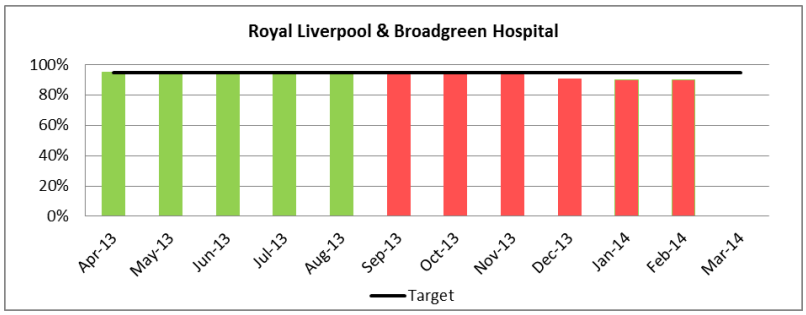
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
NHS LIVERPOOL CCG	1	1	0	0	0	1	0	1	0	0	0	1	5
NHS ST HELENS CCG	0	0	1	0	0	0	0	0	0	1	0	0	2
NHS WEST CHESHIRE CCG	0	0	0	1	0	0	0	0	1	0	0	0	2
NHS WEST LANCASHIRE CCG	0	1	0	0	0	0	0	0	0	0	0	0	1
NHS WIRRAL CCG	0	0	0	0	0	0	0	0	0	1	1	0	2
Total	**1**	**2**	**1**	**1**	**0**	**1**	**0**	**1**	**1**	**2**	**1**	**1**	**12**

Provider Comments: 2 cases for March. 1 of the 2 cases was a patient who became symptomatic following transfer to Whiston. The patient was on antibiotics for cellulitis which had been commenced in Whiston. Second case isolated case. Appropriate actions taken. Isolated promptly and care pathway commenced. Time line to be undertaken for patient that went to Whiston and then consult with their ICT.

NEW VTE Risk Assessments

Measure: All patients should be risk assessed on admission to hospital. Patients should be reassessed within 24 hours of admission and whenever the clinical situation changes

Royal Liverpool and Broadgreen Hospital 90.3% of admissions received a VTE risk assessment in February 2014 compared to a plan of 95%, similar performance compared to previous month.



Provider Comments: On-going underperformance is reported to be within surgical division and core, clinical support service division.
On-going actions continue to be implemented, it is hoped that by the end of Q4 13/14 the provider will be reporting above 95% following electronic reporting implementation.

Incident Reporting

Measure: Serious Untoward Incidents and Never Events

A full summary of 2013/14 serious incidents reported has been included within the latest quality report.

Royal Liverpool and Broadgreen Hospital reported 5 serious untoward incidents in April 2014.

	Apr-14
Adverse media coverage or public concern about the organisation or the wider NHS	1
Drug Incident (general)	1
Out patient appointment delay	1
Slips/Trips/Falls	2
Grand Total	**5**

Aintree Hospital 0 incidents reported by the provider in April 2014.

Southport and Ormskirk Hospital 1 incident reported by the provider in April 2014.

	Apr-14
Radiology/Scanning incident	1
Grand Total	**1**

Alder Hey Children's Hospital 3 serious incidents reported in April 2014.

	Apr-14
Adverse media coverage or public concern about the organisation or the wider NHS	1
Delayed diagnosis	2
Grand Total	**3**

Liverpool Women's Hospital 3 serious incidents reported in April 2014.

	Apr-14
Delayed diagnosis	1
Maternity Services - Intrauterine death	1
Maternity Services - Unexpected admission to NICU (neonatal intensive care unit)	1
Grand Total	**3**

Merseycare NHS Trust 7 serious incidents reported in April 2014.

	Apr-14
Admission of under 16s to adult mental health ward	1
Admission of under 18s to adult mental health ward	3
Allegation Against HC Professional	1
Serious Self Inflicted Injury Inpatient	1
Suicide by Outpatient (in receipt)	1
Grand Total	**7**

Liverpool Community Health 26 serious incidents reported in April 2014.

	Apr-14
Death in custody	2
Pressure ulcer Grade 3	12
Pressure ulcer Grade 4	12
Grand Total	**26**

All incident investigations and action plans will be discussed in detail at SUI/Complaints Monthly Management Group.

National Patient Safety Data

Measure: All Harms

All provider NPSA incident reports have been included within the latest quality dashboard. A summary has been included below for all providers with reporting rates lower than the national median average.

Royal Liverpool and Broadgreen Hospital reported 2,235 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 5.08 compared to 7.98 (Median for large acute providers). The trust reported significantly more incidents in the following areas compared to other teaching organisations;

- Patient Accidents
- Access/Admissions/Transfer and Discharge incidents

Alder Hey Children's Hospital reported 849 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 5.09 compared to 7.14 (Median for specialist acute providers). The trust reported significantly more incidents in the following areas compared to other acute specialist organisations;

- Clinical Assessments

Liverpool Women's Hospital reported 763 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 3.69 compared to 7.14 (Median for specialist acute providers). The trust reported significantly more incidents in the following areas compared to other specialist organisations;

- Treatment procedures

National Safety Thermometer

Measure: All Harms

Due to a change in national reporting March 2014 data is currently being analysed, an update will follow as soon as data is available.

New! National Dementia – Screening, Assessment and Referral

The goal of the dementia CQUIN is to incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions and to prompt appropriate referral and follow up after they leave hospital. Nationally all providers are to work towards achieving 90% patients identified, 90% of patients assessed and 90% of patients referred over three consecutive months during 2013/14.

Royal Liverpool and Broadgreen Hospital As reported in previous months RLBUH continued to fail all three measures in February 2014.
Provider Comments: ICE screening system has been developed, and latest submission was February data. Of all eligible patients for part 1, the screening component was recorded and achieved for 56.1%. For patients where screening information was recorded, and who were eligible for the diagnostic assessment component, tests were requested in 57.1% of cases. Of those where the assessment was positive or inconclusive, 61.9% were referred for further follow-up. Teaching and awareness, and on-going support, are in place. CQUIN lead team established to ensure clarity and priority.

Aintree University Hospital Similar to previous months Aintree hospital failed to achieve performance for patients who are screened and risk assessed for dementia. The provider did however achieve 100% compliance for referring patients once dementia had been diagnosed.
Provider Comments: Following close monitoring of the Trust's new electronic FAIR tool we have found a process error in our data collection system. As a result some of the exclusions have been omitted from the denominator adversely affecting our performance. The new revisions to the electronic FAIR tool and visual operating system were implemented during December 2013.
Since the implementation of the electronic tool the Trust is showing month on month improvements in performance against patients screened and assessed for dementia; Following actions are in place;

- Electronic Trust level performance and sub level reports are now available on aBI. Following the revision a weekly email highlighting the latest position to the clinical teams will be introduced to allow effective performance management by the operational teams.
- Dementia performance achievement is also included in the monthly TQM awards.

Liverpool Women's Hospital
Due to low activity being reported at the above provider 1 patient being missed can result in a dramatic drop in performance. Both providers failed to achieve 90% across all areas due to low numbers being reported.

Awaiting publication of March 2014 data in order to provide overall 2013/14 performance and CQUIN payment achievement.

Friends and Family Test

Measure: Response rates and Test Score

Response Rates - Providers will need to achieve a baseline response rate of at least 15% and by Q4 a response rate that is both (a) higher than the response rate for Q1 and (b) 20% or over. A single response rate for each provider will be calculated by combining the response rates from the A&E and acute inpatient areas.

Test Scores - Increasing the score of the Friends and Family Test question within the 2013/14 staff survey compared with 2012/13 survey results or remaining in the top quartile of trusts.

Royal Liverpool and Broadgreen Hospital
Response Rates In Q4 13/14 the provider achieved 13.4 % combined response rate (inpatients and a&e) compared to a yearend plan of 20%, this was an drop in performance compared to the previous quarter.

Combined	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average	13.3%	17.3%	20.1%	23.4%
Royal Liverpool And Broadgreen University Hospitals NHS Trust	6.3%	12.6%	14.8%	13.4%

Provider Comments: The Trust continues to undertake Text based and Volunteers survey based feedback to meet the requirements of the DH friends and family test.

Advancing Quality

Measure: All Care Bundles

The advancing quality programme began in October 2008. Year one of the programme was defined as October 2008 – September 2009 patient discharges. Participation in year one encompassed 24 North West Trusts and each Trust is enrolled in up to five of the eight clinical conditions listed below depending on their patient populations;

1. Acute myocardial infarction (AMI)
2. Isolated coronary artery bypass graft (CABG)

3. Heart Failure (HF)
4. Pneumonia (PN)
5. Hip and Knee replacement surgery (Hip/Knee)
6. Stroke
7. Dementia
8. First episode of psychosis

The programme is based on the concept of quantifying Trust performance on one aggregated measure of quality – The Appropriate Care Score (ACS) - within each of the clinical areas.

Royal Liverpool and Broadgreen Hospital

Pneumonia At December 2013 the trusts cumulative ACS score for Pneumonia care was reported below the CQUIN target, 78.1% reported compared to 78.8%.Lowest performance is reported against the following measure within the pneumonia care bundle;

- Patients given initial antibiotic within 6 hours of hospital arrival - 83.5% reported ytd.

Stroke At December 2013 the trusts cumulative ACS score for stroke care was reported below the CQUIN target, 73.2% reported compared to 89.8%. Lowest performance is reported against the following measure within the stroke care bundle;

- Patients admitted on to a stroke ward within 4hours of arrival – 79.33% reported ytd

Provider Comments: A data recording error has been identified within AQ Pneumonia which has meant that our performance has been over-reported. Error is in relation to recording of CURB-65 scores and consequently a number of records being inappropriately excluded from the AQ Pneumonia population. The Trust's ACS score is now currently below the AQ Pneumonia target ACS. Procedures for data entry have been amended appropriately to prevent similar errors moving forward.

It should be noted that although we are below our target for Stroke, the latest benchmarking data (Apr-December) indicates that we are one of the top 5 Trusts in the Northwest. CQUIN targets have been set at a Trust level, based on our 2012/13 performance. Clinical and operational pathway leads are in place for all focus areas, and an Advancing Quality Steering Group is in place which meets on a monthly basis and discusses the monthly reporting of pathway outcome measures. Actions in place include the production of missed opportunities reports, and liaison on a weekly basis to identify patients outstanding against individual measures.

Aintree University Hospital

Heart Failure At December 2013 the trusts cumulative ACS score for Heart Failure was reported below the CQUIN target, 68.7% reported compared to 72.8%. Patients given written discharge instructions prior to discharge appears to be the main issue for Aintree, 70.8% reported ytd.

Provider actions in place;

- Daily alerts of HF patients admitted to hospital
- Introduction of new care bundle and documentation.
- HF nurse team visiting areas like MAU

Stroke At December 2013 the Trust's cumulative ACS score for stroke was reported below the CQUIN target, 44.26% reported compared to 53.64%. Patients admitted on to the stroke unit within 4 hours after hospital arrival appears to be the main issue at Aintree, 45.52% reported ytd.

Provider Comments: Our Stroke team have developed and implemented new working practices which started 13/01/2014 and aim to enhance the delivery of care. However, any noticeable improvements achieved in the final quarter are unlikely to enable us to achieve the current CQUIN target.

The new practices include:

a)Having a Consultant of the week

Other points from the Stroke teams action plan include:

b)Target to get patients on the stroke ward within 3 hours

c)Use reserved thrombolysis side ward beds when required

d)Daily meeting to review exceptions

National Staff Surveys

Measure: 2013 Staff Survey Results

A number of providers of interest to Southport and Fomrby CCG reported improvements in the overall staff engagement score in 2013, Southport and Ormskirk Hospital and Mersey Care NHS Trust reported a reduction and performance was reported below the national average.

2013 survey results currently being validated and tabled by CMCSU Business Intelligence, a high level summary for all providers of interest to Southport and Formby CCG is included below;

	Overall Staff Engagement					
	Trust Score 2010	Trust Score 2011	Trust Score 2012	Trust Score 2013	Change	National Average (All trusts)
5BOROUGHS	3.69	3.65	3.73	3.76		3.74
Aintree University Hospital	3.64	3.65	3.69	3.74		3.74
Alder Hey Childrens Hospital	3.71	3.65	3.57	3.68		3.74
Bridgewater	3.52	3.60	3.69	3.60		3.74
Liverpool Community Health	3.68	3.61	3.61	3.70		3.74
Liverpool Heart & Chest Hospital	3.78	3.86	3.98	3.96		3.74
Liverpool Womens Hospital	3.59	3.48	3.57	3.73		3.74
Mersey Care NHS Trust	3.59	3.67	3.72	3.66		3.74
Royal Liverpool & Broadgreen Hos	3.60	3.60	3.66	3.73		3.74
Southport & Ormskirk Hospital	3.58	3.57	3.63	3.61		3.74
St Helens & Knowsley Hospital	3.58	3.56	3.70	3.83		3.74
The Walton Centre	3.77	3.70	3.73	3.87		3.74
Warrington & Halton Hospital	3.65	3.58	3.68	3.79		3.74

NEW National Staff Survey – Friends and Family Question

Measure: % to strongly agree / agree with the Q12d. 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'

Liverpool Heart and Chest Hospital, The Walton Centre and St Helens and Knowsley Hospital were all reported within the upper quartile. Aintree Hospital, Liverpool Women's and Royal Liverpool were all reported within the median quartile and all reported improvements in results compared to previous year. Southport and Ormskirk Hospital reported a reduction in performance compared to previous year's performance.

As part of the 2014/15 NHS Standard Contract each provider is expected to identify areas requiring improvement within the Staff Survey, action plans are due to be submitted with Quarter 1 14/15 reporting template.

Ref	Provider	Score (%)	Quartile
RVY	Southport And Ormskirk Hospital NHS Trust	50.67	1st
REM	Aintree University Hospital NHS Foundation Trust	64.73	2nd
RWW	Warrington and Halton Hospitals NHS Foundation Trust	65.25	2nd
REP	Liverpool Women's NHS Foundation Trust	67.43	3rd
RQ6	Royal Liverpool And Broadgreen University Hospitals NHS Trust	71.38	3rd
RBN	St Helens And Knowsley Hospitals NHS Trust	77.41	4th
RET	The Walton Centre NHS Foundation Trust	84.59	4th
RBQ	Liverpool Heart and Chest NHS Foundation Trust	91.85	4th

NEW Central Alerting System

At 01st April 2014 a number of Merseyside providers had on-going alerts open passed deadline date;

1. Aintree University Hospital – 1 On-going alerts. The trust expects to be non-compliant for 12 months due to equipment not being available.
2. Alder Hey Children's Hospital – 2 On-going alerts
3. Liverpool Women's Hospital – 4 On-going alerts

Trust name	Alert title	Alert reference	Issue date	Completion deadline date	Completed Within Deadline	Current Status
AUH	Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors	NPSA/2011/RRR003	28-Nov-11	Apr-12	N	ONGOING
AHCH	Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors	NPSA/2011/RRR003	28-Nov-11	Apr-12	N	ONGOING
AHCH	Window restrictors	EFA/2013/002	23-Jan-13	May-13	N	ONGOING
LWH	Electrosurgical devices.CUSA CEM™ nosecones for use with the CUSA® Excel/Excel+ ultrasonic aspirator.Product codes: C6623 and C6636.Manufactured by Integra Lifesciences.	MDA/2014/006	26-Feb-14	Mar-14	N	ACKNOWLEDGED
LWH	High Voltage Hazard Alert - National Equipment Defect Report (NEDeR) - Areva T&D Automation & Information Services - P122 protection relay	EFN/2014/05	21-Feb-14	Mar-14	N	ACKNOWLEDGED
LWH	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - UPDATE - Hawker Siddeley - URV12 Circuit Breaker	EFN/2014/08	26-Feb-14	Mar-14	N	ACKNOWLEDGED
LWH	High Voltage Hazard Alert - SUSPENSION OF OPERATIONAL PRACTICE (SOP) - UPDATE - Long & Crawford GF3T Fuse Switch	EFN/2014/09	27-Feb-14	Mar-14	N	ASSESSING RELEVANCE

New! Sickness Absence Rates

The latest data relates to sickness absence rates for staff at NHS Organisations on the electronic staff record (ESR) between April 2012 – Dec 2013.

The RAG ratings included below have been applied by comparing provider performance compared to the England average and compared to the same period in the previous year.

	Q1 12/13	Q2 12/13	Q3 12/14	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14
Engalnd Average	4.02%	4.06%	4.50%	4.38%	3.85%	3.83%	4.12%
5 Boroughs Partnership NHS Foundation Trust	4.52%	5.27%	5.13%	5.35%	4.94%	5.02%	5.69%
Aintree University Hospital NHS Foundation Trust	4.32%	4.18%	4.30%	3.99%	3.56%	3.81%	4.06%
Alder Hey Children's NHS Foundation Trust	4.68%	4.63%	6.56%	5.83%	4.63%	4.59%	4.75%
Bridgewater Community Healthcare NHS Trust	5.01%	4.73%	5.64%	5.25%	4.76%	4.84%	5.05%
Liverpool Community Health NHS Trust	5.37%	5.52%	6.31%	6.30%	5.85%	5.37%	5.53%
Liverpool Heart and Chest NHS Foundation Trust	3.51%	4.09%	4.94%	4.55%	3.22%	3.34%	3.41%
Liverpool Women's NHS Foundation Trust	4.03%	4.16%	6.10%	6.66%	4.53%	4.35%	4.52%
Mersey Care NHS Trust	5.65%	5.72%	6.01%	6.10%	5.48%	5.58%	5.40%
Royal Liverpool and Broadgreen University Hospitals	4.88%	5.09%	6.24%	5.82%	4.71%	4.53%	4.99%
Southport and Ormskirk Hospital NHS Trust	4.49%	4.27%	4.73%	4.84%	4.20%	3.86%	3.84%
St Helens and Knowsley Hospitals NHS Trust	3.27%	3.34%	3.81%	3.72%	3.33%	3.27%	3.50%
Walton Centre NHS Foundation Trust	4.10%	3.81%	4.50%	3.66%	3.61%	3.93%	4.29%
Warrington and Halton Hospitals NHS Foundation	4.09%	4.11%	3.94%	4.40%	4.12%	3.84%	3.97%

All providers of interest to Southport and Formby CCG reported a reduction in sickness absence rates in Q3 13/14 compared to Q3 12/13. Southport and Ormskirk Hospital, Aintree University Hospital, Liverpool Women's Hospital and Liverpool Heart and Chest all reported lower rates than the England Average and a reduction compared to previous year.

New! CQC Intelligence Tool

CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. CQC judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

Indicators will be analysed and one of the following levels will be applied to each measure; 'No evidence of risk, 'risk' or 'elevated risk'. CQC have then created an overall summary band for each trust, by reviewing the proportion of indicators identified as 'risk' or 'elevated risk'. Band 1 representing the highest risk and band 6 representing the lowest risk.

The table below provide details of the latest report published in March 2014;

	Royal Liverpool Hospital	Liverpool Heart and Chest	Southport and Ormskirk Hospital	Warrington and Halton Hospital	Liverpool Womens Hospital	Alder Hey Childrens Hospital	St Helens and Knowsley Hospital	Aintree University Hospital	The Walton Centre
Has the banding improved or declined since the previous report?	Recently inspected (Previously scored 6)	Declined to 4 from 6	No Change (4)	Improved to 5 from 3	Improved to 6 from 3	No change (1)	Improved to 5 from 3	Recently inspected (Previously scored 1)	No change (6)
Within the latest CQC report (March 2014) Has the provider been identified as having any **Elevated Risks?**	2 areas	1 area	3 areas	1 area	1 area	3 areas	1 area	4 areas	0 areas
Within the latest CQC report (March 2014) Has the provider been identified as having any **Risks?**	5 areas	2 areas	1 area	4 areas	1 area	5 areas	3 areas	3 areas	1 area

Latest provider reports are included within the latest quality report.

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Cheshire and Merseyside Commissioning Support Unit

Provider Level Dashboard

Patient Safety Quality Measures

Indicator	Data Sheets	Latest Data Available	National Average	Trend line Movement	Royal Liverpool & Broadgreen		Aintree University Hospital		Southport and Ormskirk Hospital		Alder Hey Children's Hospital		Liverpool Women's Hospital		The Walton Centre		Mersey Care		Liverpool Community Health	
Hospital Care Acquired Infections					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
MRSA Cases Reported	Click Here	Mar-14	0	Increase = Bad Decrease = Good	1		1		0		0		0		0		0		0	
Cdiff Cases Reported	Click Here	Mar-14	0		4		1		4		0		0		1		0		0	
Venous thromboembolism (VTE) risk assessment					Actual	Trend	Actual	Trend	Actual	Trend			Actual	Trend	Actual	Trend				
VTE Risk Assessments	Click Here	Feb-14	95.7%	Increase = Good Decrease = Bad	90.3%		95.5%		95.9%				97.3%		95.2%					
Local Incident Reporting					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Serious Untoward Incidents Reported	Click Here	Apr-14	0	Increase = Bad Decrease = Good	5		0		3		3		3		Not held at CMCSU		7		26	
SUIs Reported as Never Events		Apr-14	0		0		0		0		0		0				0		0	
Complaints Received to CMCSU	Click Here	Apr-14	0		1		0				0		0				0		0	
National Patient Safety Incident Reporting (*Per 100 admissions, **Per 1,000 bed days)					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Total Incidents Reported	Click Here	Apr 13 - Sep 13	TBD		2235	Latest report included	2602	Latest report included	1916	Latest report included	847	Latest report included	763	Latest report included	288	Latest report included	2559	Latest report included	484	Latest report included
Reporting Rates			TBD		5.0/7.9		7.2/7.9		6.3/7.2		5.0/7.1		3.6/7.1		6.6/7.14		36.6/26.3		37.82	
% Incidents reported resulting in Severe Harm			TBD		0.4%		0.2%		0.10%		0.2%		1.6%		0.4%		0.1%		1.5%	
% Incidents reported resulting in Death			TBD		0.0%		0.1%		0.60%		0.0%		0.3%		0.0%		0.6%		0.0%	
Mixed Sex Accommodation					Actual	Trend	Actual	Trend	⇔	Trend	⇔	Trend	⇔	Trend	⇔	Trend	Actual	Trend	Actual	Trend
Mixed Sex Accommodation Breaches	Click Here	Mar-14	0	Increase = Bad Decrease = Good	0		0		16		0		0		0		0		0	
Rate per 1,000 FCEs		Mar-14	0		0.0		0.0		4.6		0.0		0.0		0.0		0.0		0.0	
National CQUIN - Safety Thermometer					Actual	Trend	Actual	Trend	Actual	Trend			Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Timeliness submission of data harms data to Unify2	Click Here	Feb-14	Submitted	Increase in Harms = Bad Increase in Harmfree Care = Good	Yes		Yes		Yes				Yes		Yes		Yes		Yes	
Pressure Ulcers (All categories)		Feb-14	4.73%		6.12%		3.74%		3.62%				0.0%		3.14%		1.09%		2.01%	
Falls		Feb-14	2.04%		2.66%		1.71%		0.35%				1.1%		0.00%		2.19%		8.55%	
Patients with a catheter and being treated for a UTI		Feb-14	0.89%		0.00%		0.78%		0.12%				3.2%		0.00%		0.55%		0.42%	
VTE - Patients with a new VTE		Feb-14	0.48%		5.32%		0.31%		1.05%				0.0%		1.26%		0.00%		0.21%	
Harm Free Care		Feb-14	93.34%		87.2%		95.33%		95.10%				95.7%		96.23%		0.978142		96.6%	
National CQUIN - Dementia					Actual	Trend	Actual	Trend	Actual	Trend			Actual	Trend	Actual	Trend				
Screening for Dementia (Find)	Click Here	Feb-14	78.3%	Increase = Good Decrease = Bad	56.1%		67.42%		4.10%				50%		100%					
Risk Assessed (Assess and Investigate)		Feb-14	89.7%		57.1%		83.7%		50.0%				100%		*					
Patients Referred		Feb-14	91.7%		61.9%		100%		83%				0 patients		*					

Clinical Effectiveness Quality Measures

Indicator	Data Sheets	Reporting Frequency	National Average	Trend line Movement	Royal Liverpool and Broadgreen Hospital		Aintree University Hospital		Southport and Ormskirk Hospital		Alder Hey Children's Hospital		Liverpool Women's Hospital		The Walton Centre		Mersey Care		Liverpool Community Health	
Mortality Indicators					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Summary Hospital-Level Mortality Indicator (SHMI)	Click Here	Jul 12 - Jun 13	100	Increase = Bad Decrease =Good	1.07		1.13		106.5%											
(SHMI) Deaths occurring in hospital			73.4%		74.5%		72.8%		69.4%											
(SHMI) Deaths occurring out of hospital			26.6%		25.5%		27.2%		30.6%											
Patient Reported Outcome Measures					Actual	Trend	Actual	Trend	Actual	Trend										
Groin Hernia - Average increase in health gain	Click Here	Apr 12-Mar 13	0.086	Increase = Good Decrease =Bad	Low Numbers		0.064		0.061											
Hip Replacement - Average increase in health gain		Apr 12 -Mar 13	0.439		0.412		0.429		0.378											
Knee Replacement - Average increase in health gain		Apr 12 -Mar 13	0.321		0.354		0.296		0.308											
Varicose Vein - Average increase in health gain		Apr 12 -Mar 13	0.094		Low Numbers		Low Numbers		Low Numbers											

Provider Level Dashboard

NHS
Cheshire and Merseyside Commissioning Support Unit

Patient Safety Quality Measures																								
Indicator	Data Sheets	Latest Data Available	National Average	Trend line Movement	Royal Liverpool & Broadgreen		Aintree University Hospital		Southport and Ormskirk Hospital		Alder Hey Children's Hospital		Liverpool Women's Hospital		The Walton Centre		Mersey Care		Liverpool Community Health	
Patient Experience Quality Measures																				
Indicator	Data Sheets	Reporting Frequency	National Average	Trend line Movement	Royal Liverpool and Broadgreen Hospital		Aintree University Hospital		Southport and Ormskirk Hospital		Alder Hey Children's Hospital		Liverpool Women's Hospital		The Walton Centre		Mersey Care		Liverpool Community Health	
Regional CQUIN - Friends and Family					Actual	Trend	Actual	Trend	Actual	Trend			Actual	Trend	Actual	Trend				
Response Rate (Combined)	Click Here	Q4 13/14	17.3%	Increase = Good Decrease =Bad	13.4%		31.1%		18.5%				34.2%		23.9%					
Response Rate (Inpatinet)			28.7%		25.2%		41.6%		30.9%				25.7%		23.9%					
Response Rate (A&E)			11.6%		9.3%		24.8%		10.9%				37.6%		n/a	n/a				
Test Score (Combined)	Click Here	Q4 13/14	64	Increase = Good Decrease =Bad	53		61		47				82		81					
Test Score (Inpatinet)			72		60		82		42				80		81					
Test Score (A&E)			54		44		40		52				82		n/a	n/a				
Regional CQUIN - Advancing Quality					Actual	Trend	Actual	Trend	Actual	Trend							Actual	Trend		
Acute myocardial infarction	Click Here	Apr 13-Dec 13	95%	Increase = Good Decrease =Bad	100%		92.8%		Data validation											
Heart Failure		Apr 13-Dec 13	95%		86.9%		68.7%		73.6%											
Hip and Knee		Apr 13-Dec 13	86%		96.4%		85.9%		79.2%											
Pneumonia		Apr 13-Dec 13	86%		78.1%		76.0%		75.2%											
Stroke		Apr 13-Dec 13	90%		73.3%		44.3%		42.9%											
Coronary Artery Bypass Graft		Apr 13-Dec 13	TBD																	
Dementia		Apr 13-Dec 13	TBD														51.4%			
First-Episode Psychosis		Apr 13-Dec 13	TBD														50.0%			
National Community Mental Health Survey																	Actual	Trend		
Overall Care	Click Here	2012	74.40%	Increase = Good Decrease =Bad													76.67			
Better information more choice			69.10%														69.26			
National Staff Survey					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Overall Engagement	Click Here	2013	3.74	Increase = Good Decrease =Bad	3.73		3.74		3.61		3.68		3.73		3.87		3.66		3.70	
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'	Click Here	2013	67%	Increase = Good Decrease =Bad	71.4%		64.7%		51%				67.4%		85%					
National Inpatient Survey					Actual	Trend	Actual	Trend	Actual	Trend			Actual	Trend	Actual	Trend				
Better information more choice	Click Here	2012	68.30%	Increase = Good Decrease =Bad	71.7		68.7		62.0				78.4		68.9					
Overall score			76.50%		79.1		76.7		74.1				83.3		79.8					

Provider Level Dashboard

NHS
Cheshire and Merseyside Commissioning Support Unit

Patient Safety Quality Measures																															
Indicator	Data Sheets	Latest Data Available	National Average	Trend line Movement	Royal Liverpool & Broadgreen		Aintree University Hospital		Southport and Ormskirk Hospital		Alder Hey Children's Hospital		Liverpool Women's Hospital		The Walton Centre		Mersey Care		Liverpool Community Health	
Organisational Level Quality Measures																				
Indicator	Data Sheets	Reporting Frequency	National Average	Trend line Movement	Royal Liverpool and Broadgreen Hospital		Aintree University Hospital		Southport and Ormskirk Hospital		Alder Hey Children's Hospital		Liverpool Women's Hospital		The Walton Centre		Mersey Care		Liverpool Community Health	
Care Quality Commission					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Compliance to CQC 5 standards following recent checks	Click Here	May-14	n/a	N/A	●		●		●		●		●		●		●		●	
Central Alerts System					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Alerts reported as on-going passed deadline date	Click Here	Mar-14	0	N/A	0		1		0		2		4		0		0		0	
Ambulance Handover Times					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Handover <15 Minutes. Time taken from HAS notification to clinical handover (Assumed ACUTE responsibility)	Click Here	Mar-14	15 Mins	Increase = Bad Decrease = Good	00:09:48		00:10:27		00:13:36		00:03:14									
Patients waiting between 30-60 Minutes for Handover			0		79		61		45		0									
Patients waiting between 60+ Minutes for Handover			0		10		7		18		0									
Compliance with Recording Patient Handover between Ambulance and A&E			90%	Increase = Good Decrease = Bad	81.60%		84.50%		90.40%		85.70%									
Sickness Rates					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Sickness Absence Rates	Click Here	Q3 13/14	3.88%	Increase = Bad Decrease = Good	4.99%		4.06%		3.84%		4.75%		4.52%		4.29%		5.40%		5.53%	
Patient Lead Assessment of the Care Enviroment					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Cleanliness	Click Here	2013	95.75%	Increase = Good Decrease = Bad	99.9%	No trend	94.7%	No trend	97.7%	No trend	96.5%	No trend	98.7%	No trend	Data currently being collected		96.3%	No trend	99.5%	No trend
Food and Hydration			88.78%		92.8%		70.9%		74.3%		79.0%		87.0%				85.2%		90.7%	
Privacy, Dignity and Wellbeing			88.90%		95.8%		87.3%		89.0%		81.3%		96.0%				92.8%		79.3%	
Facilities			85.41%		93.2%		87.8%		87.2%		90.5%		90.7%				88.5%		92.4%	
NHS Litigation Authority					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
NHS Litigation Authority Assessment	Click Here	2012/13	n/a	N/A	2		3		2		3		3		1		1		1	
Quality Accounts					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Quality Accounts		2013/14	n/a	N/A	●		●		●		●		●		●		●		●	
CQC Intelligence Tool					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Overall banding relating to five key questions we will ask of all services – are they safe, effective, caring, responsive, and well-led? **Band 1 = High Risk, Band 6 = Lowest risk**	Click Here	Mar-14	Lowest risk = 6	Increase = Good Decrease = Bad	6		1		4		1		6		6					
Monitor Risk and Financial Rating					Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend	Actual	Trend
Monitor Risk Rating - *(Awaiting outcome of Monitors newly risk assessment framework_Apr 14)*	Click Here	As of March 2014	Continuity of services	Increase = Good Decrease = Bad			No evident concern				No evident concern		No evident concern		No evident concern					
			Governance				Enforcement				No evident concern		No evident concern		No evident concern					

Measure **HCAI MRSA cases**
National Requirement: **Yes**

Provider Level Data

Month	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD	Trend
Royal Liverpool Hospital	0	1	0	0	0	0	2	1	2	0	1	1	8	
Liverpool Womens Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	
Liverpool Heart and Chest	0	0	0	0	0	0	0	0	0	0	0	0	0	
Alder Hey Childrens Hospital	0	0	0	0	0	0	1	0	0	0	0	0	1	
Southport and Ormskirk Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	
St Helens and Knowsley Hospital	0	2	0	0	0	1	0	0	0	1	0	0	4	
Mersey Care NHS Trust	0	0	0	0	0	0	0	0	0	0	0	0	0	
Liverpool Community Health	0	1	0	0	0	0	0	0	0	0	0	0	1	
Warrington and Halton Hospital	1	0	0	0	0	0	0	0	0	1	0	0	2	
Aintree University Hospital	0	1	0	0	0	0	0	0	0	0	1	1	3	
5 Boroughs Partnership	0	0	0	0	0	0	0	0	0	0	0	0	0	
Bridgewater Community	0	0	0	0	0	0	0	0	0	0	0	0	0	
The Walton Cente	0	1	0	0	0	0	0	0	0	0	0	0	1	
Plan	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

CCG Level Data

CCG	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD	Trend
Southport and Formby CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	

MRSA Cases_Data source: Provider HCAI Assurance Framework

Measure **HCAI Cdiff cases**
National Requirement: **Yes**

Provider Level Data

Month	Annual Plan	Monthly Plan	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD	Trend
Royal Liverpool Hospital	35	2.92	4	7	2	7	7	3	3	4	2	4	3	4	50	
Liverpool Women's Hospital	0	0	0	0	0	1	0	0	0	0	1	0	0	0	2	
Liverpool Heart and Chest	4	0.33	0	0	1	0	1	0	0	0	0	1	0	0	3	
Alder Hey Children's Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Southport and Ormskirk Hospital	19	1.58	1	0	1	2	2	4	3	6	2	2	7	4	34	
St Helens and Knowsley Hospital	31	2.58	0	3	2	2	3	2	1	0	0	3	2	8	26	
Warrington and Halton Hospital	19	1.58	5	4	3	0	1	1	4	2	4	4	1	2	31	
Aintree University Hospital	43	3.58	9	11	6	7	11	10	5	7	4	1	4	1	76	
The Walton Center	5	0.42	1	2	1	1	0	1	0	1	1	2	1	1	12	
Mersey Care NHS Trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Liverpool Community Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
5 Boroughs Partnership	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Bridgewater Community	0	0	0	0	1	0	0	0	0	0	0	1	0	0	2	

CCG Level Data

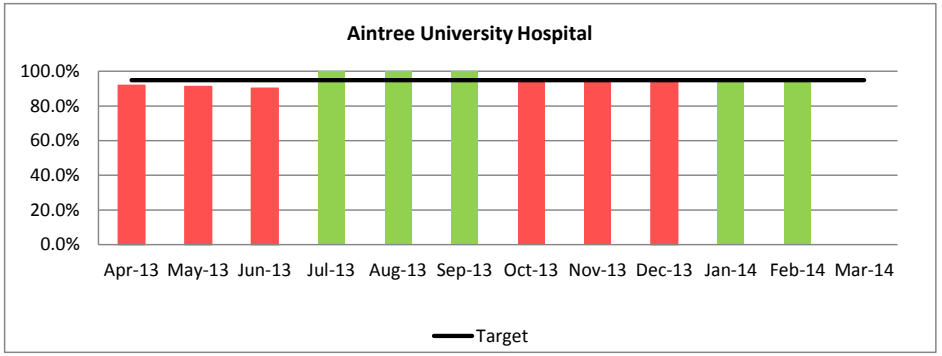
Month	Annual Plan	Monthly Plan	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD	Trend
Southport and Formby CCG	38	3.17	3	0	3	6	2	6	5	5	1	2	7	5	45	

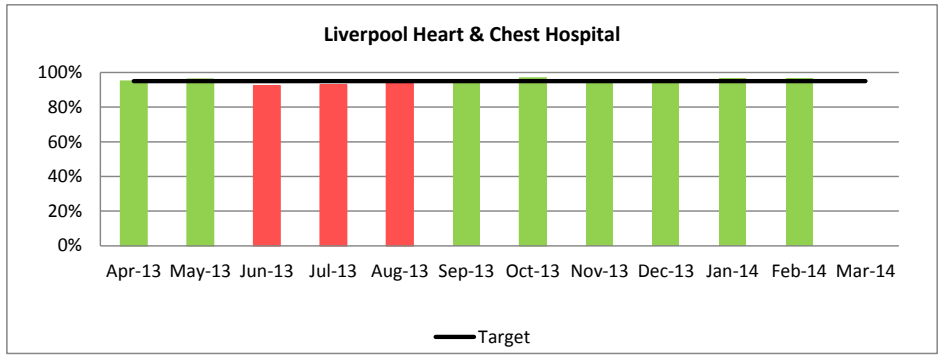
Cdiff Cases_Data source: Provider HCAI Assurance Framework

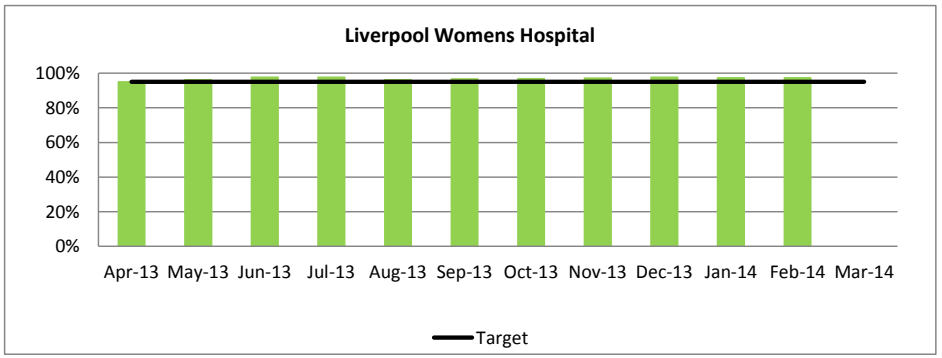
All patients should be risk assessed on admission to hospital. Patients should be reassessed within 24 hours of admission and whenever the clinical situation changes.

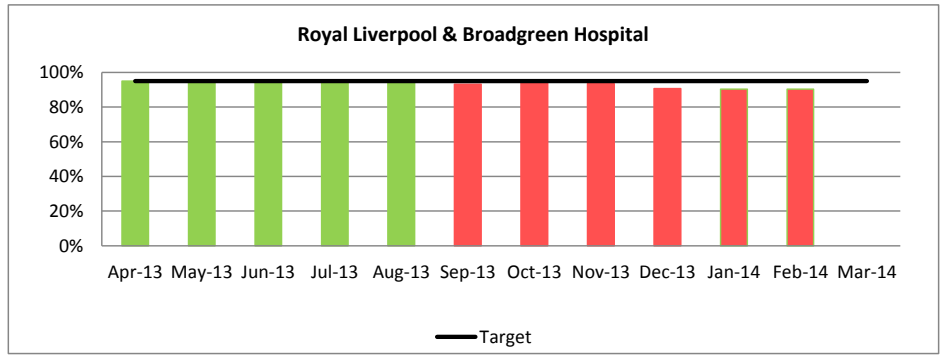
Measure: VTE Risk Assessments
Threshold: National CQUIN
Target: 95%

Trust	2011/12	2012/13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend
Aintree University Hospital	87%	92%	92%	91%	90%	100%	100%	100%	94.9%	94.6%	94.8%	95.5%	95.5%		
Liverpool Heart & Chest Hospital	96%	96%	95%	96%	92%	93%	94%	95%	97%	96.2%	95.8%	96.7%	96.7%		
Liverpool Womens Hospital	95%	96%	95%	96%	98%	98%	96%	97%	97%	97.1%	97.7%	97.3%	97.3%		
Royal Liverpool & Broadgreen Hospital	91%	90%	95%	95%	95%	95%	95%	93%	94%	93.6%	90.7%	90.3%	90.3%		
Southport & Ormskirk Hospital	95%	93%	96%	96%	95%	97%	97%	96%	95%	96.8%	96.0%	95.9%	95.9%		
St Helens & Knowsley Hospital	84%	90%	92%	94%	95%	95%	95%	95%	95%	95.0%	95.0%	94.6%	94.6%		
The Walton Centre	99%	94%	92%	92%	93%	92%	93%	94%	95%	98.5%	96.1%	95.2%	95.2%		
Warrington and Halton Hospital			94%	94%	96%	96%	95%	95%	97%	96.7%	95.2%	95.6%	95.6%		
Target	**90%**	**90%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**

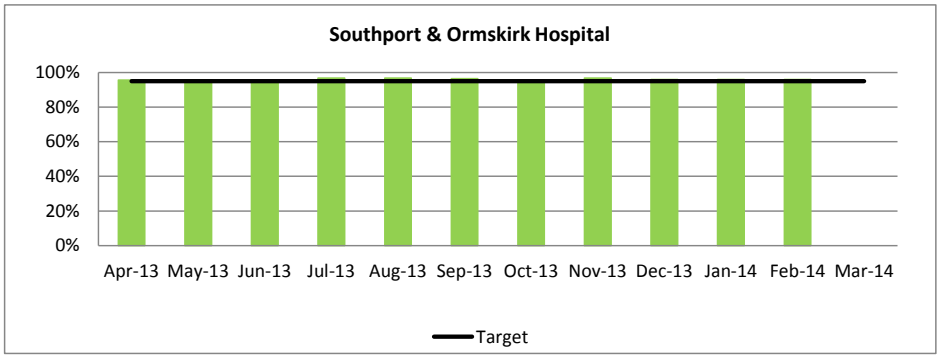


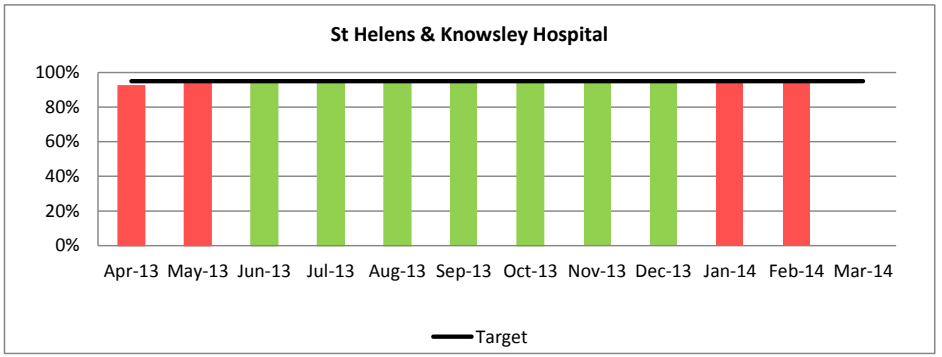


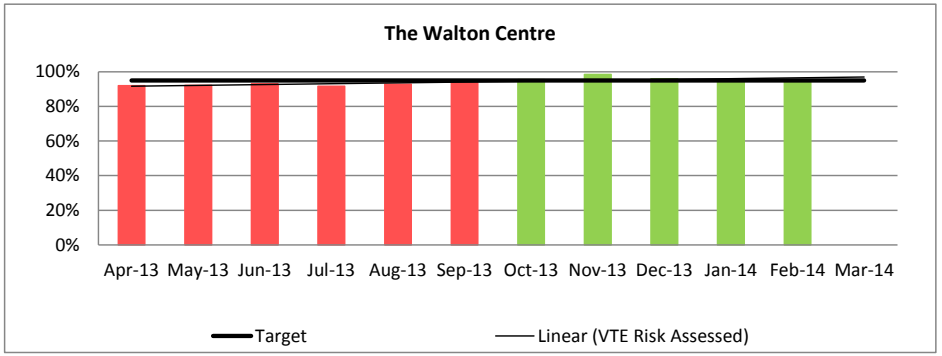


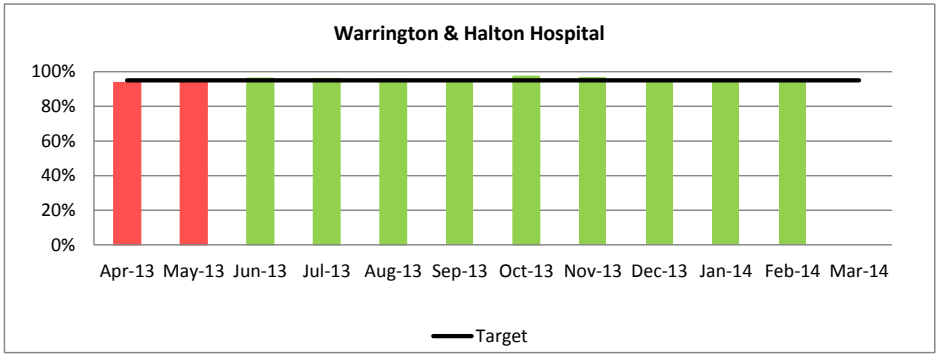


VTE Risk Assessments Data_Unify2 Data source









VTE Risk Assessments Data_Unify2 Data source

Measure: Serious Untoward Incidents
Data Source: STEIS

201314 Provider SUI Tables.pdf
Apr 14 Provider SUIs.pdf

Serious Untoward Incidents

	2013/14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Royal Liverpool Hospital	28	5												5
Liverpool Womens Hospital	17	3												3
Liverpool Heart and Chest	6	2												2
Alder Hey Childrens Hospital	12	3												3
Southport and Ormskirk Hospital	15	2												2
St Helens and Knowsley Hospital	27	1												1
Mersey Care NHS Trust	76	7												7
Liverpool Community Health	95	26												26
Warrington and Halton Hospital	49	0												0
Aintree University Hospital	27	0												0
5 Boroughs Partnership	73	2												2
Bridgewater Community	17	2												2

Never Events

	YTD	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Royal Liverpool Hospital	2	0												0
Liverpool Womens Hospital	1	0												0
Liverpool Heart and Chest	2	1												1
Alder Hey Childrens Hospital	1	0												0
Southport and Ormskirk Hospital	2	0												0
St Helens and Knowsley Hospital	2	0												0
Mersey Care NHS Trust	0	0												0
Liverpool Community Health	1	0												0
Warrington and Halton Hospital	2	0												0
Aintree University Hospital	1	0												0
5 Boroughs Partnership	1	0												0
Bridgewater Community	0	0												0

Measure: Complaints reported to Cheshire and Merseyside Commissioning Support Unit
Latest data: Apr-14

0 complaints reported at CMCSU relating to Southport and Formby CCG patients in April 2014.

Measure: National Incident Reporting
Data Source: NRLS
Latest Data: Apr 13 - Sep 13

	Reorting Rates		CMCSU Comments
	Apr - Sep 12	Apr - Sep 13	
Royal Liverpool & Broadgreen	**Lowest 25%**	**Lowest 25%**	Royal Liverpool Hospital reported 2,235 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 5.08 compared to 7.98 (Median for large acute providers). The trust reported significantly more incidents in the following areas compared to other teaching organisations; • Patient Accidents • Access/Admissions/Transfer and Discharge incidents
Aintree University Hospital	**Middle 50% of reporters**	**Middle 50% of reporters**	Aintree Hospital reported 2,607 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 7.21 compared to 7.23 (Median for large acute providers). The trust reported significantly more incidents in the following areas compared to other teaching organisations; • Patient Accidents • Documentation (including records/documentation)
Alder Hey Children's Hospital	**Lowest 25%**	**Lowest 25%**	Alder Hey Childrens Hospital reported 849 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 5.09 compared to 7.14 (Median for specialist acute providers). The trust reported significantly more incidents in the following areas compared to other acute specialist organisations; • Clinical Assessments
Liverpool Women's Hospital	**Middle 50% of reporters**	**Lowest 25%**	Liverpool Womens Hospital reported 763 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 3.69 compared to 7.14 (Median for specialist acute providers). The trust reported significantly more incidents in the following areas compared to other specialist organisations; • Treatment procedure
Liverpool Heart & Chest Hospital	**Highest 25% of reporters**	**Middle 50% of reporters**	Liverpool Heart and Chest Hospital reported 540 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 7.93 compared to 7.14 (Median for specialist acute providers). The trust reported significantly more incidents in the following areas compared to other acute specialist organisations; • Implementation of care and ongoing monitoring / review • Medical device / equipment
Mersey Care	**Middle 50% of reporters**	**Highest 25% of reporters**	Mersey Care NHS Trust reported 2559 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 36.64 compared to 26.37 (Median for mental health providers). The trust reported significantly more incidents in the following areas compared to other mental health organisations; • Self-harming behaviour •Disruptive, aggressive behaviour
Liverpool Community Health	**Lowest 25%**	**Middle 50% of reporters**	Liverpool Community Health reported 484 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 37.82 compared to 47.63 (Median for community providers). The trust reported significantly more incidents in the following areas compared to other community organisations; • Implementation of care and ongoing monitoring / review
Southport and Ormskirk Hospital	**Middle 50% of reporters**	**Middle 50% of reporters**	Southport Hospital reported 1916 incidents to the National Reporting and Learning System (NRLS) between 1 April 2013 and 30 September 2013, reporting rate of 6.32 compared to 7.23 (Median for medium acute providers). The trust reported significantly more incidents catagorised as 'other' compared to other medium acute organisations.

Measure: Sleeping Mixed Sex Accomadation Breaches
Threshold <0 = Green, >0 = Red
Financial Consequence per breach: £250 per breach

Commissioner	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Southport and Formby CCG	0	0	0	0	0	0	0	0	0	28	35	16

Provider Level	2011	2012	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trust YTD Total	£ Financial Total
5BOURGH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Aintree University Hospital	90	7	0	1	0	0	0	0	0	0	0	0	0	0	1	£250
Alder Hey Childrens Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Bridgewater	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Liverpool Community Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Liverpool Heart & Chest Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Liverpool Womens Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Mersey Care NHS Trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Royal Liverpool & Broadgreen Hospital	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
Southport & Ormskirk Hospital	66	10	0	0	0	0	0	0	0	0	0	28	35	16	79	£19,750
St Helens & Knowsley Hospital	14	1	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
The Walton Centre	0	2	0	0	0	0	0	0	0	3	0	0	0	0	3	£750
Warrington & Halton Hospital	7	15	0	0	0	0	0	5	10	1	2	6	0	0	24	£6,000

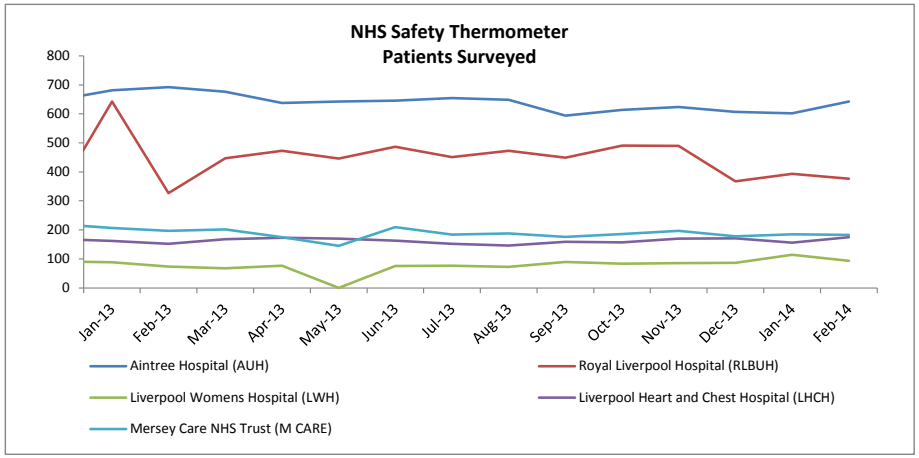
Mixed Sex Accomadation_Data source: NHS England Website

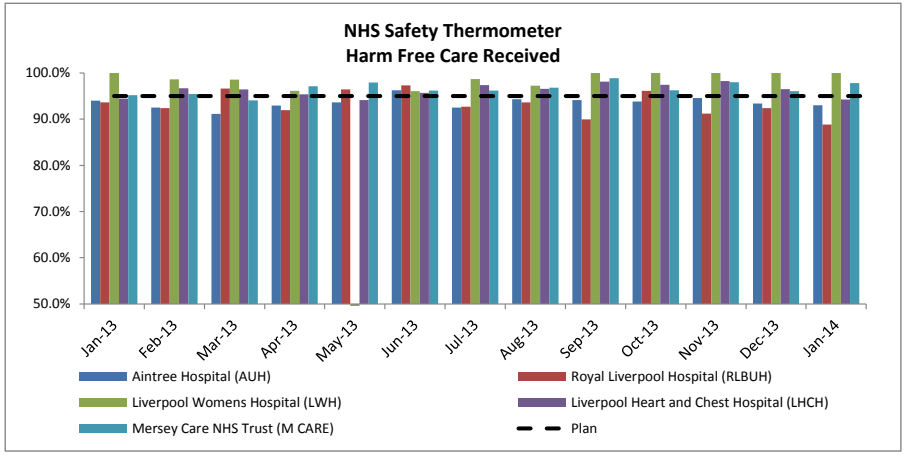
Due to a change in national reporting March 2014 data is currently being analysed, an update will follow as soon as data is available - Sorry for the inconvenience

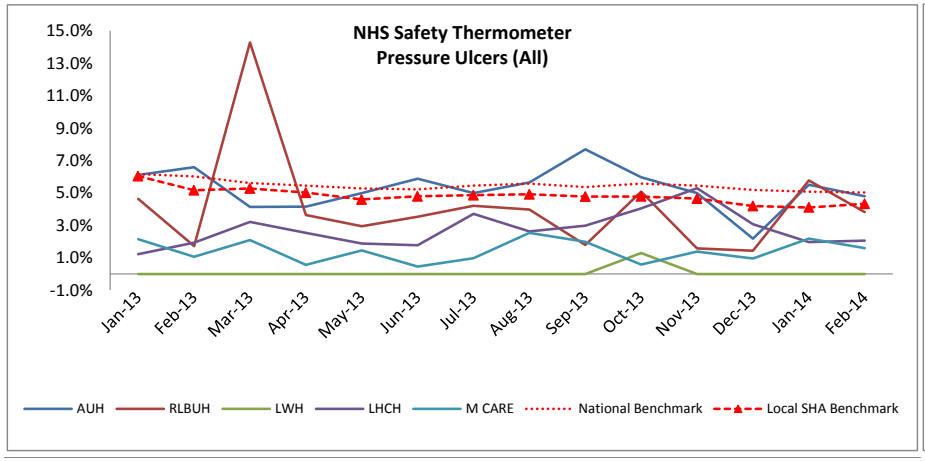
Measure: NHS Safety Thermometer Data

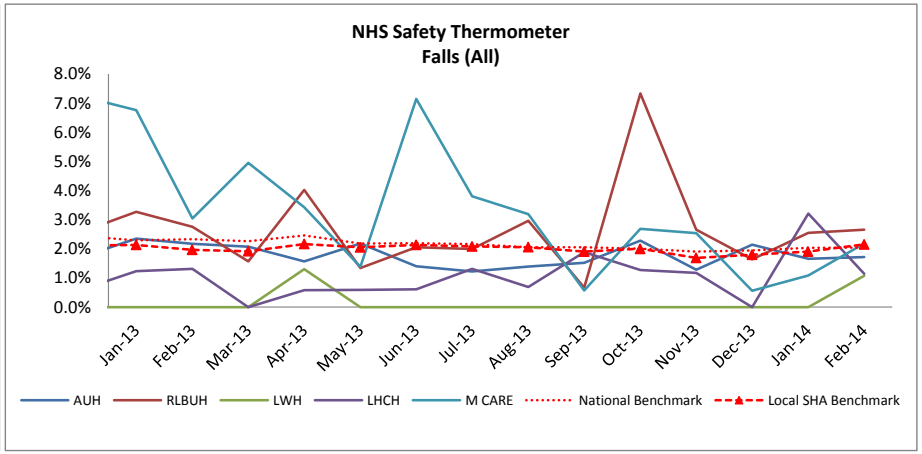
CQUIN: Yes

Part 1. Patients surveyed - All providers survey similar numbers each month, during the year RLBUH reported a slight drop in the number of surveys completed in December 2013.
Part 2. Harm Free Care - LWH report the highest standard of harm free care, RLBUH report the lowest standard of harm free care.
Part 3. Pressure Ulcers -In February 2014 RLBUH reported a reduction in pressure ulcer rates, AUH continue to report higher rates than the national average
Part 4. Falls - RLBUH reported a slight increase in falls rates and continue to report rates higher than the national and regional average.
Part 5. Catherters and UTIs - LWH reported an increase in the number of women with catheters having UTIs, 3 patients reported in February 2014.
Part 6. New VTE Cases - RLBUH continues to be the highest reporter of hospital acquired VTE cases and reports higher rates than the national and regional average



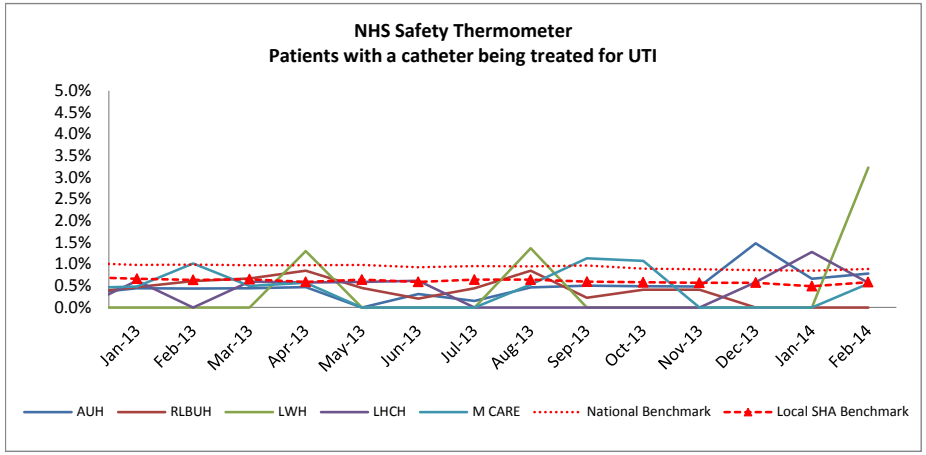


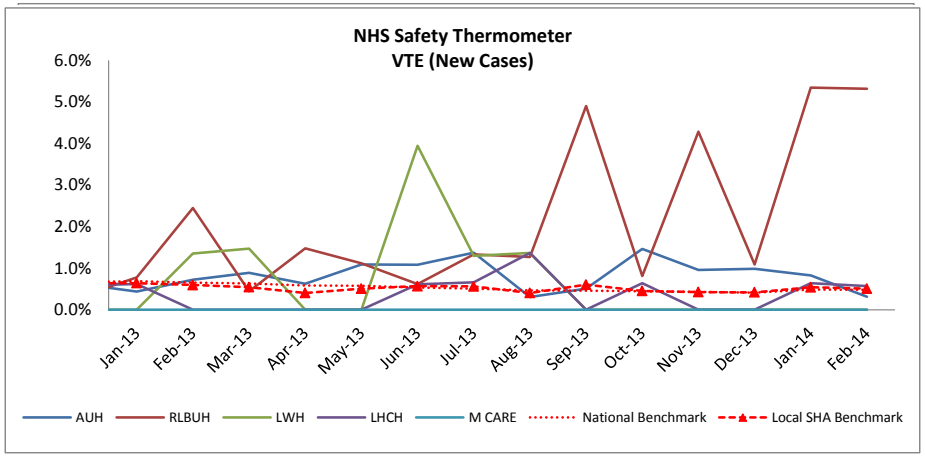




NHS Safety Thermometer_Data source: Quality Observatory

Part 6. New VTE Cases - RLBUH continues to be the highest reporter of hospital acquired VTE cases and reports higher rates than the national and regional average





Due to low numbers being reported against the measure above, 1 patient being treated can result in a significant increase in rates.

NHS Safety Thermometer_Data source: Quality Observatory

Measure: National Dementia Programme
Thresholds: 90% Threshold all areas

** = 0 admissions*

Screening for Dementia (Find)

	2012/13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	2013/14
St Helens & Knowsley Hospital	91.4%	91.9%	90.3%	91.7%	92.5%	93.0%	93.7%	90.5%	91.3%	92.6%	92.6%	96.0%		92.4%
Liverpool Heart & Chest Hospital	87.4%	100.0%	94.4%	100.0%	96.9%	96.9%	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%		98.3%
Aintree University Hospital	19.5%	37.4%	27.9%	46.1%	52.4%	47.0%	43.9%	37.6%	58.2%	52.0%	64.7%	67.4%		47.3%
Liverpool Womens Hospital	42.9%	100.0%	*	*	100.0%	*	*	75.0%	75.0%	66.7%	100.0%	50.0%		76.5%
The Walton Centre	81.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		98.4%
Royal Liverpool & Broadgreen Hosp	48.8%	45.0%	43.0%	42.9%	43.0%	29.2%	47.9%	71.1%	63.3%	57.1%	58.5%	56.1%		50.6%
Southport & Ormskirk Hospital	10.7%	13.3%	16.5%	18.2%	19.1%	11.3%	17.1%	15.2%	7.8%	4.1%	7.0%	5.6%		12.1%
Warrington & Halton Hospital	38.8%	90.4%	92.9%	92.9%	92.9%	95.1%	95.1%	95.2%	95.1%	96.1%	97.9%	97.4%		94.5%

Risk Assessed (Assess and Investigate)

	2012/13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	2013/14
St Helens and Knowsley Hospital	89.7%	94.4%	98.5%	97.8%	100.0%	98.4%	98.4%	100.0%	98.4%	100.0%	96.5%	91.5%		97.6%
Liverpool Heart and Chest	91.2%	100.0%	*	100.0%	83.3%	100.0%	80.0%	80.0%	*	100.0%	100.0%	100.0%		92.3%
Aintree University Hospital	82.4%	81.0%	89.5%	84.2%	75.0%	85.0%	66.7%	40.0%	51.6%	59.4%	56.8%	83.7%		70.3%
Liverpool Womens Hospital	n/a	*	*	*	*	*	*	*	*	*	*	100.0%		100.0%
The Walton Centre	n/a	*	*	*	*	100.0%	*	*	*	*	*	100.0%		100.0%
Royal Liverpool and Broadgreen	41.6%	60.0%	58.0%	58.0%	58.0%	94.3%	100.0%	30.3%	36.8%	34.5%	44.3%	57.1%		55.1%
Southport and Ormskirk Hospital	3.3%	16.7%	66.7%	66.7%	11.1%	18.2%	44.4%	42.9%	40.0%	50.0%	68.8%	80.0%		44.4%
Warrington and Halton Hospital	16.3%	16.1%	67.7%	67.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		86.2%

Patients Referred (Refer)

	2012/13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	2013/14
St Helens and Knowsley Hospital	55.4%	96.0%	94.7%	88.9%	92.9%	95.2%	100.0%	100.0%	100.0%	94.1%	96.4%	100.0%		96.0%
Liverpool Heart and Chest	90.9%	80.0%	*	100.0%	100.0%	100.0%	100.0%	50.0%	*	100.0%	100.0%	100.0%		90.9%
Aintree University Hospital	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
Liverpool Womens Hospital	n/a	*	*	*	*	*	*	*	*	*	*	*		*
The Walton Centre	100.0%	*	*	*	*	*	*	100.0%	*	*	*	100.0%		100.0%
Royal Liverpool and Broadgreen	n/a	*	*	*	*	*	*	57.1%	66.7%	63.6%	77.8%	61.9%		65.8%
Southport and Ormskirk Hospital	72.7%	*	100.0%	100.0%	100.0%	*	66.7%	*	100.0%	83.3%	100.0%	75.0%		86.7%
Warrington and Halton Hospital	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%

Summary Hospital-level Mortality Indicator (SHMI)

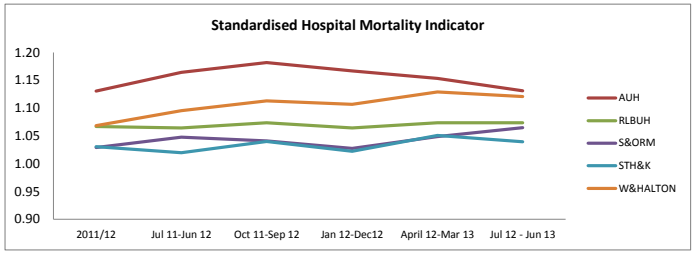
Purpose **All deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or <30 days of discharge.**

Threshold: **1 – where the trust's mortality rate is 'higher than expected' - Red**
2 – where the trust's mortality rate is 'as expected' - Blue
3 – where the trust's mortality rate is 'lower than expected' - Green
Relative risk = Observed number of deaths as a percentage of expected number of deaths
https://indicators.ic.nhs.uk/webview/

Summary Hospital-level Mortality Indicator (SHMI)

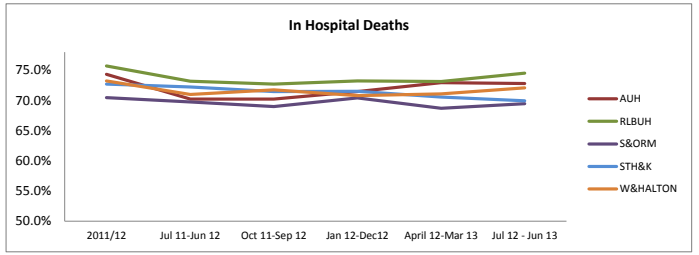
	2011/12	Jul 11-Jun 12	Oct 11-Sep 12	Jan 12-Dec12	April 12-Mar 13	Jul 12 - Jun 13
Aintree University Hospital	1.13	1.16	1.18	1.17	1.15	1.13
Royal Liverpool & Broadgreen Hospital	1.07	1.06	1.07	1.06	1.07	1.07
Southport & Ormskirk Hospital	1.03	1.05	1.04	1.03	1.05	1.06
St Helens & Knowsley Hospital	1.03	1.02	1.04	1.02	1.05	1.04
Warrington and Halton Hospital	1.07	1.10	1.11	1.11	1.13	1.12

Rolling 12 months data



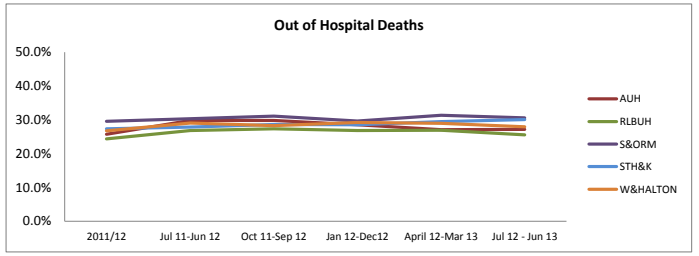
Percentage of deaths that occur in hospital

	2011/12	Jul 11-Jun 12	Oct 11-Sep 12	Jan 12-Dec12	April 12-Mar 13	Jul 12 - Jun 13
St Helens & Knowsley Hospital	72.7%	72.20%	71.43%	71.49%	70.53%	69.91%
Aintree University Hospital	74.3%	70.19%	70.19%	71.45%	72.94%	72.81%
Royal Liverpool & Broadgreen Hospital	75.7%	73.19%	72.67%	73.21%	73.11%	74.49%
Southport & Ormskirk Hospital	70.5%	69.73%	68.95%	70.40%	68.70%	69.43%
Warrington and Halton Hospital	73.2%	70.99%	71.76%	70.80%	71.06%	72.08%



Percentage of deaths that occur outside hospital within 30 days (inclusive) of discharge

	2011/12	Jul 11-Jun 12	Oct 11-Sep 12	Jan 12-Dec12	April 12-Mar 13	Jul 12 - Jun 13
St Helens & Knowsley Hospital	27.3%	27.80%	28.57%	28.51%	29.47%	30.09%
Aintree University Hospital	25.7%	29.81%	29.81%	28.55%	27.06%	27.19%
Royal Liverpool & Broadgreen Hospital	24.3%	26.81%	27.33%	26.79%	26.89%	25.51%
Southport & Ormskirk Hospital	29.5%	30.27%	31.05%	29.60%	31.30%	30.57%
Warrington and Halton Hospital	26.8%	29.01%	28.24%	29.20%	28.94%	27.92%



Standardised Hospital Mortality Indicator_Data source: Health and Social Care Information Centre

Measure: Patient Reported Outcome Measures
Level of reporting: Trust Catchment
Indicator: EQ-5D Index Adjusted Average Health Gain
Latest data available Apr - Mar 2013/14 Provisional Data
Threshold Green = Improvement in trust adjusted average heath gain compared to previous reporting and above national average
Amber = Amber = Improvement in trust adjusted average heath gain compared to previous reporting but below national average
Red = No improvement in trusts adjusted average health gain compared to previous reporting and below national average

Groin Hernia		2010/11 Finalised Data	2011/12 Provisional Data	2012/13 (Apr 12 - Mar 12) Provisional Data
Commissioner		Adjusted average health gain	Adjusted average health gain	Adjusted average health gain
England	**England**		**0.087**	**0.086**
01F	NHS HALTON CCG		0.049	*
01J	NHS KNOWSLEY CCG	0.108	0.090	0.058
01T	NHS SOUTH SEFTON CCG		0.055	0.069
01V	NHS SOUTHPORT AND FORMBY CCG		0.080	0.085
01X	NHS ST HELENS CCG		0.085	0.031
99A	NHS LIVERPOOL CCG	0.049	0.056	0.071
Provider				
NT337	SPIRE LIVERPOOL HOSPITAL	0.030	0.045	
NVG01	FAIRFIELD HOSPITAL	*	*	
RBN	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	0.074	0.080	0.042
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	0.034	0.088	0.064
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	0.082	0.057	*
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	0.064	0.073	0.061
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	0.055	0.084	*

Knee Replacement		2010/11 Finalised Data	2011/12 Provisional Data	2012/13 (Apr 12 - Dec 12) Provisional Data
Commissioner		Adjusted average health gain	Adjusted average health gain	Adjusted average health gain
England	**England**		**0.302**	**0.321**
01F	NHS HALTON CCG		0.306	0.298
01J	NHS KNOWSLEY CCG	0.186	0.260	0.347
01T	NHS SOUTH SEFTON CCG		0.303	0.348
01V	NHS SOUTHPORT AND FORMBY CCG		0.295	0.312
01X	NHS ST HELENS CCG		0.293	0.327
99A	NHS LIVERPOOL CCG	0.240	0.309	0.307
Provider				
NT337	SPIRE LIVERPOOL HOSPITAL	*	0.331	
NVG01	FAIRFIELD HOSPITAL	No Data	0.280	
RBN	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	0.288	0.272	0.317
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	0.199	0.299	0.296
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	0.234	0.316	0.354
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	0.325	0.297	0.308
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	0.299	0.302	*

Hip Replacement		2010/11 Finalised Data	2011/12 Provisional Data	2012/13 (Apr 12 - Dec 12) Provisional Data
Commissioner		Adjusted average health gain	Adjusted average health gain	Adjusted average health gain
England	**England**		**0.416**	**0.439**
01F	NHS HALTON CCG		0.422	0.384
01J	NHS KNOWSLEY CCG	0.352	0.474	0.442
01T	NHS SOUTH SEFTON CCG		0.352	0.413
01V	NHS SOUTHPORT AND FORMBY CCG		0.368	0.423
01X	NHS ST HELENS CCG		0.427	0.468
99A	NHS LIVERPOOL CCG	0.381	0.387	0.420
Provider				
NT337	SPIRE LIVERPOOL HOSPITAL	*	0.449	
NVG01	FAIRFIELD HOSPITAL	*	0.422	
RBN	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	0.378	0.443	0.430
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	0.390	0.395	0.429
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	0.363	0.326	0.412
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	0.378	0.348	0.378
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	0.382	0.395	0.407

Varicose Vein		2010/11 Finalised Data	2011/12 Provisional Data	2012/13 (Apr 12 - Dec 12) Provisional Data
Commissioner		Adjusted average health gain	Adjusted average health gain	Adjusted average health gain
England	**England**		**0.094**	**0.094**
01F	NHS HALTON CCG		No Data	*
01J	NHS KNOWSLEY CCG	*	*	*
01T	NHS SOUTH SEFTON CCG		*	*
01V	NHS SOUTHPORT AND FORMBY CCG		*	*
01X	NHS ST HELENS CCG		*	*
99A	NHS LIVERPOOL CCG	0.061	0.065	*
Provider				
NT337	SPIRE LIVERPOOL HOSPITAL	*		
NVG01	FAIRFIELD HOSPITAL	No Data		
RBN	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	*	*	*
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	*	*	*
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	0.045	0.066	*
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	*	*	*
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	*	*	*

Measure: Advancing Quality
Threshold: Various for each measure/provider
Rag Rating: Green = Achieving threshold, Red = Failing threshold

Latest AQ Report

AMI	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Aintree	**81.3**	92.0	90.0	95.7	86.7	95.0	94.4	87.1	100.0	100.0				92.8
Liverpool Heart and Che	**91.5**	91.3	86.3	93.1	92.1	96.0	89.8	93.1	91.4	97.9				92.2
Royal Liverpool	**94.9**	100.0	100.0	100.0	100.0	100.0	100	100	100.0	100.0				100.0
Southport	**95.0**	93.8	93.8	90.9	94.1	85.7	100	92.86	91.7	92.9				93.3
St Helen's	**95.0**	100.0	100.0	100.0	100.0	100.0	100	100	100.0	100.0				100.0
Warrington	**91.5**	97.1	100.0	96.0	100.0	96.0	100	100	100.0	95.1				98.2

Heart Failure	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Aintree	**73.8%**	70%	59%	64%	76%	58%	77.3%	77.8%	69.6%	70.0%				68.7%
LHCH	**62.2%**	100%	67%	67%	50%	67%	0.0%	75.0%	0.0%	100.0%				69.2%
Royal Liverpool	**83.4%**	100%	89%	89%	83%	100%	71.4%	87.5%	91.7%	75.0%				86.9%
Southport	**71.0%**	75%	80%	69%	91%	55%	80.0%	85.0%	80.0%	46.7%				73.6%
St Helen's	**82.8%**	72%	73%	90%	95%	93%	93.8%	76.9%	92.0%	77.8%				85.1%
Warrington	**86.9%**	85%	96%	92%	91%	84%	85.0%	66.7%	87.5%	85.0%				86.1%

Hip and Knee (Combine	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Aintree	**82.0%**	82.8%	85.5%	92.4%	93.7%	91.3%	83.3%	83.7%	83%	75%				85.9%
Royal Liverpool	**95.0%**	94.2%	95.5%	99.0%	96.7%	98.5%	97.7%	95.7%	95%	95%				96.4%
Southport	**82.0%**	77.6%	71.2%	78.8%	85.4%	76.1%	70.0%	75.9%	91%	87%				79.2%
St Helen's	**95.0%**	97.9%	94.8%	95.9%	98.5%	100.0%	94.4%	98.6%	100%	100%				97.7%
Warrington	**92.2%**	97.5%	97.7%	95.3%	94.5%	98.0%	94.3%	98.7%	97%	94%				96.2%

Pneumonia	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Aintree	**61.1%**	69.5%	80.0%	67.1%	81.7%	75.0%	75.7%	60.9%	83.3%	91.5%				76.0%
Royal Liverpool	**78.8%**	76.5%	88.0%	84.7%	93.0%	82.3%	80.9%	87.1%	77.8%	82.9%				78.1%
Southport	**65.4%**	69.2%	70.8%	76.6%	80.6%	70.8%	87.5%	84.6%	65.6%	78.7%				75.2%
St Helen's	**91.4%**	94.0%	94.0%	91.8%	89.5%	79.1%	76.3%	85.2%	87.1%	92.3%				88.7%
Warrington	**75.2%**	64.8%	66.7%	74.3%	71.7%	80.4%	71.7%	70.6%	75.9%	79.0%				72.1%

Stroke	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
Aintree	**53.6%**	55.0%	42.9%	59.0%	53.6%	37.1%	35.7%	53.7%	29%	34%				44.3%
Royal Liverpool	**89.8%**	70.2%	76.9%	80.9%	75.4%	69.6%	71.4%	65.9%	58%	88%				73.3%
Southport	**53.6%**	18.5%	30.0%	38.1%	58.3%	52.2%	45.5%	57.9%	50%	41%				42.9%
St Helen's	**55.1%**	32.1%	36.7%	43.2%	63.2%	56.5%	57.1%	59.6%	60%	58%				51.5%
Warrington	**62.6%**	59.5%	47.8%	50.0%	63.0%	67.7%	54.3%	55.3%	52%	53%				56.2%

CABG	ACS Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
LHCH	**95.00**	100.00	98.40	97.10	100.00	98.30	97.00	97.00	100.00	98.00				98.00

Dementia	CPS Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
5BP	**81.1%**	90.0%	89.9%	96.6%	98.0%	89.1%	87%	96%	95%	88%				92.5%
Mersey Care	**69.4%**	77.2%	77.3%	82.0%	87.3%	84.6%	92%	85%	100%	90%				88.4%

Dementia	ACS Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
5BP	**50.0%**	68.4%	68.2%	78.3%	92.3%	87.5%	87.5%	88.0%	76%	82%				81.2%
Mersey Care	**50.0%**	40.9%	7.1%	30.0%	47.1%	44.4%	66.7%	33.3%	100%	44%				51.4%

First-Episode Psychosis	CPS Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
5BP	**95.0%**	100.0%	100.0%	100.0%	93.1%	97.6%	100%	100%	100%	100%				98.8%
Mersey Care	**84.2%**	76.6%	86.4%	79.7%	89.3%	85.3%	79%	87%	88%	76%				83.1%

First-Episode Psychosis	ACS Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	YTD
5BP	**95.0%**	100.0%	100.0%	100.0%	86.7%	90.9%	100%	100%	100%	100%				97.1%
Mersey Care	**50.0%**	50.0%	58.3%	47.4%	60.0%	52.6%	33%	57%	58%	31%				50.0%

Measure: Advancing Quality
Reporting Frequency: Apr 13 - Dec 13
Benchmark: CCG and North West Providers

Southport and Formby CCG patients

Clinical Focus Area	AMI	CABG	Dementia	First-Episode Psychosis	Heart Failure	Hip and Knee (Combined)	Pneumonia	Stroke
CPS	96.3%	100.0%	92.4%	100.0%	88.8%	93.2%	91.1%	85.2%
ACS	92.9%	100.0%	75.0%	100.0%	73.8%	81.6%	73.7%	35.2%
Quartile (ACS)	Below Median	Top Quartile	Above Median	Top Quartile	Above Median	Bottom Quartile	Above Median	Bottom Quartile

Provider level summary

AMI	CABG	Dementia	First-Episode Psychosis	Heart Failure	Hip and Knee (Combined)	Pneumonia	Stroke
SOUTHPORT & ORMSKIRK has achieved ACS target 1 out of 9 months in AMI and is below target YTD by 1.7%	LIVERPOOL HEART & CHEST has achieved ACS target every month in CABG and is above target YTD	MERSEY CARE has achieved ACS target 3 out of 9 months in Dementia and is above target YTD	MERSEY CARE has achieved ACS target 6 out of 9 months in First-Episode Psychosis and is above target YTD	SOUTHPORT & ORMSKIRK has achieved ACS target 6 out of 9 months in Heart Failure and is above target YTD	SOUTHPORT & ORMSKIRK has achieved ACS target 3 out of 9 months in Hip and Knee (Combined) and is below target YTD by 2.8%	SOUTHPORT & ORMSKIRK has achieved ACS target every month in Pneumonia and is above target YTD	SOUTHPORT & ORMSKIRK has achieved ACS target 2 out of 9 months in Stroke and is below target YTD by 10.8%
WWL has achieved ACS target every month in AMI and is above target YTD		MERSEY CARE has achieved CPS target every month in Dementia and is above target YTD	MERSEY CARE has achieved CPS target 5 out of 9 months in First-Episode Psychosis and is below target YTD by 1.1%	WWL has achieved ACS target 7 out of 9 months in Heart Failure and is above target YTD	WWL has achieved ACS target every month in Hip and Knee (Combined) and is above target YTD	WWL has achieved ACS target every month in Pneumonia and is above target YTD	WWL has achieved ACS target 7 out of 9 months in Stroke and is above target YTD
ROYAL LIVERPOOL has achieved ACS target every month in AMI and is above target YTD		LANCASHIRE CARE has achieved ACS target 1 out of 9 months in Dementia and is below target YTD by 16.4%	LANCASHIRE CARE has achieved ACS target 6 out of 9 months in First-Episode Psychosis and is above target YTD	ROYAL LIVERPOOL has achieved ACS target 6 out of 9 months in Heart Failure and is above target YTD	ROYAL LIVERPOOL has achieved ACS target 7 out of 9 months in Hip and Knee (Combined) and is above target YTD	ROYAL LIVERPOOL has achieved ACS target 3 out of 9 months in Pneumonia and is below target YTD by 0.7%	ROYAL LIVERPOOL has not achieved ACS target once during the 9 months and is below target YTD by 17.5%
		LANCASHIRE CARE has achieved CPS target 4 out of 9 months in Dementia and is below target YTD by 0.8%	LANCASHIRE CARE has achieved CPS target 6 out of 9 months in First-Episode Psychosis and is above target YTD				
		CUMBRIA PARTNERSHIP has achieved ACS target 4 out of 9 months in Dementia and is above target YTD	CUMBRIA PARTNERSHIP has achieved ACS target every month in First-Episode Psychosis and is above target YTD				
		CUMBRIA PARTNERSHIP has achieved CPS target every month in Dementia and is above target YTD	CUMBRIA PARTNERSHIP has achieved CPS target 8 out of 9 months in First-Episode Psychosis and is above target YTD				

Latest Report:

YTD - April 2013 to December 2013 - (01V) NHS

Measure: National Mental Health Survey 2012/13
CQUIN Scheme: No
Threshold: Actual performance compared to england average
Description: Results across North West SHA for the Community Mental Health survey 2012/13

Key	Compared to previous year
☺	Improvement in patients satisfaction
😐	Similar experience reported
☹	Reduction in patients satisfaction

Key	Compared to England Average
	Higher score
	Similar score (Within 2 points)
	Lower score

Natioal Mental Health Survey	Overall score	Access & waiting	Safe high quality coordinated care	Better information more choice	Building closer relationships
England Average	74.4	72.4	71.3	69.1	84.7
SHA average	76.0	73.7	74.3	69.9	86.3
5 Boroughs Partnership NHS Trust	76.6	73.7	76.7	71.2	84.8
Bolton, Salford and Trafford Mental Health NHS Trust	72.5	68.6	71.3	67.0	83.0
Cheshire and Wirral Partnership NHS Trust	79.3	79.5	78.5	70.3	88.8
Cumbria Partnership NHS Trust	73.6	68.1	68.6	70.6	87.1
Lancashire Care NHS Trust	75.1	76.1	73.0	66.8	84.7
Manchester Mental Health and Social Care Trust	77.5	73.7	76.1	71.2	88.9
Mersey Care NHS Trust	76.7	74.4	76.4	69.3	86.7
Pennine Care NHS Trust	77.1	75.2	73.8	72.5	86.7

Indicator National Staff Survey
Latest data available: 2013
Datasource: http://www.nhsstaffsurveys.com/cms/
Threshold: Awaiting CQC confirmation of rag ratings, please see method for rag ratings included below
Green = Improvement compared to previous year and above national average
Amber = Improvement compared to previous year but below the national average
Red = Drop in performance compared to previous year and below national average

	Overall Staff Engagement						KF1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver						KF24. Staff recommendation of the trust as a place to work or receive treatment					
	Trust Score 2010	Trust Score 2011	Trust Score 2012	Trust Score 2013	Change	National Average (All trusts)	Trust Score 2010	Trust Score 2011	Trust Score 2012	Trust Score 2013	Change	National Average (All trusts)	Trust Score 2010	Trust Score 2011	Trust Score 2012	Trust Score 2013	Change	National Average (All trusts)
5BOROUGHS	3.69	3.65	3.73	3.76		3.74	78%	74%	77%	79%		77%	3.55	3.50	3.61	3.67		3.67
Aintree University Hospital	3.64	3.65	3.69	3.74		3.74	81%	77%	82%	82%		77%	3.59	3.66	3.68	3.70		3.67
Alder Hey Childrens Hospital	3.71	3.65	3.57	3.68		3.74	78%	75%	78%	75%		77%	3.75	3.61	3.49	3.65		3.67
Bridgewater	3.52	3.60	3.69	3.60		3.74	77%	73%	80%	77%		77%	3.34	3.47	3.58	3.47		3.67
Liverpool Community Health	3.68	3.61	3.61	3.70		3.74	74%	76%	79%	77%		77%	3.60	3.56	3.52	3.57		3.67
Liverpool Heart & Chest Hospital	3.78	3.86	3.98	3.96		3.74	86%	85%	86%	84%		77%	4.06	4.08	4.20	4.22		3.67
Liverpool Womens Hospital	3.59	3.48	3.57	3.73		3.74	76%	74%	76%	73%		77%	3.48	3.30	3.41	3.67		3.67
Mersey Care NHS Trust	3.59	3.67	3.72	3.66		3.74	81%	80%	79%	81%		77%	3.55	3.56	3.59	3.56		3.67
Royal Liverpool & Broadgreen Hosp	3.60	3.60	3.66	3.73		3.74	75%	77%	81%	81%		77%	3.53	3.52	3.65	3.77		3.67
Southport & Ormskirk Hospital	3.58	3.57	3.63	3.61		3.74	77%	76%	81%	79%		77%	3.46	3.37	3.39	3.46		3.67
St Helens & Knowsley Hospital	3.58	3.56	3.70	3.83		3.74	81%	78%	80%	82%		77%	3.48	3.52	3.74	3.95		3.67
The Walton Centre	3.77	3.70	3.73	3.87		3.74	82%	82%	83%	82%		77%	3.91	3.84	3.92	4.01		3.67
Warrington & Halton Hospital	3.65	3.58	3.68	3.79		3.74	77%	70%	78%	81%		77%	3.51	3.40	3.56	3.67		3.67

2013 NHS Staff Survey - Friends and Family Question

% to strongly agree / agree with the Q12d. 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'

All providers_Acute and Specialist Acute Providers

Ref	Provider	Score (%)	Quartile
RXF	Mid Yorkshire Hospitals NHS Trust	39.57	1st
RNL	North Cumbria University Hospitals NHS Trust	40.26	1st
RJ6	Croydon Health Services NHS Trust	41.03	1st
REF	Royal Cornwall Hospitals NHS Trust	43.03	1st
RWD	United Lincolnshire Hospitals NHS Trust	44.11	1st
RD7	Heatherwood and Wexham Park Hospitals NHS Foundation Trust	47.02	1st
RPA	Medway NHS Foundation Trust	47.28	1st
RXQ	Buckinghamshire Healthcare NHS Trust	47.44	1st
RJL	Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	48.33	1st
RXW	Shrewsbury And Telford Hospital NHS Trust	48.35	1st
RCX	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	49.59	1st
RVY	Southport And Ormskirk Hospital NHS Trust	50.67	1st
RW6	Pennine Acute Hospitals NHS Trust	50.89	1st
RFR	The Rotherham NHS Foundation Trust	51.17	1st
RA3	Weston Area Health NHS Trust	51.24	1st
RXC	East Sussex Healthcare NHS Trust	51.35	1st
RXR	East Lancashire Hospitals NHS Trust	51.49	1st
R1F1	Isle of Wight NHS Primary Care Trust (acute sector)	52.47	1st
RWA	Hull And East Yorkshire Hospitals NHS Trust	52.59	1st
RNQ	Kettering General Hospital NHS Foundation Trust	52.76	1st
RF4	Barking, Havering And Redbridge University Hospitals NHS Trust	53.31	1st
RLQ	Wye Valley NHS Trust	53.46	1st
R1H	Barts Health NHS Trust	53.55	1st
RMP	Tameside Hospital NHS Foundation Trust	54.26	1st
RBK	Walsall Healthcare NHS Trust	55.50	1st
RTX	University Hospitals of Morecambe Bay NHS Foundation Trust	55.63	1st
RTE	Gloucestershire Hospitals NHS Foundation Trust	55.76	1st
RR1	Heart of England NHS Foundation Trust	55.81	1st
RLT	George Eliot Hospital NHS Trust	55.97	1st
RNS	Northampton General Hospital NHS Trust	56.16	1st
RWG	West Hertfordshire Hospitals NHS Trust	56.57	1st
RVV	East Kent Hospitals University NHS Foundation Trust	56.83	1st
RXP	County Durham and Darlington NHS Foundation Trust	56.88	1st
RXH	Brighton And Sussex University Hospitals NHS Trust	56.92	1st
RVW	North Tees and Hartlepool NHS Foundation Trust	57.21	1st
RWE	University Hospitals Of Leicester NHS Trust	57.33	1st
RDD	Basildon and Thurrock University Hospitals NHS Foundation Trust	57.36	1st
RMC	Bolton NHS Foundation Trust	57.41	1st
RR8	Leeds Teaching Hospitals NHS Trust	57.77	1st
RFW	West Middlesex University Hospital NHS Trust	57.96	1st
RVL	Barnet And Chase Farm Hospitals NHS Trust	58.07	2nd
RAP	North Middlesex University Hospital NHS Trust	58.28	2nd
RDE	Colchester Hospital University NHS Foundation Trust	58.45	2nd
RXK	Sandwell And West Birmingham Hospitals NHS Trust	59.02	2nd
RP5	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	59.17	2nd
RLN	City Hospitals Sunderland NHS Foundation Trust	59.26	2nd
RD8	Milton Keynes Hospital NHS Foundation Trust	59.26	2nd
RQQ	Hinchingbrooke Health Care NHS Trust	59.32	2nd
RJF	Burton Hospitals NHS Foundation Trust	59.81	2nd
RBL	Wirral University Teaching Hospital NHS Foundation Trust	59.85	2nd
RHU	Portsmouth Hospitals NHS Trust	59.89	2nd
RN3	Great Western Hospitals NHS Foundation Trust	60.40	2nd
RJN	East Cheshire NHS Trust	60.53	2nd
RGQ	Ipswich Hospital NHS Trust	60.93	2nd
RCB	York Teaching Hospital NHS Foundation Trust	61.09	2nd
RFS	Chesterfield Royal Hospital NHS Foundation Trust	61.23	2nd
RVJ	North Bristol NHS Trust	61.29	2nd
RAS	The Hillingdon Hospitals NHS Foundation Trust	61.32	2nd
RWP	Worcestershire Acute Hospitals NHS Trust	61.52	2nd
RC3	Ealing Hospital NHS Trust	61.69	2nd
RTK	Ashford and St Peter's Hospitals NHS Foundation Trust	62.19	2nd
RQ8	Mid Essex Hospital Services NHS Trust	62.20	2nd
RXL	Blackpool Teaching Hospitals NHS Foundation Trust	62.39	2nd
RKB	University Hospitals Coventry And Warwickshire NHS Trust	62.42	2nd
RAX	Kingston Hospital NHS Trust	62.47	2nd
RC1	Bedford Hospital NHS Trust	62.61	2nd
RK5	Sherwood forest Hospitals NHS Foundation Trust	63.07	2nd
RE9	South Tyneside NHS Foundation Trust	63.61	2nd
RKE	The Whittington Hospital NHS Trust	64.15	2nd
RXN	Lancashire Teaching Hospitals NHS Foundation Trust	64.35	2nd
RFF	Barnsley Hospital NHS Foundation Trust	64.44	2nd
RQW	The Princess Alexandra Hospital NHS Trust	64.47	2nd
RK9	Plymouth Hospitals NHS Trust	64.63	2nd
REM	Aintree University Hospital NHS Foundation Trust	64.73	2nd
RRF	Wrightington, Wigan and Leigh NHS Foundation Trust	64.91	2nd
RV8	North West London Hospitals NHS Trust	65.06	2nd
RWW	Warrington and Halton Hospitals NHS Foundation Trust	65.25	2nd
RWH	East And North Hertfordshire NHS Trust	65.33	2nd
RBD	Dorset County Hospital NHS Foundation Trust	65.95	2nd
RBT	Mid Cheshire Hospitals NHS Foundation Trust	66.08	2nd
RNA	The Dudley Group NHS Foundation Trust	66.26	3rd
RC9	Luton and Dunstable Hospital NHS Foundation Trust	66.74	3rd
RW3	Central Manchester University Hospitals NHS Foundation Trust	66.85	3rd
RAJ	Southend University Hospital NHS Foundation Trust	67.37	3rd
REP	Liverpool Women's NHS Foundation Trust	67.43	3rd
RGP	James Paget University Hospitals NHS Foundation Trust	67.43	3rd
RBZ	Northern Devon Healthcare NHS Trust	67.58	3rd
RVR	Epsom And St Helier University Hospitals NHS Trust	67.59	3rd

Merseyside Providers

Ref	Provider	Score (%)	Quartile
RVY	Southport And Ormskirk Hospital NHS Trust	50.67	1st
REM	Aintree University Hospital NHS Foundation Trust	64.73	2nd
RWW	Warrington and Halton Hospitals NHS Foundation Trust	65.25	2nd
REP	Liverpool Women's NHS Foundation Trust	67.43	3rd
RQ6	Royal Liverpool And Broadgreen University Hospitals NHS Trust	71.38	3rd
RBN	St Helens And Knowsley Hospitals NHS Trust	77.41	4th
RET	The Walton Centre NHS Foundation Trust	84.59	4th
RBQ	Liverpool Heart and Chest NHS Foundation Trust	91.85	4th

Quartile	
Lower Quartile (25th)	58.123
Median Quartile (50th)	66.212
Upper Quartile (75th)	75.887

Average score for each quartile	
Average score for 1st quartile	52.057
Average score for 2nd quartile	62.017
Average score for 3rd quartile	70.569
Average score for 4th quartile	83.781

Trusts in the 4th quartile are the top performers

2013 NHS Staff Survey - Friends and Family Question

% to strongly agree / agree with the Q12d. 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'

All providers_Acute and Specialist Acute Providers

Ref	Provider	Score (%)	Quartile
RJE	University Hospital Of North Staffordshire NHS Trust	67.75	3rd
RWY	Calderdale and Huddersfield NHS Foundation Trust	67.84	3rd
RA4	Yeovil District Hospital NHS Foundation Trust	68.00	3rd
RTP	Surrey And Sussex Healthcare NHS Trust	68.03	3rd
RGN	Peterborough and Stamford Hospitals NHS Foundation Trust	68.23	3rd
RJ7	St George's Healthcare NHS Trust	68.26	3rd
RWF	Maidstone And Tunbridge Wells NHS Trust	68.94	3rd
RTG	Derby Hospitals NHS Foundation Trust	69.04	3rd
RYJ	Imperial College Healthcare NHS Trust	69.08	3rd
RR7	Gateshead Health NHS Foundation Trust	69.70	3rd
RD1	Royal United Hospital Bath NHS Trust	69.96	3rd
RJ2	Lewisham Healthcare NHS Trust	70.79	3rd
RAE	Bradford Teaching Hospitals NHS Foundation Trust	70.87	3rd
RHM	University Hospital Southampton NHS Foundation Trust	71.22	3rd
RN5	Hampshire Hospitals NHS Foundation Trust	71.26	3rd
RDZ	The Royal Bournemouth and Christchurch Hospitals NHS Foundation T	71.37	3rd
RQ6	Royal Liverpool And Broadgreen University Hospitals NHS Trust	71.38	3rd
RL4	The Royal Wolverhampton Hospitals NHS Trust	71.77	3rd
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust	72.18	3rd
RX1	Nottingham University Hospitals NHS Trust	72.32	3rd
RJR	Countess of Chester Hospital NHS Foundation Trust	72.44	3rd
RWJ	Stockport NHS Foundation Trust	72.52	3rd
RYR	Western Sussex Hospitals NHS Trust	72.74	3rd
RCF	Airedale NHS Foundation Trust	72.77	3rd
RJD	Mid Staffordshire NHS Foundation Trust	73.10	3rd
RD3	Poole Hospital NHS Foundation Trust	73.92	3rd
RHW	Royal Berkshire NHS Foundation Trust	74.12	3rd
RA7	University Hospitals Bristol NHS Foundation Trust	74.13	3rd
RA2	Royal Surrey County Hospital NHS Foundation Trust	75.00	3rd
RM1	Norfolk and Norwich University Hospitals NHS Foundation Trust	75.29	3rd
RQX	Homerton University Hospital NHS Foundation Trust	75.72	3rd
RTR	South Tees Hospitals NHS Foundation Trust	75.80	3rd
RLU	Birmingham Women's NHS Foundation Trust	75.92	4th
RAL	Royal Free London NHS Foundation Trust	76.24	4th
RTH	Oxford University Hospitals NHS Trust	76.42	4th
RN7	Dartford And Gravesham NHS Trust	76.79	4th
RCD	Harrogate and District NHS Foundation Trust	77.21	4th
RJC	South Warwickshire NHS Foundation Trust	77.36	4th
RBN	St Helens And Knowsley Hospitals NHS Trust	77.41	4th
RTF	Northumbria Healthcare NHS Foundation Trust	77.46	4th
RGR	West Suffolk NHS Foundation Trust	77.56	4th
RBS	Alder Hey Children's NHS Foundation Trust	77.83	4th
RH8	Royal Devon and Exeter NHS Foundation Trust	77.89	4th
RJZ	King's College Hospital NHS Foundation Trust	78.25	4th
RBA	Taunton and Somerset NHS Foundation Trust	78.42	4th
RM2	University Hospital of South Manchester NHS Foundation Trust	80.84	4th
RRK	University Hospitals Birmingham NHS Foundation Trust	81.76	4th
RNZ	Salisbury NHS Foundation Trust	81.82	4th
RA9	South Devon Healthcare NHS Foundation Trust	81.89	4th
RRJ	The Royal Orthopaedic Hospital NHS Foundation Trust	82.45	4th
RCU	Sheffield Children's NHS Foundation Trust	82.69	4th
RGT	Cambridge University Hospitals NHS Foundation Trust	83.10	4th
RRV	University College London Hospitals NHS Foundation Trust	83.41	4th
RQ3	Birmingham Children's Hospital NHS Foundation Trust	84.16	4th
RET	The Walton Centre NHS Foundation Trust	84.59	4th
RQM	Chelsea and Westminster Hospital NHS Foundation Trust	84.79	4th
RDU	Frimley Park Hospital NHS Foundation Trust	85.00	4th
RP4	Great Ormond Street Hospital for Children NHS Foundation Trust	86.59	4th
RJ1	Guy's and St Thomas' NHS Foundation Trust	86.63	4th
RPY	The Royal Marsden NHS Foundation Trust	86.65	4th
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	87.41	4th
RL1	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundati	88.29	4th
RM3	Salford Royal NHS Foundation Trust	88.51	4th
RBB	Royal National Hospital for Rheumatic Diseases NHS Foundation Trust	89.27	4th
RAN	Royal National Orthopaedic Hospital NHS Trust	89.61	4th
RBV	The Christie NHS Foundation Trust	89.80	4th
RBQ	Liverpool Heart and Chest NHS Foundation Trust	91.85	4th
REN	The Clatterbridge Cancer Centre NHS Foundation Trust	92.22	4th
RP6	Moorfields Eye Hospital NHS Foundation Trust	92.29	4th
RT3	Royal Brompton and Harefield NHS Foundation Trust	93.29	4th
RPC	Queen Victoria Hospital NHS Foundation Trust	93.67	4th
RGM	Papworth Hospital NHS Foundation Trust	93.92	4th

Merseyside Providers

Ref	Provider	Score (%)	Quartile

2013 Results due to be published during April 2014

Measure: National Inpatient Survey
CQUIN Scheme: No
Threshold: Comparison to previous year
Description: Results across North West SHA for the survey Inpatient 2012/13

Key	Compared to previous year
☺	Improvement in patients satisfaction
😐	Similar experience reported
☹	Reduction in patients satisfaction

Key	Compared to England Average
	Higher score
	Similar score (Within 2 points)
	Lower score

National Inpatient Survey	Overall score			Access & waiting			Safe high quality coordinated care			Better information more choice			Building closer relationships			clean comfortable friendly place to be		
	2011/12	2012/13		2011/12	2012/13		2011/12	2012/13		2011/12	2012/13		2011/12	2012/13		2011/12	2012/13	
England Average		76.5			84.3			65.4			68.2			84.6			79.8	
SHA average		77.4			84.6			67.0			68.9			85.5			81.0	
Aintree University Hospitals NHS Foundation Trust	77.5	76.7	😐	86.2	82.4	☹	67.6	67.7	☺	68.0	68.7	☺	84.7	84.6	😐	80.8	80.3	😐
Clatterbridge Centre for Oncology NHS Foundation Trust	86.7	87.2	☺	95.2	95.4	☺	77.7	76.6	😐	82.5	83.6	☺	91.0	92.1	☺	87.2	88.3	☺
Countess Of Chester Hospital NHS Foundation Trust	74.4	76.8	☺	80.0	83.7	☺	64.9	66.0	☺	64.8	69.3	☺	83.1	84.4	☺	79.2	80.5	☺
East Cheshire NHS Trust	76.6	74.8	☹	87.0	83.4	☹	65.0	65.1	😐	66.6	63.3	☹	84.9	82.8	☹	79.5	79.4	😐
Liverpool Heart & Chest Hospital NHS Trust	84.6	83.2	😐	94.1	89.8	☹	74.1	73.7	😐	77.5	75.4	☹	89.5	90.8	☺	87.8	86.4	😐
Liverpool Womens Hospital NHS Foundation Trust	82.3	83.3	☺	90.0	89.8	😐	72.0	76.1	☺	73.9	78.4	☺	89.9	88.7	😐	85.6	83.8	☹
Warrington and Halton Hospitals NHS Foundation Trust	73.8	74.5	☺	77.6	76.3	😐	66.5	65.7	😐	64.2	68.6	☺	83.0	85.1	☺	77.6	76.9	☹
Royal Liverpool and Broadgreen University Hospitals NHS Trust	77.0	79.1	☺	83.0	86.2	☺	67.4	68.2	☺	69.2	71.7	☺	85.2	87.5	☺	80.0	81.9	☺
Southport and Ormskirk Hospital NHS Trust	75.9	74.1	😐	85.6	82.2	☹	66.9	64.4	☹	63.9	62.0	😐	84.8	84.7	😐	78.2	77.0	☹
St Helens and Knowsley Hospitals NHS Trust	75.9	76.3	☺	80.3	83.3	☺	65.0	63.4	☹	67.8	67.1	😐	84.1	85.8	😐	82.4	82.2	😐
The Mid Cheshire Hospitals NHS Trust	73.5	73.9	😐	82.3	82.3	😐	59.7	62.4	☺	64.3	64.8	😐	82.4	83.4	😐	78.8	76.9	☹
Walton Centre for Neurology and Neurosurgery NHS Trust	80.4	79.8	😐	84.4	86.8	☺	69.9	70.3	😐	73.3	68.9	☹	88.1	88.0	😐	86.1	85.0	😐
Wirral University Teaching Hospital NHS Foundation Trust	76.0	78.7	☺	84.1	85.6	☺	67.1	68.4	☺	66.8	70.2	☺	82.1	86.6	☺	79.9	82.6	☺

Indicator: CQC Compliance of standards.

Detail: The results of CQCs most recent checks showing whether the care service is meeting each of the standards that the governement says the public have the rig

✓	**Compliant**
✖	**Not Compliant (Actions requiring improvement)**
✖	**Not Compliant (Enforcement Action Taken)**

	Treating people with respect and involving them in their care	Providing care, treatment and support that meets people's needs	Caring for people safely and protecting them from harm	Staffing	Quality and suitability of management	Latest Inspection	Report Available to CCG
Aintree University Hospital	✓	✖	✓	✓	✖	29.09.2013	Yes
Royal Liverpool & Broadgreen Hospital	✓	✓	✓	✓	✓	28.11.2013	Yes
Southport & Formby Site	✓	✖	✓	✖	✓	29.08.2013	Yes
Ormskirk General Hospital	✓	✓	✓	✓	✓	09.10.2013	Yes
Liverpool Heart & Chest Hospital	✓	✓	✖	✓	✓	16.10.2013 - Under review	Yes
Liverpool Women's Hospital	✓	✖	✓	✖	✓	08.07.2014	Yes
The Walton Centre	✓	✓	✓	✓	✓	29.11.2013	Yes
Alder Hey Childrens Hospital	✓	✖	✓	✖	✖	02.12.2013	Yes
Mersey Care NHS Trust (Ashworth Hospital)	✓	✓	✓	✓	✓	24.05.2013	Yes
Liverpool Community Health (HQ Wilkinson Place)	✓	✖	✖	✖	✖	02.12.2013	Yes
Spire Liverpool	✓	✓	✓	✓	✓	22.11.2013	Yes
ISIGHT Clinic Southport	✓	✓	✓	✓	✓	29.10.2013	Yes

Compliance against CQC standards_Data source:CQC

Measure: Patient Safety Alerts ongoing passed deadline date
Threshold: Amber 1 - 4 alerts ongoing passed deadline date, Red 5+ alerst ongoing passed deadline date
Latest Data: Apr-14
Datasource: NHS England

Trust name	Alert title	Alert reference	Issue date	Completion deadline date	Completed Within Deadline	Current Status
AUH	Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors	NPSA/2011/RRR003	28-Nov-11	Apr-12	N	ONGOING
AHCH	Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors	NPSA/2011/RRR003	28-Nov-11	Apr-12	N	ONGOING
AHCH	Window restrictors	EFA/2013/002	23-Jan-13	May-13	N	ONGOING
LWH	Electrosurgical devices.CUSA CEM™ nosecones for use with the CUSA® Excel/Excel+ ultrasonic aspirator.Product codes: C6623 and C6636.Manufactured by Integra Lifesciences.	MDA/2014/006	26-Feb-14	Mar-14	N	ACKNOWLEDGED
LWH	High Voltage Hazard Alert - National Equipment Defect Report (NEDeR) - Areva T&D Automation & Information Services - P122 protection relay	EFN/2014/05	21-Feb-14	Mar-14	N	ACKNOWLEDGED
LWH	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - UPDATE - Hawker Siddeley - URV12 Circuit Breaker	EFN/2014/08	26-Feb-14	Mar-14	N	ACKNOWLEDGED
LWH	High Voltage Hazard Alert - SUSPENSION OF OPERATIONAL PRACTICE (SOP) - UPDATE - Long & Crawford GF3T Fuse Switch	EFN/2014/09	27-Feb-14	Mar-14	N	ASSESSING RELEVANCE

Measure: Time taken from HAS notification to clinical handover (Assumed ACUTE responsibiility)

Handover <15 Minutes. Time taken from HAS notification to clinical handover (Assumed ACUTE responsibiility)

Provider	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Royal Liverpool and Broadgreen Hospital	00:08:31	00:06:37	00:06:08	00:06:26	00:06:05	00:08:13	00:07:49	00:08:43	00:09:04	00:09:34	00:09:32	00:09:48
Alder Hey Childrens Hospital	00:02:56	00:02:38	00:02:38	00:02:42	00:02:17	00:02:01	00:02:13	00:02:40	00:02:37	00:03:00	00:02:29	00:03:14
Aintree University Hospital	00:14:34	00:09:31	00:09:06	00:10:07	00:09:52	00:09:25	00:11:32	00:12:52	00:10:25	00:11:50	00:11:36	00:10:27
Southport and Ormskirk Hospital	00:32:27	00:15:24	00:17:20	00:14:36	00:15:57	00:16:23	00:17:00	00:14:17	00:13:49	00:11:44	00:11:36	00:13:36
St Helens and Knowsley Hospital	00:10:30	00:08:42	00:08:24	00:08:49	00:08:05	00:09:26	00:09:36	00:11:00	00:12:30	00:14:45	00:11:21	00:10:07
Warrington and Halton Hospital	00:07:24	00:07:06	00:06:59	00:06:58	00:07:54	00:09:04	00:09:21	00:09:22	00:08:20	00:09:01	00:08:17	00:08:29

Patients waiting between 30-60 Minutes for handover

Provider		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Royal Liverpool and Broadgreen Hospital	Activity	48	19	14	9	12	48	42	47	54	49	68	79
	Finance	*£9,600*	*£3,800*	*£2,800*	*£1,800*	*£2,400*	*£9,600*	*£8,400*	*£9,400*	*£10,800*	*£9,800*	*£13,600*	*£15,800*
Alder Hey Childrens Hospital	Activity	0	1	2	0	0	1	0	0	2	5	0	0
	Finance	*£0*	*£200*	*£400*	*£0*	*£0*	*£200*	*£0*	*£0*	*£400*	*£1,000*	*£0*	*£0*
Aintree University Hospital	Activity	112	36	55	56	44	37	89	125	61	90	86	61
	Finance	*£22,400*	*£7,200*	*£11,000*	*£11,200*	*£8,800*	*£7,400*	*£17,800*	*£25,000*	*£12,200*	*£18,000*	*£17,200*	*£12,200*
Southport and Ormskirk Hospital	Activity	70	50	62	60	73	73	87	68	65	40	31	45
	Finance	*£14,000*	*£10,000*	*£12,400*	*£12,000*	*£14,600*	*£14,600*	*£17,400*	*£13,600*	*£13,000*	*£8,000*	*£6,200*	*£9,000*
St Helens and Knowsley Hospital	Activity	53	57	30	60	23	49	70	79	148	183	116	83
	Finance	*£10,600*	*£11,400*	*£6,000*	*£12,000*	*£4,600*	*£9,800*	*£14,000*	*£15,800*	*£29,600*	*£36,600*	*£23,200*	*£16,600*
Warrington and Halton Hospital	Activity	19	12	7	13	21	31	33	41	19	23	23	30
	Finance	*£3,800*	*£2,400*	*£1,400*	*£2,600*	*£4,200*	*£6,200*	*£6,600*	*£8,200*	*£3,800*	*£4,600*	*£4,600*	*£6,000*

Patients waiting over 60 Minutes for handover

Provider		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Royal Liverpool and Broadgreen Hospital	Activity	4	0	0	1	1	5	3	6	5	7	5	10
	Finance	*£4,000*	*£0*	*£0*	*£1,000*	*£1,000*	*£5,000*	*£3,000*	*£6,000*	*£5,000*	*£7,000*	*£5,000*	*£10,000*
Alder Hey Childrens Hospital	Activity	0	0	0	0	0	0	0	0	0	0	0	0
	Finance	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*
Aintree University Hospital	Activity	91	19	11	22	4	4	26	48	23	29	9	7
	Finance	*£91,000*	*£19,000*	*£11,000*	*£22,000*	*£4,000*	*£4,000*	*£26,000*	*£48,000*	*£23,000*	*£29,000*	*£9,000*	*£7,000*
Southport and Ormskirk Hospital	Activity	101	13	28	8	24	18	20	20	16	9	10	18
	Finance	*£101,000*	*£13,000*	*£28,000*	*£8,000*	*£24,000*	*£18,000*	*£20,000*	*£20,000*	*£16,000*	*£9,000*	*£10,000*	*£18,000*
St Helens and Knowsley Hospital	Activity	2	8	2	2	0	7	3	16	12	34	18	18
	Finance	*£2,000*	*£8,000*	*£2,000*	*£2,000*	*£0*	*£7,000*	*£3,000*	*£16,000*	*£12,000*	*£34,000*	*£18,000*	*£18,000*
Warrington and Halton Hospital	Activity	0	0	0	5	1	3	2	6	1	4	1	3
	Finance	*£0*	*£0*	*£0*	*£5,000*	*£1,000*	*£3,000*	*£2,000*	*£6,000*	*£1,000*	*£4,000*	*£1,000*	*£3,000*

Compliance with Recording Patient Handover between Ambulance and A&E

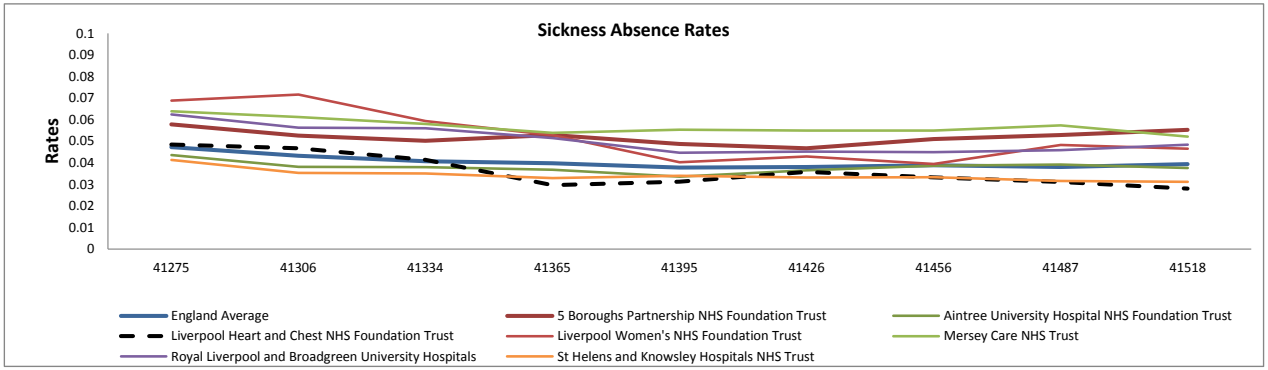
Provider	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Royal Liverpool and Broadgreen Hospital	73.90%	79.20%	82.56%	82.20%	78.90%	73.54%	69.66%	70.46%	70.70%	68.14%	71.50%	81.60%
Alder Hey Childrens Hospital	67.50%	71.60%	79.63%	72.80%	79.20%	77.60%	83.91%	85.42%	81.50%	83.82%	81.40%	85.70%
Aintree University Hospital	77.50%	73.80%	83.10%	77.00%	75.10%	71.80%	74.54%	84.44%	85.60%	83.06%	81.40%	84.50%
Southport and Ormskirk Hospital	51.30%	61.10%	66.70%	74.50%	75.20%	74.00%	76.60%	86.43%	90.20%	91.83%	92.00%	90.40%
St Helens and Knowsley Hospital	56.00%	73.60%	77.00%	75.10%	75.00%	72.20%	74.40%	73.96%	70.90%	71.14%	81.50%	86.50%
Warrington and Halton Hospital	74.80%	77.00%	78.70%	69.80%	62.00%	62.00%	69.60%	70.74%	73.40%	74.62%	79.80%	85.80%

Measure: Sickness Absence Rates
Threshold: National Average
Latest data: Q2 13/14

Green = Rates lower than england average and improvement compared to previous year
Amber = Latest performance lower than england average but is an increase compared to previous year
Red = Latest performance lower than england average and an increase compared to previous year

Monthly Performance

Trust	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13
England Average	**4.72%**	**4.33%**	**4.08%**	**3.98%**	**3.79%**	**3.80%**	**3.88%**	**3.81%**	**3.94%**	**4.18%**
5 Boroughs Partnership NHS Foundation Trust	5.78%	5.25%	5.02%	5.29%	4.87%	4.67%	5.10%	5.29%	5.53%	5.76%
Aintree University Hospital NHS Foundation Trust	4.36%	3.81%	3.80%	3.67%	3.36%	3.65%	3.87%	3.91%	3.76%	4.05%
Alder Hey Children's NHS Foundation Trust	7.19%	5.23%	5.06%	4.74%	4.56%	4.60%	4.68%	4.50%	4.90%	4.47%
Bridgewater Community Healthcare NHS Trust	5.78%	5.33%	4.63%	4.74%	4.81%	4.73%	4.98%	4.83%	5.12%	4.95%
Liverpool Community Health NHS Trust	7.04%	6.20%	5.65%	5.82%	5.82%	5.90%	5.24%	4.97%	4.95%	5.49%
Liverpool Heart and Chest NHS Foundation Trust	4.85%	4.67%	4.14%	2.97%	3.12%	3.58%	3.32%	3.11%	2.81%	3.63%
Liverpool Women's NHS Foundation Trust	6.89%	7.17%	5.94%	5.28%	4.03%	4.29%	3.94%	4.83%	4.66%	4.54%
Mersey Care NHS Trust	6.38%	6.12%	5.80%	5.39%	5.54%	5.50%	5.49%	5.74%	5.21%	5.20%
Royal Liverpool and Broadgreen University Hospitals	6.24%	5.62%	5.61%	5.15%	4.46%	4.53%	4.49%	4.59%	4.84%	4.91%
Southport and Ormskirk Hospital NHS Trust	4.99%	4.94%	4.60%	4.66%	3.96%	3.99%	3.91%	3.68%	3.58%	4.05%
St Helens and Knowsley Hospitals NHS Trust	4.13%	3.53%	3.50%	3.30%	3.39%	3.31%	3.34%	3.16%	3.11%	3.61%
Walton Centre NHS Foundation Trust	4.04%	3.24%	3.71%	3.33%	3.88%	3.64%	4.10%	4.04%	4.56%	4.46%
Warrington and Halton Hospitals NHS Foundation	4.58%	4.40%	4.22%	4.35%	4.10%	3.91%	3.76%	3.85%	3.88%	4.04%

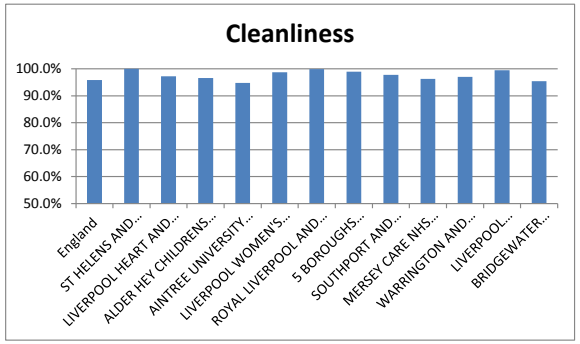


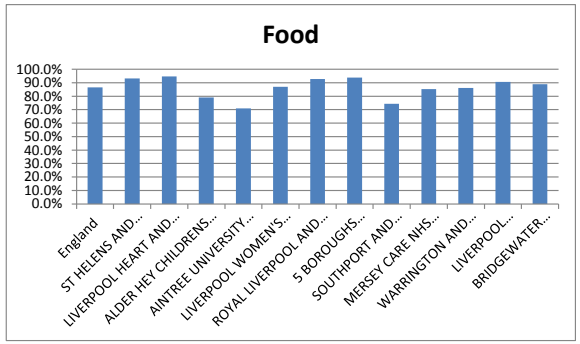
Quarterly Performance

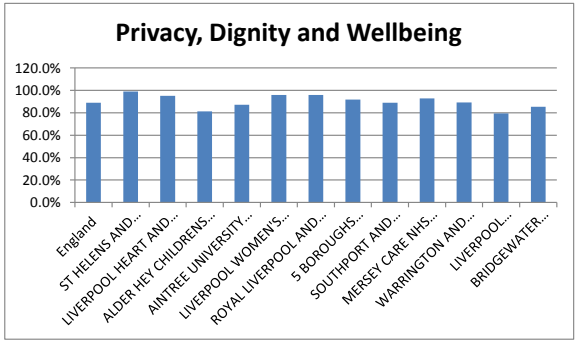
	Q1 12/13	Q2 12/13	Q3 12/14	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14
Engalnd Average	4.02%	4.06%	4.50%	4.38%	3.85%	3.83%	4.12%
5 Boroughs Partnership NHS Foundation Trust	4.52%	5.27%	5.13%	5.35%	4.94%	5.02%	5.69%
Aintree University Hospital NHS Foundation Trust	4.32%	4.18%	4.30%	3.99%	3.56%	3.81%	4.06%
Alder Hey Children's NHS Foundation Trust	4.68%	4.63%	6.56%	5.83%	4.63%	4.59%	4.75%
Bridgewater Community Healthcare NHS Trust	5.01%	4.73%	5.64%	5.25%	4.76%	4.84%	5.05%
Liverpool Community Health NHS Trust	5.37%	5.52%	6.31%	6.30%	5.85%	5.37%	5.53%
Liverpool Heart and Chest NHS Foundation Trust	3.51%	4.09%	4.94%	4.55%	3.22%	3.34%	3.41%
Liverpool Women's NHS Foundation Trust	4.03%	4.16%	6.10%	6.66%	4.53%	4.35%	4.52%
Mersey Care NHS Trust	5.65%	5.72%	6.01%	6.10%	5.48%	5.58%	5.40%
Royal Liverpool and Broadgreen University Hospitals	4.88%	5.09%	6.24%	5.82%	4.71%	4.53%	4.99%
Southport and Ormskirk Hospital NHS Trust	4.49%	4.27%	4.73%	4.84%	4.20%	3.86%	3.84%
St Helens and Knowsley Hospitals NHS Trust	3.27%	3.34%	3.81%	3.72%	3.33%	3.27%	3.50%
Walton Centre NHS Foundation Trust	4.10%	3.81%	4.50%	3.66%	3.61%	3.93%	4.29%
Warrington and Halton Hospitals NHS Foundation	4.09%	4.11%	3.94%	4.40%	4.12%	3.84%	3.97%

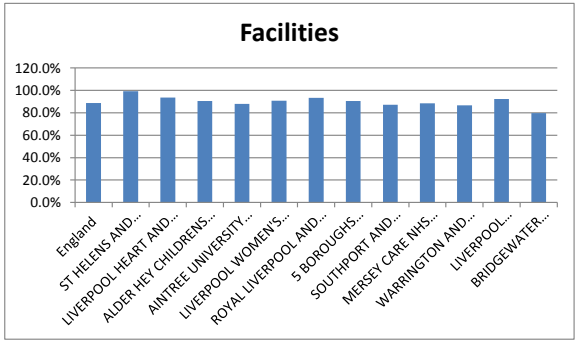
Measure: Patinet Lead Assessments of the Care Enviroment
Latest data available: 2013
Threshold: Compared to national average

Org Code	Organisation Name	Cleanliness	Food	Privacy, Dignity and Wellbeing	Facilities
	England	**95.9%**	**86.5%**	**89.1%**	**88.6%**
RBN	ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	100.0%	93.2%	99.1%	99.4%
RBQ	LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	97.3%	94.7%	95.1%	93.5%
RBS	ALDER HEY CHILDRENS NHS FOUNDATION TRUST	96.5%	79.0%	81.3%	90.5%
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	94.7%	70.9%	87.3%	87.8%
REP	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	98.7%	87.0%	96.0%	90.7%
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	99.9%	92.8%	95.8%	93.2%
RTV	5 BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST	98.9%	93.9%	91.9%	90.4%
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	97.7%	74.3%	89.0%	87.2%
RW4	MERSEY CARE NHS TRUST	96.3%	85.2%	92.8%	88.5%
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	97.1%	86.0%	89.2%	86.6%
RY1	LIVERPOOL COMMUNITY HEALTH NHS TRUST	99.5%	90.7%	79.3%	92.4%
RY2	BRIDGEWATER COMMUNITY HEALTHCARE NHS TRUST	95.4%	89.0%	85.3%	79.7%









Indicator **National Health Service Litigation Authority**
Datasource: **http://www.nhsla.com/Publications/**
Threshold: **Level indicated that organisation was successfully assessed at, at the time of their most recent assessment.**
Monitored against **Governance, Competent worksforce,Safe Enviroment, Clinical Care and learning from experience**

All the NHSLA Standards are divided into three "levels": one, two and three. NHS organisations which achieve success at level one in the relevant standards receive a 10% discount on their CNST and RPST contributions, with discounts of 20% and 30% available to those passing the higher levels. The CNST Maternity Standards are also divided into three levels and organisations successful at assessment receive a discount of 10%, 20% or 30% from the maternity portion of their CNST contribution.

Organisations at level 1 are assessed against the relevant standard(s) once every two years and those at levels 2 and 3 at least once in any three year period, although organisations may request an earlier assessment if they wish to move up a level. Organisations that drop to Level 0 or fail to attain Level 1 will be placed under improvement measures and must undertake a Level 1 assessment within six months of the date of their unsuccessful assessment. Organisations which fail an assessment and fall to Level 1 or 2 are required to be assessed at the level assigned in the following financial year.

	Aintree University Hospital	Alder Hey Childrens Hospital	Liverpool Heart & Chest Hospital	Liverpool Womens Hospital	Royal Liverpool & Broadgreen Hospital	Southport & Ormskirk Hospital	St Helens & Knowsley Hospital	The Walton Centre	Mersey Care NHS Trust	5Boroughs	Bridgewater	Liverpool Community	Warrington & Halton Hospital
Date of Assessment	Jun-09	Feb-10	Jun-10	May-11	Oct-11	Feb-10	Dec-08	Oct-10	Jan-11	Dec-11	New Organisation	Feb-11	Nov-11
Score	46/50	40/50	43/50	42/50	42/50	40/50	46/50	49/50	48/50	50/50		47/50	50/50
Level Achieved	3	3	3	3	2	2	2	1	1	1		1	1

Reports checked on 25/10/2012

Date of Assessment	Jun-12						Mar-12				Jun-12		
Score	44/50						47/50				46/50		
Level Achieved	3						2				1		

Friends and Family
Response Rates

Providers will need to achieve a baseline response rate of at least 15% and by Q4 a response rate that is both (a) higher than the response rate for Q1 and (b) 20% or over. A single response rate for each provider will be calculated by combining the response rates from the A&E and acute inpatient areas.

Combined	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average	10.9%	13.2%	15.9%	16.1%	17.1%	18.6%	19.6%	20.90%	19.90%	22.2%	24.0%	24.0%		13.3%	17.3%	20.1%	23.4%
Countess Of Chester Hospital NHS Foundation Trust	6.7%	8.1%	23.8%	23.2%	28.1%	39.3%	20.3%	23.8%	23.3%	20.8%	21.4%	22.3%		12.9%	30.2%	22.5%	21.5%
East Cheshire NHS Trust	11.2%	23.5%	24.4%	21.7%	22.9%	32.4%	26.0%	26.4%	25.6%	26.7%	24.9%	22.6%		19.7%	25.7%	26.0%	24.7%
Mid Cheshire Hospitals NHS Foundation Trust	17.4%	21.2%	21.4%	20.3%	18.3%	15.4%	22.3%	21.3%	19.8%	26.4%	25.7%	24.7%		20.0%	18.0%	21.1%	25.6%
The Clatterbridge Cancer Centre NHS Foundation Trust	43.8%	36.3%	39.5%	54.0%	49.1%	51.0%	54.0%	56.1%	38.8%	49.4%	31.8%	53.8%		39.8%	51.4%	49.6%	45.0%
Warrington And Halton Hospitals NHS Foundation Trust	9.4%	8.4%	12.6%	13.5%	7.7%	27.4%	31.9%	24.9%	22.9%	22.8%	26.3%	21.9%		10.1%	16.2%	26.6%	23.7%
Wirral University Teaching Hospital NHS Foundation Trust	5.8%	8.1%	16.5%	14.8%	18.8%	21.7%	21.9%	23.5%	25.4%	24.4%	24.4%	25.2%		10.1%	18.4%	23.6%	24.7%
Aintree University Hospital NHS Foundation Trust	14.9%	17.3%	25.3%	24.6%	22.7%	26.4%	25.7%	16.3%	27.3%	29.7%	31.2%	32.3%		19.2%	24.5%	23.1%	31.1%
Liverpool Heart And Chest NHS Foundation Trust	42.4%	30.8%	31.3%	20.9%	35.4%	25.2%	30.0%	34.6%	22.9%	32.0%	35.0%	34.2%		34.8%	27.2%	29.2%	33.7%
Liverpool Women's NHS Foundation Trust	3.2%	1.3%	25.5%	21.9%	18.1%	18.3%	9.2%	11.2%	22.6%	34.2%	37.2%	31.2%		10.0%	19.4%	14.3%	34.2%
Royal Liverpool And Broadgreen University Hospitals NHS Trust	6.9%	5.9%	6.1%	8.3%	15.2%	14.2%	17.7%	14.8%	12.0%	15.1%	15.4%	9.8%		6.3%	12.6%	14.8%	13.4%
Southport And Ormskirk Hospital NHS Trust	16.5%	16.8%	17.8%	20.5%	20.5%	21.1%	22.9%	15.1%	17.5%	18.4%	18.2%	19.1%		17.0%	20.7%	18.5%	18.6%
St Helens And Knowsley Hospitals NHS Trust	9.3%	11.4%	17.2%	15.1%	19.4%	19.5%	19.4%	26.7%	13.9%	18.0%	20.8%	18.1%		12.6%	18.0%	20.0%	19.0%
The Walton Centre NHS Foundation Trust	21.6%	23.7%	17.8%	15.6%	23.5%	17.9%	17.3%	34.2%	20.2%	23.0%	29.3%	29.2%		21.1%	19.0%	23.9%	27.2%

Inpatient	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average	21.7%	24.4%	27.1%	27.8%	28.9%	29.4%	30.4%	31.5%	28.8%	31.0%	34.2%	34.8%		24.4%	28.7%	30.2%	33.3%
Countess Of Chester Hospital NHS Foundation Trust	24.0%	27.6%	44.4%	38.2%	44.9%	41.0%	36.0%	33.8%	47.1%	38.9%	34.6%	31.8%		32.0%	41.4%	39.0%	35.1%
East Cheshire NHS Trust	17.4%	20.4%	19.3%	22.0%	18.8%	48.4%	39.2%	30.8%	34.1%	33.4%	33.3%	26.1%		19.0%	29.7%	34.7%	30.9%
Mid Cheshire Hospitals NHS Foundation Trust	35.3%	31.1%	32.9%	32.8%	30.2%	25.5%	33.7%	42.4%	32.7%	39.3%	45.9%	42.3%		33.1%	29.5%	36.3%	42.5%
The Clatterbridge Cancer Centre NHS Foundation Trust	43.8%	36.3%	39.5%	54.0%	49.1%	51.0%	54.0%	56.1%	38.8%	49.4%	31.8%	53.8%		39.8%	51.4%	49.6%	45.0%
Warrington And Halton Hospitals NHS Foundation Trust	20.6%	18.6%	24.3%	25.0%	13.2%	31.6%	35.8%	29.5%	27.9%	29.5%	43.8%	27.5%		21.2%	23.3%	31.0%	33.6%
Wirral University Teaching Hospital NHS Foundation Trust	7.7%	11.9%	18.3%	17.1%	20.6%	24.7%	21.5%	21.4%	31.3%	21.3%	23.3%	30.1%		12.6%	20.8%	24.7%	24.9%
Aintree University Hospital NHS Foundation Trust	23.4%	31.4%	32.2%	30.5%	29.7%	32.6%	33.4%	31.2%	30.2%	39.0%	43.0%	42.7%		29.0%	30.9%	31.6%	41.6%
Liverpool Heart And Chest NHS Foundation Trust	42.4%	30.8%	31.3%	20.9%	35.4%	25.2%	30.0%	34.6%	22.9%	32.0%	35.0%	34.2%		34.8%	27.2%	29.2%	33.7%
Liverpool Women's NHS Foundation Trust	5.8%	0.8%	37.5%	26.1%	17.9%	19.1%	20.0%	20.8%	11.6%	27.4%	25.3%	24.3%		14.7%	21.1%	17.5%	25.7%
Royal Liverpool And Broadgreen University Hospitals NHS Trust	16.3%	19.2%	15.5%	20.9%	31.5%	25.9%	35.1%	24.9%	18.4%	26.0%	28.5%	21.2%		17.0%	26.1%	26.1%	25.2%
Southport And Ormskirk Hospital NHS Trust	23.2%	24.5%	27.0%	32.1%	34.3%	40.1%	45.3%	26.1%	21.4%	23.7%	31.0%	38.0%		24.9%	35.5%	30.9%	30.9%
St Helens And Knowsley Hospitals NHS Trust	19.9%	21.7%	29.4%	30.8%	33.8%	31.1%	34.0%	35.8%	23.9%	30.6%	36.7%	28.0%		23.7%	31.9%	31.3%	31.8%
The Walton Centre NHS Foundation Trust	21.6%	23.7%	17.8%	15.6%	23.5%	17.9%	17.3%	34.2%	20.2%	23.0%	29.3%	29.2%		21.1%	19.0%	23.9%	27.2%

A&E	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average	5.6%	7.5%	10.3%	10.4%	11.3%	13.2%	13.8%	15.2%	15.3%	17.4%	18.6%	18.5%		7.8%	11.6%	14.8%	18.2%
Countess Of Chester Hospital NHS Foundation Trust	0.8%	2.2%	17.1%	17.5%	21.9%	39%	14.9%	19.5%	13.4%	12.6%	15.9%	18.3%		6.7%	26.1%	16.0%	15.6%
East Cheshire NHS Trust	8.0%	25.0%	28.5%	21.6%	24.9%	25%	20.4%	24.1%	21.3%	23.0%	20.7%	21.1%		20.5%	23.7%	21.9%	21.6%
Mid Cheshire Hospitals NHS Foundation Trust	11.4%	17.4%	17.4%	16.2%	14.7%	12%	17.7%	14.2%	15.4%	21.4%	18.4%	18.1%		15.4%	14.3%	15.8%	19.3%
Warrington And Halton Hospitals NHS Foundation Trust	2.9%	1.9%	5.5%	6.4%	4.4%	25%	29.6%	21.8%	19.9%	18.7%	15.1%	18.5%		3.4%	11.9%	23.7%	17.4%
Wirral University Teaching Hospital NHS Foundation Trust	4.6%	5.9%	15.4%	13.5%	17.8%	20%	22.1%	25.1%	21.2%	27.0%	25.3%	21.6%		8.6%	17.1%	22.8%	24.6%
Aintree University Hospital NHS Foundation Trust	9.9%	9.9%	21.6%	21.3%	18.6%	23%	21.2%	8.5%	25.5%	24.2%	23.9%	26.4%		13.8%	20.9%	18.4%	24.8%
Liverpool Women's NHS Foundation Trust	2.4%	1.4%	21.8%	20.5%	18.2%	18%	6.0%	7.0%	27.8%	36.3%	42.3%	34.2%		8.5%	18.9%	13.6%	37.6%
Royal Liverpool And Broadgreen University Hospitals NHS Trust	3.4%	1.0%	2.5%	3.2%	9.4%	10%	12.0%	11.4%	9.5%	11.3%	10.7%	6.0%		2.3%	7.7%	11.0%	9.3%
Southport And Ormskirk Hospital NHS Trust	12.5%	12.1%	12.5%	14.2%	13.5%	11%	8.9%	8.8%	15.1%	15.0%	10.5%	8.8%		12.4%	12.8%	10.9%	11.4%
St Helens And Knowsley Hospitals NHS Trust	3.0%	5.3%	10.1%	6.5%	11.5%	13%	11.0%	21.2%	8.0%	10.8%	11.6%	12.5%		6.1%	10.5%	13.4%	11.6%

Friends and Family

Test Score

Increasing the score of the Friends and Family Test question within the 2013/14 staff survey compared with 2012/13 survey results or remaining in the top quartile of trusts.

Combined		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average	2012	63	65	64	64	65	63	64	65	64	65	64	63		64	64	64	64
Countess Of Chester Hospital NHS Foundation Trust	71	83	74	78	64	73	61	67	68	69	66	64	71		78	66	68	67
East Cheshire NHS Trust	60	67	64	65	59	56	65	61	66	65	66	64	58		65	60	64	63
Mid Cheshire Hospitals NHS Foundation Trust	61	63	69	68	67	61	61	67	67	65	67	67	68		67	63	66	67
The Clatterbridge Cancer Centre NHS Foundation Trust	93	93	95	84	90	86	91	89	84	86	97	89	93		91	89	86	93
Warrington And Halton Hospitals NHS Foundation Trust	58	76	73	73	70	58	60	63	58	53	60	69	62		74	63	58	64
Wirral University Teaching Hospital NHS Foundation Trust	58	45	31	44	33	40	34	55	49	58	75	81	78		40	36	54	78
Aintree University Hospital NHS Foundation Trust	67	69	66	57	55	60	59	59	66	57	64	60	58		64	58	61	61
Liverpool Heart And Chest NHS Foundation Trust	92	89	90	93	90	97	94	91	95	92	89	88	96		91	94	93	91
Liverpool Women's NHS Foundation Trust	62	85	14	59	69	65	85	79	84	81	79	80	88		53	73	81	82
Royal Liverpool And Broadgreen University Hospitals NHS Trust	66	60	59	48	51	49	41	44	49	51	54	50	54		56	47	48	53
Southport And Ormskirk Hospital NHS Trust	51	51	62	55	57	61	52	49	46	46	47	44	53		56	57	47	48
St Helens And Knowsley Hospitals NHS Trust	70	76	78	78	72	78	79	79	80	78	80	77	79		77	76	79	79
The Walton Centre NHS Foundation Trust	85	86	85	75	84	79	71	76	85	83	93	91	91		82	78	81	92

Inpatient		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average		71	72	72	71	72	72	72	73	72	73	73	73		72	72	72	73
Countess Of Chester Hospital NHS Foundation Trust		84	74	79	79	78	83	82	82	77	80	83	82		79	80	80	82
East Cheshire NHS Trust		68	76	77	80	87	77	77	78	77	73	79	82		74	81	77	76
Mid Cheshire Hospitals NHS Foundation Trust		69	75	75	76	71	68	77	74	75	68	76	73		73	72	75	72
The Clatterbridge Cancer Centre NHS Foundation Trust		93	95	84	90	86	91	89	84	86	97	89	93		91	89	86	93
Warrington And Halton Hospitals NHS Foundation Trust		80	76	80	76	76	77	82	75	71	78	81	79		79	76	76	80
Wirral University Teaching Hospital NHS Foundation Trust		77	66	57	52	66	59	68	71	67	67	69	65		67	59	69	68
Aintree University Hospital NHS Foundation Trust		82	76	80	75	76	78	80	76	76	83	81	80		79	76	77	82
Liverpool Heart And Chest NHS Foundation Trust		89	90	93	90	97	94	91	95	92	89	88	96		91	94	93	89
Liverpool Women's NHS Foundation Trust		93	100	61	66	90	77	81	88	90	82	78	89		85	78	86	80
Royal Liverpool And Broadgreen University Hospitals NHS Trust		57	63	52	51	54	51	52	65	67	62	57	63		57	52	61	60
Southport And Ormskirk Hospital NHS Trust		55	66	59	65	63	50	47	42	37	49	46	58		60	59	42	48
St Helens And Knowsley Hospitals NHS Trust		79	82	77	71	74	80	79	80	79	81	77	78		79	75	79	79
The Walton Centre NHS Foundation Trust		86	85	75	84	79	71	76	85	83	93	91	91		82	78	81	92

A&E		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Trend	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
England Average		49	55	54	54	56	52	55	56	56	57	55	54		53	54	56	55
Countess Of Chester Hospital NHS Foundation Trust		72	72	77	53	69	53	55	57	57	49	48	64		74	58	56	54
East Cheshire NHS Trust		66	59	59	49	45	54	49	58	56	60	53	46		61	49	54	53
Mid Cheshire Hospitals NHS Foundation Trust		57	65	64	60	55	56	58	59	58	66	59	63		62	57	58	63
Warrington And Halton Hospitals NHS Foundation Trust		63	52	54	56	20	46	48	42	35	42	45	39		56	41	42	42
Wirral University Teaching Hospital NHS Foundation Trust		10	-15	34	20	23	16	46	34	49	79	90	90		10	20	43	86
Aintree University Hospital NHS Foundation Trust		51	49	38	39	45	44	41	46	44	45	36	38		46	43	44	40
Liverpool Women's NHS Foundation Trust		79	0	58	70	56	88	76	77	80	79	80	87		46	71	78	82
Royal Liverpool And Broadgreen University Hospitals NHS Trust		64	27	37	51	43	34	37	38	39	47	43	42		43	43	38	44
Southport And Ormskirk Hospital NHS Trust		46	57	50	46	58	55	52	52	52	46	41	40		51	53	52	42
St Helens And Knowsley Hospitals NHS Trust		64	68	79	73	83	78	79	80	77	78	77	79		70	78	79	78

Measure: CQC Intelligent Monitoring Report
Data Source: CQC
Threshold: 1 = Highest Risk, 6 = Lowest Risk

CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. CQC judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

	Royal Liverpool Hospital	Liverpool Heart and Chest	Southport and Ormskirk Hospital	Warrington and Halton Hospital	Liverpool Womens Hospital	Alder Hey Childrens Hospital	St Helens and Knowsley Hospital	Aintree University Hospital	The Walton Centre
Has the banding improved or declined since the previous report?	Recently inspected (Previously scored 6)	Declined to 4 from 6	No Change (4)	Improved to 5 from 3	Improved to 6 from 3	No change (1)	Improved to 5 from 3	Recently inspected (Previously scored 1)	No change (6)
Within the latest CQC report (March 2014) Has the provider been identified as having any **Elevated Risks?**	2 areas	1 area	3 areas	1 area	1 area	3 areas	1 area	4 areas	0 areas
Within the latest CQC report (March [illegible] provider been identified as [illegible]**ks?**	5 areas	2 areas	1 area	4 areas	1 area	5 areas	3 areas	3 areas	1 area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Monitor Financial and Risk Rating

Financial Risk Rating
1 = Highest risk - high probability of significant breach of authorisation in short-term
2 = Risk of significant breach in medium-term, e.g. 12 to 18 months, in absence of remedial action
3 = Regulatory concerns in one or more components. Significant breach unlikely
4 = No regulatory concerns
5 =Lowest risk - no regulatory concerns
Governance Risk Rating
Red = Likely or actual significant breach of terms of authorisation
Amber - Red = Material concerns surrounding terms of authorisation
Amber - Green = Limited concerns surrounding terms of authorisation
Green = No material concerns

Finanical risk

	5 Borough	AUH	AHCH	LHCH	LWH	W&HAL	Walton
Q2 12/13	4	3	4	3	4	3	4
Q3 12/13	4	3	5	3	4	3	4
Q4 12/13	4	3	5	3	3	3	3
Q1 13/14	4	3	4	3	3	2	4
Q2 13/14	4	3	4	3	3	2	4

Governance Risk

	5 Borough	AUH	AHCH	LHCH	LWH	W&HAL	Walton
Q2 12/13							
Q3 12/13							
Q4 12/13							
Q1 13/14							
Q2 13/14							

Aintree Hospital	Monitor has taken action, under the new licence for providers, to ensure that the trust deals with the continuing issues it faces. See the 'Regulatory action' tab for more details
W&Halton Hospital	Monitor is requesting further information following a financial risk rating of 2, before deciding next steps.

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MAY 2014

Agenda Item: 14/70	**Author of the Paper:**
Report date: May 2014	James Bradley Head of Strategic Financial Planning James.bradley@southportandformbyccg.nhs.uk Tel 0151 247 7070

Title: Financial Performance Report – Month 12 - 2013/14

Summary/Key Issues:

This paper presents the Governing Body with an overview of the financial position for Southport and Formby Clinical Commissioning Group for the 2013/14 Financial Year.

Recommendation

The Governing Body is asked to receive the finance update.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives	
x	Improve the quality of commissioned services, whilst achieving financial balance.
x	Achieve a 2% reduction in non-elective admissions in 2014/2015.
x	Implementation of 2014/15 phase of Care Closer to Home.
x	Review and re-specification of community nursing services for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014-15 phase of Primary Care quality Strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

Process	Yes	No	N/A	Comments/Detail
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	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
	Helping people to recover from episodes of ill health or following injury
x	Ensuring that people have a positive experience of care
x	Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
May 2014

1. Executive Summary

1.1 This report outlines a summary of the changes to the financial allocation of the CCG, and describes the financial performance of the CCG at month 12, reflecting the full 2013/14 financial year. At the end of the 2013/14 financial year, the CCG was £3.684m (Month 11 £3.177m) over-spent prior to the application of reserves.

1.2 With the application of reserves, the CCG has delivered its target surplus of £1.750m for 2013/14. The report also looks ahead to 2014/15 and references a number of risks that have emerged in the last quarter of year.

2. Introduction and Background

This paper presents the Governing Body with an overview of the financial position for NHS Southport and Formby Clinical Commissioning Group as at Month 12 and for the 2013/14 financial year.

3. Resource Allocation

The final Resource Allocation for 2013/14 is £171.880m. There have been no changes to Allocations since the Month 11 report.

4. Our Position to Date

4.1 Month 12 Financial Position

Please refer to Table A below which shows a summary position for the CCG; a more detailed analysis can be found in Appendix 1.

Table A: Financial Performance: Summary report to 31 March 2014

	Annual & Year to date			
Budget Area	**Annual Budget**	**YTD Budget**	**YTD Actual**	**YTD Variance**
	£'000	**£'000**	**£'000**	**£'000**
NHS Commissioned Services	118,216	118,216	119,692	1,476
Corporate & Support Services	5,298	5,298	4,941	(358)

Budget Area	Annual & Year to date			
	Annual Budget	YTD Budget	YTD Actual	YTD Variance
	£'000	£'000	£'000	£'000
Independent Sector	3,190	3,190	3,521	331
Medicines Management (inc Prescribing)	22,364	22,364	21,948	(416)
Primary Care	1,896	1,896	2,548	652
Commissioning - Non NHS	15,481	15,481	17,480	1,999
SUBTOTAL PRIOR TO RESERVES	166,445	166,445	170,129	3,684
Total Reserves	3,684	3,684	0	(3,684)
GRAND TOTAL EXPENDITURE	170,130	170,130	170,129	(0)
RRL Allocation	(171,880)	(171,880)	(171,880)	0
(SURPLUS)/DEFICIT	(1,750)	(1,750)	(1,750)	(0)

Please note, figures that appear in brackets represent income allocations and underspends.

Overview

The year to date financial position before the application of reserves is an overspend of £3.684m (Month 11 £3.177m), an increase of £0.507m. However this is £0.358m less than the Outturn position before Reserves that was forecast at Month 11 of £4.042m, and therefore within the forecast position.

The key issues contributing to the position within operational budgets are described below. It should be noted that, with the application of reserves, the CCG delivered the required surplus for the financial year.

NHS Commissioned Services

Whilst the financial reporting period relates to the end of March, the CCG has based its reported position on information received from Acute Trusts covering activity to the end of February.

This budget is showing a 2013/14 position of £1.476m overspend (Month 11 £1.412m forecast overspend). The marginal increase of £0.064m has arisen due to the following factors:-

- Non-contract activity being £0.050m over budget. This is due to higher out-of-area activity occurring than originally anticipated.

Some of the over spend within NHS commissioning is offset by the underspends within Liverpool Community Health NHS Trust for a financial reduction of £0.043m for CQUIN

breaches and the underspend on North West Ambulance NHS Trust, £0.031m under budget.

The Year End position with Southport and Ormskirk Trust was based on month 11 activity which showed an over spend of £0.167m. However, this over spend is reduced to £0.084m when the 50% marginal rate is applied. The over spend relates to planned care activity in a number of specialties including Trauma and Orthopaedics, Ophthalmology and Urology. A deduction was also made for £0.129m for CQUIN and Alternative Quality Contract (AQC) breaches. The overall Year End position is therefore £0.045m under budget, whereas a breakeven position was reported in month 11.

Corporate and Support Services

The CCG has operated within its 2013/14 running cost target of £2.980m, included within this budget. The underspend for the year is £0.358m. This is in line with the forecast reported at Month 11.

The overall underspent position on this budget arises due to vacancies (many of which were filled part way through the year) and the reduction in Estates charges (as notified by NHS Property Services Ltd) compared to plan. These underspends are not expected to continue into 2014/15.

Primary Care

The Primary Care budget is showing an overspend position of £0.652m for the year which is in line with the Month 11 forecast for the year.

The underlying overspend relates to costs of drugs administered in GP practices (eg. flu vaccines).

This budget area includes £1.0 million for Programme Projects. In addition to the £0.050m per Locality, this budget now includes monies moved from Reserves to fund projects initiated at Locality level and approved from the Winter Pressure and Practice Development funds.

Medicines Management (including Prescribing)

The Medicines Management budget consists of High Cost Drugs, Oxygen and Prescribing. The overall position is £0.416m underspent in the year to date (Month 11 £0.237m overspent).

The forecast and actual charges are based on information supplied by the Prescription Pricing Authority (PPA). During 2013/14 this forecast has fluctuated from month to month, and due to the size of the budget, a small variation in the forecast can have a significant financial impact.

Independent Sector

The Independent Sector is overspent by £0.331m at the year end. This has increased slightly since month 11 (£0.286m forecast overspend). The over spend is due to increases in activity at both Spire and Renacres Hospital, primarily within Trauma & Orthopaedic surgery.

Commissioning Non-NHS

Commissioning from Non NHS organisations is overspent by £1.999m at Month 11. This is broadly in line with the forecast outturn at Month 11 of £1.872m. The increase in overspend is mainly due to the continuing review of the adequacy of the provision for Continuing Healthcare and Mental Health packages.

The overspend during 2013/14 relates mainly to individual packages of care associated with Continuing Healthcare and Mental Health budgets. Through the year this has been reported as a financial risk area due to incomplete package information available from the CSU, which manages the administration of the care packages for the CCG. The reported position has consistently indicated a significant increase in costs from the prior year. However, the explanation for this movement cannot be confirmed until the underlying package data is completely validated by CSU and robust activity information provided to the CCG.

4.2 Treasury and Legacy issues

As reported previously, the PCT and SHA Legacy balances have been managed centrally by NHS England.

Given this revised direction, the balances transferred to the CCG have been significantly reduced and now consist of a small amount of IT and medical equipment, reported under Non-Current Assets.

In accordance with the guidance received from NHS England the CCG's 2013/14 financial position assumes no costs in relation to brought forward legacy provisions (other than administrative costs associated with resolution of the cases).

5. Evaluation of Risks and Opportunities

The CCG has identified a number of risks in quarter 4, principally with increased costs associated with acute care. The costs at Southport and Ormskirk Trust and in the Independent Sector have increased. Our initial review has identified increased activity in a number of specialties where referrals have also grown. These include Ophthalmology, Urology and Clinical Haematology. The CCG is working with the Trust and the CSU to understand, quantify and manage these risks.

6. Recommendations

The Governing Body is asked to receive the finance update and note that the CCG has delivered the planned surplus of £1.750m for 2013/14.

Appendices

Appendix 1 – Finance position to Month 12

James Bradley
21 May 2014

Appendix 1

01V NHS Southport and Formby Clinical Commissioning Group Month 13 Financial Position					
Cost centre Number	**Cost Centre Description**	**Annual Budget**	**Budget To Date**	**Actual To Date**	**YTD Variance**
		£000	**£000**	**£000**	**£000**
COMMISSIONING - NON NHS					
603501	Mental Health Contracts	628	628	621	(8)
603506	Child and Adolescent Mental Health	979	979	950	(29)
603511	Dementia	93	93	93	0
603516	Improving Access to Psychological Therapies	0	0	0	0
603521	Learning Difficulties	1,777	1,777	1,832	55
603596	Collaborative Commissioning	409	409	409	0
603661	Out of Hours	532	532	533	1
603682	Continuing Care	4,461	4,461	6,648	2,187
603684	CHC Adult Joint Funded	0	0	0	0
603691	Funded Nursing Care	3,331	3,331	3,133	(198)
603711	Community Services	978	978	889	(89)
603721	Hospices	853	853	851	(2)
603726	Intermediate Care	460	460	542	82
603731	Long Term Conditions	0	0	0	0
603796	Reablement	979	979	979	(0)
Sub-Total		**15,481**	**15,481**	**17,480**	**1,999**
CORPORATE & SUPPORT SERVICES					
605251	Administration and Business Support (Running Cost)	81	81	107	26
605271	CEO/Board Office (Running Cost)	408	408	432	24
605276	Chairs and Non Execs (Running Cost)	89	89	138	50
605296	Commissioning (Running Cost)	1,380	1,380	1,313	(67)
605316	Corporate costs	25	25	23	(2)
605346	Estates & Facilities	54	54	12	(43)
605351	Finance (Running Cost)	885	885	547	(338)
605391	Medicines Management (Running Cost)	58	58	52	(5)
	Sub-Total Running Costs	**2,980**	**2,980**	**2,625**	**(355)**
603646	Commissioning Schemes (Programme Cost)	704	704	701	(3)
603656	Medicines Management (Programme Cost)	342	342	347	5
603776	Non Recurrent Programmes (NPfIT)	1,080	1,080	1,080	0
603676	Primary Care IT	192	192	187	(4)
605371	IM & T	0	0	(0)	(0)
	Sub-Total Programme Costs	**2,318**	**2,318**	**2,315**	**(3)**
Sub-Total		**5,298**	**5,298**	**4,941**	**(358)**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS					
603571	Acute Commissioning	77,492	77,492	78,620	1,128
603576	Acute Childrens Services	1,981	1,981	1,960	(21)
603586	Ambulance Services	4,596	4,596	4,574	(22)
603616	NCAs/OATs	1,007	1,007	1,351	345
603631	Winter Pressures	4,042	4,042	4,042	0
603756	Commissioning - Non Acute	29,089	29,089	29,134	45
603786	Patient Transport	8	8	10	2
Sub-Total		**118,216**	**118,216**	**119,692**	**1,476**
INDEPENDENT SECTOR					
603591	Independent Sector	3,190	3,190	3,521	331
Sub-Total		**3,190**	**3,190**	**3,521**	**331**
PRIMARY CARE					
603651	Local Enhanced Services and GP Framework	987	987	1,532	545
603791	Programme Projects	910	910	1,016	107
Sub-Total		**1,896**	**1,896**	**2,548**	**652**
PRESCRIBING					
603606	High Cost Drugs	1,440	1,440	1,422	(19)
603666	Oxygen	202	202	171	(31)
603671	Prescribing	20,722	20,722	20,355	(366)
Sub-Total		**22,364**	**22,364**	**21,948**	**(416)**
Sub- Total Operating Budgets pre Reserves		**166,445**	**166,445**	**170,129**	**3,684**
RESERVES					
603761	Commissioning Reserve (Previously General Reserve)	3,684	3,684	0	(3,684)
Sub-Total		**3,684**	**3,684**	**0**	**(3,684)**
Grand Total I & E		**170,129**	**170,129**	**170,129**	**(0)**
	RRL Allocation	(171,880)	(171,880)	(171,880)	0
	(SURPLUS)/DEFICIT	(1,750)	(1,750)	(1,750)	(0)

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/71	**Author of the Paper:** Martin McDowell Chief Finance Officer Martin.mcdowell@southseftonccg.nhs.uk Tel: 0151 247 7065
Report date: May 2014	

Title: Revised 2014/15 Financial Budgets

Summary/Key Issues:

This paper presents the Governing Body with the revised 2014/15 Financial Budgets for Southport & Formby CCG.

Recommendation

Receive	X
Approve	X
Ratify	

The Governing Body is asked to:-

- approve the revised financial budgets for the financial year 2014/15.
- note that unidentified QIPP will need to be identified and planned before investment reserves can be fully deployed.

The Governing Body is also asked to receive the following notes by way of assurance:

- that the revised budgets deliver the key metrics required by NHS England in terms of 1% surplus;
- that the CCG planned running cost expenditure is within its running cost target.

Links to Corporate Objectives *(x those that apply)*	
x	Improve the quality of commissioned services, whilst achieving financial balance.
x	Achieve a 2% reduction in non-elective admissions in 2014/2015.
x	Implementation of 2014/15 phase of Care Closer to Home.
x	Review and re-specification of community nursing services for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014-15 phase of Primary Care quality Strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health serviced to inform enhanced delivery.

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 the Governing Body
May 2014

1. Summary

1.1 The opening financial budgets for 2014/15 were approved at the Governing Body Meeting in March 2014. The March meeting noted that there remained uncertainties in some areas and that an update report would be presented to the Governing Body meeting in May 2014.

1.2 This paper provides details of the CCG's 2014/15 proposed revised financial budgets for consideration and approval.

1.3 The financial budgets have been prepared in conjunction with budget holders and reflect all available planning guidance and metrics requirements.

1.4 The financial budgets reflect national guidelines and local arrangements.

1.5 A summary of the proposed revised 2014/15 Financial Budget is presented below.

Table 1 - Summary 2014/15 Revised Financial Budgets

Budget Area	**£2014/15 £m**		
	Rec	**Non Rec**	**Total**
Available Resources	**(168.5)**	**(1.8)**	**(170.3)**
Operational budgets			
NHS Commissioned Services	108.3	4.4	112.7
Corporate & Support Services	4.9	0.1	5.0
Independent Sector	3.2	0.1	3.3
Medicines Management	22.4	0.1	22.5
Primary Care	1.5	0.3	1.8
Non NHS Commissioning	17.0	0.1	17.1
Sub total Operational budgets	**157.4**	**5.1**	**162.4**
Reserves			
Unidentified QIPP	(0.3)	0.0	(0.3)
2.5% Non Recurrent schemes	0.0	1.9	1.9
Investments	0.9	0.0	0.9
Other Committed Plans	2.0	0.0	2.0
Mandate Reserve	0.7	0.0	0.7
Contingency	0.9	0.0	0.9
Sub total Reserves	**4.2**	**1.9**	**6.1**
Total Anticipated Spend	**161.6**	**6.9**	**168.5**
Forecast (Surplus)/ Deficit	**(6.9)**	**5.2**	**(1.8)**
Expressed as %			**1%**

2. Changes from Opening Budgets

2.1 Overview

There has been an increase in operational budgets of £0.3m as a result of the review of Opening Budgets. This has been met by a corresponding reduction in Reserves.

Following these revisions, the CCG continues to deliver a planned surplus of 1% (£1.75m).

The detail by cost centre is included at Appendix 1.

The major movements are described under the relevant sections below.

2.2 Resource Allocations and Surplus

The Resource allocation has increased by £0.056m since the March report, to a total Allocation for 2014/15 of £170.278m.

2.3 Operational Budgets

NHS Commissioned Services
Overall the budget for NHS Commissioned Services has increased by £0.231m since the March report.

It was noted in the March report that the CCG had not reached agreements with all providers and that this area could change significantly. Overall the changes relating to revised contracts for Acute Commissioning, Acute Children's services, the Ambulance Service and Non Acute commissioning amount to a net reduction of £0.031m since the March opening budget figures. The revised figures reflect contracts signed off since March or the latest offers under negotiation.

Within Non Contract Activity (NCAs and OATs) there is an increase to Opening Budgets of £0.262m to reflect the higher than anticipated activity that was experienced in the final quarter of 2013/14.

Corporate & Support Services
The budget reflects the senior management restructure previously agreed by the Governing Body. This has not resulted in any overall significant change to the budget area and the CCG continues to plan to operate within the allowed Running Cost Allowance of £2.917m for 2014/15.

The budget for Programme costs within the Corporate Budget area has reduced by £0.488m. This is due to a revision of the NPFIT forecast cost which has been reduced by £0.515m, with the value of the reduction in budget cost transferred to a specific reserve.

Medicines Management
There has been an overall increase of £0.065m in the Prescribing budget. This includes an increase of £0.236m to reflect the latest information from the Prescription Pricing Authority, forecasting 2014/15 expenditure based on 2013/14 full year data.

In addition, £0.465m of the budget relating to Personally Administered Drugs has been transferred out of the Prescribing budget to Local Enhanced Services within the Primary Care cost centre budget, to reflect this being a service provided for the CCGs by GPs.

The Prescribing Budget has also been increased by £0.264m for the drugs cost of the Denosumab development which will see GPs prescribing this drug under a shared care protocol in 2014/15.

Primary Care
This budget has increased by £0.6m since the March report. £0.465m relates to the transfer of the Personally Administered Drugs budget transferred from Prescribing noted above. In addition £0.1m has been included to cover the GP costs of administering Denosumab under the shared protocol arrangement and a revision to reflect the current cost of the GP Framework arrangement.

Non NHS Commissioning
Overall there has been very little movement since the opening budgets presented in March. From Appendix 1 it can be seen that there are some major movements between cost centre headings – e.g. between "Child and Adolescent Mental Health" and "Child Health CHC Packages" and between CHC Adult Fully Funded and CHC Adult Joint Funded. These changes are to allow better coding and financial monitoring and do not constitute changes to underlying budget values.

The Learning Difficulty budget line has seen a reduction of £0.184m to reflect the actual value of the active packages at the close of 2013/14.

2.4 **Reserves**

There has been a reduction in the 2014/15 Reserves budget of £0.231m since the opening budgets were presented. This reflects the increase in operational budgets which has been managed by increasing the unidentified QIPP requirement held within reserves.

This £0.299m of unidentified QIPP held within reserves will need to be identified and planned before investment reserves can be fully deployed.

3 Key Financial Risks and Pressures

3.1 Outstanding contracts – the contract with Aintree University Hospitals NHS Foundation Trust is not yet finalised. Any further pressures that arise will be funded via commissioning reserves.

3.2 The CCG plans have been prepared using 2013/14 financial year out-turn position so any growth in demand will need to be funded using CCG contingency reserves.

3.3 The commissioning of individual packages of care within Mental Health and Continuing Health Care (CHC) was identified as a major risk area for the CCG through 2013/14. 2014/15 budgets have been set on the basis of 2013/14 outturn but because there are still some unresolved issues regarding the quality of the underlying data from CSU, there remains some risk around the accuracy of the budget.

3.4 Prescribing - It should be noted that aspects of prescribing remain volatile and this area could present risks to budgets in 2014/15. Continued support from community pharmacist teams and practices will be required to deliver a balanced position.

3.5 Continuing Healthcare (CHC) restitution payments – The CCG has included provision for CHC restitution payments of £0.634m in Reserves. The value of this reserve is based on the most recent guidance from NHS England which indicates that, in 2014/15, CCGs will be charged an amount equal to a notified CHC restitution claim allocation as part of a national pooling arrangement. The CCGs allocation is £0.634m. There is significant concern amongst CCGs regarding the approach being taken by NHS England in this matter and therefore there is a risk that the national pooling approach may change.

3.6 The NHS is likely to require funding to support transformation of its services, to include initiatives such as 7-day working. At this stage, the additional costs of these schemes are

unknown, and it is possible that CCG reserves may not be adequate to cover the costs involved.

4. Conclusions & Recommendations

4.1 The Governing Body is asked to:-

- approve the revised financial budgets for the financial year 2014/15
- note that unidentified QIPP will need to be identified and planned before investment reserves can be fully deployed.

4.2 The Governing Body is also asked to receive the following notes by way of assurance:

- that the revised financial budgets deliver the key metrics required by NHS England in terms of 1% surplus;
- that the CCG planned running cost expenditure is within its running cost target.

5. Appendices

Appendix 1 Analysis by Cost Centre – Revised 2014/15 Budget compared to Opening 2014/15 Budget

Martin McDowell

May 2014

Appendix 1

Southport & Formby CCG

Comparison of 2014/15 Opening Budget to Revised Budgets

Cost centre Number	Cost Centre Description	Opening Budget 2014/15	Revised Budget 2014/15	Increase (Decrease)
		£000		£000
603501	Mental Health Contracts	810	832	22
603506	Child and Adolescent Mental Health	527	163	(364)
603687	Child Health CHC Packages		358	358
603511	Dementia	93	93	0
603516	Improving Access to Psychological Therapies	0	0	0
603521	Learning Difficulties	1,394	1,381	(13)
603531	Mental Health Services – Adults	0	0	0
603541	Mental Health Services - Collaborative Commissioning	0	0	0
603596	Collaborative Commissioning	409	409	0
603661	Out of Hours	1,078	1,069	(9)
603682	Continuing Care	6,650	5,481	(1,170)
603683	CHC Adult Fully Funded		0	0
603684	CHC Adult Joint Funded		1,322	1,322
603685	CHC Adult Joint Funded - Personal Health		34	34
603691	Funded Nursing Care	3,442	3,258	(184)
603711	Community Services	369	408	39
603721	Hospices	927	871	(56)
603726	Intermediate Care	460	430	(30)
603796	Reablement	979	979	0
Sub-Total		**17,139**	**17,087**	**(52)**
CORPORATE & SUPPORT SERVICES				
605251	Administration and Business Support (Running Cost)	100	100	(1)
605271	CEO/Board Office (Running Cost)	409	379	(30)
605276	Chairs and Non Execs (Running Cost)	113	148	35
605296	Commissioning (Running Cost)	1,361	1,399	38
605316	Corporate costs	25	25	0
605346	Estates & Facilities	42	42	0
605351	Finance (Running Cost)	684	626	(58)
605391	Medicines Management (Running Cost)	51	43	(8)
605426	Quality	132	155	23
	Sub-Total Running Costs	**2,917**	**2,917**	**0**
603646	Commissioning Schemes (Programme Cost)	670	724	54
603656	Medicines Management (Programme Cost)	493	466	(27)
603776	Non Recurrent Programmes (NPfIT)	1,225	710	(515)
603676	Primary Care IT	192	192	0
	Sub-Total Programme Costs	**2,580**	**2,092**	**(488)**
Sub-Total		**5,497**	**5,009**	**(488)**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS				
603571	Acute Commissioning	75,919	77,209	1,290
603576	Acute Childrens Services	2,069	2,148	79
603586	Ambulance Services	4,580	4,527	(53)
603616	NCAs/OATs	992	1,254	262
603631	Winter Pressures	0	0	0
603756	Commissioning - Non Acute	28,905	27,558	(1,347)
603786	Patient Transport	8	8	0
Sub-Total		**112,472**	**112,703**	**231**
INDEPENDENT SECTOR				
603591	Independent Sector	3,329	3,311	(18)
Sub-Total		**3,329**	**3,311**	**(18)**
PRIMARY CARE				
603651	Local Enhanced Services and GP Framework	892	1,511	619
603791	Programme Projects	341	270	(71)
Sub-Total		**1,232**	**1,781**	**548**
PRESCRIBING				
603606	High Cost Drugs	1,484	1,513	29
603666	Oxygen	198	200	2
603671	Prescribing	20,775	20,809	34
Sub-Total		**22,457**	**22,522**	**65**
Sub- Total Operating Budgets pre Reserves		**162,126**	**162,413**	**287**
RESERVES				
603761	Commissioning Reserve (Previously General Reserve)	6,346	6,115	(231)
Sub-Total		**6,346**	**6,115**	**(231)**
Grand Total I & E		**168,472**	**168,528**	**56**
	RRL Allocation	170,222	170,278	56
	(SURPLUS)/DEFICIT	1,750	1,750	0

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/72a	**Author of the Paper:**
Report date: May 2014	Karl McCluskey Chief Officer: Strategic Planning & Outcomes Southport & Formby Clinical Commissioning Group Karl.mccluskey@southseftonccg.nhs.uk

Title: Five Year Strategic Plan

Summary/Key Issues:

This paper details the joint five year strategic plan for South Sefton CCG and Southport and Formby CCG. The footprint for the plan is coterminous with the Borough of Sefton and it is aligned with the Health and Wellbeing Strategy in conjunction with Sefton Metropolitan Borough Council. A clear and distinct strategic vision is outlined, underpinned by defined values. The three strategic schemes are outlined (virtual ward, care closer to home and primary care), together with the strategic programmes.

This strategy is aligned with the financial strategy for the CCG. This paper now enables the CCG to complete its required submission to NHS England on 20th June 2014.

Recommendation

Receive	x
Approve	
Ratify	

The Governing Body is asked to receive this report by way of assurance and:-

- endorse the five year strategic plan as set out in this document.
- recognise and support the augmentation of the strategic programmes with three additional programme areas having been identified through engagement and consultation.
- endorse the outlined governance and reporting arrangements.
- provide the delegated authority to submit the final five year strategic plan in the varying template formats required by NHSE, based on the plan and detail contained in this paper.
- support the final enhancement of this strategic plan, in integrating the financial and quality strategy.

Links to Corporate Objectives *(x those that apply)*	
X	Improve quality of commissioned services, whilst achieving financial balance
X	Achieve a 2% reduction in non-elective admissions in 2014/15
X	Implementation of 2014-15 phase of Care Closer to Home
X	Review and Re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public
X	Implementation of 2014-15 phase of Primary Care quality strategy / transformation
X	Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy
X	Review the population health needs for all mental health services to inform enhanced delivery

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 the Governing Body
May 2014

1. Introduction

1.1 This paper sets out and describes the five year strategic plan for the CCG. It reflects the progress and content previously considered by the Governing Body in January and March this year. The content of this plan enables the CCG to meet the requirements set down by NHS England as part of the national planning process and timetable and enables the CCG to complete its required national submission on 20th June 2014.

1.2 Following discussion and consideration at this Governing Body, it is envisaged that a public facing version of this plan will be constructed and completed by 20th June. This will represent a synopsis of this paper for Governing Body consideration and review, with the public version for final agreement and publication by the end of July 2014.

1.3 It should be noted that while the CCG will have developed its five year strategic plan in line with the dates set out above, an annual process of review will be undertaken to re-assess and evaluate the strategic plan priorities and progress, to ensure that the plan remains current and live, focused on delivery and adapts to the environment in which the CCG operates. This process is described in more detail in the governance section of this report.

1.4 This Strategy sets out the strategic direction and describes the high level priorities for the CCG over the next five years. The underlying values and principles that the CCG will adopt in delivering and commissioning the plan are also outlined.

1.5 A strategic vision for the CCG is also described, reflecting the aim and ambition that the CCG has for its role as commissioner, the health & wellbeing of the population and the involvement of its partners.

2. Current Position – Our Profile

2.1 The planning footprint for this five year strategic plan combines the geographical areas served by two Clinical Commissioning Groups:-

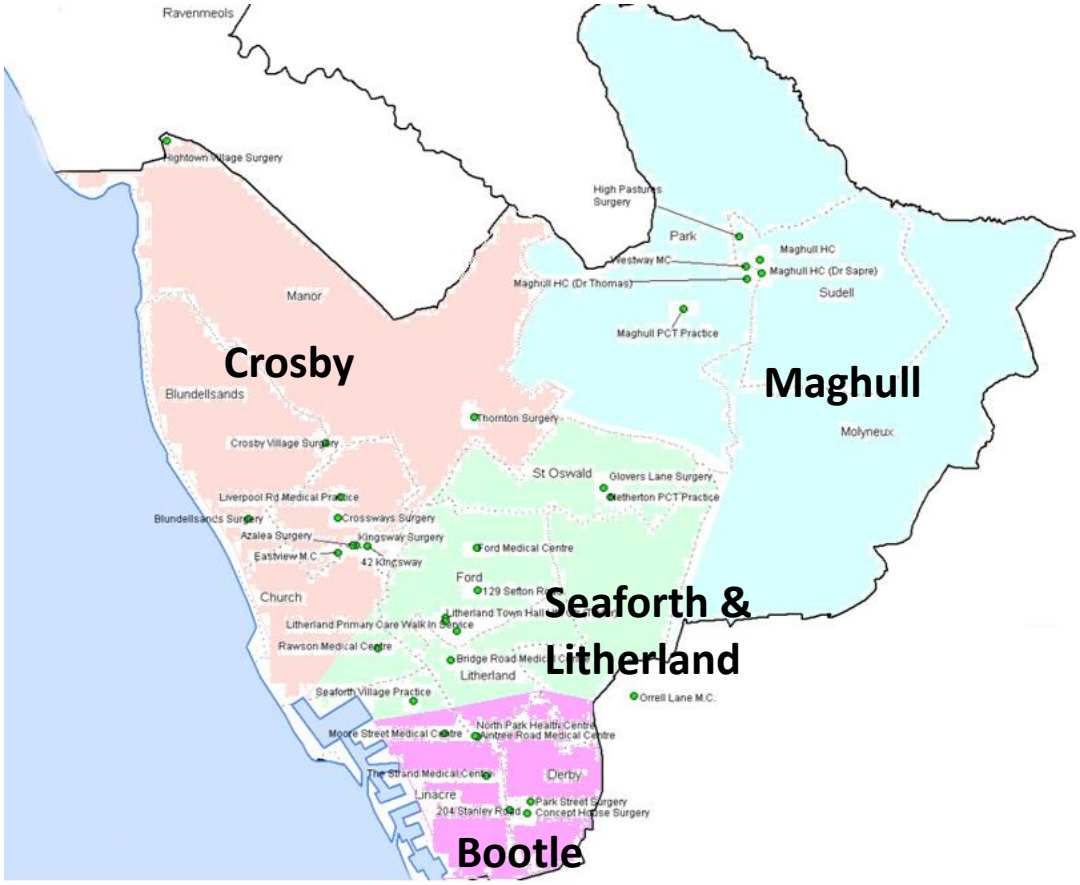
- NHS South Sefton CCG
- NHS Southport & Formby CCG.

2.2 This combined footprint is co-terminus with the geographical area served by Sefton Metropolitan Borough Council. The rationale for adopting this footprint is described in more detail in this paper, however the principle rationale relates to the fact that both CCGs and Sefton Council have developed and have in place a joint Health & Wellbeing Strategy covering all of the Sefton population. Thus the individual and combined CCG strategic plans need to be aligned with this.

2.3 NHS South Sefton Clinical Commissioning Group brings together 33 GP surgeries, serving a population of c155,000 with four distinct localities:-

- Crosby
- Bootle
- Seaforth & Litherland
- Maghull.

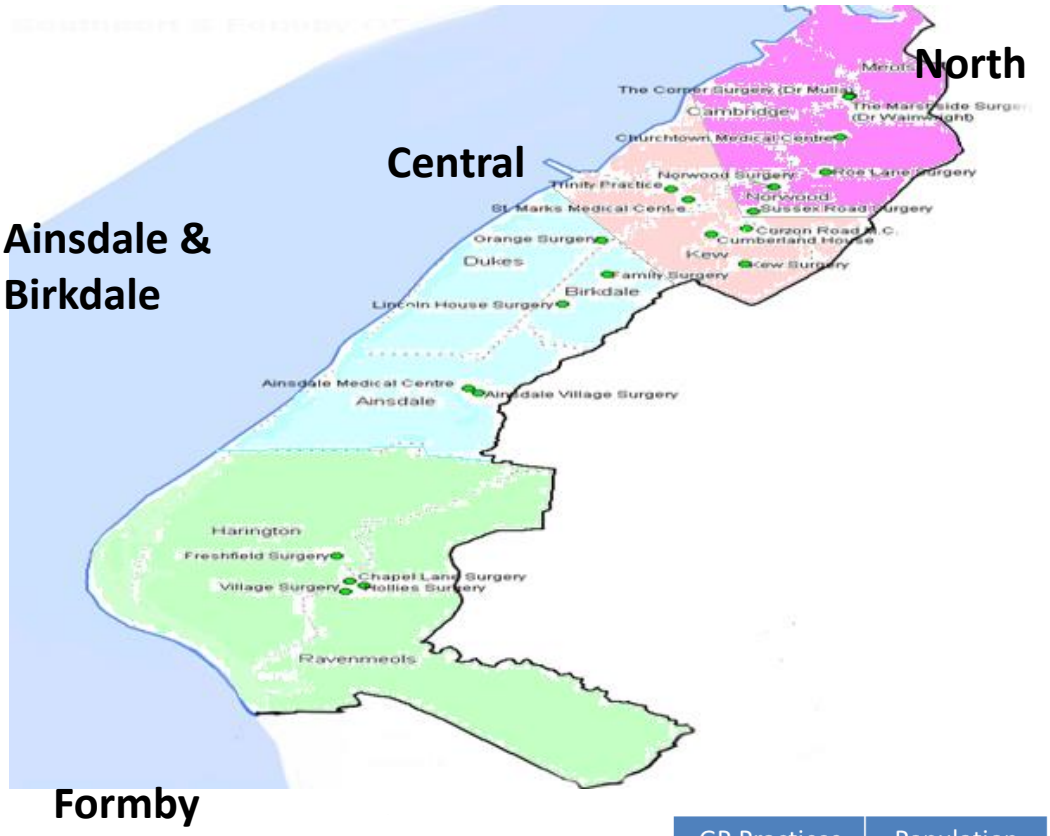
Diagram 1.0 South Sefton CCG



	GP Practices	Population
Bootle	7	39,250
Crosby	10	47,000
Maghull	6	28,500
Seaforth & Litherland	11	40,700
TOTAL	**34**	**155,540**

2.4 NHS Southport & Formby CCG brings together 20 GP surgeries, serving a population of c122,00 stretching from Ince Blundell in the South to Churchtown in the North.

Diagram 2.0 Southport & Formby CCG



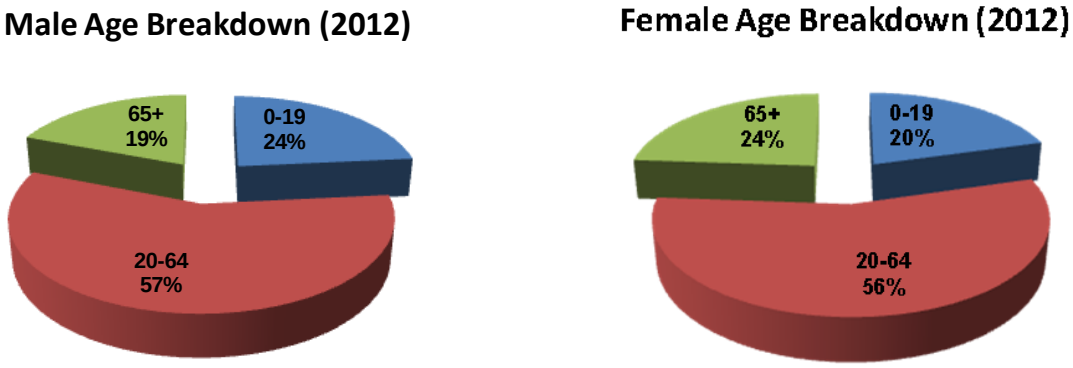
	GP Practices	Population
North	6	31K
Central	5	34K
Ainsdale & Birkdale	5	32K
Formby	4	25K
TOTAL	**20**	**122,000**

2.5 Latest 2012 population estimates show the total population of Sefton to be 273,697.

2.6 2012 mid-year population estimates show a 10 year population reduction of 2.6% since 2002. This goes against both the National and Regional trends which have both seen population increases during the same period. Since 2002 the population of England is estimated to have risen by almost 14% and the population of the North West of England by 4.4%.

2.7 There are 48% (131,144) of the population is male, with 52% (142,553) female. This is fairly similar to National picture where 51% are female and 49% male.

2.8 The age profile of males and females within Sefton shows that, while the 20-64 age group in both genders is similar, amongst females 1 in 4 are aged over 65, compare to 1 in 5 amongst males.

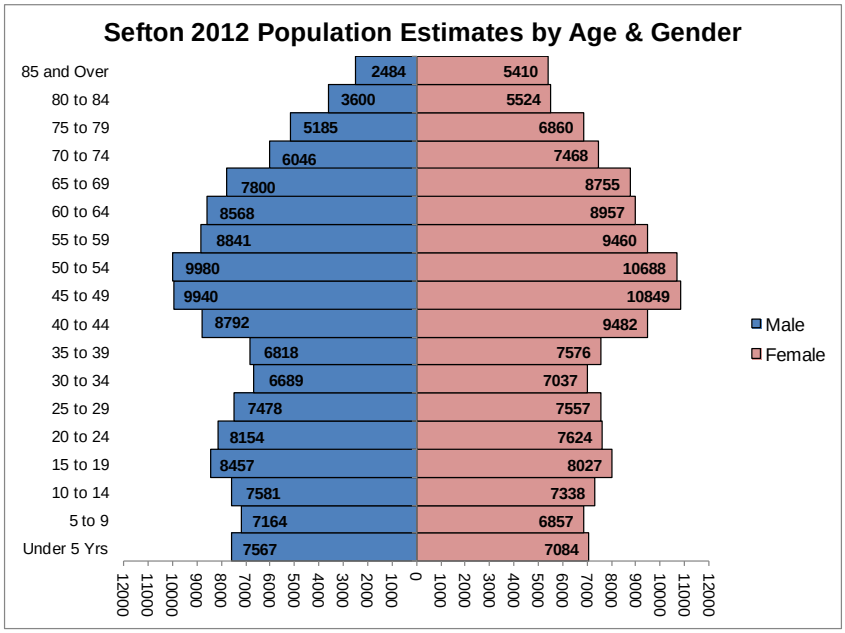


2.9 Across Sefton 58.7% (160,731) residents are working age (18-64), which is lower than both National and across the North West where the work age population account for 62.2% and 62.1% respectively

2.10 Overall the proportion of the population aged over 65 in Sefton is 22%, considerably higher that across England as a whole where over 65's account for 17% of the population.

2.11 The average age of a Sefton resident is 44.9 years, five years older than the average age across the UK, where it is 39.7 years

Diagram 3.0 Sefton Population estimates by Age and Gender



2.12 Although the Borough has become slightly more ethnically diverse between Census 2001 and Census 2011, the area is still predominantly white with more than 97% (266,741 of 273,790) residents from a white background.

Table 1.0 Ethnic Profile for Sefton

Ethincity	2001	2011	Change
White	98.40%	97.30%	-1.10%
Mixed	0.60%	1.10%	0.50%
Asian	0.50%	0.50%	0.00%
Black	0.20%	0.40%	0.20%
Chinese / Other	0.40%	0.70%	0.30%

2.13 259,629 of these are White / British making up 94.8% of the Sefton population.

2.14 In comparison, 90.2% of the North West population are White, and across England & Wales 85.9% are white.

2.15 The table below shows how the number of people from outside the UK entering the Borough has altered.

Table 2.0 Numbers from outside the UK entering Sefton

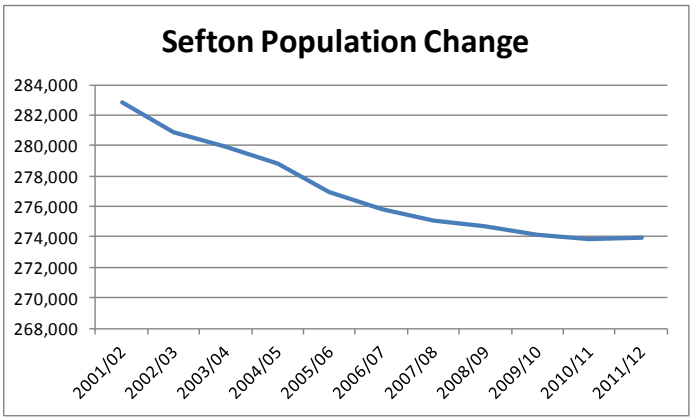
Year	Uk & Ireland	Other EU; Member Countries in March 2001	Other EU; Accession Countries April 2001 to March 2011	Other Countries
2001	274712	1496	368	3885
2011	262234	1815	2734	5273

2.16 In particular from countries that have become part of the EU since the last Census in 2001, where there has been an increase of more than 640%

2.17 Since 2001 the number of people born in the UK residing in Sefton has fallen by 4.5%.

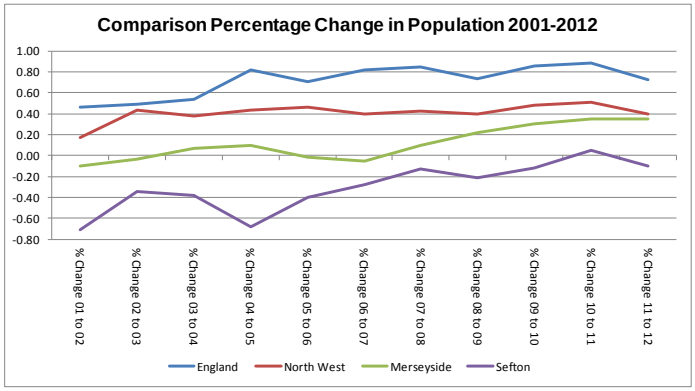
2.18 The above table shows how Sefton's population has been steadily falling. Since 2001 the population has fallen by 3.2%

Graph 1.0 Sefton Population Change from 2001-2012



2.19 The comparison chart shows the year on year percentage change in population since 2001 and compares this with changes at county, region and national level. It shows that of the areas compared Sefton is the only area to have been consistently falling since 2001, with just 2010/11 showing a slight year on year increase (0.05%).

Graph 2.0 Comparison Percentage Change in Population 2001-2012



2.20 For 2011/12 Sefton had the sixth highest reduction in population, and was one of only 25 Local Authorities across England & Wales that had a reduction in total population.

2.21 G.P. registrations since 2004 have increased by around 28%, suggesting that the number of overseas residents arriving in Sefton has been increasing and is going some way to mitigating the natural change reduction in the Borough and the number of people emigrating out. However, since 2009 the number of new registrations has been steadily falling away.

2.22 While the numbers of new immigrants registering with G.P.'s is increasing, the number of migrants requesting National Insurance numbers is falling, down by 18.6% since 2004.

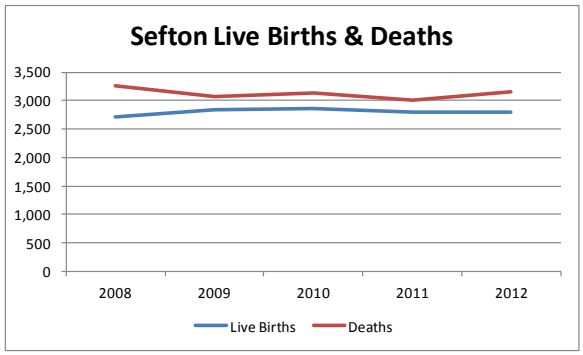
Table 3.0 Immigration Estimates for Sefton

Immigation Estimates									
	2004	2005	2006	2007	2008	2009	2010	2011	2012
New Migrant GP Registrations	636	867	829	885	919	1,082	1,051	860	814
Migrant NINo Registrations	821	1,672	1,016	1,217	830	822	886	756	668

2.23 This indicates either less work age people are migrating into the area or a proportion of those arriving are not registering to pay national insurance.

2.24 The chart below highlights that within Sefton the number of deaths have consistently been higher than the number of live births, and has been the main contributing factor in the reducing of Sefton's overall population.

Graph 3.0 Sefton Live Births & Deaths



2.25 Over the last two years the annual number of live births has fallen by 2.3% (2,862 in 2010 to 2,795 in 2012).

2.26 In contrast since 2010 the number of deaths in the Borough has risen by 0.9% (3,136 to 3,0163).

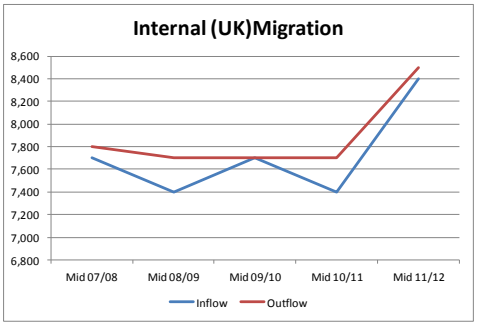
2.27 The accompanying table shows how Sefton has been, and remains out of step with the county, regional and national natural change in population, all of which have had year on year increases in population as a result of natural change.

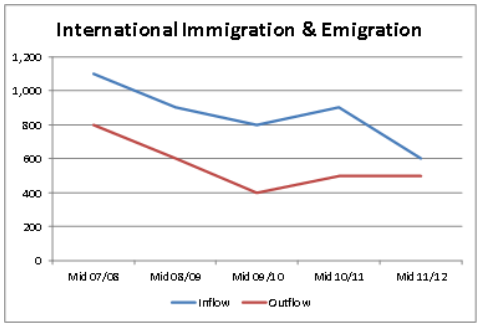
Table 4.0 Sefton Natural Population Changes

Natural Population Change						
Area	2008	2009	2010	2011	2012	Total 5 yr Changes
Sefton	-542	-222	-274	-216	-368	-1622
Merseyside	1435	1730	2081	2880	2504	10630
North West	17427	19612	21461	22380	20949	101829
England	197046	211817	225990	235258	227462	1097573

2.28 The internal migration chart, on the next page illustrates that the number of people leaving Sefton between mid 2007/08 and mid 2011/12 has consistently been higher than the numbers coming into the area, the chart also highlights that the gap between those coming in and those going out of Sefton in 2011/12 has closed.

Graph 4.0 Internal Migration & International Immigration & Emigration





2.29 In 2011/12 Sefton attracted 8,423 new UK residents, while during the same 12 month period 8,452 Sefton residents left the area, a net internal (UK) migration of -29.

2.30 By contrast, although international migration figures are far lower than internal migration, over the same five year period the number of international migrants arriving in Sefton has been consistently higher than the number of Sefton residents emigrating to foreign countries.

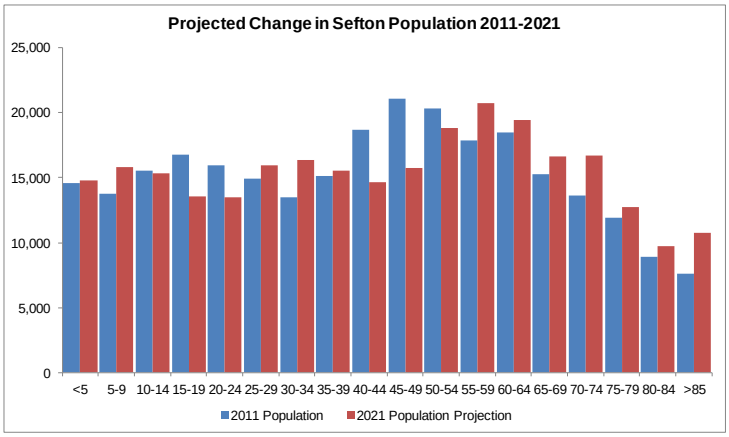
2.31 In 2011/12 630 international migrants chose to move to Sefton, while 522 Sefton residents moved overseas. This gives a net international migration figure of 108.

2.32 Overall for 2011/12 net migration (including "Other Changes") for the Borough has seen a population increase of 84.

2.33 When combined with Live Births and Deaths data for 2011/12 shows the population has an overall net change of -272.

2.34 Sefton's Overall population is predicted to rise by 1% by 2021 to 276,821. The chart breaks down the projection change in Sefton's population by five year age bands. There are increases in each five year band from 55-59 onwards with an increase in resident aged 65 and over of 16%, rising from 57,400 in 2011 to 66,500 in 2021. The biggest increase is projected to be in the number of residents age 85 and above, which is expected to rise by more than 40% from 7,600 in 2011 to 10,700 by 2021.

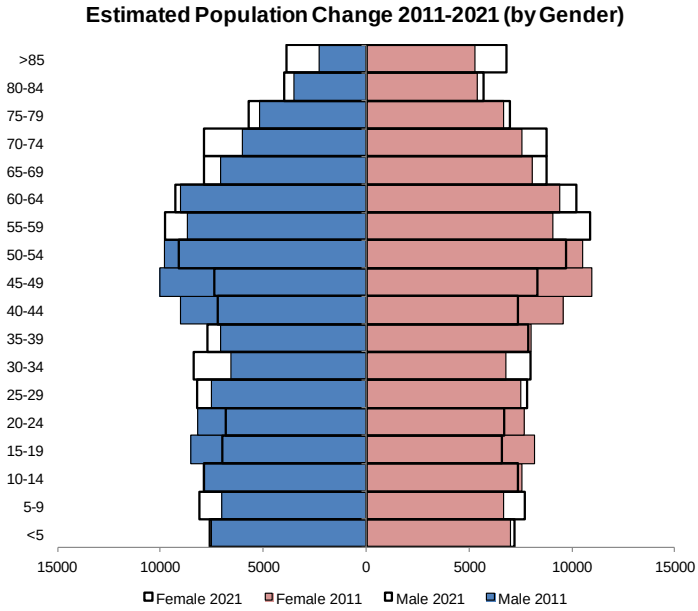
Graph 5.0 Projected Changes in Sefton Population 2011 – 2021



2.35 Despite a reduction of 4% (162,400 to 155,700) in working age population within the borough, there are increases in each of the five year age bands 25-29 (7%), 30-34 (21%) and 35-39 (2%). There are also predicted to be increases in those who are potentially reaching the end of their working life, age 55-59 (16%) and aged 60-64 (5%).

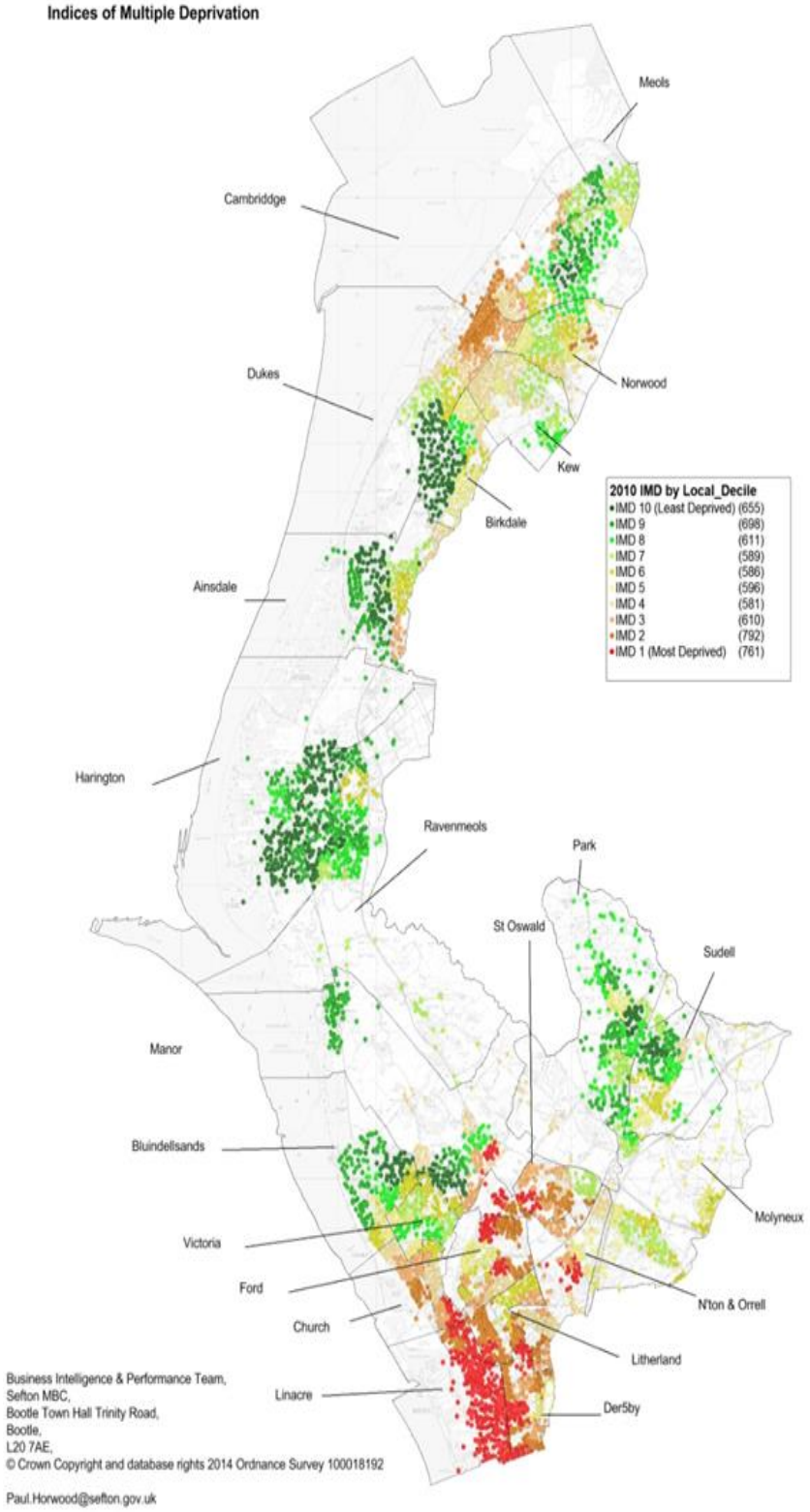
2.36 Amongst younger people it is predicted that there will be an increase in under 10's of 8% rising from 31,300 in 2011 to 33,700 in 2021. However, a reduction in those aged 11-17 of 9% from 22,900 to 20,800, means the number of Sefton residents aged under 18 will remain fairly static, increasing by just 400 from 54,200 to 54,600 or 0.7%.

Graph 6.0 Estimated Population Change 2011 -2021 (by gender)



2.37 The biggest increase for both males and females is amongst those aged 85 and above with the male over 85 population rising by almost 70% and female by 28% over the next 10 years. Across both genders there it is projected that every age band from 55-59 onwards will see an increase.

Diagram 4.0 Indices of Multiple Deprivation



2.38 Changes to Lower Super Output Areas (LSOA) boundaries as a result of the 2011 Census mean the IMD rankings are now based on 32,844 LSOA's (previously 32,482) that make up the 326 English local authorities areas. Each LSOA equates to around 1,500 people. The LSOA ranked one being the most deprived in the country and the LSOA ranked 32,844 being the least deprived. Sefton has 189 LSOA's (previously 190).

2.39 Based on average LSOA scores, Sefton is the least deprived of the six wider Merseyside authorities (inc. Halton). However, of the 326 Local Authorities contained within the IMD Sefton is ranked as the 92nd most deprived in England.

2.40 The national ranking map shows there are 36 Sefton LSOA's in the most deprived 10% of areas within England & Wales, with three of these amongst the most deprived 1% across. All three of these are within Linacre Ward.

2.41 Within the 36 LSOA's within the most deprived decile there are 49,731 residents, this equates to 18% of Sefton's population living in the most deprived 10% of areas.

2.42 Despite more than three quarters of LSOA having reduced levels of deprivation in 2010, there is minimal change in the geographical distribution of the most and least deprived areas within Sefton. However, it is important to make the point that not all individuals living in an area of higher deprivation are or feel deprived

2.43 The most deprived 20% map shows the distribution of Sefton's most deprived 20% of LSOA and highlights the concentration of deprived LSOAs within the south of the borough.

2.44 Of the 38 (20%) most deprived LSOAs in Sefton in 2004, 36 are still among the most deprived 20% in 2010.

2.45 It is likely that no one service provider can address the issues within the most deprived areas. There is a need for partners to work together to ensure that resources are used in the locations of greatest need to ensure greater impact and value for money.

3. Provider Landscape

3.1 The provider landscape is sculpted across Sefton with the following major providers:-

- Aintree University Hospital NHS Foundation Trust
- Southport & Ormskirk Hospital NHS Trust
- Mersey Care NHS Trust
- Liverpool Community Health NHS Trust
- Liverpool Women's NHS Foundation Trust
- The Royal Liverpool and Broadgreen University Hospitals NHS Trust
- The Walton Centre NHS Foundation Trust
- The Clatterbridge Cancer Centre NHS Foundation Trust
- Liverpool Heart and Chest Hospital NHS Foundation Trust.

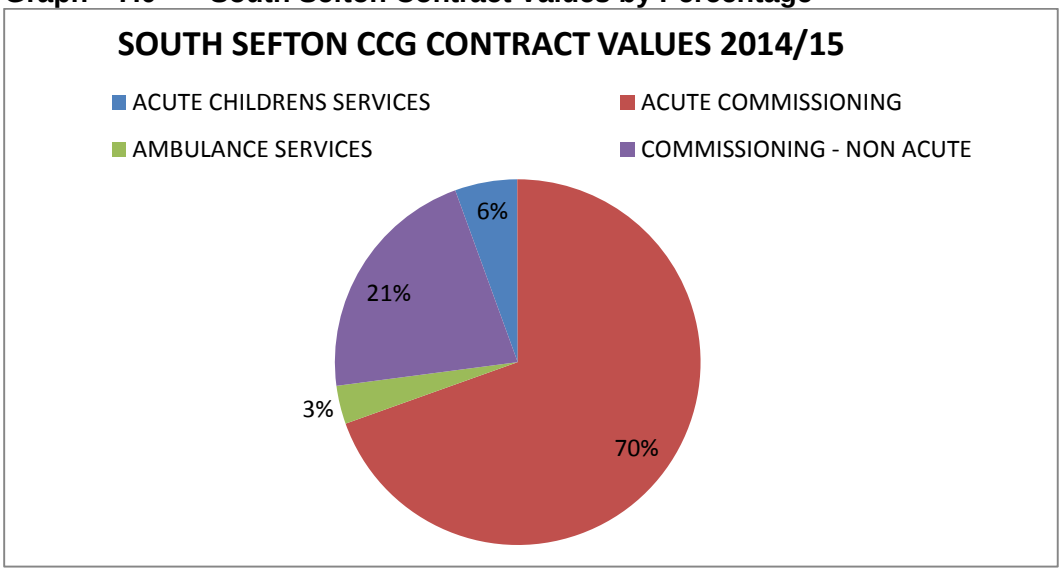
3.2 The vast majority of the Sefton population are served by Aintree Hospitals and Southport & Ormskirk Hospital, against which South Sefton CCG and Southport & Formby CCG is the lead commissioner. Sefton patients are also served by the other specialist hospitals listed above.

3.3 The table below sets out the contracted values for South Sefton CCG for 2014/15, which clearly indicates that the vast proportion of spend, 70% relates to acute services. The major provider of commissioned services is Aintree with 51% of CCG spend.

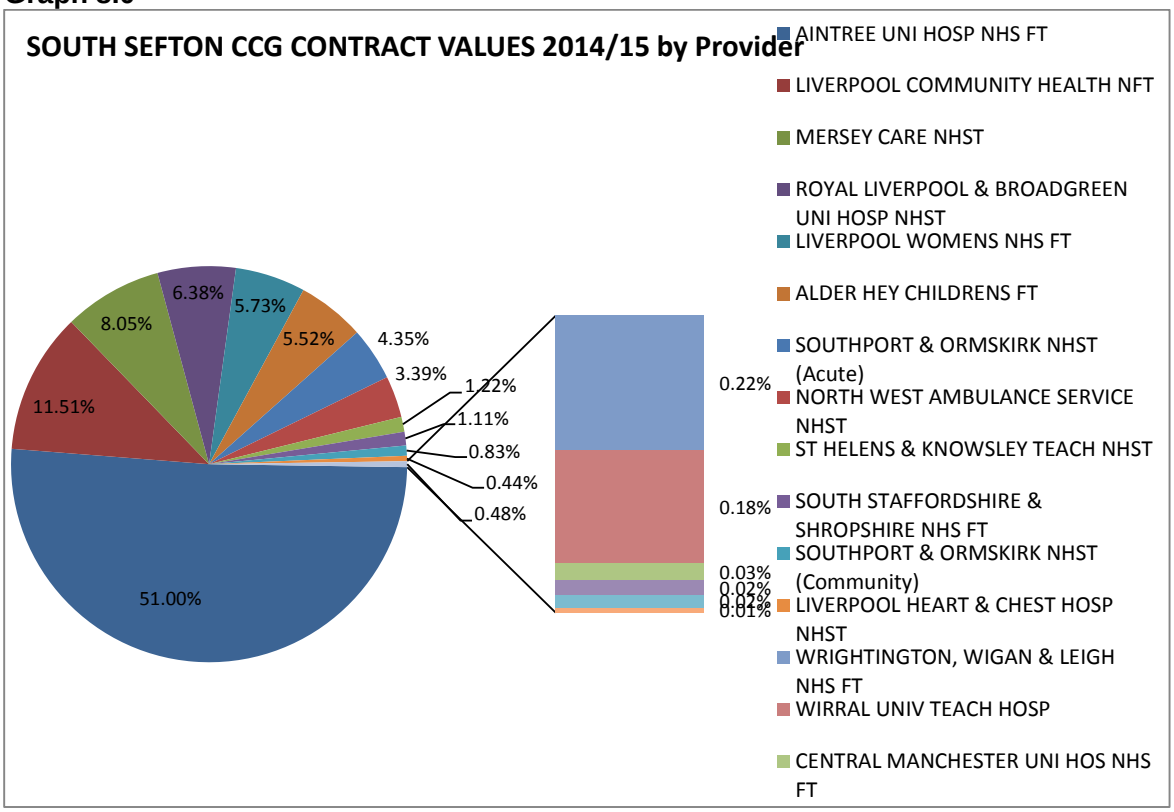
Table 5.0 South Sefton CCG Contract Values 2014/15

SOUTH SEFTON CCG CONTRACT VALUES 2014/15	Totals
ACUTE CHILDRENS SERVICES	£8,699,478
ACUTE COMMISSIONING	£109,706,965
AMBULANCE SERVICES	£5,347,427
COMMISSIONING - NON ACUTE	£33,926,726

Graph 7.0 South Sefton Contract Values by Percentage



Graph 8.0

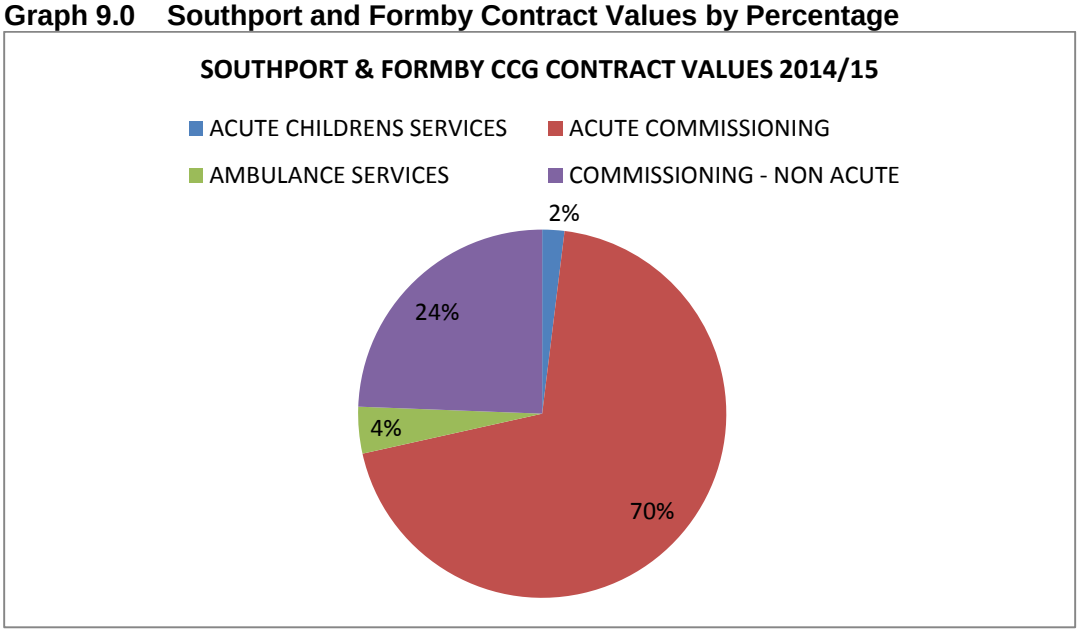


3.4 The table and graphs below set out the contracted values for Southport & Formby CCG for 2014/15, which clearly indicate that the vast proportion of spend, 70% relates to acute services. The major provider of commissioned services is Southport & Ormskirk with 56% of CCG spend.

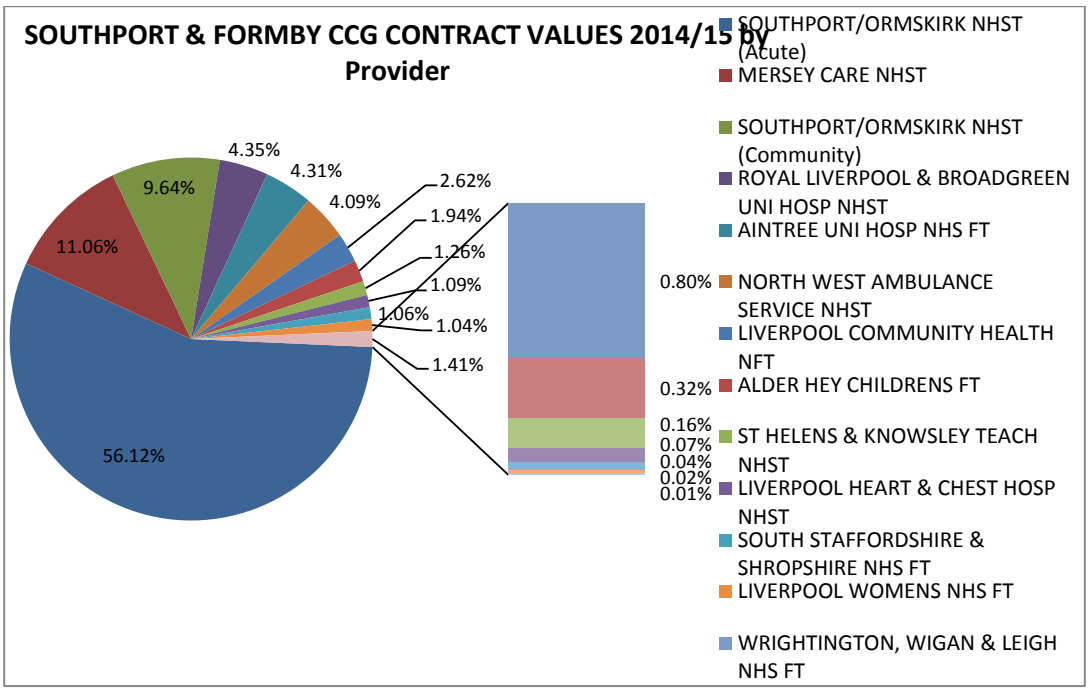
Table 6.0 Southport & Formby CCG Contract Values 2014/15

SOUTHPORT & FORMBY CCG CONTRACT VALUES 2014/15	Totals
ACUTE CHILDRENS SERVICES	£2,148,131
ACUTE COMMISSIONING	£76,926,399
AMBULANCE SERVICES	£4,526,771
COMMISSIONING - NON ACUTE	£26,969,134

Graph 9.0 Southport and Formby Contract Values by Percentage



Graph 10



3.5 The provider landscape can be described against a number of key and significant challenges, although it should be recognised that each provider has its own and unique set of challenges. In summary these can be collectively described as:-

- workforce challenges, particularly in relation to the recruitment highly skilled and professional staff;
- quality challenges related to a number of areas, in particular, emergency care, A&E, Hospital related acquired infection and sustainable access for elective care;
- specialist services configuration;
- continued financial challenges in delivering recurring efficiencies against a heightening demand for quality services.

3.6 The complexity of the extended Health Economy is further compounded given the connectivity between the providers listed above, but also the additional providers outside of the immediate Sefton and Liverpool area, with neighbouring CCGs. These include:-

- Halton CCG
- St Helens CCG
- Knowsley CCG
- Liverpool CCG.

3.7 The Merseyside health economy is challenged with integrating the plans between partner CCGs, so these can be directly related to individual providers of healthcare. In addition the national review of specialised commissioned services by NHS England in conjunction with the Boston Consulting Group has to be considered in shaping commissioning intentions and priorities going forward.

3.8 South Sefton and Southport & Formby CCGs recognise the need to collaborate with both CCG partners and provider partners to work through the implications of combined CCG and Specialised Commissioning Plans. This remains work in progress, with all CCGs developing respective plans by the end of June and clarity on Specialised Commissioning expected thereafter.

3.9 In support of this South Sefton and Southport and Formby CCG have formed a commissioning collaborative with NHS England Merseyside to work through the above. In addition, both CCGs in conjunction with Sefton Council have established a provider forum, as part of the Health & Wellbeing board to consider and understand provider implications in relation to both Health & Local Authority Plans.

3.10 Southport & Formby CCG has been working with West Lancashire CCG to ensure that strategic plans are aligned and reflect a common direction of travel and aspiration.

4. CCG Performance

The table below highlight the Key Performance Categories for both CCGs for the year 2013/14.

Table 7.0 CCG Key Performance Targets

Key Target	South Sefton CCG	Southport & Formby CCG	Reporting Basis
18 weeks referral to treatment times	The CCG achieved 93.26% for admitted patients and 97.63% for non admitted	The CCG achieved 94.29% for admitted patients and 98.07% for non admitted patients,	Monthly (month 12)

Key Target	South Sefton CCG	Southport & Formby CCG	Reporting Basis
	patients, above the 90% and 95% targets required.	above the 90% and 95% targets required.	
6 week diagnostic waiting times	The CCG achieved 0.63%, below the threshold of 1%.	The CCG achieved 0.69%, below the threshold of 1%.	Monthly (month 12)
Cancer waiting times	The CCG achieved in all of the nine waiting times standards	Southport and Formby CCG achieved in 6 of the 9 categories. Achievement to February 2014 was 90.16% against 93% for 2 week wait Breast Referrals. For the 62 day target, 81.84% was achieved cumulatively to February 2014 which failed to achieve the target of 85%.	Monthly (month 11)
Ambulance Services	NWAS achieved 75.3% of Category A calls within 8 minutes, above the 75% target (this target is only applicable and measured to NWAS overall, not CCG level)	NWAS achieved 75.3% of Category A calls within 8 minutes, above the 75% target (this target is only applicable and measured to NWAS overall, not CCG level)	Monthly (month 12)
A&E four hour waiting times	The CCG achieved 95.66% above the 95% target in month 12.	The CCG achieved 95.56% above the 95% target in month 12.	Monthly (month 12)
Mixed Sex Accommodation	No breaches were realised by the CCG.	The target for MSA breaches was breached for 13/14 with 4.1 breaches per 1,000 finished consultant episodes against a target of zero.	Cumulative (year end, month 12)
Infection Control	There have been 55 cases of C-Difficile infections reported for South Sefton CCG patients against a target of 44 for 2013/14. There have been 2 cases of MRSA against a zero target in 2013/14.	The CCG has reported zero MRSA cases at the end of March 2014 (target was zero). There have been 45 cases for C-Difficile against a target of 38 in 2013/14.	Cumulative (year end, month 12)

4.1 Both CCGs have demonstrated a strong performance against the key target areas in 2013/14. The challenge remains to create this on a sustainable basis, enabling the health economy to further innovate and transform services to meet the health needs of the population going forward.

4.2 Addressing C-Difficile rates at both major providers remains an absolute priority. The CCGs continue to work with Aintree Hospital and Southport & Ormskirk to tackle and resolve this issue.

4.3 While it is evident that mixed sex accommodation breaches have occurred at Southport & Ormskirk, this largely relates to intensive care provision. Nonetheless the CCG and the Trust are dedicated to avoiding any mixed sex accommodation breaches and are working together to ensure long term compliance with this standard are met and maintained.

5. Strategic Vision

5.1 Both CCGs have come together to develop a strategic vision that is common across South Sefton and Southport & Formby. This vision has built upon the work undertaken by the respective CCGs in developing their own plans to-date and during the CCG authorisation process. In addition, care and consideration has been taken to ensure

that this vision underpins that which has been jointly developed with Sefton Council as part of the existing Health & Wellbeing Strategy.

5.2 The Health & Wellbeing Strategy for Sefton has described its strategic vision as; **"*Together we are Sefton – A great place to be! We will work as one Sefton for the benefit of local people, businesses and Visitors*".**

5.3 Both CCG have developed this joint vision with the support and engagement of its public and partners in an effort to reflect the health requirements and needs of the population now and for the future.

OUR VISION

To create a sustainable healthy community based on health needs, with partners; focused on delivering high quality and integrated care services to all, to improve the health and well-being of our population

5.4 Both CCGs are focused and committed to ensuring that healthcare provision across Sefton, remains fit for the future and is sustainable on a long term basis to meet the growing demands for services, while maintaining and improving the quality of services. This requires the CCGs to concentrate on ensuring that the health needs of the population are at the heart of everything that we do. In striving to deliver services to meet the health needs of the population, both CCGs recognise the commonalities and variances between localities across the borough. In commissioning health services, we are committed to ensuring sensitivity to these varying populations.

5.5 The CCGs recognise the importance of working in partnership, with major and minor healthcare providers, the voluntary, community and faith sectors, the local authority and others to innovate and optimise the way Healthcare is provided. This is a fundamental commitment as part of our strategic vision.

5.6 There is also recognition in this vision that there needs to be more progress towards integration of services to support the rising demand for health services. Both CCGs are committed to driving collaboration between elements of the health sector and each other along with social care; The aim being to deliver quality and seamless services to our population.

5.7 In recognition of the constitutional requirement, both CCGs have signalled an absolute commitment to ensuring the delivery of high quality healthcare services to the public, in terms of access, equitability, clinical standards and outcomes. We believe that in conjunction with our public and partners we can considerably improve not just the health, but the wellbeing of our population

5.8 Underpinning our strategic vision, the CCGs have robustly developed and described a set of values and principles that will be pursued as part of their operating framework. These values will be evident in everything that we do, how we conduct ourselves, undertake business and engage with our public and partners.

OUR VALUES

- **We will maintain a local focus, working in partnership.**
- **We will be transparent, open and honest.**
- **We will be approachable and listen to our public.**
- **We will be caring and compassionate.**
- **We will act with integrity, courage, act fairly and with respect.**
- **We will have a person focussed approach to Health Care.**
- **We will develop a culture of challenge, ownership, innovation and improvements.**

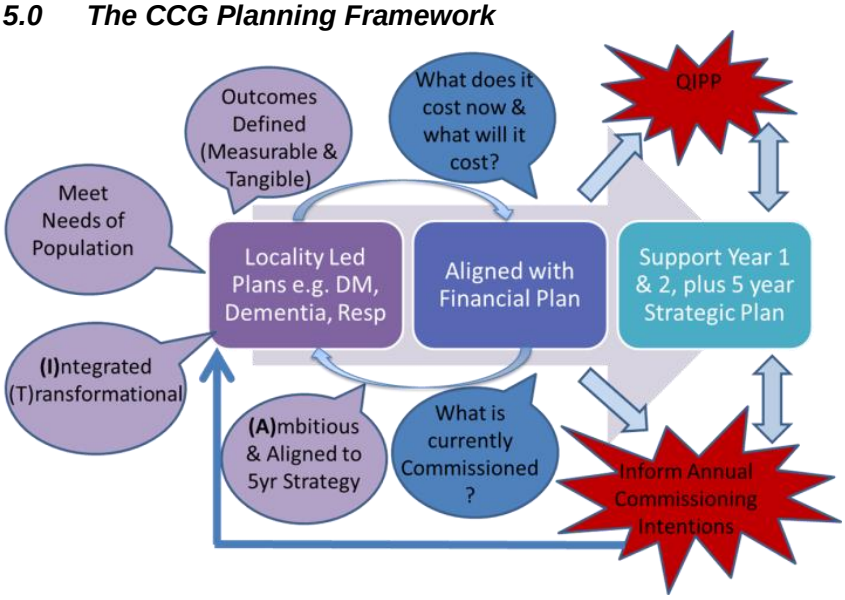
- **We will be accountable for what we do.**
- **We will enable action and prioritise effort to optimum effect.**

6. Strategic Planning Framework

6.1 In an effort to develop a supportive approach to the development of the five year Strategic Plan and two year Operational Plan, significant work with financial, clinical and senior team colleagues has been undertaken to develop a framework for building and delivering the plans. While this framework is sensitive the immediate planning requirements set out nationally, it has been important to put in place a framework that supports the annual iteration of plans that will be required going forward.

6.2 The diagram below describes the framework that has been developed for the CCG and is now in place.

Diagram 5.0 The CCG Planning Framework



6.3 This framework ensures that all the CCG plans are based upon and informed by the needs of the local population and that any outlying health issues are addressed within plans. To assist with this a variety of information and data sources have been used to identify priority areas, service gaps and outstanding health needs. These include:-

- the Joint Strategic Needs Assessment
- the annual public health report for Sefton
- office of National Statistics data and analysis on the local population and disease incidence and prevalence
- right Care analysis, enabling the CCG to identify comparative performance against similar benchmark CCGs, where a further opportunity for improvement is identified
- provider level data on performance and outcomes.

6.4 In addition, the approach to building the CCG plans has been to ensure and identify an element of every plan that is integrative (in terms of optimising the collaborative approach with Sefton Council) and also encompasses the transformation requirements set out nationally.

6.5 Each plan is also being developed, not only by the health needs of the population, but also in terms of a defined set of outcomes. Again, this is in keeping with the

requirements set out nationally. However, many of these outcomes will be more specific than the nationally defined subset and specific to the programme of work within the plan for example the End of Life programme is defining outcomes in terms of deaths in usual place of residence across five years; the aim being to reduce deaths in hospital and enhance and facilitate end of life care in the community. This approach will thus enable a relationship to be established between plans and reductions in unplanned activity (another key national requirement). It will also enable an annual review and iteration of plans to be undertaken against progress and outcomes, requiring plans to be augmented or re-directed as necessary.

6.6 In an effort to ensure absolute alignment with the national requirement on the reduction of unplanned care, all plans have this focus built into them, again attempting to define and describe the associated level of reduction in unplanned care with each programme. Indeed, it is envisaged that any future business cases will need to clearly demonstrate the associated reduction in unplanned care to enable the appropriate investment and commissioning decisions to be made on a robust basis.

6.7 This approach is aligned with the target reduction of 15% in unplanned care being set at a national level and the requirement to transfer activity and resources from acute providers to the community. It also facilitates clear financial alignment, as any planned reduction in acute unplanned activity and value will be clearly and demonstrably evident against any increase in community based activity and value, thus supporting an integrated financial and Strategic Plan.

6.8 An important component of the developing plans is to enhance understanding and definition around services currently commissioned with providers. This comprehension and understanding has naturally increased within the CCG over the last twelve months but, in addition, some very specific priority areas have been identified and singled out for particular focus for example, Mental Health, with a view to describing the model of care the CCG would wish to commission; a recovery model based on outcomes of care, rather than activity and volume. In developing our Strategic Plans on Mental Health, the CCG is exploring collaborative opportunities with Liverpool CCG, with a view to adopting a joint approach. This has been the direct result of identifying strategic priorities for mental health within CCG plans.

6.9 In parallel to the work on building the CCG plans, the 2014/15 contracting exercise has been utilised to support delivery. Some very specific areas that have been reflected in the 2014/15 contract as a means to supporting and enabling CCG plans include the following:

- requirements around data and outcomes to support the assessment of commissioned services
- requirements associated with Choose & Book to enable increased compliance amongst providers
- identification of existing contracts that need to be appropriately addressed to support the Strategic Plan, for example where contracts need to be served notice or ended to enable a more holistic or systematic approach to be taken for example Oxygen Therapy.

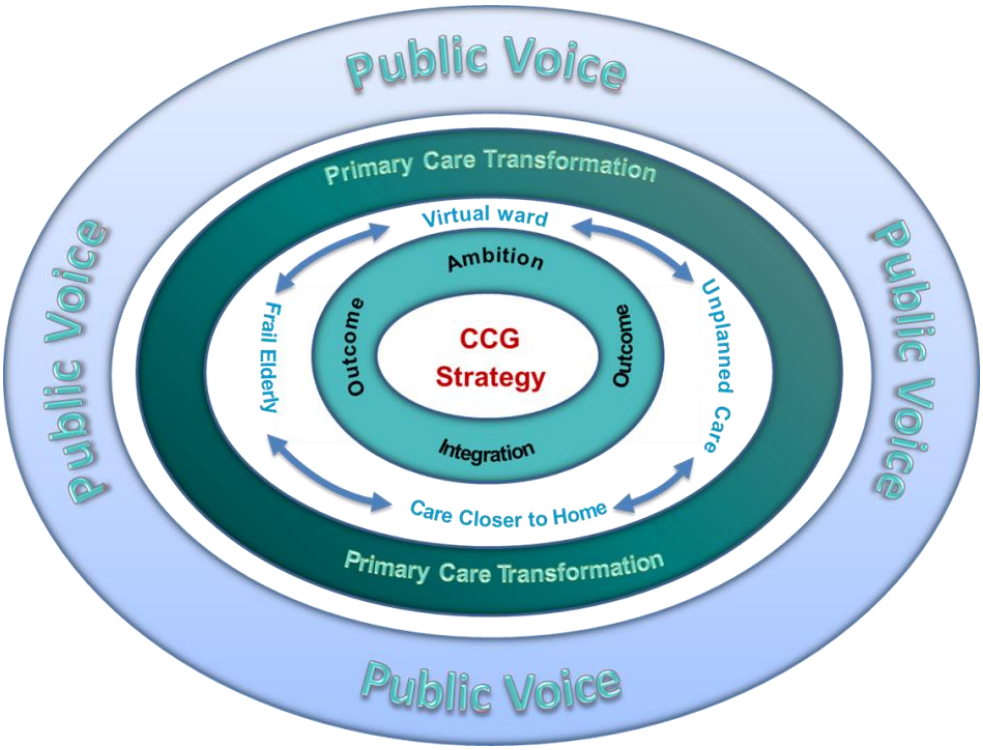
6.10 Commissioning intentions for 2014/15 are also being tested against the developing Strategic Plans, to ensure alignment and to enable any inconsistencies to be addressed. Going forward, it is envisaged that commissioning intentions will be much easier to describe, against the five year Strategic Plan. This should enable the CCG to share indicative commissioning intentions with providers by September each year, supporting providers in terms of their annual business planning cycle and job planning reviews and changes.

6.11 In an effort to adopt an integrated approach to QIPP, the framework is also designed to support the identification, achievement and delivery of QIPP Plans, ensuring that they are a component part of individual plans in addition to the required transfer of activity and value from the acute sector to the community. It is envisaged that this approach will be a transitional approach across the five years of the Strategic Plan, with a more corporate approach to QIPP delivery giving way to individual plans delivering QIPP requirements.

7. Strategic Plan: From Plan to Delivery

7.1 The diagram below reflects the three CCG identified strategic priorities and the transformation schemes as part of the CCG integrated Strategic Plan. It also highlights the importance of public engagement and involvement in developing and refining our plans.

Diagram 6.0 The CCG Integrated Strategic Plan



7.2 The CCG commenced its work on the development of its Strategic Plan in November 2013. Through a series of extensive engagement events and discussions with the public, providers, the Wider Constituent Group, locality leads and Governing Body, the strategic vision and priority areas for the CCG has been clearly defined. As such the CCG has defined three strategic priorities.

OUR STRATEGIC PRIORITIES

1) **Frail Elderly:** To support the frail elderly, with long term conditions, to optimise self-care based in the community or home setting, while preventing unnecessary and unplanned admission to hospital.

2) **Unplanned Care:** To support patients of all ages to manage their healthcare needs at home or in the community setting, while preventing unnecessary and unplanned admission to hospital.

3) **Primary Care Transformation:** To support the healthcare needs of the population through enhanced primary and community care services, supporting

self-care and enabling appropriate intervention at home or in the community and preventing unnecessary and unplanned admission to hospital.

7.3 These priority areas are completely aligned with the national agenda being set by NHS England. At a local level, these priority areas recognise the growing health need of the expanding frail elderly population. It also supports the local requirement and goals associated with reducing unplanned care. Indeed evidence of delivery against this is already apparent in 2013/14 with reduced numbers attending A&E, particularly with respiratory conditions.

7.4 The strategic priority that is primary care is also consistent with the agenda being set by NHS England. The local recognition that primary care has a significant and pivotal role in preventing ill-health, involving patients and carers more fully in managing their health is central to the establishment of this strategic priority within the CCG.

7.5 While these three strategic priorities are aligned with the major health needs and issues for the population of Sefton, there is recognition that other significant areas also need to be addressed within the strategic and operational plans. Three specific areas have been identified for particular focus, in line with the equity of access requirements set out nationally. These are:-

- Children
- Mental health
- Cancer.

7.6 An exclusive focus on the three strategic areas risks the CCG failing to address some very specific health needs in relation to children, mental health and cancer. Indeed, many elements of both the cancer and mental health plans will naturally fall under the three strategic priorities. For example, the dementia component of the mental health plan clearly fits with the frail elderly strategic priority, but additional attention needs to be given to the younger population with mental health conditions. Similarly, cancer is largely associated with the older element of population, but not exclusively, so as such it is right to identify this area for additional focus in an effort to address the wider health needs.

7.7 The children's health agenda is certainly covered in relation to unplanned care and indeed elements of the children's plan for example asthma are very much associated with unplanned care, other issues, like alcohol and ill-health prevention are less so. Thus it is appropriate to identify this are for specific attention in relation to health needs.

7.8 Against the planning footprint of the borough, both Sefton CCGs have identified the major transformation schemes to support realisation of the Strategic Plan. These are:-

OUR TRANSFORMATION SCHEMES

1. **Virtual Ward (South Sefton CCG)**
2. **Care Closer to Home (Southport and Formby CCG)**
3. **Primary Care Transformation**

7.9 Both 1 and 2 above can be described as the locality models for delivery. They have enhanced community support at their heart to enable patients with Long Term Conditions to self-care and to be optimally supported from a health and social care perspective, in a non-acute environment. Their aim is to transform the way in which care is provided in the community and home setting, to build a multidisciplinary team of integrated community resources around individual patients, with the locality General Practitioners central to the clinical management and co-ordination of care. These initiatives have the support of Sefton Council and indeed there is joint agreement between the CCG and the Council that the Better Care Fund should be orientated to

support an enhancement of both of these schemes to further optimise impact on unplanned acute activity.

7.10 Both CCGs have placed a significant emphasis on the role that primary care has to play in transforming the health system across Sefton. This is evident within then CCGs Primary Care Quality Strategy which aims to focus on developing and enhancing the following areas:-

Primary Care Access: Improving access and opening hours of GP practices across the week.

A&E: Review and aftercare of patients attending A&E to assist in future admission avoidance.

Exception Coding: Clinicians reviewing patients who are exception reported from QOF outcome reports, using 13/14 baseline levels with practice plans to review clinical areas where levels exceed 5%.

Public Health: To reduce life threatening illnesses, by increasing uptake of immunisations and smears, reducing health inequalities in preventable illnesses and support practices to achieve good practice comparable to their peers.

Shared Care: Prescribing management under named Consultants for specific conditions, through the GP.

Phlebotomy: Local provision at practice level, avoiding unnecessary requests of secondary care.

Drug Administration: The controlled administration of very specific medication injections with a view to avoiding unnecessary secondary care attendance.

Data Validation: The review of secondary care coding data at a patient level to enable coordinated and appropriate joined up care with primary care.

Travellers / Gypsy Scheme: Focused care on this element of the population, given propensity for illness and development of long term conditions, with a view to avoiding unnecessary unplanned care.

Care Closer to Home / Virtual Ward: Engagement and commitment of GP's in integrating care with community services, based on a locality delivery model.

Practice Development Plan: Support for the development of a strategic plan at practice level, in line with the CCG strategic priorities to ensure sustainable quality primary care services in terms of resources and estate.

OUR STRATEGIC PROGRAMMES

7.11 Seven strategic programme areas have been identified to support the level of planning and delivery detail required in relation to the Strategic Plan. These include:-

1. Mental Health & Dementia
2. Cardiovascular Disease (including stroke)
3. Respiratory Disease
4. Cancer
5. Children's Health
6. End of Life
7. Diabetes.

7.12 The CCG has undertaken an extensive level of engagement and development sessions with the public, providers and other stakeholders to build, shape and inform the strategic programmes. This work has not only been instrumental in driving the content of the strategic programmes, it has assisted in identify three additional programme areas for the CCGs to tailor their plans to. These are-

1. Neurology
2. Liver Disease
3. Kidney Disease.

7.13 While Specialist Neurology and Neurosurgery fall under the commissioning of NHS England, the CCG recognises that particular attention needs to be given to the range of neurological conditions e.g. Motor Neurone Disease, Parkinson's, Epilepsy, Alzheimer's Disease that is evident within our population. Indeed, given the age profile of our population and the growing incidence of neurological conditions, their impact on individuals, families, carers and health services, it is right to provide additional focus on this area as part of the strategic plan.

7.14 The national trend of increasing liver disease, often associated with alcohol abuse is certainly evident within areas of Sefton. Indeed alcohol consumption amongst children has been identified as a challenging area for the CCG to address. The long term health and economic consequences of alcohol abuse and liver disease are well recognised and an area that CCGs wish to target as part of their strategic plans

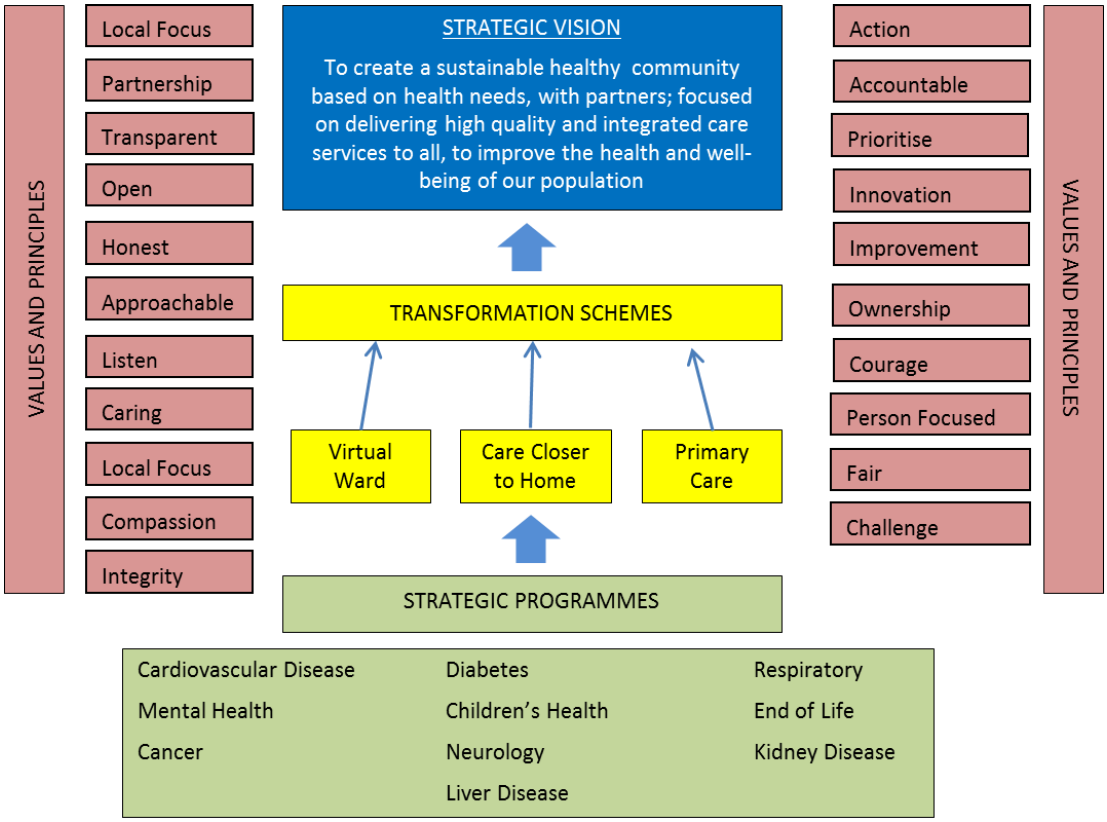
7.15 Specialist Kidney (Renal) Services are commissioned by NHS England, however the CCG recognises that acute kidney injury can be a major factor in elderly patients, resulting in admission and prolonged stay in hospital. If the CCGs are to address the strategic priority of unplanned care, it is right that particular focus and attention be given to this area.

7.16 In developing the strategic programmes above, the CCGs have ensured that each programme addresses the following:-

- population Health Needs
- plans to address and support these across five years
- defined outcomes
- associated reduction in unplanned activity.

7.17 The diagram below describes the way in which the strategic programmes for the CCG support and underpin the three major transformational schemes, contributing to the achievement of the overall strategic vision. The values and principles for the CCGs permeate all aspects of the strategic plan from the strategic programmes to the transformation schemes.

Diagram 7.0 From Strategic Programmes to Transformation and Delivery



7.18 Each of the strategic programmes has a designated clinical and managerial lead focused on development and in particular delivery and implementation. This leadership is focused on progressing plans with a number of key outcomes in mind.

- To reduce unplanned and unnecessary hospital admission.
- To support and promote self-care.
- To develop and support primary care services in enabling individuals to remain well and in their home environment.
- To develop and support community services in enabling individuals to remain well and in their home environment.
- To enhance and enable support from the community, voluntary and faith sectors in promoting self-care and care at home, without the need for unnecessary hospital admission.
- To integrate health and social care in support of self-care and admission avoidance.
- To ensure alignment of plans with public health to optimise health impact.
- To underpin and contribute to the major transformation of primary care and community services.
- To underpin and support the delivery of our locality care clinical model, Virtual Ward and Care Closer to Home.

7.19 The CCGs are reviewing the adequacy of leadership support for the strategic programmes. The table below highlight the latest leadership assignment across the CCGs.

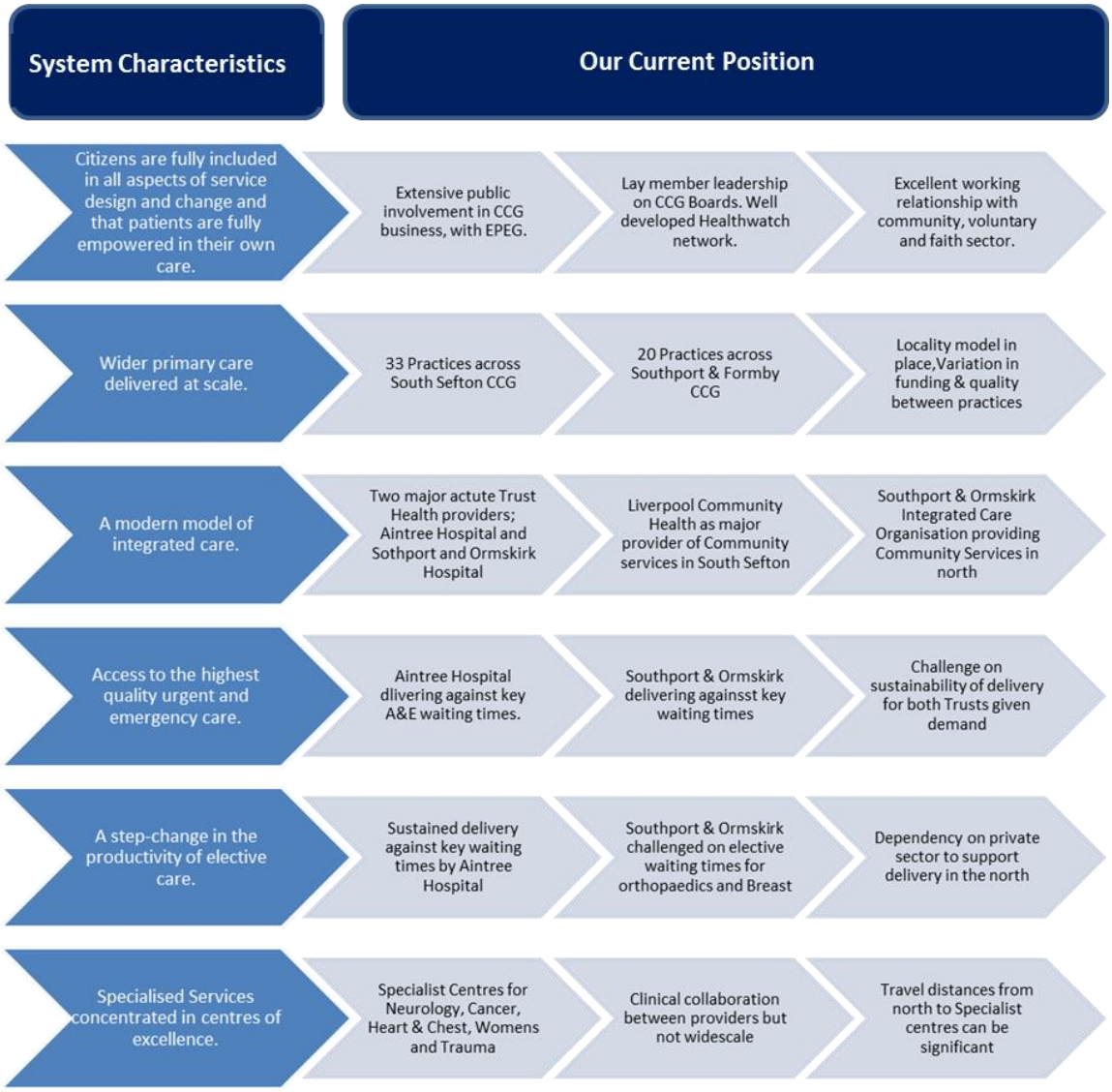
Table 8.0 Strategic Programme Leads

Programme	Clinical Lead S&F CCG	SSCCG	Managerial Lead
CVD	Vacancy	Vacancy	Sharon Forrester
Respiratory	Vacancy	Vacancy	Jenny Kristiansen
Diabetes	Dr Doug Callow	Dr Nigel Taylor	Terry Hill
Cancer	Dr Graeme Allan	Dr Debbie Harvey	Sarah McGrath
Mental Health	Dr Hilal Mulla	Dr Ricky Sinha	Jenny Kristiansen
Children	Dr Rob Caudwell	Dr Wendy Hewitt	Jane Uglow
End of Life	Dr Jackie Reddington	Dr Debbie Harvey	Moira McGuinness
Urgent Care	Dr Niall Leonard	Dr Andy Mimnagh	Terry Hill
Virtual Ward	-	Dr Debbie Harvey	Tina Ewart
Care Closer to Home	Dr Niall Leonard	-	Billie Dodd
Primary Care	Dr Bal Duper	Dr Bal Duper	Angela Parkinson

8.0 System Characteristics

8.1 ***"Everyone Counts: Planning for Patients 2014/15 to 2018/19"***, was published by NHS England in December 2014 and described six system characteristics for a sustainable model of healthcare. As part of the five year strategic plan, both CCGs have assessed their current position against these characteristics and described a future state under the strategic vision. This is depicted in the diagram below.

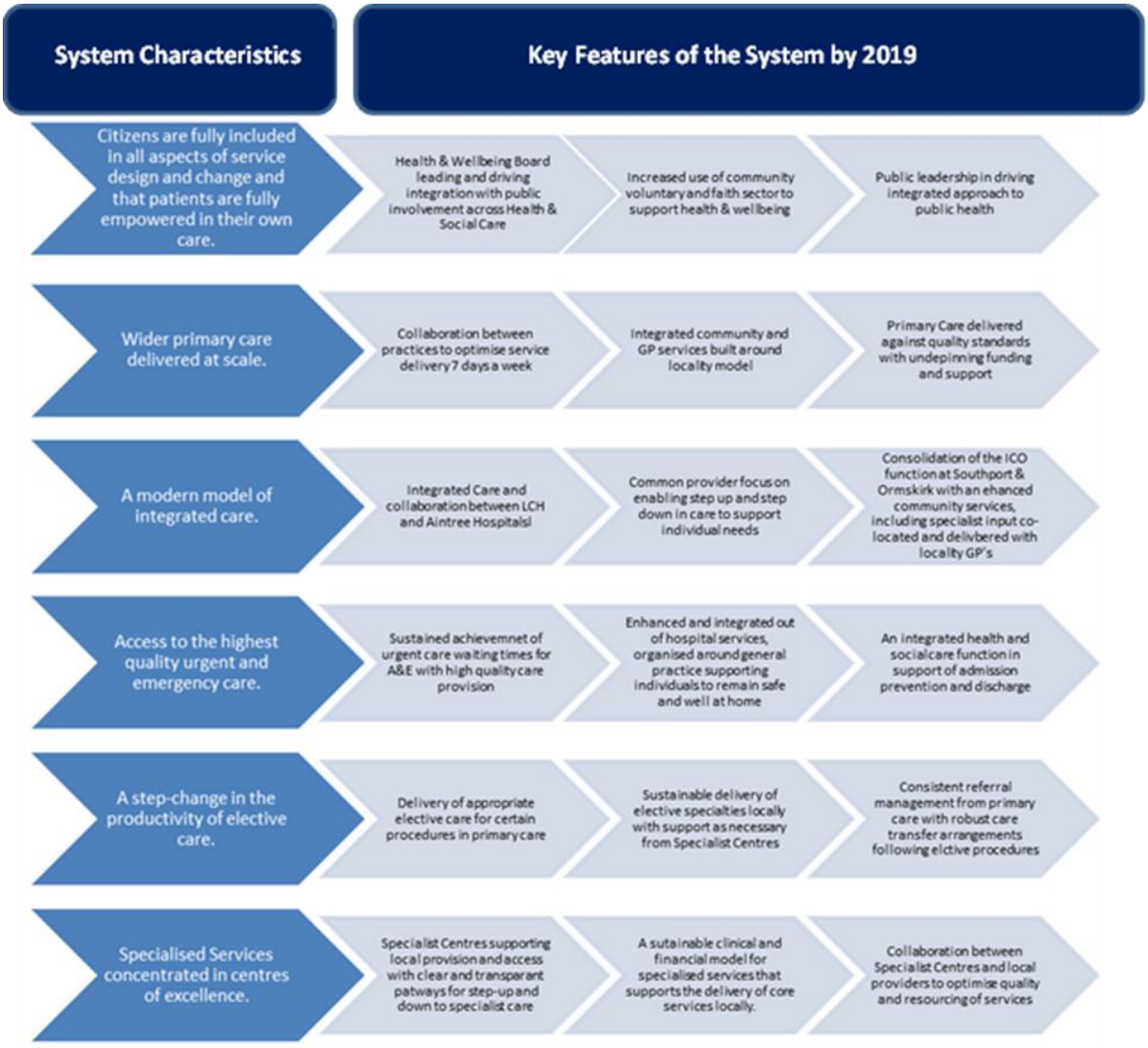
Diagram 8.0 The 6 System Characteristics for a Sustainable Health Economy – Our Current Position.



8.2 This analysis highlights some real significant progress across both South Sefton CCG and Southport & Formby CCG and is testament to the real difference that clinically led commissioning is making, even at this early stage. It is important that both CCGs build upon this early platform of success and achievement, to move into a new phase of enhanced service transformation in support of the three strategic priorities (Frail Elderly, Unplanned Care and Primary Care).

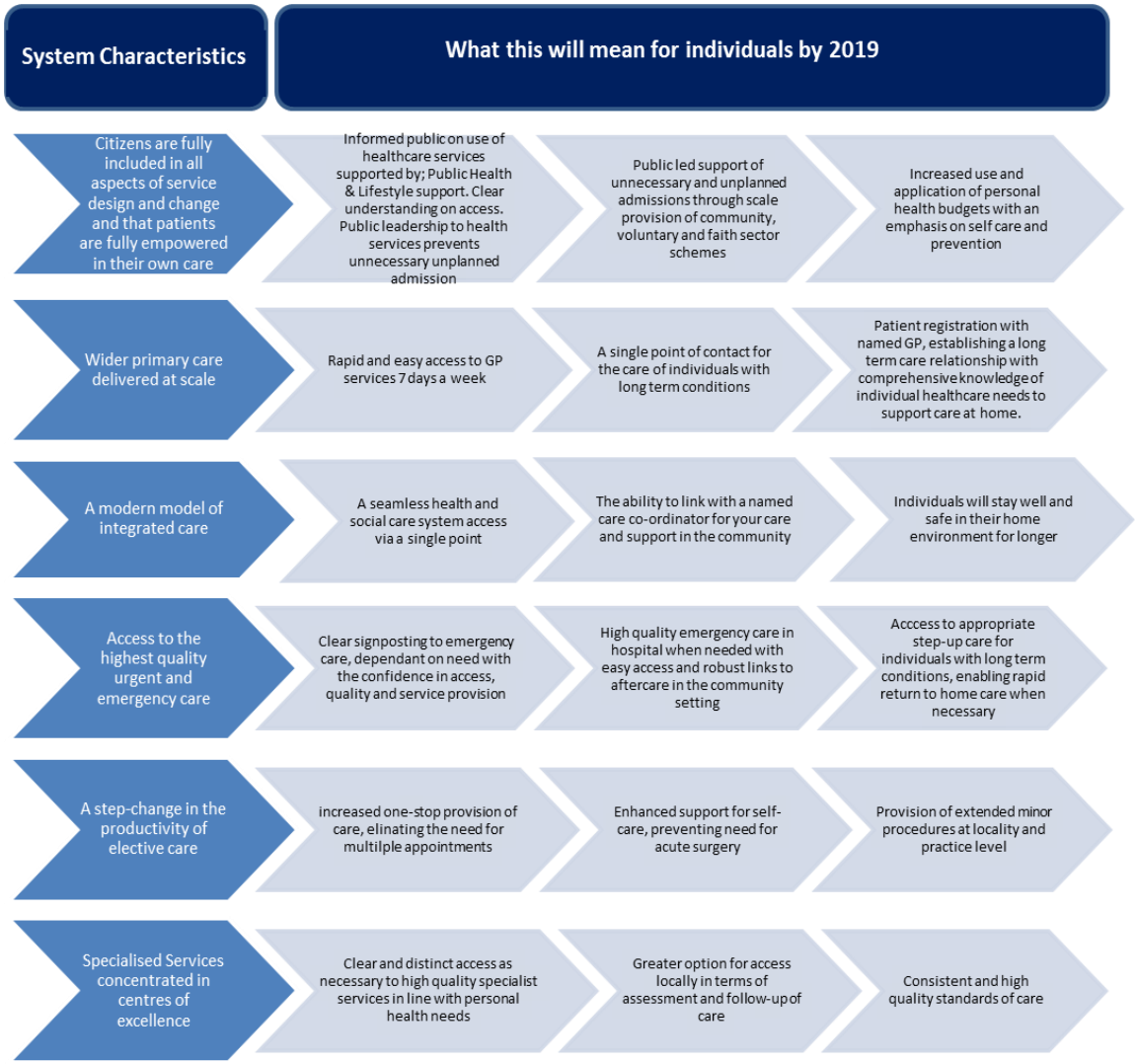
8.3 The diagram below describes the health system features that both CCGs are striving to achieve as part of their five year strategic plan. This places a key emphasis on self care and care closer to home with enhanced public support, novel input from the community, voluntary and faith sector. It also describes an advanced model of primary care, with enhanced and supported GP services working in an integrated way with community services.

Diagram 9.0 Key Features of the Sefton Health System by 2019



8.4 The diagram below begins to describe the difference this will make to individuals and what they can expect to see from their health system by 2019.

Diagram 10.0 What will it mean for individuals: The Sefton Health System by 2019

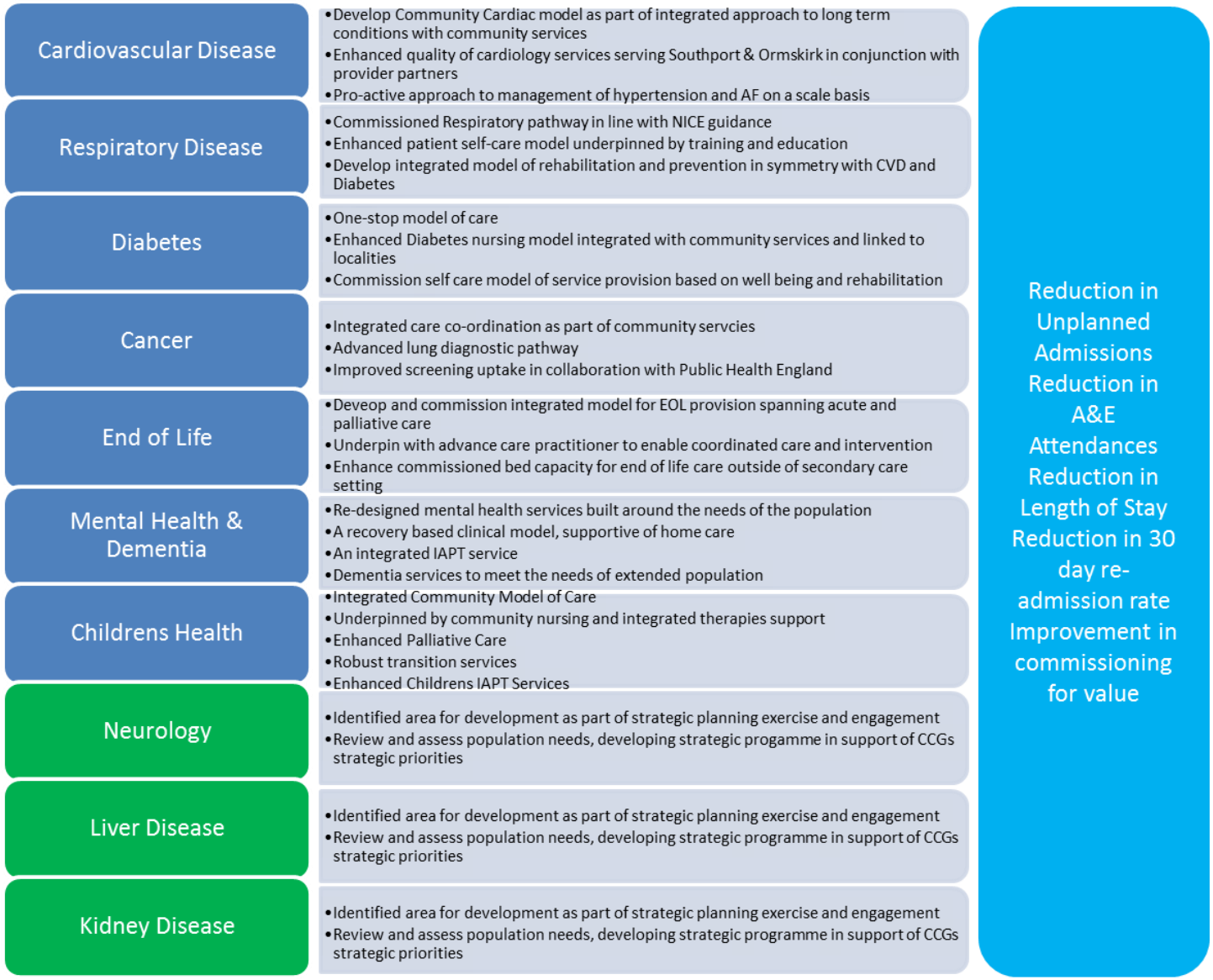


8.5 Implicit within the above is the strong emphasis on individuals, carers and families taking increased responsibility for their own health, with the healthcare provision supporting this at every point. This goal is set against a commitment to deliver enhanced primary and community services, while ensuring that high quality hospital care is accessible when needed and remains free at the point of delivery.

8.6 The diagram below references the key strategic programmes and summarises the key elements of their plans, together with the targeted outcomes for each. Every programme is focused on improving the quality of patient care, but in addition and in line with the strategic vision and priorities, remains absolutely geared towards:-

- A reduction in unnecessary and unplanned care.
- A reduction in the length of stay for patients, relevant to the specific programme.
- A reduction in attendances at A&E.
- A reduction in the 30day re-admission rate for patients discharged from hospital.
- An improvement in the “Rightcare Value”.

Diagram 11.0 Strategic Programmes: Key Elements & Outcomes



8.7 The extensive engagement process that the CCG has undertaken with the public, providers and other stakeholders has identified three additional programme areas for the CCGs to target. Having identified these, the CCGs are now in the process of identifying the necessary leadership to drive progress in these areas forward. This will result in detail plans being developed against these programmes with a similar outcome aim.

9. Outcome Ambitions

9.1 The two year operation plan for the CCG, centres around the development of targets or goals for the six ambition outcomes prescribed by NHSE. The aspiration for the CCGs across five years is set out below.

Outcome Ambition 1 – Partial Years of Life Lost

9.2 Each CCG is required to test and review the opportunity for improving the numbers of years of life lost for its population. An initial approach to this has been developed using the NHS Ambitions Atlas to enable the CCG to compare performance against peer CCGs. This approach suggested that Sefton CCG was currently third in terms of performance in its peer group and that an ambition to achieve the best in its peer group across five years would equate to a 19.7% improvement over five years.

9.3 The CCG has tested this data further, reviewing it with Public Health Colleagues in Sefton Council and with NHSE, both at regional and national levels. Current advice is that while this indicator is helpful, it requires a significant population number in order to eliminate significant annual variables. Application of this outcome at a CCG population level is difficult, especially where CCGs are not co-terminus with previous PCT organisations. For illustrative purposes the trend for the CCG is set out below.

	Value				**% change**			
SFCCG	2009	2010	2011	2012	09-10	10-11	11-12	09-12
	2052	2566	2283	2498	20%	-12%	9%	18%

9.4 While the CCG has described a level of ambition for this outcome, it remains heavily qualified and is subject to further collaborative work with Public Health England.

Outcome Ambition 2 – To Reduce Unplanned Hospital Admission

9.5 The CCG has defined a high level of ambition, to reduce the amount of unplanned hospital admissions and activity by 15% across five years. The trajectory for this is set out in the table below.

	2013/14 (based on month 8 forecast)	2014/15	2015/16	2016/17	2017/18	2018/19
South Sefton	-10.5% (-1,865 admissions from 12/13 baseline)	0%	-1.0%	-1.0%	-1.5%	-2.0%
Southport & Formby	-5.8% (-862 admissions from 12/13 baseline)	0.00%	-2.00%	-4.00%	-2.50%	-2.00%

9.6 This requires the CCG to sustain the current evident level of performance in 2013/14 and repeat this in 2014/15. This is deemed to remain challenging, particularly in view of the mild winter experienced this year.

Ambition Outcome 3 – Improving experience of in-patient care

9.7 As part of the Quality Agenda, the annual in-patient survey lends data on the patient experience within our local providers. This is the data source for this ambition. An improvement in performance is considered achievable and desirable, given the emphasis that the CCG places on quality of care and patient experience. The CCG is striving for a 10% improvement as part of its ambition plan.

Ambition Outcome 4 – To improve Patient Experience of Out of Hours Services

9.8 The data informing this ambition is derived from the National GP patient survey. Only one years data is available at CCG level, enabling the robust construction of a CCG level of ambition difficult. An improved performance to realise 5th in peer group equates to an improved position of 2.8% by 2018/19 from current baseline of 6.2%.

Ambition Outcome 5 – Improve the Health Related Quality of Life for people with one or more long term conditions.

9.9 The data underpinning this ambition is also derived from the GP patient survey and as such presents limited trend analysis for planning purposes.

9.10 The CCG has set an improvement in this ambition by 9%. This remains ambitious, given the pressures within primary care, but also is sensitive to the level of historical performance available.

Ambition Outcome 6 – Improve Emergency Ambition Performance

9.11 This ambition is a composite of several other indicators and thus has a degree of complexity to its construct. The key elements include:-

- Ambulatory Care
- Avoidable Admissions
- Asthma, Diabetes and Epilepsy for u19 years
- Lower Respiratory Tract Infections in Children

9.12 The source data for the above is providers and it should be noted that this has been the subject of changes in coding and coding quality in recent years. This has led to some very fluctuating trends from year to year. Despite this, the CCG has demonstrated some significant improvement, largely assist by the range of Diabetes and Childhood initiatives relating to respiratory. The CCG is aiming to improve this performance by 20% over the duration of its plan.

10. Better Care Fund

10.1 South Sefton CCG and Southport & Formby CCG have worked with Sefton Council to enable the draft Better Care Fund to be submitted on 14th February and a revision to this on 4th April. Detailed plans continue to be developed jointly, building on the shared vision set out in the Health & Wellbeing Strategy.

Our Vision for Sefton, as described in our Health and Wellbeing Strategy, is:-

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

10.2 Our Health and Wellbeing Strategic Objectives are:

- ensure all children have a positive start in life

- support people early to prevent and treat avoidable illnesses and reduce inequalities in health
- support older people and those with long term conditions and disabilities to remain independent and in their own homes
- promote positive mental health and wellbeing
- seek to address the wider social, environmental and economic issues that contribute to poor health and wellbeing
- build capacity and resilience to empower and strengthen communities.

10.3 **Over the next 5 years,** we will aim to deliver transformed services for the people of Sefton focusing on moving care from hospital to community based resources and supporting people in their own homes. Where care and other support is needed, we will look to make it available *in the right place, at the right time, at the right quality, whilst being cost effective.*

10.4 **In seeking to deliver our 5 year ambition we will focus on:**

- early Intervention and Prevention
- health promotion
- self-care, self-help, self-management, with the longer term aim of reducing reliance on public sector services
- encouraging self-determination and responsibility
- information, advice, signposting and where necessary, redirection to appropriate services
- developing integrated approaches across professional and organisational boundaries e.g. primary and secondary care clinicians working together in the community, assessment, meeting care needs, single gateway, seamless front door
- facilitating a significant shift in culture and behaviours, across professions and organisations, but also in individuals in our community
- Innovation and whole system change.

10.5 To achieve this we have committed to the following principles:

- everything we do is to improve outcomes and the experiences of people
- we will engage with the people who use our services as partners, establishing a new and equal relationship with our professional staff in co-designing and continually improving services
- we will provide person centred care that considers an individual's physical and mental health and well-being needs
- we will provide care and services focused around the individual - there is no wrong front door - promoting early intervention and prevention, encouraging people to self-help where possible
- we will ensure the location of services is in, or as close as possible to, people's own homes, with hospital and residential care targeted at those who require that level of care
- we will ensure our workforce is fully engaged and contributes to the development of this vision and the services that are part of it
- we will maximise the opportunities to make an even greater difference to people's lives through working with other sectors e.g. housing, voluntary sector.

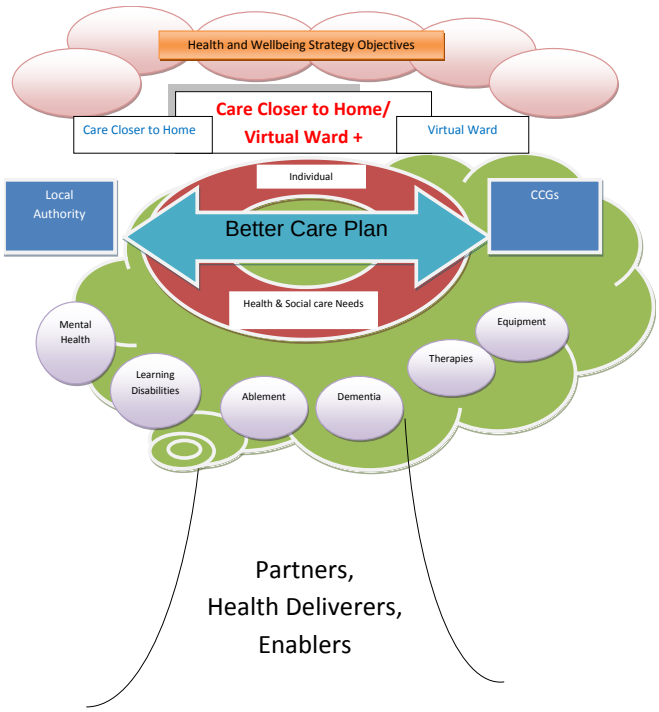
10.6 In addition to the above, the BCF has attempted to describe the significant changes to services and patterns of services that are likely to be evident over the next 5-10 years, most notably:-

- an increase in the number of people living independently and receiving care at home when needed.

- families, charities, volunteers and neighbours will increasingly be the providers of services playing a pivotal role in the prevention agenda and promoting dementia friendly communities.
- decreases in unnecessary admission and readmissions to hospital.
- social care focused on enabling people to live independently, rather than on assessing and meeting need: with staff focusing on assessing what people can do for themselves and only meet the needs of the most vulnerable.
- increased use of appropriate home technology, tele-health and telecare
- participation of people in applied research studies, particularly in primary care and related to the acceptability of technology.
- appropriate use of joint Health and Social Care packages.
- young people transitioning seamlessly from Children to Adult Services provision.
- carers supported to continue in their unpaid caring roles.
- a reduction in social isolation.
- effective and appropriate mental health provision.
- end of Life / Palliative Services, where people are treated with dignity and respect.
- enhanced, targeted and focused re-ablement across community, intermediate and hospital based care.
- 7 day services, where appropriate
- integrated access for all referrals using NHS number as the primary identifier.
- people, partners, providers, the two CCGs and Council working in an integrated way, to reduce the longer term reliance on public sector services.
- people and their families taking primary responsibility for looking after themselves early in order to remain fit and healthy whilst planning how they will personally financially contribute towards any care that may be required.

10.7 In terms of alignment and consistency the changes described above are at one with the system characteristics described as part of the CCGs five year strategic plan and support deliver of the major transformation schemes (Virtual Ward, Care closer to home).

Diagram 12.0 The Better Care Fund Model for Sefton



10.8 Our joint vision, as highlighted in the above figure, has been developed from patient and public participation using a “Fruits” and “Roots” model to deliver better integrated care and improve outcomes.

10.9 The aims are to:-

- **improve the health and wellbeing** of people in our community, with a focus on tackling inequality;

- co-ordinate care around individuals targeted to their specific needs with the ambition of **working towards a single assessment framework** to assess and meet the needs of individuals in their homes and communities, with seamless delivery of health and social care. This means ensuring there is a good quality care plan in place for all those at risk, backed by co-ordinated provision commissioned to deliver on the required support and outcomes envisaged in each and every plan

- **improve the quality and experience of care**, with the right services available in the right place at the right time and use these experiences to evaluate and improve services;

- **maximise independence** by providing appropriate support at home to those who need it and in the community, and empower all people to self-care and self-manage their own health and wellbeing;

- provide **proactive and common case management**, which avoids unnecessary admissions and readmissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health and self-manage their long term conditions;

- facilitate integrated care through **Primary Care** across the Borough. Our ambition is that community, social care services, specialist mental and physical health services will be organised to work effectively through our model of integrated care, enabling Primary Care to ensure their patients are getting the very best person-centred care;

- collaborate with our **providers** to develop new models of service delivery, driven by clinical and professional staff on the ground;

- adopt national and international best practice and embrace innovation and ideas.

10.10 The key thrust of the joint work with Sefton Council on the Better Care Fund is targeting efficiency in relation to:-

- admissions avoidance
- reduced length of stay
- reduction in delayed discharges.

10.11 The BCF remains aligned with the CCG Strategic Plan and aims to support a reduction in unplanned admissions to hospital by 15%, underpinned with a pooled budget from existing monies of £24m across the borough from 2015/16.

11. Governance

11.1 In order to drive and support deliver against the strategic vision, the three major transformation schemes (Virtual Ward, Care Closer to Home, Primary Care) and the seven strategic programmes, both CCGs have reviewed infrastructure, performance and leadership arrangements.

11.2 This review has not only focused on accountability and assurance systems, with reporting arrangements to the respective CCG Governing Bodies, but also at a delivery level in terms of the programmes.

11.3 The key governance, performance and delivery enhancements are as follows:

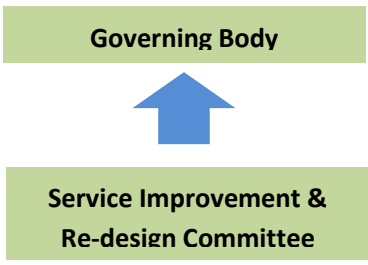
- a clinical and managerial lead for each strategic programme;
- each programme developed in conjunction with the PMO to ensure alignment with core strategic priorities and outcomes;
- the development of key outcome measures for each programme in relation to impact on unplanned admissions, A&E attendances, Length of stay, 30day re-admission rates;
- each programme to report to Service Improvement & Re-design Committee as part of revised Governing Body and committee structure;
- each major transformation scheme and its leadership to report to Service Improvement & Re-design Committee as part of revised Governing Body and committee structure;
- the quality delivery aspects of all programmes and transformation schemes to be tested through Quality Committee;
- a progress report on all programmes and major transformation schemes to be considered at each Governing Body meeting, to enable board members to be sighted on progress, test and assure on delivery and provide support in addressing any complex multi-organisational or political issues;
- the development of performance dashboards for each of the major transformation schemes, supported and overseen by the PMO.

11.4 In addition to the above, both CCGs recognise the integrity of their strategic plan with the Health & Wellbeing Strategy and the Better Care Fund Plan. It is envisaged that the Health & Wellbeing Board will be similarly briefed on progress in relation to the CCGs strategic plan, through representation in the form of the Accountable Officer and the respective CCG Chairs.

11.5 It should be noted that in an effort to refocus and support delivery further, that South Sefton CCG and its two major partners (Southport & Ormskirk Hospital Trust and West Lancashire CCG) are undertaking a review of the Care Closer to Home Programme. This is aimed at gaining further alignment with the respective CCG strategic plans, including West Lancashire CCG. It is also aimed at re-aligning the health system priorities to support and deliver the locality based clinical model, described earlier in this document.

11.6 The diagram below describes the reporting and accountability arrangements for the major transformation schemes and the component strategic programmes

Diagram 13.0 Strategic Programmes and Major Transformation Schemes: Reporting Arrangements



NHS Southport and Formby CCG Governing Body

Audit Committee

SMT: **Martin McDowell**. Chair: **Helen Nichols**

Key functions and responsibilities: To support the establishment of an effective system of integrated governance, risk management and internal control and to review and approve the arrangements for discharging the Group's statutory financial duties.

Remuneration Committee

Chair: **Helen Nichols**

Key functions and responsibilities: Determining the remuneration and conditions of service of the senior team, approval of severance arrangements and approval of disciplinary arrangements for employees, including the Chief Officer

Finance and Resources

SMT: **Martin McDowell**
Chair: **Helen Nichols**
Clinical Director: **Dr Evans**

Key functions and responsibilities

- To advise the Governing Body on all financial matters
- To review and manage the overall financial position
- To ensure that the performance of commissioned services is monitored in line with CCG expectations
- To advise on procurement and contracting arrangements
- To monitor contract and procurement arrangements
- To review and monitor Foundation Trust applications
- To review and monitor CHC financial position
- To determine banking arrangements
- To approve arrangements for exceptional/novel treatments including IFR
- To review and monitor workforce performance
- To review and monitor Commissioning Support Unit performance

Quality Committee

SMT: **Debbie Fagan**
Chair: **Dr Rob Caudwell**
Clinical Director: **Dr Doug Callow**

Key functions and responsibilities

- To monitor standards and provide assurance on the quality of commissioned services
- To review and monitor Serious Incidents
- To promote a culture of continuous improvement and innovation with respect to safely, clinical effectiveness and patient experience
- To provide an assurance to the Governing Body that there are robust processes for managing risk
- To ensure appropriate Safeguarding arrangements are in place
- To provide corporate focus, strategic direction and momentum for quality, and risk management
- To review and monitor medicines management
- To approve corporate and clinical policies

Service Improvement and Redesign

SMT: **Karl McCluskey and Jan Leonard**
Chair: **Dr Niall Leonard**
Clinical Directors: **Dr Kati Scholtz**

Key functions and responsibilities

- To identify potential areas of service improvement
- To establish the rationale and evidence base supporting the need for improvement
- To ensure that localities are fully engaged in processes
- To assess and approve business cases
- To monitor and measure impact of improvements
- To facilitate engagement with stakeholders
- To ensure that all service reviews and the implementation of new services comply with all relevant laws and legislation
- To support improvements in Primary Care
- To monitor programmes including Virtual Ward, Care Close to Home, Children's, Mental Health, planned and unplanned care

Supporting the Quality Committee: The CGSG will provide assurances on the processes for reviewing the GBAF and CRR and make recommendations to the Committee. The group will review policies and procedures and recommend them as appropriate to the committee for approval.
Supporting Audit Committee: The group is part of the CCGs Risk and Control Framework and will enable the Audit Committee to obtain assurances on key internal control requirements.

Corporate Governance Support Group

Chair: **Tracy Jeffes**

Key functions and responsibilities:
Ensuring compliance with relevant legislation and standards, monitoring activity and providing assurances in respect of :

- *Public Sector Equality Duty (PSED)*
- *Health and Safety (Incidents and LSMS)*
- *Third Party Claims*
- *Governing Body Assurance Framework and Corporate Risk Register*
- *Information Governance (IG Toolkit)*
- *Freedom of Information Requests*
- *Subject Access Rights Notifications*

Engagement and Patient Experience Group

Chair: **Tracy Jeffes**

Key functions and responsibilities:
Reviewing relevant data, analysing trends and themes, ensuring compliance and providing advice in respect of:

- *Patient Experience themes and trends*
- *Complaints (secondary)*
- *Complaints (primary care)*
- *PALS*
- *NHS Constitution*
- *Engagement and consultation*
- *Soft Intelligence*
- *Stakeholder Engagement and Involvement*

Supporting the Service Improvement and Re-Design Committee: The EPEG will provide patient experience intelligence to this committee. This provides a framework for enabling patient experience to inform commissioning decisions.
Supporting the Quality Committee: EPEG will provide patient experience intelligence to the quality committee, particularly in respect of quality and safety issues that are signalled through complaints and PALS.

11.7 The key revised committee structure for both South Sefton and Southport & Formby CCG is set out on the diagram on the following page. This adds further context in terms of the accountability and reporting lines for the Transformation schemes and the strategic programmes.

12. Conclusions

12.1 The CCG has a detailed five year strategic plan developed, which has been build with the input of members, the public, providers and the community, voluntary and faith sectors.

12.2 The strategic plan has a clear vision for the health system that is Sefton, which is agreed by both South Sefton CCG and Southport & Formby CCG.

12.3 The key transformation schemes to support delivery of the strategic plan are the Virtual Ward, Care Closer to Home and Primary Care.

12.4 The major transformation schemes are underpinned by seven strategic programmes, with an additional three programmes identified through engagement and consultation.

12.5 Both CCGs have described a clear definition of the Health system now and in 2019, what it will mean for individuals and what the system characteristics will be.

12.6 CCG Governance arrangements have been enhanced to ensure leadership of both the transformation schemes and the strategic programmes.

12.7 The CCG committee structure has been revised to ensure that the necessary progress and monitoring can occur via the Service Improvement & Re-design Committee.

12.8 Regular reporting on scheme and programme progress, together with any issues for escalation will be undertaken at each Governing Body Meeting.

12.9 Outcome and performance metrics have been developed for each Strategic Programme.

12.10 The Better Care Fund Plan does not sit separate to the CCG Strategic Plan and the ambitions described in both are aligned and complementary.

12.11 The financial component of this plan is described in the CCG financial strategy. It is envisaged that this will be integrated into this document by the end of June 2014.

12.12 All the financial detail and structure of the financial strategy is aligned to the content of this strategic plan.

12.13 This strategic plan assumes an underpinning quality strategy which addresses and supports all aspects of the CCG compliance requirements. It is intended that this strategy will be augmented to reflect the integrated quality strategy by the end of June 2014.

12.14 A public facing version of this strategic plan, in summary form will now be developed for the end of June, for publication and dissemination.

13. Recommendations

The Governing Body is asked to receive this report by way of assurance and:-

- endorse the five year strategic plan as set out in this document;
- recognise and support the augmentation of the strategic programmes with three additional programme areas having been identified through engagement and consultation;
- endorse the outlined governance and reporting arrangements;
- provide the delegated authority to submit the final five year strategic plan in the varying template formats required by NHSE, based on the plan and detail contained in this paper;
- support the final enhancement of this strategic plan, in integrating the financial and quality strategy.

Karl McCluskey
May 2014

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/72

Report date: May 2014

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Title: Five Year Financial Plan

Summary/Key Issues:

This report sets out a longer term financial strategy and the assumptions which underpin it. It identifies the relationship between the financial plan and the CCG's overarching strategic direction. The underlying risks facing the CCG are also outlined. The report assesses the base case scenario for the CCG and develops a financial strategy for the 5 years up to and including 2018/19.

Recommendation

Note	X
Approve	X
Ratify	

The Governing Body is asked to approve the financial strategy and note:

- the range of assumptions used to provide estimates for future year planning periods
- the potential risks concerning future CCG Resources
- that the strategy enables the CCG to deliver its financial targets during the period
- the requirement to develop robust QIPP plans to address potential downside scenarios.

Links to Corporate Objectives *(x those that apply)*	
X	Improve the quality of commissioned services, whilst achieving financial balance.
X	Achieve a 2% reduction in non-elective admissions in 2014/2015.
X	Implementation of 2014/15 phase of Care Closer to Home.
X	Review and re-specification of community nursing services for re-commissioning from April 2015 in conjunction with membership, partners and public.
X	Implementation of 2014-15 phase of Primary Care quality Strategy/transformation.
X	Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy.
X	Review the population health needs for all mental health services to inform enhanced delivery.

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
May 2014

1. Introduction

1.1 The purpose of this paper is to set out a 5 Year Financial Strategy for the CCG for the period between 2014/15 and 2018/19. The paper outlines the key considerations in producing the plan and discusses the key issues, principles and assumptions that underpin it. The Strategy is a dynamic plan that will adjust in line with changes to the external environment such as government policy and the development of the CCGs commissioning plans.

1.2 The first iteration of the Financial Strategy was presented to the Finance and Resource Committee in November 2013, and this report provides an update to that strategy. This iteration incorporates all of the latest guidance and information received from NHS England in terms of financial planning across this timescale.

1.3 The guidance "Everyone Counts: Planning for Patients 2014-15 to 2018/19" sets out the aims for the NHS. The planning guidance also set out the requirements for CCG financial plans for 2014/15:

- To deliver a 1% surplus at year end
- 2.5% non-recurrent spend (including 1% for transformation / "call to action fund")
- A minimum 0.5% contingency reserve is created.

In developing the longer term strategy it has been assumed that the financial planning requirements set out in Everyone Counts should still be applied over the 5 years of the Strategy. The only exception to this is the requirement to hold non-recurrent reserves which reduce to 1% from 2015/16.

1.4 The CCG's Financial Strategy needs to be in line with its commissioning intentions and show integration with key partners. All CCGs are required to submit planning templates that cover the following areas:

- Strategic plan
- Operational plan
- Financial plan
- Better Care Fund

1.5 An initial version of the Financial Strategy was submitted to NHS England on 14th February 2014, and an updated version was submitted on 4th April 2014. A final version will be submitted in June 2014.

2. Key Principles and assumptions

2.1 The Financial Strategy considers the likely funds available to the CCG – the Resource Allocation set by NHSE – against its planned spend on health care services which it is responsible for and its administrative (running) costs. It reflects and supports the CCG's

commissioning intentions. A Financial Strategy may be distinguished from the Annual CCG Budget by attempting to assess resources and spending beyond the next financial year. There are benefits to longer term planning in that commissioning changes may take more than 12 months to implement. It also enables the organisation to identify financial risks early and make plans to address them.

Revenue Allocations

2.2 A new funding formula for CCGs was published by NHS England in December 2013. This identified that Southport and Formby CCG was considered "over-funded", compared to its target allocation, as identified in Table 2.

Table 2

	£000	
Baseline allocation @ M6 2013/14	£159,704	
Target allocation	£152,718	
Initial distance from target	£6,986	4.57%

Baseline allocation @ M6 2013/14	£159,704	
Approved allocation transfers	£2,437	
Revised baseline allocation	£162,141	
Target allocation	£152,718	
Revised distance from target	£9,423	6.17%

2.3 The CCG is estimated to be over target by 6.17% and therefore received the lowest level of funding available to CCGs with confirmed uplifts of 2.14% in 2014/15 and 1.70% in 2015/16. This option was considered by NHS England to provide stability and not expose CCGs to unexpected changes in funding. The CCGs that were most under-funded were given additional increases to their baselines with the highest increase being 4.92% in 2014/15 and 4.79% in 2015/16. There still remains wide variation in terms of levels of CCG distance from target across England ranging from 11.02% under target to 33.49% over target, with those furthest under target lobbying for a quicker pace of change. On this basis, it would be sensible for the CCG to develop a downside scenario which develops a plan to reach its target by the end of 2018/19. This would entail delivering significantly more QIPP savings during this timescale.

2.4 In establishing a Distance from Target (DFT) figure, NHSE has acknowledged that the formula has a tolerance of +/- 5% in terms of its margin for error. When CCG's fall within this range, they will have been deemed to be "within target", under current policy.

Allocations have been confirmed for 2015/16 financial year, but the CCG should be mindful that the pace of change policy may be accelerated in the period from 2016/17 to 2018/19. The CCG should take advantage of the intervening period to develop robust QIPP plans for the following two downside scenarios:

i. the CCG is required to reach 5% above DFT by end of 2018/19.
ii the pace of change policy is applied so that all CCG's reach target by end of 2018/19 in which case the CCG's expenditure will need to be in line with target.

2.5 NHS funding has been guaranteed real-terms (above inflation) growth during the life of the current parliament and this has been confirmed at national level within NHS England's board paper on financial planning. However, the picture that emerges at local level is somewhat different. The CCG will have additional expenditure commitments in 2014/15

which will need to be funded from its growth allocation. The table below highlights the key changes which have been factored into the CCG's financial planning strategy,

Table 3

	£000
Southport & Formby CCG growth	3,470
Additional commissioning obligations	
CHC Restitution payments	(634)
Support for patients aged over 75	(613)
Other NHS Mandate pressures	(731)
Remaining growth funding	1,492
Real growth	0.92%

2.6 The estimate of real growth available to the CCG is therefore 0.92% which compares unfavourably with the current GDP deflator of 2.14% and concludes that the CCG does not receive real-terms growth funding when considering the additional expenditure streams outlined above.

2.7 The additional commitments comprise of the following

CHC restitution – CCG's have been notified of a "top-slice" arrangement to create a £250m national pool to deal with outstanding CHC restitution payments. This is subject to ongoing debate across the NHS finance community, particularly given that assurances had been given that CCG's would not inherit PCT legacy debt.

Transforming care of elderly (over 75) and other vulnerable people – CCG's have been asked to earmark funding of £5 per head to reduce avoidable admissions into hospital settings. Whilst this may reduce savings elsewhere in the CCG's budgets, the operational plans for achievement are not fully completed and on this basis, the CCG plans to fund this development through growth funding as opposed to potential QIPP savings.

National Programmes – CCG's have been asked to plan for the roll-out of a number of schemes which will be announced at different stages throughout the year. The amount set aside at national level is £530m and the CCG has yet to receive confirmation as to what programmes will be included against this funding although it would appear that the recent announcement of £90m to support improved diagnosis and care for dementia sufferers will be funded using this resource.

Expenditure assumptions

2.8 The CCG will need to ensure that it contains its expenditure levels within its specified allocation and that it meets its financial targets during the period under review. The bulk of the expenditure will be spent on commissioned health care services whilst a much smaller proportion will be spent on the capped running costs (for Southport and Formby CCG this is £2.917m in 2014/15).

In terms of the financial strategy, the key issue will be the degree of control that the CCG can exercise on the costs of the services it commissions. These can vary either due to inflationary price changes or changes in activity. The price changes for NHS providers will be set nationally by Monitor in conjunction with NHSE, and guidance is outlined overleaf in Table 4. The application of continued efficiency assumptions in the tariff will pose a significant financial risk to providers of healthcare.

Table 4

Tariff assumptions					
	2014/15	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Secondary care health cost inflation	2.8%	2.9%	4.4%	3.4%	3.4%
Provider sector efficiency	-4.0%	-4.0%	-4.0%	-4.0%	-4.0%
Tariff uplift / deflator	-1.2%	-1.1%	+0.4%	-0.6%	-0.6%

2.9 It should be noted that the NHS faces significant pension cost increases in 2015/16 and 2016/17 which have been factored into the tariff. Other assumptions used in modelling the Financial Strategy are outlined in appendix 1.

3. Investments and QIPP

3.1 The Financial Strategy is required to support the CCG's overarching strategic direction. Investment plans and QIPP plans support the CCG's strategy to reduce unplanned care and move care from acute to community settings. The following investments support this initiative:

- Care Closer to Home
- Accountable professional – support for patients over 75 and those with complex health needs
- Primary Care Quality Strategy
- End of Life Facilitator
- Better Care Fund
- Community Children's Nursing Outreach Team
- CVS

3.2 Appendix 2 outlines the investments planned by the CCG over the next 5 years. The CCG is required to have a non-recurrent investment reserve of 2.5% in 2014/15, which reduces to 1% thereafter. This reduction in non-recurrent programme spend transfers a number of non-recurrent schemes into recurrent spend from 2015/16. This includes the expenditure associated with Care Closer to Home and the Primary Care Quality Strategy, which the CCG can now develop with greater certainty in respect of funding.

3.3 The investment plan also outlines costs associated with approved business cases. Many of these are expected to deliver cost savings elsewhere in the health system (eg. SIP feeds)

3.4 The CCG has a number of programmes of work that also support the strategic direction of supporting patients with long term conditions, providing care closer to home and thus reducing unplanned episodes of hospital care. These programmes of work are in the following areas:

- Diabetes
- Cardiovascular disease (CVD)
- Respiratory
- Cancer
- Children
- End of Life
- Primary Care
- Mental Health

QIPP

3.5 The level of QIPP efficiency savings within the Financial Strategy is reported in Appendix 3. At this stage it focuses upon the following areas:

- tariff efficiencies,
- reductions in the costs associated with unplanned care.
- reductions in prescribing costs
- management cost reductions from 2015/16

3.6 The reductions in unplanned care have assumed a 15% reduction in emergency admissions by 2018/19. This uses 2012/13 as the baseline year. A significant reduction has been achieved in 2013/14, and the plan assumes that this is maintained in 2014/15. Smaller reductions are then seen in each subsequent year. Reductions in A&E attendances have also been achieved in 2013/14, and the plan assumes reductions of 2% each year from 2015/16.

3.7 An amount of unidentified QIPP is included in the plan. There is a link between investment plans and cost improvement plans. Full investment plans can only be released when the QIPP plans have been delivered. The CCG has a designated QIPP target to reach each year, and due to the financial pressures facing the CCG, there is an additional cost improvement target in 2014/15. This will allow the CCG to meet its financial obligations. Work has started to identify additional cost reduction opportunities centred on more efficient provision of healthcare and more effective financial management. The work programmes in paragraph 3.4 are being costed to quantify the opportunities available.

3.8 NHS England has published indicative Running Cost Allowances (RCA) for the 5 year period ending 2018/19. This shows a 10% reduction in 2015/16, with smaller reductions in subsequent years. The CCG plans to hold contingency in 2014/15 to enable it to make a contribution to this target but it is likely that QIPP savings will be required against the RCA in order to deliver the 2015/16 requirement. This has been factored into the model and the CCG will be required to outline its plans to deliver these savings accordingly.

3.9 If NHS allocation uplifts reduce further after 2015/16 then further efficiencies will be needed to ensure the CCG can deliver its financial duties. This will be achieved by extending its QIPP programme to use it as a mechanism to manage financial risk. Future iterations of the Financial Strategy will model a downside scenario that shows the CCG reach its target allocation by 2018/19.

Better Care Fund

3.10 The allocation information published by NHS England also includes figures in relation to the Better Care Fund (BCF). The BCF (previously referred to as the Integration Transformation Fund) was announced in June 2013 as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with more integrated care and support. It aims to improve the lives of some of the most vulnerable people in society by enabling the provision of the right care, in the right place, at the right time, including through a significant expansion of care in community settings.

3.11 The Fund nationally provides for £3.8 billion worth of funding in 2015/16. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the BCF in 2015/16. Table 5 summarises the values in terms of Southport and Formby CCG contributions.

Table 5

	BCF Additional Allocation (A)	Total transfer to BCF (B)	Net contribution to BCF (B-A)
	£000	£000	£000
NHS Southport & Formby CCG	£2,884	£8,845	£5,961

3.12 In 2015/16, the £8.845m will be transferred to the Better Care Fund, and commissioning plans will be agreed between Sefton MBC and the two Sefton CCGs. The pooled fund with Sefton MBC and South Sefton CCG will total £24.032m, and a high level expenditure plan is detailed in table 6:

Table 6

Area of spend	2015/16 planned spend (£000)
Existing section 256 agreements	5,700
Disabled Facilities Grant	1,900
Social Care Capital Grant	900
Carers breaks	500
Reablement	1,800
Demographic pressures on social care	3,000
Transformational schemes	10,232
Total BCF expenditure plans	**24,032**

4. Mitigating Financial Risk

4.1 The key risks to the CCG achieving its financial duties are:

- NHSE policy relating to the Pace of Change for CCG Allocations
- The relative gap between annual allocation growth and national price or tariff uplifts net of the efficiency factor.
- Activity growth for services subject to cost and volume payment systems e.g. PbR and CHC. We have seen significant additional pressure in quarter 4 of 13/14 in this area.
- Increased costs due to PbR case mix changes or higher cost best practice tariffs.
- National NHS Mandate "must do's" which require investment, including costs associated with 7 day working.
- Failure to deliver the savings from the CCG's QIPP schemes.
- Significant reduction in allocation associated with the Better Care Fund
- The financial viability of providers

4.2 The CCG will need to ensure that the risks are managed. One element of the financial system that may reduce risk is to plan not to spend 100% of the CCG allocation but keep some back to use as a contingency reserve to deal with in-year cost pressures. The Financial Strategy builds in a 0.5% contingency reserve to accommodate unforeseen overspends. It is also important that the investment plans associated with the Better Care Fund and reductions in unplanned care are effective. If cost savings are not delivered then investment plans will need to be delayed until the required savings are planned and delivered.

5. Financial Strategy

5.1 The CCG has developed its financial strategy model using both national guidance and locally determined assumptions. The Financial Strategy complies with all national guidelines. The outputs of this model are reflected in the appendices within this paper:

i). Planning assumptions 2014-19
ii). Investment profile 2014-19
iii). QIPP Plans 2014-19
iv). Summary Financial Position 2014-19

5.2 Appendix 4 shows the draft anticipated financial position to 2018/2019 over the key spending categories. The base budgets for the key expenditure categories are carried forward over the years with adjustments made for activity growth, inflation, QIPP, pricing changes, and other known investments and pressures.

5.3 A number of factors will influence the CCG's financial strategy in terms of changes from its current base model (i.e. projected expenditure for 2013/14). These will include:

i) Growth assumptions for individual CCG's.
ii) The introduction of the target allocation and "pace of change" in terms of how quickly CCG's will move towards target.
iii) The CCG's ability to manage in-year pressures particularly in relation to increasing demand for services.
iv) The CCG's planned investment programme:
v) The CCG's ability to deliver QIPP savings both in cash-releasing terms and non-cash releasing terms (e.g. improved quality / managing demand through different service models etc.).

All of these issues are interlinked and will need to be carefully monitored and evaluated as part of the strategic planning process. If in-year costs increase at a higher than expected level, then the CCG will either have to deliver more savings through QIPP or alternatively look to defer its planned investment programme.

5.4 Estimates of in-year pressures faced by the CCG have been built into the strategy. Some of the key assumptions involved have been listed in appendix 4 of the report.

5.5 The Financial Strategy demonstrates that the CCG will stay in financial balance over the next 5 years – as limited allocation growth together with tariff efficiency and other CCG QIPP savings combine to give re-investment and development opportunities to the CCG over the period. This strategy is based upon the CCG being able to control expenditure at 13/14 levels, building in planned investments and deployment of contingency. The risks to achieving this are significant, and the CCG needs to continue to monitor expenditure trends on a monthly basis and develop effective QIPP plans.

6. Conclusions

6.1 This paper sets out the key issues behind the creation of a longer term Financial Strategy for the CCG to 2018/2019. In developing the Strategy assumptions need to be made given the significant uncertainties that there are over allocations and spending that will apply to CCGs from 2014/2015.

6.2 The paper proposes that the CCG will need to ensure that it has access to sound financial management and systems coupled with robust governance arrangements if it is to be able to

ensure delivery of its financial duties – given the financial risks inherent within the current NHS system.

6.3 The paper sets out the development of a model to support its longer-term goals and duties over the next 5 years to 2018/2019. The modelling suggests that the CCG will meet its financial obligations, but it is important to note that this is subject to a number of assumptions. One assumption is continued growth in funding. Downside scenarios (see section 2.4) will be developed to reflect the changes needed should the CCG be required to meet its target allocation by the end of the planning period (2018/19).

7. Recommendations

The Governing Body is asked to approve the Financial Strategy and note:

- the range of assumptions used to provide estimates for future year planning periods;
- the potential risks concerning future CCG Resources;
- that the strategy enables the CCG to deliver its financial targets during the period;
- the requirement to develop robust QIPP plans to address potential downside scenarios.

Appendices

- Appendix 1 – Planning assumptions 2014-19
- Appendix 2 – Investment profile 2014-19
- Appendix 3 – QIPP Plans 2014-19
- Appendix 4 – Summary Financial Position 2014-19

Martin McDowell
James Bradley
May 2014

	2014 -15	2015 -16	2016 -17	2017 -18	2018 -19
	%	%	%	%	%
Allocation assumptions					
CCG Allocation Growth	2.14%	1.70%	1.80%	1.70%	1.70%
Movement to Target	0.00%	0.00%	0.00%	0.00%	0.00%
Net Growth/(reduction)	**2.14%**	**1.70%**	**1.80%**	**1.70%**	**1.70%**
Running Costs assumptions					
Running Cost Allowance	0.00%	-10.00%	0.00%	0.00%	0.00%
Cost increase assumptions					
Tariff assumptions - provider inflation	2.80%	2.90%	4.40%	3.40%	3.40%
Tariff assumptions - Efficiency Savings	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
CQUIN Increase	0.00%	0.00%	0.00%	0.00%	0.00%
Non-demographic growth - Prescribing	5.00%	5.00%	5.00%	5.00%	5.00%
Non-demographic growth - Acute	0.50%	0.50%	0.50%	0.50%	0.50%
Prescribing Efficiency Savings	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
Non-demographic growth - Continuing Healthcare	4.00%	4.00%	4.00%	4.00%	4.00%
Demographic Growth	0.18%	0.15%	0.29%	0.11%	0.25%
Business Rules					
Non Recurrent requirement for CCGs	1.50%	1.00%	1.00%	1.00%	1.00%
CCG Surplus	1.00%	1.00%	1.00%	1.00%	1.00%
Contingency	0.50%	0.50%	0.50%	0.50%	0.50%
"Call to Action" Fund	1.00%				

NHS Southport & Formby CCG **APPENDIX 2**

Investment Profile 2014-19	**2014/15**			**2015/16**			**2016/17**			**2017/18**			**2018/19**		
	Rec £000's	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**
Investment Plans															
NHS COIN Infrastucture Costs (IT)	55	0	**55**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Pick-up of MacMillan GP Sessions	28	0	**28**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
MacMIllan Project Funding	0	0	**0**	0	0	**0**	0	8	**8**	16	0	**16**	0	0	**0**
MERIT compliance (Ongoing)	43	0	**43**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Aspergers	69	0	**69**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
IVF - change in criteria	108	0	**108**	75	0	**75**	38	0	**38**	0	0	**0**	0	0	**0**
Accountable professional - support for over 75s	613	0	**613**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
NHS Mandate investments	731	0	**731**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Transforming Primary Care	0	0	**0**	368	0	**368**	0	0	**0**	0	0	**0**	0	0	**0**
EMIS Web Roll-out (LCH)	0	0	**0**	31	0	**31**									
Care Closer to Home	909	0	**909**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Sub-Total - investment plans	**2,556**	**0**	**2,556**	**474**	**0**	**474**	**38**	**8**	**46**	**16**	**0**	**16**	**0**	**0**	**0**
Non-Recurrent Investment Plan	**1.50%**			**1.00%**			**1.00%**			**1.00%**			**1.00%**		
Trust support for winter pressures.	0	810	**810**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
CVS	0	0	**0**	0	307	**307**	0	307	**307**	0	307	**307**	0	307	**307**
Advancing Quality Infrastructure	0	70	**70**	0	63	**63**	0	57	**57**	0	0	**0**	0	0	**0**
Alcohol Nurse Liaison Service (S&O)	0	82	**82**	0	82	**82**	0	82	**82**	0	82	**82**	0	82	**82**
Winter Pressures	0	200	**200**	0	320	**320**	0	320	**320**	0	320	**320**	0	320	**320**
Community Childrens Nursing Team	0	174	**174**	0	174	**174**	0	174	**174**	0	174	**174**	0	174	**174**
End of Life facilitator	0	44	**44**	0	44	**44**	0	44	**44**	0	0	**0**	0	0	**0**
SIP Feeds Review	0	22	**22**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Care Home Medicines review	0	92	**92**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
CHC Restitution	0	634	**634**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
EMIS Web Roll-out (LCH)	0	25	**25**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Other	0	328	**328**	0	640	**640**	0	696	**696**	0	825	**825**	0	853	**853**
Sub-Total - non-recurrent investment plan	**0**	**2,481**	**2,481**	**0**	**1,630**	**1,630**	**0**	**1,680**	**1,680**	**0**	**1,708**	**1,708**	**0**	**1,736**	**1,736**
Call to Action Fund (2014/15)															
Mersey Rehab Project	0	640	**640**												
CVS	0	307	**307**												
Transforming Primary Care	0	368	**368**												
Other	0	0	**0**												
Sub-Total - Call to Action Fund	**0**	**1,315**	**1,315**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total - Investment Plans	**2,556**	**3,796**	**6,352**	**474**	**1,630**	**2,104**	**38**	**1,688**	**1,726**	**16**	**1,708**	**1,724**	**0**	**1,736**	**1,736**

NHS Southport & Formby CCG **APPENDIX 3**

Cash Releasing - QIPP Profile 2014-19	**2014/15**			**2015/16**			**2016/17**			**2017/18**			**2018/19**		
	Rec £000's	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**	**Rec £000's**	**Non-R £000's**	**Total £000's**
Tariff Saving	4,643	0	4,643	4,731	0	4,731	4,670	0	4,670	4,708	0	4,708	4,694	0	4,694
Prescribing	809	0	809	822	0	822	832	0	832	842	0	842	852	0	852
Running Cost Allowance reductions	63	0	63	311	0	311	19	0	19	18	0	18	17	0	17
EOL Facilitator	44	0	44	0	0	0	0	0	0	0	0	0	0	0	0
Care Home Medicines Review - drugs	150	0	150	0	0	0	0	0	0	0	0	0	0	0	0
Care Home Medicines Review - admissions	58	0	58	0	0	0	0	0	0	0	0	0	0	0	0
SIP Feeds review	29	0	29	0	0	0	0	0	0	0	0	0	0	0	0
Admissions avoidance - Care Closer to Home	0	0	0	9	0	9	295	0	295	204	0	204	173	0	173
GP Care Home Pilot	76	0	76	0	0	0	0	0	0	0	0	0	0	0	0
Unidentified plans	0	0	0	0	0	0	58	0	58	101	0	101	138	0	138
Total (QIPP Target)	**5,873**	**0**	**5,873**	**5,873**	**0**	**5,873**	**5,873**	**0**	**5,873**	**5,873**	**0**	**5,873**	**5,873**	**0**	**5,873**
Additional schemes:															
Ophthalmology - intraocular pressure	85	0	85	0	0	0	0	0	0	0	0	0	0	0	0
Unidentified schemes	278	21	299	0	0	0	0	0	0	0	0	0	0	0	0
Admissions avoidance - Care Closer to Home	0	0	0	177	0	177	0	0	0	0	0	0	0	0	0
Total (Additional Schemes)	**363**	**21**	**384**	**177**	**0**	**177**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Grand Total	**6,236**	**21**	**6,257**	**6,050**	**0**	**6,050**	**5,873**	**0**	**5,873**	**5,873**	**0**	**5,873**	**5,873**	**0**	**5,873**

Summary of Financial Position 2014-19	2014/15			2015/16			2016/17			2017/18			2018/19		
	Rec	Non-R	Total	Rec	Non-R	Total	Rec	Non-R	Total	Rec	Non-R	Total	Rec	Non-R	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Base Allocation	162,141	0	162,141	165,611	0	165,611	162,465	0	162,465	165,390	0	165,390	168,201	0	168,201
Growth	3,470	0	3,470	2,815	0	2,815	2,924	0	2,924	2,812	0	2,812	2,859	0	2,859
Pace of Change impact	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Agreed allocation adjustments	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Better Care Fund - Additional allocation	0	0	0	2,884	0	2,884	0	0	0	0	0	0	0	0	0
Better Care Fund - Transfer to pooled budget	0	0	0	(8,845)	0	(8,845)	0	0	0	0	0	0	0	0	0
PY Surplus / Lodgement returned non-rec	0	1,750	1,750	0	1,750	1,750	0	1,700	1,700	0	1,700	1,700	0	1,750	1,750
Running Cost Allocation	2,917	0	2,917	2,606	0	2,606	2,587	0	2,587	2,569	0	2,569	2,552	0	2,552
Total Resources	**168,528**	**1,750**	**170,278**	**165,071**	**1,750**	**166,821**	**167,977**	**1,700**	**169,677**	**170,770**	**1,700**	**172,470**	**173,613**	**1,750**	**175,363**
Planned Application of Funds															
Acute Health Expenditure	82,958	3,638	86,596	82,474	2,166	84,640	83,200	2,175	85,374	83,008	2,162	85,170	82,963	2,149	85,111
Community Expenditure	15,951	800	16,751	15,903	838	16,741	16,011	840	16,851	15,936	837	16,773	15,883	834	16,717
Mental Health Expenditure	14,634	270	14,904	14,535	267	14,802	14,657	268	14,925	14,622	267	14,889	14,609	265	14,874
Continuing Care Expenditure	11,511	0	11,511	11,989	0	11,989	12,504	0	12,504	13,018	0	13,018	13,572	0	13,572
Prescribing Expenditure	22,246	123	22,369	22,569	123	22,693	22,932	123	23,055	23,262	123	23,386	23,632	123	23,756
Other Primary Care Expenditure	3,162	619	3,781	3,535	274	3,809	3,544	276	3,820	3,564	211	3,775	3,573	211	3,783
Other Costs Expenditure	5,632	151	5,784	5,631	59	5,690	5,660	59	5,720	5,662	15	5,677	5,665	15	5,680
Contingency Reserve	446	391	837	1,266	0	1,266	2,103	0	2,103	2,952	0	2,952	3,816	0	3,816
Other Reserves	1,684	328	2,012	1,684	640	2,324	1,684	696	2,380	1,684	825	2,509	1,684	853	2,537
NHSE Mandate Investments	731	634	1,365	731	0	731	731	0	731	731	0	731	731	0	731
Better Care Fund (investments)	0	0	0	(1,891)	0	(1,891)	(1,891)	0	(1,891)	(1,891)	0	(1,891)	(1,891)	0	(1,891)
Committed reserves	0	0	0	0	0	0	0	153	153	0	1,599	1,599	0	2,898	2,898
|Unidentified QIPP	(278)	(21)	(299)	(278)	0	(278)	(336)	0	(336)	(437)	0	(437)	(574)	0	(574)
Total Programme Expenditure Commitments	**158,677**	**6,934**	**165,611**	**158,148**	**4,367**	**162,515**	**160,799**	**4,590**	**165,389**	**162,113**	**6,038**	**168,151**	**163,663**	**7,348**	**171,011**
Running cost expenditure	2,917	0	2,917	2,606	0	2,606	2,587	0	2,587	2,569	0	2,569	2,552	0	2,552
Total expenditure commitments	**161,594**	**6,934**	**168,528**	**160,754**	**4,367**	**165,121**	**163,386**	**4,590**	**167,976**	**164,682**	**6,038**	**170,720**	**166,215**	**7,348**	**173,563**
Planned Surplus / (Deficit)	**6,934**	**(5,184)**	**1,750**	**4,318**	**(2,617)**	**1,700**	**4,590**	**(2,890)**	**1,700**	**6,088**	**(4,338)**	**1,750**	**7,397**	**(5,598)**	**1,800**
Programme Surplus (%)	**4.11%**		**1.0%**	**2.62%**		**1.0%**	**2.73%**		**1.0%**	**3.57%**		**1.0%**	**4.26%**		**1.0%**

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/73	**Author of the Paper:** Susanne Lynch Deputy Head of Medicines Management slynch@nhs.net Tel: 0151 247 7146
Report date: May 2014	

Title: Prescribing Performance Report

Summary/Key Issues:

This paper presents the Governing Body with an update on prescribing spend for February 2014 (month 11).

Recommendation

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

Note	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Achieve a 2% reduction in non-elective admissions in 2014/15.
x	Implementation of 2014/15 phase of Care Closer to Home/Virtual Ward plan.
x	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

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

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

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

Southport and Formby Clinical Commissioning Group

Report to the Governing Body
March 2014

1. Executive Summary

The Southport and Formby CCG position for month 11 (February 2014) is a forecast overspend of £200,173 or 1.02% on a budget of £19,587,637.

2. Introduction and Background

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

3. Key Issues

The number of items prescribed has increased by 3.35% for 2013/14 to month 11 against the same period for 2012/13.

The cost of prescribing has increased by 2.01%for 2013/14 to month 11 against the same period for 2012/13.

4. Content

The Medicines Management Team are working closely with finance to explore factors that have affected the prescribing spend for 2013 2014. There are national factors (e.g. budgetary shifts to other organisations, forecasting formula changes by DOH in Q3 and category M drugs tariff changes) that have affected the outturn position as well as local factors (e.g. top slicing of a non-medical prescribing budget, new anti-dementia shared care drug spend).

Medicines Management are working with the operational group GP members to ensure fair adjustments are made to practice out turns where applicable.

5. Recommendations

The Governing Body is asked to receive the prescribing update by way of assurance.

6. Appendices

Appendix 1 Southport and Formby CCG forecast at out turn Month 11.

Susanne Lynch
May 2014

Appendix 1

Southport and Formby CCG forecast at out turn Month 11

		SECTION 1: Actual Cost &	SECTION 3: FINANCIAL INFO - Total Prescribing Budget vs Forecast Out-turn			
Code	Prescriber Name	Total Act Cost 2013/14	Prescribing Budget Total	Forecast Out-turn (PPD)	£ Over / Underspend	% Over / Underspend
NHS Southport and Formby CCG		**£18,109,814**	**£19,587,637**	**£19,787,810**	**£200,173**	**1.02%**
S&F - Central Southport		**£5,027,448**	**£5,393,248**	**£5,493,277**	**£100,029**	**1.85%**
N84005	CUMBERLAND HOUSE SURGERY	£1,224,380	£1,281,063	£1,337,828	£56,765	4.43%
N84013	CURZON ROAD MEDICAL PRACTICE	£501,223	£528,570	£547,664	£19,094	3.61%
N84021	ST MARKS MEDICAL CENTRE	£2,186,323	£2,407,527	£2,388,902	-£18,625	-0.77%
N84617	KEW SURGERY	£459,676	£493,875	£502,268	£8,393	1.70%
Y02610	TRINITY PRACTICE	£655,847	£682,213	£716,616	£34,403	5.04%
S&F - Formby		**£3,705,822**	**£4,048,537**	**£4,049,190**	**£653**	**0.02%**
N84006	CHAPEL LANE SURGERY	£1,147,142	£1,218,623	£1,253,432	£34,809	2.86%
N84018	THE VILLAGE SURGERY FORMBY	£1,442,774	£1,578,204	£1,576,457	-£1,747	-0.11%
N84036	FRESHFIELD SURGERY	£495,132	£578,990	£541,009	-£37,981	-6.56%
N84618	THE HOLLIES	£620,774	£672,720	£678,292	£5,572	0.83%
S&F - North Southport		**£4,657,654**	**£5,057,919**	**£5,089,216**	**£31,297**	**0.62%**
N84008	NORWOOD SURGERY	£1,192,623	£1,304,643	£1,303,128	-£1,515	-0.12%
N84017	CHURCHTOWN MEDICAL CENTRE	£1,880,778	£2,039,144	£2,055,045	£15,901	0.78%
N84032	SUSSEX ROAD SURGERY	£299,710	£327,646	£327,480	-£166	-0.05%
N84611	ROE LANE SURGERY	£373,893	£416,003	£408,536	-£7,467	-1.79%
N84613	THE CORNER SURGERY (DR MULLA)	£523,568	£571,845	£572,080	£235	0.04%
N84614	THE MARSHSIDE SURGERY (DR WAINW	£387,082	£398,638	£422,947	£24,309	6.10%
S&F - South Southport		**£4,718,890**	**£5,087,933**	**£5,156,127**	**£68,194**	**1.34%**
N84012	AINSDALE MEDICAL CENTRE	£1,844,295	£1,970,388	£2,015,182	£44,794	2.27%
N84014	AINSDALE VILLAGE SURGERY	£519,618	£550,292	£567,763	£17,471	3.17%
N84024	GRANGE SURGERY	£1,584,119	£1,717,194	£1,730,899	£13,705	0.80%
N84037	LINCOLN HOUSE SURGERY	£349,556	£413,528	£381,945	-£31,583	-7.64%
N84625	THE FAMILY SURGERY	£421,302	£436,531	£460,338	£23,807	5.45%

NHS
Southport and Formby
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MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/74	**Author of the Paper:**
Report date: May 2014	Martin McDowell Chief Finance Officer martin.mcdowell@southportandformbyccg.nhs.uk Tel 0151 247 7065
Title: Approval of CCG Annual Accounts	
Summary/Key Issues: Annual Report and Accounts	

Recommendation

Receive	x
Approve	
Ratify	

The Governing Body is asked to receive this report and:

- note the process for approval of NHS Southport and Formby CCG annual accounts and report.
- note their invitation to the Audit Committee Meeting, convened to consider approval of annual accounts and report.
- formally declare that:
  So far as the member is aware, that there is not relevant audit Information of which they clinical commissioning group's external auditor is unaware; and
- *That the member has taken all the steps that they ought to have taken to make them self-aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information".*

Links to Corporate Objectives *(x those that apply)*	
x	Improve the quality of commissioned services, whilst achieving financial balance.
x	Achieve a 2% reduction in non-elective admissions in 2014/2015.
x	Implementation of 2014/15 phase of Care Closer to Home.
x	Review and re-specification of community nursing services for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014-15 phase of Primary Care quality Strategy/transformation.

x	Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

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 the Governing Body
May 2014

1. Introduction and Background

1.1 The CCG submitted its draft annual accounts before the specified deadline of 12 noon on 23rd April 2014.

1.2 The CCGs Audit Committee received a narrative report from CCG officers regarding the content of the CCG's accounts in the meeting held on 30th April 2014. The CCGs draft annual report was also presented for comment.

1.3 The CCGs external Auditors were also in attendance at this meeting.

2. Approval of the Accounts and Annual Report

2.1 Under the CCGs Scheme of Reservation and Delegation (Appendix D of the CCG Constitution) reference is made to the power to approve the annual accounts and report.

2.2 Section 4 delegates responsibility for the approval of the annual accounts and report to the CCG's Audit Committee. The CCGs Audit Committee will meet on 3rd June 2014 at 9.00am to consider findings of the external audit review, with a view to exercising this power. All Governing Body members are welcome to attend this meeting of the Audit Committee.

2.3 In terms of members duties regarding declarations required to support the annual accounts the Chief Finance Officer wrote to Governing Body member on (see appendix 1) to advise Governing Body Members of their duties. This was followed up with a verbal briefing in the last Governing Body Development Session held on 30th April 2014.

2.4 Governing body members are now asked to formally declare that as required as par to the CCGs audit process.

3. Recommendations

3.1 Governing Body members are asked to note the process for approval of the Annual Accounts and annual report.

3.2 Governing Body members are asked to note their invitation to the Audit Committee meeting, convened to consider the approval of the annual accounts and annual report.

3.3 Governing Body members are asked to formally declare that:

- *So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware; and,*

- *That the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information"*.

Appendices

Appendix 1 Copy email to Governing Body Members

Martin McDowell
Chief Finance Officer
May 2014

Emailed to all NHS Southport and Formby CCG Governing Body Members on 17th April 2014

Sent on behalf of Martin McDowell Chief Officer

Dear All,

The final version of the CCG Annual Reporting Guidance 2013/14 was published on the 27th March 2014. This confirms within the Members Report section of the Guidance (Section 4.7.1.12) that at the meeting of the Governing Body that approves the Annual Report and Accounts, each member must state, and it must be minuted that they have done so, that as far as he/she is aware there is no relevant audit information of which the clinical commissioning group's auditors are unaware. In addition that he/she has taken all steps that he/she ought to have taken as a member of the Governing Body in order to make himself aware of any relevant audit information and to establish that the clinical commissioning group's auditors are aware of that information.

The draft minute that will be discussed and subsequently included in both the relevant Governing Body Meeting Minutes and the Annual Report itself reads as follows:

Each individual who is a member of the Governing Body at the time the Members' Report is approved confirms:

- *So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware; and,*
- *That the member has taken all the steps that they ought to have taken as a member in order to make them self aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.*

In order for Governing Body members to be in a position to confirm this statement I recommend that:

1. There is an initial informal and verbal briefing by me on the Accounts process to the Governing Body at its meeting in April, which is followed up with;
2. A paper to the Audit Committee meeting scheduled for April that covers the process and discussion points raised in the April Governing Body meeting and;
3. A subsequent report back to the full Governing Body meeting in May where I and those on the Audit Committee can provide assurance to the full Governing Body membership before the minute is approved.'

Kind regards,

Martin McDowell
CHIEF FINANCE OFFICER
NHS Southport and Formby CCG

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
MAY 2014

Agenda Item: 14/75	**Author of the Paper:**
Report date: May 2014	Helen Nichols Chair of Audit Committee Governing Body Lay Member Tel:0151 247 7071 (PA to CFO)

Title: Audit Committee Annual Report 2014

Summary/Key Issues:

Following the first full financial year in which the CCG has been in existence, the Audit Committee can provide assurance to the Governing Body that:

- an effective system of integrated governance, risk management and internal control is in place to support the delivery of the CCG's objectives and that arrangements for discharging the CCGs statutory financial duties are now established,
- there were no areas reported by Mersey Internal Audit Authority(MIAA) where weaknesses in control, or consistent non-compliance with key controls, which could have resulted in failure to achieve the objective,
- the ISA260 Audit Highlights Memorandum will be reported by PWC to the June meeting as part of the Annual Accounts approval process. This will be followed the publication of the Annual Audit Letter to the Governing Body in its July 2014 meeting.

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve the quality of commissioned services, whilst achieving financial balance.
x	Achieve a 2% reduction in non-elective admissions in 2014/2015.
x	Implementation of 2014/15 phase of Care Closer to Home.
x	Review and re-specification of community nursing services for re-commissioning from April 2015 in conjunction with membership, partners and public.

x	Implementation of 2014-15 phase of Primary Care quality Strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (14/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

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

1. Role of the Audit Committee

1.1. The Codes of Conduct and Accountability, issued in April 1994, set out the requirement for every NHS Board to establish an Audit Committee. That requirement remains in place today and reflects not only established best practice in the private and public sectors, but the constant principle that the existence of an independent Audit Committee is a central means by which a Governing Body ensures effective internal control arrangements are in place. In addition, the Committee provides constructive support to Senior Officers to achieve the strategic aims of the Clinical Commissioning Group.

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

i) to support the establishment of an effective system of integrated governance, risk management and internal control, across the whole of the CCGs activities to support the delivery of the CCGs objectives, and

ii) to review and approve the arrangements for discharging the CCGs statutory financial duties.

1.3. The committee met as follows:

- 1 May 2013
- 11 September 2013
- 15 January 2014.

1.4. The Committee comprises three members of the Clinical Commissioning Group Governing Body:

- Lay Member (Governance) (Chair)
- Lay Member (Patient Experience & Engagement)
- Practice Manager Governing Body Member.

1.5. The Audit Committee Chair and one other member are necessary for quorum purposes.

1.6. In addition to the Committee Members, Officers from the CCG are also asked to attend the committee. The core attendance comprises:

- Chief Finance Officer
- Chief Nurse
- Chief Accountant
- Chief Corporate Delivery and Integration Officer.

1.7. In carrying out the above work, the Committee has primarily utilised the work of Internal Audit, External Audit, the work of the other sub committees of the board and other assurance functions as required. A number of representatives from external organisations attend to provide expert opinion and support:

- Audit Manager MIAA
- Audit Director PWC
- Local Counter Fraud Officer MIAA.

1.8. Attendance at the meetings during 2013/14 was as follows:

Post	**Name**	**1 May 2013**	**11 Sep 2013**	**15 Jan 2014**
Audit Chair	Helen Nichols	✓	✓	✓
Lay Member - Patient Experience & Engagement	Roger Pontefract	✓	✓	✓
Practice Manager - Governing Body Member Resigned 31.03.2014	Roy Boardman	✓	✓	✓
Chief Finance Officer	Martin McDowell	✓	✓	✓
Chief Nurse and Quality Officer	Debbie Fagan	✓	✓	x
Chief Accountant From 15 July 2013	Ken Jones	n/a	✓	✓
Chief Corporate Delivery and Integration Officer	Tracy Jeffes	x	x	✓
Internal Audit	Adrian Poll	✓	✓	✓
External Audit	Stuart Baron/Rachel McIlwraith	✓	x	✓
Local Counter Fraud Service	Stewart Davidson/Bernard McNamara/Roger	✓	✓	✓

	Causer			

1.9. The Audit Committee supports the Governing Body by critically reviewing governance and assurance processes on which the Governing Body places reliance. The work of the Audit Committee is not to manage the process of populating the Assurance Framework or to become involved in the operational development of risk management processes, either at an overall level or for individual risks; these are the responsibility of the Governing Body supported by line management. The role of the Audit Committee is to satisfy itself that these operational issues are being carried out appropriately by line management.

2. Internal Audit

2.1. **Role** - an important principle is that internal audit is an independent and objective appraisal service within an organisation. As such, its role embraces two key areas:

- the provision of an independent opinion to the Accountable Officer (Chief Officer), the Governing Body, and to the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives.

- the provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements

During 2013/14 Mersey Internal Audit Agency (MIAA) have reviewed the operations of the CCG, have found no major issues and concluded that overall it has met its requirements. They have reported back on a number of areas. In all cases action plans have been implemented and are being monitored. In all areas reviewed to date ***'Significant Assurance'***, has been reported i.e. although some weaknesses their impact would be minimal or unlikely.

There were no areas reported by MIAA where weaknesses in control, or consistent non-compliance with key controls, could have resulted in failure to achieve the review objective. Regular progress reports will continue to be provided to each Audit Committee meeting.

2.2. **External Audit**

Role - the objectives of the External Auditors are to review and report on the CCG's financial statements and on its Statement on Internal Control.

At this stage of the year External Audit (PWC) are in the early stages of their first audit of the CCGs annual accounts. It is anticipated that the ISA260 Audit Highlights Memorandum will be reported to the June Meeting as part of the Annual Accounts approval process.

This will be followed by the publication of the Annual Audit Letter to the Governing Body in its July 2014 meeting.

2.3. **Counter Fraud Specialist**

Role – to ensure the discharge of the requirements for countering fraud within the NHS, the role is based around seven generic areas, creating an antifraud culture, deterrence, prevention, detection, investigation, sanctions and redress. The Local Counter Fraud

Specialist presented the plan for approval in May 2013 and provided regular updates at subsequent meetings. The Local Counter Fraud Service have also presented to Practice Manager Meetings, Protected Learning Time for GPs, and to the Governing Body. A proposed Counter Fraud Strategy has also been presented to Audit Committee.

3. Regular Items for Review

The Audit Committee follows a work plan approved at the beginning of the financial year, which includes, as required:

- losses and special payments;
- outstanding debts;
- financial policies and procedures;
- tender waivers;
- declarations of interest;
- self-assessment of Committee's effectiveness;
- Information Governance Toolkit
- minutes of the sub committees of the Governing Body.

4. Conclusions

4.1. The Audit Committee is a key committee of the Governing Body, with significant monitoring and assurance responsibilities requiring commitment from members and support from a number of external parties. The work plan has been developed in line with best practice described in the Audit Committee Handbook and forms the basis of our meetings. In all of these areas the Audit Committee seeks to assure the CCG that effective internal controls are in place and will remain so in the future.

4.2. Following the first full financial year in which the CCG has been in existence, the Audit Committee can provide assurance to the Governing Body that;

- an effective system of integrated governance, risk management and internal control is in place to support the delivery of the CCG's objectives and that arrangements for discharging the CCGs statutory financial duties are now established,

- there were no areas reported by Mersey Internal Audit Authority(MIAA) where weaknesses in control, or consistent non-compliance with key controls, which could have resulted in failure to achieve the objective,

- the ISA260 Audit Highlights Memorandum will be reported by PWC to the June meeting as part of the Annual Accounts approval process. This will be followed the publication of the Annual Audit Letter to the Governing Body in its July 2014 meeting.

5. Recommendations

The Governing Body is asked to receive the content of this first annual report.

Helen Nichols
Lay member - Governance
NHS Southport and Formby CCG

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
January 2014

Agenda Item: 14/76	**Author of the Paper:**
Report date: May 2014	Debbie Fagan Chief Nurse & Quality Officer debbie.fagan@southportandformbyccg.nhs.uk Tel: 0151 247 7252

Title: Francis Report and Action Plan

Summary/Key Issues:

This report provides the Governing Body with the latest version of the CCG Francis action plan. The action plan has been updated to reflect 'Hard Truths' (DH November 2013), the Government's response to the Francis Inquiry and the subsequent nationally commissioned independent reviews. The CCG action plan is monitored on a regular basis by the Quality Committee and was last presented in April 2014. Good progress has been made to date and the next version of the action plan which will be able to demonstrate further achievements relating to the areas of the NHS Constitution, complaints, CCG organisational development / culture and the Primary Care Quality Strategy as an example. Although positive progress is being made, the CCG will continue to strive on the sustained achievement and embedding of all aspects of this action plan to ensure it is part of how the organisation conducts its business.

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)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
	Achieve a 2% reduction in non-elective admissions in 2014/15.
	Implementation of 2014/15 phase of Care Closer to Home plan.
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
	Review the population health needs for all mental health services to inform enhanced delivery.

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

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
May 2014

1. Introduction and Background

1.1 This paper provides a summary of the key points from the document '*Hard Truths - the journey to putting the patient first'* (DH November 2013) Volumes 1&2.

1.2 *'Hard Truths'* sets out the Government's final response to the Francis Inquiry into the care at Mid Staffordshire NHS Trust. The report requires all commissioning, service provision, regulatory and ancillary organisations in healthcare to consider the findings and recommendations and decide how to apply them.

1.3 This document summarises the key points to provide the CCG Quality Committee with an understanding of the main principles within the document. A detailed action plan has also been developed in response to the recommendations relevant to the CCG.

The reports can be found at:

https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response

1.4 The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, published in February 2013, called for a 'fundamental culture change' across the health and social care system to put patients first at all times.

Robert Francis QC, the Inquiry Chair, called for action across six core themes:

- culture;
- compassionate care;
- leadership;
- standards;
- information;
- openness, transparency and candour.

1.5 The Government's initial response, "*Patients First and Foremost"*, set out a plan to prioritise care, improve transparency and ensure that where poor care is detected, there is clear action and clear accountability. The Government's final response '*Hard Truths – the journey to putting patients first'* (November 2013) and its accompanying volumes build on this to provide a detailed response to the 290 recommendations the Inquiry made across every level of the system.

1.6 It also responds to six further independent reviews which the Government commissioned to consider some of the key issues identified by the Inquiry:

- review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England;

- *'The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings'*, by Camilla Cavendish;

- *'A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England'*, by Professor Don Berwick;
- *'A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture'* by Rt Hon Ann Clwyd MP and Professor Tricia Hart;
- *'Challenging Bureaucracy'*, led by the NHS Confederation;
- the report by the Children and Young People's Health Outcomes Forum, co-chaired by Professor Ian Lewis and Christine Lenehan.

1.7 Since the Inquiry reported, the Government has already instigated a number of changes that will improve inspection, increase transparency, and put a clear emphasis on compassion, standards and safety. It also addresses increased accountability for failure and building capability.

1.8 The accompanying '*Volume Two: Response to the Inquiry recommendations'* provides a detailed response to each of the 290 recommendations made by the Inquiry across every level of the system. The document makes clear which recommendations have been accepted, by whom and what progress is being made towards their implementation.

The Department of Health will lead the system in providing an annual report on progress across the system each autumn.

201 recommendations have been accepted in full, 60 recommendations accepted in principle, 20 accepted in part and 9 not accepted at all.

2. Overview of the Main Chapters of the 'Hard Truths' Report

2.1 Chapter One: Preventing Problems

2.1.1 Patient participation in planning services

The report highlights that there has been statutory guidance published for clinical commissioning groups on involving patients in planning services and their own care, along with a set of supportive tools. 80% of CCGs to be commissioning support for patients' participation and decisions in relation to their own care. Guidance published – '*Transforming Participation in Health and Care'.*

2.1.2 Transparency

The CCG is required to consider how transparency is measured in those provider services commissioned and have assurance about the level of patient safety attained.

2.2 Chapter Two: Detecting Problems Early

2.2.1 Whistleblowing

It is essential to ensure that providers have good and accessible systems in place for whistleblowing. The CCG should also provide easily accessible processes to allow staff to approach them to raise concerns.

2.2.2 National Institute of Clinical Excellence (NICE)

It remains a key element to ensure that NICE guidance is considered and other best practice standards achieved when commissioning and monitoring providers.

2.3 Chapter Three: Taking Action Promptly

2.3.1 Working together

There is an increased need to work closely with regulators (CQC, Monitor) to ensure that the CCG takes a co-ordinated approach to overseeing quality issues within providers and that information is shared across the system.

2.4 Chapter Four: Ensuring robust accountability *(This chapter places the greatest emphasis on the role of regulators, professional bodies and commissioners)*

2.4.1 The issues identified by the Inquiry's report in relation to commissioning include:

- a lack of clarity about the remit and purpose of commissioning organisations;
- a lack of co-operation and information sharing between commissioners and regulators;
- an excessive focus on the financial bottom line and on the management of what could be easily measured, rather than what mattered to patients; and
- a lack of focus on the quality of care and patient experience.

2.4.2 The report recommends that all organisations in the NHS have to commit to making patient safety a reality and should consider how they make this commitment visible to their staff and to the public in the months and years ahead.

2.4.3 Further points to note for CCGs

- NHS England will explore the development of a parallel set of arrangements (fit and proper person's test for Board level appointments) for clinical commissioning groups.
- Clinically-led clinical commissioning groups put doctors, nurses and other health professionals at the heart of commissioning, with an explicit focus on improving health outcomes for the whole population and reducing inequalities in health.
- Following authorisation, NHS England will continue to hold clinical commissioning groups to account for quality and outcomes as well as for financial performance, through the clinical commission group assurance framework. NHS England also has powers to intervene where there is evidence that clinical commissioning groups are failing or are likely to fail.
- The basic tool available to commissioners is the contract. NHS England is therefore reviewing the provisions in the standard NHS contract in order to make it easier for commissioners to intervene when they have concerns about patient safety or outcomes. Details will be published in December 2013 as part of the NHS standard contract for 2014/15.

- Excellent commissioning can pro-actively address the risk of services becoming unsafe by spotting trends in the population and responding by changing the nature of the services.

2.5 Hard Truths Chapter Five: Ensuring staff are trained and motivated

2.5.1 Recruitment

Human Resource policies need to align more closely with the NHS Constitution and the principles of compassionate care.

2.5.2 Care of the older person

Care of the frail elderly and, in particular, elimination of malnutrition and dehydration should be assured.

2.5.3 Bureaucracy

The report stated that the HSCIC is to act as a 'gateway' for information requests and national bodies are to have a single transparent process, reducing the burden of bureaucracy. NHS England Clinical Bureaucracy Index is to track how well trusts are using digital technology in data collection.

3. Recommendations

Members of the CCG Quality Committee are asked to note the new actions on the following areas as detailed within the action plan.

- Safe staffing, from April 2014, all hospitals will publish self-determined staffing levels on a ward-by-ward basis together with the percentage of shifts meeting safe staffing guidelines. This will be based on speciality. This will be mandatory and will be done on a monthly basis. By the end of next year this will be done using models and tools approved independently by NICE.

- Complaints reporting and better complaints information - trusts will report quarterly on complaints data and lessons learned and the Health Service Ombudsman will increase significantly the number of cases she considers. In addition, all hospitals will be required to set out clearly how patients and their families can raise concerns or complain, with independent support available from their Healthwatch or alternative organisations.

- A statutory duty of candour, which will apply to providers, and a professional duty of candour on individuals will be strengthened through changes to professional guidance and codes. NHS England will also review Quality Accounts before the 2014/15 cycle to ensure that they give patients appropriate information about the services they use and that they add value to the quality assurance infrastructure used by Trusts and local and national organisations.

- The Government will consult on proposals about whether trusts should reimburse a proportion or all of the NHS Litigation Authority's (NHSLA) compensation costs when they have not been open about a safety incident.

- A new criminal offence for wilful neglect - the Government will legislate at the earliest available opportunity to make it an offence to wilfully neglect patients so that organisations and staff, whether managers or clinicians, responsible for the very worst failures in care are held accountable.

- A new Fit and Proper Person's Test which will enable the Care Quality Commission to bar unsuitable senior managers who have failed in the past from taking up individual posts elsewhere in the system.

- All arms-length bodies and the Department of Health have signed a protocol in order to minimise bureaucratic burdens on trusts.

- A new Care Certificate, as recommended by the Cavendish Review, to ensure that Healthcare Assistants and Social Care Support Workers have the fundamental training and skills needed to give good personal care to patients and service users. The Chief Inspectors will ensure that employers are using the Disclosure and Barring Service to prevent unsuitable staff from being re-employed elsewhere.

- The Care Bill will introduce a new criminal offence applicable to care providers that supply or publish certain types of information that is false or misleading, where that information is required to comply with a statutory or other legal obligation.

4. Updated Sections

The following sections have been updated since the action plan was circulated in February 2014.

Section 1 - Accountability/oversight and leadership

- This section can be all rag rated green aside from the point relating to CCG being aware of the NHS constitution which is amber. This action has a target date of May 2014 however and there is a clear action plan in place to ensure compliance within agreed timescale.

- Significantly the agreement of quality schedules (14/15) with providers and the monitoring of these quality schedules through clinical quality performance groups (CQPGs) ensures that all the proposed actions are embedded and implemented within the organisation and their performance against the implementations are monitored monthly.

Section 3 - A common culture made real throughout the system

- Recommendation 17 is now part of the NHS standard contract and a provider quality and performance report is part of that contract, consequently this is now rated as green.

Section 4 - Commissioning for standards

- The CCG Primary Care Quality Strategy has now been developed and is still awaiting implementation. The CCG lead has advised that certain things need to be agreed before implementation can occur – remains amber.

- The Engagement and Patient Experience Group (EPEG) is now utilising a range of networks and a wealth of methods to ensure feedback and views from the public are obtained – changed to green.

Section 7 – Implementing the recommendations

- The CCG will be undertaking a survey of organisational culture and will be undertaking a development session with the wider operational team to align work plans with Francis – this remains Amber as this has a target date of May 2014.

James Hester
May 2014

CCG Francis Action Plan April 2014

Theme		Recommendation	Comments/Proposed Actions	Assurance	Responsible Officer	Target date	Status (RAG)
1	**ACCOUNTABILITY/ OVERSIGHT AND LEADERSHIP** Putting the patient first (3-8)	3. Embed values and principles demonstrated within the NHS constitution 4. The core values expressed in the NHS constitution should be given priority of place and the overriding value should be that patients are put first. 7. All NHS staff should be required to enter into an express commitment to abide by NHS values and the Constitution, both of which should be included in contracts of employment 8. Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well	-The CSU to support CCG in ensuring all staff are aware of the NHS Constitution and its ethos , and that it is included in commissioning and work plans -Board Development session - values and assurance -All providers to be asked to embed the CNO strategy of the 6Cs into their culture of care and recruitment -All providers to perform an assessment of organisational culture -Provider Quality Schedules/Reports to refer to nationally mandated components of the NHS Constitution -Workforce indicators included in the Provider Quality Schedules - Feedback from EPEG is incorporated into CCG plans and reported to the Quality Committee -Liaise with CSU to gain assurance from Providers that NHS values and Constitution are included in	-The CCG will be undertaking a development session with the wider operational team to align work plans with Francis. These actions are monitored via the quality schedule (Schedule 4, Part A&C) Any new posts will have the NHS constitution and	DF/TJ FLC SA/BD/JL SA/BD/JL SA/BD/JL SA/BD/JL TJ/JH DFai/TJ	May 2014 October 2013 April 2014 January 2014 January 2014 April 2014 November 2013 October 2013	Amber Green Green Green Green Green Green Green

CCG Francis Action Plan April 2014

			contracts of employment and those of the staff from service providers to whom which they outsource business - Review CCG commissioning plans to ensure they reflect the NHS Constitution	values included in contracts of employment. Existing employees and outsourced employees will demonstrate compliance vicariously through adherence to the providers HR policies. (whistleblowing, being open etc)	Senior Management Team (SMT)	July 2013	Green
2	**COLLATION OF SOFT INTELLIGENCE AND PATIENT FEEDBACK** Effective Complaints Handling / Learning and information from complaints. (109-122) (133-134)	110. Lowering barriers 113. Complaints handling 118. Investigations 119. Support for complainants 120. Learning and information from complaints	- CSU to work with CCGs and providers to obtain real time information on complaints -Complaints information to form part of the quality dashboard / performance report for quality committee -CSU to obtain information from NHS England regarding 1º care and assure the CCG of 1º care quality.	These actions are monitored via the quality schedule (Schedule 4, Part C, PS15) Standing agenda item at CQPG	DFai/TJ DF DF	November 2013 September 2013 September 2013	Green Green Green

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		133. Role of commissioners in complaints 134. role of commissioners in provision of support for complaints	-Ensure that the CCG have a ratified complaints policy	Policy is being reviewed and updated and to be approved by Quality committee	DF	May/June 2014	Green
3	**A COMMON CULTURE MADE REAL THROUGHOUT THE SYSTEM –** an integrated hierarchy of service (17)	17. Involvement in the design of new quality standards in collaboration with the NHSCB	- Continued collaboration with NHS England to develop new quality standards.Development of narratives between NHS England and CCGs around the five domains of the NHS Outcomes Framework and how commissioners can drive improvement in outcomes. This material will be made available as a resource for CCGs shortly on the NHS England website -A 'framework for improving quality through commissioning' is being developed and additionally the new standard contract has been issued which contains the quality schedule and revised national CQINNs -Inclusion of monitoring of compliance with these standards to be prominent within the performance management framework. To include audit, reviews and potential contract penalties.	Part of the NHS standard contract. A provider Quality & Performance report is part of the contract	DF DF DF	NHS England updated Feb 2014 NHS England updated Feb 2014 NHS England updated Feb 2014	Green Green Green

CCG Francis Action Plan April 2014

4	**COMMISSIONING FOR STANDARDS (123-137)**	123. Responsibility for monitoring delivery of standards and quality 124. Duty to require and monitor delivery of fundamental standards 125. Responsibility for requiring and monitoring delivery of enhanced standards 126. Preserving corporate memory 127. Resources for scrutiny 128. Expert support 129. Ensuring assessment and enforcement of fundamental standards through the contracts 130. Relative position of commissioner and provider 131. Development of alternative sources of provision 132. Monitoring tools 135. Public accountability of commissioners and public engagement 137. Intervention and sanctions for substandard or unsafe services	-A CCG Primary Care Quality Strategy has been developed and is awaiting implementation. -The CCG & CSU will engage with local media to ensure consistent messages to the wider public. -The CCG will ensure views of the public are captured considered and fed into each stage of commissioning and contracts process. -The Governing Body will review its vision and objectives to ensure these are fit for purpose. -The CCG will review its work with providers to commission services that reflect need. -The CCG Patient & Public Engagement strategy will be reviewed to ensure this reflects the need of the public to inform service commissioners. -The CCG will review and agree how safeguarding information is appropriately brought into contractual management processes across Health and Social Care. -Develop a mixed approached of traditional and digital initiatives to engage with and gain feedback from public to ensure that a wide range of views are obtained.	EPEG are utilising a range of networks and a wealth of methods to ensure we have a robust approach	MC DF/TJ/Lyn Cooke DF/TJ FLC SA/BD/JL TJ DF TJ/AJ	Ongoing Ongoing Ongoing March 2013 Ongoing April 2013 April 2013 November 2013	Amber Green Green Green Green Green Green Green

CCG Francis Action Plan April 2014

			-Information from 'friends and family test', information from CQUIN targets and intelligence gathered from GP "Quality Matters" will be reported to the CCG Quality committee via the EPEG report		JH	January 2014	Green
			- Further development of quality standards will build on current best practice and other areas such as workforce, integrated care and collaborative working.		SMT	Ongoing	Amber
			-CQUINs will be further developed to support these.		SA/BD/JL	March 2014	Green
			- Ongoing collaboration with other CCGs in relation to transformation programmes / service		TJ/FLC	Ongoing	Green
			- Where new services are developed, procurement processes will be underpinned by the choice and patient experience.		MC	Ongoing	Green
			- The CCG will at times require providers to produce recovery plans when targets or standards are not being met.		SA/BD/JL	As necessary	Green
			-Quality standards in contracts will continually be reviewed and enhanced.		SA/BD/JL	Ongoing	Green
			-CQUINs will be reviewed annually as part of the contracting process.		SA/BD/JL	Ongoing	Green
			-Ensure the CCG identifies a member of SMT and GP clinical leads as required to represent the CCG at the Merseyside QSG		SMT	March 2013	Green

CCG Francis Action Plan April 2014

			-Ensure a periodic review is in place to give assurance that the CCG structure is fit for purpose to deliver on the functions the CCG need to undertake -Ensure processes are in place and operationalised to performance manage the contract with CSU -Lay members appointed to governing body -The CCG governing body will be held in public from May 2013 onwards		SMT/KM TJ TJ TJ	March 2013 March 2013 October 2012 May 2013	Green Green Green Green
5	**LOCAL SCRUTINY (138)**	138. Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found that they are at risk from substandard or unsafe services	-The CCG will continue to work on its contingency planning and provide an update to the Governing Body.		DF	October 2013	Green
6	**PERFORMANCE MANAGEMENT & STRATEGIC OVERSIGHT (139-143)**	139.The need to put patients first at all times 140.Performance managers working constructively with regulators 141.Taking responsibility for quality 142.Clear lines of responsibility supported by good information flows 143.Clear metrics on quality	-Commissioners to ensure systems are in place for regular quality walkarounds within provider organisation. -Ensure governance arrangements are in place to report on quality and patient safety issues within the CCG -The CCG will ensure it is an active participant across the health and social care system to ensure patients are protected.		DF DF DF	March 2013 March 2013 May 2013	Green Green Green

CCG Francis Action Plan April 2014

			-The CCG will maintain open dialogue with the Regulators and identify key personnel to attend and impart information at the Merseyside Quality Review Meetings		DF/FLC	May 2013	Green
			-The CCG will ensure it leads action where necessary to protect patients and collaborate with other stakeholders to protect patients.		SMT	Ongoing	Green
			-Quality standards will be reviewed as appropriate to ensure they reflect best practice.		DF	Ongoing	Green
7	**IMPLEMENTING THE RECOMMENDATIONS (1-2)**	1.All commissioning organisations in healthcare should consider the findings and recommendations of the report and decide how to apply them to their own work. 2. The NHS and all who work in it must adopt and demonstrate a shared culture in which the patient is the priority in everything done.	-Chief Nurse to be identified as SMT lead on the application of the recommendations to the work of the CCG		SMT	February 2013	Green
			-SMT to support the GP Clinical Leads in their leadership role to ensure implementation of the recommendations by Providers going forward through effective commissioning		SMT	February 2013	Green
			-Liaise with the OD Team from the CSU to ensure the CCG OD Plan is reflective of the Inquiry recommendations		TJ	June 2013	Green
			-Report findings and recommendations to be an agenda item for discussion at SMT, Quality Committee, Audit Committee, Governing Body and Wider Constituent Meeting		DF	April 2013	Green
			-Recommendations and resulting action plan to feature as part of the annual workplan of the Quality Committee		DF	March 2013	Green

CCG Francis Action Plan April 2014

			-Audit Committee to consent to receive regular updates on the action plan as part of the assurance process		DF	March 2013	Green
			-Review the CCG common set of core values and standards that are outlined within the CCG Constitution to ensure they are reflective of the culture advocated within the Inquiry recommendations		DF/SA/BD/JL	March 2013	Green
			-Ensure the CCG core values and standards are accessible and explicit on the public website		DF	June 2013	Green
			-Explore ways in which values can be incorporated into PDP/appraisal and wider CCG staff / board development		TJ	July 2013	Green
			-Liaise with CSU OD Lead and Comms Lead for advisement and support on the identification of actions to deliver this recommendation internally within the CCG		DF/TJ	June 2013	Green
			-Explore with CSU OD Lead available tools to support measurement internally within the CCG and externally with commissioned providers	The CCG will be undertaking a survey of organisational culture and will be undertaking a development session with the wider operational team to align work plans with Francis.	DF/TJ	May 2014	Amber

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/77	**Author of the Paper:**
Report date: May 2014	Kevin Thorne Integrated Commissioning Manager South Sefton CCG

Title: Sefton Strategy for Older Citizens 2014 - 2019

Summary/Key Issues:

In view of Sefton's ageing population it is vital to make strategic plans to deal with its impact and to develop a collaborative approach from all agencies and service providers.

Recommendation

The Governing Body is asked to approve the Sefton Strategy for Older Citizen's 2014-19 and agree that the Sefton Partnership for Older Citizen's (SPOC) be asked to prepare an Action Plan, monitor its implications and present regular progress reports to the Programme Group of Sefton's Health and Wellbeing Board.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
	Improve quality of commissioned services, whilst achieving financial balance.
X	Achieve a 2% reduction in non-elective admissions in 2014/15.
X	Implementation of 2014/15 phase of Care Closer to Home/Virtual Ward plan.
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
	Review the population health needs for all mental health services to inform enhanced delivery.

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
South Sefton
Clinical Commissioning Group

Report to the Governing Body
May 2014

1. Introduction and Background

1.1 Sefton has the highest proportion of residents aged 65+ and 75+ of all metropolitan boroughs in England.

1.2 Sefton's 50+ population is 41.5% of its total population – much higher than the average for England and for the North West.

1.3 The previous strategy for older citizens covered the period 2010 to 2013 and requires updating.

2. Key Issues

2.1 In view of Sefton's ageing population it is vital to make strategic plans to deal with its impact and to develop a collaborative approach from all agencies and service providers.

2.2 The Sefton Partnership for Older Citizen's (SPOC) aims to identify the needs of older citizen's, to bring together networks which provide them with support and to give older citizens the opportunity to be a part of the collaborative planning process that delivers services.

3. Conclusions

The aims of the new strategy are to challenge stereotypes of older people, to set a clear direction for communities with an ageing population and to provide a framework for collaborative planning with older citizen's as equal and key partners.

4. Recommendations

4.1 That the Governing Body approves the Sefton Strategy for Older Citizen's 2014-19.

4.2 That the Sefton Partnership for Older Citizen's (SPOC) be asked to prepare an Action Plan; to monitor its implications; and to present regular progress reports to the Programme Group of Sefton's Health and Wellbeing Board.

5 Appendices

Appendix 1: Creating A Place Where Older People Can Live, Work And Enjoy Life As Valued Members Of The Community.

Kevin Thorne
May 2014

Final Draft

SEFTON STRATEGY FOR OLDER CITIZENS 2014 - 2019

Creating A Place Where Older People Can Live, Work And Enjoy Life As Valued Members Of The Community

Sefton Partnership For Older Citizens

WHY WE NEED A STRATEGY

- In March 2013 the House of Lords published an influential report which concluded that there had been a "collective failure to address the implications" of our rapidly ageing population, and that Government and society were "woefully underprepared".
- By 2030 the 65+ population in England is likely to rise by 50%, and the 85+ population by 100%.
- The challenges arising from this have begun to be addressed by national policy makers in areas such as the age of retirement, pension reform, the funding of residential care and housing policy.
- However a 2013 report on "Delivering Dignity" highlighted the extent of undignified care of older people in hospitals and care homes, where people were "let down when they were vulnerable and most needed help".
- The "demographic time-bomb" is therefore one of the biggest issues faced by society as a whole, and by policy makers at national and local level.
- We must also recognise that we live in a climate of diminishing resources which will require individuals, families and communities to take greater responsibility, with less reliance upon the state. The need to build community resilience to help address the needs of our ageing population will therefore be a key element in the development of this strategy.
- The expectations of people are also changing. We need to plan ahead for the cohort of people who are now in their 40's and 50's whose requirements in later life will differ from those who are currently in their 80's and 90's

SEFTON'S UNIQUE POSITION

- Sefton has the highest proportion of residents aged 65+ and 75+ of all metropolitan boroughs in England.
- Sefton's 50+ population is 41.5% of its total population – much higher than the average for England and for the North West.
- There are 28,400 people in the 75+ age group of whom about half live alone. This is projected to increase as a percentage of the total population and in actual numbers.
- These statistics are highlighted in the Sefton Health and Wellbeing Strategy and give rise to specific concerns about related issues such as the number of older carers and people with depression and dementia in our communities, and inequalities across the borough
- The growth in the number of older citizens in Sefton presents great challenges in terms of its impact on health and social care services, but it also opens up real opportunities to build upon the knowledge, wisdom and contributions of older people in helping to make Sefton a more cohesive community, and one which is a great place in which to live and work.

THE CONTRIBUTION OF OLDER CITIZENS

- The perception in society is that older people are a drain on the country's resources – but the opposite is actually the case.
- A report in 2011 assessed the cost of state pensions, age-related welfare, and use of the NHS – then compared this with the contribution of older people to income taxes, VAT inheritance tax and capital gains tax
- The report also assessed the contribution of the over 65's to volunteering, unpaid caring, and looking after grandchildren.
- The conclusion was that the NET contribution of over 65's to the UK economy in 2010 was £40billion, rising to £75billion per annum by 2030.

- In the promotion and implementation of this strategy an attempt will be made to enhance the profile of older citizens in Sefton, and to change the perception of them as a drain of resources to one of active citizens

SEFTON PARTNERSHIP FOR OLDER CITIZENS (SPOC)

- SPOC is recognised as one of the major and most effective partnership groups in Sefton. Its aim is to identify the needs of older citizens, to bring together the networks which provide them with support, and to give older citizens the opportunity to be part of the planning of services.
- Half of the members of SPOC are elected by the three older people's forums which operate in Southport, Bootle and Maghull. They meet monthly and regularly attract 100+ people. The remaining members of SPOC are the providers of services to older citizens from the public, voluntary, community and faith sectors. This regular exchange of information and views enables SPOC to keep abreast of, and take action upon, the issues which impact on Sefton's older population.
- SPOC will be the lead organization in the monitoring and delivery of the Sefton Strategy for Older Citizens.

EVOLUTION OF OUR OLDER CITIZENS' STRATEGY

- Sefton's first "Strategy for Older Citizens" covered the period 2010-2013 and was prepared following extensive consultation with older citizens.
- It was updated and refreshed in 2011 in conjunction with the members of the three older people's forums.
- The strategic priorities were translated into over 40 specific actions, which were set out in an Action Plan which has been progressed with partner organizations in the public, voluntary, community and faith sectors and has been monitored and updated on a six monthly basis. The majority of the actions have been successfully achieved.
- Following the approval of the new Strategy for 2014-2016 the proposal is to prepare and deliver a similar detailed Action Plan, in order to ensure that the strategic objectives are achieved in a similar way. The new strategy for 2014-2016 incorporates some of the objectives of the first strategy which have not yet been fully achieved, modifies others which have been updated to reflect changing circumstances, and introduces some new objectives which have been identified as a result of SPOC's activities during the past three years.

AIMS OF THE NEW STRATEGY

- To challenge the stereotypes of older people, and to set out how the Sefton community can respond to the opportunities and challenges of an ageing population, whilst recognising the current constraints upon public expenditure;
- To set a clear direction for our communities and strive to ensure that the needs of people aged 50+ are met;
- To provide a framework of joint objectives which organisations and public services should use to shape their own plans to meet the changing needs of an ageing society;
- To identify and recognise the increasingly diverse population of older people in Sefton and work harder to ensure that organisational and service responses are sensitive to their specific needs;
- To bring a shared focus to the work of a wide range of agencies and partners, and strengthen the case for funding from national and regional programmes;
- To involve older people as active and equal partners in the process by enabling them to use their strengths in building community networks and activity.

- To encourage people to plan much earlier for the financial and other implications of their retirement, such as the possible impact of fuel poverty.

OBJECTIVE 1 – TO ADVOCATE THAT THE VOICE OF OLDER CITIZENS IS REFLECTED IN THE PLANNING AND DELIVERY OF SERVICES

In order to achieve this we will strive to:-

- Explain and promote the objectives of the strategy to all major groups, organisations and key individuals responsible for the delivery and "age-proofing" of services.
- Extend the geographical spread and membership of the older people's forums.
- Seek new and user-friendly ways of seeking information from, and communicating information to, community groups and individuals to increase awareness of the services which are available to support their needs.
- Ensure that the views of older citizens are fully taken into account as services are reconfigured to meet public sector financial constraints.
- Maintain membership and links with regional groups which represent older citizens, to ensure that SPOC keeps abreast of emerging national and regional issues.
- Keep under constant review the terms of reference and membership of SPOC, and the structures which it establishes to deliver its objectives, and the need to ensure that it is representative of the diverse population of the borough.

OBJECTIVE 2 – TO REDUCE THE LEVEL OF LONELINESS AND SOCIAL ISOLATION EXPERIENCED BY OLDER PEOPLE IN SEFTON

In order to achieve this we will strive to:-

- Identify those who are socially isolated and/or are experiencing depression who would benefit from support services.
- Encourage older people to build community networks in local areas throughout the borough, including the development of inter-generational activities, and by working with schools
- Support opportunities which help older people to build social contacts and connections, via community and voluntary sector based services, initiatives which build community resilience and utilise existing community assets, alongside the effective promotion of and signposting to relevant activities.
- Participate in the development of the Dementia Action Alliance and support its objectives and work programmes.

OBJECTIVE 3 – TO ENCOURAGE THE PROVISION OF HEALTH AND WELLBEING SERVICES FOR OLDER PEOPLE WHICH ARE EFFECTIVE AND OF HIGH QUALITY

In order to achieve this we will strive to:-

- Translate the high priority given to the needs of older citizens by the Health and Wellbeing Board, and in the Health and Wellbeing Strategy, into effective and innovative actions which will focus upon the "preventative agenda" for the over 50's.
- Promote, publicise and update the brochures on "Five Ways to Wellbeing" and encourage older citizens to participate in activities which will improve their physical and mental health.
- Focus particular attention on the health and wellbeing needs of the older citizens in areas of the borough where life expectancy is lowest.
- Facilitating older people gaining access to green spaces, Sefton's coastline, and a sustainable environment.

- Build partnerships with the clinical commissioning groups, and seek the support of GPs in signposting older citizens to health and wellbeing activities and social networks.
- Ensure that older citizens receive comprehensive information and support about the types of services and the providers available in their local area.
- Work with partners in the public and voluntary sector to identify older citizens or older carers in Sefton with care and support needs which are not being met to enable missing services to be developed and provided.

OBJECTIVE 4 – TO HELP OLDER PEOPLE TO ACHIEVE FINANCIAL SECURITY

In order to achieve this we will strive to:-

- Assist older people to achieve an adequate income by providing more comprehensive pre- and post-retirement advice, information and seeking to maximise the take-up of benefits.
- Liaise with employers to enable older people to continue to work if they wish to do so, through flexible employment opportunities.
- Make applications for external funding to support the needs of older people in Sefton whenever opportunities arise.
- Encourage those over 50 to plan early for the financial implications of retirement.
- Work with partners in the public and voluntary sectors to provide information and improved financial advice to older citizens who may need to raise finance to help fund their care needs.
- In response to the Care Bill, work with partners in the public and voluntary sectors to ensure that following eligibility assessments, older citizens receive an appropriate financial assessment and understand any requirements to contribute to some or all of their care and support plan.

OBJECTIVE 5 – TO WORK WITH LOCAL AGENCIES TO PROVIDE SERVICES WHICH ARE OF HIGH QUALITY, JOINED-UP, AND AGE-PROOFED

In order to achieve this we will strive to:-

- Work with the providers of public transport networks, and community transport providers, to deliver accessible and affordable services which meet the needs of older people in accessing the services which they require.
- Engage actively with the emerging proposals for the transformation of social care, and develop mechanisms which will ensure that the views and concerns of older citizens are fully taken into account.
- Work with partners to ensure that there is a consistent approachfor older citizens with eligible needs to get the care and support they require, and that service provision is better coordinated by the relevant providers.
- Support the work of existing providers and the development of strategies and plans to provide improved services for older citizens e.g. dementia strategy; carers' strategy; plans for end-of-life care; and the "cancer champions" project for older citizens.
- Seek ways of providing training opportunities for older citizens in the use of information communication technology.

OBJECTIVE 6 – TO HELP OLDER PEOPLE TO FEEL SAFE AND SECURE WITHIN THEIR COMMUNITIES

In order to achieve this we will strive to:-

- Strengthen engagement with the police, fire and rescue services, in order to highlight the safety concerns of older citizens, particularly relating to anti-social behaviour.

- Raise awareness of the range of services and initiatives which are available to keep people safe across Sefton, both at home and in their communities.
- Encourage the planning and provision of appropriate housing to meet the changing age profile of the population.
- Assist older citizens who need adaptations to their homes to have access to services to enable them to remain safe and independent.
- Ensure that older citizens who require repairs to enable them to live in a safe and comfortable home have access to advice and support services.
- Encourage partners to work towards providing information and advice to older citizens about their housing options, to help them secure housing suited to their needs.
- Monitor the uptake of safeguarding adults training and safeguarding alerts, and ensure that this remains a high priority in all relevant care settings, and work with Sefton's Adult Safeguarding Board to develop plans which protect vulnerable citizens.

OBJECTIVE 7 – TO CHALLENGE PROVIDERS TO TReAT VULNERABLE OLDER CITIZENS WITH DIGNITY AND RESPECT IN ALL CARE SETTINGS

In order to achieve this we will strive to:-

- Build an effective partnership with "Healthwatch" to ensure that communication with, and the engagement of, older people's groups is maximised in the monitoring of service delivery.
- Monitor the implementation of the recommendations of the "Delivering Dignity" report (Local Government Association, NHS Confederation, and Age UK) and the Francis Report on Mid-Staffordshire Hospital, and keep under constant review the implications for older people in Sefton.
- Provide support and constructive challenge to the commissioners of adult social care, and health services, and bring to their attention any concerns from older citizens about quality standards in hospitals, nursing, residential, and domiciliary care settings.

OBJECTIVE 8 – TO PROMOTE AND RESPOND TO THE IMPACT THAT THE NEW CARE BILL WILL HAVE ON OLDER CITIZENS IN SEFTON

In order to achieve this we will strive to:-

- Monitor the implementation (up to 2016) of the 2013 Care Bill and ensure that its implications for older citizens in Sefton are widely communicated and understood.
- Identify older citizens in Sefton who are currently self-funding their care, and seek intelligence regarding the projected population of older citizens in Sefton, who may be impacted upon by these changes, to ensure anticipated needs are considered and used to inform responses to the implementation of the Care Bill
- Facilitate a clear process for older citizens receiving care and support to move into and/or out of Sefton in line with guidelines detailed in the Care Bill.
- Make older citizens in Sefton aware of the changes proposed within the Care Bill on eligibility criteria, and deferred payment of care home costs, meaning they do not have to sell their home during their lifetime.
- Ensure that any eligible older citizen in Sefton is provided with a care and support plan(or a support plan in the case of a carer) and that those who do not have eligible needs are given support and information to help prevent further needs developing.
- Provide information, as it emerges, on the implementation of the 'Dilnot Social Care Cap' and its possible implications.

OUTCOMES OF THE STRATEGY

- If this strategy is implemented effectively, older people will have access to quality advice, be well informed, be able to make a positive contribution to their community, and will play an active part in decisions which affect their lives.Older citizens will also become free from discrimination in the delivery of services.
- For a minority of people, living longer will mean increased dependence, poor health and frailty – and the strategy addresses the needs of older people who are in this situation.
- The strategy also supports the needs of the majority of older people living in Sefton for whom living longer will mean:-
  - leading full, active and healthy lives for longer;
  - playing a key role in the local community through continued employment or voluntary work;
  - enjoying sport, social and leisure activities; and
  - using computers and other forms of technology to stay in touch with family and friends, to shop and to access information.

CONCLUSION

- The Sefton Partnership for Older Citizens wants Sefton to be a place where old age is enjoyed rather than endured.
- A positive outlook and strong support networks are vital if later life is to be enjoyed to the full. This strategy demonstrates how this can be achieved.

MAKING CONTACT

If you require this document in a different format (large print, audio, language, etc.) please contact:-

Sefton Council for Voluntary Services,
3rd Floor, Burlington House, Crosby Road North, WaterlooL22 0LG
Tel. 0151 928 2233 E-mail: sarah.hurn@seftoncvs.org.uk

GETTING INVOLVED

If you would like to get involved, and to help influence the development of services for older citizens in Sefton, please contact:-

Sefton Pensioners' Advocacy Centre,
Shakespeare Centre, 43/51 Shakespeare Street, Southport PR8 5AB
Tel. 01704 538411 E-mail: info@spacadvocacy.org.uk

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/78	**Author of the Paper:**
Report date: May 2014	Jan Leonard Chief Redesign and Commissioning Officer jan.leonard@southportandformbyccg.nhs.uk Tel: 01704 387034

Title: Primary Care Update

Summary/Key Issues:

1. The CCG is unable to continue to commission services via Local Enhanced Services within Primary Care. This paper describes the process for changing to an NHS Standard Contract and the financial resource allocation aligned to the Quality Schemes within the contract.

2. This paper also provides progress on the Primary Care Quality Strategy.

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Achieve a 2% reduction in non-elective admissions in 2014/15.
x	Implementation of 2014/15 phase of Care Closer to Home/Virtual Ward plan.
x	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

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				SLT

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body

May 2014

1. Background

Southport and Formby CCG Governing Body approved a Primary Care Quality Strategy document, 'A Sense of Purpose' in 2013. One of the key actions from this, in line with national drivers, was a plan to transform primary care locally through investment in a local quality contract.

From 1 April 2014 CCGs have been unable to use Local Enhanced Services (LESs) to commission services from General Practice. This paper sets out the rationale for the CCGs use of the money that was formally commissioned via LESs for General Practice via a Local Quality Contract effective from August 2014.

2. Quality and Strategic Objectives

The schemes within the Local Quality Contract will deliver against the following Corporate Objectives:-

Improved quality of commissioned services, whilst achieving financial balance
In particular the scheme for data validation will review information from Acute services and challenge inaccuracies.

Achieve a 15% reduction in non-elective admissions across 5 years
The schemes to address A&E attendances and primary care access will assist in the delivery of this indicator to reduce secondary care activity.

Implementation of 2014-15 phase of Care Closer to Home / Virtual Ward plan
The Community Health Scheme will support practices to meet with community staff which will develop further the relationships and networks within localities.

Review and Re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership and partners
The Community Health Scheme will enable the membership to contribute to this process

Implementation of 2014-15 phase of Primary Care quality strategy / transformation
The proposed investment will deliver this objective.

Improving Outcomes
We anticipate that the schemes will also deliver against the following outcome ambitions from the strategic plan:

- to Reduce Unplanned Hospital Admission;
- improve the Health Related Quality of Life for people with one or more long term conditions;
- improve Emergency Ambition Performance.

3. NHS Standard Contract

The CCG will use an NHS standard contract to commission the schemes from general practice. The contract will be for a three year period with an annual review.

The CCG has reviewed and consulted on the clinical efficacy of all pre-existing LESs and have reduced the number of schemes from 15 in Southport & Formby to 10. The final list of schemes are:

- A&E attendances
- Primary care access
- Exception coding
- Community health
- Phlebotomy
- Shared Care
- Drug administration
- Data Validation
- Travellers / Gypsy scheme
- Practice Development plan.

A panel will assess the practice achievement based on practice submissions.

4. Funding

One of the most difficult issues in allocating funding has been the difference in unit price of core funding that currently exists within GMS / PMS and APMS practices. Historically a GP Framework scheme was in operation that, through a practice development scheme, provided additional investment to those practices receiving lower amounts of core funding. This scheme will end with the existing LES's and the money re-invested. Due to the inequity in core funding that exists, a number of different options have been considered to enable the best value for money for investment in improving Primary Care Quality.

The following option has been selected as the preferred option.

Option 6 Local Minimum Income Protection £75

This option applies a Local Minimum Income Protection Guarantee to any contract below £75 per patient for the first year of the contract. The rationale for this is in order to ensure that there is sufficient capacity and resource in primary care in order to deliver improvements in quality. Whilst recognising that this is in excess of previous funding levels under the LES arrangements, there was concern that funding below this level was insufficient and that practices would struggle to achieve the anticipated outcome measures. There is also concern that failure to achieve the anticipated outcome measures could result in additional expenditure being required at a future point to address the unmet need or through more costly patient pathways. Practices in receipt of this payment will be asked to complete a Practice Development Plan to describe how the additional investment will be used to underpin the delivery of the schemes.

This option also identifies areas in current NHS England contracts which may overlap with the requirements of the Local Quality Contract. Where practices are currently receiving payments via their core contract, the local elements will not be applicable.

5. Primary Care Quality Strategy

The Governing Body approved the Primary Care Quality Strategy in September 2013. This document outlined the domains and workstreams for a 3 year period. A Primary Care Quality Strategy Board was established as a sub-committee of the Quality Committee to oversee the implementation of the strategy.

Membership of the Board includes:

- Primary Care Quality Lead (Chair)
- Senior Clinician and Practice Manager from each CCG
- Lay Member from each CCG
- Senior CCG Managers
- Healthwatch
- LMC
- NHS England Merseyside
- Public Health
- Merseyside Property Partnerships.

Year 1 of the strategy is operational from April 2014. An evolving project plan and current rag rated status for the workstreams is attached.

6. Recommendation

The Governing Body are asked to receive the contents of this report.

7. Appendices

Appendix 1 Project Plan and current RAG-rated status for the Workstreams

Jan Leonard
16 May 2014

Southport and Formby

Primary Care Qualtity Strategy 2014	year 1 RAG rating	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
PCQS Board Meetings													
Demography	Subscribe to PCC (AP)												
	Look at models of federation												
	GP within each locality to model collaborative working												
Workforce Development	Work with NHSME on mapping programme												
	Each locality to work on one business case to be locality based commissioned and managed (provision of community services)												
Clinical Services	PC lead input into the scheme in areas such as urgent care												
	Evaluate acute visiting scheme pilots locally												
IT	GP to GP transfer to be at 100% (in GMS/ PMS contract variation 14/15)												
	Ericom PCQ Budget 2013/14 brought forward from year 3 (AP)												
Premises	Map out with our partner estates capacity												
Health Outcomes	Publication of funding allocation at practice level												
	Local Qualtiy contract												
	HCA Apprenticeship												
NHS England													
Over 75's													
Unplanned Admissions													
Accountable GP													
Choice of GP Practice (cross boundary)													

Southport and Formby Primary Care Plan 2014/15	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March 2
S+F Governing Body Meetings	30		25		27		29		17			
Primary Care Quality Strategy Board		13										
Quality Committee				10			9					
Finance and Resource Committee		12	9	14		8	13	10				
Remuneration Committee												
LMC committee meetings	15	20	17		19	16	21	18	16			
Senior Leadership Team												
Senior Management Team												
Wider Group Meetings												
PLT Forums												
Primary Care Team Meetings												
Locality Meetings												
Operational Team Meetings												
PM Meetings												
NHS England Primary Care Leads Meetings												
PCQS Board Meetings	Identify leads for PCQS domains Agree /develop work programmes for year 1 Local Quality Contract Agree dates for 2014/15 PCQSB meetings LMC identify S+F GP for PCQSB Discussion forum (google group) Locality Collaborative Models PCC event											
Demography	Senior GP nominated in each locality 6 /12 work stream to inform model of collaboration 2 localities identified (wave 1) PCC event on federation for 2 localities	Engage 2 further localities S+F (wave 2)				Locality report to PCQSB September (GP Lead 1st wave)		Locality report to PCQSB November (GP Lead 2nd wave)				
Workforce Development	Mapping Workforce - demonstration of primary care data capture tool (PCDCT)	Liasion with PM Lead re demonstration of PCDCT to PMs by Health Education North West	PM meetings									
	Locality Clinical Provision of Community Services											
Clinical Services	Care Closer to Home - Primary care lead input into the scheme in areas such as 'urgent care'	Bal Duper input into Care Closer to Home										
	Acute Visiting Scheme	GTD pilot scheme costings / meetings										
	GP - GP transfer	Superceded by changes to national contract 14/15										

IT	Ericom (Brought forward from year 3)	Funding for Ericom identifed, work ongoing to implement with iMerseyside										
Premises	Map out with our partner estates capacity	Merseyside Property Parnerships on the PCQSB										
Health Outcomes	Publication of funding allocation on practice by practice basis	Publication of baseline contract funding (NHSE) for 19 out of 20 practices completed										
	Local Quality Contract (LQC) Extension of current LES Schemes to July 1st 2014 CSU BI / PMO/Data Facilitor meetings Project plan / options paper / LQC / financial information to SMT/SLT 29th April 2014	Meet LMC PCQSB Send LQC to practices Primary Care Event Devise reporting templates / Quarterly invoice	Practices state intention to sign up Finance set up monthly payments schedules 1 - 4 NHS Standard Contracts issued to practices CSU BI Primary Care dashboards on portal	July 1st LQC operational Quarter 1 LES invoices processed Update PCQSB Plot practice activity	Progress to S+F Governing Body	Plan contract review meetings for Oct/Nov/Dec	Contract review meetings Review year 2 specifications PCQSB Agree funding for PC access year 2 Exception Coding Variations to Governing Body Oct 29th			variations to Year 2 LQC to practices	Practices given opportunity to sign up to year 2 - Agree sub group of PCQSB to agree end of year achievments in quarter 1	Annual submissions by GP practice - Outcomes to be determined in quarter 1
	Email to practices to establish practice needs Hugh Baird advertising course / recruiting course tutor Job description / course qualification under discussion	Internal meeting 6th May Discussion at PM meetings Expressions of interest		Potential recruitment/ interviews		Potential start date for HCA's						
NHS England												
Over 75's												
Unplanned Admissions												
Accountable GP												
Choice of GP Practice (Cross boundary)												

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2014

Agenda Item: 14/79	**Author of the Paper:**
Report date: May 2014	Debbie Fairclough Debbie.fairclough@cmcsu.nhs.uk

Title: Revised Governance Structures 2014

Summary/Key Issues:

A review of committee structures and associated reporting arrangements has been undertaken to ensure that there is clear, accountable clinical leadership and involvement throughout all decision making processes. Consideration has also been given to the ways in which the CCG can ensure achievement of the strategic objectives as well as exploring opportunities for the improvement and transformation of services.

This paper provides an overview of this work and the changes to the committee structures.

Recommendation

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

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Achieve a 2% reduction in non-elective admissions in 2014/15.
x	Implementation of 2014/15 phase of Care Closer to Home/Virtual Ward plan.
x	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement		N		
Clinical Engagement	Y			
Equality Impact Assessment		N		
Legal Advice Sought	Y			
Resource Implications Considered	Y			Administrative support will be required
Locality Engagement				Locality leads will be involved in meetings
Presented to other Committees				SMT

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
May 2014

1. Introduction and Background

During February and March 2014 a review was undertaken in light of the emergent strategic plan to ensure that the CCGs committee arrangements were fit for purpose in ensuring the CCG achieves its strategic objectives and were operating optimally.

The review also took account of any areas of duplication and refined those Terms of Reference to differentiate between accountability, responsibility, assurance and operational responsibility. This provides a clearer focus for each committee with overlap or duplication reduced to an absolute minimum.

This review coincided with the NHS England timescales for review and updates of CCG Constitutions, and as such all changes to the committee process and the Terms of Reference have been incorporated into the revised CCG Constitution.

2. Key Issues

2.1 Committees

The review took account of the role and responsibilities of the Governing Body, Quality Committee, Finance and Resources Committee, Audit Committee and Remuneration Committee. Whilst it was apparent that the CCG had effectively delegated its functions to the sub committees, and that the sub committees has established appropriate support groups to assist in the discharge of those functions, there was a gap in respect of conflicts of interest and service improvement.

Members of Senior Team considered the challenges facing the CCG in respect of the transformation of services and the associated decision making arrangements and resolved to establish two new committees;

The Approvals Committee (Conflicts of Interest)

Key functions

- To provide neutrality in the evaluation and decision making processes. The committee comprises non-conflicted members of the Governing Body or other committees and its decisions will be noted by the Governing Body.

- Is responsible for ensuring that the CCG applies conflict of interest principles and policies rigorously and provides the CCG with independent advice and judgment where there is any doubt about how to apply them to individual or group cases involving commissioning clinical services

The Service Improvement and Re-design Committee

Key functions

- To identify potential areas of service improvement.
- To establish the rationale and evidence base supporting the need for improvement.
- To ensure that localities are engaged in processes.
- To assess and approve business cases for recommendation to the F&R committee.
- To monitor and measure impact of improvements.
- To facilitate engagement with stakeholders.
- To ensure that all service reviews and the implementation of new services comply with all relevant laws and legislation.
- To support improvements in Primary Care.
- To monitor programmes including (but not limited to) Virtual Ward, Care Close to Home, Children's, Mental Health, planned and unplanned care.

Whilst the existing committees required changes to their Terms of Reference, these were relatively minor and did not materially change the role and function of those committees. The changes were essentially to clarify roles and responsibilities as well as changes to job titles.

The full committee structure it attached at Appendix A.

2.2 Clinical Leadership

To ensure that clinical leadership is embedded at every level, the CCG will identify Clinical Directors and an associated portfolio for delivery. The Clinical Directors will be responsible for leading specific programmes of work as well as supporting and influencing decision making within the committee and business processes.

The locality lead GPs will also be key members as the CCG drives its Engagement Strategy to a locality level.

Their role in supporting the Service Improvement and Redesign committee will be crucial in ensuring that credible and persuasive proposals and recommendations are submitted to Finance and Resource Committee for financial approval and onwards to the Governing Body.

Clinical Director's involvement in the Quality Committee will complement the existing membership by formalising the specialist expertise in a number of areas as well as their general expertise and knowledge of the quality challenges faced by the local health economy.

Their involvement in the Finance and Resources Committee will facilitate in a more meaningful way the bringing together of clinical and financial decisions that will positively impact on our local populations.

2.3 CCG Leads

Each committee is supported by an identified member of the Senior Management Team as well as CCG leads for programme areas. This "matrix" way of working will ensure that there is multi skilled input during all meetings and those areas of complementary work or duplication can be identified.

Whilst leads will retain their specific roles as part their operational "day to day" portfolio for which they are accountable; they are also expected to support the work of committees by

sharing their knowledge of the local health system and objectively contributing to the debate.

2.4 Lay Member

Lay Member representation will ensure that there is robust independent challenge and scrutiny throughout business processes. The Lay Member for Patient and Public Involvement will act as the champion for ensuring that patient experience informs all decision making and that there is effective stakeholder engagement throughout all programmes.

The Lay Member for Governance will provide impartial and objective views on the business processes and ensure that all CCG representatives act with utmost probity at all times.

2.5 Work programme

Each committee will be supported by an agreed work programme that will be reflective of all statutory requirements as well as internal business processes.

The Project Management Office, in conjunction with CCG leads and the Cheshire and Merseyside Commissioning Support Unit (the CSU) will ensure that committees are in receipt of information and intelligence to enable them to effectively discharge their duties.

3. Recommendation

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

4. Appendices

Appendix 1 Full Committee Structure.

Debbie Fairclough
May 2014

NHS Southport and Formby CCG Governing Body

Audit Committee

SMT: **Martin McDowell**. Chair: **Helen Nichols**

Key functions and responsibilities: To support the establishment of an effective system of integrated governance, risk management and internal control and to review and approve the arrangements for discharging the Group's statutory financial duties.

Remuneration Committee

Chair: **Helen Nichols**

Key functions and responsibilities: Determining the remuneration and conditions of service of the senior team, approval of severance arrangements and approval of disciplinary arrangements for employees, including the Chief Officer

Finance and Resources

SMT: **Martin McDowell**

Key functions and responsibilities

- To advise the Governing Body on all financial matters
- To review and manage the overall financial position
- To ensure that the performance of commissioned services is monitored in line with CCG expectations
- To advise on procurement and contracting arrangements
- To monitor contract and procurement arrangements
- To review and monitor Foundation Trust applications
- To review and monitor CHC financial position
- To determine banking arrangements
- To approve arrangements for exceptional/novel treatments including IFR
- To review and monitor workforce performance
- To review and monitor CSU performance

Quality Committee

SMT: **Debbie Fagan**

Key functions and responsibilities

- To monitor standards and provide assurance on the quality of commissioned services
- To review and monitor Serious Incidents
- To promote a culture of continuous improvement and innovation with respect to safely, clinical effectiveness and patient experience
- To provide an assurance to the Governing Body that there are robust processes for managing risk
- To ensure appropriate Safeguarding arrangements are in place
- To provide corporate focus, strategic direction and momentum for quality, and risk management
- To review and monitor medicines management
- To approve corporate and clinical policies

Service Improvement and Redesign

SMT: **Karl McCluskey and Jan Leonard**

Key functions and responsibilities

- To identify potential areas of service improvement
- To establish the rationale and evidence base supporting the need for improvement
- To ensure that localities are engaged in processes
- To assess and approve business cases
- To monitor and measure impact of improvements
- To facilitate engagement with stakeholders
- To ensure that all service reviews and the implementation of new services comply with all relevant laws and legislation
- To support improvements in Primary Care
- To monitor programmes including Virtual Ward, Care Close to Home, Children's, Mental Health, planned and unplanned care

Supporting the Quality Committee: The CGSG will provide assurances on the processes for reviewing the GBAF and CRR and make recommendations to the Committee. The group will review policies and procedures and recommend them as appropriate to the committee for approval.
Supporting Audit Committee: The group is part of the CCG's Risk and Control Framework and will enable the Audit Committee to obtain assurances on key internal control requirements.

Corporate Governance Support Group

Chair: **Tracy Jeffes**

Key functions and responsibilities:
Ensuring compliance with relevant legislation and standards, monitoring activity and providing assurances in respect of :

- *Public Sector Equality Duty (PSED)*
- *Health and Safety (Incidents and LSMS)*
- *Third Party Claims*
- *Governing Body Assurance Framework and Corporate Risk Register*
- *Information Governance (IG Toolkit)*
- *Freedom of Information Requests*
- *Subject Access Rights Notifications*

Engagement and Patient Experience Group

Chair: **Roger Driver/Roger Pontefract**

Key functions and responsibilities:
Reviewing relevant data, analysing trends and themes, ensuring compliance and providing advice in respect of:

- *Patient Experience themes and trends*
- *Complaints (secondary)*
- *Complaints (primary care)*
- *PALS*
- *NHS Constitution*
- *Engagement and consultation*
- *Soft Intelligence*
- *Stakeholder Engagement and Involvement*

Supporting the Service Improvement and Re-Design Committee: The EPEG will provide patient experience intelligence to this committee. This provides a framework for enabling patient experience to inform commissioning decisions.
Supporting the Quality Committee: EPEG will provide patient experience intelligence to the quality committee, particularly in respect of quality and safety issues that are signalled through complaints and PALS.

Approvals Committee – Conflicts of Interest

- To provide neutrality in the evaluation and decision making processes. Comprises non-conflicted members of the Governing Body or other committee and its decisions will be noted by the Governing Body.
- Responsible for ensuring that the CCG applies conflict of interest principles and policies rigorously and provides the CCG with independent advice and judgment where there is any doubt about how to apply them to individual or group cases involving commissioning clinical services